

29 Clinical Indemnity Scheme

- 29.1** The National Treasury Management Agency (NTMA) has a statutory obligation to manage personal injury and property damage claims against certain State authorities.¹ The legislation also prescribes a risk management role for the NTMA, to advise and assist State authorities in minimising their exposure to future claims. When performing these functions, the NTMA is known as the State Claims Agency (SCA).
- 29.2** The principal objectives of the SCA are to
- ensure that the State's liabilities in respect of claims and the expenses relating to their management are contained at the lowest achievable level
 - implement risk work programmes, including risk advisory services, in State authorities with the aim of reducing the costs of future litigation against the State.
- 29.3** There are currently 54 State authorities, with over 200,000 employees, within the SCA's remit. The remit covers claims against the State itself and certain State authorities including government ministers, the Attorney General, healthcare enterprises, the Commissioner of An Garda Síochána, prison governors and various other bodies.²
- 29.4** At the end of 2012, the SCA had 5,755 claims under management with an estimated potential liability in excess of €1.1 billion. The broad categories of claims managed are employer liability, public liability, property damage and clinical. Just under half of the active claims at the end of 2012 fell into the clinical category, and these accounted for over 85% of the estimated potential liability for all claims.
- 29.5** Clinical claims are managed under a number of SCA schemes, the largest of which is the Clinical Indemnity Scheme (CIS).
- 29.6** This report reviews the SCA's management of the CIS and, in particular
- the economy of its operations in terms of the statutory obligation to contain claim liabilities and expenses at the lowest achievable level
 - the efficiency of claims management in terms of the methods and time taken to settle and dispose of claims
 - the actions and initiatives taken to fulfil its statutory responsibilities in relation to risk management.

¹ National Treasury Management Agency (Amendment) Act, 2000.

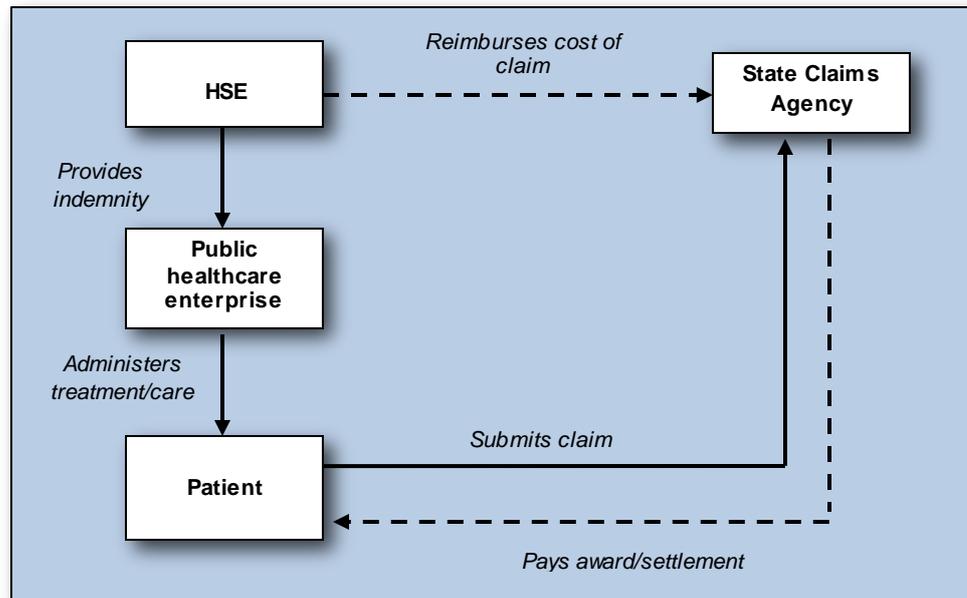
² The SCA's sphere of activity was significantly expanded in February 2011 to encompass new classes of claims and additional authorities.

Scope of the Clinical Indemnity Scheme

- 29.7** The CIS was established in July 2002 in order to address two significant issues that had arisen in respect of the pre-existing medical indemnity arrangements.
- The commercial insurance market had reached a point whereby it was no longer willing to provide insurance cover in the field of obstetrics due to the escalation in court awards and costs in cases of birth-related cerebral dysfunction.
 - Due to diverse insurance and indemnity arrangements, the previous system for resolving medical indemnity claims often featured multiple legal teams and was generally acknowledged to be costly, time consuming and adversarial in nature.
- 29.8** The scheme covers all medical malpractice and clinical negligence claims arising from the diagnosis, treatment and care of patients taken against public healthcare enterprises and their clinical, nursing and allied healthcare practitioners. Consultant hospital doctors are covered under the CIS in respect of alleged incidents of clinical negligence occurring on or after 1 February 2004.
- 29.9** Since 1 February 2004, the CIS has also covered the excess on the indemnity ceiling set by private insurers for consultants working in whole-time private practice. The current ceiling set by private insurers for consultants in high risk specialties (e.g. obstetricians, neurosurgeons, orthopaedic surgeons) is €565,000 per claim, subject to an annual aggregate limit of €1.695 million. For other specialties, the ceiling is €1.13 million per claim, with no annual aggregate limit.
- 29.10** Under the scope of the CIS, the SCA can arrange legal representation at coroners' inquests for agencies and individual practitioners where this is requested. However, it does not provide representation at disciplinary or criminal proceedings or before professional regulatory bodies.

Funding of the Scheme

- 29.11** Clinical indemnity is provided on the basis of a form of 'enterprise liability' which is a concept generally involving enterprises assuming liability for the actions of their employees. In the case of the CIS, the State assumes responsibility for the indemnification (through the HSE) and management (through the SCA) of claims on behalf of health enterprises.
- 29.12** The CIS is funded on a 'pay-as-you-go' basis. The SCA meets the cost of awards and associated expenses in the first instance before being reimbursed on a monthly basis from the HSE Vote. Roles in respect of the CIS are set out in Figure 29.1.

