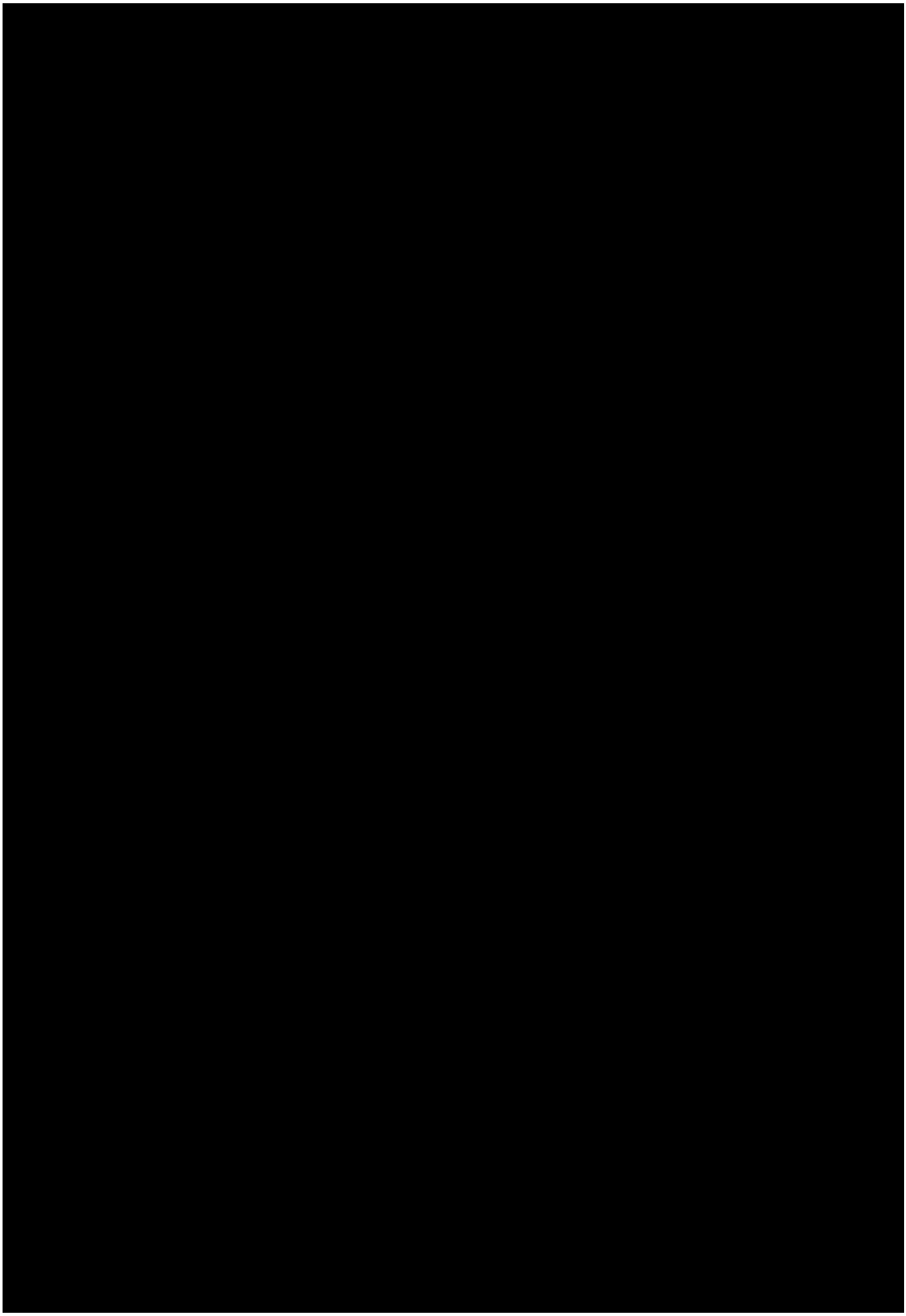

[redacted]

Financial Management Directorate

HSS

EXEC

HSS(F) 21/98

The Chief Executive of each Health and Social Services Trust
The Director of Finance of each Health and Social Services Trust
The Chief Executive of each Health and Social Services Board
The Director of Finance of each Health and Social Services Board
The Chief Executive of the Central Services Agency
The Director of Finance of the Central Services Agency
The Chief Executive of the Northern Ireland Blood Transfusion (Special Agency)
The Chief Executive of the Regional Medical Physics Agency

14th May 1998

Dear Sir/Madam

CLINICAL NEGLIGENCE CLAIMS: STRUCTURED SETTLEMENTS

The purpose of this circular is to provide guidance on the use of structured settlements in clinical negligence and personal injury litigation. Structured settlements should always be considered for settlements of £250,000 and above, and may represent good value for money for smaller settlements as well.

Annex A sets out the guidance to be followed.

Yours sincerely

N JONES
Policy and Accounting Unit

ANNEX A

CLINICAL NEGLIGENCE AND PERSONAL INJURY LITIGATION: STRUCTURED SETTLEMENTS

EXECUTIVE SUMMARY

1. Structured settlements (settlements of litigation involving the guaranteed payment of a tax-free stream of income over the plaintiff's life) can offer reassurance to plaintiffs and their carers and value for money to the HPSS. They should always be considered for any settlement resulting in costs to the HPSS of £250,000 (exclusive of costs) or over, and may be good value for lower settlements as well.

2. Proposals for structured settlements must be approved by the HSS Executive on the basis of a "value for money" (VFM) report submitted by the Trust. The VFM report may be completed in-house, using the guidance in the Appendix, or by external advisers. The external advisers should be employed in accordance with HSS (F) 20/96 'Use of Management Consultants'.

3. The HSS Executive, Policy and Accounting Unit, should be notified as soon as possible of any claim which is likely at some point in the future to result in a structured settlement.

   The Central Services Agency should also be informed as soon as possible of any claim which is likely at some point in the future to be structured, as the settlement will require funding from the Clinical Negligence Central Fund.

BACKGROUND

1. The cost of clinical negligence is an increasing burden on the HPSS. Trusts will wish to consider ways to moderate these costs, including as appropriate:

   i. adopting prudent risk management strategies;

   ii. adopting a systematic approach to claims handling in line with best current practice and guidance issued by the HSS Executive (HSS(F) 20/98).

2. Structured settlements are one way of reducing the financial impact of clinical negligence on the HPSS, while offering additional security to plaintiffs. A structured settlement cannot be imposed on either party so clearly there needs to be benefit to both parties for it to proceed.

FEATURES OF A STRUCTURED SETTLEMENT

3. Awards for damages traditionally comprise a single lump sum payment, one element of which ("future loss") is calculated so that, if prudently invested, it would provide a stream of income representing loss of future earnings and/or the need for continued care for the expected remainder of the plaintiff's life. The amount of the lump sum is

agreed by the court either as a result of a hearing or an out-of-court agreement. Structured settlements on the other hand allow for part of the damages to be paid in the form of annual tax-free instalments for the duration of the plaintiff's life.

FORMS OF STRUCTURED SETTLEMENT AVAILABLE

4. There are two forms of structured settlement:

   i. *Annuity-backed structured settlement.* At the point of settlement the Trust makes a lump sum payment to an insurance company to purchase an annuity for the plaintiff. This will guarantee an annual stream of income for the remainder of the plaintiff's life.

   ii. *Self-funded structured settlement.* The Trust itself gives an undertaking to make the stream of future payments to the plaintiff out of normal revenue funding.

5. In general, self-funded settlements offer better value for money to the HPSS because they avoid paying for the insurance company's profit element and secure the benefit of spreading the cash flow impact over time (see below). However,

   i. they might, in the past, have been less acceptable to plaintiffs and their solicitors because of the perceived risk that the HPSS body might at some future time be wound up or merged. This is considered further at paragraph 9-10 below;

   ii. many HPSS bodies have traditionally been unwilling to take the additional element of risk (ie that the plaintiff will in fact live longer than the life expectancy assumed in calculating the structure).

ADVANTAGES OF STRUCTURED SETTLEMENTS

6. The attraction for the plaintiff is that he/she receives a stream of future payments guaranteed for life, usually index-linked to the Retail Price Index. In addition, provided that the paperwork agrees with the procedure set down by the Inland Revenue, the instalment payments are free from all taxes. A 1994 Law Commission Report strongly supported the use of structured settlements and its main recommendations have now been taken up in the Damages Bill introduced in February 1996. There was also a specific clause in the 1995 Finance Act giving formal recognition to structures and their tax-free status which is now a matter of law. A further advantage for the plaintiff is that the projected settlement can be tailored individually to the plaintiff's needs.

7. The advantage to the HPSS is that structured settlements can offer better value for money than a lump sum settlement. Directly, the HPSS defendant may be able to negotiate a significant discount (compared with a lump sum comparator) in recognition of the tax and other advantages to the plaintiff. Indirectly, the plaintiff's future needs may be better met by regular payments which are more likely to be spent

upon the purposes for which damages were awarded. This should result in a significant reduction in the likelihood of the plaintiff incurring further additional costs to the HPSS. A final advantage (self-funded settlements only) is that the damages no longer need to be paid out in one lump sum and thus the cash flow demands will be spread more evenly over time.

FUNDING OF STRUCTURED SETTLEMENTS

8. When details of a structured settlement, either self-funded or annuity-based, have been formally agreed between the plaintiff(s) and the Trust, the later should make the relevant payment and seek reimbursement from the Clinical Negligence Central Fund, operated by the Central Services Agency. (See para 4.2 of HSS(F) 19/98).

CONCERNS FROM PLAINTIFFS ABOUT THE SECURITY OF THE ARRANGEMENTS

9. Despite the fact that no public body has ever failed to meet any of its agreed financial obligations there has been concern amongst plaintiffs and their representatives that structured settlements, which could last 40 to 50 years into the future, may not be fully secure. Plaintiffs may seek a binding guarantee from the Department to underwrite the settlement.

10. The HPSS (Residual Liabilities) Northern Ireland Order, which came into force on 26 August 1996 requires the Department of Health and Social Services to make provision for any residual liabilities of a Trust or Board which ceases to exist by transferring them to another HPSS body or the Department. This removes the perceived problem of security.

PROCESS FOR CONSIDERING AND APPROVING STRUCTURED SETTLEMENTS

11. Trusts are fully responsible for their decisions over the handling of clinical negligence and personal injury litigation although central guidance from the HSS Executive must be followed. In particular, Trusts are accountable for securing the best possible value for money in any settlement of litigation. **Structured settlements should always be considered whenever the cost to HPSS funds is likely to exceed £250,000** and may represent good value for money for lower awards also. This figure may be revised in the light of experience. If, on consideration, a structured settlement does not appear to offer value for money, or despite best endeavours the plaintiff is not prepared to accept one, the details should be recorded and made available on request to internal audit and the HSS Executive.

12. All structured settlements require approval from the HSS Executive. If in the view of the Trust a structure might offer value for money, and it appears that the plaintiff may be agreeable, the Trust should:

    i. ensure that Policy and Accounting Unit of the HSS Executive is notified at the earliest opportunity;

ii. commission or complete a VFM report in the form set out in the Appendix and submit this to the HSS Executive, Policy and Accounting Unit;

iii. inform the Central Services Agency as funding will be required from the Clinical Negligence Central Fund.

13. The VFM report should assess the value for money to the taxpayer as a whole, as well as to the HPSS, comparing the proposed structured settlement with a conventional lump sum award. Both self-funded and annuity-backed structures should be considered. In addition the Trust will need to submit details of:

i. the statement of claim

ii. the Court Order if available

iii. a legal opinion on causation

iv. a legal opinion on quantum ie the lump sum comparator

v. a legal opinion confirming that the value of any discount offered on the structure is the maximum that could be achieved in negotiation or that no discount is appropriate

vi. the date of any Court judgement/settlement.

CONSIDERATION OF A STRUCTURED SETTLEMENT

14. It is usual to wait until a provisional agreement on the quantum of damages has been reached before considering the case for a structured settlement, even if certain aspects of the proposed settlement are still in dispute. However, a structured settlement can be considered at any stage in the legal process but should certainly be considered with legal advisers before any offer to settle is made.

15. The overall value for money of a proposed structure may depend on whether a suitable discount can be negotiated. It would therefore be wise to tackle this issue at an early stage in the negotiations.

DISCOUNT AND MINIMUM GUARANTEE PERIODS

16. Discounts are received in recognition of the administrative costs of servicing the structure and the tax advantages to the plaintiff. A discount should always be sought in recognition of these additional costs since it may be critical to the overall value for money for the HPSS.

17. Minimum guarantee periods (ie an undertaking to pay the annuity for a minimum period even if the individual insured dies before the end of the period) are commonly offered by insurance companies when selling annuities. Plaintiffs may therefore ask

for similar minimum guarantee periods for structured settlements, whether annuity-backed or self-funded. The HSS Executive does not believe that such guarantees are appropriate for most clinical negligence cases where the object is to compensate the plaintiff for loss of earnings or to provide for the costs of care during the plaintiff's lifetime. The main exception would be in circumstances in which there are others financially dependent on the plaintiff.

18. Discounts and guarantees have often been linked in negotiations (although there is no inherent reason for this). It is common for one to be given up in consideration for the other. Each case should be considered on its own merits; general advice may be obtained on request from the HSS Executive.

PREPARATION OF THE VALUE FOR MONEY REPORT

19. The Trust may prepare the VFM report in-house if they consider that they have the expertise to do so. This will involve obtaining quotations for annuity-backed structures, preferably from at least 2 insurance companies, and comparing these on a discounted cash flow basis with the cost of a self-funded structure. Trusts are not licensed under the Financial Services Act to obtain quotes from life offices; thus in some respects specialist advice will be required. However, Directors of Finance of Trusts will become increasingly familiar with the workings of such settlements. Alternatively, the VFM report may be commissioned from a specialist accountancy firm. Any external advisers must be employed in accordance with the guidance set out in HSS(F)20/96 "Use of Management Consultants".

20. It is essential that the VFM report submitted to the HSS Executive is based on a position that has already been conditionally agreed with the plaintiff's advisers. As a structured settlement cannot be imposed by either party in the litigation process on the other, then the plaintiffs must equally be satisfied that this form of settlement represents better value for them. The HSS Executive does not have a role in the negotiation.

FACTORS TO BE CONSIDERED IN COMPARING THE OPTIONS

21. The following factors should be taken into account:

    i. what investment returns would be available to the plaintiff from a lump sum payment (this is needed to compare any excess HPSS care costs for the proposed structure with the lump sum comparator);

    ii. how long the plaintiff is expected to live;

    iii. the length of guarantee of payment to the plaintiff;

    iv. the estimated future costs of care (if any);

    v. the agreed size of the annual payment under either of the structure options;

vi. the size of discount negotiated (if any);

vii. the cost of the insurance company quotations (annuity-backed settlements);

viii. the estimated loss of taxes to the Treasury under either of the structuring options.

There may be other factors to take account of and the above list is therefore not exhaustive.

22. The cost streams on each option should then be compared on a net present value (NPV) basis. Sensitivity analysis should be used to test the robustness of the conclusion to the main uncertainties involved (see paragraph 4 of the Appendix to this Annex).

ROLE OF THE HSS EXECUTIVE

23. The HSS Executive will need to be assured that all relevant factors have been considered and that the preferred option does indeed represent best VFM. If the VFM report is deficient the HSS Executive may need to come back to the Trust for additional information. Cases which exceed the HSS Executive's delegated limits in this area will also be forwarded to DFP for approval.

24. Provided that a VFM report has been submitted, the HSS Executive will provide initial comments within 15 working days and a final decision within a further 10 working days from receipt of full replies to any queries. Where DFP approval is also required, this will run in sequence to the HSS Executive's approval and will operate to the same timescale. The total approval process therefore should be completed within 30 working days provided all information is provided from the outset.

25. Once approval has been given for a structured settlement then

i. **for annuity-based settlements**

the Trust will be authorised by the HSS Executive to purchase the annuity (insurance) from one of the particular insurance companies. The insurance company will be selected on the basis of the most cost efficient quotations obtained. (For payment and reimbursement procedures - see HSS(F) 19/98, para 4.2).

ii. **for self-funded settlements**

payment and reimbursement procedures should follow HSS(F) 19/98, para 4.2.

