AGENDA ITEM
6.3

QUALITY & SAFETY COMMITTEE

UPDATE REPORT IN RELATION TO THE PREVENTION OF SUICIDE

Date of meeting	18/05/2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Louise Mann, Assistant Director, Quality, Safety & Safeguarding
Presented by	Greg Dix, Executive Director of Nursing
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR DISCUSSION / REVIEW

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
CTMHB Safeguarding & Public Protection, CTMHB Child & Adolescent Mental Health Services, CTMHB Adult Mental Health Services, CTM Safeguarding Board.	Ongoing from September 2019	SUPPORTED

ACRONYMS	
CAMHS/AMH	Child & Adolescent Mental Health Service/Adult Mental Health
DU	Delivery Unit
IRG	Immediate Response Group
PRUDiC	Procedural Response to Unexpected Death in Childhood

MASH	Multiagency Safeguarding Hub

1. SITUATION/BACKGROUND

This report will provide an update to previously reported concerns to Quality & Safety Committee in relation to suicides within Cwm Taf Morgannwg (CTM) of young people under the age of 25 years. The previous report highlighted an escalation in the number of young people within CTM completing suicide from the index case reported in August 2019; there were 14 deaths by apparent suicide of children and young people under 25 years in 2020. There have been no reported suicides of the under 25's during 2021 to date. The previous report identified a regional grouping of the deaths and an action plan to identify vulnerable individuals at risk and provide preventative, targeted support was commenced.

There have been further anxieties raised by statutory agencies that there has been a perceived escalation in suspected completed suicides affecting all age groups throughout the Cwm Taf Morgannwg region during 2020 and concern in relation to the impact of actions taken during the pandemic. This has led to the Safeguarding Board and partner agencies response to work in partnership to develop strategies that will aid in the reduction, prevention & early intervention of suicide, to plan and provide crucial support.

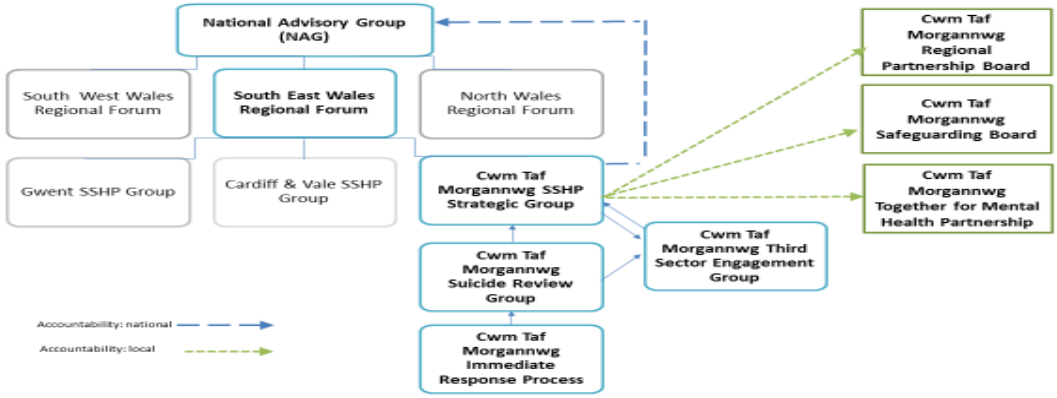
The Health Board along with its prevention and early intervention work with young people, is undertaking a review of all adult apparent suicides during 2020, where there has been a contact with our mental health or drug and alcohol services to identify any themes, trends or learning to improve practice. This will incorporate the period prior to and during the lockdown sanctions of the pandemic first wave by way of comparison

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

The effect of suicide on communities is profound and an all agency response is required. The focus of the police led Immediate Response Group has broadened out to all suicides in an attempt to progress learning and prevention, identify themes and trends. The CTM Safeguarding Board host a multi-agency strategic group and suicide review group to ensure that all CTM suicides are captured. This further work is required to interrogate real time monitoring of suicidal behaviour; apply learning to the prevention of suicide and promotion of stability of well-being within our vulnerable populations.

