THE STATE HOSPITALS BOARD FOR SCOTLAND

MENTAL HEALTH PRACTICE STEERING GROUP

ANNUAL REPORT 2024

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1 Core Purpose of Service/Committee

The main purpose of the Mental Health Practice Steering Group (MHPSG) is to promote continuous improvement in the mental health of State Hospital patients and the highest standards of clinical care and to deliver on specific pieces of mental health work commissioned by Clinical Governance Group.

2 Summary of Core Activity for the last 12 months

This year's core activity for the MHPSG has been –

- Proving ongoing governance and oversight of core TSH processes
- Reviewing National Clinical Guidelines and Standards
- Moving into the final phase of a pilot programme for proposed Outcome Measures for patients' Mental Health
- Redesigning and developing the CPA document and associated processes

3 Comparison with Last Year's Planned QA/QI Activity

Future Area of Work	Update
Review and propose changes to the Care Programme Approach process	The updated CPA document has been to all internal and external stakeholders for comment and is now in final draft stage. Alongside this we have been testing the processes required to progress this within TSH. This has included having a Mock CPA in June 2024 and there are new tasks assigned after this. Significant work has been done to update RIO to automate CPA processes. The anticipated roll-out is to happen by end of financial Q4.
Develop and test ways to increase the utility of clinical outcome measures for frontline staff	The MHPSG has now completed the pilot study on two outcome measures, the FORUM and CGI. The paper from this will be completed by end of August 2024. Our intention is to feed this into the new Working Group on Outcome Measures.
Support the development of the implementation plan for the new Clinical Care Model.	The MHPSG will be endeavouring to support the implementation of the Clinical Model in whatever way it can.
Establish the viability of a Structured Clinical Care Model at TSH	A SLWG under the MHPSG will be created to begin examining this. This is the next focus for MHPSG once the outcome measure and CPA work is completed. Work on this will begin during Q1 of 2025-26.
Continue to develop Trauma Informed Care at TSH	The MHPSG continues to monitor the training being provided.
Develop potential Family Interventions	The MHPSG is scoping what might be possible in this field. Work on this will begin during Q1 of 2025-26.

4. Quality Assurance Activity

The activity of the group is largely based around monitoring and improving several key areas of service delivery in the context of reviewing and monitoring clinical practice within the Hospital; including Psychological Services input data; risk assessment completion; Relational Approaches to Care; Trauma Informed Care; Person-centred improvement projects, Equality Outcomes; intelligence emerging from stakeholder feedback and trend reports.

4.1 Reviewing and monitoring of National Clinical Guidelines and Standards

Over the last review period (1 May 2023 to 30 June 2024) the MHPSG were involved in the review of 14 guidelines/ standards. One was deemed not relevant. Of the remaining 13 guidelines/standards, 8 had varying degrees of relevancy to physical health services within the Hospital and were circulated for consultation purposes. There were Evaluation Matrices conducted for 2 of the 5 remaining guidelines/standards and 3 evaluation matrices are in the process of being completed.

Guidelines/Standards Body	No. of publications reviewed	No. applicable to TSH	Evaluation Matrix required
MWC	7	6	1
SIGN	2	0	1
NICE	2	0	2
Scottish Government	2	1	1
Public Health Scotland	1	1	0

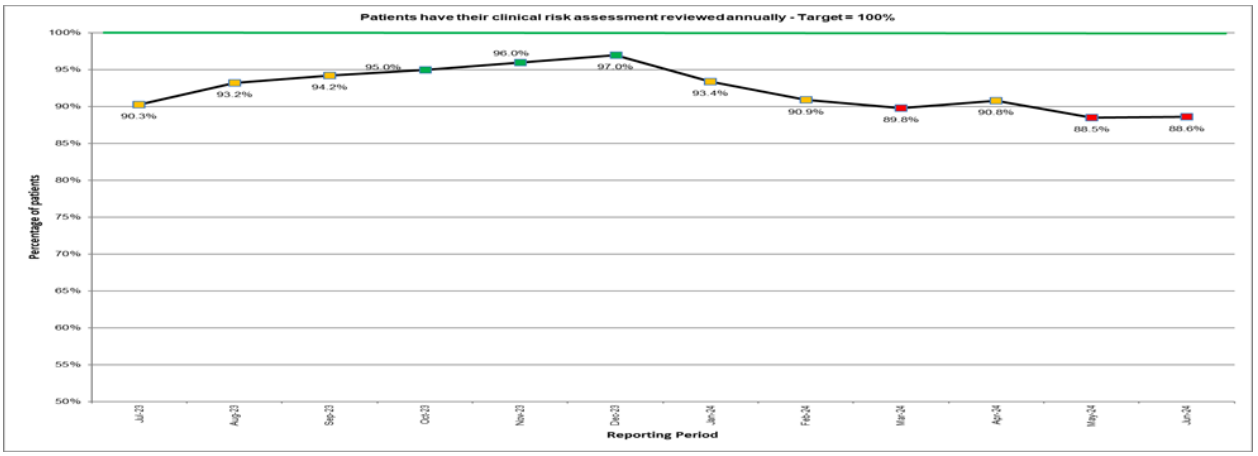
The 2 guidelines/standards that required and the 3 evaluation matrices that are in progress are:

Body	Title	Current Situation	Date Issued
NICE	Depression in adults	Review matrix completed - 100% compliance achieved	June 2023
NICE	Alcohol use disorders: Diagnosis and management	Matrix completed - 100% compliance achieved	July 2023
SIGN	Assessment, diagnosis, care and support for people with dementia and their carers	Multi-disciplinary review group have met on 2 occasions and gap analysis should be completed at the next meeting scheduled for mid-July 2024. Should come to MHPSG in August for final agreement and sign off	November 2023
Scottish Government	Responding to substance use amongst inpatients on mental health wards: A practical guide for mental health services	Review group arranged to meet in August	March 2024
MWC	Investigation into the death of Mrs F	Review group arranged to meet in August	May 2024

An Action Plan detailing work ongoing from outstanding recommendations is attached to this report (see Appendix 1). There are currently 7 outstanding recommendations in relation to 7 previously completed gap analysis. Six of these were all linked to the new Clinical Model therefore progress had been delayed due to work being paused. Clinical Model implementation has now taken place and progress is ongoing.

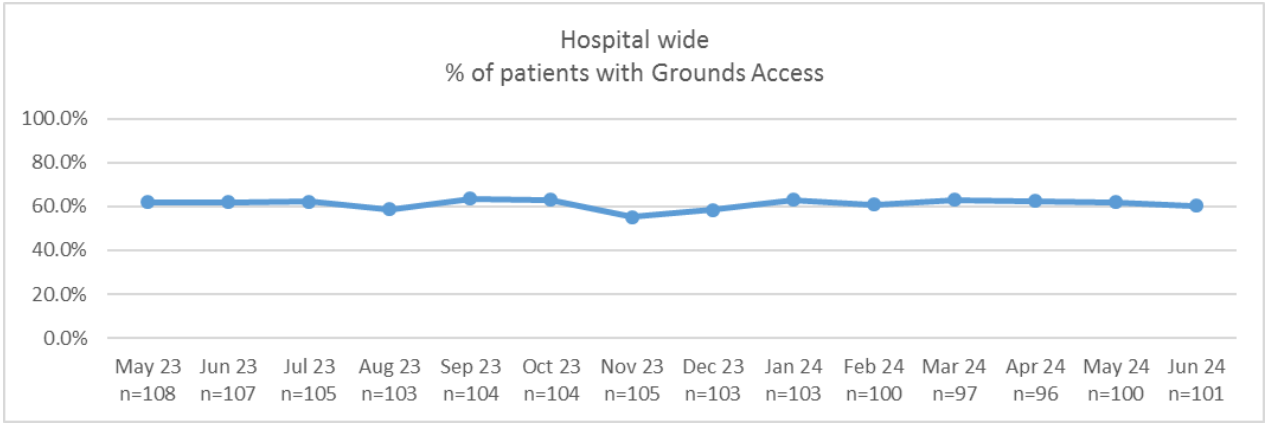
4.2 Risk Assessment Completion

This information is collated by Health Records on a monthly basis and monitored as part of the hospital KPI's. In addition, the MHPSG has historically monitored this bi-annually. Due to recent issues with the percentage of risk assessments being reviewed MHPSG will monitor this quarterly in tandem with KPI's and any issues will be taken back by Psychology representation on the group to implement an improvement plan.



4.3 Grounds Access

Grounds access is monitored by the MHPSG on a 6-monthly basis and information on this is provided to the Service Leadership Teams on a monthly basis.