OTHER STEPS REQUIRED TO IMPLEMENT A STRUCTURED SETTLEMENT

26. Preparing the VFM report and securing approval from the HSS Executive is only one aspect. Implementing a structured settlement may involve;

i. detailed appraisal of the plaintiff's current and future financial needs;

ii. formulating a financial package best suited to meet those needs;

iii. broking of the markets to identify the most appropriate and the most cost effective annuity and assurance products;

iv. negotiating the form of the structure, including the frequency of payments and any guarantee periods;

v. assisting in drafting the various orders and agreements for consideration by the lawyers;

vi. preparation of all reports required for the approval of the Inland Revenue, the Court and the Court of Protection;

vii. attendance at conferences and at Court and advising as necessary;

viii. appearing in Court to give evidence;

ix. preparation of all documentation required for the purchase of the annuity package;

x. monitoring after implementation of the actual working of the structure which has been put in place.

27. Most of these tasks can be subcontracted to specialist accountants. If the Trust chooses to do so they will need to consider whether to pay:

i. a fixed fee for specified tasks whether the work results in a successful structure or not;

ii. time related fees for specified tasks whether the work results in a successful structure or not;

iii. contingent fixed fee for specified tasks (ie no cost if no structure results);

iv. contingent commission (expressed as a percentage of the value of the structure) for specified components.

28. However the work is to be performed, the parties should agree as early as possible which functions should be carried out by whom and on what basis to avoid unnecessary duplication of costs.

Any external advisers must be employed in accordance with the guidance set out in HSS(F) 20/96 "Use of Management Consultants".

APPENDIX 1

STRUCTURED SETTLEMENTS: VALUE FOR MONEY REPORT

Introduction

1. There is no fixed format for the value for money (VFM) report since the details will vary from case to case. However, certain essentials need to be included in every case.

Documentation Required

2. As already stated in the Annex, the following documents are required as well as the VFM report itself:

   i. the statement of claim

   ii. copy of the Court Order if available

   iii. a legal opinion on causation

   iv. a legal opinion on quantum ie the lump sum comparator

   v. a legal opinion confirming that the value of any discount offered on the structure is the maximum that could be achieved in negotiation

   vi. the date of any Court judgement/settlement.

   If a structured settlement is negotiated prior to judgement then paragraph 2(vi) will be waived.

Contents of VFM Report

3. The VFM report must incorporate the following information:

   i. Quantum - the VFM report figure must be supported by appropriate legal advice and any difference fully explained.

   ii. Discount - full details should be given with an assurance that the Trust has negotiated the maximum possible (or if no discount, that in the overall circumstances of the negotiation why it was not possible to secure one).

   iii. Guarantee period - full details of any guarantee period should be given, especially in the unusual case of a period extending beyond the expected lifetime of the plaintiff.

iv. Life expectancy - the figures quoted in the report must correspond with expert opinion from both sides. If there is a significant discrepancy between the two sides the reason for the final weighting (usually by percentage) must be explained.

v. The assumed composition of the lump sum comparator. This will in general consist of 3 elements (bearing in mind that, subject in the case of patients to any oversight by the Court of Protection, the sum may actually be spent in any way the plaintiff chooses):

a. an amount to cover capital equipment needs (eg adaptations to the plaintiff's house);

b. a "contingency fund" which (in the case of patients) will be at the disposal of the Court of Protection;

c. a sum sufficient to provide for the plaintiff's estimated care needs for his/her expected lifetime (the expiry date for this component must cover the life expectancy and if it does not an explanation must be provided).

vi. The cost of an annuity sufficient to cover the plaintiff's estimated care costs at c. above.

vii. The proposed self-funded structure - in general the lump sum element will correspond to elements a. and b. above and the annual payments to the estimated care costs at c. Any deviations should be explained.

The report must make clear that both sides have agreed to the proposals both for the annuity-based structure and (if acceptable) the self-funded structure.

VFM Calculations

4. Once the basic data has been explained, the report should compare the net present value (NPV) of the 3 options, namely the conventional lump sum settlement and the annuity-backed and self-funded structured settlements. There are certain mandatory parameters which will be reviewed periodically:

i. the discount rate used to calculate the NPV of future cash flows should be set at 6% (unearned return on money);

ii. the general rate of inflation should be taken as 2.5%;

iii. costs of care should be assumed to rise by 2% per annum faster than the general rate of inflation;

iv. Investment assumptions.

Where assumptions are used in the calculations, or if any of the figures for costs are subject to uncertainty, then the calculations should be subjected to sensitivity analysis. This should use plausible ranges of assumptions or important uncertainties to identify possible effects on the merits of the options being compared.

5. The calculation for each of the options should then proceed as follows:

A. Unstructured or Lump Sum Settlement

The public sector pays a single lump sum to the plaintiff **(A)** (the lump sum comparator) and pays for any care the plaintiff receives when this lump sum expires **(B)**. The public sector also receives income tax which is paid on the income generated by the investment of the lump sum **(C)**. No fees are paid to the settlement advisors.

Cost = A + B - C.

B. Annuity-Backed Structured Settlement

The public sector pays a lump sum to the plaintiff **(D)** and provides for the purchase of an annuity from a life office **(E)**. The public sector also pays for any care costs incurred by the HPSS which are not met by the annual income from the annuity **(F)**. No tax is paid on the structured settlement. Fees for the advisors are paid by the Life Office.

Cost = D + E + F.

C. Self-funded Structured Settlement

The public sector pays a lump sum to the plaintiff **(D)** and makes additional payments until the death of the plaintiff (or for the length of any guarantee period). The public sector self-funds these payments and the expected NPV of these is **(G)**. The public sector also pays for any care costs incurred by HPSS which are not met by the annual payments **(F)**. Fees for the settlement advisors are paid by the public sector **(H)**.

Cost = D + G + F + H.

HSS
EXECUTIVE

21 January 1999

The Chief Executive of each Health & Social Services Board
The Directors of Finance of each Health & Social Services Board
The Chief Executive of each Health & Social Services Trust
The Director of Finance of each Health & Social Services Trust
The Chief Executive of the Central Services Agency
The Director of Finance of the Central Services Agency
The Chief Executive of the Northern Ireland Blood Transfusion Service (Special Agency)
The Chief Executive of the Regional Medical Physics Agency

Dear Sir/Madam

CLINICAL NEGLIGENCE CLAIMS HANDLING - PRE-ACTION PROTOCOL FOR THE RESOLUTION OF CLINICAL DISPUTES

The purpose of this circular is to bring to your attention a pre-action protocol for handling clinical negligence claims which NHS Trusts and Health Authorities in Great Britain will be expected to follow from April 1999.

Background

The Clinical Disputes Forum, a multi-disciplinary body based in GB was formed in 1997 to develop less adversarial and more cost effective ways of resolving disputes about healthcare and medical treatment. In July 1998 a working group of the Forum produced a protocol which, although not intended to be comprehensive, provides a code of best practice for dealing with cases where litigation is a possibility.

The protocol covers two central areas:

(i) a set of good practice commitments by those involved, with particular emphasis on better handling of potential disputes and more effective and efficient management of information and investigation;

(ii) a set of steps to be followed where litigation is in prospect, focusing on management of information, for example, the handling of health records and exchanges of formal letters.

The protocol aims to improve the pre-action communication between parties by establishing a timetable for the exchange of information relevant to the dispute and by setting standards for the contents of correspondence. Compliance with the protocol should assist parties in making an informed judgement on the merits of their case earlier than usually happens because they will have earlier access to the information required. This will provide opportunity for improved communications between the parties, intended to lead to an increase in the number of pre-action settlements.

It is the intention of the Lord Chancellor's Department to include the protocol as Practice Directions to accompany new Civil Procedure Rules coming into force in April 1999. Courts in Great Britain will be able to treat the standards laid down in the protocol as normal pre-action conduct.

Application to Northern Ireland

It is expected that Northern Ireland will follow Great Britain in this respect and therefore application of the pre-action protocol in dealing with clinical disputes is highly recommended.

I enclose a copy of the protocol for your attention. The content of this circular should be drawn to the attention of all claims managers and other relevant staff.

Yours faithfully

Paula Magee

PAULA A MAGEE
Policy and Accounting Unit

Enc

C.G 01/11/04

19 APR 2001

DEPARTMENT OF FINANCE AND PERSONNEL

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DAO(DFP) 5/01

5 April 2001

Dear Accounting Officer

CORPORATE GOVERNANCE: STATEMENT ON INTERNAL CONTROL

Purpose of this DAO letter

1. The purpose of this letter is to

   (a) draw attention to changes, **for the 2000 -2001 financial year accounts**, to the wording of the model statement on the system of internal financial control, as the first stage of a process of moving towards a wider statement on internal control.

   (b) set out the process of moving from the requirement for a Statement on Internal Financial Control (SIFC) to a Statement on Internal Control (SIC).

Both these statements are to be included in the accounts of

a. departments
b. executive agencies
c. trading funds
d. executive Non-Departmental Public Bodies,and
e. any other accounts that are laid before the NI Assembly

2. Included below is a timetable with key stages up to the financial year 2003-04 for which the final version of the Statement on Internal Control will be mandatory. A transitional statement on internal control which is indicative of further work to be done, may be adopted in years 2001-02, and 2002-03.

Cancelled DAOs

3. This letter supersedes the requirements of DAO(DFP) 2/98 and DAO(DFP) 5/99 which are now cancelled.

Background

4. DAO(DFP) 2/98 introduced a Statement on Internal Financial Control (SIFC) to the accounting requirements in central government. Since then best practice in the private sector has developed with the introduction of the Stock Exchange's "Combined Code" of requirements for listed companies and publication of "Internal Control: Guidance for Directors on the Combined Code" (the "Turnbull Report")[1] which examines how specific requirements within the Combined Code should be implemented. These requirements are:

> Provision D.2 "The Board should maintain a sound system of internal control to safeguard shareholders' investment and the company's assets
>
> Provision D2.1 "The directors should, at least annually, conduct a review of the effectiveness of the group's system of internal control and should report to shareholders that they have done so. The review should cover all controls, including financial, operational and compliance controls and risk management."
>
> Provision D2.2 "Companies which do not have an internal audit function should from time to time review the need for one".

5. Following the general principle that best practice in accounting requirements in the private sector should be reflected in central government[2], consideration has been given to how the provisions of the Turnbull Report can be adapted to the sector. Following consultations with Principal Finance Officers, this letter promulgates the requirements.

Timetable

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[1] Internal Control: Guidance for Directors on the Combined Code can be found at http://www.icaew.co.uk/intnalcontrol

[2] Foreword to Accounting Standards (Accounting Board)

6. A timetable detailing the key steps in moving from the Statement of Internal Financial Control to the Statement of Internal Control for each financial year is set out in the table below:

YEAR	TIMETABLE FOR IMPLEMENTATION
1999-2000	SIFC
2000-2001	SIFC plus; A paragraph stating the Accounting Officers awareness of the requirement for a SIC.
2001-2002	SIC if possible - transitional statement allowed.
2002-2003	SIC if possible - transitional statement allowed.
2003-2004	SIC

7. Paragraph 8 below provides wording for an additional paragraph for inclusion in the statement of internal financial control, for the year ended 31 March 2001, to indicate awareness of the need for a wider Statement of Internal Control and to provide assurance that steps are being taken to meet the DFP requirements in respect of that wider statement.

8. The additional paragraph, to be inserted at the end of the existing statement, reads as follows:

> **"Implementation of a Statement of Internal Control**
>
> "As Accounting Officer, I am aware of the recommendation for departments to produce a Statement of Internal Control, and am taking reasonable steps to comply with DFP's requirement for this statement to be prepared for the year ended 31 March 2002, in accordance with guidance issued by DFP."

9. The full text of the amended statement of internal financial control for 2000-2001 is set out at Annex A1 for use by Departments in Appropriation Accounts, and at Annex A2 for use by Executive Agencies, Trading Funds, and Executive NDPBs, and other accounts laid before the Assembly.

10. Organisations are encouraged and should aim to prepare a Statement on Internal Control for 2001/02 wherever possible. However, it is recognised that some bodies may need to do further work before all relevant risk management and review processes are fully in place. In such cases it would be permissible to prepare a transitional statement which would include a description of planned work. An illustrative example of the transitional statement is at Annex A3. The facility to produce a SIC which is indicative of further work to be done may be adopted for each of the financial periods which begin on dates on or after 1 January 2001 up to 31 December 2001, and on or after 1 January 2002 up to 31 December 2002. Bodies which anticipate having to prepare such a statement for the second of these years will be asked to verify that they will be able to produce a statement of internal control in accordance with Annex A4 in respect of the financial period beginning on or after 1 January 2003. That will mean that by the beginning of that financial period all development work should be complete and all the required processes should be in place.

Format of the Statement of Internal Control

11. The SIC should be developed in accordance with the pro-forma format at Annex A4 to this letter. The detail of the parts of the pro-forma that are in bold italic text should be drafted to provide a brief but comprehensive summary of the actual processes in place in the body, including a description of how current initiatives (whether centrally or locally driven) are being taken forward. In particular, the narrative description of the processes in place should be used for reporting on progress or compliance with particular central initiatives which have a reporting requirement.[3]

12. Accounting Officers may need to amend the opening paragraph of the pro-forma SIC to give a meaningful description of the boundaries of their accountabilities. In particular, Agencies may need to reflect more fully the relationship with their department, and NDPBs may need to reflect the relationship with the sponsoring department and the role of the NDPB's Board. Whilst all SICs must encompass at least the responsibilities of the Accounting Officer, those bodies which have governance arrangements involving a wider base may consider preparing an SIC which encompasses those wider arrangements. The inter-relationship between the SIC for a sponsoring department and those of related bodies, and the manner of their presentation in the departmental resource account will be for the

[3] An example of such a requirement at the time of production of this letter would be reporting on compliance with the principal recommendations in the Cabinet Office report "Successful IT: Modernising Government in Action").

departmental Accounting Officer to determine in the context of the actual structures of control.

Status and auditability of Statements on Internal Control

13. The SIC is an integral part of the annual reporting of the body, to be presented alongside the accounts. It should be prepared by the Accounting Officer along with the accounts and passed to the external auditors for review. A summary of the NIAO's approach to the review of Statements on Internal Control is at Annex B.

Risk management

14. The Turnbull report states that a sound system of internal control "depends on a thorough and regular evaluation of the nature and extent of the risks to which the company is exposed". It further states that the purpose of internal control "is to help manage and control risk rather than to eliminate it". The SIC should therefore be the end result of a process of management that is embedded in the planning, operational, monitoring and review activities of the body[4], these activities being the critical elements of the statement. Production of the SIC should not be conducted as an "add-on" end of year activity. The Statement on Internal Control should explain the nature of control, and any material changes in control, exercised through the whole of the accounting period.

Internal Audit

15. The Turnbull Report referred to the need for internal audit or other monitoring processes to assure management and the board that the system of internal control is functioning as intended. Accounting Officers are already required to make provision for internal audit under the provisions of Government Accounting Northern Ireland. Accounting Officers should, as part of their annual review of the system of internal control, ensure that their internal audit provision is adequately resourced to deliver a service in accordance with the standards in the Government Internal Audit Manual.

Enquiries

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[4] Draft guidance on risk management was produced by Treasury in February 2000 in "Management of Risk – A Strategic Overview" (The "Orange Book"). The final version of this will be issued shortly after this letter. A version of this guidance, developed to be especially appropriate to smaller organisations ("Management of Risk – Guide for Smaller Bodies") has been produced. These documents are advisory, and each body should identify for itself the methodology for embedded risk management that is most appropriate for its business and circumstances.

16. Any enquiries on the content and application of this letter should be addressed in the first instance to

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Network [redacted]
Mark.mcnaughten [redacted]

Further Action

17. Departments should ensure that their executive agencies, trading funds, executive Non-Departmental Public Bodies, and other sponsored bodies are aware of the requirements of this letter.

