Royal College of Psychiatrists
Consultation Response

DATE: 13th November 2009

RESPONSE OF: THE ROYAL COLLEGE OF PSYCHIATRISTS

RESPONSE TO: National Framework for Reporting and Learning from Serious Incidents requiring investigation

The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and is the professional and educational organisation for doctors specialising in psychiatry.

We are pleased to respond to this consultation. This consultation was contributed to by the following groups in the College:

- Child and Adolescent faculty
- Forensic faculty
- Medical Directors network
- North West division
- Northern and Yorkshire division
- Old Age faculty
- South West division

Additionally the Registrar had the benefit of attending a specific patient safety event where a great deal of consideration was given to this consultation on 'National Framework for Reporting and Learning from Serious Incidents requiring investigation'.

This consultation was approved by: Prof Sue Bailey-Registrar

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Consultation response to the National Framework for Reporting and Learning from Serious Incidents requiring incidents

1. Executive Summary

1.1 We believe it is a good start to treat serious incidents in mental health with serious incidents in other parts of the health economy. Though the words "learning from serious incidents" are in the title, we would suggest that the focus of the document that follows is on recording and investigating serious incidents. Again we welcome the emphasis upon the systematic measures from the outset and in particular that reporting is not seen as an exercise in blaming individuals or responsibility shifting. Bringing some National Standardisation to serious incidents must be welcomed but we appreciate that in pulling together this document the National Patients' Safety Agency (NPSA) is up against the multiple reporting processes within the NHS itself. This in turn makes operationalisation of any recommendations more difficult. In this context we found the algorithm on page 5 to be very helpful.

2. Purpose, scopes and responsibilities

2.1 It is helpful that healthcare is acknowledged as a complex, high risk activity in which things will go wrong. However, this could be expanded to state that there is intrinsic risk in many healthcare activities from cardiac surgery to community care. It is also regrettable that in the paragraph containing reference to risk, this is neither defined nor put into context. We would argue that risk is about balancing the probability of a positive or negative event happening within a specific time frame.

3. Definition of a serious incident

3.1 Whilst recognising that this is a challenging task, the responses from different parts of the College have highlighted that it is a matter of concern that some of the lists of incidents within the document that should be seen as serious incidents are in themselves poorly defined or not defined at all. A particular example of this is "adverse media coverage or public concern".

3.2 We appreciate that the scenarios were intended to be helpful and deliver clarity; however we are of the view that they are open to wide interpretation and potential ambiguity and we would suggest that they should be removed. We have particular concerns about the term "a person suffering from abuse". This appears to be a new standard definition. The word "abuse" includes a very wide set of behaviours. Whilst any form of abuse must be investigated, it is not clear whether all types of abuse should be defined as a serious incident requiring the level of investigation suggested within this document.

3.3 Whilst we acknowledge there is some attempt to define abuse, it is only by referring to definitions that appear in "No Secrets" and "Working together to safeguard children" that it is made clear. However, although "No Secrets" is referred to it does not appear in the reference list. The definition of abuse implied in the "No Secrets" guidance published by the Department of Health in 2006, is that abuse is the violation of an individual's human or civil rights by any other person or persons. The "No Secrets" guidance then goes on to list different forms of abuse and this list includes "neglect and acts of omission" which include failure to provide access to appropriate health or social care, and educational services. Another type of abuse which is listed is "discriminatory abuse" and although ageism is not mentioned specifically under this heading, ageist abuse could and perhaps should be included in this category.

3.4 It is widely accepted that discrimination against the elderly in terms of unequal access to healthcare resources is very common and many people working with the elderly believe it is so widespread that almost all of the healthcare system in the UK might be considered institutionally ageist. Therefore by adopting the broad "No Secrets" definition of abuse, anyone working with older adults would be forced to either turn a blind eye to ageist abuse or report every incident under the proposed new framework, which would be very time consuming. Therefore, particularly with regard to old age,

the definition of serious incidents needs to be expanded with examples of what should and should not be considered serious incidents.

3.5 Abuse should be defined in the document and if definitions and other documents are referred to they should be very clearly and accurately referenced. The definition of abuse in the "No Secrets" guidance is too broad to be useful in this context. It may be more helpful to list issues and scenarios which should be considered serious incidents for investigation and some which should not. We would equally have particular concerns about this in the safeguarding context towards children. For instance – has the placement of the child under 16 on an adult psychiatric ward ceased to be a serious untoward incident? It is not included in the examples given.

