

Health and Wellbeing Board Agenda



BRISTOL CCG

Date: Thursday, 24 November 2022

Time: 2.30 pm

Venue: Bordeaux Room, City Hall, College Green,
Bristol, BS1 5TR

Issued by: Jeremy Livitt, Democratic Services

City Hall College Green Bristol BS1 5TR

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Date: Thursday, 17 November 2022



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Agenda

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| 9. New Way Leg Club - Kay Libby, Age UK | 2.55 pm
(Pages 3 - 9) |
| 12. Suicide Prevention Reports - Leonie Roberts, Bristol City Council | 3.50 pm
(Pages 10 - 50) |





**Bristol, North Somerset
and South Gloucestershire**
Integrated Care Board

Bristol Health and Wellbeing Board

Title of Paper:	Integrated Working – New Way Leg Clinic
Author (including organisation):	Kay Libby, Age UK Bristol & Tracey Elliott, Grange Road Surgery
Date of Board meeting:	24th November 2022
Purpose:	Oversight, Information and discussion

- Paper to be no more than two pages long; full reports or more information can be added as appendices
- Draft papers are reviewed by the Public Health team
- Final papers will be published on the [public website](#)
- Board correspondence: HWB@bristol.gov.uk

1. Executive Summary

This paper described the positive outcomes of a community-based clinic for lower leg wounds and requests the support of the Board in promoting an integrated approach across the city. Clinical treatment partnered with voluntary sector support enables a person-centred approach that treats health and social needs.

2. Purpose of the Paper

We seek the support of Board members for extending this integrated approach across the city. Of particular interest, is how to secure commitment to an integrated approach for the treatment of lower leg wounds alongside support with a wide range of social needs. Currently, the clinical side is funded by Swift PCN until February 2023 and the social side provided by Age UK Bristol is funded by the Ageing Well programme until March 2023.

3. Background, evidence base, and what needs to happen

Swift PCN identified the following issues with leg wound treatment:

- Restricted surgery appointment time which compromised treatment
- Limited assessment, diagnosis and treatment plans
- Variation in staff skills and knowledge of leg ulcers
- Non-healing wounds often due to lack of evidence-based treatment
- Many patients required 2 – 3 appointments per week for several years.

Evaluation of voluntary sector input to the clinic by University of West of England in 2021 found statistically significant positive results. In 2022, the clinic has seen these benefits:

- **10,025.52** per year saved in staffing costs through improved use of resources
- **260 clinic hours** released across 5 practices
- Improved patient outcomes - **67% healing since January 2022**
- Social interaction leading to **improved wellbeing, happier, healthier patients**
- **Quality of life (QOL) improved** - improved clinical outcomes, shared experiences with peers
- **Reduction** in prescriptions
- Prevention of unplanned **hospital admissions**
- **Reduction** of health inequalities
- Reduction in **waste and carbon footprint**.

Learning from this model could inform integrated delivery of support for other long term conditions and we are keen to share our findings.

4. Community/stakeholder engagement

The people who use the leg clinic are consulted about the activities and interests, and asked for their views on any changes within the clinic environment. We check with people how they feel about a communal, community based service compared to visiting the GP surgery and have had very positive feedback. Local people volunteer to support the clinic.

5. Recommendations

Board members are asked to consider how they can support commitment to an integrated model like this from their position in the wider integrated care system. We see the need for **joined up oversight and monitoring** of outcomes of this integrated way of working. GP surgeries are concerned with securing clinical benefits, while the benefits of the social outcomes are more easily recognised by social care and those concerned with the potential to avoid hospital admission.

We would also like Board members' support in encouraging key partners in the health and care system to **prioritise integrated models for leg wound care**. Swift PCN has funded the clinical side of the leg clinic, and the Ageing Well programme has funded the voluntary sector input. We would like the Board's support to encouraging a **more joined up approach to funding** so that the model can be continued and expanded in areas of need.

6. City Benefits

We have evidence that a community-based, integrated model using compression bandaging for dressing leg wounds results in faster healing of leg ulcers, reduced re-infection rates, reduces associated stigma, enables peer support and promotes wellbeing through people's greater involvement and engagement in their communities.

There are **benefits for statutory services** as a result of preventative work reducing the potential for people to need more costly health and social care interventions.

There are **wider community** benefits as the people who use the service are encouraged to participate in other local clubs, services and activities. The clinic is situated in the Withywood Centre, bringing people in to use this valuable community resource – significant numbers visit the community centre's café after treatment.

There are **benefits for individuals**. we serve an area of significant deprivation and are able to support people by maximising their income and helping them to apply for benefits to which they are entitled. Age UK Bristol facilitates a collaborative network of 45+ voluntary organisations and can refer people to a wide range of practical, social and emotional help. Patients often say that attending the clinic is 'the highlight of my week'. Two of our current volunteers are ex leg-clinic patients and are inspiration for others. Another volunteer used to attend with her husband who had his leg wounds dressed and then volunteered with the clinic when he died. There are benefits to our volunteers in reducing their own experience of social isolation. One now visits her GP less often due to low mood. Our volunteers report feeling happier, more connected and less anxious as a result of volunteering in the clinic.

7. Financial and Legal Implications

Funding is not sought from the Health & Wellbeing Board.

8. Appendices

Powerpoint presentation describing the clinic with short video input from service user.

New Way Leg Clinic, South Bristol

Tracey Elliott, Grange Road Surgery

Victoria Fyfe, Swift PCN

Kay Libby and Abi Hill, Age UK Bristol



New Way Leg Clinic

- **Swift PCN** re-established the **New Way Leg Clinic** with funding until Feb '23. Age UK Bristol funded by Ageing Well prog until March '23 to pilot an integrated approach
- Two clinical sessions each week at The Withywood Centre. Ave 40 patients per week from 7 GP surgeries in South Bristol
- Team of nurses and HCAs treat leg wounds using compression bandaging techniques
- Age UK Bristol provides a social element, with support/signposting to practical, social, emotional support in vol sector and sets up new opportunities based on people's needs e.g. FAB Café



I was really worried [about] what to expect... and then when I actually walked through the door and I could see they were treating several people at the same time, with various conditions and levels of a leg problem, I was feeling at ease, I was thinking, 'It's not just me'

John, leg clinic participant

New Way Leg Clinic - Benefits

Brings together strengths of health and voluntary sector:

- **Improved healing rate**
- **Reduced re-infection rate**
- **Reduces stigma** associated with leg wounds
- **Reduction in prescriptions**
- **Prevention of unplanned hospital admissions**
- **Clinic hours** released for other priorities

- **Reduction in health inequalities**
- **Peer support** – patients and also volunteers
- **Engagement and activity to promote wellbeing**
- **Enables other support needs** to be identified e.g. benefits, housing, social care
- **Reduction in waste and carbon footprint**



New Way Leg Clinic – Next Steps

Things that need further work:

- Securing low-cost **nail cutting** services to be provided in the clinic
- **Larger space** to meet demand and improve welcoming atmosphere
- **Transport.**

The future:

- **Joint funding** to enable **integrated approach**
- Offer to share our learning with **Locality Partnerships** across BNSSG
- **Integrated model** could work with other long term conditions.



Bristol Health and Wellbeing Board

Title of Paper:	Suicide Prevention
Author (including organisation):	Leonie Roberts
Date of Board meeting:	24th November 2022
Purpose:	oversight and assurance

1. Executive Summary

This paper provides an update on the implementation of the suicide prevention in Bristol. This includes the 2022 suicide prevention annual report. The aim of the annual report is to provide and analysis of trends in suicide to identify any areas for action. The priorities for Bristol are:

- Maintain high quality local research, data and monitoring of suicide
- Take action to reduce access to means of suicide
- Work with communities and partners to improve mental health and reduce risk in specific groups
- Build knowledge, motivation, and confidence to prevent and respond to suicide
- Work with our local media in delivering sensitive reporting of suicide.

2. Purpose of the Paper

The purpose of the paper is to provide an update on preventing suicides in Bristol. The update includes data and information on suicides in Bristol and the current strategy in place to reduce the rate of suicide.

3. Background, evidence base, and what needs to happen

Suicide is a preventable tragedy with a devastating impact. The Preventing Suicide in England – a cross governmental strategy was launched in 2012 and it sets out clear and evidence-based priority action areas at national and local levels.

The number of suicides in Bristol do fluctuate from year to year, but on average 43 people die by suicide each year. The rate of suicide is higher in men, particularly among middle aged men. Nationally people among the most 10% deprived are more than twice as likely to die by suicide than the least deprived. Risk factors include debt, breakdown of relationship and loss of employment.

The ambition is to reduce the rate of suicide in Bristol by 25% by 2028 which is set out in the Bristol Suicide Prevention Strategy 2022-2025.

4. Community/stakeholder engagement

The production of the strategy and annual reports has been completed in partnership with a diverse range of stakeholders including the NHS, police, highways, universities, and voluntary sector organisations.

5. Recommendations

We ask that the Health and Wellbeing Board members and partners review the report and strategy and provide views and identify any areas where you can contribute to reducing the rate of suicides in Bristol.

City Benefits

Reduction in the number of suicides in Bristol. This has wider implication for friends, family and the wider community.

6. Financial and Legal Implications

N/A

7. Appendices

Preventing Suicide in Bristol Annual Report 2022
Suicide Prevention Strategy 2022-2025



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Introduction

Suicide is a preventable tragedy with a devastating impact. Every year too many people in Bristol take their own life and many more people are deeply affected by the loss of a relative, friend or colleague through suicide. It is a priority to prevent suicide across the country, but especially so here in Bristol. Our suicide rates are higher than the national average, and the Southwest has the highest suicide rates of any English region. [Public Health Outcomes Framework - Data - OHID \(phe.org.uk\)](https://www.phe.org.uk/publication/public-health-outcomes-framework-data)

The Bristol Suicide Prevention Strategy will be refreshed in three years (2025) to ensure it reflects current need and the latest evidence.