Yours sincerely

Andrew McCormick

ANDREW MCCORMICK
Treasury Officer of Account

MODEL WORDING FOR THE STATEMENT ON THE SYSTEM OF INTERNAL FINANCIAL CONTROL FOR THE FINANCIAL YEAR 2000-2001: VERSION 1 - FOR USE BY DEPARTMENTS IN APPROPRIATION ACCOUNTS

This statement is given in respect of the appropriation account for Vote 00. As Accounting Officer for this Vote, I acknowledge my responsibility for ensuring that an effective system of internal financial control is maintained and operated in connection with the resources concerned. [I carry out this responsibility in conjunction with the department's principal Accounting Officer, the relationship between us being set out in a written statement.]

The system of internal financial control can provide only reasonable and not absolute assurance that assets are safeguarded, transactions authorised and properly recorded and that material errors or irregularities are either prevented or would be detected within a timely period.

The system of internal financial control is based on a framework of regular management information, financial regulations, administrative procedures including segregation of duties, and a system of delegation and accountability. In particular, it includes *[see note 3]*:

- comprehensive budgeting systems with an annual budget;
- procedures to review and agree the budgets;
- the preparation of regular financial reports which indicate actual expenditure against the forecasts;
- clearly defined capital investment control guidelines;
- as appropriate, formal project management disciplines.

The department has an internal audit unit, which operates to standards defined in the Government Internal Audit Manual. The work of the internal audit unit is informed by an analysis of the risk to which the department is exposed, and annual internal audit plans are based on this analysis. The analysis of risk and the internal audit plans are endorsed by the department's Audit Committee and approved by me [and the department's principal Accounting Officer]. At least annually, the Head of Internal Audit (HIA) provides me with a report on internal audit activity in the department. The report includes the HIA's independent opinion on the adequacy and effectiveness of the department's system of internal financial control.

My review of the effectiveness of the system of internal financial control is informed by the work of the internal auditors and the executive managers within the department who have responsibility for the development and maintenance of the financial control framework, and comments made by the external auditors in their management letter and other reports.

Implementation of a Statement of Internal Control

As Accounting Officer, I am aware of the recommendation for departments to produce a Statement of Internal Control, and am taking reasonable steps to comply with DFP's requirement for this statement to be prepared for the year ended 31 March 2002, in accordance with guidance issued by DFP.

[Details of the action taken, or proposed, to correct weaknesses in the system of internal financial control, or an explanation of why corrective action is not considered necessary, should be given here. The wording should be tailored to reflect the circumstances of the case, including where the action taken or proposed is the responsibility of the principal Accounting Officer rather than the Accounting Officer for the Vote.]

Notes

1. *Each Accounting Officer must prepare a statement for each Vote for which he or she is responsible.*

2. *The statement should be included as a separate document normally coming between the "Statement of Accounting Officers' responsibilities" and the Summary of Outturn.*

3. *Changes to the wording should be kept to a minimum. However, the key areas described in the third paragraph are the minimum features to be expected in the system and Accounting Officers are encouraged to describe any additional features of the system of internal financial control which are relevant to the effectiveness of the system, such as improvements in control procedures or new accounting systems with additional control facilities. Accounting Officers may also wish to mention any special reviews or similar work undertaken within the department to verify or improve the system of internal financial control. Any such information should be given as an additional paragraph. It may also be appropriate to refer to such reviews in*

the fifth paragraph which comments on the means by which the Accounting Officer satisfies him or herself on the effectiveness of the system.

SUGGESTED WORDING FOR THE STATEMENT ON THE SYSTEM OF INTERNAL FINANCIAL CONTROL FOR THE FINANCIAL YEAR 2000-2001: VERSION 2 - FOR USE BY EXECUTIVE AGENCIES, TRADING FUNDS AND EXECUTIVE NDPBs

As Accounting Officer, I acknowledge my responsibility for ensuring that an effective system of internal financial control is maintained and operated by (name of body).

The system can provide only reasonable and not absolute assurance that assets are safeguarded, transactions authorised and properly recorded, and that material errors or irregularities are either prevented or would be detected within a timely period.

The system of internal financial control is based on a framework of regular management information, administrative procedures including the segregation of duties, and a system of delegation and accountability. In particular, it includes *[see note 3]*:

- comprehensive budgeting systems with an annual budget which is reviewed and agreed by [a committee of] the Management Board [or other appropriate description];
- regular reviews by the Management Board of periodic and annual financial reports which indicate financial performance against the forecasts;
- setting targets to measure financial and other performance;
- clearly defined capital investment control guidelines.
- as appropriate, formal project management disciplines;

(Name of body) has an internal audit unit, which operates to standards defined in the Government Internal Audit Manual. The work of the internal audit unit is informed by an analysis of the risk to which the body is exposed, and annual internal audit plans are based on this analysis. The analysis of risk and the internal audit plans are endorsed by the body's Audit Committee and approved by me. At least annually, the Head of Internal Audit (HIA) provides me with a report on internal audit activity in the body. The report includes the HIA's

independent opinion on the adequacy and effectiveness of the body's system of internal financial control.

My review of the effectiveness of the system of internal financial control is informed by the work of the internal auditors, the Audit Committee which oversees the work of the internal auditor, the executive managers within the body who have responsibility for the development and maintenance of the financial control framework, and comments made by the external auditors in their management letter and other reports.

Implementation of a Statement of Internal Control

As Accounting Officer, I am aware of the recommendation for departments to produce a Statement of Internal Control, and am taking reasonable steps to comply with DFPs requirement for this statement to be prepared for the year ended 31 March 2002, in accordance with guidance issued by DFP.

[Details of the action taken, or proposed, to correct weaknesses in the system of internal financial control, or an explanation of why corrective action is not considered necessary, should be given here. The wording should be tailored to reflect the circumstances of the case. If, in the case of an executive agency, the action taken or proposed involves an Accounting Officer in the parent department, that should be explained.]

Notes:

1. *The statement should be signed by the appointed or designated Accounting Officer.*

2. *The statement should follow the statement of the Accounting Officer's responsibilities. If the latter is included as part of the Foreword, so may the new statement.*

3. *Changes to the wording should be kept to the minimum. However, the key areas described in the third paragraph are the minimum features to be expected in the system and Accounting Officers are encouraged to describe any additional features of the system of internal financial control which are relevant to the effectiveness of the system, such as improvements in control procedures or new accounting systems with additional control facilities. Accounting Officers may also wish to mention any special reviews or*

similar work undertaken within the department to verify or improve the system of internal financial control. Any such information should be given as an additional paragraph. It may also be appropriate to refer to such reviews in the fifth paragraph which comments on the means by which the Accounting Officer satisfies him or herself on the effectiveness of the system.

Statement on Internal Control – Transitional Statement

['The Transitional Statement provides an illustration for a body that is developing its internal control processes but considers that further elements are required to be introduced together with a continued period of trial and assessment prior to the preparation of a full statement on the system of internal control as illustrated in Annex A4.]

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of departmental policies, aims and objectives, set by the department's Ministers, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Government Accounting.

The system of internal control is designed to manage rather than eliminate the risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control is based on an ongoing process designed to identify the principal risks to the achievement of departmental policies, aims and objectives, to evaluate the nature and extent of those risks and to manage them efficiently, effectively and economically. I expect to have the procedures in place in March 2002 necessary to implement DFP guidance. This takes account of the time needed to fully embed the processes which the department has agreed should be established and improve their robustness.

We have carried out appropriate procedures to ensure that we have identified the department's objectives and risks and determined a control strategy for each of the significant risks. As a result, risk ownership has been allocated to the appropriate staff and the department has set out its attitude to risk to the achievement of the departmental objectives.

The management board has ensured that procedures are in place for verifying that aspects of risk management and internal control are regularly reviewed and reported on. There will be a full risk and control assessment before reporting on the year ending 31 March 2003. Risk management has been incorporated more fully into the corporate planning and decision making processes of the department.

The board receives periodic reports concerning internal control. The appropriate steps are being taken to manage risks in significant areas of responsibility and monitor progress on key projects.

Following the identification of the department's key objectives and risks, further work has been done to bring about more consistency in the way in which the department treats risks.

In addition to the actions mentioned above, in the coming year the department plans to:

- Regularly review and update the record of risks facing the organisation;
- set up a system of key performance and risk indicators;
- develop and maintain an organisation-wide risk register; and
- arrange for reports from the chief executives of the department's agencies on internal control activities.

The department has an Internal Audit Unit, which operates to standards defined in the Government Internal Audit Manual. They submit regular reports which include the HIA's independent opinion on the adequacy and effectiveness of the department's system of internal control together with recommendations for improvement.

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers within the department who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their management letter and other reports.

ANNEX A4

Statement on Internal control – PROFORMA

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of departmental policies, aims and objectives, set by the department's Ministers, whilst safeguarding the public funds and departmental assets for which I am personally responsibility, in accordance with the responsibilities assigned to me in Government Accounting. *(Accounting Officers may wish to amend this paragraph to provide a comprehensive explanation of the accountability arrangements surrounding their organisation.)*

The system of internal control is designed to manage rather than eliminate the risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control is based on an ongoing progress designed to identify the principal risks to the achievement of departmental policies, aims and objectives, to elevate the nature and extent of those risks and to manage them efficiently, effectively and economically. This process has been in place [for the year ended 31 March 200x/since XX] and up to the date of approval of the annual report and accounts and accords with DFP guidance.

As Accounting Officer, I also have responsibility for reviewing the effectiveness of the system of internal control.

Summarise here the process that has been applied in reviewing the effectiveness of the system of internal control as appropriate to the circumstances of the reporting body.

Examples of some of the types of processes are:

- ***procedures for identifying the body's objectives and key risks;***
- ***the development of the control strategy and risk management policy;***
- ***the allocation of risk ownership;***
- ***the role of the Audit Committee or other relevant committee;***
- ***involvement and role of internal audit;***
- ***procedures for ensuring that aspects of risk management and internal control are regularly reviewed and reported on;***
- ***systems used to ensure compliance with specific regulations or procedures laid down by central departments;***
- ***details of monitoring procedures for subsidiary bodies;***

- ***monitoring of progress with current initiatives and compliance and extant external requirements.***

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers within the department who have responsibility for the development and maintenance of the internal control framework, and commitments made by the external auditors in their management letter and other reports.

Record here details of actions taken, or proposed, to deal with material internal control aspects of any significant problems disclosed in the annual report and accounts. The wording should be tailored to reflect the circumstances of the case.

ANNEX B

NIAO's APPROACH TO THE REVIEW OF STATEMENTS ON INTERNAL CONTROL

Review procedures

1. The NIAO's approach to the review of internal control statements will, in essence, be the same as that for statements on the system of internal financial controls. The relevant part of the Comptroller and Auditor General's certificate will read along the following lines:-

> *'I review whether the statement on page – reflects the [name of audited body]'s compliance with DFP's guidance, "Corporate Governance: Statement of Internal Control". I report if it does not meet the requirements for disclosure specified by DFP, or if the statement is misleading or inconsistent with other information I am aware of from my audit of the financial statements'.*

2. *The NIAO review procedures draw on the relevant section of the Auditing Practices Board's guidance, Bulletin 5/99 'The Combined Code: Requirements of Auditors under the Listing Rules of the London Stock Exchange', tailored as appropriate for a central government context. The objective of the review is to assess whether the audited body's description of the processes adopted in reviewing the effectiveness of the system of internal control appropriately reflects that process. This will be substantively covered by:*

   - *Consideration of whether the disclosures are consistent with the NIAO's review of board and committee minutes and their knowledge of the audited body obtained during the audit of the financial statements;*
   - *NIAO attendance at audit committee meetings at which corporate governance, internal control and risk management matters are considered;*
   - *Consideration of the process adopted by the Accounting officer for his/her effectiveness review, and of the documentation prepared to support the statement.*

3. *The NIAO's work on internal control will not be sufficient to enable them to express any assurance on whether the audited body's controls are effective. In addition, the financial statement audit should not be relied upon to draw to the*

Accounting Officer's attention all matters that may be relevant to their consideration as to whether or not the system of internal control is effective. Auditors are not expected actively to search for misstatements or inconsistencies, but if they become aware of such a matter they will discuss it with senior management to establish the significance of the lack of proper disclosure.

The NIAO's work on understanding the business and controls

4. *As noted above, the auditor's work on the financial statements audit is not driven by the requirement for an internal control statement and cannot be relied upon to indicate that controls are effective. Nevertheless the NIAO audit approach, 'Audit 21', is a risk based approach based upon obtaining a good understanding of the business, the risks that it faces and how those risks are managed. Although the emphasis remains to an extent on financial risks and controls, this work should provide a sound base for the auditor's consideration of the Accounting Officer's internal control statement. It should also provide opportunities to make recommendations for improvements to internal controls.*

5. *Risk management and internal control issues are often a feature of the NIAO's wider Value-for-Money audit role. The NIAO recognise that risk-taking is essential if public bodies are to innovate and improve and, as a member of the Public Audit Forum, have stated that they will support well thought through risk taking and innovation.*

3

Department of Health, Social Services & Public Safety
An Roinn Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

Subject:

Clinical Negligence – Prevention of Claims and Claims Handling

Circular Reference: HSS (F) 20/2002

Date of Issue: 12 September 2002

For Action by:

- Chief Executive HPSS Boards
- Chief Executive HPSS Trusts
- Chief Executive Central Services Agency
- Chief Executive NI Blood Transfusion Service
- Chief Executive Regional Medical Physics Agency

For Information to:

- Health Promotion Agency
- NI Practice and Education Council for Nursing and Midwifery
- NI Post Graduate Council for Medical and Dental Education
- Directors of Finance of HPSS Boards
- Directors of Finance of HPSS Trusts
- Clinical Negligence Contact Points

Summary of Contents:

The purpose of this circular is to advise HPSS Boards, Trusts and certain agencies ("HPSS bodies") of developments in the management of clinical negligence claims.

Enquiries:

Any enquiries about the contents of this Circular should be addressed to:

Adrian Murphy
Finance Policy and Accountability Unit
Department of Health, Social Services and Public Safety
Room 522,
Dundonald House,
Stormont
BELFAST
BT4 3SJ

Tel: [redacted]
adrian.murphy[redacted]

Related documents

HSS (F) 20/98
HSS (F) 21/98
HSS (F) 28/99
HSS (F) 19/2000

Superseded Documents:

HSS (F) 1/1990
HSS (F) 26/97
HSS (F) 20/98 Supplement No 1
HSS (F) 17/2001

Review Date:

30 September 2003

Status of Contents:

Action

Implementation:

Immediate

Additional Copies:

Tel: [redacted]
FPAU[redacted]

Department of Health, Social Services & Public Safety
An Roinn Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

HSS(F) 20/2002

12 September 2002

Dear Colleague,

CLINICAL NEGLIGENCE CASES – PREVENTION OF CLAIMS AND CLAIMS HANDLING

The purpose of this circular is to advise HPSS Boards, Trusts and certain agencies ("HPSS bodies") of developments in the management of clinical negligence claims.

The guidance reflects the Department's intention of developing an approach that:

- Provides for redress for individuals and their families who have suffered as a result of clinical negligence;
- Provides value for money for the taxpayer;
- Protects staff from vexatious allegations; and,
- Ensures that where necessary appropriate action is taken to prevent the occurrence of similar incidents in the future

Implementation of the changes recommended may require substantial change in the clinical negligence management process for some HPSS bodies. In recognition of this, the Department anticipates reviewing the guidance and its implementation by 30 September 2003.

HPSS bodies are encouraged to follow the principles and timescales recommended within the Clinical Negligence Pre-action Protocol drawn up by the Lord Chancellor's Department for use in England and Wales. It is acknowledged however that full implementation of that protocol here is possible only with the support of the legal profession. The Northern Ireland Court Service are currently working with the Law Society of Northern Ireland to introduce a local protocol for personal injury cases and are about to address a protocol for clinical negligence cases. In due course, HPSS bodies and the legal profession will be obliged to follow this NI protocol and any amended principles or timescales.

The Department is currently considering the establishment of a Claims and Litigation Steering Group tasked with:

- Assessing the implications of the NIAO and PAC reports on clinical negligence, ensuring relevant action is taken;
- Assessing the implications of the CMO Review of Clinical Negligence in England and Wales and considering any relevant recommendations;
- Advising the Department on the future managerial and administration of litigation claims and the promulgation of good practice.

