Gníomhaireacht Bainistíochta an Chisteáin Náisiúnta
National Treasury Management Agency

An Ghníomhaireacht um Éilimh ar an Stát
State Claims Agency

Update on recommendation made by Committee of Public Accounts in its Periodic Report No. 7, published 2019.

The PAC made the following recommendation in its Periodic Report No. 7 April 2019 – July 2019, published November 2019:

> *The number and cost of claims against the State continues to escalate year on year, particularly claims arising from clinical negligence. To date there is no evidence of a functioning systems-wide approach in the Health Service Executive to incorporate learnings from associated incidents across the entire health sector. The failure to incorporate learnings is itself likely to contribute to the increase of such claims. The Committee recommends that the Health Service Executive, in conjunction with the State Claims Agency and the Department of Health, puts in place a formal system to incorporate learnings from incidents of clinical negligence across the health sector in order to reduce the number of such incidents in the future.*

Previous update provided by SCA, 2021

The HSE has established a Steering Group, on which the SCA is represented, to develop a national system to share learning following patient safety incidents. The Group met in February 2020 but was then suspended due to redeployment of staff during the Covid-19 crisis. It has now been reconvened and met on 7 May. A meeting is also scheduled for 1 October.

The SCA continues to analyse incidents under its incidence surveillance protocol and to issue patient safety notifications or other communications to the HSE as required. If appropriate, these notifications are developed in consultation with the HSE. In addition, specific Covid-19 related reports and patient safety notifications have been issued to the HSE.

SCA Update 24th February 2023

Patient Safety Together platform

Reference was made in the SCA's previous update on this recommendation (see above) to the development of a Steering Group, on which the SCA was represented, to develop a national system to share learning in the aftermath of patient safety incidents.

The Steering Group was suspended due to COVID-19 but reconvened in 2021. The group subsequently developed and launched, in January 2023, Patient Safety Together, a national system to share learning following patient safety incidents. It is the HSE's 'sharing of learning' programme, supporting the HSE's Patient Safety Strategy. It is coordinated by the Quality and Patient Safety Incident Management Team (QPSIM) of the HSE's National Quality and Patient Safety Directorate (NQPSD).

The learning generated through Patient Safety Learning will be identified through analysis of available data sets including incident report data (using the National Incident Management System (NIMS)), audit reports, complaints' data, and other published national and international safety alerts and research.

Outputs will include:

- Patient Safety Alerts, which are high-priority communications in relation to patient safety issues, which require HSE services and HSE-funded agencies to take specific actions within an identified timeframe
- Patient Safety Supplements, which are short publications presenting patient safety information that can be shared for learning purposes.

The SCA was a key stakeholder in the development of the platform, with its Head of Clinical Risk sitting on the Steering Group and SCA Senior Clinical Risk Managers sitting on a working group.

It is planned that the SCA will contribute data derived from its own analysis of incidents and claims to the Patient Safety Together programme to inform outputs.

SCA clinical incident and claims analysis

In addition to supporting the HSE's Patient Safety Together platform, the SCA, in fulfilment of its statutory risk management mandate, has its own programme of work to ensure that learning from patient safety incidents and clinical negligence claims is shared, as appropriate, with relevant organisations. This is derived from its continuous analysis of incidents and claims.

Learning from incidents and claims is disseminated by various mechanisms:

- Reports on specific topics or themes shared with HSE at national level (HSE senior management, relevant HSE programmes and directorates)
- Reports on specific topics or themes distributed widely throughout the HSE
- Publication of reports on specific topics or themes
- Distribution of Patient Safety Notifications throughout the HSE
- Publication and distribution of the SCA's Clinical Risk Insights newsletter with articles on incidents, claims and risk mitigation
- Learning events, such as conferences, other events and webinars
- Educational activities delivered to hospitals, health and social care services, undergraduate and postgraduate institutes of education
- Invited presentations by specialty experts at national conferences

In addition, the SCA collaborates directly with the HSE on clinical risk through the Clinical Risk Forum, a forum chaired by the SCA for the discussion, with senior managers in the HSE, of clinical risk matters.

The SCA can also ensure that learning from claims informs policy at a national level through its membership of national committees and groups such as the Independent Patient Safety Council and the National Clinical Effectiveness Committee, which is responsible for the development of National Clinical Guidelines and National Clinical Audit.