NCISH Quality Improvement Plan (2024-2027)

Introduction

The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) collects data about people who died by suicide under the under the recent care of specialist mental health services in the UK and crown dependencies. Our evidence-based recommendations have been cited in national policies, clinical guidance and regulation, and have improved patient safety in mental health settings and reduced patient suicide rates, contributing to an overall reduction in suicide in the UK.

NCISH key elements for safer care

We have identified key elements for safer care for patients that have been shown to reduce suicide rates in implementing organisations. These recommendations have been developed as quality statements in our continually updated Safer Services Toolkit that mental health care providers can use as a basis for self-assessment.

This document, alongside our driver diagram (appendix), details our plans to develop our work to ensure continued quality improvement.

Improvement goals

(1) **Contribute to lower suicide rates, particularly in people under mental health care and in patient sub-groups:** We will produce evidence-based recommendations to improve safety, with outputs to change practice. We will continuously monitor suicide rates, overall and in sub-groups highlighted in the national suicide prevention strategies.

(2) **The early publication of aggregate data:** We will develop Real-Time Surveillance (RTS) of suspected suicide under mental health care. We will explore earlier publication of the most up-to-date post-inquest data.

(3) **Provide organisational-level access to local data:** We will provide annual comprehensive local data to mental health organisations, which includes regional and national comparators.

(4) **Strengthen local partnerships:** We will work closely with suicide prevention leaders in trusts to provide a point of contact for local quality improvement support while maintaining data returns, with potential benefit for reducing clinician burden.

(5) **Develop NCISH as a resource:** We will develop a living web repository of evidence and summaries of quality-assured reports relevant to suicide prevention.

Improvement methods

Here we detail our methods for stimulating healthcare improvement at a national, regional and local level for each of our five overall improvement goals.

1 Contribute to lower suicide rates

National

- We will continue to collect national data on people who die by suicide under the recent care of mental health services, and present findings and clinical recommendations in an annual state of the nation report, with associated resources for shared onward learning.
- We will produce biennial spotlight reports in response to emerging concerns and policy priorities. These spotlight reports extend our scope to include the general population, related outcomes (such as self-harm), and differing methodologies. Our next spotlight report is due for publication in 2027.
- We will continue to foster links with national policy makers and contribute to strategies and guidelines as expert advisers, responding to calls for evidence and independent reviews as appropriate.
- Slide sets and recorded presentations will continue to be provided on our website for onward learning via teaching and local dissemination.
- We will continue to develop resources that can be used as training for staff working in mental health service, like our safer care for patients given a diagnosis of personality disorder: an online learning resource.
- A living web resource will be developed over the course of our current contract and hosted on our website (detailed in goal 5).

Regional

- We will continue to facilitate shared learning, providing evidence at NHS learning events and regional conferences.
- We will provide healthcare organisations with annual analysis of local data including a regional and national comparator (detailed in goal 3).

Local

- Our "Safer Services" toolkit and toolkit for self-harm present key elements of safer services as quality and safety statements against which healthcare organisations can assess their suicide prevention measures. These toolkits are regularly updated to reflect the most up-to-date evidence and guidance.
- Local quality improvement plans will be the mechanism for NCISH recommendations to be translated into changes in practice, and to ultimately lower suicide rates.

2 Early publication of aggregate data

National

- We are developing RTS data collection of suspected suicide under mental health care, with findings and recommendations to be published in our annual state of the nation report.
- We will explore earlier publication of the most up-to-date post-inquest data.

Regional and local

- We have worked closely with, and supported, local areas in England to collate existing RTS data of suspected suicide deaths in the general population. Lessons are feeding into national RTS work led by the Office for Health Improvement and Disparities (OHID).

3 Organisational-level access to local data

National

- We will develop our annual Safety Scorecard to include analysis of key variables in individual healthcare providers, benchmarked against regional and national comparators. We will expand provision of the scorecard to the devolved nations, providing local analysis of key variables against a national comparator, from September 2024.

Regional

- From September 2024, our Safety Scorecard will provide a regional comparator alongside local and national suicide data enabling areas to benchmark data to support quality improvement.

