Study Protocol

Identifying the impact of a colleague's suicide on NHS staff, and their support needs, to inform postvention guidance

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Lay Summary

Aim
To understand the impact on, and support needs of, NHS staff following a colleague's suicide.

Background
The rate of suicide among staff who work in the NHS is above the national average, particularly among female nurses, female doctors and male paramedics. We know that NHS staff may suffer from poor emotional and psychological health, but little is known about how NHS staff are affected when a colleague dies from suicide.

Past research shows that if people affected by suicide receive support early on, it can help them come to terms with their loss, and reduce the risk of further mental health problems and suicide. This is called postvention. It is therefore important that NHS staff receive the best support at the right time.

Working closely with Samaritans, the research team will try to understand how suicide affects staff, and what NHS employers and managers can do to best support those likely to be affected. We will use this information to write guidance about how the NHS and other workplaces can support staff after a suicide.

Design and methods
This is a 22 month study, involving face-to-face interviews with NHS staff affected by the suicide of a colleague. We will speak to staff working in different work places, such as the ambulance service, general practices and hospitals. We will also speak to staff/managers who support staff affected by suicide. The interviews will explore the effects of suicide on individuals and teams, and how they deal with their loss. The study will also identify what helps and hinders staff during the bereavement process. We will hold a stakeholder event at the end of the study and share our research findings with them. The stakeholders will include NHS staff affected by suicide, NHS Employers, organisations who specialise in suicide and mental health, such as the Samaritans and CRUSE bereavement services (i.e. Facing the Future). Our findings and conclusions will be written up to provide appropriate postvention advice and guidance to managers and relevant support organisations to help them to give the best support to staff following the suicide of a colleague.

Patient and Public Involvement and Engagement
Discussions with members of the public and NHS staff who have been affected by the suicide of a colleague have informed the need for this study and indicated there are gaps in knowledge and support given to staff. Members of the public, nurses, paramedics and doctors who have been affected by suicide will provide advice and guidance for the team throughout the study.

Scientific Summary

Background
There were 18,998 deaths attributed to suicide in England between 2011 and 2015 in the general population, constituting 12 deaths for every 100,000 people per year. Amongst health professionals, the suicide rate is 24% higher than the national average, largely explained by the increased risk of suicide in female nurses (four times the national average), male paramedics and female doctors. Those affected by suicide are at greater risk of mental ill health and suicide. Although there is likely to be an adverse impact on colleagues, there is currently no postvention guidance to assist NHS organisations or managers to support staff following the suicide of a member of staff. Postvention is defined as ‘the actions taken by an organisation to provide support after someone dies by suicide; effective support can help people to grieve and is a critical element in preventing further suicides from happening’. This research will fill this gap.

Aim

To understand the impact of a colleague's suicide on NHS staff and their support needs, in order to inform postvention guidance.

Objectives

1. To undertake an integrative review of suicide impact and postvention interventions in other settings
2. To explore the impact of colleague suicide on staff wellbeing and grief reactions to such an event
3. To explore staff views about risk factors, which may have contributed to the suicide of their NHS colleague and 'warning signs' the individual may have displayed
4. To identify what helps and/or hinders bereaved colleagues to seek support, to characterise supportive work cultures, and to identify staff preferences for future support
5. To explore how managers respond to and support their employees and colleagues following a death by suicide, and to identify current postvention activity
6. To use the findings to:

a) develop evidence-based postvention guidance for NHS organisations and managers to support and respond appropriately and effectively to bereaved or affected employees
b) apply for further funding to develop and evaluate the appropriateness and effectiveness of an empirically informed postvention support package for use across the NHS.

Methods

WP 1 An integrative review of primary research to explore evidence of the impact of suicide in the workplace, including postvention policies and evaluations in other settings (e.g. schools, armed services, railways).

WP2 A qualitative study using a case-study approach: Between 6-8 cases will be identified through existing information on cases reported in the media, those identified by the research team, stakeholders and through snowballing. In-depth interviews will explore the experiences of staff/colleagues bereaved by these suicides (n=50) and the views of managers / staff who provided support (n=20). An inductive, iterative approach to analysis will be undertaken.

WP3 Co-design workshop. Findings of WP1 and WP2 will be analysed and triangulated by the research team with PPIE support, and presented to an expert consensus group to identify key components of the postvention guidance. This stage does not have a dedicated consent form. We will use an initial brief to establish ground rules in the discussion, which will be more appropriate than a consent form. There will be one workshop held alongside the presentation as an in-person event, dependent on Covid-19 restrictions at the time. The location is intended to be a meeting room on our campus with optional remote attendance facilitated by videolink.

WP4 Co-production of postvention guidance with Samaritans, PPIE group and stakeholders.

Timelines

Four work packages over 22 months. Ethics and HRA will be sought before the start of the study.

Anticipated impact and dissemination
The guidance will enable NHS employers and managers to provide support and respond appropriately and effectively to employees bereaved or affected by a colleague's suicide. Samaritans hosts and co-chairs the National Suicide Prevention Alliance (NSPA) with over 300 members, and is well-placed to support dissemination. Co-applicants will disseminate across their networks: Appleby (National Confidential Inquiry into Suicide); Chew-Graham (RCGP); Grayling (HEE). Stakeholders: Mortimer, Chief Executive, NHS Employers, Pace, Association of Ambulance Chief Executives.

Patient and Public Involvement and Engagement
Discussions with members of the public and NHS staff who have been affected by the suicide of a colleague, have informed the need for this study and indicated there are gaps in knowledge and support given to staff. Family members, nurses, paramedics and doctors who have been affected by suicide will provide advice and guidance for the team throughout the study.

Background

There were 18,998 deaths due to suicide in England between 2011 and 2015 in the general population, constituting 12 deaths for every 100,000 people per year. The suicide rate among health professionals is 24% higher than the national average with 430 professionals killing themselves within a four year period (1). These figures are largely explained by the elevated risk of suicide among female nurses (four times the national average), male paramedics and female doctors (1).

Elevated suicide risk among doctors and nurses has been attributed to high occupational work stress, vicarious trauma (18-20), burnout (21), mental ill health, financial and relationship problems (18,19), specialist knowledge about potential methods of suicide, greater access to the means of suicide, (18, 22) and barriers to help seeking (e.g. stigma, lack of specialised services) (23). Doctors and nurses undergoing fitness to practice investigations are at particularly high risk of depression and suicide, although this is currently under investigated in nurses (24, 25). A critical literature review of suicide in nurses found that work settings associated with high stress and distress, or caring for patients with psychiatric problems, were risk factors for elevated suicide risk, as was vicarious/secondary trauma linked to work (26). An integrative review of suicide in nurses (27) found that risk factors for depression, an established risk factor for suicide, included workload, working night shifts, conflict in the workplace, and the erosion of professional autonomy. Research conducted on risk factors for mental illness among paramedics found that high exposure to trauma, distress and suicides (of patients) increased the risk of suicide in emergency care staff, who were also more likely to develop mental ill health, and experience secondary trauma (linked to exposure to trauma, suffering, and distress at work) and PTSD (28-30).