The Strategy is supported by an annual action plan which will be reviewed throughout the year by the identified partnership bodies and revised annually.

Bristol's Health and Wellbeing Board is responsible for the Suicide Prevention Strategy and Action Plan and receives an annual audit report which is also published.



Suicide Prevention Strategy 2022 - 2025

Our Vision

Bristol will be a city where people do not consider suicide to be a solution to the challenges they face, and individuals are supported by friends, colleagues, and services at times of crisis.

Individuals, employers, city partners, health and care services, the voluntary sector and communities all have a role to play in the prevention of suicide and the promotion of positive mental health. The experience of survivors, those bereaved by suicide and people who self-harm is at the heart of all that we do in respect to suicide prevention.

The ambition (set in 2018) is to reduce the rate of suicide in Bristol by **25% by 2028**.

Priorities for Bristol reflect national priorities and identified local issues:

- Maintain high quality local research, data and monitoring of suicide
- Take action to reduce access to means of suicide
- Work with communities and partners to improve mental health and reduce risk in specific groups
- Build knowledge, motivation, and confidence to prevent and respond to suicide
- Work with our local media in delivering sensitive reporting of suicide
- Reduce local rates of self-harm
- Provide support for those bereaved by suicide

Local action is supported by the following national frameworks, evidence, and resources:

- [The National Suicide Prevention Plan](#)
- [The Prevention Concordat for Better Mental Health](#)
- [Public Health England advice for local suicide prevention planning](#)



Partners and Partnerships

Partners and partnerships essential in the delivery of this plan include:

- Avon Coroner
- Avon and Somerset Police
- Avon Fire and Rescue Service
- Avon Gorge Safety Group
- Bristol's Community and Voluntary Sector
- Bristol Harbourside Water Safety Partnership
- Bristol University
- Criminal justice agencies
- Healthier Together Integrated Care System Partners
- Housing and homelessness organisations
- Mental Health Network and Thrive Bristol networks
- Network Rail
- Southwest Association of Directors of Public Health
- University of the West of England

To achieve outcomes in the most efficient and effective way, the following four partnership and programme delivery arrangements are in place:

Bristol Suicide Prevention Programme

- Covers the population of the City of Bristol
- Has in place a Strategy and plan for Bristol
- Is responsible for suicide audit and for producing an annual Suicide Prevention Report for Bristol
- Has a particular focus on local safety issues and at-risk groups.

Avon Suicide Prevention Partnership

- Covers the four local authorities of the Avon Coroner area
- Includes strategic partners such as Network Rail, Highways England, and the coroner
- Responsible for oversight of the Real Time Surveillance system
- Strategic view of developing issues risks and trends

Healthier Together Suicide Partnership

- Covers the NHS system for the populations of the three local authorities of Bristol, North Somerset, and South Gloucestershire
- Includes all health partners, local authorities, and voluntary sector
- Responsible for delivery of NHS Suicide Prevention programmes and preventive action through NHS partners
- Supports the delivery of ambitions in the Mental Health Concordat

Southwest Suicide Prevention Network

- Covers all local authorities in the Southwest of England
- Includes NHS, Voluntary sector, and regional partners
- Links to national strategy and support programmes



Monitoring and Evaluation

Knowing who dies by suicide and under what circumstances is critical, not only to helping those bereaved, but also for understanding trends, auditing changes and pinpointing areas of highest risk to enable targeted efforts to be made to reduce suicide in the future. A key part of our action plan is to bring organisations and services together to improve the timeliness of information.

Bristol Mortality Data

Local suspected suicide deaths are investigated by the Avon Coroner. Local data is shared with the 'Avon Coroner Monitoring Group', which is formed of public health leads that meet regularly to audit suicide deaths and analyse trends. The report looks at local data for a three-year period. This is so that small fluctuations due to random variation as a result of the small number of deaths every year will not overly influence decisions or change.

Bristol Self Harm Surveillance Register

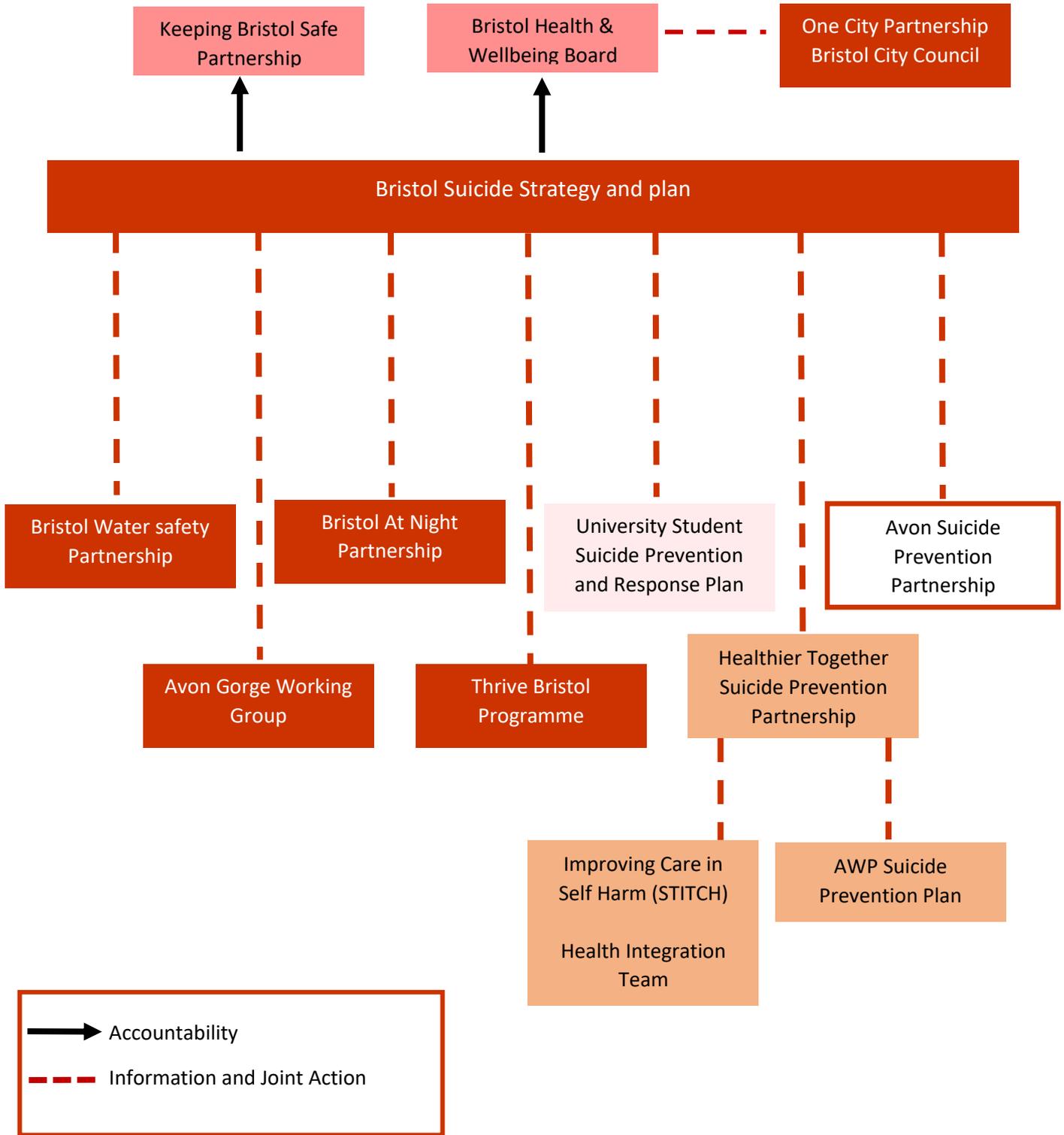
England's Public Health Outcomes Framework requires data to be collected on people who self-harm and come to hospital. The Bristol Self Harm Surveillance Register (SHSR), part funded by Bristol City Council, records self-harm and both A+E attendance and hospital admission in Bristol. Other monitoring includes local prescribing trends and medicines taken in overdose, trends in suicide under specialist mental health care.

Public Health England Fingertips Tool

The Public Health England Fingertips Tool includes data on deaths of Bristol residents who die outside of Bristol (these deaths will not be notified to the Avon Coroner).



