Filename: Suicide – rationale v1

Title: Rationale for revisions to guidance on the reporting of suicides and severe harm to NRLS

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Rationale for revisions to guidance on the reporting of suicides and severe harm to NRLS

The rationale for the changes is as follows.

1. Care Quality Commission (CQC) Registration Regulations

Registered providers have a statutory duty to notify CQC in writing about certain important events that affect people who use their service or the service itself. Previously it was optional for NHS providers to make anonymous reports about certain types of death and patient harm to the National Patient Safety Agency (NPSA). From April 2010, notification of these incidents to the CQC became a statutory requirement that trusts can discharge via reporting to the NPSA's National Reporting and Learning System, which passes the incidents on to the CQC. Further information about the relevant regulations can be found in the Care Quality Commission (Registration) Regulations 2009 available on CQC's website: www.cqc.org.uk.

CQC considers that the previous NPSA guidance on the reporting of suicides is too restrictive in what should be reported to be fully consistent with regulatory reporting requirements.

From 1st April 2010, serious incidents reported to the NPSA have been shared with the CQC in fulfilment of the requirements of The Care Quality Commission (Registration) Regulations 2009. Regulation 16 on the notification of death of a service user states that, for health service bodies (such as NHS trusts) "…the registered person must notify the Commission of the death of a service user where the death—
(a) occurred—
(i) whilst services were being provided in the carrying on of a regulated activity, or
(ii) as a consequence of the carrying on of a regulated activity; and
(b) cannot, in the reasonable opinion of the registered person, be attributed to the course which that service user's illness or medical condition would naturally have taken if that service user was receiving appropriate care or treatment…"

This regulation is not applicable to deaths of patients who are detained or liable to be detained under the Mental Health Act 1983, but the CQC does encourage NHS trusts to continue to report relevant deaths to the NPSA.

The CQC is of the view that:

- an apparent/actual suicide cannot be reasonably attributed to the natural course of a service user's illness or medical condition, and thus is a notifiable event when occurring while, or as a consequence of, services being provided;
- the exclusion of the deaths of outpatients does not reflect the largely community based service provision for people with mental health problems nor the change in national policy on mental health which places greater emphasis on the early identification and follow up of mental health needs amongst people with physical health problems.

Following discussions with experts, the CQC considers that it is appropriate that deaths from alcohol or drug abuse are not routinely regarded as notifiable, unless there has been a patient safety incident and/or where there has been an actual or apparent suicide.

2. National policy requirements

In 2011, the Government published it mental health strategy *No health without mental health - A cross-government mental health outcomes strategy for people of all ages.* The strategy captures the Government's aim to mainstream mental health in England and is clear about the expectation of 'parity of esteem' between mental and physical health services – that mental health awareness and treatment should be given the same prominence as the nation's physical health. It emphasises that 'mental health is everyone's business'. The first agreed objective of the strategy is that more

people will have good mental health - continuing to work to reduce the national suicide rate is one means identified as achieving this.

In 2012, a new cross-government suicide prevention strategy will be published**.** The consultation on the draft suicide prevention strategy identified that action that can contribute to a reduction in suicide rates can include improving care pathways between emergency departments, primary and secondary care, inpatient and community care, and on discharge and ensuring that front-line staff working with high-risk groups receive training in the recognition, assessment and management of risk and fully understand their roles and responsibilities.

It identified that:

- Emergency departments have an important role in treating and managing people who have self-harmed or have made a suicide attempt. Research has shown that there are still problems in some places with the quality of care, assessment and follow-up of people who seek help from emergency departments after self-harming.
- Attitudes towards and knowledge of self-harm among general hospital staff need further development, particularly as a high proportion of people who self-harm are not given a psychological assessment.
- Often, follow-up and treatment are not provided, in particular for people who repeatedly self-harm.
- In many emergency departments, the facilities available for distressed patients could be improved.