Northern Ireland Assembly

Committee for Health

OFFICIAL REPORT (Hansard)

Serious Adverse Incidents Framework: Department of Health

27 June 2024

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Liz Kimmins (Chairperson)
Mr Danny Donnelly (Deputy Chairperson)
Mr Alan Chambers
Mrs Linda Dillon
Miss Órlaithí Flynn

Witnesses:

Professor Lourda Geoghegan	Department of Health
Mr Kieran McAteer	Department of Health
Dr Seamus O'Reilly	

The Chairperson (Ms Kimmins): You are all welcome. We appreciate your patience; we are running a wee bit behind time today. I welcome Professor Lourda Geoghegan, Deputy Chief Medical Officer, and Kieran McAteer, director of quality, safety and environment. They are co-chairs of the Department's ongoing redesign of the current serious adverse incident (SAI) procedure. We also have Dr Seamus O'Reilly, former medical director at the Northern Health and Social Care Trust, who is assisting the Department in leading the design project. Thank you all for your attendance. We have about 40 or 45 minutes for the session, and it will be covered by Hansard. I invite you to make your brief opening remarks, and we will then open it up to questions from members.

Professor Lourda Geoghegan (Department of Health): Good afternoon, everybody. Thank you very much for giving us the opportunity to brief you on the work that we are doing on the refresh and reorientation of the serious adverse incident procedure. In advance of today's meeting, we provided you with a short update paper, and hopefully that has been helpful. We will be happy to take comments and talk about any of the areas in that paper. I will say a couple of brief things, and stop me, Chair, if we are going on too long and you want to move into questions.

Every day, there are thousands of contacts across the health and care system. It is important that we put this work in context. The majority of care delivery is of a high standard and, in many instances, provides life-saving care and treatment, but there are times when things do not go as they should, the standard may not be as high as it should be or things may go wrong. When that happens, it is really important that organisations and individuals identify when something has gone wrong, that they can come forward and talk about what has gone wrong, that there are systems in place to enable people to review and learn from what has gone wrong, and, importantly, that improvements can be identified and implemented. In that context, it is important to always recognise that a change has to be an improvement. Change for the sake of change does not necessarily always lead to improvement.

We are clear that patients, service users and family members are entitled to openness. They are entitled to understand what has happened if harm has occurred or may have occurred, to understand how the healthcare system responds and to understand the main learning that has come forward and the main improvements that need to be implemented. The other important aspect is that our staff also strive to provide high-quality, good care on a continuing basis. They are also entitled to be appropriately supported as they work through assessments and reviews when things have gone wrong. It is important that they are supported in the context of a wider open and just culture. Those are all the core aims of what a learning and improvement process and system will deliver across our complex health and social care systems.

There are undoubtedly examples of good practice happening every day and every week as part of the current procedure for learning. There is good commitment from all staff to continuous improvement. In doing some work to refresh and reorientate the current SAI system, we are keen to build on the parts that are working well, but we have some clear evidence that there are parts that need to be refreshed and improved. We know that from learning locally and from inquiries and other learning reviews, such as the Regulation and Quality Improvement Authority (RQIA) review. We also know it from work and engagements that we see nationally and internationally as we engage with partners across the other Administrations in Ireland and further afield in North America and Australia. It is apparent from our research and discussions that many of these challenges are not unique to Northern Ireland. Similar challenges are recognised in the other healthcare systems and internationally, but building on and taking account of the evidence and learning we have and what we are seeing across the other Administrations, we are now working to refresh or reorientate the SAI process, and we will be happy to go through the detail and the questions that you have on that.

We have a suite of emerging proposals about how we will refresh the process. They represent a shift and a reorientation from what is currently in place. We are developing a new framework and new standards, and our intention is that they will be subject to a public consultation, because we know that a wider understanding and consideration of the new approach is going to be important. This work is policy in development. It is continuing. We remain committed to working closely with everybody across the health and social care system, and, as I mentioned, subject to the Minister's agreement, we are working towards a public consultation in the autumn which will seek wider feedback on the proposals. The final proposals will be subject to ministerial consideration after the consultation.

Thank you, Chair and members, for your time this afternoon. We are happy to take questions. We will endeavour to answer your questions and discuss as clearly as we can. If there are matters that we do not have detail on, we will be happy to follow up on those after this afternoon's meeting.

