Suicides - notifications in England

EPSO meeting
June 2 & 3 2008
Healthcare Commission

Anthony Deery
Head of Mental Health, Learning Disabilities and Older People

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Agenda

- National policy
- Reporting requirements
- Confidential inquiry – suicides
- Our role

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Background

- *Established the Confidential Inquiry into Homicides and Suicides by mentally ill people (1996)*
- Saving Lives; Our Healthier Nation – 1997

  > *Department of Health set a target of a 20% reduction in suicide by 2010*
- *Recognised that people with mental illness represent one of the most high risk groups for suicide*
- *National Service Framework for Mental Health (1999) contained a specific standard on suicide prevention*
- *Safety First Report 2001 - Introduced a National Suicide Prevention Strategy for England (2002) – people under the care of mental health services seen as a priority.*
- *Suicide prevention toolkit 2003*

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Reporting requirements

NHS provider trusts	Independent Sector
Regional Strategic Health Authority	Registration Authority (Healthcare Commission)
Coroner's Office	
Mental Health Act Commission where patient has been detained under the Mental Health Act	Mental Health Act Commission where patient has been detained under the Mental Health Act
National Patient Safety Agency (voluntary)	National Patient Safety Agency (voluntary)

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Confidential homicide and suicide inquiry

Purpose of the inquiry

- To elicit avoidable causes of death
- Determine best practice by detailed examination of the circumstances surrounding such events

- First complete national data collection began in 1997
- Managed by the University of Manchester

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Methodology

3 stages to the data collection

1. General population suicides and deaths from undetermined cause is collected from the Office for National Statistics
2. Details on each case submitted to mental health services in each individual's district of residence, district of death and adjacent districts to identify those with a history of mental health service contact in the 12 months before death.
3. Information on Inquiry cases is obtained from clinical teams via a questionnaire sent to the consultant psychiatrist

- Inquiry data includes information on people who die by suicide or who receive an open verdict following a coroner's inquest

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Data

- data completeness for inquiry cases is high, overall 97% (range 91%-99%)since data collection began.

- the figures reported in the confidential inquiry relate to suicides in England and Wales from age 10 and over.

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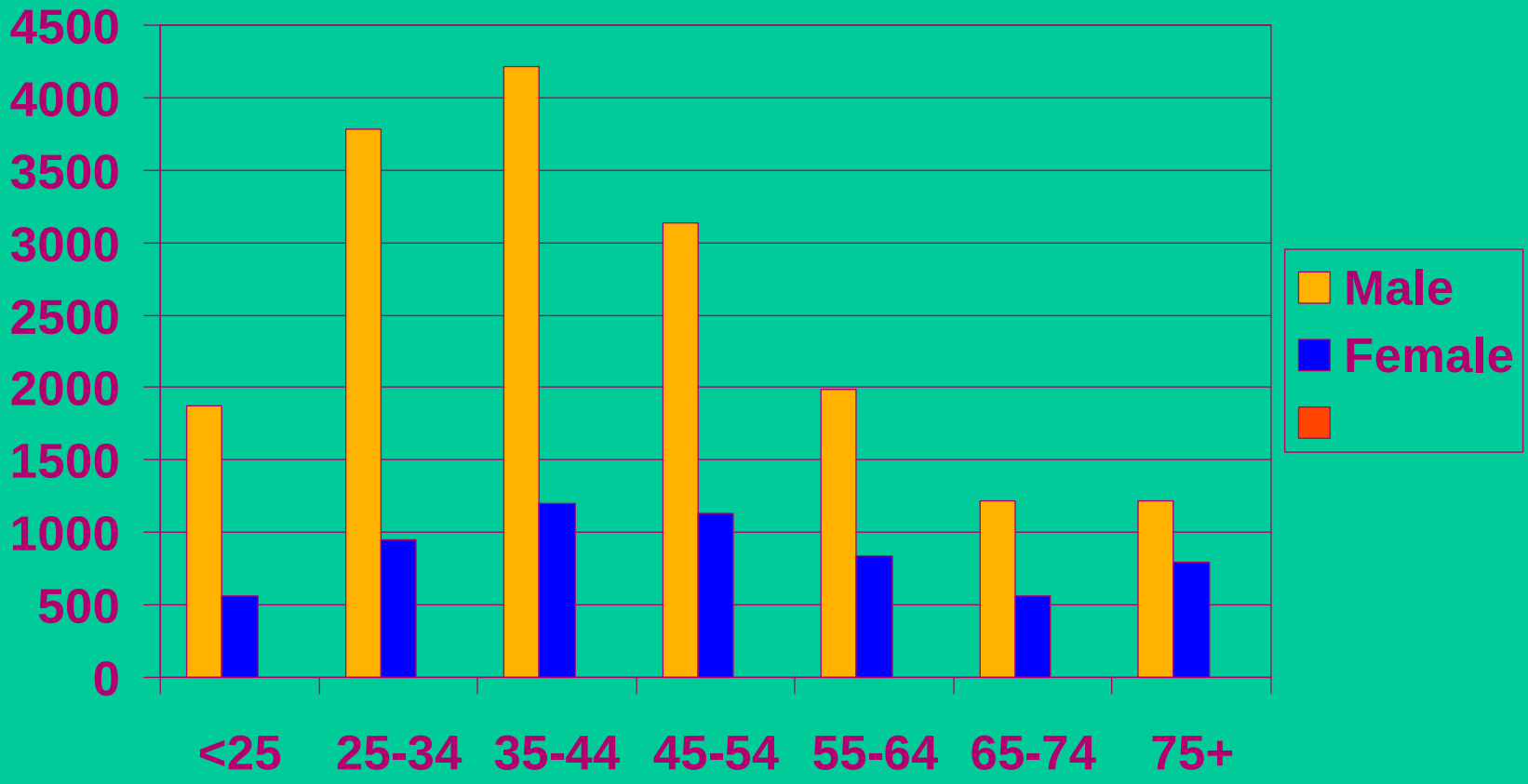
General population suicides; age and sex profile



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Trends

• Overall general population number of suicides has decreased since 1997.

• Highest in 1998 and lowest in 2004

• from 1997 to 2004 there was a fall of 30% (n67) in the number of in-patient suicides.

Most recent figures 2006

• 23,477 cases in the general population notified to the inquiry between 2000-2004

• Included 16,324 cases of suicide and 7,153 open verdicts or deaths from undetermined cause

• 74% were male giving a male to female ration of 3:1

• Highest in the 25-34 group (80% male), lowest in the over 75 group (61% male)

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Known facts

High rates are particularly associated with

- Acute episodes of illness
- Recent hospital discharge
- Social factors such as living alone
- Clinical features such as substance misuse and non-fatal self-harm