The devastating and detrimental impact of any suicide on family and friends, and of patients on their attending clinicians is well documented (3, 31, 32). It is estimated that for every one suicide, 60 people are intimately and directly affected (2). Suicide affects the physical and

psychological health and wellbeing of the bereaved (3), with a range of feelings and symptomology, including shock, confusion, horror, anger, personal failure, shame, self-blame, complex grief (when painful emotions are so enduring and severe that people have difficulty recovering from loss and resuming their own life) and post-traumatic stress disorder (PTSD); affected individuals are also at greater risk of future mental and physical ill health and suicide (3-6). Compared to other causes of sudden death, those bereaved by suicide report higher levels of rejection, shame, stigma and a need to conceal the method of suicide (5, 33). Suicide bereavement has been identified as a risk factor for attempted suicide (6, 34); it is estimated that 7-9% of people bereaved by suicide subsequently attempt suicide themselves (34, 35). There is also an association with occupational dropout (36).

Despite the elevated risk of suicide among NHS staff and consequent risk of suicide bereavement amongst colleagues, no studies to date have explored the physical, emotional and psychosocial impact of completed suicides on colleagues and teams. Additionally, no research has investigated how NHS organisations respond to such deaths and support affected staff, teams and their communities, including the use of postvention policies across NHS settings. Postvention in this context refers to 'the actions taken by an organisation to provide support after someone dies by suicide; effective support can help people to grieve and is a critical element in preventing further suicides from happening' (7).

The provision of appropriate, timely and effective postvention support for staff bereaved or otherwise affected by suicide may help individuals adjust, process, (re)negotiate, cope with loss and complex grief, and play a vital role in rebuilding staff wellbeing, reducing the potential for prolonged distress and risk of suicide (7-9). There is also substantive evidence demonstrating the value of bereavement support in enabling individuals to process and manage their grief (10). The needs of those affected are determined, in part, by how an individual died (for example-sudden death compared to death by known medical causes), which in turn affects the nature of the bereavement; understanding a person's grief reaction is therefore important in identifying suitable support within this context (11).

This support is particularly important for a population of professionals who are known to be at elevated risk of stress, distress and suicide (12, 13) and reflects current policy initiatives aiming to improve access to support for NHS staff and reduce mental ill health and distress among healthcare professionals (12-15). Despite this, early evidence derived through PPIE and Freedom of Information requests to three acute hospitals across the country has found no evidence of trust wide postvention guidance or policies for staff / managers to follow in the event of the suicide of a staff member.

This study will also explore participants' perspectives on causality and potential triggers for the suicides they have been affected by. This should provide useful contextual data regarding the work environment, enabling lessons to be learnt and shared within and between organisations and with the wider community. There is increasing evidence demonstrating that reduced wellbeing in staff has a negative impact on patient safety and the quality of care provided for patients (16, 17). Hence, supporting staff bereaved by suicide and alleviating mental ill health by mitigating any adverse consequences is also likely to confer benefits to patients.

The findings from this study will identify the impact of suicide and the support needs of bereaved colleagues. The guidance will be co-designed, based on our findings and with input from a stakeholder workshop (WP3). The study team, study stakeholder group, PPIE and Samaritans will co-produce the postvention guidance (WP4). The guidance will provide key information on timely, appropriate and effective approaches to responding to the suicide of a colleague in the NHS and will be disseminated widely to NHS managers and organisations across the NHS. Implementation will be facilitated by well-placed co-applicants, including Samaritans, Appleby, Grayling and influential stakeholders such as Danny Mortimer, Chief Executive, NHS Employers.

The study team will subsequently use the findings from the study and workshop outputs to apply for further funding to develop and evaluate the appropriateness and effectiveness of an empirically informed postvention support package for use across the NHS. The results from that work will be important to demonstrate the potential effectiveness of such an intervention.

Aims and objectives

Aim:

To understand the impact of a colleague's suicide on NHS staff, and their support needs, in order to inform postvention guidance.

Objectives:

1. To undertake a rapid review of suicide impact and postvention interventions in other settings
2. To explore the impact of colleague suicide on staff wellbeing and their grief reactions to such an event, including how staff adjust, negotiate, process and ultimately cope with the death of their colleague
3. To explore staff views about risk factors, relevant contextual factors, and warning signs, which may have contributed to the likelihood of suicide in their NHS colleagues
4. To identify what helps and hinders bereaved colleagues to seek support, and characterise supportive work cultures, and identify staff preferences for future emotional/practical support and service provision
5. To explore how managers respond to and support their employees and colleagues following death by suicide, and to identify current postvention activity
6. To use the findings to:

    a) develop evidence-based postvention guidance for NHS organisations and managers on how to support and respond appropriately and effectively to bereaved or affected employees
    b) apply for further funding to develop, and evaluate the appropriateness and effectiveness of an empirically-informed postvention support package for use across the NHS.

Research plan

Work package 1: Critical Integrative Review (Months 1-4) Objective 1

A scoping review already undertaken by the study team did not identify any primary research on the impact of colleague suicides on NHS staff. While there is existing postvention training/guidance for staff to enhance their knowledge and skills to care for parents bereaved by suicide (e.g. PABBS) (45), the study team were unable to identify any postvention guidance or policies designed specifically to support staff affected by a colleague's suicide within the NHS or similar settings.

In view of this, acknowledging heterogeneity of the limited literature, and taking account of the experience of the team, a critical integrative review (IR) methodology (3,4,5) has been identified as the best approach to addressing the research question. It is a form of qualitative evidence synthesis which integrates and/or compares the findings from qualitative studies and identifies 'themes' or 'constructs' across a range of studies (6). There is a plethora of such methods available (7). However, a defining feature of the IR that is of relevance to this study is that it can incorporate a diverse range of study methodologies and provide scope to summarise empirical, theoretical and other literature to provide a comprehensive understanding of a phenomenon (4). In this case, the need to understand postvention guidance requires that the review methodology lends itself to examination of such forms of 'evidence'. The body of evidence that will analysed in this review is likely to include:

i) Evidence of the impact of workplace suicide on colleagues in other settings (e.g. schools, military, police, universities)
ii) Existing postvention policies and guidance used in other settings (e.g. schools, police, universities, army, railways)
iii) Evidence demonstrating the effectiveness of suicide bereavement support interventions in the workplace (e.g. evaluations)

The IR method is suitable because it can include varied data sources, comprising both empirical and theoretical literature and a combination of data from diverse research designs (8), as well as guidance documents and policies. Although a synthesis of findings from work which has used different methodological approaches is complex, it can be undertaken systematically and with rigour consistent with an evidence-based approach to practice (3). The plan for the conduct of the review is presented below.

