PATIENT & CLIENT COUNCIL

Engagement on Framework for Learning and Improvement from Patient Safety Incidents Consultation

June 2025

Your Voice,
Our Journey

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Introduction

On 10 March 2025 the Department of Health (DoH) launched its Framework for Learning and Improvement from Patient Safety Incidents Consultation. The Patient and Client Council (PCC) have been contributing to the Department's development of these proposals in two ways. Firstly, in contributing through the Department's Redesign Development Group, and subsequent workstreams, and also by facilitating the Serious Adverse Incident (SAI) Engagement Platform, which has seen members of the public directly feedback to the Department on its proposals from Autumn of 2023.

PCC also published a SAI overview report as part of our work in this area in August 2024.

When the DoH launched their public consultation on proposals, they asked PCC to facilitate an online consultation event to hear directly from the public. PCC will be providing an organisational response, which will be available here when published: pcc-ni.net consultation-responses

How we engaged

On 15 May 2025, the PCC facilitated an online consultation. We encouraged individuals with experience of the existing SAI review process to register for the event, as well as those who did not. For those who signed up for the event we provided them with an option to anonymously share their story with us and in turn be shared directly with DoH. Thirteen people used this option.

Attendance at the engagement event did not preclude participants from submitting a written response to the public consultation. Both PCC and DoH encouraged participants to submit a written response to the consultation.

In total, 63 individuals registered for the event. They represented a range of experiences and backgrounds, including members of the public with lived experience of the current SAI process, those with a general interest, members of the voluntary and community sector, HSC staff, HSC leaders, healthcare regulation and PCC Council members. In total, 26 people attended the online consultation event. Participants were provided with a short briefing paper on the main proposals and related documents to read before the event.

Structure

At the opening of the online conversation, DoH officials gave a presentation on the context, background, and intentions of the new policy framework and consultation. Participants were split into three breakout rooms with conversations facilitated by a

PCC member of staff. Each breakout room had a DoH representative listening in. The discussion was framed around the following questions:

- What is important to you in a Patient Safety Incident Framework?
- Based on the proposals:
  - Do you need any clarification?
  - What aspects do you welcome?
  - Do you see any gaps or areas for development?

After the discussion, participants were brought back together. Given the breadth of attendees and the constraints on time, the PCC facilitators from each room provided feedback on the key points from each break-out discussion and DoH officials were given the opportunity to respond to a number of the issues raised.

What we heard

The following report summarises the views expressed in the online meeting and follow-up written responses shared with PCC. We heard from a range of views and experiences, and we have collated these under key themes arising from the engagement conversations. Some of these themes were reflected in the answers to more than one question.

What is important to you in a Patient Safety Incident Framework?

Transparency, Trust and Accountability

A number of participants fed back that there should be transparency and accountability not just in words, but in actions, communication, and outcomes in a Patient Safety Incident Framework. They thought individuals should be held accountable for decisions to not report potential Patient Safety Incidents. Another point raised was the power imbalance felt by those raising concerns against HSC organisations. Individuals described feeling alone through the process without support. A number of participants with lived experience of the current SAI process, expressed a significant lack of trust in the current system and HSC staff. This position was linked to issues such as Duty of Candour, openness and honesty, oversight and accountability, which are further explored below.

Independence and Oversight

Many participants described feeling powerless when Trusts refused to initiate SAI reviews. They felt there was no clear or independent route to challenge these decisions, leaving families to advocate for themselves in emotionally and administratively exhausting circumstances. One person said *“If the Trust refuses to acknowledge a SAI, how is one going to be obtained? There’s nothing in these proposals to address that”* and another said *“People involved in SAIs are traumatised, they don’t know where to go”*. A number of participants also felt that public trust and confidence in any new system would come if they could perceive the SAI process being independent.

Moving from ‘guidance’ to ‘requirement’

It was strongly expressed that the framework must move away from the status of guidance and introduce clear Standard Operating Procedures (SOPs) that set expectations and impose requirements. It was felt this would remove any discretion that could be misused. A participant said *“in my work, we use procedures—not guidance. Healthcare should be the same.”* They felt there should be clear processes and procedures set out for staff to follow. It must be clear what constitutes an incident or SAI to make sure all concerned are aware they are dealing with a SAI and acknowledge an incident has happened.

Timescales

Many raised the issue of timescales, both the length of time it takes to conduct a SAI and delays to the process. Several participants highlighted lengthy delays in initiating reviews, with some reporting waits of six to ten months or longer. These delays often impacted the mental health of those involved with a SAI. One person said *“the length of the battle takes its toll, as well as the impact of the incident itself”.*

Participants called for the provision of realistic timelines for:

- acknowledging that an incident has occurred;
- providing an initial response;
- completing of investigation; and
- final report and outcomes.

Learning and Prevention

A number of people felt that learning and prevention were important to prevent future incidents occurring. They felt that the new framework should respond to early warnings raised and allow those affected by a SAI a voice in helping to prevent future incidents. Some viewed the learning recommendations from their SAI as insufficient, and said it did not result in an impactful change. One person said their journey resulted in them feeling *"cheated by the SAI process".*

Carer Experience

A number of participants were Carers. They described their experience of the SAI process as being excluded, misunderstood, or stigmatised during reviews. This was despite their deep knowledge of the patient's care and early warning signs. One person said *"Carers are the ones who suffer most, and we're not listened to until harm happens."* Some shared their experience of being labelled as *"difficult"* or *"vexatious"* when they tried to raise concerns.

Foster Carers and Social Services Experience

We received feedback that Foster Carers and service users of Social Services did not see themselves reflected in the document as they *"do not fit the definition of carer provided in the policy and process documentation".* This group said they were anxious of raising concerns for fear of getting unfavorable treatment. It was further reflected that those affected who were involved in the SAI process, can continue to remain under the care of HSC services. It was expressed that Foster Carers and service users of Social Services are very conscious of the power imbalance between themselves and HSC who hold power when it comes to decision making around the care and support they receive.

Compassion, Trauma-informed practice and access to Independent Advocacy Support

There was strong feedback from a number of participants that compassion from HSC during the SAI process was vital. A participant shared their personal experience to say the patient in their SAI *"seemed like a number"*. In the new framework, they had a sense that it was not personal enough and that people are being referred to as *"an incident"* rather than a family member and a person. One person asked *"how does compassion become a key part of this rather than just a data driven process?"*

Some believed that trauma-informed practice should be applied within the SAI process. All engagement carried out with patients, carers, and families should be sensitive to the emotional toll the SAI process has on them. Likewise, some felt that access to independent advocacy must be clearly enshrined in the framework, as they felt it had helped support them through the SAI process. Those who had used an independent advocacy service praised the assistance provided to them, with one person describing the support as being *"instrumental in helping us through the process".* It was also stated that the framework must include protections for vulnerable groups such as older people and those with mental illness or disabilities.

Do you need any clarification?

Reporting and Learning

A number of people asked about the process for sharing data and identifying trends in SAIs. One person asked *“are there any patterns or trends in SAI incidents that shows lessons are not being learned? Who checks for this data and identifies actions – is there need for a new regional body to do this?”* It was asked, how do we learn from failures when they are identified through the process? One person queried, how are SAIs and the existing procedure currently failing to prevent the same issues occurring, and why are lessons not being learned? Likewise, it was asked is learning and feedback from SAIs shared with those affected, and how would the new framework address these issues?

There were also queries regarding specificity within the proposed Framework over who records SAIs if GPs report SAIs, and if incidents can occur over multiple locations? It was also queried how long the SAI process should take? Another question raised was whether the new framework is intended to reduce the number of SAIs and if that would impact on patient safety reporting? Finally, it was asked if there would be a new body for Patient Safety Governance to collate and manage all the data from investigations created.

Role of all those affected

There were questions about the role of all those affected by a SAI, namely how the new framework will ensure all those affected are fully represented at all stages of the process. Some shared experiences of being excluded from meetings and being prevented access to sensitive materials relating to their SAI investigation. They queried if the new framework would prevent such exclusions from happening?

Terminology used

There were some queries regarding the terminology used in the framework, including clarification on the meaning of *“systems-based learning”* as participants wanted to understand what this meant in practice and how the new framework would contribute to achieving this. Some felt there was a lack of clarity around what constitutes as a Serious Adverse Incident and what constitutes a 'Patient Safety Incident' under the new terminology. Concerns were raised that the move to ‘Patient Safety Incident’ dilutes the severity of what constitutes a Serious Adverse Incident.

What aspects do you welcome?

Acknowledgement that change is needed

Participants welcomed an acknowledgement that the current system is not working and that it requires change. They said the introduction of a framework that considers the emotional impact and lived experience of patients, families and all those affected was welcome but they felt it could be further strengthened.

Move away from "blame culture"

There was agreement that the new SAI procedure should mean there will be more transparency in the process and a step away from blame culture with more support being given to staff to speak up. They felt it could lead HSC staff to being more open and honest and less afraid to speak up when things go wrong. One person shared their personal experience that they felt that staff were afraid to have an honest and open conversation with the person due to a fear of acknowledging the issue(s) in their department.

All those affected

Many welcomed the recognition of *"all those affected"* by a SAI. They said previously SAIs only referred to the patient harmed, so this represented a positive change to recognise the impact on the wider group affected. Likewise, they welcomed the aim to involve patients, carers, and families in learning from harm.

Openness

The use of language around openness, compassion, and transparency was also well received. However, participants felt these principles would only work well if they are meaningfully implemented. Most felt these values are not currently upheld in practice and called for stronger monitoring and external accountability mechanisms to ensure learning is implemented and reviews are acted upon.

Consultation Process

Participants also welcomed the opportunity to take part in the consultation process. It was noted that NI are the only nation to have gone out to public consultation on a revised SAI/Patient Safety Incident process. However, some had issues with the consultation itself, finding the format of the consultation to be *"inaccessible".* This was particularly felt by carers and bereaved families, who called for more time to complete the consultation response, more inclusive engagement, and a trauma-informed consultation process.

Do you see any gaps or areas for development?

Reporting and Monitoring

An area which participants thought could be developed was reporting and monitoring. Some believed that there should be publicly available statistics on SAIs including how many occur each year and by Trust. Participants were also keen to know more about the implementation of recommendations from SAIs such as who is responsible for implementing them. There was critique of 'learning letters' which many did not feel worked well. They said the SAI process must continue until recommendations are implemented, as some believed that the framework in its current form failed to ensure implementation of learning or track changes post-review.

A number of participants reflected that a functioning SAI process should lead to an overall reduction in SAIs, with genuine learning from incidents leading to prevention of future incidents. It was suggested the framework could have more detail on what will be done to prevent future SAIs, as participants were concerned that the new framework was more focused on culture than prevention.

Regional System

The importance of consistency and cohesion across the HSC system was identified. It was strongly felt that patients should expect their SAI to be handled in the same way, irrespective of which Trust the incident occurred in. A participant said *"when you're in the public you don't see artificial barriers between GPs, trust areas. It would be good if the system could start speaking to the public in a whole way."* The current system allows Trusts to choose the SAI level, which one participant felt *"creates a hierarchy of victims."* Participants felt there was no clear escalation or appeal process if Trusts refuse to investigate and that Trust decision-making remains unchecked. Some participants stated that there should be oversight of Trust decisions at a Board level.

The importance of learning from SAIs was reiterated, with participants emphasising that learning must be shared across all of NI to ensure learning is not missed. Finally, it was suggested that a regional 'Speaking Up' champion or guardian could be appointed to help people to speak up when they feel they cannot do so by other routes.

Integration with Duty of Candour

There was discussion around how the Duty of Candour and SAI Framework will work together and the organisational requirement to be open and honest. Some felt the Framework should have included it or have made provisions for its future implementation.

Support

It was reflected that the SAI process can be extremely isolating for individuals and families. This was due to a feeling of *‘going up against’* a large organisation which has significant resources and staff who have significant support mechanisms, including legal support. It was expressed that if this was the experience of members of the public with professional/legal backgrounds, then the issue is likely more acute for those who do not have this expertise, capacity, or background.

Support to those affected by a SAI was identified as a gap. Participants believed there should be a regional advocacy service to support people for the duration of the SAI process and to help them navigate the system. It was also stated that the SAI process needed to acknowledge the trauma and impact on those affected. One person suggested a “Schwartz Round” could be used to support those going through a SAI. It was reflected that individuals and people affected by SAIs and the SAI process may be impacted by trauma for a prolonged period of time. A question was raised regarding the duty of care to support those affected in their long-term healing journey after a SAI has closed.

Accessible information

There was discussion around making sure the SAI documentation was easy to understand by a wider audience. It was suggested that there should be clear documentation for those involved regarding the different levels of SAI and what the process entails. There should also be standardised debrief packs for those involved. This documentation could be designed with those who have experienced or been involved in the SAI process.

Terminology used

The concern regarding terminology used was raised again by participants. Objections were raised regarding the proposed change in language from “Serious Adverse Incident” to “Patient Safety Incident”. One person said *“it sounds like it’s just being relabelled to avoid scrutiny.”* Participants felt this term downplayed the seriousness of events and risks and feared it would minimise accountability.

Exclusion of Older People

A concern was raised that the current procedure and practice was disproportionately screening older people and others at risk of falls out of the SAI procedure and that this would continue under the proposed the framework.

Absence of Meaningful Change from Current Procedure

Several participants noted that the new framework does not appear to offer substantial improvements over the current system. Many of the same principles; such as learning, compassion, openness, were already present in the current policy, but poorly implemented. A participant expressed, *“this isn’t a new system. It’s the same deck of cards being reshuffled.”* A concern was expressed that the new proposals are designed to screen out an increasing number of incidents from being SAI reviews.

Other points

Changing Culture

There was a wider discussion around the need for an open and just culture. It was said that HSC is an inherently risky business, therefore things will go wrong, and there must be an acknowledgement that things go wrong. The more pressure the system is under, the riskier it will get, but the system should at least get better at dealing with things when they go wrong.

There needs to be a culture shift to one which is honest when things go wrong and acts upon information when received. When speaking up, Trusts should seek to ensure what they are saying is true and own up to mistakes. They should also act on information received when an issue is raised.

A workplace culture can not only be present within a Trust or Team but within different professions. It was noted that sometimes SAIs happen which challenge professional standards that professions and organisations want to hold onto. It was acknowledged and welcomed that appendix two outlined the process for notification/reporting requirements to external bodies such as regulators. One person queried if regulators could and should have a bigger role in implementing learning.

Consultation Process

Many found the format of the consultation itself inaccessible, especially for carers and bereaved families. Carers expressed the event being held in the evening was not ideal considering their caring responsibilities. Some participants called for more time to consider and respond to the consultation, this included an extension to the consultation deadline. They also asked for a more inclusive engagement process, and a trauma-informed one that doesn’t exclude those most affected by SAIs.

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