Figure 29.1 Clinical Indemnity Scheme roles

- 29.13** In some cases, whether by agreement or adjudication of the courts, it may be decided that liability is to be apportioned on a percentage basis between the SCA and a third party/co-defendant. This may arise, for example, in a case where the SCA is representing a hospital and its nursing staff and a medical defence organisation is representing a doctor or consultant. For some of these claims, the SCA will meet the full cost and then recover an appropriate amount from the third party. Amounts recovered from third parties are offset against the next monthly reimbursement from the HSE.
- 29.14** The SCA's income and expenditure in respect of CIS claims are accounted for in its annual financial statements. Staff costs and overheads of the SCA are included in the administration expenses of the NTMA which are met from the Central Fund.

Medical Defence Union Settlement

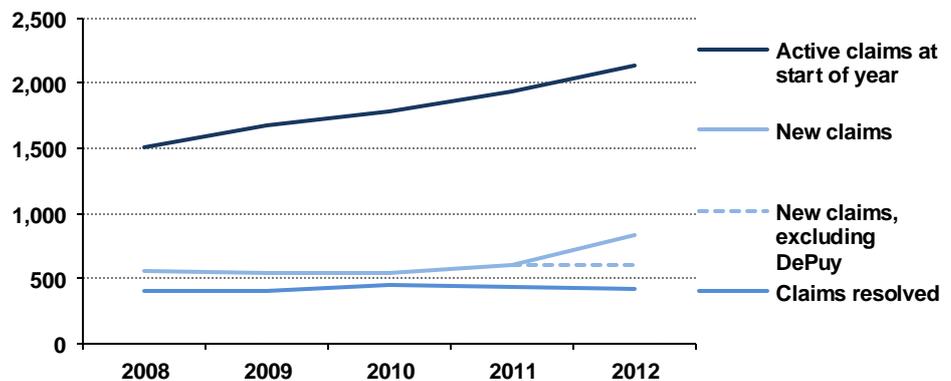
- 29.15** The Government decision approving the establishment of the CIS indicated that the scheme would not have retrospective effect. Accordingly, when the CIS was extended to cover consultants from 1 February 2004, medical defence organisations retained liability for any future claims in respect of incidents that occurred prior to that date.
- 29.16** One UK based organisation, the Medical Defence Union Limited (MDU), contended that the Irish State should take over the liabilities of its members for claims in respect of incidents occurring prior to the extension of the CIS. When the MDU refused to indemnify Irish consultants, the Department of Health implemented new arrangements in October 2004, whereby clinical negligence claims against consultants were handled by independent solicitors, nominated by the Irish Hospital Consultants Association and the Irish Medical Organisation. At the conclusion of individual cases, the solicitors were entitled to apply to the Minister for Health for ex-gratia assistance in respect of settlements and related costs. Under those arrangements, the Department of Health made ex-gratia payments totalling nearly €43 million up to June 2012.

- 29.17** Negotiations between the Department of Health and the MDU in respect of the MDU's historic liabilities commenced in 2004 and broke down in 2005. Discussions between the parties commenced in January 2011 with the aim of settling ongoing litigation. In early 2012, the SCA was given access to MDU data, enabling it to estimate the total potential liability in respect of past and potential future claims relating to incidents that occurred prior to February 2004. In September 2012, the Government decided to accept an MDU offer of €45 million in full and final settlement of its historic liabilities in Ireland.
- 29.18** The Attorney General and the Department of Health legal team agreed that the €45 million package was the best available offer and that there was a risk that the State would not recover anything from the MDU if proceedings were continued. The agreed €45 million settlement was received by the Irish State in December 2012.

Clinical Claims

- 29.19** At the end of 2012, the SCA had over 2,652 clinical claims under management, of which about 2,600 related to the CIS. Of 833 new clinical claims received during 2012, about 230 related to hip replacement procedures carried out using implants manufactured by DePuy Orthopaedics Inc. The SCA stated that it reached an agreement with DePuy during 2013, whereby the company will provide indemnity in respect of most of the cases and will reimburse costs incurred by the State to date in defending those cases.
- 29.20** Figure 29.2 traces the caseload for clinical claims over the period 2008 to 2012. DePuy claims received during 2012 are split out to show the general underlying trend in new clinical claims.

Figure 29.2 Number of clinical claims, 2008 to 2012



Source: State Claims Agency

Estimated Potential Liability

- 29.21** The SCA calculates an estimate of the potential liability associated with each individual claim. The policy is to forecast the most likely outcome scenario, in terms of the amount of the award/settlement and all associated costs, and then add a 'margin of comfort' of up to 20%. Estimates are adjusted over the life of claims to reflect new information that becomes available - a margin of up to 20% is included in each revised estimate.
- 29.22** The reasons provided by the SCA for the inclusion of a margin of up to 20% in its estimate of potential liabilities for individual cases included
- to reflect the possibility that the case may not settle prior to a court hearing, which would generally result in higher awards and legal costs
 - to reflect the possibility of unanticipated complications with regard to the plaintiff's medical condition that may entail higher general or special damages
 - the comfort factor of 20% is an acknowledged, conventional provision used by prudential insurers/indemnity providers.
- 29.23** In cases involving cerebral palsy or cerebral dysfunction, the initial estimate is set at a standard amount, pending an assessment of liability and causation. Where an element of contributory negligence or third party liability is involved, this is reflected in the estimate of potential liability for the SCA.
- 29.24** The estimates of potential claim liability are used for two purposes.
- The scheme's actuaries use this information to prepare annual budget forecasts which estimate the likely cost of managing and settling CIS claims in the coming year.
 - The annual financial statements of the SCA include a note disclosing the aggregate estimated liability of State authorities in respect of all claims under management by the SCA, at 31 December each year.
- 29.25** Figure 29.3 shows the estimated potential liability in respect of active clinical claims at the end of each year between 2008 and 2012.

Figure 29.3 Estimated potential liability for clinical claims^a, 2008 to 2012

| Year | Number of claims at 31 December | Estimated potential liability ^b | |
|------|---------------------------------|--|-----------------------|
| | | Total €m | Claim average €000 |
| 2008 | 1,675 | 449 | n/a |
| 2009 | 1,783 | 636 | 356 |
| 2010 | 1,935 | 786 | 406 |
| 2011 | 2,139 | 860 | 402 |
| 2012 | 2,652 | 970 | 366 |

Source: State Claims Agency, Annual Reports of the NTMA

Notes: a Figures shown refer to all clinical claims, including non-CIS claims.

b The estimated potential liability in 2008 is as at 30 June. Estimated potential liabilities for other years are as at 31 December.

