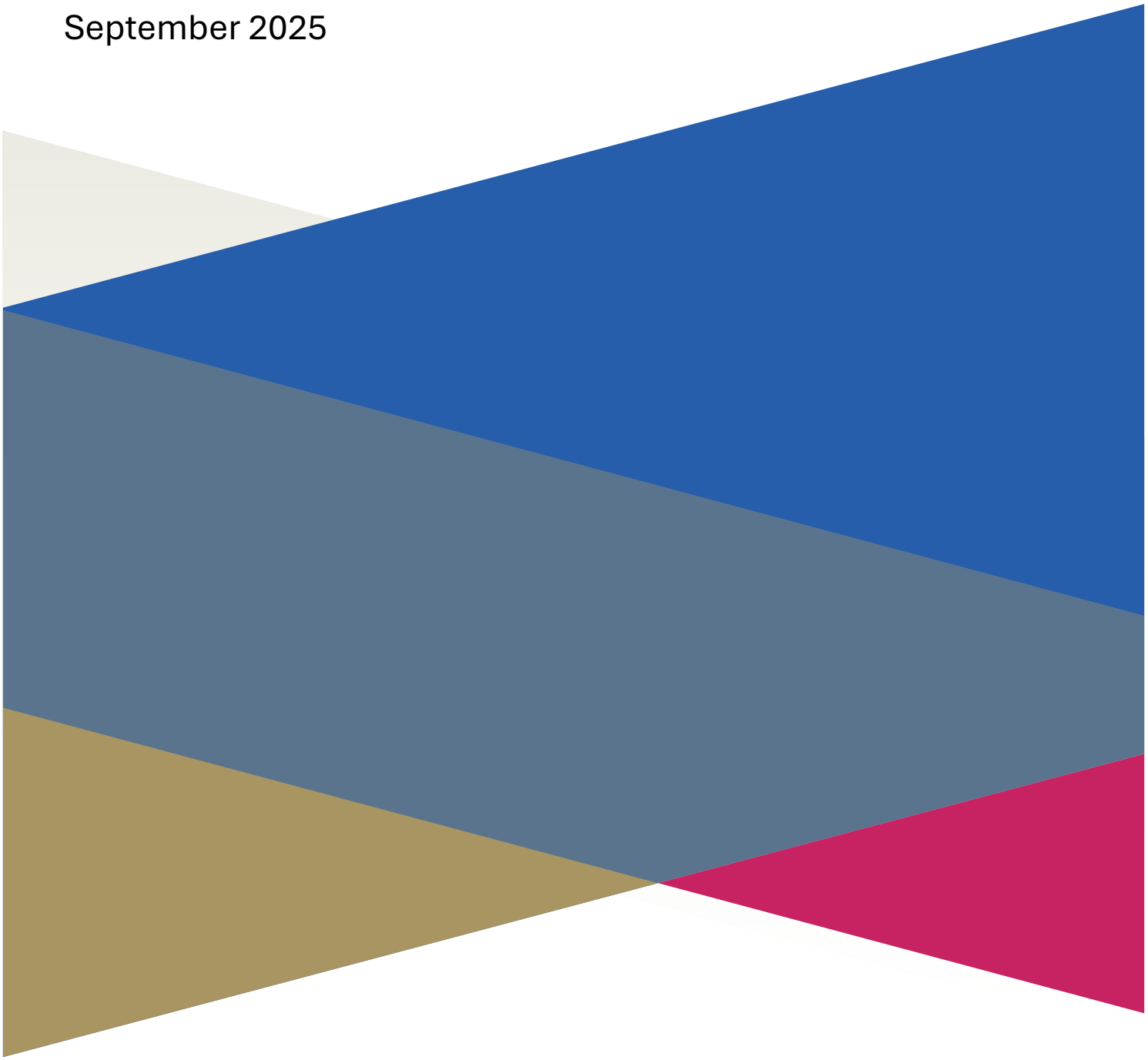
An Roinn Sláinte
Department of Health

Report of the Interdepartmental Working Group on the Rising Cost of Health-Related Claims

Implementation Plan

September 2025



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Executive Summary

This Implementation Plan has been prepared to ensure progress is made on the implementation of the recommendations contained in the Report of the Interdepartmental Working Group on the Rising Cost of Health-Related Claims (the Report), and to facilitate monitoring of that progress.

The Report identifies six strategic priorities, which aim to reduce the requirement for litigation in healthcare and improve the litigation process for those taking this path, as follows:

- Capturing data, learning from adverse events and promoting key research
- Preventing adverse events: Strategy, People and Resources
- Enhanced response when harm occurs
- Care for babies born with Neonatal Encephalopathy and other maternity initiatives
- Faster and more efficient resolution of claims
- Standardised approach to mass claims.

Each strategic priority has a corresponding set of recommendations and in total there are 30 recommendations made, that span a range of Government Departments and Agencies. The Report outlines that the primary driver of the rising cost of claims is the cost of care in a relatively small number of clinical catastrophic injury claims. The majority of these claims relate to perinatal brain injury and cerebral palsy, where early intervention is key. A number of key recommendations were made with regard to early intervention and the development of lifelong care pathways for this cohort.

The Government accepted the recommendations made and agreed to the establishment of an Interdepartmental/Agency Implementation Group to ensure that the recommendations made are implemented without delay.

In some cases, the recommendation is for a wider implementation of a measure that is already in place, in others the recommendation is to put in place something new to address an issue identified in the Report. Some of the recommendations provide leverage and support to progress measures already identified /previously recommended. The Implementation Group determined that a common approach to timelines was appropriate.

To support effective implementation, the Group categorised the 30 recommendations according to their anticipated delivery timelines as follows:

Short term: Already achieved or achievable within the current year (2025). These actions primarily focus on enhancing existing processes, and finalising measures already underway.
Medium term:1-3 years (by end of 2027). These actions include the expansion of training and resources to prevent adverse events, and building on the short term actions.

Long term: Over 3 years (but, less than 5 years). These actions involve systemic reforms, such as the establishment of lifelong care pathways and broader legislative or policy changes.

Since the publication of the Report in September 2024, and in tandem with the work of the Implementation Group on the drafting of this plan, a number of recommendations have been substantially implemented. These include the launch of the National Open Disclosure Framework in 2023 (Recommendation 3.1/3.4), along with the requirement for all relevant stakeholders to implement its provisions in 2024 (Recommendation 3.1); the commencement of the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 in September 2024 (Recommendation 3.7) and the issue by the President of the High Court of two new High Court Practice Directions concerning clinical negligence proceedings (Practice Direction HC 131 and 132) in April 2025 (Recommendations 5.1.b, 5.1.c and 5.1.d).

In addition, many other recommendations have been substantially progressed and are nearing completion/full implementation. These include a number of important civil justice measures, such as pre-action protocol regulations (Recommendation 5.1.a), periodic payment orders (Recommendation 5.2) and discount rate regulations (Recommendation 5.4), which will be finalised shortly. It should be noted that some of the recommendations require ongoing implementation and do not have a finite timeline (Recommendations 1.4, 1.6 and 6.1).

The actions associated with each of the recommendations are set out in the 'Summary of Actions' table, along with achievements to date on those actions. More detail on the actions is set out in the body of the Plan and related work in progress is outlined in more detail in Appendix 4.

This Implementation Plan, together with the actions associated with each recommendation, will form the basis of a programmatic approach to monitoring and reporting of progress on the implementation of the recommendations. Where it is possible to measure progress in a timebound, geographic or statistical/numerical basis, this will be done with evidence of progress shown. In some cases, reporting mechanisms already in place for other measures/strategies will reflect progress on these recommendations.

The Implementation Group will continue to meet to progress work on recommendations, monitor progress against the actions and timelines set out and report on progress periodically, in accordance with its terms of reference.

Since the publication of the Report and the establishment of the Implementation Group, the Programme for Government 2025, titled "Securing Ireland's Future", has been agreed. The Government has reinforced the importance of making progress on the implementation of the Report's recommendations by including a number of related commitments in the Programme for Government 2025.

Summary of Actions

Recommendation	Action	Achieved
Strategic Priority 1 - Capturing Data and Learning from Adverse Events		
1.1 (Lead – State Claims Agency) For consistency and standardisation in the recording, reporting, analysis and learning from adverse events, the Group recommends that all publicly-funded healthcare providers/settings providing clinical care should use the National Incident Management System (NIMS).	The SCA and HSE are currently in the process of developing a five-year strategy for NIMS. Outputs from the strategy, which will respond to this recommendation, will build on work already underway. Likely strategic objectives will address improving incident capture, increasing incident reviews, and improving learning and reporting from the system. Consideration will be given to providing NIMS access to organisations that do not currently have access to NIMS, in particular Section 39 organisations.	
1.2 (Lead – Health Service Executive) The Group recommends that, in line with the Incident Management Framework, each healthcare provider/setting should ensure that robust mechanisms are in place to disseminate learnings to all relevant staff and in particular to frontline workers derived from: a. the services own data relating to adverse events, b. the analysis by the HSE and the SCA of incident and claims data.	Progress the Q-funded (a quality initiative to improve healthcare) project to bring learning to the front-line	
	Using a human centred design approach, Patient_Safety_Together (the platform where the HSE share up-to-date patient safety information to support the Patient Safety Programme) will identify and explore the challenge of getting patient safety learning to the right people in depth and then co-design and co-develop resources to help address this challenge.	
	The work already progressing through Patient_Safety_Together will continue.	Ongoing
	SCA and HSE to agree mechanisms to build on work already underway, as outlined above, to ensure claims learning reaches frontline staff.	
	The quarterly claims and incident reports will be revised to mirror the regional structures and reporting requirements.	
	NIMS is being updated to mirror the establishment of the Health Regions and the Integrated Health Areas. This work has commenced with mapping of the regions underway. This will be complete by 2026.	
	The QPS functions across the HSE will be reviewed in line with Sláintecare.	
	The findings from the Q Community project will be reviewed and taken on board to help inform how best to get learning to the front-line by the HSE	
	Funding for the Patient_Safety_Together team (including additional WTEs) will be sought to enable it to grow and develop further	
	Staff to be aware of and utilise Patient_Safety_Together. Patient_Safety_Together (PST) to receive access to HSE claims data and to receive claims insight from the SCA for the development of resources issued through PST to improve safety and reduce the cost of claims.	

Short Term **Medium Term** **Long Term**

Recommendation	Action	Achieved
1.3 (Lead – Health Service Executive) The Group recommends that each healthcare provider/setting should provide reassurance to the SCA, when requested, that learnings and outputs from the SCA's analysis of claims and incidents have been shared with frontline staff, that risk mitigation strategies are in place and demonstrate efforts made to implement any recommendations made.	The process in relation to learning from claims in the HSE to help drive learning and improvement, will be mapped by the National Clinical Lead NQPS on behalf of the CCO and in collaboration with the REOs	
	The HSE will continue its collaboration with the SCA and respond where reassurance is requested.	Ongoing
	A QPS Executive Committee will be established by the HSE which will further map and oversee the development of regular reports.	
	Reports will be developed that collate a number of helpful quality and safety resources in line with the revised regional structure.	
	Well established reporting and assurance processes will be put in place demonstrating improvements in the system. This should be informed by national/local audit plans, reduction in risk scoring and reduction in harm incidents/complaints/experience/improved outcome data.	
	The HSE will continue to monitor compliance in this area through reporting on closing of audit report recommendations, incident reviews and complaints being closed.	Ongoing
1.4 (Lead – Health Service Executive) Clinical Directors or equivalent should be supported with tools to enhance feedback to frontline clinical staff on: common causes of harm, clinical care Incident analysis and common themes associated with litigation. This could be achieved through a combination of clinical meetings, local alerts and through the delivery of standardised on-line courses which should be prioritised for Continuing Professional Development (CPD) accreditation. The dissemination of learning from adverse incidents and claims data should be monitored centrally. This could be a role undertaken within the HSE.	Patient_Safety_Together will continue to be the central hub for sharing learning in the organisation. It is growing from strength-to-strength with increasing engagement from services with the site and its resources and will continue to be developed.	Ongoing
1.5 (Lead – Health Service Executive) The Group recommends that every healthcare setting providing clinical care should have the capability to undertake swift and comprehensive analysis of and response to serious adverse events that occur within its own setting. External support in accordance with HSE guidelines should be provided when requested and in major adverse outcomes.	A project lead/coordinator will be identified and will carry out an assessment of QPS staffing across Health Regions for HSE and funded services	
	Pending findings of the gap analysis - additional staffing resources will be secured for QPS nationally to increase capacity and capability of QPS teams to support timely and comprehensive analysis of and response to serious events	
1.6 (Lead – Health Service Executive) The Group recommends that healthcare providers should endeavour to capture positive outcomes and promote a balanced culture of learning.	HSE will continue to provide online up-to-date resources, learning events etc.	Ongoing
1.7 (Lead – Health Service Executive) The Group recommends that each clinical care unit should audit their primary clinical outcomes annually and publish their results in an annual clinical report.	Work in the HSE by the National Centre for Clinical Audit (NCCA), to develop the National Clinical Audit Strategy 2025-2030 will be progressed. This will align with the National Review of Clinical Audit (2019) and the HSE Patient Safety Strategy 2019-2024.	
	The maternity data from 19 maternity units currently published by IMIS in an anonymised format, will be published so that units are identifiable.	
Strategic Priority 2 - Prevention of Adverse Events: Strategy, People and Resources		
2.1 (Lead – Department of Health) Recognising that having appropriately qualified and adequate numbers of staff is a key driver of patient safety, the Group recommends that workforce planning initiatives across the system be further supported, with priority given to high-risk critical areas such as delivery and neonatal units.	Engagement between DoH and DFHERIS, DCDE and the Higher Education Sector and Professional Bodies will continue with a view to increasing the number of student training places in health-related disciplines informed by long term-term health and social care workforce planning projections.	Ongoing
	Engagement between HSE and DoH will progress to increase the number of postgraduate medical training places informed by long term-term medical workforce planning projections.	Ongoing
	The recommendations of the NCHD Taskforce Final Report will be implemented.	
2.2 (Lead – Health Service Executive) The Group recommends that all units delivering clinical care should be supported to develop and maintain responsive clinical governance functions, in accordance with HSE guidelines.	The HSE working group to develop a 'Clinical Governance Operating Model for Health Regions' will be fully established.	
	The review of Clinical Governance operating model will be completed	

