NATIONAL
OPEN DISCLOSURE
PROGRAMME

National Open Disclosure Programme

Annual Report 2021

An Stiúrthóireacht um Ardchaighdeáin agus Sábháilteacht Othar
Oifig an Phríomhoifigigh Cliniciúil

National Quality and Patient Safety Direct
Office of the Chief Clinical Offic

NATIONAL OPEN DISCLOSURE PROGRAMME

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Figure 1: Mission, Vision and Values of the National Open Disclosure Office and Programme

Section 2: Key Developments during 2021

The following are the key developments in the National Open Disclosure Programme during 2021.

Development	Further information
2.1: Revised Governance for the National Open Disclosure Programme as a result of HSE centre reform.	See section 3 page 5 for further information.
2.2: Completion and Launch of Module 2 of the Open Disclosure online training programme on HSeLanD in April 2021.	See Section 6 page 16 for further details on this module.
2.3: Development of a revised and advanced Face to Face Open Disclosure Skills Workshop - Pilot Programme with Sligo University Hospital and Community Healthcare Organisation 1.	See Section 6 page 18 for further information.
2.4: Development of an Open Disclosure Train the Trainer Programme to support the revised and advanced Face to Face Skills Workshop.	See section 6 page 20 for further information.
2.5: The completion of the work of the Performance Measurement Committee (sub-committee of the National Open Disclosure Steering Committee) on the development of recommendations for a Performance Measurement programme for Open Disclosure and submission of the recommendations of the committee to the National Open Disclosure Steering Committee for consideration.	See section 6 page 21 for further information.
2.6: Expansion of the National Open Disclosure Office.	See section 3 page 6 for further information.
2.7: The completion of the report on the analysis of the inclusion of open disclosure in the curriculum for doctors, nurses, midwives and health and social care professionals in undergraduate programmes.	See section 6 page 25 for further information.
2.8: The continued roll out of the Open Disclosure National Education and Training Programme.	See section 6 page 15 for further information.
2.9: The publication of the National Open Disclosure Programme quarterly newsletters.	All of our newsletters are published on the HSE website and available here.
2.10: The development and publication of the Open Disclosure Quick Reference Guide and Toolkit.	The Open Disclosure Quick Reference Guide and Toolkit is available here.

Section 3: Governance of the National Open Disclosure Programme

HSE Patient Safety Strategy 2019-2024 Commitment 6: Leadership and Governance to Improve Patient Safety:

"We will embed a culture of patient safety improvement at every level of the health and social care service through effective leadership and governance".

The HSE centre reform which occurred during 2021 involved changes to the governance and accountability arrangements for the National Open Disclosure Programme. The National Open Disclosure Office and Programme now sits within the Quality and Patient Safety Incident Management function of the newly established National Quality and Patient Safety Directorate (NQPSD).

The National Quality and Patient Safety Directorate (NQPSD) was established in mid-2021. NQPSD is part of the HSE Office of the Chief Clinical Officer, and is led by Dr Orla Healy, National Clinical Director, Quality and Patient Safety.

Purpose

The NQPSD works in partnership with HSE operations, patient representatives and other internal and external partners to improve patient safety and the quality of care by:

- building quality and patient safety capacity and capability in practice
- using data to inform improvements
- developing and monitoring the incident management framework and open disclosure policy and guidance
- providing a platform for sharing and learning; reducing common causes of harm and enabling safe systems of care and sustainable improvements.

Teams

In line with the "Patient Safety Strategy 2019-2024", the NQPSD delivers on its purpose through the following teams:

- Patient Safety Programme: Oversee and monitor the implementation of the HSE Patient Safety Strategy.
- QPS Improvement: Use of improvement methodologies to address common causes of harm.
- QPS Intelligence: Using data to inform improvements in quality and patient safety.
- **QPS Incident Management:** developing and monitoring the Incident Management Framework, **Open Disclosure Policy** and National Incident Management System.
- QPS Education: Enabling QPS capacity and capability in practice.
- QPS Connect: Communicating, sharing learning, making connections.
- Establishment and operation of the National Centre for Clinical Audit.

The National Open Disclosure Steering Committee which is chaired by the National Clinical Director for Quality and Patient Safety, Dr Orla Healy, oversees the progress of the Open Disclosure programme of work. In fulfilling this role, the National Open Disclosure Steering Committee advance, champion, support and provide strategic advice on the on-going implementation of the National Open Disclosure Programme and policy.

The newly established post of General Manager in the National Open Disclosure Office reports to the Assistant National Director of Incident Management and further to the National Clinical Director for Quality and Patient Safety who reports to the Clinical Chief Officer

The responsibility for the implementation of the HSE Open Disclosure Policy lies at local level. The roles and responsibilities of managers and staff are set out in the HSE Open Disclosure Policy, 2019. The national Open Disclosure team support services through the provision of training and education programmes, training and education resources and other resources to support staff in managing the open disclosure process effectively.

Expansion of the National Open Disclosure Office

In 2021, approval was obtained for the following posts in the National Open Disclosure Office:

(i) General Manager x 1 w.t.e.
(ii) Grade VII x 1 w.t.e.

The recruitment process for the General Manager was commenced but not completed until early 2022. The Grade VII recruitment process was completed with the successful candidate appointed and in post in December 2021.

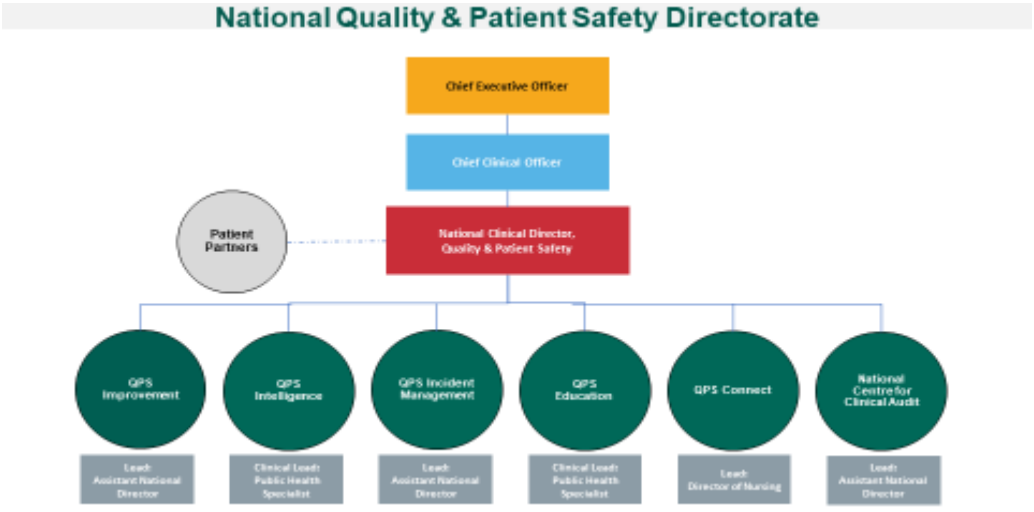


Figure 2: NQPSD Organogram. Open Disclosure sits within the QPS Incident Management function.

Section 4: Update on the Operational Plan for the National Open Disclosure Office 2021.

HSE Patient Safety Strategy 2019-2024 Commitment 6: Leadership and Governance to Improve Patient Safety:

"We will embed a culture of patient safety improvement at every level of the health and social care service through effective leadership and governance".

The table below provides a summary of the operational plan of work for the National Open Disclosure Office for 2021 and how each deliverable within the plan supports the achievement of the strategic goals of the Office of the Chief Clinical Officer.

Deliverable 1: Continue the roll out of a performance measurement programme for the national open disclosure programme taking into consideration current and pending legislation.
How this deliverable supports the strategic goals of the CCO: Measurement of compliance with HSE Open Disclosure Policy and preparation for the measurement of compliance with the Patient Safety Bill.
Update: The work of the Open Disclosure Performance Measurement Committee (a sub-committee of the National Open Disclosure Committee) was recommenced in 2021. The work of this group was previously stood down in 2020 due to Covid-19 and the redeployment of staff. The committee developed a number of recommendations for the development of a performance measurement framework for Open Disclosure. These recommendations were submitted to the National Open Disclosure Steering Committee (NODSC) on 24th November 2021 for consideration and were agreed.
Comment/Further Information: See Section 9 for further details and information on the measurement of the performance of the National Open Disclosure Policy and Programme.

Deliverable 2: Continue to deliver and support the delivery of the National Open Disclosure Training and Education programme:
How this deliverable supports the strategic goals of the CCO: Supports the implementation of and compliance with the HSE Open Disclosure Policy. Supports the preparation for the commencement of the Patient Safety Bill and revised Part 4 of the CLA Act 2017.
Update: Extensive work continued throughout 2021 on the roll out of the National Open Disclosure Training and Education Programme across all health and social care services. This includes: • the completion and launch of E-Learning Module 2 (Open Disclosure: Applying Principles to Practice) in April 2021; • the continued promotion and uptake of E-Learning Module 1 (Communicating Effectively through Open Disclosure); • the development of a new 3 hour Open Disclosure face to face skills workshop which involved a pilot programme with staff in Sligo University Hospital and CHO1; • the revision of the Open Disclosure Train the Trainer Programme to meet the changes in the revised face to face skills workshop; • the monitoring of the uptake of all training programmes and maintenance of the national training database; • the continued evaluation of all training programmes; • the publication of quarterly training reports and annual training report;

- the continuation of the Open Disclosure webinar series;
- the revision of current training resources and the development of additional resources to support the training programme;
- the facilitation of refresher training for current open disclosure trainers and leads;
- improving access to and uptake of open disclosure training for all staff, with a particular focus on medical staff;
- the completion of the report on the analysis of open disclosure inclusion in undergraduate programmes.

Comment/Further Information

See Section 6 for more detailed information on the rollout of the national training programme during 2021.

Deliverable 3: Strengthen the Governance Framework for the National Open Disclosure Programme.

How this deliverable supports the strategic goals of the CCO:
Strengthened accountability at local level.
Improved oversight of programme

HSE centre reform during 2020 involved changes to the governance and accountability arrangements for Open Disclosure. The HSE National Open Disclosure Policy was revised and went out for consultation in 2021 and has a strengthened governance section on open disclosure in line with corporate restructuring and the findings of the HSE Accountability Gap Analysis work group 2019.

Comment/Further Information

See Section 3 for more detailed information on the governance of the National Open Disclosure Programme.

Deliverable 4. Revise and launch the HSE Open Disclosure Policy

How this deliverable supports the strategic goals of the CCO:
Strengthened accountability at local level.
Improved oversight of programme

Update:

The HSE National Open Disclosure Policy underwent consultation in 2021 with all sections revised and updated in line with (i)the expert reference group Interval Cancer reports on CervicalCheck, BreastCheck and BowelScreen (October 2020);
(ii) recommendations by the Independent Patient Safety Council to the Minister on a National Policy Framework for Open Disclosure in Healthcare in Ireland;
(iii) the HSE Accountability Gap Analysis work group 2019;
(iv) the National Review of Clinical Audit 2019
(v) The HSE Incident Management Framework and Guidance 2020;
(vi) the Patient Safety Strategy 2019 – 2024 and
(vii) open disclosure programme developments and learning nationally;
The impact of the HSE cyber-attack which happened on the 14th May, 2021, led to a delay in the consultation process which was completed in Quarter 4 of 2021. Extensive feedback was received from across internal and external stakeholders including patient representatives and patient advocacy groups.

Comment/Further Information:

The launch of the revised policy is on hold until the publication of (i) the Department of Health National Open Disclosure Policy Framework and (ii) the final Patient Safety(Notifiable Incidents) Bill as the policy will require further alignment with these publications.