Bristol Relationships Accountability





Suicide Prevention Strategy 2022 - 2025

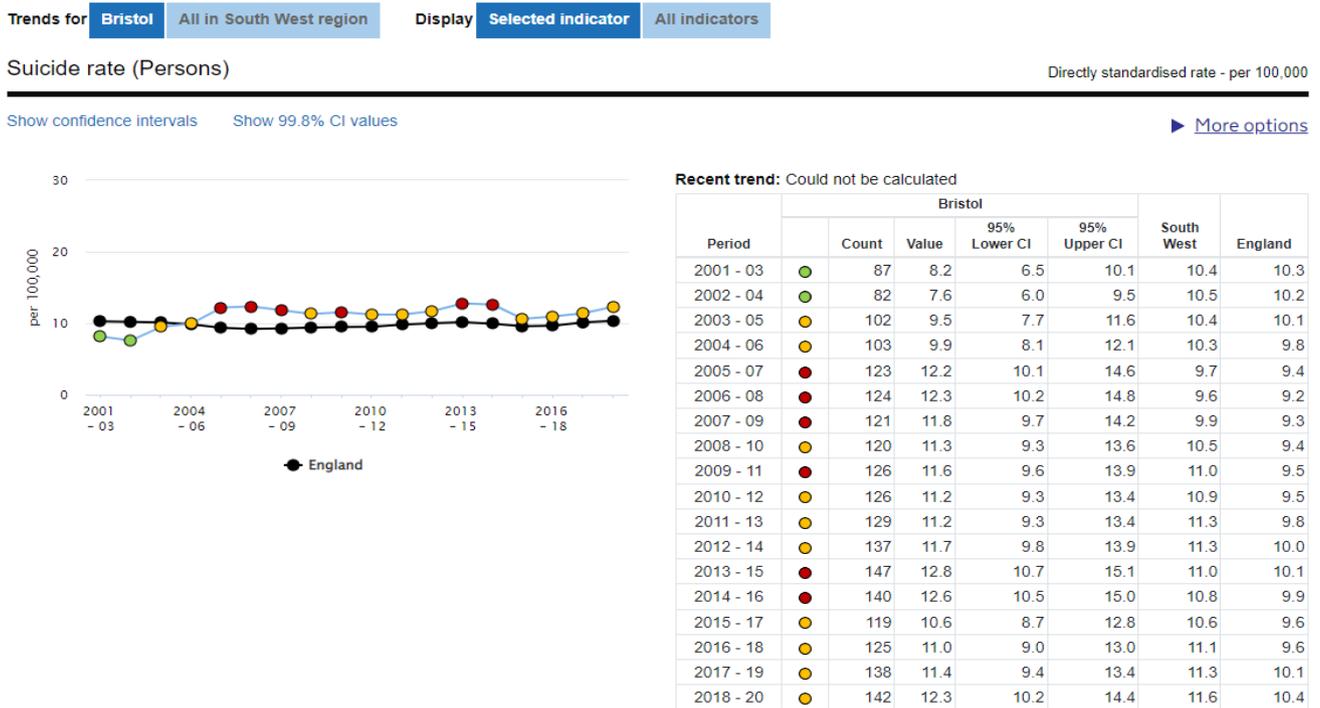
Bristol's Position

There were 142 suicide deaths registered in Bristol in 3 years between 2018-20 (Public Health England, 2019).

76% (108) of those deaths were among males and 24% (34) among females.

The current 3-year average suicide rate in Bristol is 12.3 per 100,000, similar to the England average of 10.4 per 100,000 population. The suicide rate for females is 5.5 per 100,000 population and for males 19.1 per 100,000 population; more than three times the female rate. When compared to other Core Cities Bristol has a slightly higher rate of suicides. Of note Birmingham rates are lower than both Bristol, other Core Cities and England for both males and females which would be helpful gain an understanding of.

Figure 1 Bristol trends 2001- 2020 compared to England and SW region



[Suicide Prevention Profile - OHID \(phe.org.uk\)](https://phe.org.uk)



Suicide Prevention Strategy 2022 - 2025

Figure 2 Bristol years of life lost to Suicide, age standardised rate per 10,000 (2018-20)

Indicator	Period	Bristol		Region England			England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Suicide rate (Persons)	2018 - 20	-	142	12.3	11.6	10.4	18.8		5.0
Suicide rate (Male)	2018 - 20	-	108	19.1	18.0	15.9	28.5		5.5
Suicide rate (Female)	2018 - 20	-	34	5.5	5.4	5.0	10.3		2.8
Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) (Persons)	2018 - 20	-	132	39.3	-	34.0	79.3		17.4
Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) (Male)	2018 - 20	-	101	59.3	-	51.5	120.6		21.1
Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) (Female)	2018 - 20	-	31	18.6	-	16.5	37.9		8.0

[Suicide Prevention Profile - OHID \(phe.org.uk\)](https://phe.org.uk)

Figure 3 Core City comparator of Suicide rates stratified by gender

OHID Suicide Profile indicators: England and Core City LAs, latest statistics at 17th June 2022 / Colour coding represents range within Core Cities group

Indicator name:	Period	England	Birmingham	Bristol	Leeds	Liverpool	Manchester	Newcastle upon Tyne	Nottingham	Sheffield
Suicide rate (DSR, 10yrs+, per 100,000, 3-yr average, persons)	2018-20	10.4	8.4	12.3	13.3	10.1	9.3	11.8	11.5	11.3
Suicide rate (DSR, 10yrs+, per 100,000, 3-yr average, female)	2018-20	5.0	3.3	5.5	7.4	3.6	4.1	5.4	4.8	4.3
Suicide rate (DSR, 10yrs+, per 100,000, 3-yr average, male)	2018-20	15.9	13.8	19.1	19.5	16.6	14.6	18.2	17.8	18.3
Years of life lost due to suicide (ASR 15-74yrs per 10,000, 3-yr average, persons)	2018-20	34.0	26.6	39.3	45.4	35.5	30.9	38.7	38.0	35.9
Years of life lost due to suicide (ASR 15-74yrs per 10,000, 3-yr average, female)	2018-20	16.5	10.8	18.6	26.4	15.1	15.1	17.3	16.8	12.7
Years of life lost due to suicide (ASR 15-74yrs per 10,000, 3-yr average, male)	2018-20	51.5	42.6	59.3	64.9	55.0	45.7	59.1	57.5	59.1
Suicide crude rate (10-34yrs, per 100,000, 5-yr average, male)	2013-17	10.5	8.1	9.8	13.2	9.5	8.2	10.3	9.6	9.1
Suicide crude rate (35-64yrs, per 100,000, 5-yr average, male)	2013-17	20.1	19.9	26.0	24.9	23.3	21.2	25.7	24.8	21.0
Suicide crude rate (65yrs+, per 100,000, 5-yr average, male)	2013-17	12.4	12.7	9.8	11.0	9.5	11.8	9.6	13.1	10.2

Data collated by BCC PH Intelligence from ONS (OHID Fingertips)

The economic case for action

Suicide must primarily be seen as a traumatic human tragedy. Economists have looked at the costs of suicide death and attempted suicide and self-harm. Although the number of studies estimating these costs remains limited (McDaid, 2016b) costs are substantial. The Bristol economic evaluation found costs of self-harm and attendance at hospital to be £700 per patient: this approximates to over £2 million per year in Bristol. Previous work in the UK has estimated that the average cost per completed suicide for those of working age only in England is £1.67m (at 2009 prices) (McDaid, 2016b). This includes intangible costs (loss of life to the individual and the pain and suffering of relatives), as well as lost output (both waged and unwaged), police time and the costs of coroner inquests.



Suicide Prevention Strategy 2022 - 2025

There were 142 deaths due to suicide in Bristol in 2018-20. Therefore, the total estimated human cost of suicide is **£237.14m**

What is effective in suicide prevention?

Preventing Suicide in England: A Cross Government Outcomes Strategy to Save Lives has set clear and evidence-based priorities for local suicide prevention groups.

- Provide better information and support to those bereaved or affected by suicide
- Reduce the risks in key high-risk groups e.g., men
- Improve the mental health in specific groups e.g., children and young people, survivors of abuse or violence
- Reduce access to means such as installing a safety barrier at 'frequent use sites' or restricting sales/ prescribing of high-toxicity medications is effective in preventing suicide (Bennewith, Hawton).
- Reduce rates of self-harm as a key indicator of suicide risk
- Support the media in delivering sensitive approaches to suicide and suicidal behaviour. Whilst we cannot prove that good reporting prevents suicide, we do know poor reporting (especially graphic portrayal of high-lethality methods) leads to rises in suicides

In addition, training of larger groups of people, such as frontline staff, has proven impact in reducing stigma and increasing skills, knowledge, and confidence (Walrath et al 2015). NHS England's Five Year Forward View for Mental Health (2016) recommends that by 2020/21 all GPs should receive core mental health training. It would seem appropriate that Bristol GPs are confident in recognising and responding to those at risk of suicide.



Local Voices

No, I haven't told any of them (about self-harm). No. It's either a combination of lies about skiing trips or something else. (laughs) I don't do the heart on the sleeve thing. It's just easier for my day to day.

Mungo, 23.

Interviewed after hospital admission for suicide attempt

Debbie, 37.

Interviewed after hospital admission and suicide attempt

".....the (mental) illness, lack of job. It was just...enough was enough...I thought that would be better for everybody if I wasn't here anymore because I just saw I was making people suffer."

"... I felt like I was stuck in a rut and the drugs and the alcohol ... I ended up feeling more and more worthless every time you get shot down..... you start to feel defeat yourself and eventually I think I just got to that point where

Paul, 23.

Interviewed after a suicide attempt

Jo, 31

Speaking after a suicide attempt

"...I mean obviously through my early childhood he [Dad] was a bad drinker. I'd been beaten so much over the years that I kind of became used to it and it was literally I could sit here, and he could punch me and be beating me...."

"...and it's really disheartening when you get rejected when you've spent a few hours on an application and then you just get rejected I'd gone to.... interview... I was cycling home and I just thought I can't do this; this is too much, and I didn't want to live so I took an overdose."

Ellie, 23

Talking after hospital admission for suicide attempt

Ellen, 71

Talking about a suicide attempt

"I can't get out due to health problems so it can be ...3 days I go without talking to someone... I dread the winter nights.... sometimes I need that to get through another pointless day where I feel as if I am a waste of space"



Examples of local priority action

Avon Gorge:

A multi-agency working group has been established to look at solutions around the Avon Gorge and Clifton Suspension Bridge, chaired by the Police.

Self-Harm:

Investment in liaison services supports those who present at hospital due to an episode of self-harm patients receive a NICE recommended psychosocial assessment. UHBristol and North Bristol Trust have 7-day liaison psychiatry services and domestic violence advisers in A+E.

Debt

'Thrive Bristol' has strengthened mental health support for people in debt, and vice versa, building on the University of Bristol's HOPE study.

HMP BRISTOL:

All staff with prisoner contact have SASH suicide and self-harm learning sessions, weekly quick time learning e-mails, a regular newsletter and weekly complex case reviews. Bristol Samaritans supports all local prisons, through the Prisoner Listener Service.

Men:

Bristol Anti Stigma Alliance - in partnership with Time to Change' - has undertaken a range of events focusing on men and mental health.

Women:

Targeted work is being developed to support women affected by domestic abuse, as well as work to improve prevention, detection, and management of perinatal mental health issues (through the BNSSG Perinatal and Infant Mental Health Group).

