

Board of Directors

24 September 2020

Paper title:	Suicide Prevention Annual Update	Agenda item 21
Presented by:	Philippa Hubbard, Acting Chief Operating Officer	
Prepared by:	Grainne Eloi, Deputy Director of Nursing and Professions Simon Long, Head of Nursing	

Purpose of the report		
This paper provides a summary and update on the work continuing both regionally and locally to reduce suicide and increase awareness.	For approval	
	For discussion	X
	For information	

Executive summary		
<p>Death by suicide accounts for 800,000 deaths globally each year. During the period 2001-2017 an average of 40 people die each year in the Bradford district due to suicide. The Trust continues to work alongside partners within the Integrated Care System and the Bradford Local Authority to embed the national and regional strategies for suicide prevention within the Trust. Bradford District Care Foundation Trust (BDCFT) has adopted a zero suicide philosophy where each and every death by suicide is seen as preventable. Suicide is no longer viewed as inevitable, or a terminal prognosis. We know that where this same approach has been taken internationally, there have been dramatic results.</p> <p>Organisations from across the region continue to work together to reduce suicide across the region. This includes NHS mental health organisations, emergency services, local authorities, prison services, and voluntary/third sector services. The Trust has a suicide prevention group leading on the delivery of the strategies for the Trust.</p>		
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	<p>State below 'Yes' or 'No'</p> <p>No</p>	If yes please set out what action has been taken to address this in your paper

Recommendation
<p>The Board of Directors is asked to:</p> <ul style="list-style-type: none"> Acknowledge the ongoing work and partnership working across the Trust and region to reduce suicide

Strategic vision				
Please mark those that apply with an X				
Providing excellent quality services and seamless access	Creating the best place to work	Supporting people to live to their fullest potential	Financial sustainability growth and innovation	Governance and well-led
X		X		X

Care Quality Commission domains				
Please mark those that apply with an X				
Safe	Effective	Responsive	Caring	Well Led
X	X	X	X	X

Relationship to the Board Assurance Framework (BAF)	The work contained with this report links to the following strategic risk(s) as identified in the BAF: <ul style="list-style-type: none"> •
Links to the Corporate Risk Register (CRR)	The work contained with this report links to the following corporate risk(s) as identified in the CRR: <ul style="list-style-type: none"> • Risk 2102
Compliance and regulatory implications	The following compliance and regulatory implications have been identified as a result of the work outlined in this report: <ul style="list-style-type: none"> • Regulation 12

Meeting of the Board of Directors

24 September 2020

Suicide Prevention Annual Update

1. Purpose & Background

Death by suicide accounts for 800,000 deaths globally each year. In 2015, 4820 people are recorded as having died by suicide in the United Kingdom, however in 2017 there were 5,821 suicides registered in the UK, a rate of 10.1 deaths per 100,000 population. Males accounted for three-quarters of suicides registered in 2017 (4,382 deaths), which has been the case since the mid-1990s. The highest age-specific suicide rate was 24.8 deaths per 100,000 among males aged 45 to 49 years; for females, the age group with the highest rate was 50 to 54 years, at 6.8 deaths per 100,000. Suicide is the leading cause of death in young people in England and is the leading cause of death for males aged between 5 and 49. Suicide is also the leading cause of death of females between the ages of 5 and 34.

During the period 2001-2017 an average of 40 people die each year in the Bradford district due to suicide. There are three sources of data about suicides for Bradford District:

1. Reported via national surveillance system available from Public Health England (available to 2017) – these data enable us to look at rates by gender, over time and in comparison to other areas.
2. Bradford District Suicide Audit (last conducted for 2013-2015).
3. Suspected suicides as reported from West Yorkshire Police (available to February 2017)

Although fluctuated over the years, when compared to other local authorities within Yorkshire and Humber, Bradford district has the third lowest suicide rate in the region at 9 deaths per 100,000 population. The highest being Rotherham at 15.9 deaths per 100,000 population, Leeds at 11.8 per 100,000 population. Within the Integrated Care System (ICS), Bradford has the lowest suicide rate, therefore regionally and nationally is low, with national rate being 9.6 deaths per 100,000.

The Five Year Forward View for Mental Health set out an ambition to reduce the number of suicides in England by 10 per cent by 2020 and the NHS Long-term Plan reaffirms the NHS's commitment to make suicide prevention a priority over the next decade. South West Yorkshire Partnership Foundation Trust is currently leading the suicide prevention strategy, previously presented to the Board of which the Trust participates in.