Deliverable 5. Write & publish the 2020 Annual Report for the National Open Disclosure Office
How this deliverable supports the strategic goals of the CCO: Provide assurance to the CCO and the Board of the HSE on the progress of the National Open Disclosure Programme. HSE Board oversight of the annual report was a key recommendation from Dr Gabriel Scally's "Scoping Inquiry into the CervicalCheck Screening Programme" in September 2018.
Update: The annual report on the work of the National Open Disclosure Programme in 2020 was completed, presented to the Safety and Quality Committee of the Board of the HSE and is published on the HSE website.
Comment/Further Information: The 2020 Open Disclosure Programme annual report is available here

Deliverable 6. Continue to promote the importance of staff support at local level
How this deliverable supports the strategic goals of the CCO: Ensures that appropriate policies, procedures, guidelines and training are in place to support staff in the implementation of the open disclosure programme. Highlights the need for staff to be supported following patient safety incidents.
Update: Supporting staff involved in/affected by patient safety incidents is one of the principles of Open Disclosure and is incorporated into all Open Disclosure training and education programmes. The "ASSIST ME: A Model of Staff Support following Patient Safety Incidents in Healthcare" document was revised in liaison with the HSE Employee Assistance Programme and published in January 2021. A Poster of the ASSIST ME Model of staff support was also developed, circulated and published on the Open Disclosure section of the HSE website.
Comment/Further Information: See Sections 6 and 12 for more detailed information on how the National OD office engaged with staff during 2020.

Deliverable 7. Promote a patient centred approach through patient engagement and providing support to the public
How this deliverable supports the strategic goals of the CCO: Ensures that the voice of the patient is included in the roll out of the HSE Open Disclosure Policy and Programme
Update: The work of the National Open Disclosure Office involves on-going communication and collaboration with patient representatives and patient advocacy services. This work continued virtually throughout 2021 via a number of engagement processes.
Comment/Further Information: See Section 11 for more detailed information on work/collaboration with patient representatives and patient advocacy groups.

Deliverable 8. Implementation of current Open Disclosure Legislation – Part 4 of The Civil Liability Amendment Act 2017 and the (Civil Liability (Open Disclosure) (Prescribed Statements) Regulations 2018
How this deliverable supports the strategic goals of the CCO: Increase transparency, openness and access to accurate and reliable patient information Aligns with the Patient Safety Strategy in ensuring our commitment to patient safety and enhancing our safety improvement capabilities.
Update: Training on Part 4 of The Civil Liability Amendment Act 2017 and accompanying regulations continued throughout 2021. Information on the legislation is included in all face to face training programmes and staff are prompted to consider the legislation and directed to further information on the legislation in Module 1 and Module 2 of the Open Disclosure online education programmes on HSeLanD.
Comment/Further Information: See Section 7 for further information on Open Disclosure Legislation

Deliverable 9. Preparation for the commencement of the Patient Safety (Notifiable Incidents) Bill (PSB) 2019 and revised Part 4 of the Civil Liability Amendment Act.
How this deliverable supports the strategic goals of the CCO: Increase transparency, openness and access to accurate and reliable patient information Aligns with the Patient Safety Strategy in ensuring our commitment to patient safety and enhancing our safety improvement capabilities.
Update: The PSB remained a priority for the Minister for Health during 2021. The progress of the Bill has been affected however by Covid-19. Information on the provisions of the PSB is included in all Open Disclosure face to face training programmes. The National Open Disclosure Team liaised regularly with the National Patient Safety Office (NPSO) in the Department of Health (DOH) throughout the year.
Comment/Further Information: See Section 7 for more detailed information on Open Disclosure Legislation Visit our webpage here to access further information on open disclosure legislation

Deliverable 10. The Development of Open Disclosure Resources
How this deliverable supports the strategic goals of the CCO: Supports the implementation of and compliance with the HSE Open Disclosure Policy. Supports staff and services in managing open disclosure meetings effectively and in compliance with the HSE Open Disclosure policy.
Update: The National Open Disclosure team developed and published a number of new resources in 2021 to support staff, services and the public during the open disclosure process and to support staff and services in the implementation of the HSE Open Disclosure policy.
Comment/Further Information: See Section 6 for further information on the resources developed and updated during 2021. Visit the open disclosure webpage here to access a wide range of open disclosure resources.

Deliverable 11. Continue work with all stakeholders
How this deliverable supports the strategic goals of the CCO: Supports the implementation of and compliance with the HSE Open Disclosure Policy. Supports staff and services in managing open disclosure meetings effectively and in compliance with the HSE Open Disclosure policy.

Update: The work of the National OD Office involves on-going communication and collaboration with a large number of internal and external stakeholders. This work continued throughout 2021 via virtual engagement predominately.
Comment/Further Information: See Section 12 for more detailed information on work/collaboration with internal and external stakeholders throughout 2020.

Deliverable 11. Publish a quarterly newsletter on the National Open Disclosure Programme
How this deliverable supports the strategic goals of the CCO: Supports the implementation of and compliance with the HSE Open Disclosure Policy.
Update: The National Open Disclosure Office published four newsletters during 2021 which were circulated to all services and which are published on the HSE Open Disclosure webpage. The purpose of these newsletters is to provide updates on the programme and legislation to all services and to advertise upcoming events.
Comment/Further Information: Visit our webpage here to access all copies of the Open Disclosure newsletter.

Deliverable 12. Implementation of the Scally Recommendations pertaining to Open Disclosure
How this deliverable supports the strategic goals of the CCO: Supports the overall implementation of the recommendations made by Dr Gabriel Scally in the report "*Scoping Inquiry into the CervicalCheck Screening Programme*" September 2018
Update: Work continued throughout 2021 on the implementation of the Scally recommendations.
Comment/Further Information: See Section 5 for more details on the implementation of the Scally recommendations pertaining to Open Disclosure.

Section 5: Update on the Implementation of the Recommendations from the report by Dr Gabriel Scally into CervicalCheck ("Scoping Inquiry into the CervicalCheck Screening Programme" September 2018).

HSE Patient Safety Strategy 2019-2024 Commitment 5: Using Information to Improve Patient Safety

"*We will use information from various sources to provide intelligence that will help us recognise when things go wrong, learn from and support good practice and measure, monitor and recognise improvements in patient safety.*"

The following table provides an update on the 9 recommendations pertaining to Open Disclosure made by Dr Gabriel Scally in his report into CervicalCheck in September, 2018.

Table 1: Scally Recommendations and update on implementation

Scally Recommendation	Update
28. The HSE's Open Disclosure Policy and HSE/State Claims Agency guidelines should be revised as a matter of urgency. The revised policies must reflect the primacy of the right of patients to have full knowledge about their healthcare as and when they so wish and, in particular, their right to be informed about any failings in that care process, however and whenever they may arise. The revision process should be overseen by a working party or committee with a minimum of two patient advocates amongst its members.	**Status:** Completed. Policy revised and launched June 2019. Further revision of the policy commenced in 2021.
29. The option of a decision not to disclose an error or mishap to a patient must only be available in a very limited number of well-defined and explicit circumstances, such as incapacity. Each and every proposed decision not to disclose must be subject to external scrutiny and this scrutiny process must involve a minimum of two independent patient advocates.	**Status:** Completed. This recommendation is addressed in section 3.15 of the National Open Disclosure Policy, June 2019.
30. A detailed implementation programme must be developed that ensures the principles and practice of open disclosure are well understood across the health service. In particular, medical staff must be required, as a condition of employment, to complete training in open disclosure.	**Status:** Partially completed. The HSE has an open disclosure implementation programme in place to include a National Open Disclosure Office, national lead, national training programme, Open Disclosure leads and trainers in all hospital groups, acute hospitals, CHOs, NAS, screening services and in voluntary agencies. A national steering committee with representation from across all service areas, including representation from external agencies, oversees the national programme of work. Open Disclosure training was identified by the Director General of the HSE in 2018 as mandatory training for all HSE staff and for staff employed in services funded by the HSE.

	Medical staff are required under the provisions of the HSE Open Disclosure policy to complete open disclosure training.
Scally Recommendation	**Update**
31. A Governance Framework for open disclosure must be put in place that includes evaluation and audit.	Completed: National OD Office and National Steering Committee established in 2019. Strengthened governance section in 2019 OD policy. OD leads and trainers in place in all HSE areas performance measurement work streams established.
32. An Annual Report on the operation of open disclosure must be presented in public session to the full Board that is to be appointed to govern the HSE.	Completed. 2019 and 2020 reports presented to Safety and Quality Committee of the Board of the HSE and are published on the HSE website here
33. The Department of Health should enter into discussions with the Medical Council with the aim of strengthening the guide for registered medical practitioners so that it is placed beyond doubt that doctors must promote and practice open disclosure.	This is an action for the Medical Council. The OD Office has provided input to the revision of the Medical Council Code of Ethics for Medical Practitioners in the context of open disclosure.
34. A statutory duty of candour must be placed both on individual healthcare professionals and on the organisations for which they work. 35. This duty of candour should extend to the individual professional-patient relationship.	The Patient Safety Bill will legislate for Open Disclosure of certain patient safety incidents. The incidents are deemed of particular gravity by the legislator. Sanctions with non-compliance will be applied meaning that assurance with compliance needs to be robust. The National Open Disclosure training programme includes updates on Part 4 of the CLA Act 2018 and the General Scheme of the Patient Safety Bill in training programmes and associated resources. Specific information sessions on the legislation have been delivered across the system.
48. NSS should consider, with external assistance, the relevance of the HSE policy on 'Open Disclosure' as it develops in light of this Scoping Inquiry, for all of its screening programmes	Open Disclosure workshops have been provided for senior staff working in National Screening Services (NSS). NSS has an Open Disclosure Lead. There are a number of staff trained as trainers in NSS. Leads from NSS attended 1 day workshop for leads which was focused on implementation. Training was provided by the National Open Disclosure lead and team for all of the teams involved in the Communication of the RCOG review findings. There is representation from National Screening Services on the National Open Disclosure Steering Committee. As noted, the current draft revision of the HSE Open Disclosure policy has gone out to consultation and will incorporate feedback from the National Screening Service which highlights that the National Screening Service (NSS) has fully adopted the HSE Open Disclosure Policy for use in the case of any patient safety incident or unexpected adverse event. Communication of the limitations of screening has been recommended by three Expert Reference Group Interval Cancer Reports and is being taken forward by the NSS. All screening programmes in the HSE manage patient safety incidents in line with the HSE Incident Management Framework and the Open Disclosure Policy.

Section 6: Update on the National Open Disclosure Training and Education Programme 2021

HSE Patient Safety Strategy 2019-2024 Commitment 2: Empowering and Engaging Staff to Improve Patient Safety

"*We will work to embed a culture of learning and improvement that is compassionate, just, fair and open. We will support staff to practice safely, including identifying and reporting safety deficits and managing and improving patient safety".*

The National Open Disclosure Training and Education Programme continued throughout 2021. Open Disclosure training was identified by the Director General of the HSE in 2018 as mandatory training for all HSE staff and for staff employed in services funded by the HSE, with mandatory training requirements taking effect as from 1st January, 2019.

The pandemic and associated Covid-19 Government restrictions continued to impact on how the training programme was delivered throughout 2021 with the majority of training being accessed online/virtually. Some face to face training was re-commenced by the national Open Disclosure training team towards the end of the year.

The uptake of on-line training was also impacted during 2021 by the HSE cyber-attack which impacted services between May and September 2021.

During 2021 delivery of the National Open Disclosure Training and Education Programme included the following components:

- The uptake of Module 1 of the Open Disclosure on-line training and education programme on HSELanD – *"Communicating Effectively through Open Disclosure*" (**30,765 completions in 2021).**
- The launch of Module 2 of the on-line training and education programme on HSeLanD in April 2021: "Open Disclosure: Applying Principles to Practice" (**6,324 completions in 2021).**
- The development and pilot of a revised, accredited Open Disclosure 3 hour face to face skills workshop in collaboration with Sligo University Hospital and CHO1 staff.
- The development of a revised 1.5 day train the trainer programme to complement the new face to face skills workshop.
- The continuation of the Open Disclosure webinar series.
- The maintenance of national training databases and provision of quarterly training reports.
- Quarterly Update/information meetings for open disclosure area and site leads.
- Continued work to improve the access to and uptake of Open Disclosure training by medical staff.
- The development of further open disclosure training and education resources.
- Presentations at training days, conferences, post graduate programmes etc.

2021 Full Training Report

A detailed training report which includes a breakdown of the uptake of training per programme and per service area is available here.

Summary of the uptake of Open Disclosure Training in 2021:

The National Open Disclosure Training Programme currently aims to achieve 90% staff completion of open disclosure training every 3 years (30% per year). This is based on the requirement to complete mandatory training every 3 years.