STUDENTS:

Bristol is home to two major universities and becomes home to many thousands of students each year. Joint work between the NHS, local authority and the universities is focused on created safe environments both on and off the campus.

BRISTOL AT NIGHT

Bristol is a destination city with a thriving night – time economy. Mental health and suicide awareness training has been made available across the sector. This is supported by work on alcohol awareness, drink spiking and a new drug testing pilot.



Suicide Prevention Strategy 2022 - 2025

Appendix 1: Evidence and data sources

Date	Title	Publisher/Source
2016	The Five Year Forward View for Mental Health	NHS England
2016	Suicides in the UK: 2015 registrations	Office for National Statistics
2016	Guidance for creating a Suicide Prevention Plan	Public Health England
2017	'Preventing Suicide in England: third progress report on the cross-governmental outcomes strategy to save lives'	HM Government
2016	Media Guidelines for Reporting Suicide	Samaritans
2016	National confidential Inquiry into suicide and Homicide by People with Mental Illness	University of Manchester
2015	Inquiry into Local Suicide Prevention Plans in England: APPG for Suicide and Self harm Prevention	HM Government
2015	Preventing suicide in England: Two years on. Second annual report on the cross-government outcomes strategy to save lives	HM Government
2015	Aiming for 'zero suicides': An evaluation of a whole system approach to suicide prevention in the East of England	Centre for Mental Health
2015	Help is at Hand: Support after someone may have died from suicide	Public Health England
2014	Preventing suicide: A Global Imperative	World Health Organisation
2014	Information sharing and suicide prevention: Consensus statement	Department of Health
2012	Preventing suicide in England: A cross-government outcomes strategy to save lives	HM Government
2016	Map of guidance and evidence: interventions to prevent and manage suicide and self-harm	Public Health Wales Observatory`
2015	Preventing suicide among lesbian, gay and bisexual young people	Public Health England
2017	Suicide Prevention Profile Perinatal Mental Health Profile Crisis Care Profile	Public Health England
2011	2011 Census	Nomis
2015	Primary Care Mortality Database	Health and Social Care Information Centre
2015	Health and Social Care Information Centre Indicator Portal	Health and Social Care Information Centre
2012-2016	ONS mid-year population estimates	Office for National Statistics
2010-2016	SUS hospital episodes data via NHS South, Central and West Commissioning Support Unit ABI database	NHS South, Central and West Commissioning Support Unit
2017	GP Patient Survey July 2017 gp-patient.co.uk	NHS England
2015	Annual Population Survey: UK Armed Forces Veterans residing in Great Britain	Ministry of Defence, ONS
2017	https://fingertips.phe.org.uk/search/suicide#page/0/gid/1/pat/6/par/E12000009/ati/102/are/E06000022	Public Health England



Suicide Prevention Strategy 2022 - 2025

2016	Safety in Custody Statistics	Ministry of Justice and National Offender Management Service
2010-2015	<i>The 'RaRE Research Report: Risk and Resilience Explored'</i> www.queerfutures.co.uk/wp-content/uploads/2015/04/RARE_Research_Report_PACE_2015.pdf	PACE
2015-16	<i>Bristol Quality of life Survey</i>	Bristol City Council
2016	<i>Joint Strategic Needs Assessment (JSNA)</i>	Bristol City Council
2016	<i>Nomis Labour Market Profile 2016 for Bristol LA</i>	Nomis, ONS

Appendix 2: References

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Preventing Suicide in Bristol Annual Report 2022

Leonie Roberts, Consultant in Public Health

Magdalena Szapiel, Senior Public health Specialist



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Acknowledgements

To members of the Suicide Prevention Group, the Avon Suicide Prevention Audit Group and all those who work with to make Bristol a safer and more compassionate city.

1.0 Introduction

Suicide is a preventable tragedy with a devastating impact. In England one person will die every 2 hours by suicide and many more will attempt suicide. Suicide can have a lasting effect on individuals, their friends, families, colleagues, and communities.

Every single life lost to suicide is one too many.

Around 40 lives are lost to suicide in Bristol each year.

The current 3-year average suicide rate in Bristol is 12.3 per 100,000, similar to the England average of 10.4 per 100,000 population. The suicide rate for females is 5.5 per 100,000 population and for males 19.1 per 100,000 population, more than three times the female rate.

The trend has been remained fairly static with each 3-year rate since 2005-07 reporting as being between 10.6 and 12.8 per 100,000 which equates to between 120 and 147 preventable deaths per 3-year period.

The reasons leading to an individual taking their own life can be complex. There are many social, economic, psychological, and cultural factors that can all interact to lead a person to suicidal behaviour.

There are also many protective factors that can help to reduce suicidal behaviour. These include being in full-time employment, have a strong and support friends and family and the ability to access effective mental health.

The Preventing Suicide in England – a cross governmental strategy to save lives was launched in 2012 under the 2010 to 2015 Conservative and Liberal Democrat coalition government. It set clear and evidence-based priority action areas at a national and local level. The Mental health and wellbeing plan is currently out for consultation.

The Bristol ambition is to become a Zero suicide city.



2.0 Analysis of trends in suicide in Bristol

The analysis draws on data from a variety of different sources including Primary care Mortality Database, Office for National Statistics, Ministry of Justice and National Offender Management Service and Public Health Outcomes Framework.

Suicide deaths are defined as deaths from suicide and undetermined intent, classified by underlying cause of death, using international Classification of Diseases (ICD-10) codes X60-X84 (age 10+), Y10-Y34 (ages 15 and over).

Due to small numbers in any one year, analysis is conducted over a number of years to ensure statistical significance.

Rates are calculated using a three-year rolling average.

2.1 Suicides in Bristol from 2006 to 2020

The number of suicides in Bristol fluctuate from year to year but, on average 43 people die by suicide each year.

Bristol has seen an increase in the number of deaths registered as suicide in 2018-2020 which is consistent with the pattern for England. This may be down to a change in the coroner's law. Before 2018, in order for a Coroner to return a verdict of suicide in an inquest, the fact that the deceased deliberately took his/her own life must be established beyond reasonable doubt (criminal standard of proof). This was changed to the civil standard of proof i.e. the balance of probabilities following *Maughan, R (On the Application Of) v Senior Coroner for Oxfordshire* [2018] EWHC 1955 (Admin) case.

Table 1 Number of deaths from suicide and injury of undetermined intent in Bristol registered between 2006 and 2020. Source: Primary Care Mortality Database via NHS digital

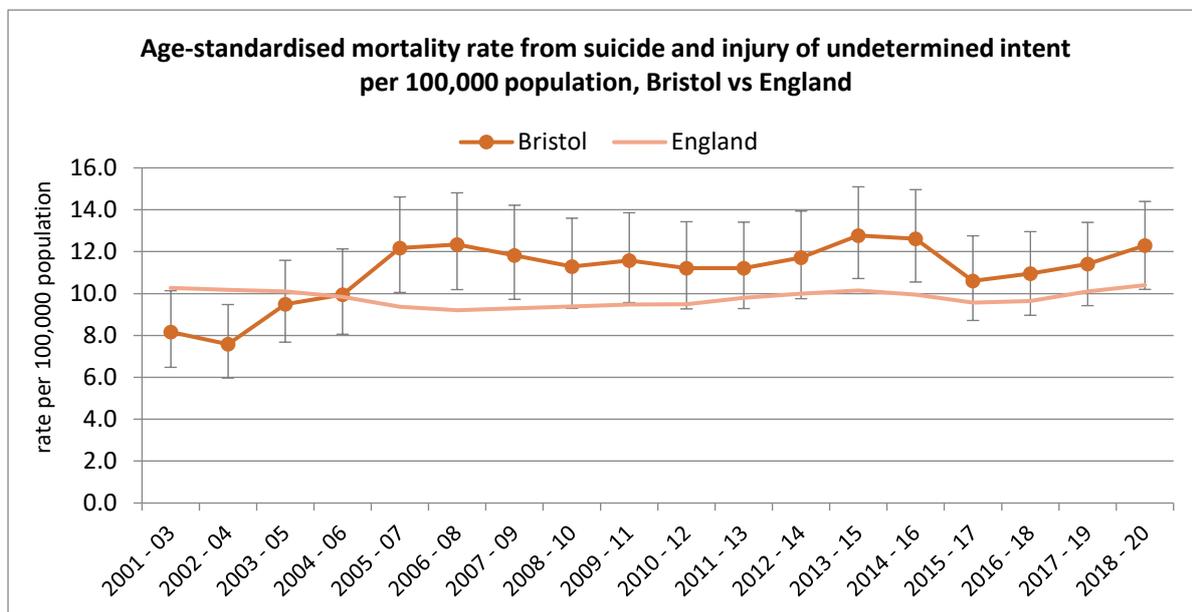
Year of registration	Male	Female	Total
2006	34	7	41
2007	36	8	44
2008	32	13	45
2009	24	8	32
2010	35	8	43
2011	41	10	51
2012	24	8	32
2013	32	14	46
2014	43	16	59
2015	27	15	42
2016	27	12	39
2017	29	9	38
2018	34	14	48
2019	43	9	52

2020	31	11	42
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Figure 1 below shows the age standardised mortality rate from suicide and injury of undetermined intent from 2001 to 2020. Although the rate has risen this rise is not statistically significant (note the overlapping confidence intervals) and between 2017-2019 and 2018-2020, the last two reporting periods, although rates are higher than England these are not statistically different to the England average.

Put simply, this means that the rate of death by suicide in Bristol has remained relatively stable since 2005.

Figure 1: Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population, Bristol vs England. Source: Public Health England, Public Health Outcomes framework



2.2 Gender and age

Historically, both in England and locally the rate of male suicides have been consistently higher, although the ratio of male to female suicide rates has changed over time. The female rates peaked in the 1960 (Thomas and Gunnell, 2010).