Short Term Medium Term Long Term

Recommendation	Action	Achieved
2.3 (Lead – Health Service Executive) The Group advocates continued support for HSE patient safety initiatives and in doing so, recommends that available funding be prioritised and ring-fenced within the existing core allocations, to support ongoing patient safety initiatives in healthcare settings. This includes: • Funding to support evidence-based interventions aligned to the patient safety strategy, including data collection, analytical tools, training (including multi-disciplinary training in maternity services and simulation) and other tools for the sharing of learning. • Consideration should be given to making some elements of core training mandatory. • Continued focus on initiatives to address the common causes of harm.	The HSE will continue to implement the Patient Safety Strategy (2019-2024) with a focus on initiatives to address the common causes of harm, ensuring national level resources are aligned to support continued local action for patient safety.	Ongoing
	Update the Patient Safety Strategy	
	Complete scoping exercise to develop a national maternity dashboard and take steps to implement this	
	Secure additional resources to support the Patient Safety Strategy implementation and associated programmes (related to Common Causes of Harm), Sharing Learning Patient_Safety_Together etc. and take necessary steps to ring fence the funding	
Strategic Priority 3 - Enhanced Response When Harm Occurs		
3.1 (Lead - Department of Health) The Group recommends the adoption of the National Open Disclosure Framework by all relevant stakeholders and the incorporation of the Framework into their organisational policies and procedures at the earliest opportunity.	Annual self-reporting on implementation progress to the Minister has commenced	Ongoing
	Open Disclosure Framework launched	Achieved
	Implementation/Communication about the Open Disclosure Framework will continue.	Ongoing
3.2 (Lead – Health Service Executive) The Group recommends that a team of trained personnel should be available to each hospital dedicated to responding to serious adverse events, when they occur. Where appropriate, this team may comprise external regional support. An example of this is the Obstetric Event Support Team (OEST) in maternity care.	HSE Regional Executive Officers and Regional Clinical Directors will establish SIMTs/forums and ensure they are available in each hospital and at regional level – This will be carried out in line with model for Regional Quality and Patient Safety when agreed.	
	NQPS to carry out a review of IMF	
	A review of the OEST model will be carried out, Including its potential for expansion (NPEC)	
3.3 (Lead – Health Service Executive) The Group recommends that rapid access to appropriate clinical investigations and care when complications occur be prioritised in each hospital.	The HSE will continue to treat patient and service users with respect and sensitivity, and ensure all adverse events are acknowledged in line with Open Disclosure processes	Ongoing
	Where complications occur, patients will continue to be assessed and treated based on clinical need and their clinical history and past engagement will inform their plans of care.	Ongoing
3.4 (Lead - Department of Health) The Group recommends that guidelines and training for meaningful debriefing with the patient/family following an adverse event should be put in place in each hospital.	Annual self-reporting on progress of implementation of the National Open Disclosure Framework to the Minister has commenced.	Ongoing
3.5 (Lead – Health Service Executive) The Group recommends that all hospitals should ensure that bereavement or adverse event nurse/counsellors are available to liaise with families, along with a family liaison person or social worker, to signpost families to services and entitlements (it is acknowledged that elements of this care already exist in many hospitals).	The Bereavement Implementation Plan will be updated	
	Further steps will be taken to support hospitals/unit management teams to have succession plans in place for clinical midwife/bereavement nurse specialists	
	The HSE will work to embed the designated person role.	
3.6 (Lead - Department of Children, Disability and Equality) The Group recommends that necessary supports should be available immediately, within existing resource allocation, to assist parents with the additional care needs of children with catastrophic birth injuries while the longer-term support needs are being determined and arranged. Early intervention has been shown consistently to optimise outcomes and has the potential to reduce the risk of claims increasing due to inflation or unmet needs or suboptimal outcomes translating into larger costs. This may ultimately reduce the cost of damage settlements determined by the Courts.	Map Existing Pathways and Supports	
	Analyse findings from mapping to identify gaps in policy, services, and coordination affecting access and outcomes for this cohort.	
	Prepare a response to enhance current pathways	
	Commence phased implementation	

Short Term **Medium Term** **Long Term**

Recommendation	Action	Achieved
3.7 (Lead - Department of Health) The Group recommends that the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 be commenced by the Minister for Health at the earliest possible opportunity. All relevant stakeholders should be required to familiarise themselves with the provisions of the Act through mandatory training. All healthcare providers should take steps to ensure that patients are made aware of their entitlements under the Act.	All sections of The Patient Safety Act 2023 related to Open Disclosure and Notifiable Incidents have been commenced. The final remaining section of the Act will be commenced shortly following the passage of a technical amendment through the Oireachtas.	
3.8 (Lead – Department of Health (Policy), Health Service Executive (Operational)) The Group recommends that a robust complaints and patient experience feedback mechanism should be developed within all clinical care units. This data should be collated and analysed by individual units as part of a broader assessment of patient experience within our healthcare institutions. These should be shared with frontline staff to assist learning and understanding of positive and negative experiences of healthcare.	Structured consultation process will take place to engage at all levels of the system and with all relevant parties	
	National Complaints policy will be developed with inclusion of national research recommendations on the principles and values that support a person-centred complaints management process	
	Complaints policy to be supported with a fit for purpose robust IT Complaints Management System which is fully integrated with complaints process and readily accessible to all frontline staff in healthcare institutions	
	The National Maternity Care Experience Survey will be implemented, and results published	
	Continued programme of Your Service Your Say	Ongoing
	Continued delivery of the National Care Experience Programme	Ongoing
	The National Mental Health Care Experience Survey will be further developed and implemented, and the results published	
	The National Cancer Care Experience Survey will be implemented, and results published	
Strategic Priority 4 - Care for babies born with Neonatal Encephalopathy and other Maternity Initiatives		
4.1 (Lead - Department of Health) The Group recommends that data on Neonatal Encephalopathy (NE) be collected on a statutory basis, and that a register of cerebral palsy cases in Ireland should be developed.	The Department of Health will engage with the HSE to explore further whether the data mandatorily notified under the Patient Safety legislation relating to babies referred or considered for referral for therapeutic hypothermia, could assist with meeting the recommendation that data on NE be collected on statutory basis.	
	The Department of Health will engage with stakeholders concerning work that is already underway to develop a Cerebral Palsy register and take steps to ensure that the existing proposal meets the appropriate standards and aligns with Departmental requirements.	
	Pending the outcome of the action above, continue to collaborate with stakeholders to ensure that a CP register is put in place that is sustainable in the long run	
4.2 (Lead – Health Service Executive) The Group recommends that the work of National Neonatal Encephalopathy Action Group (NNEAG), and its efforts to reduce to the greatest extent possible the incidence of birth-related CP/catastrophic birth injury, should receive ongoing support and endorsement.	Ongoing discussions will continue involving the Department of Health, NWIHP and the SCA in relation to reviewing the work of NNEAG.	Ongoing
	A revised TOR for NNEAG will be developed, incorporating a revised statement of purpose, aims, priorities, and mechanisms of evaluation.	
4.3 (Lead – Health Service Executive) The Group recommends that the investigation and follow-up of infants with HIE needs further development and standardisation. All babies presenting with HIE should have a standardised assessment including placental examination, MRI brain scan and follow up neurodevelopmental assessment.	Babies requiring therapeutic hypothermia are referred to one of four centres. Clear communication from receiving hospital and referring hospital during and after discharge will be enhanced	
	Practical advice and support for parents whose baby is referred for treatment will be enhanced	
	The Model of Care for neonatology for Ireland will be updated. Further pathways are contingent on this model of care.	
	Recent recommendations regarding neonatology in smaller maternity units will be implemented as appropriate.	

Short Term **Medium Term** **Long Term**

Recommendation	Action	Achieved
4.4 (Lead – Health Service Executive) The Group recommends that research initiatives that advocate earlier diagnosis and intervention in cerebral palsy should be supported and that a taskforce should be put in place to devise a model of care for babies with HIE so that standardised follow up will lead to the early detection and intervention in those babies with CP.	Model of Care for Neonatology to be completed by Q2 2026 with a model of Care for babies affected by HIE to follow	
4.5 (Lead - Department of Children, Disability and Equality) The Group recommends that care pathways, once developed, which start at birth and continue through life, for children who have suffered a catastrophic birth injury, should be considered for implementation on a national basis. The Group recognises that the initial development of new care pathways will be managed within existing resources. The State provision of such care could facilitate immediate and more effective evidence-based care and lead to growing national expertise, reducing the reliance on ad hoc private care arrangements. In addition, the provision of early claims resolution in the context of perinatal brain injury has the potential to meet family needs in real time, facilitate early clinical intervention and reduce the risk of claims increasing in value due to inflation or unmet needs translating into higher costs. While initially these care pathways would be limited to the cohort of children who have suffered a catastrophic birth injury, consideration should also be given in the future to rolling out these services to all children with cerebral palsy over a longer period of time, as national expertise and capacity develops and a review has been undertaken with regard to their effectiveness and efficiency for the initial targeted cohort. This would also need to be informed by an assessment of the feasibility of potentially increasing eligibility including resourcing constraints.	Map existing pathways and supports	
	Analyse findings from mapping to identify gaps in policy, services, and coordination affecting access and outcomes for this cohort	
	Prepare a response to enhance current pathways	
	Commence phased implementation	
	Further actions will be identified following the outcome of the Medium-Term Actions above (linked to Recommendation 3.6)	

Short Term Medium Term Long Term

Recommendation	Action	Achieved
Strategic Priority 5 - Faster and More Efficient Resolution of Claims		
5.1 The Group recommends the implementation without delay of recommendations made in a number of previous reports, along with some additional recommendations, advocating changes and improvements to the management of clinical negligence claims to include: a. The introduction of a pre-action protocol with sanctions for a party who fails to adhere to the protocol, as recommended in the Meenan Report. **(Lead – Department of Justice)** b. The facilitation of earlier mediation, where possible and agreeable to both parties. **(Lead – State Claims Agency)** c. Amendments to case management Rules of Court should be made, to include a stipulation that equivalent rules apply to both sides, and that joint expert meetings (hot-tubbing) should be required to take place. **(Lead - Courts Service)** d. A dedicated Court list should be established with judges in place with specialist knowledge of medical negligence litigation, or other appropriate measures to facilitate the earlier hearing of medical negligence cases. **(Lead – Courts Service in conjunction with the Judiciary)**	a. Pre-Action Protocol regulations will be finalised b. SCA to continue to offer mediation, where appropriate and agreeable to both parties, at the earliest possible time b. The operation of Practice Direction (HC131) is already in place. This will be kept under close review. c. A new High Court practice direction (HC131) has come into effect from 28th April. This new practice direction, coupled with existing practices relating to 'Hot-Tubbing', achieve the desired outcome and effectively allow that the recommendation is met. d. The President of the High Court has issued a new practice direction (HC 132) establishing the new Clinical Negligence List and this is in place. It will be kept under regular review and amended or modified where necessary.	Ongoing Achieved Achieved Achieved
5.2 (Lead – Department of Justice) The facility for Courts to award Periodic Payment Orders should be resumed.	Periodic Payment Orders regulations will be in place	
5.3 (Lead – Sub-group established) The Group recommends that a panel of medical expert witnesses should be developed initially on a voluntary basis. This could be overseen by an existing regulatory body with appropriate expertise. Members of the panel would meet a series of criteria including that they are in active practice or recently retired, with relevant expertise and are trained as expert witnesses. They should be available to appear as expert witnesses for plaintiffs and defendants. Membership should function as a quality assurance and members of the panel should receive Continuing Professional Development accreditation.	A subgroup of the RCOC Implementation Group consisting of the Department of Health, the Department of Justice, the HSE, the SCA and the Courts Service will be established to consider this recommendation in light of existing Court rules and law in this area along with new High Court directions. The subgroup to undertake consultation with relevant parties The subgroup to reach its conclusions	Achieved - existing mechanisms in place meet this recommendation - no further action required Achieved Achieved
5.4 (Lead – Department of Justice) The Group recommends that the personal injury discount rate, also known as the real rate of return, should be reviewed at regular intervals by the Minister for Justice.	Discount Rate regulations to be finalised A review mechanism to be agreed	

Short Term **Medium Term** **Long Term**

Recommendation	Action	Achieved
5.5 (Lead – Department of Health) The Group recommends that a medical records system, with unique identifiers, be put in place to facilitate better and more timely provision of records and that a system be put in place so that a patient or their solicitor can view their electronic medical records. In addition, a training programme for hospital staff should be put in place regarding best practice around medical records.	The Health Information Bill will be enacted	
	Continue the deployment of the National Maternity Clinical Management System MN(CMS) across maternity hospitals	
	Advance the business case and funding for development/progressing eHR under the NDP	
	HSE to ensure appropriate training in place to support the roll out of eHR	
5.6 (Programme for Government Commitment – No Lead) Prioritise the introduction of a court supervised mediation-based process for managing neonatal brain injury medical negligence cases.	Consult with relevant parties (SCA, Department of Justice & the Courts Service)	Achieved
	Implementation of civil justice measures in Recommendations 5.1.a, b and d, 5.2 and 5.4 above	
	Monitor and review the impact of those measures	
	Consider any further measures necessary	
Strategic Priority 6 - Standardised Approach to Mass Action Claims		
6.1 (Lead - Department of Health and State Claims Agency) As set out in the Report, a range of alternative dispute resolution processes have been implemented. The Group recommends that the State should continue to use various forms of alternative dispute resolutions (e.g., mediations, binding mediations, ex-gratia schemes, compensation schemes, evaluations, assessments and tribunals) as appropriate, in order to offer an alternative to the adversarial court process.	Relevant State parties to continue to use of alternative dispute resolution approaches to litigation in appropriate circumstances, with the learning from existing or previous models to be taken on board. Examples of this include the Surgical Symphysiotomy Ex-Gratia Payment Scheme, the Kerry CAMHS Compensation Scheme, the H1N1 Vaccine claims, the DePuy Hip mass action and the CervicalCheck Tribunal.	Ongoing
6.2 (Lead – Department of Health) The Group also recommends the development of a Vaccine Damage Scheme to ensure a controlled approach to management of potential claims, which should be undertaken urgently in line with previous commitments.	A Government Decision will be secured to develop the legislation underpinning the scheme	
	Heads of Bill will be drafted	
	A panel of experts to make determinations will be appointed	
	Administrative arrangements will be put in place	
	Communications strategy will be put in place	

Short Term Medium Term Long Term

Introduction and Context, Approach to Implementation and Monitoring and Reporting

This Implementation Plan has been prepared to ensure progress is made on the implementation of the recommendations contained in the Report of the Interdepartmental Working Group on the Rising Cost of Health-Related Claims (the Report), and to facilitate monitoring of that progress.

Government approval and Publication of the Report
Following Government approval, the Minister for Health published the Report of the Interdepartmental Working Group on the Rising Cost of Health-Related Claims on the 19 September 2024, along with two ancillary reports, 'Plaintiff experiences of the medico-legal environment in Ireland (UCC)' and 'A Comparative analysis of clinical negligence claims in a range of jurisdictions (HRB)'. The reports are available on the Department of Health's website.

The Government accepted the recommendations in the report and agreed to the establishment of an Implementation Group to examine each of the recommendations in further detail and drive forward implementation of the recommendations.

We wish to thank the members of this Group and their colleagues in their organisations for their input to the preparation of this Implementation Plan. We look forward to working with them to progress the implementation of the recommendations. The Group will monitor and report on progress made in this regard.

Interdepartmental Working Group on the Rising Cost of Health-Related Claims 2024 Report
On 31st January 2023, Government approved the formation of an Interdepartmental Working Group to examine the rising cost of health-related claims, with a particular focus on high value claims and to identify measures that could be put in place to reduce future costs. The Terms of Reference included examining international best practice and the exploration of strategies to reduce adverse incidents and to enhance measures to address patient concerns and improve care following adverse events. The Group was also asked to provide updates on the implementation of the recommendations set out in the report of the "Expert Group to Review the Law of Torts and the Management of Clinical Negligence Claims" (Meenan Report) and to consider the health system's approach to mass action claims.

The Group, chaired independently by Professor Rhona Mahony and comprised of membership from across relevant Government Departments and Agencies, held its first meeting in March 2023.

The Group's considerations focussed on the following key themes:

- Examining best international practice to establish how we compare and what lessons can be learned from elsewhere in terms of indemnity models that are in place in other jurisdictions, the cost of claims, the clinical incident rate and the incidence of cerebral palsy;
- Examining whether there are ways to further improve the quality of services/improve patient safety and thereby reduce the number of adverse incidents;
- When an incident occurs, exploring ways to enhance the process to resolve matters faster and more efficiently;
- Seeking to identify ways to reduce costs through a number of civil justice reforms, including the resumption of Periodic Payment Orders (PPOs), the development and implementation of a pre-action protocol (PAP), case management rules and stabilising issues regarding the Real Rate of Return and;
- Considering the health system's approach to mass action claims.

Establishment of the Implementation Group

Further to Government approval, and following an examination of the recommendations, invitations were issued to the relevant Departments and agencies seeking nominations to the Implementation Group.

The Implementation Group is chaired by the Department of Health and comprised of Government Departments and State Agencies, that have relevant policy or operational responsibility for particular recommendations made in the Report.

The Implementation Group held its first meeting on 30 September 2024 and agreed its Terms of Reference (TOR). Membership of the Group and its Terms of Reference are set out in Appendix 1.

The Implementation Group was tasked with examining the recommendations made in the Report in further detail and in particular to:

1. Carry out a mapping exercise for each recommendation to identify what is currently in place and what measures are needed that are not in place in order to fully implement each one.

2. Identify the steps required to implement each recommendation and an associated timeframe for doing so. This should include an identification of recommendations that could be instituted in the short, medium and longer term.

3. Estimate the costs of implementing each recommendation and identify potential savings to be made in terms of the cost of claims in the short, medium or long term.

4. Identify key milestones for implementation for each recommendation and carry out a risk analysis on each, identifying any potential threats to their implementation.

5. Where it is identified that funding will be required, e.g., in the development of care pathways for children who have suffered a catastrophic birth injury:

- identify how funding could be reprioritised from within existing HSE resources for the initial development of these services.
- estimate the likely future costs and potential savings in the longer term to roll out these services, following a review of the effectiveness and efficiency of the roll out to the initial cohort. If necessary, support external to the Group may be engaged.