The Chairperson (Ms Kimmins): Thank you for that and for the briefing paper. It is something that we have discussed as a Committee, and I am sure that you are aware that one of our priorities is around accountability and improving the governance of our health service, particularly to protect patients but also to protect staff. We had the Royal College of Nursing (RCN) in a number of weeks ago, and one thing that has been coming up increasingly is safe staffing levels and safe staffing legislation. I have asked a number of times about the impact of the workforce crisis that we are seeing now and the numbers of SAIs. While the system remains unreformed, because this work is going on, it concerns me that there is probably a lot more, given the pressures that staff are facing. Things can happen. People are under real pressure. I am very conscious of that in the background of everything that we are dealing with, and we really have to reform that process, so the work is welcome. That is not really a question; it is just to set the context about some of the discussions that we have been having as a Committee, because it is affecting people right across our health and social care service at present. I am sure that you are aware of the issues with staffing levels, particularly in children's social work services, and the levels of risk that are increasing and what can potentially happen and may already be happening as a result, which is no one's fault, you know, in terms of the staff.

I am interested to see, in the redesign, what measures are being considered to make the process more beneficial and more compassionate to service users and families. At the minute, I am dealing with a family in relation to an incident that happened 11 years ago, and we are still not much further on. That gives you a sense of — I know from the briefing that you are aware of it — the length of time that things can take. In my experience, people sometimes feel that they do not really get an outcome, and they do not really know what learning there has been. The Committee is very focused on that.

That was a long interlude, but I just want to get a wee bit of feedback on what measures you are looking at as part of that ongoing work.

Professor Geoghegan: I will talk a little about how we are thinking about the redesign of the process, and Kieran can maybe talk about the engagement with families. We can share with you how we are taking account of all the work that has been done with families, service users and carers to date, how we are folding that in and how we are doing further engagement and taking account of service users in our workloads. Seamus has reviewed all the literature around the good principles for including family members, carers and patients, and similarly for staff. We plan to include a set of principles on both in the material that we consult on in the autumn.

Around the process, first of all, you are right. At the moment, we have probably about 500 serious adverse incidents, which we abbreviate to "SAI", every year. The majority of those are of lower complexity. You are probably aware that, at the moment, there are demarcations called level 1, level 2 and level 3. At this stage, that demarcation is not actually helpful, to be honest, because those levels relate to the kind of review or the actions that you take after something happens. Part of the work that we need to do is to come back a bit and separate out whether something has happened; what has happened; how we support people to identify that something has happened; and how we support them, in a structured way, to assess it reasonably quickly. We then work out what kind of detailed reviews, or otherwise, are needed. First, it is about disconnecting parts of the process.

A substantial majority of the incidents are of lower complexity, and we are finding that a lot of process is devoted to those lower-complexity cases. In some instances, the staff will say to us that they are going on too long, it is too process-driven and it is not necessarily identifying learning that is helpful in improving or changing the system. In that context, what we will want is to create some flexibility so that not every lower-complexity event needs something as complicated as the higher-complexity events. The corollary of that is that complex events and incidents happen. They are complex either because of the service area or because of the events that happen, and we want to disentangle some of the process from the lower-complexity ones to free up people to make sure that they have good space and time to work on the more complex ones. We want to avoid a scenario where we have a process going on for an extended period that does not really give people, particularly family members, patients and their carers, any outcome, and then we also have a series of complex incidents that require more attention, more energy and more expert skill, and it is really important that we have light and space to work on those ones. I will come back to your piece about what would be beneficial. By the way, this is a challenge that all healthcare systems are dealing with. We know from the work that Seamus is doing and from the connections with other healthcare systems across the UK and Ireland that everybody is grappling with how you balance having a proportionate process with having a good, robust, structured way of identifying learning. We do not want to be in a place where people are engaged in an elongated process that is not really leading anywhere. The refresh is about disentangling a lot of that, but in a structured way. We will have a regional framework and a regional set of standards, and organisations will be expected to work within the parameters of those regional standards, evidencing how they are meeting those standards.

That is broadly it. It is about strengthening the principle of proportionality. We have had some good examples, even recently in the last number of days, when I have spoken to colleagues in trusts, where proportionality has become really important. Something has happened, it has been identified quickly, and then a good, robust after-action review is done quickly to identify the learning, improvements are put in, and that is completed. There is no reason why something like that needs to be in an elongated process over a month. At the moment, with the process being quite prescriptive, organisations find themselves, having done that quick piece, also putting in an elongated process, which is not necessarily using their skills, time and resource as well as it should. That is the principle behind what we are doing.

Do you want to talk a bit about the engagement?

