20 Management of the Clinical Indemnity Scheme

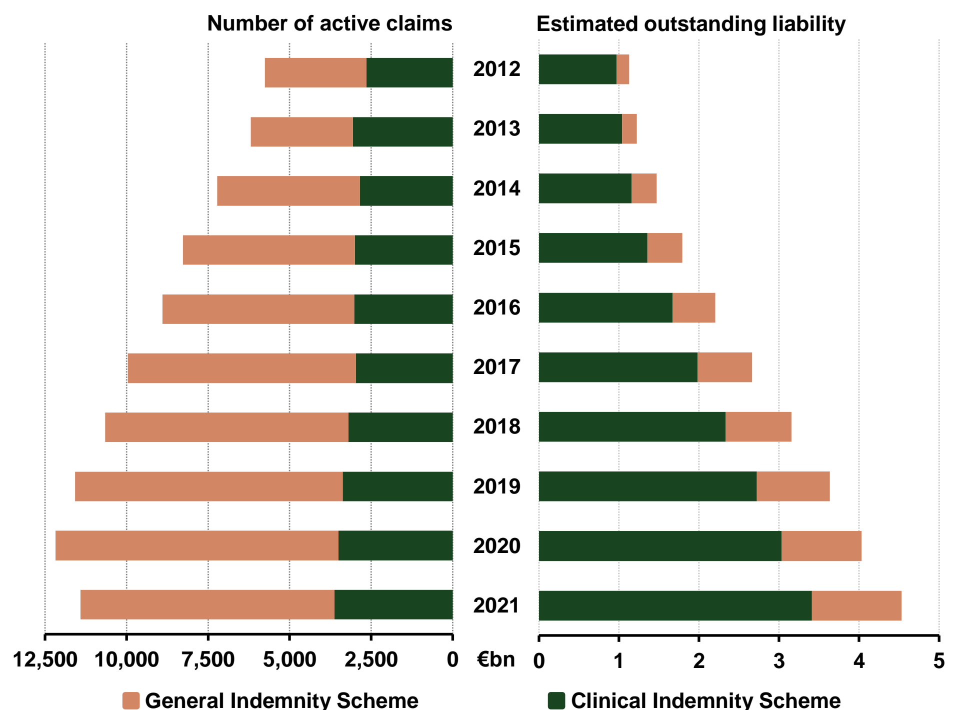
20.1 The National Treasury Management Agency (NTMA) manages personal injury claims including clinical negligence claims and third party property damage claims on behalf of the State and delegated State authorities (DSAs). It also has a risk management role, advising and assisting the DSAs in minimising their claim exposures. In addition, the NTMA manages third party costs against the State arising from all categories of litigation. When performing these functions, the NTMA is known as the State Claims Agency (SCA).

20.2 The SCA provides claim and risk management services through two State indemnity schemes — the Clinical Indemnity Scheme (CIS) and the General Indemnity Scheme (GIS).[1,2]

20.3 Since 2012, both the total estimated outstanding liability and the number of claims have generally been trending upwards. At the end of 2012, the estimated outstanding liability was €1.1 billion; by the end of 2021, it had increased to €4.5 billion, representing a four-fold increase over the period. The number of active cases being managed by the SCA at the year-end almost doubled over the same period, from 5,755 in 2012 to 11,408 active cases in 2021.[3]

20.4 At the end of 2021, CIS claims comprised almost 32% (3,626) of total claims, but accounted for over 75% (€3.4 billion) of the total estimated outstanding liability (see Figure 20.1). The cost of managing and resolving CIS claims in 2021 was €357.4 million, of which €76.5 million (21%) related to legal services and other costs.

Figure 20.1 Estimated outstanding liability and number of claims, 2012 to 2021



Source: State Claims Agency. Analysis by the Office of Comptroller and Auditor General.

1 Under the Clinical Indemnity Scheme, indemnity is provided to State authorities in respect of the provision of professional medical services.

2 Under the General Indemnity Scheme, indemnity is provided to State authorities in respect of personal injury and third party property damage due to negligence by the State body, its servants and/or agents.

3 Active claims are those that have been notified to the SCA through a legal process and that have not yet concluded at the reporting date.

20.5 This examination was undertaken to review the SCA's management of the CIS, with a particular focus on

- incident reporting and monitoring
- the claims and key cost drivers impacting the increasing liability
- how the SCA ensures that lessons learned from past cases are used to inform future outcomes and projections, and
- the system of accountability for claims incurred.

