Report by category:

Category:	5. Any Other Responses
Organisation:	**University of Sheffield**

Section: 1 << Questions Answers >>

A. Executive Summary - page 6

Although there is reference to 'eafeguarding people' this is somewhat 'generic' term. No reference is made to the term in relation to the existing DH guidance on safeguarding adults "No Secrets" (DoH 2000), nor is there any link to definitions in which the NHS might feature as an alleged perpetrator of neglect and/or abuse. The guidance and current review suggest strongly that health organisations are major partners in the development and implementation of multi agency safeguarding of adults. There is no reference or linkages in the Executive Summary, as the majority of the Framework, to the need to link SUI procedures to existing safeguarding policies and procedures. The ES makes no reference to safeguarding adults, and this reinforces the apparent lack of engagement of Health agencies within the arena of adult safeguarding. DEFER

Action:

Comments:

B. Purpose, scope and responsibilities - page 7

Specific reference to safeguarding adults would be appropriate in this section. There is a need to stress the importance of multi agency working where safeguarding arrangements apply. The statenment that Serious incidents are relativey uncommon requires some substantiation: what are the figures...what is 'relatively uncommon' defined as? DEFER

Action:

Comments:

C. Purpose of the serious incident framework - page 7

Action:

Comments:

D. Definition of a serious incident - pages 7-9

Many of the definitions provided for SUIs would fit with abuse and/or neglect and indeed abuse is included within SUI definition. However there is no cross-referencing to safeguarding procedures and existing systems for safeguarding of either adutls or children, which is of concern. DEFER

Action:

Comments:

E. Roles and Responsibilities pages 10-11	The impression gained from the document is that SUIs are perceived as of prime importance and only considered as an NHS issue. If the SUI concerns an adult safeguarding issue then adult safeguarding processes and multi-agency perspectives need to be incorporated into the SUI systems and the safeguarding issues need to be dealt with as such with a muti-agency approach and remit. Issues arising in care home settings that would be referred/reported to adult safeguarding and to CQC tend to disappear within an internal SUI investigation when they occur within an NHS setting. If a person dies as a result of neglect in a hospital setting then safeguarding/police/coroner's investigations really should be possible. What is the role of NPSA in linking to and learning from relevant Serious Case Reviews that arise from SUIs that are related to adult safeguarding issues? DEFER
Action:	
Comments:	
F. Expectations of providers of NHS funded care, Commissioning PCTs and SHAs pages 11-17	How are the lines of accountability to commissioning PCTs and to SHAs tested out? What are the mechanisms by which SUIs are monitored and are these robust enough? What are the links with local authority Departments of Adult Social Care in relation to adult safeguarding, or to Departments of Children's Social Care in realtion to child safeguarding? What are the strategic links of the PCT and/or SHA to local safeguarding boards? DEFER
Action:	
Comments:	
G. Management of a serious incident - page 17	Nothing here on adult safeguarding. Immediate response section should include something on linking to adult safeguarding processes as necessary (and consideration of the need for this to happen) DEFER
Action:	
Comments:	
H. Identification and Response - pages 18-24	Although reference is (thankfully) made to incidents involving children and young people and 'Working Together', no reference is made to 'No Secrets' and adult safeguarding; this is of concern. Child protection is listed within sections on grading but there is nothing comparable relating to adults. DEFER
Action:	
Comments:	

I. Investigation - pages 24-26

Root cause analysis framework is useful, but links need to be made to adult safeguarding systems and processes. Investigation teams could usefully link to local adult safeguarding units (including police public protection units) where available. DEFER

Action:

Comments:

J. Action Plan Development & Implementation - page 27

Links to adult and safeguarding systems at local levels necessary to enhance this area of work. DEFER

Action:

Comments:

K. Monitoring and Closure - pages 27-28

Links to adult and safeguarding systems at local levels necessary to enhance this area of work. DEFER

Action:

Comments:

L. Dissemination of Learning - pages 29-31

Links to Serious Case Review and adult protection systems at local levels necessary to enhance this area of work. Lessons learned from elsewhere should include lessons learned from Serious Case reviews concerning institutional settings. DEFER

Action:

Comments:

M. Communication & the Media - pages 31-34

Action:

Comments:

Section: 2 << Questions Answers >>

Q1. Is the grading of 'Serious Incidents' clear? Please comment - Pages 20-21, Appendix A - page 36

Some grade 2 and/or 3 could possibly fall within adult safeguarding e.g. avoidable unexplained deaths of vulnerable adults. In addition, on pages 20-1 child protection is listed but safeguarding of adults is not. Grading is quite clear, but lacking in linkage to other organisations (for example police, local authorities etc)DEFER

Action:

Comments:

Q2. Does the Framework provide clarity regarding roles and responsibilities in reporting and learning from serious incidents? If not, how can this be improved?