Mr Kieran McAteer (Department of Health): Yes. I will pick up on the point around the compassionate and meaningful engagement of families, service users and others affected by an incident. As Lourda said, it is clear from the evidence-based approach by the inquiry into hyponatraemia-related deaths (IHRD), the RQIA report and other reports that the strong theme coming through is that, often, families, staff and service users are not supported in that way. Regardless of which type of review is undertaken, be it a more comprehensive, in-depth review or one of the more concise reviews, we have a clear focus in the framework that one of the core principles is that families and others affected should be engaged at the outset. They should be kept updated and have an opportunity to feed back on how the process went so that we can continuously improve, adapt and refine how the review processes are undertaken. It is a strong core theme in the framework. We also have supporting guidance that underpins exactly how we think that should be done. We are co-producing that currently with a group that involves three family members or service users with lived

experience of the current process, colleagues in the Patient and Client Council (PCC), colleagues in RQIA and other colleagues across trusts. That is absolutely a core pillar of the frameworks and standards. As Lourda said, Health and Social Care (HSC) organisations will need to demonstrate how they have enacted the framework and standards and how they have involved families and others in a meaningful way at the outset in a way that is in line with their wishes, kept them informed and offered them an opportunity to feed back on their experience. That is how we are addressing that issue.

The Chairperson (Ms Kimmins): In all the papers that we have, two that really jump out at me are the hyponatraemia and neurology inquiries. From what I know of both of those since I have come into this role, there has not been a good experience for families. That is probably a real understatement. The paper that we have talks about a real, specific focus on putting patients at the centre of the process. Can you describe to me how that will differ from what —. Kieran, you talked about engagement, and that is so important. From the learning of all those other examples and what has gone before, how will that differ? What will be the difference in the experience for patients by putting them at the centre of the process? In my view, that should have always been the way. With hindsight, I do not think that is how it worked out in practice, but now we have an opportunity to change that.

Dr Seamus O'Reilly: I will reply to that. It is fair to say that, although there has been engagement in the past, it has often been limited. That has become clear, as you say, through some of the feedback and some of the inquiries that we have had. It is not unique to Northern Ireland. Years ago, in New Zealand, it was discovered that there was a lot of lip service being paid to that engagement because people did not really understand what engagement should look like. We have looked across the piece, and we also linked in with colleagues in Australia to look at how we might do it better by setting a standard and having a core theme.

There are five themes under our framework. Patient, family and carer engagement are key pieces of that. In our standards, we talk about putting those people at the centre, listening to and involving them, and making them active partners throughout the SAI process, but doing so in line with their wishes, because some families do not wish to be involved in the SAI process. From start to finish, there is a real focus on how we engage with them, and there is clear guidance on what good engagement looks like. That will be in our standards and measured against the standards that we have set against that. It will be compassionate and empathetic, but we need to describe what that means so that it is clear what staff and those involved in or impacted by a patient safety incident or an SAI should expect.

Sitting alongside that will be a set of principles that very much builds on the charter for patients' expectations following a serious adverse incident that was developed following the IHRD. We are building on that and taking account of what is done elsewhere. We are clear that, from when a patient safety incident is identified to when the learning has been implemented and improvement has been demonstrated, patients, carers and their families will be part of the process and will be kept informed throughout so that it will not end with a report being handed over to them with recommendations and learning but will continue after that, giving them the opportunity to feed back on the process in its entirety and to say whether the questions were answered and they were satisfied with how the review was carried out. We will learn as we go on, but the change is very much that they become an active partner, and we will clearly define the expectations for that.

The Chairperson (Ms Kimmins): Thank you for that, Seamus. That is really important. This is more of a comment, but in the example that I used of a family that I have been dealing with, the incident that occurred, or a number of incidents, actually — every one of them could have been avoided, for all sorts of reasons. That is why I talk about hospital pressures and things like that. That family feels like they have had to go to their elected representatives to get answers and progress updates, go to solicitors and all of those things. When a young person has, without wishing to go into too much detail, lifelong implications, that adds stress and pressure on families, and we need anything that can alleviate that, which brings people with them. Again, the time frame for that is important. Hopefully we will see real practical change in how this is dealt with.

Mr McAteer: I will add to that. As Lourda described at the outset, if we can free up more resource to engage in those more complex reviews, part of the intent would be that the compassion, engagement, support and resources to do that well will be freed up accordingly. There is a read-across with the intent of both of those.

Mrs Dillon: Thank you. To be honest, I have millions of questions, but I know that there will be opportunities to delve into this deeper. For today, based on some of what the Chair said, I also have dealt with people and families who, to be frank, have been left deeply traumatised by how they were

treated when a serious adverse incident occurred. You are right to talk about empathy and all those things, because you absolutely have to have that when you are dealing with people who are already traumatised. If there is a serious adverse incident, there are usually serious consequences. Honesty is what they want, over and above everything else.