3.6 Further, within the definitions of serious incidents; the College's Forensic faculty would particularly wish to challenge within the core "never events", the inclusion of escape from a medium secure perimeter. We have received comments from the College's Medical Directors group about, for instance, appendix F (page 44) which puts hanging from non collapsible rails in the same category as removing the wrong leg. There used to be many ways in which it might be possible to kill oneself on an average ward and although these have been very carefully addressed by service providers there may still be other ways this could occur.

4 Roles and Responsibilities

4.1 Whilst at first read the roles and responsibilities appear to have clarity, we would actually on further study question this. One point we would now query is the nature and ongoing role of commissioning and the Strategic Health Authorities. We would suggest that in today's world, the future commissioning of Primary Care Trusts would be far more core to this process together with those who deliver services. We do not think that this document, particularly in relation to mental health, places enough emphasis on the number of

independent provider organisation, particularly in the field of forensic psychiatry.

4.2 We also do not think it takes into account the new and innovative arrangements that are being encouraged within current Department of Health policy. For example the range of providers may be far more diverse within particular sub contracting occurring by mental health Foundation Trusts and other organisations. In these there will have to be a great deal more care, attention and time placed to these lines of accountability and there would need to be an understanding of each organisation. We believe that foremost in this area of work is the Care Quality Commission and Monitor; these should appear higher in the agenda as they will ultimately be the bodies that deal with Foundation Trusts. We would be particularly interested in their views on this document.

5. Role of the NPSA

5.1 We acknowledge the role of the NPSA but would also query what shared knowledge and delivery of role and responsibility could occur across the Care Quality Commission and the NPSA itself. With respect to media management, (page 15), we believe that there has been a slight shift in response from the media, in particular to homicides. We are also aware, as we are involved in an initiative between the Royal College of Psychiatrists and the Department of Health, to ensure that those speaking with the media are informed about the real facts concerning homicide and mental illness. We believe that gradually there has been more fair, accurate and unbiased reporting by the national media, but would suggest that there needs to be a focus on local media coverage. Our overarching comment on roles and responsibilities is that although the aim to improve services is mentioned in this section, we believe that this should be placed much higher up in hierarchy in this document. Otherwise this document risks becoming bogged down in process, rather than bringing about improved patient safety and quality improvement. There does

not seem to be a broad responsibility, in ensuring that improved practice is implemented and/or monitored to drive up improvement.

6. Identification and response

6.1 In identification and response, there is considerable difference between attempted suicide and deliberate self harm. This differentiation has not been made clear in the document and again should be dealt with through a hierarchy of appropriate response. In the table of grading the serious incidents there therefore needs to be greater clarity as to what is included under "mental health attempted suicide as inpatients" particularly in relation to the spectrum of self harming behaviour which may not be considered. Whilst we would agree that using root cause analysis may be viewed as a gold standard for investigating serious incidents, such an in-depth investigation would not be required for both grade 1 and grade 2 incidents. Although appendix A describes the investigation types which should be used for grade 1 and 2, there may be some incidents that fall into grade 1 which would not require the high level of detail suggested for all grade 1 investigations. Overall we think there is a risk of root cause analysis becoming the Holy Grail and an end in itself. It would be beneficial for learning to take place from the root cause analysis so as to drive change in a timely and appropriate manner, with an honest and open dialogue particularly with relatives and outside agencies.

7. Investigations

7.1 The emphasis upon openness with families is applauded and the tools and resources are seen as helpful. However, where do complaints procedures and legal action by families integrate into this process? We think that legal action on a complaint should be dealt with in this document in the same amount of detail as is given to dealing with the media. Contained within this is the far larger issue of how investigations are dealt with across the whole field of public sector activity, whether this be an investigation in relation to homicides, suicides, or the Centre for Maternal and Child Enquiries. We still believe there is a great deal of duplication and there are core common principles in

conducting these examinations, where one form of inquiry could learn from the other. We would urge that there should be a core common training so that lessons are learnt. A minimum number of training session, could be rapidly disseminated across and to all those to whom they are relevant. This would ensure that safeguards and quality improvement could be brought about as quickly and swiftly as possible. The provision of an action plan template provides useful consistency across organisations.

8. Monitoring and closure

8.1 Whilst welcoming a clearer description of the monitoring process and the graded process, it does overall appear to be proportionate in terms of a response. For instances of varying seriousness, we wonder how monitoring and closure can also be included within it, especially the case of serious incident evidence of follow through and outcome from the recommendations made.