During the period 2018-2020 76% of suicides and undetermined death in Bristol were males. (Public Health Outcomes Framework, OHID)

The differences between male and female suicides may be due to the method of suicide as men are more likely than women to choose high lethality methods, such as hanging.

Figure 2 illustrates the age standardised mortality rate for suicide and injury of undetermined intent among females from 2001 to 2020. The number of female suicides rose between 2011

and 2015. Between 2015 and 2020 Bristol is not statistically different from the England average.

Figure 2 FEMALES: Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population, Bristol vs England. Source: Public Health England, Public Health Outcomes framework

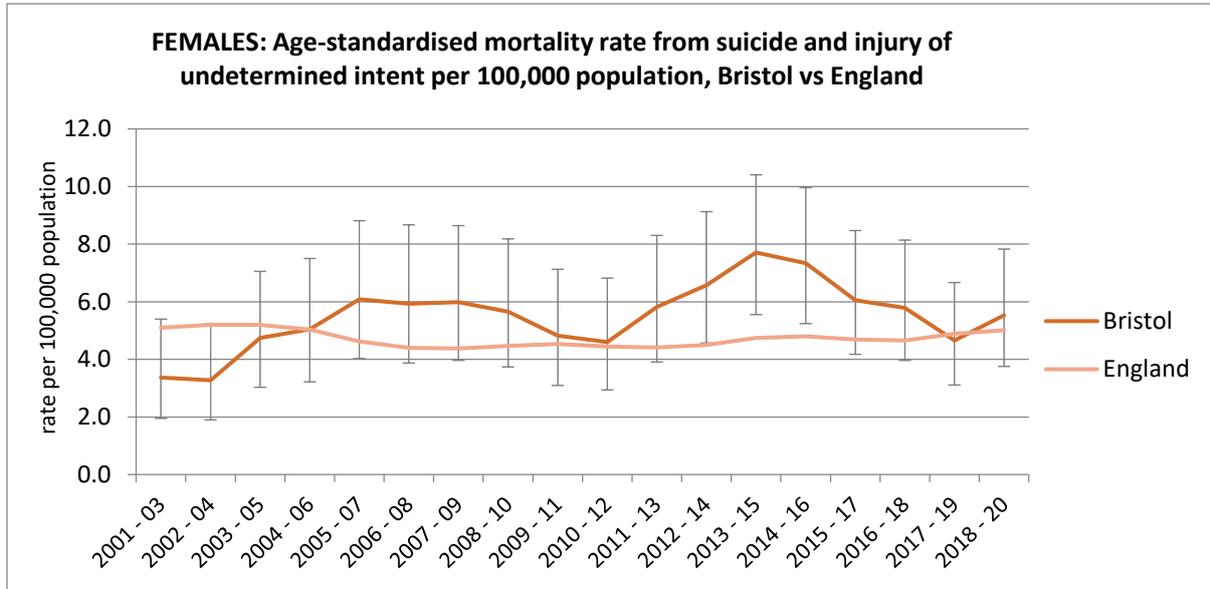


Figure 3 shows the age-standardised mortality rate from suicide and injury of undetermined intent between 2001 and 2020. The rate of suicide among men has not significantly changed over time. Between 2010 and 2020 the rate of suicide among men is not statistically significant from the England average

Figure 3 MALES: Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population, Bristol vs England. Source: Public Health England, Public Health Outcomes framework

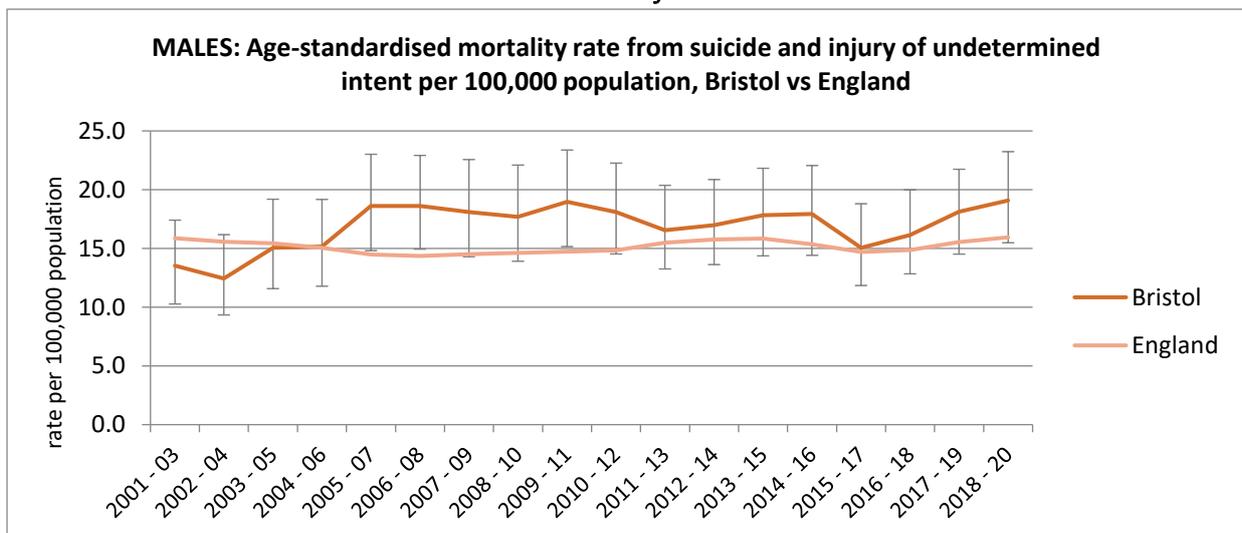


Table 2 and the figures 4 and 5 provide a breakdown of suicide death by age group for males and females. This shows that the rate of suicide is greater among middle-aged men within Bristol, and this is statistically higher than the England average. It also shows that the rate among young and middle-aged women is higher in Bristol, but this is not significantly different from the England average, meaning that this difference could be due to chance variation.

Table 2 Deaths from suicide and injury of undetermined intent by age group (5-year averages; 2016-2020) – crude rate per 100,000. Source: Primary Care Mortality Database 2021 via NHS Digital & ONS population estimates for Bristol values and ONS Suicides in England and Wales, 1981 to 2020

Age band	Bristol		England	
	Male	Female	Male	Female
10 - 34	9.0	3.8	11.2	3.7
35 - 64	25.9	8.0	19.7	6.1
65+	14.7	4.9	12.4	4.0

Figure 4 MALES: Deaths from suicide and injury of undetermined intent by age group (5-year averages, 2016-2020) – crude rate per 100,000. Source: Primary Care Mortality Database 2021 via NHS Digital & ONS population estimates for Bristol values and ONS Suicides in England and Wales, 1981 to 2020

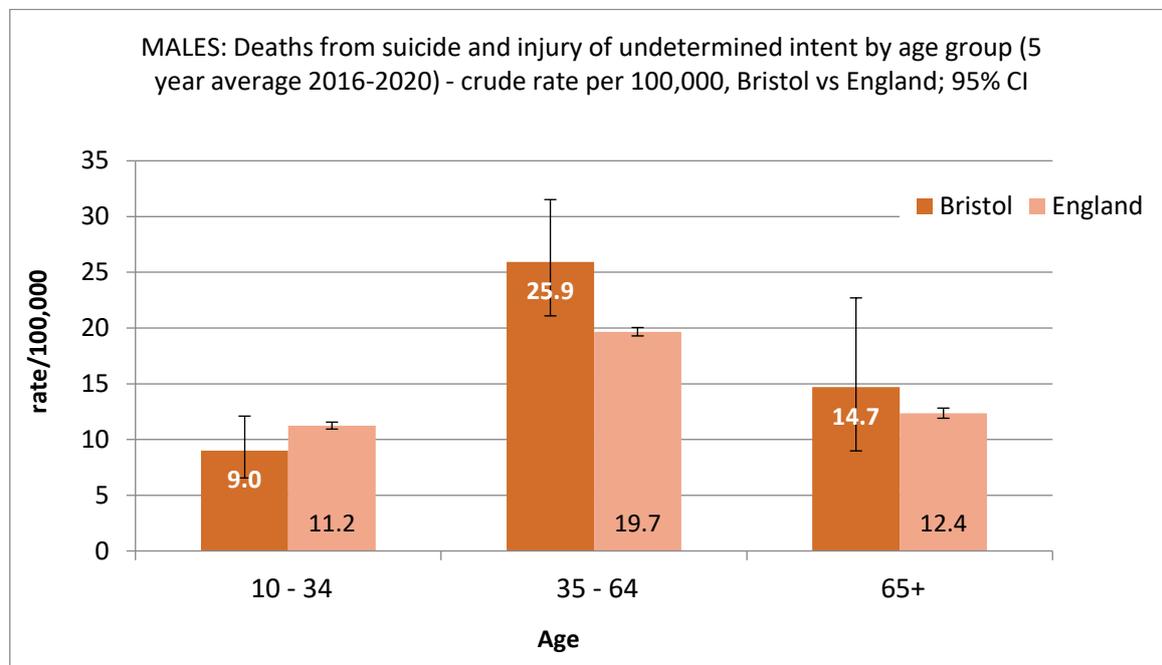
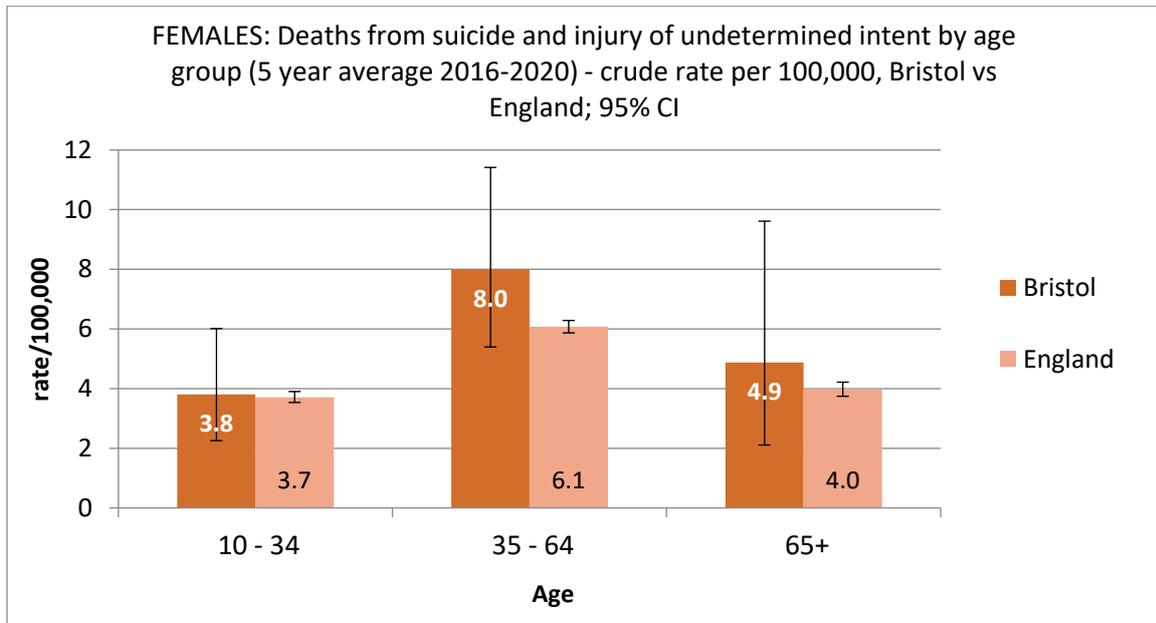


