

Suicide audit in Primary Care Trust localities:

A tool to support population based
audit of suicides and open verdicts

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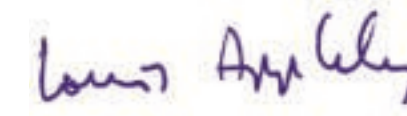
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Foreword

Suicide prevention is a key national priority for all health and social services. Indeed all Primary Care Trusts have a responsibility to carry out suicide audit. There is a variety of suicide audit systems in place across the country at present. Some PCTs and specialist Mental Health Trusts have established local systems for collecting information whilst others have nothing apart from limited ONS data available to them. This toolkit is designed to assist PCTs in establishing a system for collecting relevant information on suicides to inform local, regional and national suicide prevention strategies.

The National Confidential Inquiry into Suicide and Homicide by People with a Mental Illness (NCI) has been collecting data systematically since 1996. However, this only captures information on people who have been in touch with secondary care mental health services in the 12 months prior to the suicide event. It therefore only captures approximately 25% of the suicides that occur. This toolkit will enable PCTs to supplement the knowledge obtained from the NCI by adding more detailed information about the 75% of people who die by suicide who are not in contact with mental health services.

I am pleased to commend this best practice toolkit which will enable PCTs to learn lessons from individual suicides which may help to prevent future tragedies of this kind.



Professor Louis Appleby
National Director for Mental Health

This document is available with supporting database and additional materials from the National Institute for Mental Health in England at: www.eastmidlands.csip.org/suicide_db/index.html

Executive summary

Aims of the toolkit:

- 1) To support Primary Care Trusts (PCTs) and other bodies to establish a system for suicide audit which fits their local context
- 2) To support the development of local suicide prevention strategies
- 3) To produce data which could potentially be merged at regional and national levels to identify trends

This toolkit offers a ready-made methodology and database for conducting suicide audit efficiently and effectively with a minimum of additional effort at local level. Its adoption will also provide a simple way for PCTs to demonstrate that they are performing suicide audit to a recommended standard of good practice. PCTs are already expected to undertake suicide audit, thus the toolkit's benefits outweigh cost.

This toolkit is designed to assist Primary Care Trusts in establishing a system for collecting relevant information on suicides to inform local, regional and national suicide prevention strategies. The establishment of a common national data set (see Appendix 2) would for the first time provide an opportunity to analyse comparable data on all suicides at a more detailed level than is possible using ONS data.

The toolkit does not prescribe how this should be best done at a local level, though it does give some working examples of how it can be done. However, whatever system is established at a local level, it is recommended that if an audit is undertaken, then it should include the minimum amount of data, as set out in Appendix 2, that should be collected to allow the potential for both regional and national analysis of comparable data.

The purpose of this local audit is to learn lessons from individual suicides which may help to prevent future suicides: this is in the public interest.

Background

There is a variety of suicide audit systems in place across the country at present. Some PCTs and specialist Mental Health Trusts have established local systems for collecting information whilst others have nothing apart from limited ONS data available to them.

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCI) has been collecting data systematically since 1996. However, this only captures information on people who have been in touch with secondary care mental health services in the 12 months prior to the suicide event. It therefore only captures approximately 25% of the suicides that occur. Although the NCI produces very helpful and informative reports on this important cohort of people it tells us little about the rest of the population concerned.

For further information in relation to this area and the rationale for choosing the variables used in this audit tool see the accompanying document "Suicide Audit in Primary Care Trust localities: A Whole Systems Approach". This provides an overview of the current position in relation to suicide audit.

This document comes in five sections

Main report: This section provides a fuller description of the aims, background and rationale of this document

Appendix 1: Audit Process Checklist

Appendix 2: Data collection proforma to audit Suicide and Open verdicts within PCT localities

Appendix 3: Areas for collecting information and their rationale

Appendix 4: Further information and references

In addition, the accompanying document – Suicide Audit in Primary Care Trust localities: A Whole Systems Approach – provides detailed and practical guidance to developing clinical audit of suicides within PCT localities. It aims to provide guidance on how to undertake a whole systems approach to suicide audit within a PCT in order to improve clinical practice by:

- Briefly describing national policy guidance that requires PCTs and Mental Health Trusts to undertake suicide audit
- Exploring the concept of “population” suicide audit and its relation to clinical suicide audit
- Describing the routine and non-routine sources of data for suicide and death by undetermined injury including use of National Confidential Inquiry and local Coroner data
- Reviewing the existing literature to:
 - determine the methodologies that have been used for suicide audit
 - identify which methods are more effective in terms of improving clinical practice
- Describing the difference between adverse incident reviews and clinical audit of suicides

Acknowledgements

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- Bury PCT
- Central Cornwall PCT
- Central Liverpool PCT
- Cornwall Partnership Trust
- Devon Partnership Trust
- Mid-Devon PCT
- National Confidential Inquiry into Homicide and Suicide
- Northampton PCT
- North and East Cornwall PCT
- North Liverpool PCT
- Southampton PCT
- South Liverpool PCT
- Southport and Formby PCT
- South Sefton PCT
- South Somerset PCT
- Torbay PCT
- West of Cornwall PCT

Suicide audit tool **Aims**

Aims of the toolkit:

- 1) To support Primary Care Trusts (PCTs) and other bodies to establish a system for suicide audit which fits their local context
- 2) To support the development of local suicide prevention strategies
- 3) To produce data which could potentially be merged at regional and national levels to identify trends.

