Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Consultation Response Form

This consultation seeks views on the development of a new process for the review of Serious Adverse Incidents (SAI) for the purposes of learning and improvement. Please see accompanying consultation document for more information.

Response Form (If not responding online via Citizen Space)

Please indicate your answers by placing an X next to your selection. You may also provide further comments in any text boxes provided.

Please send responses using this document electronically to the email address below, or via post to the address below.

Email address

PSIConsultation@health-ni.gov.uk

Postal Address

Serious Adverse Incident Redesign Programme
Serious Adverse Incident and HSC Complaints Policy Branch
Department of Health
Castle Buildings, Stormont Estate
Belfast, BT4 3SQ

Please note the deadline for responses has been extended from 17.00 on 6 June 2025 to 17.00 on 20 June 2025.

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About you

The Department of Health (DoH) is committed to protecting your privacy. For more information about what we do with your personal data please see our consultation privacy notice.
When completing this section, you only need to answer the questions that are relevant to you.

1. Are you responding

☐ as an individual? (Please complete questions 2-4)

☒ on behalf of an organisation? (Please complete question 5)

(Required)

2. Are you a child / young person (under the age of 18)?

☐ Yes

☐ No

3. Do you have lived experience, or close hand experience, of the Serious Adverse Incident process under the current Procedure for the Reporting and Follow up of Serious Adverse Incidents 2016?

☐ Yes

☐ No

☐ Prefer not to say

4. If yes, please confirm if you experienced the current procedure as:

☐ a Patient

☐ a Family Member

☐ a Carer

☐ Other

☐ Prefer not to say

If other, please specify:

This is the end of this section for those answering as an individual.

5. If you are responding on behalf of an organisation, please provide your name and position, the name and address of the organisation and an email address.

Dated: 6th June 2025

Dr Julie Anderson Chair RCPsychiNI & Vice President RCPsych

- on behalf of Royal College of Psychiatrists in Northern Ireland, 144 High Street, Holywood, Co. Down, BT18 9HS

Contact Details: thomas.mckeever@rcpsych.ac.uk

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Screening

6. **Have you any comments on either the Equality/Good Relations, Rural or data protection screening documents?**

☐ Yes

☒ No

If yes, please offer further detail regarding this below.

7. **Any there any areas or issues you feel we should be considering in future screenings?**

☐ Yes

☒ No

If yes, please offer further detail regarding this below.

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Vision

8. **Do you agree with the vision which is described on page 19 of the consultation document?**

☐ Yes

☒ No **subject to below**

Please offer further detail regarding this below.

This question addresses the five points laid out in the Vision. We agree with these points, however "… compassionate engagement and support…" is stated in many parts of the document but not in the Vision. We would ask: Why not?

We suggest that there should be one modification and three additional points: The modification is to the second point that there should be "… a meaningful and *compassionate engagement and support* for all those affected".

The three additional points should be:

1) "A meaningful and compassionate engagement and support for All Staff affected", which is recurrently stated in the documents.

2) "Consistent and Systematic Framework across organisations" which is quoted in the documents.

3) Strong link of the Framework to Governance. This is essential to be able to implement long term change.

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High-Level Themes

9. **Do you agree with the High-Level Themes which are described on pages 20-33 of the consultation document?**

☐ Yes

☒ No **subject to below**

Please offer further detail regarding this below.

It is very difficult to identify the "High-Level Themes" in this document. The material in Pages 20 to 33 is not well laid out and is confusing. The headings for the sections are not consistent - this should be better explained - and we had difficulty understanding it. These should be more clearly labelled, described and discussed.

We agree that the focus should be on "Learning and Improvement from Patient Safety Incidents".

We disagree with the terminology. When one identifies a group as "All those affected" and a separate one for "Staff" - this does not make sense. Instead, there should be an overall definition for "all those affected" with a subgroup of those related to the Patient and one for the Staff.

It does not seem appropriate to use the term "Victim" in this context. The argument to justify this is difficult to follow and has other unhelpful nuances.

This whole section is vague and difficult to follow.

10. Do you feel any High-Level Themes are missing?

☒ Yes **subject to below**

☐ No

If yes, please offer further detail regarding this below.

This Consultation suggests a shift to Trusts having much more autonomy as regards what and how to review, with Trust Boards being responsible for ensuring review arrangements are in line with the Regional Policy. The has some potential merits but also some risks including:

- **Staff who raise concerns being silenced more easily in this context**
- **Restricted external/regional scrutiny and insight**
- **The opposite of the stated intention i.e. "system wide learning"**
- **Culture and practice becoming insular**
- **Worsening the current trend of "no learning"**

Sharing standards will not be enough, as the practical terminology and structure of the process should be the same. There are Patient Safety Incidents which involve more than one Trust. The suggested arrangements could cause confusion. The Regional Mental Health Service project, which seeks to address variations in Mental Health services across Trusts, should be recognised and directly engaged within this Consultation. It is very important to standardise the system for Patient Safety events across Northern Ireland. This is particularly important to engage families in the Learning Framework. There should be a Single Learning Framework and a single set of documents.

