Meeting Date	**25 February 2020**	**Agenda Item**	**3.3**
Report Title	**Self-harm and Suicide Prevention**		
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Report Sponsor	Janet Williams-Interim Director MH & LD SDU		
Presented by	Dr. Rhonwen Parry - Head of Psychology & Therapies		
Freedom of Information	Open		
Purpose of the Report	The purpose of this report is to advise Swansea Bay Quality and Safety Forum on activity and priorities to support the Work streams of both the Regional and local multi-agency Self-harm and Suicide Prevention Planning Fora.		
Key Issues	Governance arrangements and reporting lines Work steams to support Strategic objectives and local actions plans		

Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☐	☐	☒	☐

Recommendations	Members are asked to: • **NOTE** the report

SELF-HARM AND SUICIDE PREVENTION

1. INTRODUCTION

The Welsh Government Strategy *Talk to Me 2*, sets out the strategic aims and objectives to reduce suicide and self-harm in Wales over the period 2015-2020.

The six main objectives of *Talk to Me 2* are:

1. Improve awareness, knowledge and understanding of suicide and self-harm amongst the public, individuals who frequently come into contact with people at risk of suicide and self- harm and professionals in Wales
2. To deliver appropriate responses to personal crises, early intervention and management of suicide and self-harm
3. Information and support for those bereaved or affected by suicide and self-harm
4. Support the media in responsible reporting and portrayal of suicide and suicidal behaviour
5. Reduce access to the means of suicide
6. Continue to promote and support learning, information and monitoring systems and research to improve our understanding of suicide and self-harm in Wales and guide action

In July 2017 The Welsh Government produced Local Guidance for local suicide prevention fora which follows in the footsteps of the national strategy *Talk to Me 2*.
The fact that a majority of people who die by suicide (two thirds) are not in contact with mental health services means that suicide prevention is a shared public sector, health and mental health service priority.

This has led to the re-establishment of South West Wales Regional Suicide Prevention Group in 2018 (hosted by Carmarthen County Borough Council) and the setting up of the Swansea Bay Multi-agency Group in May 2019-hosted by Public Health.

There is a regular review of suicide by people known to mental health services - the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) The Inquiry report refers to ‘patient suicides’ as those that occur within 12 months of mental health service contact. The most recent report (Appleby et al, 2019) covers the period 2007-2017. The findings show that over the whole reporting period Wales followed the general trend of lower figures being maintained but with an increase in 2017 (in line with National variation). The report breaks the data down by region, population characteristics, methods, location, health diagnoses (including Mental Health) and social risks.

2. BACKGROUND

The South West Wales Regional Suicide Prevention Group reports to the National Suicide and Self Harm Steering Group led by Professor Ann John (Public Health Wales).

An overarching set of strategic objectives were set in 2018 to support Local groups to develop their actions plans. The Regional Group has representation from the Health Boards covering the region (Hywel Dda and Swansea Bay UHB), Welsh Ambulance, Local Authorities, SW Police, Network Rail, HM Coroner and Third Sector organisations across the Region. This shows the shared commitment to reduce suicides. ***This will require a dedicated long-term focus and a commitment to continue to work together so that suicide and self-harm prevention truly becomes everyone's business.***

In July 2019 Welsh Government announced additional funding to establish local coordinators to support each region in the realisation of local Action Plans (recruitment in process).

In order to develop a Local Action Plan across the footprint of Swansea Bay University Health Board, a Local Multi-agency Group (Swansea and Neath Port Talbot Suicide and Self harm Prevention MAG) was established in May 2019. This group, led by Public Health, has representation from Swansea Bay Health Board (Mental Health, School Nursing and Primary Care), Swansea and Neath Port Talbot Local Authorities (Child and Adult services), the Police, South Wales Ambulance and third sector organisations. The Swansea and Neath Port Talbot MAG reports to the South West Wales Regional Group

The work programme of the group was informed by the outcome of a multi-agency workshop convened in March 2019. A further workshop was facilitated in November 2019 to consolidate priorities in line with National and Regional Priorities and informed by the most recent National Confidential Enquiry into Self –harm and Suicide published in November 2019 (NCISH. Appleby et al.).

