10. Organisational competences to support the work of the team

10.1. Supervision and training for practitioners

- An ability to support the capacity of services to organise supervision and training for staff at all levels of seniority, following the principles that:
  - training and supervision are necessary if individual practitioners and the whole team are to work in line with best practice
  - opportunities for training and skill development should be available and accessible for all levels of staff
  - 'one-off' training needs to be supplemented by supervision and focused support to be effective
- An ability to ensure that practitioners at all levels of the team (both junior and more senior) can access supervision and training that matches:
  - their experience and prior training
  - the roles they are expected to carry out and the level of responsibility they are expected to have
- An ability to support proactive training in leadership, to prepare individuals for leadership roles (e.g. through training and mentorship)
- An ability to help teams to put in place systems that can identify the training and supervision needs of its individual members
- An ability to help teams identify and resolve obstacles to supervision and training that takes place in the inpatient context
- An ability to recognise the value of whole-team training, in addition to individual training, and to help services overcome barriers to this (e.g. providing staff cover to enable the whole team to meet)

10.2. Responding to and learning from serious incidents at an organisational level

In inpatient units, a serious incident is one that leads to avoidable death or serious harm to patients or staff, where the consequences for children/young people, families/carers, staff or organisations are significant, and where there may be implications for patient safety or an organisation's ability to deliver ongoing healthcare.

- An ability to provide guidance and support for all employees impacted by a serious incident
- An ability to appoint appropriate individuals to investigate the circumstances leading up to the incident

- An ability to offer support to individuals and teams to help them review the incident, to discuss their reactions and feelings, and to receive help if necessary
- An ability to communicate with the people involved and impacted by the incident (e.g. providing clinical follow-up and support)

Family engagement and communication

- An ability to ensure that the terms of reference of any investigation explicitly include arrangements for engaging and communicating with the child/young person's family/carers or significant others
- An ability to ensure that that the persons making contact are suitable to take up this role (e.g. have the appropriate communication skills and an appropriate level of authority)
- An ability to ensure that information is provided to the family/carers and significant others in a timely and compassionate manner (in line with the Duty of Candour)
- An ability to put in place appropriate support for the child/young person's family/carers and significant others

- Where there are other children/young people in the family, an ability to put in place developmentally appropriate support and to support the parents/carer's capacity to care for them

Establishing an independent review

- An ability to identify an independent team with relevant experience, expertise and authority, including lay membership where appropriate, which is empowered to:
  - investigate the circumstances of the incident
  - compile a record of the care and treatment of the children/young people who were involved

- write a clear report

- An ability to ensure that reviews are set up, completed and disseminated in as timely a manner as is practicable

Competences for the team conducting an investigation

- An ability for the investigating team to:
  - review relevant documentation
  - identify other agencies and services that the children/young people were in contact with
  - interview members of the clinical and professional teams that the children/young people were in contact with
  - review and evaluate the course and quality of treatment
  - review legal and ethical matters, particularly in relation to sharing information within and between services
  - seek the views of families/carers and significant others

- An ability to review the degree to which the service is operating in line with national and local guidance designed to reduce the risk of an incident, e.g.:
  - monitoring the physical environment for risk of suicide (e.g. ligature points) and actively taking steps to modify risks/dangers when they are identified
  - ensuring there is an appropriate response when children/young people leave inpatient wards without staff agreement (e.g., use of the Mental Health Act)
  - having agreed protocols in place for managing children/young people with comorbid substance misuse
  - maintaining safe staffing levels
  - maintaining a consistent staff group who are familiar with the children/young people in their care (e.g. by minimising staff turnover)
  - putting in place appropriate training for staff who carry out critical tasks (e.g. direct observations or search and restraint)

Clinical policies relating to the management of self-harm and suicide

- An ability to review policies relevant to the safe management of people who are self-harming or suicidal, e.g.:
  - care planning
  - risk assessment
  - routine search
  - restraint
  - use of seclusion
  - use of observation
- An ability to determine the ways in which these policies are implemented in practice (including arrangements for regular staff training)

Use of information and reporting systems

- An ability to draw on knowledge of the information systems used by NHS Trusts, and the reporting arrangements used locally and nationally to record and to flag serious incidents
- An ability to examine information and reporting systems to ascertain:
  - the degree to which staff in the organisation routinely and systematically record information, particularly information potentially relevant to the management of self-harm, suicide and other serious incidents (e.g. in care plans, risk assessments, clinical summaries and communications with other parts of the service)
  - the degree to which the organisation follows-up and acts on reports of adverse events and potential areas of concern (e.g., use of seclusion and physical restraint)
  - the degree to which reporting of serious incidents to national external bodies is appropriate (e.g. Care Quality Commission, NHS Improvement)

Effectiveness of leadership

- An ability to identify how information about potential adverse events or area of concern is considered by senior leaders in the organisation, e.g.:
  - whether, how and at what level the Trust and/or its delegated authority (e.g. sub-committee of the Trust Board, Clinical Governance lead, Client Safety Services, Quality Oversight Group) receives, takes account of and responds appropriately to information about serious incidents, unexpected deaths and previous incident reports
- An ability to consider the quality of reports of previous investigations (e.g. Serious Incidents Requiring Investigation (SIRI) reports), e.g. to consider:
  - the standard of investigation
  - the quality of the report
  - the appropriateness of the actions it recommends
- An ability to determine if and how recommendations from previous investigations have been implemented