There were **38,276** completions of open disclosure training programmes in 2021. This includes Module 1 and Module 2 of the e-learning programme and face-to-face skills training. The programme is aiming to achieve a 30% uptake of training by staff per year i.e. a 90% uptake of training by staff over a 3 year period based on the requirement to do refresher training every 3 years. This target will be dependent on the continued commitment of services to meet compliance with open disclosure mandatory training requirements. There are a number of further actions planned by the National Open Disclosure Office during 2022 to promote the uptake of training.

Year	Number of completions of Open Disclosure Training Programmes	% uptake based on headcount for that year
2019	9,859	7.3%
2020	39,314	27.3%
2021	38,376	25.4%
Total 2019-2021	**87,549**	**60.7% (based on an average headcount of 144,262)**
Note: The uptake of online training in 2021 was impacted by the HSE cyber-attack from May to September, 2021 which explains the slight decrease in comparison with training figures in 2020.		

Table 1: % Uptake of training 2019-2021

Note: Detailed training data with breakdown per training programme and per health service area is available in the National Open Disclosure Training Report for 2021 available here.

Launch of Module 2 of the Open Disclosure E-Learning Programme: "Open Disclosure: Applying Principles to Practice"

Module 2 of the Open Disclosure E-Learning programme was launched on 30th April, 2021, as a follow on module to Module 1 and to complement Module 1 and the face to face skills training programme. Additional skills training is mandatory for those staff who may be involved in formal open disclosure meetings (e.g. doctors, managers, senior nurses/midwives/health and social care professionals, patient liaison staff, complaints officers, QPS staff). The aim of Module 2 is to support staff in preparing for and managing a formal Open Disclosure meeting including guidance on the management of some of the complexities that may arise during the open disclosure process. It is important that staff complete Module 1 first to access the theory that underpins the practical components of this module.

This 45 minute module was developed by the HSE National Open Disclosure Office in collaboration with Aurion and HSELanD. The module extends to three hours of learning through the "extend my learning" features within the module.

The development of the module included oversight by and input from many stakeholders including staff from HSE services, patient representatives, RCPI, RCSI, General Practice and the State Claims Agency.

The module is interactive and contains a number of case histories and videos which were developed using actors and a number of HSE staff. The case histories within the module were provided by staff from the relevant services including mental health services, intellectual disability services, national ambulance service, emergency department and general practice. The module includes an extensive list of resources to support staff when engaging in the open disclosure process. The module was tested by a focus group of staff from multiple disciplines and their feedback considered and incorporated prior to the module being launched.

CPD Points

This module has been awarded 3 external CPD points by the Royal College of Physicians Ireland and 3 CEUs by the Nursing and Midwifery Board of Ireland.

There is also a learning transfer evaluation connected to this course. This evaluation becomes available about 3 months after the course has been completed. It has been designed to find out how staff have been able to apply what they have learnt to their practice.

Feedback on Module 2

'The content was easy to follow and contained practical scenarios"

"It was perfectly laid out and very descriptive"

"I would prefer more video content than text reading"

"I'm not in a position to critique the course because it is excellent in it's production but pitched at a level much higher than I am likely to encounter"

" I really enjoyed the videos displaying examples"

"There is nothing I would change about this programme"

"Course throws up a lot of contentious issues which require a bit more time and discussion"

"Course was very easy to follow- don't know how it could be improved"

"Enjoyed the programme, easy to use, good content and user friendly"

"Is a nice program to help me have better communication with patients"

"IT IS SO HELPFUL"

I would like:

"Examples in the Primary Care setting would be helpful. More allied health professional examples would also be beneficial"

"Explain the legal actions people can take when not satisfied"

"Face to face training -and complete the 2 learning modules together"

"Excellent programme, ...having audio and video scenarios keeps it interesting and more true to life ,it provides learning and decision making skills in real time..

Enjoyed the programme immensely".

The development and pilot of a revised, accredited Open Disclosure 3 hour face-to-face skills workshop in collaboration with Sligo University Hospital and CHO1 staff.

The HSE National Open Disclosure Training programme had been adapted to reflect the changing needs of services and in response to feedback given in regard to the previous training model which included a one hour face to face briefing and a four hour skills based workshop.

Following on from the launch of the E-learning modules a working group was set up by the National Open Disclosure Team with consultant doctors, QPS and management staff in Sligo University Hospital and CHO1 to develop an advanced, face to face, skills based training programme which would provide a follow up to and complement the on-line modules. The role of the Working Group was to develop, roll out and evaluate a revised face to face training programme. It was agreed that this would be achieved by:

- Establishing feedback from key stakeholders (e.g. open disclosure leads and trainers, staff in pilot areas) in relation to the priority components for a revised face to face programme.
- Reviewing open disclosure practice and processes already in place in the pilot areas.
- Ensuring that the workshop is aligned with the provisions of the HSE Open Disclosure policy and Part 4 of the Civil Liability Amendment ACT 2017 and also taking into consideration the provisions for mandatory open disclosure in the pending Patient Safety Bill.
- Establishing the key communication skills involved in open disclosure discussions.
- Developing a programme based on the above.
- Testing this programme in the pilot areas.
- Evaluating the programme.
- Conducting an analysis of the evaluation received.
- Amending the programme based on the feedback received.
- Make recommendations in relation to the national roll out of the revised face to face training.

The intended outcome of the training, based on the programme content and delivery mechanism, was that staff would:

- be more knowledgeable about the National Open Disclosure programme including relevant legislation and resources;
- recognise the impact of communication and importance of being empathic, person centred and to be more aware of their own communication style;
- have an opportunity to practice the key skills required to effectively manage an open disclosure meeting to get the best outcome for the patient/ relevant person and staff involved;
- be more confident in managing the open disclosure process and associated challenges as part of a team;
- be aware of the patient perspective, the support needed and available for them;
- recognise the importance of team dynamics, support for each other and their own support needs throughout the open disclosure process.

Following a number of scoping meetings/exercises and evaluation of a survey which was sent out to all open disclosure area leads, the content for the programme was agreed and the team developed the training programme which includes an overview of the Open Disclosure Programme, the Open Disclosure process, legislation, case scenarios and role play activities, the management of communication challenges, the management of complexities that may arise during the process, how to document open disclosure discussions and how to support patients, their relevant persons and staff during the process.

Representatives from the Face to Face Pilot Working Group from Sligo University Hospital

L-R Back: Catherine Hand (Open Disclosure Trainer and Educator), Mr John Kelly (Orthopedic Surgeon), Prof Catherine Mc Hugh (Endocrinologist), Dr Aine Mitchell (ED Consultant)

L-R Front: Teresa Donnelly (Director of Centre for Nursing and Midwifery Education) Moya Wilson (QPS Lead, SUH), Angela Tysall (Open Disclosure Programme Lead)

Four test workshops were facilitated in Sligo University Hospital and two in CHO1 in quarter 4 of 2021. 50 staff attended these workshops including 13 consultant doctors and representatives from nursing, clinical practice, risk management, health and social care professionals and management staff. All of the workshops were evaluated.

Evaluation findings:

1. How relevant was this training for you?

	Answer Choices	Response Percent	Response Total
1	Extremely relevant	64.44%	29
2	Very relevant	33.33%	15
3	Moderately relevant	2.22%	1

2. Will this training influence or change your practice?

	Answer Choices	Response Percent	Response Total
1	Yes	86.67%	39
2	No	2.22%	1
3	No response	11.11%	5

4. What is your overall assessment of the training?

	Answer Choices	Response Percent	Response Total
1	Very satisfied	80.00%	36
2	Satisfied	20.00%	9

5. How much learning did you gain from this training?

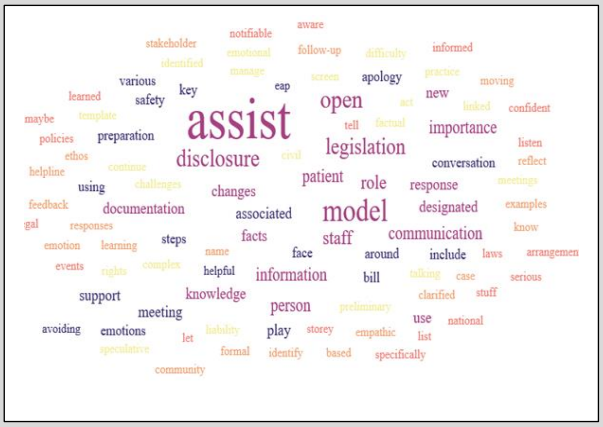
	Answer Choices	Response Percent	Response Total
1	Learned a lot	77.78%	35
2	Learned somewhat	20.00%	9
3	Learned little	0.00%	0
4	Learned nothing	0.00%	0
5	No response	2.22%	1

3: 100% of participants indicated that they would recommend the training to colleagues

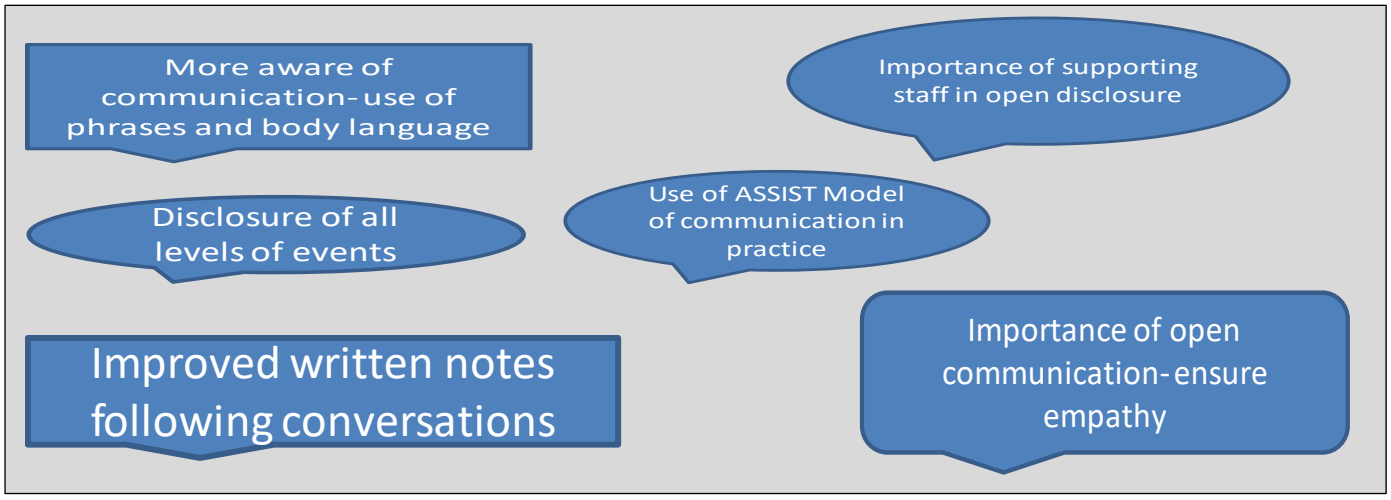
6. 89% of participants indicated that, following attendance at training, they felt confident or very confident to engage in the open disclosure process going forward

Key Learning Points identified by course participants:

- ASSIST Model and ASSIST ME
- Avoiding using information to manage emotional response
- Be factual not speculative when talking
- Being open
- Civil Liability and Patient Safety legislation
- Communication awareness and skills
- Complex conversation challenges
- Continue open disclosure process
- Designated person and their role
- Documentation template for meetings
- Emotions of staff /patient identified well
- Empathic responses samples helpful
- Importance of follow-up
- Formal open disclosure process clarified



Changes in practice identified following attendance at the revised face-to-face skills training:



Roll out of this workshop is planned across all directorates in Sligo University Hospital with clinical leadership present for all sessions. An ED Consultant, has been identified as a clinical lead for Open

Disclosure for SUH and she has also trained as an open disclosure trainer and is actively involved in the roll out of the training in the ED. The open disclosure and clinical leads in SUH and CHO1 are instrumental in the roll out and success of this pilot programme as they continue to engage with the national Open Disclosure team. This approach, with clinical leadership, is the desired model going forward for the roll out of open disclosure training across all service areas.

Open Disclosure Train the Trainer Programme (TTT):

The Open Disclosure TTT programme was revised in 2021 to support the new skills workshop. The previous 2 day face-to-face TTT programme was condensed to a 1.5 day programme with a half day of virtual training followed by a full day of face to face training.

