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Agenda for a meeting of the Health and Social Care Overview and Scrutiny Committee to be held on Thursday, 6 April 2017 at 4.30 pm in Committee Room 1 - City Hall, Bradford

Members of the Committee – Councillors

CONSERVATIVE	LABOUR	LIBERAL DEMOCRAT
Gibbons **Poulsen**	**Greenwood** **A Ahmed** **Duffy** **Mullaney** **Sharp**	**N Pollard**

Alternates:

CONSERVATIVE	LABOUR	LIBERAL DEMOCRAT
Barker **Ellis**	**Berry** **S Hussain** **T Hussain** **H Khan**	**Griffiths**

NON VOTING CO-OPTED MEMBERS

Susan Crowe	Strategic Disability Partnership
Trevor Ramsay	Strategic Disability Partnership
G Sam Samociuk	Former Mental Health Nursing Lecturer
Jenny Scott	Older People's Partnership

Notes:

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If any further information is required about any item on this agenda, please contact the officer named at the foot of that agenda item.

From:
Parveen Akhtar
City Solicitor
Agenda Contact: Palbinder Sandhu/Claire Tomenson
Phone: 01274 432269/432457
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To:

A. PROCEDURAL ITEMS

1. ALTERNATE MEMBERS (Standing Order 34)

The City Solicitor will report the names of alternate Members who are attending the meeting in place of appointed Members.

2. DISCLOSURES OF INTEREST

(Members Code of Conduct - Part 4A of the Constitution)

To receive disclosures of interests from members and co-opted members on matters to be considered at the meeting. The disclosure must include the nature of the interest.

An interest must also be disclosed in the meeting when it becomes apparent to the member during the meeting.

Notes:

(1) Members may remain in the meeting and take part fully in discussion and voting unless the interest is a disclosable pecuniary interest or an interest which the Member feels would call into question their compliance with the wider principles set out in the Code of Conduct. Disclosable pecuniary interests relate to the Member concerned or their spouse/partner.

(2) Members in arrears of Council Tax by more than two months must not vote in decisions on, or which might affect, budget calculations, and must disclose at the meeting that this restriction applies to them. A failure to comply with these requirements is a criminal offence under section 106 of the Local Government Finance Act 1992.

(3) Members are also welcome to disclose interests which are not disclosable pecuniary interests but which they consider should be made in the interest of clarity.

(4) Officers must disclose interests in accordance with Council Standing Order 44.

3. MINUTES

Recommended –

That the minutes of the meeting held on 2 March 2017 be signed as a correct record (previously circulated).

(Palbinder Sandhu – 01274 432269)

4. INSPECTION OF REPORTS AND BACKGROUND PAPERS

(Access to Information Procedure Rules – Part 3B of the Constitution)

Reports and background papers for agenda items may be inspected by contacting the person shown after each agenda item. Certain reports and background papers may be restricted.

Any request to remove the restriction on a report or background paper should be made to the relevant Strategic Director or Assistant Director whose name is shown on the front page of the report.

If that request is refused, there is a right of appeal to this meeting.

Please contact the officer shown below in advance of the meeting if you wish to appeal.

(Palbinder Sandhu - 01274 432269)

5. REFERRALS TO THE OVERVIEW AND SCRUTINY COMMITTEE

Any referrals that have been made to this Committee up to and including the date of publication of this agenda will be reported at the meeting.

B. OVERVIEW AND SCRUTINY ACTIVITIES

6. RESPIRATORY HEALTH IN BRADFORD AND AIREDALE 1 - 12

The Strategic Director, Health and Wellbeing will submit a report (**Document "AK"**) which provides an overview of respiratory health in Bradford District and outlines what partners across the NHS and local authority are doing to improve outcomes for people in the District. There is a specific focus on asthma and chronic obstructive pulmonary disease (COPD) as these conditions account for a significant amount of the poor health and subsequent costs associated with respiratory disease in the District.

Recommended –

That the Committee note the information provided in the paper and support ongoing work seeking to address the main challenges going forward.

(Toni Williams – 01274 437401)

7. BRADFORD DISTRICT SUICIDE AUDIT AND PREVENTION PLAN 13 - 50

The Strategic Director, Health and Wellbeing will present **Document "AL"** which provides an overview of findings from a recently conducted audit of deaths by suicide in the District 2013-15 and also presents the District's new multi-agency Suicide Prevention Plan in draft form prior to its anticipated launch in April 2017.

Recommended –

That the Committee note and comment on the audit of deaths by suicide and the District Suicide Prevention Plan 2017-2021.

(Peter Roderick – 01274 437352)

8. HEALTH AND SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE WORK PROGRAMME 2016/17

The City Solicitor will provide a verbal update on the Committee's work programme 2016/17.

(Caroline Coombes – 01274 432313)

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Report of the Strategic Director of Health and Wellbeing to the meeting of the Health and Social Care Overview & Scrutiny Committee to be held on 6 April 2017

AK

Subject:

Respiratory Health in Bradford and Airedale

Summary statement:

Respiratory disease is an important cause of poor health and early death in Bradford District. The District performs relatively poorly compared to other areas in England. Recognising this, partners across the District, including the local authority and NHS, have prioritised respiratory health with the aim of improving health outcomes, including improving the health status of people with respiratory disease and reducing deaths from respiratory disease.

This paper provides an overview of respiratory health in Bradford District and outlines what partners across the NHS and local authority are doing to improve outcomes for people in the District. There is a specific focus on asthma and chronic obstructive pulmonary disease (COPD) as these conditions account for a significant amount of the poor health and subsequent costs associated with respiratory disease in the District.

Bev Maybury
Strategic Director of Health and Wellbeing
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Portfolio:

Health & Wellbeing

1. Summary

Respiratory disease is an important cause of poor health and early death in Bradford District. The District performs relatively poorly compared to other areas in England. Recognising this, partners across the District, including the local authority and NHS have prioritised respiratory health, with the aim of improving health outcomes, including improving the health status of people with respiratory disease and reducing deaths from respiratory disease. In Bradford this work is being driven by the Bradford Breathing Better Programme, and in Airedale, Wharfedale and Craven (AWC) through the AWC Respiratory Action Plan Group.

2. Background

Respiratory diseases are diseases that affect the air passages, including the nasal passages, the bronchi and the lungs. They include acute conditions such as pneumonia, and long term conditions such as asthma and COPD. They are influenced by lifestyle factors such as smoking, as well as environmental factors such as air quality.

Some of the greatest health burden locally is associated with asthma and COPD. COPD is also an important cause of early death. It is for these reasons why asthma and COPD are local priorities, particularly for the NHS, in terms of respiratory health.

COPD is a disease of the lungs that causes obstructed airflow from the lungs. Symptoms include breathing difficulty, cough, sputum production and wheezing. It is caused by long term exposure to irritating gases or particulate matter, most often cigarette smoke. Although not curable, COPD is treatable. With proper management, most people with COPD can achieve good symptom control and quality of life, as well as reduced risk of other associated conditions.

Asthma is a condition characterised by the narrowing of the airways which makes breathing difficult. This can trigger coughing, wheezing and shortness of breath. For some people asthma is a manageable condition, however, for others it can be a major problem that interferes with daily activities and may lead to a life threatening asthma attack. Whilst asthma can’t be cured, its symptoms can be controlled.

3. Report issues

3.1 National Priorities and the Government Strategy for COPD and Asthma

In 2011 the then Coalition Government published their strategy for COPD and asthma, with the aim of improving the respiratory health and wellbeing of all communities, and reducing health inequalities. The strategy sets out the outcomes that need to be achieved in COPD and asthma to improve health outcomes and reduce health inequalities. There are six overarching objectives:

- To improve respiratory health and wellbeing of all communities and minimise inequalities between communities;
- To reduce the number of people who develop COPD by ensuring that they are aware of the importance of good lung health and wellbeing, with risk factors understood, avoided, or minimised, and proactively address health inequalities;
- To reduce the number of people with COPD who die prematurely through a proactive approach to early identification, diagnosis and intervention, and proactive

care and management at all stages of the disease, with a particular focus on areas with high prevalence;
- To enhance quality of life for people with COPD across all social groups with a positive, enabling experience of care and support right through to end of life;
- To ensure that people with COPD, across all social groups, receive safe and effective care, which minimises progression, enhances recovery and promotes independence;
- To ensure that people with asthma, across all social groups, are free of symptoms because of prompt and accurate diagnosis, shared decision making regarding treatment, and ongoing support as they manage their own condition, and to reduce the need for unscheduled health care and risk of death

3.1 What is the scale of the problem in Bradford District?

3.1.1 Overview of respiratory health

Respiratory disease is a leading cause of dying early in Bradford District. Rates of early death from respiratory disease in Bradford are amongst the highest in England and the second highest in Yorkshire and Humber. Each year more than 500 people die from respiratory disease in the District; an estimated 25% of these deaths are preventable. The main causes of death from respiratory disease include COPD and pneumonia.

It is not only early death that is an issue, but the associated health problems. Respiratory diseases such as COPD and asthma have a significant impact on the quality of life of those who are affected. Exacerbations can result in attendance at A&E or admission to hospital. On average, 30% of people with COPD attend A&E on at least one occasion each year, whilst one in five people are admitted to hospital each year. In 2015/16 in Bradford District there were 1,343 admissions where the main reason for admission was COPD, and 866 for asthma.

3.1.2 COPD

Number of people with COPD

13,009 people across the three CCGs in Bradford District have been diagnosed with COPD. Disease rates are lowest in City CCG, however, this is, in part, a reflection of the younger age structure of the City population. As the number of older people increases, the number of people with COPD is expected to increase across the District.

One of the main challenges in managing COPD is that many people are unaware that they have the condition. Late diagnosis has a substantial impact on symptom control, quality of life, patient outcomes, and cost. Often people aren't diagnosed until the disease is at an advanced stage; this is because people sometimes do not recognise the symptoms of COPD because they develop gradually; many people think that the symptoms they are experiencing are normal or associated with age; and when people present to their GP the symptoms may be treated rather than the cause of the symptoms investigated.

Whilst 13,009 people in the District have been diagnosed with COPD, it is estimated that the actual number of people with COPD is closer to 19,000; an estimated 6,099 people remain undiagnosed (equivalent to 32% of those thought to have COPD). The proportion of people with COPD who remain undiagnosed varies between CCGs and also between GP practices. Whilst some degree of variation is expected, the variation

described suggests that some GP practices are better than others at detecting COPD, and that there is capacity for improvement.

Figure 1: Number of people diagnosed and undiagnosed with COPD, City, Districts and AWC CCGs, 2015/16

	AWC CCG		City CCG		Districts CCG	
	n	%	n	%	n	%
Estimated number of people with COPD	4,539	2.87%	2,814	2.28%	11,754	3.5%
Number of people recorded on GP register with COPD	3,299	2.1%	1,533	1.2%	8,177	2.4%
Estimated number of people who remain undiagnosed	*1,240*	*27%**	*1,281*	*46%**	*3,578*	*30%**

Source: Quality and Outcomes Framework and Public Health England

* In the first two rows the percentages refer to the number of people with COPD as a percentage of the whole population. In the third row the percentages describe the number of people who remain undiagnosed as a percentage of all those with COPD – diagnosed and undiagnosed.

Management of COPD

Most of the care for people with COPD is provided in primary care. Effective management can lead to improvements in symptom control and quality of life, and also a reduction in exacerbations and associated hospital admissions and death. NICE guidance and the GP Quality and Outcomes Framework (QOF) sets out a number of standards for the way in which people with COPD should be managed. For example, people with COPD should have an assessment of breathlessness (one of the main symptoms of COPD) on a regular basis. There is variation between CCGs (and also between GP practices) which suggests that there is scope to improve the management of COPD.

Figure 2: Variation in the management of COPD in primary care, City, Districts and AWC CCGs, 2015/16

	% of patients with COPD who have had a review, incl. an assessment of breathlessness using the MRC dyspnoea score[1] in the preceding 12 months	% of patients with COPD with a record of FEV_1[2] in the previous 15 months
AWC	77.4%	70.1%
City	76.8%	72%
Districts	81.5%	71.3%
GP practice range	31.7% - 100%	41.2% - 100%

Source: Quality and Outcomes Framework

A significant challenge in effectively managing COPD is multimorbidity. Multimorbidity is the presence of more than one long term condition; in the District multimorbidity for people with COPD appears to be the norm. More than three quarters of people with

[1] MRC dyspnoea score is a scale for scoring the degree of a person's breathlessness.

[2] The FEV_1 refers to a person's forced expiratory volume which is a measure of lung capacity.

COPD have at least one other long term condition, such as high blood pressure or diabetes. This is a challenge because of the way in which health care services are traditionally delivered. The use of many services to manage individual conditions can be inefficient and frustrating for patients. Individuals with more than one long term condition are much more likely to experience problems with the coordination and integration of their care, and are more likely to have an unplanned hospital admission.

3.1.3 Asthma

Number of people with Asthma

40,762 people across the three CCGs in Bradford District have been diagnosed with asthma. Disease rates are similar across all three CCGs, but higher than the England average. This number is likely to be an underestimate of the actual number as, as is the case for COPD, some people with asthma will not have been formally diagnosed. Getting a diagnosis and starting appropriate treatment early can lead to better long term outcomes, improved quality of life, symptom control, and fewer exacerbations. Modelled estimates of the number of people with asthma do exist, however, they are now out of date and, therefore, there are some concerns over their accuracy. Whilst it is not possible to estimate the number of people who have asthma but who have not been diagnosed, it is important to recognise the importance of having an accurate and timely diagnosis.