Work undertaken by the Implementation Group to date

The focus of the work of the Implementation Group to date has been on development of this Implementation Plan, identifying what is already in place in service of the recommendations, what needs to be developed further, and on capturing progress made to date on the implementation of recommendations.

The Group has met on eleven occasions to date. The Group devised a template to assist recommendation lead owners in gathering relevant information and to assist in the development of an Implementation Plan, against which progress could then be monitored by the Group. This allows for a consistent framework for the Implementation Plan.

A copy of the template is included at Appendix 2.

Development of the Implementation Plan

Lead owners were identified and agreed for each of the recommendations. Lead owners were then asked to complete a workplan template for their recommendations. Completion of the templates by the owners of each recommendation captured:

- The work already ongoing where this is relevant
- The intended output /outcome
- Progress made to date
- The steps required to achieve the outcome, including identification of resources or dependencies required

- Timelines for the steps to be completed

The Implementation Plan presented here has been drawn up based on these completed templates. It captures at a high level the current position, where relevant, and the actions which will be undertaken to implement the recommendation, and relevant timelines associated with that implementation.
The recommendations aim to reduce the requirement for litigation in healthcare and to improve the litigation process for those taking this path, leading to both the human and financial costs of health-related claims being reduced.

Challenges and risks
Some of the challenges include:

- Clarity of ownership/responsibility for recommendations.
    - Identifying owners for a small number of the recommendations posed a challenge and required further exploratory work to be carried out to achieve this. In some cases, a policy response is required in the first instance with operational implementation to follow, and so the ownership of the recommendation is shared between two bodies.
- Competing demands for resources and decisions on the allocations of those resources given the many competing demands within the health sector.
- The current move to RHA's and associated changes in HSE structures may present a particular challenge for consistent implementation of the recommendations in a report such as this nationally.
- Competing policy and resource priorities both at Government and HSE level. While the recommendations of the report are not specifically referenced in the HSE's National Service Plan for 2025, it is the case that many initiatives already in train will serve to progress the implementation of the Report's recommendations. Nonetheless, it is hoped that implementation of the recommendations will be reflected in the National Service Plan for 2026 to support the allocation of resources and ensure consideration is given to the recommendations where relevant decisions are being made.
- Where there is a requirement for legislation to underpin a recommendation, a lead owner is needed in a Government Department. The legislative process is such that any recommendation with a primary legislative need is likely to take longer to implement.

Programme for Government 2025, "Securing Ireland's Future"

Since the publication of the Report and the establishment of the Implementation Group, the Programme for Government 2025, titled "Securing Ireland's Future", has been agreed. The Government has reinforced the importance of making progress on

the implementation of the Report's recommendations by including a commitment in the Programme for Government 2025 to:

> *Implement the recommendations of the Report of the Interdepartmental Working Group on the Rising Cost of Health-Related Claims and make it easier and less stressful for patients when things go wrong.*

The Programme for Government also includes the following commitments under the Patient Safety heading, which are relevant:

> *Prioritise the introduction of a court supervised mediation-based process for managing neonatal brain injury medical negligence cases.*
>
> *Consider the establishment of a dedicated medical negligence court.*

It is anticipated that implementation of other recommendations, in particular the civil justice reforms and the implementation of two recent High Court practice directions will have a significant impact on medical negligence cases and increase the use of mediation significantly and have a positive impact on the experience of families who need to take this path. The progress will be kept under review and further measures considered if necessary.

The High Court Practice Direction (HC 132) issued on 28 April 2025 provides for a dedicated list within the High Court for medical negligence cases. This effectively meets the objective of both recommendation 5.1.d and the Programme for Government commitment to establish a medical negligence court.

In addition, a number of other commitments aligned to recommendations in the Report are included in the Programme for Government, aimed at improving patient safety, reducing the requirement for litigation in healthcare and improving the experience of the litigation process for those taking this path.

Implementation Monitoring

This Implementation Plan, together with the workplan templates, will form the basis of a programmatic approach to monitoring and reporting of progress on the implementation of the recommendations. Where it is possible to measure progress in a timebound, geographic or statistical/numerical basis, this will be done with evidence of progress shown. In some cases, reporting mechanisms already in place for other measures/strategies will reflect progress on these recommendations.

The Implementation Group will continue to meet to progress work on recommendations and report regularly on progress against the actions and timelines set out, in accordance with its terms of reference.

The Implementation Plan

Strategic Priority 1 – Capturing Data, Learning from Adverse Events and Promoting Key Research

Recommendation 1.1

For consistency and standardisation in the recording, reporting, analysis and learning from adverse events, the Group recommends that all publicly funded healthcare providers/settings providing clinical care should use the National Incident Management System (NIMS).

Lead

State Claims Agency

Work already underway (See Appendix 4)

Actions and Time Frame

Long term

The SCA and HSE are currently in the process of developing a five-year strategy for NIMS. Outputs from the strategy, which will respond to this recommendation, will build on work already underway. The statement of purpose for the strategy will explicitly mirror the wording of this recommendation.

There will be a rolling delivery of these actions over a 5-year period, in line with the NIMS strategy.

An annual operational plan will be developed each year setting out the work programme, outputs, due dates, etc.

The following are the likely strategic objectives of the five-year strategy, subject to amendment as the strategy is finalised and agreement between the SCA and HSE.

- Improve incident capture – (Easy, Accessible, User-Friendly, Better-Quality Data).
- Increase incident reviews (system enables incident review process).
- Improve learning and reporting from the system & embed NIMS as single reporting system.
- Ensure appropriate security & governance

Consideration will be given to providing NIMS access to organisations that do not currently have access to NIMS, in particular Section 39 organisations.

Recommendation 1.2

The Group recommends that, in line with the Incident Management Framework (IMF), each healthcare provider/setting should ensure that robust mechanisms are in place to disseminate learnings to all relevant staff and in particular to frontline workers derived from:

a. the services own data relating to adverse events,
b. the analysis by the HSE and the State Claims Agency of incident and claims data.

Lead

Health Service Executive

Work already underway (See Appendix 4)

Actions and Time Frame

Where not already in place, establish local service level and Regional Incident Management Forums, or similar, in line with Regional Governance and QPS structures with clear mechanisms for sharing learning**.**

Short term

1. Progress the Q-funded project to bring learning to the front-line. In 2024 Patient Safety Together received funding through both 'Q', a quality initiative to improve health a care led by the Health Foundation in the UK and from 'HSE Spark Innovation'. Through this funding the team are collaborating with people who work in and use our health services to explore the challenge of getting patient safety learning to the right people for action, often the frontline, deskless staff. The funding will allow Patient Safety Together, using a human-centered design approach to identify and explore the problem in depth and then co-design and co-develop resources to help address this challenge. Patient Safety Together is a key function of the QPS Incident Management team and is a priority area of work.
2. Continue the work already progressing through Patient_Safety_Together.
3. NIMS is being updated to mirror the establishment of the Health Regions and the Integrated Health Areas. This work has commenced with mapping of the regions underway. It is anticipated that this will be completed in 2026.
4. The NQPS Incident Management Team have engaged with representatives from the Health Regions and the SCA to revise the quarterly claims and incident reports to mirror the regional structures and reporting requirements.

5. SCA and HSE to agree mechanisms to build on work already underway, as outlined above, to ensure claims learning reaches frontline staff.

Medium term

1. Across the HSE the QPS functions are being reviewed in line with Sláintecare. The key objective is to ensure that shared learning from incidents by the HSE and claims and incidents by the SCA is part of the QPS agenda.
2. The findings from the Q Community project will help inform how best to get learning to the front-line. As part of the current Incident Management Framework review, a particular focus of one of the work-streams is on learning (approach to incident review), improvement (recommendations, actions and assurances) and sharing learning (raising awareness).
3. Growth and funding for the Patient_Safety_Together team.
4. In order to sustain and spread this important programme of work, crucial to patient safety and the culture of learning and improving in the HSE, funding for resources (including additional WTE) and developments needs to be prioritised.
5. Implement mechanisms mentioned above.

Long term

1. Staff to be aware of and utilise Patient_Safety_Together. Patient_Safety_Together to receive access to HSE claims data and to receive claims insight from the SCA for the development of resources issued through PST to improve safety and reduce the cost of claims.
2. Ongoing implementation of mechanisms mentioned above with evaluation and audit

Recommendation 1.3

The Group recommends that each healthcare provider/setting should provide reassurance to the SCA, when requested, that learnings and outputs from the SCA's analysis of claims and incidents have been shared with frontline staff, that risk mitigation strategies are in place and demonstrate efforts made to implement any recommendations made.

Lead

Health Service Executive

Work already underway (See Appendix 4)

Actions and Time Frame:

Incident management and learning from incidents is one, albeit important, part of a well-functioning quality management system. There needs to be a continuous cycle driving a safety improvement and quality improvement approach to learning. This includes incident prevention, analysis, learning, improvement, assurance and a reduction in harm/cost of claims.

The HSE will continue its collaboration with the SCA and respond where reassurance is requested.

Short term

Process to be mapped by National Clinical Lead NQPS on behalf of the CCO and in collaboration with the REOs in relation to learning from claims in the HSE to help drive learning and improvement. The process should serve to provide assurances that such learning is shared though the appropriate HSE governance structure considering the appropriate levels of accountability.

Medium term

1. There are a number of reports available already informed by different quality and patient safety data sources. The HSE is establishing a QPS Executive Committee which will further map and oversee the development of regular reports.
2. Reports should be developed that collate a number of helpful quality and safety resources in line with the revised regional structure. This should include re-evaluation of existing sources (i.e. HPSIR), incident and audit analysis in the HSE, claims analysis from SCA and other sources i.e. complaints etc.

Long term

1. Well established reporting and assurance processes will be in place demonstrating improvements in the system. This should be informed by national/local audit plans, reduction in risk scoring and reduction in harm incidents/complaints/experience/improved outcome data.
2. The HSE continues to monitor compliance in this area through reporting on closing of audit report recommendations, incident reviews and complaints being closed.

Recommendation 1.4

Clinical Directors or equivalent should be supported with tools to enhance feedback to frontline clinical staff on: common causes of harm, clinical care Incident analysis and common themes associated with litigation. This could be achieved through a combination of clinical meetings, local alerts and through the delivery of standardised on-line courses which should be prioritised for continuing professional development (CPD) accreditation. The dissemination of learning from adverse incidents and claims data should be monitored centrally. This could be a role undertaken within the HSE.

Lead

Health Service Executive

Work already underway (See Appendix 4)

Actions and Time Frame

Medium term

1. Continue current work already underway outlined above.
2. Patient_Safety_Together is the key platform for shared learning. It must be the central hub for sharing learning in the organisation. It is growing from strength-to-strength with increasing engagement from services with the site and its resources. Current Q-Project will significantly support this work. Spark are further supporting the Patient_Safety_Together team with this project. Assurances that alerts are received and actioned is possible through the e-alert system and mapping of any potential gaps is currently underway in line with the revised structures. Assurances can be sought through the QPS Executive Committee, once established, that such channels of communication are in place. The UK-funded project will inform the HSE on effective means of reaching front-line staff.

Recommendation 1.5

The Group recommends that every healthcare setting providing clinical care should have the capability to undertake swift and comprehensive analysis of and response to serious adverse events that occur within its own setting. External support in accordance with HSE guidelines should be provided when requested and in major adverse outcomes**.**

Lead

Health Service Executive

Work already underway (See Appendix 4)

Actions and Time Frame

Short term

Identify a project lead/coordinator and carry out an assessment of QPS staffing across Health Regions for HSE and funded services – Q4 2025

Medium term

Pending findings of the gap analysis - secure additional staffing resources for QPS nationally to increase capacity and capability of QPS teams to support timely and comprehensive analysis of and response to serious events – NSP 2026.

Recommendation 1.6

The Group recommends that healthcare providers should endeavour to capture positive outcomes and promote a balanced culture of learning.

Lead

HSE

Work already underway (See Appendix 4)

Actions and Time Frame

Short term

HSE to continue to provide online up-to-date resources, learning events etc.

Recommendation 1.7

The Group recommends that each clinical care unit should audit their primary clinical outcomes annually and publish their results in an annual clinical report.

Lead

Health Service Executive

Work already underway (See Appendix 4)

Actions and Time Frame

Short term

Work is underway in the HSE by the National Centre for Clinical Audit (NCCA) to develop the National Clinical Audit Strategy 2025-2030. This will align with the National Review of Clinical Audit (2019) and the HSE Patient Safety Strategy 2019-2024. This strategy will establish a structured national framework for:

- Clinical audit governance at national, regional, and local levels.
- Standardisation of audit methodology to align with international best practices.
- Education and training programmes to build audit capacity across the healthcare system.
- Integration of digital and ICT solutions in clinical audit processes, in line with the HSE Digital Health Strategic Implementation Roadmap 2024.

Medium Term

IMIS currently publish maternity data from 19 maternity units. Currently this is anonymised. From 2025 units will be identifiable.

Strategic Priority 2 - Prevention of Adverse Events: Strategy, People and Resources

Recommendation 2.1

Recognising that having appropriately qualified and adequate numbers of staff is a key driver of patient safety, the Group recommends that workforce planning initiatives across the system be further supported, with priority given to high-risk critical areas such as delivery and neonatal units.

Lead: Department of Health (Strategic Workforce Planning)

Work already underway (See Appendix 4)

Actions and Time Frame

Short Term

1. Significant progress has been made by the Department of Health (DoH) working in collaboration with Department of Further and Higher Education, Research, Innovation and Science (DFHERIS) and the Department of Children, Disability and Equality (DCDE) to increase the health and social care student pipeline. Engagement between DoH and DFHERIS, DCDE and the Higher Education Sector and Professional Bodies is ongoing to increase the number of student training places in health-related disciplines informed by long term-term health and social care workforce planning projections.
2. Significant increases in postgraduate medical training places and the number of doctors in training have been achieved, and this work is ongoing. Engagement between HSE and DoH is progressing to increase the number of postgraduate medical training places informed by long term-term medical workforce planning projections.
3. Implement the short-term recommendations of the NCHD Taskforce Final Report, published in February 2024. Immediate actions, prioritised for implementation, include projects to improve NCHD Learning Environments and Working and Wellbeing standards on clinical sites; enhanced NCHD Induction Standards, Guides, and Supports; the launch of the HSE Occupational Health Specialist Support Hub for NCHDs; increased Flexible Training and Working Opportunities for NCHDs, and increases in NCHD post-graduate medical training places towards agreed targets for 2030.

Long Term

4. Implement the longer-term recommendations of the NCHD Taskforce Final Report. These include recommendations to support the development of our medical workforce including an evolving educational infrastructure, embracing technology to meet changing demands, and training a greater number of doctors. Engagement between DoH and HSE is ongoing to monitor and report on progress with implementation of the NCHD Taskforce recommendations.

Recommendation 2.2

The Group recommends that all units delivering clinical care should be supported to develop and maintain responsive clinical governance functions, in accordance with HSE guidelines.

Lead

Health Service Executive

Work already underway **(See Appendix 4)**

Actions and Time Frame

Short Term

Fully establish the HSE working group to develop a 'Clinical Governance Operating Model for Health Regions'.

Medium Term

Complete the review of Clinical Governance operating model.

Recommendation 2.3

The Group advocates continued support for HSE patient safety initiatives and in doing so, recommends that available funding be prioritised and ring-fenced within the existing core allocations, to support ongoing patient safety initiatives in healthcare settings. This includes:

- Funding to support evidence-based interventions aligned to the patient safety strategy, including data collection, analytical tools, training (including multi-disciplinary training in maternity services and simulation) and other tools for the sharing of learning.
- Consideration should be given to making some elements of core training mandatory.
- Continued focus on initiatives to address the common causes of harm.

Lead

Health Service Executive

Work already underway (See Appendix 4)

Actions and Time Frame

Short term

The HSE will continue to implement the Patient Safety Strategy (2019-2024) with a focus on initiatives to address the common causes of harm, ensuring national level resources are aligned to support continued local action for patient safety.

