GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board	**AGENDA ITEM 6.1** **31 July 2019**

University Health Board Report
UPDATE OF REPORTED SUICIDE IN WALES AND CWM TAF REGION

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Purpose of the Health Board Report
The purpose of this report is to provide an analysis and benchmark of suicide rates starting with the Wales position, then an overview of localised data some of which is for the former Cwm Taf area but some for Cwm Taf Morgannwg. The intention of this report is to examine trends in years, not months, as suicide rate does not follow a natural epidemiological pattern. The report will also examine the Health Boards current position in relation to a number of areas identified as being good practice in reducing suicide risk.

Governance	
Link to Health Board Strategic Objective(s)	The Board's overarching role is to ensure its Strategy outlined within 'Cwm Taf Cares' 3 Year Integrated Medium Term Plan 2019-2022 and the related organisational objectives aligned with the Institute of Healthcare Improvement's (IHI) 'Triple Aim' are being progressed, these in summary are: • To **improve** quality, safety and patient experience • To **protect** and **improve** population health • To **ensure** that the services provided are accessible and sustainable into the future • To **provide** strong governance and assurance • To **ensure** good value based care and treatment for our patients in line with the resources made available to the Health Board. This report focuses on all of the objectives
Supporting evidence	National Confidential Inquiry (NCI) on Suicide and Homicide for people with mental illness

Engagement – Who has been involved in this work?							
This report has been developed from a range of work undertaken across the Health Board and has previously been presented to the Mental Health Act Monitoring Committee.							
University Health Board Resolution to:							
APPROVE		**ENDORSE**		**DISCUSS**	√	**NOTE**	√
Recommendation	The Health Board is asked to: • **NOTE** the data on suicide trends contained in this report • **NOTE** the Mental Health services position in relation to good practice in reducing suicide risk and the further work planned.						
Summarise the Impact of the Health Board Report							
Equality and diversity	Potential equality issues relate to access to services and gender differences						
Legal implications	All suicides and suspected suicides are reviewed at a Coroner's hearing						
Population Health	The socio-economic factors of the Cwm Taf Morgannwg region impact negatively upon the mental health of the population. High unemployment rates are linked to a higher suicide rate.						
Quality, Safety & Patient Experience	This analysis acts as a quality assurance check on how the community is responding to suicide rates and scrutiny of such data will reveal areas for improvement and action.						
Resources	None highlighted at present.						
Risks and Assurance	Risks to patients (those people known to mental health services in the previous 12 months) are mitigated through environmental measures and clinical practice. Population level risks are being addressed through a partnership approach.						
Health and Care Standards	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes: Staying Healthy; **Safe Care**; Effective Care; Dignified Care; Timely Care; Individual Care; Staff & Resources http://www.wales.nhs.uk/sitesplus/documents/1064/24729_Health%20Standards%20Framework_2015_E1.pdf						
Workforce	Increasing awareness and skills across a range of services within health and in other agencies						
Freedom of information status	Open						

UPDATE OF REPORTED SUICIDE IN WALES AND CWM TAF REGION

1. SITUATION / PURPOSE OF REPORT

The purpose of this report is to provide an analysis and benchmark of suicide rates starting with the Wales position, then an overview of localised data for the former Cwm Taf area, data for the Bridgend County Borough Council population area has been requested from the national team but is not available as yet. The report examines trends in years, not months, as suicide rate does not follow a natural epidemiological pattern.

The report will also examine the full Health Boards current position in relation to a number of areas identified as being good practice in reducing suicide risk.

This report is presented against a background where Cwm Taf Morgannwg is one of the most prevalent areas of socio-economic deprivation, substance misuse and mental health problems in Wales.

