Sustaining change

The theme for this briefing paper is moving beyond recurring lessons learnt from suicide reviews to identifying and prioritising areas for change in a way that is manageable for staff. To support your approach to sustaining change we’ve collated and linked the guidance and commentary we have previously issued to recurring improvement themes identified in the review reports submitted to the SRLS.

Review process: improvements

Since the SRLS commenced, we have seen many improvements in the process and transparency of suicide reviews.

- There has been a significant improvement in involving family members and carers in the suicide review process. All NHS boards now have a policy of proactive engagement with bereaved families when appropriate.
- The connection between learning from suicide reviews and appropriate actions being taken is clearer from improved action plans associated with individual suicide reviews.
- We have seen improvement in the way clinical staff are engaged in the process but there is still room for development. Frontline staff must have the opportunity to learn from the findings of reviews.

We know through our Suicide Reviews Team Network that mental health services continue to refine the way that lessons learnt from suicide reviews inform wider service development. Those lessons may be directly relevant to the completed suicide but most relate to wider service issues that are highlighted by the review process.

Recurring themes: prioritising change areas

Since June 2015, we have grouped service and care related issues under six key quality indicators (KQIs). This has highlighted the recurring nature of many of the themes and raises wider questions about making sustainable change. The range of issues identified can seem daunting and there is a risk that staff may feel overwhelmed by the volume of information coming out of suicide reviews. Too much change may leave staff with limited capacity to make the changes that really matter. If an organisation is to manage change effectively, it can be helpful to target specific areas that require improvement.

The six KQI themes help in the classification of areas where recurring issues arise but it is the detail that highlights the specific problems that need to be addressed. Two specific examples being:

- poor engagement with family members and carers lead to less effective risk assessment and planning of care being identified in the reports, and
- communication difficulties between primary care and mental health services leads to differing expectations of treatment and gaps in care.

There are many potential sources of information that highlight specific areas for manageable change. Unsurprisingly the themes identified under our KQIs below are in line with those themes identified by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.
To help services prioritise change areas we have set out below the specific issues we have identified under the six KQI themes in the reporting period.

<table>
<thead>
<tr>
<th>KQI 1 – transitions of care</th>
<th>Between:</th>
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<tbody>
<tr>
<td>addictions and general psychiatry – who has overall clinical responsibility?</td>
<td></td>
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<tr>
<td>primary care and mental health services – sharing expectations of care and treatment</td>
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<tr>
<td>liaison, mental health and primary care – communication of patient contact and potential risk factors</td>
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<td>home treatment teams, crisis teams, inpatient services</td>
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<td>psychology and psychiatry</td>
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<td>non-attendance procedures – what happens when patient breaks contact?</td>
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<td>caseload review by consultants at junior doctor changeover.</td>
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<tr>
<th>KQI 2 – risk management</th>
<th>Full and accessible psychiatric history</th>
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<tr>
<td>Taking a longitudinal view of risk</td>
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<tr>
<td>Recording of significant social and clinical factors</td>
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<tr>
<td>Access to records – impaired by different records systems, for example AHPs and psychology</td>
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<tr>
<td>Communication of dynamic risk status to all involved – making sure important changes are shared among clinical team</td>
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<tr>
<td>Third party information/corroboration (by family and others)</td>
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<tr>
<td>Taking a record in patient notes of any discussions by telephone or email</td>
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<tr>
<td>Communication and supervision between non-medical and medical practitioners</td>
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<tr>
<td>Use of objective non-judgmental language when describing behaviour related to risk assessment</td>
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<tr>
<td>Use of standardised risk assessment tools</td>
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<tr>
<td>Regular communication and supervision in complex cases where a number of agencies are involved</td>
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<tr>
<td>Joint working between social and health care services</td>
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<tr>
<th>KQI 3 – effective management of safe therapeutic observation practices</th>
<th>Procedures for ‘pass’ decision making and communication with family</th>
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<tr>
<td>Access to dangerous items – ligatures</td>
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<td>Management of observation levels including ‘general’</td>
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<td>Inpatient observation</td>
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<td>Restriction of freedom versus dignity</td>
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<th>KQI 4 – medicines management</th>
<th>Prescribing issues</th>
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<td>Dispensing issues</td>
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<tr>
<td>Concordance with medication and patient education</td>
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<th>KQI 5 – family involvement</th>
<th>Impact of suicide on family members including children</th>
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<tr>
<td>Post event information about patient (to and from family members and carers)</td>
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<td>Care teams engagement with family members and carers</td>
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<th>KQI 6 – life factors contributory social factors</th>
<th>Previous trauma</th>
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<tr>
<td>Managing distress</td>
<td></td>
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<td>Employment issues</td>
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<td>Financial issues</td>
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From all of the above areas that have been covered in your suicide review report recommendations over the reporting period, **the top five themes** are:

- the importance of staff taking a good clinical and social history
- staff continuing to improve communication and engagement with family members and carers
- the creation of practical risk management/crisis plans that assist in the instillation of hope and recovery
- the importance of using clinical audit to improve clinical record keeping, and
- improving communication and co-ordination between addiction services and mental health teams.

