Draft HSE Open Disclosure Policy - 2024 Consultation

Personal Details

1. Name:
Vanessa Hetherington, Assistant Director, Policy and International Affairs **Irish Medical Organisation**

2. Role: (please select relevant option)		
1	Patient/family member	
2	Patient advocate	
3	Staff nurse	
4	Doctor	
5	Allied health professional	
6	Quality and Patient Safety Manager (includes QSSI, QPS, Risk staff working in this area)	
7	Middle management	
8	Senior/executive manager	
9	Educator	
10	Regulator	
11	Other (please specify):	X

3. Are you completing this survey on behalf of an organisation or in a personal capacity?		
Answer Choices		
1	Organisation	X
2	Personal capacity	
3	Other (please specify):	

4. If completing on behalf of an organisation, what type of organisation		
Answer Choices		
1	Health and Social Care Provider	
2	Legislator	
3	Health and Social Care Service Regulator	
4	Professional Regulator	
5	Advocacy Organisation	
6	Academic Institution/Higher Education Institute	
7	Other (please specify):	Trade Union and Representative Body for all doctors in Ireland

Section A – What is Open Disclosure?

5. How should the policy address the objectives set out above for this section?

The IMO supports Open Disclosure whereby patients have the right to an apology and explanation when things go wrong. Doctors have a duty to be open, honest and transparent with patients, to reflect on adverse events and to take steps to ensure that such incidents are not repeated. However fear of litigation and damage to reputation continue to be major barriers to open disclosure and reporting of patient safety incidents. A highly adversarial medico-legal environment combined with a simplistic political and media discourse contribute to a blame culture whereby patient safety are distilled down to a clinical judgement while ignoring the multiplicity of factors which may have contributed to the outcome including insufficient staffing, delay in accessing the most appropriate investigations and subsequent treatments, the lack of provision for adequate clinics or theatre time, insufficient hospital bed capacity and infrastructure, lack of resources at General Practice level,..etc -

Concerted efforts by all stakeholders, including the HSE, must be made to move towards a more “just culture” in healthcare which recognises that mistakes can occur but acknowledges the systemic and environmental factors that contribute to an adverse event with a focus on learning. In a “just culture” reckless and negligent behaviour is not tolerated but healthcare staff are not held responsible for systemic failings over which they have no control .

The promotion of a Just Culture and avoiding a culture of blame is largely absent from the HSE Draft Guidance document until page 52.

5. How should the policy address the objectives set out above for this section?

6. Is there any information and guidance not included that should be considered?

The Policy Objectives should explicitly promote a Just Culture and avoid a culture of blame.
In addition to clear guidance on reporting factors that contribute to a just culture include:

- Recognition of the resourcing and systemic issues that contribute to patient safety incidents
- A system whereby senior decision makers and budget holders are held accountable in the same way as the medical profession.
- a supportive hospital environment and organisational culture,
- leadership from hospital management
- buy-in from clinical directors and clinicians
- sufficient resources within the hospital including a risk management department with expertise to support and engage clinical and non-clinical staff in Open Disclosure,
- good quality training
- A recognition that open disclosure, investigation and reporting of patient safety incidents as well as risk management takes time away from clinical duties

In the guidance there should be a discussion about medical harm ie that medicine in its own right carries risks and sometimes things happen that are unavoidable. The Guidance should emphasise the importance of information giving prior to a medical treatment and informed consent.

It is also important to emphasise that under the 2017 and 2023 acts that although the protected disclosure discussion that a doctor may have may have some protections but the information given can be used at a later date in a tort based civil claim.

7. Please list any specific edits/suggestions here. Please include the page number from the draft copy circulated.

The Policy Objectives should explicitly promote a Just Culture and avoid a culture of blame.

Again, although there may be some protections in open disclosure under the 2017 and 2023 Acts in relation to a discussion with the patient, the information given can be later used in a tort based civil claim.