1. Secure additional resources to support the Patient Safety Strategy implementation and associated programmes (related to Common Causes of Harm), Sharing Learning, Patient_Safety_Together, etc and take necessary steps to ringfence the funding – Estimates 2026
2. Update the Patient Safety Strategy Q4 2025
3. A National Steering Group has been established on a particular data capture tool, called Redcap. REDCap (Research Electronic Data Capture) is a secure, web-based software platform designed to support data capture for research studies and quality of care monitoring.
4. Complete scoping exercise to develop a national maternity dashboard and take steps to implement this is work in progress and expected to be completed by Q4 2025.

Medium Term

Secure additional resources to support the Patient Safety Strategy implementation and associated programmes (related to Common Causes of Harm), Sharing Learning Patient_Safety_Together etc. and take necessary steps to ring fence the funding

Strategic Priority 3 - Enhanced Response When Harm Occurs

When an event occurs a patient should be made aware of what happened and provided with appropriate care and supports. These recommendations are made in service of this.

Recommendation 3.1

The Group recommends the adoption of the National Open Disclosure Framework by all relevant stakeholders and the incorporation of the Framework into their organisational policies and procedures at the earliest opportunity.

Lead

Department of Health (NPSO)

Work already underway (See Appendix 4)

Actions and Time Frame

Short term

1. Launch of ODF – Completed - October 2023

2. Implementation/communication – ongoing

3. Self-reporting submission deadline – Q2, 2025

Recommendation 3.2

The Group recommends that a team of trained personnel should be available to each hospital dedicated to responding to serious adverse events, when they occur. Where appropriate, this team may comprise external regional support. An example of this is the Obstetric Event Support Team (OEST) in maternity care.

Lead

Health Service Executive

Work already underway (See Appendix 4)

Actions and Time Frame

Short term

1. Ensure SIMTs/forums are established and available in each hospital and at regional level – This will be carried out by HSE Regional Executive Officers and Regional Clinical Directors in line with model for Regional Quality and Patient Safety when agreed.
2. Carry out a review of IMF – This is currently in progress with a Terms of Reference currently in progress and is being led out by NQPS.
3. Carry out a review of the OEST model, including its potential for expansion - National Perinatal Epidemiology Centre, NPEC, commissioned and report has been finalised.

Recommendation 3.3

The Group recommends that rapid access to appropriate clinical investigations and care when complications occur be prioritised in each hospital.

Lead

Health Service Executive

Work already underway (See Appendix 4)

Actions and Time Frame

Short Term

1. The HSE will continue to treat patient and service users with respect and sensitivity, and ensure all adverse events are acknowledged in line with Open Disclosure processes.
2. Where complications occur, patients will be assessed and treated based on clinical need and their clinical history and past engagement will inform their plans of care.

Recommendation 3.4

The Group recommends that guidelines and training for meaningful debriefing with the patient/family following an adverse event should be put in place in each hospital.

Policy Lead: Department of Health (NPSO)

Operational Lead: Health Service Executive

Work already underway [Similar to 3.1 as linked] (See Appendix 4)

Actions and Time Frame

Short term

1. Launch of ODF – Completed in October 2023

2. Implementation/communication – ongoing

3. Self-reporting submission deadline – Q2, 2025

Recommendation 3.5

The Group recommends that all hospitals should ensure that bereavement or adverse event nurse/counsellors are available to liaise with families, along with a family liaison person or social worker, to signpost families to services and entitlements (it is acknowledged that elements of this care already exist in many hospitals).

Lead

Health Service Executive

Work already underway (See Appendix 4)

Actions and Time Frame

Short Term

The Bereavement Implementation Plan will be updated by end of 2025 – NWHIP.

Medium Term

1. Further steps will be taken to support hospitals/unit management teams to have succession plans in place for clinical midwife/bereavement nurse specialists – 2026.
2. The HSE will be working on embedding the designated person role. This will be dependent on the allocation of sufficient resources in some services.

Recommendation 3.6

The Group recommends that necessary supports should be available immediately, within existing resource allocation, to assist parents with the additional care needs of children with catastrophic birth injuries while the longer-term support needs are being determined and arranged. Early intervention has been shown consistently to optimise outcomes and has the potential to reduce the risk of claims increasing due to inflation or unmet needs or suboptimal outcomes translating into larger costs. This may ultimately reduce the cost of damage settlements determined by the Courts.

Lead

Department of Children, Disability and Equality/HSE (Primary Care and Community Services)

Work already underway **(See Appendix 4)**

Actions and Time Frame

Medium Term

1. Map existing pathways and supports – Q1 2026
    - National map of current care pathways
    - Identification of regional and systematic gaps
    - Inventory of existing HSE strategies in this area
2. Analyse findings from mapping to identify gaps in policy, services, and coordination affecting access and outcomes for this cohort – Q2 2026
    - Gap analysis report
    - Review of feasibility of integrating the Acorn programme
    - Recommendations for priority areas requiring attention
3. Prepare a response to enhance current pathways – Q4 2026
    - National Care Pathway Framework
    - Clinical and operational guidance for CDNTs
    - Referral and transition protocols
4. Commence phases implementation – Q2 2027

Recommendation 3.7

The Group recommends that the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 be commenced by the Minister for Health at the earliest possible opportunity. All relevant stakeholders should be required to familiarise themselves with the provisions of the Act through mandatory training. All healthcare providers should take steps to ensure that patients are made aware of their entitlements under the Act.

Lead

Department of Health (NPSO)

Work already underway **(See Appendix 4)**

Actions and Time Frame

Short term

1. Commencement of PSA 2023 - Act commenced on 26 September 2024.

2. Commencement of remaining Section of PSA 2023 – Q3, 2025

3. Ongoing guidance re PSA 2023 – Q4, 2025

Recommendation 3.8

The Group recommends that a robust complaints and patient experience feedback mechanism should be developed within all clinical care units. This data should be collated and analysed by individual units as part of a broader assessment of patient experience within our healthcare institutions. These should be shared with frontline staff to assist learning and understanding of positive and negative experiences of healthcare.

Policy Lead: Department of Health (NPSO)

Operational Lead: Health Service Executive

Work already underway (See Appendix 4)

Actions and Time Frame

Policy Lead - Department of Health (NPSO)

Short term

1. Stakeholder Engagement - Structured consultation process to engage at all levels of the system and with all relevant parties – ongoing.

2. Policy and Legislation development - National Complaints policy to be developed with inclusion of national research recommendations on the principles and values that support a person-centred complaints management process - Q4 2025

3. Policy and Legislation development - Complaints policy is supported with a fit for purpose robust IT Complaints Management System which is fully integrated with complaints process and readily accessible to all frontline staff in healthcare institutions – ongoing.

4. Implementation of Programme - The National Maternity Care Experience Survey will be implemented, and results published – Q4 2025

Medium term

1. Implementation of Programme - The National Mental Health Care Experience Survey will be further developed and implemented, and the results published – 2025/2026

2. Implementation of Programme - The National Cancer Care Experience Survey will be implemented, and results published – 2026.

Operational lead – Health Service Executive

Short Term

1. Continue to meet the requirements of the Health Act in relation to complaints received by the HSE (continued programme of Your Service Your Say).

2. Continue partnership between the Health Information and Quality Authority (HIQA), the Health Service Executive (HSE) and the Department of Health, with patient representatives providing their input at each stage of the programme (continue the programme of delivery of the National Care Experience Programme).

Strategic Priority 4 - Care for babies born with Neonatal Encephalopathy and other Maternity Initiatives

Recommendation 4.1

The Group recommends that data on Neonatal Encephalopathy (NE) be collected on a statutory basis, and that a register of cerebral palsy cases in Ireland should be developed.

Lead

Policy: Department of Health (CMO)

Work already underway **(See Appendix 4)**

Actions and Time Frame

Part 1: Neonatal Encephalopathy (NE) be collected on a statutory basis:

Short term

The Department of Health will engage with the HSE to explore further whether the data mandatorily notified under the Patient Safety legislation relating to babies referred or considered for referral for therapeutic hypothermia, could assist with meeting the recommendation that data on NE be collected on statutory basis.

Part 2: That a register of Cerebral Palsy (CP) cases in Ireland should be developed

Short term

The Department of Health to engage with stakeholders concerning work that is already underway to develop a Cerebral Palsy register and take steps to ensure that the existing proposal meets the appropriate standards and aligns with Departmental requirements.

Long term

Pending the outcome of the action above, continue to collaborate with stakeholders to ensure that a CP register is put in place that is sustainable in the long run.

Recommendation 4.2

The Group recommends that the work of National Neonatal Encephalopathy Action Group (NNEAG), and its efforts to reduce to the greatest extent possible the incidence of birth-related CP/catastrophic birth injury, should receive ongoing support and endorsement.

Lead

Health Service Executive

Work already underway **(See Appendix 4)**

Actions and Time Frame

Short term

Following the publication of the Interdepartmental Working Group on the Rising Costs of Healthcare Claims, there have been ongoing discussions involving the Department of Health, NWIHP and the SCA in relation to reviewing the work of NNEAG. It is anticipated that a revised TOR for NNEAG will be developed by end-Q3 2025, incorporating a revised statement of purpose, aims, priorities, and mechanisms of evaluation.

Recommendation 4.3

The Group recommends that the investigation and follow-up of infants with HIE needs further development and standardisation. All babies presenting with HIE should have a standardised assessment including placental examination, MRI brain scan and follow up neurodevelopmental assessment.

Lead

Health Service Executive

Work already underway **(See Appendix 4)**

Actions and Time Frame

Short Term

1. Babies requiring therapeutic hypothermia are referred to one of four centres. Clear communication from receiving hospital and referring hospital during and after discharge to be enhanced.
2. Practical advice and support for parents whose baby is referred for treatment to be enhanced – explanatory leaflet, how to access the hospital, parking, etc.

Medium Term

The Model of Care for neonatology for Ireland to be updated. Further pathways are contingent on this model of care.

Long Term

Recent recommendations regarding neonatology in smaller maternity units to be considered.

Recommendation 4.4

The Group recommends that research initiatives that advocate earlier diagnosis and intervention in cerebral palsy should be supported and that a taskforce should be put in place to devise a model of care for babies with HIE so that standardised follow up will lead to the early detection and intervention in those babies with CP.

Lead

Health Service Executive

Work already underway **(See Appendix 4)**

Actions and Time Frame

Medium Term

1. Model of Care for Neonatology to be completed Q2 2026
2. Model of Care for babies affected by HIE to follow.

Recommendation 4.5

The Group recommends that care pathways, once developed, which start at birth and continue through life, for children who have suffered a catastrophic birth injury, should be considered for implementation on a national basis. The Group recognises that the initial development of new care pathways will be managed within existing resources.

The State provision of such care could facilitate immediate and more effective evidence-based care and lead to growing national expertise, reducing the reliance on ad hoc private care arrangements. In addition, the provision of early claims resolution in the context of perinatal brain injury has the potential to meet family needs in real time, facilitate early clinical intervention and reduce the risk of claims increasing in value due to inflation or unmet needs translating into higher costs.

While initially these care pathways would be limited to the cohort of children who have suffered a catastrophic birth injury, consideration should also be given in the future to rolling out these services to all children with cerebral palsy over a longer period of time, as national expertise and capacity develops and a review has been undertaken with regard to their effectiveness and efficiency for the initial targeted cohort. This would also need to be informed by an assessment of the feasibility of potentially increasing eligibility including resourcing constraints.

Lead

Policy: Department of Children, Disability and Equality

Operational: Health Service Executive

Work already underway **(See Appendix 4)**

Actions and Time Frame

Full implementation of this Recommendation will be long-term, as it is dependent on the outcome of the medium-term actions below (linked to Recommendation 3.6)

The ultimate outcome is to support timely, coordinated, and equitable access to services for children who experience catastrophic birth injuries, through the development and implementation of a clearly defined care pathway in line with national policy.

Medium Term

1. Map existing pathways and supports – Q1 2026
    - National map of current care pathways
    - Identification of regional and systematic gaps
    - Inventory of existing HSE strategies in this area
2. Analyse findings from mapping to identify gaps in policy, services, and coordination affecting access and outcomes for this cohort – Q2 2026
    - Gap analysis report
    - Review of feasibility of integrating the Acorn programme
    - Recommendations for priority areas requiring attention
3. Prepare a response to enhance current pathways – Q4 2026
    - National Care Pathway Framework
    - Clinical and operational guidance for CDNTs
    - Referral and transition protocols
4. Commence phased implementation – Q2 2027

Strategic Priority 5 - Faster and More Efficient Resolution of Claims

Recommendation 5.1

The Group recommends the implementation without delay of recommendations made in a number of previous reports, along with some additional recommendations, advocating changes and improvements to the management of clinical negligence claims to include:

a. The introduction of a pre-action protocol with sanctions for a party who fails to adhere to the protocol, as recommended in the Meenan Report.
b. The facilitation of earlier mediation, where possible and agreeable to both parties.
c. Amendments to case management Rules of Court should be made, to include a stipulation that equivalent rules apply to both sides, and that joint expert meetings (hot-tubbing) should be required to take place.
d. A dedicated Court list should be established with judges in place with specialist knowledge of medical negligence litigation, or other appropriate measures to facilitate the earlier hearing of medical negligence cases.

Lead(s)

a. **Lead**: Department of Justice
b. **Lead:** State Claims Agency
c. **Lead**: Courts Service
d. **Lead:** Courts Service in conjunction with the Judiciary

Recommendation 5.1a

Work already underway **(See Appendix 4)**

Actions and Time Frame

Short term

Finalise regulations: The regulations are currently being drafted and are expected to come into effect by the end of Q4 2025.

Recommendation 5.1b

Work already underway **(See Appendix 4)**

Actions and Time frames

Short term

1. SCA to continue to offer mediation, where appropriate and agreeable to both parties, at the earliest possible time - Ongoing.
2. Courts Service: The operation of Practice Direction (HC131) will be kept under close review.

Recommendation 5.1c

Work already underway **(See Appendix 4)**

Actions and Time Frame

Short term

1. The High Court is implementing processes aligned with this recommendation, and to this end, a new High Court practice direction (HC131) has come into effect from 28th April. This new practice direction, coupled with existing practices relating to 'Hot-Tubbing', achieve the desired outcome and effectively allow that the recommendation is met.
2. This new practice direction will be reviewed after 6 months in operation and depending on how it is operating, consideration will then be given to bringing forward Court rules to enhance the powers available to courts in this area.

Recommendation 5.1d

Work already underway **(See Appendix 4)**

Actions and Time Frame

The High Court is implementing processes aligned with the recommendation and has established a new Clinical Negligence List with effect from 28th April 2025, which achieve the desired outcome and effectively allow that the recommendation is met.

The Practice Direction (HC 132) will be kept under regular review and amended or modified where necessary.

Recommendation 5.2

The facility for Courts to award Periodic Payment Orders should be resumed.

Lead

Department of Justice

Work already underway **(See Appendix 4)**

Actions and Time Frame

Short term

Regulations drafted and to be signed by end Q4 2025

Recommendation 5.3

The Group recommends that a panel of medical expert witnesses should be developed initially on a voluntary basis. This could be overseen by an existing regulatory body with appropriate expertise. Members of the panel would meet a series of criteria including that they are in active practice or recently retired, with relevant expertise and are trained as expert witnesses. They should be available to appear as expert witnesses for plaintiffs and defendants. Membership should function as a quality assurance and members of the panel should receive Continuing Professional Development accreditation.

Lead

Sub-group established.

Work already undertaken (See Appendix 4)

Actions and Time Frame

Short Term

1. Establish a subgroup consisting of the Department of Health, the Department of Justice, the HSE, the SCA and the Courts Service to consider this recommendation in light of existing Court rules and law in this area along with new High Court directions.

2. The subgroup to undertake consultation with relevant parties

3. The subgroup to reach its conclusions

The subgroup having considered the existing court rules and judgments and the feedback received from those consulted, concluded that:

- there would be significant challenges to putting such a panel in place, particularly for constitutional reasons, for example, it is a matter for each side who they wish to call:
- there are a number of existing mechanisms available which allow access to medical experts, such as professional networks, private medical expert agencies, professional organisations and medical directories and databases held by insurers and law firms:
- there are ample rules and case law governing how expert witnesses are to perform in the process of giving evidence:
- there are synergies with other recommendations in the Report on the Rising Cost of Health-Related Claims, such as Recommendation 5.1 a (PaP regulations) and

5.1c (amendment to case management rules and hot-tubbing), that once implemented, would help to achieve a similar outcome:

- professional bodies could be asked to encourage their members to put themselves forward to be expert witnesses and undertake appropriate training.