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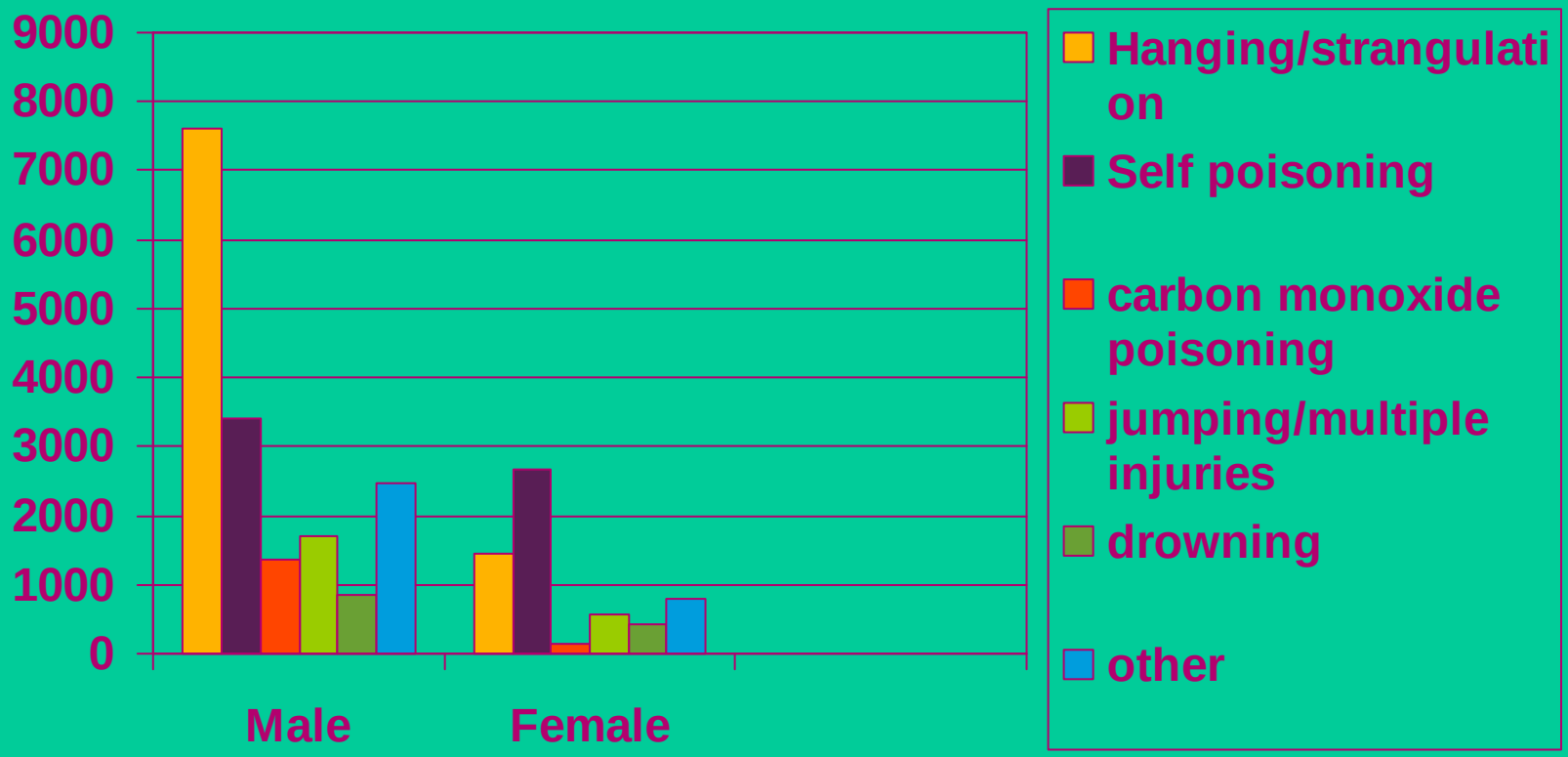
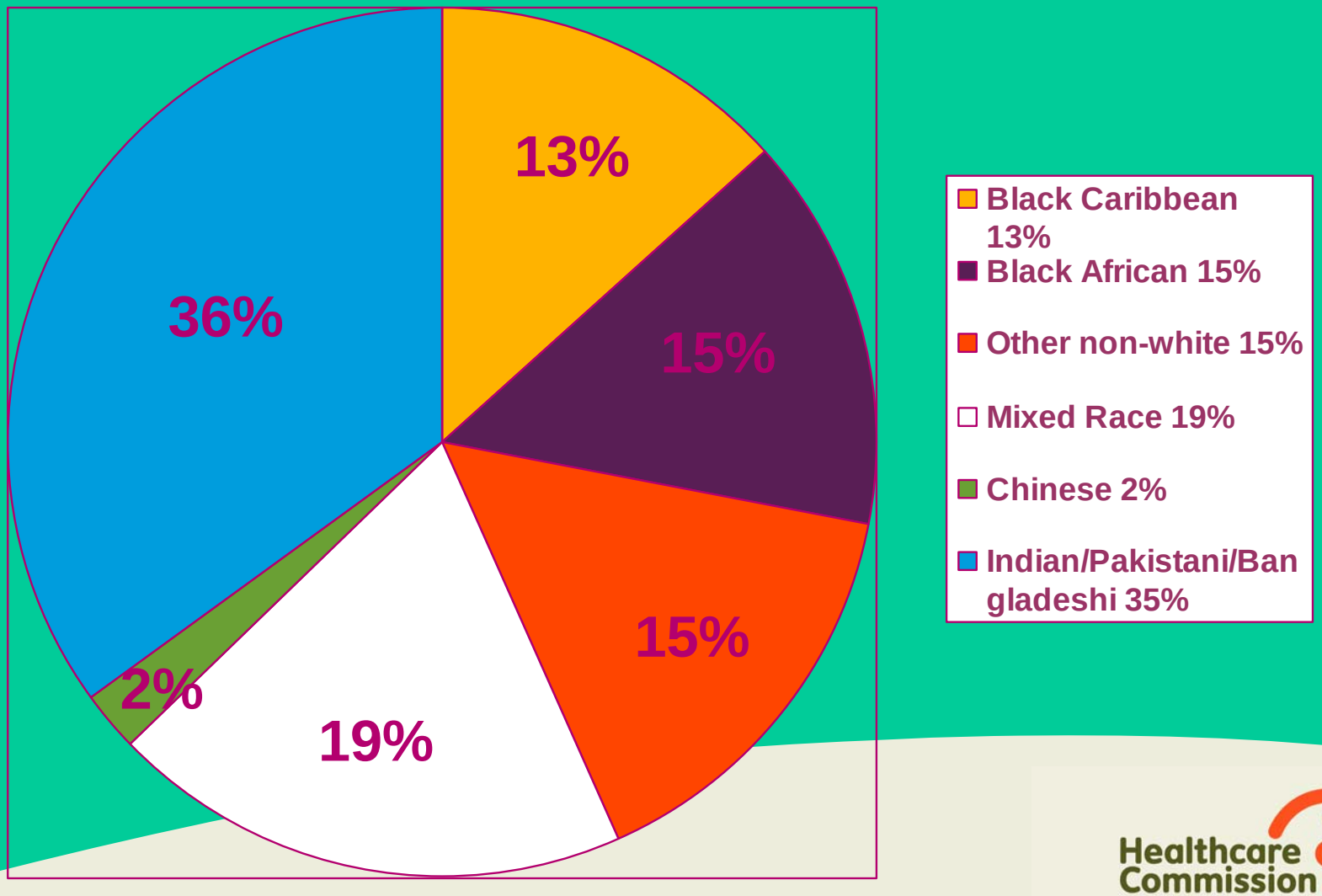
Methods of suicide



Ethic origin (not including white)



Contact with mental health services

- 27% (6,367) of the total sample for the period 2000-2004 were known to be in contact with mental health services in the year before death which marked a slight increase from 24% in the previous period

Preventability

- 19% (1017) of cases it was felt that the suicide could have been prevented
- These cases were more likely to:-
  - > be suffering from an affective disorder
  - > have been an in-patient at the time of death
  - > have detectable symptoms at final contact

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contd

- cases under the age of 25 seen to be more preventable, as were cases of people with a severe mental illness

Least preventable

- people with drug dependence

Overall estimate of possible preventable deaths

- inpatients 41%
- community 12%

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Key service recommendations

	Description	Full
1	The removal of ligature points on in-patient wards including non-collapsible curtain rails	95%
2	Community Services include an assertive outreach team	97%
3	Community Services include a single point of access for people in crisis available 24hrs a day (as part of the mental health service)	70%
4	There are written policies/strategies regarding follow-up within 7 days of discharge from psychiatric in-patient care	95%
5	There are written policies/strategies regarding response to patients who are non-compliant with treatment	73%
6	There are written policies/strategies regarding the management of patients with a dual diagnosis	55%
7	There are written policies/strategies regarding information sharing with criminal justice agencies on risk	85%
8	There are written policies/strategies regarding multi-disciplinary review and the sharing of information with families after suicide	86%
9	Training and record keeping: front line clinical staff receive training in the management of suicide risk at least every three years	86%

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Our role

- To assess if trusts and independent sector providers have the systems in place
- Assess performance against the national suicide target
- Undertake service reviews and national audits
- Investigate where we have cause for concern

Safety First', the 2001 five year report of the National Confidential Inquiry into suicide and homicide by people with mental illness, put forward a series of recommendations for mental health services. These were formulated into eight measurable standards in the guidance document 'Preventing

Suicide: A toolkit for Mental Health services' published in October 2003.

Data source

Special data collection

Construction

Indicator:
'Preventing Suicide: A toolkit for Mental Health Services' sets out eight measurable standards for suicide prevention, namely:

Standard one: appropriate level of care
Standard two: in-patient suicide prevention
Standard three: post discharge prevention of suicide
Standard four: family/carer contact
Standard five: appropriate medication
Standard six: co-morbidity/dual diagnosis
Standard seven: post-incident review
Standard eight: training of staff

The toolkit also describes a process by which audits against these standards may be carried out, and which trusts may choose to follow in conducting their own suicide prevention audits. More broadly, a robust audit will include the following main stages:

1) The selection of a sample of cases that are either at risk of suicide or have committed suicide
2) The obtaining of information from clinical records to answer the questions set out in the audit tool (and/or, as locally appropriate, other relevant questions linked to the eight standards)
3) Interviews with relevant clinical service managers
4) The findings of the audit presented as both a written report and as an oral presentation to managers and clinicians
5) Timetable agreed with clinical teams to address any standards not yet fully met
6) Re-audit to ensure remedial action has been effective or, if no remedial action was required, there is an agreed date for a re-audit to ensure continued compliance with the eight standards.

