Board of Directors – Public Session

SUMMARY REPORT	Meeting Date:	22nd March 2023
	Agenda Item:	16

Report Title:	**Suicide Prevention Progress Report**	
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Other meetings this paper has been presented to or previously agreed at:	**Committee/Tier 2 Group/Tier 3 Group**	
	Date:	
Key points/ recommendations from those meetings		

Summary of key points in report

This report outlines the key findings from the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) Annual Report for 2023. It relates the national findings to the situation in Sheffield and Yorkshire and the Humber. The national findings are important in local suicide prevention planning because the larger numbers provide a clearer picture of those factors that place people at increased risk of death by suicide. From these factors, a number of areas for intervention are apparent, including:

1. Treatment for people who self-harm
2. Reducing harmful use of street drugs and alcohol
3. Awareness of loss of contact from services
4. Helping those who are socially isolated and lonely
5. Careful discharge planning and follow up
6. Safer inpatient environments, including ligature anchor point removal
7. Being aware of economic adversity, including loss of job, benefits and housing
8. Having trauma-informed care embedded in pathways

The work that SHSC is currently undertaking in relation to these areas with the potential to impact on suicide prevention is summarised.

Recommendation for the Board/Committee to consider:

Consider for Action		**Approval**		**Assurance**	**X**	**Information**	

The Board is asked to receive this report and consider the assurance it provides.

Please identify which strategic priorities will be impacted by this report:				
Covid-19 Recovering effectively	*Yes*	X	No	
CQC Getting Back to Good – Continuing to improve	*Yes*	X	No	
Transformation – Changing things that will make a difference	*Yes*	X	No	
Partnerships – working together to make a bigger impact	*Yes*	X	No	

Is this report relevant to compliance with any key standards ?					State specific standard
Care Quality Commission Fundamental Standards	*Yes*	X	No		**The regulations of the Health and Social Care Act 2012**
Data Security and Protection Toolkit	*Yes*		No	X	
Any other specific standard?	*Yes*		No	X	

Have these areas been considered? YES/NO					If Yes, what are the implications or the impact? If no, please explain why
Service User and Carer Safety and Experience	Yes	X	No		**Suicide prevention is a key patient safety intervention in mental health services**
Financial (revenue &capital)	Yes		No	X	**The report does not explicitly consider financial impact, although links with major pieces of work including the transformation programme are apparent**
Organisational Development /Workforce	Yes	X	No		**Development of a workforce skilled in suicide prevention is a key intervention**
Equality, Diversity & Inclusion	Yes	X	No		**Suicide prevention is an intervention that can reduce health inequalities**
Legal	Yes	X	No		**Human Rights Act 1998, Article 2: Right to Life Mental Health Act 1983 Health and Social Care Act 2012**
Sustainability	Yes	X	No		**Evidence-based interventions for suicide prevention are also associated with improved sustainability**

Section 1: Analysis and supporting detail

Background

1.1 Death by suicide is a tragedy for individuals, families and communities, and its prevention is a public health and clinical priority. Although most people who die by suicide are not known to mental health services, the presence of mental health problems (particularly mood disorders) is a significant risk factor for death by suicide. People with mental health problems who are receiving specialist mental health care are disproportionally likely to die by suicide.

1.2 The Sheffield Health and Social Care (SHSC) Clinical and Social Care Strategy identifies suicide prevention as a central outcome of delivering the Strategy's high-level objectives to improve quality and reduce inequalities in care. The fundamental principles of the Strategy, that care should be Person-Centred, Trauma-Informed, Strengths-Based and Evidence-Led, are applied to our prevention work through the enabling strategies and Transformation Programme.

1.3 Suicide prevention requires wider cooperation and coordination than that at the level of an individual organisation. SHSC is part of the broader Sheffield and South Yorkshire programmes on suicide prevention.

1.4 The annual report of the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) was published on 9th March 2023. The current paper applies the national findings from NCISH to the work that SHSC is undertaking in areas that have the potential to impact on suicide prevention.

