PE1604/V:
Healthcare Improvement Scotland's submission of 31 March 2017

Thank you for your letter of 3 March regarding the above petition. Your letter asks for clarification on two issues and we hope the information provided below is helpful.

- **How many health authorities are meeting Healthcare Improvement Scotland's targets to commence a suicide review within 2 weeks and complete it within 3 months?**

The guidance on timelines for undertaking suicide reviews is aligned to our National Framework for learning from adverse events.

Our main focus is on whether NHS boards are meeting their own timescales for the review process, the expectations subsequently set out for families and carers and how progress is communicated.

While we do not record figures for the commencement of the review, we do have figures on the timescale from the date of death to the date the review was carried out.

Over a 1-year period from February 2016 - February 2017, 37% of suicide reviews were carried out within 3 months from the date of death.

We know from the reports that we receive, that for a variety of reasons, the process of carrying out the review, writing the report and responding to recommendations can take longer than the 3 months, including taking into account the support, engagement and communication needs of families and carers. It is important that there is regular and consistent communication with families and carers, including when the process has been delayed and the reasons why.

- **How can bereaved families or carers raise concerns with Healthcare Improvement Scotland when they consider that health authorities are not learning from suicide reviews, particularly where these have been highlighted in findings by the Scottish Public Services Ombudsman?**

We have produced an information leaflet for families and carers which includes our contact details. The leaflet was co-produced with patients, service users, families and carers, and support services.

The leaflet explains the purpose of suicide reviews, how families and carers may wish to be involved, the role of Healthcare Improvement Scotland, the role of other organisations that may be involved, and provides contact details for support services.

Family members and carers of people who have completed suicide do contact us, although the numbers are small compared to the total number of reviews of suicides taking place across the country. We routinely will give an overview of Healthcare Improvement Scotland's function in the process and try to help guide the family member or carer to the appropriate agency to deal with their specific issue. We have focused on the concerns and questions of families and carers in the latest edition of our Briefing Paper for the community of practice.

The Scottish Public Services Ombudsman (SPSO) is represented on our Suicide Review Team Network, contributing to both the quality assurance and improvement support work strands of the Suicide Reporting and Learning System. The SPSO is responsible for the monitoring of its findings and this is not an area in which Healthcare Improvement Scotland is involved.

Yours sincerely