Suicide Prevention Toolkit

- Knowledge of suicide
- Ensuring sustainability
- Implementing change
- Making informed decisions for change
- Working together
- Getting started

AQuA: Advancing Quality Alliance
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Aims of this Toolkit

1. Share information on mental health services/support, considering what ‘good’ looks like
2. Provide an approach to implementing high quality/effective mental health services/support

Who this Toolkit is for

This Toolkit is for anyone involved in designing, delivering, providing or commissioning suicide prevention services/support

Prevention can be defined as actions and activities targeted at groups or populations that reduce the likelihood of an individual reaching the point of feeling suicidal or considering suicide

Intervention can be defined as direct efforts to stop an individual from attempting to take their own life intentionally

Postvention is ‘activities developed by, with or for suicide survivors, in order to facilitate recovery after suicide and to prevent adverse outcomes including suicidal behaviour’ (1)

About this Toolkit

Overview

You can access each of the sections in this Toolkit by clicking on the link boxes below:

- Knowledge of suicide
- Working together
- Getting started
- Making informed decisions for change
- Implementing change
- Ensuring sustainability
- Suicide prevention resources

At the bottom of each page in this Toolkit you will see the box below. Clicking on this will bring you back to this page.

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The links in this document are not fully supported by all PDF viewers. It is recommended that you use Abode Acrobat Reader to benefit from the full functionality within this Toolkit.
To provide high quality and effective suicide prevention services/support

- Knowledge of suicide
  - Understand suicide and mental illness
  - Understand the policy context and the information from the National Confidential Inquiry into suicide and homicide by people with mental illness
  - Clarity on postvention and postvention services
  - Suicide cluster response plans
  - Development of Joint Strategic Needs Assessment (JSNA)
  - Understand how to implement learning (investigation/serious incident reporting, serious untoward incidents, involving families)
  - Improve connectivity with coroners

- Working together
  - Effective engagement/involvement
  - Establish a core group (use of Stakeholder Analysis and Benefits Wheel)
  - Governance arrangements

- Getting started
  - Create a driver diagram
  - Create a ‘Plan on a Page’
  - Develop a communication strategy

- Making informed decisions for change
  - Use quantitative and qualitative data
  - Define measures and develop baseline
  - Presenting data (using SPC)
  - Understand variation
  - Process map current and future state

- Implementing change
  - Use of Model for Improvement
  - Action planning

- Ensuring sustainability
  - Use of Sustainability Model and Guide

PRIMARY DRIVERS

SECONDARY DRIVERS

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Knowledge of suicide

- Knowledge of suicide
- Working together
- Getting started
- Implementing change
- Making informed decisions for change
- Ensuring sustainability

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## Suicide and mental illness

### Suicide

‘The action of killing oneself intentionally’ (2)

### Headline facts

Every Suicide is a tragedy; suicide is a major issue and a leading cause of years of life lost. Suicide is largely preventable (3). Globally, it is estimated that over 800,000 people die by suicide every year and it therefore remains a significant public health problem. The impact of suicide is widely felt and should be considered an individual tragedy, a life altering experience for those bereaved, and a traumatic event for the community and local services involved.

The Office for National Statistics (ONS) indicate that the suicide rate in England has been in steady decline for most of the last decade until 2008. Since then there has been a small increase in the number of suicides. A recent study published by the University of Liverpool suggests the economic downturn has had an impact on suicide rates. Researchers calculated that more than 1000 suicides between 2008 and 2010 could be attributed to unemployment.

### Impacts

The impacts are immediately and profoundly distressing for all those affected leading to:
- long term psychological trauma
- destruction of social bonds
- reduced quality of life and increased ill health

### Stressful life events that can lead to suicide

Certain stressful life events can play a part increasing in the risk of an individual dying by suicide, these include:
- the loss of a job
- debt
- living alone, becoming socially excluded or isolated
- bereavement
- family breakdown and conflict including divorce and family mental health problems
- imprisonment

(4) & (5)

### At risk groups

Years of research has identified certain groups who are at higher risk of dying by suicide. These groups include:
- young and middle-aged men
- people in care of mental health services, including inpatients
- people with a history of self-harm, the risk is higher with increasing age at initial self harm
- people in contact with the criminal justice system
- alcohol or drug misuse
- specific population groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers

(4) & (5)

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(2) Oxford English Dictionary
(3) WHO. Preventing Suicide: A global imperative. (2014)
(5) HM Government, Preventing Suicide in England,, Two years on. (2015)
About suicide and mental illness: Policy context

Documents highlighting the needs for better information and support for those bereaved or affected by suicide as a key priority are:

- Preventing suicide in England: one year on First annual report on the cross-government outcomes strategy to save lives, 2014
- Preventing suicide in England - A cross-government outcomes strategy to save lives, 2012

Comparison between different national strategies by national governments and the UK:

- Suicide and self harm prevention strategy for Wales 2015-2020
- Suicide Prevention Strategy 2013-2016 (Note: no new strategy developed)
- Draft Strategy for Suicide Prevention in the North of Ireland (Note: published 2016)
National Confidential Inquiry into suicide and homicide by people with mental illness

The National Inquiry has collected and analysed data relating to suicide and homicide by people with mental illness for 20 years. The National Inquiry is hosted by The Centre of Mental Health and Safety, University of Manchester (6).

Key findings:
• There are now around three times as many suicides by CH/RT (Crisis Resolution and Home Treatment) patients as in-patients. The crisis team is now the main setting for suicide prevention in mental health.
• Many people who died by suicide had a history of drug or alcohol misuse, but few were in contact with specialist substance misuse services. Access to these specialist services should be more widely available, and they should work closely with mental health services.
• More patients who died by suicide were reported as having economic problems, including homelessness, unemployment and debt.
• There has been a rise in the number of suicides by recent UK residents; those who had been in the UK for less than 5 years, including those who were seeking permission to stay.

(6) Link to webpage: http://research.bmh.manchester.ac.uk/cmhs/
Suicide Clusters

The centre for Disease Control suggests that when a cluster of deaths by suicide are developing in a given geographical area for community interest, then a co-ordinated and timely multi-agency response is required to address the issue to prevent further escalation (8).

Rate of suicide by NHS area of residence (2012-2014)

<table>
<thead>
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<th>Area of residence</th>
<th>Per 100,000 pop.</th>
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<td>Cheshire and Merseyside</td>
<td>10.04</td>
</tr>
<tr>
<td>West, North, and East Cumbria</td>
<td>9.9</td>
</tr>
<tr>
<td>Greater Manchester</td>
<td>10.3</td>
</tr>
<tr>
<td>Lancashire and South Cumbria</td>
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Nationally the highest rate of suicide was in Cornwall and Isles of Scilly at 13.8 per 100,000 population, and the lowest in South West London, at 6.9 per 100,000.

Number of suicides

Between 2004-2014, the Inquiry was notified of 49,269 deaths in the general population that were registered as suicide or ‘undetermined’, an average of 4,479 per year.

Since 2004, there has been a fall in male suicide rates in those aged 25-34; increase in those aged 45-54 and 55-64; and no overall changes in other age groups.

In females, rates fell in those aged 25-34 and rose in 55-64 year olds.

Primary diagnosis

The most common primary diagnoses were affective disorders (bipolar and depressive illness) (6.196, 45%), schizophrenia (includes other delusional disorders) (2.356, 17%), and personality disorder (1.259, 8%). Numbers in patients with affective disorders have risen since 2006 by 87 (17%).