Integrative Review Plan

1. Problem identification: this will involve clear identification of the problem, in consultation with our PPIE Advisory Group; clarifying the purpose of the review and variables; establishing the focus and boundaries of the review.
2. Literature search: designing a well-defined and documented search strategy (including identification of search terms, databases [e.g. MEDLINE, CINAHL, ProQuest Nursing and Allied Health, Web of Science, and PsychInfo], search strategy, and inclusion and exclusion criteria.

3. Data evaluation: although there is no prescribed way to evaluate the quality of data sources in an IR, a data extraction form will be developed in consultation with our PPIE Advisory Group and clinical partners to ensure data evaluation is comprehensive.
4. Data analysis: we will use a constant comparative method (data reduction, display, comparison, conclusion, and verification) to extract themes, patterns and relationships to inform our conclusions
5. Presentation of conclusions arising from the analysis of the evidence, including explicit identification of limitations and reflections on the review process (4,8)

An information specialist at the University of Birmingham will provide technical expertise and guidance for the literature search. Members of the study team have a range of experience and expertise in the conduct of literature reviews undertaken as part of large empirical studies (Maben, Appleby, Riley, Efstathiou, Chew-Graham). Efstathiou will lead WP1, provide supervision of the post-doctoral researchers who will undertake the search and collation of the papers/sources, and coordinate the contribution of the wider team.

The review will be published and, together with PPIE input derived from NHS staff affected by colleague suicide, will inform the interview schedules for WP2. Our strategy is to informally review and reflect on questions as we progress to ensure they remain fit for purpose. The research team will review the questions following the completion of WP1 and make adjustments where indicated by the initial findings.

Work package 2: Qualitative study (months 5-15) - Objectives 2-5

This qualitative study will adopt a case-study approach (the case will centre around the deceased staff member) (47) involving between 6-8 cases, each associated with **between** 8-12 participants (including colleagues who worked alongside the deceased, managers and team leaders) per case, until data saturation is achieved. Qualitative research is an appropriate methodology for any research in an under-investigated sensitive topic area, such as the colleague suicide in health care. In-depth interviews will enable participants to express their experiences and feelings in their own words, allow researchers to explore meaning making and the lived experiences, realities, emotions and feelings of those affected by suicide. This approach also values emotions as data while ensuring that data are collected with care and empathy and reported sensitively (48).

The number of planned interviewees is intentionally set. Participation in qualitative processes has been shown to be therapeutic and discursive processes, such as our post-interview outreach discussion to each participant, will help to promote this. Participants are interviewed individually; there is elevated risk of group re-traumatisation from this methodological approach other than that already in existence from participants' working relationships. Organisational response is an important subjective standpoint from participants in each case study and it is important their views are captured. The research does not target management teams or attempt to spotlight organisational policy. Where internal organisational problems exist, these will remain defined by the organisation itself. Post-vention guidance will be published based on our findings from interviews and literature

review and the choice to adopt or disregard this will be entirely at the discretion of the myriad NHS organisations in existence.

The decision to interview staff participants about their lived experienced of suicide bereavement stems from an epistemological and ontological stance that knowledge and reality can only be sought from those who experience it (49). Researchers and the wider study team subscribe to the understanding that both participants and researchers are emotional beings (50), who will require sensitivity and support throughout the research process. Employing care and empathy during research is essential for eliciting information from participants (51, 52) and is particularly important when studying vulnerable participants and sensitive topics such as suicide bereavement (53). The creation of a comfortable interview environment and careful and sensitive interview techniques (for instance, allowing interviewees to become distressed and to pause, stop or end the interview) will be demonstrated throughout.

It is important participants are interviewed in a location in which they are comfortable and feel able to speak openly. We will facilitate face-to-face interviews wherever the participant wishes. This could their home, a rented meeting space or in a private space at the University of Birmingham. We can also arrange for interviews to take place in a branch of the Samaritans.

Researchers themselves are not disembodied or dispassionate observers who can bracket off their emotions; they are also emotional beings (50, 54). A reflexive approach acknowledges that feelings and emotions can provide a useful source of insight into the research process. The researchers' emotions as data can therefore serve as an appropriate tool for understanding, analysing and interpreting data (55). For this reason, the researchers will take contemporaneous field notes during the study interviews, in order to document observations and reflections which arise, including the emotion work (56) required when undertaking research on such a sensitive and emotive topic (57); this data will be transcribed and integrated into the analytic process and stored securely and destroyed once transcribed. The researcher data will not contain any identifiable information.

We recognise that this challenging work has the potential to pose a threat to the interviewees and researchers' wellbeing and so we have established processes to ensure that the interviewees have time for debriefing and access to psychotherapeutic support, and that the researchers will also be well supported in this regard. Team members (JM, NE, CCG, LA, Samaritans) have extensive experience of researching in sensitive areas, including mental health, bereavement and suicide research.

Recruitment and sampling

Cases of staff suicide will be identified through information reported in the media, those identified by the research team, our stakeholders and through snowballing. Cases will be selected across a range of NHS sites (e.g. hospitals, ambulance trusts, community) throughout England and Wales. Affected individuals previously known to the study team will be approached on a case by case basis. In-depth interviews in each case study will explore the experiences of staff bereaved or otherwise affected by suicide and the views of staff (including managers) who have provided support for them.

We will purposively sample to include maximum variation (58) taking account of the following contextual information:

- The length of time the deceased staff member/colleague worked in the organisation.
- The profession, grade, seniority of the deceased person.
- The type and size of organisation – a range of settings to include organisations in secondary care (acute, mental health), community (e.g. GP practices) and ambulance trusts.
- Relationship of the colleague/manager participant to the deceased and time elapsed since the event.
- Where the suicide occurred (e.g. at work/home).

We will invite colleagues who worked with the deceased staff member, and/or colleagues who self-identify as being significantly affected by the death, to take part in an in-depth interview. Colleagues who worked alongside the deceased may include ambulance staff and members of the ward team, including doctors, nurses, healthcare assistants, physiotherapists, occupational therapists, dieticians, managers, team leaders and administrative staff. We will sample purposively, taking account of the contextual information (above) of NHS staff who have been bereaved or affected by the suicide of a colleague.

Any member of the research team can suggest participants to approach and the chief investigator and facilitator or study researchers can make the formal approach. Eligible participants who are made aware of the research through publicity by Samaritans or the PPIE group, for instance, can directly contact the CI or study researchers. Any eligible employer/manager can also send out the study invitation letter on behalf of the study team.

