NATIONAL
OPEN DISCLOSURE
PROGRAMME

National Open Disclosure Programme

Annual Report 2019

Seirbhís Sláinte
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á Forbairt

Building a
Better Health
Service

National Quality Improvement Team

CONTENTS

Section 1: Open Disclosure: A Values Based Programme

Section 1.1: Mission, Vision, Values of the National Open Disclosure Office

MISSION

Promoting and supporting a culture of honesty and transparency through compassionate and empathic communication with our patients, service users, their families and staff.

VISION

Everyone experiences open, compassionate and timely communication and will be supported when things go wrong, for whatever reason, in our services.

VALUES

Care
Compassion
Trust
Learning
Person Centred
Kindness
Empathy
Openness
Honesty

1.2 Ethos of the National Open Disclosure Policy and Programme

The ethos of the national Open Disclosure Policy and programme is based on ensuring that the rights of all patients (and their relevant persons, as appropriate) to be communicated with in an open, honest, timely and empathic manner following patient safety incidents are met and respected and that they experience dignity, respect and compassion throughout the communication process. Open disclosure is a core professional requirement which is anchored in professional ethics. Communicating effectively with persons affected in a compassionate and thoughtful manner, especially when providing information about a patient safety incident, is a crucial part of the therapeutic relationship and if done well can mitigate anxiety and enhance trust in the staff, the organisation and the health care system generally. The ethos of the policy also seeks to ensure that all staff involved in and/or affected by patient safety incidents are identified and provided with adequate care and support in the immediate aftermath of the incident and in an on-going basis throughout the incident review and open disclosure process.

The implementation of the policy has been managed using a supportive approach in an effort to promote a culture of openness and transparency across all health and social care services that facilitates and enables efficient and effective reporting of patient safety incidents, learning and quality improvement.

Section 2: Key Developments in Open Disclosure during 2019

2.1: Establishment of the National Open Disclosure Office

The National Open Disclosure Office was established in 2019 and began operation on 13th May. Recruitment for the office commenced in September 2018 - the current staffing includes a Programme Manager, two trainers and educators and an office administrator. The National Open Disclosure Office sits within the HSE Quality Improvement Team in the office of the Chief Clinical Officer.
The National Open Disclosure Policy and Programme is co-ordinated via the National Open Disclosure Office and reflects the strategic and policy direction established by the HSE Leadership Team and is consistent with the policies and strategy of the HSE and Department of Health.

Functions: The National Open Disclosure Office provides strategic guidance on the implementation of:

- The HSE Open Disclosure Policy and accompanying guidelines
- Part 4 of the Civil Liability (Amendment) Act 2017
- The Civil Liability (Open Disclosure) (Prescribed Statements) Regulations 2018
- The provisions relating to open disclosure within the forthcoming Patient Safety Bill
- The recommendations of Dr Gabriel Scally in his report "Scoping Enquiry into the CervicalCheck Screening Programme", September, 2018.
- The National Open Disclosure Training Programme.

Governance: See Office Organogram in Appendix A of this document.

2.2: The establishment of the National Open Disclosure Steering Committee

The HSE established a National Open Disclosure Steering Committee in April 2019. The inaugural meeting of this committee was held on 30th April, 2019 and three further meetings were convened between April and December 2019.

This committee is chaired by Dr Philip Crowley, National Director, HSE Quality Improvement Team. The chair of this committee reports to the Chief Clinical Officer. Committee membership includes representatives from across the HSE divisions and external stakeholders – see Appendix B for the list of current membership of this committee. The terms of reference of this committee and minutes of meetings are available on the HSE website here.

The **role** of the National Open Disclosure Steering Committee is to oversee the progress of the Open Disclosure programme of work. In fulfilling this role, the National Open Disclosure Steering Committee will champion, advance, support and provide strategic advice on the on-going implementation of the National Open Disclosure Programme and policy.

This is achieved by:

- Assessing and monitoring performance against the agreed programme of work by defining and receiving reports on programme work.
- Ensuring appropriate policies, procedures and guidelines are developed/updated and evaluated for the programme.
- Seek assurance and evidence of staff compliance with Open Disclosure education and training.
- Ensuring risk identification, assessment, mitigation and escalation processes pertaining to the National Open Disclosure programme are in place.

The overall **aim** of the National Open Disclosure Steering Committee is to oversee that:

(i) The HSE has a robust policy and guidelines for Open Disclosure in place that complies with legislation and best international practice.
(ii) Implementation of the policy and guidelines takes place at all levels of the health service through the accountability structure of the HSE.
(iii) There is regular evaluation and audit carried out to assess the implementation of the Open Disclosure Policy and programme nationally.

2.3: Revision of the HSE Open Disclosure Policy

The HSE Open Disclosure Policy was revised between September and December 2018. The draft revised policy went out for consultation in December 2018 and a final draft was submitted to and approved by the HSE Directorate on 6th March, 2019. The consultation group included patient representatives and patients and families affected by matters arising in CervicalCheck.

This revision incorporates the Scally recommendations (see section 4 below) and aligns with the provisions of Part 4 of the Civil Liability (Amendment) Act 2017 (CLA), the 2018 regulations accompanying Part 4 of the CLA Act, the Assisted Decision Making (Capacity) Act 2015 and the HSE Incident Management Framework 2018. The revised policy was launched formally by Mr Paul Reid, CEO of the HSE, on 12th June 2019. The launch was supported by a full communications programme which included the development of a manager's pack, a policy summary document, a team presentation and team talk sheet to facilitate managers to update staff, a summary poster, broadcast email, website update, videos and a letter from the Chief Clinical Officer (CCO) to all managers and staff.

The National Open Disclosure training programme and resources were revised to reflect the policy changes and a number of training days were facilitated by the National Open Disclosure Team for open disclosure leads and trainers across the country to update them on the revised policy and the adjustments to the national training programme.

2.4: Implementation of the Recommendations made by Dr Gabriel Scally in his report "Scoping Enquiry into the CervicalCheck Screening Programme", September, 2018.

The report by Dr Gabriel Scally "Scoping Inquiry into the CervicalCheck Screening Programme" was published in September 2018. This report included fifty recommendations, nine of which pertained to Open Disclosure. See section **4** of this report for a detailed update on the work undertaken by the National Open Disclosure Office during 2019 in relation to the implementation of these recommendations.

Section 3: Update on the Operations Plan for the National Open Disclosure Office 2019.

Action as per Operations Plan 2019	Update	Comment
1. Establishment of the National Open Disclosure Office	The office was established and commenced operation on 13th May 2019.	The office is now fully operational with staff recruitment and induction programmes completed. See **section 2.1** above for further information.
2. Review and update of the HSE National Open Disclosure Policy	The HSE National Open Disclosure Policy was revised and re-launched on 12th June, 2019.	See **section 2.3** above for further information.
3. Establishment of National Open Disclosure Steering Committee	The National Open Disclosure Steering Committee was established with the inaugural meeting of the committee occurring on 30th April, 2019.	See **section 2.2** above for further information.
4. A Governance Framework for Open Disclosure must be put in place that includes evaluation and audit.	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 policy document. The policy also sets out the requirements in relation to evaluation and audit.	See **section 6** for further information on the governance arrangements for open disclosure.
5. Improve staff support at local level	The National Open Disclosure Office is working with the Quality Assurance and Verification Division in relation to (i) a review of the staff support systems available for staff who are involved in patient safety incidents and (ii) the development of guidance in relation to the same. The requirement for effective staff support services and a culture that is fair and just is included in the HSE Open Disclosure Policy and HSE Incident management Framework. The "ASSIST ME" Model of staff support was developed as part of the National Open Disclosure programme and is available here The Open Disclosure Website has been updated to direct staff to the support services that are available to them here.	

Action as per Operations Plan 2019	Update	Comment
6. Legislation: **(a) Roll out of Part 4 of the Civil Liability Amendment Act (CLA) 2017 and accompanying 2018 regulations.** **(b) Preparation for the commencement of the Patient Safety Bill (pending).**	This work is on-going. An overview of Part 4 of the CLA Act and accompanying 2018 Regulations is available on the HSE Open Disclosure webpage here. An FAQ document on Part 4 of the CLA Act 2017 and the 2018 Regulations was developed and is available on the HSE Open Disclosure webpage here. Training programmes and workbooks have been updated to include information on open disclosure legislation. Update training days have been facilitated for trainers and leads. Presentations were facilitated at grand rounds/conferences in 9 hospitals by staff from the National Open Disclosure Office.	See section **5** below for further information.
7. Revise the National Open Disclosure Guidelines	The revision of the National Guidelines is deferred until 2020.	Revision to commence January 2020.
8. Open Disclosure Train the Trainer Programme (TTT)	7 TTT programmes were delivered between September and December 2019 with 111 staff from across all services completing the training.	See section **5** below for further information on the national training programme.
9. Development of an Open Disclosure e-learning Programme	Significant work was undertaken on the development of Module 1 (Briefing module on Open Disclosure for all staff) and an explainer video. This programme is due for launch in Quarter 1 of 2020. Work was commenced on Module 2 ("Applying Principles to Practice") which is focused on learning how to prepare for and manage a formal Open Disclosure meeting". This module is aimed at all staff engaging in formal Open Disclosure meetings.	
10. Maintain the National Open Disclosure Training Databases	The National Open Disclosure Office operates a national database of trainers and of training. The training delivered by trainers across all health and social care services is logged on the national database. Reports are then generated from this database to inform senior management locally, the National Steering Committee, CCO, CEO and annual report.	

Action as per Operations Plan 2019	Update	Comment
11. Complete an evaluation and consultation process which will enable the design of Key Performance Indicators for Open Disclosure.	A Performance Measurement Committee was established in 2019 – this committee is a sub-committee of the National Open Disclosure Steering Committee.	See section **7** below for further information on the work of the Performance Measurement Committee.
12. Development of additional resources to support staff and services.	The following resources were developed and launched in 2019: • Revision of National Policy • Policy Summary Document • Managers pack • Team presentation, • Team talk sheet, • Summary poster. • Training programme and resources for staff involved in the communication of the RCOG results – see 13 below.	The following resources are developed in draft: • Managing Open Disclosure in a General Practice Setting. • A recommended approach to disclosing another clinician's error. • Cast study booklet.
13. Membership of Royal College of Gynaecologists (RCOG) Working Group – Communicating the results of the RCOG Review	The National Open Disclosure staff have actively supported Dr Peter McKenna and his team in providing training for the teams involved in the communication of the RCOG review findings (6 workshops) and in the development of support materials to support the same.	• A specific training programme was developed and delivered. • Development of pre, during and post meeting checklist to support the meetings. • Development of sample case scenarios to establish learning. • Development of guidance on how to conduct the meetings with patients and families involved in the review.

