Cover Sheet

Public Trust Board Meeting: Wednesday 12 July 2023

TB2023.65

Title:	**Progress report on reducing the risk of suicide within the OUH**

Status:	**For Information**
History:	

Board Lead:	**Chief Nursing Officer**
Author:	**Clinical Programme Manager/Deputy Chief Nursing Officer**
Confidential:	**No**
Key Purpose:	Assurance

Executive Summary

1. This paper provides an update to the Trust Board on the progress with the immediate term actions that were undertaken following the recommendations of the paper 'Reducing the risk of suicide within the OUH and PFI estate that was presented to the Trust Management Executive in December 2022. This paper also provides an update on long term actions that are in progress.
2. A suicide risk reduction group was established to initially consider the current position of the trust against the PHE Prevention of Suicide in public places document.[1]
3. Immediate actions focused on the West Wing stairwell and seven recommendations were presented to the Trust Management Executive for consideration and they approved recommendations one to six.
4. In the last 10 years, there have been 5 incidents where a patient or a member of the public jumped from a height and of these 3 were incidents of a fall from the west wing stairwell area. Theses 5 incidents sadly resulted in the death of the person involved. There are a further 3 relevant incidents that resulted in the death of the individual and these were isolated in nature.
5. This paper provides an update on the immediate actions that have been undertaken and on progress with the medium/long term actions.

Recommendations

6. The Trust Board is asked to note the progress made with both immediate and medium/long term actions.
7. The Trust Board is asked to note the SRRG has been reinstated under the lead of the interim Chief Nursing Officer to enable oversight and support further actions to be designed and progress to delivery.

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/76 9006/Preventing_suicides_in_public_places.pdf

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Progress report on reducing the risk of suicide within the OUH

1. Purpose

1.1. This paper provides an update to the Trust Board on the progress with the immediate actions that were undertaken actions following recommendations of the paper 'Reducing the risk of suicide within the OUH and PFI estate that was presented to the Trust Management Executive in December 2022. This paper also provides an update on long term actions that are in progress.

2. Background

2.1. In the last 10 years, there have been 5 incidents where a patient or a member of the public jumped from a height and of these 3 were incidents of a fall from the west wing stairwell area. Theses 5 incidents sadly resulted in the death of the person involved. There are a further 3 relevant incidents that resulted in the death of the individual and these were isolated in nature.

2.2. It should be noted that suicide is a rare event that is difficult to predict.

2.3. Vulnerable individuals who may attempt suicide on the OUH estate are likely to come from one of two groups: those who are patients of the Trust and members of the public who access the Trust to attempt suicide.

2.4. The Trust Board has approved a proposal of remodelling of the main West Wing Stairwell that will raise the screening surrounding the stairs. The decision on timing for completing this proposal is currently being progressed.

2.5. The view of the consultant clinical neuropsychologist is that the remodelling action will reduce the risk within the west wing stairwell, however work should continue on further mitigation of risk within the Trust to prevent the risk re-establishing in other ways.

2.6. An MDT suicide risk reduction group (SRRG) was formed by the previous Chief Nursing Officer to consider further risk reduction measures that could support the wider Trust in relation to suicide risk reduction. The group membership included senior specialists in; psychological medicine, security, senior nursing representing all divisions, estates and PFI, education, legal services and health and safety.

2.7. Based on the 3 incidents within the West Wing stairwell that all led to the loss of life it was prioritised for review by the SRRG and a number of proposed immediate/short term actions were presented to the Trust Management Executive in December 2022.

2.8. The SRRG has sought advice from Network Rail (NR) to learn from their experiences of managing this form of risk across a large system[2+3]

2.9. The group has also considered guidance from Public Health England[4] regarding reduction of risk of suicide in public places.

2.10. As per the guidance in Public Health England[3] document, a risk assessment was produced to identify and record potential locations within the Trust buildings that could be used for a suicide attempt (jump from height).

2.11. The risk assessment is a live document (held by the Health and Safety team) and as such has been used to record ongoing actions for preventing suicide i.e., the formation of the Suicide Risk Reduction Group and actions listed in this document.

2.12. Discussion at the SRRG meeting identified other areas of the Trust where there is a potential risk of suicide. These areas have been visited and information collected and added to the risk assessment. A comprehensive review of the OUH estate has been underway and a number of risk assessments have been undertaken by the health and safety team and are now being progressed with the assurance team onto a risk register.

2.13. The SRRG was temporarily stood down whilst the short term and immediate actions in the West Wing were progressed. The SRRG has been reinstated under the leadership of the Interim Chief Nursing Officer, to complete the development and implementation of long term actions.