Yes, but see points made in response to E above. Accept

Action:

Comments:

Q3. How should the framework be finally disseminated (e.g. via Central Alert System)?	As widely as possible, suggest using Central Laert and other systems; staff should be trained in framework and its usage. accept
Action:	
Comments:	
Q4. What are the main changes your organisation would need to make in order to comply with the Framework? What would be the risks of implementing or not?	N/A
Action:	
Comments:	
Q5. Please rate the overall ease of understanding/readability of the Framework (rate from 1-10 where 10 is easiest).	8
Action:	
Comments:	
Q6. Who has reviewed the framework in your organisation? (List of job titles and committees - personal names not needed)	N/A
Action:	
Comments:	
Q7. What would be the benefits of implementing the Framework?	
Action:	
Comments:	
Q8. Is the Framework currently targeted at the correct level?	
Action:	
Comments:	
Q9. Are there any bodies who should have been consulted on the Framework, but appear not to have been? *Appendix D - Page 41*	With the exeption of the Care Quality Commission, the agencies consulted in the development of the Framework are essentially health orientated. Given that Serious Incidents could well fall within safeguarding procedures, whether for adults or for children, the lack of any active participation by social care agencies in drafting the Framework appears to have been a missed opportunity and a serious omission. DEFER
Action:	
Comments:	

Q10. Do you believe that national implementation of the Framework will improve reporting and learning from the most serious incidents? Please give reasons for your answers and any ideas how this can be further improved.

I would hope that implementation of a revised Framework would achieve the much-needed improvement. ACCEPT

Action:

Comments:

Q11. Additional comments:

As a non-clinical academic it is not really appropriate for me to comment on those areas of the consultation which are specifically related to more clinically driven aspects of health organisations. However, it is important to stress the need for safeguarding (in particular that which relates to adults) as a multi agency activity to be more fuly integrated within the document and in any subsequent revision of the national framework. As previously mentioned, it is noticeable and regrettable that 'Working Together to Safeguard Children' is referenced, whilst 'No Secrets' is not. This repeats the omission that was made in the protocol agreed between the DoH, the Health and Safety Executive and the Association of Chief Police Officers re the investigation of Serious Untoward Incidents which was produced in 2006. Even with the referencing of 'Working Together' the attention paid to child safeguarding is somewhat limited and in need of further attention, whilst adult safeguarding requires inclusion at relevant points.

Action:

Comments:

Section: 1 << Questions Answers >>

A. Executive Summary - page 6

Although there is reference to 'eafeguarding people' this is somewhat 'generic' term. No reference is made to the term in relation to the existing DH guidance on safeguarding adults "No Secrets" (DoH 2000), nor is there any link to definitions in which the NHS might feature as an alleged perpetrator of neglect and/or abuse. The guidance and current review suggest strongly that health organisations are major partners in the development and implementation of multi agency safeguarding of adults. There is no reference or linkages in the Executive Summary, as the majority of the Framework, to the need to link SUI procedures to existing safeguarding policies and procedures. The ES makes no reference to safeguarding adults, and this reinforces the apparent lack of engagement of Health agencies within the arena of adult safeguarding. DEFER

Action: Accepted

Comments: Further clarity aorund SOVA and "no secrets" will be included

B. Purpose, scope and responsibilities - page 7

Specific reference to safeguarding adults would be appropriate in this section. There is a need to stress the importance of multi agency working where safeguarding arrangements apply. The statenment that Serious incidents are relativey uncommon requires some substantiation: what are the figures...what is 'relatively uncommon' defined as?
DEFER

Action: Accepted

Comments:

C. Purpose of the serious incident framework - page 7

Action:

Comments:

D. Definition of a serious incident - pages 7-9

Many of the definitions provided for SUIs would fit with abuse and/or neglect and indeed abuse is included within SUI definition. However there is no cross-referencing to safeguarding procedures and existing systems for safeguarding of either adutls or children, which is of concern.
DEFER