Findings from NCISH 2023: Suicide in the UK General Population 2010-2020

1.5 For the general population, in the decade 2010-2020 (the most recent year for which national data is available) there was a yearly average of 6,214 deaths by suicide in the UK nations. In 2020, the rate of death by suicide for men was 11.2 per 100,000 people in the general population. For women the rate was 5.9 per 100,000 people. A general pattern in overall suicide rates through the decade is a rise from circa 2008, followed by a fall from 2012 and another rise from 2016 onwards. In 2020, overall rates fell by 6%, a finding in keeping with earlier observations that times of national crisis (in this case the Covid-19 pandemic) are associated with reduced deaths by suicide because of a protective effect of social cohesion during crisis.

Suicide in the Sheffield General Population 2010-2020

1.6 Sheffield has generally been below the England suicide rate, although in 2018-2020 this increased so that the Sheffield rate was higher. In the context of Yorkshire and the Humber, this region has had a consistently higher rate by comparison with the England average. Sheffield had a lower suicide rate than Yorkshire and the Humber in 9/10 years in the decade 2010-2020, including in 2018-2020.

Suicide in UK Mental Health Service Users 2010-2020

1.7 Rates of death by suicide amongst mental health service users approximately halved between 2010 (98.5 deaths per 100,000 service users) and 2020 (47.2 per 100,000), although the decrease has been slower since 2015. In considering this change, it is important to emphasise the increasing number of people receiving care within mental health services during this period, for example in lower intensity services such as IAPT. In 2020, service user deaths by suicide accounted for 27% of all deaths by suicide in the general population, an approximately threefold excess.

Suicide in SHSC Service Users

1.8 We do not currently have data in SHSC that is adjusted for population in a way to allow direct comparison with other local, regional and national data. This is an area for further development in our approach to suicide prevention.

1.9 However, we do review the deaths of all service users who died by suicide or suspected suicide through the mortality review process and, where appropriate, the serious incident investigation process. These processes report through to Quality Assurance Committee and Board of Directors.

1.10 We have been provided by NCISH with an SHSC rate of death by suicide of 8.65 per 10,000 people receiving mental health care for the period 2017-2019. This places SHSC in the group of NHS Mental Health Trusts with higher rates for that period. The data is significantly delayed via this external route and we are working to calculate our own figures for 2020 onwards, which will be incorporated within the Learning from Deaths reports to Board of Directors.

Characteristics of UK Service Users in NCISH

1.11 Demographically, people who died by suicide were more likely to be male, living alone, unmarried and unemployed. Economic adversity was a risk factor for suicide, including loss of job, benefits and home.

1.12 Clinically, people who died by suicide were most likely to have a diagnosis of a mood disorder or a psychotic condition such as schizophrenia, although people diagnosed with “personality disorder” were also at significant risk (11% of deaths). Individuals with “personality disorder” were more likely to have reported past trauma, including abuse, in their lives. People who died were also more likely to have more than one mental health condition and to have a history of self-harm, and drug and alcohol problems. It was disproportionately likely that their most recent inpatient admission was a readmission and that they had missed recent appointments.

1.13 Approximately one quarter of the UK service users who died were receiving care on part of an acute care pathway – crisis care, home treatment or inpatient care. Half of the inpatient service users who died were on leave from wards. For those discharged from inpatient care, the third day following discharge was the highest risk. For people not receiving care on acute care pathways, the services involved included community mental health teams and substance misuse services.

Learning from NCISH

1.14 In relation to inpatient care, the importance of safer environments is clear. This closely correlates with the work that SHSC is undertaking to modernise its acute inpatient estate, including the removal of ligature anchor points. In relation to the observation that periods of leave from wards are high risk, it is relevant that SHSC has recently updated its Section 17 leave policy, including requirements around risk assessment, and that online training has been developed. Follow up within 72 hours of discharge is part of the acute pathway, linked with the finding in NCISH that the immediate post-discharge period is a time of higher risk.