- 29.26** Obstetrics-related claims, though accounting for 20% of the clinical claims volume, represent 55% of the total estimated liability. This is due to the high settlement values associated with cerebral palsy cases and other serious birth-related claims.
- 29.27** Auditors appointed by the SCA carry out an annual review of the estimated potential liability assigned to a sample of claims.¹ The purpose of the review is to confirm that the SCA policy for estimating potential liability is being applied by claims managers and that estimates for individual cases appear reasonable, in view of the case information on file.
- 29.28** The review carried out by the internal auditors in 2012 considered a sample of 105 claims (11 of which were closed files) with estimated potential liabilities totalling €134.5 million.² In 19 cases, it was found that the potential liability assigned was too high, generally because the estimate had yet to be adjusted to reflect actual payments made. In two cases, the potential liability was found to be underestimated because adjustments had yet to be made to reflect the latest available information.
- 29.29** At an overall level, the review concluded that the estimated potential liabilities for the sample of claims were "generally within reasonable parameters", although it did not quantify the parameters applied.

Claims Management

- 29.30** Clinical claims managers at the SCA, with legal or insurance backgrounds, are responsible for investigating claims and formulating individual claim management strategies. The objective is to investigate claims in a thorough and timely fashion in order to facilitate early decision-making in relation to liability and strategy. The steps involved in investigating claims include
- reviewing medical records
 - examining statements by clinical persons involved
 - commissioning opinions from relevant experts
 - appointing solicitors to deal with legal proceedings
 - obtaining additional statements or further explanations
 - consulting with solicitors and/or counsel, as required.
- 29.31** When a claim is made under the CIS, the practitioner that provided the clinical care is required to review all medical records relating to the incident and prepare a statement setting out his/her involvement in the patient's treatment.

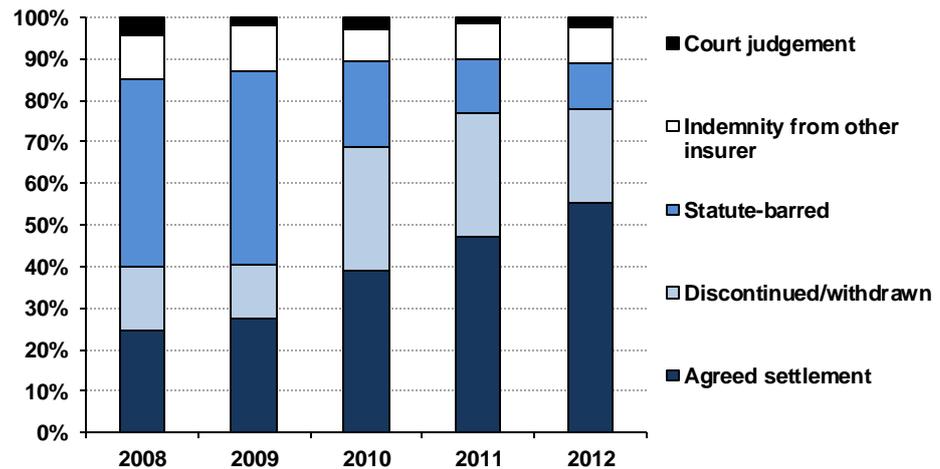
¹ The scope of the review is wider than the CIS and covers all claims under management by the SCA.

² The sample was selected from a list of active claims at 31 August 2012 and a list of claims that had been closed between 10 November 2011 and 31 August 2012.

Settlement of Claims

29.32 In cases where the SCA investigation concludes that the relevant State authority bears some or all liability, it seeks to settle claims expeditiously and on reasonable terms. If it considers that the State is not liable, the SCA's policy is to apply all necessary resources to defend the claim. Figure 29.4 illustrates the processes by which CIS claims have been resolved since 2008.

Figure 29.4 How CIS claims were resolved, 2008 to 2012



Source: State Claims Agency

29.33 The SCA resolves the majority of CIS claims by negotiating a settlement, either directly with the plaintiff's legal team, or through a process of mediation. The SCA advocates mediation as a preferable alternative to the adversarial courts system for resolving clinical negligence cases. Mediation may be initiated by the parties or suggested by the court.

29.34 Between 2008 and 2012, the proportion of claims that were resolved at no cost to the SCA declined significantly. Claims that may be resolved at no cost include cases that become statute-barred due to the lapse of time and cases where it is established that a third party or co-defendant is fully liable.¹ The SCA indicated that the decline in those cases was due to

- a reduction of about 75% in the number of cases where initial letters of claim were received but no formal proceedings were issued within the two year limit
- a reduction in the number of cases relating to treatment/care provided by consultants prior to the extension of the CIS in February 2004 - in many of these cases, liability for the claim remained with the medical defence organisation that indemnified the consultant.

29.35 Less than 3% of CIS claims are resolved through the courts. The cases that do go to court are generally those involving infant cerebral palsy or other catastrophic injuries.

¹ In general, proceedings must be issued within two years of the event giving rise to personal injury.

Periodic Payment Orders

- 29.36** Periodic payment orders (PPOs) involve awards/settlements in catastrophic injury cases being paid on a periodic basis (normally annual), rather than as a single lump sum. A PPO would generally involve the payment of an initial lump sum followed by annual payments over the duration of the claimant's life, to cover the cost of future care and medication. Under a PPO system, there is uncertainty as to the total future liability associated with awards/settlements, because annual payments continue until the death of the claimant.
- 29.37** In October 2010, a working group chaired by a High Court judge completed a report examining the case for introducing a PPO system in respect of catastrophic injury cases. The working group recommended the introduction of legislation to empower the courts to make consensual and non-consensual PPOs to compensate injured parties in cases of catastrophic injury where long-term care will be required.
- 29.38** While PPOs have yet to be legislated for, the SCA advised that it has settled 24 catastrophic injury cases on the basis of a suspended PPO arrangement, involving the payment of an initial lump sum including provision for the cost of two years' future care. It was anticipated that the required legislation would be in place before the next court dates for these cases, i.e. two years after the making of the initial order.

