# INDEPENDENT PATIENT SAFETY COUNCIL

# | ANNUAL REPORT | 2021 |

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 for the year ended 31st December 2021.

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 (2020), the Independent Patient Safety Council provided the Minister for Health with recommendations on a national policy framework for open disclosure in healthcare in Ireland. Our recommendations presented 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. Throughout 2021, these recommendations have been used by the NPSO to guide policy development in this area, and the Council have been kept informed of and advised on the development of the national framework. Guided by Council, this work will continue, with the publishing of a draft framework and holding of a public consultation in 2022.

In 2021, the IPSC also worked to support the development of policy on the Management of Clinical Complaints and Patient Safety Incidents in the Irish health service. As part of this initiative, the Council worked to commission research which would be used to inform Council's recommendations and subsequent policy development in this important area. The valuable expertise and knowledge of Council was harnessed through a dedicated workshop, the output of this work formed a key element of the research work commissioned,

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, 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 National Patient Safety Office 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.

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 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

**Table 1. Independent Patient Safety Council Membership**

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|---|---|
| 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 (RIP, November 2021, Dr Place's valuable contribution to the work of the IPSC, since his appointment in 2019, is noted) |
| 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 (resigned October 2021) |
| 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 Cathal O'Keeffe | Head of Clinical Risk, State Claims Agency |
| Dr Orla Healy | National Clinical Director for Quality and Patient Safety, HSE (commenced October 2021) |
| **Secretariat** | |
| Ms Róisín Cunniffe (August 2021- present) | Policy Officer, National Patient Safety Office, Department of Health |
| Ms Ciara Norton (January – August 2021) | Policy Officer, National Patient Safety Office, Department of Health |

# 5. Independent Patient Safety Council Activity in 2021

## Council activity

The Independent Patient Safety Council met twice in 2021, in April and December. Both 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 2021

The Council undertakes its work because 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 2021, the Council was asked by the Minister for Health, Stephen Donnelly, to progress its work regarding open disclosure policy in healthcare at the national level following on from Council's recommendations to him in relation to the development of a national policy framework regarding open disclosure in healthcare in Ireland.

Council also undertook to advise on Ireland's (first) National Action Plan on Antimicrobial Resistance 2017-2020, known as iNAP 1 in preparation for its successor, iNAP 2. A workshop in this regard was held at the IPSC April 2021 meeting, where thoughts of Council members were gathered.

Council was also asked to review and advise on development of policy on complaints and incidents management currently under development by NPSO.

## COVID-19

The Covid-19 pandemic continued to impact greatly on the way the work of the Independent Patient Safety Council was carried out in 2021.

Despite the impact from the COVID-19 pandemic on work priorities within the health sector throughout 2021, 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. 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. (see Appendix 1)

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.

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

## Progress on Framework Development

In 2021, on foot of these recommendations and high-level implementation approaches, 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 at its meetings in April and December 2021.





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

In April 2021, a Background Note on Clinical Complaints and Patient Safety Incidents Policy and Legislation in the Irish health service was provided to Council. Council were asked to make recommendations on principles and cultural norms that will under pin policy development in this area. Research was to be commissioned to inform Council recommendations in this regard. Following this meeting in April, Council provided feedback on the tender for this research work.

In December 2021, Council were updated regarding the ongoing tender process for research in this area (the Department had been unsuccessful to date in awarding a tender on this work) and a Discussion Workshop regarding Clinical Complaints and Patient Safety Incidents was held with Council.

The purpose of this workshop was to scope the values underpinning the management of clinical complaints and patient safety incidents. The opinions of the IPSC were integrated into the research tender process for clinical complaints and patient safety incidents and helped shape research policy in this area.

The IPSC will continue to engage on the research and policy in this area in 2022.

# 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.



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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 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.

## NOTES

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