

World Patient Safety Day 2026 in Ireland: Safe Care for Non-Communicable Diseases

Executive Summary

This paper is a patient-led proposal for [World Health Organisation World Patient Safety Day 2026](#) initiative for Ireland based on the 2026 theme, **Safe Care for Non-Communicable Diseases**. It calls on all partners across health and social care, government agencies, advocacy groups, education and health insurers to build on the successful Chronic Disease Management Programme as a model of care to close remaining access gaps, so that every person living with a non-communicable disease can receive safe, integrated and personalised care.

The OECD report [The Health and Economic Benefits of Tackling Non-Communicable Diseases](#) provides clear evidence in support of a prevention-focused approach that treats NCD management as both a patient safety priority as well as a social and economic priority.

This plan follows a simple pathway: why action is needed, what Ireland can build on, where the main access gaps remain, and next steps for a truly integrated approach. The final section brings these points together as a concise set of calls to action for World Patient Safety Day 2026.

The aim is to improve outcomes and the quality of their lives for people with NCDs, while reducing avoidable healthcare costs while also making a positive contribution to the economy through increased productivity and economic output.

Summary of Calls to Action:

World Patient Safety Day 2026 provides a catalyst for further action on safe care for non-communicable diseases in Ireland through a truly integrated approach that includes all partners in all determinants of health: health and social care, government departments, advocacy groups, education, community services and health insurers.

The calls to action are presented in summary below and developed in more detail in the final section of this plan. Together, these actions can improve quality of life, reduce avoidable healthcare use and support wider social and economic participation. They will contribute to economic growth, workforce productivity and reduced healthcare costs.

1. The highest priority is to **extend and strengthen the Chronic Disease Management programme to the entire population** living with a chronic disease – provided by the HSE in conjunction with the private health insurers. This will provide proven health benefits to another 500,000 people across Ireland, while also reducing hospital emergency and

outpatient department attendance. The OECD report shows the benefits to people, communities, society and the economy.

In the immediate to short term, we call for the **inclusion of obesity in the Chronic Disease Management programme.**

2. Provide truly person-centred, integrated care across all determinants of health – starting with **the integration of mental health support in primary care settings.**
3. The safest, most effective and efficient care depends on an activated, informed patient, supported by family and community, in partnership with and competent, caring professionals. It is therefore important to **empower every person with the knowledge, skills and confidence to be an active partner** and advocate for their care.

Background and Rationale – WHO World Patient Safety Day

World Patient Safety Day brings governments, partners and communities together around a shared patient safety priority. Ireland can use the WHO theme to accelerate practical action on prevention, early diagnosis, treatment, long-term management and self-care for people living with non-communicable diseases.

The theme for 2026 is **Safe Care for Non-Communicable Diseases** - from prevention and diagnosis to treatment, long-term management and self-care.

Patients for Patient Safety Ireland, formed under the [WHO Patients for Patient Safety](#) programme, works through partnership and collaboration to address the wider determinants of health, including economic, social and geographical factors. This approach supports the aim that every person living with a non-communicable disease can access safe, effective care that reflects their circumstances and experience.

The approach of Patients for Patient Safety Ireland is to engage in partnership and collaboration to address the wider perspectives of health including economic, social and geographical determinants, to ensure every person living with these conditions can access safe, effective care.

This document sets out the high-level aims and objectives based on the theme for this year, with a schedule of activities typically for ten to twelve months, which then transition to a more operational phase. We will engage in collaboration with the health services, advocacy groups and other partners in this plan.

The high-level plan and updates on progress will be shared with the WHO Global Patient Safety Network via the WHO Integrated Health Services Hub: <https://ihshub.org/topics/4216/feed>

WHO Landing Page and Campaign Materials: [World Patient Safety Day 2026](#) – and may be used as a reference point and for guidance.

WHO Brand Resources: including logos, Zoom backgrounds, screensavers, posters, etc. on [WPSD 2026 WHO Brand Resources](#)

Evidence and Discussion Points

OECD Report

The OECD report [The Health and Economic Benefits of Tackling Non-communicable Diseases](#) dated 15th April 2026 states: “NCDs cut lives short, affect quality of people’s life, and reduce their ability to work. This raises health expenditure and reduces workers’ productivity and economic output. Yet many of these impacts are avoidable, through action on health risk factors, early diagnosis of disease and improved treatment.”

This evidence supports a prevention-focused approach that treats NCD management as both a patient safety priority and a social and economic priority.