Inclusion/exclusion criteria:

Inclusion criteria

- NHS staff (18-70 years) who self-identify as having been affected, emotionally, psychologically and/or physically by the suicide of a NHS paramedic, nurse or doctor working in the NHS.
- Managers, supervisors, other support staff (for example, chaplains, occupational health, counselling services) who have provided informal or formal support for colleagues affected by suicide and/or have been affected.
- Suicide case must have occurred a minimum of month before the data collection period to minimise risk of distressing participants.
- Suicide case can have occurred any time in the 10 years before the data collection period. This reflects our wish to capture experiences from participants at a time they feel comfortable with, which may be several years after a death by suicide.

If we encounter barriers to recruitment using the case study approach and are unable to recruit sufficient numbers per case, the study team will opt to recruit staff more widely across the NHS in order to explore the views and experiences of staff who have been affected by the suicide of a colleague. Team members RR, JM, CCG, AG, MvH have expertise in recruiting NHS staff for research on sensitive topics through professional forums and networks. Samaritans will also use their networks to publicise the study. The PPIE group and study stakeholders will

also be asked to assist with publicising the study or identifying cases. Information about the study will be communicated sensitively and strategically. The study team will recruit employers/managers for the case studies based on their experiences of supporting staff and providing resources/training at sites where a staff suicide has occurred. The study team have existing contacts with such sites which will enable us to facilitate recruitment through these existing networks. Snowballing will also be employed to identify eligible participants associated with the case. Collectively, the study team are aware of a number of case study sites and will approach these in the first instance.

If the team encounter any challenges in identifying sufficient cases, the team will approach a sample of coroners to assist in identifying eligible cases. Coroners will be sampled purposively, in proximity to urban areas with larger hospitals to optimise the identification of cases. We will request the name of the deceased and information about the employer.

Methods

In-depth interviews will be employed in order to capture the feelings, views, experiences and beliefs of participants on the topic. The overall sample will involve up to 70 (an approximation between the minimum (n=48) and maximum (n=96) number of) interviews comprising:

(i) Up to 50 semi-structured interviews with colleagues of NHS staff who have died by suicide, in order to explore their experiences of grieving and help-seeking, the perceived responses of other colleagues, and the impact on their work/ team/ morale. We will also aim to identify what helped or hindered those seeking support and their views about risk factors and any preceding warning signs displayed by their colleague who died, as well as exploring their experiences of/preferences for supportive interventions for affected staff. These findings will inform the development of the postvention guidance which will focus on how organisations can best support staff affected by suicide.

(ii) Up to 20 semi-structured interviews with NHS managers, and/or organisational representatives who have had experience of supporting staff following the suicide of a member of staff (e.g. managers, team leaders, occupational health, chaplaincy, counselling services), to explore their current postvention responses (e.g. support offered, communication with staff, media and relatives), and their views on/experience of the impact of these on colleagues, teams, staff absence rates and/or sick leave related to the suicide, and any training or intervention gaps

Semi-structured interviews have been chosen since they allow and encourage interviewees to fully participate in the interview process which will be regarded as a mutually and fully participatory event (59-61). One-to-one interviews also afford anonymity to the study participants, help the researcher and participant build rapport and trust and enable the researchers to gain a more in-depth understanding of the impact of suicide on colleagues and any subsequent help-seeking behaviour, while maintaining confidentiality, sensitivity and flexibility (62). It is anticipated that the interviews will last between 60-90 minutes and, will be conducted face-to-face or using a secure remote online platform (UoB Zoom) at a time/location chosen by the interviewee. The study team will adhere to current social distancing guidelines related to COVID-19 and undertake online interviews if this is required.

Due to the potential to cause distress and ways in which this may impact on return to work following an interview, with possible implications for patient safety, the interviews will be conducted outside of working hours. During all interviews, a flexible topic guide will be used to ensure key issues are covered, but allowing participants to introduce other points they consider important. Staff will be reimbursed £40 for their time - in our experience, participants often choose to donate this money to charity.

We recognise the potential for elevated risk when conducting interviews remotely. Our main risk strategies for this scenario are a) a pre-interview risk assessment, b) the availability of the Samaritans referral system at any time during an interview and c) the immediate availability of CCG, a clinician, during the interviews. We will inform participants in advance of the support options available to them, which can include a friend or family member nearby if they feel this would be helpful.

Ethical considerations

Ethics, Health Research Authority (HRA), research governance and local R&D permissions will be sought before the commencement of the study.

Participants who are sent a letter directly from the study team, via a third party (i.e. PPIE, Samaritans) or via their employer can express an interest in taking part in the study, by completing the reply slip in the invitation letter, whereupon they will be sent a PIL which will detail the purpose of the project, advantages and disadvantages of taking part and assurances given in relation to confidentiality. Participants will also be asked to provide written consent (via email) and asked to sign a consent form at least 24 hours prior to taking part to indicate their willingness to participate, after having had the opportunity to ask any questions which they may have about the study. Staff who have agreed to take part will be asked to complete a participant questionnaire containing background and demographic questions which will enable the researchers to link cases. This will be returned to the researchers electronically, via a secure email application (i.e. NHS.net).

Digital signatures provide a secure way of managing inkless consent processes. There are inbuilt digital signature functions in Adobe and Microsoft programmes, and these will be used so the participant can sign remotely and securely. The researcher will also verbally re-confirm consent before the interview begins.

Permission will also be sought for the use of anonymised quotes in publications. The study team will adopt the 'process consent model' (63) of informed consent in research, whereby researcher and participants collectively negotiate the terms of participation during the life of the project. The approach is considered to be more empowering for participants by redressing the power imbalance and thus, making participation more equitable (64). Consent is not regarded as a one-off process, for example participants can choose to contact the researcher after the first interview with additional information, if they wish, and can withdraw from the study before their data is anonymised and analysed without giving a reason.

Taking part in any qualitative interview on a sensitive topic can be potentially distressing for participants (51). Suicide and suicide bereavement are highly sensitive and emotive topics and the study team recognise that taking part in interviews may be psychologically and

emotionally distressing for both participants and researchers. In order to limit any potential harm to research participants, the study team have made a number of provisions to mitigate distress and ensure participants have access to support if needed. The provisions include: an interview risk assessment protocol for researchers, signposting information on available support for participants, de-briefs with a trained therapist and a post-interview researcher-participant check-in. These options are detailed as follows.

