Patient Safety Together:
learning, sharing and improving

Terms of Reference - HSE National Patient Safety Alerts Committee

1. Background

Patient safety is a key priority across our entire healthcare system. The vision of the Health Service Executive's (HSE) Patient Safety Strategy (HSE, 2019) is that all patients will consistently receive the safest care possible. Yet, it is universally acknowledged that healthcare is complex and, sometimes things can go wrong and patients may experience harm as a result.

Through a new national system *Patient Safety Together; learning, sharing and improving*, sharing of learning from incidents and other patient safety sources can be shared including through HSE National Patient Safety Alerts [NPSA] and patient Safety Supplements [PSS]. This national system will facilitate the identification, development, publishing and dissemination of critical safety information within the HSE and its funded services.

- "A HSE National Patient Safety Alert is a high priority communication in relation to patient safety issues, which requires HSE services and HSE funded agencies to take specific action(s) within an identified timeframe, in order to reduce the risk of occurrence or recurrence of patient safety incidents that have the potential to cause serious harm or death".
- A Patient Safety Supplement [PSS] will be issued to inform HSE staff and HSE funded agencies of timely and relevant quality and patient safety information for learning purposes.

2. Purpose / Aim of the HSE NPSA Committee

The purpose of the HSE NPSA committee is to oversee the identification, development, publishing, dissemination and evaluation of critical safety information to support and improve patient safety within the HSE and HSE funded services.

3. Objectives:

3.1 To apply system learning to improve patient safety by developing HSE NPSAs and PSSs

3.2 To determine the selection and acceptance criteria for developing HSE NPSAs and PSSs

3.3 To oversee a national system for identifying, developing, communicating and evaluating learning following patient safety incidents through HSE NPSAs for information that requires immediate action and through PSSs dealing with a range of specific patient safety topics.

3.4 To apply a Priority rating system for categorisation of HSE NPSAs (please see Standard Operating Procedure Section 7.3.1.1)

3.5 To incorporate a design thinking approach to identifying problems and solutions

3.6 To work collaboratively with other organisations to inform potential safety alerts/safety supplement content

3.7 To consider the relevance of Health Product Regulatory Authority (HPRA) safety alerts for the HSE NPSA or PSS process

4. Scope

4.1 In-Scope

i. Any Alert/Learning under the remit of the HSE's Chief Clinical Officer (CCO) relating to patient safety

ii. Any Alert/Learning from within the wider HSE and HSE funded services that is referred to the HSE NPSA Committee