Our understanding was that previously there was greater reporting / accountability to SPPG. We do not think that Trusts should be allowed on their own to determine, based on their own judgement and data, what is reviewed and how and what is reported.

This Consultation is on very similar lines to what has happened in England, but more information about the similarities and differences with England should be identified. We would benefit from the learning from the system in England. Will the processes be similar? Will the learning Tools share an evidence base?

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Draft Proposals

11. Do you support the over-arching approach described in the Framework for Learning and Improvement from Patient Safety Incidents?

☒ Yes **subject to below**

☐ No

Please offer further detail regarding this below.

We are assuming this question refers to the separate document "Framework for Learning and Improvement from Patient Safety Incidents". It is interesting that in the introduction to this section on page 35 of the main Consultation document it refers to "..compassionate engagement with all of those affected by Patient Safety Incident, including staff.." which supports the point we have made above on terminology. This is repeated in this document.

The structure of this document does not lend itself easily to understand it and there is much repetition throughout all of the documents. A more concise and consistent presentation would have been more useful.

We broadly agree with the types of Patient reviews and indications as described. We also agree that all people affected should be at the centre of the process and the development of an Improvement Plan. We support the section on Inequalities in Health & Social Care.

While agreeing that responses to Patient Safety Incidents should be proportionate, we have concerns about the flexibility between HSC organisations on how they respond. We have described this above in Q10.

Governance is critical and needs to be consistent both at HSC Organisation level and Regional oversight level. We agree with the principles of the Regional oversight and the distribution of learning arising from Patient Safety Incident Reviews and Improvement Plans.

We will make specific comments about the involvement of "All those Affected" and "Staff Affected" in the two separate questions related to the two separate documents.

There is no mention of how "system wide learning" will be identified and disseminated, other than to say, "a range of different dissemination methods and innovations should be considered". Previously this was through the outcome of Reviews being shared with SPPG etc. We feel this needs to be detailed more.

Any learning tools that are used should be consistent across the Region & evidence -based.

The diagram on page 25 Annex 3 would need to be simplified to be more effective. We will also comment on the "Just Culture" theme in Q14 to avoid repetition.

12. Do you agree that a set of Standards are essential for organisations to meet the expectations and outcomes of the Framework and supporting documentation?

☒ Yes **subject to below**

☐ No

Please offer further detail regarding this below.

These Standards are very wordy and could be open to different interpretations. One could not disagree with many of the standards as described. However, what needs to be emphasised is the Regional governance and HSC organisation governance structures for the implementation of these standards.

The Standards for: Engagement, Involvement and Support for all Those affected is comprehensive and puts patients and their families and supporters at the centre of the process.

The Standard: Engagement, Involvement and Support for Staff will be responded to in Q14 especially on the issue of Just Culture.

The person who is the single point of contact for Patients, their families/supporters and for Staff, needs to be well trained in the role they are to take on.

13. **Do you support the Principles for Engaging, Involving and Supporting All those Affected by a Patient Safety Incident and do you feel any principles are missing?**

☒ Yes **subject to below**

☐ No

Please offer further detail regarding this below.

The Principles for Engaging, Involving and Supporting All those Affected by a Patient Safety Incident are well described. The person who is the single point of contact must have the appropriate training for this post.

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14. Do you support the Principles for Engaging, Involving and Supporting Staff Affected by a Patient Safety Incident and do you feel any principles are missing?

☐ Yes

☐ No **We cannot reply Yes/No as 2 questions are posed here.**

Please offer further detail regarding this below.

There are a number of issues that need to be addressed with regard to Staff.

1. It is confusing to have one category for "...All those Affected" and then a separate category for "...All staff affected". They are two different groups, as described but should be sub-groups within "...All those Affected ".

2. This document and several of the other documents refer to Staff who are affected by a Patient Safety Incident being treated through applying "Just culture" principles.

The two links given to the "Just Culture" documents in the NHSE, reference 20 & 24 on pages 12 & 15 in the Document "Framework for Learning and Improvement from Patient Safety Incidents", are invalid and do not function. NHSE has developed the "Being Fair Tool" (NHSE Being Fair Tool) to replace the "Just Culture" guide, which it states is out of date and not fit for purpose in the context of the Patient Safety Incident Response Framework (PSIRF). This should be reconsidered as part of this Consultation in Northern Ireland and the relevant sections revised.

3. The issues identified as to what Staff should expect in the 1) Before an Incident occurs 2) Early Engagement 3) Throughout the Review and 4) Following the Final Review report - are broadly to be welcomed. However, Managers and the one-point contact for Staff need to be appropriately skilled.

4. Creating a Learning Culture is important and takes time and skill. It is good that it is recognised that it is not always appropriate to identify learning points immediately after a Patient Safety Incident, unless it is a critical safety issue. Staff need time and space to adjust to what has happened.

5.There is reference to "Being Open" which we support. However, there is no mention of the Duty of Candour which is concerning. The potential for a Duty of Candour with criminal sanction will adversely impact on Being Open in the sense that staff will be cautious and follow legal advice - whereas Staff want to and need to be open, to learn, be supported and acknowledge error if that has occurred.