The Department will wish to work closely with HPSS representatives in taking this work forward.

If you have any queries regarding this circular, please contact Adrian Murphy, Finance Policy and Accountability Unit, Room 522 Dundonald House (Tel (028) 9052 4321 or email Adrian.Murphy@dhsspsni.gov.uk)

Yours sincerely,

ANDREW HAMILTON
Director of Financial Management

CLINICAL NEGLIGENCE CASES – PREVENTION OF CLAIMS AND CLAIMS HANDLING

Introduction

1. Definition

Clinical negligence is defined as:

" a breach of duty of care by members of the health care professions employed by HPSS bodies or by others consequent on decisions or judgements made by members of those professions acting in their professional capacity in the course of their employment, and which are admitted as negligent by the employer or determined as such through the legal process".

The term health care professional includes hospital doctors, dentists, nurses, midwives, health visitors, pharmacy practitioners, registered ophthalmic or dispensing opticians (working in a hospital setting), members of professions allied to medicine and dentistry, ambulance personnel, laboratory staff and relevant technicians.

Summary

2. The Northern Ireland Audit Office (NIAO), in its recent report on "Compensation Payments for Clinical Negligence", identified a number of areas that require improvement within the systems and procedures for dealing with clinical negligence and any resulting compensation claim.

3. This guidance: (i) advises on action the Department has initiated towards enhancement of the clinical negligence settlement process ("claims process"); (ii) promulgates the use of the guidance contained in Circular HSS (F) 20/98 Supplement No 1 which is now superseded, and (iii) encourages the taking of certain measures to improve the complete clinical negligence process.

Action Initiated

Centralised Database

4. A principal finding of the recent NIAO Report on Clinical Negligence was that the lack of a central regional database of all clinical negligence information constrained the sharing of knowledge, experience and good practice within HPSS Bodies. In order to address these concerns, a small working group from across the HPSS has been established with the objective of delivering an interim regional database by – mid September 2002 and a longer-term objective of delivering a more functional and comprehensive database by March 2003. Separate instructions will be issued regarding input of data to the central database on a regular basis.

5. To maintain an effective central database it is essential that all HPSS bodies dealing with clinical negligence cases maintain appropriate databases in line with guidance contained in Annex B of Circular HSS (F) 20/98. The Department will regularly review the data supplied by HPSS bodies to the central database to ensure full compliance with this guidance.

Accounting for Clinical Negligence

6. The Department has accepted the necessity to review the basis of valuation of provisions for clinical negligence held by HPSS bodies and has consequently adopted a revised valuation methodology for its Departmental Resource Accounts for 2001-02 aimed at acknowledging the actual claims experience of HPSS bodies. A small group of finance practitioners and other professionals tasked with preparing detailed guidance on the accounting and budgeting treatment of clinical negligence claims for HPSS bodies will report on this issue by 28 February 2003.

Pre-Action Protocol for the Resolution of Clinical Disputes

Content of Protocol

7. This protocol was brought to the attention of HPSS bodies as an example of good practice in January 1999 as circular HSS (F) 20/98 Supplement No 1. It was not

intended to be comprehensive but rather to provide a code of best practice for dealing with cases where litigation is a possibility. It covers two central areas: (i) a set of good practice commitments by those involved, with particular emphasis on better handling of potential disputes and more effective and efficient management of information and investigation; and (ii) a set of steps to be followed where litigation is in prospect, focusing on management of information (e.g. the handling of health records and exchange of formal records).

8. In particular, the commitments state that by implication HPSS bodies should:
    a) Ensure key staff are appropriately trained;
    b) Develop a coordinated approach to clinical governance;
    c) Set up an adverse incident reporting system;
    d) Use the results of adverse incidents and complaints positively;
    e) Ensure that patients are fully aware of how to raise their concerns or complaints;
    f) Establish efficient and effective systems of recording and storing patient records;
    g) Advise patients of a serious adverse outcome.

9. The timetable for the protocol steps requires that:
    a) Medical records should be provided within 40 days of the request for them, with any delay beyond this having to be explained to the plaintiff's solicitor;
    b) HPSS bodies should adopt a policy on which cases will be investigated fully;
    c) HPSS bodies should acknowledge a Letter of Claim within 14 days of receipt;
    d) HPSS bodies should provide a reasoned answer within 3 months of the Letter of Claim.

10. The protocol aims to improve the pre-action communication between parties by establishing a timetable for the exchange of relevant information and by setting standards for the contents of correspondence. It includes guidance on alternative approaches to settling disputes ("Alternative Dispute Resolution"). Compliance with the protocol timetable should assist parties in making an informed judgement on the merits of their case earlier than usual and will provide an opportunity for improved communications between the parties, intended to lead to an increase in pre-action

settlements.

11. The Clinical Disputes Forum drew up the protocol in GB. The Northern Ireland Court Service are now working with the Law Society of Northern Ireland to introduce a local protocol for personal injury cases and are about to address a protocol for clinical negligence cases.

Compliance with Protocol

12. In order to put this into effective operation, the Department has re-issued the protocol and it is included as Appendix A. As the protocol was developed in GB, compliance with it is not mandatory for the legal profession and some of the legal references are not appropriate for Northern Ireland. However, HPSS bodies are advised that compliance with its basic principles and timetables advocated is encouraged, subject to legal advice. The protocol is also available from the Lord Chancellor's Department at the following website address: (www.lcd.gov.uk/civil/procrules_fin/contents/protocols/prot_rcd.htm).

13. HPSS bodies are asked: (i) to ensure that all claims managers and other relevant staff have access to it; (ii) to examine their caseload to check the level of compliance with the time limits shown in it and rectify instances where the limits have been exceeded; and, (iii) to confirm in writing that their staff are actively taking its contents into account in processing cases. Appendix B contains an annual statement to be signed by Chief Executives confirming or otherwise that these and a number of other new obligations are being met. The statement must be submitted by 30 June of each year.

14. Governance arrangements implemented in pursuance of the obligations within the protocol must integrate fully with the clinical and social governance framework envisaged within "Best Practice – Best Care". The framework is designed to ensure that high quality, effective care is delivered and that where things go wrong they are quickly put right and lessons are learnt to help prevent reoccurrence. This will require HPSS provider organisations to put and keep in place arrangements for monitoring and improving the quality of health and social care that they provide in line with the introduction of a statutory duty of quality.

Promulgation of Other Good Practice

15. In addition to the action initiated above, a number of other measures are required to further improve the operation of the clinical negligence process for HPSS bodies and plaintiffs.

Corporate Responsibility for the Management of Clinical Negligence

16. Chief Executives are reminded of their obligation set out in circular HSS (F) 20/98 to ensure that clinical negligence is managed appropriately. They should be aware of the increasing complexity and potentially considerable increase in clinical negligence workload that has been predicted and consider this when assessing managerial arrangements. The Department asks each HPSS body to confirm that managerial responsibility and arrangements for reporting clinical negligence information to board level complies with this guidance. Appendix B contains an annual statement to be signed by Chief Executives confirming or otherwise that these obligations are being met.

17. Alongside compliance with the principles and timetables of the pre-action protocol, HPSS bodies must ensure that the complete clinical negligence compensation process from incident through to legal settlement is managed professionally. There should be no attempt by HPSS bodies to delay the process at any stage, for example, HPSS bodies should promptly instigate search for, and provision of, medical records for legal discovery and in particular, once a court date has been set, should not seek to put off or delay the court process.

18. Existing procedures for handling of claims are set out in circular HSS (F) 20/1998. Retention of information in compliance with these minimum requirements is essential and HPSS bodies must ensure that full information on each element of the claim is held, in particular making sure all legal costs associated with the case are separately identified.

19. To strengthen the procedures in relation to provision of data to the Clinical Negligence Central Fund, revised arrangements have been put in place (Appendix C).

In future, each responsible Director will be asked to certify that the material submitted: has been extracted from financial or management information systems; has been fully reviewed; and any estimates made are based on professional opinion obtained and/or historical precedent. Circular HSS (F) 17/2001 is now withdrawn.

20. Information regarding forecast and actual provisions on clinical negligence is currently required from HPSS bodies on a monthly basis in compliance with circular HSS (F) 9/2002. HPSS bodies are reminded that accurate forecasts are essential to manage overall clinical negligence expenditure within the Departmental budget.

21. HPSS bodies are no longer required to provide quarterly information on clinical negligence claims to the Department and the Central Services Agency. The Department will instead use data extracted on a quarterly basis from the central clinical negligence database to manage Departmental cash flow.

Apologies and Explanations

22. There is a view, based on the experience in GB of dealing with clinical negligence cases where limited injury or loss has occurred, that a patient who suffers an adverse effect as a result of treatment can be diverted from making a claim for compensation. It is suggested that this can be done at the stage where the patient is first told of the adverse result. If this stage is well handled a number of potential claims will not proceed.

23. In line with the concept of being as honest and open with patients as possible, it is recommended that the following should be given: (i) an expression of sympathy and sorrow or regret at the outcome of the treatment; (ii) as full and factual an explanation as possible, without any admission of liability, of what has happened and its effects; (iii) if appropriate, an offer of early corrective treatment and/or rehabilitation; and (iv) advice on accessing the complaints system.

24. It is recommended that HPSS bodies consider how best this policy may be adopted within each clinical/professional area based on the competence and expertise of the staff involved. HPSS bodies should set guidelines for the involvement of complaints officers or more senior members of staff in fulfilling this obligation on behalf of the

Board or Trust. It is acknowledged that staff within HPSS bodies may require coaching or training to put such change into effect.

Alternative Dispute Resolution

25. Paragraph 5 of the pre-action protocol refers to alternative approaches, requiring the consent of the parties to settling clinical negligence disputes including arbitration, mediation and determination by an expert. The use of 'mediation' in particular has found favour in GB as a method that will work in certain cases. It should be explored as a possible option in any instances where ongoing negotiations with the plaintiffs suggest that it would work. Information on its use is available on the NHS Litigation Authority website (www.nhsla.com) and on the Law Society of Northern Ireland website (www.lawsoc-ni.org). In judging whether to try this option, or other alternatives, regard would need to be given to the likelihood of success. Otherwise, it could become just another step in the process with both a consequential delay and generation of additional cost.

Admission of Liability in Cases that are Difficult to Defend

26. There are and have been many instances where the defence of cases has been prolonged even when the defendants have recognised that their liability is clear cut. This raises a question as to whether HPSS bodies should prolong the defence of difficult cases to defend when to do so would incur unnecessary additional expense. The Department recognises that often the plaintiffs will not want to settle any earlier in the proceedings and strategically it may not be sensible to admit liability, or otherwise agree to settlement, until the last stages of negotiation (e.g. "at the door of the Court").

27. Nevertheless, it is recommended that in each case where it is realised that defence will be difficult to sustain, consideration be given to admitting liability and attempting to reach settlement. In taking a decision to pursue this course, consideration will have to be given to the relative costs of a likely increase in amount of settlement weighed against potential savings in legal and other costs for both parties.

Structured Settlements

28. To date, the Department is aware of only two cases in which structured settlements have been used. Whilst recognising the fact that, ultimately, the take up of such settlements is a matter for the plaintiffs to determine, the Department would commend the guidance contained in Circular HSS (F) 21/98 and exhort HPSS bodies to make use of structured settlements whenever possible in cases where settlements will be £250,000 or more, or where to do so might also represent good value for money. Each HPSS body is asked to review relevant ongoing cases to ensure that full consideration has been given to using structured settlements. It should also be noted that under the Damages Act 1996 Courts may now sanction structured settlements where the parties consent, and the Act further provides for the Department to guarantee such settlements on behalf of HPSS bodies.

Review of Cases

29. HPSS bodies are asked to carry out an immediate review of all the ongoing clinical negligence cases they have on record and, as a minimum, to review all ongoing cases on an annual basis. The review must examine cases:

    a) To review fully the base data held for each to ensure no duplication of records. (In a number of instances, cases have been registered when a 'letter of disclosure' is received and then again when an actual claim is lodged);
    b) To consider suitability of immediate closure of all cases held without contact/action on behalf of the plaintiff for 3 years or more;
    c) To consider the expected value of compensation and associated costs and expected settlement date in line with accounting guidance.

30. The Department will seek immediate positive assurance from Chief Executives, by 3 January 2003 and by 30 June of each subsequent year, that such a review has been carried out and will request a summary of its main findings. This links in with the timetable for submission of annual forecast information to the Department and CSA. Appendix D contains the immediate confirmation statement for return by 3 January 2003. In providing this immediate assurance, it is acceptable to place reliance on

evidence obtained during any previous formal review carried out for the 2001-02 annual accounts. As with other assurances required, Appendix B contains an annual statement to be signed by Chief Executives confirming or otherwise that these obligations are being met.

Action Required

31. HPSS bodies should:

a) Maintain an accurate clinical negligence database in line with HSS (F) 20/98 (Paragraphs 5 and 16 above);
b) Take action to comply with the 'pre-action protocol' (Paragraph 13 above and Appendix A), and;
    i. Ensure that all claims managers and other relevant staff have access to it;
    ii. Examine their caseload to check the level of compliance with the time limits shown in it and rectify instances where the limits have been exceeded; and,
    iii. Confirm in writing that their staff are actively taking its contents into account in processing cases;
c) Confirm managerial arrangements are in line with HSS (F) 20/1998 (Paragraph 16, 17 & 18 above);
d) Implement revised administrative arrangements (Paragraph 18, 20 and 21 above);
e) Implement Departmental recommendations regarding apologies and explanations (Paragraph 22, 23 and 24 above);
f) Review ongoing cases to ensure adequate consideration has been given:
    i. to adopting alternative dispute resolution techniques (Paragraph 25 above);
    ii. to admitting liability and attempting to settle cases which can be difficult to defend (Paragraph 26 & 27 above), and;
    iii. to using structured settlements (Paragraph 28 above);
g) Carry out the review of cases dealt with in paragraphs 29 and 30 by 3 January 2003 and annually by 30 June each year and confirm to the Department that a

formal review has been carried out, with a brief indication of findings.

32. For this purpose, HPSS bodies are asked to use the pro forma at Appendix D and to submit immediate confirmation by 3 January 2003, with the annual confirmation statement at Appendix B required by 30 June of each year.

33. For its part the Department will lead the review group mentioned in paragraph 6 above and in due course will produce full guidance on accounting for clinical negligence.

Returns

34. All returns required in compliance with the circular should be sent to:

Finance Policy and Accountability Unit,
Room 414,
Dundonald House
Belfast
BT4 3SF

Other Guidance

35. To assist HPSS bodies, a complete list of the guidance on clinical negligence issued by the Department's Finance Directorate is contained in Appendix E.

Further Enquiries

36. Any enquiries regarding the content of this Circular should be addressed to Adrian Murphy, Finance Policy and Accountability Unit, Dundonald House (Telephone numbe[redacted]) or by e-mail to adrian.murph[redacted]

Pre-Action Protocol for the Resolution of Clinical Disputes

Clinical Disputes Forum

CONTENTS

EXECUTIVE SUMMARY

1 The Clinical Disputes Forum is a multi-disciplinary body which was formed in 1997, as a result of Lord Woolf's 'Access to Justice' inquiry. One of the aims of the Forum is to find less adversarial and more cost-effective ways of resolving disputes about healthcare and medical treatment. The names and addresses of the Chairman and Secretary of the Forum can be found at Annex E.

2 This protocol is the Forum's first major initiative. It has been drawn up carefully, including extensive consultations with most of the key stakeholders in the medico-legal system.

3 The protocol –

- encourages a climate of openness when something has 'gone wrong' with a patient's treatment or the patient is dissatisfied with that treatment and/or the outcome. This reflects the new and developing requirements for clinical governance within healthcare;
- provides **general guidance** on how this more open culture might be achieved when disputes arise;
- recommends **a timed sequence** of steps for patients and healthcare providers, and their advisers, to follow when a dispute arises. This should facilitate and speed up exchanging relevant information and increase the prospects that disputes can be resolved without resort to legal action.

4 This protocol has been prepared by a working party of the Clinical Disputes Forum. It has the support of the Lord Chancellor's Department, the Department of Health and NHS Executive, the Law Society, the Legal Aid Board and many other key organisations.