The half day virtual programme provides an update and facilitates questions and answers on the following areas:

- Overview, background and implementation of programme
- Drivers of Open Disclosure
- Open Disclosure Policy
- ASSIST Model
- Principles of Open Disclosure
- Patient perspective
- Staff perspective
- Open Disclosure Legislation
- The Scally recommendations

The 1 day face to face training programme includes the following:

- The Open Disclosure process
- Preparation for delivery of an Open Disclosure workshop
- The role of the trainer
- Provision of training resources
- Opportunity for participants to deliver various components of the Open Disclosure Skills workshop

A number of additional resources were developed to support the new workshop and TTT programme as follows:

- Virtual training resource manual
- Open Disclosure Training Facilitator's Guide
- Case scenario template and sample scenarios

In 2021 nine staff were trained as trainers in SUH and sixteen staff in CHO1 attended the virtual half day training programme with the full day programme planned for January 2022.

Webinars

The National Open Disclosure Office facilitated 9 webinars during 2021. The purpose of these webinars is to maintain communication with Open Disclosure leads, trainers and staff working across all of our health and

social care services, external agencies and patient representative / patient advocacy groups. Webinar topics are identified thorough the webinar evaluation process in an effort to provide information on topics which are of interest and of benefit to our audience. Each webinar was CPD accredited by RCPI (2 external CPD points) and NMBI (1.5 CEUs). Numerous stakeholders were involved in the delivery of the webinar programme. Due to the HSE cyber-attack, and the impact on HSE applications and technology, the webinar series had to be put on hold in Q2 and Q3, therefore no webinars were facilitated during this period. The total attendees across 2021 webinars = **2,498**. Details of webinars delivered by the programme include:

Webinar Title	Date	Total Attendees
The Role of the National Advocacy Service (NAS) and Patient Advocacy Service (PAS) in the Management of Complaints and Open Disclosure (NAS and PAS)	3rd February 2021	202
Applying the Principles of Open Disclosure in a Service for Individuals with an Intellectual Disability (St Michael's House)	17th February 2021	332
Making Difficult Conversations Easier (Professor Eva Doherty, RCSI)	9th March 2021	406
Implications for Open Disclosure in Mental Health Services (St John of God Community Services)	30th March 2021	190
A Culture of Safety (Dr John Fitzsimons and Dr David Vaughan, National QIT)	28th April 2021	286
Update on (i)Open Disclosure Legislation and (ii)the development of an Open Disclosure National Policy Framework (National Patient Safety Office, DOH)	12th May 2021	221
Making Difficult Conversations Easier Part 2 (Professor Eva Doherty, RCSI)	13th October 2021	490
The Role of the Designated Person (National Open Disclosure Office)	20th October 2021	247
Implications for Open Disclosure in Mental Health Services (St John of God Community Services)	17th November 2021	124

Evaluation of the Webinar Programme: Attendees at all webinars were invited to complete a short survey immediately after each webinar. Averages were calculated across all evaluations. Of the webinar feedback received (816 responses in total):

Respondents who Agreed or Strongly Agreed that:	Average % based on completed evaluations
The content of the webinar was relevant to them	**96%**
The webinar has helped them to develop their knowledge and understanding of the subject area	**97%**
The subject area was presented effectively	**97.9%**
The pace of the webinar was satisfactory	**96.9%**
Plan to apply what they learned from the webinar in their work	**95.2%**

97.8% of respondents stated that the webinar met or exceeded their expectations. All respondents were invited to leave additional feedback / comments. Examples of some comments include:

"Presenters were amazing and made the content relatable and friendly to all seeking to improve in this area."

"This is about one of the very best webinars I have attended since the pandemic started (and there have been loads)."

"Practical suggestions, workable for a range of work environments and food for thought on a number of levels for everyday life!"

"Fantastic presentation and a lot of learning points. Should be mandatory for all HCW's"

"Excellent and the compassion from the presenters was palpable which is so need in Healthcare, they epitomized Person Centred Care"

Uptake of training by Medical Staff:

Work continued during 2021 to improve the uptake of open disclosure training by medical staff as follows:

- Engagement with and involvement of medical staff in the development of Module 2 of the Open Disclosure online programme;
- Involvement of medical staff in the development and testing of the revised face to face skills programme – developing a workshop that would meet the specific needs of medical staff and delivered in a manner which would meet their preferred learning style;
- Medical representation on the National Open Disclosure Steering Committee;
- Invitation to and attendance of medical staff at Open Disclosure webinars;
- Inclusion of medical staff in the Open Disclosure train the trainer programme;
- Open Disclosure Clinical Lead role developed in Sligo University Hospital;
- Using specialty specific case scenarios in training that medical staff can relate to;
- Using a directorate approach to training and encouragement of clinician presence in training programmes;
- Record of NCHD uptake of training on the Doctors Integrated Management Eportal/National Employment Record by the NDTP;
- Inclusion of Open Disclosure training as mandatory since July 2021 for interns in the NCHD hub on HSeLanD - via the Intern Network Executive;
- Inclusion of Open Disclosure in the Medical Council Safe Start Programme for new registrants:
- Submission to the annual report of the IHCA;
- Completion of the analysis of the inclusion of Open Disclosure in undergraduate programmes;
- Promotion of the on-line modules at all events;
- Ensuring that training bodies are aware of the online modules and resources available to support staff when they are preparing for and engaging in an open disclosure meeting;
- The development of the Open Disclosure Quick Reference Guide and Toolkit;
- Ensuring that all Open Disclosure training programmes are CPD accredited.

In 2021 **2,435 doctors** (Consultants / NCHDs) have been recorded as participating in open disclosure training. Total attendance at open disclosure training for doctors (Consultants/NCHDs) since Feb 2019 = **6,644**
***(Note:** These figures are reflective for training which took place from February 2019 as attendance data for Consultants / NCHDs was not broken down / recorded pre February 2019. As there are various training programmes available, staff may have attended more than 1 training session, and therefore may be counted more than once).*

Based on a headcount figure of 12,975 for medical / dental staff across HSE and HSE funded services, this is a completion rate of approximately **51.2%** of total attendance at open disclosure training by medical staff since Feb 2019. This headcount data is extracted from an Employment Data Report provided by Strategic Workforce Planning and Intelligence, National HR Directorate.

Open Disclosure Training Consultants 2021

Face to Face Open Disclosure Training	**63**
E-learning Module 1	**212**
E-learning Module 2	**48**

Total training recorded for Consultant's in 2021 is **323**

Total training recorded for Consultants since February 2019 is **2216**.

Open Disclosure Training NCHDs 2021

Face to Face Open Disclosure Training	**289**
E-learning Module 1	**1442**
E-learning Module 2	**381**

Total training recorded for NCHDs in 2021 is **2112**.

Total training recorded for NCHDs since July 2019 is **4428.**

An analysis of the inclusion of Open Disclosure in Undergraduate Programmes

In July 2020, the National Director of Quality Improvement, wrote to the colleges and universities to update them on the work of the HSE in relation to Open Disclosure, to make them aware of the resources available to them and to establish what level of training is being provided in undergraduate programmes on Open Disclosure. An information template was included with this letter for return by the colleges. 36 schools were contacted to include nursing and midwifery, medicine, psychology, dental and Allied Health, Health Sciences and Social Sciences. Dr Crowley had written to the colleges and universities previously in 2016 in relation to Open Disclosure and the need for this topic to be included in these programmes. See summary of the data received in the table below.

School/Department	Number of schools contacted	Departments where open disclosure is included in curriculum	Comments
Medicine	8	8	
Nursing and Midwifery	15	14	Outstanding school plans to revisit this in the context of the next programmatic review for all undergraduate and post graduate programmes.
Allied Health, Health Sciences and Social Sciences	8	8	
Dental	3	1	Will be included in next curriculum going Forward for 2 schools wh OD is not currently Included in curriculum.
Psychology	2	1	

The National Open Disclosure Office will link in with the schools who indicated that open disclosure is not currently included in their curriculum to ensure that it has been included in the next curriculum as indicated in the returns received.

Development of Training and Education Resources during 2021

The following resources were developed by the National Open Disclosure team during 2021: Management of an Open Disclosure Meeting: Quick Reference Guide and Tool Kit (April 2021)

Open Disclosure Share the Learning Template (March 2021)

The ASSIST Communication Model POSTER (January 2021)

Assist Me Staff Support Poster June 2021

Open Disclosure E-Learning Poster 2021

Training Manual and training packs for the revised Train the Trainer Programme

The following resources were updated during 2021:

Open Disclosure meeting checklists (April 2021)

ASSIST ME" A Model of Staff Support following Patient Safety Incidents in Healthcare (January 2021)

Section 7: Open Disclosure Legislation

The HSE Patient Safety Strategy 219-2024 Commitment 6: Leadership and Governance to improve Patient Safety

"*We will embed a culture of patient safety improvement at every level of the health and social care service through effective leadership and governance"*

This section of the report will provide a background and update on current and pending open disclosure legislation to include Part 4 of the Civil Liability Amendment Act 2017, The Civil Liability (Open Disclosure) (Prescribed Statements) Regulations 2018 and the pending Patient Safety (Notifiable Patient Safety Incidents) Bill 2019.

Background and Overview of the Legislation:

(i) Part 4 of the Civil Liability Amendment Act 2017 and the Civil Liability (Open Disclosure) (Prescribed Statements) Regulations 2018

The legislation was informed by the Report of the Commission on Patient Safety and Quality Assurance (Madden 2008). Draft Heads for voluntary open disclosure and clinical audit were provided for in the General Scheme of the Health Information and Patient Safety Bill (HIPS) November 2015. It was subsequently decided by Government that the provisions for open disclosure should be separated from HIPS and included in the Civil Liability (Amendment) Act 2017.

The Civil Liability (Amendment) Act 2017, Part 4 of which provides for voluntary open disclosure, passed all stages in the Dáil and Seanad on 15th November 2017 and was signed into law by the President on 22nd November 2017. The Act was formally commenced by the Minister on 22nd September 2018 with the accompanying Civil Liability (Amendment) Act 2017 (Prescribed Statements) regulations 2018 Regulations signed on 23rd September 2018. During Report Stage of the Dáil on 6th Nov 2017, the Minister committed at that time to progress legislation regarding mandatory open disclosure for a defined set or list of serious events.

Part 4 of the Act sets out the provisions for health service providers to make voluntary "Open Disclosure" of "patient safety incidents". The Act outlines in detail the procedure for preparing for and making an open disclosure which includes the provision of a written statement to the patient at an open disclosure meeting containing the information in relation to the incident and any apology provided. The Act provides that the information provided in making an open disclosure, or an apology, if given, does not constitute an express or implied admission of fault or liability in relation to the incident or any clinical negligence action arising from the incident, will not be admissible as evidence of fault or liability in Court in relation to the incident or clinical negligence action arising from the incident, will not invalidate the indemnity or insurance cover of the health service provider and shall not constitute an express or implied admission of fault, professional misconduct, poor professional performance or unfitness to practice in relation to any complaint made by the patient to a regulatory body subsequently.

The regulations provide the form of various written statement(s) to be provided and/or maintained on record by the health service provider in relation to various stages of the open disclosure process. When seeking the legal protection provided within the provisions of the Civil Liability (Amendment) Act 2017 staff must manage open disclosure strictly in the manner as set out within the 2017 Act.

ii) The Patient Safety (Notifiable Patient Safety Incidents) Bill 2019.

This Bill forms part of a broader programme of legislative and policy initiatives, including the Civil Liability (Amendment) Act 2017, that seek to embed a culture of open disclosure across the Irish Health Sector. The Bill introduces a new requirement for mandatory open disclosure of specific patient safety incidents, (referred to as notifiable patient safety incidents). This mandatory open disclosure and external notification of notifiable incidents will equally apply to the public and private health services.

The Bill includes a schedule containing a list of serious, primarily death related incidents, that will be subject to mandatory open disclosure and notification, e.g. patient death following wrong site surgery, patient death associated with a medication error. The Bill also provides the Minister for Health with the power to make regulations setting out additional incidents that will be subject to mandatory notification. It ensures provision for serious incidents captured in primary legislation while the regulatory power reserved to the Minister provides scope to respond to changes in practice and advances in medical understanding. It provides for notification of incidents to HIQA, the Chief Inspector of Social Services, the Mental Health Commission and the State Claims Agency. It also provides for the extension of HIQA's remit to the private hospital sector and contains provisions supporting the conduct of clinical audit in the health service. The Bill provides for offences for failure to comply with the requirements of this legislation: However, these apply to the health services provider and not individual practitioners.