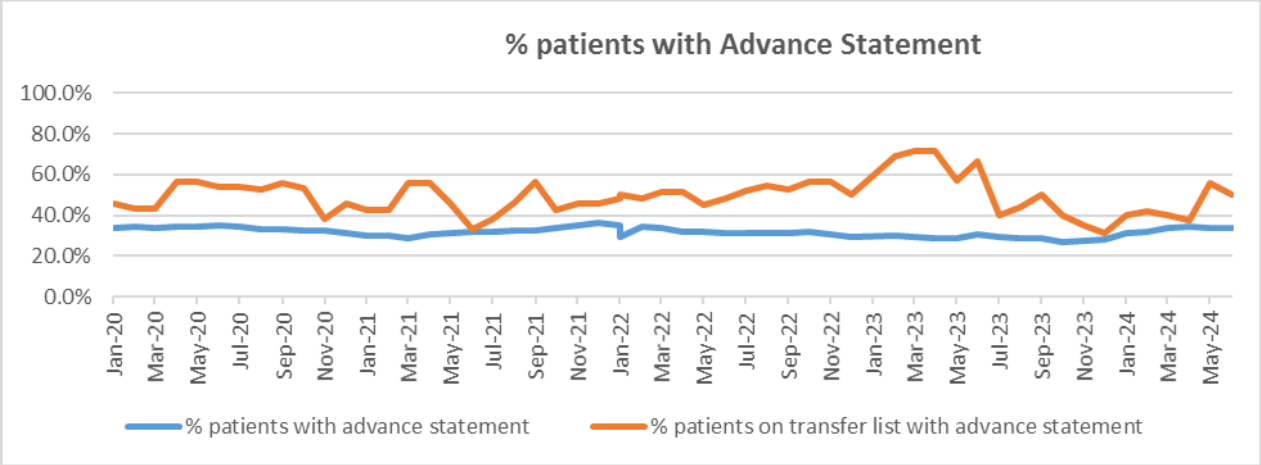


The graph above shows Grounds Access has remained in control over the last 12 months to May 23.

The new Grounds Access policy went live on 4 June 24. This included the roll out of the the Grounds Access RiO forms. These forms will allow the Clinical Quality department to monitor the overall time from CTM recommendation to provision of grounds access and identify where there are hold-ups in this process. All aspects of the Grounds Access policy are covered by these forms including suspension, withdrawl and reinstatement.

4.4 Advance Statements

Advance Statements are monitored by the group on a 6 monthly basis and either reviewed or discussed with the patient on a 6 monthly basis at patients' annual and intermediate case reviews.



The graph above reports on the percentage of patients with an Advance Statement. The graph shows the percentage of patients with an Advance Statement is in control with some limited variance over time. A key stage for patients to create an Advance Statement is prior to them leaving the State Hospital to another hospital setting. The graph also shows the percentage of patients on the transfer list, moving to a hospital setting with an Advance Statement. In the period July 23 to June 24 this has ranged from 31.3% to 55.6%

The MHPSG continue to work closely with Advocacy to ensure that patients are given the opportunity to produce an Advance Statement

As part of the Medicine's Committee, consent to Treatment Audit, RiO was checked to ensure that the information regarding patients' Advance Statements correlated with the information recorded on the T3B form.

On all 52 (100%) occasions, the section on the advance statement was completed by the DMP. This is an improvement on 2022.

	2020	2021	2022	2023
Yes	57 (98.3%)	60 (98.4%)	53 (96.4%)	52 (100%)
No	1 (1.7%)	1 (1.6%)	2 (3.6%)	0 (0)

However, on 5 occasions the information on the T3B did not correlate with the information RiO.

- On 2 occasions the T3B audited was in place prior to the Advance Statement being made and subsequently the T3B's have been updated to reflect this.
- On 1 occasion the T3B stated that the patient both has and has not an Advance Statement – the patient does not have an Advance Statement.
- On 1 occasion the patient has an Advance Statement and this is not reflected in the T3B
- On 1 occasion the patient does not have and Advance Statement and the T3B says that he does have one.
- The relevant RMO's were notified of this at the time of the audit and steps were taken to rectify

5 Quality Improvement Activity

5.1 Clinical Outcomes Pilot Report

The MHPSG created a working group in Autumn of 2022 to begin the process of piloting a new clinical outcome measure for patients at TSH. Two options were brought to the MHPSG, the first was the Clinical Global Impression Scale (CGI) and the second the Forensic Outcome Measure (FORUM). We agreed to pilot both measures in separate hubs across multiple time points.

Data was collected using the two tools over an 18-month period. In addition, a questionnaire was created to gather feedback from the Clinical Teams on the utility of both tools, staff and patient engagement and if the data generated would demonstrate changes to a patient's recovery. The final report will be presented to the MHPSG in August 24 and the findings will be brought to two workshops that are being set up in the hospital to progress this.