Bradford District Care Foundation Trust (BDCFT) has adopted a zero suicide philosophy where each and every death by suicide is seen as preventable. Suicide is no longer viewed as inevitable, or a terminal prognosis. We know that where this same approach has been taken internationally, there have been dramatic results.

Organisations from across the region continue to work together to reduce suicide. This includes NHS mental health organisations, emergency services, local authorities, prison services, and voluntary/third sector services.

2. Suicide Prevention in West Yorkshire and Harrogate

During 2017, A suicide prevention advisory network was developed (SPAN) chaired by Dr M Doyle from South West Yorkshire Partnership Foundation Trust (SWYPFT). Bradford District Care foundation Trust (BDCFT) is a member of the SPAN and worked collectively with partners to develop a suicide prevention strategy across West Yorkshire which was launched in 2017. Previously presented to the Board, in summary the overall aim of this five-year suicide prevention strategy is to develop working relationships between partner agencies to provide an evidence-based but practical framework across the West Yorkshire region to help reduce the frequency of suicide. This was supported by a federation of NHS Trusts namely the three mental health trusts across the ICS.

The SPAN continues and its membership includes representation from the three mental Health Trusts, local authority public health teams, West Yorkshire Police, West Yorkshire Fire and Rescue Service, HM Prison and Probation Services, Care UK and Yorkshire Ambulance Service and Public Health England.

In 2019/20 a Suicide prevention operational group was formed to ensure the delivery of strategy and is accountable to the Mental Health Learning Disability Autism Program Board. It's membership includes Senior representation from West Yorkshire and Harrogate ICS and Health and Public Health partners.

NHSE Wave 3 funding of £520k per year, has been secured for the next three years and a second year of funding of £173k has been agreed for bereavement by suicide postvention services provided by MIND. This builds on trailblazer funding of £114k and transformation funding of £94k received last year. This continues to fund targeted support for men at risk, development of a suicide prevention campaign and ground-breaking Artificial Intelligence research at the University of Huddersfield.

3. Suicide Prevention in Bradford

Within Bradford a summary of suicide statistics in 2019 shows that:

- Majority were Male (78%)
- Average age 45 for Males and 50 for Females

- Almost 4 in 5 suicides were by people who identified as White British (79%)
- Major means of suicide was hanging (61%)
- Second highest was self poisoning (half from prescribed medication, half from overdose of illicit drugs)
- 41% of all suicides lived alone at the time of death
- 29% were unemployed
- 41% were single
- suicide rates 6 times higher in most deprived areas
- 57% has a diagnosed mental health issue

As previously presented to the Board, in West Yorkshire there are five local authorities; Bradford, Calderdale, Kirklees, Leeds & Wakefield. Each local authority has a public health department and each of these departments have developed a local suicide prevention plan.

Bradford District Care NHS Foundation Trust is a member of the Bradford District Suicide Prevention group that is led by Public Health within the Bradford Local Authority.

The Bradford District Suicide Prevention group created an action plan for Bradford. This group (consisting of BDCFT; City of Bradford Metropolitan District Council, West Yorkshire Police, Bradford CCGs, Samaritans, West Yorkshire Fire and Rescue, and Bradford MIND) is also part of the West Yorkshire and Harrogate health care partnership.

The Bradford District Suicide Prevention group is updating the action plan. The seven priorities are making progress.

1: Reduce the risk of suicide in key high-risk groups: Three small commissions for August have been agreed using NHSE money to increase activity within

- LGBT+ by digital outreach
- Men living with poor mental health of isolation (men in sheds) & BAME;
- A further investment with sharing voices re: BAME Mental Health

2: Tailor approaches to improve mental health in specific groups: A Covid19 rapid mental health needs assessment will be complete in July and themes for further work will be identified.

3: Reduce access to the means_of suicide: further work is currently under review by the group to identify areas of focus.

4: Support those bereaved or affected by suicide: Alongside the ICS, further provision has been commissioned and the pathway more streamlined.

5: Sensitive media approaches to suicide/suicidal behaviour: work is still ongoing in this area.

6: Support research, data collection and monitoring: the COVID-19 Mental Health needs assessment will be completed in July.

7: Self-harm prevention: currently working with services on a specific focus of LGBT+ and BAME youth. There has also been some local concerns regarding carers and self harming which requires further work.