We would often deal with cases in a policing sphere, for example, in which we are regularly told, "Our priority is ensuring that families and victims are not further traumatised", and then you see police withholding information when they take court cases. That does not reflect back to families that that service wants to deliver for them and make sure that their pain is minimised. We need to be brutally frank about this: we have found that it has been very similar in the health service over many years, where it has been what would be termed — I am not saying this is what it is, but this is how it looks to families — as dishonesty, a cover-up, hiding things or drawing cases out in the hope that people will either go away or pass away. We need to address that. That is the first and foremost thing that needs to be addressed, and it is that absolute honesty with families — "Here is what we can do, and here is what we can't." Then you go into the wider stuff that the Chair also mentioned: safe staffing levels. How do we be honest about that? We say that we learn from mistakes. We know that things happen when staffing levels are not at the level that they should be, but it is not being addressed. The RCN is telling us that repeatedly. What are we doing about that? What are we doing to make that better or improve it? We do not need to wait for another incident to happen; we already know that staffing levels are a real danger to patients and, to be honest, to staff. I will leave it there, Chair, because it is a lot, and we will get other opportunities. What you are doing is actually positive. I welcome it, and we need to see improvements in this sphere, but we need to be honest with people about how we are going to do it and the challenges that we will face.

Professor Geoghegan: I will talk about the openness piece, and colleagues will come in. The member's comments on honesty and openness are important, because we know that from our everyday interactions with people across the healthcare system and from direct feed-in from people and families with lived experience of our work. People want to know what happened, why it happened and what can be done to make sure it does not happen again. Part of what we are doing is keeping an intentional line of sight on that exact thing, simplifying things and taking them out of a complicated process. We find that the complication of the process can muddy that. Some of what we are doing is keeping it clear and straightforward and articulating clearly what people want.

People want openness, and they want to understand what happened. All of us who are on professional registers already have a professional duty to deliver that. From a medical perspective, I have just reviewed 'Good Medical Practice', which is our updated practice guidance for 2024, and bang smack in the requirements of being a doctor is the need to be open when things go wrong. All other professional codes that are subject to registration have similar responsibilities. We know that some recent national inquiries have commented and reflected even further on other roles and responsibilities and whether there should be formal duties and requirements to be open and honest. That is our expectation, and, from my perspective, what is required of anyone who is a medical staff member. Colleagues from nursing and allied health professionals (AHP) have similar responsibilities. Part of what this work needs to do is to dial that up, as well as to support and enable the context and culture so that staff can step forward in that regard. Sometimes it is frightening, and sometimes it is not actually clear if something has gone wrong. However, in my experience, a family member will value the honesty of an early conversation to say that something may have gone wrong.

Therefore, part of this work is about enabling, reorientating and supporting a change in the culture. In that context, we need to support staff to enable them to come forward openly so that they feel supported. We also need organisations to step up and support staff. This is why you will see in the material when we go to consultation is that the first principle of engaging a patient's family members is writ large and the second one is about supporting staff. They are the two really important parts of this. We are very conscious that individuals have responsibilities, but organisations need to step up to support individuals to enact their responsibilities. I am not sure whether colleagues want to come in on the staffing piece. I will say a little about staffing; not necessarily in the context of SAIs that people are identifying around staffing but on the reorientation of the process. Another reason that we really want to support staff is that an SAI is a complicated thing. If you have had a complex incident happen, there is a structured approach to reviewing and assessing it. Quite a lot of expertise is needed to support staff to look at that in a structured way to see whether staffing levels did or did not impact on it. Sometimes, the obvious thing is not just as obvious. Sometimes, you may, in numerical terms, have enough staff, but you might not have the right staff. You might have too few staff, but you might have people who are really skilled and have actually prevented something happening. Part of what we need to do is to work with staff to help them to really assess and critically appraise what has happened in a structured way. Unless they have space and time to do that, it can be challenging. Again, that is where

we are reorientating to try to free up space from less complex incidents in order to give space to the more complex incidents.

At the moment, organisations and providers can access additional skills and expertise through various mechanisms, either to chair some of the complex incident review panels or to act as panel members. Through the process, we will consider whether we need to dial that up and strengthen the pool of people who may be available to provide additional expertise to do the reviews. The staffing piece is important contextually, but it is not always as straightforward to try to ascertain exactly how much it would have influenced what may or may not have happened.