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(7) University of Manchester. National Confidential Inquiry into Suicide and Homicide by people with Mental Illness: Making Mental Health Care Safer, Annual Report and 20 year review, October 2016
(8) Centre for Disease Control (1998) Recommendations for A Community Response Plan for the Prevention and Containment of Suicide Clusters: MMWR August 1998/37(s-6);1-12

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Common methods of suicide

The most common methods of suicide were hanging and strangulation (23,324, 47%), self-poisoning (overdose) (10,502, 21%), and jumping and multiple injuries (mainly jumping from a height or being struck by a train) (5,225, 11%)

(7) University of Manchester. National Confidential Inquiry into Suicide and Homicide by people with Mental Illness: Making Mental Health Care Safer, Annual Report and 20 year review, October 2016
About suicide and mental illness: National Confidential Inquiry cont.

Patient suicide: number and rates

- During 2004-2014, 13,921 deaths (28% of general population suicides) were identified as patient suicides, i.e. the person had been in contact with mental health services in the 12 months prior to death. This represents an average of 1,266 patient suicides per year.

- The most common methods of suicide by patients were hanging (43%), self-poisoning (25%), and jumping/multiple injuries (15%).

- The number of self-poisoning deaths fell after 2004 but increased since 2006.

- The number of suicides by gas inhalation and drowning decreased over the report period.

- Opiates were the most common type of drug in self-poisoning (24%).

- The next most common substances used in deaths by self-poisoning were tricyclic antidepressants (12%), and anti-psychotic drugs (11%). The next most common substances were paracetamol/opiate compounds (9%) and SSRI/SNRIs (9%). Paracetamol was used in 6% of deaths.

- The annual number of self-poisoning deaths by tricyclic antidepressants fell after 2004 and it is estimated that there will be further fall in 2014. There was a fall in self-poisonings using paracetamol deaths since 2009, though it is estimated this will decrease in 2014.

In-patient suicide numbers and rates

- There were 1,207 in-patient deaths by suicide between 2004-2014, 9% of patient suicides, an average of 110 per year.

- From 2004 to 2013, there was a 51% fall (82 cases) in the number of in-patient suicides.

- Deaths by hanging on the ward are usually from low-lying ligature points (i.e. strangulation). The number of deaths by this method fell by 56% (19 cases) from 2004 to 2013.

- There were 326 suicides in detained in-patients, 27% of all in-patient suicides, an average of 30 per year.

- 254 in-patients died after absconding from the ward, 21% of all in-patient suicides, an average of 23 deaths per year.

(7) University of Manchester. National Confidential Inquiry into Suicide and Homicide by people with Mental Illness: Making Mental Health Care Safer, Annual Report and 20 year review, October 2016
Suicide after discharge from hospital

- There were 2,305 suicides within 3 months of discharge from in-patient care, 17% of all patient suicides and 18% of suicides in community patients, an average of 210 deaths per year.

- Post discharge suicides were most frequent in the first week after leaving hospital when 340 deaths occurred, an average of 31 per year, 15% of all suicides within 3 months of hospital discharge.

- 274 patients (13%) died before the first follow-up appointment. Between 2004 and 2013, there was a decrease in the number and proportion of patients who died before first follow-up, with the proportion falling to 6% in 2013 and 2014.

CR/HT numbers and rates

- There were 1,940 suicides in patients under CR/HT teams, 15% of the total sample, an average of 176 deaths per year.

- Overall, the annual number of suicides under CR/HT increased over the report period, from its introduction in 2004-06. The Inquiry estimates that for 2014 there are around three times as many patient suicides under CR/HT.

- 622 patients (34%) had been discharged from in-patient care in the preceding 3 months, 240 (39%) died within 2 weeks of discharge, 153 (26%) within a week.

- In 833 patients (43%) the patient lived alone. In 253 (54% excluding unknowns) the care plan included additional social support from outside the home, e.g. from a relative, friend or neighbour. However, those living alone were less likely to receive additional support (72, 39%).
Evidence suggests that people who know someone who has died by suicide are at greater risk of attempting to or take their own life by suicide by up to 300% (9).

Postvention services are essential to ensure that those bereaved by suicide feel supported at their time of need. Therefore, it is crucial that there is a clear protocol for the reporting of suspected suicides in place to allow for the early activation of postvention for bereaved families and for more detailed monitoring and surveillance at a local area (10).

Northern Ireland’s Model (shown on the next page) is recognised as an exemplar of good practice nationally and internationally and more recently has been cited by the All Party Parliamentary Group on Suicide and Self-Harm Prevention. The Northern Ireland model (11) utilises the Continuum for Promoting Mental Health and Suicide Prevention.

As part of postvention, the model includes:

- support for suicide survivors and communities bereaved by suicide
- access to services
- counselling and phone based crisis counselling
- suicide cluster response plans

1. Prevention work to build capacity and resilience at individual and community level

2. Education and awareness raising on the promotion of mental health and suicide prevention

3. Early recognition of signs and symptoms

4. The provision of appropriate and accessible services

5. Crisis response and postvention following suicide

6. Using and building the evidence for this work

7. Co-ordination of activities and services and sharing of good practice

Suicide Cluster Response Plans are based on robust suicide audits and clear action plans, should an emerging cluster be identified. Results of the annual suicide audit should inform the local Joint Strategy Needs Assessment (JSNA) outlined on the next page.

Essential elements of, and necessary conditions for, the suicide audit (12)

1. Collecting and analysing data
   - Sources of local data: Coroner, GPs, MH Trust, Acute Trust, Other
   - Local audit database
   - Local audit report, identifying high-risk populations and places
   - Non-local influences, e.g. National Suicide Prevention Strategy: national statistics
   - Findings used to generate local strategy and action plan
   - Action plan implemented and evaluated

   Necessary conditions
   - Audit tool easy to use and fit for purpose
   - Complete and timely data set; meaningful comparators
   - Good relationships and trust between agencies, ensuring access to data
   - Adequate staff time and resources

2. Reviewing and implementing findings
   - SAG or equivalent, to review findings and agree actions
   - Task & finish group for each action; clear lines of accountability and reporting
   - Effective leadership; Holistic and seamless understanding of process; Full ‘buy-in’ from all stakeholders and partner agencies

Each Local Authority Area is required to produce a Joint Strategic Needs Assessment (JSNA). A JSNA looks at the current and future health and care needs of local populations to inform and guide the planning and commissioning (buying) of health, well-being and social care services within a local authority area.

The JSNA:
• is concerned with wider social factors that have an impact on people’s health and wellbeing, such as housing, poverty and employment
• looks at the health of the population, with a focus on behaviours which affect health such as smoking, diet and exercise
• provides a common view of health and care needs for the local community
• identifies health inequalities
• provides evidence of effectiveness for different health and care interventions
• documents current service provision
• identifies gaps in health and care services, documenting unmet needs

Across the north west of England there are a number of examples available of JSNA led audits of suicide in local areas along with suicide prevention strategies.