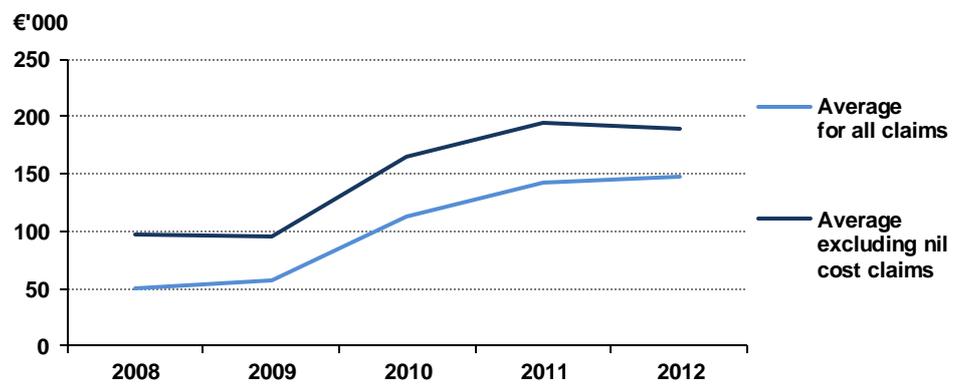
Cost of Claims

- 29.39** The primary objective of the claims management function within the SCA is to minimise the costs incurred by the State.
- 29.40** The direct costs incurred by the SCA in managing CIS claims comprise damages agreed or awarded and associated expenses. These expenses can include legal fees (SCA and plaintiff), medical fees, engineers' fees, actuary fees, expert fees and witness expenses.
- 29.41** Figure 29.5 sets out the costs of CIS claims resolved in each year from 2008 to 2012. Figure 29.6 shows the trends in the average cost per claim resolved between 2008 and 2012, both for all claims and excluding nil cost claims.

Figure 29.5 Cost of CIS claims resolved, 2008 to 2012

| Cost element | 2008 | 2009 | 2010 | 2011 | 2012 |
|--|---------------|---------------|---------------|---------------|---------------|
| | €'000 | €'000 | €'000 | €'000 | €'000 |
| Cost for all claims resolved | | | | | |
| Awards/settlements | 9,490 | 13,150 | 30,140 | 36,630 | 36,120 |
| Legal fees – SCA | 4,450 | 4,590 | 7,680 | 8,600 | 9,330 |
| Legal fees – plaintiff | 5,380 | 4,600 | 11,020 | 14,250 | 13,790 |
| Other | 830 | 370 | 890 | 1,040 | 1,030 |
| Total | 20,150 | 22,710 | 49,730 | 60,520 | 60,270 |
| Average cost per claim resolved | | | | | |
| Awards/settlements | 24 | 33 | 68 | 87 | 88 |
| Legal fees – SCA | 11 | 11 | 18 | 20 | 23 |
| Legal fees – plaintiff | 13 | 11 | 25 | 34 | 34 |
| Other | 2 | 1 | 2 | 2 | 2 |
| Total | 50 | 56 | 113 | 143 | 147 |

Source: State Claims Agency

Figure 29.6 Average cost per CIS claim resolved, 2008 to 2012

Source: State Claims Agency

29.42 Both measures show a marked escalation between 2009 and 2011. Over that period, the average cost per claim resolved increased from around €56,000 to €143,000. This contrasts with the average estimated potential liability for active clinical claims which was over €400,000 at the end of 2011 and about €366,000 at the end of 2012 (see Figure 29.3).

29.43 The reasons provided by the SCA for the escalation in costs since 2008 include

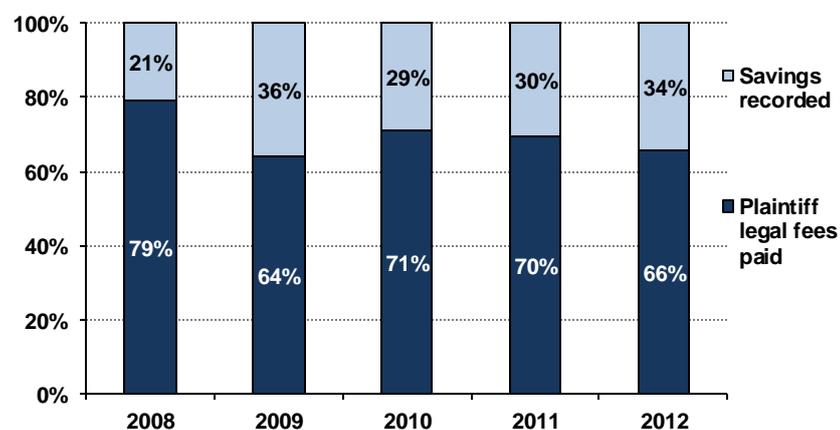
- The effect of 2,500 consultants, whose claims were previously handled by medical defence organisations, joining the CIS from 1 February 2004. By their nature, claims involving treatments provided by consultants tend to be larger than average.
- Many of the cases resolved towards the end of the period were relatively more complex as the SCA had prioritised the settlement of non-complex clinical negligence claims during the initial period after the CIS scheme was set up.

- The rate of medical costs inflation was significantly higher than the rate of general inflation during the period. This was reflected in judgements of the High Court, with the cap on general damages for serious and catastrophic injury cases increasing by 29% from €350,000 to €450,000 per case.