CIS management process

20.6 The SCA has comprehensive guidance and quality procedures in place governing the management of clinical negligence claims.[1]

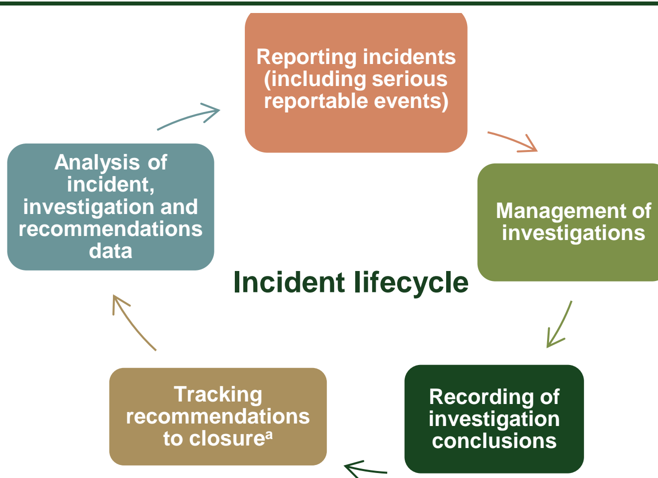
20.7 The average claims processing time for a clinical negligence claim varies depending on the particular clinical speciality involved.[2] Since 2012, the average time taken to finalise a clinical claim has increased from 4.26 to 4.97 years (17%). The largest increase (59%) was in respect of surgery related claims — 5.25 years in 2021. For maternity services related claims, the average processing time increased by 39%, from almost four years in 2012 to almost 5.4 years in 2021.

20.8 The SCA stated that while it endeavours to make all due efforts to resolve claims quickly, factors causing delays can include the speed with which plaintiffs and their legal representation prosecute claims, particularly where clinical negligence is alleged. It also stated that commissioning of expert witness reports to inform liability and causation issues can also add to the life span of a claim, as can the time taken to reach agreement of a plaintiff's legal costs.

National Incident Management System (NIMS)

20.9 The National Incident Management System (NIMS) is a confidential end-to-end risk management tool developed by the SCA in 2014 and which became fully operational in 2016.[3] NIMS enables the SCA and the DSAs to manage adverse incidents that could result in a claim, throughout the incident lifecycle (see Figure 20.2).[4]

Figure 20.2 NIMS incident lifecycle



Source: State Claims Agency

Note: a Relates to the initial recommendations made at DSA level.

1 An overview of the clinical negligence claims management process, from the time of the incident to the closing of the claim, is included in Annex 20A.

2 The lifetime of each claim is measured as the time from the date the claim is received to the date when all matters associated with it, including costs, have been agreed, but not necessarily paid.

3 NIMS replaced its predecessor — the National Adverse Events Management System (NAEMS).

4 NIMS is used by DSAs to fulfil their statutory responsibility under the National Treasury Management Agency (Amendment) Act 2000, to report incidents to the SCA and is also used for their own incident and risk management purposes.

Incident reporting

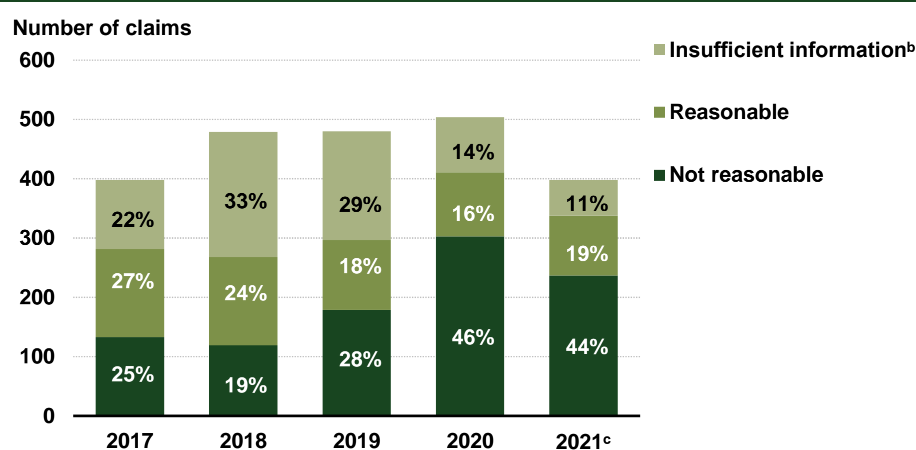
20.10 SCA guidance sets out that early reporting of incidents will increase the chance of a positive claim resolution. The SCA stated that there is evidence that high levels of incident reporting and a culture of learning are associated with lower levels of litigation.[1]

20.11 Overall, in the period 2017 to 2021, only 25% of claims received had previously been reported by the DSAs as incidents on NIMS prior to claim notification.

20.12 Of the 75% of claims not previously reported as incidents on NIMS over the period 2017 to 2021, (see Figure 20.3), the SCA concluded that

- in 22% of cases, there was insufficient information available to determine whether or not the incident should have been reported;
- it was reasonable for the incident giving rise to the claim to have been recorded on NIMS in 21% of cases i.e. it should have been recorded; and
- in around one third of all cases (32%), the DSA would not have been aware of the incident, and so could not reasonably be expected to have reported it.

Figure 20.3 Classification of claims not previously reported as incidents for acute hospitals, 2017 to 2021[a]



Source: State Claims Agency

Notes:
a Mass action claims are excluded.
b Includes four claims that were not populated.
c The level of claims received in 2021 may have been impacted by reduced activity due to Covid-19.