For the reasons outlined above, it is considered that no further action is required, and this recommendation is fulfilled.

Recommendation 5.4

The Group recommends that the personal injury discount rate, also known as the real rate of return, should be reviewed at regular intervals by the Minister for Justice.

Lead

Department of Justice

Work already underway **(See Appendix 4)**

Actions and Time Frame

Short term

Regulations to be drafted and finalised by end Q4 2025.

Medium term

A review mechanism agreed by end of Q1 2026.

Recommendation 5.5

The Group recommends that a medical records system, with unique identifiers, be put in place to facilitate better and more timely provision of records and that a system be put in place so that a patient or their solicitor can view their electronic medical records. In addition, a training programme for hospital staff should be put in place regarding best practice around medical records.

Lead

Department of Health regarding the Health Information Bill and EHR roll out

Work already underway **(See Appendix 4)**

Actions and Time Frame

Short term

Enactment of the Health Information Bill: The Health Information Bill was published in July 2024 and cleared Second Stage in Dáil Éireann in September 2024. The Bill has now been restored to the Dáil Order Paper at Committee Stage.

Medium Term

Continue the deployment of the National Maternity Clinical Management System MN(CMS) across maternity hospitals.

Long term

1. Advance the business case and funding for development/progressing EHR under the NDP
2. HSE to ensure appropriate training in place to support the roll out of EHR

Recommendation 5.6 *(Programme for Government Commitment)*

Prioritise the introduction of a court supervised mediation-based process for managing neonatal brain injury medical negligence cases.

Lead

No Lead

Since the publication of the Report and the establishment of the Implementation Group, the Programme for Government 2025, titled "Securing Ireland's Future", has been agreed. The Government has reinforced the importance of making progress on the implementation of the Report's recommendations by including a commitment in the Programme for Government 2025 to:

Implement the recommendations of the Report of the Interdepartmental Working Group on the Rising Cost of Health-Related Claims and make it easier and less stressful for patients when things go wrong.

The Programme for Government also includes a commitment to:

Prioritise the introduction of a court supervised mediation-based process for managing neonatal brain injury medical negligence cases.

A meeting of the relevant parties, the Department of Health, the Department of Justice, the State Claims Agency and the Courts Service took place in July 2025 to consider this Programme for Government Commitment, in light of other relevant civil justice reforms that are already underway or planned.

It is anticipated that implementation of other recommendations, in particular the civil justice reforms and the implementation of two recent High Court practice directions will have a significant impact on medical negligence cases and increase the use of mediation significantly and have a positive impact on the experience of families who need to take this path. The progress will be kept under review and further measures considered if necessary.

Work already underway (See Appendix 4)

Actions and Time Frame

Short term

1. Consult with relevant parties, i.e. the Department of Justice, the State Claims Agency and the Courts Service to consider this Programme for Government Commitment in light of other relevant civil justice reforms that are already underway or planned.
2. Implementation of civil justice measures in Recommendations 5.1.a, b and d, 5.2 and 5.4 above.

Medium Term

1. Monitor and review the impact of the civil justice measures, once fully implemented.
2. Consider any further measures necessary

Strategic Priority 6 - Standardised Approach to Mass Action Claims

Recommendation 6.1

As set out in the Report, a range of alternative dispute resolution processes have been implemented. The Group recommends that the State should continue to use various forms of alternative dispute resolutions (e.g., mediations, binding mediations, ex-gratia schemes, compensation schemes, evaluations, assessments and tribunals) as appropriate, in order to offer an alternative to the adversarial court process.

Lead

Department of Health and State Claims Agency

Work already underway (See Appendix 4)

Actions and Time Frame

Relevant State parties to consider use of alternative dispute resolution approaches to litigation in appropriate circumstances, with the learning from existing or previous models to be taken on board. Examples of this include the Surgical Symphysiotomy Ex-Gratia Payment Scheme, the Kerry CAMHS Compensation Scheme, the H1N1 Vaccine claims, the DePuy Hip mass action and the CervicalCheck Tribunal.

This is ongoing and does not have a finite timeframe.

Recommendation 6.2

The Group also recommends the development of a Vaccine Damage Scheme to ensure a controlled approach to management of potential claims, which should be undertaken urgently in line with previous commitments.

Lead

Department of Health (Corporate Legislation Unit)

Work already underway (See Appendix 4)

Actions and Time Frame

Medium term

1. Get a Government Decision to develop the legislation underpinning the scheme - This may be listed on the Autumn Legislative Programme, the timeline to develop the legislation is TBC at this time and will depend on the complexity of legislation required.
2. Heads of Bill will be drafted
3. Appoint Panel of experts to make determinations – end of Q2 2026
4. Put administrative arrangements in place – end of Q2 2026
5. Put Communications Strategy in place – end of Q3 2026

Appendix 1 – Implementation Group and Terms of Reference

Membership of the Group

Department of Health	Mr Greg Dempsey, Chair (to 28 February 2025)
	Mr David Leach (from 17 July 2025)
	Ms Brenda Lynch
	Ms Madeline Meade
	Mr Maurice O'Donnell (NPSO)
	Ms Breda Rafter
Department of Justice	Mr Michael Holohan
Health Service Executive	Dr Cliona Murphy
	Ms Elaine Kilroe
	Ms Margaret Brennan
	Ms. Maire Lennon
Courts Service	Mr Tom Ward
State Claims Agency	Dr Cathal O'Keeffe
Department of Children, Disability and Equality	Ms Aideen Rogers

Rising Cost of Health-Related Claims Report Implementation Group
Terms of Reference (Revised October 2024)

The Implementation Group will be chaired by the Department of Health and be comprised of Government Departments and State Agencies, that have relevant policy or operational responsibility for particular recommendations made in the Report.
The Implementation Group will be tasked with examining the recommendations made in the Report in further detail and in particular to:

1. Carry out a mapping exercise for each recommendation to identify what is currently in place and what measures are needed that are not in place in order to fully implement each one.
2. Following on from the mapping exercise, identify the steps required to implement each recommendation and an associated timeframe for doing so. This should include an identification of recommendations that could be instituted in the short, medium and longer term.
3. Estimate the costs of implementing each recommendation and identify potential savings to be made in terms of the cost of claims in the short, medium or long term.
4. Identify key milestones for implementation for each recommendation and carry out a risk analysis on each, identifying any potential threats to their implementation.
5. Where it is identified that funding will be required, e.g., in the development of care pathways for children who have suffered a catastrophic birth injury:
    - identify how funding could be reprioritised from within existing HSE resources for the initial development of these services.
    - estimate the likely future costs and potential savings in the longer term to roll out these services, following a review of the effectiveness and efficiency of the roll out to the initial cohort. If necessary, support external to the Group may be engaged.
6. Produce an Implementation Plan for the Minister to bring back to Government, within 6 months of its first meeting.
7. Monitor the implementation of the Plan on an on-going basis and provide an update to the Minister outlining progress on implementation within 12 months of its first meeting.

Clinical Indemnity Unit
Department of Health
October 2024

Appendix 2 – Workplan Template

Recommendation Workplan Template

General Information

Recommendation No. & Description	
Associated Recommendations	Please indicate if this recommendation is part of a group of similar recommendations which need to be considered as a group.
Lead Responsible	Name, role and organisation
Other responsible	Name and organisation of other individuals involved. Please indicate if these are part of the Implementation Group
Does recommendation reflect work already ongoing?	Please give as much detail as possible. Is the existing work aligned with the recommendation? Is the scope or coverage different? Would delivery effectively allow a determination that the recommendation is met?
Short / Medium or Long term proposal?	Please indicate whether this is short term (say, six months) or longer. Are there any interim outputs which needed to be considered? Is there a need for a pilot?

Description of work

In summary, set out work already undertaken	What is the current position? Is the recommendation already delivered in some parts of the system, and simply needs to be extended.
Brief description of intended output / outcome for this recommendation	A short description of what the anticipated outcome will be, and the associated benefits. In this section, one might consider whether alternatives to the recommendation, with similar outcomes and benefits, may be more appropriate
Persons and organizations involved	Set out the organisations which will be impacted by the changes, and what engagement or mandates will be required

Workplan

(in this section, set out the main actions required, any interim outputs, resources (particularly staff and external expertise) and an indicative due date. Examples might include – determine current position, undertake desktop research, develop options paper, secure approval, implement solution)

Action Step	Key output / deliverable	Resource Required	Due Date

Costs & Risk

Risks	Set out any risks identified, and any mitigants
Costs required	Set out any costs associated with delivering the recommendation, including external expertise or ICT.

Appendix 3 - Glossary of Terms and Definitions

AMRIC	Antimicrobial Resistance and Infection Control
BST	Basic Specialist Training
CCO	Chief Clinical Officer
CDNT	Community Disability Network Team
CMO	Chief Medical Officer
CMS	Clinical Midwife Specialist
CP	Cerebral Palsy
CSCST	Certificate of Successful Completion of Training
CUMH	Cork University Maternity Hospital
DFHERIS	Department of Further and Higher Education, Research, Innovation and Science
DCDE	Department of Children, Disability and Equality
DNE	Dublin and North East
EHDS	European Health Data Space
EHR	Electronic Health Record
ePOE	Electronic Point of Occurrence
EQUIPS	Evidence Based Quality Improvement and Patient Safety Research Network
ESRI	Economic and Social Research Institute
EU	European Union
HSCPs	Health and Social Care Professions
HEA	Higher Education Authority
HEIs	Higher Education Institutions
HIE	Hypoxic-Ischemic Encephalopathy
Hot Tubbing	Also known as 'concurrent evidence'. The practice whereby both parties' experts give their evidence together in the form of a discussion chaired by a judge.
HPSIR	Hospital Patient Safety Indicators Reports
HRB	Health Research Board
HSCPs	Health and Social Care Professions
HSE	Health Service Executive
HST	Higher Specialist Training
IECA	Irish Court of Appeal
IFSP	Individualised Family Support Plan
IMF	Incident Management Framework
IMGTI	International Medical Graduate Training Initiative
IMIS	Irish Maternity Indicator System
MN - (CMS)	National Maternity Clinical Management System
NCCA	National Centre for Clinical Audit
NCH	new Children's Hospital
NCHD	Non-Consultant Hospital Doctor
NE	Neonatal Encephalopathy
NFH	National Forensic Hospital
NIMS	National Incident Management System
NNEAG	National Neonatal Encephalopathy Action Group
NOCA	National Office of Clinical Audit
NPEC	National Perinatal Epidemiology Centre
NPSA	National Patient Safety Alerts
NPSO	National Patient Safety Office

NQPS(D)	National Quality and Patient Safety, a Directorate of the HSE
NTO	National Tertiary Office
NRH	National Rehabilitation Hospital
NRP	Neonatal Resuscitation Programme
NWIHP	National Women and Infants Health Programme
ODF	Open Disclosure Framework
OEST	Obstetric Event Support Team, a support service provided by the HSE
ONMSD	Office of the Nursing and Midwifery Services Director
PAP	Pre-Action Protocol
PPO(s)	Payment Protection Order(s)
PROMPT	Practical Obstetric Multidisciplinary Training
PSA	Patient Safety Act
PST	Patient Safety Together (the platform where the HSE share up-to-date patient safety information to support the Patient Safety Programme)
QI	Quality Improvement
QPS	Quality Patient Safety
QPSIM	Quality Patient Safety Incident Management
RCOC	Rising Cost of Claims
REDCap	Research Electronic Data Capture
REO(s)	Regional Executive Officer(s)
RHA	Regional Health Area
RRoR	Real Rate of Return
SCA	State Claims Agency
SIMTs	Serious Incident Management Teams
TAE	Talent Attraction & Engagement
TOR	Terms of Reference
UCC	University College Cork
VTE	Venous Thromboembolism
WTE	Whole-Time Equivalent

Appendix 4 – Work Already Underway

Recommendation 1.1

- NIMS now underpins and supports the HSE's National Incident Management Framework.
- NIMS is currently available to all State authorities whose claims area delegated to the SCA for management. These include:
    - HSE hospitals and health and social care services;
    - Section 38 hospitals and community health and social care organisations; and
    - a limited number of Section 39 organisations.
- The HSE, in collaboration with the SCA has been leading on the Electronic point of occurrence entry (ePOE) roll out, developed to enable easier reporting.
    - ePOE has now been implemented in 29 statutory and Section 38 hospitals and community healthcare locations.
    - 45,000 Health Care workers can access NIMS directly to enter an incident.
    - The Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 was commenced by the Minister for Health on 26th September 2024. This requires mandatory reporting and open disclosure of certain notifiable incidents. NIMS is the technology at the centre of reporting these incidents to HIQA and the Mental Health Commission.

Recommendation 1.2

- Sharing learning is already a key element of the Incident Management Framework.
    - Mechanisms at Regional Level include local and regional incident management forums.
    - Information is shared across services from reviews, incidents reported etc.
- Nationally, the HSE launched Patient_Safety_Together (Patient Safety Together: learning, sharing and improving) in January 2023 to enable the HSE to share learning across the organisation.
    - There have been multiple resources developed and published on the Patient_Safety_Together website page.
    - As part of its work, the HSE National Patient Safety Alerts Committee was established. The committee reviews patient safety intelligence and oversees the development of HSE National Patient Safety Alerts (NPSA) and Patient Safety Supplements.

    - All resources are published.
    - The NPSAs are also cascaded through an electronic system to all HSE hospitals and community services. This is currently being reviewed in line with the revised organisational structure. PatientSafetyTogether is a small function of the QPS Incident Management (QPSIM) team.
    - They have received awards for their work and funding from a UK-based organisation to support their work and explore how best to get learning to the front-line.
- The SCA has a statutory clinical risk management role. Its activities include reviewing, analysing and extracting learning from incident and claims data, and sharing learning from claims and incident analysis with health and social care services through a range of channels.
- The SCA shares lessons learned directly with the HSE and individual hospitals and services. Where appropriate, the SCA seeks reassurance that risks identified are being mitigated and may make specific recommendations, the implementation of which is monitored.
- The SCA also conducts surveillance of adverse incidents reported on NIMS on an ongoing basis in order to identify issues of concern. Identification of risk may prompt engagement with hospitals or services to ensure that appropriate risk mitigation is in place. The identification of a trend may prompt the issuing and publication of a Patient Safety Notification, engagement with a relevant national programme or stakeholders or other action to address the issue.
- Learning is also shared widely through a variety of channels including published reports, articles in the SCA's Clinical Risk Insights newsletter and educational events such as webinars and conferences. It also forms the basis of education provided directly to health and social care services, undergraduate and post-graduate training institutions.
- The SCA also provides regular high level scheduled incident and claims reports to the HSE and individual hospitals/services.

Recommendation 1.3

- As outlined above, the SCA undertakes analysis of incidents and claims and shares lessons learned directly with the HSE and individual hospitals and services.
- Where appropriate, the SCA seeks reassurance that risks identified are being mitigated, in line with its statutory risk management mandate, and may make specific recommendations, the implementation of which is monitored.

Recommendation 1.4

From the HSE perspective ongoing education occurs with regard to causes of adverse incidents and education around serious medical conditions. Examples of this include:

- Nursing and Midwifery Webinar series
- Clinical risk Matter Series
- National Sepsis Summit
- NWIHP Learning event series
- Quality Patient Safety and Risk in Maternity Services
- Patient Safety Together and its many outputs for example:
    - HSE National Patient Safety Alerts
    - Patient Safety Supplements
    - Patient Safety Together Community
    - HSE Patient Safety Together Digest
    - HSE Patient Safety Together Spotlight series
- At hospital level regular Quality Risk and Patient Safety (QRPS) educational bulletins provided to staff focussing on different aspects of Quality, Risk and Patient safety.

Recommendation 1.5

- The HSE Incident Management Framework outlines procedures and processes to be followed when a serious adverse event occurs.
- The review of the IMF has commenced as a collaborative piece between the HSE and Department of Health.
- QPS staff and teams (where resourced and in place) across hospital and community settings provide the guidance and support and training to teams to undertake reviews.
- Time frames have been specified for completion of reviews which are monitored via national KPIs.