4.2 Out of Scope

i. Non patient safety related Alerts/Learning

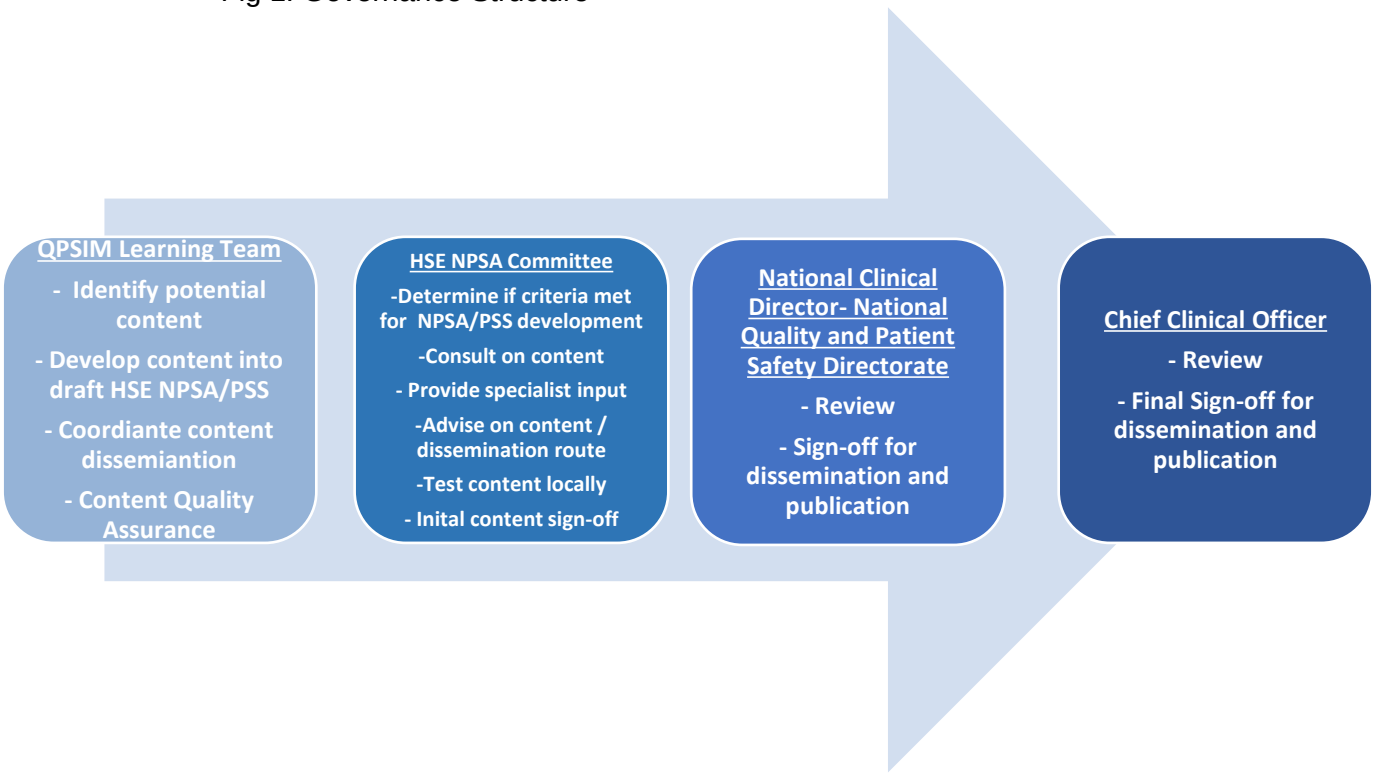
ii. Alerts/Learning not approved by the HSE NPSA Committee / National Clinical Director (NCD) - National Quality and Patient Safety Directorate NQPSD / CCO

iii. Alerts/Learning outside the governance of the HSE or HSE funded services

5. Governance Structure

- The *Quality and Patient Safety – Incident Management (QPSIM) Team* of the HSE's NQPSD have responsibility to coordinate, standardise and improve the effectiveness of patient safety critical communications within the HSE.
- A *QPSIM Learning Team* will routinely identify potential learning content for HSE NPSAs or PSS, help develop draft publications and coordinate content dissemination.
- The multi-agency, multidisciplinary specialist *HSE NPSA Committee* will consult and advise on content received from the learning team and other sources (brought to the committee's attention via members), and engage Subject Matter Experts as required. The committee will oversee the development and ensure the validity and vigour of HSE NPSAs and PSS.
- Sign-off of the content will be by the HSE NPSA Committee Chair/Co-Chair, then the NCD - NQPSD and finally from the CCO (Fig 1). Ownership of the content remains with the CCO.
- Implementation of recommendations and actions are the responsibility of the Senior Accountable Officer in line with the HSE Performance and Accountability Framework

Fig 1: Governance Structure



6. Role and Responsibilities of HSE NPSA Committee

i. Review data and content received from QPSIM Learning Team and agree on next steps
ii. Undertake a further deep dive of data if indicated
iii. Oversee the development of national QPS publications – HSE NPSAs and PSSs for the purpose of sharing patient safety learning
iv. Provide specialist input as required
v. Review draft HSE NPSA and PSS publications
vi. Agree urgency and prioritisation of workload
vii. Review any identified patient safety risks, emerging changes and contribute to problem solving
viii. Undertake regular content curation
    - Content Quality Assurance
ix. Undertake initial sign-off of content for forwarding to the NCD-NQPSD and CCO

Further detail of how the committee works is outlined in a separate *Standard Operating Procedure for identifying, developing and disseminating NPSAs and PSSs.*