3. Progress

3.1. Immediate actions progress:

3.1.1. The SRRG under the leadership of the interim CNO has been re-established

3.1.2. The first meeting took place in June 2023 and it was decided that there was a requirement to review and update the terms of reference (TOR) to ensure that the focus and direction for the group in supporting risk mitigation is clear.

3.1.3. The SRRG will continue to risk assess areas in the trust that require discussion and consideration for interventions.

3.1.4. Signage has been located in prominent areas of the West Wing to indicate constant CCTV surveillance is in operation.

[2] https://railsuicideprevention.co.uk/about/preventing-railway-suicides/

[3] https://www.shponline.co.uk/rail-safety/suicide-prevention-on-the-railways-in-conversation-with- network-rails-ian-stevens/

[4] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_dat

a/file/76 9006/Preventing_suicides_in_public_places.pdf

3.1.5. Posters have been designed in conjunction with Samaritans outreach to be used in high traffic areas to display information on how to obtain help. These are currently in print and will be displayed in all required areas.

3.1.6. Each main west wing stair lobby area now has a telephone installed for use by staff and public or the vulnerable person to contact the Samaritans directly through a dedicated direct number. The telephone is multi-function to provide access to internal help if a staff member requires assistance if they discover a vulnerable person displaying vulnerable behaviour.

3.1.7. The high walkways seating area within the West Wing has been changed to non-mobile bench seating away from the glass panelling to prevent being utilised as a step over the glass to the drop below.

3.1.8. Frosting has been applied to all glass panelling around the stair well in the West Wing and the high walkways linking to the children's hospital in the PFI West Wing.

3.1.9. A trial of temporary hatching (marked out floor area) has been placed on the floor adjacent to the glass panels on the lobby area of two levels of the west wing stair well. (As per the NR strategy). [1]

3.1.10. A temporary workforce pool of Registered Mental Health Nurses (RMNs) commenced in May 2023 to enable the deployment of RMNs to clinical areas across nursing and midwifery to support the safer management of our patients with complex mental health needs and those that require enhanced observation due to these needs.

3.2. Medium/long term actions progress:

3.2.1. In conjunction with the Director of Estates, Facilities and Capital Development the SRRG will explore opportunities to increase the presence of security within the West Wing and children's hospital and consider whether this can be achieved within current workforce.

3.2.2. The Director of Nursing, Midwifery and AHP Practice Development and Education is exploring education options and is progressing a post graduate education programme that will include managing patients with complex mental health needs. Suicide risk reduction and prevention will be incorporated into the programme.

3.2.3. The Director of Nursing Midwifery and AHP Practice Development and Education is in discussion with Oxford Brookes University on how we can increase the opportunities and provision of dual registration RN undergraduate training to increase the number of RN with dual skills for

our future workforce. It should be noted that this is in its very early stages of discussion.

3.2.4. The SRRG will consider any opportunities for the use of digital solutions including passive 3G/4G/5G detectors to alert when an individual has accessed a low footfall- high risk area.

3.2.5. The SRRG will consider if there are options to be able to restrict access to high-risk areas with no requirement for public access.

Conclusion

3.3. The risk of suicide within our estate and PFI estate is a recognised risk and a number of immediate actions have been completed and further medium/longer term actions are being further explored and actioned.

3.4. The SRRG will meet monthly to discuss and progress the actions and the Trust Management executive will be updated on continuing progress