5.2 Motivation of new patients and ensuring positive engagement

The Skye Activity Centre provided a report to the group on the new ways of working with newly admitted patients to ensure engagement with the Skye Activity Centre.
This included:

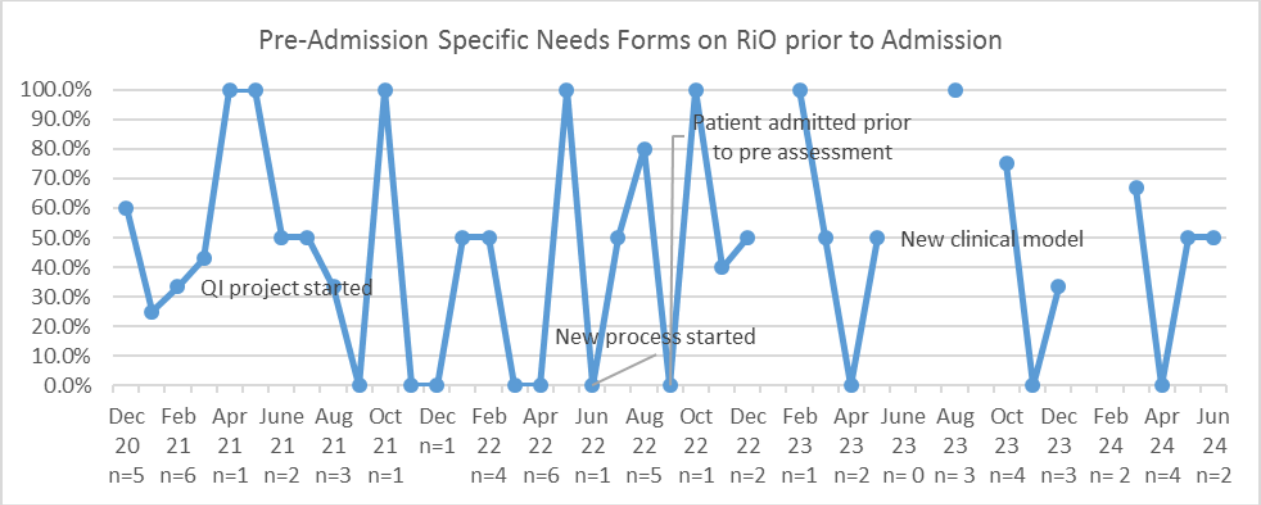
- Access to hub induction
- Access to sports induction
- Access to Skye Centre Induction
- Admission Service sessions – Friday am and Tuesday pm

The data was from the period September 23 to January 24. The offering is based on individual patient presentation and shows where possible patients have access to Skye Activity Centre activity as soon as admitted. Further information will be available at the August MHPSG so we can start to look at data over time

5.3 Pre-Admission Specific Needs Assessment Form, QI project

There is an expectation that all reasonable steps are taken, prior to Hospital admission, to proactively identify and address individual patient needs. This process calls for TSH to ensure appropriate support is in place by the time of admission, to mitigate the risk of health inequalities, which may arise because of a delay in access to support mechanisms. This is a legal requirement, The pre-admission specific needs form is used to collect this information. The form is forwarded, by the secretary of the Patient Pathway Meeting, to the person referring the patient to The State Hospital to complete once the patient has been accepted for Admission.

In light of the new Clinical Model, responsibility for this was moved to the Admission and Assessment Service Leadership Team. As can be seen in the graph below there is still no sustained improvement in the form being completed. Going forward this will be reported by the Admissions Service' SLT through the Clinical Model Oversight Group



5.4 Review of the CPA process

The MHPSG submitted a proposal to the Clinical Governance Group in June 2020 to review the CPA processes in TSH. The CGG supported the proposal. The last two years has seen the MHPSG focussing on this piece of work, which has now led to the initial testing of the draft CPA document, which has been evaluated and reviewed by internal and external stakeholders. Tjhis has been accompanied by significant work on the associated processes and RIO infrastructure 'behind' the CPA document.

There have been a number of key changes to date -

- Refocussing the documentation so that it has a more patient-centred style.
- Shortening the documentation to make it more user-friendly.
- Decoupling it from associated documents – eg HCR-20.
- Taking advantage of the single patient record to allow for substantial automation of the administrative processes.
- Encouraging use of the electronic patient record to ensure up-to-date and accurate information is available to clinicians at all times.
- Allowing clinicians to take ownership and responsibility of proposed treatment and management options for patients.
- Allowing clinicians and patients to review their treatment regularly and have this documented to allow care to be directed more effectively
- Adding the activity timetable to the document so that review of activity can be made more effective
- Linking the outcomes from treatment to activity and the formulation.
- We hope to add to a later iteration the finalised Outcome Measure that is chosen for TSH.
- What has become apparent during the initial testing phase is that MHPSG require specialist assistance to ensure an effective roll-out of the document and processes. As such, we have begun work with the Project Management Team to construct a training plan with associated communication strategy and project timeline.