Suicide audit in Primary Care Trust localities: A tool to support population based audit of suicides and open verdicts

1 Introduction

This toolkit is designed to assist Primary Care Trusts in establishing a system for collecting relevant information on suicides to inform local, regional and national suicide prevention strategies. The establishment of a common national data set (see Appendix 2) would for the first time provide an opportunity to analyse comparable data on all suicides at a more detailed level than is possible using ONS data. The toolkit does not prescribe how this should be best done at a local level, though it does give some working examples of how it can be done. However, whatever system is established at a local level, **it is recommended that if an audit is undertaken, then it should include the minimum amount of data, as set out in Appendix 2**, that should be collected to allow the potential for both regional and national analysis of comparable data. It is important to note that the data collected will be confidential and kept at a local PCT level. Any arrangements to collate and analyse data above PCT level (such as Strategic Health Authority, regional or national) will need to be subject to a separate arrangement.

The purpose of this local audit is to learn lessons from individual suicides which may help to prevent future suicides: this is in the public interest. The audit process requires a full and frank exchange of views about any lessons to be learned from each case and suggestions for service improvement. In order that this full and frank exchange of views should not be inhibited, informants are being asked to give their opinions in confidence. Information supplied for the purpose of this audit will not form part of the deceased person's medical record and a copy should not be kept by the person completing the form.

2 Background

There is a variety of suicide audit systems in place across the country at present. Some PCTs and specialist Mental Health Trusts have established local systems for collecting information whilst others have nothing apart from limited ONS data available to them.

The National Confidential Inquiry into Suicide and Homicide by People with a Mental Illness (NCI) has been collecting data systematically since 1996. However, this only captures information on people who have been in touch with secondary care mental health services in the 12 months prior to the suicide event. It therefore only captures approximately 25% of the suicides that occur. Although the NCI produces very helpful and informative reports on this important cohort of people it tells us little about the rest of the population concerned.

For further information in relation to this area and the rationale for choosing the variables used in this audit tool see the accompanying document "Suicide Audit in Primary Care Trust localities: A Whole Systems Approach" (CD ROM). This provides an overview of the current position in relation to suicide audit.

3 Suicide Audit

All PCTs have a responsibility to carry out suicide audit. Although numbers may vary between PCTs and across time suicides can have a devastating effect upon family, friends, practice staff, and many others. Within a population of 100,000 people there are expected to be 10 suicides per year. While this may appear too infrequent to be worth significant attention the implications for those involved can be devastating.

The National Suicide Prevention Strategy for England sets out a programme of activity to reduce suicide based on six goals

- to reduce risk in key high risk groups
- to promote mental well-being in the wider population
- to reduce the availability and lethality of suicide methods
- to improve reporting of suicidal behaviour in the media
- to promote research on suicide and suicide prevention;
- to improve monitoring of progress towards the Saving Lives: Our Healthier Nation (DoH, 1999a) target for reducing suicide.

Standard Seven of the National Service Framework for Mental Health (DoH, 1999b) says that local health and social care communities should prevent suicides by delivering on the other six standards “and in addition... develop local systems for suicide audit to learn lessons and take any necessary action.”

As part of the local delivery plan all PCTs are currently required to provide a local action plan for delivery of interventions towards achieving the national target to reduce suicide rates by 20% by 2010.

Suicide audit should therefore be seen as part of an overarching whole systems approach to suicide prevention. The recommendations from local suicide audit within PCTs and Mental Health Trusts should feed into the local mental health economy and their governance systems through, the Local Implementation Team (LIT), local suicide prevention strategy and mental health promotion strategy.

3.1 Suicide audit and confidentiality

It should be stressed that suicide audit is not research. However, many of the concerns that exist in relation to research, the use of information and how confidentiality is maintained are also relevant to suicide audit. Research Ethics Committee approval should not be required for suicide audit, however Suicide Audit Groups may wish to obtain further guidance (including from the Local Research Ethics Committee) on confidentiality and anonymity to reassure themselves and others.