Cost Control

- 29.44** The extent to which the SCA can influence the level of court awards and agreed settlements is limited. Whilst the quality of the defence case put forward or the effectiveness of negotiations may be important, the outcome of the award or settlement is likely to be heavily influenced by the seriousness of the adverse incident and the extent of clinical negligence that occurred.
- 29.45** The SCA has undertaken a number of recent initiatives aimed at reducing the level of fees paid to its own retained legal firms.
- In 2011, the SCA completed a competitive procurement process to establish a panel of solicitors for the provision of legal services in respect of all claims under its management. The SCA has stated that establishment of the panel has enabled it to reduce the rates for legal fees paid to its retained solicitors firms by 25%. In addition, the SCA imposed caps on the levels of the fees paid to its panel solicitors in respect of cases involving catastrophic injury.
 - In 2012, the SCA initiated a competitive tendering process for barristers under which fees were capped at up to 25% below pre-existing levels. The lower fees apply to a wide range of legal services in respect of the District Court, Circuit Court and High Court. The SCA expects panels for both junior and senior counsel to be in place by October 2013.
- 29.46** The SCA states that it seeks to achieve the maximum possible reduction on bills for legal costs submitted by plaintiffs' legal teams. The policy of the SCA is to record savings negotiated in respect of plaintiffs' legal costs on the basis of the difference between amounts invoiced and amounts settled and paid on a claim by claim basis. In 2012, it estimated that the average amount paid to settle plaintiffs' legal costs in respect of CIS claims was around two-thirds of the amounts originally invoiced (see Figure 29.7).

Figure 29.7 Recorded savings on plaintiffs' legal costs, 2008 to 2012



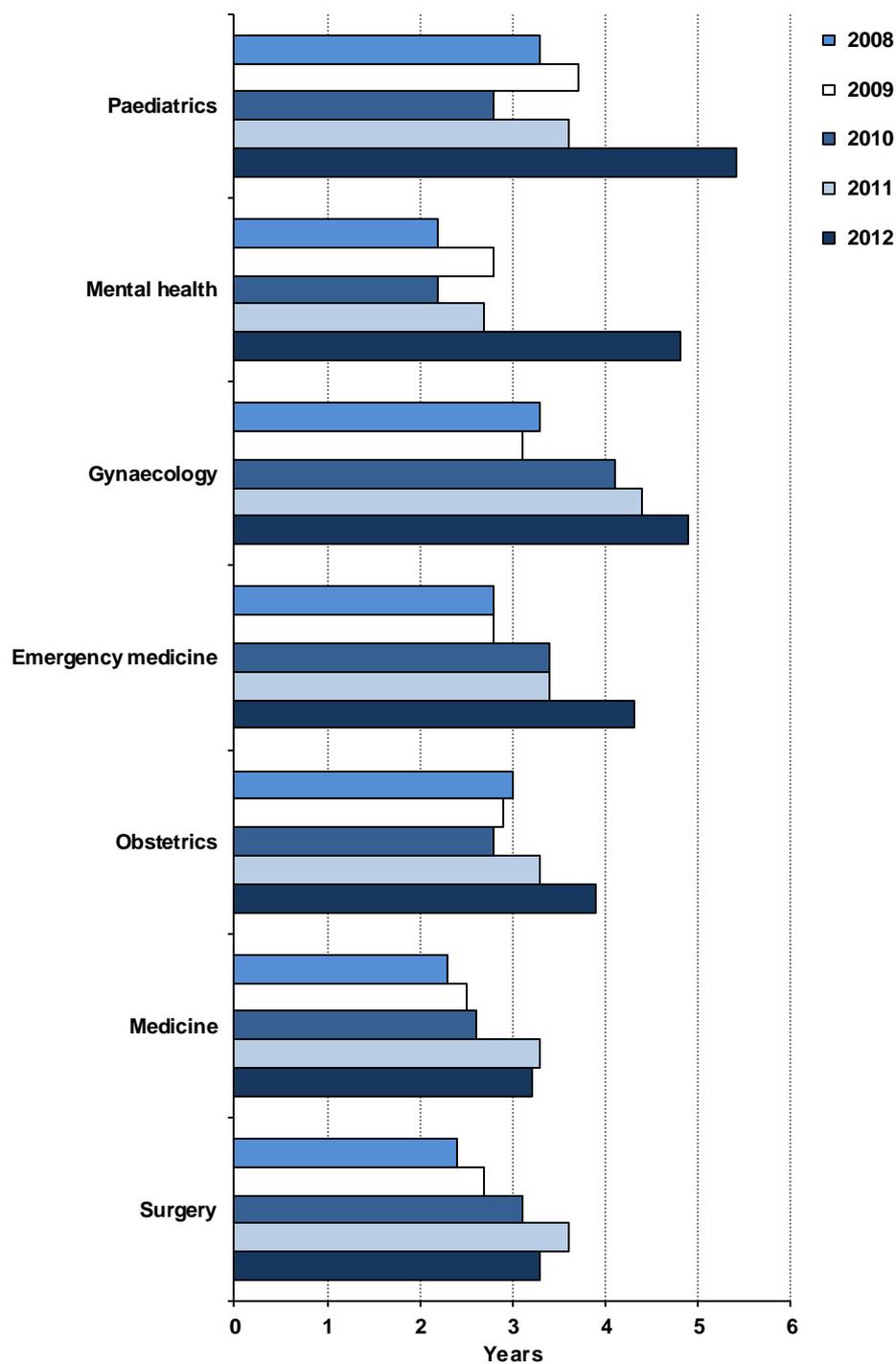
Source: State Claims Agency

- 29.47** Examination of a sample of CIS claims files carried out as part of this review found evidence that the SCA robustly challenges invoiced plaintiff legal costs and secures significant savings. However, in half of the sample cases examined, recorded savings had not been calculated in accordance with the SCA's policy for recognising legal costs savings.
- 29.48** Subsequently, an analytical review was carried out of recorded legal costs savings for all CIS claims resolved between 2008 and 2012. In 174 instances, with recorded savings totalling about €2m, it was found that savings had been recorded in respect of claims where no legal costs had actually been paid. In some other cases, where there was shared liability with a third party, the full amount of legal savings achieved was recorded against the SCA portion of the legal bill. As a result, there is a doubt over the reliability of the amount of legal savings recorded by the SCA.

Lifespan of Claims

- 29.49** The average time taken to resolve claims is a measure of the efficiency of the claims management function within the SCA. Figure 29.8 shows the average time taken to settle CIS claims for the major clinical specialties between 2008 and 2012. The lifetime of each claim was measured from the date it was recorded on the SCA's computer system until the date it was marked as closed on the system.
- 29.50** The average time taken to resolve claims in each of the clinical specialties increased over the period. In the case of mental health, the average duration more than doubled from 2.2 years for claims resolved in 2008 to 4.8 years for claims resolved in 2012.