Figure 5 FEMALES: Deaths from suicide and injury of undetermined intent by age group (5-year averages; 2016-2020) – crude rate per 100,000. Source: Primary Care Mortality Database 2021 via NHS Digital & ONS population estimates for Bristol values and ONS Suicides in England and Wales, 1981 to 2020



2.3 Socio-economic factors

There is a strong association between area level deprivation and suicide and suicidal behaviour within the literature. (Mcdaid and Science, 2017) .

Nationally, people among the most 10% of society are more than twice as likely to die by suicide than the least deprived.

Figure 6 and table 3 provides the breakdown of suicide death by deprivation* in Bristol. Although there is an apparent trend linked to deprivation within Bristol, this is not statistically significant, meaning that this difference could be due to chance variation, and is less marked for women.

Figure 6 Mortality from suicide and injury of undetermined intent in Bristol by deprivation quintile and gender; 2011-2020, age standardised rate per 100,000 population. Source: Primary Care Mortality Database 2021 via NHS Digital, ONS population estimates, English Indices of Deprivation 2019 - Department for Communities and Local Government

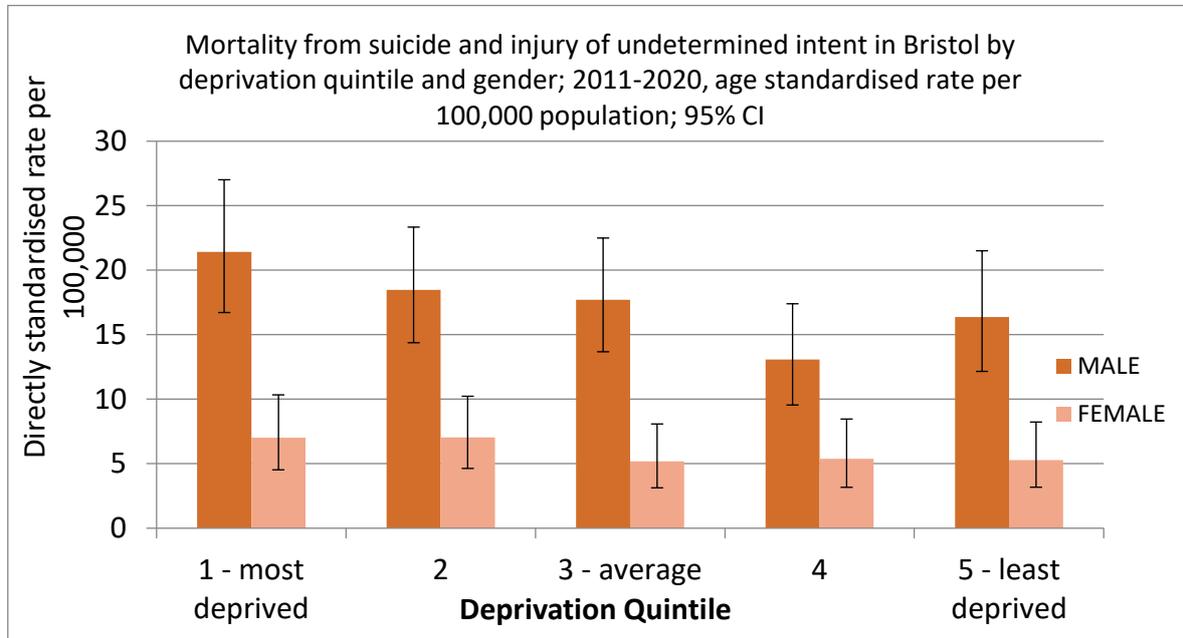


Table 3: Mortality from suicide and injury of undetermined intent in Bristol by deprivation quintile 2011-2020, age standardised rate per 100,000 population. Deprivation quintiles based on IMD 2019 deprivation scores.

Deprivation quintile	Number of deaths	ASR	LL	UL
1 - most disadvantaged	104	14.1	11.5	17.2
2	104	12.8	10.4	15.6
3	92	11.5	9.2	14.2
4	74	9.4	7.2	12.0
5 - least disadvantaged	75	10.6	8.3	13.4
Bristol	449	11.8	10.7	13.0

2.4 Method of death

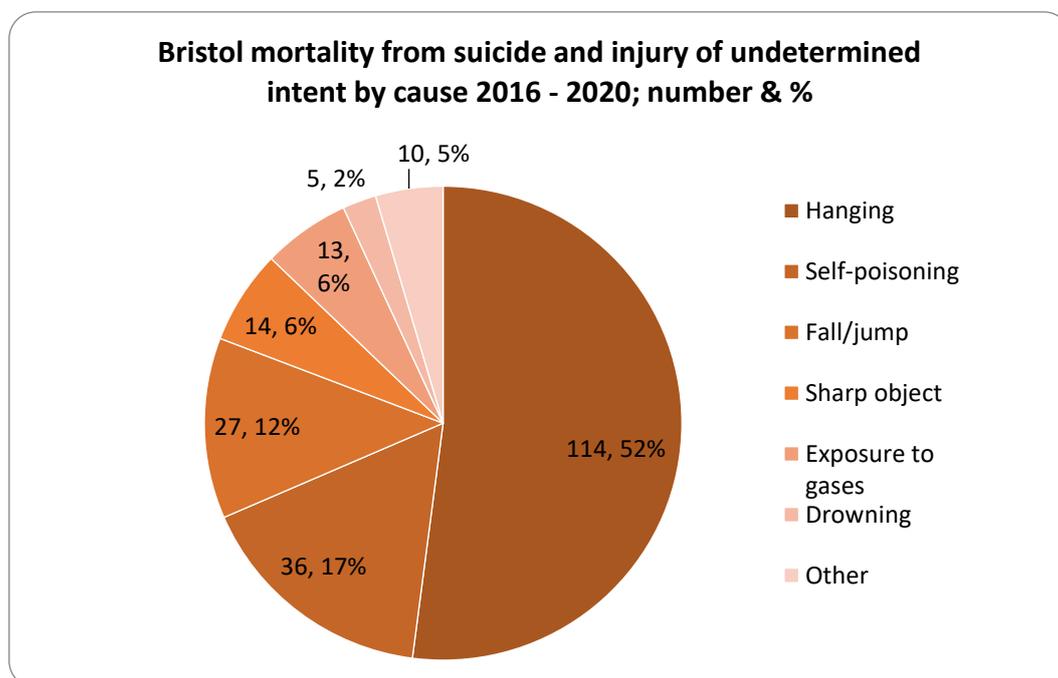
Hanging was the most common cause of mortality from suicide and undetermined death between 2016 and 2020 for both men and women, this is similar to the rest of England. This was followed by self-poisoning. There is a relatively high proportion of deaths from falling or jumping compared to the England average (over a half of deaths due to a fall/jump have been located in the vicinity of Avon Gorge and Clifton Suspension Bridge)

There are different patterns for men and women and Table 4 and figure 7 provides a summary of all of the methods used by gender.

Table 4 Method of suicide by gender and cause 2016-2020. Source: Primary Care Mortality Database 2021 via NHS Digital

Cause of death	Male (number)	%	Female (number)	%
Hanging	86	52.4%	28	50.9%
Self-poisoning	20	12.2%	16	29.1%
Fall/jump	22	13.4%	5	9.1%
Sharp object	12	7.3%	2	3.6%
Exposure to gases	11	6.7%	2	3.6%
Drowning	4	2.4%	1	1.8%
Other	9	5.5%	1	1.8%
Total	164		55	

Figure 7: Mortality from suicide and injury of undetermined intent by cause, Bristol 2016-2020. Source: Primary Care Mortality Database 2021 via NHS Digital



2.5 Place of death

In common with the rest of England 58% of all suicides and undetermined death took place at home between 2016 and 2020.

% took place in a public place such as a park or railway. 8.7% of deaths took place in the Avon Gorge/Portway area.

