Correspondence

Investigating a serious incident – a personal perspective

I am a higher trainee in psychiatry. Like most of my colleagues in the National Health Service (NHS), the very thought of a serious incident (SI) occurring at any time in my career fills me with unease. So when a helpful senior suggested that I could take part in an investigation to understand the process better, I eagerly accepted. Thus began what would become an eye-opening special interest session.

The Royal College of Psychiatrists Curriculum for Specialist Training states that one of the intended learning outcomes of higher training is to develop an understanding of clinical governance. This equates to demonstrating awareness (at ST4 level) and understanding (at ST5 level) of risk management and healthcare governance issues. By the end of ST6, a trainee is expected to demonstrate the ability to handle a singular untoward incident (SUI) and to work nationally, regionally or locally to develop and implement clinical guidelines and care pathways.[1]

In preparation for the work at hand, I was given a large document for 'bedtime reading' by the SI officer. The revised Serious Incident Framework was published in March 2013 and updated in 2015[2] to reflect the changed landscape of the NHS brought on by the introduction of the Health and Social Care Act in 2012. As I read through the 90-page document it became clear that although it helps to correctly identify and thoroughly investigate serious incidents, its underpinning purpose was to learn from such incidents in order to prevent recurrence.

The term SI is used interchangeably with SUI, or serious incident requiring investigation (SIRI). In the NHS, an SI is not limited to a suicide or homicide, but includes all 'adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified.' This definition is very broad and there is no set list of incidents that can be classified as an SI, and it is suggested that lists should not be created locally so as to avoid jeopardising the process.[2]

Serious outcomes alone are not sufficient to delineate what amounts to an SI because adverse outcomes may not always be the result of acts of omission or commission. If an SI is declared but further investigation reveals that the definition of an SI is not fulfilled, the incident can be downgraded to focus efforts where they are more relevant.

In November 2014 the duty of candour regulations came into force in the NHS. This is a statutory duty to be open and honest with people who use services, and other relevant persons, when something goes wrong that appears to have caused, or could lead to, significant harm.[3] In practice, this can be misunderstood and it is not uncommon for those affected by the SI to assume that it is an admission of wrongdoing by the NHS. Far from it – the duty of candour seeks to engage the affected individuals very early in the process, helping them to understand not only the importance and purpose of the investigation, but also keeping them safe, informed and supported.

As the investigation was under way, I was overwhelmed to learn that I had to submit my report within a few weeks – the workload seemed huge and complicated. According to the framework, all concise and comprehensive SIs should be reported within 60 days. I was provided with a fact-finding document and timeline of the SI that helped to set the scene. Using the root cause analysis (RCA) model and getting my teeth into the case history helped me cut to the chase. The RCA model helps to structure the process by explicitly asking key questions about the incident: what, who, when, where, how and why?

The process itself was not easy and I felt the weight of the responsibility. It called for me to be objective, questioning, inquisitive and thorough. It involved setting up a time of reference as the focus of the investigation and identifying those closely involved in the incident. I had to identify whether there were any issues of concern or inconsistencies in the evidence. This was followed by the more difficult experience of having discussions with respective teams, interviewing the professionals involved and clarifying team policies and procedures. The very nature of the SI investigation tends to instil a sense of disquiet and apprehension. If the situation calls for it, criminal proceedings, disciplinary procedures, or bodies such as the General Medical Council, Nursing and Midwifery Council or Care Quality Commission may hold individuals or organisations to account. However, the SI investigation itself does not seek to apportion blame and neither is it punitive.[2]

It was a relief when all pertinent evidence was finally gathered. It was no small task making sense of all the available information and analysing it to produce an objective and succinct report. The report requires identification of probable causes – both root causes and contributory causes – if any. Other factors, including organisational, environmental, team, task, communication and patient factors are also examined. It is important to highlight any areas of good practice and incidental findings if they bear any relevance to the incident being investigated.

I drafted my report until a tangible sequence and explanation flowed through it. The report was disseminated and discussed at the local care group. The panel and Chair went through the report and certain action plans were recommended. It felt rewarding to be appreciated by the Chair for my efforts in investigating a very complicated case. I am happy that within the NHS there is a transparent, timely, collaborative and objective system to address the person at the centre of the incident and having been a small part of it gave me a sense of fulfilment.

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1 Royal College of Psychiatrists. Curricula. Royal College of Psychiatrists, 2017. Available at: http://www.rcpsych.ac.uk/traininpsychiatry/corespecialtytraining/curricula.aspx

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2 NHS England. *Serious Incident Framework: Supporting Learning to Prevent Recurrence*. NHS England, 2015.