7. Membership

i. Committee Chair – Clinical experience essential
ii. Co-chair – Assistant National Director QPSIM
iii. Patient Safety Learning Team Lead
iv. Patient Representatives (x2)
v. Human Factors / QI Lead
vi. HPRA Representative
vii. Nursing/Midwifery Representative
viii. HSCP Representative
ix. QPS Acute Services Representatives - National and Local
x. QPS CHO Representatives – National and Local
xi. National Library Representative
xii. Medication Safety Representative
xiii. National Doctors Training and Planning Representative
xiv. Learning Team Coordinator
xv. Other subject matter experts as required such as;
    - Design Thinking
    - Biomedical engineer
    - Clinical Specialists
    - Procurement Specialists

7.1 Additional Membership

The Chair/Co-Chair of the committee may extend an invitation to personnel or representatives from other areas or departments with respect to particular aspects of the guidance e.g. communications.

Representatives of the HPRA in attendance at meetings of the committee may contribute to the discussions, for example, by providing regulatory information concerning health products, to clarify points of fact, and to offer an interpretation of data, as relevant to the remit of the HPRA. HPRA representatives will not have voting rights on Committee decisions.

8. Accountability and Reporting Relationships

The HSE NPSA Committee will be accountable to the Chief Clinical Officer through the National Clinical Director NQPSD.
Bi-annual updates on the activity of the committee will be forwarded to the Safety & Quality Committee of the HSE Board

9. Decision Making

- As long as there is a quorum, the HSE NPSA Committee may act despite the absence of one or more of its members.
- In the event that decisions are to be taken and feedback has not been received from a member within the time allocated, it will be interpreted that the member is in agreement with that decision.
- Despite the above, if a decision relating to an individual specific stakeholder group is required this cannot be taken without direct input from their HSE NPSA Committee member.

10. Frequency of Meetings

- The HSE NPSA Committee will meet on a monthly basis or more frequently if required.
- The schedule of meetings will be agreed at the first HSE NPSA Committee meeting.

11. Quorum for Meetings

The quorum for Core Committee meetings will be the Chair or Co-Chair and eight other members.

- To enable the Committee to respond to serious issues in a timely manner the quorum for emergency meetings, in exceptional circumstances, will be the Chair or Co-Chair and five other members.

12. Evaluation / Audit Process

The evaluation/audit process for the HSE NPSA and PSS system will be designed by the QPSIM Learning Team and approved by the HSE NPSA Committee.

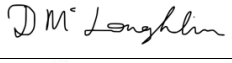
13. Conflicts of Interest

In the interest of proper standards of conduct, the activities of the HSE NPSA Committee must be conducted in an objective manner and be seen to be so conducted. A conflict of interest arises when a member's interests or opportunity for gain or profit are, or could be interpreted as being, in conflict with those of the HSE NPSA Committee. Any interests of a member's family or other connected persons of bodies which could involve a conflict of interest should also be disclosed. All members must confirm their commitment to the disclosure of any employment and/or business interests which may be – or be seen to be - in conflict, or in potential conflict, with the objectives and activities of HSE NPSA Committee.

14. Approval of Terms of Reference

These terms of reference have been approved by the Chief Clinical Officer, National Clinical Director NQPSD and the Chair of the HSE NPSA Committee. Any subsequent changes proposed at meetings of the HSE NPSA Committee and are subject to agreement by all members and approval by the NCD and CCO.

Signatures approving Terms of Reference:

Name	Signature	Date
Chair of the HSE NPSA Committee		**12 March 2023**
Co-Chair of the HSE NPSA Committee		**10.03.2023**
National Clinical Director – NQPSD		**14.03.2023**
Chief Clinical Officer		**14.03.2023**

References:

- Health Service Executive (2019) *Patient Safety Strategy 2019-2024* Available at: https://www.hse.ie/eng/about/who/nqpsd/patient-safety-strategy-2019-2024.pdf

- Health Service Executive (2020) *Incident Management Framework*. Available at: https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/incident-management/hse-2020-incident-management-framework-guidance.pdf