Proposal for a National Health Service (Mental Health) Patient Safety Doctrine

This proposal was written with the assistance of ChatGPT (GPT-5, OpenAI). It aims to provoke a structured discussion on the formulation, validation, and roll-out of a Patient Safety Doctrine for mental health patients in the United Kingdom. The Lampard Inquiry is considering a significant number of deaths over an extended time period. This proposal hypothesises that the relevant mental health model care has systemically failed and is incapable of self-correction, and should be replaced by rapid evolution into a radical solution.

Introduction

This proposal adapts the structured processes of military doctrine development into the area of national mental health policy. While military doctrine often incorporates obfuscation and deception at strategic, operational, and tactical levels, this report deliberately excludes such elements. Instead, it emphasises transparency, ethics, trust, and evidence-based practice as their guiding principles. A structured methodology that includes clear and well established principles, testing with validation, dissemination of information, and is accepting of controlled revision at all levels, is employed to provide a rigorous framework for mental health system reform.

1. **Strategic level:** Government policy sets the *what and why* of public Mental Health Policy *aims*, working with the operational level to set the objectives that will deliver on those *aims*

2. **Operational level:** works with the strategic level to set the *objectives* that must be met to deliver on policy aims; determines *how* resources are to be allocated nationally through regional bodies

3. **Tactical level:** regional bodies design the methods of patient care *delivery* through the creation of *Safety Cases* that collectively will fulfil the operational objectives within the resources allocated, realigning objectives, resources and delivery as required; changes in objectives will to have to rise through the operational to the strategic level for consideration and approval.

Patient care will have a planning and a delivery phase. Planning should be iterative and mutable across all three levels to ensure alignment between policy aims and achievable patient outcomes. Delivery will develop into a continuous process of care, adapting to the circumstances in which it effected, receptive to changes in both aims and objectives yet influencing both when aggregated outcomes are evaluated.

The **Patient Safety Doctrine** will be written at the **Operational Level. Execution** is driven by the needs of policy from above. and it is directed by the realities of delivery fro below. The intended outcome is to not only place the safety of patients at the very heart of their treatment, but design that treatment from essential safety requirements from the very outset.

The methodologies used to guide this document are employed in the most demanding environments:

1. Nuclear industry

2. Aviation & aero space

3. Railways

4. Oil, gas and petrochemicals

5. Defence and military systems

6. Healthcare (emerging application)

1. Doctrine Development Principles

The development of doctrine follows structured steps that can be adapted from the military to the health context:

- **Strategic Context and Guidance:** Rooted in government policy, public health priorities, and population needs.

- **Conceptual Development:** Draws from psychology, psychiatry, sociology, lived experience, and innovation.

- **Drafting and Structuring Principles:** Establishes consistent language, responsibilities, and objectives.

- **Testing and Validation:** Ensures doctrine works in practice through pilots, trials, and structured evaluation.

- **Publication and Dissemination:** Doctrine is codified into accessible documents and training packages.

- **Continuous Revision and Feedback:** Doctrine evolves in response to new evidence, feedback, and culture shifts.

Annex A maps the change of approach to move from a military to a mental health care environment.

2. Application to Mental Health Doctrine

- A national Mental Health Doctrine would align with the national health strategy and the population needs, providing coherence between NHS priorities, prevention strategies, and treatment pathways.
- Be informed by psychology, psychiatry, sociology, and innovation, combining scientific evidence with service-user insight and modern digital tools.
- Operate at three levels (strategic, operational, tactical), to ensure consistency of intent from government policy down to frontline clinical practice.
- Be tested through pilots, hospital units, and community roll-outs, to reduce risk before national scale-up.
- Be disseminated through training, institutions, and guidelines, to ensure uniformity and accessibility for all NHS Trusts and local authorities.
- Be continuously revised based on outcomes, evidence, and culture, to keep doctrine relevant, equitable, and sustainable.

3. Testing and Validation: Safety Case Approach

Validation of doctrine shall follow upon the adoption of a safety case structure. Testing and validation are the essential components that test clinical practice against reality, and through feedback, to allow doctrinal imperatives to align with empirical evidence from wards and the community.