Dr O'Reilly: I will just build on that, Linda. In our framework, we have included real recognition of contributory factors and a systems-based approach when it comes to an SAI, so staff who do those reviews will be trained to look at the system and what the contributory factors were in the system that led to a particular incident. Part of that is to look at the environment, staffing and mix of staff who were on the ward at the time. We are very much factoring that in. Each review process will now be built on that systems-based approach.

Mr McAteer: I will just add as well, Linda, that it supports that open and just learning culture. With regard to the "open" part of it, staff can have more confidence that the review process will look to identify all the systems-based issues and contributory issues and will have less focus on a blame culture. Staff will be more open and willing, hopefully, to come forward — not that they do not already in the vast majority of cases. Of course, as Lourda said, we know that there is lots of good practice in that regard, but staff can be confident that the new process will look to identify all contributory factors and the systems-based learning that can lead to the most meaningful improvement.

The other thing that I should say is that the Department is currently bringing forward proposals for a "Being open" framework, which will very much complement the redesign of that SAI process. Again, the focus of the" Being open" framework is that we encourage and enable HSC organisations to embed a truly open culture, that they have mechanisms in place with support systems and training to allow staff to feel free to come forward and be open in that psychological safe space, and that, from the top of those organisations downwards, they embrace that openness culture. The ambition is that the framework will help to embed a commitment to openness, both routine openness in day-to-day activity and engaging with colleagues, the public, patients and families, right through to openness when things go wrong. That is where it dovetails with the SAI redesign piece. We see that as key and as complementary to realising an open and just culture.

Ms Flynn: Thank you for your answers so far. I have three questions. Linda and the Chair mentioned the briefing that we had recently from the RCN. With regard to the learning that is coming out of the whole process on SAIs and investigations that are carried out, at the briefing, the RCN, basically, said that you could paper the walls with the reports and recommendations that have come out. There definitely seems to be a sense that we need to ask, "Who is taking account of all the learning that is coming out of those processes?". In the new framework, who will have the oversight? Who will have overall responsibility to ensure that recommendations and learning are implemented in the system? Is the whole structure going to change, as opposed to what you have in place at the minute?

My second question is on something Kieran mentioned earlier. If you have more resource, it will enable more attention to be given to the more complex cases that you are dealing with. I understand that. Obviously, you are dealing with a lot of complex cases, but the more intensely complex ones require a lot more people and time. Some of the feedback that I have had from patients and families in these processes is that, part of the problem is that, if the case is complex, the difficulty is getting your case to the point of an SAI. Without mentioning any specific details, I was dealing with one family in particular who had to go through the trust's complaints process multiple times, an independent review process from the Health and Social Care leadership, and then it took them nearly five years to get to an SAI. Where families and patients believe that their case should go to an SAI review, how do you determine what "adverse" and "serious adverse" is? Will there be clarification on that?

Finally, you mentioned the new framework that you are putting in place. You had some communication and input directly from families. As you mentioned, the plan is that, in future, families will become "active partners". That is really good language to use. This is all a two-way process. The staff are involved and everyone's needs must be taken into account. In co-production with the families until this point — I know that the review is still under way and has not been out to consultation — you mentioned that three families have been involved until this point. Can you tell me how that was decided on or how those families were chosen? What will be the plan, going forward? If you are

building up to going out to public consultation in the autumn, is there any specific programme of work planned for a wider engagement with families and relatives? I think you mentioned, Lourda, at the start, wider engagement with families and relatives and, of course, the staff.

Professor Geoghegan: I will separate these questions out. Kieran, you might talk about the engagement piece, because we are happy to explain how we have got to where we are. A lot of other engagement is planned. Seamus, you might talk about determining the level of the incident. As the member mentioned, there is an important bit in this about intersection with other processes. I would preface our comments by saying that part of this work is about reclaiming serious adverse incident learning for serious adverse incident learning, to make sure that it hands off properly to other processes but does not get completely caught up in them, as you described. Then there is the bit about taking account of learning and oversight for learning. Kieran, will you talk about engagement?

Mr McAteer: Yes. I mentioned at the outset that we had the IHRD and the RQIA, so we have rich learning in what families and staff have said, and there is clear learning from those reports. We have set out some of that: at the centre of a review, staff should feel supported and families should be involved in a way that they are content with. We have taken account of that legacy, the wealth of information that has come forward. Seamus said that we are also building on the IHRD work stream around service user experience and bringing forward their charter and we have a group now looking at that, which is going to be co-produced to modernise it and bring it up to speed.