- Manchester: A local suicide prevention plan 2017 - 2019
- Blackpool JSNA
- Bolton’s Health Matters (2014/15)
- Cheshire and Merseyside Suicide Reduction Network (CMSRN)
- St Helens Suicide Prevention Action Plan (2014-2016)
The potential for learning from some incidents in healthcare is so great, or the consequences to patients, families and carers, staff or organisations so significant, that these incidents warrant using additional resources to mount a comprehensive response, following consistent and clearly defined principles and procedures, with a significant management focus and formal governance arrangements around reporting, investigation, learning, action planning, implementation and closure.

The National Patient Safety Agency (NPSA) established the building blocks for doing this in the first National Framework for Reporting and Learning from Serious Incidents Requiring Investigation published in 2010.

This was supplemented by the Serious Incident Framework produced by NHS England in March 2013, which reflected the changes within the NHS landscape following the Health and Social Care Act 2012.

Since the publication of this guidance there have been further changes, particularly within NHS England. In order to continue building on the foundations set by the NPSA, NHS England has developed a revised Serious Incident Framework which replaces previous versions. This revised Framework takes account of the changes and acknowledges the increasing importance of taking a whole-system approach to quality, where cooperation, partnership working, thorough investigation and analytical thinking are used to understand where weaknesses/problems in service and/or care delivery exist, in order to draw learning that minimises the risk of future harm.

NHS England has produced guidance relating to serious incident investigation.

NHS England – ‘Serious Incident Framework; Supporting learning to prevent recurrence’
Serious incidents in healthcare are rare, but it is acknowledged that systems and processes have weaknesses and that errors will inevitably happen. But, a good organisation will recognise harm and the potential for harm and will undertake swift, thoughtful and practical action in response, without inappropriately blaming individuals.

The recognised system-based method for conducting investigations, commonly known as Root Cause Analysis (RCA), should be applied for the investigation of Serious Incidents.

This endorses three levels of investigation:

- **Concise investigations** - suited to less complex incidents which can be managed by individuals or a small group of individuals at a local level

- **Comprehensive investigations** - suited to complex issues which should be managed by a multidisciplinary team involving experts and/or specialist investigators

- **Independent investigations** - suited to incidents where the integrity of the internal investigation is likely to be challenged or where it will be difficult for an organisation to conduct an objective investigation internally due to the size of organisation, or the capacity/capability of the available individuals and/or number of organisations involved.
Implementing learning: Involving families

**The Help is at Hand (2015 edition) (13)**

This is a resource produced by Public Health England and the National Suicide Prevention Alliance in response to the call in the National Suicide Prevention Strategy (2012) for more support for those bereaved by suicide. On page 23, under the heading “If the person died while under the care of mental health services” it states:

“A member of the mental health services team should make contact with you and ask for your views to be added to the investigation. You should be kept fully informed throughout the process, unless you ask not to be, and there should be an identified person you can contact if you have questions or concerns. You may want to have your own legal representative at the inquest, so you have someone who can guide you through the process, give you advice and ask questions. Having a legal professional can also be valuable if you want to challenge any decisions made or if you are considering a compensation claim.”

**National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report (2015) (14)**

The findings outlined in this report makes it clear that working more closely with families could improve suicide prevention. Staff interviewed said that greater involvement of the family by the service would have reduced the risk in 14% of cases, a total of 2,338 deaths over the whole study period. The figure is slightly higher, at 16%, in England where it has also risen in recent years - this may reflect a growing need to consult families or a greater awareness of their potential role.

Families and carers are a vital but under-used resource in mental health care. The findings suggest that closer working with families would have safety benefits:

- Services should consult with families from first contact, throughout the care pathway and when preparing plans for hospital discharge and crisis plans.
- Staff should make it easier for families to pass on concerns about suicide risk and be prepared to share their own concerns.

It is suggested that services can improve contact with families when a patient does not attend an appointment and identifies that only 22% of services contacted the family when a patient who went on to die by suicide missed their final appointment before the suicide occurred.

(13) Help is at Hand 2015
Help is at Hand is available online at www.supportaftersuicide.org.uk.

(14) National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report (2015), University of Manchester. Available online at: National Confidential Inquiry
Postvention as it is currently used in practice refers to an organised response in the aftermath of a suicide to accomplish any one or more of the following:

- To facilitate the healing of individuals from the grief and distress of suicide loss
- To mitigate other negative effects of exposure to suicide
- To prevent suicide among people who are at high risk after exposure to suicide

Postvention research developed by Dr Frank Campbell, in Baton Rouge, Louisiana, US, suggests the impact of a suicide on others is very wide reaching.

Based on data from a 7-year period, those seeking suicide bereavement support services were most likely to be (ranked in order):

- Mother of the deceased
- Sister of the deceased
- Wife of the deceased
- Daughter of the deceased
- Friend of the deceased or son of the deceased (tied)
- Father of the deceased
- Brother of the deceased
- Girlfriend of the deceased
- Step-father of the deceased
- Cousin of the deceased or fiancé of the deceased (tied)

(15) Cerel et al, in press, reference in “Responding to Grief, Trauma and Distress After Suicide: U.S. National Guidelines Survivors of Suicide Loss Task Force April 2015
(16) Pittman et al., 2014, p.86
The response of a given individual to suicide can vary substantially based on a number of factors, including a person’s role and relationship with the circumstances of the death and the deceased. Different people with the same relationship to the deceased may have a relatively mild, moderate, severe, or even debilitating reaction to the death. Some people will exhibit very brief reactions to the loss, while others will have long-term responses and even lifelong needs as a result of the suicide.

Reactions may also vary based on different cultural norms and ethnic styles of coping with grief. In addition, people’s needs related to the death will likely change over time as they move through the healing process, even years later. This may be particularly true for the offspring of parents who have died by suicide, who may be subject to a struggle with suicidality much later in their own adult life (Agerbo, Nordentoft, & Mortensen, 2002; De Groot & Killen, 2013; Kuramoto, Runeson, Stuart, Lichtenstein, & Wilcox 2013; Qin, Agerbo, & Mortensen, 2002; Qin, Agerbo, & Mortensen, 2005).
Cerel et al. (2014) developed the Continuum model that organises people who are exposed to a suicide loss into four nested tiers:

(1) exposed
(2) affected
(3) suicide bereaved short-term
(4) suicide bereaved long-term

Determining how a particular person might be categorised is not linked to the person’s title, role, or relationship in reference to the deceased. People will fit either in one category or another depending on the person’s reaction to the death. The model opposite (17) accounts for people who experience in any way an impact from being exposed to a suicide and categorises them in a fashion designed to augment the delivery of effective assistance to everyone who might be affected. In other words, it describes people based on how research and interventions might best be designed to most effectively help the broadest range of people in the aftermath of suicide.

(17) Cerel, McIntosh, Meimever, Mapel, & Marshall, 2014
### The Continuum Model: Effects of Suicide Exposure

<table>
<thead>
<tr>
<th>Suicide Exposed</th>
<th>Suicide Affected</th>
<th>Suicide Bereaved Short-Term</th>
<th>Suicide Bereaved Long-Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide Exposed</td>
<td>This includes absolutely anyone whose life or activities in any way intersect with a particular suicide fatality.</td>
<td>This is a subset of those affected and includes everyone who has a reaction that is clearly related to grief, meaning that it stems from some type of personal or close relationship between the bereaved person and the deceased. The bereavement of people in this category would last for a duration that might be called “typical” in the wake of death of a loved one by any cause.</td>
<td>This is a subset of those bereaved short-term and includes all bereaved people who encounter extraordinary difficulties in the course of their grief with their intensive bereavement likely to endure for at least a year or longer. The individuals in this category are likely to require professional therapeutic assistance.</td>
</tr>
</tbody>
</table>

It is imperative that each Trust should have a protocol/plan for communication and resolution following a serious suicide-related incident.