1 The SCA measures the performance of incident reporting by individual DSAs, by assessing whether each claim had previously been reported as an incident on NIMS.

Delta CPRI performance monitoring

20.13 The SCA uses 'claims previously reported as incidents' (CPRI) to calculate the 'delta CPRI' — a key performance indicator of the comprehensiveness of DSA incident reporting.[1]

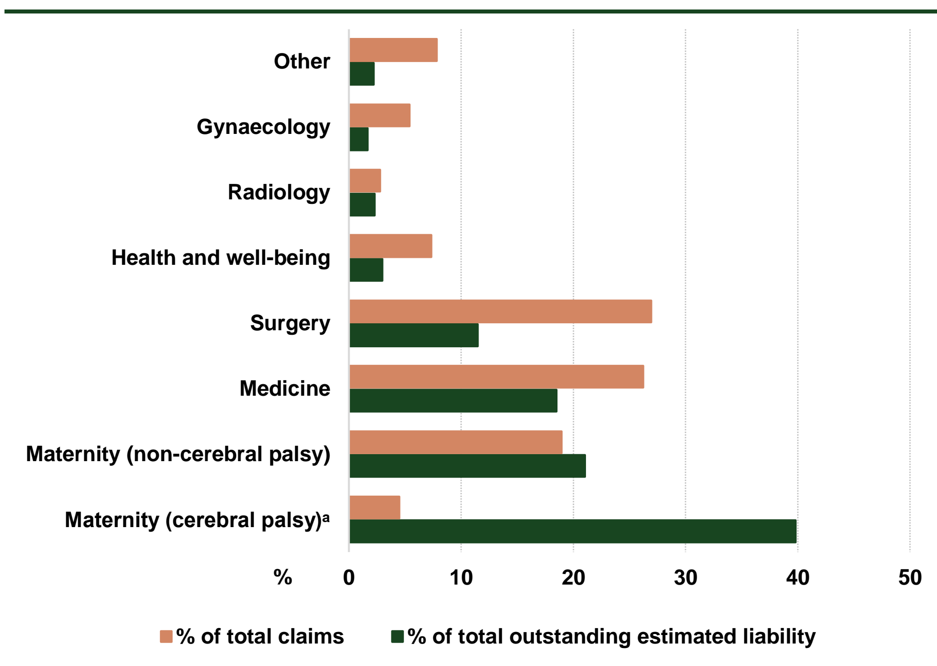
20.14 The SCA monitors each DSA's performance in reporting incidents leading to claims on a quarterly basis, by reference to expected incident reporting targets individually set and communicated to DSAs by the SCA. For the 52 acute hospitals within the clinical indemnity scheme, the analysis for 2020 shows that

- 20 hospitals did not have an average of at least one new claim per quarter and so for statistical reasons were not included in the analysis
- 24 hospitals had under-reported incidents leading to claims by 10% to 30%, and
- eight hospitals had under-reported such incidents by 40% or more.[2]

Estimated outstanding liability

20.15 At the end of 2021, the estimated outstanding liability for CIS claims was around €3.4 billion, of which maternity services accounted for just under €2.07 billion (61%). Cerebral palsy claims, which predominantly relate to maternity services, accounted for 40% (€1.36 billion) of the overall CIS estimated outstanding liability, but represented just 4.5% of the total number of active claims (see Figure 20.4).

Figure 20.4 Clinical claims by service and estimated outstanding liability, at end 2021



Source: State Claims Agency

Note: a There are also an additional 11 cerebral palsy claims included in other services such as medicine, surgery, health and well-being and radiology.

1 'Delta CPRI' is defined by the SCA as the difference between the number of claims expected to have been previously reported as incidents and the actual number of claims previously reported as incidents. A low delta CPRI value is an indicator of high levels of incident reporting.

2 2021 data unavailable at time of publication.

Calculation of liability

20.16 The SCA calculates an estimated potential liability for each individual claim. Its policy is to forecast the most likely outcome, in terms of the award or settlement and all associated costs, taking account of settlement levels in previous similar cases, and then to add a 'margin of comfort' of 20%. The estimated liability is broken down into general damages; special damages; plaintiff legal costs; and agency legal costs. Estimates are subsequently adjusted over the life of the claim if required to reflect any new information that becomes available.

20.17 In cases involving cerebral palsy or other catastrophic brain injuries, an initial reserve is set at a standard amount.

20.18 A previous report of the Comptroller and Auditor General on the Clinical Indemnity Scheme included a recommendation that 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. This would result in removal of the 'margin of comfort' addition.[1] While the recommendation was agreed to by the NTMA/SCA, it has not been implemented. During this examination, the SCA stated that it maintains a cautious approach in setting estimated liabilities and continues to build a degree of prudence into its estimates.

