Bradford District Care
NHS Foundation Trust

Board of Directors – Meeting held in Public

13 July 2023

Paper title:	Annual Update: Suicide Prevention	**Agenda Item** **13.0**
Presented by:	Grainne Eloi, Interim Director of Nursing, Professions and Care Standards	
Prepared by:	Christopher Dixon, Head of Nursing (Mental Health)	
Committees where content has been discussed previously	Quality and Safety Committee	
Purpose of the paper Please check **ONE** box only:	☐ For approval ☐ For information ☒ For discussion	
Link to Trust Strategic Vision Please check **ALL** that apply	☒ 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	
Care Quality Commission domains Please check **ALL** that apply	☒ Safe ☒ Caring ☒ Effective ☒ Well-Led ☒ Responsive	

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.

Executive Summary
The Office of National Statistics (ONS) published their annual suicide data for all regions and local authorities on the 6th September 2022. This is based on inquest findings in 2021. West Yorkshire continues to have a higher suicide rate than the England average, according to the latest data release from the Office of National Statistics (ONS). In Leeds, suicide rates have risen from 13.3 to 13.9 per 100,000 people, in Wakefield from 16.2 to 17.3, in Calderdale from 15.6 to 16.9 and in Bradford from 9.2 to 9.8. Bradford has the lowest suicide rate in Yorkshire and the Humber but has seen a rise comparative to the 2020 data. Bradfords suicide rate is below the national rate of 10.7 deaths per 100,000 people; while this was statistically significantly higher than the 2020 rate of 10.0

deaths per 100,000 people, it was consistent with the pre-coronavirus (COVID-19) pandemic rates in 2019 and 2018.

The Trust continues to work alongside partners within the West Yorkshire Health and care partnership 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 region 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?	☐ **Yes** (please set out in your paper what action has been taken to address this) ☒ **No**

Recommendation(s)
The Board of Directors is asked to: • Acknowledge the work and support the plan

Relationship to the Board Assurance Framework (BAF)	
The work contained with this report links to the following strategic risks as identified in the BAF: ☒ **SO1**: Engaging with our patients, service users and wider community to ensure they are equal partners in care delivery (QSC) ☒ **SO2**: Prioritising our people, ensuring they have the tools, skills and right environment to be effective leaders with a culture that is open, compassionate, improvement-focused and inclusive culture (WEC) ☒ **SO3**: Maximising the potential of services to delivery outstanding care to our communities (QSC) ☒ **SO4**: Collaborating to drive innovation and transformation, enabling us to deliver against local and national ambitions (Board) ☐ **SO5**: To make effective use of our resources to ensure services are environmentally and financially sustainable and resilient (FBIC) ☐ **SO6**: To make progress in implementing our digital strategy to support our ambition to become a digital leader in the NHS (FBIC)	
Links to the Strategic Organisational Risk register (SORR)	The work contained with this report links to the following corporate risks as identified in the SORR: • N/A

Compliance & regulatory implications	The following compliance and regulatory implications have been identified as a result of the work outlined in this report: • N/A

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Annual Report: Suicide Prevention

1 Purpose

The Office of National Statistics (ONS) published their annual suicide data for all regions and local authorities on the 6th September 2022. This is based on inquest findings in 2021. West Yorkshire continues to have a higher suicide rate than the England average, according to the latest data release from the Office of National Statistics (ONS).

In Leeds, suicide rates have risen from 13.3 to 13.9 per 100,000 people, in Wakefield from 16.2 to 17.3, in Calderdale from 15.6 to 16.9 and in Bradford from 9.2 to 9.8.

Bradford has the lowest suicide rate in Yorkshire and the Humber but has seen a rise comparative to the 2020 data. Bradfords suicide rate is below the national rate of 10.7 deaths per 100,000 people; while this was statistically significantly higher than the 2020 rate of 10.0 deaths per 100,000 people, it was consistent with the pre-coronavirus (COVID-19) pandemic rates in 2019 and 2018.

This paper provides the Board a summary and update on the work continuing both regionally and locally to reduce suicide and increase awareness.

2 Proposed Outcome

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.

In January 2022 the West Yorkshire Health and Care Partnership Suicide Prevention strategy & Action Plan (2022-2027) was published. The overall objective of the strategy is for zero suicides in West Yorkshire, with a five-year target to achieve a minimum 10% reduction in the suicide rate.

