COPNI Commissioner for Older People for Northern Ireland

Severe Adverse Incident Redesign Programme
Serious Adverse Incident and HSC Complaints Policy Branch
Department of Health
Castle Buildings, Stormont Estate
Belfast
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By email: PSIConsultation@health-ni.gov.uk

20/06/25

Re: Serious Adverse Incident Redesign Programme - Framework for Learning and Improvement from Patient Safety Incidents consultation

Dear Sir/Madam

I write to you on behalf of the Commissioner for Older People for Northern Ireland (COPNI), Siobhan Casey. COPNI welcomes the opportunity to respond to this consultation, supporting the introduction of a new Regional Framework for Learning and Improvement from Patient Safety Incidents. I am grateful for the recent meeting between COPNI and the Department's policy team which helped us understand the extent to which you have engaged meaningfully with a range of stakeholders, particularly service users, during the redesign programme.

Northern Ireland is ageing. Soon, there will be more older people here than children.[1] As people age, many experience an increased need for health and social care services.[2] The continued ageing of the population will lead to a greater demand for such services, placing "enormous pressure on the resources of the health and social care sector".[3] In this context, ensuring the safety and wellbeing of patients is crucial. COPNI agrees that people in Northern Ireland expect health and social care to be delivered safely and to a high standard. Moreover, COPNI maintains that when care "fails to meet an acceptable standard and a Patient Safety Incident occurs, they are entitled to openness, to understand/ask why the Patient Safety Incident occurred and how the system can learn and improve to prevent such reoccurrence."[4]

COPNI has repeatedly called for embedding a culture of openness, learning and improvement in the health and social care sector. For instance, several recommendations in our *Home Truths* report reference creating open and transparent communication within health and social

[1] NISRA (2025) '2022-based Population Projections for Northern Ireland, Tabular 5 Year Age Bands'.
[2] For instance, Census 2021 results found that 185,300 people aged 65 plus in Northern Ireland live with a limiting long-term health problem or disability, equating to 56.8%. NISRA (2022) 'Census 2021, Main Statistics for Northern Ireland, Statistical Bulletin, Health, Disability and Unpaid Care', page 18.
[3] Commissioner for Older People for Northern Ireland (2024) 'At the Centre of Government Planning: The Programme for Government and Preparing for an Ageing Population', page 29.
[4] Department of Health (2024) 'Framework for Learning and Improvement from Patient Safety Incidents', page 3.

care workplaces.[5] Recently, in our response to the Department of Health's (DoH) *Being Open Framework* consultation, COPNI highlighted that doing so will "lead to such communication becoming a reflex when failings do occur".[6]

Through conversations with those affected by Serious Adverse Incidents and their families, COPNI has heard that the current Serious Adverse Incident procedure[7] is not fit for purpose. Families explained that the procedure lacks transparency, timeliness and consistency in engaging with patients and families. The process has been described as overly complex and bureaucratic, leading to (in some cases) years-long delays in investigation and feedback. This has a very adverse effect, which not only hinders learning and improvement, but also contributes to prolonged distress for those affected. Families and carers also noted an absence of meaningful involvement in the Serious Adverse Incident process, as well as inadequate communication that undermines trust and misses insights that could help inform learning and improvement.

These issues, among others, must be addressed in the delivery of the new Regional Framework. The Framework and supporting documentation's emphasis on openness, learning and improvement will, if implemented fully and resourced properly, help enhance practices, identify gaps and prevent future harm. The Framework has the potential to improve the overall patient experience and promote a healthy work environment for staff. Given though that the Framework "describes the high-level strategic approach to Patient Safety Incidents" and "does not describe the operational detail"[8], COPNI can only be hopeful that it will translate into actionable steps and tangible outcomes.

In relation to the Framework and supporting documentation, COPNI offers the following comments.