The General Scheme of the Bill was approved by Government on 5th July 2018 and the Oireachtas Committee on Health pre-legislative scrutiny on 26th September 2018. Government Decision 3 December 2019 approved text and authorised the Minister to introduce the Bill to Dáil Éireann. It progressed through first and second stage on 12 December, 2019 and was restored to the Dáil Order paper on 28th July 2020.

Schedule 2 of the Bill contains a number of amendments to Part 4 of the Civil Liability (Amendment) Act 2017 to align the open disclosure procedural requirements set out in the Civil Liability (Amendment) Act 2017 with the provisions of this Bill.

Amendments arising from the First and Second stage of the Bill include the following:

- Amendment connected with Section 9 of the Health Act 2007 (Investigations by HIQA);
- Amendment to expand the provisions of the Bill regarding "openness and transparency";
- Amendment to align the open disclosure procedural requirements set out in the Civil Liability (Amendment) Act 2017 with the provisions of this Bill;

There are 11 further stages to progress this legislation including 5 stages in Dáil Éireann, 5 stages in Seanad Éireann before the President signs into law. Commencement timelines for the Bill to be considered.

(**Note:** at the time of writing this report the Bill has passed Committee Stage on 10th March, 2022 and there are two further amendments to the Bill proposed at the next stage i.e. Report stage – one amendment pertaining to providing HIQA's Chief Inspector of Social Services with a discretionary power to carry out or commission a review of certain significant patient safety incidents which have occurred during the provision of clinical care to residents of nursing homes and the second amendment pertaining to an additional notifiable patient safety incident in relation to cancer screening services.)

The AND for QPS and National Open Disclosure Team liaise regularly with the National Patient Safety Office (NPSO) in relation to the progress of the Patient Safety Bill and review of Part 4 of the Civil Liability Amendment Act.

Information and Training on Open Disclosure Legislation: (i) Part 4 of the Civil Liability Amendment (CLA) Act 2017 (ii) The Civil Liability (Open Disclosure) (Prescribed Statements) Regulations 2018 (iii) The General Scheme of the Patient Safety Bill July 2018 and revised Bill December 2019.

Work continued throughout 2021 on the implementation of Part 4 of the CLA Act 2017 and the accompanying regulations and on preparation for the pending Patient Safety Bill. Information on the legislation is included in all face-to-face training programmes, including the train the trainer programme. Information on the legislation is included in the revised open disclosure kills workshop established in 2021. Staff are prompted to consider the provisions of the CLA Act 2017 and directed to further information on the legislation in Module 1 and Module 2 of the E-learning programme.

The Department of Health facilitated a webinar for the National Open Disclosure office, as part of the office webinar series, on 12/05/2021, providing an update on the legislation and next steps. 220 people attended this webinar. The National Office facilitated a webinar on the role of the designated person in October 2021 with 247 attendees on the day.

Open Disclosure leads and staff from across all service areas were updated on the legislation via meetings, the office quarterly newsletter and webinars. The HSE Open Disclosure website has pages dedicated to the legislation and containing links to (i) the legislation, (ii) HSE guidelines on managing the open disclosure process in line with the provisions of Part 4 of the CLA, (iii) the CLA forms and (iv) a FAQ document on the CLA Act and associated regulations. The HSE policy also provides information for staff on the protective provisions of the CLA Act 2017 and directs staff to these resources.

Survey regarding the use of the Civil Liability Amendment Act Legislation in 2021

A survey was communicated to all QPS leads in HSE acute and community services to establish the number of occasions that open disclosure was managed under the provisions of Part 4 of the Civil Liability Amendment Act during 2021.

Survey Results

21 QPS leads responded to the survey.

Of these 4 (19%) indicated that they had managed open disclosure under the provisions of Part 4 of the Civil Liability Amendment Act 2017 in their service while 17 (81%) indicated that they had not.

Section 8: Recommendations of the Independent Patient Safety Council on a National Policy Framework for Open Disclosure in Healthcare in Ireland.

HSE Patient Safety Strategy 2019-2024 Commitment 4 Reducing Common Causes of Harm

"We will undertake to reduce patient harm, with particular focus on the most common causes of harm".

The Independent Patient Safety Council was appointed by the Minister for Health, Simon Harris 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 Council members bring a wide variety of expertise and experience from their various perspectives including citizens, education, patient safety, health policy, healthcare leadership, and many more.

In 2020, the Council was asked to present the Minister with recommendations on a National Policy Framework for Open Disclosure in Healthcare in Ireland, to assist organisations and clinicians to apply the principles of open disclosure to communicate with patients when healthcare does not go to plan.

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 report produced by Crowe *"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)*", is available here.

Findings of the Independent Patient Safety Council

The findings of the independent research and national stakeholder and public consultation by Crowe Consultants on behalf of the Independent Patient Safety Council include the following.

- Open disclosure practice in health and social care in Ireland has been getting better in the past few years but there are still times when patients/service users and families do not get all of the right information;
- When something doesn't go the way it was supposed to in health and social care, most patients/service users and families want:
    - to get the right information at the right time so that they can clearly understand what happened;
    - someone to say sorry about what happened in a sincere way;
    - to know what has been done; and
    - to know that the services have taken action to make sure that the chances of it happening again are reduced.

- Patients/service users and their families can find it difficult to get the right information or to understand what happened and they need help and support to do this.
- Staff also need support
- Health and social care workers fear the consequences of being open, e.g., potential for litigation, loss of reputation
- Existence of blame culture

Recommendations of the Independent Patient Safety Council (IPSC) for the development of a National Open Disclosure Policy Framework.

There is some degree of overlap with the principles on which the current HSE open disclosure policy is based and many of these recommendations reflect existing practice. These recommendations are intended to support what is positive about the current policy and practice and to build on this and expand beyond the HSE. Considerable work has been undertaken in the HSE to improve the organisation's approach to open disclosure and these recommendations are intended to support this through the national policy framework.

The recommendations made by the IPSC are based on a set of key principles and are intended to apply across the entire health and social care sector and to all adverse events and patient safety incidents, including those requiring lower and higher level responses. The recommended key principles underpinning the policy framework are as follows:

- Open, Honest, Compassionate, and Timely Communication
- Patient/Service User and Support Persons' Entitlements in Open Disclosure
- Supporting Health and Social Care Staff
- Promoting a Culture of Open Disclosure
- Open Disclosure for Improving Health and Social Care Policy and Practice
- Clinical and Corporate Governance for Open Disclosure

Each of the principles outlined above comes with a list of recommendations and the full report and recommendations are available here.

Update on the development of the National Open Disclosure Policy Framework:

What is an open disclosure policy framework?

The framework aims to provide unity and consistency of approaches to open disclosure across public and private health service providers, service and health professional regulators, healthcare educators and other relevant bodies and organisations. It will provide an overarching approach and can be drawn from to suit the needs of

the various organisations. It will address issues such as high-level principles, common approaches to support and harness positive open disclosure cultures and behaviours. It will identify mechanisms and initiatives that support the consistent, coherent and sustainable implementation of open disclosure.

What is the scope of the framework?

The framework will sit at a level above that of the HSE policy and at a high level to allow for adoption and alignment of approaches across healthcare providers, regulators, educational bodies and other relevant bodies. It will aim for a principles and policy direction approach more so than policy application and practice. The framework has the potential to continue the positive progress of the good work and ongoing progress which has been made by HSE's open disclosure policy and to bring about further improvements. It aims to make open disclosure the norm, not merely the focus of mandatory disclosures in keeping the focus on the concepts of humanity and empathy and recognising the importance of early communications and reducing any further possible harm or trauma.

The development of the Framework

The framework is currently being developed by the National Patient Safety Office in the Department of Health. The framework is informed by the HSE Open Disclosure Policy and will apply to the wider health sector. It will include sections on evidence of learning from Open Disclosure and informing policy change, monitoring and reporting at organisational level, independent support services for patients, implementation and annual reporting by healthcare providers and other bodies to the DoH. There will be a focus on identifying good practice and supporting ongoing culture change.

The development of the framework involves working closely with the HSE and other stakeholders. The draft document will be going out for consultation during 2022. The final published document will inform the HSE Open Disclosure policy and programme going forward.

Related reading:

Independent Patient Safety Council Recommendations Framework Open Disclosure with Crowe Report

Explanatory leaflet on report findings and the Independent Patient Safety Council Recommendations

Section 9: Performance Measurement

HSE Patient Safety Strategy 2019-2024 Commitment 5: Using Information to Improve Patient Safety

"*We will use information from various sources to provide intelligence that will help us recognise when things go wrong, learn from and support good practice and measure, monitor and recognise improvements in patient safety.*"

The National Service Plan 2021

Open disclosure was included in the HSE National Service Plan (2021) as follows:

"Patient Experience and Engagement Priority Areas for Action 2021

Increase transparency, openness and access to accurate and reliable patient information

Develop processes, education and training programmes to support staff and services to comply with incident reviews, legislation including preparation for the commencement of the Patient Safety (Notifiable Patient Safety Incidents) Bill 2019, pre-action protocols and policies relating to open disclosure, mandatory reporting, assisted decision making, consent and other human rights and equality issues"

The Open Disclosure Performance Measurement Committee

The Open Disclosure Performance Measurement Committee was established in September 2019 as a sub-committee of the National Open Disclosure National Steering Committee. The committee members were unable to meet in 2020 due to the impact of COVID 19 and the redeployment of staff and the group was reconvened again during 2021.

The overall **purpose** of the National Open Disclosure Performance Measurement Sub-Committee was to make recommendations to the National Open Disclosure Steering Committee on the development of a measurement framework for the National Open Disclosure Policy and Programme. The objective of the National Open Disclosure Performance Measurement Sub Committee was to provide strategic guidance on:

(i) The development of KPIs for Open Disclosure for the HSE Service Plan.
(ii) The development and implementation of the Open Disclosure Policy Compliance self-assessment tool
(iii) The measurement of patient experience in relation to open disclosure
(iv) A best practice approach to the measurement of performance of the Open Disclosure training, programme and policy.

The Recommendations of the Open Disclosure Performance Measurement Committee to the National Open Disclosure Steering Committee

The Open Disclosure Performance Measurement Committee, following a number of meetings of the group, made the following recommendations to the National Open Disclosure Steering Committee with regard to the development of a performance measurement programme for the Open Disclosure Policy and Programme.

Recommendation 1: The development of a KPI for Open Disclosure for the HSE Service Plan

An initial KPI in relation to measuring the performance of services in regard to compliance with the provisions for mandatory open disclosure in the pending Patient Safety Bill (PSB) in alignment with the open disclosure process as outlined in the legislation. A significant amount of defining, measuring, validating and testing of any metric (including data collection and dissemination) related to the Patient Safety Bill will be required to include a 'Key Performance Indicator' into the National Service Plan. A Working Group should be established to complete this work with representation from, inter alia, NIMS, Screening Services, Community Services, Acute Services, National Quality & Patient Safety and the Integrated Information Services. NIMS will be adapted in terms of functionality to allow for data capture. The remit of assurance will be wider than this however in terms data validation, escalation etc. and the working group will seek to develop this.

Recommendation 2: The development and implementation of Open Disclosure Policy Compliance

To develop a robust assurance framework on the implementation of the Open Disclosure Policy (2019) and subsequent Patient Safety Bill to support the service delivery system. This includes the review of guidance of the National Standards for Safer, Better Healthcare (3.5 Open Disclosure); the development of an Open Disclosure Policy audit tool, and modification to the Incident Management Framework audit tool.

Recommendation 3: The measurement of patient experience in relation to open disclosure.

Development of a Patient Experience Survey or other assessment tool to measure patient's/relevant persons' experience following the open disclosure process to be designed and implemented. Again a work-stream with patient representatives, QPS staff and others will be set-up to support this important and sensitive piece of work. Additionally, an invitation to quote has been submitted to support this work-stream.

Recommendation 4: The Uptake of Open Disclosure Training

Develop an indicator to accurately capture the percentage of relevant staff who are up to date with their Open Disclosure training within the past 3 years. In lieu of accurate data, the National Open Disclosure Office to continue to provide quarterly and annual activity reports on the uptake of open disclosure training per service area including e-learning modules, face to face training programmes and other virtual training programmes to demonstrate compliance with 3 yearly mandatory training requirements. A Working Group should be established to complete this work with representation from, inter alia, NIMS, Screening Services, Community Services, Acute Services, National Quality & Patient Safety, Office of Midwifery and Nurses Services Directorate (OMNSD), National Doctor and Training Programme (NDTP) Health and Social Care Professionals (HSCP) and HR.