Chronic Disease Management Programme

- The Chronic Disease Management Programme provides a strong foundation to build on. Its high uptake, inclusive design and focus on prevention, patient education and self-management show that a person-based, structured model can improve access and empower patients. The next step is to extend this model, or an equivalent programmatic approach, to every person living with a non-communicable disease.
- The 80% uptake figure is a strong baseline and is probably conservative. However, the remaining group of approximately 20% of eligible people should be examined carefully to understand whether practical, social, geographical, stigma-related or other barriers are preventing access, particularly for marginalised and underserved communities. ([The First Report of the Chronic Disease Management Prevention Programme in General Practice](#) and [The Third Report of the Structured Chronic Disease Management Treatment Programme in General Practice](#))

Chronic Disease Hubs

- Chronic Disease Hubs are welcome developments, with multidisciplinary teams supporting person-centred care closer to home. Their rollout should be accelerated across Ireland to improve outcomes, reduce avoidable hospital visits and make specialist community support more consistently available.

Enhanced Community Care Programme

- This programme, designed to move care from acute hospitals into local community settings across Ireland, includes the Chronic Disease Management Programme and other services. It is designed to move care from acute hospitals into local community settings across Ireland.

Foundation and Key Principles

Sláintecare

The Sláintecare programme provides the policy foundation for this approach: helping people stay well in their own homes and communities for longer and delivering the right care in the right place at the right time. The calls to action below apply those principles to safe, effective care for people living with non-communicable diseases.

(<https://about.hse.ie/our-work/slaintecare-our-strategy-for-improving-irelands-healthcare-system/>)

Truly integrated care should include all determinants of health, including social and commercial: person centred, based on the patient experience i.e. signposting and integration of support from the health service, GPs, pharmacies, advocacy groups, social prescribing, etc.

Empower every person using all channels that interact with every person across all the determinants of health.

General Principles

The safest, most effective and efficient healthcare depends on an activated, informed patient, supported by family and community, in partnership with and competent, caring professionals.

Social stigma still exists around many manageable conditions, from obesity to addiction, which can lead to delayed diagnoses, delayed treatment and poorer outcomes. Stigma must be acknowledged and addressed in order to provide care to people with non-communicable diseases in line with the Sláintecare principles.

Under the theme for WHO World Patient Safety Day 2026, safe care and improved outcomes can be further enhanced through:

1. **Increased personalisation** – person-centred care, specific to every person's health journey and experience, with a focus on empowerment and self-management with special attention to:
 - a. those with multi-morbidities
 - b. transitions of care
 - c. polypharmacy
2. **Continuity**, especially in transitions of care. Support sustained use of programmes like ExWell, and mental health supports.
3. **Integration** – include all agencies and groups for seamless integration across determinants of health, not limited to health and social care services.

Health Literacy and Patient Empowerment

Address the barriers to effective self-care, including stigma, basic literacy, health literacy, language barriers and cultural attitudes.

Advocacy Groups in Ireland provide excellent, trustworthy patient education and information resources, often in partnership with the HSE e.g. [Irish Heart Foundation Guide to My Heart Health](#) and [Think Type 1 Diabetes Think Test - Diabetes Ireland](#).

With [40% of Irish adults struggling to read medical information](#), every opportunity should be taken to empower people to build the knowledge, skills and confidence to be active partners in their own care and in the care of their loved ones.

- Integrate health literacy into Social, Personal, and Health Education (SPHE), a compulsory subject in secondary schools, to ensure that everyone leaves school with an understanding of their health and their own role as an active partner in their care.
- Patient education and self-management support within the Chronic Disease Management Programme – integrated into the Personalised Care Plan, delivered primarily by practice nurses during reviews.
- Collate patient education and health literacy resources e.g. leaflets, videos, posters, education resources from advocacy groups, etc. Signpost to them in all settings and make them broadly available e.g. videos in waiting rooms, reverse of appointment letters, community centres, libraries, Citizen Information Centres, Family Resource Centres, etc.
- Publish directories of voluntary and state supports in local communities for people living with NCDs in each health region at a Community Health Network level.
- Support local **Community Health Forums** run by the community in local settings e.g. libraries, community centres, etc.
- **Making Every Contact Count:** <https://healthservice.hse.ie/staff/training-and-development/making-every-contact-count-training-programme/> with clear benefits as seen in this video: <https://www.youtube.com/watch?v=eDSmn1XKNq8>

Chronic Disease Hubs and Community Health Infrastructure:

People have a variable experience in terms of supports within their community to help with managing life with a chronic condition. Issues that might have an impact include public transport, proximity of their GP or hospital, the existence of a local advocacy group, and local schemes and systems to support people with a health problem.