Figure 29.8 Average lifetime of CIS claims resolved^a (years), 2008 to 2012



Source: State Claims Agency

Note: a The average number of claims resolved annually for each specialty, over the five year period, ranged from 13 for paediatrics to 110 for surgery.

29.51 The SCA provided the following reasons for the rise in the average time taken to resolve claims over the period.

- The clinical claims portfolio has matured in terms of complexity over the period, influenced largely by its extension to cover consultants from 1 February 2004.
- Significant delays occurred, particularly over the past three years, in relation to the listing of medical malpractice cases within the High Court's personal injuries list.
- More aggressive negotiating tactics have been adopted by plaintiffs' solicitors who resist early settlement in an attempt to gain advantage for their clients e.g. by commissioning multiple medical experts' reports (which can take considerable time) and delaying matters until a specific court date, where the matter is then settled. This may also result in higher plaintiffs' legal costs.
- There are certain cases where the SCA may also delay settlement e.g. where the Agency may be engaged in co-defendant or third party negotiations concerning apportionment of liability or where it is seeking an indemnity. Also, the SCA may for strategic reasons resist settlement in order to minimise or avoid costs in the future.

Claims Management Performance

29.52 Under a formal performance management system in operation within the SCA, annual goals and objectives are set for clinical claims managers. Individual plans for each claims manager are signed-off by the head of the Clinical Claims Unit and progress against objectives is monitored throughout the year. In addition, there are a number of key performance indicators (KPIs) in place for the Clinical Claims Unit. Performance against the KPIs is audited by the SCA's internal auditors. Figure 29.9 provides information on the performance of the Clinical Claims Unit for the period 2008 to 2012.

29.53 The KPIs reported generally relate to the level of claims management activity and the time taken to process transactions. In relation to its overriding objective of minimising the cost of claims, the SCA stated that it does not set specific annual targets for cost savings to be achieved and that it would be impossible to do so, given the turnover of claims in any year and on-going disputes over cost resolution.

Figure 29.9 Clinical Claims Unit performance, 2008 to 2012

| Indicator | Target ^a | Performance ^b | | | | |
|---|---------------------|--------------------------|------|------|----------------|----------------|
| | | 2008 | 2009 | 2010 | 2011 | 2012 |
| Active claims fully investigated | ≥20% | ✓ | ✓ | ✓ | ✓ | ✓ |
| Active claims subject to negotiation, where liability is not in dispute | ≥30% | ✓ | ✓ | ✓ | ✗ (26%) | ✗ (23%) |
| Average time from notification of claim to recording on system ^c | ≤5 days | N/A | N/A | N/A | ✗ (34 days) | ✗ (24 days) |
| Claims settled at no cost to SCA | ≥35% | ✓ | ✓ | ✓ | ✓ | ✗ (23%) |
| Claims with costs but no compensation payments | ≥20% | ✓ | ✓ | ✓ | ✓ | ✓ |

Source: State Claims Agency

Notes: ✓ Target met or exceeded ✗ Did not meet target

a The targets for some of the indicators were adjusted during the period. The targets shown are the ones set for 2012. Performance is reported relative to the original targets for each year.

b Performance figures for 2008 to 2010 specifically relate to the CIS. From 2011 onwards, KPI figures relate to all clinical claims, rather than just the CIS.

c Performance reporting commenced in 2011.

29.54 In relation to the duration of claims, the SCA stated that it has not set specific targets for reductions to be achieved. It stated that targets in this area would not be appropriate as the extent of investigations required and the complexity of negotiations varies from claim to claim and in some cases, a faster resolution could only be achieved at the expense of a higher settlement.

Risk Management

29.55 One of the SCA’s objectives is to advise and assist healthcare enterprises on measures to be taken to prevent the occurrence, or reduce the incidence, of adverse clinical events that could result in medical negligence claims. The management of risk within each health enterprise is the responsibility of the enterprise itself.

29.56 As the SCA does not have statutory powers of enforcement or recourse to sanctions in relation to its recommendations, it relies on persuasion and the prioritisation of patient safety as the focus of its risk management activities.

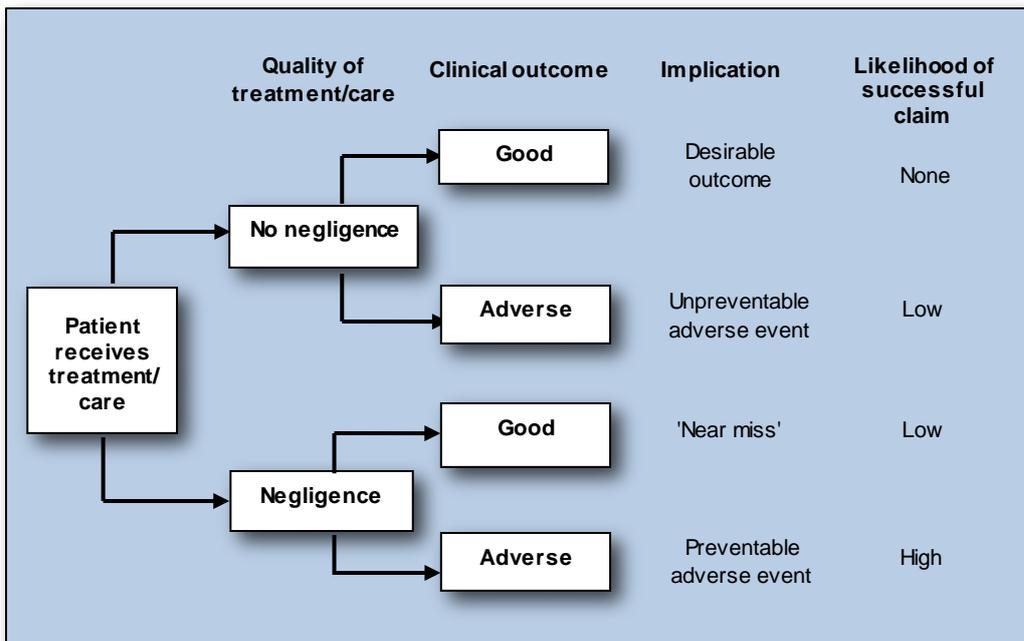
Adverse Clinical Events

29.57 Adverse clinical events are events causing injury or other adverse effects for a patient, arising as a consequence of the provision, or non-provision, of clinical care. In a small proportion of cases, adverse clinical events can lead to claims under the CIS.

