INDEPENDENT PATIENT SAFETY COUNCIL

| ANNUAL REPORT | 2025 |

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 2025.

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 2025, the Department of Health (DoH), and in particular the National Patient Safety Office (NPSO), continued to operationalize the advice of the Council in the various work streams undertaken over the previous number of years. A number of new work areas were also commenced by the Council 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 which took place in April 2025. In the context of this first round of reporting, a dedicated discussion workshop was held with council in November 2025 to explore the ongoing implementation of the framework. Council will continue to Have a rule in the ongoing progression of this policy.

A new stream of work was commenced by the Council regarding the DoH/Health Service Executive (HSE) incident Management Framework review, including the nomination of a member of Council to the oversight group and the holding of a discussion workshop with the Council regarding the review as part of the April 2025 meeting.

A dedicated workshop was also carried out with the IPSC in respect to the development of Ireland's third One Health National Action Plan on Antimicrobial Resistance 2026-2030 (iNAP3). The information gathered through this event was very informative in the development of the next national antimicrobial action plan. The results of the workshop and the final publication of the action plan were presented to Council at its November meeting.

I would like to express my thanks and gratitude to the Council members for their ongoing attention to the work of the Council, Including their ongoing support and contribution to the varied and valuable work streams of the IPSC. 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 2025

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
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
Mr Tiberius Pereira	Patients for Patient Safety, Ireland
Secretariat	
Ms Róisín Cunniffe	Policy Officer, National Patient Safety Office, Department of Health

5. Independent Patient Safety Council Activity in 2025

Council activity

The Independent Patient Safety Council met three times in 2025: on the 8th of April, 3rd of June and 27th of November. The 1st two meetings of the year were held virtually, via Microsoft Teams, the November meeting was held in person to facilitate Council networking and engagement. The meetings in April and November were full Council meetings, while the meeting in June was a dedicated workshop on a specific topic (the development of iNAP3).

The National Patient Safety Office (NPSO) acts as the secretariat and provides support to the Independent Patient Safety Council. The three meetings were attended by relevant NPSO and Department of Health personnel.

6. HSE Incident Management Framework (IMF) Review

IPSC nomination- IMF Review Advisory Group

The Council was circulated with a request regarding nomination to the HSE incident Management Framework review advisory group. Prior to the meeting in April, one expression of interest was received from the Council for appointment to this group. This nomination was agreed with the Chair. Dr Eva Doherty was appointed to the group, as the IPSC nomination. She attended the meetings of the group throughout 2025 and provided update to Council as appropriate.

Discussion workshop

A workshop with the IPSC was facilitated by members of the NPSO, with a view to having a structured discussion with Council which would produce a distinct workshop discussion paper which along with the nomination of council of a member to the oversight group, would work to contribute to the IMF review. In order to provide context for the workshop a presentation on the review of the HSE Incident Management Framework was provided, followed by a group discussion on the following questions:

1) What are the challenges with the current IMF?
2) What are the opportunities for improvement?
3) Who needs to be involved to drive these improvements?
4) If a wider survey was to be issued to gather views on how the current IMF impacts patients and families and how it could be improved, what existing networks and channels could best reach this audience?

A substantial discussion was had by Council on the questions above and the review of the IMF in general. A summary paper detailing these discussions Was put together by the NPSO, circulated to the council for agreement and is found at Appendix 1.

7. INAP 3 development workshop

A workshop was held by the NPSO with the IPSC on the 23rd of June 2025, in order to gain perspective and opinions of the Council on the development of the next national antimicrobial action plan for the progression of this work. The output of the workshop was summarized in a short discussion paper which was circulated to the Council following the workshop, agreed and used to contribute to the development of work in this area.

Discussion workshop

A presentation was provided to the Council by the NPSO to provide an overview of Ireland's iNAP journey to date, the implementation of the current national action plan on Antimicrobial Resistance (AMR), and the approach to the development of the next national action plan on AMR. Following the presentation, a group discussion was structured around three broad questions.

1. What is your experience of AMR?
2. Are we reaching the people we need to?
3. What should our priority actions be?

The summary discussion paper is found at Appendix 2.

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

Background

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, which took place in April 2025.

Information regarding the work of the IPSC in respect to this area is detailed at Appendix 3, including a link to the final National Policy Framework for Open Disclosure in Healthcare in Ireland.

Discussion workshop – November 2025

A discussion workshop was held with the IPSC at its November meeting in order to ascertain insights from the council on optimizing annual reporting with respect to Open Disclosure. The workshop focused on three main areas.