The West Yorkshire Health and Care Partnership strategy outlines the five core principles to guide West Yorkshire-wide decision making as: co-production, evidence-based action, system-wide impact, a life course approach and combatting stigma.

Suicide Prevention in Bradford

Bradford District Care NHS Foundation Trust continues as a member of the Bradford District Suicide Prevention group., The suicide prevention group continues to develop and is share chaired with VCS organisations to ensure wider skill and insight. The SPG have led a number of campaigns to tackle issues that influence suicide, these have included radio adverts about getting support to reduce or stop drinking and talking to someone and mini film clips about self-harm and making the call to get support.

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.

In accordance with the West Yorkshire Health and Care Partnership Suicide Prevention strategy & Action Plan (2022-2027) BDCFT have agreed our local strategy in accordance with the five core principles:

- *Co-production*

We will have service user and Carer representation on the suicide prevention (SP) steering group. Co production will be key to all transformation projects within BDCFT.

- *Evidence-based action*

We will share and use our data to influence and review our response to suicide monthly through the SP Steering group
We will share and use our data and the intelligence from WY SPAN, SPOG and Bradford Steering Group to inform change

- *System-wide impact*

We will engage and attend the strategic and operation WY groups SPAN and SPOG, Bradford steering Group and feed data and intelligence to inform evidence based outcomes

- *A life course approach*

We recognise the need for an all age community response and will engage with VCS, service users, carers and community services to inform decision making

- *Combatting stigma*

We will hold a Suicide Prevention Awareness events across the district and invite, staff, service users, carers, VCS, PCNs, Acute Hospitals, Emergency Services.

3 Options

BDCFT Initiatives 22/23

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.

Emergency Mental Health Crisis support

A key objective within the NHS Long term plan for implementation by 23/24 is to ensure for people of all ages to receive mental health crisis care, around the clock, 365 days a year.

BDCFT provides the First Response service which is now via a freephone number available 24 hours a day. This provides immediate support via phone and if required mental health assessments within the community within 4 hours of contact.

BDCFT has been successful in gaining funding to establish core 24 psychiatric liaison cover at Bradford Royal Infirmary and 24 hour cover at Airedale NHS Foundation Trust which commenced in July 2022. The Acute Liaison Psychiatry service (ALPS) will respond to mental health crises within one hour, and conduct a full biopsychosocial assessment, co-produce an urgent and emergency mental health care plan and refer for onward treatment, transfer or discharge within four hours. ALPs are currently supporting the Child and Adolescent mental health service (CAMHS) crisis team by undertaking all ages assessments in A&E departments with the CAMHS crisis team providing follow up community support to meet the 7 day follow up targets.

BDCFT continues to work in partnership with our voluntary care services to provide alternative forms of provision for those in crisis. BDCFT services signpost following assessment to Sanctuaries, safe havens and crisis cafes which provide a more suitable alternative to A&E for many people experiencing mental health crisis, usually for people whose needs are escalating to crisis point, or who are experiencing a crisis, but do not necessarily have medical needs that require A&E admission.

On the 22nd of May 2023 a crisis house offer was launched in Shipley to support service users in crisis access 24 hour community residential support for up to seven days. The service users will have on site support worker input with BDCFT intensive home treatment service providing triage and admission to the service for specialist assessment and treatment.

Community Mental health

By 2023, £39million of ringfenced investment will be made into newly formed core models of community mental health care for SMI based on ‘Place’. It is the first major system change to community mental health services in over 30 years and will require our secondary care staff to work differently and in collaboration with our community partners in PCN and VCS.

The Community mental health framework replaced the Care Programme Approach (CPA) for community mental health services. It enables services to shift away from an inequitable, rigid and arbitrary CPA classification and bring up the standard of care towards a minimum universal standard of high-quality care for everyone in need of community mental healthcare.

The community transformation programme will see a new community-based offer which will include access to psychological therapies, improved physical health care, employment support, personalised and trauma informed care, medicines management and support for self-harm and coexisting substance use.

The new models will continue BDCFTs efforts to ensure timely access to the right level of service to aid recovery which will continue to support the reduction in mental health crisis and associated risks such as self-harm and suicide.

Inpatient Care

On a national scale within adult mental health wards there are approximately 20-30 deaths per year from hanging or strangulation from a ligature fixed to an anchor point.

Ligature incidents using anchor points occur relatively infrequently in our organisation with 8% of all ligature incidents over a 12-month period (February 22- February 23) involved a ligature fixed to an anchor point; 26 out of 330 reported incidents. There has been a 16% reduction in ligature incidents in 22/23.