Action as per Operations Plan 2019	Update	Comment
14. Develop an archive of documents for the Open Disclosure Office with reference numbers	Work has commenced on the development of an Open Disclosure toolkit template and in the revision of all documents on the Open Disclosure website. Work has commenced on an archive system for these documents.	
15. Representation on national workgroups and committees	The National Open Disclosure Office is represented on the following committees and workgroups: • Records management workgroup. • National Consent Policy Review Group. • RCOG – communication of RCOG results. • Clinical audit working group and steering group.	

Section 4: 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).

Scally Recommendation	Update on Implementation
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.	The HSE Open Disclosure Policy has been revised and was launched on 12th June 2019. The primacy of the right of patients to be communicated with in an open, honest, timely and compassionate manner following patient safety incidents is reflected in the policy. The policy revision included consultation with patient representatives including patients/families affected by matters arising in Cervical Check. Revision of the National Open Disclosure guidelines was deferred to 2020 due to the extensive programme of work of the office and the pending commencement of the Patient Safety Bill.
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.	This recommendation is addressed in section 3.15 of The National Open Disclosure Policy, June 2019. Note: Incapacity is not an indication not to disclose - patients with reduced capacity have the same rights to open disclosure as other patients and must be supported to be involved in the process. Where the patient does not have any capacity, open disclosure to their relevant person must be considered taking into consideration the known will and preference of the patient.
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.	The HSE has a robust 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 some voluntary agencies. A national steering committee with representation from across all service areas and external stakeholders oversees the national programme of work. National HR are currently liaising with the relevant trade unions in relation to the recommendation that medical staff must be required, as a condition of employment, to complete training in open disclosure. 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. An Open Disclosure e-learning programme is due for launch in Quarter 1 of 2020 with a further module in development. The RCPI have been commissioned to build a 4 module programme on communication and open disclosure specifically for medical staff.
Scally Recommendation	**Update on Implementation**
31. A Governance Framework for open disclosure must be put in place that includes evaluation and audit.	• The National Open Disclosure Office was established in May 2019. • A National Open Disclosure Steering Committee was established in April 2019. This committee oversees the national programme of work. • A Performance measurement committee, which is a sub-committee of the national Open Disclosure steering committee, was established in September 2019 – see chapter 7 for further details of the work of this committee and see Appendix C for the membership list of this committee. • There are Open Disclosure leads and trainers in all areas. • There are Open Disclosure leads in all acute hospitals. • The National Open Disclosure Policy states clearly that the primary responsibility and accountability for the effective management of patient safety incidents, including the open disclosure process, remains at organisational level where the patient safety incident occurs. The policy sets out the roles and responsibilities of HSE staff at corporate, managerial and individual staff levels. • The requirement to monitor performance in relation to open disclosure is included in the National Open Disclosure Policy. Compliance with open disclosure requirements is included in the Incident Management Framework (IMF) compliance self-assessment tool. Open disclosure is recorded on the National Incident Management System (NIMS) with a mandatory requirement on the system to provide a reason if open disclosure has not happened.
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.	The 2019 annual report on Open Disclosure will be available for presentation to the Board of the HSE in 2020.

Scally Recommendation	Update on Implementation
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 National Open Disclosure Office works closely with the Medical Council and Royal Colleges in relation to supporting the implementation 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.	These recommendations are being addressed in the forthcoming Patient Safety Bill - the National Open Disclosure Office is currently providing training/ information on Part 4 of the CLA Act 2018 and General Scheme of the Patient Safety Bill in all of its 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 from National Screening Services (NSS). • NSS has an Open Disclosure Lead identified. • An Open Disclosure lead has been identified in individual screening services. • There are a number of staff trained as trainers in NSS with further staff due to attend the Open Disclosure Train the Trainer programme. • Leads from NSS attended a 1 day workshop for leads which was focused on implementation. • Training was provided by the National Open Disclosure Team for all of the teams involved in the Communication of the RCOG review findings.

Section 5: The National Open Disclosure Training and Education Programme

The National Open Disclosure Training and Education Programme continued throughout 2019 and was augmented by the recruitment of two trainers and educators as part of the establishment of the National Open Disclosure Office.

The National Open Disclosure Training Programme includes the following components:

- 1 hour briefing sessions for all staff.
- 4 hour CPD accredited skills workshops aimed at all staff who may have to engage in formal open disclosure meetings e.g. all managers, medical staff, quality and risk staff, patient liaison staff, complaints officers.
- 2 days train the trainer programme.
- Update/information days for trainers and leads.
- Presentations at study days, conferences, grand rounds etc.
- The provision of on-line training, education and support resources for trainers, leads, staff and services.
- Open disclosure training is incorporated into local and corporate staff induction programmes.

Work commenced in 2019 on the development of 2 e-learning modules on HSELanD to support the above programme. Module 1 "Communicating effectively through Open Disclosure" is a briefing module on open disclosure aimed at all staff. This programme will be ready for launch in quarter 1 of 2020. Module 2 is designed as a follow on module to support staff who are preparing for and engaging in formal Open Disclosure meetings. Work on this module is in the early stages with plans to launch it in quarter 3 of 2020.

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. The 1 hour briefing session delivered by trainers or Module 1 of the e-learning programme (when available) will suffice for most staff. All managers and medical staff (any staff who are likely to be involved in higher level open disclosure meetings) are required to attend the 4 hour skills workshop. Refresher training is required every 3 years.

Open Disclosure Train the Trainer Programme (TTT):

The National Open Disclosure Team delivered 7 train the trainer programmes (2 day programmes) between September and December 2019 with 111 staff attending from across a variety of HSE services and divisions and services funded by the HSE. Training was initially prioritised for areas with no trainers or with low numbers of trainers.

To access the TTT programme attendees must have completed a half day workshop which they aim to access locally. The national team also provided a number of workshops to facilitate staff who were unable to access this workshop locally. A nomination form must be completed and signed by the attendee's line manager. This form is then sent to the Open Disclosure lead for the area who will then review, prioritise (as appropriate) and forward to the National Open Disclosure Office. The

training recommendation is that all staff who attend the Train the Trainer programme must deliver a minimum of four half days training each year. This is important to ensure that they maintain competency and confidence as trainers. These staff, with the support of the local open disclosure leads and national office staff, must be committed to deliver the relevant training programmes to all staff to ensure compliance with the HSE Open Disclosure Policy and to meet service requirements.

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.

Four specific information sessions for open disclosure trainers and leads were facilitated on the above legislation between December 2018 and the end of Quarter 1 of 2019. Information on this legislation was also incorporated into five update training days for trainers and leads which were facilitated post the launch of the revised policy and in two full day workshops which were facilitated for open disclosure leads.

All training programmes and accompanying workbooks have been revised to incorporate information on the legislation. Presentations have been delivered in Grand Rounds and conferences in 9 hospitals by staff from the National Open Disclosure Office. Presentations have been delivered in five national consultant conferences and in 2 other national conferences reaching a large number of doctors. A specific webpage providing an overview of the legislation and links to relevant resources was developed on the Open Disclosure part of the HSE Quality Improvement Team website. An FAQ document on the CLA Act and Regulations was developed and is available on the Open Disclosure webpage here.

The planned revision by Government of Part 4 of the Civil Liability Amendment Act 2017 and the Civil Liability (Open Disclosure) (Prescribed Statements) Regulations 2018 to align them with the provisions in the Patient Safety Bill will require a revised training programme to be delivered across all health and social care services. A substantial lead in time to the commencement of the Patient Safety Bill will be required to not only educate staff on the Patient Safety Bill and develop resources to support the implementation of the Bill but also to provide training on the revised Civil Liability Amendment Act 2017 and amend current resources on this Act.

Improving access to and uptake of Open Disclosure Training by Medical Staff:
A targeted programme of work was commenced in relation to improving the access to and uptake of open disclosure training by medical staff. International evidence demonstrates that professional training is imperative to support and enhance the disclosure process. While training is widely available across all health care areas the uptake of training by medical staff varies across the system and therefore an on-going programme of work in the HSE and with various external stakeholders will be necessary going forward. The open disclosure team was involved in the discussions around and provided input into the development of a four module programme on Communication by the RCPI which will be launched in 2020. Module 2 of the e-learning programme is specifically targeted at medical staff and managers. 17 doctors were trained in 2019 as open disclosure trainers in an effort to create leadership in this area and to drive a medical model of training. Data collection commenced in February 2019 in relation to the number of doctors attending Open Disclosure training. Open disclosure training was carried out by the open disclosure team in the RCPI and RCSI.

Support was provided in the development and presentation of a specific open disclosure programme by Dr Karen Palmer (ICGP) as part of the GP Continuing Medical Education (CME) programme. Open disclosure is included in the training programme for GPs.
A further programme of work is planned in 2020 to include (i) an analysis of the inclusion of open disclosure in undergraduate programmes for doctors, nurses, midwives and allied healthcare professionals (ii) work with the National Doctors Training Programme (NDTP) to address mandatory open disclosure training requirements for NCHDs and Interns, (iii) the development of Module 3 face to face training programme with input from medical staff and which will be a follow on programme from Module 1 and Module 2 of the e-learning programme (iv) continued engagement with the Royal Colleges to promote and support training and (v) engagement with the Medical Council in relation to the inclusion of open disclosure training as part of CPD requirements.

Update training days for Open Disclosure Leads: Two specific workshops were facilitated for open disclosure leads from September to December 2019 – these workshops were focused on implementation strategies.

Open Disclosure Training for the HSE Leadership Team: Two half day workshops were facilitated for the leadership team in the HSE at the request of the CEO, Mr Paul Reid, who personally attended a full 4 hour workshop.

Record of Training: All training delivered by open disclosure trainers is logged on a national database of training (via Smartsurvey). Trainers are also expected to maintain local training records. See Appendix D of this document for a detailed breakdown of training provided to date and in 2019 per area e.g. CHO, Hospital Group, National Ambulance Service, Screening Services, Voluntary Bodies and Corporate Staff.