Recommendation 5: The establishment of a Project Group

This work needs to continue as a project with the specific aforementioned work-streams reporting into the project oversight group. Terms of Reference to be developed collaboratively with the, what will now be disbanded, Open Disclosure Performance Measurement Sub-Committee and submitted to the Steering Group as final steps for that group.

These recommendations were accepted by the National Open Disclosure Steering Committee on 24th November, 2021.

As the objectives set out for this sub-committee to develop the recommendations were achieved and the recommendations of this committee have been accepted by the NODSC this sub-committee has now been stood down. Work streams will now be established to work on each of these recommendations during 2022 and reporting into the NODSC.

Current Open Disclosure Performance Measures

Performance of the National Open Disclosure Office and Programme:

The National Open Disclosure office has a detailed operational plan. This operational plan is aligned with the annual operational plan for the National Quality and Patient Safety Directorate and the Office of the Chief Clinical Officer. Updates on the work of the office are provided to the National Open Disclosure Steering Committee who provide advice and guidance on the work of the office. An annual report is produced and provided to the Safety and Quality Committee of the Board of the HSE.

Performance of the National Open Disclosure Training Programme:

On a quarterly basis, the National Open Disclosure Office provides a breakdown of training statistics for the programme. This report is issued to Chief Officers of the Community Healthcare Organisations; Hospital Groups Chief Executive Officers; NAS; National Screening Services; Open Disclosure Leads; Open Disclosure Trainers and the National Open Disclosure Steering Committee.

This end of year report looks at all open disclosure training statistics for 2021 and also provides statistics for the last 3 year period. The data for these statistics is generated through the National Open Disclosure Training Database, HSeLanD and HSE Strategic Workforce Planning & Intelligence. Data in relation to staff that have completed face to face training is logged onto the National Open Disclosure Training Database by the open disclosure trainer. Data in relation to staff that have completed online training is generated through a report run on HSELanD. Percentage of training uptake is then established by comparing these figures with staff headcount data from the Employment Data Report provided by HSE Strategic Workforce Planning and Intelligence, National HR Directorate.

This report can be used as a guide to inform services of training data available to the National Open Disclosure Office. The accuracy of the statistics run for different organisations is dependent on the correct data being entered on the system. A reminder is sent to all open disclosure trainers to upload their training in advance of the publication of this report. The e-learning statistics are dependent on staff members identifying themselves as working in the correct services / organisations on HSeLanD. It is therefore important for staff to update their work location on HSeLanD.

Further limitations identified in relation to data presented in this report, is that the data includes everyone who completed any form of open disclosure training in the three years (36 months) prior to the report. This includes staff that have retired, resigned from the HSE or moved post within the HSE over that period. As there are various training programmes available, staff may have attended more than 1 training session and therefore may be counted more than once. It is therefore essential for assurance purposes and to identify gaps in training that individual services/organisations can ensure that their staff are compliant in meeting mandatory open disclosure training requirements by accurately maintaining training records at a local level.

The National Open Disclosure Office strongly urges services to nominate a HSeLanD Data Manager who can apply to have access to a detailed report (including individual staff details) of all HSeLanD learning within their organisation. This data can be cross-checked with local HR files to identify staff that that have not yet completed the training module.

Training target:

The National Open Disclosure Training Programme aims to achieve a 30% uptake of open disclosure training per year i.e. a 90% uptake of training every 3 years. This is based on the requirement to complete mandatory training every 3 years.

Total Trained Per Year

Total Trained 2019: **9,859** (**7.3%** uptake of programme by staff based on headcount for that year)

Total Trained 2020: **39,314** (**27.3%** uptake of the programme by staff based on headcount for that year)

Total Trained 2021: **38,376** (**25.4%** completion based on headcount for that year)

Total trained over 3 year period: **87,549.**

The uptake of open disclosure training by staff over the 3 years (2019-2021) based on an average headcount figure of 144,262 **= 60.7%**

Performance of the National Open Disclosure Steering Committee (NODSC)

The performance of the NODSC is measured in line with the Terms of Reference of the committee.
Note: The performance measures included in the Terms of Reference for the NODSC are as follows:

- Percentage of attendance at meetings by members.
- Completion of follow up actions.
- An annual evaluation of committee objectives.

Percentage of attendance at meetings	59.5%
Completion of follow up actions	There were 15 follow up actions by the committee in 2021 12 actions were completed = 80% 3 actions are in progress = 20%
An annual evaluation of committee objectives.	The terms of reference for the committee were reviewed and updated in November 2021.

Open Disclosure Website Performance:

Visits to the Open Disclosure website were significantly impacted by the HSE cyber-attack during 2021. There were 16,667 visits to the Open Disclosure landing page on the HSE website. The top 10 pages viewed are outlined in the table below.

Number	Page	Number of views
1	Open Disclosure Landing page	16,657
2	Open Disclosure Leads	5,283
3	Open Disclosure Webinars	3,031
4	Open Disclosure Training	2,730
5	Open Disclosure Resources for Staff and Organisations	1,819
6	Open Disclosure Legislation	1,800
6	Open Disclosure Policy	1,420
7	Open Disclosure Meeting Checklist	1,337
8	Open Disclosure Information for HSE Employees	1,156
9	Open Disclosure Legislation documents	676
10	Open Disclosure Information and resources for trainers	433

Top 10 Document Downloads

Number	Document
1	Open Disclosure Covid-19 Guidelines
2	Open Disclosure Policy Summary
3	Open Disclosure Full Policy
4	Open Disclosure Webinar – Making Difficult Conversations Easier
5	Open Disclosure – the role of the designated person
6	Webinar: Patient Advocacy Service and National Advocacy Service
6	Open Disclosure Meeting Checklists
7	Open Disclosure Quick Reference Guide and Toolkit
8	Civil Liability Amendment Act 2017 FAQ document
9	Open Disclosure designated person checklist
10	Open Disclosure Briefing Presentation

Section 10: Open Disclosure "Share the Learning".

HSE Patient Safety Strategy 2019-2024 Commitment 5: Using Information to Improve Patient Safety

"We will use information from various sources to provide intelligence that will help us recognise when things go wrong, learn from and support good practice and measure, monitor and recognise improvements in patient safety."

The focus of the "share the learning" section of this year's annual report is on the management of open disclosure to vulnerable patients/service users. Some people may require additional support which must be made available and accessible where circumstances exist that may make them more vulnerable. People may be vulnerable in terms of their ability to understand and to be fully informed and also in their ability to communicate their wishes/decisions with regard to their on-going care and treatment.

General considerations when managing Open Disclosure in situations where a patient/service user may be vulnerable.

Staff must work on the presumption that every adult person has the capacity to make decisions about their care. A person whose decision-making capacity is in question is entitled to open disclosure on an equal basis with others and to be provided with all the necessary supports to facilitate their involvement in the open disclosure process. There is no 'one size-fits all' way to support a person. The support required by a vulnerable person will depend on the following factors:

- the nature and complexity of the incident taking account of the person's individual circumstances and needs;
- the person's ability to understand the information about the incident, the consequences of the incident and options available in relation to the management of the incident including their care/treatment plan;
- the person's ability to communicate their understanding and preferences;
- whether the person is accustomed to making their own decisions and dealing with such situations.

What constitutes the best approach to supporting a person during the open disclosure discussion will require professional judgement by the health and social care team. It will require a tailored approach based on the person's individual circumstances and needs. However, there are core steps that should be taken in supporting vulnerable people:-

- Ensure the person has all the relevant information needed and that this information is explained or presented in a way that is easy for the person to understand e.g. using and easy read document or communication aids;
- Ensure that the meeting is scheduled at a particular time of the day when the person's understanding is better;
- Ensure the meeting occurs in a place where the person feels more at ease;
- Establish if there is anyone else who can help or support the person to understand the disclosure, for example, a relative, friend, advocate or staff member who they know and trust? (It is important that the person helping and supporting does not put pressure on the person to decide one way or the other);

- Consider if the person needs a memory aid;
- Ensure every practicable effort has been made to communicate effectively where the person has communication difficulties including practical supports such as eye glasses, hearing aid and other communication support tools, as required.

Where a person has diminished capacity, it is still essential to encourage and facilitate the person to participate as fully as possible in the open disclosure discussion. Consider involving an independent advocate to provide support in this situation according to the person's wishes.

Professional interpreter services must be made available, where required, in circumstances where the person's first language is not English or the person is deaf or hard of hearing. The use of family members to interpret should be avoided except in emergency situations.

Consideration must be given also to the management of open disclosure for persons who are vulnerable to avoid causing them additional stress, distress or psychological harm. The appointment of a designated person to provide support during the incident management and open disclosure process is important. Ideally the designated person will be a person with whom the person has an established relationship e.g. key worker, named nurse. The appointment of an appropriately trained advocate must also be considered in these circumstances. The role of the advocate is to assist the patient/service user in (i) understanding information provided, (ii) communicating their will and preference and (iii) ensuring that their views are considered and discussed.

When a patient safety incident involves a child the team involved, in conjunction with the parent(s)/legal guardians of the child, will make an informed decision as to what the child should be told taking into consideration the child's age, comprehension and emotional maturity. The child's best interests are of paramount importance and the child's wishes will be taken into account and given weight according to their maturity.

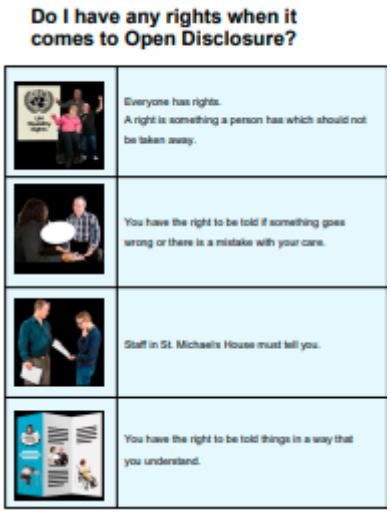
Learning from our work with staff in St Michael's House Intellectual Disability Services and St John of God Community Mental Health Services

The National Open Disclose Team work closely with management and staff in St Michael's House and in St John of God services to provide guidance and support and to learn from the experience of these services in managing open disclosure to often very vulnerable service users and service users with highly complex communication support needs.

> ***"Whatever it is or however bad we think it is we must and will communicate it …far, far worse and wrong that we don't or that we withhold information"***
>
> Clinical Safety Manager, Saint John of God Community Services

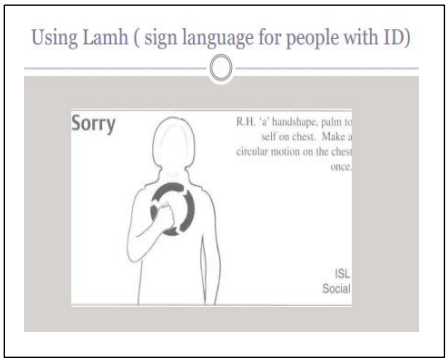
These teams operate a rights based, supportive approach to Open Disclosure ensuring that the focus of the open disclosure is on the specific circumstances relating to the patient safety incident, the individual involved, the specific needs of the service user involved and ensuring that the service user is involved in the open disclosure process from the outset. The staff in St Michael's House, with input from the national Open Disclosure team, have developed an easy read version of the HSE Open Disclosure Policy which they use when engaging in open disclosure discussions with service users. The staff in St John of God have developed an

Open Disclosure Standard Operating Procedure which sets out the expected and required open disclosure response to safety incidents, staff roles and responsibilities and the service implementation plan.