5.5 Relational Approaches to Care Group (RATC)

A first draft of the booklet to accompany the Relational Approaches to Care workshop has been completed and is currently with Sandra Dunlop for editing. The RATC group had an "away morning" in February 2024 to bring the group together given some changes in membership and explore possible areas of future work. The group will discuss this further at the next RATC meeting.

5.6 Trauma Informed Care

The MHPSG notes that Trauma Training has remained a priority. There are two levels to this, Level 1 ("Trauma Informed" – awareness training) and Level 2 ("Trauma Skilled" – to help staff feel confident in recognising and understanding how to work with trauma). These are both components of the NES National Trauma Training Programme.

Level 1 and Level 2 training are delivered on a bi-monthly rolling programme facilitated jointly by staff from PTS and Nursing Practice Development. 51 staff have been trained at level 1 and 161 at Level 2 over 2023-24. Pre and post training evaluation shows an increase in staff trauma knowledge following training. In addition, these trainings will also allow a smaller cohort of staff to progress to Level 3 where they will be able to deliver Safety and Stabilisation work. Monitoring of this will continue through 2024-25.

6. Stakeholder Experience

6.1 Stakeholder Feedback

The MHPSG membership previously included PCiT Lead. Since their retiral, The Skye Centre SCN is now the link for the PCIT as this service has been subsumed under the remit of the Skye Centre. Since this process has taken place, work is underway to include information regarding patients' presentation and progress under the remit of the PCIT- visits, volunteer role in the Nu 2 U charity shop, spiritual and pastoral care and PPG- in the CPA process as part of the Skye Centre reports. Prior to this there was no established process for including these aspects of patients progress in the CPA reviews.

In addition, significant work has taken place to review and update the recruitment process for volunteers from outside the hospital to assist as patient visitors and in activity centres. These individuals contribute to the activity being delivered, bringing specific skills and knowledge and thereby enhancing the interventions and activity offered.

Community meetings have been re-established in all wards, with the information from these feeding into the PPG and to SCNs and Lead Nurses, providing another avenue for patients to contribute their ideas, suggestions and concerns.

7. Planned Quality Assurance/Quality Improvement for the next year

7.1 The MHPSG will focus on the following key areas of work over the next twelve months:

- Finalise the new CPA documentation and implement associated changes to the Care Programme Approach process. This should be completed by financial Q4 of 2024-25.
- Working with the Hospital Project Management to execute the CPA project. This will take place during Q3-Q4 of 2024-25.
- Pass the FORUM and CGI outcome measure report to the new Working Group tasked with looking at Outcome Measures by end of Summer 2024.
- Structured Clinical Care - the group intends to complete a needs analysis in relation to SCC at TSH. This will help direct our intentions with this after the completion of the CPA project. The group accepts that only one larger project can be managed at a time so hopes to start this during Q1 of 2025-26.
- Family Interventions: the group intends to pull together a scoping exercise around what is currently delivered in this domain and compare with this best practice. This will be a focus for Q1 of 2025-26.
- In addition, the MHPSG will continue to overview and support as required the development and implementation of the Clinical Model.
- The MHPSG will oversee the audit process surrounding the new Grounds Access electronic system.

8. Changes to membership

There have been some changes to the group membership over the last year. Morven Grant is replacing Chelsea Burnside as AHP representative and Kim McLelland has joined the group to represent Ward-level nursing staff. Lindsey Young now represents Social Work, replacing David Hamilton. Yvonne McCabe left as PCIT representative and Dr Sheila Howitt is on Maternity Leave.

9. Next review date

The Mental Health Practice Steering Group will report to Clinical Governance Committee in August 2024

Appendix 1: Governance arrangements for Committee

Committee membership:

The MHPSG is attended by a group of multi-disciplinary staff from across all disciplines working in the Hospital.