Trusts are assessed on how far their audits have progressed along these stages within a 12 month period.

The National results of staff trained in the evidence base
C5: are staff trained to update skills and techniques relevant to their clinical work

Evidence based *NICE clinical care pathways	National Average %
How to give information to patients on diagnosis, medication and side effects	14
How to undertake Care programme Approach	18
How to assess SUs at risk of suicide	18
How to assess carers	15
How to ask patients about the use of drugs and alcohol	12
How to handle patients under influence of drugs & alcohol	10
How to treat dual diagnosis	10
Psychological training therapies	15

*** National Institute for Health and Clinical Excellence**

Source HC Staff survey 2007

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Future

continue to focus on

- Local accountability – intelligent board information
- Quality of the environment
- Staff training – particularly around evidence based treatments and risk assessments
- Reduce absconding from inpatient units
- Effective implementation of the care programme approach especially around transition from ward to community settings

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Thank you

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The principles and practice of information-led regulation

EPSO meeting

June 3 2008

Richard Hamblin

Head of Information Policy

Healthcare Commission

Agenda

What we contribute as a regulator

How information is critical to our contribution

Explain what we do and what we don’t

Dispel myths

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What we seek to do as a regulator

Stimulate improvement in health services

Provide assurance that services are of an acceptable standard

Identify problems before they become crises

Respond quickly to concerns

Provide comparative information on performance level with the aim of stimulating improvement

Be proportionate, risk-based, and avoid duplication

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It’s not about making all the decisions in the office

No super computer on which we press a button and the result comes out

We visit as often as is necessary

Information is more than just numbers

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The NHS is a very data rich environment

Extensive use of existing data streams

215 individual data streams (mainly nationally collected data sets)

40 different organisations (government, NHS, other regulators, academic departments, royal colleges)

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Assessing core standards

24 core standards – 44 part standards

Introduced 2004 – first time the NHS had standards

Cover 7 domains

In theory represented consistent practice in 2004

We assess annually but how

- Can't inspect everywhere
- Too broad for straightforward measurement

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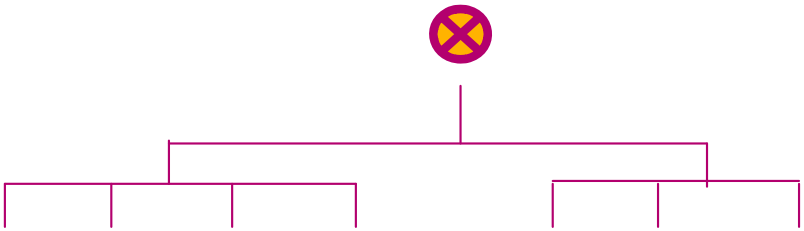
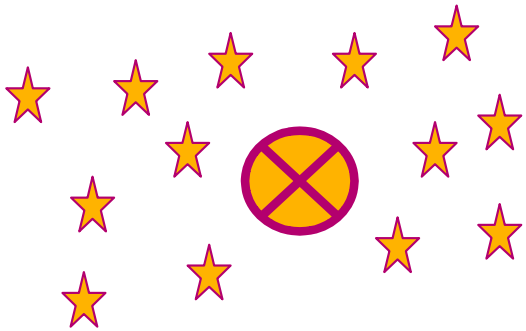
1 issue – 1 measure

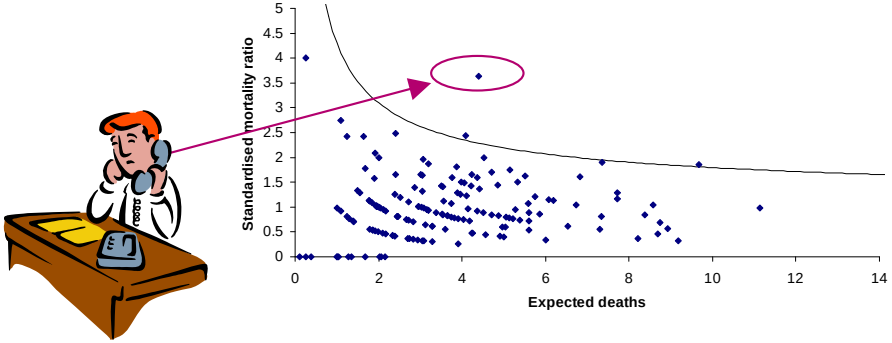
Assessment frameworks – many related measures



1 issue – many (unrelated) measures



Identify and respond to outliers



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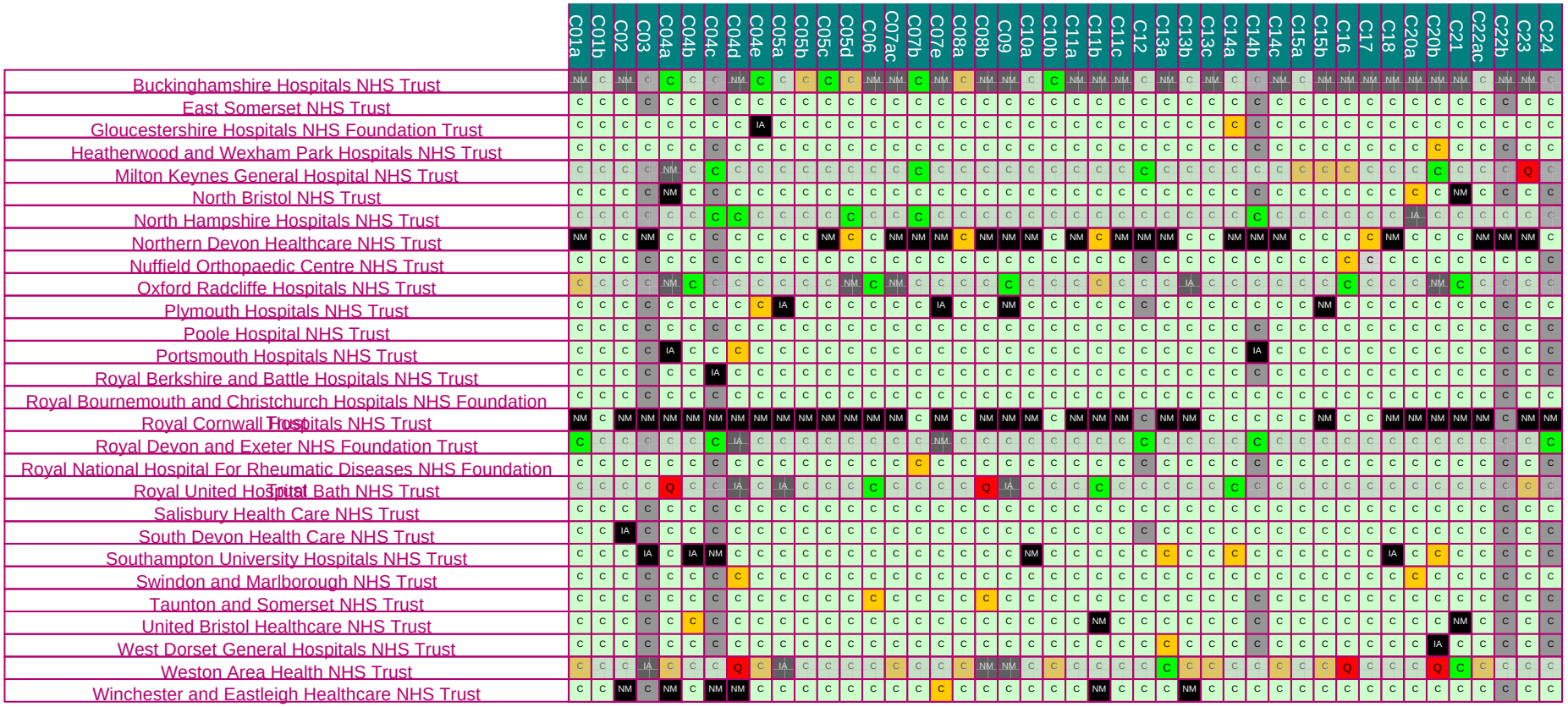
Randomly selected inspections



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Does it work?