Recommendation 1.6

- A multitude of learning events and conferences are held across HSE services every year which showcase and provide shared learning opportunities, e.g., NWIHP sponsor learning events across the country. These focus on common causes of preventative harm.
- HSE Webinars across a range of QPS topics are provided. Programme newsletters are provided, including regular newsletters from the Open Disclosure programme.
- **Patient Safety Together: learning, sharing and improving** is where the HSE share up-to-date patient safety information – this includes:

- the HSE Patient Safety Digest (available on HSE Web site) contains up to date journal articles, reports and information relating to patient safety;
- HSE National Patient Safety Alerts are high-priority communications issued in relation to critical patient safety issues;
- Patient safety supplements share relevant quality and patient safety information for learning purposes and to raise awareness;
- Patient safety stories give voice to the experience of both patients/service users and staff who have been involved in, or impacted by patient safety issues;
- Quality and Patient Safety Annual Conferences – NWIHP;

Learning Events – NWIHP –Sepsis, Maternal mortality and mental health, Therapeutic hypothermia

Recommendation 1.7

- Clinical audit is a cornerstone of Quality Improvement (QI) in healthcare. It allows systematic review clinical performance against clinical standards, identify areas for improvement, and implement evidence-based interventions. It is an essential enabler to anticipate and respond to risks to patient safety, designed to reduce the risk of harm and improve patient outcomes. Some examples of how audit can improve patient care is the regular audit of the National Sepsis Clinical Guidelines, implementing improvements at local and national level improves outcomes for patients. When clinical audit is conducted well, it enables the quality of care to be reviewed objectively within an approach that is supportive, developmental and focussed on improving standards and safety of care.
- The National Centre for Clinical Audit was established in 2022 to implement and National Governance for Clinical Audit, and support both national and local programmes of clinical audit and registries.
- National Clinical Audit reports are published on an annual basis. This includes NPEC reports.
- There is a HSE funded programme of National clinical audits and registries- some are commissioned, and some are led by HSE teams. This is overseen and monitored by the National Centre for Clinical Audit, NQPS and the CCO. Some examples include: the National Paediatric Mortality Register, National Audit of Hospital Mortality, published by NOCA and are available at the link here: NOCA Audits: National Clinical Audits for Improving Patient Care. And the RCPI Speciality Quality Improvement programmes for Histology, Radiology and Endoscopy and published here: RCPI SQI Programmes and HSE audits e.g. the ED Triage Audit published here: National_Clinical_Audit_of_ED_Triage_Report

- Local Clinical Audits are usually published in hospital or community services annual reports or hospital websites, through journal publications, conferences and study days (not an exhaustive list).
- As well as national audits, all services undertake a programme of annual local audits following the National Centre for Clinical Audit 'Clinical Audit- A Practical Guide', to ensure audits are meeting standards and can avail of the protections of the Patient Safety Act 2023. Maternity services and all care groups also collect data for the ONMSD Quality Care metrics.
- Maternity Units and Networks that currently provide comprehensive annual reports are the Rotunda, the Coombe, the National Maternity Hospital, South South West Region and West North West Region.
- Other reporting mechanisms include: Maternity safety statements and the IMIS report. All maternity units contribute to NPEC reports on Therapeutic hypothermia, Perinatal mortality, Severe Maternal Morbidity and Home birth audit.
- This Irish Maternity Indicator System (IMIS) National Report, published annually by NWIHP, publishes data from the 19 maternity hospitals and/or units in Ireland. It encompasses 40 metrics across a range of categories, including deliveries, obstetric risks and complications, neonatal care, breastfeeding, laboratory metrics, hospital activities, and demographics.

Recommendation 2.1

The strategic workforce planning activities currently underway are designed to build a sustainable health and social care workforce to meet future demand for health services.

- At the end of June 2025, employment levels show there were **149,099 WTE** (equating to 170,181personnel) directly employed in the provision of Health & Social Care Services by the HSE and Section 38 hospitals & agencies. There were 127,032 Whole Time Equivalent (WTE) staff working in DoH funded health services at the end of June 2025. This is an increase of 25% over 2020 numbers.
- There are over 29,286 more staff (25,492 funded by Health), working in the health system than there were at the beginning of 2020. This includes:
- 10,050 more nurses and midwives (9,721 DoH funded)
- 5,019 more health and social care professionals (4,044 DoH funded)
- 3,806 more doctors and dentists (3,816 DoH funded)

Strategic Workforce Planning activities include:

- Long term strategic health and social care workforce planning, supported by evidence-based tools, to improve the availability of health professionals and reform their training to support integrated care across the health service.
- Increasing future supply of healthcare workers by working with the education sector, regulators, and professional bodies to increase the availability of healthcare professionals to meet demand for health and social care services.
- Increasing specialist medical postgraduate training places to increase the number of Non-Consultant Hospital Doctors (NCHDs) in training and the future supply of consultant doctors. This includes increasing the numbers of NCHD postgraduate training places informed by workforce planning projections.
- Monitoring progress with implementation of the recommendations of the National Taskforce on NCHD Workforce.
- HSE resourcing strategies to address the gap between supply and demand of healthcare professionals to ensure the availability of all staff categories to meet current and future health service workforce demand.
- Building workforce analytics and intelligence reporting across HSE Health Regions.

The Department of Health is using evidence-based tools to support strategic workforce planning. In particular, the Department will utilise the recently developed planning projection model to support strategic workforce planning activities. This model is an evidence-based planning tool that has the capacity to produce a variety of workforce projections, under different scenarios with differing levels of healthcare policy and reform, and varying levels of inward migration of foreign educated healthcare workers.

The scope and capacity of the health and social care workforce planning model will be further expanded by incorporating new datasets and research to strengthen the Department's Health and Social Care long-term workforce planning projections.

This modelling also complements other work including:

- An Analysis of Medical Workforce Supply published by the DoH in March 2023.
- A System Dynamics Model of Nursing & Midwifery Workforce Supply published by the Department of Health in September 2022.
- Work carried out by the Economic and Social Research Institute (ESRI) on behalf of the HSE to develop workforce demand projections across (acute) hospital groups.
- Work ongoing by the ESRI on behalf of the HSE to develop workforce demand in the community.
- Work ongoing by the ESRI on behalf of the Department of Health updating projections of future capacity requirements.
- The statistical model developed by the HSE National Doctor Training and Planning (NDTP) which underpins the development of speciality specific medical workforce plans.

Increases in health and social care student places

- Significant progress has been made working with the Higher Education Sector and Professional Bodies to increase student training places for the health sector. In September 2022 an agreement was secured with the Irish Medical Schools for an additional 200 Irish/EU medicine student places by 2026. Over the period 2014 to 2023 first-year nursing places in Irish Higher Education Institutions (HEIs) grew from 1,570 to approximately 2,100 – an increase of almost 34%.
- Across 2023 and 2024 a total of 762 recurring additional student places in health-related disciplines were provided in Higher Education Institutes plus 389 additional student places in Northern Ireland across medicine, nursing, midwifery and allied health professions.
- In June 2025, the Government approved a significant expansion in training places for Health and Social Care Professions (HSCPs). This will see up to 310 additional student places created in 2025 and a further 151 in subsequent years, in disciplines critical to disability, health, and education services.
- The decision follows a joint proposal arising from collaboration between Department of Health, Department of Further and Higher Education, Research, Innovation and Science (DFHERIS), Department of Children, Disability, Equality (DCDE), and Department of Education and Youth, supported by the Higher Education Authority (HEA) and the Health Service Executive (HSE).
- This represents a vital investment in the future workforce for health, disability, and education services, and in meeting Programme for Government commitments.

Increases in medical intern posts and postgraduate medical training places

There has been a 20% increase in the number of medical intern posts available over a six-year period from 2019/20 to 2024/25, and significant increases in specialist postgraduate medical training places have been achieved over the same period, including:

- 27% increase across Basic Specialist Training (BST)
- 32% increase across Higher Specialist Training (HST)
- 29% increase in the total number of doctors enrolled in training programmes.

Provisional figures for the 2025/2026 training year indicate the total number of doctors enrolled in postgraduate medical training in Ireland currently is approximately 5,960, representing a 4.9% increase in places compared to 2024/2025.

Table X: Increases in postgraduate medical training places 2019/20 to 2024/25.

	2024/2025 Training Year	2023/24 Training Year	2020/2021 Training Year	2019/2020 Training year	% 6 -year Increase (2019 v 2024)
Interns	879	873	995^	734	20%
BST	2,042	1,966	1,758	1,605	27 %
HST	2,520	2,382	2,013	1,904	32%
IMGTI	178	145	115	170	5%
Post CSCST Fellowships	62	69	8	8	675%
Total Training NCHDs	**5,681***	**5,435***	**4,881 ***	**4,421***	**29 %**

Table Notes:

^In 2020 in response to the Covid-19 pandemic the Minister for Health requested the HSE to increase medical intern posts to provide a post for all Irish Medical School graduates (CAO and Non-CAO) who wished to accept a post. This resulted in the total number of intern posts increasing to 995, a 36% increase on 2019. This increase was for one year only, as a direct result of the Covid-19 pandemic.

**Includes a small number of trainees who are undertaking a period of approved out of programme leave during training to undertake research, clinical training posts abroad, approved programme leave & a small number of trainees who are repeating a year of training for various reasons e.g. Sick leave, maternity leave/remediation/completing examination requirements*

Additional Government investment in the health and social care workforce in the last number of years and a substantial increase in the healthcare workforce since 2020

- Through the National Maternity Strategy 2016-2025 to date €28 million has been invested in New Development Funding, supporting the recruitment of over 550 additional Whole Time Equivalent (WTE) staff into our maternity services. This includes 382 WTE nurses and midwives and 44 WTE consultants. This investment and these additional staff have supported the delivery of the Strategy's actions and its overall vision of quality maternity services that are safe, nationally consistent and woman-centred.
- As part of the Governance and Workforce Pillar of the Strategy, a review of the Birth Rate Plus maternity unit staffing model is underway, and multiple workstreams are being actioned from the recommendations of the Expert Review Body on Nursing and Midwifery. A National Midwifery Staffing Taskforce has been established to address recruitment and retention of midwives.

The resourcing of the HSE workforce is anchored in the 5 pillars of the HSE Strategic Resourcing Plan which was launched in 2023.

1. **Engage & Retain Our Workforce**
2. **Attract a High Performing and Diverse Workforce**
3. **Build the Healthcare Talent of the Future**
4. **Support the Health & Wellbeing of our Workforce**
5. **Build a Positive and Inclusive Workplace Culture**

Each pillar has a suite of strategic actions which are being progressed. They include short-term to longer-term timeframes, as well as ongoing activities.
These initiatives are service-wide, and some are targeted particularly in critical areas.

The Strategic Actions under each pillar are outlined below.

Pillar 1 Engage & Retain Our Workforce

- HSE Staff Engagement Survey 'Your Opinion Counts' - to inform improvements and benchmark against industry standards
- HSE Retention Toolkit – to support retention nationally and locally at site level
- Career Pathways on HSE Career Hub – to support workforce recruitment and retention
- Enable professionals to work to the top of their licence – to maximise workforce capacity

Pillar 2 Attract a High Performing and Diverse Workforce

- Development of Engagement Capability with candidates (on HSE Career Hub) – to promote opportunities and expand candidate pools
- International Support Materials – roadmaps and supporting information for international workforce in the HSE
- 'Project Home' – an initiative to encourage Irish health and social care graduates back home to work in the Irish health service
- Recruiting and Retaining Home Grown Talent – to support workforce supply and retention
- Targeted Strategies for Medical Consultants to fill posts – to develop focused talent attraction and engagement strategies for hard to fill posts
- Recruitment Modernisation programme – to standardise and consolidate the recruitment experience and process to support better outcomes

Pillar 3 Build the Healthcare Talent of the Future

- Expand educational routes to entry to practice e.g. NTO pathways – to increase domestic workforce supply
- Apprenticeships – to support increases and diversity in the workforce
- Talent Attraction & Engagement (TAE) - maximising the use of technology to capture the widest audience and to support diversity
- TY Work Experience guidelines - to engage with students early and support future career decisions to work in the health service

Pillar 4 Support the Health & Wellbeing of our Workforce

- Promote existing staff supports – to encourage engagement with supports e.g. Employee Assistance Programme, Occupational Health, Rehabilitation
- Review of flexible working policies – to support workforce needs and to position the HSE as an employer of choice in a competitive global talent market.

Pillar 5 Build a Positive & Inclusive Workforce Culture

- Reasons for Leaving – feedback from employees to support and inform employee engagement and recruitment and retention strategies
- International Support Materials - supporting information to help build a positive and inclusive workforce culture.
- Regularly harness staff ideas – to support staff motivation, job satisfaction and engagement

Recommendation 2.2

- All units providing clinical care are required to have clinical governance in place in line with HSE guidance**.**
- HSE currently has guidance on clinical governance development and assurance check lists. These are available online and published by the HSE and Department of Health. Under the National Maternity Strategy there was a requirement to establish a maternity network with clinical midwifery and quality and safety leads as well as data analysis capacity since the reorganisation of the HSE into RHAs, maternity clinical networks reflect this change.

Recommendation 2.3

- At HSE national level National Quality and Patient Safety (NQPS) (part of Chief Clinical Officers Office) works in partnership with HSE operational system (the six Health Regions), patient representatives and other internal and external partners to improve patient safety and the quality of care. This work is underpinned by the Patient Safety Strategy (2019). In line with the Strategy the NQPS delivers on its purpose through the following work programmes;

    - **QPS Connect / QPS Improvement**: Using of improvement methodologies to address common causes of harm. Communicating, sharing learning, making connections

  Areas of work include:
    - Improvement Collaborative Handbook 2023
    - Quality Improvement Guide and Toolkit 2024
    - NQPS QUICKPatientSafety Mobile App
    - Q Community
    - Q Exchange
    - Quality Coaching Development
    - Leadership skills for engaging staff in QPS
    - Common Causes of Harm – supporting national programmes with educational materials for HSE staff and public, some examples include:
    - QPS TalkTime - fortnightly webinar -:
        - QPS TalkTime Ep.23: A spotlight on sepsis in infants and children
        - QPS TalkTime Ep. 24: Everyone needs a medicines list for safety, How do we achieve this?
    - Walk and Talk Improvement Podcast
        - Episode 18: My Health, My Voice: Matthew's story
        - Episode 19: The psychology of diagnosis with Professor Eva Doherty
        - Episode 20: Striving for diagnostic excellence with Dr Hardeep Singh
        - Episode 21: Making a diagnosis: the role of GPs with Dr John Brennan
        - Could it be sepsis?
        - Reducing and managing sepsis - what do you need to know as a healthcare professional?
        - Deconditioning: Patient Harm Hidden in Plain Sight
    - Patient Partnership – liaison with Patients for Patient Safety Ireland

  Leaflets

  - My Health, My Voice leaflet (PDF, 2 Pages, 2.49 MB)
  - My Health, My Voice poster (PDF, 1 Page, 2.32 MB)
    - Video

        - My Health, My Voice voice recording - YouTube
    - Evidence Based Quality Improvement and Patient Safety Research Network (EQUIPS)

- **QPS Intelligence:** Using data to inform improvements in quality and patient safety.
    - QPS Data for Decision Making Toolkit

- **QPS Incident Management:** Working with people to identify, understand and share safety learning, advocate for open disclosure and develop the national incident management system in the HSE.
    - Incident Management Framework
    - National Open Disclosure programme
    - Just Culture
    - Patient Safety Together
        - HSE National Patient Safety Alerts
        - Patient Safety Supplements
        - Patient Safety Stories
        - Patient Safety Community
    - Patient Safety Act (2023) implementation
    - NIMS
    - Learning
    - Safety Alerts

- **QPS Education:** Enabling QPS capacity and capability in practice. Outputs include:
    - Prospectus for QPS Education and Learning Programmes the QPS Prospectus of Education and Learning Programmes
    - QI Knowledge and Skills Guide
    - Introduction to Human Factors
    - National Facilitators Education Programme
    - QI Training and Education – HseLanD
        - Introduction to Quality Improvement
        - Foundation in Quality Improvement
        - Working as a Team for Improvement
    - QI Training and Education
        - Postgraduate Certificate in Quality Improvement Leadership in Healthcare (RCPI)
        - Situation Awareness For Everyone (S.A.F.E) Collaborative Programme
        - S.A.F.E is a 6-month collaborative patient safety education programme, and is designed to enable

- **National Centre for Clinical Audit (NCCA):** Supporting Clinical Audit service providers locally and nationally. Resources and publications
    - Clinical Audit Practical Guide
    - Clinical Audit Nomenclature –Glossary of Terms for Clinical Audit
    - Data Protection and GDPR FAQs for Clinical Audit
    - Clinical Audit Toolkit
    - Generic Local Clinical Audit Template

NCCA Training & Education

- Fundamentals of Clinical Audit (HSeLand and virtual)
- Advanced Training in Clinical Audit
- Clinical Audit Action Hour

Commitment 4 of the HSE Patient Safety Strategy (2019) to Reduce Common Causes of Harm. The Patient Safety Strategy recognises the significant action already taken across health services to drive a culture of high quality and safety and seeks to support and build on that work. The following are examples of existing programmes in the HSE who's focus includes reducing *Common Causes of Harm*.