29.58 Figure 29.10 illustrates how claims can arise in relation to clinical care or treatment provided.

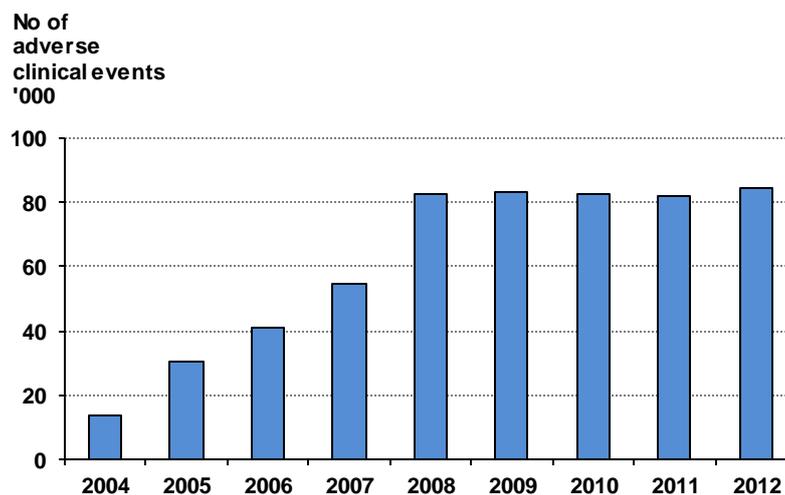
29.59 Enterprises covered by the CIS have a statutory duty to report all adverse clinical events to the SCA. All such events must be reported on a web-based IT system, known as the National Adverse Events Management System (NAEMS), which links hospitals and other healthcare enterprises to a central database hosted by the SCA.

Figure 29.10 How claims may arise



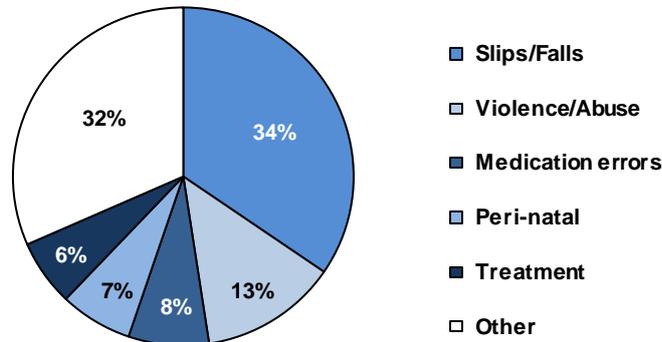
- 29.60** The NAEMS database provides key information at national and local level to assist in identifying clinical risks. It enables the SCA to identify and analyse developing trends and patterns and assists with claims investigation and management. It is intended that healthcare enterprises use the system to identify clusters of adverse events and perform root-cause analysis at a local level.
- 29.61** During 2013, the SCA provided each health enterprise with a report detailing the number of adverse clinical events reported by it and providing a comparison with a peer healthcare enterprise. During the course of this examination, the SCA was asked to provide a breakdown, by location, of adverse clinical events reported and new claims received over the period 2008 to 2012. The SCA indicated that it had no standard management report of such consolidated data and that the requested information would take a considerable amount of time to assemble.
- 29.62** Figure 29.11 shows the number of adverse clinical events reported over the period 2004 to 2012.

Figure 29.11 Adverse clinical events reported, 2004 to 2012



Source: State Claims Agency

- 29.63** Having increased very significantly between 2004 and 2008, the number of adverse clinical events being reported to the SCA has been relatively stable at between 80,000 and 85,000 each year.
- 29.64** Comprehensive and early reporting is critical to the SCA's ability to investigate adverse clinical events that may lead to claims and to carry out its risk management function effectively. The SCA estimates that related adverse clinical events had been reported in advance by the relevant health enterprise for less than 40% of the claims received between 2008 and 2012. There are valid reasons why a prior adverse clinical event may not have been reported for some types of claim e.g. complications may not arise for some time after a surgical procedure. Nevertheless, the rate of prior adverse clinical event reporting in claims cases appears low.
- 29.65** Figure 29.12 provides a breakdown of the major types of adverse clinical events reported in 2012.

Figure 29.12 Types of adverse clinical events reported in 2012

Source: State Claims Agency

Risk Management Activity

- 29.66** A team of six clinical risk advisors, with nursing, allied healthcare or medical backgrounds, is responsible for the CIS risk management programme. The SCA advised that the development of the risk management programme is informed by trend analysis of adverse clinical events notified by health enterprises, closed claims analysis, evidence based research and international best practice.
- 29.67** The main elements of the 2012 CIS risk management programme were
- reporting to healthcare enterprises on the results of analysis of adverse events and claims data
 - publishing risk management guidance for health enterprises and providing practical risk management tools
 - providing information and training through seminars, website publications and newsletters
 - providing risk management solutions directly to healthcare enterprises in respect of specific risk issues
 - assisting with the development and implementation of risk management policies and procedures for individual healthcare enterprises
 - carrying out risk management reviews.
- 29.68** The SCA provided details of some specific initiatives that have been developed, in collaboration with the HSE, with the aim of supporting the healthcare sector in delivering safer patient care.
- Open disclosure to patients and/or their families is being promoted in relation to adverse clinical events, whereby healthcare enterprises are encouraged to acknowledge the event that occurred, explain the cause, outline the expected consequences and planned future management, issue an apology and provide details of measures taken to reduce the likelihood of the event recurring in the future.

- A national early warning score system has been rolled out to support healthcare staff in promptly recognising and responding appropriately to deteriorations in the condition of patients on general wards.
- A strategy in respect of slips, trips and falls, which account for about one third of adverse clinical events reported annually, is being implemented at local, regional and national level.