15. Is there anything else you would like to add to your consultation response?

☒ Yes **as set out below**

☐ No

If yes, please offer further detail below.

This Consultation aims to deliver a more streamlined and simplified process for reviewing Patient Safety Incidents. As we have stated, we find the documentation very dense and difficult to follow. As a result there may be some misunderstandings on our part in the response. However, this looks like a very complex process overall and that is of concern.

We are also concerned about the risk of HSC organisations, especially Trusts, developing their own systems and documentation. We have expanded on this in our response.

Being Open is mentioned - but not enough is said about it - and there is no mention of the issues associated with a Duty of Candour.

We are somewhat concerned that the reach of this process may have extended into areas which lie with the Coroner. This interface needs to be discussed and clarified.

We totally support the aim of moving away from a Blame Culture to a Learning Culture but there is no discussion on how these cultural changes will occur. They just do not happen without a lot of planning, education and staff involvement. None of this is reflected in these documents. There needs to be a clear roadmap of how this culture change will be implemented and transparency about its effectiveness, for both staff and patients, in order for this much needed and vital culture change to become a lived reality.

Regarding the stated Page 8 view that "The continual improvement of existing data systems within the HSC now allows us to connect data relating to Patient safety from multiple sources. With this information, HSC organisations can improve patient safety by beginning to understand their own unique patient safety risk profile": This statement probably over-estimates the quality of our data systems at present and the 'feedback loop' in practice. Much more detailed guidance is needed.

1.0 Background about RCPsychiNI:

The Royal College of Psychiatrists (RCPsych) is the statutory body responsible for the supervision of the training and accreditation of Psychiatrists in the UK and for providing guidelines and advice regarding the treatment, care, and prevention of mental and behavioural disorders. Among its principal aims are to improve the outcomes for those with mental illness and to improve the mental health of individuals, families and communities.

The College has approximately 450 Members in Northern Ireland (including Doctors in training) who provide the backbone of the local Psychiatric service, offering acute and community treatment, as well as specialist care and consultation across a large range of settings.

This response is submitted on behalf of the Devolved Council of the Royal College of Psychiatrists in Northern Ireland.

2.0 General Comments:

We welcome the opportunity to comment on this Consultation Framework for Learning and Improvement from Patient Safety Incidents. We totally agree that there needs to be a redesign in the whole process around Patient Safety Incidents. This is for the benefit of Patients, their families and supporters as well as the Staff who are affected. There are many positive and forward-thinking points in the proposals. It is also welcome that there is a clearer recognition of the impact that Patient Safety Incidents have on staff, as this has not always been the case.

The "Background and the Case for Change" outlines very well the history of Serious Adverse Incident (SAI) and the important learning points from the previous Inquiries and the impact on Patients and their Carers. We endorse the need for change. However, we need to make some overarching general comments about this Consultation.

1) **This is an important and sensitive subject. There seems to have been only one engagement event during the Consultation period. This should have been given higher priority with a number of events.**
2) **The format and content of the Consultation documents are set out in a way that is not conducive to ready understanding of the**

issues that are being addressed and the intended changes. They are unnecessarily very dense and wordy documents, not well laid out and with confusing terminology. This cannot be excused by saying that this draft is a "high level strategic approach" - it really does require greater clarity.

3) **From our understanding of these documents, we have concerns that the proposals will possibly make things worse. We have outlined above our views in the answers to the specific questions in the Consultation.**
4) **There are some points that are very positive and we have also highlighted these in our above responses to the specific questions.**
5) **Annex B highlights the stakeholders in the Consultation development. We would ask why was the Royal College of Psychiatrists not included? We were met with about this issue in the years before Covid, but for some reason not at this later juncture.**
6) **It is not clear which aspects of Patient Safety Reviews in other Nations are considered acceptable for Northern Ireland and which are not. When one looks at this document, it is very similar to the England position. However, unlike England's version, it is much vaguer and without any specific toolkits. The very useful comparison with the services in England should have been better highlighted, so all can see where there is any divergence being introduced in Northern Ireland and understand why.**
7) **It has been difficult to decide where to comment on certain issues as the various issues are repeated in several places amongst the five documents.**
8) **Annex C: There is no specific question about Annex C but we have comments to make on this.**
    - **<u>Suspected Mental Health Related Homicides</u>: The term "Enhanced Care Programme" is a specific term used and understood in services in England but not in Northern Ireland. Where it states "when a homicide has been committed by a person", this can only be decided by the Judicial process, so caution would be required in order to word this appropriately for the SAI process. "Specialist Mental Health Services" will need to be defined to ensure that all Trusts have the same understanding of the term.**
    - **<u>Suspected Suicide in any HSC facility</u>: What is considered as a HSC Facility should be further explained. Also, in the case of it happening during an agreed leave or unplanned leave, a time limit should be stipulated.**
    - **<u>A suspected suicide occurring within 3 months of a planned discharge from a HSC Facility</u>: Mental Health services may never have been involved in such events. It would have to be clear who would carry out the Review – especially in the**

context of the current serious understaffing of Mental Health Services.