- Accelerate rollout of the hubs across Ireland
- Equitable access to services around the country e.g. pulmonary rehab, medical assessment units
- Address current staffing challenges arising from funding being withdrawn while recruitment was in progress
- Invest in community health infrastructure for future expansion including premises, ancillary staff (especially nurses), and linked primary care teams
- Include options for **mental health support**, integrated into chronic disease management programmes. According to the WHO: “Strong links between mental disorders and other chronic diseases exist, not only with respect to how to effectively manage them, but also in terms of their causes and consequences.... The redesign of health systems and services towards integrated chronic care poses several challenges ... Providing seamless, holistic care that caters to the overall health needs of the person is a feasible and efficient way of preventing and managing mental disorders and other chronic diseases.”
<https://www.who.int/publications/i/item/9789241506793>
- Explicitly integrate **Social Prescribing** in all community settings. Community-level interventions can help lower perceived stigma and encourage uptake by mapping supports

across the patient journey, from symptoms and diagnosis through treatment, Living Well programmes, self-management, counselling and peer support.

<https://mentalhealthreform.ie/social-prescribing/>

- **Directories** would give each person location-based, person-centred support from the HSE, other agencies, advocacy groups and community services. Location-based directories can be made available through the **HSE App**.

Expansion of the CDM programme or similar programmatic model

- A significant minority of people with chronic disease do not have medical cards and are therefore not eligible for the CDM Programme. Many are economically active, and unmanaged chronic conditions can lead to avoidable illness, increased sickness absence, reduced productivity and higher direct and indirect healthcare costs.
- The OECD report singles out obesity as the highest priority risk factor. Ireland was the first European country to adapt the Clinical Practice Guidelines for the Management of Obesity from the world-renowned Canadian Clinical Practice Guidelines. The [HSE Model of Care for the Management of Overweight and Obesity](#) was first published in 2021. It is imperative that full funding is provided for a nationwide rollout of the Model of Care to provide comprehensive chronic disease management for every person living with obesity.
- Health insurers should follow the HSE's lead by including structured chronic disease reviews, such as two GP reviews a year, as standard cover for their members with chronic conditions. This would support better outcomes while reducing expensive claims for expensive hospital admissions.
- Increase the number of conditions, either through CDM or another programmatic approach.
 - Non-communicable diseases that are stable long-term conditions such as obesity, chronic kidney disease, arthritis, Parkinsons, dementia, bipolar disease, peripheral vascular disease, chronic pain, adult ADHD and perhaps even long-term surveillance post initial treatment for some cancers. Conditions like ME, lymphoedema, etc. can also be considered.
- Recognise the increased risk of **poor mental health** and other impact to people with NCDs and their caregivers, who also need support as set out in [Family Carers Ireland Paying the Price Physical Mental and Psychological Impact](#) and [Family Carers Ireland State of Caring 2026](#)
- Other common supports required by people with chronic conditions to be delivered as part of CDM e.g. Occupational Therapy, podiatry.

Diagnostics

- Faster and more streamlined access to diagnostic test results. Enable GPs to have direct access to diagnostics without the dependency on a consultant.
- Access to point of care testing will provide associated benefits for the patient.

Digital

- Accelerate the rollout of telehealth solutions e.g. video consultations, remote monitoring

- Integrate with patient education and empowerment resources provided by advocacy groups, community groups and others. This can include patient education resources, the Living Well Programme, ExWell, networking, counselling and Peer Support.
- Use the HSE App to empower people with knowledge, skills and confidence to be active partners in their care. Build on the success of the integration of the Quit Smoking and Get Active programmes.
- As Digital for Care is rolled out, patient education and empowerment resources can be personalised to every person via the app.
- Similarly, the patient can be signposted to supports in their local area, based on directories for local services available to each person based on location.
- Speed up information transfer between different settings e.g. discharge notes from hospital to GPs
- In the medium to longer term, telehealth can be used for proactive health monitoring of critical risk factors, especially for at-risk groups for early detection and chronic disease management, while also empowering every person to be an active partner in their care.

Medication Safety

- Pharmacists are an important source of information on medication use for patients with non-communicable diseases, who are often using multiple medicines together.
- Roll out [iSIMPATRY](#), a pharmacist-led medicine review model proven to provide improved outcomes for patients by reducing hospital admissions, time in hospital and use of other primary care and social care settings, while also being cost-effective.
- Drug prices: drugs e.g. for obesity are significantly cheaper in Northern Ireland

Detailed Calls to Action

World Patient Safety Day 2026 provides a catalyst for further action on safe care for non-communicable diseases in Ireland – a truly integrated that includes all partners in all determinants of health: health and social care, government departments, advocacy groups, education, community services and health insurers. These calls to action support the aims of Sláintecare through practical action - especially prevention, early detection, self-management and delivery of the right care in the right place at the right time.