The Department of Health’s Code of Practice (2005) on confidentiality and disclosure of information states that in relation to anonymised or aggregated patient information:

“Whenever practicable, patient data disclosed for purposes other than patient’s care should be anonymised. Anonymised information is information that does not identify an individual. It requires the removal of name, address, full post code, date of birth, NHS number and local patient identifiable codes, and any other detail or combination of details that might support identification.”

It will be an issue for each local Suicide Audit Group (PCT and other partners) to determine locally how they ensure that confidentiality is maintained.

3.2 Whose responsibility?

Suicide audit requires a range of skills and knowledge, so the PCT will need to establish a Suicide Audit Group (SAG). This will need to include:

- Public Health (for analysis of database),
- Clinical Governance – coordination of data collection and feedback to primary care, Clinical Audit (for expertise in data collection and holding)
- Mental Health Lead / commissioner (for coordination and guidance, possibly lead),
- Secondary Care representatives – including CAMHS and older people’s services (for expertise in audit they are already performing and to agree data sharing as there be will be common goals), and
- IT expertise (for holding and managing database).

Others who may need to be approached for input may include:

- Coroners
- Local Authority departments such as housing, social services and education
- Users of primary care services
- Criminal justice system agencies e.g. prisons, young offender institutions, etc.

3.3 Who to include within the audit

The audit should include all deaths from suicide and undetermined injury. The audit should include:

- Residents of the PCT who die in the PCT area
- People of no fixed abode who die in the PCT area
- People who die in prisons within the geography of the PCT

Close links will need to be established with the local secondary mental health services to ensure complete coverage and avoidance of duplication in information collection.

When a PCT resident dies elsewhere or a resident of another PCT dies in the area, there should be liaison between the two PCTs involved and agreement as to which will take the lead. In the absence of such liaison the PCT where the death occurred should lead.

4 The suicide audit process

An average sized PCT with a population of 100,000 people will have 10-15 suicides/undetermined injury deaths per annum. Therefore it is likely that on average there will be 1 or 2 each month which will need to be audited by the PCT. There are two processes that will take place:

- (i) the process of co-ordinating the collection of information on all suicides and deaths by undetermined injury (to be undertaken by the Suicide Audit Group) – see blue Key Action Point Boxes.
- (ii) the process of undertaking a Significant Event Audit of individual deaths (to be undertaken by the practice where the person was registered or by the SAG in the event of the person not being registered with a practice) – see green Key Action Point box. There is a duty to undertake Significant Event Audits in primary and secondary care. The learning from practice-based significant event audits and secondary care Mental Health Trusts can be brought together with an analysis of the audit data collected by the Suicide Audit Group to inform local suicide prevention strategies.

Key Action Point 1 – Establish a Suicide Audit Group (SAG) to co-ordinate the process of gathering individual case audits and developing the local action plan/suicide prevention strategy

Rationale

To co-ordinate planning on local suicide prevention

Questions to address at the first meeting of the SAG:

- Who are the key players in the PCT and externally (including prisons)?
- How committed are other key players to participate?
- What type of involvement should they have?
- Who should take the lead role and co-ordinate the SAG?
- Does it make sense to do this in combination with other PCTs?
- What resources will be needed to gather information on individual cases (i.e. the co-ordination of individual Significant Event Audits (SEA)?
- How will SEAs be undertaken where the person was not registered with a Practice?
- How necessary is it for the SAG to meet together or could things be done electronically?

4.1 What information to collect?

Appendix 3 lists variables based on a literature search and gold standards from published and unpublished research material.

Key Action Point 2 – Identify what information is currently being collected on suicides and open verdicts (undetermined injury) within the PCT area

Rationale

To inform and support Practices and the SAG in reviewing evidence and developing a local suicide prevention strategy

Questions to address:

- What information is needed? (see Appendices 2 and 3 for minimum data set and rationale)
- Where is this information being collected?
- How can they be collated?
- What progress can be made to collecting information in areas where this is currently difficult?

4.2 Where from?

Three key sources of information are necessary, although there may be others.

4.2.1 Coroner related information

Coroner data forms the basis of the audit but will depend on the set up and nature of local coroner's office (see Section 5.3 of Suicide Audit in Primary Care Trusts: A Whole Systems Approach for further information on liaison and data collection). Several coroners are already supplying information free of charge and others have agreed, for a small fee, to provide the information on the variables listed in Appendix 2. The alternative to the coroner supplying the information is to reach an agreement with the Coroner for someone from the PCT to have access to the Coroner's file on each suicide / open verdict case. This is considered to be more time consuming and less efficient but as numbers are small it may prove an effective alternative if the Coroner is unwilling to complete the relevant sections. This has been used in the pilot sites and in research projects but appears to be less sustainable.

Key Action Point 3 – Establish effective contact with your local coroner

Rationale

To ensure that all suicides and open verdicts trigger a Significant Event Audit (SEA)

Agree with the coroner's office:

- A method of acquiring data from coroners
- A form in which the data will be provided (see database for areas of data collection)
- The frequency of data provision
- Any financial costs.