2.6 Safety in custody statistics

The number of apparent self-inflicted deaths within Bristol Prison increased from 3 to 8 in 2014-2016 and this continued to 2018 but has since gone down to 3. The rate of self-harm incidents has increased significantly between 2015 and 2021

Table 5. Deaths in Bristol Prison between 2010 and 2021. Source: Ministry of Justice and National Offender Management Service, Safety in Custody Statistics: Safety in Custody summary tables to December 2021

Bristol Prison	2010-12	2011-13	2012-14	2013-15	2014-16	2015-17	2016-18	2017-19	2018-20	2019-21
Apparent self-inflicted deaths:	4	3	1	3	8	9	8	2	3	3
Apparent natural cause deaths:	3	2	2	3	4	4	3	4	3	1
Total deaths:	7	5	3	6	12	14	13	7	7	5

Table 6. Self-harm incidents in Bristol Prison between 2004 and 2021. Source: Ministry of Justice and National Offender Management Service, Safety in Custody Statistics: Safety in Custody summary tables to December 2021

Year	Self-harm incidents
2004	156
2005	190
2006	102
2007	164
2008	149
2009	79
2010	131
2011	111
2012	87
2013	84
2014	80
2015	246
2016	256
2017	427
2018	426
2019	957



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2020	878
2021	514

3.0 Local Suicide Audit

To provide a closer analysis of local issues, patterns and possible areas for intervention Avon and Wiltshire Mental Health Partnership NHS Trust gather data from Avon coroner’s Court in Bristol to identify high risk groups, locations of concerns, patterns and trends and evidence for targeted interventions.

This analysis is shared with the Avon Suicide Audit group consisting of suicide prevention leads from Bristol, North Somerset, South Gloucestershire, and Bath and Northeast Somerset.

There were 312 deaths from suicide and undetermined intent during the last three-year period 2016-18 which were reviewed by the Coroner’s Court in Avon. There has not been an audit completed since this point due to difficulties in accessing the data. The real time surveillance programme of work will fill this gap going forward.

3.1 Ethnicity

Ethnicity was only recorded on three quarter of the sample taken so it is not possible to draw accurate conclusions. Ethnicity is not one of the mandatory items that coroners are required to complete.

Ethnicity has been recorded in 243 cases of which 60% were White British, 11% White Other and 7% Black, Asian, or other minority ethnic group (2016-2018)

3.2 History of self-harm

Table 7 below shows that overall 40 percent of people who died by suicide had a history of some form of self-harm. For females this was 47 percent. However, this information was inconsistently recorded within the coronial records and was largely extracted from reviewing the narrative surrounding the person’s death.

Table 7 Proportion of cases with a recorded history of self-harm, all deaths 2016-2018

History of self-harm	Male	Female	Total
Yes	38%	47%	40%
No	7%	6%	7%
Not recorded	55%	47%	53%

3.3 Access to health and support services

25% of people had been in contact with secondary care mental health services within 12 months of their deaths, which is consistent with national data. A further 38% of people had been in contact with some sort of counselling or other primary care-based psychological care service in the community.

Table 8 Access to mental health and support services, all deaths 2016-2018

Service	%
GP only	38%
Mental health services	25%
Drug & alcohol services	2%
Other	1%
Not recorded	33%
Total	100%

4.4 Key psychological diagnosis or recorded health problems at the time of death.

Over 70% of people had been identified as experiencing some form of diagnosable mental and/or physical health problem prior to their death.

Physical health problems including chronic pain was recorded for 17% of the diagnoses. The most common association is with low mood and anxiety.

Table 9 Key diagnosis before death between 2016 and 2018 (This is greater than 100% due to multiple problems)

Diagnosis noted	% in total
Low mood	38%
Anxiety	18%
Physical health problems (incl. COPD & cancer)	14%
Other mental health disorders	11%
Alcohol abuse	9%
Personality disorder	7%
Drug abuse	6%
Bi-polar affective disorder	4%
Chronic pain	3%
Schizophrenia	3%
PTSD	2%
Depression	2%
Attention deficit hyperactivity disorder (ADHD)	2%
Not recorded	29%

4.0 Self-harm

In 2020/21 in Bristol there were 1,717 emergency admissions to hospital due to intentional self-harm (the rate of 332.4 per 100,000 population, significantly higher than England average of 184 per 100,000). That is a 6% increase comparing to the previous year. 68% of those admissions were among females. The rates of intentional self-harm were almost 2 times higher among women than men. In 2020/21, there were 1,173 female admissions in Bristol, a rate of 443.5 per 100,000. Number of male admissions was significantly lower at 538 – a rate of 221.8 per 100,000 in 2020/21 (Joint Strategic Needs Assessment Data Profiles, Self-Harm Chapter [JSNA Health and Wellbeing profile 2021-22 Self-harm \(bristol.gov.uk\)](https://www.bristol.gov.uk/jсна/health-and-wellbeing-profile-2021-22/self-harm)). However, as the majority of self-harm does not warrant hospital admission the numbers above are only the tip of the iceberg.

It has been estimated that about 50% of people who died of suicide have previously self-harmed (Preventing suicide in England: Fifth progress report of the cross government outcomes strategy to save lives; [Preventing suicide in England: Fifth progress report of the cross-](#)



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[nment outcomes strategy to save lives \(publishing.service.gov.uk\)](#)) The risk of suicide is heightened within the first year after self-harm.

The Bristol self-harm register recorded detailed information on those presenting to emergency department in Bristol Royal Infirmary up until 2018.

Demographics

- There were 1,750 episodes of self-harm presenting to the Bristol Royal Infirmary (BRI) in 2018. This was made up by 1286 individuals, therefore roughly 1 in 3 of the episodes were repeat attendances.
- Male self-harm attendances in 2018 were higher than those in 2017
- Female patients make up a greater proportion of self-harm patients at BRI 59.8 v 40.2. Females were on average younger
- 12.7% of attendances are among students (aged 15 and over) Restricting that to those 18 and over – 80% of presentations were among university students. 220 presentations per year,

Cited causes

- 7% cited debt, money, finance or gambling as precipitating factors for self-harm
- 7.7% were indicated to be in patients who had experienced domestic violence. This excludes those who have experienced historic child abuse.

Method of self-harm

- Self-poisoning was the most frequently used method of self-harm (66.4%) About 8.8% of people used both self-injury and self-poisoning

Mental health

- 4 out of 5 patients had a history of self-harm
- 69.4% had received previous psychiatric treatment

Self-harm resulting in a death by suicide

- Data for suicide is only available until 2017. Overall, 77 people who attended BRI following self-harm died by suicide.



5.0 Bristol Suicide Prevention Action Plan 2017 – 2022

The Bristol ambition is to become a Zero Suicide City.

The [Preventing Suicide in England – a cross governmental strategy \(2012\)](#) was launched in 2012 and set clear and evidence-based priority action areas at a national and local level.

1. Provide better information and support to those bereaved or affected by suicide
2. Reduce the risk in key high-risk groups
 - a. Young and middle-aged men,
 - b. people with a history of self-harm
 - c. people in the care of mental health services
 - d. people in contact with the criminal justice system
 - e. specific occupational groups
3. Tailor approaches to improve mental health in specific groups including children and young people and users of drugs and alcohol.
4. Reduce access to means
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring
7. Reduce rates of self-harm as a key indicator of suicide. This was added in the Preventing Suicide in England: Third progress report. (Department of Health, 2017)

The [NHS Mental Health Implementation Plan](#) published in 2019, sets out an ambition to reduce the number of suicides in England by 10 per cent by 2021. It also states that by 2023/24, all systems will have suicide bereavement support services providing timely and appropriate support to families and staff in place.

The Bristol Suicide Prevention Action Plan is based on the national strategy, 'Preventing Suicide in England: a cross-government outcomes strategy to save lives and takes account of the NHS Mental Health Plan ambitions.

The action plan is delivered by a range of partners, including NHS, local authority, academic, voluntary sector, and criminal justice services. During the period of the current plan there have been many changes including the launch of the NHS Mental Health Transformation programme, the establishment of Integrated Care Systems and since 2020 the Covid pandemic. This report marks the final year of the current plan and the launch of a new Suicide Prevention Strategy supported by an annual plan

Action	Lead Partners	RAG
Action Area one: Provide Better Information and support to those bereaved by suicide		
<p>Coroners and emergency services to provide resources for those bereaved by suicide. E.g., a copy of 'Help is at Hand'.</p> <p>Progress against action: Help at Hand is made available to all those bereaved by suicide.</p>	Samaritans / Cruse / Coroner service	Action complete
<p>Coroner and services involved in suicides (e.g., Police, Pathologists) to provide accessible, concise information and support on the processes and standards in a Coroner Inquiry to family members.</p> <p>Progress against action: Avon & Somerset Police ask the families bereaved by suicide if they would like to be contacted by the Avon-wide Beside service. If they consent, then their contact details are shared with the Avon Real Time Surveillance System coordinator. The Police are also able to provide the 'Help is at Hand' leaflet.</p>	Coroner service	Ongoing
<p>Assess levels of bereavement support and 1-1 counselling available for those affected by suicide, and whether needs are being met.</p> <p>Progress against action: A suicide bereavement service has been established with NHS funding, this service is being evaluated and will produce a report, however, this action is still ongoing.</p>	Clinical Commissioning Group	Ongoing
<p>Review the implementation of the <i>PHE guidance on Support after a Suicide: a guide to providing local services</i> in Bristol and to identify gaps.</p> <p>Progress against action: This action is complete – this was reviewed by the RTSS group and the Avon wide Bereavement service is now in place</p>	Public Health	Action Complete
Tailor approaches to improve mental health and reduce risk in specific groups including children and young people		
<p>University Students: Develop strengthened approach between University of Bristol, UWE, Public Health, NHS, and national partners to improve student mental health in Bristol and reduce suicides</p> <p>Progress against action : Joint work has been undertaken by both universities to implement mental</p>	University, Bristol City Council, NHS	Action completed
		This remains