The collated themes from the suicide review reports submitted to the SRLS provide a source of information to enhance your local analysis of mental health adverse event reviews. This can help frontline staff to decide which improvement area to focus on, for example through structured discussion supported by tools such as our *Reducing suicide risk: mental health team discussion framework*. To further support staff we have highlighted some of our relevant resources which you can find on our Community of Practice website.

**Record keeping and communication:**
- Use of Care Programme Approach in complex cases ([December 2014 Briefing Paper](#))
- Record keeping, information technology, multidisciplinary and multi-agency involvement ([June 2014 Briefing Paper](#))

**Addiction and mental health services:**
- Use of Care Programme Approach in complex cases ([December 2014 Briefing Paper](#))
- Overdose – making it harder to act on impulse ([June 2014 Briefing Paper](#))
- Record keeping, information technology, multidisciplinary and multi-agency involvement ([June 2014 Briefing Paper](#))

**Involvement of family members and carers:**
- Communication with patients, and their family, on admission ([December 2014 Briefing Paper](#))
- Communication with family members and carers ([December 2014 Briefing Paper](#))
- Making mental health services understandable and user friendly to service users and their family ([June 2014 Briefing Paper](#))
- Supporting family members who have been in an abusive relationship with the person who has completed suicide ([June 2014 Briefing Paper](#))
- Guidance on making sure family members and carers are involved in the suicide review ([Learning and Development page](#))

We have a hard copy leaflet for explaining suicide reviews to family members and carers when you first meet with them as part of the review process, please contact us if you would like copies.

**Hard to engage patients:**
- Use of Care Programme Approach in complex cases ([December 2014 Briefing Paper](#))
Deteriorating patients:
- Use of Care Programme Approach in complex cases (December 2014 Briefing Paper)
- Communication with patients, and their family, on admission to mental health services (December 2014 Briefing Paper)
- When patients go missing from hospital (June 2014 Briefing Paper)
- Knowing where at risk patients are – getting the balance right (December 2013 Briefing Paper)
- Out of hospital – suicide risk identification and risk reduction (December 2013 Briefing Paper)

Many of these themes are being addressed through national improvement programmes, such as Healthcare Improvement Scotland’s Scottish Patient Safety Programme for Mental Health (SPSP-MH). Having accessible information on your services’ engagement in national programmes and other ongoing improvement work is important in supporting staff to understand how they can sustain change. Here is an update on our related improvement programmes.

Improvement programmes

Scottish Patient Safety Programme for Mental Health

There is a SPSP-MH work stream development day on 9 March 2016 to review the safety principles. The safety principles sit under the five main work streams (communication at transitions, leadership and culture, restraint and seclusion, risk assessment and safety planning, and safer medicines management). For each safety principle, interventions and processes are being designed which aim to contribute to a reduction in harm, measurable through the SPSP-MH outcome measures.

As phase 2 of the programme is due for completion by the end of August 2016, there is an event on the 10 March to develop phase 3. The first two phases have been working with inpatient units and phase 3 will see the programme consider expansion into community, child and adolescent mental health services (CAMHS), older adult and perinatal psychiatry, although this list is not exhaustive. For further information please contact the team on spsp-mentalhealthteam.hcis@nhs.net.

Improving observation practice

The revision of the national good practice statement is well underway, building on current examples of observation practices which are person-centred and aligned with the recovery model of care.

The patient and service user group met in August 2015 and highlighted the need to keep in mind the partnership between the clinician and patient, focusing on key principles of mutual respect and trust. The group discussed the different perceptions of risk held by those engaged in the intervention and the importance of making the most of every therapeutic opportunity.

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1 Engaging People – observation of people with acute mental health problems: a good practice statement, CRAG 2002
To support the revision, the SPSP Improving Observation Practice team is designing an improvement programme in collaboration with NHS boards and partner agencies. All NHS boards have nominated an executive lead who, together with members of the Review Group and Nurse Advisory Group, attended a development day in October 2015. The group discussed various aspects of the guidance review during this session including consultation with staff, approaches to testing, measurement and education requirements. Based on these discussions, we have developed an options appraisal which is being considered by the executive leads and will inform how the improvement programme will be taken forward.

If you would like to know more about the revision or be involved in the testing phase then please contact us on hcis.SuicideReviewTeam@nhs.net.