4.2.2 Primary Care related information

The 'New GMS' contract under the Quality and Outcomes Framework requires Significant Event Audit to be sent to the PCT – one of which should be a suicide audit¹. We suggest that the collection of the data set should ideally link into this process and that Clinical Governance should take the lead for invoking the Significant Event Audit and ensuring that the common data set is retrieved. This would provide an opportunity for collecting useful information for the audit which may have common lessons for other practices.

The audit tool should be sent out to the Primary Care Practice by the PCT once the suicide/open verdict has been reported to the PCT by the coroner. It should be noted that this may result in several months delay whilst awaiting the inquest. The practice could be free to request the form when they become aware of the event if they prefer, rather than wait for the coroner's verdict where information points towards a possible suicide or open verdict as the time delay can affect the memory of participants in the SEA.

¹An "average sized practice" will only experience a suicide every 2 years.

Key Action Point 4 – Establishing a system to gather Significant Event Audit (SEA) feedback from Practices

Rationale

To inform the development of a local Suicide Prevention Strategy

The SAG will need to establish:

- Who will send out the SEA request if not triggered in the Practice
- Who will send out the forms
- Who will they be returned to
- Who will input the information
- What information is provided to the coroner in cases where an SEA precedes the coroner's verdict
- Who would trigger a SEA prior to verdict where the PCT becomes aware of an event
- Who will undertake the SEA if the person was not registered with a Practice.

Key Action Point 5 – Undertaking a Significant Event Audit (see Appendix 4 for sources of information on SEAs)

Rationale

To support and inform the local Practice

The Practice should agree with PCT Governance Lead:

- The format of reporting for a Significant Event Audit (if not already established)
- The final version of the form (including variables contained in Appendix 2)
- Who and when this will be sent out (annually and/or after being informed of a suicide)
- Who the form will be returned to
- Who will input data
- Who will Chair a SEA (in some circumstances this will be a chair nominated by the SHA)
- Who will co-ordinate the SEA
- Which other agencies involved in the care of the individual will be informed of the SEA e.g. Connexions teams, probations, drug and alcohol services, etc.
- Who will inform the Suicide Audit Group of the findings from the SEA.

4.2.3 Secondary mental health care

Secondary mental health services will already be collecting information for those who have been in contact with their services in the 12 months prior to the event, which will have lessons for local communities and primary care too especially relating to 'means' and last contacts. This information is being collected in two main ways. Firstly, the Trusts will be undertaking their own Serious Untoward Incidents (SUI) inquiries which are in part similar to the concept of significant event audits in primary care. Secondly, they will be collecting data for the National Confidential Inquiry. However, experience from the piloting phase of the toolkit found that Trusts did not keep the data supplied to the National Confidential Inquiry and were not able to access a local breakdown of the national data. Therefore, the piloting experience has found that they are very interested in participating in a whole system's approach to a gathering data through the use of the toolkit. Please see the website for the National Confidential Inquiry for more information about how this process works <http://www.national-confidential-inquiry.ac.uk/nci/index.cfm> and the detailed information which results.

Key Action Point 6 – Examine with Secondary Care mental health services any data collection, management and sharing opportunities

Rationale

To avoid duplication of effort, ensure no cases are missed and effect learning opportunities between the two areas

Questions to ask:

- Does it make more sense to have a joint database of information regarding suicides because of overlap?
- Would it be better to maintain separate databases but agree to share information on the content?
- How can we ensure that suicide cases are not missed or are not double counted between primary and secondary care?

4.3 Action planning and setting the standards

This should be decided by the audit team but can vary depending on the data collected, for example:

- having the mechanisms to collect audit data,
- aiming for no suicides from a particular railway viaduct in the next year,
- aims geared towards hotspots
- how many of the variables in the audit tool have been completed in a given year.

Key Action Point 7 – Collation and analysis of SEAs on an annual basis

Rationale

To inform the local Suicide Prevention Strategy

Questions to ask:

- Who is involved in ensuring data for a given year is collated?
- Will the PCT public health personnel be involved in providing an analysis and interpretation of the results prior to the report being distributed to those involved in setting targets and standards?

Key Action Point 8 – Agree principle(s) and aims for the forthcoming year

Rationale

To establish priority areas for action

Questions to address:

- Who is going to co-ordinate the process of implementing actions
- How will actions be implemented?
- To whom or where should the implementation team be accountable?
- What is the Public Relations and Media Strategy for the next year?

Key Action Point 9 – Dissemination of the report

Rationale

To share learning and information about future actions

The SAG should agree:

- Who the report should be going to
- What the content will be
- How it will be disseminated
- Who to send feedback to
- A mechanism for reviewing the process of audit, its findings and monitoring the agreed action.