Management of asthma

Most of the care for people with asthma is provided in primary care. Effective management can lead to improvements in symptom control and quality of life, and also a reduction in exacerbations and associated hospital admissions and deaths. NICE guidance and the GP Quality and Outcomes Framework (QOF) sets out a number of standards for the way in which people with asthma should be managed. For example, people with asthma should be reviewed on a regular basis, and young people with asthma should have a record of their smoking status because smoking can exacerbate the condition. There is variation between CCGs (and also between GP practices) which suggests that there is scope to improve the management of asthma.

Figure 3: Variation in the management of asthma in primary care, City, Districts and AWC CCGs, 2015/16

	% of patients who have had an asthma review in the last 12 months	% of patients with asthma between the ages of 14 and 19 years in whom there is a record of smoking status in the preceding 12 months.
AWC	70.4%	83.8%
City	76.6%	92%
Districts	71.0%	86.5%
GP practice range	47.9% - 95.6%	64.1% - 100%

Source: Quality and Outcomes Framework

3.1.4 Smoking

Smoking has long been recognised as one of the main causes of preventable illness and early death. It is particularly important in the context of asthma and COPD because it is one of the main causes of COPD, and is also an exacerbating factor for asthma. According to annual population surveys, one in five adults in Bradford is a regular smoker – this compares to one in six in England. Smoking is more common in people in routine and manual jobs, where in Bradford the smoking prevalence is 30.1%. – this compares to 26.5% in England. Smoking in pregnancy rates in Bradford remain higher than the national average – 15% compared to 10.6% in England as a whole.

A further more detailed analysis of smoking numbers and the impact of smoking on health outcomes is available on request as part of the tobacco control needs assessment.

3.1.5 Air quality

Air pollution is a major environment related risk factor for respiratory disease. The effect of poor air quality on health depends on two things: the individual level of exposure, or how much; and secondly for how long. Air pollution builds up at a regional scale so that background emissions arising from industrial sources are combined with urban sources of air pollution from local industry, traffic, and heating sources. Transport emissions in particular contribute to poor air quality in urban locations. Although there are local 'hotspots' within the District that exceed air quality standards set by the World Health Organisation, it is important to recognise the transboundary nature of air pollution, and the need for policies at multiple levels.

There are two pollutants that are of significant concern from a public health perspective: oxides of nitrogen which are produced from fuel combustion; and fine particles (PM) arising from a range of sources, including transport and industry. There is a growing body of evidence describing the association between fine particles, poor respiratory health, and deaths from respiratory related disease. Fine particles can be inhaled deeply and lodge in lung tissue before entering the bloodstream. Recent reviews have also demonstrated an association between transport related air pollution and the onset of childhood asthma.

3.2 Improving respiratory health in Bradford District

Improving respiratory health and reducing health inequalities remains a priority for the Department of Health and Wellbeing, wider local authority and NHS partners. Action to improve outcomes focuses on two main areas:

- Primary prevention involves addressing the risk factors for respiratory conditions to reduce the number of people developing them in the first instance. The main preventable risk factor for COPD is smoking.
- Secondary prevention involves action to improve the management and care of people with respiratory conditions such as COPD to slow down progression of the disease, and for COPD and asthma to control the conditions to reduce the frequency of exacerbations and complications.

3.2.1 Tobacco control

Since the transfer of Public Health to the local authority in 2013, the Department of Health and Wellbeing, has been responsible for improving the health of people in Bradford District. This includes commissioning services to support people to stop

smoking, and also activities to prevent people, particularly children and young people, from taking up smoking in the first instance.

Stop smoking support in the District is provided by a team of specialists within a central service, and also via a network of providers in primary care and pharmacy. The specialist stop smoking team within the Department of Health and Wellbeing provides stop smoking support at a range of venues including GP practices, libraries, supermarkets, and children's centres, to ensure that support is accessible to those that want to access it. As smoking is more common in routine and manual working groups, support to quit in the workplace is provided by the specialist team and is targeted at organisations with a high proportion of routine and manual workers. Within the secondary care setting, for people referred to the service on admission to hospital, support to quit smoking is provided by a specialist team on the ward.

Smoking in pregnancy has been a priority for a number of years. Recognising the importance of stopping smoking during pregnancy, the Department of Health and Wellbeing has funded a specialist midwife to, over a three year period, train staff, and establish policies and procedures to ensure that a systematic and evidence based approach to tackle maternal smoking is embedded throughout the antenatal care pathway.

In addition, The Department of Health and Wellbeing, CCGs and Public Health England have funded the implementation of BabyClear across the district; a programme through which all antenatal midwives receive training to ensure consistency of advice and interventions for pregnant women. This is complemented by a number of other interventions including the identification of smoking cessation/smoke free home champions in health visiting and children's centres. Bradford Districts CCG has been given additional funding by NHS England to address concerns around the high numbers of women smoking at the time of delivery. Projects are currently in development to train hospital based midwives and midwifery support workers in the BabyClear philosophy to work with women on the antenatal day ward; the introduction of carbon monoxide screening at 36 weeks to improve the accuracy of reporting; and engagement with women from our local communities to improve the uptake of smoking cessation services.

A multipronged approach to reduce the number of young people taking up smoking is needed. Local priorities include:

- Continuing to de-normalise smoking and discourage young people from being influenced by adult smoking.
- Promoting the implementation of smoke free areas for organisations involved in the care or education of young people and children.
- Making ever contact count – ensuring that all opportunities in health and social care (including primary and secondary care) are maximised to support people to stop smoking. This includes identifying smokers, and signposting and referring to services where appropriate.
- Ensuring that all national and regional campaigns are well publicised, and resources made available to primary and secondary health care and social care professionals. Local services are marketed based on local intelligence and research.

3.2.2 Bradford City and Districts: Bradford Breathing Better

Bradford City and Districts CCGs are working collaboratively to deliver a programme of work (known as Bradford Breathing Better) to improve respiratory health outcomes for children, young people and adults in Bradford with COPD or asthma. The primary aim of Bradford Breathing Better is to promote early and appropriate diagnosis, and through effective and proactive care, support people to manage their conditions, reducing exacerbations and unplanned hospital admissions. Specifically, Bradford Breathing Better will:

- Improve care and management of people who are diagnosed with a respiratory condition through care planning and patient education.
- Provide patients with the skills and tools to self care and self manage their condition and exacerbations appropriately.
- Ensure that pathways, prescribing and technology are consistent across primary and secondary care.
- Reduce non-elective admissions as a result of improved care and management.

All work will be overseen by a programme board which will be established, with clinical leadership coming from the two CCGs. Once in place, workstream leads will be agreed and timescales set.

To launch Bradford Breathing Better, a stakeholder workshop was held in January 2017, with representation from patients, GPs, nurses, the British Lung Foundation, Asthma UK, community teams, and non-clinical support teams, with the aim of shaping the direction of the programme. Although still in the planning stage, some quick wins have been identified across four workstreams: self care, prescribing and formulary, clinical templates, and pathways.

Self care

One of the priorities locally is to support individuals to manage their condition, be it COPD or asthma, and to understand any triggers for exacerbations, so that exacerbations can be managed in a timely, safe and supportive way. Patients have told us that they feel vulnerable when they have a flare up of their condition, and often they have no alternative available, particularly out of hours, but to call emergency services. This often leads to an A&E attendance or an unplanned hospital admission. The aim of this workstream is to provide each patient with a detailed, personalised care plan which outlines how to manage their condition, what to do if they start to feel unwell, and to prescribe rescue packs to those who are suitable for this option.

Prescribing and formulary

A significant amount of CCG spend on COPD and asthma is on prescribing, therefore, it is important to look at the outcomes that we are achieving for this spend. In order to ensure that people receive the right medication at the right time, a prescribing formulary that covers primary and secondary care will be developed, with any changes considered at an individual's annual review. Furthermore, there is a growing body of evidence to show that prescribed medication is not always used effectively; an estimated 15% of people use their inhalers incorrectly, meaning that their respiratory condition might not be as well controlled as it could be. Accordingly, approaches to improve inhaler technique will also be considered.

Clinical template

Primary care teams currently have a number of templates open for them to follow to support the management of people with COPD and asthma in primary care settings.

This can be cumbersome and confusing. Therefore, as part of Bradford Breathing Better we will look to simplify the process by creating one overarching template. This will support appropriate prescribing, proactive care planning, and facilitate referral to other services such as smoking cessation services, and pulmonary rehabilitation.

Pathways
People with COPD and asthma are primarily managed in primary care settings, however, some will require care in hospital settings. It is important that a consistent approach to managing COPD and asthma is taken across primary and secondary care, and, therefore care pathways will be reviewed. Pathways will be evidence based and compliant with best practice contained within the NICE Quality Standards for both COPD and asthma. Training and education will also be delivered to staff to ensure that pathways are implemented and embedded across primary and secondary care.

In addition to the four outlined workstreams, a primary care practice nurse list will be established. Each GP practice will have a dedicated nurse lead that will support the development and implementation of the Bradford Breathing Better Programme, and will be the main point of contact. Lessons learnt from other CCG programmes will be transferred to Bradford Breathing Better – this includes the development of clinical searches, data reporting to practices, and education and support for primary care.

3.2.3 Airedale, Wharfedale and Craven (AWC) Respiratory Action Plan
AWC have adopted the principles of the NHS Right Care Programme to improve respiratory health outcomes in Airedale, Wharfedale and Craven. The Right Care Programme is based on the principle of unwarranted variation. Some variation between clinical commissioning groups (CCGs) in terms of health outcomes, hospital activity, prescribing, and what CCGs spend on health care is expected; this is because CCG populations are different. However, some variation is unwarranted, and by using data and evidence to identify such variation, areas and programmes which offer the best chances of improving outcomes for people in the District, as well as making the best use of resources, can be identified.

Much of the respiratory work programme in AWC focuses on improving outcomes for people with asthma and COPD. The focus is primarily on primary care because this is where most people with these conditions are routinely managed, but also includes some pathway development work between primary and secondary care, to ensure that when people do require management in hospital settings, that their care is as joined up as possible.

The respiratory work programme is delivered by the Respiratory Action Plan Group. Actions to date include:

- The establishment of an AWC Respiratory Network, with practice nurse leads in every GP practice.
- Raising awareness of the importance of self-management of care plans.
- Community pharmacy education and training event.
- Review of ambulatory care pathways.
- Exploring the feasibility of providing Incheck Dials (a hand held device that measures peak inspiratory flow and enables healthcare professionals to help people to use their inhalers properly) to GP practices.
- Dedicated training and education events with primary care staff, including practice managers, practice nurses and GPs.

- Equipment review to enable community pharmacies to review inhaler techniques.
- Development of a primary-secondary care asthma pathway to ensure seamless care between primary and secondary care after being discharged from hospital.

3.2.4 Air quality

The Council is signed up to the West Yorkshire Low Emissions Strategy, which was published in December 2016. The strategy has three aims:

- To accelerate improvements in air quality, above that which would occur without intervention, to achieve air quality limit values, set out in law in all parts of West Yorkshire by 2020 at the latest;
- Working within the wider economic, social, and environmental context for West Yorkshire, to create a Low Emissions Future that will maximise opportunities to improve air quality, minimise risks of worsening air quality, and create healthier places to live, work, and visit.
- Immediate focus on tackling transport emissions, targeting interventions that will deliver the most significant air quality improvements in the areas of greatest concern.

With its focus on tackling transport emissions, tighter controls over higher pollution emitting vehicles are being developed under a Clean Air Zone policy. Through the implementation of this strategy clear health benefits are expected. For example, if we reduce Leeds/Bradford car journeys by 10% by 2021, then 10 cardio-respiratory deaths could be prevented each year.

3.3 Key challenges

Respiratory disease is similar to diabetes in that the population often do not think that there is anything they can do to a) prevent it, b) to control it, and c) recognise the huge impact that it has on their quality of life. A key challenge locally is how we raise the profile of respiratory health in our population, and support people to take responsibility for their own health and wellbeing. Further challenges include:

- Smoking rates in pregnancy remain high;
- There are high relapse rates after quitting smoking at six months;
- Opportunities remain with social care, primary care and secondary care to refer and support people to stop smoking services as a routine part of care pathways.
- Raising awareness amongst children and young people on the importance of lung health.

4. **Options**

Not applicable

5. **Contribution to corporate priorities**

The ongoing work by partners in the local authority and NHS on respiratory health supports the Council's priorities with regards to improving health and wellbeing, and reducing health inequalities, as outlined in the Health Inequalities Action Plan and the Joint Health and Wellbeing Strategy.

6. **Recommendations**

That Members of the Health and Social Care Overview and Scrutiny Committee note the information provided in the paper and support ongoing work seeking to address the main challenges going forward.

7. **Background documents**

- Department of Health (2011). An Outcomes Strategy for Chronic Obstructive Pulmonary Disease and Asthma.
- NHS Right Care (2012). Atlas of Variation in Healthcare for People with Respiratory Disease.
- Bradford metropolitan District Council (2015). Tobacco Control Needs Assessment.
- West Yorkshire Combined Authority (2016). West Yorkshire Low Emissions Strategy 2016-2021.

8. **Not for publication documents**

None

9. **Appendices**

None

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Report of the Strategic Director of Health and Wellbeing to the meeting of the Health and Social Care Overview and Scrutiny Committee to be held on 6 April 2016.