Risk assessment protocol - the study team will also employ a risk assessment protocol devised by the Chief Investigator and study co-applicants Chew-Graham for an NIHR RfPB study exploring the causes, conditions and context underpinning distress and suicidality among junior doctors. The pre-interview risk assessment will be conducted prior to the main interview, and is included the overall distress protocol. This will enable researchers to identify potential areas for concern in advance and respond appropriately. Should the researchers have concerns for the mental health and wellbeing of any participant, they will adhere to this graded risk assessment protocol which provides a clear plan of action for managing participant distress. If a participant becomes distressed during the interview, they will be given the option of pausing or terminating the interview. Any participant will have the opportunity to speak to the study therapist within 24 hours of the interview taking place. Participants can also make an appointment within two weeks of the interview for a debrief. Participants are able to access two free appointments if needed.

If a participant communicates clear ideas of self-harm or suicidal plans, or is considered to be at significant risk, the researcher will accompany them to A&E for an urgent assessment. The researcher and participant will also have the option of using the third party referral system offered by Samaritans whereby the researcher can access support on the participant's behalf, through a dedicated helpline. Using the study risk protocol, the researchers will be able to contact CCG at any point during an interview, who will ensure she is available for this if required. CCG is a clinician with considerable experience of managing individuals who are distressed and will offer advice to the researcher, and speak to the participant, if appropriate. In addition to the opportunity to access the study therapist for help and support, all participants will be provided with details about organisations which offer mental health support and/or bereavement counselling.

A trained person-centred psychotherapist with experience of working with research teams investigating bereavement and sensitive issues which are likely to emerge from this study will be available to support participants and researchers if required. Within two weeks of the interview taking place, participants will have the option of speaking to this trained therapist who, by arrangement, will be available for a post interview debrief over the telephone.

Additionally, with the participant's consent, the researcher will check-in with them within three days following the interview to determine whether there have been any harmful or beneficial effects of participating in the study, and offer a further opportunity to add or clarify data. The study team are particularly mindful of the possible risk of re-traumatization for those recollecting their experiences and great care and sensitivity will be taken throughout the research process to minimise the potential for harm.

Two experienced qualitative researchers (researcher one, minimum two years post-doctoral experience; researcher two, four years post-doctoral) with experience of sensitive

interviewing will be recruited to the project. Key requirements for appointment will be appropriate experience of working on research projects about distressing/sensitive issues which employed qualitative methods, and the excellent communication skills which will be necessary to build trust and rapport and manage discussions of a sensitive and potentially distressing nature. In order to reduce any potential harm to the immediate research team, the researchers and chief investigator will have post-interview debriefs with a trained therapist; the researchers will also have regular meetings with the CI to discuss any concerns or impact which may arise from the study. Researchers will be asked to document such events so that they can be discussed with the CI and/or therapist. The research team will follow the study's lone worker policy when undertaking any face-to-face interviews.

Additionally, members of the PPIE study advisory group and the transcribers will also be able to access to the trained therapist, if required. Transcribers will be provided with self-referral information for the Samaritans and other avenues through which they can find support.

While participation raises potential ethical concerns, there are also recognised potential benefits from taking part in research. Participation in qualitative interviews has been found to be potentially therapeutic and gives participants an opportunity to talk through their experiences and be heard, which may not have been available to them before (65). They may find telling their stories to be cathartic (66), or a way of gaining closure (67) which can contribute to healing (68).

The findings will be confidential and participants provided with assurances concerning confidentiality and anonymity; data will be collected, transferred and processed in accordance with GDPR (2018). Data will be de-identified and findings will be not be attributed to individuals nor specific settings. As above, two researchers will be employed (1x1.0 FTE and 1x 0.6 FTE) in order to collect and manage the data and, importantly, to provide mutual support, on a day-to-day basis. The PI and researchers will meet on a fortnightly basis, with additional contact if required to manage the impact of undertaking difficult or distressing interviews.

Data analysis

The methodology for all qualitative data collection will employ an inductive, iterative approach underpinned by grounded theory; an appropriate methodology to explore under-researched areas (69). The qualitative interviews will be digitally audio recorded, fully transcribed and anonymised. Transcripts will be imported into the qualitative analysis software package NVivo. Analysis will be ongoing and iterative, employing the constant comparative method until data saturation is achieved, such that no new analytic categories emerge (70). The project researchers will generate an initial coding framework, grounded in the data, which will be added to and refined, with material regrouped and recoded as new data are gathered. Codes will be gradually built into broader categories through comparison across transcripts and higher-level recurring themes are developed.

The analysis will employ a within and cross-case analysis to draw comparisons, identify similarities, differences and contrasting themes across cases (e.g. in accounts, contexts) and to provide descriptive and theory generating findings; an approach which is more effective at generating theoretical frameworks (71). The cross case synthesis will identify patterns and

seek out rival propositions The analysis will generate descriptive accounts (e.g. the experiences of participants and ways in which they have been affected by the suicide of a colleague, coping strategies, experiences of help-seeking, and access/barriers to support, (un)supportive practices, unmet need) and explanatory accounts (e.g. grief reaction, grieving processes, role of employers in mitigating the impact of workplace suicide, perceptions about contributing factors/antecedents of suicide). These accounts will guide theory generation / development in order to inform our Theory of Change Model and add to our understanding of the impact of suicide, grief reactions, support needs of staff and activities which help or hinder staff in managing and processing loss. The analysis will consider contextual factors such as the relationship with the deceased, type/size of organisation, profession, and seniority of the deceased. The theory and information generated from this study will be used to inform the theory of change model incorporating change mechanisms – such as activities which support staff and inform the development of appropriate measures for capturing impact measures such as grief reaction. This will also be used to support the follow up study to evaluate the appropriateness and effectiveness of an empirically informed postvention support package for use across the NHS.

The multidisciplinary team, which is comprised of Samaritans, social scientists and academic-practitioners including medical, paramedic and nursing professional representatives, will each independently code a sub-sample of anonymised transcripts for each case, in order to generate and refine codes and thematic categories and provide researcher triangulation, thereby increasing the credibility of the research findings (70, 72). There is considerable expertise in undertaking qualitative analysis within the team (RR, JM, CCG, NE), thus providing assurances as to the capability and capacity of the research team to analyse the data generated by this study. The findings and theories generated will be used to co-design the evidence based postvention guidance with Samaritans, Stakeholders, study co-applicants and PPIE groups.

Work package 3: Stakeholder Co-Design Workshop (months 15-17) (Objective 6)

To take place online using Zoom or face-to-face, if this is permitted in line with current COVID-19 restrictions. Stakeholders will be identified/approached through existing contacts of the research team and where interview participants have consented to be contacted about the workshops.