- *National Clinical Programme for Sepsis*
- *National Medication Safety Programme*
- *The Deteriorating Patient Improvement Programme*
- *VTE programme*
- *AMRIC*
- *OEST*

In particular, in relation to Maternity Services, there is also the following:

- The National Women and Infants Programme
- There are key courses particularly for those working in maternity services, these include **Basic life support, Neonatal resuscitation programme, Children's First.**
- Much work has been undertaken with regard to multidisciplinary teaching and training, e.g., the roll out of NRP to all maternity units, PROMPT (Practical Obstetric Multidisciplinary Training) training and teaching aids, clinical skills facilitators on sites, centres for midwifery education and the appointment of National Simulation lead and development of courses.

National Incident Management System (NIMS) - The HSE, in collaboration with the SCA, have been leading out on the electronic point of occurrence (ePOE) roll-out. It has now been implemented in 31 statutory and Section 38 hospitals and community healthcare locations and 43,000 Health Care workers can access NIMS directly.

Recommendation 3.1

- Framework was launched by the Minister for Health in October 2023
- Implementation and adoption by relevant stakeholders in their organisational policies (ongoing).
- Meeting with stakeholders to discuss the Framework, answer queries and provide guidance (ongoing)
- Drafted guidance document for the Framework for circulation.
- Annual self-reporting on implementation progress to the Minister to commence in April 2025.

Recommendation 3.2

- Arrangements are already in place in many hospitals and across hospital networks /groups to support incident management including Regional Incident Management Teams / forums e.g. DNE Regional Peri Operative Incident Review Forum. Serious Incident Management Teams (standing SIMTs) in place across hospitals. OEST already actively supporting 19 Maternity Units.
- The OEST as a model for response being reviewed and potentially expanded. The IMF framework is being refreshed and NWIHP and National Q and S will engage.

Recommendation 3.3

- Each patient and service user are treated with respect and sensitivity, and all adverse events are acknowledged in line with Open Disclosure processes.
- Response to emergency situations in Acute Hospitals is already a standard practice. Patients are assessed and treated based on clinical need irrespective of cause.
- A patient's clinical history and past engagement with health services will inform their plans of care.

Recommendation 3.4

- Framework was launched by the Minister for Health in October 2023
- Implementation and adoption by relevant stakeholders in their organisational policies (ongoing).
- Meeting with stakeholders to discuss the Framework, answer queries and provide guidance (ongoing)
- Drafted guidance document for the Framework for circulation.
- Finalising draft Electronic Annual Report forms.
- Annual self-reporting on implementation progress to the Minister to commence in April 2025.

Recommendation 3.5

- Complaints and Patient Advice and Liaison staff already play key role in this area.
- This recommendation links directly with HSE policy to assign a Designated Person. There is also a legislative requirement to assign a designated person under the Patient Safety Act.
- The designated support person referenced in the current IMF is the same role as the designated person referred to in the Open Disclosure Policy. This role has been incorporated since 2019. The Open Disclosure Policy 2025 sets out the requirement of a designated person for all category 1 incidents and notifiable incidents. The HSE has developed a number of supports for staff taking on this role, for example an in-person training event in Q1 2025 that was attended by over 100 staff taking on or embedding this role. The role is well established in some settings and relatively new to others.
- The second version of the National Standards for Bereavement Care, following pregnancy loss and perinatal death, were published in 2022.
- All 19 maternity hospitals/units have been funded for a minimum of one Clinical Midwife Specialist (CMS) in Bereavement and Loss in their unit, and additional funding has been provided to increase the number of dedicated Bereavement and Loss CMS resources in larger units.
- In addition, the NWIHP have funded Medical Social Workers across the 19 maternity hospitals/units.

Recommendation 3.6

Children's Disability Network Teams nationally currently have procedures in place to assess and monitor children identified as at risk on discharge from hospital following a catastrophic birth injury

CDNT Procedure for Referral and Initial Engagement with At-Risk Infants Discharged from Hospital

1. Referral Receipt and Initial Review

When a baby identified as at risk is due to be discharged from hospital, the Community Disability Network Team (CDNT) **may** receive a referral from hospital staff or the attending consultant. An interim or discharge summary may accompany the referral.

Upon receipt, the CDNT reviews the referral, taking into account the level of risk and the child's anticipated needs. The team will confirm receipt of the referral with both the referring hospital and the family, and will communicate the outcome of the referral review (e.g. acceptance or redirection).

2. Coordination with Hospital and Family Engagement

If the referral is accepted, the CDNT will contact the hospital team to confirm the baby's discharge status, discuss the child's current medical and developmental condition, and ensure effective handover and continuity of care.

The CDNT will also contact the family to arrange an initial home visit. This visit will be conducted by the most appropriate professional(s) based on the identified needs of the child.

3. Prioritisation and Ongoing Support for High-Risk Infants

Infants assessed as having complex needs or being at high risk will be prioritised for early intervention and follow-up. Ongoing supports will be provided by relevant CDNT professionals, and active coordination will be maintained with hospital services and the local community paediatrician.

4. Individualised Family-Centred Planning

Children availing of CDNT services may require access to a range of specialist supports, tailored to their specific needs and delivered through an Individualised Family Support Plan (IFSP). This plan will be developed in collaboration with the family from the outset and will be reviewed regularly throughout the child's developmental stages.

Support areas may include:

- Developmental assessments
- Specialised seating and equipment
- Motor management and physical therapy
- Feeding, eating, drinking, and swallowing (FEDS) support
- Nutritional guidance
- Augmentative and alternative communication (AAC)
- Ongoing physical and clinical reviews

These services will be prioritised based on presenting needs and risk levels, within available resources.

5. Key Working Approach

Where possible, a key worker or key contact will be assigned to each child with complex needs. This clinician will serve as the primary communication link between the family and the wider CDNT, ensuring clarity, consistency, and responsiveness in care planning and delivery. It is acknowledged that key working practices may vary across CDNTs during ongoing national implementation.

Recommendation 3.7

- The Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 was commenced by the Minister for Health on 26 September 2024 (other than Section 68).
- Prior to commencement of the Act, there were a number of preparatory steps required. The Act establishes a mandatory requirement for the notification of certain serious patient safety incidents. To facilitate this notification process, a new module to the existing National Incident Management System (NIMS) was designed, built, tested and signed off by key stakeholders, including the HSE, State Claims Agency, HIQA and the Mental Health Commission.
- In addition, to facilitate commencement of the Act, the HSE developed a new open disclosure training policy and communications plan for all staff regarding the new disclosure and notification requirements under the Act. The HSE advise that the new open disclosure training module is now available to all staff.
- Also, prior to commencement, the Department needed to make a technical amendment to the Act to address a minor drafting error. This amendment was approved by government decision S180/20/10/2859, is technical in nature and does not alter the policy intention of the Act. The Bill which contains this amendment completed all stages in the Seanad on 9 July 2024 and was signed by the President on 15 July 2024.
- It commenced on 19 August 2024. Guidance has been issued by DoH in relation to implementation of the Act.
- In 2024, the HSE and HSE funded services progressed a comprehensive implementation plan to prepare the organisation and its staff for its implementation. Key areas of work focused on:

- The establishment of a HSE Patient Safety Act Implementation Working Group under the remit of the Chief Clinical Officer with representation from HSE staff across many different services, HSE-funded organisations, patient partners and external agencies (for example the Patient Advocacy Service)
- The enhancement of the NIMS to enable the reporting of notifiable incidents to the relevant regulator using the system. This technical development was supported by a collaborative project involving the Department of Health, HSE, HIQA, the Mental Health Commission and the State Claims Agency. HSE staff supported the testing of the technical developments. The HSE developed numerous resources for its staff to support them. In addition to the Patient Safety Act requirements, the HSE and SCA significantly improved the reporting functionality on NIMS in relation to open disclosure for all incidents, not just notifiable incidents.

- The development of necessary open disclosure resources and training materials, including the production of new resources and the revision of existing resources. The HSE and patient partners developed two e-learning programmes for HSeLanD: one on the Patient Safety Act 2023 and one on the Designated Person role. The HSE further developed many templates and guidance documents for staff. This is elaborated on further in this report.
- The HSE worked with legal services to interpret and understand the requirements of the Patient Safety Act. A guideline on the Notifiable Incidents is in development currently and will complement the forthcoming HSE Open Disclosure Policy 2025.
- The provision of promotional and educational engagement activities, delivered through a range of channels, aimed at meeting the widest audience. This included the development and delivery of a virtual and an on-site training presentation on the new legislation to HSE and HSE-funded services. In the months prior to commencement and afterwards, the team presented to senior management teams, clinical leadership teams, patient safety forums, grand rounds and specialist services training sessions events across the country.
- Prior to the commencement of the Act an organisational readiness survey was shared with services. The learning was shared by services across the health and social care system as they worked to implement the requirement of the Act. It also provided a prompt to services of the questions they should be asking themselves about their preparations.

Additionally, the HSE website pages include information on the Patient Safety Act:

Summary page on the PSA

https://www2.healthservice.hse.ie/organisation/qps-incident-management/open-disclosure/patient-safety-notifiable-incidents-and-open-disclosure-act-2023/

And the Open Disclosure resource page, which includes the PSA resources

https://www2.healthservice.hse.ie/organisation/qps-incident-management/open-disclosure/resources-for-staff-and-organisations/

Resources created for Themed Week (the slide shows for public and staff areas), which highlighted the forthcoming changes of the Act. These can be found under ‘resources’ on this page;

https://www2.healthservice.hse.ie/organisation/nqpsd/featured-articles/hse-open-disclosure-themed-week-2024/

- We are also developing patient information leaflets covering this and wider open disclosure information.

Recommendation 3.8

The NPSO has commissioned international and national research which is complete. Reports with recommendations have been prepared on the following:

1. International evidence brief to review international pathways for Clinical Complaints across 5 OECD Countries. (2021)

2. National research study on principles and values which underpin patient safety incidents (2023)

3. Expectations in respect of Patient Complaints concerning Clinical Judgement (2024).

- A comprehensive stakeholder engagement process has been ongoing since 2022, while the development of policy and legislation is ongoing but at an early stage.
- The National Care Experience Programme undertakes surveys in a range of care areas that seek to capture the experiences of people using these services and publishes the results. The programme currently implements the National Inpatient Experience Survey, the National Maternity Experience Survey, the National Bereavement Experience Survey, the National Nursing Home Experience Survey and the National End of Life Survey. Development work on a National Mental Health Experience Survey and a National Cancer Care Experience Survey is underway.

Operational Lead: Health Service Executive (HSE)

Work already underway

- Your service / Your say - national complaints policy
- National Inpatient Experience Survey
- National Maternity Bereavement Survey
- Patient Safety Complaints and Advocacy Service
- Local complaints/compliments pathways- monitored by clinical risk departments. Complaints and compliments analysis undertaken by National Complaints team
- NIES and NMBS action plans developed, published and monitored at service level.

Recommendation 4.1

Part 1: Data on Neonatal Encephalopathy (NE) be collected on a statutory basis

The Patient Safety (Notifiable Incidents and Open Disclosure Act 2023 was commenced by the Minister for Health on 26 September 2024 (other than Section 68). The Act establishes a mandatory requirement for the notification of certain serious patient safety incidents and includes the following in the definition of a notifiable incident in Schedule 1:

> *"A baby who—*
>
> *(a) in the clinical judgment of the treating health practitioner requires, or is referred for, therapeutic hypothermia, or*
>
> *(b) has been considered for, but did not undergo therapeutic hypothermia as, in the clinical judgment of the health practitioner, such therapy was contraindicated due to the severity of the presenting condition".*

As outlined in the summary of actions, the Department of Health will engage with the HSE to explore further whether the data mandatorily notified under the Patient Safety legislation relating to babies referred or considered for referral for therapeutic hypothermia, could assist with meeting this part of the recommendation.

Part 2: That a register of Cerebral Palsy (CP) cases in Ireland should be developed

The project to establish a cerebral palsy registry in Ireland is part of the ELEVATE Programme of research, which is funded under the Science Foundation Ireland (now Research Ireland) Strategic Partnership Programme with co-funding from the Cerebral Palsy Foundation. The ELEVATE Programme is led by University College Cork (UCC)'s INFANT Research Centre with partners from Trinity College Dublin (TCD), the RCSI, and tertiary-level maternity hospitals. ELEVATE is a five-year research programme that aims to improve the prevention, detection and treatment of early brain injury and CP in Ireland. The programme of research is comprised of 4 work packages (WP); WP1 (PREDICT), WP2 (DETECT), WP3 (IMPROVE) and WP4 (INTERVENE). The objectives to develop and implement a national Irish CP Registry fall under WP3.

A Steering Committee has been established and its work is underway. The Steering Committee is accountable to the ELEVATE programme Executive Management Team (EMT) and the Infant Strategic Advisory Board. The EMT is responsible for the financial monitoring and spend approval in the programme, and therefore financial oversight is beyond the remit of this Steering Committee. The EMT are responsible for submitting reports to Research Ireland and the Cerebral Palsy Foundation on behalf of the Steering Committee, in compliance with the Grant Conditions and the most current Research Ireland Policy Documents. The Clinical Lead and Principal Investigator are accountable to the Steering Committee. The Chair of working groups or sub-committees report to the Steering Committee.

Membership of the Committee is multidisciplinary and representative of the core stakeholders. It comprises of persons with interest, knowledge and expertise on CP and includes stakeholders with healthcare professional expertise, and academic or methodological expertise. The HSE is well represented on the Group which includes representatives from the National Clinical Programmes. Membership of the Steering Committee also includes at least two Patient and Public Involvement (PPI) representatives.

As outlined in the summary of actions table, the lead unit in the Department of Health will engage with stakeholders concerning this work that is already underway to develop a Cerebral Palsy register and take steps to ensure that the existing proposal meets the appropriate standards and aligns with Departmental requirements.

Recommendation 4.2

- NNEAG is a partnership arrangement between the National Women and Infants Health Programme (NWIHP), the Department of Health and the State Claims Agency to deal with issues of joint concern related to the occurrence of neonatal encephalopathy in Irish maternity units /hospitals. The purpose of the NNEAG is to identify and address issues relating to avoidable incidents of neonatal encephalopathy in our 19 maternity units/hospitals.
- The work of the NNEAG began in August 2019 with engagement across the stakeholder groups. Originally the 15 recommendations from the NNEAG were being progressed through 5 work streams. In 2021, with the creation of the OEST, the workstream on sharing the learning transitioned into the OEST and the work streams were reduced to 4. The remaining work streams are:

Work Stream 1: A National Obstetric Clinical Advisory Group

- This group is chaired by the Clinical Director of NWIHP, it has representation from across the clinical sites and meets at least quarterly. It provides clinical advice to and oversight of all other workstreams

Work Stream 2: Standardised Maternity-specific Review Tool Creation and National Roll-out

- The group completed the creation and roll out of a maternity-specific adverse event review tool for standardised use in maternity reviews where appropriate
- A pilot is currently running in a maternity unit in conjunction with the OEST.

Work Stream 3: Mandatory training for fetal monitoring, obstetric emergencies and neonatal resuscitation

- A multidisciplinary group was convened to develop a suite of national training standards from obstetric emergencies, fetal monitoring and neonatal resuscitation.

