INDEPENDENT PATIENT SAFETY COUNCIL

| ANNUAL REPORT | 2022 |

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 2022.

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. As captured in the 2021 annual report, throughout 2021 and 2022, 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. Guided by Council, this work will continue to publishing of a draft framework and holding of a public consultation in 2023.

In 2022, 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. This work built on the dedicated workshop carried out in December 2021. The output of this work formed a key element of the research work commissioned in this area, research which has been used to inform Council's recommendations regarding patient safety incidents management and subsequent policy development. The 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.

I would like to express my thanks and gratitude to the Council members for 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.

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.

4. Independent Patient Safety Council Members 2022

Table 1. Independent Patient Safety Council Membership

Ms Noeline Blackwell, Chair	CEO, Dublin Rape Crisis Centre
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
Assoc Prof Paul D'Alton	UCD School of Psychology and Head of Psychology, St. Vincent's University Hospital
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
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
Secretariat	
Ms Róisín Cunniffe	Policy Officer, National Patient Safety Office, Department of Health (August 2021 - present)

5. Independent Patient Safety Council Activity in 2022

Council activity

The Independent Patient Safety Council met twice in 2022, in June and December. Both meetings took place virtually. 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.

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.

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)

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

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.

At its meetings in 2022, in June and December, Council were updated and advised on the ongoing development of the framework. In June, Council engaged on the drafting of the framework including the use of a targeted consultation, as part of this drafting process, ahead of the full public consultation carried out in Autumn 2022.

At its December 2022 meeting, Council were provided with a post-consultation report and discussed and fed into the finalisation of the framework. This discussion included an in-depth consideration of the draft framework and consultation results (Appendix 2) in the context of the Council's original Recommendations on a National Policy Framework for Open Disclosure in Healthcare in Ireland.

Council's feedback regarding the consultation and finalisation of the framework contributed to its publication in 2023.

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

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.

In 2022, a research consultant (Crowe) was appointed to look at this area, focusing initially on patient safety incidents. At the June 2022 meeting, the research consultant held a workshop with Council on the *Emerging themes from research on culture and values underpinning patient safety incidents*. The results of this workshop fed into the draft report in this area presented to Council by Crowe in December 2022. This report informed the development of Council Recommendations on the principles to underpin patient safety incidents management, finalised in 2023.

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.

APPENDIX 2

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

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