Action: Accepted

Comments: Further supplemantary definitions to be added

E. Roles and Responsibilities pages 10-11

The impression gained from the document is that SUIs are perceived as of prime importance and only considered as an NHS issue. If the SUI concerns an adult safeguarding issue then adult safeguarding processes and multi-agency perspectives need to be incorporated into the SUI systems and the safeguarding issues need to be dealt with as such with a muti-agency approach and remit. Issues arising in care home settings that would be referred/reported to adult safeguarding and to CQC tend to disappear within an internal SUI investigation when they occur within an NHS setting. If a person dies as a result of neglect in a hospital setting then safeguarding/police/coroner's investigations really should be possible. What is the role of NPSA in linking to and learning from relevant Serious Case Reviews that arise from SUIs that are related to adult safeguarding issues?
DEFER

Action: Accepted

Comments:

F. Expectations of providers of NHS funded care, Commissioning PCTs and SHAs pages 11-17	How are the lines of accountability to commissioning PCTs and to SHAs tested out? What are the mechanisms by which SUIs are monitored and are these robust enough? What are the links with local authority Departments of Adult Social Care in relation to adult safeguarding, or to Departments of Children's Social Care in realtion to child safeguarding? What are the strategic links of the PCT and/or SHA to local safeguarding boards? DEFER
Action:	Rejected
Comments:	Local policy
G. Management of a serious incident - page 17	Nothing here on adult safeguarding. Immediate response section should include something on linking to adult safeguarding processes as necessary (and consideration of the need for this to happen) DEFER
Action:	Accepted
Comments:	
H. Identification and Response - pages 18-24	Although reference is (thankfully) made to incidents involving children and young people and 'Working Together', no reference is made to 'No Secrets' and adult safeguarding; this is of concern. Child protection is listed within sections on grading but there is nothing comparable relating to adults. DEFER
Action:	Accepted
Comments:	
I. Investigation - pages 24-26	Root cause analysis framework is useful, but links need to be made to adult safeguarding systems and processes. Investigation teams could usefully link to local adult safeguarding units (including police public protection units) where available. DEFER
Action:	Accepted
Comments:	
J. Action Plan Development & Implementation - page 27	Links to adult and safeguarding systems at local levels necessary to enhance this area of work. DEFER
Action:	Accepted
Comments:	
K. Monitoring and Closure - pages 27-28	Links to adult and safeguarding systems at local levels necessary to enhance this area of work. DEFER
Action:	Accepted
Comments:	

L. Dissemination of Learning - pages 29-31

Links to Serious Case Review and adult protection systems at local levels necessary to enhance this area of work. Lessons learned from elsewhere should include lessons learned from Serious Case reviews concerning institutional settings. DEFER

Action: Accepted

Comments:

M. Communication & the Media - pages 31-34

Action:

Comments:

Section: 2 << Questions Answers >>

Q1. Is the grading of 'Serious Incidents' clear? Please comment - Pages 20-21, Appendix A - page 36

Some grade 2 and/or 3 could possibly fall within adult safeguarding e.g. avoidable unexplained deaths of vulnerable adults. In addition, on pages 20-1 child protection is listed but safeguarding of adults is not. Grading is quite clear, but lacking in linkage to other organisations (for example police, local authorities etc)DEFER

Action: Accepted

Comments: Grading to be further developed - examples

Q2. Does the Framework provide clarity regarding roles and responsibilities in reporting and learning from serious incidents? If not, how can this be improved?

Yes, but see points made in response to E above. Accept

Action: Accepted

Comments:

Q3. How should the framework be finally disseminated (e.g. via Central Alert System)?

As widely as possible, suggest using Central Laert and other systems; staff should be trained in framework and its usage. accept

Action: Accepted

Comments:

Q4. What are the main changes your organisation would need to make in order to comply with the Framework? What would be the risks of implementing or not?

N/A

Action:

Comments:

Q5. Please rate the overall ease of understanding/readability of the Framework (rate from 1-10 where 10 is easiest).