Resources for trainers, staff and organisations: The Open Disclosure website hosts a large number of resources to support trainers, clinicians and organisations in the implementation of the national Open Disclosure Policy and programme.
Resources for trainers are available here
Resources for Clinicians and Organisations are available here
Information and resources on Open Disclosure legislation are available here

Website Update: The open disclosure webpage was updated in 2019 in preparation for the launch of the revised policy and to host the associated additional resources developed. The website also hosts details of the work of the National Steering Committee here

Section 6: Governance

Open disclosure is an integral component of the incident management process. Primary responsibility and accountability for the effective management of patient safety incidents, including the open disclosure process, remains at organisational level where the patient safety incident occurs. Effective governance arrangements are required to support timely and effective open disclosure. Central to this is an explicit management commitment to safety that promotes a culture of openness, trust and learning between persons who may be affected by patient safety incidents and those delivering and managing the services within which the patient safety incident occurs.

Governance arrangements for open disclosure must clearly set out the roles, accountabilities and responsibilities of staff at all levels of the service. These accountability arrangements for open disclosure must be clearly defined and include details of delegated accountability, responsibility or authority. An organisation chart must be available setting out these arrangements. To underpin the effectiveness of these arrangements, explicit management commitment to the development of capacity and capability and the consistent use of NIMS for the management of data and information relating to open disclosure is required.

The HSE Performance and Accountability Framework 2018 sets out the HSE accountability structure and contains a list of the accountable officers per work area. The Performance and Accountability Framework clarifies;

- The named individuals who have delegated responsibility and accountability for all aspects of service delivery across the four domains of the National Scorecard.
- That these named individuals are accountable and responsible for managing the performance of services within their allocated budget.
- For the named accountable officer, what is expected of them, what happens if targets are not achieved and in particular the nature of the supports, interventions and sanctions that will apply if these targets are not achieved.

Accountable officers are fully responsible and accountable for the services they lead and deliver. They are required to have formal performance management arrangements in place with the individual services they are responsible for, to ensure delivery against performance expectations and targets.

It is the responsibility of all managers to proactively identify issues of underperformance and to act upon them promptly and to the greatest extent possible to avoid the necessity for escalation within the organisation.

Table 1: The accountability structure for the HSE is set out below (as per the HSE Performance and Accountability Framework 2018):

1	Service Managers and the CEOs of Section 38 and 39 agencies **to** the Hospital Group CEOs and CHO Chief Officers.
2	Hospital Group CEOs, CHO Chief Officers, the Head of PCRS and Heads of other national services **to** the National Directors Acute Services Operations and Performance, Community Services Operations and Performance and National Services.
3	National Directors Acute Services Operations and Performance, Community Services Operations and Performance and National Services **to** the Deputy Director General Operations.
4	The Deputy Director General Operations **to** the Director General.
5	The Director General **to** the Directorate.
6	The Directorate **to** the Minister.

Note: The **HSE Performance and Accountability Framework 2018** predates the abolition of the Directorate and the role of Director General. It also predates the establishment of the Board. Therefore, for Directorate one should read Executive Management Team, for Director General read Chief Executive Officer and we welcome that there is now re-established clear independent Board accountability for all HSE business and that the operational line reports now through the Chief Executive Officer to the HSE Board.

Section 7: Performance Measurement

A: The Open Disclosure Performance Measurement Committee

The Open Disclosure Performance Measurement Committee has been established as a sub-committee of the Open Disclosure National Steering Committee to identify a process to assess compliance with the HSE Policy and Programme on Open Disclosure and the recommendations of Dr Gabriel Scally (2018) in his report "Scoping Inquiry into the CervicalCheck Screening Programme, September 2018". The first meeting of this committee took place on 16th September with a further meeting on 8th November.

The overall **purpose** of the National Open Disclosure Performance Measurement Sub Committee is to support and provide guidance to the National Open Disclosure Steering Committee on the development of measures to assess the implementation of the Open Disclosure Policy and Programme. The fundamental purpose of the group is to establish a process that ensures (i) compliance with the HSE Open Disclosure Policy, (ii) that the correct cohort of staff attend open disclosure training and (iii) a system is in place for implementing Open Disclosure training to identified HSE staff within the services. This process will demonstrate the training offered, support accessed and available, recording and monitoring and reporting governance structures from Bed to Board.

To support the National Open Disclosure Steering Committee, the National Open Disclosure sub Committee will 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 and (iii) the measurement of patient experience in relation to open disclosure.

The role of the National Open Disclosure Performance Measurement Subcommittee is to agree best practice approaches to measure the performance of the Open Disclosure programme of work by (i) assessing and monitoring performance against the agreed programme of work by defining and receiving reports on the work of the national programme work (ii) assessing and monitoring compliance with the HSE Open Disclosure Policy by defining and receiving reports on policy compliance and (iii) seeking assurance and evidence of staff compliance with Open Disclosure education and training programmes.

The overall objectives of this group are as follows:

- To identify processes to establish system wide accountability and responsibility for the implementation of the Open Disclosure Programme and policy.

- To consider how to receive assurance from the operational divisions/services on the implementation of the policy and guidelines.

- To identify a process to collect the evidence of staff compliance with Open Disclosure education and training.

- To identify a process to provide data to support the implementation of an Annual Operations Plan and Annual Report for Open Disclosure

- To oversee and inform the commission of audit and evaluation of the implementation of the policy and guidelines on Open Disclosure.

- To consider best approach to measure patient experience during the Open Disclosure process

Update on work of this Group to date
A working group has been established and draft terms of reference developed.

Performance measures/processes have been identified in the following areas:

a) Performance of the national programme.

b) Performance of the national open disclosure training programme.

c) Key performance indicator on policy compliance.

d) Assurance: Policy compliance self-assessment tool.

Healthcare audit

Data analysis from the National Incident Management System

e) Measuring patient experience.

f) Implementation of recommendations from national reports, audit reports, evaluation reports.

a) Performance of the National Programme: The National Open Disclosure office has a detailed operations plan. This operations plan is aligned with the annual operations plan for the National Quality Improvement Team and the annual operations plan for 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 full Board of the HSE.

b) Performance of the National Open Disclosure Training Programme: All training provided by the national training team and area trainers and leads is logged on a national training database which indicates the date and where the training occurred e.g. CHO, Hospital Group etc, the hospital site, the care group e.g. primary, social, mental health etc, the type of training and number of attendees with a further breakdown of number of medical staff who attended. Records are produced from the national database.

Trainers are also required to maintain local training records and to adhere to local policies on the recording of training on local databases e.g. SAP, QPulse.

All open disclosure workshops are CPD accredited and include an evaluation process.

c) The development of key performance indicators: Two key performance indicators have been outlined and work has commenced on the drafting of these indicators.

d) Assurance: Policy compliance self-assessment tool: Work was undertaken with the Quality Assurance and Verification Division (QAVD) in the inclusion of evidence of compliance with the HSE Open Disclosure Policy in the Incident Management Framework (IMF) compliance self-assessment tool which is available for all services to access – see link below. https://www.hse.ie/eng/about/qavd/incident-management/

Assurance: Healthcare Audit: A proposal was submitted to and approved by the HSE Quality Assurance and Verification Division (QAVD) for the inclusion of Open Disclosure in the 2019 healthcare audits. These audits were not undertaken due to the need to have the compliance self-assessment tool completed prior to the audit process.

Assurance: National Incident Management System (NIMS) Data: Open disclosure is included on the NIMS system with details recorded as to whether open disclosure has occurred with a mandatory field to be completed to indicate why open disclosure has not occurred. Work is on-going with the NIMS working group to set the open disclosure question as a mandatory field.

(e) Measurement of patient experience: Work was undertaken with Patients for Patient Safety Ireland and other patient representatives in the development of an open disclosure patient and family experience questionnaire. This questionnaire is in Draft format. The revision of the National Open Disclosure Policy includes the requirement for follow up with the patient/relevant person to establish their experience of the open disclosure meeting as follows:

"Following a formal open disclosure meeting the designated person will contact the patient or relevant person on a mutually agreed date and time to establish their experience of the open disclosure meeting in relation to the following:

- *Did the patient and/or relevant person feel that they were treated with dignity and respect during the open disclosure meeting?*
- *Did the patient and/or their relevant person feel that they were listened to and heard during the open disclosure meeting?*
- *Did the patient and/or their relevant person receive an appropriate and meaningful apology?*
- *Did the patient and/or their relevant person receive answers to their questions?*
- *Increase transparency, openness and access to accurate and reliable patient information.*

(f) Implementation of recommendations from national reports, audit reports, evaluation reports. Updates on the implementation of the Scally recommendations were provided regularly throughout the year to the office of the CCO and in the annual report on open disclosure.

B: The National Service Plan

Provisions for open disclosure are included in the 2020 National Service Plan as follows:

- Continue to support staff and services to comply with investigative reports, legislation, including the Patient Safety Bill, and policies relating to open disclosure, mandatory reporting, assisted decision-making and consent.

- Enhance the national support to ensure that effective open disclosure occurs in all instances of harm in our health services through the newly established national team. We will train trainers including medical personnel across the entire health system and will provide on-going support and mentoring to them as they in turn roll out open disclosure training in their local area.

Regular updates are provided to the CCO through the National Director of Quality Improvement on the work being undertaken by the National Open Disclosure Office and National Steering Committee to meet the provisions in the service plan.

Section 8: Partnering with Patients and Service Users

The work of the National Open Disclosure Team involves on-going communication with and partnering with patient representative groups, patients, service users and their families. This work is critical to the success of the programme and in ensuring that the patient voice is heard and incorporated into all that we do.

Engagement with Patient Representatives and Patient Advocacy Groups:

The National Open Disclosure Team work in close association with patient representatives and patient advocacy groups and continually promote the power of patient stories at national conferences and in training and education programmes. Patients for Patient Safety Ireland (PFPSI) have identified open disclosure as one of the key areas they wish to support and there is on-going communication with and involvement of this group.

Examples of Patient Involvement during 2019:

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

Revision of the National Open Disclosure Policy: The consultation process for the revision of the policy included consultation and collaboration with patient representatives including PFPSI and patients and families affected by matters arising in CervicalCheck.