Staff, patients, families/carers and friends can all be affected by a suicide, or a serious suicide attempt. The support provided is of primary importance and can help all those involved gain resolution and come to terms with their loss in a safe and natural way.

As well as establishing a first-point-of-contact system between the Trust and those affected, it is important to be able to provide support and information about relevant support groups and organisations in the locality and further afield.

Health professionals affected by the suicide of a service user should be supported by their line managers in a timely manner and always offered the opportunity to self-refer to appropriate services. Service managers should ensure that all staff involved in a service user’s care are made aware of the death and offered the same support.

Strategies to link survivors with grief support services come in two forms: the passive postvention model (PPM) and the active postvention model (APM) (Campbell, 1997).

### Passive Postvention Model

This model requires survivors to identify and contact and engage with available bereavement support services, resulting in estimated averages ranging from 97 days (Cerel & Campbell, 2008) to 4.5 years (Campbell & Cataldie, 2003; Campbell, Cataldie, McIntosh, & Millet, 2004) for survivors to find services that traditional first responders (e.g., police, coroner or medical examiner, fire and rescue services, emergency medical service providers) may neither be trained nor have the time to fulfil. (Aguirre & Slater, 2010, p. 535)

### Active Postvention Model

This model uses an established communications protocol, notifying an authorised organisation of the death through a variety of mechanisms depending on the community; usually through the coroner or local police service. Permission to contact those affected is secured by the relevant personnel, sometimes using an opt-out system to increase the chances of those bereaved gaining support. The organisation then deploys a team or individual to contact the relevant people affected within a timely manner.

Active postvention models can also include a Community Response Plan, whereby actions are activated, if deemed appropriate, within the affected community to reduce the risk of contagion – this is covered in more detail within “Identifying and responding to suicide clusters and contagion: a practice resource” (PHE 2015)
Inquests

An inquest is a formal court hearing at which a coroner must establish who died and how, when and where the death occurred. An inquest must be held if a sudden death was violent or traumatic, or if the cause of an unexpected death has not been explained by illness or disease. Inquests are public hearings and are usually held at designated coroner's courts in the district where the death occurred.

Coroners responsibilities

Coroners are required by law to investigate any sudden or unexplained death. They are independent of both local and central government and are required to act in accordance with laid down rules and procedures. In most cases no further action is required and the death can be registered as normal. In some cases the coroner may decide a post mortem examination is necessary to determine the cause of death. However in some circumstances, the coroner may decide to hold an inquest to further establish the facts surrounding the death.

The coroner will investigate where a death appears to:
• be due to violence
• be unnatural
• be of sudden and of unknown cause
• have occurred in legal custody

Coroner Investigations: A Short Guide

“In NHS mental health services, providers must ensure that any death of a patient detained under the Mental Health Act (1983) is reported to the CQC without delay. However, providers are responsible for ensuring that there is an appropriate investigation into the death of a patient detained under the Mental Health Act (1983) (or where the Mental Capacity Act (2005) applies).

In circumstances where the cause of death is unknown and/or where there is reason to believe the death may have been avoidable or unexpected - i.e. not caused by the natural course of the patient’s illness or underlying medical condition when managed in accordance with best practice including suicide and self-inflicted death (see Part One; section 1) - then the death must be reported to the provider’s commissioner(s) as a serious incident and investigated appropriately. Consideration should be given to commissioning an independent investigation as outlined in Appendix 3.”

NB: Relevant organisations (i.e. those who co-commission and/or co-manage care) should develop a memorandum of understanding or develop, in agreement with one another, incident investigation policies about investigations involving third parties so that there is a clear joint understanding of how such circumstances should be managed.

Deaths in mental health detention: An investigation framework fit for purpose? (INQUEST February 2015)

“The report documents concerns about the lack of a properly independent investigation system unlike deaths in prison and police custody which are independently investigated pre-inquest and the consistent failure by most NHS Trusts to ensure the meaningful involvement of families in investigations.

Ultimately, it highlights the lack of effective public scrutiny of deaths in mental health detention that frustrate the ability of NHS organisations to learn and make fundamental changes to policy and practice to protect mental health in-patients and prevent further fatalities and argues for urgent change to policy and practice.”
Male patients
Services should ensure that they and partner agencies address factors that add to risk in male patients - especially alcohol misuse, isolation and economic problems such as debt and unemployment.

It is important that male patients have access to psychological as well as drug treatments within the service, that contact is not easily lost and risk is monitored, and that courses of treatment are completed.

Crisis resolution/home treatment
Preventing suicide: a toolkit for mental health services
The findings of the Inquiry suggest that it is in the safety of CR/HT that current bed pressures are being felt. CR/HT has brought a number of benefits to patients, but the safe use of these services should be monitored.
Commissioners (in England) and providers should review their acute care:
• CR/HT should not be used by default for patients who are at high risk or who lack other social supports
• CR/HT should be an intensive community-based alternative to in-patient care: skills and contact time should reflect this specialised role

Acute admissions out of area
The Suicide and Homicide Inquiry suggests acute admissions out of area should end - they are likely to make care planning more difficult and to add to suicide risk at the time of discharge.

Prescribing
Clinicians should be aware of the potential risks from opiate-containing painkillers and should enquire about patients' access to these drugs when assessing suicide risk.
Prescribers of these drugs should limit the duration of prescription of opiates, as they do with antidepressants, to reduce the risk of accumulating a lethal quantity. This is primarily a role for primary care but pharmacists can play a part in encouraging safe prescribing.

Physical healthcare
The Inquiry findings suggest that good physical health care may help reduce suicide risk in mental health patients:
• Physical health needs, especially long-term needs, should be reflected in mental health care plans
• Mental health staff should regularly review care with GPs or specialist clinics
• Wards should take precautionary measures including physical health assessment as soon as practicable after admission, and avoidance where possible of high drug dosage and polypharmacy
Knowledge of suicide

Mental Health Services: Clinical messages cont.

Key elements of safer care in mental health services:

1. Safer wards
   — Removal of ligature points
   — Reduced absconding
   — Skilled in-patient observation
2. Care planning and early follow-up on discharge from hospital to community
3. No ‘out of area’ admissions for acutely ill patients
4. 24 hour crisis resolution/home treatment teams
5. Community outreach teams to support patients who may lose contact with conventional services
6. Specialised services for alcohol and drug misuse and “dual diagnosis”

7. Multidisciplinary review of patient suicides, with input from family
8. Implementing NICE guidance on depression and self-harm
9. Personalised risk management, without routine checklists
10. Low turnover of non-medical staff

Key elements of safer care in the wider health system:

1. Psychosocial assessment of self-harm patients
2. Safer prescribing of opiates and antidepressants
3. Diagnosis and treatment of mental health problems especially depression in primary care
4. Additional measures for men with mental ill-health, including services online and in non-clinical settings

National Confidential Enquiry into Suicide and Homicide by People with Mental Illness (2016)
The Oxford Model is a way of taking forward the lessons learnt from serious untoward incidents or complaints, and sharing that learning with a broader audience to identify further issues or concerns and help staff and partner organisations learn how similar events can be prevented from happening in the future.

