PE1604/H

Health and Social Care North Lanarkshire Letter of 14 October 2016

Please find the response below from NHS Lanarkshire on the questions posed in the above petition.

(i) What measures are in place to provide protection for the health and safety of patients who are released from hospital or receiving care in the community under a Compulsory Treatment Order?

Although in most cases those subject to a community CTO will have been an inpatient, not everyone on a community CTO needs to have been hospitalised.

Patients who are subject to a Community CTO have a number of measures in place to support them. They will be reviewed by their RMO (Responsible Medical Officer) (psychiatrist) and will have a number of other health and social care professionals and housing colleagues involved in their care depending on need. This may include community nursing, occupational therapist, psychologists, social workers and support workers on the nature of the person's needs.

Due to the fact they are subject to a CTO they will also have a Mental Health Officer involved in their care. The RMO is responsible for agreeing with those involved, including the patient and patient's named person (usually a close relative) a care plan which will include identifying needs, how those needs will be met, the person responsible for ensuring the needs are met, and a risk assessment and management plan. The patient and health and social care professionals involved will attend tribunals, where the CTO and support measures in place will be monitored.
They will have access to the additional safeguards under the Mental Health Act such as Advocacy, the ability to write an advance statement as well as regular review of their order in the timescales set out in the act.
Depending on the needs of the individual, MAPPA may form part of how the individual's care is managed.

The person will also have access to their GP and physical interventions as required.

(ii) How are investigations conducted in cases where a patient who was released from hospital or was receiving care in the community under a Compulsory Treatment Order commits suicide to ensure that lessons are learned to improve patient care in the future?

There would be a Significant Adverse Incident Review (SAER) or a Health Improvement Scotland (HIS) Suicide review which are conducted in Line with NHSL's Management of Adverse Event Policy. The review team liaise with the family and invite and support them to participate in the process. They will review all documentation and meet with all relevant staff.

Following the review there is a report which details any learning points and contains an action plan. This Action plan is monitored until completion and any actions plans are also supported through MH&LD governance structures. SAERs and Suicide Reviews are also reviewed through the Support, Care and Clinical Governance Committees of the Health and Social Care Partnerships.

(iii) The Committee also heard evidence from the petitioner on the impact on families when a patient commits suicide and families' desire to be involved in the investigation process. What support is offered to families by your health board and how are families involved in the process in such a way that it is clear to them that the incident is being taken seriously and lessons learned from it?

Appreciating that this is a very difficult time for families, we identify one member of the review team to liaise with the family. They will advise them regarding the review process and invite them to participate. It is important to note that this is a review process not an investigation. The review team also provide written carers information in the form of the After Suicide Booklets which contains information and advice as well as signposting to a variety of supports available to families.

The review team will be led by the family regarding how they wish to be involved in the process and take note of any questions or lines of enquiry they wish the review team to consider.

With the family's permission the review team will liaise with them throughout the process and following the review they will provide an opportunity to meet and discuss the findings, learning points identified, action plan and next steps. We have also fed back to a number of families at a later stage regarding the progress of the action plans and any improvements that have been made as a result of these.

This is a very difficult process and for some occurs too soon for them to be able to face being involved. We try to adopt a person centred approach to this and be guided by the families regarding what they feel is the best approach from them.

Please do not hesitate to get in touch with any queries.

Yours Sincerely,

Ross McGuffie

Head of Planning, Performance and Quality Assurance

Health and Social Care North Lanarkshire