Launch of the Revised HSE Open Disclosure Policy: The policy was launched at a formal event on 12th June 2019. Attendees included members from the National Patient Forum, SAGE and PFPSI as well as independent patient advocates and patients and families affected by matters arising in CervicalCheck. A video of Ms Bernie O'Reilly, chairperson of PFPSI, was produced and communicated to all services through an email broadcast to the system, LinkedIn and Twitter. Ms Lorraine Walsh, a patient affected by matters arising in CervicalCheck, was a speaker at the event.

Training and Education: There is a patient representative on the oversight group for the development of the Open Disclosure e-learning modules on HSELanD. Module 1 includes a video of a patient representative talking about open disclosure, her experience and the importance of the policy. Quotes from patients are used in all training and education programmes.

The development of a patient and/or family experience questionnaire: A questionnaire was developed in 2019 to capture the experience of patients, service users and their families on open disclosure. This questionnaire was developed in collaboration with a number of patient representatives.

Co-presentation at events: The National Open Disclosure Team continually promotes the involvement of patients and the learning from patient stories at local and national events. The National Open Disclosure Programme lead co-presented an open disclosure workshop with Ms

Bernie O'Reilly at the Pharmaceutical Society of Ireland road show for the launch of the revised code of conduct for pharmacists.

Presentations to Patient Representative Groups:

Presentations on open disclosure and the legislation were provided to PFPSI and to the National Patient Forum during 2019.

Patient Safety Complaints Advocacy Training for the National Open Disclosure Office Staff:

Two members of the National Open Disclosure Team have enrolled for the Level 7 course on Patient Safety Complaints Advocacy in January 2020. This is a new course being facilitated through the Open Training College.

Section 9: Stakeholder Involvement

The HSE National Open Disclosure Team works actively with a multitude of internal and external stakeholders, including patient representative groups, on an on-going basis as part of the implementation strategy for the National Open Disclosure Policy and programme. This work involves meetings, supportive communications, responding to queries, supporting local policy development, attending training days, delivering training and supporting the delivery of training, speaking at study days and conferences, attendance and presentations at grand rounds and providing feedback on work streams and documents.

The following is a list of *some* of the engagements in 2019 with various internal and external stakeholders:

Royal College of Physicians Ireland (RCPI)	• Facilitation of Open Disclosure Workshop for NCHDs. • Provision of input to the Communication Programme for Medical Staff. • Facilitation of Open Disclosure workshop to attendees of the Diploma in Leadership and Quality for Community Care. • The RCPI were invited to nominate a representative for the National Open Disclosure Steering Committee – to be confirmed.
Royal College of Surgeons Ireland(RCSI)	• Full day open disclosure workshop facilitated as part of the RCSI Human Factors Programme. • The National Open Disclosure Steering Committee includes representation from the RCSI. • There is representation from RCSI on the oversight group for the open disclosure e-learning programmes.
University College Dublin (UCD)	• Open disclosure workshop and assessments of candidates on the Graduate Diploma in Quality and Risk Management.
Pharmaceutical Society of Ireland (PSI)	• Participation in the development of the revised code of conduct for pharmacists. • Presentation on Open Disclosure at PSI road show in Galway as part of the launch of the new code.
Medical Protection Society (MPS)	• Presentation on National Open Disclosure programme and legislation at MPS Conference. • Utilisation of MPS training materials and promotion of the MPS ASSIST Model of communication for managing open disclosure discussions with patients, service users and their families.
State Claims Agency (SCA)	• The National Open Disclosure Steering Committee includes representation from the SCA. • There is on-going communication with the SCA in relation to matters pertaining to open disclosure and

	the legislation. • There is representation from the SCA on the oversight group for the development of the open disclosure e-learning programmes.
Irish Medical Organisation (IMO)	• Presentation on Open Disclosure and legislation at the IMO annual general meeting in Killarney. • Presentation on Open Disclosure and legislation at the IMO national conference in Dublin.
Irish Hospital Consultants Association (IHCA)	• Updates provided on the implementation of legislation and the open disclosure training programme.
The College of Psychiatrists of Ireland	• Workshop on open disclosure facilitated at national conference. • Update on open disclosure programme and legislation provided.
General Practice	• Meetings with ICGP in relation to open disclosure training for GP Trainees and GP Principals. • Presentation on open disclosure and legislation and focus group on open disclosure as it relates to general practice. • Support provided to GP Trainer in the facilitation of an open disclosure programme to the CME group.
Medical Council	• 2 meetings with the Medical Council to update on (i) implementation of Open Disclosure Policy and legislation and (ii) training programme for medical staff.
Federation of Voluntary Bodies (FedVol)	• Open disclosure workshop facilitated at FedVol study day. • Train the trainer facilitated for staff working in 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. • Meeting with CNME Directors regarding open disclosure training.
Irish Epilepsy Nurses Association	• Presentation on open disclosure and legislation at national conference.
Patients for Patient Safety Ireland	• Continuous communication with the chairperson of PFPSI. • Presentation to PFPSI on open disclosure programme and legislation. • Consultation on the revision of National Open Disclosure Policy. • Consultation and collaboration on the development of a patient/family experience questionnaire. • Representation of PFPSI on National Open Disclosure Steering Committee.

	• Representation of PFPSI on the oversight group for the open disclosure e-learning programmes.
Irish Patients Association	• Meeting and telephone communication to update on Open Disclosure Policy, programme and legislation.
National Patient Forum	• Presentation on National Open Disclosure programme, policy and legislation at National Patient Forum meeting in Dublin.
National University of Ireland, Galway (NUIG)	• Presentation at national workshop in relation to open disclosure and legislation organised by Dr Dara Byrne.
University Hospital Limerick	• Presentation on open disclosure and legislation at Quality Improvement Conference.
Letterkenny University Hospital	• Presentation on open disclosure and legislation at Quality Improvement Conference.
HSE National Human Resources (HR) Team	• Facilitation of 5 hour workshop on open disclosure and legislation to National HR staff.
The National Doctors Training Programme (NDTP)	• The National Open Disclosure Steering Committee includes representation from the NDTP. • The NDTP has been supporting the National Open Disclosure Team in setting up and promoting mandatory open disclosure training arrangements for NCHD's through the Doctors Integrated Management System / National Employment Record (DIME / NER).
Mater Misericordiae University Hospital	• Presentation at grand rounds on open disclosure and legislation. • Meeting with executive committee. • Meeting with Hospital Board.
St Vincent's University Hospital	• Presentation on open disclosure and legislation at grand rounds on two occasions.
Mayo University Hospital	• Co facilitated workshop on incident management and open disclosure for senior management staff, consultants and NCHD's.
Cavan Hospital	• Full day programme of briefing sessions on open disclosure and legislation to senior management and staff.
National Screening Services (NSS)	• Facilitation of Open Disclosure workshop for NSS managers and staff.

Section 10: Applying the Principles of the HSE Open Disclosure Policy to practice – Specific examples of practice and learning we derived.

The following are some examples of the management of the principles of Open Disclosure across various settings in the HSE. These scenarios, which do not contain identifiable patient data, demonstrate many of the critical components involved in the open disclosure process and how this process contributes to learning and quality improvement. The feedback on the scenarios and learning derived has been provided by the services/staff involved.

1: Applying the Principles of Open Disclosure to the Communication of the RCOG results to the women and families affected.

The National Open Disclosure Team were invited to participate in the provision of support, guidance, resources and training for the teams involved in the communication of the RCOG results to the women and/or families affected. This was part of a wider information and preparation programme. The aim of the information and training programme was to (i) provide a standardised approach to the communication process and structure of the meetings, (ii) ensure that the teams involved were adequately informed of the background to and context of the meetings, (iii) ensure that the teams were adequately prepared for the meetings, (iv) ensure that the meetings were conducted in a compassionate manner (v) discuss the importance of using a structured process that must also take into account the individual story/ circumstances of each patient/family involved and (vi) prepare the team in relation to the management of certain situations that could arise during the course of the meetings e.g. managing distress/anger/anxiety, managing requests for the meeting to be recorded and/or to have legal representation present, managing requests for a copy of medical records to be obtained and managing frequently asked questions. The ultimate aim was to ensure that the communication process was managed in an open, informed, empathic, compassionate manner and that every effort was made to meet the needs and expectations of the women and/or families involved.

A specific training programme and meeting checklist were developed by the national open disclosure team. The training programme was informed by the HSE open disclosure policy and guidance and the MPS ASSIST model of communication. Five training programmes, which were very well attended, were delivered in various sites across the country.

General feedback from staff who attended the training sessions and who conducted the meetings was that the information and training programme contributed significantly to the management of the meetings and that the ASSIST Model of communication was very helpful in providing structure to the communication process.

Learning: (i) The impact of adequate preparation and training on open disclosure meetings.

This scenario highlights the importance of the accessibility by all staff to open disclosure training generally and to accessing specific 1-1 or team on-site training in preparation for open disclosure

meetings, when required. This is sometimes referred to as "just in time" training in other jurisdictions. The role of the open disclosure trainers and leads across the HSE includes providing 1-1 support for staff/teams on the ground, when required, to assist them in preparing for and managing open disclosure meetings. Open disclosure trainers and leads frequently provide this level of support which is very effective. Adequate preparation for open disclosure meetings for the open disclosure team and for the patient and family is critical and if managed well will lead to a better experience for all those involved in the meeting.

2. Acute Hospital: Case Scenario 1

Incident: Prescribing error on discharge prescription from acute hospital leading to an adverse outcome for the patient.

Open disclosure of the above incident was managed by the hospital in accordance with the HSE Open Disclosure policy. The hospital staff became aware of the incident when the patient was readmitted to the hospital and the error became apparent. The error was acknowledged immediately and an apology provided. A review of the incident was undertaken and a formal open disclosure meeting was arranged at a later stage. Preparation for the formal open disclosure meeting included the appointment of a designated person who liaised with the family in advance of the meeting.

The open disclosure documentation template, which is available on the HSE Open Disclosure website, was used as a guide to ensure that all of the components of an effective open disclosure conversation were addressed during the meeting. The meeting was attended by 3 family members, a patient advocate, the Consultant in charge of the patient's in-hospital care and the QPS Manager who is also the on-site open disclosure lead and was the assigned designated person for this patient and family. The error and the physical and psychological impact on the patient and family, as a consequence of the error, was fully acknowledged and a sincere apology was provided. The consultant accepted responsibility for the prescribing omission that had occurred. A full explanation was provided in relation to how the error occurred and this involved providing documentation from the clinical record in relation to the same. Questions raised by the family were responded to openly and honestly. The meeting afforded the family the opportunity to tell their story and to voice other concerns that they had in relation to the care of their loved one by the hospital. The further concerns raised by the family were acknowledged by the team and a further apology provided in relation to the same. The family were reassured that the matters raised would be investigated and appropriate actions taken to address any deficits in care. A follow up meeting with the family was arranged with the QPS manager to discuss the concerns raised and to provide an update on actions arising from the review of care. Car parking exemption was provided by the hospital.