In order to ensure that the strategy will be delivered within Bradford, BDCFT have a suicide reduction steering group which meets monthly and has representation from corporate and operational services within the trust and service user and carer representation. The terms of reference have recently been revised (appendix one) and the group leads on developments, sharing learning and ensuring that the Trust developments are in line with the national, regional and district strategies.

4. Further Developments

The suicide reduction steering group within BDCFT continues to lead on the continued development of suicide prevention within the Trust and has developed a Trust draft strategy that links in with the wider Bradford and West Yorkshire strategies (appendix two). The strategy now requires ratification prior to its launch which will be presented to the Clinical Board.

4.1 Training needs analysis & Suicide Awareness

SafeTALK training sessions continue to be successfully delivered across West Yorkshire. The sessions have been well attended with the feedback being very positive.

ASIST training delivery plan was achieved between November 2018 and November 2019. All of the First Response team were trained in Asist. Further work is now required and has been initiated with the SPAN to develop an ICS training plan.

As the Board are aware, The My Wellbeing College, within the Trust, developed a suicide awareness package and delivered short sessions across services, organisations, and the general public.

4.2 Thematic Review & Risk Assessment

The Trusts previous thematic review (2018/19) recommended improvements within the serious incident investigation and support processes. During September 2019 a Rapid Process Improvement Workshop (RPIW) took place to examine the process, identify and put in place improvements to the system to ensure a more streamlined approach to serious incident reviews. The RPIW consisted of

members of the serious incident review team, the risk team, service representation and representation from the clinical commission groups. The following changes were put in place:

- A patient safety review is now conducted and completed within the first two weeks of an incident to ensure that staff are fully supported and processes have been examined with any immediate learning acted on to ensure services are safe.
- These patient safety reviews, and finalised serious investigation reports are now presented to a panel consisting of the Medical Director, Chief Operating Officer and Director of Nursing for approval.
- A steering group was created to explore the support needs, availability and developments required for staff and services involved in serious incidents. Prior to this, the serious incident investigators have been the substantial providers of support (both practically and emotionally) for staff involved in such incidents and the recommendation from the independent review is that the support should be separated from the investigation process. The steering group met throughout 2019/20 and established an identified group of 12 professionals that would be trained in critical incident support and be available on a rota basis to support staff and services within 72 hours of an incident occurring. Training was procured from Tidal Training which consisted of a five day training programme in critical incident support. Three days of this training has been completed but unfortunately paused due to the COVID-19 pandemic. This is now due to be completed in August 2020 and this support service can then be initiated.
- The steering group has also refined and created improved materials for staff regarding the processes and requirements (statement provision, coroner court attendance). Training for staff who are required to attend coroners court is also being developed, alongside Bradford University and Bradford Teaching Hospitals Foundation Trust, which includes role play at mock courts to prepare staff for court attendance. This is currently on hold due to the current pandemic.

4.3 Regulation 29A

Following serious incidents and the Care Quality Commission inspection (CQC), during the summer of 2019, the acute wards held an improvement week in response to the CQC regulation 29a. This was closely followed by a safety week and the following improvements made:

- The introduction of daily lean management across inpatient wards and community services which provides daily assurance that services are “safe today”.

- The purposeful inpatient admission process has also been introduced across acute wards.
- The functional medical model has now been introduced.
- The Trust has revised its ligature assessment process and detailed reports have been presented to the Quality and Safety Committee. The new ligature assessment process has been in place throughout the last 12 months and ligature awareness training has been designed and delivered across all inpatient areas. Following a clinical summit in 2019, a business case was presented proposing a phased approach for the installation of an anti-ligature full door alarms on selected rooms and doors, a new anti-barricade system across inpatient services and improvements to certain windows in order to reduce the risk of ligatures. Within two phases, phase one would see the completion of the anti-barricade system and replaced doors on selected rooms across 8 high risk wards. Although delayed due to the pandemic, this work has now been completed and the full door alarm system currently in the testing phase and to be commissioned in July 2020. An internal clinical review of these systems has been proposed before the commencement of phase two (remaining doors on selected high risk wards to receive full door alarms) in September 2020.

Grainne Eloi – Deputy Director of Nursing and Professions
Simon Long – Head of Nursing

July 2020

Appendix One



Suicide Prevention
ToR - July 2020.docx

Appendix Two



Suicide Prevention
Strategy.docx