3 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20 Duty of Candour. Available at: http://www.cqc.org.uk/content/regulation-20-duty-candour#legislation-links

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Management of common mental disorders for psychogeriatric patients in Hong Kong – a comparison of two clinics

The enhanced Common Mental Disorder Clinic (CMDC) was developed by the Hospital Authority of Hong Kong in 2015 to shorten new-case waiting time at the psychiatric specialist out-patient clinic (SOPC) for adult patients with common mental disorders (CMDs).[1] Patients with CMDs usually have to wait for a long time for their first psychiatric consultation and during that period symptoms may worsen and become more distressing. They may require a longer duration of treatment if their problems have become more complicated. CMDC aims at providing early treatment to nip the problem in the bud. It consists of two doctors, three nurses, two occupational therapists and one clinical psychologist. Each patient is under the care of a multidisciplinary team. The additional allied health input aims to reduce doctors' burden. It is hoped that after one year of treatment, a substantial number of patients can be discharged from the programme.

CMDC started its operation in the Kowloon East Cluster of Hong Kong in July 2016 – Kowloon East is one of seven clusters governed by the Hospital Authority and it serves a population size of about 1.1 million. Psychogeriatric patients are normally seen at SOPC, with waiting times of 110 weeks in 2015. We intend to include psychogeriatric patients in the new programme with a view to shorten the waiting time.

A pilot study has been conducted by recruiting 30 consecutive psychogeriatric patients, with CMDs, from CMDC and SOPC retrospectively. The difference in clinical factors between the two groups, as well as any benefit of shortening the waiting time by triaging suitable psychogeriatric patients from SOPC to CMDC, were assessed. Aims of the pilot programme were to demonstrate any benefit of extending CMDC to psychogeriatric patients and to guide future modifications needed for this group.

There was no statistically significant difference in the age and gender distribution of the two groups. The waiting time for the CMDC group (median of 89.5 days, IQR=52.8) was significantly shorter than the SOPC group (mean 425 days, s.d.=220) ($P < 0.00001$). All CMDC psychogeriatric patients were referred for psychological intervention. The clinical psychologist appointment was available within 1 month after referral. Only about half of the patients attended the psychological intervention arranged for them. For the SOPC group, 8 patients (26.7%) from the SOPC group were referred for psychological intervention with a waiting time of at least 9 months. Two (25%) refused the intervention. About 60% of patients in both groups received treatment by general practitioners or private psychiatrists before being referred to us. At 6 months, 28 patients (93%) remained in CMDC, and 23 patients (76.7%) remained in SOPC.

CMDC significantly reduced waiting times for a medical consultation and psychological intervention for elderly patients with CMDs by 80%. The waiting time of psychogeriatric SOPC was also shortened to about 50 weeks after the new programme ran for 10 months. CMDs are common in the elderly population and they are suitable candidates for the clinic. Acceptance towards psychological intervention is only modest for this group of patients as the CMDC programme was not tailor-made for elderly patients. If the clinic is to be extended to psychogeriatric patients, the content of the groups will need to be more age-specific.

Primary care settings present important opportunities for the detection and management of depression in older adults.[2] Programmes in which primary care providers and mental health specialists collaborate effectively could improve patient outcomes for those with CMDs.[3] It is worthwhile involving primary care doctors in the new programme by providing care after patients are stepped down from CMDC.

Psychological intervention by nurses helps to reduce the frequency of medical consultations. Doctors' time can thus be spent on less stable patients. Nurse-led clinics were also found to present an opportunity by freeing up specialists to see more complex patients.[4]

Acceptance of psychological intervention may be related to the age group of patients; this information would be useful for guiding future services. Comparison will be performed again when the CMDC group has completed the 1-year programme. A larger number of patients are expected to be discharged from the CMDC in comparison to SOPD after 1 year. The number of doctor consultations will be compared. We hope that by studying the characteristics of patients who can be discharged successfully after completion of the programme, we can identify suitable patients to be referred to it.

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1 Common Mental Disorder Clinic, Kowloon West Cluster. Guideline for Common Mental Disorder Clinic Cross-cluster Referral. HAHO-COC-GL-Psy-010-V1.

2 Park M, Unützer J. Geriatric depression in primary care. *Psychiatr Clin North Am* 2011; **34**: 469–87.

3 Unützer J, Park M. Strategies to improve the management of depression in primary care. *Prim Care* 2012; **39**: 415–31.

4 Uppal S, Jose J, Banks P, Mackay E. Cost-effective analysis of conventional and nurse-led clinics for common otological procedures. *J Laryngol Otol* 2004; **118**: 189–92.

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Author's reply – the cognitive therapy of depression

Although Dr Moorey and I both deprecate theoretical whimsy and while there is much that we can agree on concerning cognitive–behavioural therapy (CBT) and psychoanalysis, we profoundly disagree on several other matters including, especially, the content and remit of that paper of mine on which he commented.[1,2]

Regarding CBT, we both agree that it has the most comprehensive evidence base of all the psychological therapies

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