Learning: (i) The impact of open disclosure on patient safety and quality improvement. (ii) The role of the designated person.

(i) The impact of open disclosure on patient safety and quality improvement. This case scenario demonstrates the importance of open disclosure of the prescribing error, the learning from the error that had occurred and the action taken by the organisation to try to ensure that the error did not happen again to the patient involved and to other patients. The scenario also demonstrates how the open disclosure process provides an opportunity for the service to implement further learning and improvement from the additional information provided by the family through their story. The additional information provided by the family ultimately lead to an improved level of care being provided to the patient involved and to other patients. Examples of changes implemented by the hospital included a revised process for the management of discharge letters and prescriptions, the development and roll out of a new Medical Prescription Administration Record (MPAR) and an improved communication process being set up between the team and General Practice. **(ii) The role of the designated person.** In the scenario above the designated person assisted the family in preparing for the open disclosure meeting, attended the meeting as a person who had an established relationship with the family and as a support to both the family and consultant during the meeting. The designated person maintained communication with the family and patient keeping them updated and providing continued support after the meeting. The appointment of a designated person (key contact person) is a critical component in the incident review and open disclosure process.

3. Acute Hospital: Case Scenario 2

Incident: Missed diagnosis

Open disclosure of the above incident was managed by the hospital in accordance with the HSE Open Disclosure policy. The hospital staff became aware of the incident when the patient was subsequently readmitted to the hospital on the day after the incident (missed diagnosis) had occurred and required emergency surgery. The incident was acknowledged to the patient on the day following surgery and an explanation and apology was provided at this stage. A further formal open disclosure meeting was arranged following the review of the incident. The designated person contacted the patient in the interim period and liaised with the patient in relation to setting up the meeting.

The open disclosure documentation template, which is available on the HSE Open Disclosure website, was used as a guide to ensure that all of the components of an effective open disclosure conversation were addressed in the meeting. The meeting was attended by the patient who, although had been advised to bring a support person with them, stated that he/she preferred to attend alone. The meeting was attended by the QPS lead (who was also the designated person in this scenario) and the consultant in whose care the diagnosis had been missed. The patient had another underlying medical problem requiring surgical intervention. The error and the physical and psychological impact on the patient and family, as a consequence of the error, was fully acknowledged and a sincere apology was provided. A full explanation was provided in relation to how the error had occurred. The consultant acknowledged that while the surgery would have been required the previous day, it would have been planned surgery and the emergency situation would

have been avoided. Reassurance was provided in relation to the learning that had occurred from the incident and how this learning has been shared in an effort to try to prevent a recurrence of the incident. The patient expressed anxiety in relation to their underlying medical problem which had contributed to the misdiagnosis and which was still not addressed. It was established that the patient was listed for a surgical appointment and consent was obtained to follow this up on his/her behalf and to arrange an immediate appointment. The meeting notes detailing the salient points of the discussion that had occurred, the apology provided and actions agreed were sent to the patient for validation and agreement. A follow up meeting was arranged with the patient and there was follow through on the actions agreed. The patient's surgery took place within one month following the meeting.

Learning: (i) The importance of making reparation to the patient following patient safety incidents and (ii) The need to consider the balance between staff members and patient/family members attending open disclosure meetings.

(i) The importance of making reparation to the patient following patient safety incidents

This scenario highlights the importance of following through on actions agreed with the patient as part of the reparation process following a patient safety incident. Experiencing open disclosure and particularly receiving a sincere and meaningful apology can be very healing for the patient and helps to maintain their trust and confidence in healthcare generally and in the service providing the care to them at that time. In this scenario the patient's underlying medical condition was still a matter of great concern for them and the actions proposed and follow through on these actions to address this concern were greatly appreciated by the patient. It is important that patients are included in and have input to solutions and actions that are proposed in response to patient safety incidents and that their story, will and preferences are heard.

(ii) The number of attendees at open disclosure meetings

In this scenario the open disclosure team were concerned that the patient was attending the meeting without a support person despite their recommendation that the patient would benefit from the support of a trusted family member or friend. In an effort to provide as supportive an environment as possible it was agreed that the open disclosure team would be reduced to 2 members of staff (one male, one female) including the designated person with whom the patient had an established rapport. The team also discussed, in advance of the meeting, how they would manage the situation should the meeting cause any distress to the patient. The team respected the patient's wishes to attend alone and the meeting went well. It is important to consider the balance in relation to the number of staff members (and their genders) and family members attending the meeting as if there are a large number of staff present in the room and no gender balance the patient may feel uncomfortable. The patient should be informed in advance of the meeting who they will be meeting and their roles.

4. Community Healthcare Organisation: Case Scenario 3

Incident: Look back review in relation to poor outcomes and misdiagnosis leading to a requirement for Multiple Disclosures

The look back review began when a preliminary assessment, which had been carried out through the auditing of care, identified a number of people as potentially having had poor outcomes. Each of these cases indicated a requirement for Open Disclosure. The level of harm at this stage was unknown and therefore a letter was written to each of the people concerned. This letter carried an apology, details of how to contact a helpline and information regarding a recall stage.

All staff involved, from those manning the helpline to external clinicians assisting with the recall stage, were provided with training on open disclosure which included guidance on how to deliver a meaningful apology and factual explanation in relation to what had happened. Every person that attended a recall appointment received a verbal apology and was offered an opportunity to attend a more formal meeting with a clinician and a senior manager. One formal meeting was requested at this stage of the recall and the forms (Civil Liability Amendment Act Forms) were used for the first time by the health services provider. At this meeting the process for using the legal documentation was followed closely. It was reported as being cumbersome and awkward and that it over formalised a situation that required a more personalised approach. A softer approach was adopted at subsequent meetings. The client did accept the paperwork with the apology written on it, but did question the motivation around the form.

What was more important for the client was the opportunity to receive honest answers to their questions and to be involved as an equal partner in the process. Documentation recorded at the meeting was sent in draft form to the client after the meeting for verification and then the final notes were sent. This was important in gaining trust and agreement and it informed future Open Disclosure meetings.

A series of formal Open Disclosure meetings were held with those individuals (and their families/guardians) who were identified as having experienced harm. These meetings were conducted as per the HSE Open Disclosure policy (2019) and the Civil Liability Amendment Act (CLA) (2017).

Each meeting began with an explanation of the formal documentation (CLA form), the apology being read and the documentation being given to the respective client. On more than one occasion the client refused the formal document preferring the integrity of a verbal apology, they felt they did not need another apology in writing. One family member expressed it best when he stated:-

“Will you stop apologising? It is in every letter, every phone call, even the woman on the helpline…”

This client refused the CLA form and in keeping with the legal process a second legal form was completed to indicate that the client refused the legal documentation. The records of the meetings which were sent to the clients and which contained the apology were more readily accepted by the clients than the CLA Forms.

At the end of the look back review a large cohort of people had been communicated with at both low level and high levels of open disclosure and the response had been one of continued trust, engagement and greater understanding on both sides with little or no litigation. The service reported that this approach supported a method of continuous open engagement rather than a formal legal process when things go wrong.

Learning:

- Open engagement should be standard practice long before any formal meeting and should be visible in all communications such as letters/phone calls/ face to face meetings.
- The client must be an equal partner in the process from day one.
- The act of being genuinely sorry does not come across in a pre-written apology.
- There is a need to be able to communicate an apology at every level of progression of the open disclosure process, with or without CLA forms.
- The production of an official form at the beginning of an open disclosure meeting tended to detract from how open the service had been in communications prior to the meeting.
- The written records of the meetings and the production of those records afterwards was of far greater importance to the clients than receiving a prepared statement or CLA form.

5. Acute Hospital: Scenario 4

Poor communication following the death of a patient

The condition of an elderly gentleman with a chronic condition, who had been in hospital for about two weeks, deteriorated quickly over a weekend and he died. His family were understandably upset as although they knew he was ill they did not expect him to die and they were not with him at the time of his death.

The family made a number of requests to meet with the patient's team under whose care the patient was at that time. The consultant declined to meet with the family as he was not on duty on the weekend when the patient died and a review of the patient's death indicated that he had died as a result of his underlying condition. There was no evidence that any clinical incident had occurred and the review indicated that the patient received the appropriate level of care. There was a delay of a number of weeks after which the Clinical Director agreed to meet with the family.

The family were very upset and distressed at this meeting. They wanted an explanation in relation to what happened and why the patient died so suddenly. They were also upset that the consultant who had been caring for him did not attend the meeting and had refused to meet with them. The Clinical Director answered their questions and provided an overview of the patient's care and treatment up to the time of his death. He also expressed his condolences to the family. The family requested a copy of his medical record and this was facilitated.

Learning:

(i) The failure of the patient's consultant to meet with the family at the earliest opportunity, following their request, caused increased distress, anger and loss of trust and confidence in the service. Open and timely communication is key and prevents misconceptions occurring in relation to the care and treatment provided to patients.