1 WHY THIS PROTOCOL?

MISTRUST IN HEALTHCARE DISPUTES

1.1 The number of complaints and claims against hospitals, GPs, dentists and private healthcare providers is growing as patients become more prepared to question the treatment they are given, to seek explanations of what happened, and to seek appropriate redress. Patients may require further treatment, an apology, assurances about future action, or compensation. These trends are unlikely to change. The Patients' Charter encourages patients to have high expectations, and a revised NHS Complaints Procedure was implemented in 1996. The civil justice reforms and new Rules of Court should make litigation quicker, more user friendly and less expensive.

1.2 It is clearly in the interests of patients, healthcare professionals and providers that patients' concerns, complaints and claims arising from their treatment are resolved as quickly, efficiently and professionally as possible. A climate of mistrust and lack of openness can seriously damage the patient/clinician relationship, unnecessarily prolong disputes (especially litigation), and reduce the resources available for treating patients. It may also cause additional work for, and lower the morale of, healthcare professionals.

1.3 At present there is often mistrust by both sides. This can mean that patients fail to raise their concerns with the healthcare provider as early as possible. Sometimes patients may pursue a complaint or claim which has little merit, due to a lack of sufficient information and understanding. It can also mean that patients become reluctant, once advice has been taken on a potential claim, to disclose sufficient information to enable the provider to investigate that claim efficiently and, where appropriate, resolve it.

1.4 On the side of the healthcare provider this mistrust can be shown in a reluctance to be honest with patients, a failure to provide prompt clear explanations, especially of adverse outcomes (whether or not there may have been negligence) and a tendency to 'close ranks' once a claim is made.

WHAT NEEDS TO CHANGE

1.5 If that mistrust is to be removed, and a more co-operative culture is to develop –

- healthcare professionals and providers need to adopt a constructive approach to complaints and claims. They should accept that concerned patients are entitled to an explanation and an apology, if warranted, and to appropriate redress in the event of negligence. An overly defensive approach is not in the long-term interest of their main goal: patient care;
- patients should recognise that unintended and/or unfortunate consequences of medical treatment can only be rectified if they are brought to the attention of the healthcare provider as soon as possible.

1.6 A protocol which sets out 'ground rules' for the handling of disputes at their early stages should, if it is to be subscribed to, and followed –

- encourage greater openness between the parties;

- encourage parties to find the most appropriate way of resolving the particular dispute;
- reduce delay and costs;
- reduce the need for litigation.

WHY THIS PROTOCOL NOW?

1.7 Lord Woolf in his Access to Justice Report in July 1996, concluded that major causes of costs and delay in medical negligence litigation occur at the pre-action stage. He recommended that patients and their advisers, and healthcare providers, should work more closely together to try to resolve disputes co-operatively, rather than proceed to litigation. He specifically recommended a pre-action protocol for medical negligence cases.

1.8 A fuller summary of Lord Woolf's recommendations is at Annex D.

WHERE THE PROTOCOL FITS IN

1.9 Protocols serve the needs of litigation and pre-litigation practice, especially –

- predictability in the time needed for steps pre-proceedings;
- standardisation of relevant information, including records and documents to be disclosed.

1.10 Building upon Lord Woolf's recommendations, the Lord Chancellor's Department is now promoting the adoption of protocols in specific areas, including medical negligence.

1.11 It is recognised that contexts differ significantly. For example: patients tend to have an ongoing relationship with a GP, more so than with a hospital; clinical staff in the National Health Service are often employees, while those in the private sector may be contractors; providing records quickly may be relatively easy for GPs and dentists, but can be a complicated procedure in a large multi-department hospital. The protocol which follows is intended to be sufficiently broadly based, and flexible, to apply to all aspects of the health service: primary and secondary; public and private sectors.

ENFORCEMENT OF THE PROTOCOL AND SANCTIONS

1.12 The civil justice reforms will be implemented in April 1999. One new set of Court Rules and procedures is replacing the existing rules for both the High Court and county courts. This and the personal injury protocol are being published with the Rules, practice directions and key court forms. The courts will be able to treat the standards set in protocols as the normal reasonable approach to pre-action conduct.

1.13 If proceedings are issued it will be for the court to decide whether non-compliance with a protocol should merit sanctions. Guidance on the court's likely approach will be given from time to time in practice directions.

1.14 If the court has to consider the question of compliance after proceedings have begun it will not be concerned with minor infringements, e.g. failure by a short period to provide relevant information. One minor breach will not entitle the 'innocent' party to abandon following the protocol. The court will look at the effect of non-compliance on the other party when deciding whether to impose sanctions.

2 THE AIMS OF THE PROTOCOL

2.1 The ***general*** aims of the protocol are –

- to maintain/restore the patient/healthcare provider relationship;
- to resolve as many disputes as possible without litigation.

2.2 The ***specific*** objectives are –

Openness

- to encourage early communication of the perceived problem between patients and healthcare providers;
- to encourage patients to voice any concerns or dissatisfaction with their treatment as soon as practicable;
- to encourage healthcare providers to develop systems of early reporting and investigation for serious adverse treatment outcomes and to provide full and prompt explanations to dissatisfied patients;
- to ensure that sufficient information is disclosed by both parties to enable each to understand the other's perspective and case, and to encourage early resolution;

Timeliness

- to provide an early opportunity for healthcare providers to identify cases where an investigation is required and to carry out that investigation promptly;
- to encourage primary and private healthcare providers to involve their defence organisations or insurers at an early stage;
- to ensure that all relevant medical records are provided to patients or their appointed representatives on request, to a realistic timetable by any healthcare provider;
- to ensure that relevant records which are not in healthcare providers' possession are made available to them by patients and their advisers at an appropriate stage;
- where a resolution is not achievable to lay the ground to enable litigation to proceed on a reasonable timetable, at a reasonable and proportionate cost and to limit the matters in contention;
- to discourage the prolonged pursuit of unmeritorious claims and the prolonged defence of meritorious claims.

Awareness of Options

- to ensure that patients and healthcare providers are made aware of the available options to pursue and resolve disputes and what each might involve.

2.3 This protocol does not attempt to be prescriptive about a number of related clinical governance issues which will have a bearing on healthcare providers' ability to meet

the standards within the protocol. Good clinical governance requires the following to be considered –

(a) **Clinical risk management:** the protocol does not provide any detailed guidance to healthcare providers on clinical risk management or the adoption of risk management systems and procedures. This must be a matter for the NHS Executive, the National Health Service Litigation Authority, individual trusts and providers, including GPs, dentists and the private sector. However, effective co-ordinated, focused clinical risk management strategies and procedures can help in managing risk and in the early identification and investigation of adverse outcomes.

(b) **Adverse outcome reporting:** the protocol does not provide any detailed guidance on which adverse outcomes should trigger an investigation. However, healthcare providers should have in place procedures for such investigations, including recording of statements of key witnesses. These procedures should also cover when and how to inform patients that an adverse outcome has occurred.

(c) **The professional's duty to report:** the protocol does not recommend changes to the codes of conduct of professionals in healthcare, or attempt to impose a specific duty on those professionals to report known adverse outcomes or untoward incidents. Lord Woolf in his final report suggested that the professional bodies might consider this. The General Medical Council is preparing guidance to doctors about their duty to report adverse incidents and to co-operate with inquiries.

3 THE PROTOCOL

3.1 This protocol is not a comprehensive code governing all the steps in clinical disputes. Rather it attempts to set out **a code of good practice** which parties should follow when litigation might be a possibility.

3.2 The **commitments** section of the protocol summarises the guiding principles which healthcare providers and patients and their advisers are invited to endorse when dealing with patient dissatisfaction with treatment and its outcome, and with potential complaints and claims.

3.3 The **steps** section sets out in a more prescriptive form, a recommended sequence of actions to be followed if litigation is a prospect.

GOOD PRACTICE COMMITMENTS

3.4 **Healthcare providers** should –

(i) ensure that **key staff**, including claims and litigation managers, are appropriately trained and have some knowledge of healthcare law, and of complaints procedures and civil litigation practice and procedure;

(ii) develop an approach to **clinical governance** that ensures that clinical practice is delivered to commonly accepted standards and that this is routinely monitored through a system of clinical audit and clinical risk management (particularly adverse outcome investigation);

(iii) set up **adverse outcome reporting systems** in all specialties to record and investigate unexpected serious adverse outcomes as soon as possible. Such systems can enable evidence to be gathered quickly, which makes it easier to provide an accurate explanation of what happened and to defend or settle any subsequent claims;

(iv) use the results of **adverse incidents and complaints positively** as a guide to how to improve services to patients in the future;

(v) ensure **that patients receive clear and comprehensible information** in an accessible form about how to raise their concerns or complaints;

(vi) establish **efficient and effective systems of recording and storing patient records**, notes, diagnostic reports and X-rays, and to retain these in accordance with Department of Health guidance (currently for a minimum of eight years in the case of adults, and all obstetric and paediatric notes for children until they reach the age of 25);

(vii) **advise patients** of a serious adverse outcome and provide on request to the patient or the patient's representative an oral or written explanation of what happened, information on further steps open to the patient, including where appropriate an offer of future treatment to rectify the problem, an apology, changes in procedure which will benefit patients and/or compensation.

3.5 **Patients and their advisers** should –

(i) **report any concerns and dissatisfaction** to the healthcare provider as soon as is reasonable to enable that provider to offer clinical advice where possible, to advise the patient if anything has gone wrong and take appropriate action;

(ii) consider the **full range of options** available following an adverse outcome with which a patient is dissatisfied, including a request for an explanation, a meeting, a complaint, and other appropriate dispute resolution methods (including mediation) and negotiation, not only litigation;

(iii) **inform the healthcare provider when the patient is satisfied** that the matter has been concluded: legal advisers should notify the provider when they are no longer acting for the patient, particularly if proceedings have not started.

PROTOCOL STEPS

3.6 The steps of this protocol which follow have been kept deliberately simple. An illustration of the likely sequence of events in a number of healthcare situations is at Annex A.

OBTAINING THE HEALTH RECORDS

3.7 Any request for records by the **patient** or their adviser should –

- **provide sufficient information** to alert the healthcare provider where an adverse outcome has been serious or had serious consequences;
- be as **specific as possible** about the records which are required.

3.8 Requests for copies of the patient's clinical records should be made using the Law Society and Department of Health approved **standard forms** (enclosed at Annex B), adapted as necessary.

3.9 The copy records should be provided **within 40 days** of the request and for a cost not exceeding the charges permissible under the Access to Health Records Act 1990 (currently a maximum of £10 plus photocopying and postage).

3.10 In the rare circumstances that the healthcare provider is in difficulty in complying with the request within 40 days, the **problem should be explained** quickly and details given of what is being done to resolve it.

3.11 It will not be practicable for healthcare providers to investigate in detail each case when records are requested. But healthcare providers should **adopt a policy on which cases will be investigated** (see paragraph 3.5 on clinical governance and adverse outcome reporting).

3.12 If the healthcare provider fails to provide the health records within 40 days, the patient or their adviser can then apply to the court for **an order for pre-action disclosure**. The new Civil Procedure Rules should make pre-action applications to the court easier. The court will also have the power to impose costs sanctions for unreasonable delay in providing records.

3.13 If either the patient or the healthcare provider considers **additional health records are required from a third party**, in the first instance these should be requested by or through the patient. Third party healthcare providers are expected to co-operate. The Civil Procedure Rules will enable patients and healthcare providers to apply to the court for pre-action disclosure by third parties.

LETTER OF CLAIM

3.14 Annex C1 to this protocol provides **a template for the recommended contents of a letter of claim**: the level of detail will need to be varied to suit the particular circumstances.

3.15 If, following the receipt and analysis of the records, and the receipt of any further advice (including from experts if necessary – see Section 4), the patient/adviser decides that there are grounds for a claim, they should then send, as soon as practicable, to the healthcare provider/potential defendant, a **letter of claim**.

3.16 This letter should contain a **clear summary of the facts** on which the claim is based, including the alleged adverse outcome, and the **main allegations of negligence**. It should also describe the **patient's injuries**, and present condition and prognosis. The **financial loss** incurred by the plaintiff should be outlined with an indication of the heads of damage to be claimed and the scale of the loss, unless this is impracticable.

3.17 In more complex cases a **chronology** of the relevant events should be provided, particularly if the patient has been treated by a number of different healthcare providers.

3.18 The letter of claim **should refer to any relevant documents**, including health records, and if possible enclose copies of any of those which will not already be in the potential defendant's possession, e.g. any relevant general practitioner records if the plaintiff's claim is against a hospital.

3.19 **Sufficient information** must be given to enable the healthcare provider defendant to **commence investigations** and to put an initial valuation on the claim.

3.20 Letters of claim are **not** intended to have the same formal status as a **pleading**, nor should any sanctions necessarily apply if the letter of claim and any subsequent statement of claim in the proceedings differ.

3.21 **Proceedings should not be issued until after three months from the letter of claim**, unless there is a limitation problem and/or the patient's position needs to be protected by early issue.

3.22 The patient or their adviser may want to make an **offer to settle** the claim at this early stage by putting forward an amount of compensation which would be satisfactory (possibly including any costs incurred to date). If an offer to settle is made, generally this should be supported by a medical report which deals with the injuries, condition and prognosis, and by a schedule of loss and supporting documentation. The level of detail necessary will depend on the value of the claim. Medical reports may not be necessary where there is no significant continuing injury, and a detailed schedule may not be necessary in a low value case. The Civil Procedure Rules are expected to set out the legal and procedural requirements for making offers to settle.

THE RESPONSE

3.23 Attached at Annex C2 is a template for the suggested contents of the **letter of response**.

3.24 The healthcare provider should **acknowledge** the letter of claim **within 14 days of receipt** and should identify who will be dealing with the matter.

3.25 The healthcare provider should, **within three months** of the letter of claim, provide a **reasoned answer** –

- if the **claim is admitted** the healthcare provider should say so in clear terms;
- if only **part of the claim is admitted** the healthcare provider should make clear which issues of breach of duty and/or causation are admitted and which are denied and why;
- if it is intended that any **admissions will be binding**;
- if the claim is denied, this should include specific comments on the allegations of negligence, and if a synopsis or chronology of relevant events has been provided and is disputed, the healthcare provider's version of those events;
- where additional documents are relied upon, e.g. an internal protocol, copies should be provided.

3.26 If the patient has made an offer to settle, the healthcare provider should **respond to that offer** in the response letter, preferably with reasons. The provider may make its own offer to settle at this stage, either as a counter-offer to the patient's, or of its own accord, but should accompany any offer by any supporting medical evidence, and/or by any other evidence in relation to the value of the claim which is in the healthcare provider's possession.

3.27 If the parties reach agreement on liability, but time is needed to resolve the value of the claim, they should aim to agree a reasonable period.

4 EXPERTS

4.1 In clinical negligence disputes **expert opinions** may be needed –

- on breach of duty and causation;
- on the patient's condition and prognosis;
- to assist in valuing aspects of the claim.

4.2 The civil justice reforms and the new **Civil Procedure Rules** will encourage economy in the use of experts and a **less adversarial expert culture**. It is recognised that in clinical negligence disputes, the parties and their advisers will require flexibility in their approach to expert evidence. Decisions on whether experts might be instructed jointly, and on whether reports might be disclosed sequentially or by exchange, should rest with the parties and their advisers. Sharing expert evidence may be appropriate on issues relating to the value of the claim. However, this protocol does not attempt to be prescriptive on issues in relation to expert evidence.

4.3 Obtaining expert evidence will often be an expensive step and may take time, especially in specialised areas of medicine where there are limited numbers of suitable experts. Patients and healthcare providers, and their advisers, will therefore need to consider carefully how best to obtain any necessary expert help quickly and cost-effectively. Assistance with locating a suitable expert is available from a number of sources.

5 ALTERNATIVE APPROACHES TO SETTLING DISPUTES

5.1 It would not be practicable for this protocol to address in any detail how a patient or their adviser, or healthcare provider, might decide which method to adopt to resolve the particular problem. But, the courts increasingly expect parties to try to settle their differences by agreement before issuing proceedings.