4.4 Completing the Cycle

The recipients of a general report or more specific ones could include:

- Local Implementation Team (LIT)
- PCT Board
- Primary health care teams
- PCT pharmacy advisers
- Local Strategic Partnerships (LSPs)
- All who provide information for the audit (e.g. GPs, clinical governance leads or the whole practice, coroners, secondary care)
- DAAT (many are also carrying out suicide audits and would value being involved)
- The local NIMHE Development Centre
- Strategic Health Authority
- Local and Regional Directors of Public Health.

Appendix 1

| Key Action Point | Audit process checklist | Achieved (Yes / No) |
|------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|
| 1 | <p>The PCT establish a Suicide Audit Group (SAG)</p> <p>Have the key players in the PCT and externally been identified and joined the SAG? (including local prisons)?</p> <p>Are other key players committed?</p> <p>Are their roles and responsibilities clear?</p> <p>Has it been agreed who should take the lead role and co-ordinate the SAG?</p> <p>Does it make sense to do this in combination with other PCTs?</p> <p>Have the necessary resources for the SAG been identified and committed?</p> <p>Is it clear how SEAs be undertaken where the person was not registered with a Practice?</p> <p>Has a method of co-ordinating the SAG been agreed?</p> | <p>YES / NO</p> <p>YES / NO</p> <p>YES / NO</p> <p>YES / NO</p> <p>YES / NO</p> <p>YES / NO</p> <p>YES / NO</p> <p>YES / NO</p> |
| 2 | <p>Identify what information is currently being collected on suicides and open verdicts (undetermined injury) within the PCT area</p> <p>Is it clear what information is needed?</p> <p>Does the SAG know where this information is being collected?</p> <p>Is there a process for gathering the information that is available?</p> <p>Is there a plan to collect information gaps in areas where this is currently difficult?</p> | <p>YES / NO</p> <p>YES / NO</p> <p>YES / NO</p> <p>YES / NO</p> |
| 3 | <p>Establish effective contact with your local coroner</p> <p>A method of acquiring data from coroners has been agreed</p> <p>A form in which the data will be provided has been agreed</p> <p>The frequency of data provision has been agreed</p> <p>Any financial costs have been agreed</p> | <p>YES / NO</p> <p>YES / NO</p> <p>YES / NO</p> <p>YES / NO</p> |

| | | |
|---|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|
| 4 | <p>Establishing a system to gather Significant Event Audit feedback from Practices</p> <p>A person has been identified to send out the SEA request from the PCT</p> <p>A person has been identified who will send out the forms</p> <p>A person has been identified who they will be returned to</p> <p>A person has been identified who will input the information</p> <p>A decision has been made on what information is provided to the coroner in cases where an SEA precedes the coroner's verdict</p> <p>How information is passed to the coroner has been agreed</p> <p>An individual has been identified who would trigger a SEA prior to verdict where the PCT becomes aware of an event</p> <p>An individual has been identified who will undertake a SEA if the person was not registered with a Practice</p> | <p>YES / NO</p> <p>YES / NO</p> <p>YES / NO</p> <p>YES / NO</p> <p>YES / NO</p> <p>YES / NO</p> <p>YES / NO</p> <p>YES / NO</p> |
| 5 | <p>Undertaking a Significant Event Audit</p> <p>The format of reporting for a Significant Event Audit (if not already established) agreed</p> <p>A form has been designed to gather data from the SEA or the NIMHE database is to be used</p> <p>It is clear who the form (or database) will be returned to</p> <p>It is clear who will input data</p> <p>A Chair has been appointed for the SEA</p> <p>It is clear who will co-ordinate the SEA</p> <p>Other agencies involved in the care of the individual will be informed of the SEA and invited to participate e.g. Connexions teams, probations, drug and alcohol services, etc</p> <p>It is clear who will inform the Suicide Audit Group of the findings from the SEA</p> | <p>YES / NO</p> <p>YES / NO</p> <p>YES / NO</p> <p>YES / NO</p> <p>YES / NO</p> <p>YES / NO</p> <p>YES / NO</p> <p>YES / NO</p> |
| 6 | <p>Examine with Secondary Care mental health services any data collection, management and sharing opportunities</p> <p>Agreement has been reached with secondary care to share information</p> <p>A decision has been made on whether to maintain separate databases or a single joint database</p> <p>Methods have been agreed to ensure that suicides and open verdicts are not missed or are not double counted between primary and secondary care</p> | <p>YES / NO</p> <p>YES / NO</p> <p>YES / NO</p> |

Appendix 2

Data collection proforma to audit Suicides and Open Verdicts within PCT localities

Audit of Suicides and Open Verdicts within PCT localities

Introduction

This proforma is provided for PCT Suicide Audit Groups to utilize with the electronic database in the local data collection process. In some cases, PCTs may wish to simply enter data into the database directly, in others it might be preferred to use this proforma and then transfer data. The decision on which approach to use is left to the PCT and the local Suicide Audit Group.