7. Please list any specific edits/suggestions here. Please include the page number from the draft copy circulated.
The report should emphasise that when medical professionals are working in under resourced conditions which previously had been determined to be unsafe and prevents them from practising as per normal clinical guidelines or where a medical professional has been working unsafe illegal hours that this is recognised as the prominent contributing factor and that a senior member of management staff will also be present at the open disclosure meeting.

8. The draft Open Disclosure Policy 2024 includes the requirements of the Patient Safety Act and Department of Health National Open Disclosure Framework. Do you believe they should be incorporated in the policy?		
Answer Choices		
1	Yes	
2	No	
3	Don't know	
4	Other (please specify):	

9. Please share any additional comments / suggestions below

Section B - Open Disclosure Requirements

10. How should the policy address the objectives set out above for this section?

11. Is there any information and guidance not included that should be considered?

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12. Please list any specific edits/suggestions here. Please include the page number from the draft copy circulated.

2.5 lays out the roles and responsibilities of all staff in the HSE while Paragraph 2.5.10 lays out the role and responsibilities of the patients' principal health practitioner which may be the patient's consultant or General Practitioner and is responsible for leading the open disclosure process and disclosing the incident.

GPs are independent contractors and not employees of the HSE and there are no supports available to GPs in the Primary Care setting. While legislation and professionals ethical guidance regarding open disclosure applies to GPs, the HSE Open Disclosure policy does not. There can be no requirement on a GP to lead the open disclosure process regarding an incident that occurs in another service.

Furthermore, where a patient safety incident is a direct result of resource deficits and decisions made by, senior managers and budget holders, then they should be responsible for leading the Open Disclosure process.

13. Are all the roles and responsibilities adequately covered? If not, please highlight any roles and responsibilities that should be included.

Answer Choices		
1	Yes	
2	No	
3	Don't know	

14. The Department of Health (DoH) National Open Disclosure Framework 2023 introduces the requirement for health and social care service providers to complete an annual report on open disclosure and submit this to the Minister of Health. The Framework describes the requirements for the report (i.e. training compliance, total number of open disclosures completed, etc.). At what level of the organisation should these reports be produced (the DoH will be issuing templates for this purpose)

Answer Choices

14. The Department of Health (DoH) National Open Disclosure Framework 2023 introduces the requirement for health and social care service providers to complete an annual report on open disclosure and submit this to the Minister of Health. The Framework describes the requirements for the report (i.e. training compliance, total number of open disclosures completed, etc.). At what level of the organisation should these reports be produced (the DoH will be issuing templates for this purpose)		
1	National Open Disclosure Office Annual Report only	
2	Health Region	
3	Integrated Health Area	
4	Hospital, Care Service Provider (i.e. care home), service	
5	Don't know	
6	Other (please specify):	

15. Please share any additional comments / suggestions below

The IMO is unclear of the value in reporting on the total number of Open Disclosures completed as laid out in the National Open Disclosure Framework which may be open to misinterpretation. Arguably the reporting of appropriate, measurable data relating to improvements in Patient Safety and Quality of care would be more useful.

Indeed, a key element of open disclosure is to inform patients of learning and the measures that have been taken to prevent the incident from reoccurring, however, there is no requirement under the National Open Disclosure Framework for healthcare managers to report on these measures to the Minister.

Section C – When does open disclosure apply?

16. How should the policy address the objectives set out above for this section?

17. Is there any information and guidance not included that should be considered?

18. Do you agree with the requirements for open disclosure in relation to the different levels of harm/complications?		
Answer Choices		
1	Yes	
2	No	
3	Don't know	

19. Please list any specific edits/suggestions here. Please include the page number from the draft copy circulated.

20. Please share any additional comments / suggestions below
In relation to low level harm and no harm events it is important to balance the harms that information can do to the patients wellbeing where it may be of no consequence in the long run, or there is no answer, in these cases, we may be psychologically burdening patients with information that in itself may cause harm, and which the lack of the information would have made no material difference to them. Formalising a process gives weight to the information shared, which may not be appropriate for relatively irrelevant or unimportant information. Part of the duty of care and skill of the clinician is to focus on what is important, taking into account the patient's needs, wants and preferences.