Membership in 2023-24:
Dr L Kennedy, Consultant Forensic Clinical Psychologist (Chair)
Dr J Patrick, Consultant Forensic Psychiatrist (Co-Chair)
Dr Sheila Howitt, Consultant Forensic Psychiatrist
Jamie Pitcairn, Research & Development Manager
Kim McLelland, Senior Charge Nurse
Stuart Lammie, Lead Nurse
Hannah McAllister, Senior Nurse in Nurse Practice Development
David Hamilton and Lindsey Young, Social Worker
Alex MacLean, Senior Charge Nurse
Chelsea Burnside and Morven Grant, Occupational Therapist
Julie McGee, Clinical Quality Facilitator
Yvonne McCabe, Person Centred Improvement Team Charge Nurse – no longer part of group
Minute Secretary: Barbara Howat

Role of the committee

The main purpose of the MHPSG is to promote continuous improvement in the mental health of State Hospital patients and the highest standards of clinical care. More specifically the remit includes:

- Promoting continuous improvement in the mental health of the patients, incorporating the highest standards of clinical care.
- Increasing the proportion of care that is evidence based or best practice and providing guidance on mental health interventions.
- Ensuring that clinical and non-clinical staff have a voice in the redesign, development, planning and prioritisation of mental health services through the health planning process and the optimum allocation of resources to benefit patients.
- Monitoring and driving improvement in the effectiveness and efficiency of overall service delivery for mental health needs.
- Providing a forum for consultation, discussion and debate, drawing on expertise within and out-with the Hospital.
- Contributing to work streams emerging from stakeholder feedback.

Aims and objectives

To establish and maintain systems to gather, assess and implement (where appropriate or required) evidence based and best practice guidance in mental health as published by NHS, Healthcare Improvement Scotland (HIS), NICE, Mental Welfare Commission (MWC) and other bodies, including:

- Standards (mandatory)
- Mental Health Strategy
- Clinical Outcome Measures
- Health Technology Assessments
- Safety Action Notices/Patient Safety Alerts
- SIGN Guidelines
- Best Practice Statements
- National audits
- NICE Technology Appraisals
- MWC Guidance and Investigations
- And NICE guidelines

- To prioritise and oversee a programme of clinical audit and clinical policy development, review and implement to enable the delivery of optimum care to patients.
- To deliver on specific pieces of mental health work commissioned by Clinical Governance Group.

Meeting frequency and dates met

Meetings are held monthly on the third Thursday of the month. There have been no cancelled meetings this year.

Management arrangements

The group reports directly to the Clinical Governance Group every twelve months.

Appendix 2 - MHPSG Guidelines and Standards Action Plan

MHPSG - Guidelines & Standards Action Plan – Achieved actions from previously completed gap analysis

NICE 181 – Rehabilitation for adults with complex psychosis

Reviewed by:

Guideline & Outstanding Recommendation	Evidence Level	Person Responsible	Update (inc date)	Projected Completion Date
For people diagnosed with a coexisting autism spectrum disorder, follow recommendations in the NICE guideline on autism spectrum disorder in adults.		J Kerr/ MHPSG Chair	Practice will comply with Scottish guidance - MWC & SIGN. Compliance work currently ongoing via MHPSG (see SIGN 145 & MWC documentation). Once this is achieved, this recommendations will be achieved.	December 2024

SIGN 145 – Assessment, diagnosis & interventions for autism spectrum disorders

Reviewed by Dr De Villiers & sub group – July 2020

Guideline & Outstanding Recommendation	Evidence Level	Person Responsible	Update (inc date)	Projected Completion Date
All professions & service providers working in the ASD field should review their training arrangements to ensure that staff have up-to-date knowledge & adequate skill levels.	R	S Dunlop/H McAllister	Training in assessment & management of ASD is required & is an identified gap. Training strategy required. NES? 7/10/20 – A new online learning module has been developed. This is currently in beta version & awaiting user testing & content review. The module will provide core basic education for all clinical staff within the hospital in relation to: • Causes, diagnosis & prevalence of autism. • Areas in which individuals with autism characteristically have difficulties. • Behaviours that are sometimes exhibited by individuals with autism. • How to communicate effectively with individuals on the autistic spectrum. • How to provide person centred support to individuals who have autism. 06/21 - The initial target timescale for launch of the module on the LearnPro platform was Dec 2020. It is hoped for the module to be out for testing during June 2021. 02/21 – ADOS training now complete 09/21 - As part of the 'Clinical Model' work stream, Glasgow Caledonian University has been commissioned to undertake a Training Needs Analysis & deliver a training & development programme for the intellectual disability service. Training in assessment & management of ASD will be included within this programme. This project was suspended due to COVID-19 and then due to staff absence - contact resumed and work in progress with questionnaires pending. 12/12 - Module testing and content review was unfortunately delayed due to capacity issues and competing work priorities and demands. This work stream has been identified as high priority and steps are being taken to complete the end user testing and associated content review to enable formal launch of the module before the end of January 2022. 03/22 – meeting with J. Clark, H. Crawford, and L. Stevens (GCU) to remobilise Training Needs Analysis work held. Actions are agreed and underway. 04/22 – Testing of the online module is now complete. Some technical components of the module required a rebuild/amendments to meet new 'responsive design' standards. (Note – Responsive design enable the content to be viewed on mobile devices as well as computers). The module has been uploaded to LearnPro. S Dunlop to obtain final 'sign-off' for the module from Dr De Villiers prior to formal launch. 06/22 – Linda Stevens (GCU) met with members of Iona Clinical Team to start needs analysis work. Follow-up meetings also arranged due to difficulties with attendance. 07/22 – meeting with Linda Stevens (GCU) to establish progress. Linda has just returned from period of unplanned leave so no further progress. Requested that this work is remobilised ASAP and progress update provided by mid-July. 08/22 – Autism module went live in June 2022 and so far 63 staff have completed it. 11/22 – Not a good response rate to training needs survey by GCU. Work ongoing. Further to November meeting, interest noted by Skye Centre to be involved in this process given links already provided by Psychology. 03/23 – Tried to make contact with Mark Gallacher from GCU in Linda Steven's absence to discuss the circumstances and seek an outcome to this as it has been going on for some time.	Summer 2025