20.19 The SCA also stated that the actuarial review of annual cash projections takes into account the estimated versus settled figures for cohorts of claims. The SCA traditionally has relied on the actuarial cash projections analysis and internal audit's biennial confirmation that case estimated liabilities are set within reasonable parameters and that claims are dealt with in accordance with or better than industry standards. However, the SCA has stated that from 2023 it intends to track outturns against estimated liability on an ongoing basis.

Cost drivers for increased estimated liabilities

20.20 The main cost drivers in the estimated CIS liability are the number and type of claims on hand, and the average damages awarded.

20.21 The average award is influenced by a small number of high-value claims, typically catastrophic injury cases, and particularly those relating to cerebral palsy. In 2021, there were 335 active cases relating to catastrophic injury, with an estimated outstanding liability of €2.4 billion. The average estimated outstanding liability for a catastrophic injury claim is €7.24 million, compared to €300,000 for clinical negligence claims not categorised as catastrophic injury.

20.22 The life expectancy of claimants, which is actuarially derived, has a significant bearing on the estimates of liability. For example, a child injured at birth may be expected to require additional care and supports over their whole life, while an older person injured in an occupational accident may require care and supports over a shorter period.

20.23 The real rate of return that may be expected on investments is also a determinant of the estimates. As a result of a Court of Appeal decision in a specific case in 2017, the SCA adjusted the real rate of return it uses for liability estimation from 3% to 1% for future care-related special damages, and to 1.5% for all pecuniary losses. The lower the rate, the higher the estimated claim liability.

1 *Report on the Accounts of the Public Services 2012*, Chapter 29 'Clinical Indemnity Scheme'. The report is available here.

Periodic payment orders

20.24 Most settlements of claims are done on the basis of an award on a lump sum basis. This results in claimants being exposed to certain risks, including that they require care for longer than their actuarially assessed life expectation; or that inflation is higher than projected over their life time.

20.25 Where there may be uncertainty about the care needs of a claimant, especially in a catastrophic injury case, a settlement may be made on an interim payment order basis, where the adequacy of the settlement may be reviewed after an appropriate period.

20.26 As an alternative to one-off lump sum awards of damages, statutory periodic payment orders (PPOs) were introduced in October 2018, whereby claimants' future care costs are covered on an annual basis until the death of the claimant (an initial lump sum may also be paid, if appropriate).

20.27 Typically, PPO payment amounts are adjusted to take account of inflation. The adequacy of the *Harmonised Index of Consumer Prices* (HICP) used in calculating increases in annual PPO payments is under review by Government, following a court determination in 2019 that HICP inflation-related increases on a PPO award will be insufficient to cover the cost of care over time.

20.28 The SCA expects that most claims will continue to be settled on a lump-sum or interim payment order basis, excepting a change to the statutory index used to adjust PPO payment amounts. From January 2020 to July 2022, no statutory PPOs were made. There were just six PPOs in 2019.

Cerebral palsy

20.29 The total estimated liability of cerebral palsy claims, occurring in maternity services, received in the ten-year period 2012 to 2021 was €1.6 billion — almost €400 million of which has been paid with an outstanding liability of €1.2 billion.[1] Six hospitals account for 59% of the outstanding liability and 56% of paid damages. However, the SCA does not publish claim data at individual hospital level, and does not calculate comparative performance measures for hospitals, such as number of cerebral palsy cases per 1,000 live births per year.

20.30 The SCA stated that no national cerebral palsy registry exists in Ireland. There is currently only one region that has an active register, so data on recorded cerebral palsy cases is confined to that geographical area.

1 Additionally, legal and other costs paid related to these claims totalled €55 million.

Information flow and lessons learned

20.31 The SCA has a Clinical Risk Unit (CRU) which reviews, analyses and distils learning from reported incidents and claims data, and which shares the lessons with DSAs and national stakeholders to inform risk mitigation strategies at a local and national level.[1]

20.32 CRU key activities in the lessons learned process include

- NIMS data analysis, including incident surveillance and subsequent action
- reports on incident and claims analysis
- patient safety notifications
- education and training, conferences and webinars
- membership of a number of advisor bodies, including the Patient Safety Council and National Neonatal Encephalopathy Action Group (NNEAG)
- identifying risk trends and bringing them to the attention of the relevant DSA.[2]

20.33 The SCA focuses on services with the highest risk profiles, prioritising the clinical risk issues that are most likely to lead to significant claims. It carries out an annual targeted litigation risk management work programme, working closely with the relevant State authorities, and in particular the Health Service Executive (HSE). The NTMA (Amendment) Act 2000, states, *inter alia*, that the SCA's role is to advise and assist DSAs in relation to risk management. The SCA stated that ultimately the responsibility for the management of risks lies with the relevant DSA, and not with the SCA.

20.34 The SCA also stated that it is very difficult to measure the impact of its activities on the incidence of clinical negligence claims, due to the difficulty in detecting a statistically significant trend in claim numbers and in attributing trend movements to SCA related activities, given the multiple factors involved in the activities to improve patient safety and to mitigate risk. It further stated that measurement of impact is also complicated by the time lag between incidents occurring and claims being finalised and changes in clinical activity during that time.