AL

Subject: Bradford District Suicide Audit and Prevention Plan

Summary statement:

This report presents to Scrutiny an overview of findings from a recently conducted audit of deaths by suicide in the District 2013-15, and also presents the District's new multi-agency Suicide Prevention Plan in draft form, prior to its anticipated launch in April 2017.

Bev Maybury
Strategic Director of Health and Wellbeing

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(Specialty Registrar in Public Health)
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Portfolio:

Health and Wellbeing

Overview & Scrutiny Area:

Health and Social Care

1. SUMMARY

This report presents to Scrutiny an overview of findings from a recently conducted audit of deaths by suicide in the District 2013-15, and also presents the District's new multi-agency Suicide Prevention plan in draft form, prior to its anticipated launch in April 2017.

Between 2013 and 2015, the coroner's files which were audited showed 76 conclusions of suicide in the District, while the Office for National Statistics (ONS) published figures (which include narrative conclusions) record 148 deaths in the same period. The audit considers key demographic information on those who took their own life, as well as service contact and medical/social history, and the manner and means of the deaths. This information, together with national strategies and evidence, informs the District's new prevention plan.

2. BACKGROUND

Suicide is a tragic event which, though rare, affects a large number of people each time it occurs, sending ripples through family and community life. As part of the District's new Mental Wellbeing Strategy 2016-2021, there is a commitment to support the development and implementation of a District-wide suicide prevention plan, sitting under the 'Our Wellbeing' aspiration of the strategy. This plan is now in its final stages of development, and is included as an appendix to this report. It is based on the premise that many suicides are preventable, and if early support or crisis intervention is offered we know we can see a different outcome in people's lives.

The suicide rate has been rising nationally since 2008, and Bradford has slightly higher rate of suicide than the England average. In Bradford, the ONS estimates that the 3 year rolling average rate of deaths by suicide is 11.4 per 100,000 people (2013-2015); this is above the national average of 10.1 per 100,000, and means Bradford has the 5th highest rate in Yorkshire and Humber. Using this way of counting suicides, the District sees around 40-50 suicides every year, or around one each week. In 2013, 3 out of 4 deaths from suicide in Bradford were by males, with the highest number of male suicides occurring between 20 and 44 years of age.

3. REPORT ISSUES

<u>National evidence and policy on suicide prevention</u>
Decades of international research on suicidal trends and prevention has identified that there are no cast iron methods of predicting or preventing a suicide. However a number of risk factors are common in many cases which can aid the targeting of resources and prevention work. These include:

- **Age and sex**, with males three times as likely to take their own life, and the peak age for suicide rising over the last 20 years from 20-29 to 35-45. Suicide is the second most common cause of death for 5-19 year olds, the leading cause of death for 20-34 year olds, and the second most common cause of death for 35-49 year olds.

- **having a mental health problem**, be it a mood disorder such as depression, anxiety or personality disorder, or an illness with psychotic episodes
- **having made a previous suicide attempt**
- **having a history of self-harm**
- **ethnicity**, with research showing lower rates of suicide amongst Islamic communities and higher rates amongst black males
- **the misuse of substances** (drugs and alcohol)
- **having a physical health problem**, particularly chronic pain
- **being in contact with the criminal justice system**
- **having ready access to the means of suicide**, for instance doctors (anaesthetic medication) and farmers (guns)
- **relationship breakdown**
- **financial strain** (research has shown a link between Work Capacity Assessments/benefit sanctions and suicide rates)
- **adverse life events**, for instance unemployment
- **previously bereavement by suicide,** for instance of a family member or close contact

Based on these risk factors, the Government's Suicide Prevention Strategy for England from 2012 set out 6 areas for action:

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring

This strategy was updated in January 2017, and sets out an ambition for a reduction in national rates of suicide of 10% by 2021, as well as making it mandatory for each local area to develop a suicide prevention plan by the wend of 2017. Other key policy and evidence resources include:

- NHS England Five Year Forward View for Mental Health (2016)
- Public Health England (2016): Local Suicide Prevention Planning: a Practice Resource
- Health Select Committee (2017): TBC

<u>Local Partnership Work around suicide prevention</u>

As part of the District's new Mental Wellbeing Strategy 2016-2021, there is a commitment to support the development and implementation of a District-wide suicide prevention plan, sitting under the 'Our Wellbeing' aspiration of the strategy. It is recognised that any efforts to tackle suicide rates cannot be seen in isolation from wider work to improve mental wellbeing in the District, ranging from services to support those with mental health problems to population level work to improve the mental wellbeing and emotional resilience of the residents of Bradford.

Partners in the district – including local GPs, representatives from Bradford District Care NHS Trust, Bradford Clinical Commissioning Groups, City of Bradford, West Yorkshire Police and West Yorkshire Fire and Rescue, as well as Bradford MIND, Bradford Samaritans, and Sharing Voices – meet regularly as part of the District's Suicide Prevention Group. During 2016, the group was reviewing the national and international evidence for effective suicide prevention, data and intelligence on suicides in Bradford, and has now produced a local plan of action in line with Public Health England guidance.

Additionally, Bradford District Care NHS Trust convenes its own internal suicide reduction and as part of its statutory duties it investigates the death by suicide of patients under its care in a Serious Incident investigation. The Child Death Overview Panel, responsible for reviewing all deaths of under 19s in the District, also reviews the small number of child suicide cases the District has seen.

Audit of deaths by suicide

In February 2017, access was granted for two public health staff members to audit Bradford-based suicide case files from the office of H M Coroner for the Western Area of West Yorkshire. The files which were audited showed that between 2013 and 2015 there were 76 conclusions of suicide in the District, while the ONS published figures (which include narrative conclusions) record 148 deaths in the same period.[1] Of the cases:

- 78% of those who took their own life were male, and 22% were female. The mean age at death was 45 for males and 50 for females (47 overall), with the highest number of deaths (30) in the 40-49 age bracket
- Fewer people who killed themselves were from a South Asian background than might be expected given the ethnicity structure of the population of the District, and more people who killed themselves were from a Central Eastern European background; this conclusion should however be interpreted with caution due to the low numbers involved
- 61% of all deaths were by hanging or strangulation and 17% were by self poisoning; other methods included falling from a height, jumping under a train, and cutting/ stabbing
- 78% of deaths occurred in the deceased's own home, with 22% in a more public place or workplace. A suicide note was left in 45% of cases
- 39% of people who died lived alone, and 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 took their own lives 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 killed themselves (71%) had seen their GP in the 6 months before death

[1] Data from the ONS counts deaths coded as 'undetermined intent' as well as suicide verdicts in an attempt to correct underestimation of the true number of suicides. In England and Wales, it has therefore been customary to assume that most injuries and poisonings of undetermined intent are cases where the harm was self-inflicted but there was insufficient evidence to prove that the deceased deliberately intended to kill themselves; this convention has been adopted across the UK (ONS 2012)

- At post mortem, drugs and/or high levels of alcohol were found in the system of the deceased in 50% of cases, suggesting that half of all cases were under the influence of drugs/alcohol at the moment they took their own life
- Adverse life events experienced by those who took their own life 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

Using life expectancy estimates produced by the ONS, it is estimated that these deaths represent 2672 potential years of life lost, years which, if effective intervention had occurred, may have been saved.

Multi-agency Suicide Prevention Plan

The Bradford Suicide Prevention Plan has been endorsed by the district's Mental Wellbeing Partnership Board, and has the following vision statement:

> 'We ultimately aspire to prevent all suicides in the District; for us, no suicide is inevitable. As a short-term goal, we have and ambition for a 10% reduction by 2021; achieving this would mean that 5 lives will be saved each year after 2021.'

Given that the plan forms a part of the wider District mental wellbeing strategy, it takes the form of an action plan, grouped into the following categories:

1: Reducing the risk of suicide in key high-risk groups

…including actions to reduce inpatient and community mental health service user suicides through timely discharge planning, policies on absconding and self-discharge, and enhanced discharge follow-up, train blue light professionals in suicide prevention, tackle high suicide rates in men and drug/alcohol misusers

2: Using tailored approaches to improve the mental health of the population

…including actions to develop 'CARE Cards' guiding universal workers in steps to spotting suicidal individuals, increasing availability of Safetalk/ASIST suicide prevention training across the district

3: Reducing access to the means of suicide

…including actions to Ensure best practice in in-patient settings with regard to safe clinical areas, work with Network Rail and WY Police to identify 'hotspots'

4: Providing better information and support to those bereaved or affected by suicide

…including actions to improve access to suicide-specific bereavement support, make copies of 'Help is at Hand' (PHE support guide) more widely available

5: Supporting the media in delivering sensitive approaches to suicide

…including actions to Provide briefing for local journalists on sensitive approaches using Leeds NUJ/Council written guidance, campaigning and awareness raising around WHO World Suicide prevention day (Sep 10th 2017), promoting evidence-based mobile apps: '5 ways to wellbeing' and 'Stay alive'

6: Supporting research, data collection and monitoring
…including conducting an audit of the coroner's files for suicide death inquests, and learning from serious incidents/after suicide for people in contact with secondary care

The full plan is attached as an appendix to this report.

4. FINANCIAL & RESOURCE APPRAISAL

There are no financial issues arising from this report; the action plan is based on partnership working and has no funding attached.

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

There are no significant risks arising out of the implementation of the proposed recommendations; there is a requirement from national government to have a Suicide prevention plan for each local authority area by the end of 2017 (HM Government Suicide Prevention Strategy for England), and the main risk is to be in breach of this requirement.

6. LEGAL APPRAISAL

There are no legal issues arising from this report.

7. OTHER IMPLICATIONS

7.1 EQUALITY & DIVERSITY

There are no new or reviewed services, or removal of policies, practices, strategies, or functions, as a result of this report. Suicide rates are higher nationally in more deprived communities and certain ethnic groups (e.g. black African males).

7.2 SUSTAINABILITY IMPLICATIONS

There are no Sustainability issues arising from this report.

7.3 GREENHOUSE GAS EMISSIONS IMPACTS

There are no greenhouse gas emissions impacts arising from this report.

7.4 COMMUNITY SAFETY IMPLICATIONS

There are no community safety implications arising from this report.

7.5 HUMAN RIGHTS ACT

There are no Human Rights Act implications arising from this report.

7.6 TRADE UNION

There are no trades union implications arising from this report

7.7 WARD IMPLICATIONS

Suicide rates differ by ward (see appendix)

7.8 AREA COMMITTEE ACTION PLAN IMPLICATIONS (for reports to Area Committees only)

Suicide rates differ by area committee (see appendix)

8. NOT FOR PUBLICATION DOCUMENTS

None

9. RECOMMENDATIONS

Recommended -

That Committee Members note and comment on the audit of deaths by suicide and the District Suicide Prevention Plan 2017-2021

11. APPENDICES

- Interim key findings: audit of deaths by suicide in Bradford District 2013-2015
- Bradford District Suicide Prevention Plan 2017-2021

12. BACKGROUND DOCUMENTS

- HM Government :'Suicide Prevention Strategy for England (2012; updated 2017)
- NHS England: 'Five Year Forward View for Mental Health' (2016)
- Public Health England: 'Local Suicide Prevention Planning: a Practice Resource' (2016)
- Health Select Committee: TBC (2017)

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Bradford Suicide Audit

Interim report
April 2017

Deaths by suicide in Bradford District 2013-2015

Peter Roderick
Specialty Registrar in Public Health
City of Bradford Metropolitan District Council

Contents

Introduction and background

Suicide is a tragic event which, though rare, affects a large number of people each time it occurs, sending ripples through family and community life. As part of the **Bradford District Mental Wellbeing Strategy 2016-2021**, there is a commitment to support the development and implementation of a District-wide suicide prevention plan, sitting under the 'Our Wellbeing' aspiration of the strategy. This plan is in its final stages of development, and is based on the premise that **many suicides are preventable**, and if early support or crisis intervention is offered a different outcome can be perhaps seen in people's lives. Responsibility for coordinating actions to prevent suicide in local areas rests with the Director of Public Health, and is a partnership effort involving the NHS, Local Authority, Police and wider partners.

The collection of **data on deaths by suicide in a local area is fundamental** to prevention efforts. Public Health England recommends the carrying out of an audit of suicides in each local area, collecting data about suicides that have occurred from sources such as coroners and health records in order to build an understanding of local factors, such as high risk demographic groups (PHE 2016) and common location of suicides. This enables partners to target suicide prevention measures towards those at highest risk in their populations.

Whilst summary information is available on suicide rates nationally from the Office for National Statistics, **coroner files provide a more detailed source of information which can be used to analyse local trends and patterns**. This document presents the findings from an audit of the Bradford coroner's files conducted in February 2017. Files were viewed which contained information of those who Her Majesty's Coroner concluded took their own lives between 2013 and 2015 in the Bradford District.

This report, written as a summary immediately following the audit, presents **interim findings.** Key statistics are presented with little comment and no thematic analysis of narrative notes taken from the audit; it is anticipated a fuller version will follow with further commentary. Where necessary, small numbers of cases have been suppressed within the narrative to avoid disclosure of personally identifiable information.

Acknowledgments

Real human lives lie behind the numbers and statistics presented in this report, and the primary acknowledgement is to offer condolences and sympathy to the families and friends of those who have lost their lives in this most tragic of ways. This piece of work has been conducted in the hope that it will play some part in preventing future deaths by suicide in the Bradford District. Additionally, thanks is given to HM Coroner, Mr Martin Fleming, for permission and support to conduct the audit, to Linda Cahill, Senior Administration Officer in the Coroner's office, for facilitating the work and providing space for it to proceed, and to Becky Harrop, Public Health Information Analyst, for assistance in conducting the audit.