“As part of our commitment to Perfect Care and the pursuit of excellence, we have made a commitment to eliminate suicide for all those in our care.

We are aware that there are a number of key time periods and, or situations, where people are at risk of suicide, that is during the high risk period after discharge from inpatient care. These areas will be our initial focus.

The main change to our services will include post-suicide reviews led by the Medical Director or Associate Medical Director within 72 hours. We are aiming to complete reviews within two weeks (the standard achieved by the Henry Ford Hospital system whose model we are emulating). There will be no blame, criticism or implication of failure, but co-operation with the reviews by the teams and managers will be obligatory so we can learn and change what we do quickly.

Every service user with a history of intent or self-harm will also be given a personalised safety plan while a Safe from Suicide Team will be created as part of the new assessment and immediate care service. The team will continually monitor the highest risk service users who have either been referred to us or are already in our care and intervene rapidly and effectively to reduce risk. The intention is to model an approach that reflects real urgency associated with suicidal thoughts.

We also intend, in conjunction with our academic colleagues, to commission a world leading evaluation of the programme to ensure that our efforts are measured and tested to the highest possible degree and engage in research and development as we progress.”

Mersey Care NHS Foundation Trust

Mersey Care have made a commitment as an organisation to eliminate suicide for all those in their care. More information is available via the below:

- Our zero tolerance approach to suicide prevention - Mersey Care NHS FT
- Zero Suicide Policy - Mersey Care NHS FT
This section covers:

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<td>Governance arrangements</td>
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The diagram below demonstrates the different types of engagement/involvement. This continuum is useful when considering staff and service user engagement.

<table>
<thead>
<tr>
<th>Information-giving</th>
<th>Information-gathering</th>
<th>Consultation</th>
<th>Involvement</th>
<th>Partnership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct mail (email and post)</td>
<td>User groups</td>
<td>Written consultation</td>
<td>Advisory panel/committee</td>
<td>Decision making committee</td>
</tr>
<tr>
<td>Factsheets, newsletters and leaflets</td>
<td>Surveys/opinion polls (quantitative research)</td>
<td>Online consultation</td>
<td>Deliberative enquiry</td>
<td>Deliberative enquiry</td>
</tr>
<tr>
<td>Advertising</td>
<td>Public meetings</td>
<td>Outreach</td>
<td>Workshops</td>
<td>Workshops</td>
</tr>
<tr>
<td>Exhibitions</td>
<td>Focus groups/interviews</td>
<td>Public meetings</td>
<td>Online forums</td>
<td></td>
</tr>
<tr>
<td>Public meetings</td>
<td>Online forums</td>
<td>Participatory appraisal</td>
<td>Webchats (social media)</td>
<td></td>
</tr>
<tr>
<td>Websites</td>
<td>Webchats (social media)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Establishing a core group

Why have a group?

• All improvement projects need a core group to champion, troubleshoot and drive work forward.
• What is the purpose/remit of your group?

What else needs to be considered?

• How often should the group meet?
• Have the dates of meetings been booked in diaries?
• How will the group communicate between meetings?

Who should be involved?

Sometimes groups are established to achieve a particular aim, with little thought being given to who needs to be involved and why.

Things to consider are:
• Who will be the overall lead? You may want to consider here a tripartite model of leadership which is shown opposite
• Who else needs to be involved? Think about the system levels outlined in the triangle opposite
• Don’t forget to involve those affected by bereavement
• What is the role of each member within the group? What knowledge/skills will they bring?

Stakeholder Analysis and the use of Benefits Wheel are great tools to help with establishing a core group. See pages 36 and 37.

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Tripartite Model of Leadership

<table>
<thead>
<tr>
<th>Role</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Lead</td>
<td>For the day-to-day running of the project to keep it on track</td>
</tr>
<tr>
<td>Clinical Lead</td>
<td>For clinical input and expertise</td>
</tr>
<tr>
<td>Executive Sponsor</td>
<td>A senior executive/director who is responsible for the success of the project</td>
</tr>
</tbody>
</table>

Board

System level: Clinical and Network Directors and ADs

Team leaders – operational and clinical

Everyone
Establishing a core group: Stakeholder analysis

This tool can really help you:
1) identify who needs to be on your group, or
2) help ‘sense check’ those people you have already identified

Write down on sticky notes all the names of the people who you feel should be involved and why (one sticky note per person), and then plot them on the matrix in terms of their interest and their power (influence).

This should highlight any gaps.

The key points to think about here are:
- Ideally you need some members of the group to be in the high power/high interest quadrant (top right) as these individuals can drive work forward and are usually willing to do so because of their interest
- So long as there are people of high power/high interest on the group it is really helpful to have a number of people who have high interest, even if their power is low. The reason for this is because these individuals make sure actions happen

<table>
<thead>
<tr>
<th>Power</th>
<th>Interest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>High</td>
<td>High</td>
</tr>
</tbody>
</table>

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Establishing a core group: Benefits wheel

Just because someone has been identified to be part of the group does not mean that they will want to be.

This is where the Benefits Wheel comes in.

Before approaching potential group members it is useful to use the Benefits Wheel to focus your thinking about why each potential group member would want to be involved.

Draw the diagram shown opposite on a large sheet of paper. In the centre write the name of the improvement project. In each coloured band write the name of a potential group member. Inside the respective triangle write why you think they should/would like to be involved. Ask yourself ‘what is in it for them’ from a work and personal perspective. Sometimes this is harder than you think!

Once you have this information you can speak to potential group members, clearly articulating why they may wish to be involved.
Governance arrangements

To keep the project on track don't forget about governance arrangements. Things to consider are:

• **Who is accountable and who is responsible for ensuring the improvement project succeeds?**
  The same individual often ends up being both accountable and responsible but this should not always be the case. The person accountable might be your Chief Executive or a Director within your organisation, whereas many people should be responsible (i.e. the members of the core group). It is worth documenting who is accountable and who is responsible so people understand their roles and required level of commitment.

• **What should happen if something isn’t going to plan?**
  For example, what are the reporting mechanisms and escalation procedures should a deadline slip or if something goes wrong? Agree and then communicate the agreed process to all involved so they can act quickly should a problem arise.
Getting started

Knowledge of suicide

Ensuring sustainability

Implementing change

Making informed decisions for change

Working together

Getting started
### This section covers:

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<tr>
<td>Developing a communication strategy</td>
<td>47</td>
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</tbody>
</table>
“If you fail to plan, you are planning to fail!”
(Benjamin Franklin)

This quote is particularly important to consider as:

70% of improvement projects fail to deliver the promised results
(Daft, R and Noe, R., Organisational Behavior, 2000, LONDON: Harcourt)

This means that only 30% of improvement projects deliver on what they set out to achieve. However, with careful planning and the application of a small number of quality improvement tools you can considerably increase your chances of achieving success.
Creating a Driver Diagram

Put simply a Driver Diagram is a strategy on a page.

A Driver Diagram outlines:

<table>
<thead>
<tr>
<th>Overarching aim</th>
<th>The overall outcome you plan to achieve</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary drivers</td>
<td>The areas of the system which need to be changed</td>
</tr>
<tr>
<td>Secondary drivers</td>
<td>Areas of work which need to be completed to ensure delivery on the primary drivers</td>
</tr>
</tbody>
</table>

It is advised that your team/organisation develop its own Driver Diagram as this will help achieve your aim/s. You should take some time to do this. This is important because the Driver Diagram represents the strategy of what you are aiming to achieve. If the strategy is wrong you will not achieve your aim/s.