20.35 The SCA produces a number of reports that are provided to relevant DSAs quarterly which include summary details of incidents; active claims; and the estimated outstanding financial liabilities. The SCA may also, on occasion, prepare reports at the request of individual DSAs to assist them with their risk management.

20.36 The elapsed time for issuance of some once-off SCA incident and claims analysis reports varies depending on the nature of the report. For example, patient safety notifications — statements highlighting a specific risk issue — were released within a year of the reporting period, while other SCA incident and claims analysis reports — undertaken to extract and share learnings — were released on average 2.5 years after the reporting period (see Figure 20.5).[3] The SCA has stated that longer term reports and communications, based on finalised claims data, typically involve more in-depth analysis compared with shorter-term reports and communications arising from the ongoing analysis of incidents.

1 The SCA implements its risk mandate through two specialist risk units the Enterprise Risk Management Unit and the Clinical Risk Unit.

2 Further information on the CRU's activities is included in Annex 20B.

3 Publications relating to Covid-19 and the HSE cyber-attack, were not included in the calculation of the issuance timeline of SCA incident and claims analysis reports. Those reports were issued, on average, within two months of the reporting period.

Figure 20.5 Overview of the incident and claims analysis reports produced by SCA[a]

Report[b]	Year under review	Year issued	Publicly available	Content
Research reports				
National clinical claims report	2017	2020	No	Provides an in-depth analysis of clinical claims that were finalised by the SCA in 2017.
Medication incident report	2017 – 2018	2020	Yes	Provides an analysis of medication incidents that were reported by Irish public hospitals in 2017 and 2018.
Analysis of clinical claims finalised in 2017 relevant to six hospital groups	2017	2021	No	Provides an in-depth analysis of clinical claims finalised by the SCA in 2017, specific to the hospital groups.
Analysis of all available national incident and claim data related to venous thromboembolism	2004 – 2020	2020	No	Provides high level analysis of incidents and claims in the period under review.
Review of clinical claims relevant to safe surgery 2016 – 2020	2016 – 2020	2021	No	Provides details of a review of clinical claims in the context of the HSE's review of the safe surgery policy.
National clinical incidents, claims and costs report: Lessons learned, a five year review 2010 – 2014	2010 – 2014	2017	Yes	Presents a review of the most common clinical incidents and claims nationally over a five year period.
Medication related litigation in Ireland: A six year review	2011 – 2016	2019	Yes	The study aimed to identify those medications most frequently associated with clinical litigation in Ireland and to quantify the costs of such litigation.
Incident analysis reports				
Snapshot analysis of NIMS incidents through an "anaesthetic lens"	Q1 and Q2 2020	2021	No	Presents an analysis of anaesthetic related incidents over two quarters.

Source: State Claims Agency

Notes: a Covid-19 and HSE cyber-attack reports; and advice related reports are excluded.

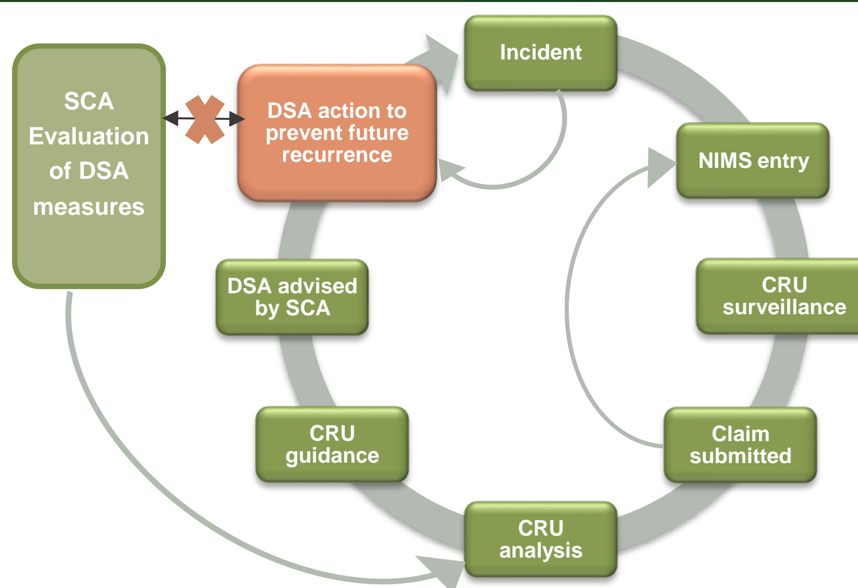
b These publications are once-off reports and are in addition to the quarterly reporting to DSAs and where published, can be found online.

Evaluation of measures adopted by DSAs

20.37 The SCA's statutory risk mandate sets out that the provision of assistance to DSAs may include, *inter alia*, the evaluation of the adequacy of the measures adopted by an authority to counter risks identified (see Figure 20.6).