Executive Summary

The files which were audited showed that between 2013 and 2015 there were **76 deaths** in the District for which conclusions of suicide were recorded. Of the cases:

- 78% of those who took their own life were male, and 22% were female. The mean age at death was 45 for males and 50 for females (47 overall), with the highest number of deaths (30) in the 40-49 age bracket
- Fewer people who killed themselves were from a South Asian background than might be expected given the ethnicity structure of the population of the District, and more people who killed themselves were from a Central Eastern European background; this conclusion should however be interpreted with caution due to the low numbers involved
- 61% of all deaths were by hanging or strangulation and 17% were by self poisoning; other methods included falling from a height, jumping under a train, and cutting/ stabbing
- 78% of deaths occurred in the deceased's own home, with 22% in a more public place or workplace. A suicide note was left in 45% of cases
- 39% of people who died lived alone, and 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 took their own lives 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 killed themselves (71%) had seen their GP in the 6 months before death
- At post mortem, drugs and/or high levels of alcohol were found in the system of the deceased in 50% of cases, suggesting that half of all cases were under the influence of drugs/alcohol at the moment they took their own life
- Adverse life events experienced by those who took their own life 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

Audit process and case definitions

The audit was conducted in February 2017 on site at the coroner's office. Paper records of all inquest files are kept by the coroner, and using an electronic database of conclusions, the coroner's assistant obtained the record numbers of all files with a conclusion of 'suicide'. Files were then manually extracted from storage and made available to the authors; only completed and closed inquests were viewed, meaning that it is possible a small number of cases still open more than a year after commencement were excluded. Files reviewed related exclusively to coroner's inquest conclusions of suicide and so did not include deaths by 'accident or poisoning of undetermined intent' which are included in the wider definition of suicide by the Office of National Statistics.

A proforma was designed based on other recent regional suicide audits (North Yorkshire, Leeds). The process for auditing individual files was as follows:

- File records were obtained
- The audit team read through the files and extracted the relevant information in order to complete the proforma
- Unclear data elements were discussed between team members and agreement reached on how to record details in a standard way
- Data was collected in electronic format and stored on encrypted files using the council's servers.

Suicide cases and rates

In total 76 cases were reviewed between 2013 and 2015, 17 female and 59 male. Table 1 presents the number of cases in each year of the audit, together with the number of cases recorded in this period by the ONS (148). As can be seen, the audit included around half the number of deaths estimated and published by the ONS as official suicide figures, which is a comparable fraction to other local audits. This is because data from the ONS counts deaths coded as 'undetermined intent' as well as suicide verdicts, in an attempt to correct underestimation of the true number of suicides.[1] In England and Wales, it has therefore been customary to assume that most injuries and poisonings of undetermined intent are cases where the harm was self-inflicted but there was insufficient evidence to prove that the deceased deliberately intended to kill themselves; this convention has been adopted across the UK (ONS 2012). Files reviewed in this audit related exclusively to coroner's inquest conclusions of suicide.

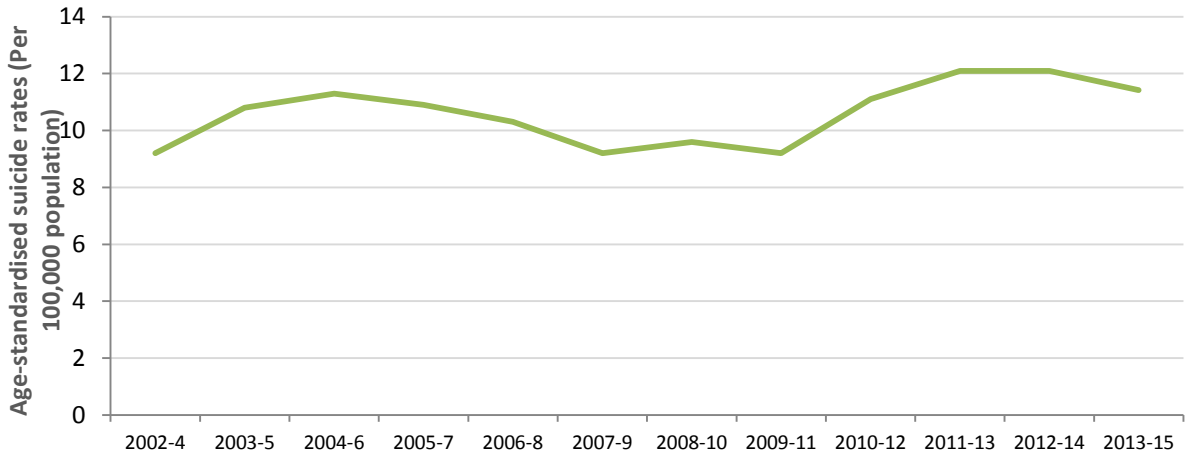
Table 1: cases of suicide included in the audit and ONS figures

	2013	2014	2015	Total
Cases included in the audit	24	29	23	**76**
ONS estimation of suicide cases	58	46	44	**148**

[1] Published figures about death by suicide are calculated from two groups of ICD 10 codes: Intentional self-harm (X60-X84) – Conclusion of suicide, and Event of undetermined intent (Y10-Y34) – Open conclusion

Figure 2 presents the rates of suicide as published by the ONS for Bradford over the last 13 years, taken in three year rolling rates in order to adjust for the effects of the relatively small number of suicides. A decline in the rate starting in 2005 reversed in 2010, and has risen since then, with a slight fall in the most recent 3 year rate to 11.4 per 100,000 population (2013-2015). This means that the District sees around 40-50 suicides every year, or on average one each week.

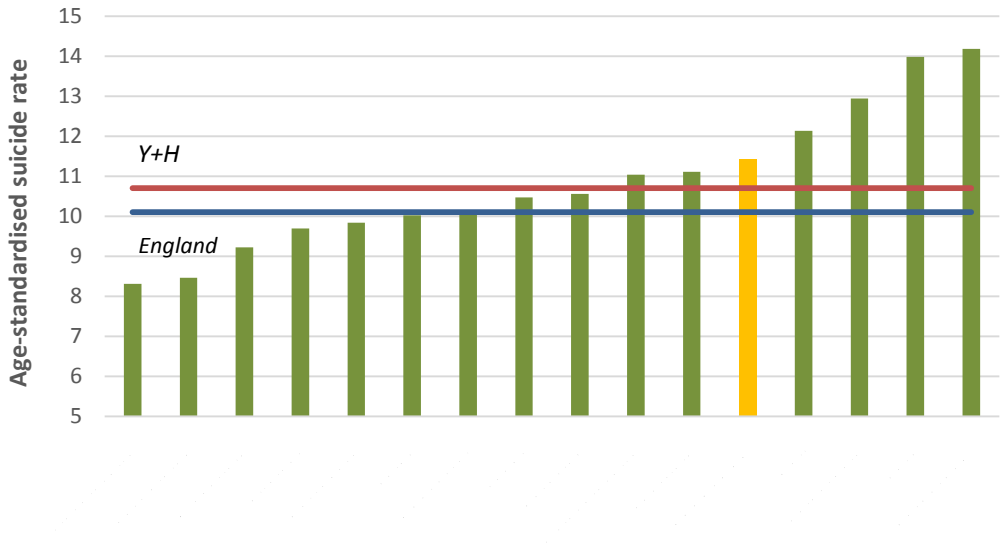
Fig. 2: Age Standardised suicide rates in Bradford, 3 year aggregates, 2002-2015



Source: ONS

Bradford has the 5th highest age-standardised suicide rate in Yorkshire and Humber (figure 3); this rate is not statistically significantly above the national average.

Fig. 3: Age Standardised suicide rates in Yorkshire and Humber, 2013-15



Source: ONS

Demographics of audit cases

Within the audit, more than three quarters of those who took their own lives were male (78%). This is similar to the national gender breakdown of suicides in 2014 where 76.1% of suicides were male. (ONS 2014)

Fig. 4: Proportion of suicides by Gender (2013-15)

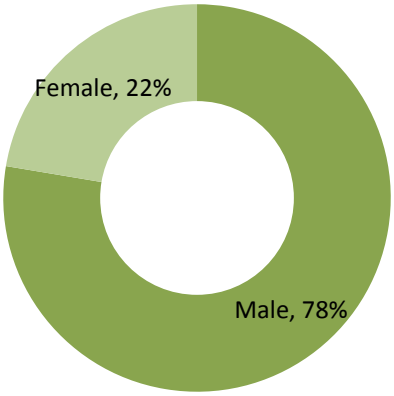
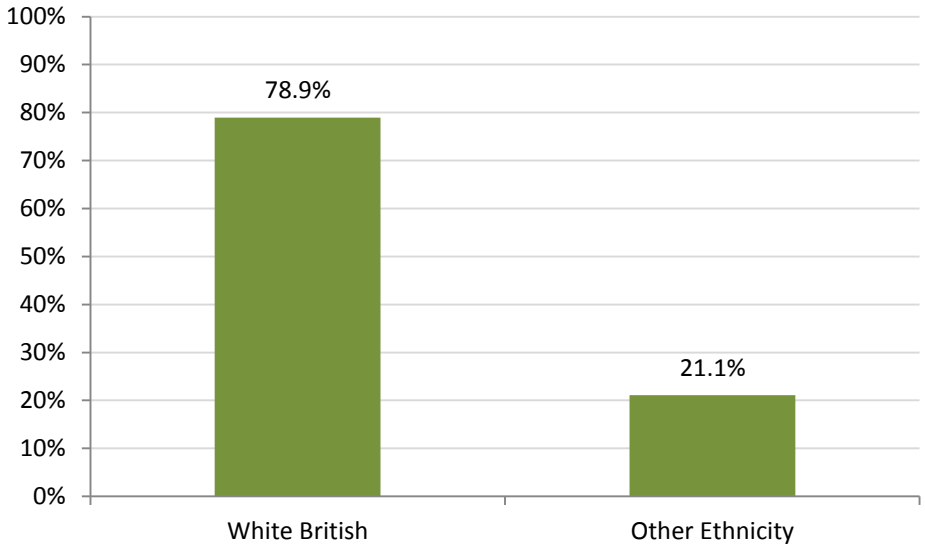


Figure 5 presents an ethnic breakdown of the cases audited. Ethnicity was not universally recorded, but was usually provided within the post mortem report on each death. Data on non-white British deaths has not been separated into categories as the small numbers involved would risk identification of cases.

Fig. 5: Proportion of Suicides by Ethnic group (2013-15)

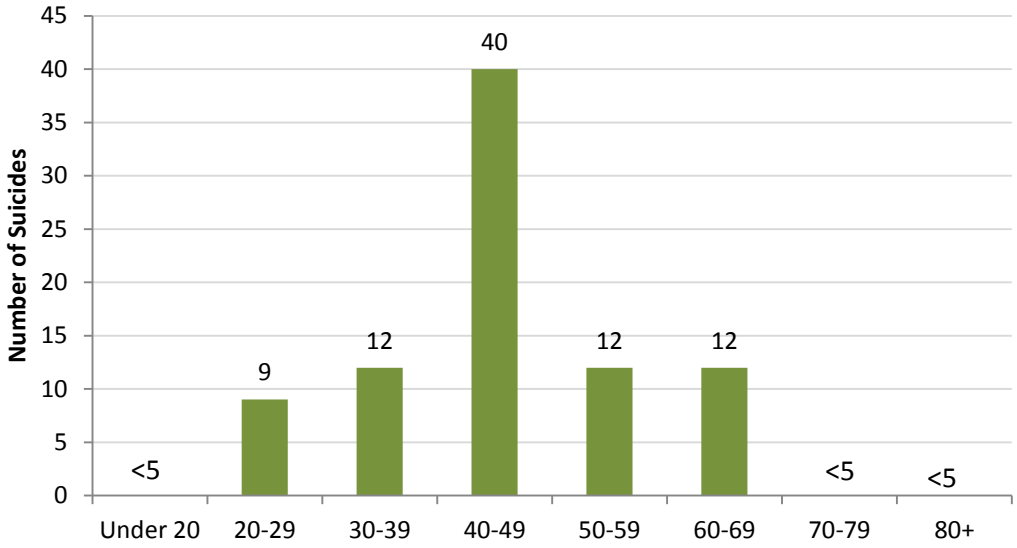


Aside from white British residents, the largest ethnic group in Bradford is Asian/British Asian (Pakistani). The percentage of cases in this category was 8%, lower than 2011 census estimates of the size of this community in Bradford (20.4%, ONS 2011). 9% of cases were from 'any other white background' and the majority were people with a Central Eastern European (CEE) background. Census 2011 data records 3% of the Bradford population as 'white other'. Although caution should be exercised in interpreting these figures, the higher

than proportionate number of suicides in the CEE community and lower number than proportionate in those of Asian/British Pakistani ethnicity is of interest.

Figure 6 shows the number of suicides separated into 10 year age bands. Male cases rose for each band and peak between the ages of 40 and 49, before reducing. The same age band (40-49) sees the peak number of female suicides; overall, with 40 suicides occurring in this age range, these years seem to be the most risky for people in Bradford to take their own life, at least across this audit period.