NHS board improvement programmes:
Translating learning from mental health adverse event reviews into service improvements

We are currently facilitating improvement programmes with NHS Grampian, NHS Greater Glasgow and Clyde and NHS Tayside.

**NHS Grampian** is testing a process for improving sharing of learning and implementation of service improvements recommended from mental health adverse events. Service improvements include use of the revised discharge checklist, pass checklist, multidisciplinary team meeting recording sheet and the Confidentiality Assurance Guidelines. The Clinical Director is also giving a series of presentations to raise awareness of the process and purpose of reviews, and how learning points identified lead to improving services and reducing risks. We have some initial information on NHS Grampian’s approaches on our Community of Practice website with updates to follow.

**NHS Greater Glasgow and Clyde** is progressing two improvement programmes: improving feedback to care teams following reviews; and improving families’ and carers’ experience of involvement in the review process.

Feedback to care teams following reviews has, to date, highlighted issues that we hear from across mental health services during our progress meetings:

- feedback can happen many months after the event
- some care team members have moved posts
- staff can feel vulnerable to being re-traumatised
- there is not always managerial buy-in or support
- staff that do attend can be repeatedly called out of the meeting (clinical duties)
- the process of reviews and aim of learning to improve healthcare systems may not be fully understood or supported, and
- staff may feel exposed to personal criticism.

There are many interesting findings coming from this work which will inform the next test of change. We will keep you updated on progress.

Improving families’ and carers’ experience of involvement in the review process is an exciting programme which is in its early stages of development. We know from the reviews we receive, and from our progress meetings with mental health services across the country, that all NHS boards now involve families in their reviews of suicides, unless there are good reasons not to. Practice varies in how this is done but the general approach is to tailor the contact to the personal situation of the relatives. Mental health services have views on the
most effective way of engaging with family members in a positive manner. While there is some variation of approach, there are common themes in how this is done. However, we have very limited information about the experiences and opinions of families and carers bereaved by suicide. This is something that is essential in developing good practice and an area that NHS Greater Glasgow and Clyde is keen to progress. The methodology being considered includes questionnaires for families and carers to complete anonymously, and semi-structured interviews undertaken by a support organisation with the required expertise and contacts. As with the other improvement programmes we will provide updates on our Community of Practice website once this programme is up and running.

**NHS Tayside** is looking at translating learning from adverse event reviews to help support improved identification, communication and care for people at risk of suicide by focusing on training mental health staff in a formulation-based approach to suicide risk assessment. Through this approach, staff will be provided with a shared framework for assessing risk to encourage a more detailed examination of risk factors, and to provide a more explicit explanation of the resultant clinical judgments than has been evident to date. Good progress has been made with rolling out training, with initial priority given to clinical areas where a number of adverse events have occurred. An agreed training plan is in place for around 200 staff in CAMHS, adult services and older people services throughout this year. There is initial face-to-face training and a follow-up half day learning set. In between these trainer-led days, staff are encouraged to participate in small improvement groups within their own clinical teams. Staff are asked to bring risk assessments completed before and after training to the learning set; a comparison of a sample of these ‘before’ and ‘after’ assessments will then be used to assess the impact of training in improving the quality of risk assessment. We will provide updates on improvements as this work progresses on our Community of Practice website.

**SRLS programme updates**

**Reducing suicide risk: mental health team discussion framework**

We gave a detailed update on the framework in our last briefing paper. Since then we have invited feedback. You may have received an email with a few questions to respond to about how you’re using it and ways that it could be improved. Please contact the team (hcis.suicidereviewteam@nhs.net) if you have not and would like to input.

There have been suggestions that the discussion framework could be used as part of different national programmes, such as Healthcare Improvement Scotland’s Quality of Care Reviews, and part of training and education packages that are being developed for the Learning from Adverse Events Programme and the Improving Observation Practice programme. Further comments and suggestions are welcome, all of which will help us to inform a more formal evaluation later in the year.

**Reporting to the SRLS**

We wrote to NHS board Chief Executives in December 2015 to clarify the SRLS reporting criteria. If a person has contact with mental health services in the year preceding death by suicide, the NHS board notifies the SRLS. The NHS board will follow its adverse event policy to carry out a review of the person’s care to identify any learning for improvement. The **National Framework for Learning from Adverse Events** sets out the levels of review which will be carried out depending on the complexity of the event and potential for learning. Once

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the level has been decided and the review report completed/signed off, this is submitted to the SRLS. There have been recent examples of level 2 or 3 reviews being completed for suicides of mental health patients which have not been submitted to the SRLS. All levels of review should be submitted to inform national learning for improvement and to ensure external quality assurance of the process. If you have any questions about what should be submitted to the SRLS or the process for reporting please contact us and we'll be happy to help on hcis.SuicideReviewTeam@nhs.net.

