# Meeting of the Board of Directors - Public

## 8 July 2021

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| **Paper title:** | Annual Report: Suicide Prevention | **Agenda item** **12** |
| **Presented by:** | Phillipa Hubbard, Director of Nursing, Professions and Care Standards | |
| **Prepared by:** | Grainne Eloi, Deputy Director of Nursing and Professions | |

| **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 | |
| | For information | X |

**Executive summary**

In 2019, there were 5,691 suicides registered in England and Wales, an age-standardised rate of 11.0 deaths per 100,000 population and consistent with the rate in 2018, (most recent published data). The Trust continues to work alongside partners within the Integrated Care System and the Bradford Local Authority to embed the national and regional Suicide Prevention Strategies within the Trust. Bradford District Care Foundation Trust (BDCFT) has adopted a zero-suicide philosophy where each death by suicide is seen as preventable.

Organisations at place and across the ICS continue to work together to reduce suicide. This includes NHS Mental Health Trusts, 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.

| Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? | **State below 'Yes' or 'No'** | If yes please set out what action has been taken to address this in your paper |
|---|---|---|
| | **No** | |

**Recommendation**

The Board of Directors is asked to:

- Acknowledge the ongoing work and partnership working across the Trust, at place and region to reduce suicide

| **Strategic vision**<br>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**<br>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:<br>• Strategic objective 1&5 |
| **Links to the Supporting Operational Risk Register** | The work contained with this report links to the following corporate risk(s) as identified in the Supporting Operational Risk Register:<br>• 2102 |
| **Compliance and regulatory implications** | The following compliance and regulatory implications have been identified as a result of the work outlined in this report:<br>• Regulation 12 |

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# Suicide Prevention Annual Update

## 1. Purpose & Background

In 2019, there were 5,691 suicides registered in England and Wales, an age-standardised rate of 11.0 deaths per 100,000 population and consistent with the rate in 2018. Around three-quarters of registered deaths in 2019 were among men (4,303 deaths), which follows a consistent trend back to the mid-1990s.The England and Wales male suicide rate of 16.9 deaths per 100,000 is the highest since 2000 and remains in line with the rate in 2018; for females, the rate was 5.3 deaths per 100,000, consistent with 2018 and the highest since 2004.

Males aged 45 to 49 years had the highest age-specific suicide rate (25.5 deaths per 100,000 males); for females, the age group with the highest rate was 50 to 54 years at 7.4 deaths per 100,000. Despite having a low number of deaths overall, rates among the under 25's have generally increased in recent years, particularly 10 to 24 year old females where the rate has increased significantly since 2012 to its highest level with 3.1 deaths per 100,000 females in 2019. As seen in previous years, the most common method of suicide in England and Wales was hanging, accounting for 61.7% of all suicides among males and 46.7% of all suicides among females.

## 2. Bradford District Suicide Data

When compared to other local authorities within Yorkshire and Humber, Bradford District has the lowest suicide rate across the Integrated Care System and within the region at 9.4 deaths per 100,000 population. The highest being Calderdale and Hull at 14.8 deaths per 100,000 population and Leeds at 12.7 per 100,000 population.