Fig. 6: Number of Suicides by age and Gender



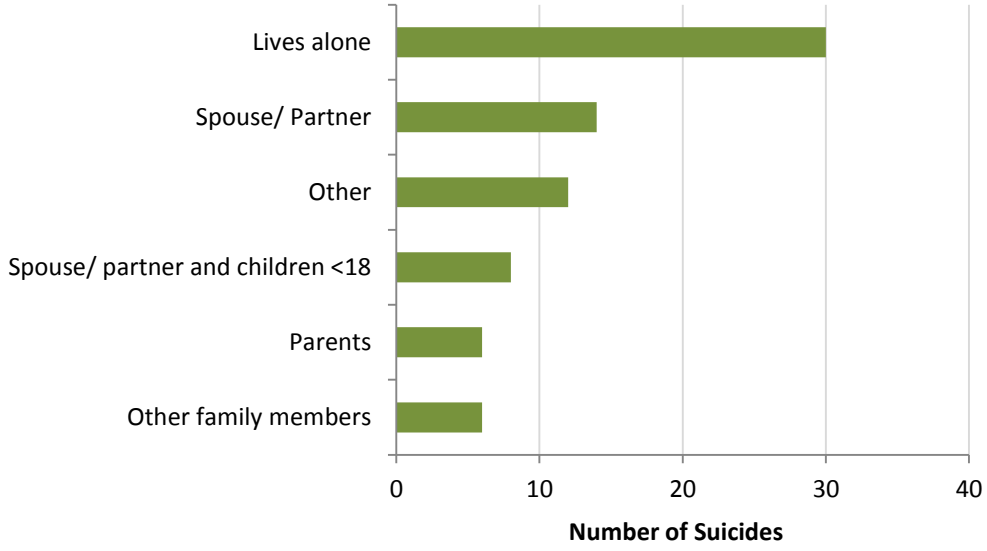
For 24% of the cases no sexual orientation could be evidenced from the records. If someone in the audit was recorded as in a long term relationship with somebody of the opposite sex (e.g. marriage), it was assumed their sexual orientation was heterosexual. Fewer than five cases were recorded as being homosexual. The assumptions which have had to be made in this area may mean these figures may be misleading, as details of sexuality may have not been relevant for the purposes of the coroner's investigations.

Within the audit, fewer than 5 people had a learning disability, and 5 people had a physical disability.

More than 80% of people who died by suicide lived in a home they either owned or privately rented (files did not distinguish between the two). Fewer than 5 cases lived in council accommodation, and fewer than 5 cases were homeless or of no fixed abode (none were rough sleeping).

38% of suicide cases lived alone at the time of death (figure 7), which is substantially higher than the national rate seen in the 2011 census where 13% of the usually resident population of England and Wales were living alone. This fits with established research linking loneliness and social isolation with higher degree of suicidal thoughts (although it is important to point out that living alone does not necessarily imply loneliness).

Fig. 7: Other house occupants at time of death



41% of people in the audit were single at the time of death, with 12% of people divorced, 8% separated, and 4% widowed (figure 8). 24% were married, 9% were in a long term relationship and 3% were cohabiting. This is in contrast to the national figures which show that the majority of people in England and Wales in 2014 (51.5%) were married or civil partnered. The proportion of those who took their own life who had no children was 45%; an additional 7% had no/limited contact with their children, and 47% either lived with or had regular contact with children (figure 9). Taken together, these findings reinforce the comments above linking suicide risk to lack of social connection, as it means a large number of people who died by suicide in the audit had no close familial connections surrounding them in their daily life.

Fig. 8: Children of the deceased

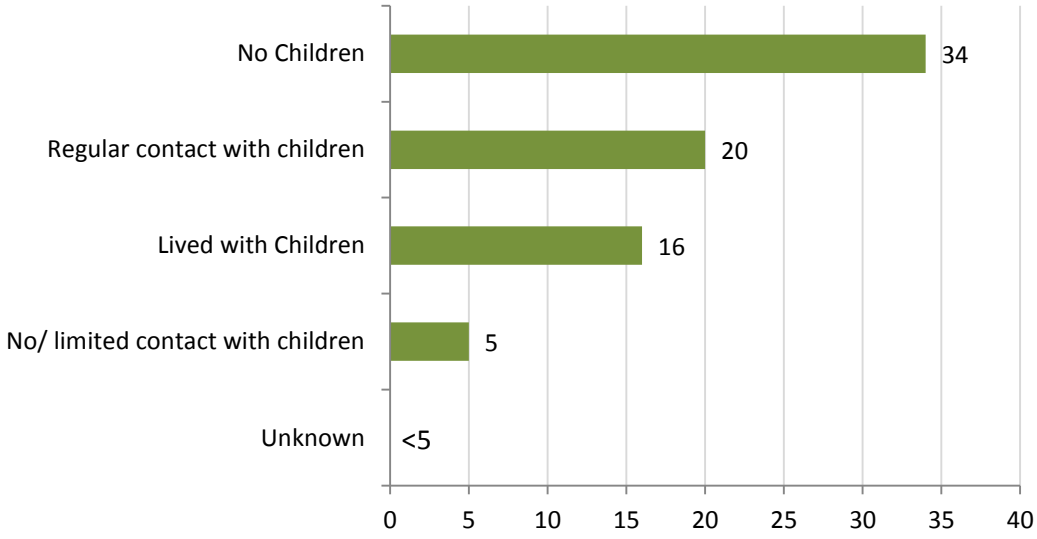
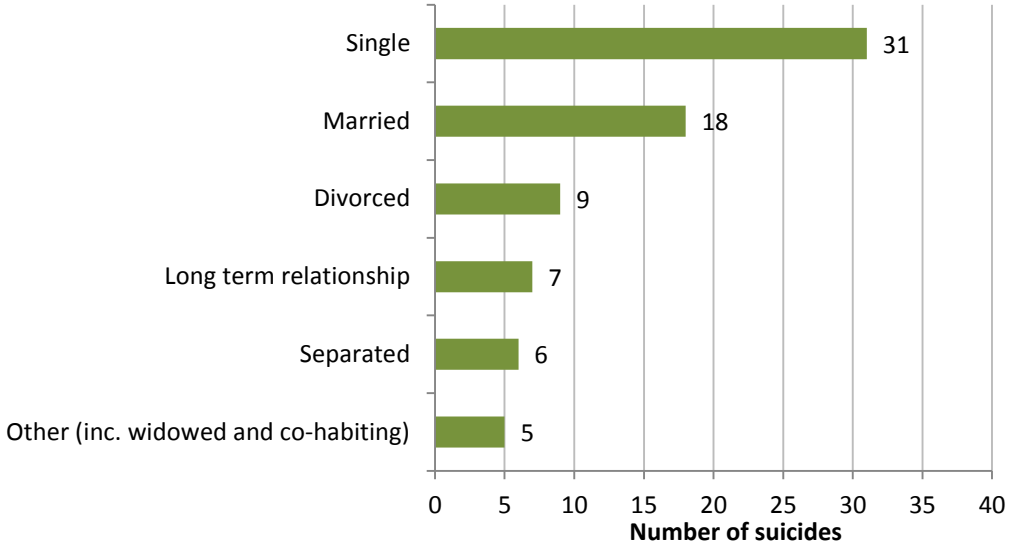
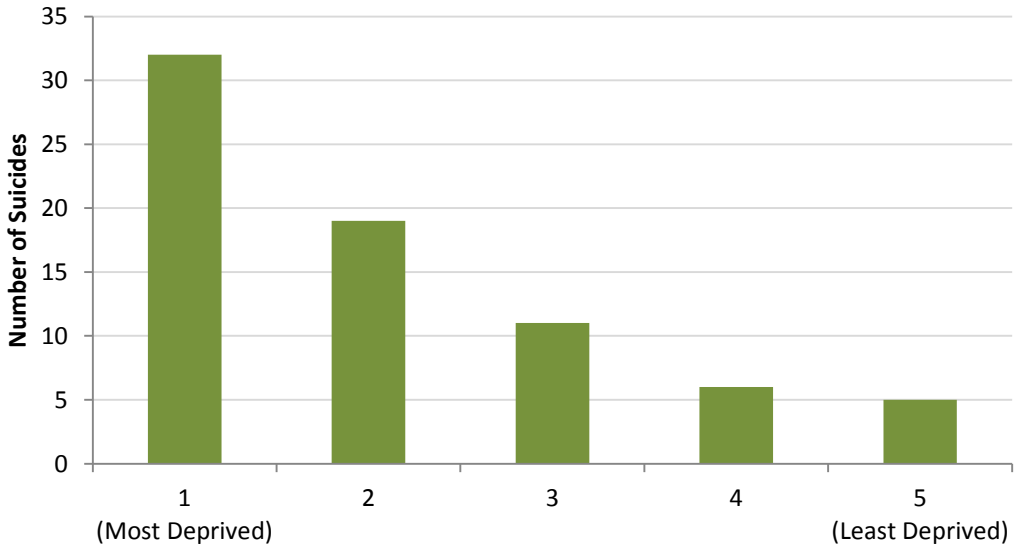


Fig. 9: Relationship status at time of death



In terms of the income and deprivation profile of those who took their own life in this audit, figure 10 shows the number of suicide cases with the postcode of each home address matched to Index of Multiple Deprivation (an index which measures multiple aspects of deprivation including income, housing and education) categories stratified into quintiles. As can be seen, there is a sharp social gradient in the suicide cases reviewed here, with the largest number of people in the most deprived quintile of IMD, and a reducing number of people in each quintile towards the least deprived.

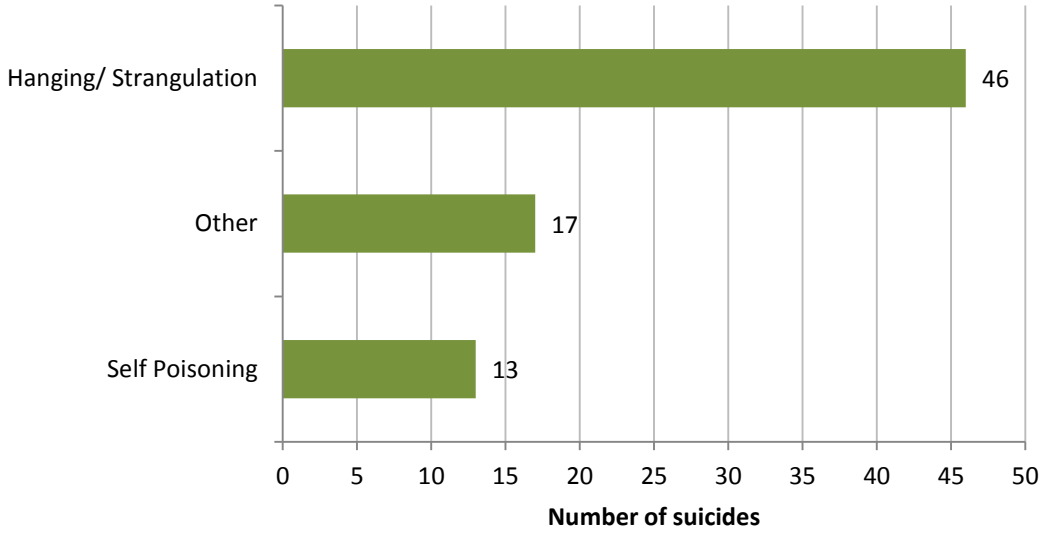
Fig. 10: Number of suicide cases in each IMD quintile



Circumstances of death

The most common method of suicide – 46 of the cases reviewed – was hanging or strangulation – these represented 61% of cases, slightly more than the national average, where in 2014 hanging or strangulation accounted for 55% of male suicides and 42% of female suicides. Less common methods included cutting and stabbing, suffocation cases involving helium (a rising trend nationally), carbon monoxide poisoning, jumping from a height, jumping under a train, and self-immolation.

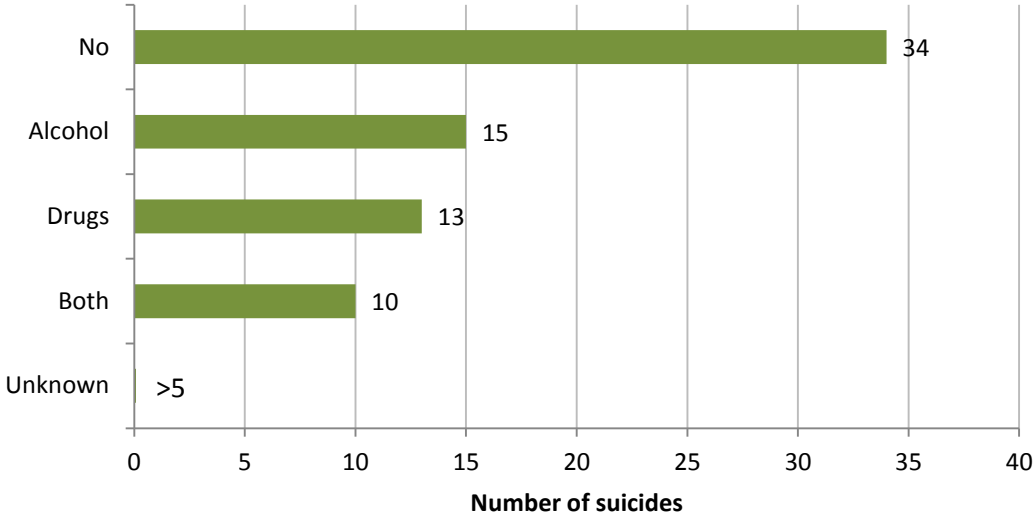
Fig. 11: Method of suicide



There were 13 cases of self-poisoning. Six of these incidents involved drugs sourced from prescription medication prescribed by the GP or by specialist mental health services, including medication for mental health issues (SSRIs such as citalopram and fluoxetine), or medicine for physical health conditions (e.g. gabapentin). None of the incidents was a paracetamol or other over-the-counter overdose. Other cases involved sourcing the self-poisoning substance as an illicit drug, or through medication ordered online and medication taken from a healthcare setting.