20.38 The SCA noted that, when incidents are reported on NIMS or when claims occur, in most cases the relevant DSA will already have undertaken a review of the incident, made recommendations and have either implemented or be in the process of implementing the recommendations. It also noted that in these situations, it is often not appropriate or practical to make additional recommendations. Instead, the SCA may seek reassurance that recommendations already made have been implemented or are being progressed. The SCA stated that all healthcare DSAs must comply with the HSE's National Incident Management Framework, which sets out reporting requirements, including the use of NIMS and thereafter the requirements for reviews, recommendations and actions.

Figure 20.6 Summary of the State Claims Agency's lessons learned lifecycle



Source: Analysis by the Office of the Comptroller and Auditor General

Reporting the financial liability for claims

20.39 The SCA's annual financial statements disclose the aggregate estimated liability of State authorities for all claims under SCA's management at 31 December each year.

20.40 The HSE reimburses the SCA in respect of settlements made in relation to the CIS, and in respect of GIS claims in HSE facilities and voluntary hospitals. It also bears the cost of claims in respect of the activities of Tusla. In addition to the costs incurred in the period of account and accounted for on a 'pay as you go' basis, the HSE's financial statements disclose the contingent liability it has in respect of CIS and GIS claims that the SCA has on hand.[1] The HSE is not required to disclose a breakdown of the liability at individual hospital or unit level.

20.41 The costs incurred by the HSE are not passed back to the hospitals or units where the incidents giving rise to the claims occurred. Consequently, claim settlements and costs are not recognised in the financial statements of the DSAs in question.

20.42 The financial statements for five major hospitals were reviewed as part of the examination. None of the hospitals disclosed any details of the financial liability arising from claims related to their activities or acknowledged any serious adverse events in the financial statements. However, the number of active/settled claims and incidents reported were included in the annual reports of two hospitals (see Figure 20.7).

20.43 The SCA stated that it has always taken the position that to publish the claims experiences of individual hospitals would create a 'league table', which could lead to misinformed comparisons between hospitals with consequent negative impacts on delivery of services.

1 The HSE discloses the estimated liability in line with the accounting standards specified by the Minister for Health under the provisions of the Health Act 2004.

Figure 20.7 Disclosures of number of active claims and estimated liability in the financial statements and annual reports, by entity[a]

Entity	Financial statements			Annual reports
	Number of active claims	Estimated outstanding liability	Additional disclosures	Additional disclosures
State Claims Agency	✓[b]	✓	Receivable from DSAs	
Health Service Executive	×	✓	Payments to the SCA	
Hospital 1	×	×		Number of active claims and incidents
Hospital 2	×	×		
Hospital 3[c]	×	×		
Hospital 4	×	×		
Hospital 5	×	×		Number of settled claims and incidents

Source: Analysis of the Office of the Comptroller and Auditor General

Notes: a Financial statements for the years 2019 to 2021 were reviewed.

b Number of active claims is not split between the CIS and GIS.

c Does not publish an annual report.

Conclusions and recommendations

20.44 Since 2012, the estimated outstanding liability for SCA managed CIS claims has steadily increased. At the end of 2021, the estimated outstanding liability for CIS claims was €3.4 billion — an increase of €2.4 billion since 2012.

20.45 Claims related to maternity services accounted for just under 61% (€2.07 billion) of the estimated outstanding clinical liability at the end of 2021. Within this speciality, cerebral palsy claims, while representing just 4.5% of the total number of claims, accounted for around 40% of the estimated outstanding liability (€1.4 billion). There were 163 active cerebral palsy claims related to maternity services at the end of 2021.

20.46 Since 2012, the average time taken to finalise a clinical negligence claim has increased by 17%. The largest increase (59%) was for surgery related claims. For maternity services related claims, the duration increased by 39% from almost four years in 2012 to almost 5.4 years in 2021.

20.47 DSAs are statutorily required to report incidents to the SCA using the online system NIMS. SCA guidance states that early reporting of incidents increases the chance of a positive claim resolution. The SCA stated that there is evidence that increased levels of incident reporting and a culture of learning is associated with lower levels of litigation.

20.48 In the period 2017 to 2021, 25% of claims received had previously been reported on NIMS as an incident. The SCA considered that another 21% of claims received should have been previously reported as incidents. About one third of claims received were deemed to be of a type that could not reasonably be expected to have been reported.

20.49 The SCA analyses the rate of reporting of incidents and has identified a number of hospitals with a poor incident reporting record.

Recommendation 20.1

The SCA should work with DSAs where the culture of incident reporting is poorest to adopt a programme of measures to bring their reporting of incidents to an acceptable level.

Chief Executive Officer's response

Agreed.

The NTMA (Amendment) Act 2000 sets out that DSAs shall report to the SCA any adverse event, meaning any act, omission or other matter in relation to which a claim has been or may be made. It should be noted that the SCA does not have the authority to compel DSAs to report incidents. The SCA already has a number of measures in place to drive improved incident reporting levels by DSAs including

- the setting of annual incident reporting targets based on CPRI scores
- writing to DSAs with low reporting levels to remind them of their statutory requirement to report incidents
- flagging low reporting levels to hospitals at engagement meetings
- continuously improving NIMS to facilitate incident reporting e.g. roll-out of ePoint of Occurrence Entry (i.e. incident recorded directly on NIMS)
- providing education and training to DSAs in relation to NIMS and incident reporting.

