



Improvement Partnership

## **IMPROVEMENT GOALS**

- 1. To improve the safety of mental health services for all patients;
- 2. To contribute to a reduction in patient suicide rates and an overall decrease in the national suicide rate;
- 3. To recommend measures to reduce the number of suicides by people receiving specialist mental health care.

#### Overall fall in mental health suicide:

**NCISH** recommendations associated with 250-300 fewer deaths per year.

#### Fewer in-patient deaths:

removal of noncollapsible ligature points resulting in fall, with trend continuing (though slowing).

#### Implementation of early follow-up:

How the project provides evidence of quality and outcomes of care nationally

NCISH recommendation for 72-hour follow-up is a key Commissioning for **Quality and Innovation** (CQ<u>UIN) indicator</u> for mental health trusts in England (2019).

#### Falls in patient homicide:

NCISH data showed a fall in patient homicide overall in 2006-2017.

#### No evidence suicide increase during COVID-19:

**Examination of local RTS** systems (2020), report accessed >95,000 times.

#### **Highest risk immediately** post-discharge:

NHS England allocated winter funding to improve the care of post-discharge patients in England following our research (2020/2021 and 2021/2022).

Monitoring the changing pattern of risk: falling numbers of in-patient suicides, rising numbers in CHRT care.

#### Fall in rate of mental health patient suicide in England:

A fall in the patient suicide rate, though the trend is slowing in recent years.

#### **PHE Local suicide** prevention planning

**National Suicide Prevention Strategy Advisory Group:** 

Chair (LA), member (NK)

#### **National Suicide** prevention:

**England 'Suicide Prevention Strategy in** England: 5-year crosssector strategy' (2023).

**Scotland** 'Creating Hope Together' (2022).

Self-harm strategy and action plan (2023)

#### **Northern Ireland**

How the project supports policy development & system

'Protect Life 2 2019-2020' (2019).

Wales 'Talk to Me 2: Suicide and Self-Harm **Prevention Strategy for** Wales 2015-2020' (2015).

**Implementing the NHS** Long-Term Plan 2019/20 -2023/24

#### **CQC** guidance development for inspectors: ligature points, early follow up.

#### **Independent commissions:**

- \*Five Year Forward View: Mental Health taskforce
- \*Improving acute in-patient psychiatric care for adults in England (2015);
- \*The King's Fund Mental Heath Under Pressure (2015)

**Online Harms White Paper** (2020)

#### **NICE Guidelines:**

- \*Self-harm management [CG16 2004; CG133 2011; QS34 2013; GID-NG10148 2022; NG225 2022].
- \*Preventing suicide in comm. and custodial settings [NG105, 2018].
- \*Suicide prevention [QS189, 2019].
- \*Transition between in-pt. and comm. [NG53, 2013].

#### Safer Services: a toolkit for specialist mental health services and primary care: based on the '10 ways',

designed for self-audit. Accessed >37,000 times

#### **Quality Improvement:**

working directly with local areas to improve suicideprevention plans based on

Community-based selfharm support: working directly with local areas to improve self-harm care.

Interactive clinics: Themed topics, ~80-150 attendees.

response: worked directly with all STPs and MH trusts UK-wide to support local suicide prevention.

Safety score card: Annual (England). Provides benchmarked trust position on safer service measures

Trust reviews: analysis of serious patient incidents, evaluation of local suicide prevention policies/strategies.

**Standards for Serious Incident Reviews:** NCISH standards for reviewing SIs, fed into RCPsych standards (2018).

Self-audit Self-harm toolkit: **Based on NICE Quality** Standard for Self-Harm [QS34]

Provision of local data to assist audit activity: summary data for trusts on request.

**Examples of good practice: Infographics** of local suicide prevention initiatives.

### Dissemination

(2024 Annual Report)

Annual conference ~600 delegates

**Animated video** 680 views **Key messages infographic** 860 downloads

**Service-user infographic** 210 downloads

#### Social media:

9,100+ X(Twitter) followers 26,200 YouTube views

#### Interactive webinars:

COVID-19; Risk Assessment; Children and young people

#### **Government calls for** evidence:

Men's Health (2023) Women's Health (2021) Suicide Prevention - Sixth Report of Session 2016-2017

#### Invitations to speak:

International, e.g. Global Health Summit, IASP, **ESSSB** 

Lecture tours, e.g. India, Australia

National, e.g. National Suicide Prevention Alliance

**Parliament** 

Service user groups, e.g.

**Local government NHS Trust, Public Health** 

School liaison Public engagement, e.g. Pint of Science, 9 Lessons & Carols for Curious

#### Welsh Assembly:

People

**Suicide Prevention Inquiry** (2018)

#### Press/ media coverage:

Radio and print interviews, reports in print and online

# project stimulates quality improvement NCISH evidence.

How the

**National COVID-19** 

# by the public and the demand for it

Impact examples from 2004 to Nov 2024. Impact report updated Dec 2024.

## Impact of NCISH: system level





- NCISH has collected **in-depth information** on **all suicides** in the **UK** since 1996.
- Our recommendations have improved patient safety in mental health settings and reduced patient suicide rates, contributing to an overall reduction in suicide in the UK.
- Our "10 ways to improve safety" are shown to reduce suicide rates.
- These 10 elements have been formulated into a <u>self-audit toolkit</u> for specialist mental health services, updated with new evidence.
- ➤ The toolkit has been downloaded ~37,000 times, since launch in 2012.





Our evidence is **cited** in the **latest** national **strategies**, **policies**, **clinical guidance** and **regulation** in all UK countries.

#### **Self-Harm Prevention Strategy, Scotland**

"...training for staff working in specific settings, safety planning, implementing NCISH recommendations...will help provide the right support at the earliest opportunity..."

#### **Suicide Prevention Strategy, England**

"Mental health trusts should continue to review and implement evidenceinformed recommendations from the NCISH Annual Report and 10 ways to improve safety"

#### **Suicide Prevention Strategy, NI**

"NCISH recommends comprehensive care planning...routine follow-up...in response to missed appointments and addressing adverse life and social circumstances...prior to discharge"

#### **NCISH recommendations underpin NICE guidelines**

Self-harm: assessment, management and preventing recurrence

Transition between inpatient mental health settings and community or care home settings

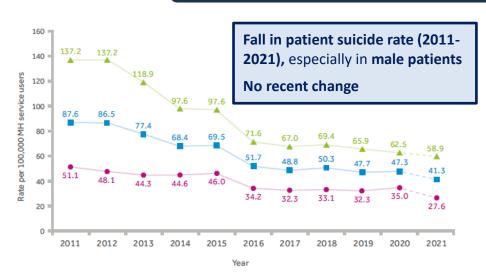
NCISH is cited in the <u>Online Harms White</u>

<u>Paper</u>, leading to the Online Safety Bill

Online Harms White Paper



#### NCISH recommendations have led to a fall in patient, and in-patient suicide rates





Year