Review reports: formats and templates

We have been asked recently about formats/templates of final review reports. We have previously provided guidance on what we would like to see included in review reports and have set reporting criteria. The aim is to make sure there is consistency of reporting while taking account of NHS boards local review approaches.

Since the SRLS was set up in 2008 we have seen all NHS boards revise suicide review processes so that these are now carried out under their NHS board’s adverse event policy. Similarly, the SRLS became part of our wider Learning from Adverse Events programme. As part of the accompanying toolkit to the national framework we published Data redaction and standardised adverse events review reports guidance paper. We have recently produced a version of this guidance which includes links to relevant SRLS guidance and details any additional information required for reporting to the SRLS. This will be circulated to the Suicide Review Team Network for comment and then published on our Community of Practice website.

Learning summaries

In September 2015 we wrote to all NHS board Chief Executives to emphasise the importance of sharing learning points following adverse event reviews and encouraged all NHS boards to use learning summaries as a routine part of adverse event management processes. This was endorsed and fully supported by the Adverse Events Programme Board, which includes executive members of NHS boards within Scotland.

Based on good practice highlighted by members of the Learning from Adverse Events Network, learning summaries are a way of sharing findings from reviews and showing in a succinct and accessible way how recommendations have led to improvements. For example, sharing learning summaries with family members and carers can help to show how the review process has made a real difference. A short-life working group has recently been set up to look at refining the template and the practicalities of its use.

In the past, we have asked you to provide us with a learning summary of each suicide review 6 months after submitting the final report to the SRLS. The intention was two-fold:

- to provide external assurance that recommendations are being progressed through action and improvement planning, and
- to inform an aggregation of service improvement themes to share across the Community of Practice.

We would welcome your feedback on using the adverse events learning summary templates as a way of sharing the key findings, recommendations and improvements from suicide reviews. Guidance on using the templates can be found on the Adverse Events Community of Practice. Summarising and sharing your improvement approaches will support all involved  

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3 Healthcare Improvement Scotland. Data redaction and standardised adverse events review reports guidance paper. 2014.
to understand the objectives of a learning review and spread important learning points across NHSScotland to help to reduce suicide risk.

**Suicide Review: Community of Practice website**

As well as our briefing papers, there is the Learning and Development page on our Suicide Review Community of Practice website where we have broken down the review process into stages as set out below.

**Deciding to carry out a review**

Before deciding to hold a suicide review you must be aware of your local review processes. Every NHS board has a key person who will be responsible for governing your local review processes and they will be able to provide you with more information. In this section we provide some guidance to support these local processes.

- Deciding to have a review
- Notification checklist when reporting to Healthcare Improvement Scotland
- Who should participate in a suicide review

**Carrying out a review**

Once you have followed your NHS board governance process and everyone involved has agreed that a suicide review should be carried out, you can use the guidance in this section to help you carry out an effective review.

- Expectations of a suicide review
- Gathering and analysing review information
- How to chair an effective review
- Participating in a review
- Recommendations for action
- SMARTER recommendations

**Service improvement**

Carrying out an effective suicide review will help you identify lessons about the care given to the person who has died. In this section we consider how lessons can be used to make effective recommendations for action, and how actions can be implemented to make service improvements. We also hope to look at measuring the impact of service improvements and ways of reviewing if these are making a difference by reducing risk and improving care.

- From plan, to change, to improvement
- Turning recommendations into improvements

**Communication**

The suicide of a person you care for is likely to have a major impact on you, your colleagues and a devastating effect on the person’s family members and carers. Communication in these circumstances can be extremely difficult. In this section we look at communicating with and involving families and carers, communicating within the culture you work in, and offer some suggestions and support on how to communicate in difficult circumstances.

- Making it safe to learn
- Making sure family members and carers are involved in the suicide review

February 2016
Next Suicide Review Team Network meeting

The Suicide Review Team Network was set up with a view to building a community of practice to share knowledge across organisational boundaries and facilitate and enable sharing of experiences, lessons, challenges and solutions.

We aim to do this by:

- providing support, advice and guidance for suicide review teams
- finding common principles to support an effective system, and
- providing a forum for the exchange of ideas and best practice.

The Network meets twice a year and is attended by NHS board suicide review co-ordinators, staff involved in the review of suicides, and partner agencies.

The next meeting will be on 7 June 2016. We have invited other agencies who have an interest in suicide reviews such as the Mental Welfare Commission for Scotland, Scottish Public Services Ombudsman and the Procurator Fiscal to attend and present on how reviews are used within their context. Equally it gives an opportunity for our community to raise awareness of why suicide reviews are carried out and how they are used to improve services and reduce risk. If you would like further information please contact the team on hcis.suicidereviewteam@nhs.net.