Herefordshire Safeguarding Children Partnership

6 December 2021

Agenda item 7

Herefordshire Safeguarding Children Partnership Report to HWBB re Children and Young People's Mental Health and Suicide during 2020

Report author	Ellen Footman (HWCCG-Head of Quality and Safeguarding) on behalf of Herefordshire Safeguarding Partners Board
Presented by	Heather Manning (CCG) and Darryl Freeman (Herefordshire Council)
Recommendation	The Herefordshire Safeguarding Children Partnership are seeking assurance from the HWBB that effective processes are in place to prevent further deaths in relation to deaths by suicide and self-harm; and that the HWBB seek assurance regarding the resilience of, and access to Mental Health Services locally.
Purpose	Assurance ☒ Decision ☐ Approval ☐ Information/noting ☐

Introduction

The purpose of the report is for the three Safeguarding Children Partners to inform the Health and Well-Being Board, (HWBB) of the *Children and Young People's Mental Health in Herefordshire during COVID-19* report (May 2021) and the *West Midlands Regional Themed Child Death Overview Panel (CDOP) in relation to deaths by suicide and Self harm - April/May 2021*; and to request that the HWBB review the resilience of Mental Health Services locally and access to them.

The Safeguarding Partners wish to highlight the increase in 'apparent suicides/self-harm deaths' across Herefordshire and Worcestershire during 2020-2021. During this reporting period there were 4 apparent suicides/self-harm deaths reported to Herefordshire and Worcestershire CDOP (*N.B. cannot be confirmed as suicide until signed off by Coroner's Court at Inquest). This compares to 5 child suicides for the reporting period 2017-2020.

HSCP also highlight to the HWBB, the apparent shortage of Tier 4 beds nationally, the national shortage of Secure Welfare Beds (for those children deemed not to meet the criteria for tier 4 beds); and the impact these shortages have locally on Mental Health services to young people; and what services are in place to support children and young people whilst they await beds. The *Children and Young People's Mental Health in Herefordshire during COVID-19* report (May 2021) and the *West Midlands Regional Themed Child Death Overview Panel (CDOP) in relation to deaths by suicide and Self harm - April/May 2021* (See Embedded documents-Appendices), highlight concerns locally and regionally.

The following issues have also been formally reported to HSCP:

- The quality and effectiveness of the Mental Health pathway between services.

- The service response for children who do not engage with emotional help and well-being support services, and who require a more assertive engagement by local services to prevent escalation of risks,

- Unmet need for children experiencing severe emotional and mental health issues as well as at point of step down from Tier 4.

West Midlands Regional Themed Child Death Overview Panel (CDOP) in relation to deaths by suicide and Self harm - April/May 2021

The West Midlands Regional Child Death Review Network in December 2020 undertook a regional themed review focusing on deaths by suicide. All CDOPs in the region were invited to submit cases for consideration with a view to identifying common themes across the region and potential learning to prevent further deaths. For each theme, the panel identified challenges and questions for all the Safeguarding Partnerships in relation to seeking and providing assurance that effective processes are in place to prevent further deaths.

Children and Young People's Mental Health in Herefordshire during COVID-19 report (May 2021)

The report highlights the increase in demand on services locally during the Covid-19 pandemic. Specifically, there has been a significant increase in the acuity and demand in relation to eating disorders and those CYP experiencing crisis. This has led to an increase in the requirement for Tier 4 beds. There has also been an increase in CYP presenting to A&E in crisis. The CCG are leading a Tier 4 Task and Finish group which is STP wide. This group has representation from HWHCT, WVT, Worcestershire Acute, Worcestershire Children's First and Herefordshire Council as well as NHSE representation. The aim of this group is to analyse data and the needs of the young people that are presenting crisis and to explore options for solutions and potential alternatives to Tier 4 and to admission on to paediatric wards. Assurance from the group regarding options should be sought by HWBB and shared with the Safeguarding Partners.

Recommendations

The Herefordshire Safeguarding Children Partnership are seeking assurance from the HWBB regarding the findings from the *West Midlands Regional Themed Child Death Overview Panel (CDOP)* Report - *April/May 2021 in relation to deaths by suicide and Self harm* and that effective processes are in place to prevent further deaths; and that the HWBB seek assurance regarding the resilience of, and access to, local Mental Health Services. (*Children and Young People's Mental Health in Herefordshire during COVID-19 report (May 2021)*.