Stakeholder engagement is a core activity underpinning the Theory of Change Model and co-design (73). The aim of the workshop is to inform stakeholders about the impact of a colleague's suicide on NHS staff, and their support needs, and to enable stakeholders (policy makers, employers, employees, professional bodies, support agencies, patients) to actively influence the content and design of the postvention guidance; for example prioritising what information to include, identifying practical recommendations which can be implemented within the NHS context, and to secure commitment from individuals/institutions to assist in the dissemination and uptake of the guidance. This process will help ensure it meets the needs of NHS employers and, most importantly, their employees. Employing the co-design model will ensure stakeholders take an active and creative role in designing this guidance, thereby fostering a sense of shared ownership and a commitment to disseminate and implement the postvention guidance across the NHS and in the workplace. The workshop will

also ask stakeholders for their ideas about the feasibility of evaluating the guidance within the NHS context.

The study findings will be presented to an expert consensus group of invited stakeholders which will include policy, professional, support agency representatives who will be sent a summary of the research findings prior to the event, to enable participants to prepare and consider any questions they would like addressed and/or issues they would like to raise. Stakeholders will then split into facilitated groups for discussion and be invited to generate ideas to inform or prioritise content for the postvention guidance, focusing on the provision of appropriate organisational support and how managers and other appropriate personnel can best support those affected by the suicide of a NHS colleague.

In addition to other influential study team members (Louis Appleby, Samaritans), stakeholder Danny Mortimer from NHS Employees has committed to ensuring wide dissemination and uptake of the guidance across the NHS. Additional key stakeholders will include policy stakeholders, including representatives from professional bodies (e.g. GMC, BMA, RCN, RCM, RCGP, RCPsych, HCPC, College of Paramedics) and support organisations (Samaritans, MIND, National Suicide Prevention Alliance, CRUSE)

Work package 4: Co-production of Postvention Guidance (months 18-22) Objective 6

Samaritans, study stakeholders, PPIE and members of the study team, (including the project researchers), will co-produce the postvention guidance. In this respect co-production will be defined as a process of generating collaborative knowledge, including implementation, analysis, engaging with both academic and non-academic stakeholders (74). The Stakeholder group comprises a range of policy and professional representatives and individuals affected by NHS staff suicide. They will draw on their varying professional and experiential knowledge to shape the content of the guidance, ensuring relevance to policy, NHS managers and the employees who should benefit from the guidance. Samaritans have been involved from the outset, informing the research questions and methodology, alongside PPIE.

Samaritans have significant expertise in developing postvention guidance (e.g. rail industry, school based postvention guidance), and will be able to apply this knowledge and experience to the process. Co-applicant, Neil Peters, the Samaritan's strategic programme manager, has co-produced postvention guidance with Network Rail and will therefore take a lead in co-producing the guidance for this study. Using the findings and stakeholder input derived from WP3, Samaritans will play a lead role in co-producing and designing the postvention guidance; for instance, they will lead on writing several sections of the guidance and provide comments and feedback on the remaining document. The guidance will complement and build on existing staff wellbeing policies (e.g. NHS People Plan) by providing specific evidence-based information to organisations and managers on the needs of staff affected by suicide (e.g. understanding grief reaction and processes) and how best to support them (i.e. evidence based interventions – what works well and what is practical within the NHS context). The postvention guidance will also provide employers with information about preparing and planning to enact postvention support so that NHS employers and managers can quickly implement a postvention action plan for mitigating any psychosocial fallout following the

suicide of a member of staff. Early intervention and responding effectively is critical in the event of a suicide.

Whilst we cannot yet determine exactly what will be in the guidance (as we want to build on the evidence we collect in our literature review and interview data), it is likely to include information on:

- Contacting and supporting the bereaved;
- Providing/signposting for individual support for bereaved and affected colleagues;
- Providing sensitive and appropriate internal and external communications to family, friends, colleagues;
- Developing a rapid response plan;
- Implementing a quick-response pathway;
- Information on forming and activating an emergency response team;
- Collecting information and implementing a serious incident review;
- Learning lessons to inform suicide prevention;
- Involving staff in remembrance, legacy and anniversaries.

The guidance will be available online and hosted on Samaritans and NHS Employers websites, free to download, in colour format with graphic design input from Samaritans in-house design team (costed into the project). The team have also costed in for a short (approx. 2 minute) video which will provide information about the key findings and guidance. A link to both guidance and video will be disseminated widely through co-applicant and stakeholder networks. The video will promote the guidance; its accessibility will ensure wider engagement within the NHS community and the public, thereby maximising impact.

Study co-applicants, Louis Appleby and Samaritans and key stakeholders – Danny Mortimer, Chief Executive, NHS Employers; Anna Parry, Head of Strategy and Programmes at the Association of Ambulance Chief Executives; Katherine Timms, Head of Policy and Standards, The Health and Care Professions Council have all committed their support to this study, and will assist in publicising and disseminating the postvention guidance widely across the NHS and their respective organisations

Dissemination, outputs and anticipated impact

The postvention guidance aligns with the key policy commitments to support the mental health and wellbeing of NHS staff, as detailed in the NHS Long Term Plan (2019) and the NHS People Plan (2019). The study's postvention guidance also supports the needs and priorities identified in the *NHS Staff and Learners' Mental Wellbeing Commission* recommendations (reflected in the NHS People Plan), to ensure the NHS offers suicide bereavement support to its staff and trainees. As such, the study's suicide postvention guidance will support policy recommendations, as it will provide clear evidence and information to Trusts/managers to ensure appropriate, timely and effective postvention support is provided to staff bereaved by suicide. This can help individuals adjust, process, (re)negotiate, cope with loss and complex grief, and play a vital role in rebuilding staff wellbeing, thus reducing the potential for prolonged distress and further suicide risk. This is particularly important given the existing

evidence of NHS staff's vulnerability to psychological distress and reduced wellbeing (75, 76) and additional vulnerability related to the effects of staff working through the COVID-19 pandemic.

The guidance will be widely disseminated through the following routes:

- A project website will be established that will be kept current and up to date with project briefings, updates and outputs (publications, blogs) on the study findings
- In conjunction with key stakeholders, the evidence-based postvention guidance for managers and organisations will be distributed and implemented widely across the NHS. The guidance will also be hosted on Samaritans and NHS Employers website
- A short 'talking heads' video to provide key information about the findings and guidance
- Academic outputs – conference proceedings (e.g. NHS Wellbeing Conference, Wellmed) and at least two peer-reviewed journal (e.g. Crises, BMJ Open) publications based on the qualitative findings
- Press releases and social media outputs, such as blogs, Tweets and Facebook posts, will publicise the key findings and guidance and be circulated to relevant alliances (e.g. zerosuicidealliance.com) for wider dissemination
- Final report to NIHR HS&DR with lay and scientific summaries.

All outputs will follow the reporting guidelines developed by Samaritans, which outline the code of practice, including appropriate use of language, when reporting information about suicides.