MWC – Autism & complex care needs

Reviewed by Dr De Villiers & sub group – July 2020

Guideline & Outstanding Recommendation	Evidence Level	Person Responsible	Update (inc date)	Projected Completion Date
HS Boards should ensure that they are able to provide a comprehensive assessment & diagnosis for any person who may have autistic spectrum disorder, which meets the standard set by SIGN 145.		J Kerr/ MHPSG Chair	Pending achievement of outstanding recommendations as per gap analysis for SIGN 145	December 2024

NICE 11 – Challenging behaviour & learning disabilities: prevention & interventions for people with learning disabilities whose behaviour challenges

Reviewed by Dr Douds & S MacAlister - August 2015

Guideline & Outstanding Recommendation	Evidence Level	Person Responsible	Update (inc date)	Projected Completion Date
Ensure that any restrictive intervention is accompanied by a restrictive intervention reduction programme, as part of the long term behaviour support plan, to reduce the use of & need for restrictive interventions	B	Dr De Villiers / L Kennedy / H Crawford, ID Task Force/ S Lammie	The ID Task Force are working towards introducing Positive Behavioural Support as the model of care within the new Clinical Model. This approach, once fully implemented, will address the need for individual plans to reduce restrictive interventions & to enable the clinical team to understand & address challenging behaviour. The ID taskforce was suspended as TSH adapted to COVID. My understanding is that the new clinical model work is suspended until at least next year – the issues are due to be addressed as part of that process. 06/21 - Actions still form part of the Clinical Model work – we await to see how that develops and the ID taskforce continue to discuss implementing positive behavioural support approaches in the new clinical model. Reducing restrictive interventions is part of that, although we are somewhat hampered by the rigid processes at TSH. 09/21 and currently ongoing – implementation of Positive Behavioural Support is part of the Clinical Model work, which is currently paused 09/22 - Work has been ongoing in relation to PBS, with staff training plans and consideration for full implementation in the ID service once we move to the new Clinical Model. 10/22 - The ID Taskforce is currently updating the operational guidance for the ID service as we move to implement the new clinical model. Louise and Hazel are leading on implementing PBS as the framework for the service 07/23 – Clinical Model moves are complete. L Kennedy, H Crawford & Z Dube (I3 SCN) had attempted to meet to discuss the PBS framework however, this did not materialise. No progress to date in relation to the implementation of the PBS framework. CQ Guidelines Facilitator trying to arrange meeting to review current situation. 07/24 - the implementation of PBS is part of a restrictive intervention programme so actions for these guidelines are interlinked. We have completed 7 PBS awareness sessions for nursing staff and CTM members within the ID service with 58 staff being trained. Further training is planned for the Autumn. We have started implementation of PBS with PBS plans being commenced for individuals. Changes to the environment as part of providing a PBS informed capable environment have been commenced with patient participation in this. PBS link nurses on the wards have been identified. This in turn links with the Clinical Care policy and patient specific plans developed	Completed July 2024