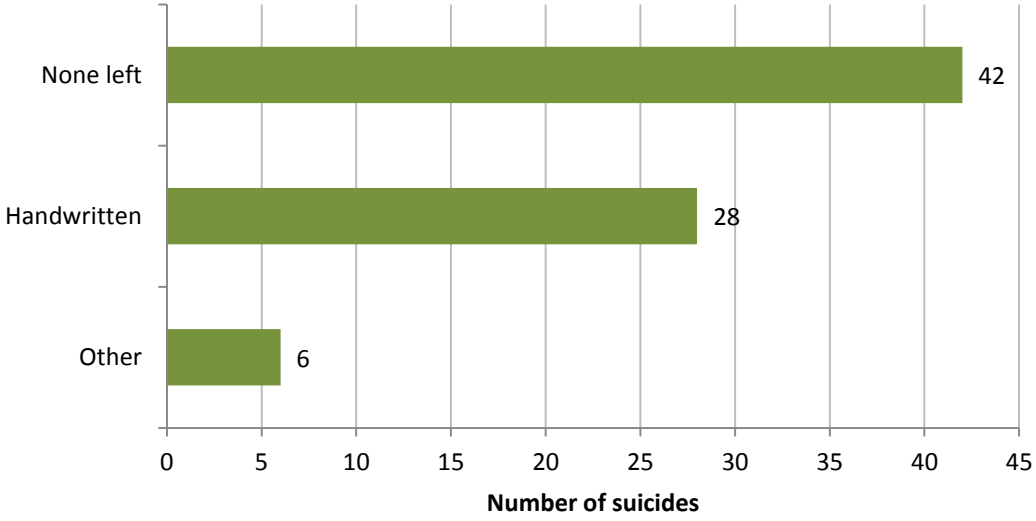
Post mortem reports give a toxicological summary of substances found in the system of all the deceased after death; this information should be treated with caution, as substances metabolise and/or pass out of the body at different rates before and after death, with time between death and discovery of the body playing a part in this. However a fairly accurate picture of illicit drug use and high levels of alcohol can be painted, and figure x shows that half of all people whose cases were reviewed died under the influence of drugs or alcohol at time of death – 13% with both drugs and alcohol, 20% with solely alcohol, and 17% with solely drugs. The disinhibitive effects of alcohol and drugs in relation to suicide completion is supported by national research, which also shows people under the influence are likely to choose more lethal methods of attempting to take their own life.

Fig. 12: Use of alcohol or drugs at the time of death



Fewer than half of all suicides left what could be considered a suicide 'note'; of those that did, 28 (82%) left a handwritten note. The leaving of a note could indicate a more planned suicide with a longer-term determination to end life; this suggests that some suicides in Bradford were less planned and were impulsive.

Fig. 13: Suicide note by type

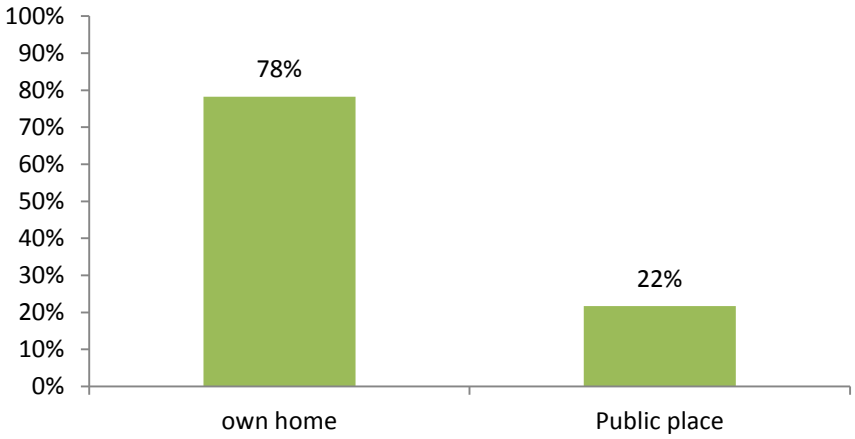


In addition to this data, evidence of a website or social media being used to discuss or research suicide in the weeks prior to death was seen in some cases.

Geographical location

In line with national trends, most suicides in this audit occurred in the person's own home (figure 14). Of those which did not, there were rail track suicides, suicides in public places due to jumping from a height, and a number of hangings in parkland, open land or in the deceased's own workplace. Of the 22% of suicides which occurred in a public place, all of the deceased were Bradford residents. The distance travelled from own home to place of death ranged from 500 metres to 12.75km, representing a range of travel circumstances to death including walking and driving.

Fig. 14: Location of Suicide



The following table shows the 5 area committees in Bradford (on the same geographies as parliamentary constituencies) with the number of suicides in each area. Each area committee contains a roughly similar size population, and as can be seen there are a very similar number of suicides in each area, although a slightly lower number in Shipley Area.

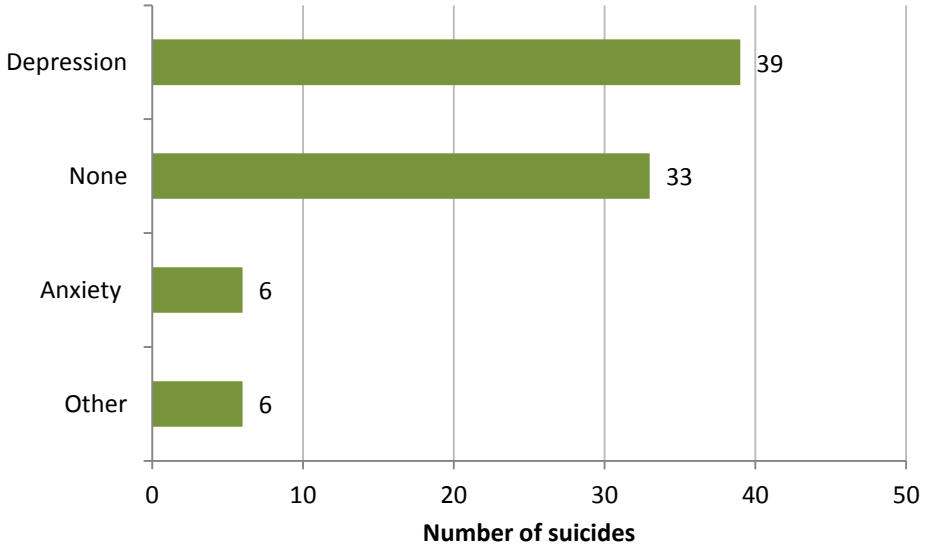
Table 2: Suicides in Bradford by area committee

Area Committee	Number of suicides
Bradford East	15
Bradford South	15
Bradford West	16
Keighley	16
Shipley	11
Unknown	3

Mental illness

More than half (57%) of those who took their own lives reviewed in the audit had at least one diagnosed mental illness, and more than half (51%) had depression – in some cases alongside other mental illnesses (figure 15)[2].

Fig. 15: Diagnosed mental illness in cases of suicide



In addition to this, 20 of those who didn't have a diagnosed mental illness had anecdotal reference to a suspected or historical mental health problem which was not currently being treated. This means having a mental illness was a significant risk factor for suicide risk in this group of cases.

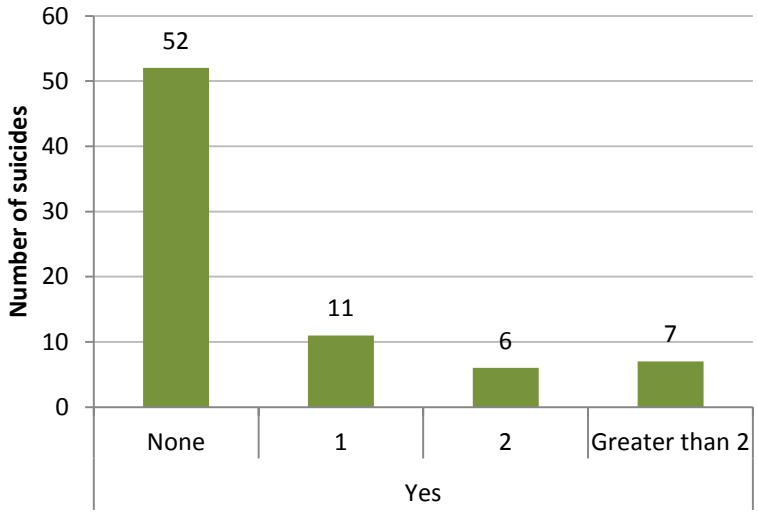
Of the mental illness medications – for instance antidepressants, mood stabilisers and anti-psychotics – which had been prescribed for some of those who took their own life, the most common were citalopram (29%) and fluoxetine (18%). Eleven other types of chemicals were mentioned in the prescription history of the cases audited, often in combination with one another. Since Citalopram and Fluoxetine are two of the most common SSRIs (anti-depressants), their prominence is not necessarily unexpected.

There was evidence of non-adherence to medication (e.g. failure to take drugs in the days leading up to the death) in 24% of people who were on medication for their mental health. It is likely that non-adherence to medication at points close to suicide may make somebody with a diagnosed mental health condition less mentally stable and inhibit decision making processes.

[2] 'Other' includes Borderline Personality Disorder, Paranoia/Psychosis, PTSD, Bi Polar disorder, Schizophrenia, and Mental health and Behavioural Issues due to alcohol/substance misuse. Many of these conditions overlapped in the analysis and are presented in the above each time they were mentioned in the cases' inquest record.

Figure 16 shows data on previous suicide attempts of cases reviewed. 52 cases of those who took their own lives had never attempted suicide previously; 11 had done so once, 6 twice, and 7 more than twice. 'Attempting' suicide was sometimes hard to delineate from serious self-harm in the records, so numbers should be interpreted with caution. 9 of the cases reviewed (12%) had a history of self-harm. Larger proportions of the individuals who took their own lives disclosed thoughts of suicide beforehand: 58% disclosed these thoughts to somebody at some point in the past, 49% had disclosed them in the days prior to death, and 63% had ever disclosed them. This may represent a window of opportunity for preventative measures to be taken.

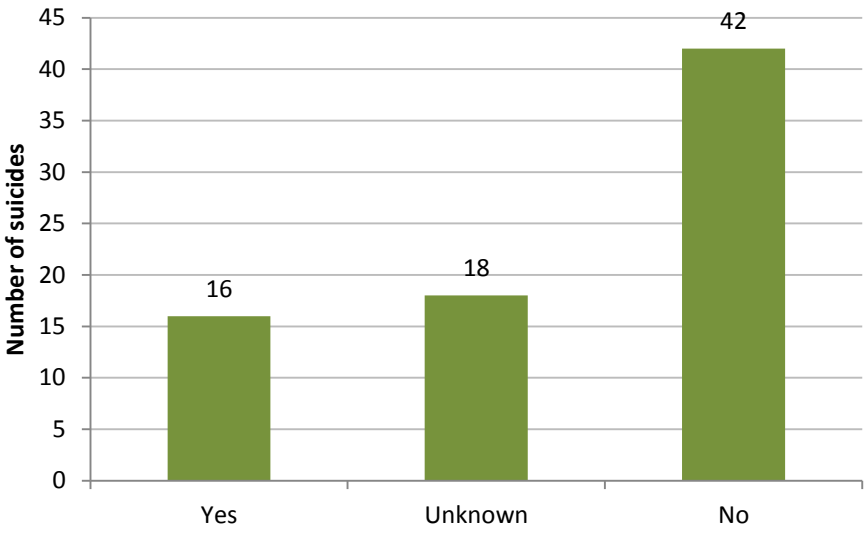
Fig. 16: Previous suicides attempts, by number of attempts



Health service contacts

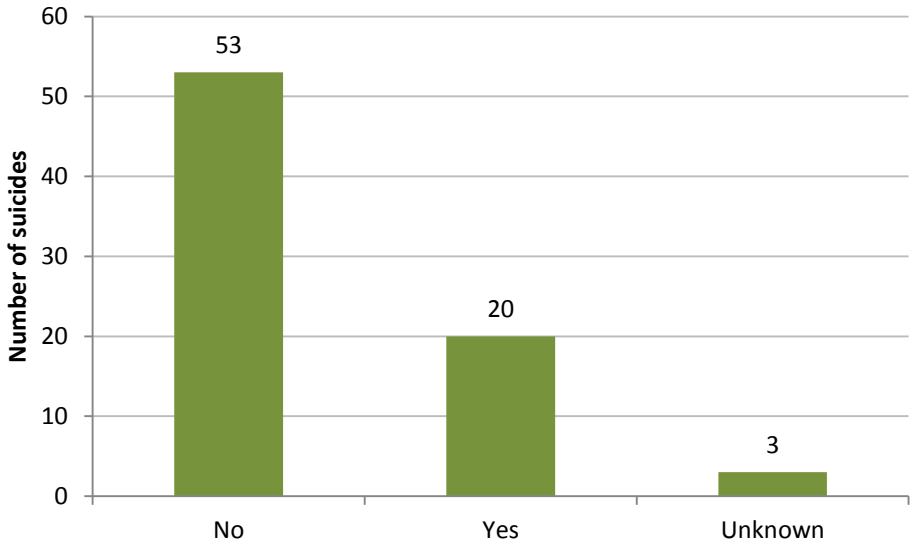
A number of people who took their own lives in the audit had a history of alcohol and/or substance misuse, with a variety of past and current treatment histories. Figure 17 shows that 21% of cases (16) were currently misusing drugs or had done in the past.