Three times more likely to pick up undeclared non-compliance

Consistent judgements made (improving over time)

85% of decisions to inspect draw on qualitative data

Capacity to identify “deeper dives” (Dignity)

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It’s not a once-a-year all or nothing exercise

- Quarterly updates to field staff
- Ongoing monitoring

  >outliers

  >time-series

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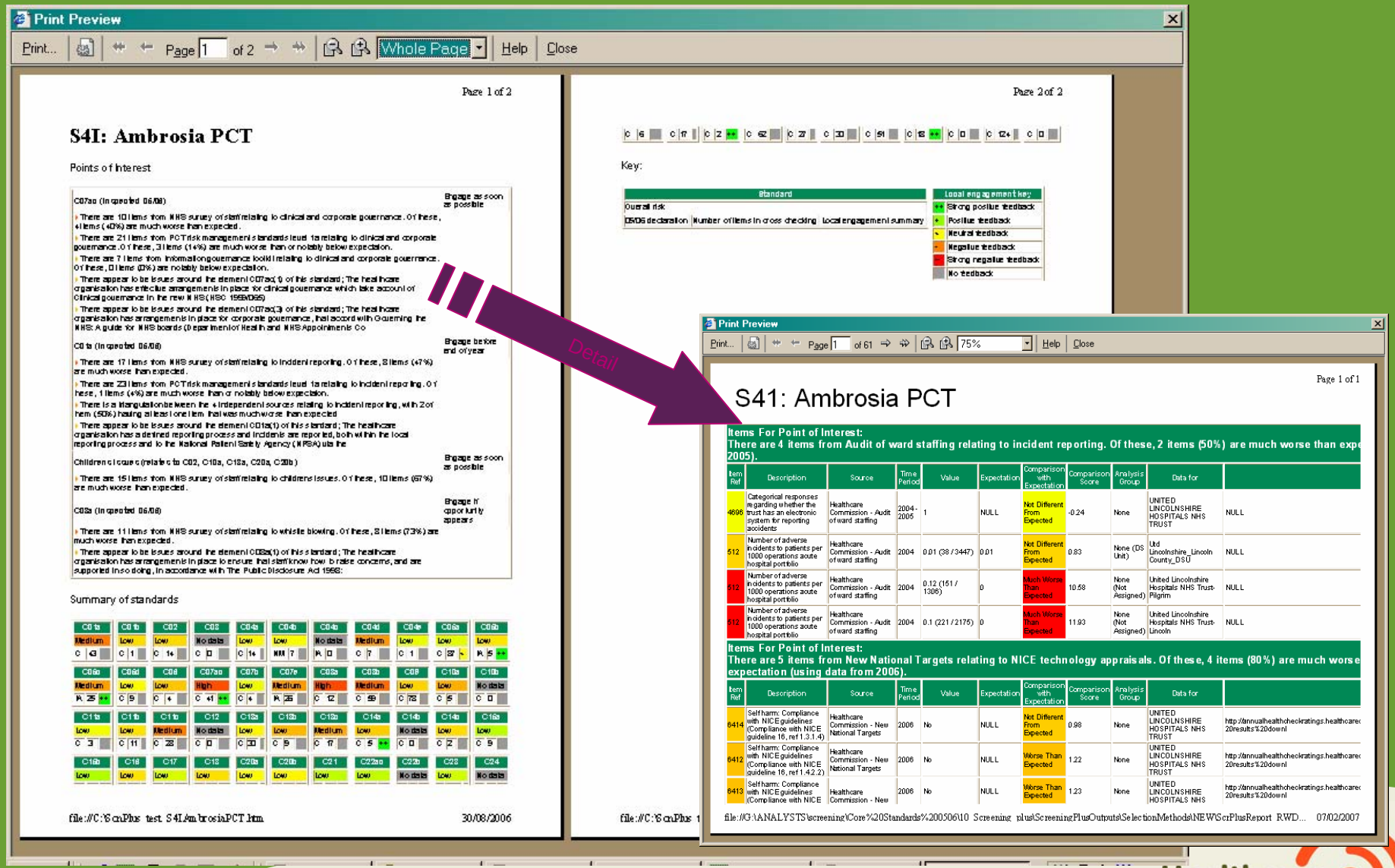
Screening Plus



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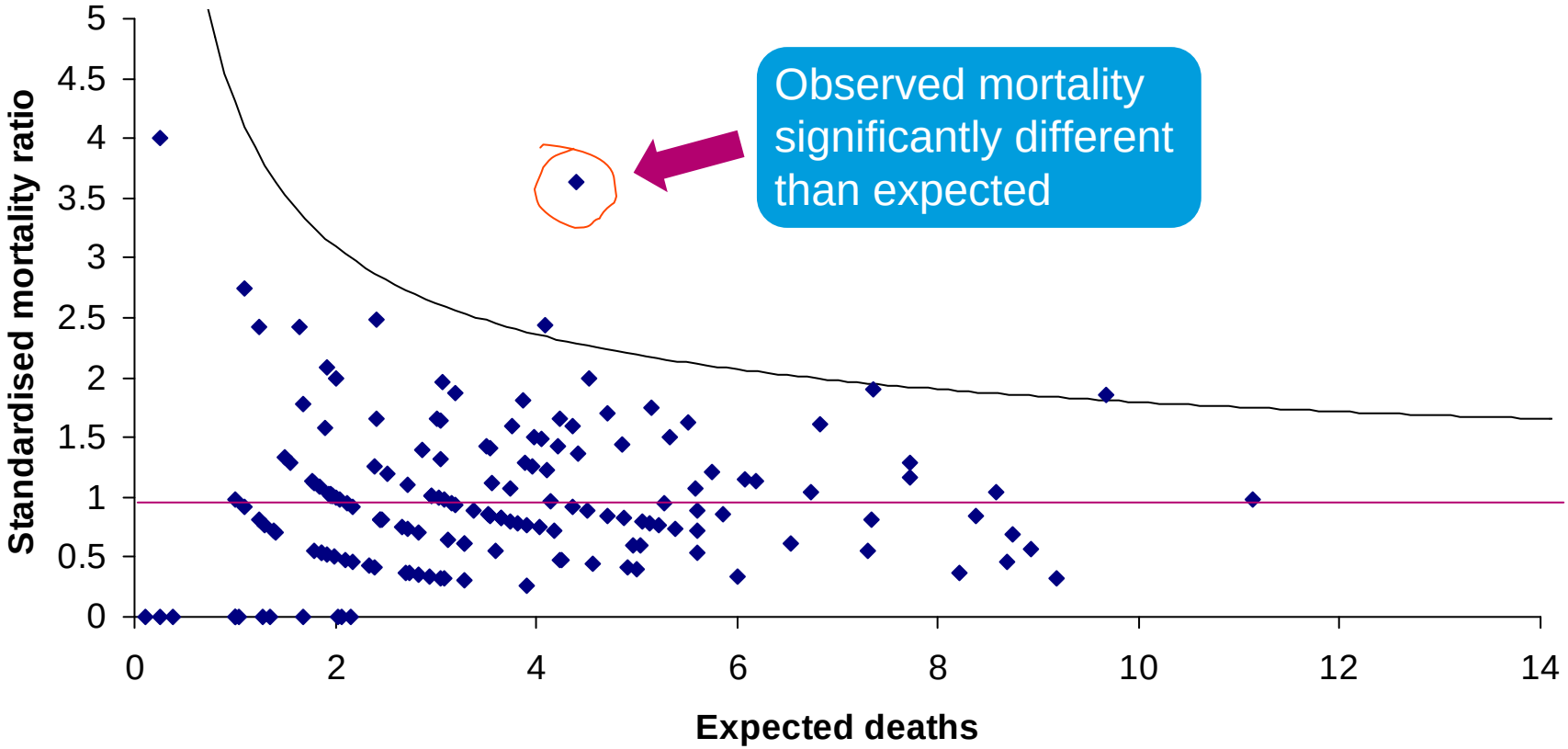
What is an outlier?

