PE1604/R

Healthcare Improvement Scotland Letter of 20 January 2017

Thank you for your letter of 9 December seeking the views of Healthcare Improvement Scotland on the above petition, calling on the Scottish Parliament to urge the Scottish Government to expand the remit of the review into the arrangements for investigating the deaths of patients under Section 37 of the Mental Health (Care and Treatment) (Scotland) Act 2015 to include an inquest-type system for all deaths by suicide in Scotland; and to include both patients who were released from hospital or receiving care in the community under Compulsory Treatment Orders.

Your letter seeks clarity on what guidance is currently provided to NHS boards on how to review the death of a patient by suicide in the community, as well as Healthcare Improvement Scotland's views on a number of related issues, and we have answered these questions below.

Introduction

Healthcare Improvement Scotland, through its Suicide Reporting and Learning System, assists NHS boards to improve the way they review the care given to people in contact with mental health services who complete suicide.

When a person in contact with mental health services, including community mental health services, completes suicide the effects are often devastating for family members, friends and the staff involved. When a suicide takes place NHS boards need to understand what happened and learn from any lessons identified. The lessons learnt are important to improve services and help staff recognise where risk exists. Suicide reviews are the way that NHS boards, and their mental health services, analyse what happened and recognise where anything can be done to make things safer for other people at risk. As well as having all the necessary procedures and governance in place to carry out adverse event reviews of suicides and mechanisms for any necessary service improvement, there must be a culture that allows for this to be done in an open and transparent way. By doing this we can convert lessons into improvement and provide care in a way that will reduce risk for others in similar circumstances.

1. Guidance currently provided to NHS boards on how to review the death of a patient by suicide in the community

Healthcare Improvement Scotland has developed a number of resources to support NHS boards carry out adverse event reviews of suicides. The Suicide Reporting and Learning System (SRLS) was set up to assist NHS boards to improve the way they review the care given to people in touch with their mental health services who complete suicide, to help identify and reduce risk.

- The Learning and Development section of the community of practice website provides guidance on each stage of the review process.

- Detailed guidance on the review process and what should be included in the final review report is set out in Suicide Reporting and Learning System: What we are looking for your review reports.

- Turning review report recommendations into improvements can be supported by use of the Reducing Suicide Risk Mental Health Team Discussion Framework.

Additionally, mental health services submit completed review reports to the SRLS for analysis. The SRLS provides feedback to NHS boards on effectiveness of the review process and aggregates mental health services national learning themes to drive improvement. Learning points are shared through the Community of Practice website and through 6-monthly briefing papers which make recommendations for action on current service improvement issues.

Mental health services carry out these reviews under their NHS board's adverse event policy, and the SRLS forms part of Healthcare Improvement Scotland's wider Learning from adverse events programme. The Learning from adverse events through reporting and review: A national framework for Scotland (National Framework) provides a clear, consistent governance framework for managing adverse events (including suicides) that supports preventative measures and reduces the risk of serious harm to people. All NHS boards' adverse event policies are aligned with the National Framework.

2. Views on the petitioner's suggestions for improving guidance on requiring review panels to be led by independent persons and providing families with a timeframe for the review process.

The National Framework includes information on the composition of review teams and the timeframe for review processes (p.18). Death by suicide is a category 1 event and in most cases a level 1 significant adverse event review is carried out. When deciding on the level of review the NHS board will consider a range of factors, including the category of the event and the potential for learning to inform system and service improvement. The National Framework sets out that for level 1 reviews the commissioning manager should agree the review lead, and the review team should be sufficiently removed from the event with no conflict of interest, to be able to provide an objective view. The review should be commenced within 2 weeks and complete within 3 months.

A suicide review is the term used to refer to an adverse event review commissioned to review the care given to a person in contact with mental health services who has completed suicide. The SRLS has provided mental health services with guidance on Who should participate in a suicide review. The guidance provides a checklist for services when considering who should form part of the review team and who should participate in the review. Suicide is a multi-faceted event and this is reflected in the circumstances, the people involved, and the services that have been in contact with the person who has died. The key to carrying out an effective review is to get the right people involved with clear leadership of the review team. The SRLS has provided guidance for review team leads: How to chair an effective review which details the knowledge and skills required. It also states that the lead should have the

appropriate level of independence to lead and produce an objective review, for example, be independent from the service and clinical team that is under review.

It is important that the purpose of a suicide review is clearly set in the Terms of Reference and communicated with staff, family members, carers, and agencies which may have role in relation to suicide. The expected timeframe, and the reasons for any delays in the review processes, should be communicated with all concerned.

The purpose of a suicide review is to help all mental health staff, clinical and managerial, improve the service for others by:

- recognising where risk can be reduced
- identifying where clinical practice and service improvements can be made, and
- sharing good practice found during reviews.