In St Michael's House communication with service users and their families is guided by the following:

- Communication supports are a human right
- ADM requires us to provide information in a way that suits the individual
- HSE Communication Guiding Principles for Disability services
- HSE Provision of Information Guiding Principles for Disability services
- St. Michael's House Ethical Decision Making Framework



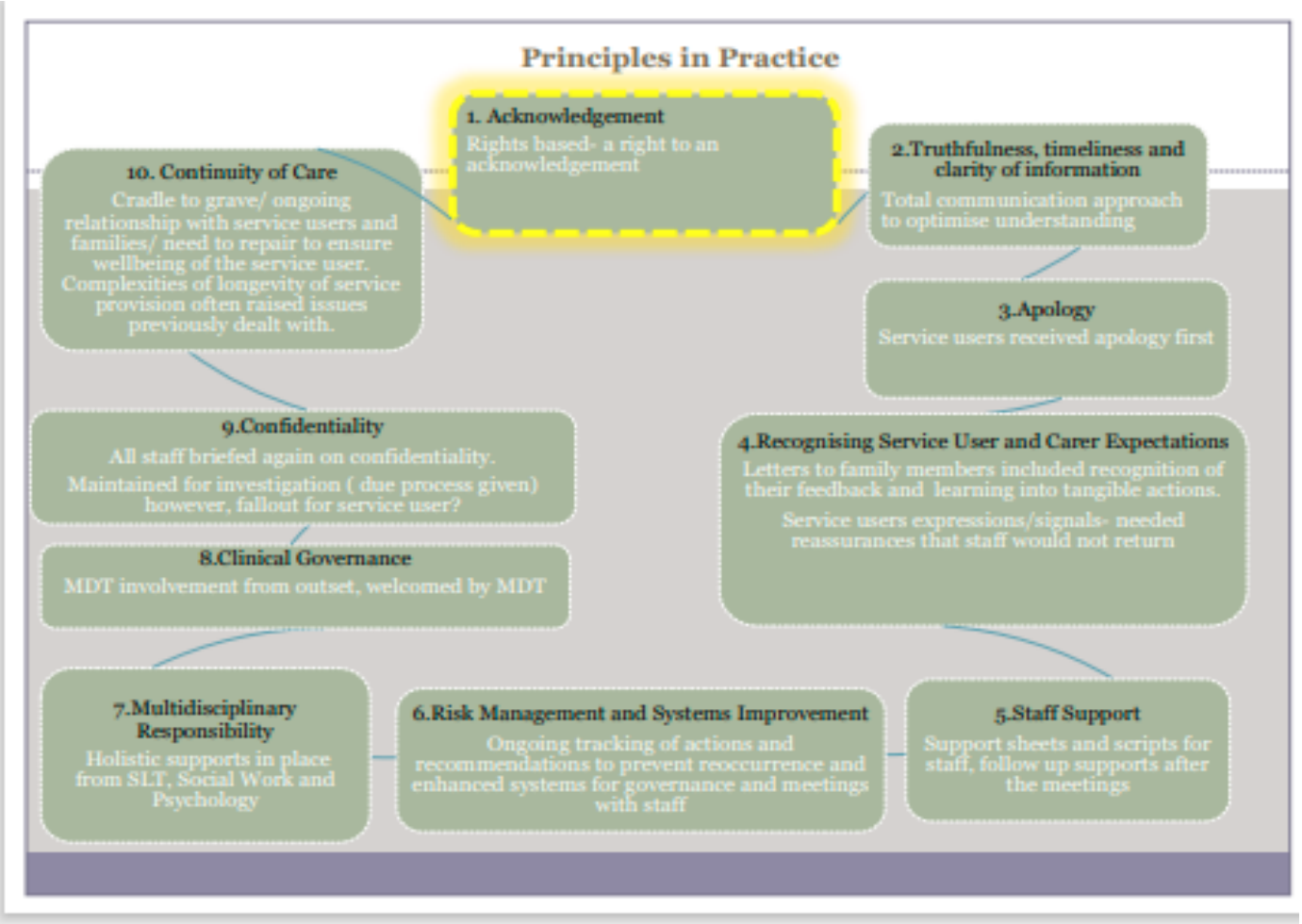
"In human services things go wrong- how we respond is a significant and important part of service provision"

(Elaine Teague: Director of Quality and Safety and Feabhra Mullally: Risk and Incident Manager, St Michaels House)

The Saint John of God Community Services (SJOGCS) standard operating procedure sets out the service commitment to ensuring that all individuals are supported to communicate through a total communication approach and in line with each individual's will and preference as per the SJOGCS Total Communication Policy 2019. SJOGCS also recognises the important role of staff members/ key workers and advocates in supporting individuals with their assessed communication preferences at all times in line with their individual communication profile

Applying the 10 Open Disclosure Principles to Practice when engaging in Open Disclosure with Vulnerable Service Users (St Michaels House)

The diagram below sets out how each of the 10 principles of Open Disclosure were applied to practice when managing open disclosure to a vulnerable service user.



Using a rights based approach to open disclosure and decision making in the context of the service user response to patient safety incidents and open disclosure is in line with the provisions of the Assisted Decision Making Capacity Act 2015. This act says that everyone is presumed to be able to decide for themselves unless the opposite is shown. The new law sets out ways to support people who lack capacity to make decisions. The new assisted decision-making act moves away from a 'best interests' approach for people who need support with decision making. It is a move to a rights-based approach to decision making with respect for the will and preference of the person.

NATIONAL OPEN DISCLOSURE PROGRAMME

OPEN DISCLOSURE: Share the Learning Template

The National Open Disclosure Office developed a" Share the Learning" template and guidance document which is available on the OD website. It is available to use by open disclosure leads and staff in services to support a learning culture. Open disclosure leads in all services are asked to share examples of the management of the principles of Open Disclosure across the various settings in the HSE. The case scenario provided in the "share the learning" template below demonstrates how the principles outlined above are used in the management of open disclosure to a vulnerable person. All identifiable patient data has been removed to ensure confidentiality of the services and patients involved.

Case Scenario ID Services (Anonymised)

Note: For the purpose of this scenario the service user will be referred to as Tom (fictional character)

Date Incident occurred:	xxxxxx 2021	**Category of Clinical Incident:**	Harm Event (Category 3)
Service	ID setting		
1. Summary of incident – provide a brief description of the incident.	Tom is an 18 year old man who has recently moved from school into an adult day service. Tom has an autism spectrum disorder and complex communication. Tom attends a day service with five other people. Tom was injured in his day service- he was observed to have a cut on his leg and his elbow. It was unclear how this injury occurred. He may have tripped and fallen or may have been bumped into by someone else or he may have been pushed by someone. An open disclosure meeting was arranged to meet with Tom and a further open disclosure meeting was arranged with his mother.		
2. Who was involved in meeting the patient/ relevant person?	An open disclosure meeting took place to explain and apologise to Tom for his injury. It was important that Tom was met with first, as Tom is an adult and under the Assisted Decision Making (Capacity) Act (2015) his capacity to receive an apology was assumed. Communication supports were considered and gathered for the meeting with Tom. These included the team reviewing how Tom communicates and a total communication approach was used to optimise understanding for Tom in relation to what was being said in the meeting. The team refreshed their Lamh/ sign language, including the word for "sorry" and		

	pictures to guide Tom through the meeting. The team also used an easy read agenda to help with the meeting. The open disclosure meetings took place in an environment that was familiar to Tom and where he is most relaxed. The OD team encouraged Tom and his supporter to bring an item of comfort for Tom also (in this case it was a comfort blanket that Tom likes to bring with him to places when he is nervous). It was pre-arranged that Tom would do something with his support staff after the meetings that he really liked; for example going to a Trampoline park to ensure that Tom had a clear indication that the meeting was finished and he would have an opportunity to spend time doing a fun activity with someone he trusted. The next Open Disclosure meeting involved Tom's mother. The team asked her where she would most like to meet; we offered to meet her in her own apartment, in the main offices or in Tom's residential house. Tom's Mum chose the main offices. Following on from the OD process, a review of the service was completed. It transpired that Tom was most likely pushed out of the way by another service user and he subsequently fell. A safeguarding investigation was completed. A programme was established to support the other service user to wait and allow others to pass before he pushed passed others. Additional OD meetings were held as this information came to light.
3.Subsequent meetings (Impact of Covid-19)	Unfortunately there had been an outbreak of COVID 19 in the residential house so the staff team were required to wear full PPE in subsequent meetings with Tom. The OD team were conscious that Tom would not know them or recognise their faces. To help mitigate this, the team carried large photo pictures of their faces and pinned them onto the torso section of their gowns while speaking with Tom, so as to be as personal as possible and so that this would be a less frightening experience for him.
4. What were the key issues that arose during the open disclosure process?	The key consideration for Tom was ensuring that Tom had time to process the information being given to him, giving Tom time to look over the pictures but also respecting that when Tom wanted to leave that he could (we used a STOP sign that Tom is familiar with so when something is finished he would hand this to staff and leave the room). This was respected in the meeting. For Tom's Mum it was important that she felt her concerns were listened to and to reassure her that everything possible was being done to keep Tom safe. She had not

	experienced anything like this previously as during school Tom had a special needs assistant with him at all times. 
5 (a) What went well during the open disclosure process?	The OD team arranged to have sandwiches and cakes as Tom's Mum had taken time off work to attend the meeting. They placed a table cloth on the office table with flowers in a vase to create a less intimidating/ official atmosphere. This was especially important as the meeting took place during a pandemic so masks were required in a healthcare setting. Although restrictions on food and drink had been lifted in healthcare settings/ meetings; social distancing was still required, which the team perceived might be another possible barrier to creating a relaxing/ less intimidating atmosphere. Support sheets and sample scripts were developed for staff to aid them in what to expect and to prepare them for how Tom and his Mum might feel or act during and after the meeting and how best to support them. Staff were supported in relation to answering any questions they had in relation to the open disclosure process and consideration of questions that they could be asked by Tom and his Mum and how to respond appropriately and reassuringly during and after the meeting. • It was a rights based process- respecting the right of the person to receive information and an apology. • The team worked on the assumption of Tom's capacity to be involved in the open disclosure discussion and the importance for Tom to receive an apology; • Supports were provided to assist Tom to understand the information provided and the apology. • Follow up supports were implemented for Tom, his Mum and the staff involved. • The level of communication provided was at both Tom's and his Mum's level of understanding.

5 (b) What did not go well?		The meeting took place during a pandemic so masks and social distancing were required in the health setting. This made it more difficult so other things needed to be considered to try to put Tom and his mother at ease as much as possible in the meetings. Due to the nature of the incident, this required a safeguarding process to be initiated to ensure the safety of Tom and the other people in the day centre. Due to this, information was screened and statements needed to be sought- this caused a time delay in the full information being disclosed to Tom and to his mother.
6. What was the learning/what changes in practice have been made?	(i)	There are practical and creative ways to lessen the stress and worry that an official meeting can cause a service user by creating a more relaxing environment, nice scents, flowers, comfort items and communication aids to support Tom to have the best possible understanding of what was being said in the meeting.
	(ii)	Open Disclosure is not a 'one off' event- there were a small number of meetings with Tom and his mum over a period of time.
	(iii)	Due to the safeguarding screening, there was a delay in the **full** information being disclosed to Tom's mother about what had allegedly happened. Tom's Mum was told initially that something may have happened but was not told any further details. This naturally caused a lot of stress and worry for Tom's mother, who told us that she would rather not know that something had gone wrong with her son's care without being told the full details of what this might be. The learning for the service provider is to try establish all the facts available as quickly as possible, to disclose these to the service user (and family with the service user's consent) as soon as possible and continue to provide additional information as it becomes available. In the event that the full information has not come to light then the management and open disclosure team must discuss, agree and record the reason for any delay in information being provided to service users and families.
	(iv)	Open Disclosure is the right thing to do, but it is important to do it right. Tom's needs were paramount and the service were guided by him and the people who knew him well.
6. How was the Open Disclosure process documented?		The open disclosure notes made in preparation for the meetings are held in the Quality and Safety Department. Templates of letters and easy read letters/ scripts are

		also kept in the Quality and Safety Department files in the Open Disclosure resource tool box to support staff in the open disclosure process. The record of the open disclosure discussion was made in the service user's personal care record/file. Letters sent to the service use (including easy read letters) were also stored in the service user's personal file. We were satisfied with the documentation of the meetings as the information was focused on the individual's communication style and needs to support them to understand in the best possible way.

Acknowledgements:

The team in the National Open Disclosure Office would like to thank the management and staff in St Michael's House and in Saint John of God Community Services for their continued support of the programme, their guidance on the management of open disclosure to vulnerable persons and the extensive work they have carried out in the implementation of the HSE Open Disclosure.

Thank you also to the service who provided the anonymised case example to share the learning.