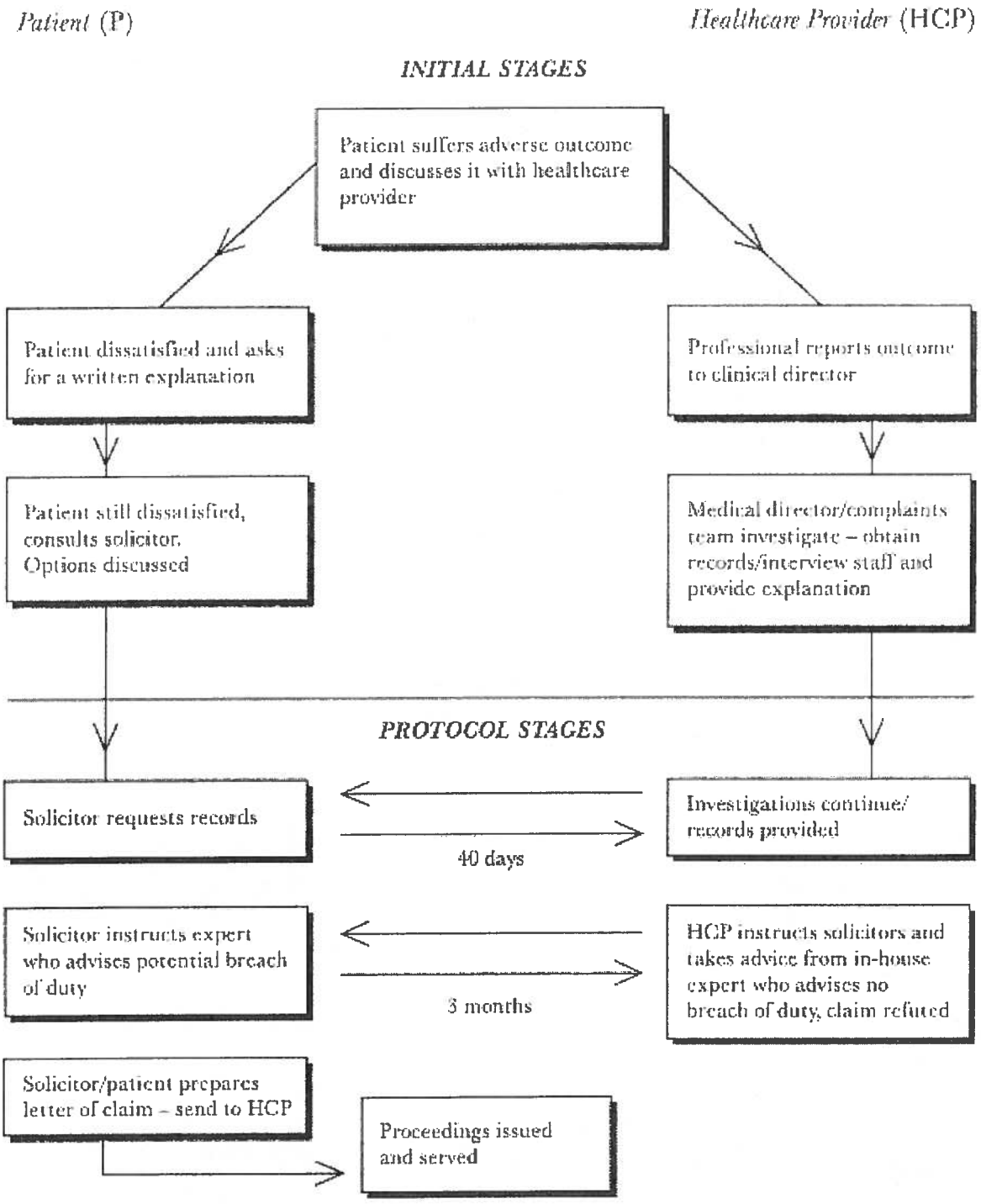
5.2 Most disputes are resolved by **discussion and negotiation**. Parties should bear in mind that carefully planned face-to-face meetings may be particularly helpful in exploring further treatment for the patient, in reaching understandings about what happened, and on both parties' positions, in narrowing the issues in dispute and, if the timing is right, in helping to settle the whole matter.

5.3 Summarised below are some other alternatives for resolving disputes –

- The revised NHS Complaints Procedure, which was implemented in April 1996, is designed to provide patients with an explanation of what happened and an apology if appropriate. It is not designed to provide compensation for cases of negligence. However, patients might choose to use the procedure if their only, or main, goal is to obtain an explanation, or to obtain more information to help them decide what other action might be appropriate.
- Mediation may be appropriate in some cases: this is a form of facilitated negotiation assisted by an independent neutral party. It is expected that the new Civil Procedure Rules will give the court the power to stay proceedings for one month for settlement discussions or mediation.
- Other methods of resolving disputes include arbitration, determination by an expert, and early neutral evaluation by a medical or legal expert. The Legal Services Commission has published a booklet on "**Alternatives to Court**", LSC August 2001, CLS information leaflet number 23, which lists a number of organisations that provide alternative dispute resolution services.

ANNEX A

ILLUSTRATIVE FLOWCHART



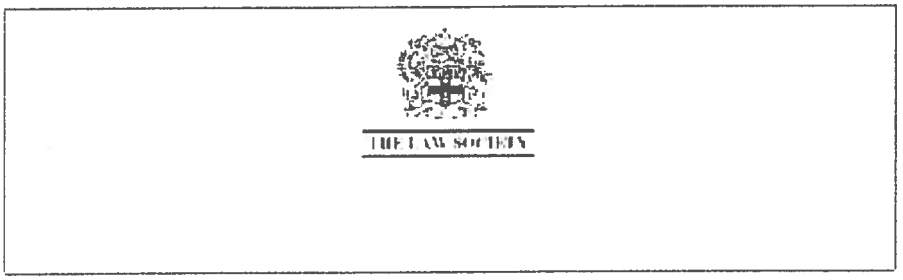
ANNEX B

MEDICAL NEGLIGENCE AND PERSONAL INJURY CLAIMS

A PROTOCOL FOR OBTAINING HOSPITAL MEDICAL RECORDS

CIVIL LITIGATION COMMITTEE

REVISED EDITION
JUNE 1998



APPLICATION ON BEHALF OF A PATIENT FOR HOSPITAL MEDICAL RECORDS FOR USE WHEN COURT PROCEEDINGS ARE CONTEMPLATED

PURPOSE OF THE FORMS

This application form and response forms have been prepared by a working party of the Law Society's Civil Litigation Committee and approved by the Department of Health for use in NHS and Trust hospitals.

The purpose of the forms is to standardise and streamline the disclosure of medical records to a patient's solicitors, who are investigating pursuing a personal injury claim against a third party, or a medical negligence claim against the hospital to which the application is addressed and/or other hospitals or general practitioners.

USE OF THE FORMS

Use of the forms is entirely voluntary and does not prejudice any party's right under the Access to Health Records Act 1990, the Data Protection Act 1984, or ss 33 and 34 of the Supreme Court Act 1981. However, it is Department of Health policy that patients be permitted to see what has been written about them, and that healthcare providers should make arrangements to allow patients to see all their records, not only those covered by the Access to Health Records Act 1990. The aim of the forms is to save time and costs for all concerned for the benefit of the patient and the hospital and in the interests of justice. Use of the forms should make it unnecessary in most cases for there to be exchanges of letters or other enquiries. If there is any unusual matter not covered by the form, the patient's solicitor may write a separate letter at the outset.

CHARGES FOR RECORDS

The Access to Health Records Act 1990 prescribes a maximum fee of £10. Photocopying and postage costs can be charged in addition. No other charges may be made.

The NHS Executive guidance makes it clear to healthcare providers that 'it is a perfectly proper use' of the 1990 Act to request records in that framework for the purpose of potential or actual litigation, whether against a third party or against the hospital or trust.

The 1990 Act does not permit differential rates of charges to be levied if the application is made by the patient, or by a solicitor on his or her behalf, or whether the response to the application is made by the healthcare provider directly (the medical records manager or a claims manager) or by a solicitor.

The NHS Executive guidance recommends that the same practice should be followed with regard to charges when the records are provided under a voluntary agreement as under the 1990 Act, except that in those circumstances the £10 access fee will not be appropriate.

The NHS Executive also advises –

- that the cost of photocopying may include 'the cost of staff time in making copies' and the costs of running the copier (but not costs of locating and sifting records);
- that the common practice of setting a standard rate for an application or charging an administration fee is not acceptable because there will be cases when this fails to comply with the 1990 Act.

RECORDS: WHAT MIGHT BE INCLUDED

X-rays and test results form part of the patient's records. Additional charges for copying X-rays are permissible. If there are large numbers of X-rays, the records officer should check with the patient/solicitor before arranging copying.

Reports on an 'adverse incident' and reports on the patient made for risk management and audit purposes may form part of the records and be disclosable: the exception will be any specific record or report made solely or mainly in connection with an actual or potential claim.

RECORDS: QUALITY STANDARDS

When copying records healthcare providers should ensure –

1. All documents are legible, and complete, if necessary by photocopying at less than 100% size.
2. Documents larger than A4 in the original, e.g. ITU charts, should be reproduced in A3, or reduced to A4 where this retains readability.
3. Documents are only copied on one side of paper, unless the original is two sided.
4. Documents should not be unnecessarily shuffled or bound and holes should not be made in the copied papers.

ENQUIRIES/FURTHER INFORMATION

Any enquiries about the forms should be made initially to the solicitors making the request. Comments on the use and content of the forms should be made to the Secretary, Civil Litigation Committee, The Law Society, 113 Chancery Lane, London WC2A 1PL, telephone [redacted] or to the NHS Management Executive, Quarry House, Quarry Hill, Leeds LS2 7UE.

The Law Society

May 1998

APPLICATION ON BEHALF OF A PATIENT FOR HOSPITAL MEDICAL RECORDS FOR USE WHEN COURT PROCEEDINGS ARE CONTEMPLATED

This should be completed as fully as possible

Insert Hospital Name and Address

TO: Medical Records Officer

Hospital

1 (a)	Full name of patient (including previous surnames)	
(b)	Address now	
(c)	Address at start of treatment	
(d)	Date of birth (and death, if applicable)	
(e)	Hospital ref. no if available	
(f)	N.I. number, if available	
2	This application is made because the patient is considering	
(a)	a claim against your hospital as detailed in para 7 overleaf	YES/NO
(b)	pursuing an action against someone else	YES/NO

3	Department(s) where treatment was received	
4	Name(s) of consultant(s) at your hospital in charge of the treatment	
5	Whether treatment at your hospital was private or NHS, wholly or in part	
6	A description of the treatment received, with approximate dates	
7	If the answer to Q2(a) is 'Yes' details of	
	(a) the likely nature of the claim	
	(b) grounds for the claim	
	(c) approximate dates of the events involved	
8	If the answer to Q2(b) is 'Yes' insert	
	(a) the names of the proposed defendants	
	(b) whether legal proceedings yet begun	YES/NO
	(c) If appropriate, details of the claim and action number	

9	We confirm we will pay reasonable copying charges	
10	We request prior details of (a) photocopying and administration charges for medical records	YES/NO
	(b) number of and cost of copying x-ray and scan films	YES/NO
11	Any other relevant information, particular requirements, or any particular documents not required (e.g. copies of computerised records)	
	Signature of Solicitor	
	Name	
	Address	
	Ref.	
	Telephone Number	
	Fax number	

Please print name beneath each signature.
Signature by child over 12 but under 18 years also requires signature by parent

Signature of patient

Signature of parent or next friend if appropriate

Signature of personal representative where patient has died

FIRST RESPONSE TO APPLICATION FOR HOSPITAL RECORDS

NAME OF PATIENT Our ref Your ref		
1	Date of receipt of patient's application	
2	We intend that copy medical records will be dispatched within 6 weeks of that date	YES/NO
3	We require pre-payment of photocopying charges	YES/NO
4	If estimate of photocopying charges requested or pre-payment required the amount will be	£ / notified to you
5	The cost of x-ray and scan films will be	£ / notified to you
6	If there is any problem, we shall write to you within those 6 weeks	YES/NO
7	Any other information	
	Please address further correspondence to	
	Signed	
	Direct telephone number	
	Direct fax number	
	Dated	

SECOND RESPONSE ENCLOSING PATIENT'S HOSPITAL MEDICAL RECORDS

Address

Our Ref.
Your Ref.

	NAME OF PATIENT:	
1	We confirm that the enclosed copy medical records are all those within the control of the hospital, relevant to the application which you have made to the best of our knowledge and belief, subject to paras 2-5 below	YES/NO
2	Details of any other documents which have not yet been located	
3	Date by when it is expected that these will be supplied	
4	Details of any records which we are not producing	
5	The reasons for not doing so	
6	An invoice for copying and administration charges is attached	YES/NO
	Signed	
	Date	

ANNEX C

TEMPLATES FOR LETTERS OF CLAIM AND RESPONSE

C1 LETTER OF CLAIM

Essential Contents

1. **Client's name, address, date of birth, etc.**
2. **Dates of allegedly negligent treatment**
3. **Events giving rise to the claim:**
   - an outline of what happened, including details of other relevant treatments to the client by other healthcare providers.
4. **Allegation of negligence and causal link with injuries:**
   - an outline of the allegations or a more detailed list in a complex case;
   - an outline of the causal link between allegations and the injuries complained of.
5. **The Client's injuries, condition and future prognosis**
6. **Request for clinical records (if not previously provided)**
   - use the Law Society form if appropriate or adapt;
   - specify the records require;
   - if other records are held by other providers, and may be relevant, say so;
   - state what investigations have been carried out to date, e.g. information from client and witnesses, any complaint and the outcome, if any clinical records have been seen or experts advice obtained.
7. **The likely value of the claim**
   - an outline of the main heads of damage, or, in straightforward cases, the details of loss.

Optional information

What investigations have been carried out

An offer to settle without supporting evidence

Suggestions for obtaining expert evidence

Suggestions for meetings, negotiations, discussion or mediation

Possible enclosures

Chronology

Clinical records request form and client's authorisation

Expert report(s)

Schedules of loss and supporting evidence

C2 LETTER OF RESPONSE

Essential Contents

1. Provide **requested records** and invoice for copying:
    - explain if records are incomplete or extensive records are held and ask for further instructions;
    - request additional records from third parties.
2. **Comments on events and/or chronology**:
    - if events are disputed or the healthcare provider has further information or documents on which they wish to rely, these should be provided, e.g. internal protocol;
    - details of any further information needed from the patient or a third party should be provided.
3. **If breach of duty and causation are accepted**:
    - suggestions might be made for resolving the claim and/or requests for further information;
    - a response should be made to any offer to settle.
4. **If breach of duty and/or causation are denied**:
    - a bare denial will not be sufficient. If the healthcare provider has other explanations for what happened, these should be given at least in outline;
    - suggestions might be made for the next steps, e.g. further investigations, obtaining expert evidence, meetings/negotiations or mediation, or an invitation to issue proceedings.

Optional Matters

An offer to settle if the patient has not made one, or a counter offer to the patient's with supporting evidence

Possible enclosures:

Clinical records

Annotated chronology

Expert reports

ANNEX D

LORD WOOLF'S RECOMMENDATIONS

1. Lord Woolf in his Access to Justice Report in July 1996, following a detailed review of the problems of medical negligence claims, identified that one of the major sources of **costs and delay** is **at the pre-litigation stage** because –

   (a) Inadequate incident reporting and record keeping in hospitals, and mobility of staff, make it difficult to establish facts, often several years after the event.

   (b) Claimants must incur the cost of an expert in order to establish whether they have a viable claim.

   (c) There is often a long delay before a claim is made.

   (d) Defendants do not have sufficient resources to carry out a full investigation of every incident, and do not consider it worthwhile to start an investigation as soon as they receive a request for records, because many cases do not proceed beyond that stage.

   (e) Patients often give the defendant little or no notice of a firm intention to pursue a claim. Consequently, many incidents are not investigated by the defendants until after proceedings have started.

   (f) Doctors and other clinical staff are traditionally reluctant to admit negligence or apologise to, or negotiate with, claimants for fear of damage to their professional reputations or career prospects.