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<p>health and suicide awareness programmes across the campus and learning programmes. This work was supported by an Office for Students funded programme which was student led. With very high numbers of students in the city, this work continues to be a high priority. There was a report produced after end of UUK project. universities have a copy.</p>		<p>a priority area - work ongoing</p>
<p>Children and young people: Review, develop and launch the mental health badge within the Healthy School's scheme. Continue roll out of mental health training to the wider children and young people's workforce.</p> <p>Progress against action: The school's mental health badge has been relaunched. Bristol was successful in obtaining funding for young people's mental health</p> <p>The Healthy Schools Programme was relaunched in Bristol in January 2020, but engagement with schools has been very difficult due to the COVID pandemic and the impact that this had on schools. The number of schools who have achieved Healthy Schools awards is therefore very low.</p> <p>The basic mental health and wellbeing criteria are contained in the Healthy Schools Essential award. Schools who achieve this can then go on to work towards the Specialist Mental Health and wellbeing award. The mental health criteria for these two awards have been designed reflect a whole school approach to mental health.</p> <p>To date 3 schools have achieved the Essential Award and 1 of these schools has also achieved the Specialist Mental Health and Wellbeing award.</p> <p>In 2020 BNSSG CCG obtained funding for 3 mental health support teams in schools. Two of these teams were placed in education settings in South Bristol and East Central Bristol. Schools in areas of highest deprivation were targeted, where risk factors for poor mental health are higher.</p> <p>Bristol was allocated a third team in January 2022, which was placed in settings in North Bristol, again focusing on areas of highest deprivation.</p> <p>Bristol is due to get another 1.5 teams by 2024, which will provide this service for 50% of the school age population.</p>	<p>Public Health</p>	<p>Action completed</p> <p>This remains a priority area - work ongoing</p>

<p>In 2021/22 BCC commissioned Off the Record (OTR) and 1625IP to deliver mental health training to the wider children and young people workforce. This was targeted at professionals working with vulnerable young people and those working in post 16 settings.</p> <p>During this period</p> <ul style="list-style-type: none"> • 179 professionals were trained in resilience building • 18 professionals were trained in supervision skills. • Two courses were interrupted by staff sickness, and it has been difficult to rearrange these during 2021/22, so this training will therefore be completed in Autumn 2022. 		
<p>Reduce the risk in key high-risk groups including men, people in contact with mental health services, debt and financial vulnerability, people in contact with criminal justice system</p>		
<p>Men including debt/financial issues: Develop and implement a targeted approach for the promotion of men’s mental health. This will include suicide prevention training, and the development of health improvement programmes targeting men</p> <p>Deliver the Hope project across BNSSG which targets individuals in acute distress created by debt, unemployment, financial difficulties and welfare difficulties</p> <p>Progress against action: The Hope Project provides emotional and practical support for men aged 30-64. The project has been recognised nationally and an independent evaluation has been published in BMC Psychiatry and Journal of Mental Health.</p>	<p>Suicide prevention transformation fund and Public Health</p>	<p>Identified action completed</p> <p>This remains a priority area - work ongoing</p>
<p>People in contact with Mental Health Services and/or drug and alcohol services: Avon and Wiltshire Partnership Trust (AWP) to provide an update on the action identified in their suicide prevention strategy</p> <p>Progress against action: The AWP suicide prevention strategy objectives are aligned to the <u>National Suicide Prevention Strategy for England</u> (NSPS), and aims to reduce the suicide rate in the group of people who come into direct and indirect contact with our services. We also aims to provide better</p>	<p>AWP</p>	<p>This remains a priority area - work ongoing</p>

<p>support for those bereaved or affected by suicide.</p> <p>The focus of our efforts will centre on the seven main NSPS objectives:</p> <ol style="list-style-type: none"> 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 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 7. Reducing the rates of self-harm as a key indicator of suicide risk 		
<p>Criminal justice/prison: Improve timely information about suicide affecting those in prison and the criminal justice system</p> <p>Progress against action: The caveat is that self-harm and suicide prevention is led by more than one of the teams, the prison and the health provider have reporting, and escalation routes are through their respective organisations, HMPPS and for health reportable to NHSEI H&J Commissioning. Collaborative working and review is in place.</p> <p>Reporting is through more than one route and although there will be quarterly reporting, the reporting and action plan and prevention methods will be more frequent</p> <ul style="list-style-type: none"> • HMP Bristol have Suicide Prevention plans in place and leads for this work “ • “Quarterly reporting of suicide and self-harm in HMP Bristol and identified preventative actions.” <p>Collectively we had been looking to engage with this network, thinking not only about the risk whilst in prison but also the connection and ongoing need on release.</p>	<p>HMP/NHS England</p>	<p>This remains a priority area - work ongoing</p>
<p>Women: Provide suicide prevention and awareness training to staff working with victims and survivors of</p>	<p>Next Link /</p>	<p>This remains</p>

<p>abuse. Promote appropriate forms of support and knowledge of referral to specialist agencies for victims of abuse.</p> <p>Progress against action:</p> <ul style="list-style-type: none"> - Training programme has been developed with Keeping Bristol Safe Partnership. This includes a Tier 1 training that will cover basic awareness of domestic abuse and other key areas relating to the Domestic Abuse Act 2021. This will launch in Autumn 2022. Tier 2 workshops with focus on key areas with shorter sessions will follow in 2023. - Work has been delivered with the Domestic Abuse and Survivor Forum to ensure the voice of lived experience is included in our training and they have also been consulted on approach and content - Currently a mapping of training activity is being carried out to see what else is being delivered in the city to ensure a more strategic approach is being taken and duplication avoided. - Housing staff have been delivered a number of basic awareness sessions via webinar, and given information on the Domestic Abuse Act 2021 and the implications for Housing - A housing IDVA has been employed who is based in housing and is offering advice and delivering training 	<p>University of Bristol</p> <p>Samaritans</p>	<p>a priority area - work ongoing</p>
<p>Reduce access to means</p>		
<p>High risk areas: Avon Gorge Working Group to report to Avon Suicide Prevention Group on key concerns, improvements, actions and risks.</p> <p>Progress against action: The notes of the last meeting are not out as yet. The last available set of notes were from March. There isn't anything in there that can be shared. This work is also still ongoing</p>	<p>Avon Gorge working Group</p>	<p>Ongoing</p>
<p>Reduce the rates of self-harm</p>		
<p>The STITCH HIT reports to the group on key findings, priorities and progress. This includes communicating with and following up on people who present at emergency departments after self-</p>	<p>STITCH steering Group</p>	<p>Ongoing</p>



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<p>harming and signpost to appropriate services.</p> <p>Progress against action: A review is currently being undertaken to set up a data collection system for self-harm presentations at emergency departments and minor injury units.</p>		
Support local media in reporting suicide and suicidal behaviour		
<p>Ensure the Samaritans Guidance for media reporting of suicide is implemented by local media outlets</p> <p>Progress against action: There has been substantial support for the local media in the reporting of suicide and suicidal behaviour. Media coverage will continue to be monitored and support given where appropriate.</p>	Samaritans	Ongoing
Provide training to Bristol people to enable them to prevent and respond to suicide		
<p>Commission and deliver suicide prevention training across the city</p> <p>Progress against action: Thrive Bristol’s training programme includes courses on suicide prevention. Each year approximately 350 people attend, from voluntary , faith and community organisations, advice services, and housing. At least 90% of respondents report an improvement in their knowledge, skills, and confidence.</p> <p>ZSA suicide prevention module has been promoted widely and UoB has rolled it out to staff and students (a new student module was launched in Jan 2022). Suicide prevention is now included in mandatory training to taxi drivers, delivered by BCC. There is also a new ZSA module for taxi drivers later this year.</p>	Public Health	Ongoing

6.0 Summary and Recommendations

The NHS 2019 national ambition to reduce the number deaths by 10% has not been achieved either nationally or locally. However, Bristol Suicide rates have remained relatively stable and are comparable to the rest of England. In summary, action has prevented any increase in deaths but has not achieved the ambitions to reduce deaths.

The current evidence supports continued focus on preventative action with men, students, young people, people in contact with mental health services, offenders and on self-harm prevention. Evidence also suggests a focus on treating depression and anxiety and an understanding of the impact of this and support, for GPs who require not only the skill and time to recognise potential risk, but also the resources and systems through which to provide a compassionate response.

Looking forward, the impact of successive lock downs and the Covid pandemic combined with pressures on the cost of living and a global instability means that it is highly likely there will be an increase in emotional and mental health problems. Indeed, this is already being reported by schools and GPs. Furthermore, the establishment of Integrated Care System and the implementation of the Healthier Together Community Mental Health framework brings new opportunities for closer working with the NHS and wider partnership working.

To support delivery over the next three years a new Suicide Prevention Strategy and Plan for Bristol is being developed to take account of the new set of partnership arrangements and ensure an ongoing focus on priority areas for suicide prevention in Bristol, including delivery of the mental health concordat. The new Strategy and plan will be published on the Bristol City Councils web site.



Terminology

Suicide the National Statistics definition includes all deaths from intentional self-harm for persons ages 10 and over, and deaths where the intent was undetermined for those aged 15 and over.

Suicide attempt is used to mean any non-fatal suicidal behaviour and refers to intentional self-inflicted poisoning, injury or self-harm which may or may not have a fatal intent or outcome. (World Health Organization, 2014)

This definition is complicated as it includes non-fatal self-harm without suicidal intent.

Suicidal behaviour refs to a range of behaviours that include thinking about suicide (or ideation), planning for suicide, attempting suicide and suicide itself. (World Health Organization, 2014)

Suicidal ideation active Thoughts about taking action to end one's life including identifying a method, having a plan, or having intent to act (McHugh *et al*, 2019)

Suicidal ideation passive Thoughts about death or wanting to be dead without any plan or intent (McHugh *et al*, 2019)

Self-harm The Royal College of Psychiatrists defines self-harm to an intentional act of self-poisoning or self-injury carried out by a person, irrespective of the type of motivation or degree of suicidal intent. (Royal College of Psychiatrist, 2010)

Non-suicidal self-injury self-injurious behaviour with no intent to die

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