Related documents:

St Michael's House Easy Read Open Disclosure Policy available here

Saint John of God Community Services Open Disclosure Standard Operating Procedure available here

Section 11: Partnering with Patients and Service Users

HSE Patient Safety Strategy 2019-2024 Commitment 1: Empowering and Engaging Patients to Improve Patient Safety

"*We will foster a culture of partnership to maximise positive patient experiences and outcomes and minimise the risk of error and harm. This will include working with and learning from patients to design, deliver, evaluate and improve care".*

"Patient and family engagement is an integral strategy to develop high-quality, integrated and people-centred health services. Patient engagement is critical to shaping the way forward. It has the potential to saves lives through safety and quality improvements informed by patient experience" (WHO 2016).

Engaging and partnering with patients, service users and their families, patient representative groups and patient advocacy services is an integral component in the continued implementation of the HSE National Open Disclosure Policy and Programme. The overall philosophy and approach of the programme is based on the patient voice and patient rights, needs, expectations and preferences.

Examples of the involvement of Patients/Patient Representatives in the National Open Disclosure Programme during 2021:

National Open Disclosure Steering Committee:

There are two patient representative members on the National Open Disclosure Committee.

Patient participation and involvement in the oversight and development of Open Disclosure E-learning Modules on HSELanD:

Module 2 of the Open Disclosure E-Learning Programme "Open Disclosure: Applying Principles to Practice" was launched in April 2021. This module includes a video of a patient representative, Ms Lorraine Reilly, telling her and her family's story and stressing the importance of Open Disclosure and training for staff. This video was developed specifically for inclusion in module 2 to include the voice of patients and patient representatives.

There was a patient representative on the oversight group for the development of both Open Disclosure e-learning modules on HSELanD.

The development of the revised skills based Open Disclosure face to face workshop and Train the Trainer programme

The revised train the trainer programme developed to support the new skills workshop included attendance, input and feedback from a patient representative from the patient forum in Sligo University Hospital.

Webinars:

Invitations are sent to members of Patients for Patient Safety Ireland, the National Patient Forum, staff from Patient Advocacy Service and National Advocacy Service to attend all webinars facilitated by the National Open Disclosure Office. These webinars are regularly attended by representatives from all of these groups who engage proactively in the chat and question and answer sections of the webinars.

Webinars facilitated by the National Open Disclosure Office included the following:

- The Role of the National Advocacy Service (NAS) and Patient Advocacy Service (PAS) in the Management of Complaints and Open Disclosure
- The Role of the Designated Person in Supporting Patients and their Families. This webinar was delivered in collaboration with a Patient Liaison Manager with focus on patient/ service user support in services.

Consultation on the revision of the HSE Open Disclosure Policy

Consultation on the revision of the HSE Open Disclosure Policy included the following groups:

- Patients for Patient Safety Ireland
- The National Patient Forum
- Patient Advocacy Service (PAS)
- National Advocacy Service (NAS)
- Independent patient representatives

Patient Advocacy:

Two members of the National Open Disclosure Team successfully completed the Level VII Patient Safety Complaints Advocacy Course in 2020. Two further members of the team successfully completed the course in 2021.

There is a strengthened section on the importance of the role of independent advocacy services in providing support to patients and families in the revised open disclosure policy with links to advocacy services available.

The national Open Disclosure team have established very positive working relationships with patient advocacy services and look forward to working more closely with these services going forward in an effort to strengthen a culture of openness and transparency across all services.

Section 11: Stakeholder Involvement

HSE Patient Safety Strategy 2019-2024 Commitment 2: Empowering and Engaging Staff to Improve Patient Safety

"*We will work to embed a culture of learning and improvement that is compassionate, just, fair and open. We will support staff to practice safely, including identifying and reporting safety deficits and managing and improving patient safety".*

"*Business is about relationships. The success or failure of any policy or product starts and ends with stakeholders. Failure to engage can cost time, money and reputation, and lead to a great idea going nowhere. Engagement is an ongoing process throughout the lifecycle of your policy or product. Stakeholder engagement is the process by which an organisation involves people who may be affected by the decisions it makes or by its implementation. It is more than just communication. Communication will only give a sense of 'yes', 'no' or 'maybe'. Developing an understanding of what people are thinking and saying requires both listening and responding."* (Taysom, 2021)

The successful implementation of the HSE Open Disclosure policy and programme is dependent on collaborative working with many stakeholders to include HSE services, HSE funded services, professional and regulatory bodies, indemnifying bodies, trade unions, patient representative and patient advocacy groups, royal colleges, training bodies, the Department of Health and other government agencies. All of these agencies support us in driving the importance of open disclosure, improving the uptake of open disclosure training and the implementation of the HSE Open Disclosure policy.

The HSE National Open Disclosure Team work proactively with many internal and external stakeholders, on an on-going basis as part of the implementation strategy for the National Open Disclosure Policy and programme. The type of collaboration varies from provision of training, attending meetings, engaging in and supporting various work streams, presentations at study day/conferences, providing and receiving data, embedding open disclosure in policies, curriculums, systems and programmes, responding to queries, providing support and guidance, supporting local policy development and sharing learning.

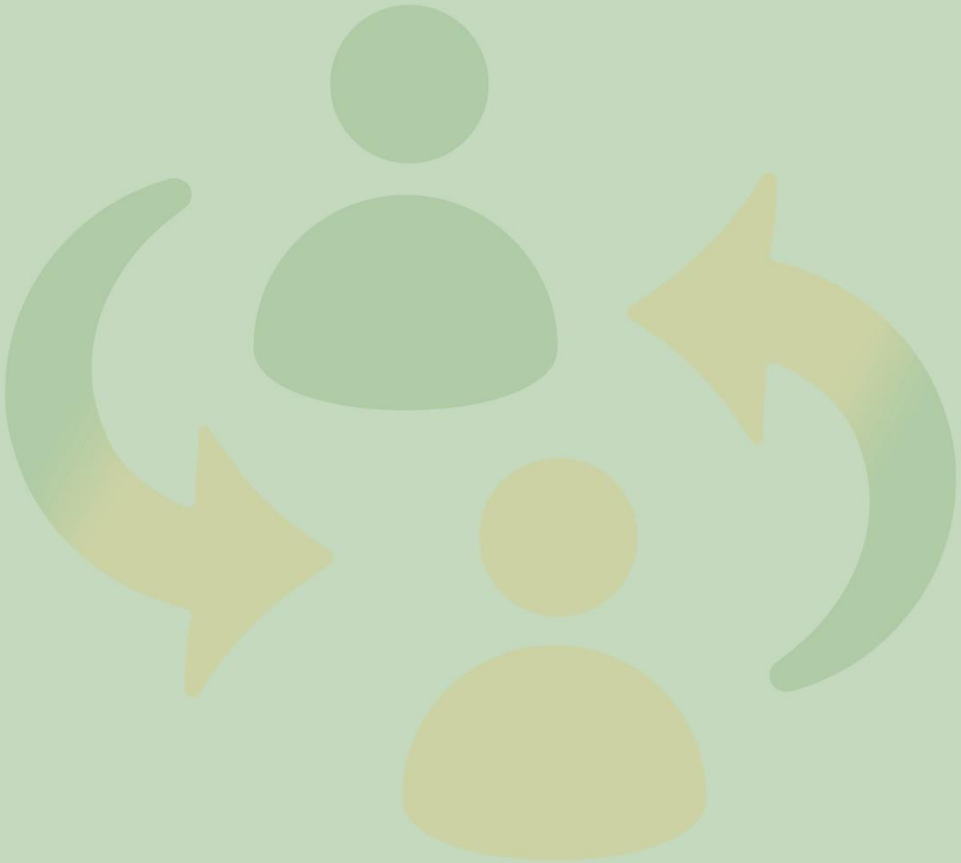
The following is a list of *some* of the engagements in 2021 with various internal and external stakeholders:

Stakeholder	Summary of engagement
HSE Services	• Training programme supported across all HSE and HSE funded services. • Quarterly update meetings with Open Disclosure leads across all service areas. • Quarterly newsletters circulated to all service areas. • Quarterly and annual training reports circulated to all service areas. • National Open Disclosure Programme annual report circulated to all services and published on website. • Open Disclosure webinar series – current circulation list of invites is 3314 people across all service areas. • Representation from HSE services on National Open Disclosure Steering Committee (NODSC) and Performance Measurement sub- committee of the NODSC. • Consultation on HSE Open Disclosure Policy Revision.

	• Representation from services on oversight committee for the development of the Open Disclosure online modules on HSeLanD. • Open Disclosure leads in all service areas and site leads in acute hospitals. • Open Disclosure trainers in all service areas. • Open Disclosure office email responding to queries, invitations and providing resources to all HSE and HSE funded services. • Pilot of revised face to face training programme with Sligo University Hospital and CHO1. • Involvement of nursing and medical staff in University Hospital Limerick in the development of eLearning Module 2 scenarios and video.
Stakeholder	**Summary of engagement**
State Claims Agency	• Update on OD programme provided to State Claims Agency staff via Zoom. • Representation on oversight committee for the development of the online training modules on HseLanD. • Representation on NODSC. • Representation on Performance Measurement Committee. • Consultation on HSE Open Disclosure Policy Revision.
HIQA	• Meeting re proposal to include open disclosure in current and planned patient experience surveys. • Update provided to HIQA staff on National OD programme.
Royal College of Physicians Ireland (RCPI)	• The National Open Disclosure Team promote the RCPI "Gateway to Communication" programme at all training and education events and via email/newsletter. • The RCPI award CPD for the Open Disclosure E-learning programmes, face to face skills training, webinars and train the trainer programme. • Members from the RCPI were included in the oversight group for the development of the E-learning programmes.
Royal College of Surgeons Ireland(RCSI)	• The National Open Disclosure Steering Committee includes representation from the RCSI. • There was representation from RCSI on the oversight group for the open disclosure e-learning programmes. • Presentation to RCSI Masters in Surgical Science. • "*Making Difficult Conversations Easier*" webinars x 2 delivered by Professor Eva Doherty, RCSI as part of Open Disclosure webinar programme.
University College Dublin (UCD)	• Open disclosure workshop and assessments of candidates on the Graduate Diploma in Quality and Risk Management.
Irish Medical Organisation (IMO)	• Meeting with IMO to discuss Scally Recommendation Number 30. • Telephone/email communication to update on Open Disclosure Legislation and Open Disclosure training programmes.
Irish Hospital Consultants Association (IHCA)	• Submission for IHCA Annual Report in September 2020. • Included in consultation on revised Open Disclosure policy.
General Practice	• Input provided by a GP for E-learning Module 2. • Open Disclosure included in training programme for GP trainees and GP Principals.

Stakeholder	Summary of engagement
Medical Council	• Email communications to progress inclusion of Open Disclosure in Medical Council Safe Start Programme and to promote Open Disclosure Training programmes.
Federation of Voluntary Bodies (FedVol)	• The Federation of Voluntary Bodies are included in all general communications from the National Open Disclosure Office and are invited to all training /information events. • The National Open Disclosure website contains contact details for the Open Disclosure Leads identified across the various voluntary agencies.
Nursing and Midwifery Planning and Development Unit (NMPDU) **Centre of Nursing and Midwifery Education (CMME)**	• The National Open Disclosure Steering Committee includes representation from the NMPDU. • Open Disclosure training is delivered in various CNME's across the country.
Patient representatives and patient advocacy groups	• See Section 10 for details
National University of Ireland, Galway (NUIG)	• Open disclosure overview and update facilitated by OD team on NUIG Advanced Nurse Practice and Medicinal Prescribing Course.
The National Doctors Training Programme (NDTP)	• The National Open Disclosure Steering Committee includes representation from the NDTP. • The NDTP continues to support the National Open Disclosure Team in promoting mandatory open disclosure training arrangements for NCHD's through the Doctors Integrated Management System / National Employment Record (DIME / NER).
National Screening Services (NSS)	• There is representation from NSS on the National Open Disclosure Steering Committee. • Open Disclosure team is represented on CervicalCheck implementation group. • Open Disclosure lead identified for screening services.
St John of God Service, Dublin	• Webinars x 2 delivered on *"Open Disclosure in The Mental Health Setting"* as part of the OD webinar services. • National OD office
Patient Advocacy Service/National Advocacy Service	• See section 10 for details.

NATIONAL
OPEN DISCLOSURE
PROGRAMME



For further information and additional resources visit
www.hse.ie/opendisclosure

Email: *opendisclosure.office@hse.ie*