Equality Screening, Disability Duties and Human Rights Assessment

The Equality Screening, Disability Duties and Human Rights Assessment document states that the "data does not indicate that any one age group is more disproportionately affected by

[5] Commissioner for Older People for Northern Ireland (2018) 'Home Truths: A Report on the Commissioner's Investigation into Dunmurry Manor Care Home', pages 160 & 161.
[6] Commissioner for Older People for Northern Ireland (2025) 'COPNI Response to Department of Health consultation on Being Open Framework', page 2.
[7] Health and Social Care Board (2016) 'Procedure for the Reporting and Follow up of Serious Adverse Incidents'.
[8] Department of Health (2025) 'Serious Adverse Incident Redesign Programme, Framework for Learning and Improvement from Patient Safety Incidents, Consultation Document', page 18.

the current Serious Adverse Incident procedure than another".[9] It is difficult to understand how the characteristic of age is not disproportionately affected given the age profile of health and social care users in Northern Ireland. COPNI will therefore take this opportunity to highlight the potential consequences of our ageing population on Patient Safety Incident procedures.

In 2024, there were 350,857 older people aged 65 and above in Northern Ireland. By 2044, this figure is projected to increase to 487,842.[10] Northern Ireland's ageing population risks overwhelming our health and social care services. COPNI's *At the Centre of Government Planning* report highlights that "the percentage of people in need of care will likely grow correlatively" with the rise in the number of older people in Northern Ireland.[11] Older people are more likely to live with one or more long-term health conditions,[12] increasing the complexity of care required, the pressure on services and the risk of complications.

COPNI has called for greater recognition of and planning for the consequences of an ageing population.[13] Such calls should be considered in planning and implementing Patient Safety Incident procedures, ensuring they are adaptable to and address the needs of this growing demographic. As discussed at our recent meeting, many older people and their older spouses and children do not always have the time and tenacity to fully participate in unnecessarily long, drawn-out processes. Thus, COPNI welcomes that "consideration will be given to older patients, families and carers when engaging with them as part of the Patient Safety Incident Review Process".[14]

Vision of the Framework for Learning and Improvement from Patient Safety Incidents

In 2018, the previous Commissioner Eddie Lynch undertook an investigation of Dunmurry Manor Care Home. Its findings and recommendations are contained within *Home Truths: A Report on the Commissioner's Investigation into Dunmurry Manor Care Home*.[15] The report

[9] Department of Health (2020) 'Equality Screening, Disability Duties and Human Rights Assessment Template', page 9.
[10] NISRA (2025) '2022-based Population Projections for Northern Ireland, Tabular 5 Year Age Bands'.
[11] NISRA 'Census 2021, Custom Table, Health Problem or Disability (Long-term) – 2 Categories by Age – 4 Categories'.
[12] In Northern Ireland, 219,030 people aged 65 plus reported living with 1 or more long-term health conditions in Census 2021. NISRA 'Census 2021, Custom Table, Age – 7 Categories by Health Conditions (Number) – 2 Categories'.
[13] Commissioner for Older People for Northern Ireland (2024) 'At the Centre of Government Planning: The Programme for Government and Preparing for an Ageing Population'.
[14] Department of Health (2020) 'Equality Screening, Disability Duties and Human Rights Assessment Template', page 15.
[15] Commissioner for Older People for Northern Ireland (2018) 'Home Truths: A Report on the Commissioner's Investigation into Dunmurry Manor Care Home'.

and COPNI's subsequent engagement with the department have detailed the need for a change in culture and the significance of embedding openness within the sector:

> *Many people who gave evidence described a system of fear and helplessness where they believed that making a complaint was at best, pointless and at worst, counterproductive. This must change. We need to change the culture to one where there is a clear duty on all authorities to be open and honest with residents and their families in relation to the care of their loved ones no matter in what setting they find themselves.*[16]

As well as openness and transparency, timeliness has been a significant concern for families involved in Serious Adverse Incident procedures under the current system. In some cases encountered by COPNI, the older person has passed away before the conclusion of their Serious Adverse Incident investigation. Families have also reported to COPNI long delays in being informed about the Serious Adverse Incident process, a lack of regular updates, and extended periods of uncertainty. This has caused considerable distress, compounding the emotional impact of the incident itself and leading to feelings of exclusion and mistrust. For families that are grieving the loss of a loved one, in unexplained circumstances, this can lead to delays in processing grief, arresting the stages of that grief and prolonging the suffering of individuals. These delays also affected the ability of families to engage meaningfully with the reviews or contribute important information. Families have highlighted to COPNI the need for a quicker, transparent, more robust process that prioritises the engagement of the patient and their families.