Appendices (below)

Appendix 1

Learning summary and challenges identified by West Midlands Regional Themed Child Death Overview Panel (CDOP) in relation to deaths by suicide and Self harm - April/May 2021

Authors: Dr Neeraj Malhotra, Consultant in Public Health, Chair Black Country CDOP, Mr Adrian Over, Independent Chair Herefordshire and Worcestershire CDOP, Dr Joanna Garstang, Designated Doctor for Child Death, Birmingham and Solihull CCG 02 July 2021

1.0 Background

The 2018 Child Death Review Statutory and Operational Guidance suggests that '*Some child deaths may be best reviewed at a themed meeting. A themed meeting is one where CDR partners arrange for a single CDOP, or neighbouring CDOPs, to collectively review child deaths from a particular cause or group of causes. Such arrangements allow appropriate professional experts to be present at the panel to inform discussions, and/or allow easier identification of themes when the number of deaths from a particular cause is small*'. The guidance suggests suicide as a theme that might be reviewed at a regional level.

The guidance also states *'Themed panels will demand a customised approach and an experienced chair. Consideration might be given to experts attending from a neighbouring clinical network or region. Themed panels should occur within 12 months of the child's death. Designated doctors for child death should work together to decide which cases might best benefit from review at a themed panel.*'

1.1 Methods

At a meeting of the West Midlands Regional Child Death Review Network in December 2020, it was agreed to trial a regional themed review focusing on deaths by suicide. All CDOPs in the region were invited to submit cases for consideration with a view to identifying common themes across the region and potential learning to prevent further deaths.

The themed panel met virtually on 29 April 2021. All CDOPs in the region were invited to send two representatives, with representatives from mental health services, public health, paediatrics, education, children's safeguarding and a lay member.

The panel reviewed deaths of children aged less than 18 years from suicide or self-harm that had occurred across the West Midlands during 2019-2020 where coroner's inquests had been completed. A total of nine deaths were reviewed. Two deaths occurred during the COVID pandemic. Other deaths that occurred during the pandemic could not be reviewed as inquests were awaited. Members of the panel met again on 27 May 2021 to analyse the findings and key learning points arising from the panel discussion; and to draw up this summary.

1.2 Limitations

The themed panel acknowledges that a small sample of deaths was reviewed; and that some issues identified may be unique although common learning points in relation to the context of the children's lives were identified. It was recognised that despite the best efforts of professionals,

families and friends, some deaths may be unpreventable. Nonetheless, that should not stop every effort being made to identify common issues and to improve professional processes and practice.

2.0 Findings

For each theme, the panel identified challenges and questions for all of the Safeguarding Partnerships in relation to seeking and providing assurance that effective processes are in place to prevent further deaths.

2.1 Theme – Young people seeming to thrive prior to suicide

2.11 Learning point 1

Most of the young people whose deaths were reviewed had experienced adverse childhood experiences. Some appeared to be thriving at school and home while struggling with issues of self-identity and belonging. Family, friends and schools were unaware of some of the young people's turmoil.

2.12 Learning point 2

Several of the young people had not previously indicated any suicidal intent and their deaths were precipitated by a sudden crisis such as a relationship breakdown or argument.

2.13 Challenges

How do all partner agencies create a supportive environment for young people to talk about mental health? How might that be improved?

How are crisis services for young people in need promoted to partner agencies, parents/carers and young people?

How can partner agencies help young people to recognise their feelings and seek appropriate support?

How can partner agencies ensure that children who may have mental health needs that are masked by high academic performance and achievement have those needs identified and addressed?

How are partner agencies addressing online safety and the potential online and social media triggers of self-harm and suicide?

2.14 Question for local Safeguarding Partnerships:

How can education (including early years and further education) providers reassure partners that children are being taught how and supported to identify early warning signs of vulnerability in themselves and others and how to identify networks of trusted adults (at home, in school and in the community) who they might talk to in the event of concerns about themselves or any of their peers?

2.2 Theme – Access to mental health services

2.21 Learning point 3

Some young people had experienced difficulty in accessing and engaging with mental health services in a timely manner. There were disparities in access to mental health support between young

people presenting to primary care or hospital; and professionals struggled with pathways for referring young patients for mental health support.

2.22 Challenges

How can partner agencies ensure ease of access to the most appropriate mental health services for young people, their families and professionals who work with and support them?

How can partner agencies improve the sharing of information about self-harm and suicide attempts, particularly between universal agencies such as GPs, school nurses and education providers so that children can be supported more effectively?

2.23 Questions for local Safeguarding Partnerships:

How can local health providers reassure safeguarding partners that there are consistent risk assessments and clear pathways in place for referrers to use when they are worried that a child's mental health needs have not been addressed?

How can local Safeguarding Partnerships support the development of a common language between children's mental health services and other agencies to facilitate a greater recognition of shared responsibility in supporting and meeting the needs of children with mental health challenges?

How can children's mental health services reassure their local safeguarding partners that children are not discharged from services because of non-engagement without adequate consideration of risks and potential alternative strategies?