Element	Action and Execution
Proving Doctrine Effectiveness	Implementation and testing of Safety Cases and their alignment to the Patient Safety Doctrine
Sub-claims that Break Down Key Outcomes	Consistent application across services; improved outcomes for patients and carers; adaptability across different contexts (hospital units, regional Trusts, national policy).
Structured Arguments Linking Evidence to Claims	Clear chains of logic supported by pilots, trials, and data, that demonstrate how doctrine achieves intended outcomes.
Evidence from Pilots, Trials, Metrics, and Feedback	NHS Trust pilot results, roll-play walk-throughs, academic research, service-user reports, and national performance metrics.
Confidence Assessment (High, Medium, Low)	Explicit statement of certainty levels to ensure transparency (e.g., high for crisis reduction; medium for adaptability across diverse settings).
Residual Risks and Limitations	Possibility of false positives in risk assessments; regional service inequities; cultural variation influencing uptake and outcomes.
Iterative Review and Update Cycles	Doctrine to be reviewed every 3 years, or sooner after major crises, ensuring ongoing relevance and improvement.

War-gaming of the testing and validation can be undertaken by Blue and Red teams at different levels. With one team representing the carers and the other patients, the effectiveness of the doctrine and its practise through safety cases can measured before its being released into the wards.

By employing varying levels of role-play and location, it would be possible to develop the equivalent of a flight-test programme for these new methodologies right the way through to tuning policies to specific locations. Stage-props and physical locations would enhance the reality of the war-games for the players:

1. **Documentation walkthrough:** a single discussion group in a single room
2. **Static war-games:** in a single room Blue and Red teams would talk through sustaining and breaking respectively the safety cases
3. **Active war-games:** either in location simulations or commissioned wards (or parts thereof) Blue and Red teams would move both doctrine and practise to a ready state

- *The experiences of one group might prove invaluable to the effectiveness of this process - the patients. Under strict ethical guidance they represent a resource like none other.*

4. Worked Example: Inpatient Admission Safety Cases

This example demonstrates how the safety case methodology, adapted from high-hazard industries, can be directly applied to mental health admissions. It provides three worked examples: the initial assessment prior to admission and ward allocation, and the ward acceptance stage prior to detailed care planning.

The number of safety cases can be increased to achieve optimum patient safety, while constrained by managerial effectiveness. The three example safety cases take a patient from THE FIRST presentation to a mental health unit to occupancy on a ward.

Further safety cases would then be integrated to WRITE a care plan and oversee treatment and observation. Safety Case 1: Initial Assessment (Decision to Admit & Allocate Ward)

Top-level claim: The patient requires inpatient care and has been allocated to the most appropriate ward.

Sub-claims:

- Admission clinically necessary (psychiatric assessment, severity).

- Risks cannot be managed in the community (structured risk tools, safeguarding).

- Admission lawful and rights-respecting (MHA/MCA paperwork, consent/capacity review).

- Ward selection appropriate (PICU vs. acute vs. specialist).

- Safe transfer plan in place (escort, observation, immediate medication if required)

Residual risks: transfer incidents, delays.

Mitigations: crisis team escort, pre-transfer safety checks.

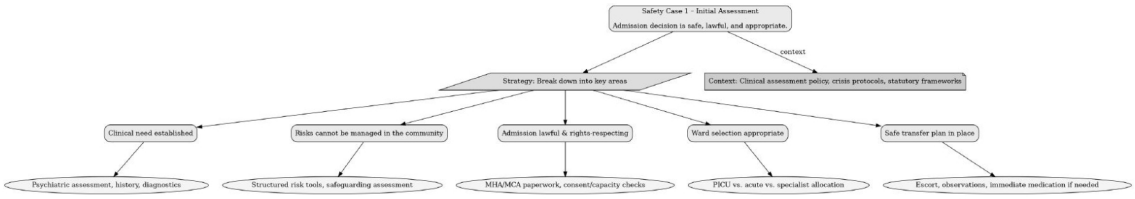

Diagram: Safety Case 1 – Initial Assessment

Safety Case 2 – Ward Acceptance (Pre-Care Plan Stage)

Top-level claim: The patient's admission to the ward is safe and lawful, with risks managed before the care plan is finalised.