3. GOVERNANCE AND RISK ISSUES

The Mental Health and Learning Disability Service Delivery Unit is actively engaged in both the Regional SH and S Group and the Local SBUHB Multi-agency Group. It also contributes to National work streams such as the Mental Health Leaders Collaborative (Improvement Cymru) and the National SUI Steering Group. Self-harm and Suicide Prevention are high on the agenda of these fora.

NICE quality statements relevant to self-harm and suicide prevention NICE quality statement (2018)	NICE quality standard
People using mental health services who may be at risk of crisis are offered a crisis plan.	QS14: Service user experience in adult mental health services, quality statement 9
People accessing crisis support have a comprehensive assessment, undertaken by a professional competent in crisis working.	QS14: Service user experience in adult mental health services, quality statement 10
People who have self-harmed are cared for with compassion and the same respect and dignity as any service user.	QS34: Self-harm, quality statement 1
People who have self-harmed have an initial assessment of physical health, mental state, safeguarding concerns, social circumstances and risks of repetition or suicide.	QS34: Self-harm, quality statement 2
People who have self-harmed receive a comprehensive psychosocial assessment.	QS34: Self-harm, quality statement 3
People who have self-harmed receive the monitoring they need while in the healthcare setting, in order to reduce the risk of further self-harm.	QS34: Self-harm, quality statement 4
People who have self-harmed are cared for in a safe physical environment while in the healthcare setting, in order to reduce the risk of further self-harm.	QS34: Self-harm, quality statement 5
People receiving continuing support for self-harm have a collaboratively developed risk management plan.	QS34: Self-harm, quality statement 6
People receiving continuing support for self-harm have a discussion with their lead healthcare professional about the potential benefits of psychological interventions specifically structured for people who self-harm.	QS34: Self-harm, quality statement 7
People receiving continuing support for self-harm and moving between mental health services have a collaboratively developed plan describing how support will be provided during the transition.	QS34: Self-harm, quality statement 8
People who have a risk of suicide identified at preparation for discharge from an inpatient mental health setting are followed up within 48 hours of being discharged.	QS159: Transition between inpatient mental health settings and community or care home settings, quality statement 4

In addition to the above indicators the NCISH Report (2019) recommends 10 key Ways to improve safety. Activity priorities within the MH and LD Delivery Unit are underpinned by these safety indicators. These include:-

1. Safer wards-anti-ligature audit programme
2. Early follow-up on discharge-CTP audit including evidence of Risk assessment
3. Family involvement in learning lessons-through improvements in SI process, knowledge and skills of Reviewers and support for clinicians.
4. Review of data on completed suicides to understand trends and incidence within the population known to our services.
5. Training and development priorities to increase awareness and target training for staff working in high risk area (through the Unit Learning and Development Group)
6. Initiatives to improve staff well-being. Early stages of development of a 'self-help' app (through our Learning and development team).
7. Joining up of Awareness Raising training programmes (Learning and Development Team and Liaison Psychiatry.
8. Improve uptake –'Train the Trainers' WARRN
9. Commissioned Review of contemporary literature to inform identification additional bespoke training.
10. Crisis Care Concordat work-stream. Includes peer support –High Risk Clinical Case Reviews.

11. Continued input to the Local and Regional Self-harm and Suicide Prevention For a.
12. Direct support to engagement events. World Mental Health Day October 2019. MAG workshop March 2019 and March 2020.

4. FINANCIAL IMPLICATIONS

N/A

5. RECOMMENDATION

Members are asked to :

- **NOTE** the content of this report.

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☒
	Co-Production and Health Literacy	☒
	Digitally Enabled Health and Wellbeing	☒
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☒
	Excellent Staff	☒
	Digitally Enabled Care	☐
	Outstanding Research, Innovation, Education and Learning	☐
Health and Care Standards		
(please choose)	Staying Healthy	☒
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☐
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☐
Quality, Safety and Patient Experience		
Self-harm and Suicide prevention requires a whole system approach.		
Financial Implications		
N/A		
Legal Implications (including equality and diversity assessment)		
N/A		
Staffing Implications		
Awareness raising, training, development and staff support.		
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)		
Briefly identify how the paper will have an impact of the “The Well-being of Future Generations (Wales) Act 2015, 5 ways of working.		

Report History	
Appendices	NCISH Report 2019. HQIP