Outcomes for patients admitted with heart valve disorders



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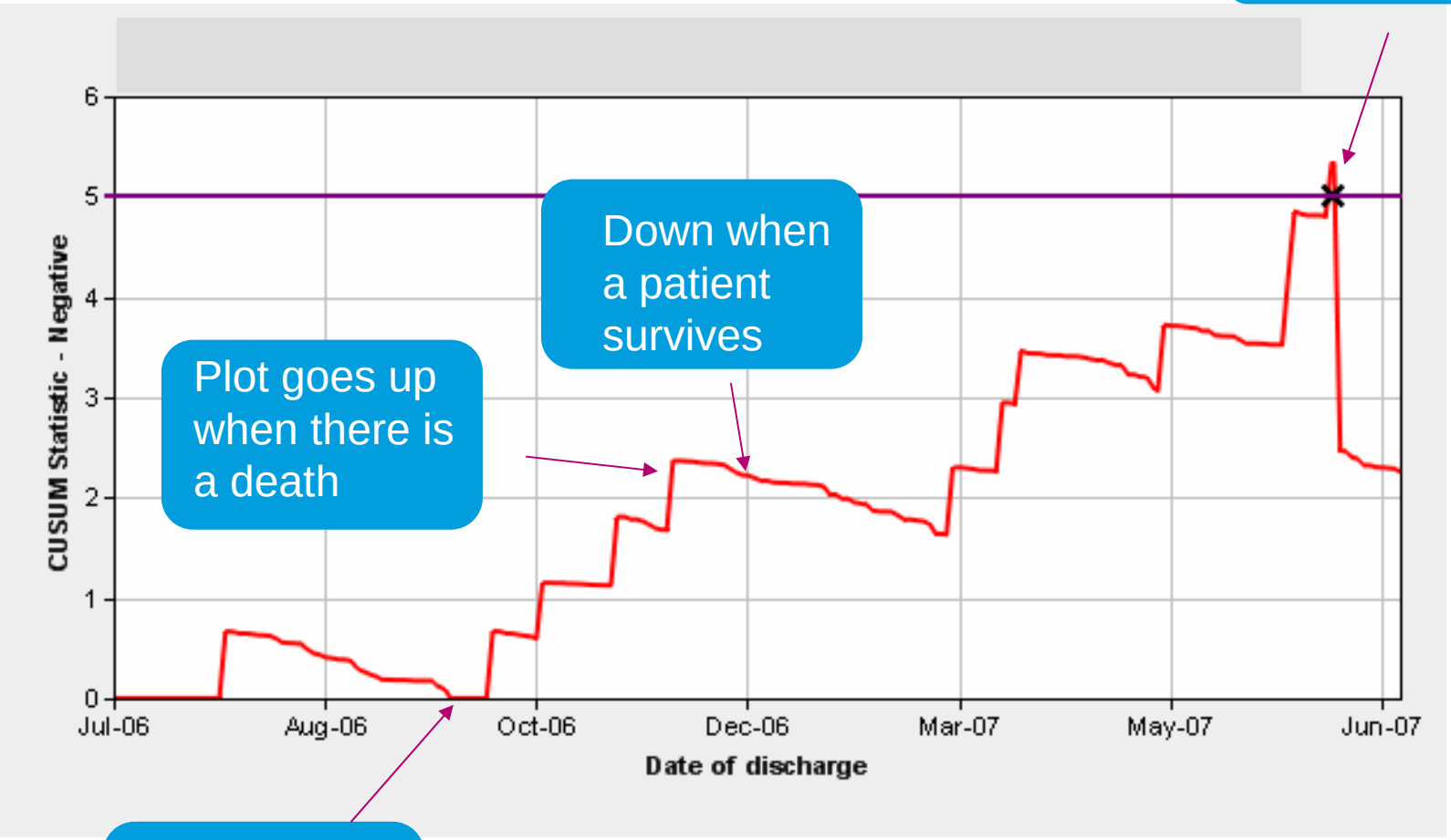
Poor outcomes over time – CUSUM



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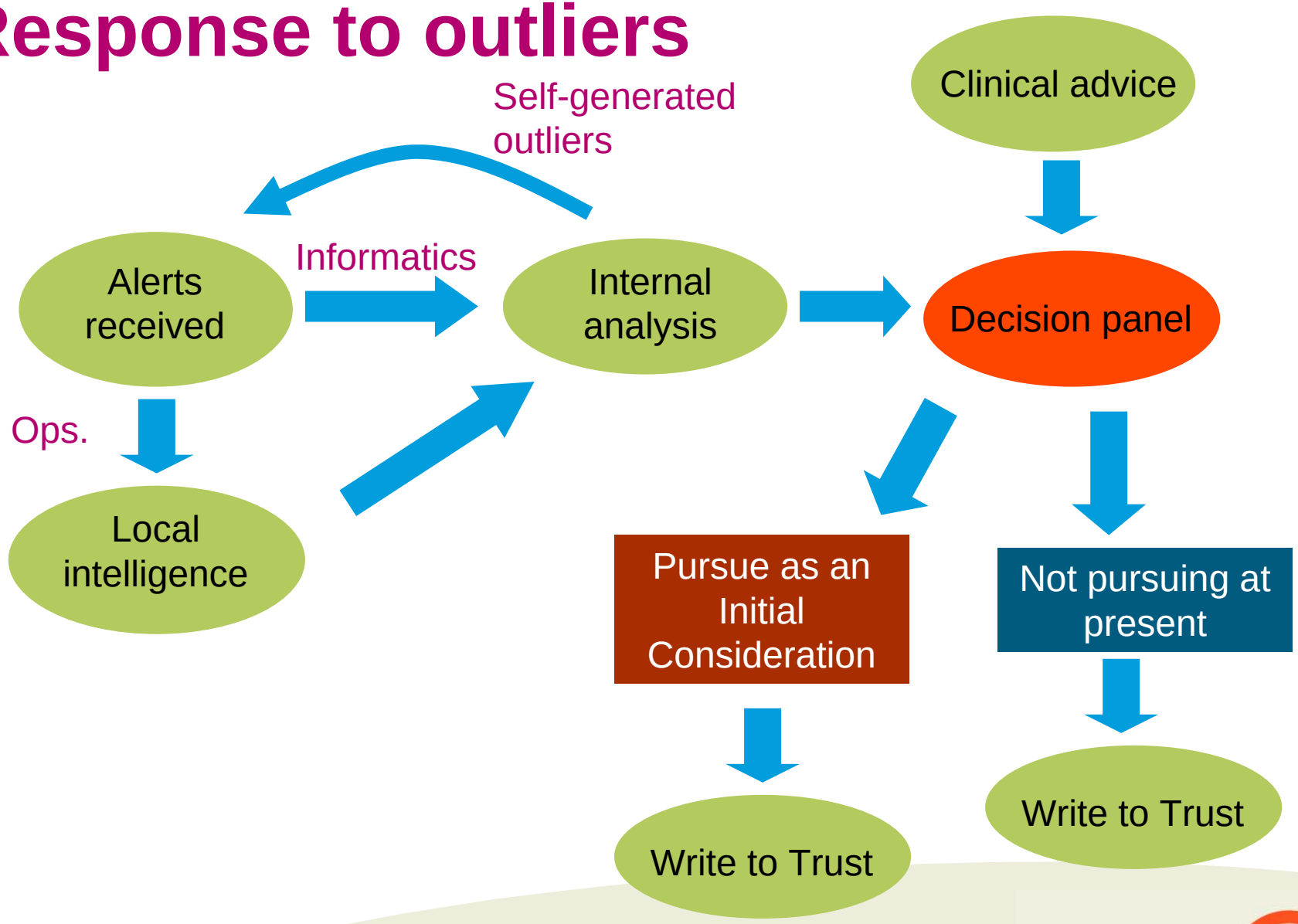
Response to outliers