## Regional Suicide Statistics 2017-2019

Better 95% | Similar | Worse 95% | Lower | Similar | Higher | Not compared

| Indicator | Period | England | Yorkshire and the Humber region | Barnsley | Bradford | Calderdale | Doncaster | East Riding of Yorkshire | Kingston upon Hull | Kirklees | Leeds | North East Lincolnshire | North Lincolnshire | North Yorkshire | Rotherham | Sheffield | Wakefield | York |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Suicide rate (Persons) | 2017 - 19 | 10.1 | 12.0 | 10.7 | 9.4 | 14.8 | 13.7 | 13.0 | 14.8 | 10.8 | 12.7 | 11.2 | 11.8 | 12.3 | 14.6 | 10.0 | 13.5 | 11.8 |
| Suicide rate (Male) | 2017 - 19 | 15.5 | 18.3 | 17.4 | 15.6 | 21.4 | 20.5 | 20.6 | 22.3 | 17.5 | 19.2 | 18.4 | 16.6 | 18.7 | 22.3 | 15.2 | 18.9 | 18.2 |
| Suicide rate (Female) | 2017 - 19 | 4.9 | 5.9 | 4.2 | 3.5 | 8.5 | 6.8 | 5.6 | 7.4 | 4.4 | 6.4 | * | 7.1 | 6.1 | 7.5 | 4.9 | 8.3 | 5.6 |
| Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) (Persons) | 2017 - 19 | 33.0 | - | 37.0 | 28.0 | 54.8 | 47.5 | 44.8 | 48.1 | 35.7 | 44.0 | 34.1 | 38.6 | 43.2 | 49.5 | 31.8 | 53.8 | 33.8 |
| Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) (Male) | 2017 - 19 | 50.2 | - | 59.8 | 44.3 | 78.5 | 71.0 | 71.6 | 69.1 | 57.6 | 66.2 | 53.5 | 55.3 | 64.6 | 71.7 | 48.2 | 78.2 | 51.8 |
| Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) (Female) | 2017 - 19 | 15.9 | - | 14.7 | 11.8 | 31.5 | 23.5 | 17.7 | 26.3 | 13.4 | 22.4 | * | 21.7 | 21.2 | 28.1 | 15.4 | 29.9 | 15.8 |
| Suicide crude rate 10-34 years: per 100,000 (5 year average) (Male) | 2013 - 17 | 10.5 | 11.7* | 13.6 | 7.8 | 11.9 | 14.8 | 8.0 | 13.1 | 12.1 | 13.2 | 9.2 | 15.5 | 9.9 | 20.7 | 9.1 | 13.0 | 10.7 |
| Suicide crude rate 35-64 years: per 100,000 (5 year average) (Male) | 2013 - 17 | 20.1 | 22.5* | 21.9 | 23.0 | 24.8 | 22.8 | 17.5 | 32.6 | 18.3 | 24.9 | 25.8 | 15.5 | 19.7 | 24.4 | 21.0 | 22.0 | 30.4 |
| Suicide crude rate 65+ years: per 100,000 (5 year average) (Male) | 2013 - 17 | 12.4 | 11.2* | 8.8 | 13.6 | 12.1 | 9.5 | 9.5 | 11.5 | 8.5 | 11.0 | 12.8 | 5.1 | 14.2 | 16.0 | 10.2 | 7.8 | 16.1 |

An audit of all suicides in Bradford District was conducted in 2017 and examined 76 conclusions of suicide in the District. This compares to Office of National Statistics (ONS) published figures of 148 deaths over the same period. The ONS definition of suicide, however, includes deaths given a narrative coroners verdict.

Of the cases examined in Bradford District:

- 78% of those who completed suicide were male
- 22% were female
- The mean age at death was 45 for males and 50 for females (47 overall), with the highest number of deaths in the 40-49 age bracket
- Fewer people who completed suicide were from a South Asian background than might be expected given the ethnicity structure of the population of the District, and more people were from a Central Eastern European background; this conclusion should however be interpreted with caution due to the low numbers involved between 2016-18, over three quarters were men
- 39% of people who died lived alone
- 65% were not in a long term relationship of any sort

- 43% of cases had a long term physical health problem
- More than half (57%) of those who completed suicide had at least one diagnosed mental illness, and of those who did not, 61% had anecdotal reference to suspected or historical mental health problems
- 28% of cases had been in contact with secondary mental health services (for instance the community mental health team) in the 12 months prior to death; none were inpatients at the time of death
- Nearly three quarters of those who completed suicide (71%) had seen their GP in the 6 months before death
- Adverse life events experienced by those who completed suicide prior to death included: family difficulties or break up, debt or financial worries, bereavement, loneliness/isolation, unemployment, suffering from abuse (sexual, emotional, physical, or neglect), a sense of shame, being affected by the suicide of a close contact, having benefits recently stopped or being sanctioned, and problems at work