The severity of these incidents are more significant therefore a focus on ligature risk assessment, and consequential actions to mitigate, is important. BDCFT introduced a revised staff training package with the emphasis on clinical risk assessment and also introduced Symphony Doorsets to service user bedroom areas which provide a ‘full weight’ door alarm, activating an alarm when pressure is placed on the top and/or sides of the door.

All ligature risk assessments are completed using the new assessment framework and evidence collected within the CQC action plan evidence folder. Monthly updates are provided by clinical managers for all wards within their portfolios to the LERS group highlighting any areas of exception relating to risk assessments or actions within them being out of date or unlikely to be completed within timescales.

All service users discharged from acute mental health inpatient services are provided community follow up within 72 hours of discharge. The 72 hour follow up is a key part of the work to support the Suicide prevention agenda within the Long Term Plan. The National Confidential Inquiry into Suicide and Safety in Mental Health (2018) found that the highest number of deaths occurred on day 3 post discharge. By completing follow up in 3 days BDCFT support the suicide prevention agenda, ensuring patients have both a timely and well planned discharge.

Learning from Suicides

A significant amount of work has been undertaken throughout 2021 to create a learning environment and embed Human Factors into our investigation approach. The Patient Safety team continue to work within the Serious Incident Framework, however have started an implementation programme for the Patient Safety Incident Response Framework (PSIRF) as part of the NHS Patient Strategy, which will be introduced in late 2023. The changes in the new framework will enable the Trust to enhance its standard investigation processes with different approaches, a more tailored approach depending on the nature of each incident, and a focus on identifying learning. The Trust is working with partners 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.

Investigators have all completed Human Factors training and will undergo additional training in relation to new investigative approaches over the next year. Other resources and training in patient safety and human factors are now available and the Trust is preparing a matrix to support staff at all levels to access appropriate training options.

The Patient Safety team are also participating in the 'Learn Together' research project which is studying Patient and Family Involvement in Serious Incident Investigations (PFI-SII) to enhance learning in relation to involvement. In 2023 the team will be involved in a mental health specific project as part of this work specifically to look at approaches to involvement where suicide is suspected or confirmed.

Staff Training

BDCFT provides Care programme approach (CPA) care planning, CPA clinical role which outlines the responsibilities of each professional group. BDCFT formulation based risk training is in accordance with the National institute for Health and Social Care Excellence (NICE) Self-harm: assessment, management and preventing recurrence Guidance on Risk assessments.

BDCFT MH Care Group May 2023 Training compliance (80% Target):

CPA care planning: 92%
CPA Roles and Responsibility: 96%
CPA Clinical Risk: 92%

BDCFT is working in alliance with the West Yorkshire Health and Care Partnership Suicide Prevention group to align best practice and implement evidenced based risk training to ensure practitioners are providing safe and effective care which reduces the risk of self harm and suicide.

4 Risk and Implications

The recent ONS statistics relating the regional and local increases to suicide rates is a stark reminded of the increasing risk of suicide within the local population. The current cost of living crisis and covid pandemics impact on the mental health of the population possess additional pressures to BDCFT services with increasing referral rates particularly related to children and young people.

The continued development of all age 24 hour crisis mental health support services with our community partners will be a key facet in mitigating suicide risk.

The Continued emphasis on learning from suicides and incorporating the identified improvements into risk training for BDCFT staff members will also reduce the suicide risk.

5 Results

BDCFT is meeting both the long term plan objectives in respect to mental health emergency crisis care and the West Yorkshire Health and Care Partnership Suicide Prevention strategy & Action Plan (2022-2027).

As outlined Bradford has seen a rise in suicide rates during 2021 from 9.2 to 9.8. per 100,000 but continues to be the lowest in the West Yorkshire Health and Care Partnership and lower than the national average.

As outlined within the annual update continued implementation and accessibility for all members of the public to 24 hour crisis services with appropriately skilled practitioners is key to reducing the incidents of suicide.

Changes to improve the inpatient environment combined with dedicated training packages such as ligature risk training also reduces the risk of inpatient suicides.

It should be noted that our voluntary services are a key partner in supporting people in crisis and community responses to recovery are central to Bradfords Act as One ambition to help people live ‘Happy, Healthy at Home’.

Christopher Dixon
Head of Nursing (Mental Health)
June 2023