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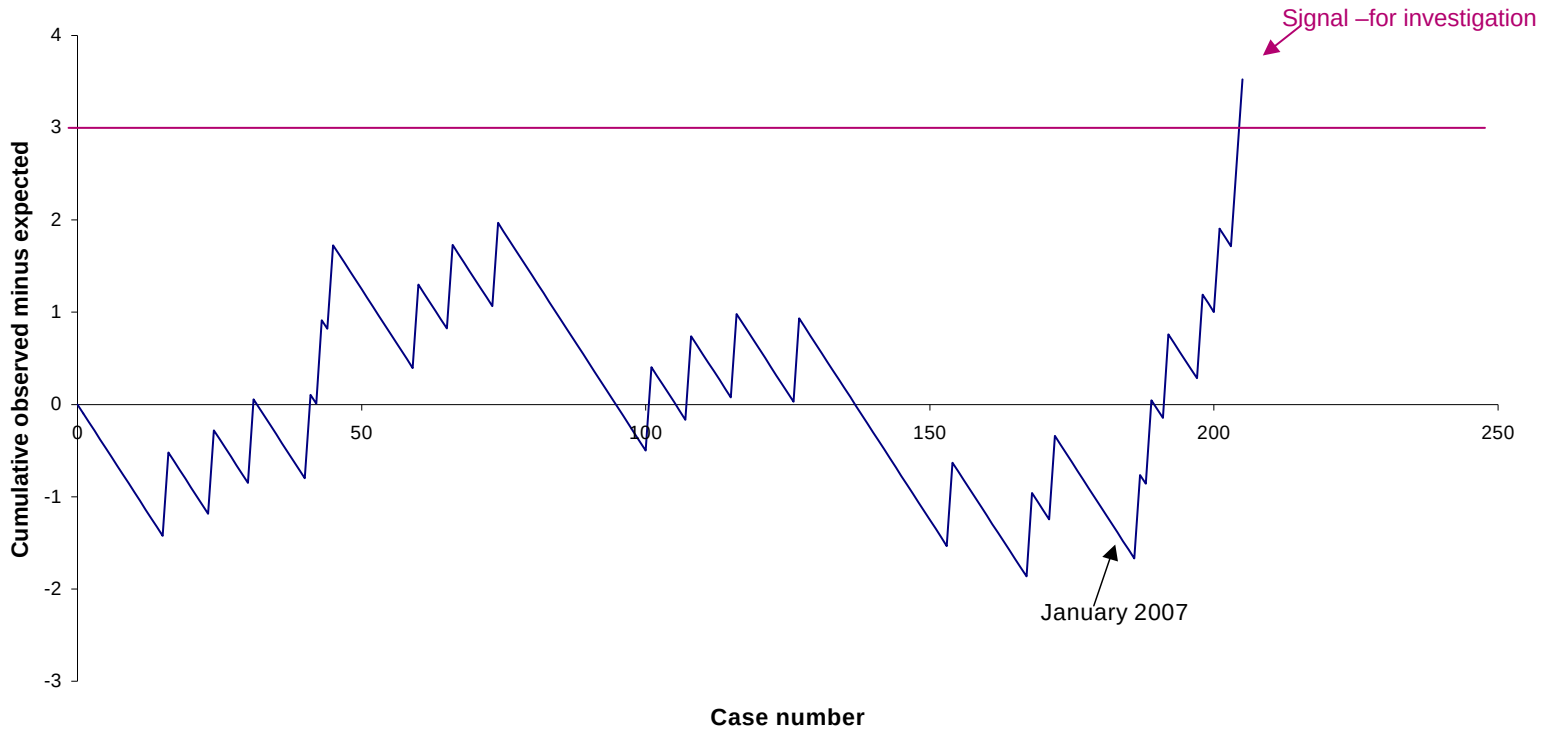
Using outcomes data for continuous monitoring of heart transplant success

Figure 2: Cumulative O-E chart for Papworth from January 2002 to September 2007, unadjusted for patient risk



Source: UK Transplant

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But what do you do when the numbers aren't there?

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An important question

- Independent sector has relatively little comparative data
- Social care has even less
- But both have a lot of qualitative information

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Using unstructured data to help adjust risk

What is unstructured data?

- Qualitative information
- A mixture of non – numeric and numeric data
- Data from ‘non-standard’ sources

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What we do with it

- Review material received
- Decide on what can be used
- Code and weight the unstructured data (local intelligence)

  >Data quality

  >Patient experience

  >Association with assessment criterion

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Some examples received from Patient and the Public Involvement Fora

Staff were consulted about the plans and involved in the design and planning of the unit. (Low)

The forum continues to experience good working relationships with X. (Low)

Following reconfiguration, C has failed to adequately seek the views of patients and the public. The C did no consultation when taking the decision to close X and Y in Z, despite confirming afterwards that they started to discuss it as early as A. The forum learned of closures of X and Y through a C press release that announced that the closures had taken place. The forum raised this with the Trust, OSC and SHA. Moreover, the forum feels strongly that C failed in its statutory duty to consult with patients and the public. The forum continues to receive concerns from local people regarding X and Y closures. (High)

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The trust has also held focus groups and consultation events with patients for example a session on Self Directed Care which gained ideas and opinions of patients with long term conditions in order to influence services. Forum members also took part in this event.(Medium)

PALS officers attend as many PPI Forum meetings as possible. Recently a draft PALS report format for X has been shared with members for comments. A 2 way referral process exists between the forum and PALS. Since reconfiguration there has been a lack of direction in Y as the Z trust have taken on the role. The forum is aware that the new PCT needs to fill this gap in the future. (Medium)

Does it work?

Information (in all its senses) is the only way to understand all of what is really happening

