INDEPENDENT PATIENT SAFETY COUNCIL

ANNUAL REPORT | 2020

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.

3. Independent patient safety council terms of reference

3.1

- 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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1. Chairperson's Statement

I am pleased to introduce the inaugural Annual Report of the Independent Patient Safety Council for year ended 31st December 2020.

The Independent Patient Safety Council 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 our first annual report, I am pleased to note that the Independent Patient Safety Council provided the Minister for Health with recommendations on a national policy framework for open disclosure in healthcare in Ireland.

Open disclosure is an issue of concern for many patients and service users. While much has been done to advance it in our healthcare system in Ireland, barriers to, and potential for, improvement in open disclosure remain. Our recommendations present high-level principles and approaches to implementation to support the development and embedding of a national policy framework for open disclosure in healthcare in Ireland.

In its first year of operation, the Council dedicated time to establishing clear ways of working and guiding principles. The establishment of these principles has helped support the Council to work together and more effectively with the common aim of making a positive contribution to patient safety policy in Ireland. This work will continue in 2021.

I would like to express my thanks and gratitude to the members of the Council who all went above and beyond what was expected of them, in their attention to the work of the Council, despite the challenges associated with the COVID-19 pandemic. I would also like to acknowledge the unfailing support of the staff of the National Patient Safety Office in the Department of Health who facilitated our meetings and various requests and provided support for 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.

The Council meets 2 to 3 times per year and agrees an annual work programme with the Minister for Health.

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 web page 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

Table 1. Independent Patient Safety Council Membership

Ms Noeline Blackwell, Chair	CEO Dublin Rape Crisis Centre
Mr Phelim Quinn	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
Assoc Prof Paul D'Alton	UCD School of Psychology and Head of Psychology, St. Vincent's University Hospital
Dr Brian Place	Member, Galway Patient Council
Ms Peggy Maguire	Director General of the European Institute of Women's Health (EIWH)
Mr Brian Fitzgerald	Deputy CEO, Beacon Hospital
Prof Una Geary	Director of Quality, Safety and Improvement, St. James' Hospital
Dr Suzette Woodward	International Patient Safety Expert
Dr Philip Crowley	National Director, Quality Improvement, Health Services Executive (commenced November 2020)
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)
Dr Colm Henry	Chief Clinical Officer, HSE, resigned September 2020
Ms Kerrie Leonard	Patient Public Interest, resigned December 2020
Secretary Ms Ciara Norton	Policy Officer, National Patient Safety Office, Department of Health

5. Independent Patient Safety Council Activity in 2020

Council activity

The Independent Patient Safety Council met three times in 2020, in January, July and November. The January meeting took place in the Department of Health, Miesian Plaza, Baggot Street, Dublin 2. The July and November meetings took place virtually due to COVID-19 restrictions. The National Patient Safety Office (NPSO) acts as the secretariat and provides support to the Independent Patient Safety Council. The meetings were attended by relevant NPSO and Department of Health personnel.

Work Programme 2020

The Council undertakes 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. For the work programme for 2020, the Council was asked by the then Minister for Health, Simon Harris, to undertake an examination of open disclosure policy in healthcare at the national level and make recommendations to him in relation to the development of a national policy framework regarding open disclosure in healthcare in Ireland. Open Disclosure in healthcare is the open discussion that the healthcare provider has with patients or service users, their families or support people when something goes wrong that has harmed or had the potential to cause harm to a patient or service user.

COVID-19

The Covid-19 pandemic impacted greatly on the way the work of the Independent Patient Safety Council was carried out. The Council adapted quickly to new work practices to ensure that the work could continue, by agreeing to attend meetings online by Zoom and Teams and by working remotely.

Despite the impact from the COVID-19 pandemic on work priorities within the health sector throughout 2020, it is recognised by the Council that its work was given continued priority and support by the Department of Health who were taking a leadership role in responding to the Covid-19 pandemic.

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6. Recommendations to the Minister on a National Policy Framework for Open Disclosure in Healthcare in Ireland

The Independent Patient Safety Council 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 Independent Patient Safety Council requested the Department of Health to commission an independent evidence review and a national stakeholder and public consultation to provide them with the necessary background.

In April 2020, Crowe Consultants were commissioned by the National Patient Safety Office, Department of Health on behalf of the Independent Patient Safety Council to;

- Undertake research and consultation on "what is a coherent approach to open disclosure in healthcare in Ireland and how can it be ensured that open disclosure is implemented and effectively embedded in Irish health services?" and
- Support the Independent Patient Safety Council to produce recommendations on principles, approaches and the implementation of open disclosure in healthcare in the Irish context.

Report of Recommendations to the Minister on a National Policy Framework for Open Disclosure in Healthcare in Ireland and the Evidence to Support the Independent Patient Safety Council

In January 2021, the Council provided the Minister for Health with its Recommendations on a National Policy Framework for Open Disclosure in Healthcare in Ireland.

Minister for Health, Stephen Donnelly welcomed the Recommendations as a significant step forward in developing, fostering and embedding a culture of open, honest and transparent communication across the health sector, in particular for patients, service users and their families when something goes wrong that has harmed or had the potential to cause harm to a patient or service user.

On foot of these recommendations and high-level implementation approaches, the Department of Health will develop a National Policy Framework for Open Disclosure in Healthcare in Ireland.

The Independent Patient Safety Council Recommendations for a National Policy Framework on Open Disclosure and the Crowe Report, Evidence to Support the Independent Patient Safety Council for the Development of Recommendations on a National Policy Framework for Open Disclosure in Healthcare in Ireland (2021), can be accessed at the following link:

https://www.gov.ie/en/publication/6d9878-the-independent-patient-safety-council/#recommendations-to-the-minister-on-a-national-policy-framework-for-open-disclosure-in-healthcare-in-ireland

7. 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.

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8. Development of Guiding Principles for the Independent Patient Safety Council

A process was undertaken to develop principles that will guide the work of the Council. The Council had a number of discussions and a facilitated workshop to devise and agree a common set of guiding principles to ensure that the Council makes a valued contribution to the development of patient safety policy in Ireland. The principles developed for the Independent Patient Safety Council were approved in November 2020.

Guiding Principles

INDEPENDENT PATIENT SAFETY COUNCIL

To provide independent advice and guidance that leads to continuous and sustained improvements in patient safety across Ireland, we should focus in the following five ways:

1. Promoting a culture of patient safety and a just culture which ensures ongoing learning, openness and transparency and accountability at all stages and levels of the health system.
2. Building awareness and understanding of the very latest concepts and theories, advising on ways in which the system can educate and equip staff and service users with the skills and opportunities to improve patient safety and engrain safety throughout the whole system.
3. Be informed by intelligence and insights from multiple sources ensuring equality, a human rights-based approach and diversity of voice by drawing from people's experiences and stories, together with the patient safety science and safety data.
4. Advising on the prioritisation of programmes and high value interventions leading to continuous and sustained improvements in patient safety.
5. Promoting the importance of implementation and evaluation of the effectiveness of the prioritised interventions ensuring any changes required recognise the complex environment in which people work and live, particularly the realities of the current culture and behaviours of individuals and teams and the conditions within which they work.

Adopted by the Independent Patient Safety Council, November 2020

NOTES

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