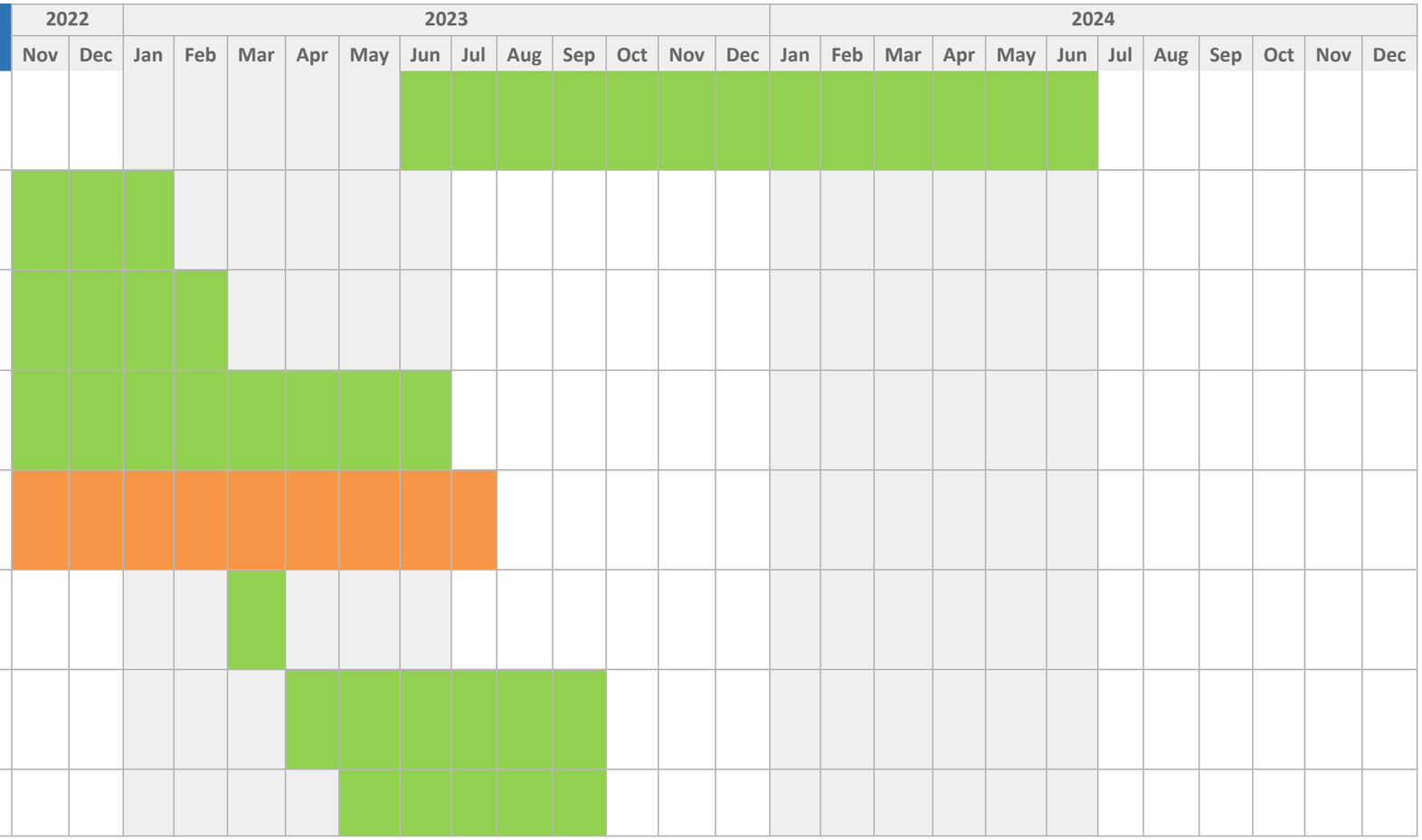
4. Recommendations

4.1. The Trust Board is asked to note the progress made with both immediate and medium/long term actions.

4.2. Note the SRRG has been reinstated under the lead of the interim Chief Nursing Officer to enable oversight and support further actions to be designed and progressed to delivery.

5. Appendix 1: Immediate Actions

Immediate Actions	Start Date	Completion Date	Progress
Review and re-establish the Suicide Risk Reduction Group. (SRRG) for a further 12 months	06/2023	06/2024	Complete and in progress
Display signage to indicate that CCTV is in operation within the west wing stairwell areas	11/2022	01/2023	Complete
Apply frosting to occlude the glass screens in the high walkways and stairways in West Wing	11/2022	02/2023	Complete
Install telephones on each west wing stair lobby to enable direct dial to helplines.	11/2022	06/2023	Complete
Design and display information posters directing vulnerable people to helplines	11/2022	07/2023	In progress
Remove all seating that can be used as a step near areas of risk. Replace with non-mobile bench seating.	03/2023	03/2023	Complete
Apply temporary part floor hatching in stairway lobby, to deter standing in high areas of west wing stairwell	04/2023	09/2023	Complete
Commence a trial of a RMN temporary staffing pool.	05/2023	09/2023	Complete



6. Appendix 2: Medium to Long-Term Actions

Medium to Long-Term Actions	Start Date	Completion Date	Progress
Planning of a Post Graduate Certificate course in mental health and first aid to increase skills of registered nurses. *First course to start September 2024*	02/2023	09/2024	In progress
Health and Safety risk assessments of areas in the trust to be added to the trust risk register	08/2023	08/2023	In progress
Presentation of risk register to Trust Risk Committee	09/2023		Not yet commenced
Consideration of Digital solutions	10/2023		Not yet commenced
Explore opportunities for wider security provision and restricted access areas via the SRRG	07/2023		In progress