2.3 Theme – Optimising learning from suicides

2.31 Learning point 4

CDOP and safeguarding reviews of suicides focus on more recent events leading up to deaths but those reviews may miss key information about children's earlier adverse experiences that may limit learning and prevention of further deaths.

2.32 Challenges

How do we maximise learning from deaths of children as a result of suicide and self-harm?

2.34 Question for local Safeguarding and Child Death Review Partnerships:

How can partners ensure that reviews of children's deaths as a result of suicide and self-harm include consideration of the child's full life history?

3.0 Conclusions

The regional review identified common themes across several deaths, which may not have been recognised had deaths only been reviewed at local CDOPs, showing the benefit of this process. It is now for local safeguarding partnerships and agencies to take this learning forward to help reduce risk of future deaths.

Appendix 2

NHS
Herefordshire and Worcestershire
Clinical Commissioning Group

Children and Young People's Mental Health in Herefordshire during COVID-19

Heather Manning Deputy Designated Safeguarding Nurse, HWCCG May 2021

Introduction -

COVID-19 has brought with it pressures specific to Mental Health in all age groups. Service provision specifically for Children and Young People (CYP) and support can be accessed in a variety of ways and this has continued throughout COVID-19. This report summarises some of the increased demand on current services and gives some oversight of the intended improvement plans.

CAMHS –

There has been a significant increase in the acuity and demand in relation to eating disorders and those CYP experiencing crisis. This has led to an increase in the requirement for Tier 4 beds. It has also been noted that CYP with Autistic Spectrum Disorder (ASD) crises have increased with the ASD sometimes being undiagnosed until the crisis occurs.

Referral rates have now reverted to more usual levels, but there has been a higher than usual acceptance level due to their nature and therefore suggesting that CYP are in need of specialist CAMHS services. If this trend of acceptance rates continues, capacity against demand would need to be reconsidered.

Kooth is an online counselling and emotional well-being platform for children and young people, accessible through mobile, tablet and desktop and free to use. Kooth activity has increased month on month since the service started in April 2020. The reach was slow to start with due to launch issues but in Q3 2020-2021 there were over 1600 logins to the online service.

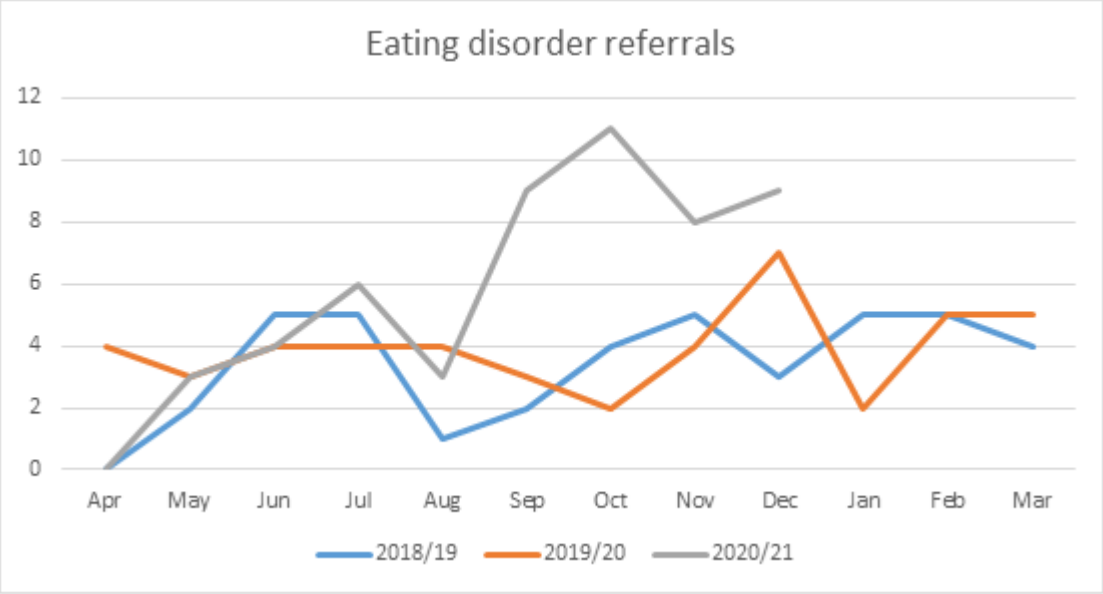
There has also been an increase in CYP presenting to A&E in crisis. These children are seen in A&E to try to divert admission, but when presenting out of hours, they are admitted to the Paediatric Ward as per NICE guidance. There has been an increase in attendance recently with a significant increase noted in November and December 2020.