A copy of the electronic database, the rationale for variables and further relevant information are available to be downloaded at http://www.nimhe-em.org.uk/suicide_db/index.html. The web-based data set is to be downloaded and kept at a local PCT level.

Confidentiality and anonymity

It should be stressed that suicide audit is not research. However, many of the concerns that exist in relation to research, the use of information and how confidentiality is maintained are also relevant to suicide audit. Research Ethics Committee approval should not be required for suicide audit however Suicide Audit Groups may wish to obtain further guidance (including from the Local Research Ethics Committee) on confidentiality and anonymity to reassure themselves and others.

The Department of Health's Code of Practice (2005) on confidentiality and disclosure of information states that in relation to anonymised or aggregated patient information:

“Whenever practicable, patient data disclosed for purposes other than patient’s care should be anonymised. Anonymised information is information that does not identify an individual. It requires the removal of name, address, full post code, date of birth, NHS number and local patient identifiable codes, and any other detail or combination of details that might support identification.”

It will be an issue for each local Suicide Audit Group (PCT and other partners) to determine locally how they ensure that confidentiality is maintained.

| | | |
|----------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|
| 7 | Collation and analysis of SEAs on a annual basis | |
| | Appropriate people have been identified to be involved in ensuring data collated for the forthcoming year | YES / NO |
| | PCT public health personnel will be involved in providing an analysis and interpretation of the results prior to the report being distributed to those involved in setting targets and standards | YES / NO |
| 8 | Agree principle(s) and aims for the forthcoming year | |
| | A person has been identified to co-ordinate the process of implementing actions | YES / NO |
| | Local arrangements have been produced | YES / NO |
| | An implementation team has been established with appropriate reporting mechanisms | YES / NO |
| | A Public Relations and Media Strategy has been agreed for the forthcoming year | YES / NO |
| 9 | Dissemination of the report | |
| | A list of organisations and individuals who will be sent the report has been agreed | YES / NO |
| | Methods of dissemination have been agreed (event, post, email, website, etc) | YES / NO |
| | A person has been identified who will receive feedback on the report | YES / NO |
| | A mechanism for reviewing the process of audit, its findings and monitoring the agreed action has been established | YES / NO |

Time resource required

The time required to undertake audits using this tool has been established through extensive piloting and are estimated to be as follows:

- Approximately 30 minutes per month administration time to produce the Monthly Suicide Summary Report and document the relevant GPs.
- Approximately 15 minutes per case to prepare the GP questionnaire and covering letter, forward to Patient & Practitioner Services, update in-house logging/tracing systems and check if Sections 1 & 2 have already been received from the Coroner.
- Approximately 30 minutes per case (plus traveling time) if a visit to the Coroner's Office is required
- Approximately 15 minutes per case for Patient & Practitioner Services to locate the patient's medical notes and forward the GP questionnaire.
- Approximately 15 minutes per case for the Coroner to complete Sections 1 & 2.
- Approximately 15 minutes per case for specialist mental health Trust to complete Section 4.
- Approximately 30 minutes per case to follow up GP &/or mental health Trust, as required, match up all the completed Sections and input the results onto the database.
- Approximately 15-30 per case for the Primary Care Team to complete the Section 3.

Appendix 3

Areas for collecting information and their rationale

Areas for collecting information in suicide audit and their rationale

A designed for purpose database to support local suicide audit is available to be downloaded at http://www.nimhe-em.org.uk/suicide_db/index.html

The rationale and method of determining the choice of variables has been based on:

1. Literature searches
2. Searches of grey literature and research projects
3. Discussions with coroners, GPs, clinical governance leads, public health leads, secondary care, Peninsula Medical School, National Confidential Inquiry for Homicides and Suicides, NIMHE Primary Care Suicide Prevention Project Group and sites who piloted earlier versions of the audit tool.

Inclusion of qualitative data will enhance local interpretation of statistical data.

| | Variable | Rationale for data collection |
|--------------------------------|---------------------|-----------------------------------------------------------|
| Section 1: Demographic details | | |
| 1.1 | Date of birth | Younger and older people at increased risk |
| 1.2 | Date of death | To indicate gap between any possible contact/intervention |
| 1.3 | Age | Younger and older people at increased risk |
| 1.4 | Sex | Young men at increased risk |
| 1.5 | Sexual orientation | Paucity of information known about this as a risk factor |
| 1.6 | Resident's postcode | Postcode for link to deprivation and mapping "hotspots" |
| 1.7 | Ethnicity | Paucity of information known about this as a risk factor |
| 1.8 | Place of birth | New and increasing immigrant populations to England |
| 1.9 | Marital status | Single /recently widowed increases risk |