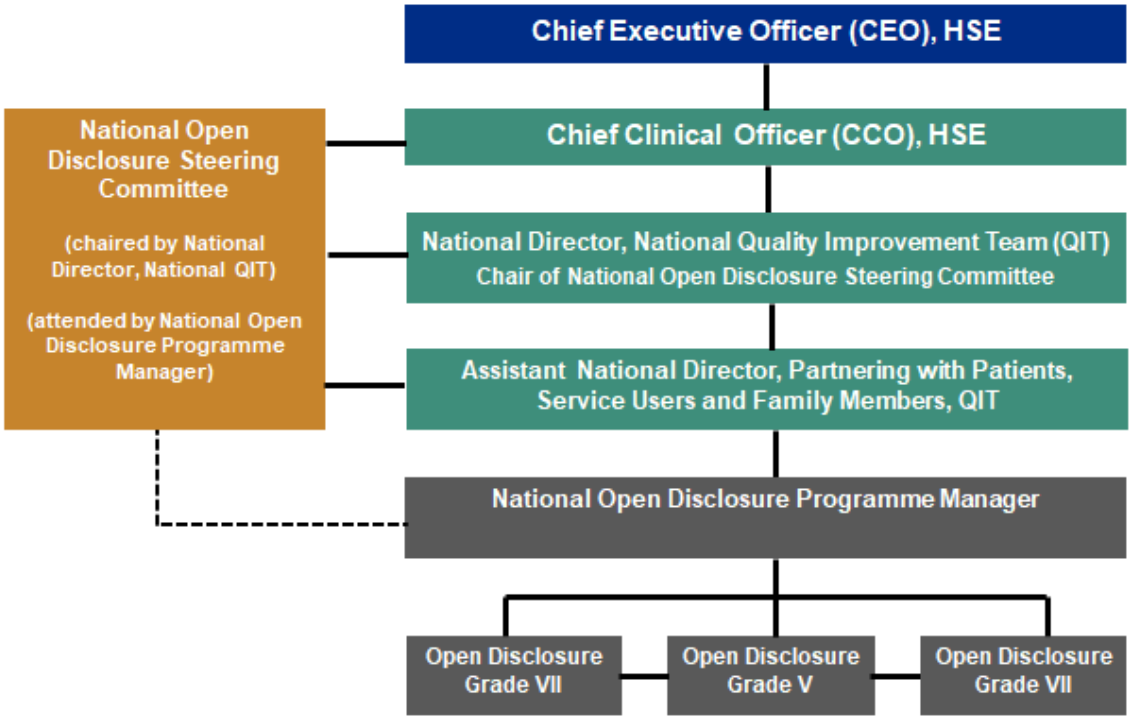
(ii) It is important to establish the expectations of the family prior to the meeting and to address these during the meeting.

(iii) Even though the meeting was conducted very professionally by the Clinical Director and other members of the hospital team, the absence of the patient's own consultant and the delay experienced by the family had a negative impact on the outcome of the meeting. This could have been avoided.

Appendix A: National Open Disclosure Office Organogram

National Open Disclosure Programme

National Open Disclosure Office Organogram



Appendix B: Membership of National Open Disclosure Steering Committee

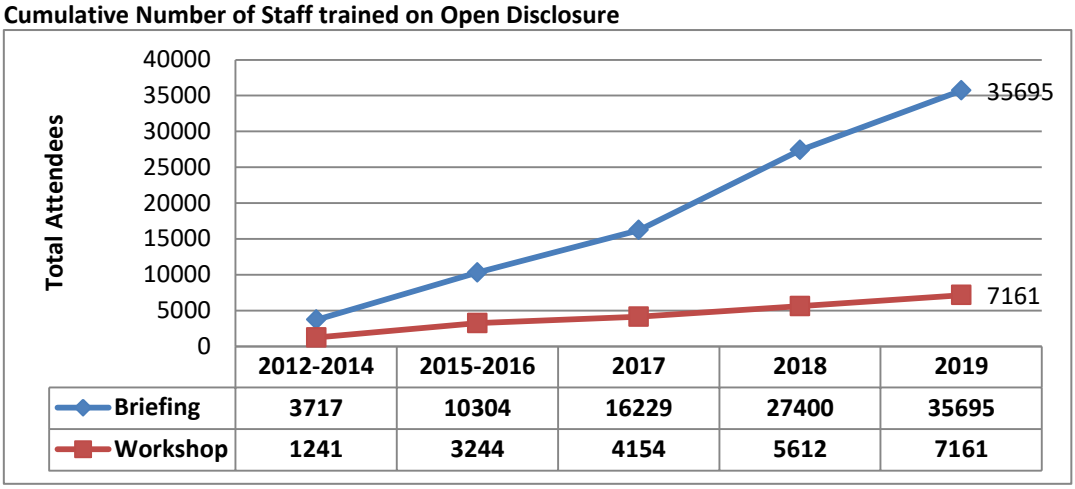
Name	Role	Membership Date
Dr. Philip Crowley (Chairperson)	National Director	30/04/19
Mr Greg Price	Assistant National Director, National Quality Improvement Team	30/04/19
Eileen Ruddin	A/AND of Performance and Contracting	30/04/19
Margaret Brennan	National QPS Lead Acute Operations	30/04/19
Cathal O'Keeffe	State Claims Agency, Head of CIS	30/04/19
Professor Ann O'Doherty	Clinical Director, BreastCheck	30/04/19
Anne Marie Kiernan	Quality, Risk & Patient Safety Manager, NSS	30/04/19
Martin Dunne	National Director, NAS	30/04/19
Margaret Casey	Acting Area Director, DML / Director, Nursing and Midwifery Planning and Development Unit - Midlands	04/12/19
Mary Samuel	Development Manager, National Health and Social Care Office	30/04/19
Cornelia Stuart	Assistant National Director, Quality Risk & Safety, QAVD	30/04/19
JP Nolan	Head of Quality and Patient Safety Community Services	30/04/19
Professor Frank Murray	Director, National Doctors Training & Planning	30/04/19
Dr. Susan Kent	National HR	30/04/19
Colette Cowan	CEO University Limerick Hospital Group	30/04/19
Bernadette O'Reilly	Patient Representative	30/04/19
Stephen Teap	Patient Representative	30/04/19
Dr David Vaughan	QPS Lead, Children's Group	02/07/19
Professor John Hyland	RCSI	04/12/19
Kate Killeen White	Chief Officers	19/12/19
TBC - Nomination sought	RCPI	
Attended by: Angela Tysall	Programme Manager, Open Disclosure Office	
Note taker: Kelly McDyer	Administrator, Open Disclosure Office	

Appendix C: Membership of Performance Measurement Committee

Name	Role	Service
Angela Tysall	National Open Disclosure Lead	National Open Disclosure Office, NQIT
Mary Friel	Trainer and Educator	National Open Disclosure Office, NQIT
Catherine Hand	Trainer and Educator	National Open Disclosure Office, NQIT
Gareth Clifford	Quality, Standards and Compliance Officer	Acute Operations
Irene O'Hanlon	General Manager QPS	National QPS, Community Operations
Margaret McGarry	Office of Quality, Risk & Safety	Quality and Verification Division
Dr Susan Kent	National OD Steering Committee Representative	National HR
AnneMarie Kiernan	Quality, Risk & Patient Safety Manager	National Screening Services
Annemarie Oglesby	QPS Lead	NAS
Carley Impey	HSE Business Intelligence Unit, Team Lead	HSE Business Intelligence Unit
Brid Ann O'Shea	NIMS, Office of Operations	Quality Assurance and Verification Division
Dr Jennifer Martin	Evidence for Improvement Lead	National Quality Improvement Lead
Ann Duffy	Senior Clinical Risk Manager	State Claims Agency

Appendix D: Training Report 31st December 2019

Cumulative Number of Staff trained on Open Disclosure

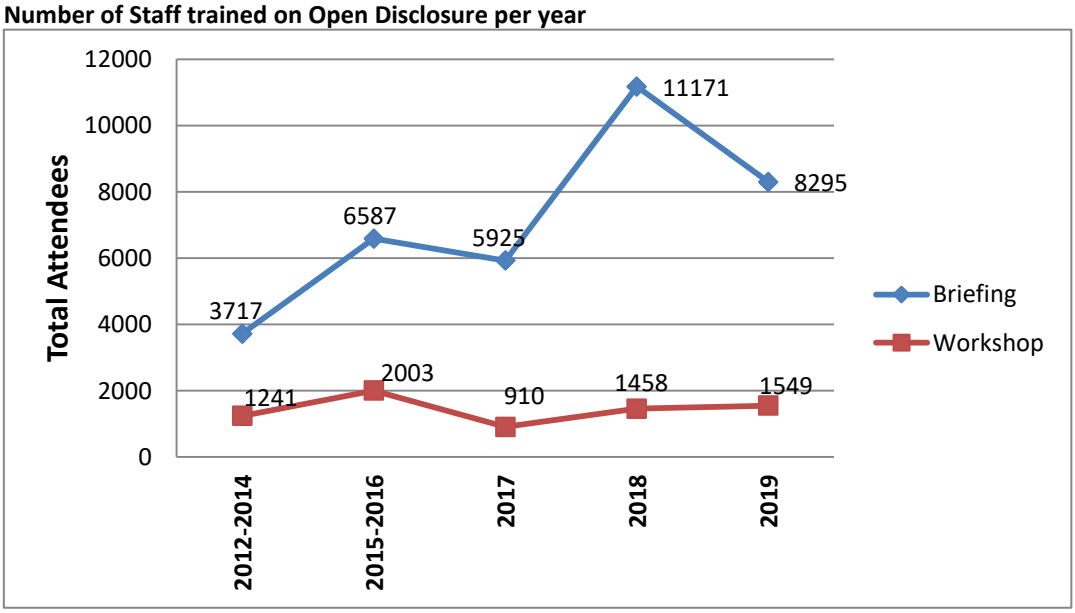


	2012-2014	2015-2016	2017	2018	2019
Briefing	3717	10304	16229	27400	35695
Workshop	1241	3244	4154	5612	7161

Number of staff trained on Open Disclosure grew from a total of 4,958 (end of year 2014) to 42,856 (end of year 2019)

Total trained: 42,856

Number of Staff trained on Open Disclosure per year



Training was paused in 2019 as a result of the launch of the revised policy in June 2019 and the alignment of the policy with the relevant legislation.

A number of Trainer & Lead update days were facilitated to provide updates on the revised policy and the adjustments to the national training programme. Training recommenced following these updates.