1.15 Trauma-informed care is paramount. This includes care for people who self-harm, many of whom have experienced trauma in their lives. In NCISH, people with a diagnosis of “personality disorder” who died by suicide had often reported a history of trauma. Amongst those from the LGBT+ community who died by suicide, there was an association with previous trauma and abuse. Trauma-informed care is a cornerstone of SHSC’s Clinical and Social Care Strategy. Training in trauma-informed care is being provided across the organisation and the principle is at the heart of our Transformation Programme. For example, it can be evidenced in Primary and Community Mental Health transformation by the work that is undertaken by teams to support traumatised people, including people who self-harm.

1.16 A key theme relates to isolation and loss of contact with services. In our partnership with primary care and VCSE, we have developed “Community Connector” roles to help people navigate day-to-day challenges in their lives. For people with severe mental health problems, we have re-established an Assertive Outreach team to prevent those who are most vulnerable falling out of contact with services.

1.17 Suicide prevention requires partnership working. The NCISH report highlights the risks of economic adversity, including loss of income and home. Although these are not directly within the influence of healthcare services, especially during an economic downturn, we can influence by working in partnership across Sheffield and South Yorkshire with colleagues in local authorities and VCSE. A specific example is reducing the risk of suicide associated with alcohol and substance misuse, which requires a range of measures from individual treatment through to education and public health interventions, e.g. licensing.

Broader Approaches – Real Time Surveillance

1.18 In conjunction with the South Yorkshire Integrated Care Partnership, SHSC participates in a Real Time Surveillance system for intervention following suspected suicide. Suicide data from formal external routes, such as coronial inquests and national inquiries, is often subject to delays inherent in due process. In South Yorkshire, we have established a system facilitated by the Police where a death by suspected suicide is notified to involved partners in order that the bereaved can be appropriately supported (being bereaved through suicide is itself a risk factor for suicide) and that appropriate immediate investigation can be undertaken.

Section 2: Risks

2.1 The primary risk is of patient harm due to ineffective approaches to suicide prevention. This report describes a range of work that is underway. The risks relate to the diversity of work from estates to service transformation, and risks related to partnership working. The mitigation of the risk is captured in relation to each specific piece of work. The overarching risk is of not capturing and synthesising progress with accurate data, including within SHSC’s major change programmes.

Section 3: Assurance

Benchmarking

3.1 Current benchmarking, including the need for further development, is contained within the body of the report.

Triangulation

3.2 Progress with suicide prevention can be triangulated with a range of patient safety measures including incidents, complaints, vacancies, sickness, turnover, training and supervision.

Engagement

3.3 SHSC's suicide prevention training has been co-designed with experts by experience. As the visibility of suicide prevention in SHSC increases, we will work to co-design and co-produce all aspects of the approach. This is an area for further development.

Section 4: Implications

Strategic Priorities and Board Assurance Framework

1. Covid-19 - Recovering effectively.
2. CQC – Continuing to improve
3. Transformation - Changing things that will make a difference
4. Partnerships – Working together to have a bigger impact

4.1 Managing the key BAF risks of staffing, environments and information systems will all have a positive impact of developing suicide prevention.

Equalities, diversity and inclusion

4.2 Suicide prevention is a key component of reducing inequalities because people with a range of protected characteristics are at increased risk of death by suicide.

Culture and People

4.3 Suicide prevention has training implications including risk assessment, safety planning, person-centred care and trauma-informed care.

Integration and system thinking

4.4 Suicide prevention is a place and system priority.

Financial

4.5 The explicit financial impacts are not considered in this paper but relate to the financial aspects of the range of work being undertaken that has an impact on suicide prevention.

Sustainable development and climate change adaptation

4.6 Evidence-led care for suicide prevention is more sustainable because it avoids inappropriate medicines, advocates for a considered approach to inpatient care and relies upon person-centred care that is integrated within communities.

Compliance - Legal/Regulatory

4.8 Relevant law includes Human Rights Act 1998, Health and Social Care Act 2012 and Mental Health Act 1983.

Section 5: List of Appendices

None attached