Opening speech for Minister for Committee Stage of the Patient Safety (Notifiable Patient Safety Incidents) Bill 2019.

10th March 2022

- I would like to thank the House for giving me the opportunity to present the Patient Safety (Notifiable Patient Safety Incidents) Bill at Committee Stage. This Bill is extremely important and will change the culture in our health services.

- I want to acknowledge the broad support it received at First and Second Stages.

- When things do go wrong, patients and their families expect three things: to be told honestly what happened, what can be done to deal with any harm caused, and to know what will be done to prevent a recurrence to someone else.

- In every health service the world over, things will occasionally go wrong. What matters is how the health service responds and deals with these situations when mistakes and errors occur.

- Much has been done to advance open disclosure in our health service in Ireland. The HSE introduced a national open disclosure policy in 2013 and there are plenty of examples of open disclosure occurring as it should in our health service. Unfortunately, it doesn't always happen. All of us here today are aware of these tragic cases.

- This Bill provides for mandatory open disclosure of serious patient safety incidents. It provides for the notification of those reportable incidents to the relevant regulator, and extends the remit of HIQA to private hospitals. It also contains provisions supporting clinical audit in the health service.

- This Bill will lead to a safer, better health service by placing patients and their needs front and centre.

- As you know, the Government approved this Bill in December 2019, subject to certain amendments, and it passed First and Second Stages in the Dáil on December 12, 2019. It was due to proceed to Committee Stage in early 2020 but events overtook us with the arrival of Covid-19 .

- I would like to outline a number of amendments, some of which were part of the Government decision when the Bill was approved in December 2019.

- Firstly, I will seek to clarify the amendment to section 9 of the Health Act 2007 which will strengthen the Ministerial powers to request an investigation by HIQA into ongoing patient safety risk in Ireland's health and social services.

- Secondly, I am proposing an amendment to section 12 of the Bill which addresses openness and transparency. As previously drafted, section 12 set out that both health service providers and health practitioners, when making an open disclosure under this Bill, must provide all relevant information to the patient (or their relevant person). Where appropriate, they must also inform other health services of a notifiable incident.

- I have now added further draft provisions to section 12, which expand the impact of this section and ensure these provisions are enshrined in the relevant policies set by the HSE and national standards set by HIQA. It also ensures they are enshrined in the codes of professional conduct or practice set by the relevant regulatory authorities.

- Finally, Schedule 2 of the Bill contains a list of amendments to the Civil Liability (Amendment) Act 2017. These amendments are purely technical. They aim

to align the two pieces of legislation with specific reference to the organisation of the open disclosure meeting, the provision of information to the patient and their family, and the procedure to follow should a patient not wish to participate in an open disclosure meeting. These amendments do not introduce any new substantive provisions to either Bill.

- These three amendments are given effect in a number of sections throughout the Bill and I will outline the detail of the amendments as they arise.

- I'd like to flag two amendments I will be introducing at Report stage.

- Firstly, I propose to give HIQA's Chief Inspector of Social Services a discretionary power to carry out a review of certain serious patient safety incidents which have occurred during the provision of health care, where some or all of the care of a patient was carried out in a nursing home.

- This proposed amendment will seek to support patients and their families when something goes wrong with the clinical care they received in a nursing home. It will ensure that appropriate external processes are in place to review serious patient safety incidents.

- This amendment follows the report of the COVID-19 Nursing Home Expert Panel recommendations, which called for suitable structures to be put in place for external oversight of individual care concerns arising in nursing homes.

- This power will not replace nursing homes' responsibility to address concerns that are raised by patients and families. It will put in place an appropriate escalation pathway to ensure these concerns are addressed in a way that will provide answers to families and patients.

- Secondly, the overarching intention of this Bill is to embed and support a culture of open disclosure. It is also fair to say that many aspects of the Bill have been informed by the learnings from CervicalCheck; in particular, the need to ensure accountability by service providers and clinicians in carrying out open disclosure to patients and families.

- I, together with my Department and the National Screening Service, have given a lot of consideration to these learnings, and the work of the Expert Reference Groups on Interval Cancers. These expert reports were commissioned as part of the Scally Review in 2018. They set out a new and comprehensive approach to reviews of interval cancers in people who have been screened by

Ireland’s breast, bowel and cervical cancer screening programmes.

- We intend to introduce a notifiable incident directly related to cancer screening services. These measures are currently with the Office of the Parliamentary Counsel for drafting and I will also introduce this amendment at Report Stage.