Impact

In addition to academic publications, a lay summary of the study findings will be circulated widely through co-applicant networks, the stakeholder advisors, and those identified during the recruitment phase of the study (e.g. HEE and NHS Trusts). Key stakeholder Danny Mortimer, Chief Executive, NHS Employers, will play an active role in dissemination and implementation and is well placed to do so. NHS Employers is the voice of employers across the English NHS, and leads work relating to workforce policy and practice. Danny also serves as deputy chief executive of the NHS Confederation, of which NHS Employers is part. Danny has committed to ensuring the guidance is widely disseminated and implemented across the NHS. Natalie Grosvenor, Director of the NHS People Plan work stream with a remit for mental health, is also well placed to utilise the findings for knowledge mobilisation and facilitate dissemination of the postvention guidance across the NHS, including to 'blue light' services (e.g. paramedics, police, fire brigade).

Co-applicant Professor Louis Appleby, who leads the National Suicide Prevention Strategy for England and directs the National Confidential Inquiry into Suicide, will disseminate a lay summary of the findings, and a link to the guidance and video through these working groups and contacts.

Samaritans hosts and co-chairs the National Suicide Prevention Alliance (NSPA), which has more than 300 members and so is well-placed to disseminate the study outputs via the

monthly newsletter (sent to 450 people and read by 1,000); the Resource Hub, which had 11,000 page views in the last year; and social media posts, for example Twitter.

Co-applicant Kathryn Grayling, who is a Clinical Fellow at HEE and has been tasked with implementing the action plan based on the NHS Staff and Learner's Commission recommendations, will disseminate and facilitate uptake of the postvention guidance through the following routes:

- The Pan ALB Wellbeing Group, which feeds directly into the NHS People Plan through the 'NHS as the best place to work' stream
- The NHS Employers Wellbeing Champion Network
- The HEE Wellbeing Oversight Board
- NHS Improvement
- The College of Paramedics - improvement collaborative (which includes HRDs from all UK ambulance trusts within a wider stakeholder group of 73 trusts)

Through her remit on the Staff and Learner's Wellbeing Commission, Kathryn also works in conjunction with Natalie Grosvenor, who is Director of the NHS People Plan work stream with a remit for mental health. Natalie and other key persons are well placed to facilitate dissemination of the postvention guidance, which include blue light services (e.g. paramedics, police, fire brigade).

Stakeholder Anna Pace, Head of Strategy and Programmes at the Association of Ambulance Chief Executives, is well-placed to disseminate the guidance widely: to UK ambulance service CEOs, Human Resource Directors and national staff wellbeing leads. She has agreed to facilitate recruitment of case study sites in the ambulance service.

Katherine Timms, Head of Policy and Standards for the Health and Care Professions Council, which represents non-medical/nursing professions (i.e. occupational therapists, paramedics, physio), will disseminate the guidance through her networks.

Other dissemination routes include the Nursing Midwifery Council; Health Care Professions Council; Royal College of Nursing; Royal College of Midwives, Royal College of General Practitioners, Royal College of Psychiatrists.

Stakeholder advice will also be sought on approaches to disseminating the study findings and postvention guidance and will help with informing and engaging the wider community.

Project team

This multidisciplinary and highly experienced research team is well placed to successfully deliver this project and maximise impact. The team will meet face-to-face (3x) and via Skype / Zoom / teleconference every 1-2 months depending on the stage of the project, for updates on progress and expert input e.g. development of documentation to meet the requirements of research ethics processes, topic guides, coding, plans for the stakeholder event, postvention guidance, publications and to provide support for each other and the researchers in the team. The meetings will provide an opportunity to discuss the needs of participants and the study team.

Chief Investigator:

Dr Ruth Riley (20%) is a qualitative methodologist whose research interests focus on the mental health and wellbeing of healthcare professionals and improving access to support for NHS frontline staff. She is currently the Chief Investigator of a recently funded mixed method NIHR study exploring the working conditions, cultures and contexts associated with psychological distress among junior doctors. Prof Chew-Graham, Drs Gopfert, and van Hove are co-investigators on this study. Ruth was previously the Chief Investigator of a NIHR funded study exploring the barriers and facilitators to help-seeking among GPs with mental ill health, alongside Chew-Graham. She will manage the study, supervise the project researchers and provide methodological and topic-specific expertise, and contribute to analysis, dissemination and coordinate the follow-up grant. She is supported and mentored by Prof Jill Maben, an experienced NIHR HS&DR Chief Investigator.

Co-investigators:

Louis Appleby (3%) Professor of Psychiatry at the University of Manchester is an academic psychiatrist, who leads the National Suicide Prevention Strategy for England and directs the National Confidential Inquiry into Suicide and Safety in Mental Health. He conducted a review of GMC processes in response to suicide risk in doctors under investigation. He was a member of the Pearson Commission on NHS Staff & Learners' Mental Wellbeing Committee (2018-19). He will provide topic specific expertise on the mental health and suicidality of doctors and advise on the dissemination of the research findings and recommendations to relevant stakeholders in order to maximise impact.

Jill Maben (8%) is Professor of Health Services Research and Nursing. Jill is a nurse and social scientist and her research focuses on staff-wellbeing at work and supporting staff to care well for patients. She has extensive experience of the management of national studies, and expertise in staff wellbeing research and its links to patient care experience and interventions to support NHS staff. She has held five previous NIHR HS&DR grants (three as PI), including a realist evaluation of Schwartz Rounds in the UK (HS&DR - 13/07/49). Jill was a member of the Pearson Commission on NHS Staff & Learners' Mental Wellbeing in 2018-19 and will provide topic, methodological and professional expertise and mentorship and support to the CI Dr Riley throughout the study.

Kathryn Grayling (5%) works for NHS Employers with a clinical background as a paramedic for Yorkshire Ambulance NHS Trust. Kathryn's current remit is implementing the action plan based on the Commission recommendations. She currently sits on the Pan ALB Wellbeing Group, Chief Nursing Officer's Wellbeing Group and is contributing to the NHS Long Term Plan – Making the NHS the Best Place to Work Group on behalf of the Pearson Commission. Kathryn is also managing the HEE research contract exploring paramedic wellbeing in response to high professional suicide rates. She will provide topic specific expertise, advise on the design, facilitate recruitment of paramedics and assist with dissemination.

Carolyn Chew-Graham (5%), Professor of General Practice Research, Keele University, is an academic GP with expertise in mental health interventions in primary care, a co-investigator on the recently funded junior doctors study with Riley, and worked previously with her on the GP study, exploring barriers and facilitators to help-seeking among GPs with mental illness.