“Soft” intelligence often allows us to spot problems early

119 requests for investigation – 85 considered - many led to intervention

21% of all data items used in AHC are qualitative

10% of decisions to inspect purely on basis of qualitative information

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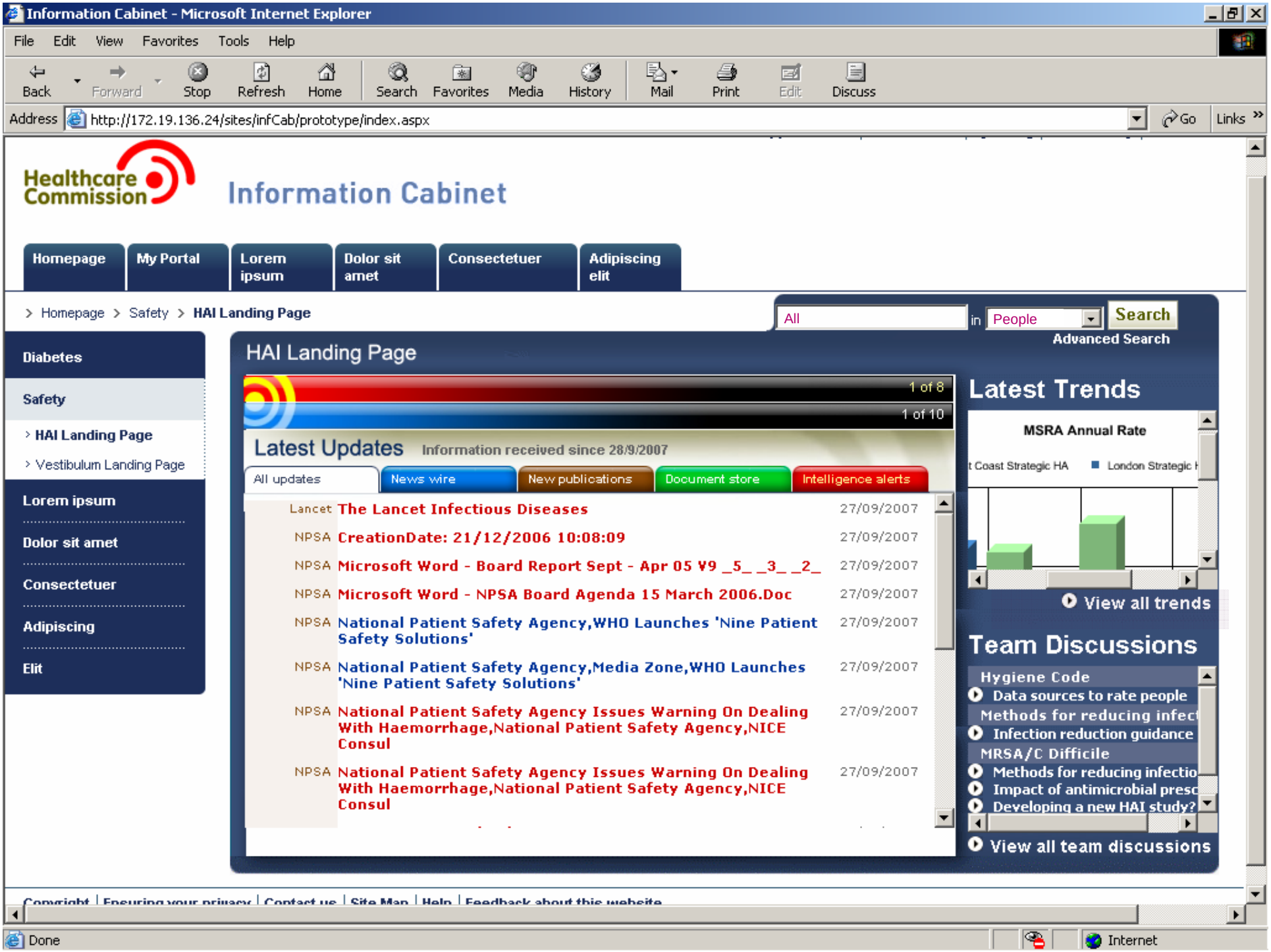
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NPSA Microsoft Word - NPSA Board Agenda 15 March 2006.Doc 27/09/2007
NPSA National Patient Safety Agency,WHO Launches 'Nine Patient Safety Solutions' 27/09/2007
NPSA National Patient Safety Agency,Media Zone,WHO Launches 'Nine Patient Safety Solutions' 27/09/2007
NPSA National Patient Safety Agency Issues Warning On Dealing With Haemorrhage,National Patient Safety Agency,NICE Consul 27/09/2007
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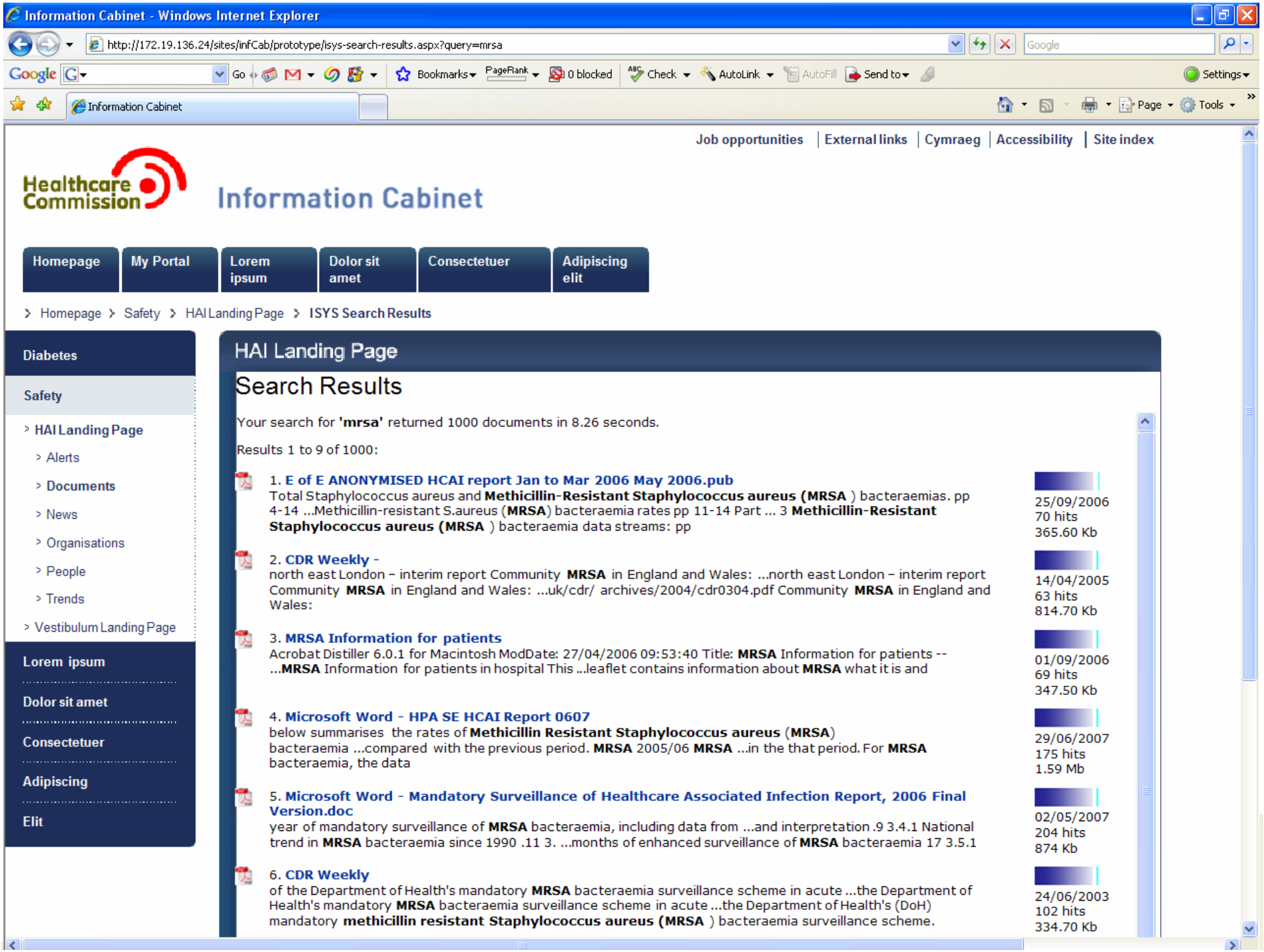
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70 hits
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2. CDR Weekly -
north east London – interim report Community MRSA in England and Wales: ...north east London – interim report Community MRSA in England and Wales: ...uk/cdr/ archives/2004/cdr0304.pdf Community MRSA in England and Wales:
14/04/2005
63 hits
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3. MRSA Information for patients
Acrobat Distiller 6.0.1 for Macintosh ModDate: 27/04/2006 09:53:40 Title: MRSA Information for patients -- ...MRSA Information for patients in hospital This ...leaflet contains information about MRSA what it is and
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below summarises the rates of Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia ...compared with the previous period. MRSA 2005/06 MRSA ...in the that period. For MRSA bacteraemia, the data
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5. Microsoft Word - Mandatory Surveillance of Healthcare Associated Infection Report, 2006 Final Version.doc
year of mandatory surveillance of MRSA bacteraemia, including data from ...and interpretation .9 3.4.1 National trend in MRSA bacteraemia since 1990 .11 3. ...months of enhanced surveillance of MRSA bacteraemia 17 3.5.1
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of the Department of Health's mandatory MRSA bacteraemia surveillance scheme in acute ...the Department of Health's mandatory MRSA bacteraemia surveillance scheme in acute ...the Department of Health's (DoH) mandatory methicillin resistant Staphylococcus aureus (MRSA) bacteraemia surveillance scheme.
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The importance of publishing comparative information

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How might it work

Pressure on providers

Patients as consumers – choosing the best providers

Informed and empowered patients – getting the best from their providers

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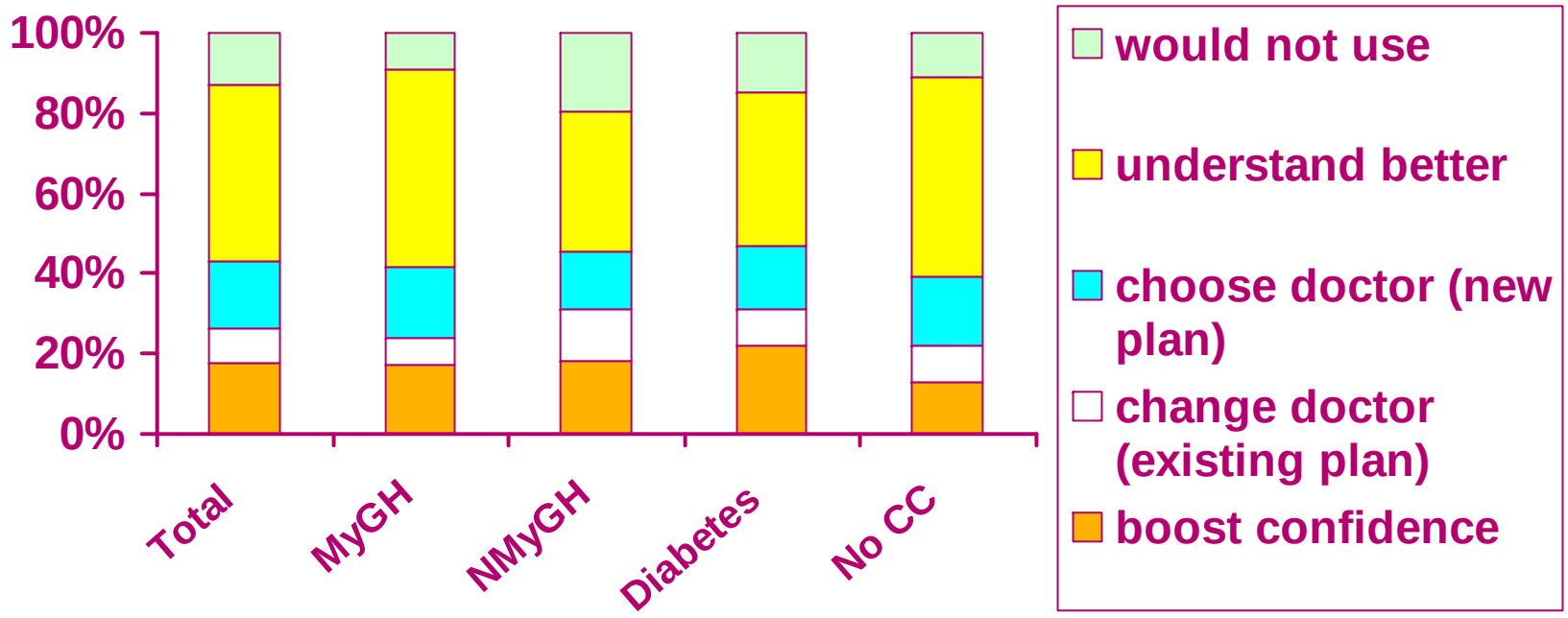
Proportion of respondents citing different uses for data (forced choice of one use)



For all groups "understand better" is a significantly greater proportion than any other

Use versus self-reported interest does not vary (except for the would not use group)

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How does satisfaction affect interest?