The next page shows you an example of a driver diagram (previously shown on page 5). This relates to this Toolkit, but it should provide you with an overview of how a Driver Diagram can help you achieve your aims. This page through to page 44 shares information on how to ‘build’ your own.
Creating a Driver Diagram

To provide high quality and effective suicide prevention services/support

Knowledge of suicide

- Understand suicide and mental illness
- Understand the policy context and the information from the National Confidential Inquiry into suicide and homicide by people with mental illness
- Clarity on postvention and postvention services
- Suicide cluster response plans
- Development of Joint Strategic Needs Assessment (JSNA)
- Understand how to implement learning (investigation/serious incident reporting, serious untoward incidents, involving families)
- Improve connectivity with coroners

Working together

- Effective engagement/involvement
- Establish a core group (use of Stakeholder Analysis and Benefits Wheel)
- Governance arrangements

Getting started

- Create a driver diagram
- Create a ‘Plan on a Page’
- Develop a communication strategy

Making informed decisions for change

- Use quantitative and qualitative data
- Define measures and develop baseline
- Presenting data (using SPC)
- Understand variation
- Process map current and future state

Implementing change

- Use of Model for Improvement
- Action planning

Ensuring sustainability

- Use of Sustainability Model and Guide

PRIMARY DRIVERS

SECONDARY DRIVERS

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Back to Links page
Creating a Driver Diagram cont.

The Overarching Aim

Many improvement projects are started with a simple desire to improve things. However, this means you never really know whether you have reached where you need or want to be. It is advisable to take some time to understand what you need/want to achieve and develop this into the improvement project aim.

Aims should be **SMART**: Specific, Measurable, Achievable, Relevant and Time-bound

An example of a SMART aim is outlined below:

**Increase use of phone based crisis counselling by**

[insert number] to [insert number] **by** [insert date] **in** [geographical area]

Primary Drivers

These are the areas which you need to focus on to achieve your aim. Examples of Primary Drivers are shown in the Driver Diagram on page 43.

Secondary Drivers

These are the areas of work which will actually make your primary drivers happen, which in turn will enable you to meet your overarching aim/s. So, as you can see from the Driver Diagram on page 43 there are a number of secondary drivers which need to be undertaken to help achieve the aim of providing high quality and effective suicide prevention services/support.

A Driver Diagram blank template can be downloaded from the AQuA website by clicking here. Please note: you need to be logged in to do this.
Creating a ‘Plan on a Page’

A ‘Plan on a Page’ is a one page document which defines the improvement project, thereby demonstrating how the strategy (outlined in the Driver Diagram) will be delivered. Anyone looking at the ‘Plan on a Page’ document should be able to understand the improvement project aim/s and what is involved. A ‘Plan on a Page’ template is shown on the next page.

The ‘Plan on a Page’ is often supported by additional documentation such as a Stakeholder Analysis (page 36) and a communication strategy (page 47).

It is advisable at this stage to start developing a ‘Plan on a Page’ because it:

- clearly outlines the improvement project in a concise way (which is also useful when explaining the improvement project to others)
- can be used as a ‘sense check’ to ensure all key areas have been considered
- should help keep the improvement project focused on what it aims to achieve as it should be used as a reference point throughout the lifespan of the improvement project
- can support in improvement project authorisation (if needed)

A ‘Plan on a Page’ template can be downloaded from the AQuA website by clicking here. Please note: you need to be logged in to do this.
Creating a ‘Plan on a Page’ cont.

<table>
<thead>
<tr>
<th>What is our purpose?</th>
<th>Plan on a Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aim (using SMART)</td>
<td></td>
</tr>
<tr>
<td>Scope (what is in scope and what is out of scope)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What will we achieve?</th>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliverables</td>
<td></td>
</tr>
<tr>
<td>Team and roles (including who has ultimate accountability)</td>
<td>Governance (who the group reports to and escalation procedure should any challenges arise)</td>
</tr>
<tr>
<td>Other resources needed and source of resources (equipment, training, funding and how you will get them)</td>
<td></td>
</tr>
</tbody>
</table>

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Developing a communication strategy

Communication is key when involved in any improvement project.

It is important to be able to answer the following questions:

- Which stakeholders need to be kept informed? (for example, staff groups and families)
- What communication channels will be used? For further information refer to Engagement/Involvement information on page 34.
- What information needs to be communicated?
- How often does information need to be communicated?
- Who has overall responsibility for ensuring this information will be communicated?

Think about using a number of communication methods tailored to meet the needs of each stakeholder group so they receive the right amount of information they need.

It is very easy for people to become disengaged by receiving too much or too little information, so it is useful to write a communication strategy so it is clear to everyone what is required.
Making informed decisions for change

- Knowledge of suicide
- Working together
- Implementing change
- Getting started
- Ensuring sustainability
- Making informed decisions for change
This section covers:

<table>
<thead>
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<th>Topic</th>
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</tr>
<tr>
<td>Process mapping: The 10 steps</td>
<td>64</td>
</tr>
</tbody>
</table>
Data can be quantitative or qualitative.

<table>
<thead>
<tr>
<th>Quantitative</th>
<th>Is typically descriptive data such as number of suicides</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualitative</td>
<td>Gathers information that is not in numerical form. For example, open-ended questionnaires, unstructured interviews and unstructured observations</td>
</tr>
</tbody>
</table>

Some people do find data collection confusing. If you struggle with some of the information within the following pages don’t worry, just give AQuA a call and a member of staff will explain in further detail.
Developing a baseline and collecting data on a regular basis is key to using data to inform practice.

Obviously, you want to collect the right data. However, it is surprising how many people/teams/organisations collect the wrong data only to find that it doesn’t provide them with the information they need to make the right decisions. To ensure this doesn’t happen to you make sure you can clearly answer the questions below:

- What population are we focusing on? i.e. which staff/which groups are affected by bereavement?
- What are we trying to achieve?
- What is the definition of each measure?
- How will the data be collected? Is this data already collected or do you need to implement a process for collecting this?
- How often will it be collected?
- Who has overall responsibility for making data collection happen?
- Who will collect the data?
- Who will analyse the data?
- How will decisions then be made on next steps?

Once you are clear about what your measures are, and the process of how this is going to be managed, you need to develop your baseline.

You develop your baseline by gathering historical data. It is advisable to have 6 months – 1 year’s data as a minimum.

It is vital that you understand your baseline before making any changes. Making changes based on assumptions and inaccurate data can at best result in you not achieving your aims and at worst having disastrous impacts on the services you wish to improve.
Data: Presenting your data

How data is presented is crucial to its interpretation. A great way to present quantitative data is by using SPC (statistical process control), specifically control charts.

Control charts help you:
- recognise variation
- evaluate and improve the underlying process
- prove/disprove assumptions and (mis)conceptions
- help drive improvement
- use data to make predictions and help planning
- reduce data overload

AQuA has developed a guide on using SPC which can be downloaded from the AQuA website by clicking here. Please note: you need to be logged in to do this.

Your organisation may well have access to its own SPC software, but if not call AQuA and a member of staff will be able to organise you access to SPC.