Training provided / facilitated by the National Open Disclosure Office

	2019 BRIEFING	2019 WORKSHOP	2019 TOTAL BRIEFING / WORKSHOP	TOTAL BRIEFING TO DATE	TOTAL WORKSHOP TO DATE	OVERALL TOTAL WORKSHOP / BRIEFING
Training delivered by the National Open Disclosure Office	1150	228	**1378**	3551	1341	**4892**

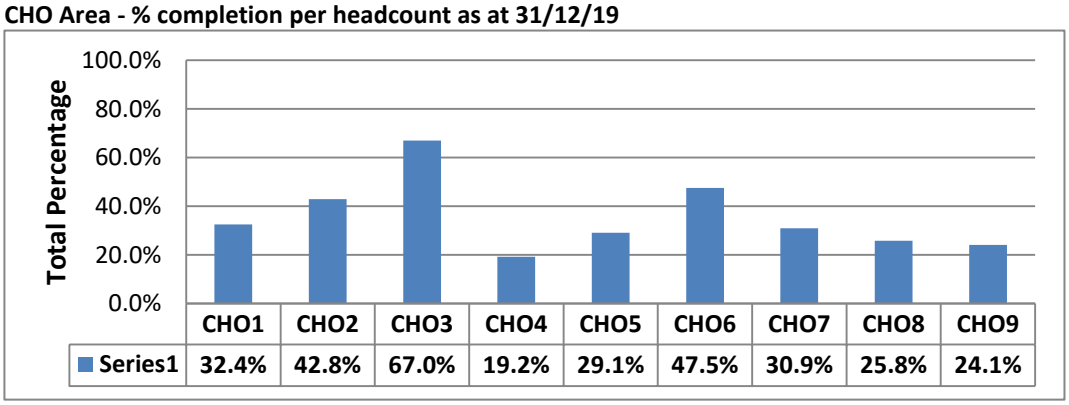
- In **2019**, the National Open Disclosure Office delivered training to **1378** people.
- This brings the **overall total** of people trained by the office since the recording of training to **4892**.
- This includes train the trainer programmes delivered by the National Open Disclosure Office and also presentations on Open Disclosure at conferences, grand rounds, study days etc.

National Open Disclosure Train the Trainer Programme

- In 2019, 111 people were trained through the Train the Trainer (TTT) programme and subsequently added to the Open Disclosure Trainer's Database.
- As of 31st December 2019 there are 354 trainers on the database representing Hospital Groups, CHO Areas, National Ambulance Service, National Screening Services, and Federation of Voluntary Agencies.
- Work commenced on a data cleanse of the trainer's database to identify and remove trainers who are not actively training.
- As of 31st December 2019 there are 354 trainers on the database representing Hospital Groups, CHO Areas, National Ambulance Service, National Screening Services, and Federation of Voluntary Agencies.

Training Overview for staff from HSE Community Healthcare Organisations

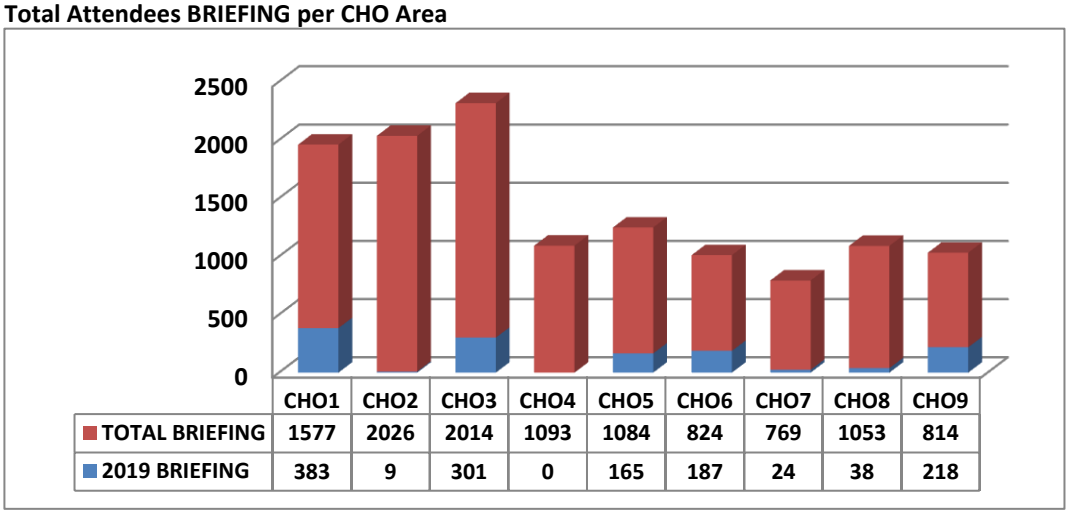
CHO Area - % completion per headcount as at 31/12/19



	CHO1	CHO2	CHO3	CHO4	CHO5	CHO6	CHO7	CHO8	CHO9
Series1	32.4%	42.8%	67.0%	19.2%	29.1%	47.5%	30.9%	25.8%	24.1%

In total there has been 13,677 staff who have attended a briefing and/or workshop in CHO Areas. Based on a combined headcount* of 42,175 for CHO Areas this is an average of **32.4% completion rate for CHO Areas**. Breakdown of completion per CHO Area is outlined in the figure to the left.

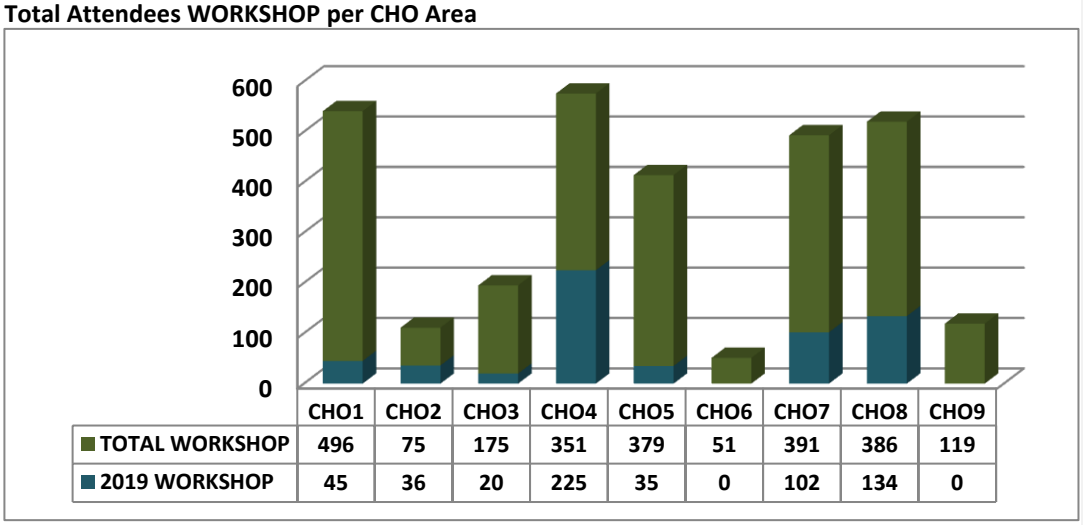
Total Attendees BRIEFING per CHO Area



	CHO1	CHO2	CHO3	CHO4	CHO5	CHO6	CHO7	CHO8	CHO9
TOTAL BRIEFING	1577	2026	2014	1093	1084	824	769	1053	814
2019 BRIEFING	383	9	301	0	165	187	24	38	218

Total number of staff who attended a briefing in CHO Area for 2019 and overall total

Total Attendees WORKSHOP per CHO Area



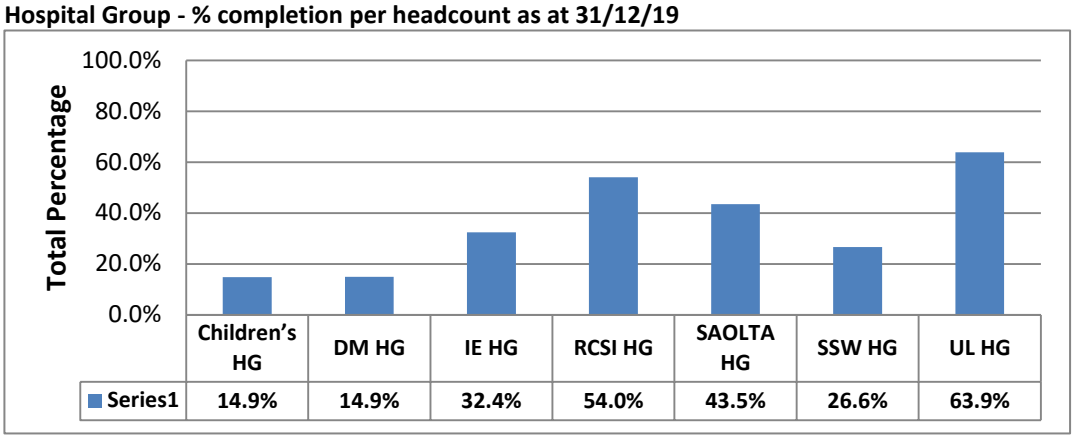
	CHO1	CHO2	CHO3	CHO4	CHO5	CHO6	CHO7	CHO8	CHO9
TOTAL WORKSHOP	496	75	175	351	379	51	391	386	119
2019 WORKSHOP	45	36	20	225	35	0	102	134	0

Total number of staff who attended a workshop in CHO Areas for 2019 and overall total

(*Headcount figures extracted from the HSE Children's First Data E-Learning Report December 2019, which references the data from Health Service Personnel Census, October 2019)

Training Overview for staff in HSE Hospital Groups

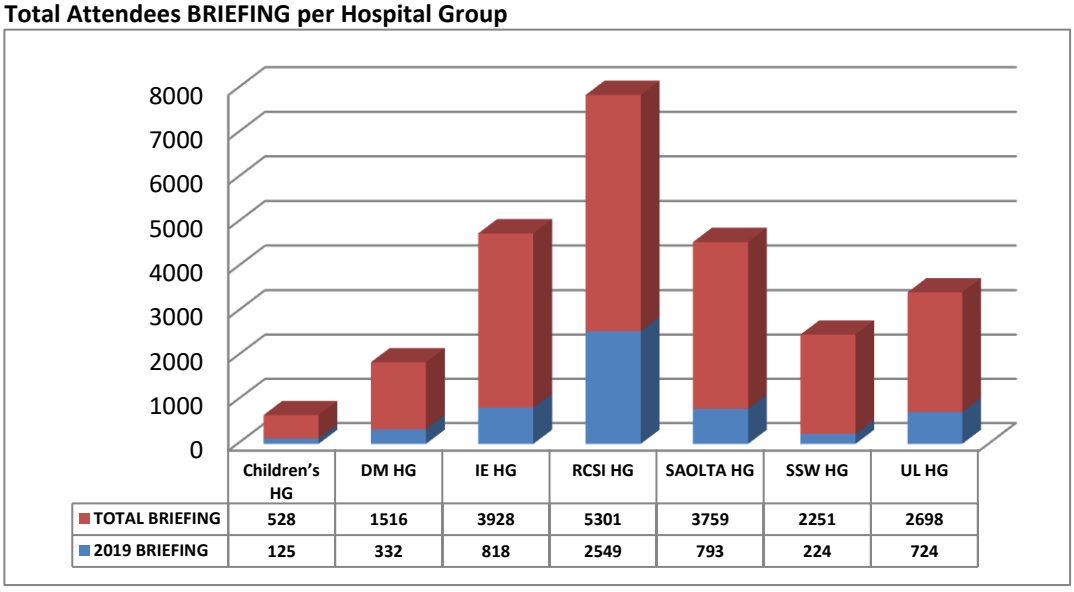
Hospital Group - % completion per headcount as at 31/12/19



	Children's HG	DM HG	IE HG	RCSI HG	SAOLTA HG	SSW HG	UL HG
Series1	14.9%	14.9%	32.4%	54.0%	43.5%	26.6%	63.9%

In total there has been 23,183 staff who have attended a briefing and/or workshop in a HSE Hospital Group. Based on a combined headcount* of 67,196 for all hospital groups this is an average of **34.5% completion rate in Hospital Groups**. Breakdown of completion per Hospital Group is outlined in the figure to the left.