8

Action:

Comments:

Q6. Who has reviewed the framework in your organisation? (List of job titles and committees - personal names not needed)	N/A
Action:	
Comments:	

Q7. What would be the benefits of implementing the Framework?	
Action:	
Comments:	

Q8. Is the Framework currently targeted at the correct level?	
Action:	
Comments:	

Q9. Are there any bodies who should have been consulted on the Framework, but appear not to have been? Appendix D - Page 41	With the exeption of the Care Quality Commission, the agencies consulted in the development of the Framework are essentially health orientated. Given that Serious Incidents could well fall within safeguarding procedures, whether for adults or for children, the lack of any active participation by social care agencies in drafting the Framework appears to have been a missed opportunity and a serious omission. DEFER
Action:	Accepted
Comments:	

Q10. Do you believe that national implementation of the Framework will improve reporting and learning from the most serious incidents? Please give reasons for your answers and any ideas how this can be further improved.	I would hope that implementation of a revised Framework would achieve the much-needed improvement. ACCEPT
Action:	Accepted
Comments:	

Q11. Additional comments:

As a non-clinical academic it is not really appropriate for me to comment on those areas of the consultation which are specifically related to more clinically driven aspects of health organisations. However, it is important to stress the need for safeguarding (in particular that which relates to adults) as a multi agency activity to be more fuly integrated within the document and in any subsequent revision of the national framework. As previously mentioned, it is noticeable and regrettable that 'Working Together to Safeguard Children' is referenced, whilst 'No Secrets' is not. This repeats the omission that was made in the protocol agreed between the DoH, the Health and Safety Executive and the Association of Chief Police Officers re the investigation of Serious Untoward Incidents which was produced in 2006. Even with the referencing of 'Working Together' the attention paid to child safeguarding is somewhat limited and in need of further attention, whilst adult safeguarding requires inclusion at relevant points.

Action: Accepted

Comments: Will be included

Organisation: **Action Against Medical Accidents**

Section: 1 **<< Questions** **Answers >>**

A. Executive Summary - page 6

Action:

Comments:

B. Purpose, scope and responsibilities - page 7

Action:

Comments:

C. Purpose of the serious incident framework - page 7

Action:

Comments:

D. Definition of a serious incident - pages 7-9

For the avoidance of any doubt, we would like it to be made more clear that whilst this framework provides a working definition of 'serious' incidents, any incident where harm has been caused, or may result for a patient should be investigated and reported both to the patient and to NHS/patient safety direct ('low harm' and above).Accept We recomment a slight re-wording of the definition to include incidents which may result in the kind of harm described, (rather than "resulting in"). This would bring incidents which have the potential to result in such harm within the definition, which we are sure would be the intention. For example, systemic failures in diagnostic/screening procedures.Accept

Action: Accepted

Comments:

E. Roles and Responsibilities pages 10-11

Action:

Comments:

F. Expectations of providers of NHS funded care, Commissioning PCTs and SHAs pages 11-17

Action:

Comments:

G. Management of a serious incident - page 17

Action:

Comments:

H. Identification and Response - pages 18-24

Action:

Comments:

I. Investigation - pages 24-26

Action:

Comments:

J. Action Plan Development & Implementation - page 27

Action:

Comments:

K. Monitoring and Closure - pages 27-28

Action:

Comments:

L. Dissemination of Learning - pages 29-31

Action:

Comments:

M. Communication & the Media - pages 31-34

Action:

Comments:

Section: 2 **<< Questions** **Answers >>**

Q1. Is the grading of 'Serious Incidents' clear? Please comment - Pages 20-21, Appendix A - page 36

Action:

Comments:

Q2. Does the Framework provide clarity regarding roles and responsibilities in reporting and learning from serious incidents? If not, how can this be improved?

Action:

Comments:

Q3. How should the framework be finally disseminated (e.g. via Central Alert System)?

Action:

Comments:

Q4. What are the main changes your organisation would need to make in order to comply with the Framework? What would be the risks of implementing or not?

Action:

Comments:

Q5. Please rate the overall ease of understanding/readability of the Framework (rate from 1-10 where 10 is easiest).

Action:

Comments:

Q6. Who has reviewed the framework in your organisation? (List of job titles and committees - personal names not needed)

Action:

Comments:

Q7. What would be the benefits of implementing the Framework?

Action:

Comments:

Q8. Is the Framework currently targeted at the correct level?

Action:

Comments:

Q9. Are there any bodies who should have been consulted on the Framework, but appear not to have been? *Appendix D - Page 41*

Action:

Comments:

Q10. Do you believe that national implementation of the Framework will improve reporting and learning from the most serious incidents? Please give reasons for your answers and any ideas how this can be further improved.