Local

- Our Safety Scorecard will include local analysis of 10 key demographic and clinical variables, with regional and national comparators, encouraging alignment of local and national data and to aid local identification of areas for focus and learning. We will continue to encourage services to review this information in conjunction with our "Safer Services" toolkit.

4 Strengthen local partnerships

Regional

- Over the course of our contract period, we will strengthen partnerships with regional areas, with suicide prevention leaders as key points of contact. This will aid dissemination of findings and recommendations to improve safety at a regional level, including to commissioners.
- We will continue to facilitate shared learning, providing evidence at NHS learning events and regional conferences, and collaborating with local areas to produce infographic examples of good practice in local suicide prevention initiatives.

- We will continue to work with trusts to develop infographics illustrating examples of good practice in adopting a personalised, collaborative and comprehensive approach to assessment and management of suicide risk.

Local

- We work with our national partners the National Collaborating Centre for Mental Health (NCCMH) to facilitate shared learning workshops and learning clinics, coordinated by our dedicated NCISH QI Lead. Local quality improvement will be the mechanism for NCISH recommendations to be translated into changes in practice, and to ultimately lower suicide rates.
- As part of these learning workshops we will provide feedback on local quality improvement plans and respond to queries arising from local data.

5 Develop NCISH as a resource

National

- We plan to continue to position NCISH as an expert resource for clinicians, patients, carers, and policy makers. We will achieve this by developing a living web resource which will be updated in real time with the latest NCISH recommendations and quality-assured suicide prevention-relevant reports. This will be a trusted expert resource to signpost stakeholders, including clinical staff, policy makers, and experts by experience, to relevant information for local quality improvement. This resource will be developed over the course of our current contract period, and continually updated.

Regional and local

- We have a webpage which shows local and regional infographics of good practice. We will continue to develop these resources, collaborating with local areas to add up-to-date infographic examples of regional and local suicide prevention initiatives to promote shared learning from local suicide prevention projects.

Patient and public involvement

We involve experts by experience at every stage of our work, from governance to study design, and dissemination. The Centre for Mental Health and Safety has a dedicated PPIE group - Mutual Support for Mental Health Research (MS4MH-R). MS4MH-R are a group of people who have experience of self-harm, suicidality, or mental illness as either patients or carers, who use their wealth of perspectives, insights and experience to help NCISH in the design, delivery, and sharing of key findings and recommendations. Each of our projects includes a plan for PPIE input which is considered at study conception. We have an established PPIE plan, reviewed and updated annually. We have consulted with our PPIE group in the development of this quality improvement plan, and the patient safety issues we think need to be reflected in our work.

Communications

We have a comprehensive communications strategy to support implementation of our evidence-based recommendations into practice. Our primary audiences are clinicians, commissioners, policy makers and

patients. We produce shareable resources including executive summary reports, infographics, short, animated videos, data slides, video recordings of presentations, and easy read reports. We will continue to hold our (virtual) annual NCISH conference with contributions by experts by experience and academic experts. We will continue to co-develop local infographic examples of good practice with mental health care providers to encourage shared learning from local suicide prevention efforts.

Evaluation

Regular review of progress is via meetings with our Project Board and contract review meetings with HQIP. We will evaluate the impact of our quality improvement plan by:

1 Contribute to lower suicide rates

- Continuous monitoring of suicide rates, including in key clinical groups.
- Monitoring attendance at NCISH conferences and views of our online resources, including views of our living web resource, when available, and downloads of our toolkits.
- We propose that one of our spotlight studies might examine suicide rates in organisations that have implemented NCISH recommendations, as based on quality statements in our "Safer Services" toolkit.

2 Early production of aggregate data

- Assessing completion of patient RTS data returns against expected suicide numbers.
- Assessing general population RTS against official statistics as published by the Office for National Statistics (ONS).

3 Organisational-level access to local data

- Encouraging local evaluation of suicide prevention against NCISH "Safer Services" toolkit, with reference to expanded annual provision of local data in our Safety Scorecard.

4 Strengthen local partnerships

- Compiling feedback from local organisations on our expanded Safety Scorecard and quality improvement work.

5 Develop NCISH as a resource

- Continuing our stakeholder survey, updated annually to reflect latest NCISH publications, and monitoring engagement.

Appendix: Driver diagram