2. Lord Woolf acknowledged that under the present arrangements **healthcare providers**, faced with possible medical negligence claims, have a number of **practical problems** to contend with –

   (a) Difficulties of finding patients' records and tracing former staff, which can be exacerbated by late notification and by the health care provider's own failure to identify adverse incidents.

   (b) The healthcare provider may have only treated the patient for a limited time or for a specific complaint: the patient's previous history may be relevant but the records may be in the possession of one of several other healthcare providers.

   (c) The large number of potential claims which do not proceed beyond the stage of a request for medical records, or an explanation; and that it is difficult for healthcare providers to investigate fully every case whenever a patient asks to see the records.

ANNEX E

HOW TO CONTACT THE FORUM

The Clinical Disputes Forum

Chairman

Dr Alastair Scotland
Medical Director and Chief Officer
National Clinical Assessment Authority
9th Floor, Market Towers
London
SW8 5NQ

Telephone: [redacted]

Secretary

Sarah Leigh
c/o Margaret Dangoor
3 Clydesdale Gardens
Richmond
Surrey
TW10 5EG

Telephone: [redacted]

CLINICAL NEGLIGENCE - CHIEF EXECUTIVES CONFIRMATION STATEMENT

HPSS Body _____

I, _____ confirm that:

(Please strikethrough any items that cannot be confirmed)

Pre action Protocol

(a) Claims managers and other relevant staff have access to the pre-action protocol;

(b) Caseloads have been examined for compliance with the time limits recommended and that appropriate action has been taken to rectify instances where the limits have been exceeded;

(c) Staff are actively taking the contents of the protocol into account in processing cases;

Corporate Responsibility

(d) Managerial arrangements are in line with HSS (F) 20/1998;

Case Review

(e) All ongoing cases have been reviewed for accuracy of the base data, have been fully considered for immediate closure as appropriate and that the expected value of compensation costs has been reviewed in line with accounting guidance. A summary of the main findings of this review is attached.

Signed _____

Date _____/_____/_____

To be submitted by 30 June each year

ADMINISTRATION OF THE CLINICAL NEGLIGENCE CENTRAL FUND

1. Responsibility

   The Clinical Negligence Central Fund (CNCF) is responsible for meeting the costs of all clinical negligence settlements regardless of the date of origin. HPSS Trusts are responsible for the management and accounting of cases arising after the date of inception of each trust with host HPSS Boards being responsible for those claims relating to the pre Trust period.

2. Cases instigated pre 1 January 1990

   A number of cases instigated before the transfer of liability from the medical defence organisations to the Crown benefit from reinsurance arrangements. In such cases, Boards are responsible for that element of the any settlement and costs incurred for the case up to the limit of the reinsurance arrangements.

3. Reimbursement of Expenditure

   a. HPSS bodies are responsible for the payment of the agreed settlement and related costs and on payment apply to the Central Fund for reimbursement.

      The Central Fund will reimburse the following costs:

      i. Settlement amount.
      ii. Plaintiff's Solicitors fees
      iii. Plaintiff's Counsel fees.
      iv. Plaintiff's expert reports/witnesses/opinions.
      v. Defendant's Counsel fees.
      vi. Defendant's expert reports/witnesses/opinions.
      vii. Payments made to Compensation Recovery Unit.

b. HPSS bodies are advised that legal costs in defence of a claim will not be reimbursed by the Central Fund.

c. HPSS bodies may apply to the Central Fund for reimbursement of costs paid out in respect of a claim in advance of its settlement. These claims for reimbursement may be on a monthly basis and must be supported by copy invoices of costs paid.

SUBMISSION OF RETURNS TO THE CENTRAL SERVICES AGENCY

4. The Central Services Agency will continue to administer the Central Fund.

5. All HPSS bodies are required to supply to the Central Services Agency and Finance Policy and Accountability Unit of the Department by 30 June each year details of all potential settlements in the current financial year.

6. The date of 30 June has been selected to coincide with the work performed on clinical negligence settlements in accordance with FRS 12. HPSS bodies may wish to use this information to complete the returns required for Central Fund purposes. The details supplied should include the best estimate of the costs of settlement, based on legal advice and the expected date of settlement.

7. The Department will extract data from the Central Clinical Negligence Database details of the settlements that HPSS bodies expect to pay within the following quarter and inform the Central Services Agency to assist management of cash flow. Quarterly forecast returns from HPSS bodies are therefore no longer required.

8. The annual returns should be in the format outlined in Annex 1 of this Appendix. For administrative convenience, all HPSS bodies must submit the required returns i.e. nil returns must also be submitted.

9. The information requested is essential for Departmental monitoring purposes and for cash flows into and out of the Central Fund.

HPSS bodies are advised that failure to adhere to the timetable may result in a delay

in reimbursement. Furthermore, if the information does not flow in a timely and reasonably accurate way, the Department retains the right to review the arrangements.

Therefore, it is in the overall interests of the HPSS to submit returns in accordance with the timetable and to ensure that the completed returns are as accurate as possible.

PAYMENT OF CLAIMS

10. When the payment of the settlement amount is confirmed on a specific date, the HPSS body is required to make the payment and then apply to the Central Fund for reimbursement.

11. Requests for reimbursement to the Central Fund should be made on a monthly basis and in arrears, i.e. at the end of the month HPSS bodies submit a statement to the CSA of claims to be reimbursed. A proforma Request for Reimbursement is included at Annex 2. This request must be accompanied by all the required supporting documentation and copy invoices in respect of each individual claim and must be signed by the Claims Manager.

12. In circumstances where the final settlement amount is significantly in excess of the original or updated quarterly estimate the HPSS body must explain the reason for the variance to the CSA as administrators of Central Fund and to Finance Policy and Accountability Unit.

SUBMISSION OF RETURNS TO THE DEPARTMENT

13. Returns must be forwarded:

Finance Policy and Accountability Unit,
Room 414,
Dundonald House
Belfast
BT4 3SF

ANNUAL RETURN **Annex 1**

ESTIMATED CLINICAL NEGLIGENCE COSTS FOR**

HPSS Body _____ 12 MONTHS TO _____

Case Reference Number	Estimate Settlement Date	Estimated Costs £000s
TOTALS		

** Enter Financial Year

[This return must be submitted to the Central Fund by 30 June of the current financial year]

I, _____ certify that the material submitted has been extracted from financial or management information systems, has been fully reviewed and any estimates made are based on professional opinion obtained and/or historical precedent

Date: _____ Signed: _____
(Chief Executive)

ANNEX 2

REQUEST FOR REIMBURSEMENT

_____ HPSS Body

INFORMATION TO BE SUPPLIED IN SUPPORT OF EACH PAYMENT REQUEST

1. Case Reference.

2. Date of settlement of claim.

3. Date of payment of settlement.

4. Amount of settlement.

5. Details of costs incurred.*

The above information must be supplied in support of each request for payment.

* Copy invoices must be supplied in respect of each cost that is to be reimbursed from the Central Fund. (Costs which can be reimbursed from the Central Fund are listed in Section 1 of this Circular).

_____ Signed (Claims Manager)

_____ Date

CLINICAL NEGLIGENCE - CHIEF EXECUTIVES CONFIRMATION STATEMENT

HPSS Body _____

I, _____ confirm that:

(Please strikethrough any items that cannot be confirmed)

Corporate Responsibility

a) Managerial arrangements are in line with circular HSS (F) 20/1998

Case Review

b) All ongoing cases have been reviewed for accuracy of the base data, have been fully considered for immediate closure as appropriate and that the expected value of compensation costs has been reviewed in line with accounting guidance. A summary of the main finding of this review is attached.

Signed _____

Date _____/_____/_____

Required by 3 January 2003

GUIDANCE ISSUED BY THE DEPARTMENT – FINANCE CIRCULARS

Circular Reference and Title	Subject	Extant
Circular HSS (F) 1/90 "Medical Negligence: New Arrangements"	The circular advised on the introduction of the then new arrangements for meeting medical negligence claims. In essence, it referred to the change from arrangements whereby Medical Defence Organisations bore the legal costs and damages of claims to bring them within the ambit of Boards.	This circular is now withdrawn.
Circular HSS (F) 26/97 "Clinical Negligence Claims - Interim Guidance"	This circular provided interim guidance on the funding of clinical negligence claims, dealing with: the division of responsibility between Boards and Trusts; the establishment of the Clinical Negligence Central Fund; and accounting/audit arrangements.	This circular is now withdrawn.
Circular HSS (F) 19/98 "Clinical Negligence Central Fund: Funding and Administrative Arrangements"	This circular provided more detailed guidance on the Clinical Negligence Central Fund ("CNCF") etc. than HSS (F) 26/97. It indicated that Trusts should maintain a database of information on clinical negligence and detailed key information that Trusts should supply to the CSA when submitting payment requests.	This circular was withdrawn by HSS (F) 17/2001
Circular HSS (F) 20/98 "Clinical Negligence Claims: Claims Handling"	The circular contained guidance for Trusts on handling claims relating to incidents occurring after their establishment. It indicated the delegated limit for out of court settlements (£250k) and set minimum standards: (i) to which Trust policies on claims handling should conform; and (ii) for the basic organisation of claims handling.	Main Circular Extant Supplement 1 now withdrawn
Circular HSS (F) 21/98 "Clinical Negligence Claims: Structured Settlements"	It provided guidance to the effect that consideration should be given to the use of structured settlements in all cases of £250k and above and suggested that they might also represent good value for money for smaller settlements. It provided detailed guidance on their use.	Extant

Circular HSS(F) 28/99 – "Clinical Negligence Claims - Procedures for Submission of Settlements Over £250,000 for Approval"	The circular reaffirmed that any claims that might settle in excess of £250k should be submitted to the Department for approval and set out in detail the arrangements for HSS bodies to follow for submission of these cases. A Supplement to it referred to the need for cases to be submitted on a timely basis and the time required for DFP approval in respect of potential payments in excess of £1m.	Extant
Circular HSS (F) 19/2000 – "Clinical Negligence Central Fund: Accounting Arrangements"	The circular advised that the role of the CNCF had been expanded to manage the payment of all clinical negligence settlements, both pre and post the establishment of Trusts, and to coincide with the introduction FRS12 to the accounts of HPSS bodies. It advised on revised accounting arrangements in respect of clinical negligence costs and superseded the accounting guidance contained in Circular HSS (F) 19/98.	Extant
Circular HSS (F) 17/2001 – "Clinical Negligence Central Fund: Administrative Arrangements"	The circular gave details of revised administrative arrangements for the CNCF and affected the withdrawal of Circular HSS (F) 19/98.	This circular is now withdrawn

Financial Management Directorate

HSS
EXECUTIVE

HSS (F) 19/98

The Chief Executive of each
Health and Social Services Board/Trust/Agency

The Director of Finance of each
Health and Social Services Board/Trust

15th May 1998

Dear Sir/Madam

CLINICAL NEGLIGENCE CENTRAL FUND:
FUNDING AND ADMINISTRATIVE ARRANGEMENTS

A Central Fund has been established to meet the cost of clinical negligence claims. The scheme will be administered by the Central Services Agency.

Appendix 1 sets out the funding and administrative arrangements for the fund and details how Trusts may access the fund.

Any enquiries about this circular should be addressed to Neville Jones, Policy and Accounting Unit, Belfas[redacted]

Yours sincerely

NEVILLE JONES
Policy and Accounting Unit

Health and Social Services Executive
Dunbonald House, Upper Newtownards Road, Belfast BT4 3SF Northern Ireland Telephone 01232 520500 Facsimile 01232 524196

CLINICAL NEGLIGENCE CENTRAL FUND

DEFINITION

1. Clinical Negligence is defined as:

"a breach of duty of care by members of the health care professions employed by HSS bodies. This includes medical and dental practitioners, nursing staff, professions allied to medicine, such as ambulance personnel and laboratory staff, social care and social services professionals".

RESPONSIBILITY FOR CLAIMS

2. The responsibility for the claim is dependent on the timing of the incident from which the claim arises.

Pre Trust Status

2.1 Clinical negligence claims relating to the pre Trust period are the responsibility of the host Board.

Post Trusts Status

2.2 HSS Trusts are liable for the payment of settlement costs for clinical negligence claims occurring after their inception. With effect from 1/4/98, the funding of the payment will be via a Central Fund, administered by the Central Services Agency.

Post Trust Claims

2.3 A Clinical Negligence Central Fund has been established to manage the payment of clinical negligence claims. Where a Trust/Agency is required to make a payment in respect of a clinical negligence case, the Central Fund should be accessed as outlined in paragraph 4 below. The Central Fund will be funded through the contributions from Boards, calculated on a capitation basis (see 5 below).

HANDLING OF CLAIMS

3. Trusts will be responsible for the complete process of handling claims and agreeing the amount of the final settlement. Circular HSS(F)20/98 "Clinical Negligence Claims: Claims Handling" sets out the guidance to be followed.

ADMINISTRATION OF THE FUND

4.1 The Central Fund will be administered by the Central Services Agency (CSA). As an annual exercise, Trusts/Agencies will be required to provide, by 31 January each year, details of potential settlements in the forthcoming financial year. While clearly difficult, returns should include best estimates of potential quantum and dates of settlement.

In-year, Trusts will also be required to submit to the Director of Finance and Administration of the CSA, on a quarterly basis, details of the settlements which they **expect to pay within the forthcoming 12 months**. (Returns should be in the format outlined in Appendix 1) The submission timetable is shown in Appendix 2. This will enable the CSA and Boards to estimate the potential funds required in the period. While it is fully appreciated that the estimation of the potential quantum and settlement dates is difficult, in order for the proposed procedures to operate effectively, **it is essential that the appropriate returns to the CSA are made within the designated**

timescales. Where a claim settles £50,000 or more above the original or updated quarterly estimates, Trusts should confirm to the CSA the reason(s) for the variance.

Payment of Claims

4.2 When the settlement is confirmed and payment is due, the latter should be made initially by the Trust concerned.

Reimbursement requests should be submitted to the CSA. All requests for payment should be accompanied by supporting documentation covering items listed in Appendices 3 and 4. The CSA will collate reimbursement requests and submit monthly accounts to Boards, apportioning costs on a capitation basis. When payment is received from the Boards, the CSA will forward reimbursement to relevant Trusts. The CSA will maintain a record of the payments made each quarter and of the capitation share of each Board. This record will be issued to Boards and Trusts on a quarterly basis (see 8 below).

The CSA will operate a separate bank account for the transactions relating to clinical negligence in order to separate them from its own transactions. A record will be maintained of all transactions through the Fund bank account.

FUNDING OF CENTRAL FUND

5. Boards currently receive an allocation designated for clinical negligence and they draw down the funds as and when they are required. The Central Fund will be funded by the Boards and contributions will be on capitation basis. The rationale behind this is that Boards are already funding on a weighted capitation basis.

The Central Fund will be funded as and when it is required, that is, funds will not be accumulated unnecessarily but will be accessed as the money is required to finance

settlements. As each payment is made, each Board's capitation share will be calculated and the relevant funds requested from each Board.

ACCOUNTING FOR THE FUND

6. The creation of the Central Fund will require accounting at the three levels.

Accounting by the Central Services Agency

6.1 The CSA will have to account for all transactions processed through the Central Fund bank account during the year. They will account for the funds received from the Boards as income and for the transfer of funds to the Trust as expenditure. The income will be included within "Income from other sources" in the Income and Expenditure account and will be analysed separately in note 3 to the accounts. The expenditure will be included within "Operational costs" and analysed separately in note 5. In the main there should not be any balance in the Fund bank account at the year end, however, if there is, this will be matched by a creditor to the Fund.

Accounting by the Boards

6.2 The Boards will account for their full allocation in the normal way and the amount transferred to the CSA will be accounted for as expenditure. The Boards will include the expenditure within "Healthcare, personal social services and related services purchased" and it will be analysed separately in note 2.1 to the Accounts.

Accounting by Trusts

6.3 Trusts will account for the funds received to cover the settlement as income and for the payment as expenditure. The income received will be included under "Other operating income" and will be analysed separately in note 3.

The expenditure will be included within "Operating expenses" and will be analysed separately within note 4.1.

AUDIT ARRANGEMENTS

7. Auditors may require to verify the amounts paid out in settlements by the Central Services Agency. The Central Services Agency will retain the information submitted to it in support of the payment request. The detailed supporting documentation in respect of each payment should be retained at the Trust concerned.