It is important that the review team lead is independent from the clinical team where the event occurred. It is also important that the review is owned by the organisation where the event occurred. For mental health staff who were caring for the person who died, there is an understanding that the NHS has its own responsibility to review the circumstances of the death to identify what lessons can be learnt. It is care providers who are responsible for providing high quality care services and need to have the right skills and capacity to build open relationships with the people who use their care and their families, identify and learn from past care, and put improvements into place.

Other authorities and agencies may become involved: the Procurator Fiscal, the Scottish Public Services Ombudsman, the Mental Welfare Commission for Scotland and the Health and Safety Executive all have potential roles in relation to a suicide (please see After a suicide: multiple investigations, p5). There is not one process of review or investigation that can fulfil the responsibilities of all of the agencies potentially involved, or meet all of the questions that family members may have. A suicide review is not an investigation designed to find fault or discipline staff, these issues are investigated through NHS boards' complaints and disciplinary processes. The SRLS has provided guidance on the Expectation of a suicide review and how these expectations can be met.

3. Views on how health authorities can share ways in which families have been successfully engaged with in the review process, including directly in review meetings

Improving communication and engagement with family members and carers and sharing best practice approaches continues to be a recurring theme in the suicide review reports received by the SRLS. Since the SRLS commenced in 2008 there have been 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. Not all family members want this involvement but for many it provides an opportunity to answer questions that

they may have and help build a clear picture of the care, treatment and events prior to the suicide.

Health authorities can share ways in which families have been successfully engaged in the suicide review process, including directly in review meetings, through various mechanisms including through:

- the Suicide Review Team Network
- SRLS progress meetings with NHS boards (p.4);
- SRLS Briefing Papers (see in particular February 2012 edition; June 2014 edition; December 2014 edition and will feature in the forthcoming February 2017 edition to be published on the Suicide Reviews Community of Practice website)
- adverse events learning summaries (Sharing Learning page of the Adverse Events Community of Practice website)
- mental health services suicide review groups and adverse events governance groups
- mental health services and NHS board mechanisms for sharing learning from suicide reviews, eg intranet sites, newsletters, learning events and road shows, and
- the Reducing Suicide Risk Mental Health Team Discussion Framework, Improvement Area 9: Involving family members and carers.

From the analysis of the suicide review reports submitted to the SRLS, the programme provided guidance for staff on Making sure family and carers are involved in the suicide review. Collated learning from suicide review reports also informed the development of an information leaflet for families and carers on the suicide review process and their involvement. The leaflet was developed in collaboration with mental health services, patients, families, carers and support organisations.

4. Views on whether there would be value in the action called for by the petitioner to expand the remit of the review under section 37 of the Mental Health (Care and Treatment) (Scotland) Act 2015

Section 37 of the Mental Health Act 2015 requires the Scottish Government to review arrangements for investigating deaths of patients who were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003, Criminal Procedure (Scotland) Act 199 or were voluntary patients being treated for a mental disorder.

The petitioner calls for the remit of the review to be expanded to include an inquest-type system for all deaths by suicide in Scotland; and to include both patients who were released from hospital or receiving care in the community under Compulsory Treatment Orders.

People who are in touch with NHSScotland's mental health services in the year preceding completing suicide will have their care reviewed under the NHS board's adverse event policy. This policy applies to people who were discharged from hospital or receiving care in the community under Compulsory Treatment Orders if they have been receiving care in the 12-month period before death. The review report will be quality assured by the SRLS and learning shared through local and national mechanisms to improve the quality of mental health services and to reduce suicide risk.

Mental healthcare services have a duty to improve and, where possible, reduce suicide risk within the healthcare system. This is taken forward by healthcare professionals and scrutiny and improvement organisations through NHSScotland's learning systems. We do not believe that an additional 'inquest-type' system would enhance established learning systems.

In Scotland the Procurator Fiscal has a duty to investigate all sudden, suspicious, accidental, unexpected and unexplained deaths and any death occurring in circumstances that give rise to serious public concern. An additional 'inquest-type' system is also likely to duplicate the civil, regulatory and statutory investigations that can take place following a suicide.

Further, an 'inquest-type' system may cause additional and unnecessary distress to the deceased's family and carers and the healthcare staff who may have been involved in providing their care. Healthcare Improvement Scotland is working with partner agencies towards a more co-ordinated response (including the Care Inspectorate, Crown Office and Procurator Fiscal Service, Mental Welfare Commission for Scotland) to reduce the number of reviews and investigations that families and carers may be involved in following a suicide. The aim is to minimise any distress that may be caused and to maximise opportunities for joint service improvement and risk reduction approaches.