An example of a control chart is shown on the next page. As you can see from this there is an Upper Control Limit (UCL) and a Lower Control Limit (LCL). The centreline is calculated by the mean. These are important in understanding variation which is discussed in further detail on the following pages.
Data: Presenting your data cont.

Upper control limit (UCL)

Emergency admissions, December 2012

Mean

Lower control limit (LCL)
A control chart enables the monitoring of the process levels and identification of the type of variation in the process over time, with additional rules associated with the control limits. It is advisable to have a minimum of 10 data points of baseline data to create a valid chart, however, there is increased reliability when using 20 or more data points.

There are two types of variation:

<table>
<thead>
<tr>
<th>Type of variation</th>
<th>What it is</th>
</tr>
</thead>
<tbody>
<tr>
<td>Common cause</td>
<td>If the process is stable and predictable any variation is known as ‘common cause variation’. A process is ‘in control’ if it only displays common cause variation.</td>
</tr>
<tr>
<td>Special cause</td>
<td>If the process is unstable or ‘out of control’ any variation is known as ‘special cause variation’. This means that it is not an inherent part of the process. Special cause variation highlights that something unusual has occurred within the process and is attributable to factors that were not within the original process design.</td>
</tr>
</tbody>
</table>
If you can see any of the following it means that there is a special cause variation

<table>
<thead>
<tr>
<th>Name</th>
<th>How to identify special cause variation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shift</td>
<td>Seven or more successive data points falling on the same side of the centreline</td>
</tr>
<tr>
<td>Trend</td>
<td>Seven or more successive data points heading in the same direction (either increasing or decreasing)</td>
</tr>
<tr>
<td>Zig-Zag</td>
<td>Fourteen or more successive data points decreasing and increasing alternatively (creating a zig-zag pattern)</td>
</tr>
<tr>
<td>Cyclical Pattern</td>
<td>A regular pattern occurring over time</td>
</tr>
<tr>
<td>Control Limits</td>
<td>One or more data points falling outside the control limits</td>
</tr>
<tr>
<td>Middle Third</td>
<td>The number of points within the middle third of the region between the control limits differs markedly from two-thirds of the total number of points</td>
</tr>
</tbody>
</table>

Confused? The following pages should help as they illustrate each of these rules.
Data: Variation cont.

Shift

- 7 points above centreline
- 7 points below centreline
Data: Variation cont.

Trend

- 7 points in an upward direction
- 7 points in a downward direction

UCL

Centreline

LCL
Data: Variation cont.

Zig-Zag

14 or more decreasing and increasing alternately
Data: Variation cont.

Cyclical Pattern

UCL

Centreline

LCL
Data: Variation cont.

Control Limits

- UCL (Upper Control Limit)
- Centreline
- LCL (Lower Control Limit)
- Points above UCL
- Points below LCL
Middle Thirds

Considerably less than 2/3 of all the points fall in this zone

Considerably more than 2/3 of all the points fall in this zone
Process Mapping: What is process mapping?

- What happens and how it happens
- Identifies wastes (steps/actions which do not add value) and opportunities
- From the service user perspective

1) Helps you understand the current process (current state)
2) Identifies each step/action in the current process
3) Captures what works well and where improvements can be made
4) Enables the process to be remapped to show what it will look like in the future (future state)

- Removes as much waste as possible, and enables a better way of working to be developed
- Not only what happens but also how it happens
Process Mapping: What does a mapped process look like?

This is an example of a current state process map, so represents what happens now.

In this example the pink sticky notes are steps in the process and yellow sticky notes are actions in the process.

This is an example of a future state process map for the same process as above. By mapping the current state (shown above) wastes and opportunities were identified, and therefore the future state process map (opposite):

- includes fewer steps
- makes the process quicker
- improves the quality of the process

Once the process is implemented the service user should receive a better experience than they do now.
Process Mapping: The 10 step process

Step 1: Preparation
Step 2: Identify scope
Step 3: Identify every step
Step 4: Identify every action
Step 5: Identify wastes and opportunities
Step 6: Analyse the map
Step 7: Question if anything is missing
Step 8: Develop the future state map
Step 9: Develop action plan
Step 10: Communicate
Process Mapping: The 10 step process

1. Preparation

Identify the group

Decide who needs to be involved
- Ideally you need to involve representatives from all stakeholder groups who are currently involved in the process or who may be affected by any changes
- Invite representation from service users
- Involve a decision maker who can sign off any changes

Date and Time

Identify a date and time when everyone can come together
Allow plenty of time as it is important to discuss the process in detail

Data/information

Consider what data/information you will need to share on the day
If this data/information is already available then great, but if not this may need to be collected before the group meets.
Always remember that making changes based on assumptions and inaccurate data can at best result in you not achieving your aims and at worst having disastrous impacts to the services you are trying to improve

Resources

Things you need to take
- Roll of lining paper
- Pens
- Sticky notes in four different colours to identify:
  1. start and end points of the process
  2. steps in the process
  3. actions in the process
  4. wastes and opportunities in the process
Process Mapping: The 10 step process

Step 2: Identify scope for your current state process map

This relates to the point at which the process starts and the point at which the process ends.

Once the scope has been clearly defined write the start and end points on coloured sticky notes and place them on the lining paper.

Step 3: Identify every step in the process

Write these key headings on sticky notes and place them on the lining paper in the order they happen, between the start and end points.

Step 4: Identify every action which takes place under each step

Write each action on a sticky note. Also write on the same sticky note how the action is done, who does the action, and how long the action takes.

Once complete, place the action sticky notes on the lining paper in the order they happen under each relevant step.

Step 5: Identify wastes (steps and actions which do not add value) and opportunities

This should be very much viewed from the service user perspective.

Write on sticky notes any wastes and opportunities and place these on the current state process map near to the relevant step/action sticky note.
Process Mapping: The 10 step process

Step 6: Analyse the map step by step, action by action

This is a crucial part of current state process mapping as the group really needs to understand what the map is telling you.

Consider the following if they haven’t already been discussed:

- How long are the waits are between the steps and actions in the process (you may wish to write these on the map). Is this time appropriate?
- Information flows – is the way information is received or sent the most effective/efficient/user friendly way? If not, what is the alternative?
- Is each action ‘right first time’? If not, why not? What can be done about this?
- Are there targets/legal requirements attached to any of the steps in the process? If so, what are they? Are you meeting them?
- What is happening elsewhere? Is there anything which you could learn from others?

Add the outcomes of these discussions to the current state map.

Step 7: Question if anything is missing from your current state map

Does additional data/information need to be collected? If so, collect this before moving on to developing the future state process map, even if this means ending the meeting and rearranging another time.

Always remember that making changes based on assumptions and inaccurate data can at best result in you not achieving your aims and at worst having disastrous impacts to the services you wish to improve.

Step 8: Develop the future state process map

This is developed in exactly the same way as the current state process map, but rather than focusing on what currently happens, you take everything which you have learned, and develop a future state process map outlining what the process will look like in the future, ensuring it will meet your aim/s (page 44).

Step 9: Develop an action plan

Develop an action plan as to how the new process will be implemented, clearly outlining the timescales for implementation and who is responsible for each action. Don’t forget to agree how you are going to measure the success (or otherwise) of the new process (see page 51 ‘Defining measures and developing your baseline’).