INFORMATION TO BE HELD CENTRALLY AND DISSEMINATED

8. Trusts should maintain a comprehensive database of information on clinical negligence. Circular HSS(F)20/98 "Clinical Negligence and Personal Injury Litigation: Claims Handling" gives guidance on the type of information which Trusts should retain in their database. Appendices 3 and 4 detail the key information which Trusts will be required to supply to the Central Services Agency when submitting their payment request in respect of each claim. The information in Appendix 3 is basic factual information about the case which will be collated on a quarterly basis and issued to Boards and Trusts for information purposes. They will also receive quarterly information on the Boards' shares of the settlements paid during the quarter.

The information required in Appendix 4 is more qualitative information on procedures and remedies. A review team will be established with representatives from HSS Boards and Trusts to review this information and assess the issues involved and lessons to be learnt. An annual report will be produced on the more strategic issues identified in the cases, their implications for the HPSS generally and the way forward.

QUARTERLY RETURN TO CSA ON CLINICAL NEGLIGENCE CASES FOR 1998/99

QUANTUM OF COST

TRUST _____ **12 MONTHS TO** _____

Plantiff ID*	Estimated Settlement Date	Estimated Settlement Costs £000s	Estimated Legal Costs £000s	Total £000s
TOTALS				

* Plaintiff ID to include Plaintiff's initials and case number

APPENDIX 2

TRUSTS QUARTERLY RETURN TO CSA FOR CLINICAL NEGLIGENCE CASES

CSA RETURNS TO BOARDS

		Trusts Return to CSA	CSA Return to Boards
1.	Estimate of Claims due for prospective Financial Year	1 February	8 February
2.	1st Quarter Update on Annual Estimate ...	30 June	7 July
3.	2nd Quarter Update on Annual Estimate ..	30 September	7 October
4.	3rd Quarter Update on Annual Estimate ...	31 December	8 January

APPENDIX 3

INFORMATION TO BE SUPPLIED IN SUPPORT OF EACH PAYMENT REQUEST

1. Date of settlement of claim
2. Amount of settlement
3. Legal Costs
4. Speciality
5. Nature of claim (including brief description of how occurred)
6. Date of claim
7. Board of residence of plaintiff.

APPENDIX 4

ADDITIONAL SUPPORTING INFORMATION REQUIRED

1. Break down in established procedures identified:
   - clinical
   - administrative
   - communicative
2. Changes required to establish procedures above and timetable for implementation
3. Problems identified with equipment and action taken to remedy
4. Any problems identified with claims handling procedures and steps taken to remedy
5. Is this a new risk and steps taken to review procedures.

HSS

HSS(F)20/98

The Chief Executive of each Health and Social Services Board
The Director of Finance of each Health and Social Services Board
The Chief Executive of each Health and Social Services Trust
The Director of Finance of each Health and Social Services Trust
The Chief Executive of the Central Services Agency
The Director of Finance of the Central Services Agency
The Chief Executive of the Northern Ireland Blood Transfusion (Special Agency)
The Chief Executive of the Regional Medical Physics Agency

15th May 1998

Dear Sir/Madam

CLINICAL NEGLIGENCE CLAIMS: CLAIMS HANDLING

INTRODUCTION

The purpose of this circular is to set out the guidance on the handling of clinical negligence claims by Trusts. Trusts are responsible for the handling of claims which relate to incidents occurring after their establishment. Therefore it is essential that Trusts have in place adequate procedures to ensure the proper handling of clinical negligence claims.

DELEGATED LIMITS

The delegated limit for Trusts' clinical negligence out of court settlements is £250,000. Settlements above this limit must be submitted to the Health and Social Services Executive, Policy and Accounting Unit for approval.

The following guidance must be followed in respect of all settlements of clinical negligence claims.

SUMMARY

1. Trust Chief Executives should:

   1.1 ensure that their Trust has a clear policy on the handling of clinical negligence and personal injury claims, approved by the board, which conforms to the standards set out in Annex A.

1.2 in particular ensure that:

i. there is a board member with a clear responsibility for clinical negligence issues, who will keep the board informed of major developments

ii. the Trust has access to a claims manager (or equivalent) with sufficient experience and seniority to manage claims effectively and to secure substantial savings over time in the cost of litigation, reporting directly to the board member

iii. there is a clear procedure for handling claims, which among other points will set out the circumstances in which:

- legal advice will be sought

- authority to make settlement offers can be delegated to officers below board level

iv. all claims are reviewed after closure, and a senior manager made responsible for ensuring that any necessary remedial action is taken and any general lessons disseminated

v. the board sees regular reports on the number and aggregate value of claims in progress, on their eventual outcome and on any remedial action taken or proposed

vi. the required information on clinical negligence claims is submitted as necessary to the Central Services Agency. (Circular HSS(F)19/98). **This is essential to ensure the efficient processing of reimbursement to Trusts, and for forecasting potential funding requirements.**

1.3. arrange for this letter, and the attached Annexes, to be drawn to the attention of the claims manager and other relevant staff, eg clinical directors

1.4. ensure that these policies and procedures are subject to regular scrutiny by internal audit under the supervision of the Trust's Audit Committee.

DETAIL

2. Clinical negligence is a rapidly growing cost to the HPSS and will impact, in particular, on Trusts over the next few years. A single large settlement against a Trust could place significant strain on financial resources, as well as taking up a disproportionate amount of senior management and clinical time. Trusts can reduce the incidence and adverse impact of clinical negligence by:

i. adopting prudent risk management strategies;

ii. adopting a systematic approach to claims handling in line with best current practice and guidance issued by the HSS Executive.

3. Minimum standards for the basic organisation of claims handling are set out in the attached Annex B. All Trusts should ensure that:

i. they have a clear policy for claims handling which meets all the standards set out in Annex A;

ii. this letter and its Annexes are drawn to the attention of their claims manager and other staff involved in the day-to-day handling of claims;

iii. the required information is submitted to the Central Services Agency. (HSS(F)19/98)

THE CLINICAL NEGLIGENCE CENTRAL FUND

4. The Clinical Negligence Central Fund has been established to provide funding for all clinical negligence settlements.

Trusts are only liable for clinical negligence claims which arise from incidents occurring after their inception date.

5. Trusts are fully accountable for the handling of the claim.

Guidance on the administration details of the Clinical Negligence Central Fund and the procedures to be followed by Trusts is contained in Circular HSS(F)19/98 "Clinical Negligence Central Fund: Funding and Administrative Arrangements".

Yours sincerely

NEVILLE JONES
Policy and Accounting

ANNEX A

HANDLING OF CLINICAL NEGLIGENCE AND PERSONAL INJURY CLAIMS: MINIMUM STANDARDS

Trusts hold a delegated limit for clinical negligence out of court settlements of £250,000. Settlements above this limit must be submitted to the HSS Executive, Policy and Accounting Unit for approval.

Trusts are responsible for the handling of their clinical negligence claims.

1. **Policy Statement**

1.1 Trusts must have a written policy on the handling of clinical negligence and personal injury claims, approved by the board, which as a minimum covers the remaining points set out below.

2. **Board Level Responsibility**

2.1 There will be a board member with clear responsibility for clinical negligence issues, who will keep the board informed of major developments. This may be the same individual who has overall responsibility for risk management.

3. **Experienced Claims Manager**

3.1 The Trust will have access to a claims manager (or equivalent) reporting directly to the responsible board member. This is a key appointment. Trusts must ensure that their claims manager:

(i) is of sufficient seniority to carry influence within the organisation and is given the status to do so; and

(ii) has sufficient experience of and/or training in clinical negligence issues.

4. **Qualified Legal Advice**

4.1 The Trust will have a clear policy on the circumstances in which qualified legal advice will be obtained. Whatever the locally determined policy, qualified legal advice must always be obtained at an appropriate stage for all claims involving potential expenditure above the standard delegated limit for *ex gratia* payments (£1,000) and in any case before making any firm offer to settle the claim. This should cover:

i. liability and causation

ii. an assessment of the strength of the defence and the balance of probabilities

iii. the likely quantum of damages, including best and worst case

iv. the likely legal costs of defending the claim.

Legal advice may also be helpful in deciding what expert witnesses to call, and whether the dispute could be resolved in other ways eg through mediation.

4.2 Nevertheless, the final decision to seek to negotiate a settlement or to continue defending the case should be taken by the board or by the claims manager within delegated limits (see paragraph 9 below).

4.3 Trusts will wish to bear in mind that those who advise them in any capacity should be regarded as owing a duty of care to them. They may wish therefore to ensure that their advisers carry a sufficient level of professional indemnity cover.

5. Involvement of Front-Line Staff

5.1 There should be clear procedures for involving front-line staff, in particular medical and nursing staff, whose co-operation is essential if claims are to be successfully defended. In clinical negligence cases the view of those involved in the treatment which has given rise to a claim must be considered carefully by the claims manager before a decision is made to settle or contest the claim.

6. Procedure for Handling Claims

6.1 There will be a well-understood and clearly documented procedure for handling claims. This should cover the following aspects:

i. setting up a record on the claim and maintaining a claims review system (see paragraph 7 below);

ii. establishing when needed an objective account of the original incident, giving appropriate weight to the recollection of the staff originally involved;

iii. identifying all records related to the incident;

iv. establishing and maintaining contact with all staff involved in the original incident;

v. obtaining an in-house "expert view" of the claim and, if appropriate, securing suitable external expert witnesses;

vi. initial valuation of the claim;

vii. instruction of solicitors, briefing counsel and monitoring their costs;

viii. negotiation of out-of-court settlements and the delegated limits which apply (see paragraph 9 below);

ix (for large settlements, in particular those over £250,000, where the plaintiff is agreeable) evaluation of the costs and benefits of structuring the settlement, negotiation of the details, and preparation of the VFM report for the HSS Executive;

x. procedures to identify any procedures or aspects of clinical practice requiring remedial action, including systematic review of all cases after closure;

xi. clear allocation of responsibility for carrying through any remedial action required and for disseminating any wider lessons, both within the Trust and (where appropriate) more widely;

xii. arrangements for analysis of claims against the Trust in particular of trends and emerging patterns with implications for the Risk Management policies of the Trust;

xiii. arrangements for regular reporting to the board or to a subgroup of the board, both in aggregate and on individual claims; and in particular for securing board agreement to proposals for settlements outside the claims manager's delegated limits.

7. Claims Database

7.1 The Trust will set up and regularly maintain a database with information on all claims. Care should be taken to maintain patient and staff confidentiality. Appendix 1 sets out an indication of the information which might be held on the Trust's own database for clinical negligence claims. Records should be held for a very substantial period after the claim has been closed or become inactive - it has been known for claims to be brought up to 25 years after the original incident. The use of microfiche can be considered for storage of apparently inactive files.

The Trust will be required to submit a subset of this information annually to the Central Services Agency. A service-wide report will be prepared and issued annually by a working group established to review more strategic issues involved in clinical negligence and assess remedial actions to be taken.

The information required to be submitted to the Central Services Agency is set out in Appendix 1 to Circular HSS(F)19/98 "Clinical Negligence Claims Central Fund".

8. **Linkages to Other Systems**

8.1 There will be appropriate linkages for claims handling to (a) functional directorates, (b) clinical audit, (c) risk management (including compliance with health and safety at work legislation).

8.2 Many clinical and other functional directors will already appreciate the importance to the Trust's reputation of the effective handling of claims. Nevertheless, the Trust will wish to ensure that all directorates are fully consulted on the Trust's claims handling policies and that appropriate arrangements are in place to enable them to support the Claims Manager in the day-to-day handling of claims. Clinical directors will also wish to consider how the results of retrospective review of claims can be used as input to clinical audit.

8.3 Trusts also need to recognise the close connections between risk management, complaints, and the management of claims. Where these are the responsibility of separate individuals, Trusts will wish to consider what arrangements are needed to ensure the fullest possible co-ordination.

9. **Delegated Limits**

9.1 The board will agree the circumstances, including delegated financial limits, in which settlements may be approved by (a) the responsible director, (b) the claims manager, and (c) a sub-group of the board. For claims outside these delegated limits the board should agree, case by case, a range of possible settlement values within which the director and/or claims manager has discretion to negotiate. (It should be remembered that, in the nature of the legal process, decisions on whether or not to accept an offered settlement may sometimes have to be taken at very short notice.)

10. **"Nuisance" claims**

10.1 Trusts are strongly advised to avoid settling cases of doubtful merit, however small, purely on a "nuisance value" basis. The decision to settle a case or contest it should always be based on an assessment of the risk of losing (and the cost in legal fees of continuing, bearing in mind that if the plaintiff is legally-aided these costs are unlikely to be recoverable).

11. **Reports to the Board**

1.1 The board (or a sub-group) will see regular reports on:

i. the number and aggregate value of claims, and details of any major individual claims;

ii. the progress and likely outcome of these claims, including the expected settlement date;

iii. the final outcome of the claim; and

iv. any proposed remedial action arising out of particular claims.

These reports will need to be analysed at a level of detail which will enable the board to form a view on emerging trends, and linked to similar information on adverse incidents. It is suggested that for major claims an initial report should be made within 3 months of notification, with updates at least every six months on those in which proceedings have been served or in which settlement is expected within the next twelve months.

12. Novel, contentious or repercussive payments

12.1 Despite the general approach to delegation taken in this guidance, all claims involving "novel, contentious or repercussive" expenditure should still be referred to the HSS Executive for approval. The most likely instances are:

i. claims involving some unusual and new feature which, if not correctly handled, might set an unfortunate precedent for other HPSS litigation;

ii. claims which appear to represent test cases for a potential class action, or cases which although not formally part of a class action appear to be very similar in kind to concurrent claims against other Trusts.

12.2 Trusts faced with a claim which could fall under either of these categories are asked to take action as follows:

i. Trusts should draw attention of the HSS Executive to the particular features of the claim at the earliest occasion, usually when first notifying the claim. The HSS Executive will determine whether formal DFP approval to settle the claim is required and inform the Trust of their decision, and if appropriate take responsibility for seeking authority from DFP.

ii. In all other cases, Trusts should contact the HSS Executive for advice.

13. Register of Losses and Special Payments

13.1 All payments in settlement of clinical negligence or personal injury claims should be entered into the Trust's register of losses and special payments.

ANNEX B

ILLUSTRATIVE CONTENTS OF TRUSTS CLAIMS DATABASE

Information Required

1. Patient details (name, date of birth, age, date of death)
2. Plaintiff's name
3. Plaintiff's solicitor
4. Details of all members of staff involved, including specialty and degree of involvement
5. Location of incident
6. Date of incident
7. Date of notification of claim
8. Specialty of Department of treatment
9. Nature of incident
10. Resulting harm or disability
11. Estimate of quantum
12. Estimate of plaintiff's costs
13. Other parties involved in claim and proportionate share of costs
14. Probability
15. Defence solicitor
16. Estimate of defence costs
17. Stage of claim
18. Outcome

Other Information Likely to be of Value

19. Nature of proposed defence

20. names of possible expert witnesses

21. Expert advice obtained - negligence/causation

    a. internal
    b. external
    c. exchange of witness reports?

22. Expert advice obtained - quantum

    a. medical
    b. nursing
    c. housing etc
    d. exchange of witness reports?

23. Was the incident also the subject of a complaint under the complaints procedure? Outcome?

24. Has an alternative form of dispute resolution been considered/attempted?

25. (For large claims) is structuring feasible? acceptable to the plaintiff?

Other Information to be Held

26. Objective account of incident.

27. Does the case involve novel, contentious or repercussive issues?

28. Is this a new risk and, if so, what steps have been taken to review procedures?

29. Does the case identify any systematic failings on the part of:

    i. clinical or other "front-line" staff;
    ii. clinical procedures;
    iii. operational and risk management procedures;
    iv. administrative procedures or staff;
    v. claims handling staff;
    vi. claims handling procedures;
    vii. communication issues.

    If so what are they and what action is intended to remedy the identified deficiencies and timetable for implementation of changes or improvements?

30. Any lessons of potential application to other Bodies?

31. Are there any problems with equipment identified which could usefully be communicated to other HSS Bodies?