

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 is 17.00 on 6 June 2025.



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
\square as an individual? (Please complete questions 2-4)
oximes 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		An Roinn Sláinte
		Männystrie O Poustie www.health-ni.gov.uk
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.

Rachel Craine, Policy Manager

Nursing and Midwifery Council (NMC)

23 Portland Place, London, W1B 1PZ

policy@nmc-uk.org



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 you placed offer further detail recording this	Mailitystile o Foustie	
If yes, please offer further detail regarding this below.	www.health-ni.gov.uk	



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8. Do you agree with the vision which is described on page 19 of the consultation document?
⊠ Yes
□ No
If no, please offer further detail regarding this below.



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
If no, please offer further detail regarding this below.

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



\boxtimes	Yes
П	No

If yes, please offer further detail regarding this below.

We think the high-level themes could be stronger around the role of effective leadership in fostering a culture of patient safety within health and social care (HSC) organisations. We know from the findings of several inquiries into major failings in care that poor leadership and governance is often a key contributing factor to patient safety concerns.

We think there should be greater emphasis within the framework on the role that that leaders have in:

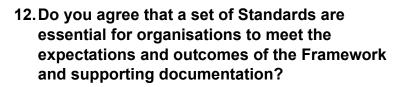
- engaging, motivating, inspiring and empowering everyone they lead.
- encouraging and ensuring effective multidisciplinary team working founded on cooperation, respect, and clear and effective communication.
- cultivating a culture of curiosity and open communication which are important to improving safe patient care.

We also think the importance of civility is missing in the themes. A culture of civility contributes to kindness and a respectful environment which creates safer and more effective teams.



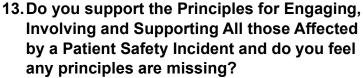
Draft Proposals

11.Do you support the over-arching approach described in the Framework for Learning and Improvement from Patient Safety Incidents?
⊠ Yes
□ No
Please offer further detail regarding this below.





⊠ Yes
□ No
Please offer further detail regarding this below.
Yes, we support there being a set of standards that all organisations will be required to meet. A set of standards will be essential in ensuring consistency in quality and approach to the management of, and response to patient safety incidents.



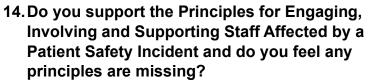


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⊠ Yes			
□ No			
Please offer	further detail reg	arding this below.	

We agree that all those affected by a patient safety incident must be placed at the heart of the learning review process. We support the focus on a single point of contact to act as the central point of information, support and updates to all those affected by a patient safety incident.

We agree HSC organisation should consider any health inequalities identified by the patient safety incident learning review process as outlined, However we think this could go further to ensure that the causal factors of inequalities are identified and addressed as part of the learning from patient safety incidents to help with creating a more equitable and safe healthcare that is fair to everyone. Our regulatory standards require nursing and midwifery professionals to provide and promote non-discriminatory care, to understand poverty, social and health inequalities, and how to work to mitigate them though good nursing and midwifery care.

The focus on robust system reviews in the context of an open and learning culture with staff treated fairly and without bias is likely to lead to reduced numbers of referrals to our fitness to practice (FtP) that are closed early in our processes.





principles are imposing:	www.health-ni.g
⊠ Yes	
□ No	
Please offer further detail regarding this below.	
We think there should be an additional point confirming that staff wi treated respectfully, fairly and without bias. This would help professi confident about speaking up, knowing they will be supported and tre	onals to feel
It is important to offer psychological support to all staff affected by pincidents. We established a Careline in October 2019 to provide supnursing and midwifery professionals going through fitness to practise proceedings. This provides emotional support and help and advice to professionals during the process. This is available 24 hours a day, every year.	patient safety port for e o all



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

your consultation response?
⊠ Yes
□ No
f yes, please offer further detail below.
We think overall the framework is aligned with good practice thinking and there is consistency of language with England, which we welcome as a UK wide regulator.
The documents capture the importance of involving and supporting staff affected by a patient safety incident however we think there is a further section missing to ensure appropriate action is taken if, during a learning review, it appears that there may be performance or FtP issues identified. These should then be managed separately – (outside the learning review which should continue) using the organisations performance management processes and ideally including the use of a tool to ensure a fair and unbiased approach – for example the NHS England Being Fair tool (this is the revised Just Culture Guide).
We would welcome continuing to work together with the Department of Health and partners across Northern Ireland to promote positive working environments and how we can encourage open and learning cultures. We embed principles of openness as part of learning sessions delivered for nursing and midwifery professionals across employer organisations in Northern Ireland, via our Employer Link Service.