Step 10: Communicate

Communicate the changes to all those affected.
Refer to sections ‘Engagement and Involvement’ (page 34) and ‘Developing a communication strategy’ (page 47).
Implementing change

Knowledge of suicide

Ensuring sustainability

Implementing change

Making informed decisions for change

Working together

Getting started
This section covers:

| Implementing change using the Model for Improvement | 70 |
Implementing change using the Model for Improvement

The Model for Improvement is a nationally recognised improvement tool which is used in many countries around the world. It provides a great framework for developing, testing and implementing changes that lead to sustainable improvements.

The Model for Improvement

Aim: What are we trying to accomplish?

Measures: How will we know if a change is an improvement?

Change: What changes can we make that will result in an improvement?

Plan

Do

Act

Study

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The use of PDSA cycles is part of The Model for Improvement.

It is useful to use PDSA cycles to test out in bite sized chunks your ideas, refining each PDSA until you reach the point where you are sure that your idea will definitely deliver your aims.

The diagram here demonstrates the point that it is likely that a number of PDSAs will need to be completed before your improvement is ready to implement fully.

Success! Improvement ready for wider implementation

Test, revise and refine each step of the way

PDSA Guidance and Worksheet can be downloaded from the AQuA website by clicking here. Please note: you need to be logged in to do this.
Ensuring sustainability

- Knowledge of suicide
- Working together
- Getting started
- Implementing change
- Making informed decisions for change
- Ensuring sustainability
This section covers:

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Ensuring sustainability

It is recommended that you and your organisation use the Sustainability Model and Guide (developed by the Institute for Innovation and Improvement).

This Model and Guide was developed as an easy-to-use tool to help teams:

- self-assess against a number of key criteria for sustaining change
- recognise and understand key barriers for sustainability, relating to the specific local context
- identify strengths in sustaining improvement
- plan for sustainability of improvement efforts
- monitor progress over time

A diagram demonstrating the Model is shown on the next page. As you can see from this there are 10 factors it recommends should be considered. The Guide enables you to assess how well you are performing against these, which therefore helps you in deciding where you need to concentrate your efforts to ensure sustainability is maintained in the long term.

The Sustainability Model and Guide can be downloaded from the AQuA website by clicking here. Please note: you need to be logged in to do this.
The Sustainability Model

(Institute for Innovation and Improvement Sustainability Model and Guide, 2010)
Suicide prevention resources

Examples of sources of support for those bereaved by suicide (as listed within Help is at Hand):

**Amparo – Merseyside & Cheshire**
[www.listeningearmerseyside.org.uk/amparo](http://www.listeningearmerseyside.org.uk/amparo)
[amparo.service@listening-ear.co.uk](mailto:amparo.service@listening-ear.co.uk)
[0330 088 9255](tel:0330 088 9255)
AMPARO provides support for family members in Merseyside and Cheshire, following suicide. Support is provided 1:1 and our staff can assist with a range of practical matters such as dealing with Police and Coroners, helping with any media enquiries, help with overcoming isolation experienced and contacting and signposting to other local support services.

**CALM (campaign against living miserably)**
[www.thecalmzone.net](http://www.thecalmzone.net)
Helpline 0800 58 58 58 / London 080 802 58 58 OPEN 7 days a week 17.00-00.00
Email [info@thecalmzone.net](mailto:info@thecalmzone.net)
Webchat [www.thecalmzone.net/help/webchat/](http://www.thecalmzone.net/help/webchat/)
CALM is a registered charity, which exists to prevent males suicide in the UK. In 2013, male suicide accounted for 78% of all suicides in the UK and is the single biggest cause of death in men aged 20-45 in the UK. The helpline is free, anonymous and confidential.

**Child Bereavement UK**
[www.childbereavementuk.org](http://www.childbereavementuk.org)
Helpline 0800 02 888 40 Monday-Friday 09.00-17.00
Email support@childbereavementuk.org
Support, guidance and information for anyone supporting a bereaved child or young person. Also support for parents when a child of any age has died.

**Cruse Bereavement Care**
[www.cruse.org.uk](http://www.cruse.org.uk)
Helpline 0844 477 9400 Monday to Friday 9.30 – 17.00 Tuesday, Wednesday and Thursday 09.30 – 20.00
Email [helpline@cruse.org.uk](mailto:helpline@cruse.org.uk)
Cruse supports people after the death of someone close. Their trained volunteers offer confidential face-to-face, telephone, email and website support, with both national and local services. They also have services specifically for children and young people.
Suicide prevention resources cont.

If U Care Share Foundation
www.ifucareshare.co.uk
Helpline 0191 387 5661
Email share@ifucareshare.co.uk
If U Care Share Foundation provides practical and emotional support to people bereaved by suicide. It also offers training in suicide prevention and support to young people at risk of suicide around North East England. It is run by people who have experienced a loss by suicide. The Road Ahead is a free resources available on their website that is written by people bereaved by suicide giving their perspectives of dealing with the daily impact of loss.

PAPYRUS Prevention of Young Suicide
www.papyrus-uk.org
Helpline 0800 068 4141 Monday-Friday 10.00-22.00 Weekends and Bank Holidays 14.00-17.00 / SMS: 07786 209 697
Email pat@papyrus-uk.org
PAPYRUS Prevention of Young Suicide offers support and advice to young people who may be at risk of suicide and to those concerned about a vulnerable young person.

Samaritans
www.samaritans.org
Helpline 116 123 Every day, 24 hours / SMS: 07725 909 090
Email jo@samaritans.org
Samaritans provide emotional support to anyone who is struggling to cope and needs someone to listen. Local branches can be visited during the day.

Samaritans : Suicide on the Railways
http://www.samaritans.org/for-business/rail-industry-suicide-prevention-programme
Samaritans work with Network Rail to promote a safer railway and reduce suicides on the network, additionally they provide guidance and support to those traumatised by a suicide incident.

SELF Isle of Wight (Supporting & Empowering Lives Foundation)
www.selfiow.org
Helpline Office hours: 525254 / Out of hours Crisis Line: 522214
Suicide prevention resources cont.

State of Mind
http://www.stateofmindsport.org
International suicide prevention campaign run through sports organisations and community groups. Commence in the NW England with Rugby League Super League Clubs and support by Sky Sports, now expanded to other sports and internationally.

Survivors of Bereavement by Suicide (SOBS)
www.uk-sobs.org.uk
Helpline 0300 111 5065 Every day 9.00 – 21.00
Email sobs.support@hotmail.com
SOBS offers support for those bereaved or affected by suicide through a helpline answered by trained volunteers who have been bereaved by suicide and a network of local support groups.

The Compassionate Friends
www.tcf.org.uk
Helpline 0345 123 2304 Every day 10.00-16.00 & 19.00-22.00
The Compassionate Friends support people when a child of any age dies through any cause. They have local support groups and online message boards with special sections for those bereaved by suicide and childless parents.

Winston’s Wish
www.winstonswish.org.uk
Helpline 08452 030405 Monday to Friday: 09.00 – 17.00, Wednesday extra hours 19.00 – 21.30
Email chris@winstonswish.org.uk
Winston’s Wish offers support and guidance to bereaved children and families.
They have produced Beyond the Rough Rock, a booklet on supporting a young person or child bereaved through suicide, and can provide information on children seeing the body and attending funerals.
For further information please contact AQuA:

Telephone: 0161 206 8029

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