The CCG are leading a Tier 4 Task and Finish group which is STP wide. This group has representation from HWHCT, WVT, Worcestershire Acute, Worcestershire Children's First and Herefordshire Council as well as NHSE representation. The aim of this group is to analyse data and the needs of the young people that are presenting crisis and to explore

options for solutions and potential alternatives to Tier 4 and to admission on to paediatric wards. The group will have an options appraisal by July 2021.

In addition to this work there is also significant investment into eating disorders and crisis from NHSE for 21/22 as part of the NHS LTP. The children and young people's eating disorder service in Herefordshire is having significant investment to increase capacity and increase early intervention. The team will grow from 2.4 WTE to 6.6 WTE.

There has been a year-on-year increase in the number of eating disorders referrals accepted by the Hereford CAMHS team: 41 in 2018/19 and 47 in 2019/20. It is expected that referrals for 2020/21 will also be higher – 44 up to end of November 2020 in the first 8 months of the current financial year. The pattern of referrals has been affected by Covid 19 with a dip in referrals in March and April in line with the first lock-down. The team has experienced a significant increase in referrals in September, October, and November. This is in line with reports from NHS England reporting an increase in reported eating disorders in children nationally, and this increase in referrals is predicated to continue. (Data up to Jan 2021)



Plans have been submitted to NHSE for the development of a 7 day a week home treatment team for Herefordshire CAMHS to provide intensive interventions to CYP to prevent crisis/divert from presentation at WVT/reduce need for T4. As part of this additional investment, plans have been submitted to NHSE to recruit a transitions team who will 'broker' transitions between CYP and adult services to improve the quality of the transition. Irrespective of thresholds, a response will be given for all referrals.

The Mental Health in Schools (MHST) programme now has one team in Hereford, with a go live date of November 2021. The staff appointed to these roles are currently in a training year. This team will provide evidence-based interventions to CYP experiencing mild to moderate mental health difficulties. The Hereford MHST will target the secondary age population. A bid has gone to NHSE for a 2nd team, targeting the primary age population.

There is ongoing work to enhance First Episode in Psychosis services to provide a CAMHS specific worker in the Early Intervention in Psychosis team and looking at ways to enhance support to CYP who experience Complex Emotional Needs with focus on transition to adult services.

Wye Valley Trust School Nursing –

The school nursing service routinely offer emotional well-being support to CYP via A&E follow ups. Comparison data is shown below -

March 2020		**March 2021**	
Self-harm	5	Self-harm	9
Depression	0	Depression	5
Mental health	0	Mental health	32
April 2020		**April 2021**	
Self-harm	6	Self-harm	14
Depression	0	Depression	1
Mental health	1	Mental health	13

It is concerning is that the numbers of CYP being referred to the school nursing service has decreased during COVID-19. There were 523 contacts for emotional support in Q4 2019-2020 compared with only 369 for Q4 2020-2021. It is therefore recognised that these children are not being identified by other services and referred for early support with a school nurse.

To compound the current difficulties, the school nurse drop-in service at schools is currently being run by appointment only to ensure COVID safe working at this time. This has reduced the number of CYP accessing the support as planning an appointment in advance does not

appear to work for this cohort. The old model of a drop-in service had much larger numbers of young people self-presenting. The school nursing service is looking to see how this aspect can be managed differently

Children Looked After (CLA) -

This cohort of CYP have continued to be seen either via video link or via telephone for Initial and Review Health Assessments during the last year. The CLA health team have completed the Strengths and Difficulties Questionnaire (SDQ) with children and their carers for some years. It is recognised that whilst high SDQ scores may raise concerns for the emotional health and well-being of the CYP, it is not viewed in isolation. The scores are discussed with the child's SW and the overall context looked at. Some children may have a high SDQ but be in a better place emotionally than previously. CAMHS referrals are made where required but it is recognised that a child may be referred by another agency such as the GP if they have presented outside of health assessments. If such referrals are made and the CLA health team are made aware, they will also monitor and liaise with the relevant professionals.

CLD Trust (Counselling, Learning, Development)

The CCG commission the CLD Trust to provide an emotional wellbeing service for children and young people across Herefordshire. They offer a variety of counselling therapy including brief sessional therapy and Cognitive Behavioural Therapy (CBT). This service works with young people who don't meet the criteria for CAMHS but are experiencing issues such as anxiety and low mood. The CCG is working with the CLD Trust to change the referrals to self-referral as well as referral from professionals. There has also been an increase in investment during 2021-2022 to increase the capacity of this service.

Conclusion –

This report is an assurance of the holistic picture of mental health support for CYP in Herefordshire.

Close monitoring of all referrals across the system will remain a priority and progress monitoring against the new provisions and services will continue.