Fig. 17: Number of suicides with a history of drug misuse



Common drugs of abuse included heroin, cannabis and cocaine. In 5 cases, death was brought about through self-poisoning using illicit drugs; the coroner concluded these were deaths with suicidal intent, perhaps because of the presence of a suicide note. Figure 18 shows the number of suicides (22%) with a history of alcohol misuse.

Fig. 18: Number of suicides with a history of alcohol misuse



28% of people who took their own life had been seen by specialist secondary mental health services in the 12 months prior to death – this includes CMHT, psychiatric and crisis services, but excludes services based in primary care e.g. IAPT. Nobody was an inpatient at the time of death but a small number (fewer than 5 cases) had been discharged a short time before. 88% of the cases who had been seen by specialist secondary mental health services in the 12 months prior to death had been seen in the month before death; a small number of cases (fewer than 5) had been seen more than a year before death, or date of last contact was not recorded.

In terms of primary care contact, 41% of individuals who took their own lives had contact in the month before death, 30% between 1 and 5 months prior to death, and 8% between 6 months and a year before death. These contacts were mainly with GPs, but include contacts with other professionals e.g. primary care mental health workers or practice nurses. Table 3 shows a breakdown of these cases into the time period prior to death they were last seen in primary care.

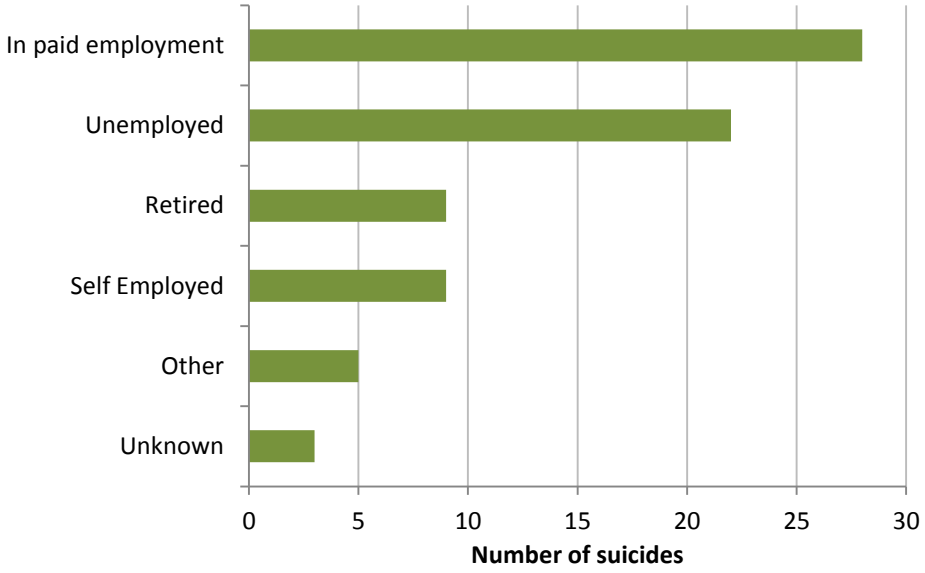
Table 3: Primary care contacts

Last Primary care contact	Number of cases
Less than 1 month	31
Between 1 and 5 months	23
6 months to 1 year	6
more than a year	14
unknown	2

Social circumstances

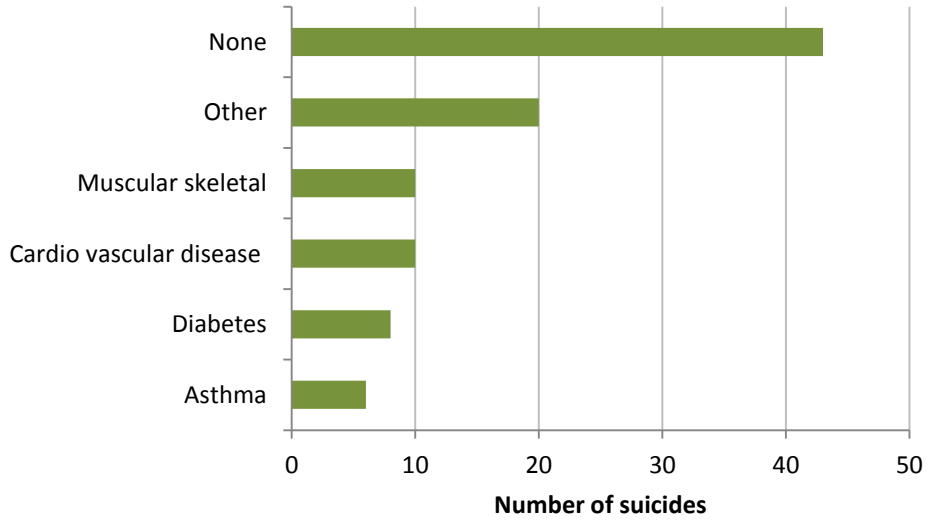
The employment status of those who took their own life in the audit is shown at Figure 19. 29% of cases were unemployed, which is higher than the unemployment rate of 6.1% in the general population at the midpoint of this audit period (May-July 2014).

Fig. 19: Employment status of suicide cases



A large number of people who took their own life in the audit (33) had a long term physical health condition (figure 20). Common problems are shown below as proportions of all suicides reviewed; given the distribution of these health conditions in the population, it is not clear if the proportion of these health conditions is higher than would be expected.

Fig. 20: Proportion of suicide cases with a physical health condition[3]

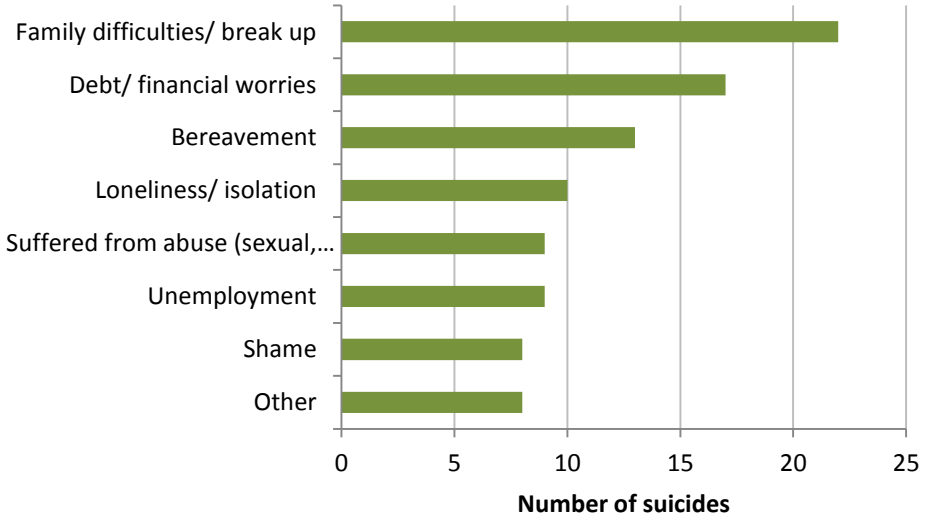


[3] 'Other' includes CKD, Sarcoidosis, Sinus problems, neurological problems, genito-urinary problems, other respiratory conditions, pancreatitis, and skin conditions.

9 of the suicide cases had been in contact with the criminal justice system, a number of these more than 12 months prior to death. No cases reviewed were of people on probation. This data is hampered by the fact that much contact with the police or criminal justice system would not have been material to the circumstances of death, so may not have come to light in the inquest process. A number of other agencies were involved in the lives of those who killed themselves prior to death; these agencies included accommodation services, employment services, occupational health departments, social services, voluntary sector services, alcohol services, faith communities, the probation service/ youth justice, and substance misuse services.

59 (78%) individuals were known to have at least one adverse life event in their recent past which could have contributed to their suicide. Figure 21 shows the proportion of people who had suffered these events. It is important to recognise that many of these events did not come in isolation; those who took their own life often had multiple life stresses, mental health conditions and/or physical health conditions.

Fig. 21: Adverse life events experienced by those who took their own life prior to death[4]



Conclusion

In conclusion, this report has laid out some of the key statistics relating to suicide in the Bradford District between 2013 and 2015. It shows a clear link between suicide and deprivation, age, gender, employment status, mental health conditions and adverse life events. Data has been presented with little comment and no thematic analysis of narrative notes taken from the audit; it is anticipated a fuller version will follow with further commentary.

[4] Other includes being affected by the suicide of a close contact, having benefits stopped, and problems at work.

References

Leeds CC (2016): Audit of Suicides and Undetermined Deaths in Leeds 2011-2013

North Yorkshire CC (2016): Suicides in North Yorkshire An audit of deaths due to suicide in North Yorkshire between 2010 and 2014

ONS (2011): Census data: ethnicity by local authority area

ONS (2012): Suicide statistics reporting: methodology

ONS (2014): Suicide statistics by gender

PHE (2016); Suicide Prevention: A Practice Resource

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Bradford District Suicide Prevention Plan 2017-2021

Background

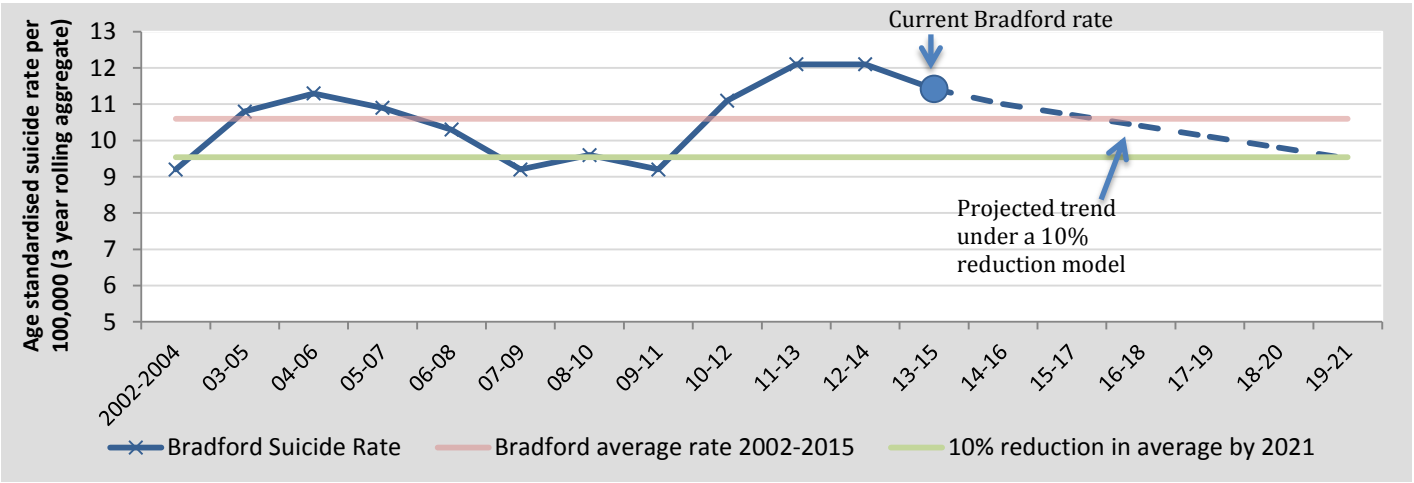
Suicide is a tragic event which, though rare, affects a large number of people each time it occurs. We know that the suicide rate is rising nationally, and Bradford has slightly higher rate of suicide than the England average. However many suicides are preventable, and if early intervention or crisis support is offered we know we can make a difference in outcome in people's lives.

In Bradford, our 3 year rolling average rate of deaths by suicide is 11.4 per 100,000 people (2013-2015). This means that the District sees around 40-50 suicides every year, which is nearly one each week. In 2013, 3 out of 4 deaths from suicide in Bradford were by males, with the highest number of male suicides occurring between 20 and 44 years of age.

Partners in the district, including local GPs, representatives from Bradford District Care NHS Trust, Bradford CCGs, City of Bradford MDC, MIND, Samaritans, West Yorkshire Police and West Yorkshire Fire and Rescue, meet regularly as part of the District's Suicide Prevention Group. During 2016, the group has been reviewing the national and international evidence for effective suicide prevention, data and intelligence on suicides in Bradford, and has now produced this plan of action. The plan forms part of the Bradford District Mental Wellbeing Strategy 2016-2021 ('Our Wellbeing' workstream)

Preventing suicide in Bradford: our aspiration

The Government's *Suicide Prevention Strategy for England*, updated in January 2017, sets out the ambition for a reduction in national rates of suicide of 10% by 2021, and identifies 6 key areas of action to achieve this goal. As the chart below shows, we are currently above our 10 year average rate (as well as above the national average of 10.1 per 100,000), so to see a reduction of 10% of our 10 year average rate by 2021, we need to see our rate reduce to 9.5 cases of suicide per 100,000 people.