As to the further involvement of families and staff members, we have staff members on our project group with lived experience of SAIs. We had an event, maybe four or five weeks ago, that more than 80 staff attended. We presented the emerging proposals and how we are seeking to prioritise better support for our staff. That was welcome. We have planned further engagement activity for families and users. It is fair to say that we have had positive feedback from the three family member service users on our group. They are very impressed by the direction of travel, by the work that we are doing and by how we have taken them on board and helped them to get up to speed so that they can provide some really helpful and meaningful input.

Professor Geoghegan: We advertised. We went out to public "recruitment", for want of a better word, so that people could apply to contribute to the work.

Ms Flynn: To take part. OK.

Mr McAteer: As Lourda said, we advertised publicly for those roles. We had a panel that looked at the criteria and selected the three individuals who are now involved. We also retained the names and contact addresses for all of them — I think that there were 25 or 30, in total — and will invite them to a future session with us. Similarly, we work with the PCC, which has set up its SAI engagement platform. The platform has already written to us, as a project team, with a covering letter that sets out some overarching themes that come from their experience of SAI and some very personal accounts of their experience. There is some really rich learning for us there. We are taking that on board and are confident and hopeful that we have addressed a lot of the issues in our core themes. We have committed to meeting with that platform. We are seeking a date for that. We had a date, but it did not work out, but we are seeking further engagement with that platform.

There is a third element. There is the group that we identified through the recruitment process and the PCC platform, but we are also engaging with the neurology engagement platform. I think that there are 12 to 15 service users on that platform. That is related to SAI recommendations from the neurology inquiry.

Across those three forums, we will have a richness and diversity of opinion. We hope that we will also get the proposals tested with a public consultation, which is to come.

Ms Flynn: I will come in off the back of that, Chair. It is brilliant that you have had that engagement, thus far. I am trying to think practically. At the outset, the Chair mentioned that we have made this one of the Committee's key priorities during the mandate, because, as MLAs, we all deal with multiple cases of families or staff who have been impacted on in one way or another. Regularly enough, the Committee also receives correspondence from people who have been impacted on by different situations. I am trying to think of whether there is a way or an avenue for us, as a Committee, to write to the people who have already contacted us — I am sure that they have tuned in to watch the Committee session, anyway — to say that, as the Department goes through this process, we can share any opportunity for families who have contacted the Committee to get involved with the

Department in that process. That would be beneficial, because not everyone is connected to the Patient and Client Council, and not everyone has had a good experience when engaging with the structures that are in place. Regardless of people's interactions with the groups and organisations that are already in place, that lived experience, for good or for bad, should be fed into your review. That lived experience is most —.

Professor Geoghegan: It is, definitely. We hope that we will get a good response to the public consultation, as well. I know that it is not everybody's cup of tea to do that, but we would really like to get a good response to the consultation. We will not do just written pieces; we will plan engagement sessions to support the public consultation about the things here, as well.

Ms Flynn: That is great.

Mr McAteer: I will add to that, briefly. We had discussions during the development phase. We have spoken to the Victims' Commissioner a few times; we have been out with our trust boards; and we have spoken to the Coroners Service and to the police. There are a lot of complex interfaces in the process, and we are trying to be as inclusive as we can be. It is proportionate to this being the development phase, but we are keen to get as many views as we can in the public consultation that is to come.

Professor Geoghegan: I have two things to say, briefly. One is about learning and the other is about intersection with other processes. There is an important bit about intersecting with other processes that needs to be disentangled and worked through. That is partially where timescales get elongated and people get confused. That, partially, is why we are having early conversations with the Coroners Service, the PSNI and so forth. It is difficult for staff who may be engaging in a serious adverse incident learning review who then, before they know it, are in that learning review but find that something else is going on with the coroner and something else is going on elsewhere. Some of this is about reorienting and straightening out that line. Something has happened, and we want to help people so that they can come forward and understand what has happened. There needs to be fairly rapid and structured assessment of what has happened in order to decide quick improvements and, then, whether we need to do something else more detailed. We do not want to be duplicating things.

We have come across instances where two or three things have had to happen, and, sometimes, you cannot entirely shut down the possibility of having to go into another process. The confusion arises where the processes all run into each other and get a bit corrupted across each other. Then, people do not really have clarity about which bit is which.

There is a very important piece for us to clarify in the middle of that, in terms of hand-offs. The SAI learning piece is for that purpose: it is to understand what happened, and what needs to be done quickly to improve and make sure that it does not happen again. If, through that, other things need to happen, including hand-offs to regulatory or professional councils and so forth, that should happen cleanly and in a timely manner. Those hand-offs do not mean that the improvement and learning should stop or should not happen. So, there is certainly a bit of disentangling and support for staff to do: there is no doubt about that, because there are a lot of complex considerations.

Is there anything to add about responsibility around learning, or the recommendations and so forth?

Dr O'Reilly: Yes. One of the challenges for every healthcare system in the world — the World Health Organization (WHO) wrote about it in 2022 — is about ensuring that learning is embedded and leads to improvement. There is little research into whether learning leads to improvement, which might surprise you. We have identified that as a core aspect within our particular framework going forward. We know that we still see the same types of incidents occurring, despite there having been SAIs, recommendations, learning, and the assurance that the learning has happened. We are still seeing them happening over again.

That is because nobody has got this fixed. I have looked at a lot of jurisdictions, including Sweden and Holland and further afield. In fact, Australia contacted me to ask whether I would help them a little around the learning process. We have a unique opportunity to refresh and to look at how people learn, how the learning gets to front-line staff and how we can ensure that learning leads to sustainable improvement.

There is a combination of factors that are used. In the past, we would have sent out learning alerts and correspondence. We would have done a little bit of training and we may have adopted a policy.

Those things will need to continue, but we need to look at learning in a different way. Whether that is through simulation or using improvement methodology, we are going to look at all of those and try to come up with some type of a learning system. You are right: that learning system needs to be owned by someone. It needs to be fed by the trusts that are doing the reviews, but it needs to be owned by someone. That probably sits best within the strategic planning and performance group (SPPG) or the Public Health Agency (PHA) as the governing body, as you say, that oversees that and ensures that that learning happens and is leads to improvement. If it is not, why is it not?

Ms Flynn: Thank you.

Mr Donnelly: Thank you. There is loads there. This is great to see. It is incredibly important that, when the incidents happen, the families and the staff involved can get to the bottom of it, get a positive outcome and get truth. As Linda said, truth and honesty are important. It is important that any learning leads to positive change.

In your answers to a couple of other questions, you talked about systemic pressures. We have heard a lot about that in briefings to this Committee from staff and staff representatives, who have told us that the pressures within the system at the moment are leading some staff members to leave their professions because they feel that it is dangerous and may be dangerous for patients. Given the incidents that happen and that may identify systemic pressures, where does that go? When you have learning that indicates that an incident happened because there were systemic pressures on staff numbers or on patient flow or because there were additional patients, how does that lead to improvement?

Professor Geoghegan: There are two aspects to your question. I will answer on this piece first, and then I will come back to talk about the responsibility on all of us when there are such system pressures, to make sure that we use our resource wisely, because that is part of the reorientation. Let us say that you have something in a front-line service, and something happens or has the potential to happen. In that context, a structured review is done, and a number of things will influence that. It will not always be just staffing, but let us say that staffing comes through as part of it. The first responsibility in that situation is to clarify and articulate really clearly whether staffing caused the incident, influenced it or was just a related factor. There is a science and an art to working through that in order to be clearly structured about what you learn about the staffing piece. The first responsibility is with the service in which that lives. That then needs to be worked through the organisation in which it lives.

All organisations, trusts and provider organisations should have a range of systems in place so that they understand their staffing, know their staffing, know what is happening in their front-line services and can escalate that. It has to live in the escalation processes and procedures of the delivery organisation, because, if it is disconnected, it will not influence what happens at the front line. It has to escalate through the management and governance structures in the organisation, and they must then react and take action, depending on what has happened or has the potential to happen. That might entail reducing the number of patients who can be seen or switching staff around. It can be a range of things, but the immediate actions have to live in the provider organisation in order, first, to cover the safety need, if you like.

Beyond that, if the safety piece is covered, it is important to think about the learning: could it be relevant to another part of the system or another part of the organisation, such as another ward? If it is, how can it be shared? Is it a specialist ward of which there might be only one or two in each trust? If so, does that trust need to think about how to share it with another trust? There is a complex piece about understanding what happened, escalating and making sure that the learning is shared.

Learning can be shared in a range of ways, but, as Seamus articulated, the evidence tells you that a lot of the sharing does not necessarily lead to improvement. That is the bit that we need to think about clearly. My core point is that you cannot disconnect what happens in the service and on the front line from the organisation in which it happens; it has to live in a managed, structured, governed system. That is why the work that we do has to work out. We have to enable the providers rather than come in and say, "You must do x, y and z".

Dr O'Reilly: In my experience, although staffing and lack of staff is always the issue that you will hear about, it is not always the only factor that leads to a serious adverse incident. You will find that other factors in the system allowed it to happen. I saw a good diagrammatic recently of a train crash — I am looking at that type of science as well — in which there were 30-odd contributory factors. One of the

factors was staffing, but a lot of it was not related to staffing. We need to distil out the fact that it is not as simple as just looking at one contributory factor in isolation. We need to look at them all, because you may be able to fix lots of the other bits and make the service safer by doing so, even though you have the same staffing levels.

Mr Donnelly: You had a staff-attended event recently with 80 staff. Did any specific themes come out of that?

Mr McAteer: At the staff event, we presented the overarching approach to the general framework as we described it in our paper. The second session was on how we intend to support staff more generally. We have touched on some of those things already: compassion, engagement, making sure that staff are kept informed throughout, making sure that staff are informed of the learning and applying just-culture principles and systems-based learning. Those were the types of issues that we discussed. There was overwhelming support — it was unanimous, I think — for the broader direction of travel in which we are going. We asked questions in each of the two sessions and had positive feedback from breakout sessions. The themes were as I described: keep staff involved; keep staff supported; be cognisant that the review can lead to undue stress and complications for staff members the longer it goes on; and understand that staff need to be supported through the learning reviews. Those were some of the themes that came through. There was strong support for the direction of travel, for what we are trying to do and for enabling a different approach to learning reviews so that some of them can be more concise rather than unnecessarily structured and elongated.

In some of the examples, as Lourda outlined, staff are confident pretty early on. They have identified all the learning, they have a good understanding of the issue that has occurred and they have involved the family in a meaningful way. Really, we should be able to move on and bank the learning, but the current process does not allow us to be that agile. There would be strong support for allowing that agility and those concise reviews.

Mr Donnelly: This is my last question. I was really glad to hear that you have had input from families and from patients on their lived experience. That is important, and that is how you will get improvement. In particular, you mentioned families that were involved in, I think, the neurology review. Is there input from those families?

Mr McAteer: We will engage with the neurology engagement forum, and, separately, the PCC has established an engagement forum. We have had some correspondence from the forum, and we will meet it shortly. We are seeking a date in July to go through the issues and go through the personal accounts and the overarching themes that it has presented to us.

Mr Donnelly: In a lot of those reviews, a duty of candour comes up. Will that be part of this framework? Will you consider that at all?

Mr McAteer: It is not something that we are looking at as part of this framework. You will have seen recent media activity and discussion around duty of candour. The new Minister is definitely keen to understand more about it. The new Minister is not long into his tenure. He has said that he is in support of openness and candidness, of supporting staff, maximising the responsibility and the willingness of staff to come forward and of looking to minimise some of the barriers or fears that may exist that do not support staff to come forward. He is in support of looking at whether any additional sanctions or legislative provision will be supportive to achieving that correct balance. It will not be part of this framework, but it is very much something that the Minister has identified as a priority and something that we will look at in the near future.

Mr Donnelly: In getting to the bottom of a serious adverse incident, you need candour, and you need people being honest, open and truthful with you.

Professor Geoghegan: It comes back to the discussion that we had about openness. It is the balance between supporting the environment so that people can come forward and be open in a way that identifies the learning and makes improvements with the organisational piece supporting that. It is a hugely important aligned piece of work, but we are trying to chunk up the work so that we can get things moved forward. As Kieran said, the Minister has said that the overall piece is a priority area for him and his officials to work through the overall context around a duty of candour.

Mr McAteer: There are a couple of aligned things, as Lourda has said. There is the duty of candour, and we will work through that. Even that, in itself, is complex, and there are different factors in that. There is the SAI redesign piece that we are discussing today and which will support an open and just learning culture. It will support system review when things go wrong, which will enable staff to feel comfortable and confident about coming forward. We are also working currently on the "Being open" framework, key ambitions of which are that we normalise openness and set standards and expectations of HSC organisations that they normalise openness and support their staff to normalise openness, both routinely in their day-to-day activity and continuing through to when things go wrong; that support mechanisms are in place; that there is a culture at the top of the organisation; and that there is a demonstrable focus on that culture. It is a cultural journey, and it is a continuous journey. Our trusts and HSC organisations adopt policies and procedures that support openness and just principles currently. This will be a regional framework that will sit above all of that, and, again, I emphasise the importance of that.

The Chairperson (Ms Kimmins): Thank you. The duty of candour issue is one that we will probably pick up on again because it is huge, and, as you said, there is some work ongoing around that. It is particularly relevant to some of the reviews and inquiries that I have mentioned. Thank you, all. That has been very informative, and, as I said, we will probably pick up with you again at the next session.

Professor Geoghegan: We will be happy to come back at an appropriate time, probably post-consultation. We are looking towards the autumn for consultation, and that will take us to the end of the year. We will be happy to come back after that.

The Chairperson (Ms Kimmins): That would be great. Thank you very much.