She will provide topic specific expertise, advise on the design, recruitment, analysis of qualitative data, dissemination of the study findings and support the researchers in managing risk. Chew-Graham is Curriculum Advisor Mental Health, RCGP.

Nikolaos Efstathiou (5%) is a Lecturer in Nursing. His expertise lies in review methodology and bereavement, grief processes, critical and end of life care. He also has extensive experience of sensitive research with people at the end of life. He will lead WP1, the integrative review, contribute to the analysis of the data and assist in the dissemination of the findings, with particular emphasis on the organisational and policy implications of the work.

Anya Göpfert (3%) is a junior doctor and has personal experience of the impact of suicide of a NHS clinician. She will provide topic-specific expertise, experiential knowledge, and advise/assist on the design, recruitment and analysis and dissemination and will facilitate the doctors' PPIE group with Maria van Hove.

Maria van Hove (3%) is a junior doctor and has personal experience of the impact of suicide of a NHS clinician. She will provide topic-specific expertise, experiential knowledge, and advise/assist on the design, recruitment and analysis and dissemination. She will also facilitate the PPIE group.

Samaritans:

Liz Scowcroft (3%) – Head of Research and Evaluation. She will manage Stephanie Aston, oversee Samaritans' input and support rapid uptake and dissemination.

Stephanie Aston (5%) – Senior Research & Evaluation Manager. She will advise on the methodology, particularly sensitivities in ethics and methods, input into the analysis of transcripts, and contribute to the development of the postvention guidance and recommendations.

Ben Phillips (11%) – Samaritans' Head of Service Programmes. Expert input into developing suicide prevention and postvention services with Samaritans. He will provide postvention expertise and contribute to co-producing the postvention guidance.

<u>Stakeholder Group</u>

The role of the stakeholder group is to provide project oversight, advise on the recruitment, application of the study findings and facilitate dissemination and implementation of the postvention guidance. They will meet twice (face-to-face) over the course of the study.

Membership:

- Danny Mortimer, Chief Executive, NHS Employers
- Anna Parry, Anna is Head of Strategy and Programmes at the Association of Ambulance Chief Executives and has commissioned research into paramedic suicide

- Kerry Gulliver, Lead for Health and Wellbeing, Director of Human Resources and Organisational Development East Midlands Ambulance Service NHS Trust
- Katherine Timms, Head of Policy and Standards, The Health and Care Professions Council
- Cathi Shovlin, Director of Workforce, University Hospitals Birmingham
- Giles Dawnay, doctor, with experience of suicide bereavement. Giles wrote an opinion piece in the British Journal of General Practice on this topic.
- Amandip Sidhu, CEO and Founder - Doctors in Distress™. Amandip has familial experience of suicide bereavement. www.doctors-in-distress.org.uk
- Janette Bourne - CRUSE representative and expert on Welsh Government's Advisory Group on Suicide and Self-Harm Prevention Strategy
- Nicky Pettitt, Nurse Consultant for Youth and Transition with an interest in NHS staff wellbeing, University Hospitals Birmingham
- Susan Price, Deputy Director for Inclusion, Health & Wellbeing, Social Cohesion, University Hospitals Birmingham
- Fátima Fernandes, Staff Support Services Manager/ Trauma Psychotherapist, London Ambulance Service NHS Trust

Study Steering Committee

The role of the study steering committee is to provide overall supervision for a project on behalf of the Project Sponsor and Project Funder and to ensure that the project is conducted to the rigorous standards set out in the Department of Health's Research Governance Framework for Health and Social Care and the Guidelines for Good Clinical Practice.

Membership:

- Susan Price, Deputy Director for Inclusion, Health & Wellbeing, Social Cohesion, University Hospitals Birmingham (TBC)
- Lucy Biddle, Senior Lecturer, University of Bristol; Chief Investigator evaluation of suicide postvention guidance in schools
- Gail Kinman, Visiting Professor of Occupational Health Psychology, Birkbeck, author of suicide postvention framework for primary care staff
- Emma Wadey, Head of Mental Health Nursing, NHS England & NHS Improvement
- Daniele Carreiri, Lecturer, University of Exeter; Chief Investigator of Care Under Pressure II
- Dawn Chaplin, Deputy Director of End of Life and Bereavement, University Hospitals Birmingham
- Matthew Gibson, Lecturer, University of Birmingham. Chief Investigator of Wellcome funded Shame and Medicine project

Data management

The University of Birmingham has data management processes and protocols in place, which the research team will adhere to.

Once digital recordings are transcribed, they will be stored for 10 years with encrypted, restricted access.

The research team plans to approach coroners for assistance with recruitment. Personal details of deceased persons are not covered by data protection regulations. However, eligible cases can only be identified with the cooperation of coroners and consenting individuals. Coroners are increasingly active participants in suicide prevention and postvention work and we will establish relationships with them to help build a process that respects privacy and data protection whilst facilitating access to potential participants.

All data will be stored in accordance with the university's existing standards. For hard documentation this will include locked storage on university property and for electronic data this will include encrypted storage on a secure server. All personal, sensitive data will be securely transferred using OneDrive.

Interviews will be audio recorded using a recorder with encryption capability. A member of the research team will transfer the recording to the secure university server as soon as possible afterwards. Once the transfer has been confirmed, the audio recording will be deleted from the original device. The recordings will be permanently deleted once transcription is complete and checked by the researcher. A confidentiality agreement with the transcription company will be in place prior to the transfer of any data. The document linking study ID and participant details will be stored securely and deleted upon completion of dissemination of the research findings.

Contact details will be stored on the secure server according to our GDPR statement (see PIL). These will be deleted once the interview has been transcribed.

Participants can withdraw data up to the point of transcription, and this date will be included in information sheets and pre-interview information. If they withdraw at this stage, their recorded data will be destroyed.

NIHR branding, acknowledgement and disclaimer

This study/project is funded by the National Institute for Health Research (NIHR) [name of NIHR programme [NIHR HS&DR 129341]. The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care.

Project Gantt Chart

Project milestone	Pre-project	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sept22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Obtain research governance, University and HRA approval	■																			
Recruitment of research fellows	■																			
Two research fellows start in post Start integrative review		■																		
Integrative review completion and write up		■	■	■	■															
Commencement of recruitment and qualitative data collection phase of study			■	■	■	■	■	■												
Commencement of recruitment Plan B if required					■	■	■	■												
Completion of qualitative fieldwork, analysis ongoing					■	■	■	■	■	■	■									
Completion of qualitative analysis; write up of summary findings for workshop, draft publications						■	■	■	■	■	■	■	■	■						
Stakeholder workshop (including planning and preparation)														■	■					
Co-production & dissemination of postvention guidance; video; submission of two peer-review publications; write report for NIHR; write follow-up bid																■	■	■	■	■

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