Turning recommendations into improvements – creating an improvement plan

There is little point in carrying out suicide reviews if you do not use any learning identified from the process to make improvements. This section identifies some key issues to consider when developing an improvement plan.

Many NHS boards have incorporated suicide reviews into their adverse event policy and procedures and, increasingly, actions arising from suicide reviews are dealt with through those processes. While the detail of these processes vary throughout NHSScotland there are principles that should apply to all suicide reviews. Like all adverse incidents, the recommendations arising from suicide reviews should be realistic and translated into achievable actions. An effective way of ensuring actions are carried out is through an improvement plan.

What is an improvement plan?

An improvement plan sets out how each recommendation from the review will be monitored, measured and shared. The plan must include responsible owners, timescales for delivery and review dates. The format of improvement plans will vary but they should be set out in a clear and accessible manner.

Key points to consider when preparing an improvement plan¹:

- There should be a clear improvement plan which sets out how each action will be monitored, implemented and measured.
- The improvement plan should be agreed by all relevant members of staff.
- The improvement plan should identify responsible owners, timescales for delivery and review dates.
- Where a recommendation, and subsequent action, is directly related to a concern raised by family members or carers this must be made clear.
- The outcome of the improvement plan should be shared with all those involved in the suicide review and the person’s care, including family members and carers where appropriate.
- All suicide review improvement plans should be locally owned and monitored through defined governance processes. Timescales for completion of actions should be regularly reviewed and rationales for exceptions documented.
- The local policy should outline which group or committee is responsible for monitoring and embedding the improvement plan, to ensure that learning has been shared and implemented. Thematic learning should be collated to inform wider service and organisational improvement plans.

¹ Healthcare Improvement Scotland. Learning from adverse events through reporting and review: A national framework for Scotland; Second edition 2015. For more information on the wider adverse events improvement planning see stage 6: Improvement planning and monitoring (page 25).
Remember that effective communication with those people who have been involved in the person’s care and the suicide review not only spreads learning; it also helps to promote a positive attitude to suicide reviews and consequently to a safer service.

For more guidance on how to find out if your recommendations have led to improvement, please see From plan, to change, to improvement in our Service Improvement section.

Contact the SRLS team if you would like any further guidance or more information.

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