20.50 The cost of managing and resolving CIS claims in 2021 was €357.4 million, of which €76.5 million (21%) related to legal services and other costs.

20.51 The main cost driver behind the increased estimated outstanding CIS liability is the average damages awarded. The estimated CIS liability is influenced by a small number of high-value claims, involving cases of catastrophic injury in a clinical setting, in particular those relating to cerebral palsy.

20.52 Currently, only one region in Ireland has an active cerebral palsy register. This captures data on recorded cerebral palsy cases for that geographical area. Similar information captured in all regions could enable a better understanding of preventable causes.

20.53 The dissemination by the SCA of advice and assistance to DSAs on the management of litigation risks, on enhancing the safety of service users/patients to minimise the incidence of claims and the liabilities of the State under the CIS, is extensive and comprehensive.

20.54 The SCA has legislative authority to evaluate the adequacy of the measures adopted by a DSA to counter identified risks. The SCA does not routinely evaluate the adequacy of the measures adopted by DSAs.

20.55 Some of the clinical risk issues identified by the SCA through its analysis and investigations have resulted in many recommendations being issued to DSAs. The SCA is of the view that it is impractical and not the best use of its resources to track implementation of these recommendations in detail.

Recommendation 20.2

The SCA should incorporate a process of evaluating the adequacy of measures adopted by DSAs countering risks identified, into its lessons learned procedures. Such a process, as provided for in its risk mandate, would help the SCA measure the effectiveness of the actions recommended and help improve accountability within DSAs.

Chief Executive Officer's response

Part agreed.

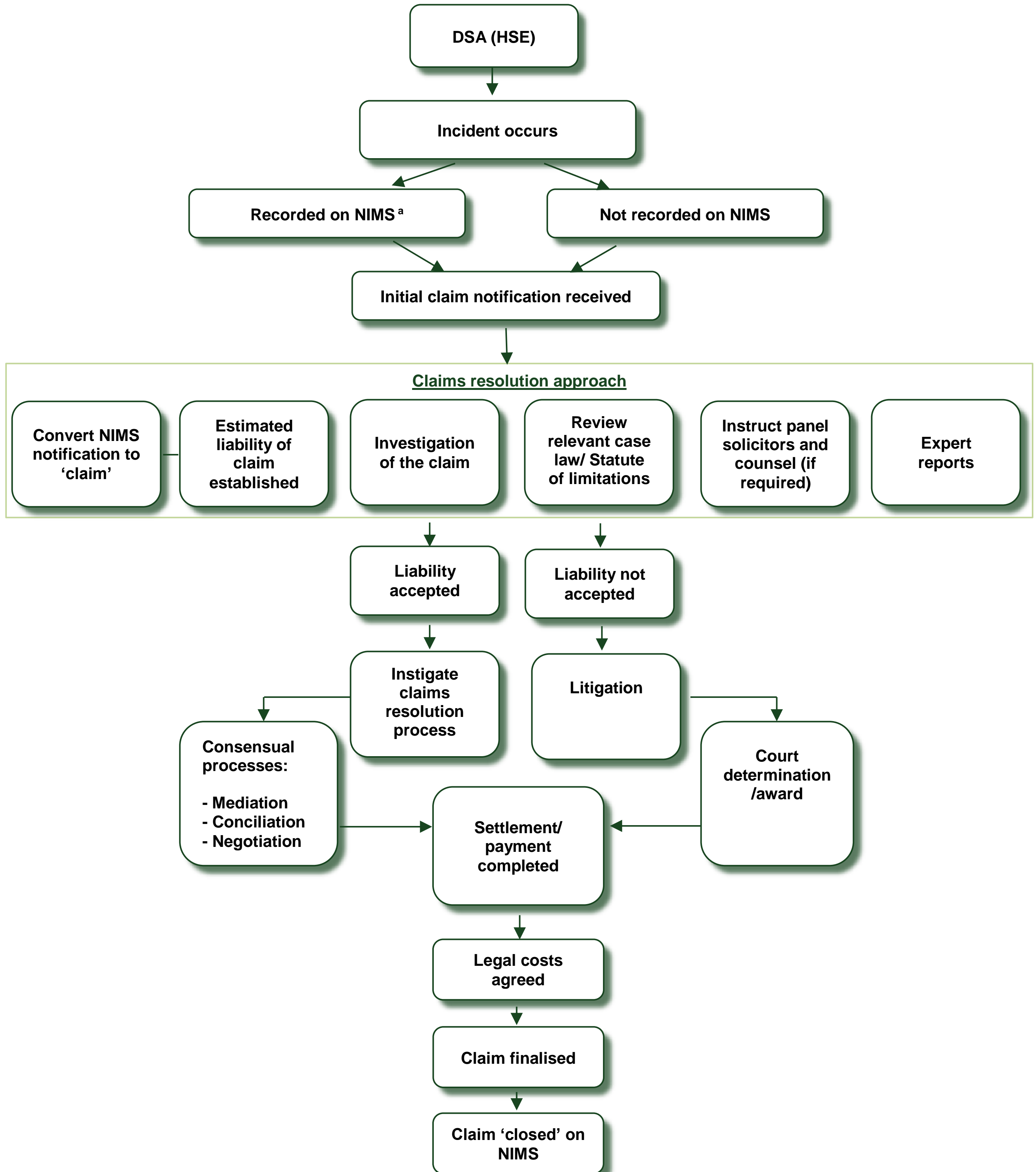
The SCA issues advices based on its analysis of incidents and claims to the HSE and other DSAs, some of which are of a general nature and issued broadly and some of which are specific and targeted. It is impractical and not the best use of its resources to track implementation by DSAs of all these advices, although the SCA does seek reassurance from DSAs on the implementation of risk mitigation measures in specific instances. While the SCA may seek to evaluate the adequacy of such measures in particular cases, it would not be an effective use of its resources to seek to routinely carry out such reviews.