Sub-Claims:

• **Legal/Administrative Completeness:** All admission forms are valid.

• **Immediate Risk Containment:** Observation levels and seclusion availability are in place.

• **Consent/Capacity Review:** Consent and capacity are reviewed at handover.

• **Resources in Place:** Staffing, environment, and medications, are all in place.

• **Induction & Safeguarding:** The patient has undergone a search, belongings check, and any safeguarding flags have been flagged.

Residual Risks: Acute agitation, absconding, and institutionalisation.

Mitigations: Observation protocols, rapid tranquillisation policies, and staff handover.

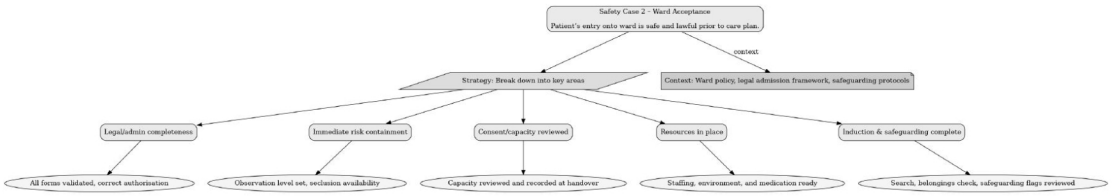

Diagram: Safety Case 2 – Ward Acceptance

Safety Case 3: Ward Observation

Top-level claim: Ward observation ensures patient and staff safety by continuously monitoring risks before and after the care plan is finalised. At the point of entry a patient does not have a care plan, but will at an appropriate time. Hence two scenarios must be catered for:

Patient Safety Status 1: Pre-Care Plan

- **Safe default observation:** Patients are observed at a safe level until their risk profile is known.
- **Precautionary level until risk profile known:** Observation is increased to a precautionary level until the patient's risk profile is fully understood.

- **Staff escalate concerns:** Staff escalate any concerns they have about a patient's safety.

- **Interim safety measures enforced:** Interim safety measures are enforced to address any identified concerns.

Evidence:

- Observation policy

- Staff handover notes

- Training records

- Environmental checklists

Residual risks:

- Over/under-observation

- Patient distress

Mitigations:

- Frequent review

- Escalation protocols

- Senior clinician oversight

Patient Safety Status 2: Post-Care Plan

- **Observations tailored to risk profile:** Observations are tailored to the patient's specific risk profile.
- **Level documented in care plan:** The observation level is documented in the patient's care plan.

- **MDT review:** The observation level is reviewed by the multidisciplinary team (MDT).

- **Integrated into therapeutic engagement:** Observation is integrated into the patient's therapeutic engagement.

Evidence:

- Care plan documents

- Risk assessments

- MDT reviews

- Observation logs

Residual risks:

- Misjudged observation level

- Complacency

Mitigations:

- Scheduled review

- Patient involvement

- Audits

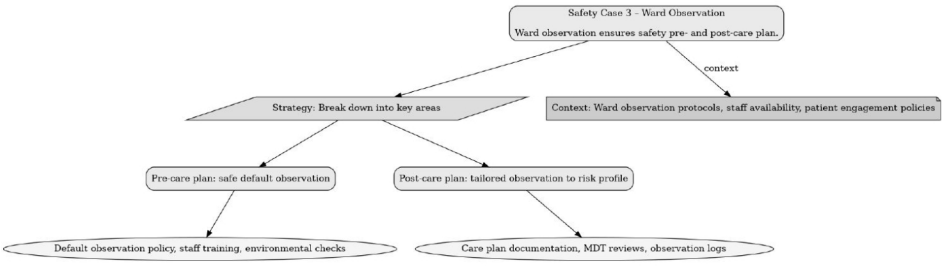

Diagram: Safety Case 3 – Ward Observation

5. Role of Mental Health Hospital Units

Hospital units play a crucial role in doctrinal rollout. They serve as centres of excellence, providing structured feedback on implementation. Their functions include:

1. Hosting pilot programmes for early intervention and crisis diversion: Units offer safe, controlled environments to test doctrine at scale.

2. Acting as regional hubs for train-the-trainer cascade models: These models extend reach by preparing trainers who then teach community teams.

3. Testing doctrine through metrics such as admissions, length of stay, and readmissions: This provides measurable outcomes to validate the doctrine.

4. Training across all staff groups (psychiatrists, nurses, social workers, HCAs): This ensures consistent understanding across professions.

5. Building strong community-hospital pathways: This reduces bottlenecks and creates smoother discharge and follow-up.

6. Residual risks include potential bottlenecks, capacity variation, and staff resistance.

7. Mitigations involve hospital avoidance pathways, equitable resourcing, phased rollout, protected training time, and digital integration.

6. National Roll-Out Model

The 'train-the-trainer' model, combined with exponential (2^n) growth, enables accelerated change. Say initially that one site implements the Patient Safety Doctrine with safety cases using a team of trainers. During the site validation process a second team of trainers is created. There are now two teams of trainers to develop a second and third site. There are now four teams of trainers to create a further for making eight, and so the growth goes on.

1. A core expert group receives intensive training, selected leaders receive immersive preparation to set the standard, and regional hubs cascade training to practitioners.

2. Each hub doubles its reach by training new trainers in successive cycles.

3. Integration with NHS institutions and digital platforms ensures reach, with online and blended learning extending access nationally.

Risks include quality drift, variation, and resistance. These are addressed through audits, refresher courses, and cultural change programmes. Mitigations include standardisation, oversight, equity prioritisation, and stakeholder engagement, ensuring a consistent, fair rollout.

7. Examples of Application

For a Patient Safety Doctrine to be successful it must reach all levels of planning and implementation:

Strategic Example: The national roll-out of a train-the-trainer cascade within three years led to measurable reductions in crisis admissions and suicides across all NHS Trusts.

Operational Example: A hospital unit redesigned its crisis admission pathways, resulting in shorter inpatient stays, smoother community transitions, and improved staff morale.

Tactical example: A GP practice that uses doctrine-aligned screening tools, enabling faster referral to community services and reducing crisis escalation.

8. Local Adaptation and Variance:

While the Mental Health Doctrine establishes national standards and structures, it explicitly recognises the need for controlled variance at hospital unit and NHS Trust levels. This ensures the doctrine remains applicable across diverse contexts within the UK.

- Regional NHS Trust Contexts: Adaptations may reflect local demographics (urban vs rural), workforce availability, and infrastructure maturity.

- Hospital Unit Flexibility: Variances in crisis pathways, specialist service demand (e.g., CAMHS vs adult services), and pilot opportunities are acknowledged.

- Controlled Adaptation: Local variances must be documented, justified, and validated against the national safety case methodology to maintain consistency and safety.

9. Safety Case Methodology (Adapted from High-Hazard Industries):

The doctrine's validation approach draws directly on safety case principles adapted from high-hazard industries, particularly nuclear engineering, aviation, and rail. These industries provide mature models of structured, transparent assurance that are directly transferable to mental health care.

- Safety case heritage: Adapted from nuclear engineering, where safety-critical systems require rigorous, transparent justification.

- Structured arguments: Top-level claims (e.g., services deliver safe, effective care) are supported by sub-claims and evidence, just as nuclear safety cases link reactor safety with subsystem assurance.

- Transparency and traceability: Every claim, assumption, and supporting evidence is documented and open to challenge.

- **Independent Assurance:** In nuclear industries, regulators scrutinise safety cases, while in healthcare, this role is fulfilled by the CQC, NHS England, and independent reviewers.

- **Learning Loops:** As nuclear incidents update safety cases, patient feedback, adverse events, and evaluations continuously inform doctrinal revisions.

Annex B provides more detail on the content of safety cases and the sources from which they are derived.

10. Conclusion

A Mental Health Doctrine can provide the UK with a structured, evidence-based framework for reform and improvement. By adapting doctrine development methods, employing a safety case validation framework, engaging hospital units, and scaling through train-the-trainer models, the doctrine can be rigorously tested, validated, and disseminated nationwide. This approach emphasises transparency, trust, and evidence, contrasting with the deception inherent in military doctrine. The use of clear worked examples demonstrates feasibility and potential impact.

Were a first-pass safety case were to be constructed for a Uk wide Patient Safety Doctrine, the following content might apply:

Element	Content
Top-level Claim	A Mental Health Doctrine provides the UK with a structured, evidence-based framework for reform and improvement.
Sub-claims	• Doctrine development methods can be adapted from military to healthcare contexts. • A safety case validation framework ensures rigour, transparency, and accountability. • Local hospital units and NHS Trusts can adapt the framework with allowance for variance. • Train-the-trainer models enable scalable national roll-out. • Transparency and trust are maintained, avoiding the use of deception inherent in military doctrine. • Worked examples prove feasibility and illustrate practical application.
Evidence	Structured methodology report, annexed safety cases, comparison with military doctrine principles, and stakeholder engagement methods.
Residual Risks	• Resistance to change at institutional level. • Incomplete uptake or uneven implementation. • Risk of bureaucratic overload if poorly managed.
Mitigations	• Early engagement with clinicians, service users, and NHS leadership. • Iterative pilots before national roll-out. • Clear communication and simplification of doctrine materials. • Ongoing monitoring and revision cycle.

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Annex A: Comparison of Military Doctrine Principles and Mental Health Adaptation

This annex provides a side-by-side comparison to illustrate how traditional military doctrine development principles can be ethically and transparently adapted for mental health reform. The comparison highlights both the continuity of structured processes and the distinct emphasis on transparency, evidence, and service-user involvement in healthcare.

Military Doctrine Principle	Mental Health Adaptation
Strategic context set by defence policy	Strategic context set by government health policy, NHS Long Term Plan, and public health needs
Conceptual development from operational experience, threat assessment, and theory	Conceptual development from psychology, psychiatry, sociology, innovation, and lived experience
Drafting principles with clarity of command intent and authority	Drafting principles with clarity of clinical, social, and ethical responsibilities
Testing and validation via wargames, simulations, and field trials	Testing and validation via pilots, clinical trials, service-user feedback, and safety case methodology
Publication and dissemination through doctrine manuals and officer training schools	Publication and dissemination through NHS training, professional bodies, online platforms, and community engagement
Continuous revision based on battlefield feedback and evolving threats	Continuous revision based on service outcomes, new research, public health priorities, and cultural change
Deception as a strategic, operational, and tactical tool	Transparency and trust are core principles; no deception is used
Safety cases developed in nuclear industry to justify reactor and system safety	Safety case methodology adapted to mental health services to justify safe, effective, transparent care; overseen by NHS regulators and informed by patient feedback

Annex B: Generic Safety Case Structure

This annex outlines the generic structure of a safety case, adapted from established guidance in high-hazard industries (DEF STAN 00-56, ISO 26262, IEC 61508, EUROCONTROL Safety Case Manual) and presented using Goal Structuring Notation (GSN) principles. This template framework is applicable across health and non-health contexts.

1. Top-Level Safety Claim:

- A concise, overarching statement of the safety objective.
- Example: "The system (or service) is acceptably safe for operation in its intended context."

2. Context and Scope:

- System or service description.
- Boundaries of what is included/excluded.
- Key assumptions.
- Applicable standards, laws, and regulatory requirements.

3. Argument Structure:

- Decomposition of the top-level claim into sub-claims (functional, operational, technical safety).
- Strategies that explain how claims are broken down.
- Traceability from top claim to evidence.

4. Supporting Evidence:

- Design evidence: hazard logs, FTA, FMEA, engineering analysis.
- Verification and validation: test reports, trials, simulations, inspections.
- Operational evidence: procedures, training records, incident reports.
- Compliance evidence: regulatory approvals, standards conformance reports.

5. Safety Assurance Argument:

- Explicit links between claims and supporting evidence.
- Explanation of why evidence is sufficient and trustworthy.
- Use of structured notations (e.g., GSN) to make logic transparent.

6. Residual Risks and Justification:

- Identification of remaining risks.
- Justification for why residual risks are acceptable.
- Explanation of mitigation and monitoring processes.

7. Conclusion:

- Reaffirmation that the overall safety objective is met.
- Statement of confidence based on evidence, argument structure, and governance.ion

• Identification of remaining risks
• Justification for why residual risks are acceptable
• Explanation of mitigation and monitoring processes