COPNI therefore welcomes the vision set out in the consultation document:

> *a new overarching Regional Framework with supporting guidance to deliver a more flexible, streamlined and simpler review process, with a focus on learning and improvement, framed within a culture of safety, openness and compassion. This will help ensure that Patient Safety Incidents are:*
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> - *of a high quality;*
> - *focused on meaningful engagement with All those Affected;*
> - *concluded in a timelier manner;*
> - *focused on understanding how and why the incident occurred; and*

[16] Commissioner for Older People for Northern Ireland (2018) 'Home Truths: A Report on the Commissioner's Investigation into Dunmurry Manor Care Home', Foreword, page 6.

- *identifying system wide learning leading to demonstrable and sustainable improvements in care.*[17]

COPNI also welcomes reframing Serious Adverse Incident investigations as "Learning Reviews" to reflect a more constructive, person-centred approach that focuses on understanding what happened, why it happened and how further harm can be prevented. The term "investigation" can carry connotations of blame or fault-finding which can discourage openness and transparency among those involved. This shift supports a culture that emphasises safety, reflection, shared learning, and continuous improvement. However, it is important that the "learnings" from such reviews are widely disseminated. In the experience of some of COPNI's lawyers and advocates, we see different teams in the same Trusts and different Trusts failing to learn from the outcomes of such reviews, and sadly, repeating the same harms.

Themes of the Framework for Learning and Improvement from Patient Safety Incidents

COPNI is supportive of the five key Themes of the Framework.

1. *Engagement, Involvement and Support of All those Affected.*
2. *Engagement, Involvement and Support of Staff Affected.*
3. *Considered and Proportionate Response to Review of Patient Safety Incidents.*
4. *Governance, Oversight and Accountability.*
5. *Learning and Improvement.*[18]

As an advocate for older people, COPNI suggests that older people's needs and rights are at the forefront of the delivery of these themes. Older people often feel vulnerable in health and social care settings. Fostering a culture where their involvement is central, their issues discussed openly and addressed effectively is essential to ensuring their voices are heard, as well as reflected in practices. Learning and improvement from Patient Safety Incidents should therefore not just be about improving processes but about incorporating older people's lived experiences into lessons learned from incidents. In this context, engagement, involvement and support of staff should involve training on age-related issues. COPNI encourages adopting continuous professional development to ensure staff are equipped to deal with the

[17] Department of Health (2025) 'Serious Adverse Incident Redesign Programme, Framework for Learning and Improvement from Patient Safety Incidents, Consultation Document', page 19.
[18] Department of Health (2024) 'Framework for Learning and Improvement from Patient Safety Incidents', pages 11-12.

unique, diverse challenges older people experience and have the knowledge to provide safe, effective care tailored to their needs.

Regional Standards for the Conduct of Patient Safety Incident Learning Reviews

COPNI agrees with and supports the Regional Standards for the Conduct of Patient Safety Incident Learning Reviews. They provide a consistent framework for organisations across our health and social care system on how to comply with the Framework. Though, the document states that the Regional Standards "represent the minimum standards that must be met by HSC organisations".[19] When standards are framed as "minimum", COPNI believes there is a risk that organisations may only meet this bare minimum threshold without going beyond. While the Standards provide a necessary baseline, organisations may view them as a ceiling rather than a floor, potentially limiting efforts to strive for continuous learning and improvement. This could result in missed opportunities for thorough analysis of and solutions to Patient Safety Incidents. Without encouraging organisations to exceed these basic requirements, there is a danger of stagnating progress in the quality of care provided to older patients. To truly enhance patient safety, a culture of continuous improvement, beyond meeting minimum Standards, is crucial. We hope this will be reflected in practices across the sector. For instance, in organisations' Patient Safety Incident Learning and Improvement Plans.[20]

Principles for Engaging, Involving and Supporting All those Affected by a Patient Safety Incident

COPNI supports the Principles for Engaging, Involving and Supporting All those Affected by a Patient Safety Incident, agreeing that All those Affected "must be placed at the heart of the learning review process".[21] Adopting a patient-centred, collaborative approach is especially key for older patients and their families. As people age, their health and social care needs evolve due to a combination of physical, emotional, social and cognitive changes. COPNI welcomes that engagement and involvement throughout the Patient Safety Incident reviews