Action:

Comments:

Q11. Additional comments:

Action:

Comments:

Organisation: **ADASS**

Section: 1 **<< Questions** **Answers >>**

A. Executive Summary - page 6

Action:

Comments:

B. Purpose, scope and responsibilities - page 7

Action:

Comments:

C. Purpose of the serious incident framework - page 7

Action:

Comments:

D. Definition of a serious incident - pages 7-9

Action:

Comments:

E. Roles and Responsibilities pages 10-11

Action:

Comments:

F. Expectations of providers of NHS funded care, Commissioning PCTs and SHAs pages 11-17

Action:

Comments:

G. Management of a serious incident - page 17

Action:

Comments:

H. Identification and Response - pages 18-24

Action:

Comments:

I. Investigation - pages 24-26

Action:

Comments:

J. Action Plan Development & Implementation - page 27

Action:

Comments:

K. Monitoring and Closure - pages 27-28

Action:

Comments:

L. Dissemination of Learning - pages 29-31

Action:

Comments:

M. Communication & the Media - pages 31-34

Action:

Comments:

Section: 2 << Questions Answers >>

Q1. Is the grading of 'Serious Incidents' clear? Please comment - Pages 20-21, Appendix A - page 36

Action:

Comments:

Q2. Does the Framework provide clarity regarding roles and responsibilities in reporting and learning from serious incidents? If not, how can this be improved?

Action:

Comments:

Q3. How should the framework be finally disseminated (e.g. via Central Alert System)?

Action:

Comments:

Q4. What are the main changes your organisation would need to make in order to comply with the Framework? What would be the risks of implementing or not?

Action:

Comments:

Q5. Please rate the overall ease of understanding/readability of the Framework (rate from 1-10 where 10 is easiest).

Action:

Comments:

Q6. Who has reviewed the framework in your organisation? (List of job titles and committees - personal names not needed)

Action:

Comments:

Q7. What would be the benefits of implementing the Framework?

Action:

Comments:

Q8. Is the Framework currently targeted at the correct level?

Action:

Comments:

Q9. Are there any bodies who should have been consulted on the Framework, but appear not to have been? *Appendix D - Page 41*

Action:

Comments:

Q10. Do you believe that national implementation of the Framework will improve reporting and learning from the most serious incidents? Please give reasons for your answers and any ideas how this can be further improved.

Action:

Comments:

Q11. Additional comments:

It however seems to me there are some potential significant omissions and oversights . One of these relates to the decision trees where no reference to the connections and linkage to and with local safeguarding procedures appears . This despite in the case of vulnerable adults who are resident in an NHS commissioned care setting being subject to regulatory compliance with CQ and there being a concomitant requirement for the matter to be considered under safeguarding procedures . However I also note that you have not involved either of the associations representing the national social care services directors of either Adults or Children. As the Directors of Adults Social Services national lead on safeguarding I would be happy to be involved in any discussions if this would be helpful . I will also copy this note to one of my colleague Directors of Children's services whom I am sure will want to engage in discussion about how Serious Untoward Incident reporting and learning fits in with national children's safeguarding requirements and processes .

Action: Accepted

Comments: This is being addressed no secrets lead at DH.

Organisation: **Garden Court Chambers**

Section: 1 << Questions Answers >>

A. Executive Summary - page 6

Neither the Executive Summary on page 6, nor the 'Serious Incident Reporting Process' flow chart on page 5, make any reference to independent investigation. The only attempt to define independence is at page 36 - see comments below. accept

Action: Accepted

Comments:

B. Purpose, scope and responsibilities - page 7

Independent investigations are not mentioned. This theme is the repeated throughout most of the document. If the purpose is to address ONLY internal investigations, this should be clearly stated. accept

Action: Accepted

Comments:

C. Purpose of the serious incident framework - page 7

Again, independent investigations are not mentioned. Nor is the need to ensure that recommendations arising from independent investigations are implemented. accept

Action: Accepted

Comments:

D. Definition of a serious incident - pages 7-9

Under 'Scope of the SIR Framework' page 9, there is again no reference to independent investigation. accept

Action: Accepted

Comments:

E. Roles and Responsibilities pages 10-11

Action:

Comments:

F. Expectations of providers of NHS funded care, Commissioning PCTs and SHAs pages 11-17

Under 'Learning and Follow up' on page 13, page 14 (PCTs) and page 16 (SHAs), there should be reference to ensuring by means of independent evidence-based review that recommendations from independent investigations are implemented. accept

Action: Accepted

Comments:

G. Management of a serious incident - page 17

Action:

Comments:

H. Identification and Response - pages 18-24

Although in Table 1 at page 21 there is reference to homicide and mention in the paragraph below Table 1. of a consistent level of RCA investigation, it should be acknowledged that independent investigations may need an alternative approach. Accept

Action: Accepted

Comments:

I. Investigation - pages 24-26

At paragraph 3.4, there is no acknowledgment that RCA may not be a sufficient approach to comply with an Article 2 ECHR requirement for an effective investigation. The training requirements be adequate for this purpose. defer

Action: Rejected

Comments: Out of scope

J. Action Plan Development & Implementation - page 27

Whether or not recommendations of an independent investigation have been implemented should be established by means of independent evidence-based review. defer

Action: Accepted

Comments:

K. Monitoring and Closure - pages 27-28

An investigation should not be considered as completed until all the recommendations arising from it have been implemented. If a recommendation is not to be implemented a reason should be given in each case. accept

Action: Accepted

Comments:

L. Dissemination of Learning - pages 29-31

Action:

Comments:

M. Communication & the Media - pages 31-34

Action:

Comments:

Section: 2 << Questions Answers >>

Q1. Is the grading of 'Serious Incidents' clear? Please comment - Pages 20-21, Appendix A - page 36

Level 3 RCA would not be adequate to satisfy Art 2 ECHR, nor sufficient for conduct of independent MHIs according to NPSA Good Practice Guidance 2008. Independent investigations should be independent of providers AND commissioners. Defer

Action: Accepted

Comments: Further clarity will be included

Q2. Does the Framework provide clarity regarding roles and responsibilities in reporting and learning from serious incidents? If not, how can this be improved?

Action: Accepted

Comments:

Q3. How should the framework be finally disseminated (e.g. via Central Alert System)?

Paragraph 3.7 makes no reference to the means by which it will be determined that lessons have been learned, for example, by implementation of recommendations, evidence, outcomes, raised standards of care or reduced incidence of SUIs. accept

Action: Accepted

Comments:

Q4. What are the main changes your organisation would need to make in order to comply with the Framework? What would be the risks of implementing or not?

Action:

Comments:

Q5. Please rate the overall ease of understanding/readability of the Framework (rate from 1-10 where 10 is easiest).

Action:

Comments:

Q6. Who has reviewed the framework in your organisation? (List of job titles and committees - personal names not needed)

Action:

Comments:

Q7. What would be the benefits of implementing the Framework?

Action:

Comments:

Q8. Is the Framework currently targeted at the correct level?

The Forward at page 3 makes it clear that this is an internal NHS document for internal NHS use in order to carry out internal investigations. However, this is only one part of a larger picture - victim interest, public accountability and Art 2 ECHR. defer

Action: Rejected

Comments:

Q9. Are there any bodies who should have been consulted on the Framework, but appear not to have been? *Appendix D - Page 41*

Action:

Comments:

Q10. Do you believe that national implementation of the Framework will improve reporting and learning from the most serious incidents? Please give reasons for your answers and any ideas how this can be further improved.

This document is not sufficiently broad to be useful for independent investigations. If the intention is to address only the internal segment of the investigation process this is fine, but it should state at the outset what it does NOT include. accept

Action: Accepted

Comments:

Q11. Additional comments:

This response is from four individuals who, between them, have extensive experience of chairing independent mental health homicide investigations, conducting research into serious case reviews, reporting nationally on serious case reviews and participating in the development of plans for domestic homicide reviews. Additional comments are contained in a separate attached document.

Action: Accepted

Comments:

Organisation: **Individual**

Section: 1 << Questions Answers >>

A. Executive Summary - page 6

Action:

Comments:

B. Purpose, scope and responsibilities - page 7

Action:

Comments:

C. Purpose of the serious incident framework - page 7

Action:

Comments:

D. Definition of a serious incident - pages 7-9

The definition and examples are too narrow. Suggest that serious harm has occurred (yet includes potential harm due to change of circumstances). What about near misses. These are often distinguished from actual harm only by good luck/ effective action - eg assault on patient/staff/visitor that could be serious but did not require surgical intervention (eg patient attempts to strangle peer but nurse intervenes). Many lessons can be learned.