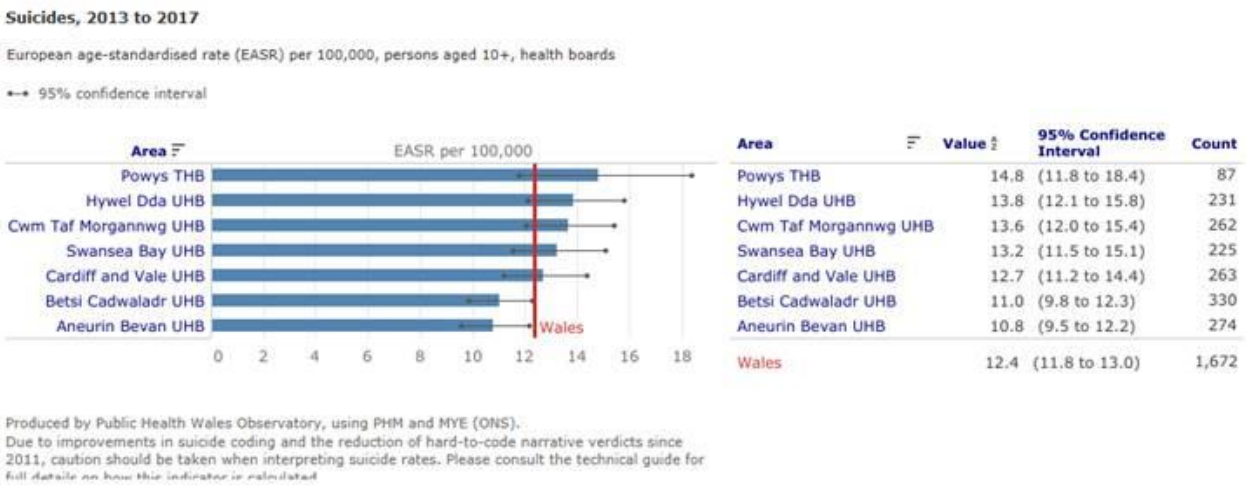
Through many years the strategic framework in the former Cwm Taf and Abertawe Bro Morgannwg has seen redesigned mental health services to provide enhanced community care, responsive primary care and effective hospital care and treatment. There have also been significant developments through extra funding in the last three years:

- The Valleys Steps initiative; a self-referral programme providing intervention and training for people with emotional disorders
- The Primary Care Mental Health Service to deliver part 1 of the Mental Health (Wales) Measure
- Increased resource to deliver psychological interventions

Whilst our strategy and new funding will respond appropriately to the increasing demand upon primary, secondary and tertiary services there also needs to be consideration to the wider community response to reducing suicide rates as a large number of people who take their life by suicide are not known to mental health services and have not visited their GP recently. Good progress has been made on this wider community based suicide prevention agenda in the last 12 months through a priority area of the Local Mental Health Partnership Board and mention of this will be made later.

2. BACKGROUND / INTRODUCTION

Information on all general population suicides (i.e. deaths by intentional self-harm and deaths from undetermined intent) by individuals aged 10 and over is collected from the Office for National Statistics (ONS). These are accessed from the Public Health Wales Observatory and are 5 year rolling figures – see latest below.



The above chart shows the most recent Cwm Taf Morgannwg University Health Board (CTMUHB) data. CTMUHB has the third highest rate of suicide at 13.6 suicides per 100,000 population yearly, some 71 suicides a year. There is some slight variance in this total population data and that which is the focus of this report as one looks at the rolling total and the other annual rates in key tables.

For the purpose of this report the focus will be on patients who die as a result of suicide (i.e. individuals who died by suicide within 12 months of mental health service contact) as per the criteria used in National Confidential Inquiry (NCI) on Suicide and Homicide by people with mental illness report.

To identify patient's national data is submitted to mental health services in each individual's district of residence or district of death and adjacent districts. Detailed clinical information is obtained for these individuals via a questionnaire sent to the Consultant Psychiatrist.

This report is based on findings reported for the local authority regions of Rhondda Cynon Taf and Merthyr Tydfil which includes all suicide and open verdicts. Despite the Bridgend population data not being available at the time of preparing the report there has been significant work in the area at population level in response to an increase in suicide seen 12 years ago. Particularly worth noting is a post suicide planning process to help identify others known to the deceased individual at immediate risk and how support needs are progressed. This work will feed into wider planning work referred to later in the report.

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

The National Confidential Inquiry (NCI) helpfully produce a national report to benchmark regions in the United Kingdom every year and there is a focus in Wales within the report. The analysis will be initially made on the all Wales information then that of the former Cwm Taf as outlined earlier.

In October 2018, the NCI produced a report examining the 10 year period between 2006 and 2016. The number and rate of suicide in the general population rose between 2009 and 2012-2013 with lower figures subsequently.

Some deaths are not registered for several months or longer which means that figures for the most recent years underestimate the final figures and these are adjusted accordingly in future reports.

There were 17,931 suicides by patients (i.e. individuals in contact with mental health services within 12 months of suicide) in the UK in 2006-2016, 28% of all general population suicides.

Table 1. Patient Suicide: Numbers by Year and UK Country

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
England	1,124	1,144	1,213	1,167	1,264	1,339	1,375	1,315	1,237	1,253	1,267
N. Ireland	61	76	76	64	73	67	76	73	73	80	73
Scotland	209	282	230	221	239	285	264	266	220	224	218
Wales	59	71	56	70	71	68	95	97	61	79	54
Total	1,453	1,573	1,575	1,522	1,647	1,795	1,810	1,753	1,591	1,636	1,612

For **Wales** the headlines were:

- There was significant drop in the suicide rate in 2014 that does not look to have been sustained (Table 2.)
- The majority remain males
- In the 2016 report the former Cwm Taf region had the highest rate in Wales at 13.7 deaths per 100,000 population over 2012 -2014. This has improved significantly to 11.4 in 2016, the third lowest in Wales (Table 3).

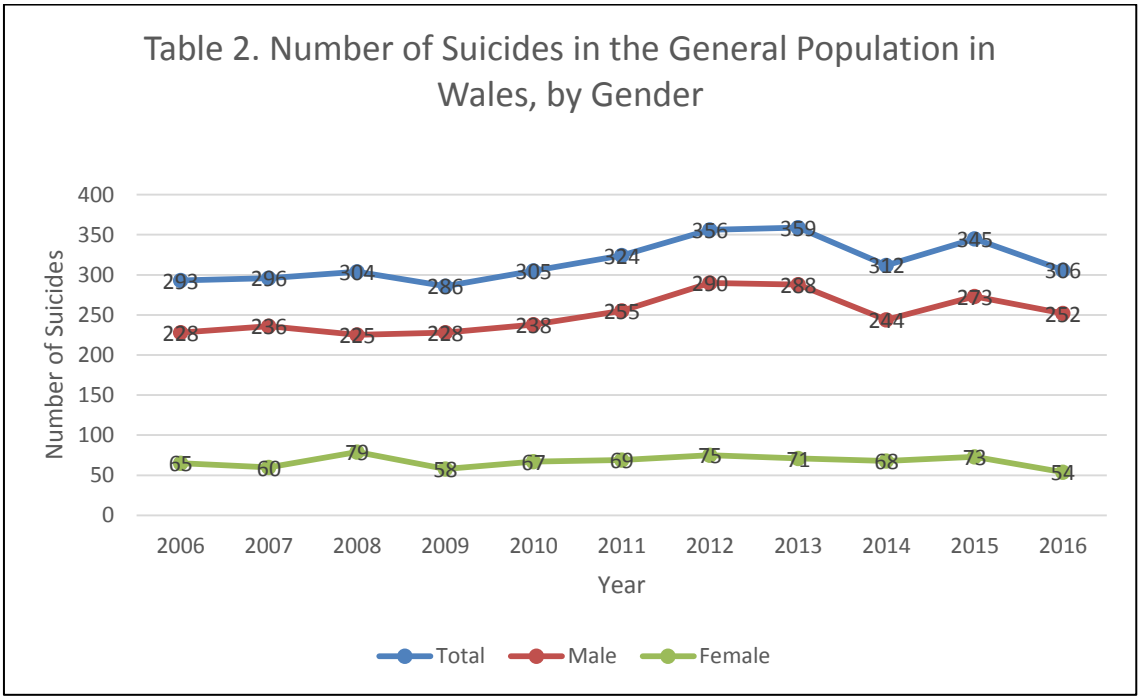
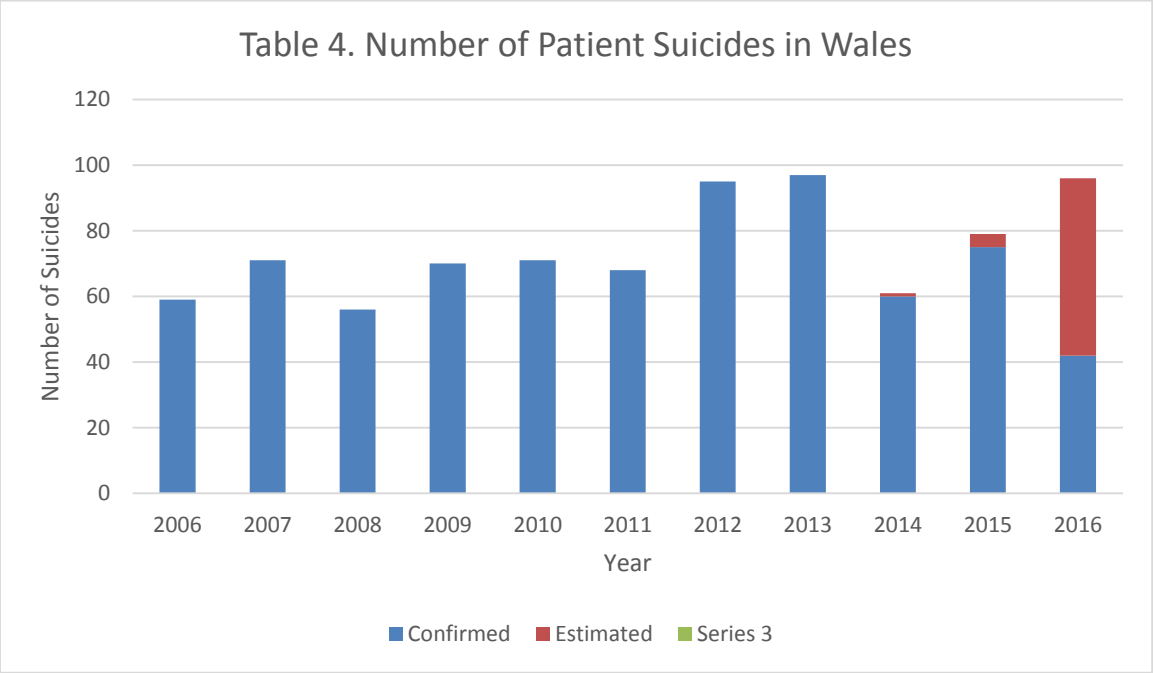


Table 3. Variation in Suicide Rates by Area of Residence in Wales 2006 – 16 (Former Cwm Taf)

Area	**Rate**
Aneurin Bevan	9.6
Betsi Cadwaladr	10.9
Cwm Taf	11.0
Hywel Dda	11.4
Abertawe Bro Morgannwg	11.5
Cardiff and Vale	12.6
Powys	14.5

During 2006-2016, 781 deaths (22% of general population suicides) were identified as patient suicides in Wales, i.e. the individual had been in contact with mental health services in the 12 months prior to death. This represents an average of 71 patient suicides per year and is lower than the mean of 28% across the UK.

There was an increase in the number of patient suicides between 2006 and 2015 with a peak in 2012 and 2013, broadly in line with general population figures. (Table 4.)



The most common methods of suicide by patients in Wales were:

- hanging/ strangulation (386, 51%)
- self-poisoning (167, 22%)
- jumping/multiple injuries (74, 10%)

The percentage of deaths by hanging/strangulation was higher compared to the rest of the UK. Deaths by self-poisoning and jumping/multiple injuries were lower compared to the rest of the UK.

Hanging/strangulation increased from 2006 to a peak in 2012 but recent figures have fallen. The number of deaths by other methods has changed little but there was a peak in 2013 in self-poisoning and jumping/ multiple injuries with lower figures subsequently. The most common substances used in deaths by self-poisoning were opiates (40, 25%), antidepressants (24, 15%), and antipsychotics (21, 13%).

Table 5 below shows the main social, clinical and behavioural features of patients who died by suicide. Compared to the other countries in the UK, the proportion living alone was lower in Wales, whilst those on sick leave was higher. There was a high proportion (29%) whose first contact with mental health care had been in the 12 months before suicide, though this figure was similar to the rest of the UK. Over half had a co-morbid condition and rates of previous self-harm, alcohol and drug misuse were high.

Table 5. Characteristics of Patients who Died by Suicide in Wales Compared to the UK (2006-2016)

	Wales N=781		Rest of the UK N=17,150	
	Number	%	Number	%
Demographic features				
Age: median (range)	45 (13-96)		45 (10-100)	
Aged under 25†	57	7	1,329	8
Male†	543	70	11,372	66
Not currently married	512	69	11,529	72
Living alone	319	44	7,677	48
Unemployed	319	43	7,271	46
On long-term sick leave	142	19	2,154	14
Black and minority ethnic group	11	1	1,071	7
Homeless	13	2	405	3
Clinical features				
Any secondary diagnosis	393	52	8,423	52
Duration of illness (<12 months)	155	22	3,140	20
First contact with mental health services:				
<12 months	207	29	4,242	28
>5 years	331	46	6,753	45
Last admission was a re-admission	52	12	1,169	14
Behavioural features				
History of self-harm	513	69	10,833	67
History of violence	178	24	3,512	22
History of alcohol	370	49	7,921	48
misuse† History of drug misuse†	292	38	5,903	36

The most common primary diagnoses were:

- affective disorders - 41%,
    - 33% with depressive illness
    - 8% with bipolar disorder

- schizophrenia including other delusional disorders 15%
- alcohol dependence/misuse 9%
- personality disorder 9%

Of the 'other' diagnoses, 39 (5%) had adjustment disorder. The diagnostic profile in Wales was similar to the rest of the UK.

Table 6. Key Service-Related Characteristics of the Patients Compared to the Rest of the UK.

Characteristic	Wales N=781		Rest of the UK N=17,150	
	Number	%	Number	%
In-patients†	56	7	1,315	8
Recent(<3 months) discharge†	134	18	2,754	16
Under crisis resolution/home treatment services†	77	10	2,339	14
Missed last contact in previous month†	171	24	3,846	25
Non-adherence with medication in previous month†	87	12	1,924	13
Contact with services				
Last contact within 7 days of	352	46	7,702	47
death Short-term risk: low or	626	88	12,763	85
none	445	64	8,593	59
Long-term risk: low or none				

There were 56 in-patient deaths by suicide in 2006-2016, representing 7% of patient suicides, similar to the rest of the UK.

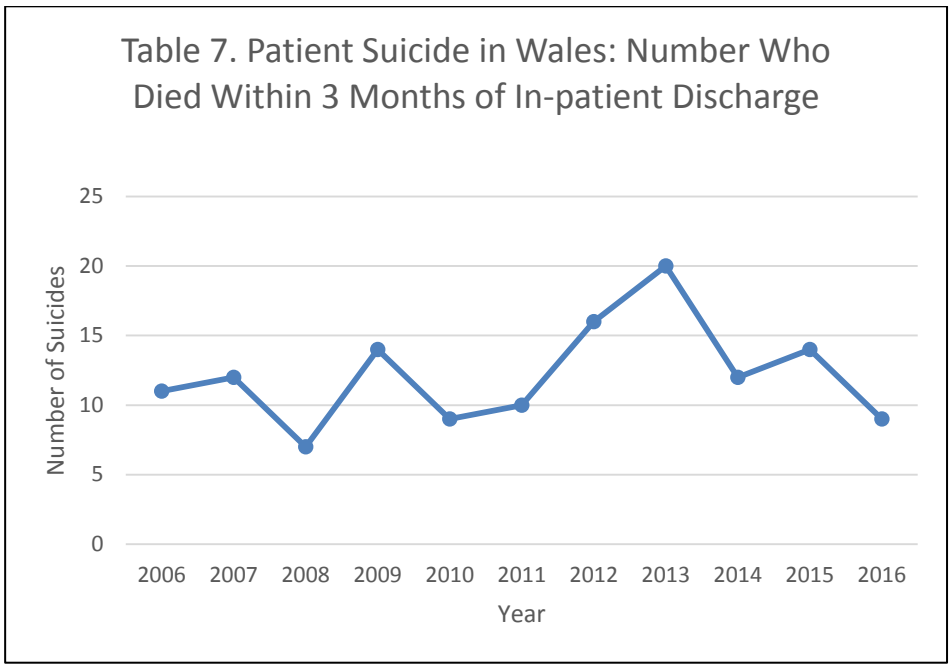
- 26% of patients died on the ward (14 people)
- 64% were on agreed leave or had left with staff agreement (34 people)
- 9% died after leaving the ward without staff agreement (5 people).

Of those who died on the ward by hanging/strangulation, the 11 people died by hanging/strangulation 64%in a single bedroom and 29% in a toilet/bathroom (29%). The most common ligature point was doors (55%) and the most common ligatures were a belt (45%) or shoelaces (27%).

7 (13%) in-patient suicides were related to people under a medium or high level of observation. In a further study of suicide by patients under observation, it was recommended that observations should be seen as a skilled intervention carried out by experienced staff.

Patients recently discharged from hospital

There were 134 suicides of people within 3 months of discharge from in-patient care in Wales, 18% of all patient suicides, an average of 12 deaths per year. (Table 7) The proportion was similar to the rest of the UK. The number of post-discharge suicides reached a peak in 2013 with lower figures subsequently.



Post-discharge suicides were most frequent in the 2 weeks after leaving hospital when 42 deaths occurred, 37% of all suicides within 3 months of hospital discharge, an average of 4 deaths per year. 19 (17%) patients died in the first week after discharge – the highest number was on the third day (5 patients).

In 16 (13%) of post-discharge suicides the patient had been detained under the Mental Health Act (MHA) at the last admission. For 45 (38%) patients the last admission had lasted less than a week. 24 (20%) patients had initiated their own discharge from hospital, including self-discharge and after breaching ward rules.

Crisis Resolution Home Treatment

There were 77 suicides of patients under Crisis Resolution Home Treatment (CRHT) teams, an average of 7 deaths per year. This represented 10% of the total sample, a lower proportion compared to the rest of the UK (14%). Since 2007 there have been more patient suicides under CRHT (71 patients) than in in-patient care (48 patients), reflecting a change in the nature of acute care.

- 33% of patients under CRHT had been discharged from in-patient care in the preceding 3 months;
- 47% died within 2 weeks of discharge from CRHT,
- 28% within a week

Section 136

In 2012-2016, there were 17 patients who had been conveyed to a hospital or custody based place of safety under Section 136 of the MHA in the 3 months prior to suicide. This represents 7% of all suicides in this time period.

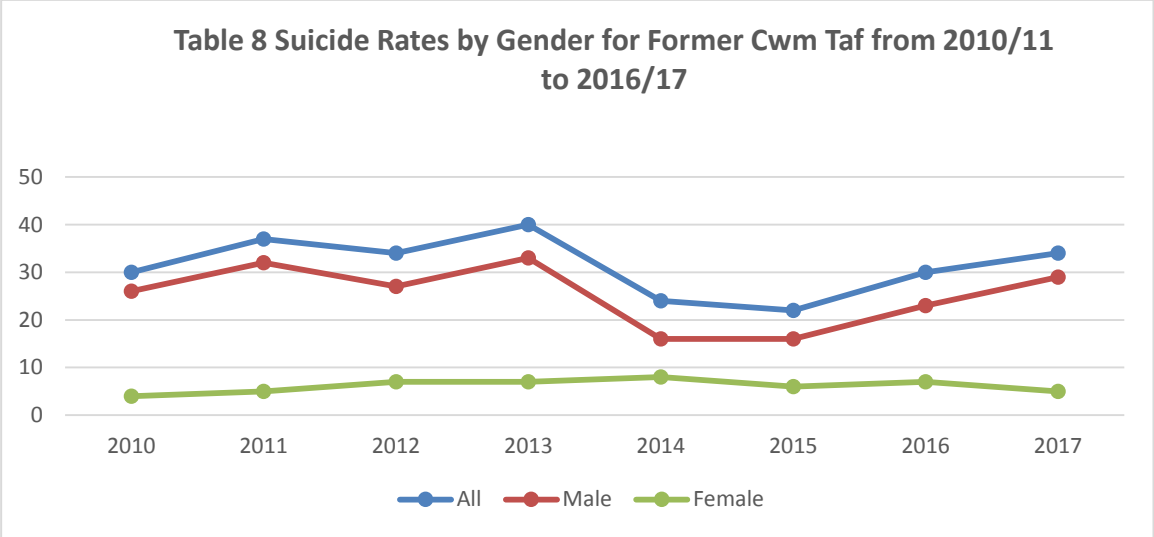
Child and Adolescent Mental Health Services

There were 17 suicides by patients aged under 25 who had been under the care of Child and Adolescent Mental Health Services (CAMHS) in 2006-2016, 35% of all suicides by patients aged under 25.

Former Cwm Taf Specific Data

The headlines were:

- Rates of male suicide fluctuate more significantly than that of females. (Table 8)
- Significantly lower rates of male suicide were seen in 2014 and 2015 that have not been sustained.
- The percentage of patient suicides in contact with services has reduced steadily over the years (Table 9)



Data for 2016 – 17 should be treated with caution as some inquests may not have yet concluded.

Table 9. Suicide and Open Verdict Rates for Former Cwm Taf Region from 2010/11 to 2015/16

Based on Date of Incident	1st April 2010 - 31st March 2011	1st April 2011 - 31st March 2012	1st April 2012 - 31st March 2013	1st April 2013 - 31st March 2014	1st April 2014 - 31st March 2015	1st April 2015 - 31st March 2016	1st April 2016 - 31st March 2017
Suicide (Male)	26	32	27	33	16	14	29
Suicide (Female)	4	5	7	7	8	9	5
Total	**30**	**37**	**34**	**40**	**24**	**22**	**34**
Suicide in Contact (Male)	9	10	6	8	5	4	4
Suicide in Contact (Female)	1	5	4	3	3	4	1
Total	**10**	**15**	**10**	**11**	**8**	**8**	**5**

What is being done to reduce the risk

The authors of the NCI report have been working with a number of agencies with a focus on quality improvement in the area of reducing suicide. Below is a graphic widely used by them – 10 ways to improve safety.

Work in the full Cwm Taf Region will be focused under the headings in the diagram above.

Safer Wards

Significant work has been undertaken to reduce ligature points in high risk areas where patients could spend significant time not directly observed. As part of this new en-suite bathroom doors have been put in place and windows refitted. Phase 1 & 2 work in the former Cwm Taf area addressed assessed ligature risks in adult acute wards with an enhanced focus in bedrooms and toilet / bathroom areas in line with findings reported earlier. In Bridgend, Phase 1 work ensured all wards has some bedrooms and bathrooms where ligature risks were addressed. Phase 3 work will complete work in the remainder of the Bridgend wards and some rooms in older persons and rehabilitation wards in the former Cwm Taf.
This issue had been 20 on the Directorate risk register, following the initial phases of work this was reviewed and reduced to 15 in June 19 and is likely to reduce further following completion of the remaining work.

There is a clear policy on the provision of safe observation and engagement with a clear focus on therapeutic engagement. This is currently being reviewed as there were different policies in place pre the boundary change albeit the principles were very similar.

There is an inpatient multidisciplinary team with a range of professionals including a Psychologist to ensure meaningful engagement on a regular basis.

Early Follow Up on Discharge
We have had a mandatory 7 day follow up appointment for patients discharged from in-patient care for many years based on a recommendation in a previous NCI report. Work was undertaken on ensuring there is capacity to move to a follow up within 72 hours in line with the most recent recommendation in the 2018 NCI report. This was successfully implemented early in 2019.

Instilling hope that discharge is not the end of our interventions is critical for people who do not need hospital care but still have social and financial pressures. On the admission ward, there is a Citizen's Advice Bureau (CAB) surgery as debt and the impact of financial reforms is one of the most significant triggers for people within the local communities and can bring people into contact with our services. MIND have employed a Personal Independence Payment (PIP) worker to assist patients subject to benefit reform who are vulnerable to having essential benefits stripped away. Gofal are also commissioned to provide a 'Hospital to Home' service to ensure patients tenancies are maintained while they are in hospital.

No Out of Area admissions
There have only been two occasions in the last 12 months where Cwm Taf needed to admit a patient to another Health Board due to local bed pressures. Occasionally someone will get admitted elsewhere in an emergency as that is where they were when they became unwell, transfers back to local services are always prioritised. A review of the bed model and capacity is planned for 19/20 to further consider future models post the boundary change. This work will commence as new management structures bed in around December and will be led by the Clinical Director.

24 – hour crisis teams
The former Cwm Taf area had open access Crisis Resolution Home Treatment (CRHT) Teams for many years and self-referrals as well as direct referrals from the police are frequent. This is not the standard approach across Wales but the Directorate has always felt it important to ensure timely access for people who feel distressed and may be suicidal and feedback is positive from key stakeholders about this. Bridgend CRHT moved to working 24/7 in June 2019.

Family involvement in 'learning lessons'
Families are always engaged by senior clinical staff in the event of a suicide of person who is a patient in local services. As part of this the learning lessons process is explained and many families actively participate in this.

Guidance on depression
Primary Care Mental Health services deliver stepped psycho-social interventions with a view to helping people manage mild to moderate difficulties and building resilience. As part of this a depression pathway has been developed for use by primary care practitioners.

Personalised risk management
There is a well-established multiagency programme of risk assessment and management training. Risk management plans are part of a regular audit cycle to ensure completeness, coproduction and them being personal to the individual's experience of previous crisis and triggers for these. Additional staff are being trained as trainers in 2019/20 in WARNN. WARRN is the Wales Applied Risk Research Network – they developed a formulation tool for use across Wales.