9. Dissemination of learning

9.1 We found the summary table to be helpful.

10. Communication and the media

10.1 This has already been referred to earlier. It provides useful information in relation to the process of dealing with the media in varying scenarios, but the core issue should be in building trust with users and carers of the services. We wonder whether examples cannot be taken from experiences in the USA where acute health units have been far more open and transparent about putting up immediately on their website, details of when there has been an untoward event or serious incident. There was the obvious fear, that this may have a negative effect with the public using this service of the local media, however, it seems that is has the opposite effect in that the public have seen this as a service that is willing to be open and honest about both achievements and failures. This may also be of great benefit to carers, who often feel they have

to wait so long for any clarity of responses as to how and what circumstances have led to the incident.

Consultation questions:

Question 1: Is the grading of 'Serious Incidents' clear?

We feel that this is work in progress and it would be particularly helpful to have more examples of incidents that fall into grade 1. There are particular concerns about attempted suicide as inpatients. The definition of attempted suicide needs to be far more clearly spelt out. Unfortunately this terminology is both outdated and ambiguous. The two accepted definitions are complete suicide and non fatal self harm. Self harm covers a range of acts including the deliberate and serious attempt to end life (e.g. undisclosed hanging) through to superficial cutting or scratching oneself to relive tension or stress which is common and would not be usefully termed attempted suicide. Clear definition in investigation of each self harm act on its own merits, is warranted. We believe the framework is reasonably clear and the algorithm is useful.

Question 2: Does the framework provide clarity regarding roles and responsibilities in reporting and learning from serious incidents? If not, how can this be improved?

A centralised system would be a good means of dissemination, as it would be available to the boards of healthcare organisations for widespread distribution through their own systems. It would be helpful to see proof that this information (as it cascades through the systems) has both been received and absorbed with suitable feedback leads.

Question 3: How should the framework be finally disseminated (eg via Central Alert System)?

Although not directly applicable to the Royal College of Psychiatrists as a professional body, we would note that this consultation document goes out at a time of downturn, recession and quality improvement, with productivity to be demonstrated along with cost benefit and cost savings. Therefore, if patient safety is to successfully remain paramount in a time of economic stress, patient safety measures must be subject to the same evidence base as anything else that needs to be delivered to drive up quality improvement.

Question 4: What are the main changes your organisation would need to make in order to comply with the framework? What would be the risk of implementing or not?

No comment

Question 5: Please rate the overall ease of understanding/readability of the Framework (rate from 1-10, where 10 is easiest)

The readability is 8 to 9.
The understandability in the specific arena of mental health is only 4 because of the vagueness around the interpretation of degrees, seriousness and what role critical thinking skills play in this whole process.

Question 6: Who has reviewed the framework in your organisation? (List of Job titles and Committees- personal names not needed)

Please refer to cover page.

Question 7: What would be the benefits of implemented the Framework?

To enable organisations to be aware of the specific incidents which require investigation. This should be for the main purpose of learning best practice in terms of investigation management of incidents, reporting procedures, and accountability structures. There is a need to put into place the learning, not only in the service under investigation, but across the whole system.

Question 8: Is the framework currently targeted at the correct level?

Yes

Question 9: Are there any bodies, who should have been consulted on the framework, but appear not to have been?

We think a significant omission is stakeholder organisations and voluntary sector organisations that may be involved in the pathway of care for mental health patients.

Question 10: Do you believe that national implementation of the Framework will improve reporting and learning from the most serious incidents?

We do believe that overall this document will improve reporting and learning from the most serious incidents, as we are aware that currently there is such variation in practice across organisations and a lack of clarity around definitions and lines of accountability. This framework is making clearer these points, but overall we believe that this document is a work in process. Without the completion of the pathway, the points we would wish to be covered in the document are best practice, quality improvement, and learning from our mistakes.

The document finished somewhat abruptly having addressed itself to process more than outcome. The key outcome is how we can all learn to function together in a way to make the possibility of such serious incidents less likely to occur. Therefore the rest of the framework appears to flow logically once an incident has been recognised as such, and appears simpler than the existing reporting structures. However, we would wish to re-emphasise that without absolute clarity at the point of deciding whether or not an incident is a serious incident, the system could be overwhelmed, resulting in failures to learn from the most serious, of serious incidents. Further down this hierarchy we think that any organisation that has patient safety at its heart would be looking for early indicators, sign of patterns of episodes and behaviours that may indicate some systemic failure in the system, or particular difficulties within part of the system. This would present an opportunity to intervene early in the pathway, to then avoid the occurrence of a serious incident at all.

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