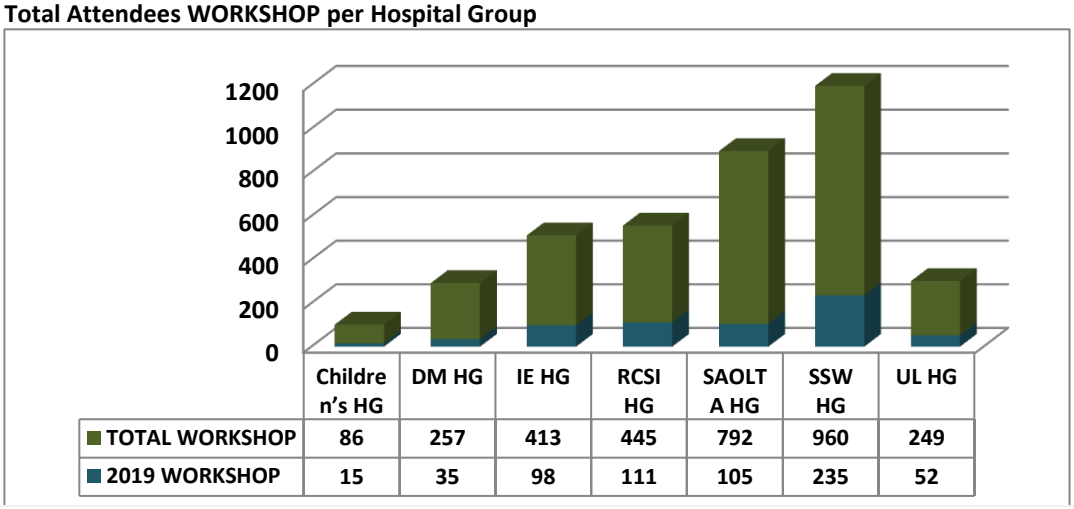
Total Attendees BRIEFING per Hospital Group



	Children's HG	DM HG	IE HG	RCSI HG	SAOLTA HG	SSW HG	UL HG
TOTAL BRIEFING	528	1516	3928	5301	3759	2251	2698
2019 BRIEFING	125	332	818	2549	793	224	724

Total number of staff who attended a briefing in a Hospital Group for 2019 and overall total

Total Attendees WORKSHOP per Hospital Group



	Childre n's HG	DM HG	IE HG	RCSI HG	SAOLT A HG	SSW HG	UL HG
TOTAL WORKSHOP	86	257	413	445	792	960	249
2019 WORKSHOP	15	35	98	111	105	235	52

Total number of staff who attended a workshop in a Hospital Group for 2019 and overall total

(*Headcount figures extracted from the HSE Children's First Data E-Learning Report December 2019, which references the data from Health Service Personnel Census, October 2019)

Training Overview for National Ambulance Service

	2019 BRIEFING	2019 WORKSHOP	2019 TOTAL BRIEFING / WORKSHOP	TOTAL BRIEFING TO DATE	TOTAL WORKSHOP TO DATE	OVERALL TOTAL WORKSHOP / BRIEFING
National Ambulance Service	47	0	**47**	701	122	**823**

Training Overview for National Screening Services

	2019 BRIEFING	2019 WORKSHOP	2019 TOTAL BRIEFING / WORKSHOP	TOTAL BRIEFING TO DATE	TOTAL WORKSHOP TO DATE	OVERALL TOTAL WORKSHOP / BRIEFING
SCREENING SERVICES	0	39	**39**	0	39	**39**

Training Overview for Voluntary Agencies

	2019 BRIEFING	2019 WORKSHOP	2019 TOTAL BRIEFING / WORKSHOP	TOTAL BRIEFING TO DATE	TOTAL WORKSHOP TO DATE	OVERALL TOTAL WORKSHOP / BRIEFING
VOL AGENCIES	208	34	**242**	208	34	**242**

Open Disclosure Training for Consultants / NCHDs

2019* **Briefing** attendance Consultants / NCHDs	1,287
2019* **Workshop** attendance Consultants / NCHDs	258
Total Consultants / NCHDs Trained	**1,545**

Note:

- Figures are reflective for training which took place between February 2019 and December 2019 as attendance data for Consultants / NCHDs was not broken down / recorded pre February 2019

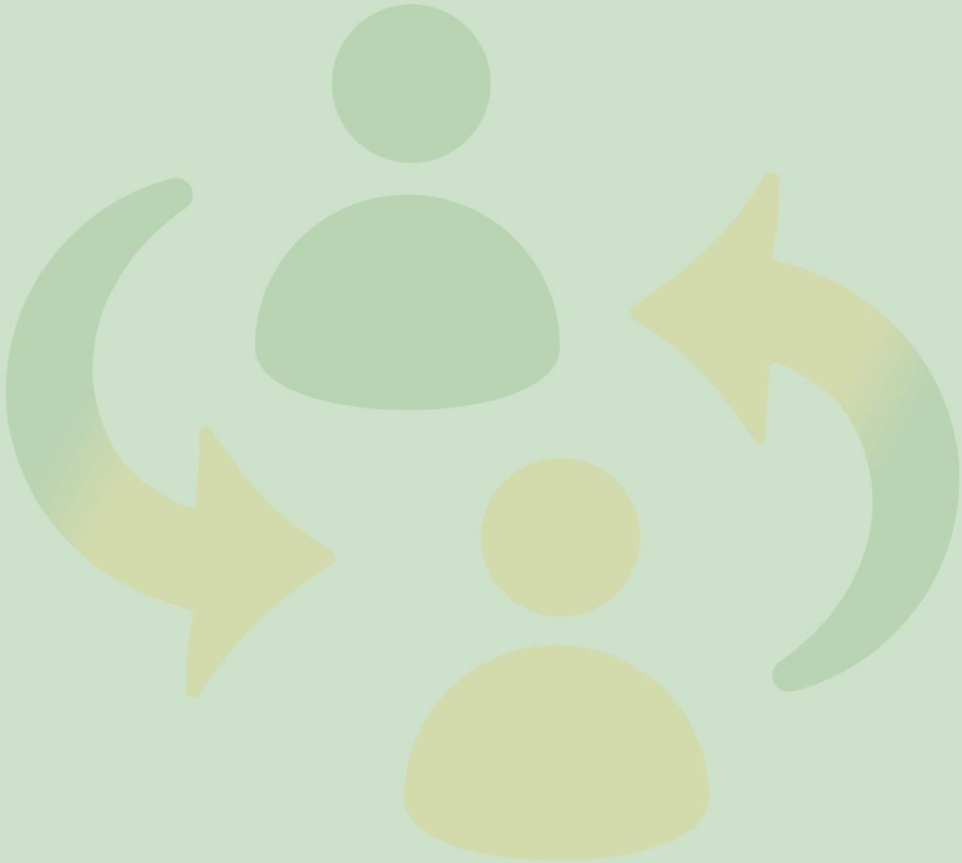
- From July 2019 trainers started to record and identify specifically whether a Consultant or NCHD attended a briefing and/or workshop

Summary Breakdown per area – 2019 & Total to Date

	2019 BRIEFING	2019 WORKSHOP	2019 TOTAL BRIEFING / WORKSHOP	TOTAL BRIEFING TO DATE	TOTAL WORKSHOP TO DATE	TOTAL WORKSHOP / BRIEFING TO DATE
CHO1	383	45	**428**	1577	496	**2073**
CHO2	9	36	**45**	2026	75	**2101**
CHO3	301	20	**321**	2014	175	**2189**
CHO4	0	225	**225**	1093	351	**1444**
CHO5	165	35	**200**	1084	379	**1463**
CHO6	187	0	**187**	824	51	**875**
CHO7	24	102	**126**	769	391	**1160**
CHO8	38	134	**172**	1053	386	**1439**
CHO9	218	0	**218**	814	119	**933**
Children's HG	125	15	**140**	528	86	**614**
DM HG	332	35	**367**	1516	257	**1773**
IE HG	818	98	**916**	3928	413	**4341**
RCSI HG	2549	111	**2660**	5301	445	**5746**
SAOLTA HG	793	105	**898**	3759	792	**4551**
SSW HG	224	235	**459**	2251	960	**3211**
UL HG	724	52	**776**	2698	249	**2947**
NAS	47	0	**47**	701	122	**823**
SCREENING SERVICES	0	39	**39**	0	39	**39**
VOL AGENCIES	208	34	**242**	208	34	**242**
CORPORATE	1150	117	**1267**	3551	868	**4419**
TTT	n/a	111	**111**	n/a	473	**473**
TOTAL	**8295**	**1549**	**9844**	**35695**	**7161**	**42856**

Note:

- Open Disclosure Training is mandatory for all staff. It is the responsibility of each service to ensure that staff are trained in this area and to maintain local records.
- The high level data in this report can be used as a guide to inform services of training data available to the National Open Disclosure Office. The data provided in this report is dependent on the data entered by open disclosure trainers on the National Open Disclosure Training Database. This data can only be as accurate as the data uploaded by trainers.
- Headcount figures were extracted from the HSE Children's First Data E-Learning Report December 2019, which references the headcount data from Health Service Personnel Census



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

Email: *opendisclosure.office@hse.ie*

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National Quality Improvement Team