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|------|----------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|
| 1.10 | Living situation at time of death | Living alone significantly increases risk |
| 1.11 | Occupation at time of death | Some professional groups at greater risk e.g. doctors, farmers |
| 1.12 | Employment status at time of death | Joblessness increases relative risk |
| 1.13 | Housing status at time of death | Homelessness increases relative risk |
| 1.14 | History of being in prison or Young Offenders Institution at any time in the 12 months before death (includes being a remand prisoner) | Increases relative risk |
| 1.15 | History of being involved with the probation service at any time in the 12 months before death | Generally quoted as related to increased risk |

Section 2: Coroner related information

| | | |
|------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|
| 2.1 | Was there a suicide note | Indication of intent |
| 2.2 | Location of event | To identify hotspots |
| 2.3 | Location postcode (where possible) | To identify hotspots |
| 2.4 | Method of death (if more than one, please give direct cause) | Interventions can be considered to reduce 'means' most directly effective |
| 2.5 | If self-poisoning, specify substance (If more than one substance, select most likely cause of death) | Safe prescriptions can have 9% impact |
| 2.6 | Where did the self-poisoning substance referred to above come from? | To inform interventions |
| 2.7 | Was alcohol taken at time of death? | Increases relative risk |
| 2.8 | Were other non-prescribed drugs taken at the time of death? | Increases relative risk |
| 2.9 | Factors contributing to suicide from coroner's perspective | Qualitative opinion to inform interventions and training strategies |
| 2.10 | Suicide or open verdict | |
| 2.11 | Brief description of incident | Qualitative opinion to inform interventions and training strategies |
| 2.12 | In the opinion of the Coroner was there anything different that could have been done which might have prevented the suicide and what lessons can be learned from this? | Qualitative opinion to inform interventions and training strategies Inform local Suicide Prevention Strategy |

Section 3: Information relating to contact with Primary Care

| | | |
|------|--------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 3.1 | Other physically disabling or distressing condition (non-psychiatric) at the time of death | Chronic disorder is known to impact on relative risk |
| 3.2 | Date of last contact primary care | To inform local learning and consider possible intervention strategies |
| 3.3 | Reason for contact | To inform local learning and consider possible intervention strategies |
| 3.4 | Number of consultations with GP | To inform local learning and consider possible intervention strategies |
| 3.5 | Date of last contact with another member of the primary health care team | To inform local learning and consider possible intervention strategies |
| 3.6 | Reason for contact | To inform local learning and consider possible intervention strategies |
| 3.7 | Who was the last primary health care team contact and their role | Where there was an opportunity for intervention this may indicate training needs – i.e. if recent contact with practice nurses/receptionists rather than GPs) |
| 3.8 | Diagnosis of mental illness in 12 months prior to suicide | Not believed to be routinely assessed in primary care but may be one strategy for making an impact |
| 3.9 | Current and / or ongoing diagnoses | Some conditions linked to increased risk |
| 3.10 | Type of mental state assessment carried out | Recognition and treatment of suicide intent can have up to 48% impact on suicide rates. This has greatly improved in primary care but 'suicide risk assessment' is less well developed. |
| 3.11 | Date of last mental state assessment in primary care | To inform local learning and consider possible intervention strategies |
| 3.12 | Documentation of suicide risk | To inform local learning and staff development strategies |

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|------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 3.13 | Risk management interventions (distinguish between planned and implemented) | To inform local learning and staff development strategies |
| 3.14 | Treatments taken up in last 12 months | Audit of what anti-depressants are being used, if trials of treatment are adequate length and dose |
| 3.15 | Did the patient adhere to their medication / treatment plan? | To inform local learning and consider possible intervention strategies |
| 3.16 | History of self-harm | To inform local learning and consider possible intervention strategies |
| 3.17 | Number of previous suicide / self-harm attempts in the 12 months prior to death | Audit to see if information is getting to GP A quarter of all suicides in UK have been seen in last 12 months in a general hospital after non-fatal act of self-harm. |
| 3.18 | Suicidal thoughts, plans or intent expressed at last primary care contact | To inform local learning and consider possible intervention strategies |
| 3.19 | Suicide risk, thoughts, plans or intent documented in the 6 months prior to suicide in primary care notes | To inform local learning and consider possible intervention strategies |
| 3.20 | Other agencies involved in 12 months prior to suicide | To inform future multi-agency working |
| 3.21 | Date of last contact with specialist mental health services (excluding any based within primary care e.g. practice based counsellors or graduate workers – but including link workers and CMHT staff) | To inform interventions and training strategies and cross reference with primary care feedback |
| 3.22 | Nature of last contact | To inform interventions and training strategies and cross reference with primary care feedback |
| 3.23 | Has this case lead to a practice based Significant Event Audit (SEA)? | Instigate local learning and develop practice |
| 3.24 | Has the Primary Care Trust been informed of any practice-based learning from the Significant Event Audit? | Implement local learning and develop practice |
| 3.25 | Did the Significant Event Audit involve consideration of any secondary health care service involvement? | Implement local learning and develop practice |