Dissemination

- An ability to draw on knowledge of the ways in which reports can be disseminated so as to be helpful to frontline staff and those close to the child/young person (by giving them access to the report; by presenting its findings or otherwise providing a full account of the circumstances leading up to the incident)

- An ability to report both in writing and to present information verbally to relevant parties

- An ability to recommend that reports are disseminated: in a timely manner to:
  - all professionals who can potentially learn from them, e.g.:
    - managers
    - staff (including frontline clinical staff, and particularly those with whom children/young people were in contact)
    - clinical and professional partners (e.g. local services or local agencies)
  - family/carers and significant others

10.3. Providing support for professional for staff after a serious incident

This section focuses on the competences associated with providing support for individuals and teams after a serious incident (e.g. a death by suicide). Separate sections detail competences associated with the formal inquiry that constitutes an organisational response to serious incidents.

Because the response to a serious incident is as much institutional as individual, the competences in this section refer both to the response expected of an organisation as well as the individual competences of those offering support to staff.

- An ability to all ensure that all relevant staff are informed after a serious incident and that support is offered in a timely manner (while avoiding the risks associated with immediate post-incident debriefing)
- An ability to ensure that working arrangements are adjusted to ensure that all staff who wish to attend meetings can do so
- An ability to identify a moderator (a neutral expert with experience and expertise in working with individuals or groups after a serious incident)
- An ability for the moderator to establish boundaries to discussions and ensure that there is clarity about its focus and about confidentiality

Working with individuals or teams

- An ability to provide information about the 'normal' consequences of a serious incident among clinicians and practitioners
- Ability to help people make sense of their experiences and responses, using psychoeducation and drawing on models of understanding

- An ability to help practitioners discuss and understand their emotional reactions to the incident, and to:
  - identify and discuss the breadth of emotions evoked (e.g. sorrow, guilt, anger, disappointment, compassion or relief)
  - identify and discuss emotions related to their sense of the role they played in the incident (e.g. a sense of failure, incompetence, fear or shame)
  - discuss the ways in which they are managing feelings about the incident (e.g. denial of feelings or, conversely, feeling overwhelmed)
  - discuss (and so recognise) limits to the control that they had over the patient's behaviour
  - recognise that (at least in the short term) the incident is likely to affect their work with children/young people and their sense of professional identity
  - verbalise fears of disciplinary or legal action

- Where a suicide has taken place, an ability to help practitioners reconstruct the known circumstances and behaviour of the child/young person prior to suicide, and to discuss:
  - how they understand the child/young person's decision to take their life
  - their sense of involvement with the child/young person and their view of themselves after the death (including e.g. potential feelings of guilt or a sense of failure)
  - accusations of blame towards people or groups seen as responsible for the child/young person's welfare
    - an ability to contain accusations of blame against others (e.g. by distinguishing between feelings of guilt and actual responsibility for the patient)
- Where a practitioner has discovered the body, an ability to organise or provide appropriate support (e.g. where there is evidence that they are suffering a traumatic response)

- An ability to judge the difference between support and therapy and to discern whether further signposting or referrals might be necessary

Working with the team

- An ability to draw on knowledge that the reactions of different members of the team to serious incidents will vary, and be influenced by their:
  - relationship with the children/young people involved
  - understanding and knowledge of the children/young people involved
  - understanding and anticipation of the event
  - personal traits
  - professional experience
- An ability to draw on knowledge that because different team members will vary in the extent and depth of their reactions, the support offered (to the whole team and to individuals) needs to reflect this, e.g.:
  - by offering individual as well as group support
  - by being sensitive to what each team member knows, and what level of detail they need to know (e.g. if detailing the manner of the death is potentially traumatising)

- An ability to extend support to staff (e.g. administrative staff or cleaners) who had no formal clinical role, but whose duties brought them into regular contact with children/young people involved in the incident

10.4. Audit and quality monitoring

- An ability to draw on knowledge that the aim of audit is to improve the quality of services
- An ability to draw on knowledge of the risk that audit and quality monitoring is seen by teams as a managerial activity (organised on a 'top-down' basis), reducing a sense of ownership (and potentially, participation)
  - an ability to increase the salience and relevance of audit for staff and children/young people, e.g. by:
    - sharing decisions about which areas to audit (along with as those based on indicators of quality that are based on national and local standards):
      - inviting staff and children/young people to indicate which aspects of services should be audited
      - encouraging audit of areas that are seen as priorities by teams and children/young people
      - encouraging children/young people and teams to lead on audits they see as a priority
    - sharing data and outcomes from the audit in an accessible form
    - sharing actions plans based on data drawn from the audit

- An ability to ensure that policies, procedures and guidelines relating to quality standards are available, and formatted in a way that makes them accessible to staff and children/young people
- An ability to ensure that services are resourced to conduct audits (e.g. ensuring that there is protected staff time to carry these out)
- An ability to ensure that the performance of services is based on multiple sources of information, including feedback from children/young people and their families/carers

- Where audits identify areas for improvement, an ability to work with staff teams to:
  - identify and disseminate information that emerged from the audit
  - agree and implement action plans
  - agree on procedures for monitoring the impact of action plans
- An ability to ensure that risks identified through audit are addressed and acted on in liaison with staff teams