[19] Department of Health (2024) 'Regional Standards for the Conduct of Patient Safety Incident Learning Reviews', page 2.
[20] Department of Health (2024) 'Framework for Learning and Improvement from Patient Safety Incidents', page 8.
[21] Department of Health (2024) 'Framework for Learning and Improvement from Patient Safety Incidents: Principles for Engaging, Involving and Supporting All those Affected by a Patient Safety Incident', page 2.

will be “flexible and adaptable and in keeping with the individual and changing needs of those affected”.[22]

COPNI is also pleased by the department’s recognition that “one size does not fit all” in terms of support service provision.[23] Older people are a diverse group and subsequently have a diverse range of needs.[24] Support services to which they are signposted, as well as the guidance they receive must recognise and be tailorable to older people’s unique circumstances to ensure their needs are addressed effectively.

COPNI also welcomes the aim of the Principles “to ensure that everyone involved regardless of their background or medical knowledge, can understand and actively participate in the process”.[25] Each perspective, whether that be from the patient, their family or staff, offers valuable insight into the Incident, helping to improve care practices, prevent future harm, as well as enhance the overall health and wellbeing of older patients. COPNI welcomes the approach of prioritising older people’s needs and experiences throughout review processes.

Principles for Engaging, Involving and Supporting Staff Affected by a Patient Safety Incident

Similarly, COPNI is supportive of the Principles for Engaging, Involving and Supporting Staff Affected by a Patient Safety Incident. As evidenced throughout this response, we agree that the health and social care sector needs to create a “safety culture…based on trust, openness, transparency and strong collective leadership” to enable staff to feel “supported and encouraged to report and participate in Patient Safety Incidents”.[26]

To do so, staff require “appropriate skills, knowledge, time and regionally standardised training”. Education and training for staff is essential to ensure there is a consistent approach to Patient Safety Incidents across the Trusts in Northern Ireland. Clear understanding of the new Framework, processes and expectations will support staff in responding appropriately and foster a culture of openness, accountability and learning. It is clear from our experience of Serious Adverse Incidents that some staff dealing with them have limited skills of

[22] Department of Health (2024) ‘Framework for Learning and Improvement from Patient Safety Incidents: Principles for Engaging, Involving and Supporting All those Affected by a Patient Safety Incident’, page 6.
[23] Department of Health (2024) ‘Framework for Learning and Improvement from Patient Safety Incidents: Principles for Engaging, Involving and Supporting All those Affected by a Patient Safety Incident’, page 5.
[24] Demographic characteristics such as gender, sexuality, race and ethnicity influence the identities of older people, as well as their experiences of ageing.
[25] Department of Health (2024) ‘Framework for Learning and Improvement from Patient Safety Incidents: Principles for Engaging, Involving and Supporting All those Affected by a Patient Safety Incident’, page 2.
[26] Department of Health (2024) ‘Framework for Learning and Improvement from Patient Safety Incidents: Principles for Engaging, Involving and Supporting Staff Affected by a Patient Safety Incident’, page 4.

investigation or review. It should be a requirement that an official responsible for conducting a review has sufficient training and the attainment of skills to follow the consistent process proposed by this review. COPNI recommends that resources and effort are expended to ensure that an appropriate level of investigatory or review skills are provided through training and development in each Trust, so that the embedding of a new process of consistent adherence to standards is achieved and maintained. Serious Adverse Incidents can no longer be appended to the workload of someone without the necessary skills and training.

COPNI recommends that each Trust appoint a designated expert in Patient Safety Incidents who can act as a point of contact for staff, offering guidance on how incidents should be handled, including what level of review to undertake. This expert role would help embed best practice, reduce variation between Trusts, and promote confidence in the system for staff, patients and their families.

COPNI also welcomes the new "data driven response to Patient Safety Incidents"[27], crucial for identifying patterns and driving meaningful improvements. Equally important is the consistent sharing of this data across the Trusts, not only at senior leadership levels, but also with frontline staff who are directly involved in service delivery. Creating mechanisms for transparent, cross-organisational learning helps ensure that lessons from incidents are not confined to a single team or Trust but contribute to a sector-wide culture of improvement, trust, and accountability, ensuring rigour of investigatory practice.