- Suggestions for raising general awareness of the requirements of Open Disclosure in the health sector in Ireland
- Recommendations on how to better track and measure the implementation of Open Disclosure
- Strategies to reach and motivate non-responding stakeholders

The Council raised a number of very valuable points, in particular around the importance of culture change and training, acknowledging the challenges of open disclosure for staff. The complexity of measuring open disclosure compliance was acknowledged, noting that patient perception of what open disclosure is and what is classified as a patient safety incident may vary. Barriers with regard to compliance and self-audit in the context of smaller organizations were also considered. Strategies around increasing compliance with open disclosure reporting were discussed, namely suggestions on engaging with umbrella organizations (such as representative bodies) and mapping of responders and gaps in responses.

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APPENDIX 1

HSE Incident Management Framework (IMF) Workshop Discussion - Summary Paper

Discussion summary paper-8 April 2025

The NPSO delivered a presentation on the review of the HSE Incident Management Framework 2020, followed by a group discussion on the following questions:

1) What are the challenges with the current IMF?

2) What are the opportunities for improvement?

3) Who needs to be involved to drive these improvements?

4) If a wider survey was to be issued to gather views on how the current IMF impacts patients and families and how it could be improved, what existing networks and channels could best reach this audience?

1. What are the challenges with the current IMF?

Discussion on this question can be grouped into a number of themes, discussed below.

Learning and language used: A key theme that emerged was around the language used in incident reporting, and the tendency to blame rather than view it as an opportunity for learning and improvement.

It was felt that there are issues around inconsistent and judgmental language. Some felt that sometimes reporting is used to blame staff.

It was noted that investigations take a long time and when a member of staff is suspended during the investigation, they are expected to simply return to work once the investigation has been completed.

It was noted that the default outcome in healthcare is for no incident to occur. Therefore, when an incident does occur, the focus should be on “why did it go wrong this time?” so that the system can be improved.

A negative approach to incident reporting makes staff less likely to engage with reporting and the system as a whole.

Patient involvement: Overall participants felt that the incident management system is not patient friendly. Families do not understand the process and require support to help understand the procedure. Often, they are not aware of the Patient Advocacy Service (PAS) and what supports are available to them. It is also difficult to receive updates on recommendations, quoted review timelines are not achieved, and this upsets families further.

Other Limitations

No “appeals” process (once report is signed).

Participants agreed that the current system had limitations. It was suggested that not all incidents are logged on NIMS. Additionally, those who report do not receive feedback on their report.

It was also suggested that there is a big gap when it comes to auditing and learning from the results; there is a lack of capacity to analyse the data.

Another area of challenge is the skill set of reviewers and training provided to review panels.

The system only records failure, it doesn’t look further and asked why something did go wrong in this case, when it normally has no issue.

2. What are the opportunities for improvement?

Use of data: Noted that, when thinking about how to make a system more useful, it’s important to consider why data is collected and what is done with it. There is a small team of analysts working at the SCA, they are limited by capacity, there are some attempts to involve AI/ machine learning.

It was suggested that incidents can get bogged down in legal details, there might be a possibility to categorise incidents better so some are progressed quicker.

Changing attitudes: it was noted that we can use the IMF to learn and improve if framed as a positive i.e. make people want to improve it.

Improve Communication: the Council recognised that there is an opportunity to improve communications, both of learnings and with patients.

Communication- the importance of letting patients know from the start that PAS exists was acknowledged.

There is a need to learn from past recommendations and to examine whether they worked, e.g. recommendations made at Portiuncula. Can we use incident reporting systems to review recommendations made on past incidents and see if they were appropriate and what the challenges have been with implementation? This also might prevent repetition of recommendations.

It was noted that the IMF document is too complex and not easily understood by many patients.

3. Who needs to be involved to drive these improvements?

Junior Staff: More junior staff should be involved, better representation from staff on the front lines. Junior doctors will often spot things.

Nurses report more incidents, doctors should be encouraged to report too.

New Staff: Staff can become complacent and fresh eyes will notice different things and ask questions. A purposeful interview of staff in their first week would be helpful.

Interview those who have experienced an incident (both staff and patients) - What actually happens Vs what we think happens.

A stakeholder analysis should be undertaken which looks at who has the power and authority, who has the influence, who has the interest.

Communication and culture

Encourage a culture of reporting “good catches” instead of only focusing on when things go wrong.

People on the front lines don’t see the impact, we need them to see this as positive.

Note: There was concern about the short turnaround of this IMF review – not enough time to engage everyone.