- National Training Standards for Obstetrics Emergencies, Fetal Monitoring and Resuscitation have been issued to all maternity units and published.
- As part of this work programme, NWIHP has also funded standardised training equipment for obstetric emergencies in all 19 maternity units.

Work Stream 4: Progressing Practice and Supportive Technology

- This group looked at risk assessment at onset of labour.
- Fetal growth restriction and its impact on emergencies in labour was identified as an area needing attention.
- This led to the development of a National Clinical Practice guideline by the Clinical Programme in Obstetrics and Gynaecology on Identification and Management of Fetal Growth Restriction.
- Publication date June 2025

Recommendation 4.3

- Optimal treatment pathway for babies with HIE has been developed and is currently in draft format.
- Models of care for Neonatology sit under the Clinical Programme for Paediatrics and Neonatology.
    - There is a draft model of care devised for care for babies with HIE.
    - This is contingent on an overarching model of care for neonatology which is in progress.

Recommendation 4.4

- Models of care for Neonatology sit under the Clinical Program for Paediatrics and Neonatology.
- There is work ongoing in the provision of support for research collaborations involving HIE.
- There is a draft model of care devised for care for babies with HIE.
    - This is contingent on an overarching model of care for neonatology which is in progress.
- There is work ongoing in the provision of support for research collaborations involving HIE.
    - Infant centre UCC. Trinity /CHI collaborations - Child Health Research Excellence Report 2023.
- All HSE clinicians are supported in pursuing research in their clinical area of expertise.
- **https://hseresearch.ie/wp-content/uploads/2019/12/10-Year-Action-Plan.pdf**

Recommendation 4.5

DCDE will work with the HSE to map the current systems and structures, care pathways, which start at birth and continue through life, for children who have suffered a catastrophic birth injury. Following from this, we will identify opportunities for enhancements and address gaps for this cohort.

We will also support children support a clearly defined transition pathway into adult services with catastrophic birth injuries, with transition planning embedded into early service delivery and long-term care planning.

Recommendation 5.1a

- Following on the recommendation by Judge Irvine's Working Group, a provision was introduced in the Legal Services Regulation Act 2015 which provided for the making of regulations by the Minister for Justice for the introduction of a pre-action protocol relating to clinical negligence actions.
- Unfortunately, difficulties arose regarding the statutory basis making a pre-action protocol under the 2015 Act.
- Consequently, a legislative amendment to the 2015 Act was enacted in 2013 as part of the Courts and Civil Law (Miscellaneous) Provisions Act 2023.
- The overall effect of the amendment is to allow the drafting of pre-action protocol regulations in relation to clinical negligence actions.

Recommendation 5.1b

- The SCA offers mediation wherever appropriate to resolve clinical malpractice cases. The Agency is proactive in offering mediation and its 2024 annual report shows that 43% of claims concluded by the SCA's clinical claims team in 2024, and where damages were paid, involved a mediation process.
- A new High Court Practice direction (HC131) has come into effect from 28 April 2025. It sets out the circumstances in which a party to clinical negligence proceedings may apply for a trial date. Its principal purpose and objective is to facilitate the early resolution of such proceedings while also ensuring that they are properly prepared for trial. It sets out the circumstances in which a party to clinical negligence proceedings can apply for a trial date and includes as a condition of applying for such a date that the applicant must provide an undertaking to offer mediation to the opposing party within a certain period of time and to engage in such mediation within a further period of time (assuming it has not already taken place). There are also other provisions designed to support any such mediation. Confirmation is also contained that the court retains its discretion in terms of assigning a trial date.

Recommendation 5.1c

- The new High Court Practice direction (HC131) referenced above includes a section on the use of experts in clinic negligence actions, which are binding on parties and their lawyers.

Court rules and the law

- It is important to be aware that equivalent rules currently do apply in clinical negligence proceedings. The current rules governing pleadings, replies to notice for particulars, discovery obligations, and the disclosure and exchange of lists of witnesses and expert reports apply equally to both plaintiffs and defendants. The requirements of 5(a)(ii) of HC 131, discussed later, will further enhance this procedural parity.
- There are also existing rules governing how expert witnesses are to perform in the process of giving evidence. Order 39 of the Rules of the Superior Courts is devoted to the subject of evidence in the High Court, the Court of Appeal and in the Supreme Court with rules 56 to 61 dealing specifically with expert evidence. The principle overarching the use of expert evidence is outlined in Rule 57(1) as follows:

  (1) It is the duty of an expert to assist the Court as to matters within his or her field of expertise. This duty overrides any obligation to any party paying the fee of the expert.
- Order 63(c) of the Rules of the Superior Courts deals with pre-trial procedures in Chancery and non-jury actions and other designated proceedings. Its operation had to be suspended by a former President of the High Court because of a lack of judicial resources. Notwithstanding this and where time allows, cases are subject to case management procedures pre-trial. In addition, with the appointment of additional judges on foot of the report of the Judicial Planning Working Group, it is hoped that the resourcing situation will improve sufficiently later this year to consider operating pre-trial procedures as anticipated under Order 63(c).

High Court Practice Directions

- The work of the Implementation Group was assisted by the timely publication of a new High Court practice direction in the area of clinical negligence (HC 131). Section 5aii of HC131 provides the following:

  Where the plaintiff obtains an expert report on any aspect of quantum they intend to rely upon, they shall, within six weeks of receipt, provide particulars of any alleged additional injuries or special damages arising from it. If the defendant intends to investigate or contest the relevant claim, they shall engage an appropriate expert within six weeks of receiving such particulars. If the

defendant subsequently obtains an expert report on quantum that they intend to rely upon, they shall, within six weeks of receipt, provide particulars of that report.

- In addition, the evidence to be given to courts can be a source of dispute between parties and in an effort to reduce this, sections 5b and 5c of HC131, provide:

  5b Schedule of Witnesses
  The applicant must have exchanged or offered to have exchanged a complete schedule of all witnesses, both factual and expert, intended to be called at trial.
  5c Exchange or offer to exchange expert reports
  i. Unless otherwise permitted by law, the applicant must have exchanged or have offered to exchange, all expert reports intended to be relied upon at trial.
  ii. Where such exchange has not yet occurred, the applicant must have made a bona fide offer to exchange expert reports, allowing the opposing party or parties in the action a reasonable opportunity to do the same.
- The inclusion of these new provisions should be considered as an incentive to parties to clarify their use of expert witnesses in advance of a trial, thereby speeding up the process for both sides, saving scarce court time and reducing the stress on injured parties and their families.
- This practice direction will be reviewed after 6 months in operation and depending on how it is operating, consideration will then be given to bringing forward Court rules to enhance the powers available to courts in this area.

<u>Hot tubbing</u>

- The Interdepartmental Group recommended that they might seek an order that a "Hot-tubbing" meeting take place between the experts, in advance of the hearing of the case. "Hot-tubbing" continues to receive the unqualified support of the judges of the High Court and parties in appropriate cases will continue to be directed to explore its use to reduce or narrow the areas of dispute.
- Evidence of this support for "Hot tubbing" is shown in the recent judgement of Barniville P in the matter of Word Perfect Translation Services -v- The Minister for Public Expenditure and Reform [2025] IECA 45.

  'Having carefully considered their reports and their evidence at the hearing before the High Court, I would like to make clear that, in my view, the two experts performed their independent role as expert witnesses in an exemplary and model fashion. Their reports were clear and comprehensive. Before they gave their evidence at the trial, the experts met and produced the Joint Report. The Joint Report was a model of its kind, and I found it immensely helpful in understanding the issues and the points of agreement and disagreement between the experts on the complex issues which arose in this case. A careful

review of the Joint Report demonstrated that the differences between the experts boiled down to a very small number of net issues, principally directed to the competition implications of the 'one lot rule'. The experts are to be commended for the constructive approach which they took in the preparation of the Joint Report. They are similarly to be commended for the manner in which they gave their evidence under cross-examination'.

- It is important to acknowledge that there are several reasons why such meetings should not be routinely directed. While these meetings can help clarify issues in some cases, a blanket requirement would risk introducing unnecessary cost and complexity, particularly where the expert issues are already well-defined in the reports. In multi-disciplinary cases, logistical arrangements can be onerous, and the value added by the process may be marginal. These considerations suggest that the direction of such meetings should remain discretionary, assessed on a case-by-case basis rather than imposed as a default.
- Notwithstanding this, courts encourage parties to do this where they indicate their willingness to engage in same and will consider the possibility of becoming a default enquiry of parties prior to matters coming to hearing.

Recommendation 5.1d

The President of the High Court has issued a new practice direction (HC 132) establishing the new Clinical Negligence List. Cases on the list will be heard by judges assigned to the personal injuries list with expertise in the area of medical negligence. Where such cases are listed for hearing, they are assigned to do so.

Recommendation 5.2

Regulations are being drafted to introduce a new indexation rate for Periodic Payment Orders. The coming into operation of the Regulations should mean an increase in the number of cases being settled by way of Periodic Payment Orders. The finalisation of the regulations is continuing and sign-off of definitions contained in the draft is awaited.

Recommendation 5.3

- A subgroup consisting of the Department of Health, the Department of Justice, SCA, HSE and the Courts Service was established.
    - The subgroup, along with considering the existing court rules and law in this area as well as new High Court practice directions, also undertook significant consultation with relevant stakeholders.
    - This included consultation with plaintiff legal firms, the Law Society, the Bar of Ireland, Medical Indemnity Insurers, the Royal College of Physicians, the Royal College of Surgeons, and the College of Anaesthesiologists.

- The subgroup also met with the founder of a private medical expert agency, a new commercial web-based service designed to solve the problems that Solicitors encounter in securing the right expert.

Outcome of consultation

- There was a wide difference of views in the submissions on the merits or otherwise of establishing a panel of medical expert witnesses. On the specific question of establishing a panel by a state agency, the involvement of the state in such a task was identified as problematic by plaintiff representatives. Existing regulatory agencies such as the Medical Council were identified as having appropriate expertise by some who made submissions while others were opposed to having any restrictions put on their choice of expert.
- A related consideration is any cost to the State from establishing such a panel, if a vehicle of the State is deemed suitable for this task. There is considerable work associated with engaging the experts to the panel, to gauge the levels of expertise of panel members, to receive feedback from members and users of experts as well as in the maintenance of the panel as well as the promotion and recruitment of the experts.
- The implementation group concluded that medical negligence cases can sometimes be adversarial in nature, where the evidence of experts is one area of contention. Any requirement to require a plaintiff to use a State-approved expert will be a step too far for some and could also be argued that this requirement would prevent access to justice.
- It was suggested that it would be open to those representing medical practitioners to agree to the appointment of a single medical expert, whose bona fides was accepted and who it was agreed would be capable of providing impartial evidence. If this were to come about, this could have the effect of reducing cost and levels of disagreement in the litigation.

Court rules and the law

- As outlined under related recommendation 5.1c, there are ample rules and case law already in place governing how expert witnesses are to perform in the process of giving evidence.
- As regards case law, the principles relating to expert evidence were set by Collins J in the Court of Appeal in the case of Duffy -v- McGee and others [2022] IECA 254. Quoting from Hodgkinson & James, Expert Evidence: Law and Practice (5th ed; 2020), the Court concluded that:

(1) Expert evidence presented to the court should be and should be seen to be the independent product of the expert uninfluenced as to form or content by the exigencies of litigation

(2) An expert witness should provide independent assistance to the court by way of objective unbiased opinion in relation to matters within their expertise. An expert witness should never assume the role of advocate

- This judgement also referenced many of the most relevant international and national case law in this area and provides a clear interpretation of how expert witnesses are to give evidence.

Recommendation 5.4

- Regulations are being drafted to introduce a Discount Rate to be used in catastrophic injury cases.
- A mechanism to ensure regular review of rate is being developed.
- The Minister for Justice will set the Discount Rate rather than the judiciary. A mechanism will be introduced to ensure that the rate will be reviewed periodically or in the event of a financial shock.

Recommendation 5.5

Health Information Bill (Department of Health)

- The purpose of the Health Information Bill is to ensure that Ireland has a fit-for-purpose national health information system that enhances patient care and treatment as well as supporting better planning and delivery of health services into the future.
- The Bill has a priority focus on digital (electronic) health records and is the first step in preparing Ireland to meet its obligations under the forthcoming EU Regulation on the European Health Data Space (EHDS). The Bill is also a strategic enabler of *Digital for Care – A Digital Health Framework for Ireland 2024-2030* and the HSE's Implementation Roadmap.
- The Health Information Bill will also facilitate appropriate sharing of patient information across healthcare sectors.
- Under section 12 the HSE may provide access to all or part of the digital health record to the patient concerned or an appropriate person. However, it should be noted that access may be restricted where the health services provider has reasonable grounds for believing that such access would be likely to cause serious harm to the physical or mental health of the patient concerned. Any such restriction should only be to the extent and as long as necessary and proportionate to protect the health of the patient.

Digital for Care strategy and electronic health record

- Work is progressing under the Digital for Care strategy to deliver a single digital health record for every citizen. Electronic Health Record (EHR) systems are already live in several hospitals, including St. James's Hospital, a number of large

maternity hospitals, the National Rehabilitation Hospital (NRH), and the National Forensic Hospital (NFH). The new Children's Hospital (NCH) will deploy the largest deployment of EHR in Ireland to date and will result in the NCH being a truly "digital-born" hospital. The provision of EHR for all the Irish population across healthcare is the ultimate ambition, as part of Sláintecare.

- A national, co-ordinated approach is being advanced through the EHR Preliminary Business Case and associated implementation strategies, with funding and governance structures aligned to the National Development Plan. The Health Information Bill will underpin secure data sharing and patient access. Future phases will extend EHR capability across acute and community settings, ensuring interoperability and integration across HSE Health Regions.
- The national maternity clinical management system (MN-CMS) is currently being deployed across maternity hospitals in Ireland and provides an electronic health record for all babies and mothers receiving care and treatment in those facilities. MN-CMS is live in Cork University Maternity Hospital (CUMH), the maternity unit at Kerry University Hospital, the Rotunda and National Maternity Hospitals, Dublin and Limerick University Maternity Hospital, with the Coombe due to go live in Q4 2025, at which point 70% of all babies born in Ireland will have an electronic health record.
- MN-CMS – like other EHR systems digitally record all key data relevant to mothers and newborns during pregnancy (for those that opt for shared care between these sites and their GPs), during childbirth and during the period of inpatient stay thereafter. As such they can provide access to good records that are accessible to all healthcare professionals involved in the provision of care and oversight for these mothers and babies. The EHR also facilitates better access to information for patients themselves and their representatives as there is no longer a reliance on providing copies of paper health records.

Recommendation 5.6

A meeting of the relevant parties, the Department of Health, the Department of Justice, the State Claims Agency and the Courts Service took place in July 2025 to consider the Programme for Government Commitment to '*Prioritise the introduction of a court supervised mediation-based process for managing neonatal brain injury medical negligence cases',* in light of other relevant civil justice reforms that are already underway or planned.

The outcome of that meeting was that it is anticipated that implementation of other recommendations, in particular the civil justice reforms and the implementation of two recent High Court practice directions will have a significant impact on medical negligence cases and increase the use of mediation significantly and have a positive

impact on the experience of families who need to take this path. The progress will be kept under review and further measures considered if necessary.

The High Court Practice Direction (HC 132) issued on 28 April 2025 provides for a dedicated list within the High Court for medical negligence cases. This effectively meets the objective of both recommendation 5.1.d and the Programme for Government commitment to establish a medical negligence court.

In addition, a number of other commitments aligned to recommendations in the Report are included in the Programme for Government, aimed at improving patient safety, reducing the requirement for litigation in healthcare and improving the experience of the litigation process for those taking this path.

Recommendation 6.1

- Existing/previous alternative dispute resolution approaches to litigation could be used as a model, with learnings taken on board. Examples of this include the Surgical Symphysiotomy Ex-Gratia Payment Scheme, the Kerry CAMHS Compensation Scheme, the H1N1 Vaccine claims, the DePuy Hip mass action and the CervicalCheck Tribunal.

Recommendation 6.2

- A model for the scheme, including operational arrangements, scope of coverage and payment levels has been prepared.
- The Minister has recently given approval to prepare a Memo for Government to establish an ex-gratia Vaccine Solidarity Scheme and to commence preparation of a General Scheme for the legislation underpinning the scheme.