Section D – The Open Disclosure Process

21. How should the policy address the objectives set out above for this section?

22. Is there any information and guidance not included that should be considered?

1) Factors such as hospital overcrowding, insufficient allocation of resources, understaffing, all contribute to patient safety incidents.

The IMO is concerned that there are significant imbalances in accountability and authority within our health system that impede quality and honest Open Disclosure with medical professionals often held accountable for incidents without the requisite authority while those with authority are rarely held accountable. Too often an adverse event occurs on a background of decisions made by senior managers in relation to the deployment or non-deployment of staff or resources. Often there are deficiencies in a system that are well known and documented, but not acted upon and only addressed when an adverse incident occurs. For example, health service managers are not held accountable in the same manner as medical professionals for non-compliance with the EWTD (European Working-Time Directive), gaps in consultant rotas, unsafe staffing levels, hospital overcrowding, long-waiting lists which can contribute to or compound patient care errors.
All non-medical contributing factors such as resource issues, understaffing, systems failures must be ascertained and included in the disclosure process.

Where an incident relates to a risk that has previously been flagged on a HSE Risk Register, that fact must also be disclosed to the patient along with the length of time that item has been on the risk register.

2) Section D lays out the key steps in the open disclosure process from preparation and planning, the Open Disclosure meeting to Documentation and written follow up, ongoing communication and sharing of the review of findings.
There must be recognition that the Open Disclosure process, incident investigation and reporting, clinical risk management processes all reduce time spent on other clinical duties. This is particularly relevant in the context of multiple Government reports suggesting that productivity in the health service has decreased.

Additional resources and protected time must be provided to allow doctors to be released from clinical duties to engage in training, open disclosure meetings, investigations reporting and risk management. Patients safety and quality of care must be prioritised and taken into account ahead of commercial concepts of productivity and efficiency.

23. Please list any specific edits/suggestions here. Please include the page number from the draft copy circulated.

24. Please advise on the best approach to written follow-up an open disclosure meeting for moderate harm or worse incidents:		
Answer Choices		
1	Minutes following the meeting	
2	A compassionate summary letter	
3	Nothing at all	
4	A mix, at minimum a compassionate letter but for more serious incidents minutes	
5	Other (please specify):	

25. Please share any additional comments / suggestions below
A compassionate summary letter would likely be a more favourable approach to the impersonal legal forms that were initially developed under Civil Liability (Open Disclosure) (Prescribed Statements) Regulations 2018. Again it is important that all non-medical contributing factors such as resource issues, understaffing, systems failures must be ascertained and included in the written follow up including whether the incident relates to a risk previously flagged on a HSE risk register.

Section E – Managing Open Disclosure in Specific Circumstances

26. How should the policy address the objectives set out above for this section?

27. Is there any information and guidance not included that should be considered?

28. Please list any specific edits/suggestions here. Please include the page number from the draft copy circulated.

29. It can be difficult to do open disclosure when multiple teams/services are involved. Do you believe that the policy goes far enough in highlighting the importance on staff working together and liaising on this?

Answer Choices		
1	Yes	
2	No	
3	Don't know	

30. Are there any other specific circumstances we should include here?

Answer Choices		
1	Yes	

30. Are there any other specific circumstances we should include here?		
2	No	
3	Don't know	

31. Please share any additional comments / suggestions below
Answer Choices

Section F – Supporting Patients, their Relevant Person and Staff

32. How should the policy address the objectives set out above for this section?

33. Is there any information and guidance not included that should be considered?

34. Please list any specific edits/suggestions here. Please include the page number from the draft copy circulated.

34. Please list any specific edits/suggestions here. Please include the page number from the draft copy circulated.

35. Do you agree with including and highlighting the supports available to patients, their relevant person and staff in the policy?		
Answer Choices		
1	Yes	it is vitally important that all patients and staff are aware of the supports available to them including supports that are available during weekend and nightshifts.
2	No	
3	Don't know	

36. Please share any additional comments / suggestions below

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