There are four sources of data about suicides for Bradford District:

1. Reported via national surveillance system available from Public Health England (2017-2019)
2. Public Health England Suicide Prevention Profile 2017-2019
3. Public Health Outcomes Framework
4. Suspected suicides as reported from West Yorkshire Police (available to February 2017)

## 3.Suicide Prevention in West Yorkshire and Harrogate

The Suicide Prevention Advisory Network (SPAN) continues to meet bimonthly hosted by South West Yorkshire Partnership Foundation Trust (SWYPFT). Previously presented to the Board, the overall aim of this five-year WY 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 group has multi agency membership, it 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 (SPOG) was formed to ensure the delivery of strategy and is accountable to the Mental Health Learning Disability Autism Program Board. Its membership includes Senior representation from West Yorkshire

and Harrogate ICS and Health and Public Health partners. This group continues to meet bimonthly.

2020/21 sees the second year of a three-year NHSE Suicide Prevention funding initiative. The SPAN has secured £520k per year, as well as a second year of funding of £173k agreed for bereavement by suicide postvention services provided by MIND. This continues to fund targeted support for men at risk and has seen the delivery of a suicide prevention campaign.

## 4. Suicide Prevention in Bradford

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

The Bradford District Suicide Prevention group created an action plan for Bradford, reported to Board last year. 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 action plan has concentrated on the seven priorities identified as risks within Bradford and have made progress on the priorities:

**1: Reduce the risk of suicide in key high-risk groups**: Three small commissions using NHSE money were agreed to increase activity within

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

**2: Tailored approaches to improve mental health in specific groups**: Bradford Sharing Voices, focusing on communication to South Asian women, BAME film clips highlighting links to networks

**3: Support those bereaved or affected by suicide**: provision is now commissioned, and the pathway has been streamlined

**4. Reduce access to the means of suicide**: working with British Transport Police

**5: Sensitive media approach to suicide/suicidal behaviour**: engagement is underway with local media to manage communication specific to suicide

**6: Support research, data collection and monitoring**: Real time surveillance with key partners, including West Yorkshire Police to review live data and emerging themes

**7: Self-harm prevention:** A pilot is underway to offer patients presenting at A&E with self-harm including poisoning, a follow up contact appointment with a voluntary community service. Two VCS have applied for the tender which will be finalised 6th July 2021

## 5. BDCFT Developments 2020/21

BDCFT Suicide Prevention steering group meets bimonthly and has representation from corporate, clinical and operational services within the Trust and service user and carer representation. The group leads on developments, sharing learning and ensuring that the Trust initiatives are in line with the national, regional and district strategies

### 5.1 Patient Safety Translational Research Centre

Dr Helen Haylor, Prof. Gerrard Armitage and Dr Tony Sparks, along with Mr K Double (service user representative) have been successful in a bid to the PSTRC. The research will explore current BDCFT approaches to Serious Incident investigations in community suicides and how we assess the quality of the suicide risk assessment. The study was presented to the Ethics Committee in June 2021 and the recruitment of carers and staff who have experienced the SI process in the last two years will commence in July 2021. This is an exciting opportunity to build the findings into the improvement journey and inform changes in practice.

### 5.2 PSTRC: CAMHS Phone App

Dr. Jennie Rob is leading on a joint application with University of Bradford, BDCFT and Lancashire Care. An application for funding was submitted on 2 June 2021 in response to NiHR themed call for research in relation to Children and Young People's Mental Health. It is a project about suicide prevention encompassing all CYP utilising digital technology in the form of a mobile phone App. The aim is to determine how and in what situations and environments (hospitals, schools and colleges) the supported use of suicide prevention mobile apps can be effectively used to help children and young people, and people who are important to them.