Action: Rejected

Comments: Near misses not to be included SIRL document - SIRL Review Group

E. Roles and Responsibilities pages 10-11

Action:

Comments:

F. Expectations of providers of NHS funded care, Commissioning PCTs and SHAs pages 11-17

Action:

Comments:

G. Management of a serious incident - page 17

Action:

Comments:

H. Identification and Response - pages 18-24

Again definition too narrow. Why only inpatient suicides. Mental health policy is to admit as last resort - how will DH know if policy successful if only inpatients treated seriously? May be counter-intuitive consequence of services being increasingly reluctant to admit most vulnerable patients for fear of investigation.

Action: Accepted

Comments: Changed as per SIRL Review Group

I. Investigation - pages 24-26

Action:

Comments:

J. Action Plan Development & Implementation - page 27

Action plan deserves much more guidance. Plans often woolly or unachievable. May not reflect what really happens in services if drawn up by committee with no reference to clinicians involved. Should be guidance for trusts to support staff to check feasibility and implementation of action plans

Action: Rejected

Comments: Only a guideline.

K. Monitoring and Closure - pages 27-28

Action:

Comments:

L. Dissemination of Learning - pages 29-31

Agree this is vital but needs radical approach - SIs are not rare but neither are they very common in an organisation. I understand what is suggested in terms of PCTs and SHAs disseminating messages by newsletter etc but this could be a niave view from top down organisations. To achieve ownership from clinicians, clinicians must be involved. Regional bodies comprising senior clinicians from each similar organisation (eg all trusts providing mental health services or all acute trusts etc) in which members had responsibilities included in their job descriptions to advise each other's services, share knowledge, develop expertise in all aspects of the process (from reporting of incident to dissemination of lessons) and, most importantly, to report back to their own organisation's clinical directors what lessons must be shared would be much more effective. Such a body could be facilitated by the SHA but the strength would be the commitment of clinical members who would, at the same time, be learning from each other and advising their own colleagues (assuming each trust had effective governance/communication processes)

Action: Defer

Comments: Review group.

M. Communication & the Media - pages 31-34

Action:

Comments:

Section: 2 << Questions Answers >>

Q1. Is the grading of 'Serious Incidents' clear? Please comment - Pages 20-21, Appendix A - page 36

No - inadequate - see above

Action: Accepted

Comments:

Q2. Does the Framework provide clarity regarding roles and responsibilities in reporting and learning from serious incidents? If not, how can this be improved?

Yes but see answer to 24

Action: Accepted

Comments:

Q3. How should the framework be finally disseminated (e.g. via Central Alert System)?

The central alert system is ok but to really reach clinicians, they need to be involved centrally (not at the end of the line) - see 24 above.

Action: Accepted

Comments:

Q4. What are the main changes your organisation would need to make in order to comply with the Framework? What would be the risks of implementing or not?

None really. Risks of not implementing are obvious.

Action: Accepted

Comments:

Q5. Please rate the overall ease of understanding/readability of the Framework (rate from 1-10 where 10 is easiest).

7 - easy to read but too vague to be effective

Action: Accepted

Comments:

Q6. Who has reviewed the framework in your organisation? (List of job titles and committees - personal names not needed)

Don't know - I have responded as an individual (consultant forensic psychiatrist, medical director and sometime secondee to CHI/HCC/CQC)

Action: Accepted

Comments:

Q7. What would be the benefits of implementing the Framework?

Learn lessons - try to improve safety - but we try to anyway.

Action: Accepted

Comments:

Q8. Is the Framework currently targeted at the correct level?

No - see 24

Action:

Comments:

Q9. Are there any bodies who should have been consulted on the Framework, but appear not to have been? *Appendix D - Page 41*

Action:

Comments:

Q10. Do you believe that national implementation of the Framework will improve reporting and learning from the most serious incidents? Please give reasons for your answers and any ideas how this can be further improved.

No because the threshold is too high and for some reason downgrades the seriousness of outpatient suicide. What if a suicidal patient is refused admission because he is suicidal?

Action:

Comments:

Q11. Additional comments:

Action:

Comments:
