INDEPENDENT PATIENT SAFETY COUNCIL

| ANNUAL REPORT | 2024 |

The Independent Patient Safety Council Rules of Procedure and Code of Conduct adopted by the Council in July 2020 and approved by the Minister require an annual report to be published.

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1. Chairperson's Statement

Dear Minister,

I am pleased to introduce the Annual Report of the Independent Patient Safety Council [IPSC] for the year ended 31st December 2024.

The IPSC was established to provide the Minister for Health with independent advice and guidance, from a broad range of perspectives, on the development of patient safety policy, and the Council works in support of the promotion of a culture of patient safety throughout the health services.

In 2024, the Department and in particular the NPSO, operationalized the advice of the Council in the various work streams undertaken over the previous number of years, ahead of the commencement of work in new areas in 2025, Including work relating to incident management and antimicrobial resistance.

In our first annual report (2020), the IPSC provided the Minister with recommendations on a national policy framework for open disclosure in healthcare in Ireland. Throughout 2021, 2022 and 2023, these recommendations were used by the NPSO to guide policy development in this area, and the Council were kept informed of and advised on the development of the national framework, Including a public consultation process on the draft framework. Council's work in this area came to fruition with the publication and launch of the National Open Disclosure Framework at the NPSO conference in Autumn 2023. Substantial stakeholder engagement in order to raise awareness and understanding of the framework took place throughout 2024 and Council were updated in this regard. This broad engagement process was carried out in preparation for the first round of reporting due to take place in April 2025.

In 2024 the Council engaged with Sláintecare regarding the ongoing HSE Regionalisation process from a patient safety perspective. Work was also carried out in 2024 in respect to streamlining the governance and support documents associated with the work of Council, as well as formalising terms of office for Council members.

The IPSC also continued to support the development of policy on the Management of Clinical Complaints and Patient Safety Incidents in the Irish health service. A research team (Crowe) presented the emerging themes from research on culture and values underpinning patient safety incidents to the Council in June 2022, which were incorporated into the drafting of Recommendations on Principles and Culture for Patient Safety Incident Management in Healthcare in Ireland by the Council. These recommendations were worked on by the research team, NPSO and the Council in 2023 and finalised in January 2024. Regarding the next piece of research in this area, a Report on a Stakeholder Consultation on Clinical Complaints Policy in Ireland was produced by the RCSI and provided to the Department of Health in June 2024.

I would like to express my thanks and gratitude to the Council members for their ongoing attention to the work of the Council, including the valuable support and contributions of both new and existing members. I would also like to acknowledge the support of the staff of the NPSO in the Department of Health who facilitated our meetings and enabled our work.

Ms Noeline Blackwell, Chair
Independent Patient Safety Council

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2. Introduction to the Independent Patient Safety Council

The Independent Patient Safety Council was appointed by the Minister for Health, Simon Harris, in 2019 and held its inaugural meeting on 27th January 2020. The Council provides advice and guidance to the Minister for Health from a broad range of perspectives on the development of patient safety policy. The Independent Patient Safety Council is required to produce an annual report.

The Independent Patient Safety Council provides, as requested, expert, independent and impartial advice to the Minister for Health regarding national patient safety policy, with a view to helping to prevent harm to patients and healthcare service users.

Patient safety is both a global and an Irish health priority. Patient Safety initiatives aim to prevent and reduce risks, errors and harm that occur to patients and service users during the provision of health care. Engaging a broad range of perspectives in patient safety policy, including the patient and service user perspective, will lead to enhanced policy making. The Council members consist of an independent chair and significant representation from healthcare leaders and from patients that bring a wide variety of expertise and experience from their various perspectives.

All relevant documents, including the minutes of each meeting and details of recommendations made by the Independent Patient Safety Council are published on the Council's webpage on the Department of Health website at the following link:

https://www.gov.ie/en/publication/6d9878-the-independent-patient-safety-council/

3. Terms of Reference of the Independent Patient Safety Council

- The Council will provide policy advice and guidance to the Department and the Minister for Health, as requested, on patient safety issues in line with a previously agreed programme of work to help prevent harm to patients and health service users.
- The Council will undertake its work on the basis of a work programme agreed with the Minister for Health so that, while independent in the carrying out of its duties, it can be assured that its efforts are being deployed in support of national policy priorities.
- The Council will work in support of the promotion of a culture of patient safety throughout the health services.
- The Council may examine the governance and implementation of policies and procedures as they relate to patient safety within the health service.
- The Council will identify applicable best practices in relation to the particular patient safety matters under consideration and associated benchmarking opportunities.
- The Council will submit reports to the Minister in relation to its activities, including in an annual report, and in relation to particular patient safety policy matters, in line with its agreed work programme. The Minister may, in turn, publish said reports.

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4. Independent Patient Safety Council Members 2024

Table 1. Independent Patient Safety Council Membership

Ms Noeline Blackwell, Chair	Online Safety Co-ordinator, Children's Rights Alliance
Ms Angela Fitzgerald	CEO, Health Information and Quality Authority
Mr Martin O'Halloran	Former CEO of the Health and Safety Authority, former board member of the Institute of Public Administration and the Governing Council of Irish Management Institute
Ms Peggy Maguire	Director General of the European Institute of Women's Health (EIWH)
Mr Brian Fitzgerald	CEO, St Vincent's Private Hospital
Dr Suzette Woodward	International Patient Safety Expert
Prof Charles Normand	Emeritus Professor of Health Policy and Management, Trinity College Dublin
Ms Brigid Doherty	Patient Public Interest
Ms Niamh Muldoon	CEO and Registrar of the Veterinary Council of Ireland
Prof Gerry Fitzpatrick	Consultant in Anaesthesiology and Intensive Care Medicine (retired) (stood down from Council May 2024)
Dr Cathal O'Keeffe	Head of Clinical Risk, State Claims Agency
Dr Orla Healy	National Clinical Director for Quality and Patient Safety, HSE
Prof Eva Doherty	Director of the Human Factors and Patient Safety training, RCSI
Ms Georgina Cruise	National Manager, Patient Advocacy Service (joined Council April 2024)
Mr Tiberius Pereira	Patients for Patient Safety, Ireland (joined Council April 2024)
Secretariat	
Ms Róisín Cunniffe	Policy Officer, National Patient Safety Office, Department of Health

5. Independent Patient Safety Council Activity in 2024

Council activity

The Independent Patient Safety Council met once in 2024, on 27th June. This meeting was held virtually, via Microsoft Teams, to maximise attendance. The National Patient Safety Office (NPSO) acts as the secretariat and provides support to the Independent Patient Safety Council. The meeting was attended by relevant NPSO and Department of Health personnel.

6. National Policy Framework for Open Disclosure in Healthcare in Ireland

The Independent Patient Safety Council (IPSC) was requested by the Minister to produce recommendations on a National Policy Framework for Open Disclosure in Healthcare in Ireland. In preparing their recommendations, the Council requested the Department of Health commission an independent evidence review and a national stakeholder and public consultation to provide them with the necessary background. Crowe Consultants were commissioned to carry out this work. In January 2021, the Council provided the Minister for Health with its Recommendations on a National Policy. In 2021, on foot of these recommendations, the Department of Health worked on the development of a National Policy Framework for Open Disclosure in Healthcare in Ireland. The Council were updated on the progress regarding and advised on the continued development of the framework including the targeted consultation process, throughout 2021 and 2022, ahead of the full public consultation carried out in Autumn 2022. Council undertook an in-depth consideration of the draft framework and consultation results, this feedback contributed to its final publication and launch of the framework in autumn 2023 [See Appendix 1 for Background documents related to this work *and the final published National Policy Framework for Open Disclosure in Healthcare in Ireland (2023)]*.

The rollout of the Open Disclosure Policy Framework progressed throughout 2024, and the Council continued to be updated in this regard. This rollout included engagement with the various relevant stakeholder groups, including service providers (primarily the HSE but including private service providers such as private hospitals), service regulators (HIQA, MHC), professional regulators (via a Medical Council led forum) and educators (via the professional regulators). This engagement entailed a number of webinars as well as some face-to-face meetings, in order to increase awareness of the framework and clarify any queries with regard to reporting requirements. Reporting guidelines were developed and disseminated, along with sample templates of the final submission forms. This work was carried out in preparation for the first round of reporting under the framework to the Minister, to take place in April 2025.

7. Terms of Office Proposal including Governance background

A terms of office proposal had been circulated to Council members ahead of the June meeting (including the relevant background governance documents). The various governance documents upon which the workings of Council are based were reviewed, streamlined and agreed by Council. The proposal regarding the terms of office had been agreed by Council ahead of the meeting and a random draw was conducted by a member of the NPSO at the meeting. The results of the terms of office draw were circulated to Council and are detailed in Appendix 2.

8. Sláintecare engagement- HSE Regionalisation

A presentation was provided to the Council by a member of the Sláintecare team, regarding the ongoing restructuring [regionalisation] of the HSE, at Council's June meeting

Council members had a number of questions regarding the process of regionalisation, in particular relating to the accountability structures, preserving what works well in the current structures, how patient and service user input will be incorporated and how patients will be enabled to influence the restructuring. The proposed new structures that would address the Council's concerns were outlined by the Sláintecare team.

The Council were also asked to consider the nomination of a person to the health regions advisory group. The chair asked Council members if they were happy to proceed with such a nomination, it was indicated that they would. Nomination to this group was progressed by the secretariat but unfortunately due to the timing of the last meeting of this group Council participation was not possible.

9. Development of Policy on the Management of Clinical Complaints and Patient Safety Incidents in the Irish health service

In 2024, the IPSC continued to support the development of policy on the Management of Clinical Complaints and Patient Safety Incidents in the Irish health service. A research team (Crowe) presented the emerging themes from research on culture and values underpinning patient safety incidents to the Council in June 2022, which were incorporated into the drafting of Recommendations on Principles and Culture for Patient Safety Incident Management in Healthcare in Ireland by the Council. These recommendations were worked on by the research team, NPSO and the Council in 2023 and finalised in January 2024 [Appendix 3].

Following an open tender process, research with regard to the area of clinical complaints was commissioned by the NPSO. As a result of this process, a Report on a *Stakeholder Consultation on Clinical Complaints Policy in Ireland* was finalised by the RCSI and provided to the Department of Health in June 2024. As a member of the Council was involved in this work in their professional capacity, from a governance perspective the Council were not in a position to contribute to the finalisation of this report.

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APPENDIX 1

Recommendations on Principles for Open Disclosure in Healthcare

The recommendations contain a set of principles which will provide the basis for the framework.

These are as follows:

Open, Honest, Compassionate, and Timely Communication

This means that patients/service users and families must be told all the right information at the right time when something has gone wrong in relation to their care, that nothing should be held back, and that they should be treated with respect and compassion by the health and social care staff and organisations involved.

Patient/Service User and Support Persons' Entitlements in Open Disclosure

This principle notes that patients/service users and families are entitled to be told when something has gone wrong in their healthcare, have it explained clearly, receive an apology, and be told what has been done to try to put it right. They should be able to get help to understand what happened and to deal with the open disclosure process.

Supporting Health and Social Care Staff

As well as supporting the patient/service user and their family when something has gone wrong in their healthcare, the staff members involved should be helped and given support to deal with what has happened in the best way – for the patient/service user and family and for themselves. Staff should have the information they need so that they know how to discuss what happened with patients/service users and families in the best way.

Promoting a Culture of Open Disclosure

This principle requires the health and social care systems to work on the problems that make it difficult for health and social care staff to provide the right information at the right time to patients/service users and their families. It means that organisations providing health and social care must encourage their staff to do this the right way and not make them fearful of what might happen if they tell someone that something has gone wrong.

Open Disclosure for Improving Health and Social Care Policy and Practice

When things go wrong in patient/service user care, there is an opportunity for the way things are done to be improved, so that this problem does not happen again or as often in future. Organisations who provide health and social care must have systems in place to learn from when things go wrong and encourage staff to be open about mistakes or problems so that things can be improved.

Clinical and Corporate Governance for Open Disclosure

This principle sets out what should be done to make sure that open disclosure is happening in the right way and what should happen if it is not. Organisations who provide health and social care must have systems in place to be able to track what is happening with open disclosure and to report on this regularly. It must be clear to all staff what should happen with open disclosure and what the consequences for not giving the right information to patients/service users and families will be. Organisations where this is not happening may have penalties.

National Open Disclosure Framework – (2022 Public Consultation Report)

Full report available here:

https://www.gov.ie/en/publication/97de69-patient-safety-and-advocacy-policy/#national-open-disclosure-framework

National Open Disclosure Framework – (2023)

Published framework available here:

https://www.gov.ie/en/department-of-health/publications/patient-safety-legislation-and-advocacy/#national-open-disclosure-framework

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APPENDIX 2

Terms of Office draw results 2024

IPSC Terms of office Draw June 2024 -Results

Title	Name	Surname	Expertise Category	Status	Term of office *
Ms	Noeline	Blackwell	Clinical Indemnity & Complaints Expertise	Active	5 years
Ms	Angela	Fitzgerald	Health systems/ leadership expertise	Active	NA
Dr	Orla	Healy	Health systems/ leadership expertise	Active	NA
Ms	Peggy	Maguire	Public with relevant expertise	Active	5 years
Ms	Georgina	Cruise	Public with relevant expertise	Active	3 years
Dr	Suzette	Woodward	Patient Safety Expert	Active	3 years
Prof	Eva	Doherty	Patient Safety Expert	Active	5 years
Prof	Charles	Normand	Health systems/ leadership & expertise	Active	3 years
Mr	Brian	Fitzgerald	Health systems/ leadership & expertise	Active	5 years
Ms	Niamh	Muldoon	Clinical Indemnity & Complaints Expertise	Active	5 views
Dr	Cathal	O'Keeffe	Clinical Indemnity & Complaints Expertise	Active	3 years
Mr	Martin	O'Halloran	Clinical Indemnity & Complaints Expertise	Active	3 years
Mr	Tiberius	Pereira	Patient Rep	Active	5 years
Ms	Brigid	Doherty	Patient Rep	Active	3 years

APPENDIX 3

IPSC Recommendations on Principles and Culture for Patient Safety Incident Management in Healthcare in Ireland

Recommendations available here:

https://www.gov.ie/en/department-of-health/publications/independent-patient-safety-council/#recommendations-on-principles-and-culture-for-patient-safety-incident-management

An Roinn Sláinte
Department of Health

Department of Health
Block 1, Miesian Plaza,
50-58 Lower Baggot Street,
Dublin 2, D02 VW90,
Ireland

Tel: +353 1 6354000
Fax: +353 1 6354001
www.health.gov.ie