The **Chronic Disease Management Programme** provides a proven model of structured, person-based care that can be extended to every person living with a non-communicable disease. Connecting health services, Digital for Care, GPs, pharmacies, advocacy groups, social prescribing and other supports in the community will provide a truly person-centred, integrated service for every person in Ireland.

1. **The highest priority is to extend the successful Chronic Disease Management Programme** to the entire population living with a chronic disease. This will provide proven health benefits to another 500,000 people across Ireland, while also reducing hospital emergency and outpatient department attendance.
 - a. **Immediate to short term: Include obesity under the Chronic Disease Management Programme**, with full funding and nationwide rollout of the [HSE Model of Care for the Management of Overweight and Obesity](#). The OECD report [The Health and Economic Benefits of Tackling Non-communicable Diseases](#) shows the impact of obesity on economic growth, workforce productivity and healthcare spending. In addition to improved outcomes for people and society, it will have economic benefits for GDP, productivity and health spending as shown in the OECD report.
 - b. **Health insurers to include structured chronic disease reviews** under the CDM programme unconditionally, as standard cover for every member with non-communicable disease. This will match the benefits provided by the public service and will significantly reduce costly claims for hospital visits in the future.
 - c. **Accelerate the rollout of Chronic Disease Hubs** across Ireland so multidisciplinary, person-centred care is available closer to home, reducing avoidable hospital visits. Urgently address staffing and budget constraints across hubs, including shortages in podiatry, diabetes nurse specialists, dietitians, endocrinologists and other essential professionals. Ensure that the hubs are adequately staffed and resourced – an investment up front will provide a return in the short to medium term, while reducing the burden on hospitals and waiting lists.
 - d. **Improve diagnostics and common supports**, including faster access to diagnostic tests and results and point-of-care testing. Enable GPs to order more diagnostic tests without the need for consultant sign-off.
 - e. **Assess access gaps that may exist with the Chronic Disease Management Programme**, especially for the estimated 20% of remaining eligible people not currently reached by CDM, with attention to barriers e.g. stigma, cultural, that may affect people in specific groups.

2. **Provide truly person-centred, integrated care to support every person** with a non-communicable disease with supports across all determinants of health.
 - a. **Integrate mental health supports** into the CDM programme in primary care settings for every person with non-communicable diseases.
 - b. Include access to supports such as occupational therapy and podiatry.
 - c. **Develop directories** at a local, Community Healthcare Network level to signpost people to advocacy group services, social prescribing and support available locally provided by the HSE, local authorities and other approved agencies, organisations and groups. These will provide continuity of care to include the Living Well programme, patient education provided by advocacy groups, ExWell, peer support and other supports.
 - d. **Support patients and introduce efficiencies in medication safety**, including national rollout of [iSIMPATY](#) for pharmacist-led medicine reviews.
 - e. **Recognise the role and contribution of family carers** and the unique physical, mental and psychological impacts of caring on carers
 - f. **Accelerate digital and telehealth solutions**, including video consultations, remote monitoring, better information transfer, personalised education through the HSE App and signposting to location-based supports using directories referred to above. These can be more personalised when the One Health Record is available.
 - g. **Support patients and introduce efficiencies in medication safety**, including national rollout of [iSIMPATY](#) for pharmacist-led medicine reviews.
 - h. **Use Big Data Insights** to understand the health experience of the population at a granular level, identify predictors of NCDs and proactively implement measures for prevention, early detection and early intervention.
3. The safest, most effective and efficient care is between an activated, informed patient, supported by family and community, in partnership with and competent, caring professionals. It is therefore important to **empower every person with the knowledge, skills and confidence to be an active partner** and advocate for their care. Empowerment and health literacy will promote prevention, early diagnosis and self-management. Trust can be developed through listening, empathy, clear communication, and integrity.

In a clinical setting, each interaction with the health professional is an opportunity for equal partnership and empowerment between the patient and clinician. Here, trust can be developed through listening, empathy, clear communication, and integrity.

Empower every person through all channels that interact with every person across all the determinants of health. Use a broad, sustained health promotion e.g. the Personalised Care Plan in CDM reviews by practice nurses, wider access to education resources e.g. the HSE App, advocacy groups, [Making Every Contact Count](#), community centres, libraries, family resource centres and citizens information centres, including:

- a. The [HSE Chronic Disease Management Prevention Programme](#)
- b. Integrate basic health education topics in the SPHE curriculum in secondary schools e.g. [WHO Concept Paper – Health Literacy in Schools](#) and [Tim Jones – Benefits of Integrating Health Literacy in School Curricula](#)

- c. Patient Empowerment and Health Literacy along the lines of the [European Patient Forum initiative on Patient Empowerment](#)