29.69 The risk management programme also provides for ongoing collaboration with the Health Information and Quality Authority (HIQA). HIQA has the statutory remit for developing and monitoring compliance with standards of quality and safety in the Irish health services and to carry out investigations, as necessary, of serious concerns regarding the health and welfare of service users.

29.70 The roles of HIQA and the SCA are closely related, particularly in the area of the promotion of best practice in the quality and safety of healthcare. Although the SCA has an inspection mandate, it states that regular inspections of all health enterprises would not be feasible, given the level of resources available.

29.71 The SCA stated that the CIS risk team has collaborated with HIQA's Safety and Quality Improvement Directorate, since the latter's inception in mid-2012. Current areas of work include a quality improvement project designed to enhance control of medication for patients moving between long term care and acute hospital care, and an EU project designed to share learning between member states in relation to quality healthcare.

Risk Management Performance

29.72 The SCA has developed a risk management strategy for the CIS. The 2013 strategy lists strategic goals, core actions, key external collaborators and performance measures/outputs. However, the strategy does not specify desired outcomes or set targets in terms of the intended effect of risk management activity.

29.73 It is the opinion of the SCA that while it is possible to establish a direct causal relationship between clinical risk management activity and the number and severity of adverse clinical events, it is not possible to establish a similar direct causal relationship for clinical claims frequency.

Conclusions and Recommendations

Claims Management

- 29.74** The number of CIS claims under management by the SCA has increased year on year. The case load at the end of 2012 (excluding DePuy cases) represents an increase of over 45% since the end of 2008. Over the same period, the average time taken to resolve cases has also risen significantly. Direct costs have increased to an average of €190,000 per case, which is nearly double the 2009 equivalent figure.¹
- 29.75** While demand under the CIS, in terms of new claims received, increased from about 500 in 2008 to about 830 in 2012 (including about 230 DePuy cases), the number of cases resolved by the SCA remained steady, at between 400 and 450 per year. If the recent trend in demand continues, it is likely that the time taken to resolve cases will rise further, unless the SCA can increase its annual output of resolved cases. This may also have implications for direct costs per case.
- 29.76** The estimated potential liability in respect of all active clinical claims at the end of 2012 was €970 million. It is the SCA policy to include a 'margin of comfort' of up to 20% in its estimates of the potential liability associated with individual claims. As a result, the potential liability in respect of active claims may be overstated.
- 29.77** Auditors appointed by the SCA carry out an annual review of the estimated potential liability assigned to a sample of claims. The review considers the extent of compliance with the SCA's estimation policy and the reasonableness of the estimates in view of the case information on file. The review carried out by the auditors in 2012 concluded that the estimated potential liabilities for the sample of claims examined were "generally within reasonable parameters".
- 29.78** It may be possible for the SCA to make use of analysis undertaken by the auditors, as part of the annual review of estimated potential liabilities, in the development of statistical probabilities of case outcomes.

Recommendation 29.1: The estimates of potential liability for cases on hand should be based on statistical probabilities and informed by analysis of the outcomes of previous cases.

Accounting Officer's Response: Agreed. The NTMA agrees that the estimates, including any 'margin of comfort', of potential liability for cases on hand should be based on statistical probabilities informed by analysis of settled cases.

- 29.79** The HSE financial statements include a note disclosing the estimated liability in respect of active claims under the CIS. The HSE does not publish a schedule of the individual healthcare facilities in respect of which claims are settled, or are outstanding. In the course of the examination, the Accounting Officer of the HSE stated that the publication of such information could encourage the generation of league tables which the HSE generally considers would not be constructive, and could have the unintended consequence of discouraging the reporting by healthcare facilities of adverse events.

¹ This excludes nil cost cases.

- 29.80** Aside from damages agreed or awarded, legal fees represent the largest category of cost incurred by the SCA in managing CIS claims. The average level of legal fees paid by the SCA per resolved case has been rising over recent years. The SCA has sought to reduce the rate of legal fees paid to its retained solicitors by 25% by engaging in a competitive procurement process to establish a panel of solicitors. It is undertaking a similar process in respect of barristers. It expects to have new panels in place for both junior and senior counsel by October 2013.
- 29.81** In relation to plaintiffs' legal costs, it is SCA policy to negotiate costs and to record as savings the difference between the invoiced amount and the amount paid on a claim by claim basis. Evidence was found that the SCA routinely challenges invoices received for plaintiff legal costs, with savings of €7.2 million recorded for 2012. However, it was noted that in a significant number of cases, the savings recorded had not been calculated in accordance with the policy, thus potentially impacting the reliability of this figure.

Recommendation 29.2: The SCA should ensure that staff are familiar with the policy for recording savings on plaintiffs' legal costs and should implement a system of spot checking on compliance with the policy.

Accounting Officer's Response: Agreed. The NTMA accepts this recommendation and has re-stated its policy for the recording of savings on legal costs to all of its claims management staff. A system of spot checking has been introduced with effect from 6 August 2013.

Risk Management

- 29.82** Enterprises covered by the CIS have a statutory obligation to report adverse clinical events to the SCA. While it is likely that only a small proportion of adverse clinical events will lead to claims under the CIS, it is desirable that all adverse clinical events would be reported to the SCA in a timely manner to enable associated risks to be identified and managed effectively. The proportion of claims received since 2008 for which a prior related adverse clinical event had been reported to the SCA was less than 40%.
- 29.83** During 2013, the SCA provided reports generated from the NAEMS database to each healthcare enterprise with information on its own reporting rate for adverse clinical events and a comparison with that of a peer hospital. Performing a cross analysis of reports of this type should enable the SCA to identify healthcare enterprises where reporting needs to be improved.
- 29.84** The SCA risk management strategy for 2013 includes strategic goals, core actions and performance measures/outputs, but does not quantify desired outcomes or set specific targets.
- 29.85** Over the long term, the ultimate aim of SCA risk management is to reduce the number and severity of adverse clinical events. In the shorter term, the SCA needs to be able to measure the effectiveness of individual risk management initiatives and its risk management programme as a whole. It should be possible for the SCA to identify appropriate performance indicators to monitor the effectiveness of its risk management programme in terms of adverse clinical event outcomes at health service provider level.