Using this as a baseline position, and with the six key areas for action within the national strategy as a framework, this is our commitment to preventing suicide in the district over the next 5 years:

Our vision is to reduce the rate of suicide in Bradford by 10% by 2021

We ultimately aspire to prevent all suicides in the District; for us, no suicide is inevitable. As a short-term goal, our ambition for a 10% reduction the next 4 years would mean ***5 lives will be saved each year*** *after 2021.*

We will do this by:

1: Reducing the risk of suicide in key high-risk groups
2: Using tailored approaches to improve the mental health of the population
3: Reducing access to the means of suicide
4: Providing better information and support to those bereaved or affected by suicide
5: Supporting the media in delivering sensitive approaches to suicide
6: Supporting research, data collection and monitoring

BRADFORD SUICIDE PREVENTION PLAN 2017-2021

Key priority	Key Action	Lead	Timescale
1. Reduce the risk of suicide in key high-risk groups			
1.1 Preventing suicide in mental health and crisis care *Outcome: Mental health services comply with best practice on suicide prevention*	a) Through the work of the Crisis Care Concordat board, ensure all who present at any stage on the crisis pathway with suicidal ideation or who have self-harmed are given appropriate support and care, free from stigma.	Crisis Care Concordat Board	Ongoing
	b) Support the work of the West Yorkshire Urgent and Emergency Care Vanguard	Deputy Director (BDCFT)	Ongoing
	c) Establish a Suicide Reduction Steering Group in BDCFT	Deputy Director (BDCFT)	April 2017
	d) Ensure BDCFT work in partnership with other mental health organisations (SWYFT and LYFPT) to share learning and reduce suicide across the 3 mental health organisations	Deputy Director (BDCFT)	Ongoing
	e) Work to reduce suicide of mental health patients in Bradford through use of NCISH findings and Serious Incident investigations, including timely discharge planning, policies on absconding and self-discharge, and enhanced discharge follow-up.	Serious Incident Lead (BDCFT)	Ongoing
	f) Monitor rate of suicide in patients under the care all mental health services within BDCFT and take measures to prevent suicide in all settings	Deputy Director (BDCFT)	April 2017
1.2 Responding well to self-harm *Outcome: suicide risks following self-harm presentation are minimised*	a) Ensure compliance with NICE guidance CG16 (short term management of self-harm in acute settings)	Urgent Care Managers (BTHFT/AFT)	April 2018
	b) Ensure compliance with NICE guidance CG133 (long term management of self-harm in primary care)	MH GP leads (3x CCGs)	April 2018
	c) Deliver specific staff training modules on self-harm within children and adult social work training programme	Workforce Development (CBMDC)	Ongoing

Key priority	Key Action	Lead	Timescale
1.3 Equipping Urgent Care *Outcome: Urgent care practitioners are equipped to come into contact with suicide*	a) Distribute 'Feeling on the Edge' (CWP) leaflets in BRI/AGH A+E departments	Urgent Care Managers (BTHFT/AFT)	September 2017
	b) Publicise the national 'Information Sharing and Suicide Prevention Consensus' within health settings	All health organisations	September 2017
	c) Identify opportunities for awareness raising and formal training (e.g. Safetalk) around suicide prevention for blue light professionals in WYP, WYFRS, and YAS	WYP/WYFRS	April 2018
1.4 Preventing suicide in Men *Outcome: male suicide rates reduce*	a) Suicide awareness messages to be promoted at traditional male settings through e.g. the Rugby League 'State of Mind' campaign	PH lead (CBMDC)	April 2018
	b) Attract national men's health promotion campaigns (e.g. CALM) into prominent advertisement places in the city centre	PH lead (CBMDC)	April 2018
	c) Support asset-based approaches to men's health and wellbeing (e.g. Men in Sheds, Eccy Meccy)	PH lead (CBMDC)	April 2018
1.5 Minimising risks of drugs and alcohol *Outcome: suicide risks of drugs and alcohol are minimised*	a) Ensure suicide prevention and risk assessment is appropriately managed in commissioned recovery based drug and alcohol services	PH lead (CBMDC)	April 2018
	b) Engage with national consultation on late night licencing legislation	PH lead (CBMDC)	April 2017
	c) Distribute CARE card to Bradford Street Angels teams	PH lead (CBMDC)	September 2017
	d) Bradford A+Es to raise staff awareness of increased suicide risk owing to acute alcohol abuse	Urgent Care Managers (BTHFT/AFT)	September 2017
1.6 Supporting those with financial problems *Outcome: services are equipped to support minimise suicide due to financial stress*	a) Write to welfare advice services, CAB and foodbanks raising awareness of recent research (e.g. Barr 2015)	PH lead (CBMDC)	July 2017
	b) Support welfare advisors using CARE cards.	PH lead (CBMDC)	September 2017
	c) Support housing options advisors using CARE cards.	PH lead (CBMDC)	September 2017

Key priority	Key Action	Lead	Timescale
2: Tailor approaches to improve the mental health of our population			
2.1 Targeted training/ awareness *Outcome: Professionals in contact with vulnerable people can make interventions*	a) Develop, publish and promote the Bradford CARE cards guiding universal workers in steps to spotting suicidal individuals and signposting	PH lead (CBMDC)	April 2017
	b) Source funding to increase availability of Safetalk/ASIST training across the district, and proactively target relevant staff from 3rd sector, social care, paramedics, housing officers, drugs/alcohol workers.	PH lead (CBMDC)	April 2018
	c) 3rd Sector partners to make suicide awareness resources (e.g. Connecting With People, Samaritans) more widely available to staff, in reception areas of GP practices, libraries, advice centres, gyms, community/day centres	Chief Executive (Samaritans)	April 2018
2.2 Take action to prevent suicide in children/ young people *Outcome: Children in Bradford supported to be emotionally healthy*	a) Support the implementation of the Bradford 'Future in Mind' Strategy	MH comm-issioning Lead (CCGs)	Ongoing
	b) Support the review and development of community perinatal mental health services in Bradford	MH comm-issioning Lead (CCGs)	April 2018
	c) Incorporate suicide awareness into the schools engagement workstream of Future in Mind, including delivering suicide awareness training to Mental Health champions.	Educational psychology (CBMDC)	April 2018
	d) Via the schools strategy group, develop a community response plan to be endorsed by schools which will guide postvention after a suicide of a young person	Educational psychology (CBMDC)	September 2018
	e) Promote the recording of self-harm incidence in schools and adapt the Leeds LSCB 'Pink book' of training and tips on self-harm and suicide for use in schools	Educational psychology (CBMDC)	September 2017
	f) Assess training programmes for school staff and select appropriate evidence based programmes to recommend for school use	Educational psychology (CBMDC)	September 2018
2.3 Prevent suicide in Primary Care	a) Run a suicide prevention section in a Clinical Senate as part of event for GPs on MH – MH pathways, crisis services, suicide and self harm prevention	MH GP leads (3x CCGs)	January 2018

Key priority	Key Action	Lead	Timescale
Outcome: GPs and other Primary care workers identify people at risk and provide appropriate early intervention	b) Raise awareness of RCGP elearning module on Suicide Prevention amongst Bradford GPs at LMC	MH GP leads (3x CCGs)	January 2018
	c) Disseminate RCGP 'Suicide mitigation in Primary care' posters to practices	PH lead (CBMDC)	September 2017
	d) Produce a 'top tips' around suicide prevention for GPs.	MH GP leads (3x CCGs)	January 2018
3. Provide better information and support to those bereaved or affected by suicide			
3.1 Provide sensitive bereavement support *Outcome: People bereaved by suicide are supported in a manner that reduces the risk of impact on their long term mental health*	a) Ensure the provision and raise awareness of local bereavement support groups and services	Hospital Chaplaincy team (BTHFT)	Ongoing
	b) Make copies of 'help is at hand' available in funeral director premises, crematorium services and coroner's office, and the z-card given to first responders.	PH lead (CBMDC)	September 2017
	c) Actively support residents setting up a local Survivors of Bereavement by Suicide (SOBS) group d)	PH lead (CBMDC)	Ongoing
	e) Work with regional suicide prevention network to improve access to suicide-specific bereavement support in Yorkshire and Humber.	PH lead (CBMDC)	January 2018
	f) Ensure that all families/carers bereaved by mental health patients under the care of BDCFT are given the Help is at Hand information and signposted to support agencies	Serious Incident Lead (BDCFT)	Ongoing
	g) Ensure staff are trained in BDCFT to offer appropriate support to families bereaved by suicide	Serious Incident Lead (BDCFT)	April 2017
3.2 Provide effective postvention *Outcome: suicidal 'contagion' is avoided*	a) Develop schools work around 'community response plan' into an agreed district-wide cluster response plan	Educational psychology (CBMDC)	September 2018
	b) Encourage mental health and primary care services to add 'Bereaved by suicide' into any suicidal risk factor assessment	PH lead (CBMDC	September 2018

Key priority	Key Action	Lead	Timescale
4: Reduce access to the means of suicide			
4.1 Prevent suicide at known hotspots *Outcome: Access to well-known places of suicide is restricted*	a) Work with network rail to identify areas of increased risk along Bradford rail lines, and to engage Bradford rail station staff with Samaritans;/network rail prevention training	CBMDC and Network Rail	April 2017
	b) Actively monitor other non-rail spots of frequent suicide in the district	CBMDC/WYP	Ongoing
	c) Analyse suicides within the audit by postcodes and work with local partners in areas with higher than average rates	PH lead (CBMDC)	Ongoing
	d) Work with CBMDC planning department to assess suicide risk in any new high-rise developments in the district, using PHE guidance	PH lead (CBMDC)	April 2017
4.2 Prevent suicide risk in healthcare settings *Outcome: Access to well-known risks is restricted*	a) Work with primary care medicines management to ensure appropriate messages are given out around analgesic and anti-depressant prescribing for patients at suicide risk	MH GP leads (3x CCGs)	April 2017
	b) Ensure best practice in in-patient settings with regard to safe clinical areas	Serious Incident Lead (BDCFT)	April 2017
5: Support the media in delivering sensitive approaches to suicide and suicidal behaviour			
5.1 Work with the Media *Outcome: Media outlets in Bradford report suicides sensitively, mindful of the impact on the community*	a) CBMDC Communications department to monitor inappropriate use of media reporting on cases relevant to Bradford and share learning	Commun-ications department (CBMDC)	April 2017
	b) Provide briefing for local journalists and provide them with a Bradford version of the Leeds NUJ/Council written guidance	Commun-ications department (CBMDC)	April 2017
5.2 Deliver effective communication *Outcome: The*	a) Campaigning and awareness raising around WHO World Suicide prevention day (Sep 10th 2017)	All organisational communication leads	September 2017

Key priority	Key Action	Lead	Timescale
aspirations of 'this prevention plan are communicated to the public and stigma is reduced	b) Launch this action plan and publish audit/evidence review	Commun-ications department (CBMDC)	April 2017
	c) Promote evidence-based mobile apps: '5 ways to wellbeing' and 'Stay alive'	All organisational communication leads	Ongoing
6: Support research, data collection and monitoring			
6.1 Undertake surveillance *Outcome: partners effectively monitor suicide incidence and trends in Bradford*	a) Conduct an audit of the coroner's files for suicide death inquests.	PH lead (CBMDC)	September 2017
	b) Disseminate all audit findings in a timely manner, and use to inform local suicide prevention training	PH lead (CBMDC)	December 2017
	c) Consider the findings of national real time surveillance projects – implement any recommendations	PH lead (CBMDC)	Ongoing
	d) Conduct an analysis of the completed suicides of mental health patients in BDCFT and use to inform suicide reduction training	Deputy Director (BDCFT)	April 2017
6.2 Learn lessons from serious incidents *Outcome: serious incidents are avoided*	a) Learning from serious incidents/after suicide for people in contact with secondary care is shared where appropriate.	Serious Incident Lead (BDCFT)	Ongoing

High Level Indicators – How will we know we've made a difference?

Indicator	Current Bradford baseline (England) Source: PHOF
Suicide Age Standardised rate per 100,000 (persons, 3 year rolling average, 2013-15)	11.4 (10.1)
Suicide Age Standardised rate per 100,000 (males, 3 year rolling average, 2013-15)	17.1 (15.8)
Suicide Age Standardised rate per 100,000 (females, 3 year rolling average, 2013-15)	5.8 (4.7)
Emergency Hospital Admissions for intentional Self-Harm: Directly age-sex standardised rate per 100,000 (2014/15)	257.3 (191.4)
Hospital admissions as a result of self-harm (10-24 years. 2014/15))	463.8 (398.8)

Key supporting documents

National:
HMGovernment (2017): *Suicide Prevention Strategy for England (Third Progress Report)*
Public Health England (2016): *Local Suicide Prevention Planning: a Practice Resource*
NHS England (2016): *Five Year forward View for Mental Health Implementation Plan*

Local:
Bradford District Crisis Care Concordat Plan (2015)
Developing a Suicide Prevention Plan for Bradford: Evidence and Literature Review (2015)
Bradford District Mental Wellbeing Strategy (2016)
Audit of deaths by Suicide in Bradford 2013-15 (forthcoming 2017)

Acknowledgements

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Glossary

BDCFT	Bradford District Care NHS Foundation Trust	CBMDC	City of Bradford Metropolitan District Council
PH	Public Health	CCG	Clinical Commissioning Group
BTHFT	Bradford Teaching Hospitals NHS Foundation Trust	AFT	Airedale Hospital NHS Foundation Trust
WYP	West Yorkshire Police	WYFR	West Yorkshire Fire and Rescue Service

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