It is important to note that it is very difficult for the SCA to identify the impact of its activities on the incidence of clinical negligence claims, due to the difficulty in detecting a statistically significant trend in claims numbers and attributing any trend to activities undertaken by the SCA, given the multiple factors involved in activities to improve patient safety and mitigate risk.

With regard to improvement of accountability within DSAs, responsibility for managing risks and setting risk management priorities remains in all cases a matter for the DSA concerned and the SCA's risk management role is an advisory one. In addition, healthcare DSAs are required to comply with the HSE's National Incident Management framework, which includes requirements for reviews, recommendations and actions.

20.56 The HSE's financial statements report the estimated CIS liability incurred as a consolidated total figure. The DSAs are provided with claims related data, including active claims, finalised claims, and financial information. However, since they do not bear the costs of claims, the DSAs covered by the CIS are not required to disclose details on the estimated liability or even to acknowledge the occurrence of serious adverse events in their financial statements.

Annex 20A Overview of claims management process



Source: Analysis by the Office of the Comptroller and Auditor General

Note: a NIMS is the confidential end-to-end risk management tool developed by the SCA that allows the DSAs to report incidents to the SCA and to manage incidents throughout the incident lifecycle.

Annex 20B Clinical Risk Unit activities

CRU activity	Description	Distributed to DSAs
NIMS data analysis	Review and analysis of incidents reported on NIMS, and appropriate follow-up actions. These actions include, but are not limited to, the development of patient safety notifications, local follow up with DSAs, or escalation to HSE.	Yes
Claims analysis (active and closed claims)	In-depth analyses of claims data undertaken in order to extract and share learning with DSAs and others.	Yes
Issuing of reports on incidents and claims analysis	Production of detailed reports on a specific incident or claim topic or theme. An in-depth analysis of incidents and / or claims data is undertaken in order to extract and share learning with the system.	Yes
Conducting CPRI analysis of new clinical negligence claims	The SCA measures incident reporting by organisations using a key performance indicator (KPI) called 'delta claims previously reported as incidents' (ΔCPRI). This KPI is designed to encourage DSAs to report incidents, building a culture of learning.	Yes
Provision of clinical risk and indemnity advices	Responding to queries from DSAs. These queries relate to risk management advice, indemnity advice, and incident reporting guidance.	Yes
Education and training for DSAs and higher education institutions	Educational sessions delivered by members of the CRU in areas such as risk management, patient safety and incident reporting.	Yes
Conferences and webinars	Conferences and webinars hosted by the CRU on a wide range of topics relevant to patient safety.	Yes
Representation on a number of national bodies and groups	CRU representation on a wide range of national bodies and groups that include the Independent Patient Safety Council, the Safety and Quality Committee of the HSE Board, and co-chairing the National Neonatal Encephalopathy Action Group (NNEAG).	Yes
On-going engagement with DSAs and stakeholders	Client and stakeholder engagements undertaken by members of the CRU. These engagements include meetings with DSAs, key stakeholders within the HSE and at a national level.	Yes
Identifying risk issues and bringing them to the attention of DSAs	Engagement with DSAs on specific risk issues, seeking reassurance from DSAs that appropriate mitigation measures are being put in place.	Yes
Co-designing and implementing with the HSE national initiatives to mitigate risk	The CRU is involved in co-designing and implementing with the HSE national initiatives to mitigate risk (e.g. the NNEAG programme).	Yes
Publication of Clinical Risk Insights newsletter	Newsletter generated by the CRU with a wide distribution — it includes articles on clinical risk management issues, case studies, NIMS updates.	Yes
NIMS continuous improvement projects	CRU staff are members of NIMS project teams and contribute to the on-going development and evolution of the system, in collaboration with the HSE	Yes

Source: State Claims Agency