4. If a wider survey was to be issued to gather views on how the current IMF impacts patients and families and how it could be improved, what existing networks and channels could best reach this audience?

Advocacy agencies/support groups.

Social media – Noted by some as ‘not ideal’ as everyone is scattered across platforms, and it often doesn’t reach the people who need it the most. The patient cohort may have already had bad experiences and can be angry and hurt, we need to be sensitive when reaching out. Trust has already been lost, and we don’t want to further damage the relationship.

The HSE patient experience survey is sent out via post and has a 50% return rate, which is an impressive response rate. There may be some learning to be taken from this.

Feedback from the cervical check review has been good, there is also the potential for learning in how that was carried out.

APPENDIX 2

iNAP3 Workshop, 23 June 2025- Workshop Discussion Summary Paper

iNAP Overview Presentation

A presentation was provided to the council by the NPSO to provide an overview of Ireland's iNAP journey to date, the implementation of the current national action plan on AMR, and the approach to the development of the next national action plan on AMR. Following the presentation, a group discussion was structured around three broad questions.

1. What is your experience of AMR?

Council members noted:

- The importance of the integration of iNAP into the overarching DoH strategy and by extension into the government programme of work. This should include concrete actions and responsible parties.
- It is easier to monitor outputs, but it is harder to monitor outcomes, though they may be a better reflection of success.
- The value of integration of iNAP and AMR awareness with third level education courses. The Medical Council has launched a competency scheme which may serve as a useful example.
- There is a perception that there is a greater awareness of AMR in agriculture.
- There is considerable work to be done in educating the public on the appropriate use of antibiotics.
- It was expressed that addressing AMR can be quite reactive in practice. While hospitals have IPC programmes in place, there is a need to be more proactive. For example, a greater focus on AMR could be considered in HIQA inspections.

  (In engagement with the CEO of HIQA following the workshop, it was noted that there is significant emphasis on AMR in HIQA inspections, and there was substantial consultation with HIQA in the development of INAP 3)
- There are challenges in delivering care for the very young or elderly patients. It can be difficult for GPs to convince caregivers that antibiotics are not appropriate. Thought should be given to how best to support prescribers in this area.
- In terms of prescribing practices, it is still very reactive in general.

2. Are we reaching the people we need to?

- It was acknowledged that educating and raising awareness of AMR with the public is hugely challenging. There is also a big difference in how patients listen to the advice from a doctor in the hospital as compared to a GP in a clinic.
- It was felt that there is a need to improve messaging and support to the "gatekeepers" of antibiotics (doctors, dentists, some nurses).
- It was suggested that it may be more difficult to regulate online GPs and that this needs to be addressed.
- It was noted that there is a need to target the public through advertising campaigns, with a focus on separate campaigns for the public and for professionals.
- It was noted that the environment is becoming more prominent in work on AMR, including climate change. It may be perceived that there has been more of a focus on human health and the agricultural sector previously.
- There has been some success in the HSE with the use of "red/green" antibiotics. Prescribers are encouraged to reduce the use of "red" antibiotics and to encourage the use of "green" antibiotics.
- There were challenges acknowledged in communicating objective scientific information. Some people may source their information from social media. It may be beneficial to have communication from authoritative sources in healthcare providers. Also, patient advocacy groups have trust and credibility that could be useful in communicating about AMR.
- It is important to look at the data on which cohort of the population uses more antibiotics (younger people, older people) and use this when targeting the public for information dissemination.
- It was noted that patients can be seriously injured by AMR, there is the possibility for outreach to advocacy groups for these voices to be heard.
- It could be useful to reach out to people who have been affected by AMR and use their stories to inform the public.

3. What should our priority actions be?

Council members suggested:

- Mandatory AMR training for all staff, similar to hand hygiene training.
- Consider reform of HIQA's inspection practices to include a greater focus on AMR. [Members noted that Angela Fitzgerald, as a Council member and CEO of HIQA, may be able to provide input on this.]

  (In engagement with the CEO of HIQA Following the workshop, it was noted that there is significant emphasis on AMR in HIQA inspections, and there was substantial consultation with HIQA in the development of IN AP3.)
- Improvements to infrastructure to better capture data around antibiotic prescribing.
- Food is a human health issue, as well as an output of agriculture. It would require the collaboration of many stakeholders, but better labelling of food products might help consumers.
- A review of iNAP2 to determine what actions were successful, prior to the implementation of iNAP3.

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APPENDIX 3

National Policy Framework for Open Disclosure in Healthcare in Ireland

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.

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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 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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