| | | |
|-------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|
| 3.26 | In the opinion of the primary care team are there lessons to be learned from this case that might help prevent suicides in the future? | Inform interventions and training strategies Inform local Suicide Prevention Strategy |
| Section 4: Information relating to acute hospital services | | |
| 4.1 | Number of times patient seen in A&E / hospital in 12 months prior to suicide? | Chronic disorder is known to impact on relative risk Previous episodes of self harm increase relative risk |
| 4.2 | Date of last discharge from A&E Department or hospital (if recently hospitalised) | To inform interventions and training strategies |
| 4.3 | Reason for attendance at A&E or hospitalisation (if hospitalised) | Chronic disorder is known to impact on relative risk Previous episodes of self harm increase relative risk |
| 4.4 | Was a psychosocial assessment carried out prior to discharge? | Evidence suggests that psychosocial assessments are not undertaken in almost half of patients attending A&E for self harm |
| Section 5: Information relating to psychiatric history | | |
| 5.1 | Past psychiatric status (includes contact before the 12 months prior to death) | 25% of all suicides have been in contact with psychiatric services in the 12 months prior to death |
| 5.2 | Date of last contact with specialist mental health services (excluding any based within primary care e.g. practice based counsellors or graduate workers – but including link workers and CMHT staff) | To inform interventions and training strategies and cross reference with primary care feedback |
| 5.3 | Nature of last contact | To inform interventions and training strategies and cross reference with primary care feedback |
| 5.4 | If applicable, dates of last admission and discharge from psychiatric in-patient ward. | To inform interventions and training strategies |

Appendix 4

Further information and references

Further reading and resources on Significant Event Audit

Church, E. & Ryan, T. (2006) Suicide Audit in Primary Care Trust localities: A whole systems approach. Care Services Improvement Partnership, National Institute for Mental Health in England.

Lewis, B. (2004) Primary Care. In: D. Duffy & T. Ryan (eds) New Approaches to Preventing Suicide: A Manual for Practitioners. London: Jessica Kingsley Publishers.

Pringle, M., Bradley, C.P., Carmichael, C.M., Wallis, H. and Moore, A. (1995) Significant Event Auditing. Occasional Paper 70. London: Royal College of General Practitioners.

Also see Issue 5 of "In Safer Hands", produced by the Royal College of General Practitioners with the support of the National Patient Safety Agency which briefly looks at significant event auditing and how primary care teams can get the most from the process. http://www.rcgp.org.uk/quality_unit/ish.asp

Websites

Centre for Suicide Research
<http://www.psychiatry.ox.ac.uk/csr/index.html>

Exeter University
<http://www.projects.ex.ac.uk/sigevent/>

National Institute for Mental Health in England
<http://nimhe.org.uk>

National Patient Safety Agency
<http://npsa.nhs.uk>

Patient UK
<http://www.patient.co.uk/showdoc/40024612>

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|------|------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|
| 5.5 | If applicable, had there been face to face contact with the patient by mental health provider within 7 days of discharge from in-patient care? | To inform interventions and training strategies |
| 5.6 | Please state the number of days between discharge and first contact | To inform local service development and practice |
| 5.7 | Number of admissions to psychiatric in-patient ward in the past 5 years (including any admission at time of death) | Increases relative risk |
| 5.8 | Psychiatric and learning disability diagnosis | Relative risk increased with psychiatric diagnoses, particularly schizophrenia and depression |
| 5.9 | History of self-harm | Increases relative risk, 1% lifetime risk, 30-47% of total suicides have history of self harm with 50% of attempts within year prior to suicide |
| 5.10 | History of violence (i.e. serious threat or assault causing significant physical harm, including sexual assault) | Increases relative risk |
| 5.11 | History of alcohol misuse | Increases relative risk |
| 5.12 | History of drug misuse | Increases relative risk |
| 5.13 | In the opinion of the Mental Health Trust are there lessons to be learned that might prevent suicides in the future? | Inform interventions and training strategies Inform local Suicide Prevention Strategy |

References

Department of Health (1999a) Saving Lives: Our Healthier Nation. London, The Stationary Office.

Department of Health (1999b) National Service Framework for Mental Health. London, Department of Health.

Department of Health (2005) Confidentiality and Disclosure of Information: General Medical Services (GMS), Personal Medical Services (PMS), and Alternative Provider Medical Services (APMS) Code of Practice 2005. London, Department of Health. (at http://195.33.102.76/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4107303&chk=GiJc0B)