PE1604/L

NHS Forth Valley Letter of 25 October 2016

Thank you for your letter dated 16 September 2016, calling for views from Health Boards on the above petition.

The view of NHS Forth Valley is that mandatory reviews for all cases of suicide would be unhelpful. In some cases of suicide there has been no involvement from health services at all. What seems most important is that health services are accountable for having a robust, tiered, adverse events review process locally, to ensure that there is reflection and leaning following the suicide of someone who is currently, or has recently, been treated by their service. This would include those on orders under the Mental Health or Criminal Procedures Act.

In NHS Forth Valley, patients on community Compulsory Treatment Orders are managed by sector based community mental health teams or the forensic community mental health service. The most risky and complex cases will have multiagency input and are often managed via the Care Programme Approach, to ensure a holistic, needs led care plan, which will include a risk assessment and management plan. Different health and safety measures should be individually tailored to address the identified risks, and are thus not consistent across all cases. For example, if there is a history of medication non compliance, depot medication or supervised medication may be utilised, to reduce the risk of relapse. If there is a history of overdose, limited amounts of medication may be dispensed at anyone time from pharmacy. If patients are particularly vulnerable they may be managed in supported accommodation.

The process for suicide review in NHS Forth Valley is the same as for any other adverse events, whether the patient is on a community Compulsory Treatment Order or not. We have a tiered approach to Adverse Event reviews, with the most complex cases going to SAER (Significant Adverse Event Review). The majority of reviews are carried out within mental health services, with a clinical manager, from outwith the clinical area involved, as chair, an independent consultant present and all staff involved in the care being invited to meet to review the· case. This includes GP, SW, police, housing, third sector, addictions services etc, as necessary, to encourage learning by all agencies involved in the patients care journey. The process is informed by reports submitted in advance and the questions or issues raised by family members in advance of the meeting. The format of the meeting and documentation is consistent with that advised by HIS. All suicide reports are forwarded to HIS in an anonymised fashion to allow for national learning and sharing. Local action plans are created and incorporated in to the clinical governance workplan. Themed learning is being collated and shared. The group report to the Board Clinical Governance Working Group for organisational assurance. A quality assurance forum has recently been introduced within mental health, to enhance the local scrutiny of the process.

Families of suicide victims are invited to participate in the review process. The Associate Medical Director and Service Manger offer to meet families in advance of the review meeting to explain the process and to hear any concerns, issues or questions the family may have. These are then incorporated into the suicide review discussion'. After the review the managers then offer to meet the family again, to feedback the outcome of the

review. The family are not invited to attend the actual review meeting. It is hoped that this will encourage staff to be more open and reflective about their practice, policies and procedures, without being defensive.

Outwith this process, staff directly involved in the care of the family's relative may already have been in contact, to offer condolences and may have agreed to meet to discuss their care.

I hope this is of assistance.

Yours sincerely

Jane Grant
Chief Executive