In our response to your *Being Open Framework* consultation, however, COPNI noted that "training initiatives require resources for implementation" and "questions arise over who will monitor and evaluate such training and who will meet the costs required".[28] The Framework and supporting documentation similarly lacks detail on how such actions will be resourced, monitored and evaluated in the long-term.

[27] Department of Health (2024) 'Framework for Learning and Improvement from Patient Safety Incidents', page 7.
[28] Commissioner for Older People for Northern Ireland (2025) 'COPNI response to Department of Health Being Open Framework', page 2.

Summary of Issues Pertinent to Older People

Distinct needs of older people: Older people are a diverse group and therefore have distinct needs. Many face a unique set of challenges when they engage with the health and social care system. Given the prevalence of older people as users of health and social care services, consideration should be given to matters of accessibility, including non-digital provision of materials such as information, forms and updates so older people can fully engage in the review processes. Some older people may benefit from the provision of an independent advocate to support their engagement in the process. These additional elements are not useful to older people only, but they are especially helpful.

Supporting older people with reduced mental capacity: A patient-centred approach is vital in ensuring older people are treated with dignity, involved meaningfully in learning reviews, and protected from harm. For instance, many older people live with reduced or fluctuating mental capacity[29] which can impact their ability to fully understand or participate in the incident response process. The need for accessible, compassionate communication is thus particularly important.

Complex needs: Older people are more likely than the general population to experience multimorbidity (have one or more long term health condition at a time).[30] Older people are also more likely to experience bad or very bad health.[31] Complex health needs, frailty and vulnerability mean that timely reviews of Patient Safety Incidents are essential to prevent older people's experiences of further harm.

Alignment with other HSC policies: One of the core recommendations from COPNI's investigation into safeguarding failings at Dunmurry Manor Care Home was that "an Adult Safeguarding Bill for Northern Ireland should be introduced without delay".[32] Engagement with the DoH's Adult Safeguarding Bill team suggests that the Bill is progressing towards implementation. The Framework for Learning and Improvement from Patient Safety Incidents should align with the forthcoming Bill (among other policies[33]) to ensure a consistent and robust approach to safeguarding vulnerable adults across the system.

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[29] For instance, the number of people living with dementia in Northern Ireland is estimated to double in the next two decades, from approximately 22,700 in 2020, to 42,800 in 2040, and treble by 2050. Wittenberg, R., Hu, B., Barraza-Araiza, L., Rehill, A. (2019) Projections of older people with dementia and costs of dementia care in the United Kingdom, 2019–2040, Care Policy and Evaluation Centre, London School of Economics and Political Science. The Bamford Centre, Ulster University (n.d.) DFC – Dementia Friendly Communities.

[30] NISRA (2021) Health Problem or Disability (Long-term) by Age - 86 Categories by Health Conditions (Number) - 3 Categories.

[31] NISRA Census 2021 - Age - 8 Categories by Health in General - 3 Categories.

[32] Commissioner for Older People for Northern Ireland (2018) 'Home Truths: A Report on the Commissioner's Investigation into Dunmurry Manor Care Home', page 30.

[33] Such as DoH's Being Open Framework and Falls policies.

Conclusion

In conclusion, COPNI welcomes the development of the new Regional Framework and supporting documentation, acknowledging their potential to drive meaningful change in health and social care practices. The Framework's emphasis on openness, transparency, collaboration and patient-centred approaches aligns with the needs and rights of older people, ensuring their voices are heard and their safety prioritised. However, for it to be truly effective, it is crucial that sufficient resources are allocated to its implementation, particularly for practitioners training and development, and procedures are embedded to support the Framework's full implementation. Without same, the opportunity to learn from Patient Safety Incidents may be limited. Therefore, it is essential that the necessary funding, time and expertise are dedicated to support its execution, ensuring healthcare providers can not only meet the standards but foster a culture of continuous learning and improvement.

We would welcome further engagement on this matter should it be necessary or helpful. COPNI will publish this response on its website 5 days after it is sent to the Department.

Yours sincerely,

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