Outreach teams
The former Cwm Taf has well established Outreach and Recovery Community Services (7 days a week) to provide care and treatment for those with most complex needs who can be difficult to engage. It is worth noting that this service is not part of the provision in Bridgend. A new CTMUHB wide mental health rehabilitation services board is being established and strategic recommendations from this will inform future Integrated Medium Term Plans. The first meeting is planned for July and is being led by the Head of Nursing.

Low staff turnover
Turnover of Registered Nurses is a continual challenge for inpatient wards as new community roles emerge and many staff achieve promotion. In the main the Health Board have a low staff turnover but further work by Heads of Profession to develop clear career strategies will further improve retention of staff who see opportunities for progression into more innovative roles, in particular in inpatient areas.

Services for dual diagnosis
The Health Board does not have dedicated dual diagnosis services but has an ongoing programme of work with Local Authorities to address the needs of people requiring both mental health and substance use interventions. A new Advance Nurse Practitioner post for dual diagnosis has been funded for the adult admission and treatment ward to further improve the care of this client group as there is a high prevalence of need on the wards and it is critical to ensure preparatory work to increase the likelihood of engagement with community services.

Other areas of good practice
There is a *walk out* protocol in the A&E departments to alert agencies to patients who may leave the department before an assessment can be completed so that this is followed through depending on initial risk assessment to ensure their safety. Previous reviews have shown this to be working well, the work needs reviewing though to ensure there is consistent practice across the full Health Board area post the boundary change.

The community teams deliver a Dialectical Behaviour Therapy (DBT) for patients with personality disorder who are at significant risk of self harm. This is available across the full CTMUHB area and is well evaluated by patients.

Strategic Work

The Health Board, led by Public Health was involved in establishing a regional Suicide and Self Harm Prevention group which has gathered significant momentum over the last 12 months after being identified as a key priority of the Local Mental Health Partnership Board. To progress the work a workshop to develop priorities was held in late 2018 and over 100 people from a range of sectors attended as did a number of people whose lives have been affected by suicide. The local group was strengthened following this and key individuals produced #Project34+ 'A Suicide and Self-harm Action Plan for Cwm Taf which is being revised to reflect the wider Health Board suicide rate and plans to address these.

Mind have been doing significant work locally. #ItTakesBallsToTalk – A suicide awareness campaign has been launched following confirmation from the Wales Rugby Union of their support to deliver this at grassroots rugby clubs in Merthyr Tydfil and Rhondda Cynon Taf.

The suicide awareness sessions began at the Cardiff Blues v Saracens game at Cardiff Arms Park on 15 December 2018, 250 balls with cooperate Mind and Samaritans help messages were given to men attending the game - £300 was raised to support this agenda.

The National Assembly for Wales Health, Social Care and Sport Committee undertook an enquiry to understand what is currently being done and where action is needed to drive the change and improvements that are required to reverse suicide trends. The Everybody's Business report on suicide prevention in Wales was published in December 2018. There were a number of recommendations, many for progression nationally, some key recommendations were to be progressed locally as follows:

- The effectiveness of the urgent referral route for GPs implemented by Hywel Dda Health Board be evaluated with a view to rolling this approach out across all Health Boards in Wales
  There is a well-established urgent assessment pathway in place for primary care, police and self-referral in Cwm Taf.
- Welsh Government develops an all-Wales triage model which would see community psychiatric nurses based in police control rooms.
  Cwm Taf is currently the lead Health Board in the South Wales Police region agency hosting this model in the police contact centre.
- The target for patients discharged from inpatient mental health care to receive a first follow-up appointment should be changed to ensure that patients are followed up within 48 – 72 hours.
  This is now in place.
- The National Advisory Group and regional suicide forums should engage with people who have personal experience of suicide ideation, including survivors of suicide attempts and people bereaved by suicide to ensure that all suicide prevention activity is informed by lived experience.

A number of the Members of the local Talk to Me group have personal experience of suicidal feelings and others lives have been affected by loved ones who have died by suicide.

4. RECOMMENDATION

The Health Board is asked to:

- **NOTE** the data on suicide trends contained in this report;
- **NOTE** the mental health services position in relation to good practice in reducing suicide risk and the further work planned.

Freedom of information status	Open