NICE 101 – Learning Disabilities: Behaviour that challenges

Reviewed by Dr De Villiers & J McQueen – October 2019

Guideline & Outstanding Recommendation	Evidence Level	Person Responsible	Update (inc date)	Projected Completion Date
People with a learning disability & behaviour that challenges have an initial assessment to identify possible triggers, environmental factors & function of the behaviour.		Dr De Villiers / L Kennedy / H Crawford, ID Task Force / S Lammie	The ID Task Force are working towards introducing Positive Behavioural Support as the model of care within the new Clinical Model. This approach, once fully implemented, will address the need for individual plans to reduce restrictive interventions & to enable the clinical team to understand & address challenging behaviour. The ID taskforce was suspended as TSH adapted to COVID. My understanding is that the new clinical model work is suspended until at least next year – the issues are due to be addressed as part of that process. 06/21 - Actions still form part of the Clinical Model work – we await to see how that develops and the ID taskforce continue to discuss implementing positive behavioural support approaches in the new clinical model. Reducing restrictive interventions is part of that, although we are somewhat hampered by the rigid processes at TSH. 09/21 and ongoing – implementation of Positive Behavioural Support is part of the Clinical Model work, which is currently paused 09/22 - Work has been ongoing in relation to PBS, with staff training plans and consideration for full implementation in the ID service once we move to the new Clinical Model. 10/22 - The ID Taskforce is currently updating the operational guidance for the ID service as we move to implement the new clinical model. Louise and Hazel are leading on implementing PBS as the framework for the service. 07/23 – Clinical Model moves are complete. L Kennedy, H Crawford & Z Dube (I3 SCN) had attempted to meet to discuss the PBS framework however, this did not materialise. No progress to date in relation to the implementation of the PBS framework. CQ Guidelines Facilitator trying to arrange meeting to review current situation. 07/24 - the implementation of PBS is part of a restrictive intervention programme so actions for these guidelines are interlinked. We have completed 7 PBS awareness sessions for nursing staff and CTM members within the ID service with 58 staff being trained. Further training is planned for the Autumn. We have started implementation of PBS with PBS plans being commenced for individuals. Changes to the environment as part of providing a PBS informed capable environment have been commenced with patient participation in this. PBS link nurses on the wards have been identified. Monitored by ID Service Leadership Team	Completed July 2024

MWC – Person Centred Care Plans: Good Practice Guide

Reviewed by: MHPSG - November 2019

Guideline & Outstanding Recommendation	Evidence Level	Person Responsible	Update (inc date)	Projected Completion Date
Display a method of having the person sign/agree their care plan & indicators of ownership.		H McAllister	Patient feedback incorporated within CPA document. Further work required around other care plans. 09/20 - Care plan work has resumed. Have met with M Richards to discuss IOP which will be reviewed by SPSP initially. On track to have patient-led care plan on RIO by the end of the year. 11/20 - MR has caught sight of patient care plan (as part of IOP) & we will put the policy out for Consultation at start of next year. 05/20 - Unfortunately the introduction of the new IOP policy has been put back until Nov, so this will mean the patient care plan won't be out for another few months. I am aiming for July though, to be in line with the new audit tool and the other changes we have made to the care planning process. It is sitting on the Test site and ready to go. I attended the SCN meeting today to discuss the new audit tool and sent it to them for consultation right after the meeting. 09/21 – COVID has meant slow progress on this piece of work however meeting with e-health colleagues on 11th Aug to discuss progression on RiO. 10/21, 11/21 – Work ongoing 03/02 – work has been on hold due to COVID-19 and RiO 21 upgrade. Work will recommence in coming months, following implementation of RiO 21. 06/22 & ongoing - IOP work now remobilised & patient led care plan is part of this work stream. Working towards implementation at end of year. 07/24 - The clinical care policy is within the implementation phase and the What Matters to Me has been included within the policy.	September 2024

NICE – Self Harm: Assessment, management and preventing recurrence / RCP – Supporting mental health staff following death of a patient by suicide

Reviewed by: MHPSG – May 2023

Guideline & Outstanding Recommendation	Evidence Level	Person Responsible	Update (inc date)	Projected Completion Date
1.14.1 Training for all staff who work with people of any age who self- harm should: • Involve people who self-harm and where appropriate, their families or carers, and staff in the planning, delivery & evaluation of training • Be available in a range of formats including interactive role play, online, face to face & through provision of resources. • Explore staff attitudes (including non-healthcare staff), values, beliefs & biases • Be appropriate to the level of responsibility of the staff member • Be provided on a regular on ongoing basis		H McAllister	07/24 - Suicide awareness training has been scheduled for a half day of training for all nursing staff. The Suicide Awareness and Prevention Policy is under review by the NPD team.	December 2024