The project has three objectives:

- To develop ideas that explain what supports and what limits the acceptance and use of mobile apps to support suicide prevention.
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- To improve these ideas using the life experiences of young people (with and without suicidal ideation), people who are important to them and healthcare professionals responsible for their care and support.

- To use the findings to identify what information needs to be included in guidance to support healthcare services and schools / colleges adopt the use of mobile apps for suicide prevention. It is unclear if the bid has been successful at this time.

### 5.3 Serious Incidents

An RPIW took place October 2020 which looked at embedding Human Factors approach to Serious Incident investigations. A significant amount of work has been undertaken this year to create a learning environment with all teams involved. The progress involves, changes to the workforce and systems, the recruitment of a Head of Patient Safety, Compliance and Risk, a new manager of Serious Incidents.

Serious Incident team continue to utilise root cause analysis as recommended in the Serious Incident Framework. This Framework has been reviewed as part of the NHS Patient Strategy and will be replaced by the Patient Safety Incident Response Framework (PSIRF). PSIRF is currently being piloted in some early adopter sites with released interim guidance highlighting changes to the framework from Serious Incidents to PSIRF. Primarily the changes are around the approach to the investigation which will move away from a standard investigation process with a focus on investigation to a more tailored approach depending on the nature of each incident with a focus on identifying learning. The new framework will not be in place until Autumn 2022 however there is ongoing work taking place in preparation for the go live date and there is work ongoing across the Bradford and Airedale Place as well as the West Yorkshire and Harrogate Integrated Care System to standardise our approach to the new framework.

Serious Incident Investigators have all completed Human Factors training and a continued review of SI process has resulted in changes to templates and processes which have helped to both clarify expectations and improve standards. Patient Safety Incident Response Team meetings take place within 72 hours of a serious incident with a focus on staff wellbeing and support as well as ensuring contact has been made with the family.

### 5.4 Critical Stress Debrief Team

The Critical Incident Stress Debrief team are now in place with senior clinicians trained on a model to offer support to staff within 24 hours following a serious incident.

Patient safety reviews take place 2 weeks after an incident and are then presented to the SI panel. At this point the terms of reference and the scope of the investigation are agreed. This is a significant shift in terms of methodology and in terms of learning

for the organisation, moving to a focused culture of patient safety and learning for the organisation.

### 5.5 SI Learning Sessions

The Deputy Director of Nursing and Deputy Director of Patient Safety, Compliance and Risk are introducing a reflective learning opportunity, whereby there is a process six-monthly to meet with the clinical teams and reflect on learning from the previous six months serious incidents. The focus is on, 'what have we learned, what has changed in practice, how can we demonstrate the change,' as well as reviewing the new templates, 'did we get our actions right?'

The Trust now has a Consultant Psychiatrist, Patient Safety Lead, who co-chairs the Patient Safety and Learning Group.

### 5.6 Ligature Update

The Trust revised its ligature assessment process in 2019/20 and detailed reports have been presented to the Quality and Safety Committee. The new ligature assessment process has been embedded, and installation of an anti-ligature full door alarms progressed. Within two phases, phase one and phase two has seen the completion of the anti-barricade system and replaced doors on rooms across 8 high risk wards. Although delayed due to the pandemic, this work has now been completed across most rooms and due to be fully completed in August 2021. An internal clinical review of these systems has also been presented for phase 3 of this program which will see (following Board approval), full door alarms fitted to the Step Forward centre, Ilkley and Baildon Ward during 2021/22.

### 5.7 The introduction and launch of a Learning Site

The page will have links to other websites (such as the academy of Fab things and the Improvement Academy) and will also have space for:

- BDCFT Learning and sharing resources, case studies, videos, blogs, interviews from our staff about things they want to share in relation to patient safety and quality
- The minutes and supporting documents from the Patient Safety and Learning Group
- Any guidance or reports valuable in terms of learning regarding patient safety
- Patient safety Briefing repository (in train)
- Link to the old Learning network
- Link to the Library

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**Date: 22 June 2021**