Are satisfied patients less interested in having information about quality?

Test 1: Correlation of interest scale with CAHPS satisfaction scale

Correlation between interest and satisfaction ratings

	r^2
Total	0.000
MyGH	0.002
NMyGH	0.011
Diabetes	0.001
No CC	0.001

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How does satisfaction affect interest?

Test 2: Comparison of interest scale with specific CAHPS attributes of patient-focused care

Mean interest scores by regularity of CAHPS attributes

	Always	Not always
Explains	7.7	7.7
Listens	7.6	7.7
Respects	7.7	7.5
Time	7.5	7.9

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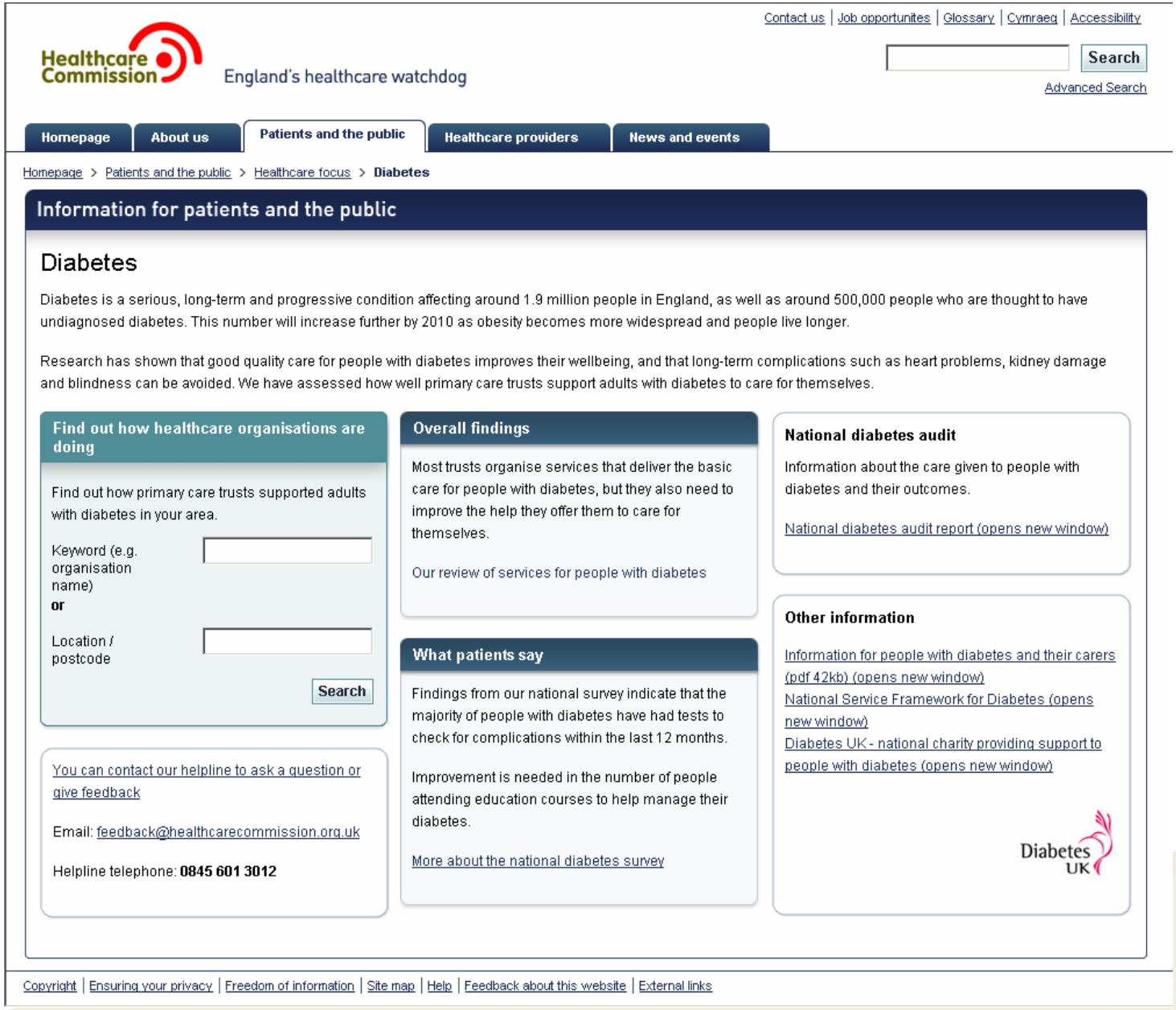
Diabetes Page



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Healthcare Commission — England's healthcare watchdog

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Information for patients and the public

Diabetes

Diabetes is a serious, long-term and progressive condition affecting around 1.9 million people in England, as well as around 500,000 people who are thought to have undiagnosed diabetes. This number will increase further by 2010 as obesity becomes more widespread and people live longer.

Research has shown that good quality care for people with diabetes improves their wellbeing, and that long-term complications such as heart problems, kidney damage and blindness can be avoided. We have assessed how well primary care trusts support adults with diabetes to care for themselves.

Find out how healthcare organisations are doing

Find out how primary care trusts supported adults with diabetes in your area.

Keyword (e.g. organisation name)
or
Location / postcode

Search

You can contact our helpline to ask a question or give feedback

Email: feedback@healthcarecommission.org.uk

Helpline telephone: **0845 601 3012**

Overall findings

Most trusts organise services that deliver the basic care for people with diabetes, but they also need to improve the help they offer them to care for themselves.

Our review of services for people with diabetes

What patients say

Findings from our national survey indicate that the majority of people with diabetes have had tests to check for complications within the last 12 months.

Improvement is needed in the number of people attending education courses to help manage their diabetes.

More about the national diabetes survey

National diabetes audit

Information about the care given to people with diabetes and their outcomes.

National diabetes audit report (opens new window)

Other information

Information for people with diabetes and their carers (pdf 42kb) (opens new window)
National Service Framework for Diabetes (opens new window)
Diabetes UK - national charity providing support to people with diabetes (opens new window)

Diabetes UK

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› Focus on services

Compare healthcare providers

Investigations and interventions

Healthcare focus

State of healthcare 2007

What people with diabetes said:	Percentage score [National average]
Percentage who said it was 'fairly or very **convenient**' for them to **get to their diabetes check-up** (where their test results and treatment are reviewed)	**Score 94%** [93]
Percentage who were diagnosed over a year ago and said they had a **diabetes check up** at least once in the **last 12 months**	**Score 97%** [97]
Percentage who said that the doctor or nurse 'always or almost always' has their most **up-to-date diabetes records** to refer to when they go for their diabetes check-up	**Score 91%** [92]
Percentage who said they 'almost always' **discussed their ideas about the best way to manage their diabetes**(2)	**Score 48%** [48]
Percentage who said they were 'almost always' **given the chance to discuss different medications**(2)	**Score 31%** [31]
Percentage who said they 'almost always' **discussed their goals in caring** for their diabetes(2)	**Score 40%** [39]
Percentage who said they were 'almost always' **given personal advice about the kinds of food to eat**(2)	**Score 42%** [45]
Percentage who said they were 'almost always' **given personal advice about their levels of physical activity**(2)	**Score 35%** [34]
Percentage who said they 'almost always' **agreed when their next appointment would be**(2)	**Score 65%** [70]

Takk!

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