These groups input into other national and local partnerships as illustrated below:

Cwm Taf Morgannwg suicide and self harm prevention (SSHP): national and local structure



Since the initial concerns in relation to young people were raised, IRG meetings in response to suicides now incorporate all ages (previously focussed on young people up to the age of 25 years); identifying and capturing affected individuals identified as vulnerable and likely to require additional support for their well-being. There is now a presence on every IRG meeting of CAMHS and AMH representation, regardless of whether the deceased is a young person or an adult of any age. This facilitates greater awareness and intelligence sharing as well as improved targeting and service planning. A positive incidental impact has been strengthened, timely transition arrangements between children's and adult mental health services.

The latest data for Wales show that 330 people completed suicide in 2019, with 75% of these being male (ONS). Early review of local data suggests that out of 55 suspected suicides in CTM in 2020, 39 (71%) were male and 16 (29%) female, predominantly in the 30-39 year age group. The Office for National Statistics (ONS) data highlights that men aged 40-44 have the highest suicide rates in Wales. Females residing in CTM in particular appear to be more at risk of suicide within the age category of 30-39. In the under 25's group, males were more at risk with 78% of all completed suicides during 2020 being male.

An ongoing desk top review of individuals where it is likely that suicide was the cause of death and whom have been in contact with our services, does not thus far reveal any direct correlation between COVID 19 and their apparent suicide. There appears to be an accumulation of events and a combination of individual, situational and socio-cultural risk factors such as poor health, job loss and financial difficulties.

During lockdown periods, services changed the way they delivered advice and support, with many services pausing face to face home visits; it is unknown if this was a contributory factor however there has been a lack of infrastructure available to support vulnerable groups during this time.

During the pandemic there have been reports in the media of a national increase in domestic violence, child abuse, alcohol misuse and people suffering with poor mental health. There is also local evidence to support this within CTM. There is a likelihood during the shielding/lockdown period for individuals to have become isolated with minimal support from extended family and support services. It is therefore envisaged that restrictions imposed by the pandemic response may have contributed to the difficult circumstances those identified within the review may have already been experiencing.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

That the committee can be assured that the prevention of suicide and self-harm maintains a priority with excellent partnership arrangements both operationally and strategically, of which CTMUHB plays a key role. Learning is multi-factorial and requires an all agency approach.

That early indicators are that there has not been an increase in suicides of all ages during the covid pandemic response. Further information will become available following the coroner's decision to hold an inquest.

To date in 2021 there have been no further suspected suicides of children or young people under the age of 25 years. It is prudent that we gain an understanding of this in order to establish the circumstances in which to best prevent suicide in this age group.

Further analysis of identified vulnerable groups and emerging themes is required to ensure that learning is made available to improve and target public service provision. Specifically in relation to health services, reviewing the way in which we provide care and treatment to individuals where risk factors for suicide have been identified is ongoing.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Safe Care
	If more than one Healthcare Standard applies please list below: Timely & Effective care

Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	Choose an item. If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not required
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Well-being Objectives	Work with communities and partners to reduce inequality, promote well-being and prevent ill-health

5. RECOMMENDATION

That the strategy of CTM regional partnerships in response to the suicide prevention agenda is **NOTED** and be assured that further work with partners is ongoing to interrogate real time monitoring of suicidal behaviour; apply learning to the prevention of suicide and promotion of stability of well-being within our vulnerable populations.

There is an ongoing Health Board review of cases during 2020 where suicide is the most likely cause of death and where the individual was in contact with our mental health, drug and alcohol services. The aim of this review is to learn and improve our service provision. Early findings suggest that a deep dive exercise may extract more meaningful data in regards to any themes, such as the numbers of women aged 30-39 years within the same region, to establish what makes a cohort vulnerable and whether there was a likely impact caused by the pandemic.

A further report to Quality & Safety Committee on the internal report and assurance on external collaborative activity in relation to suicide prevention to made available to the next meeting.