Department of Health, Social Services & Public Safety
An Roinn Sláinte, Seirbhísí Sóisialta agus Sábháilteacht Phoiblí

Subject:

Clinical Negligence – Prevention of Claims and Claims Handling

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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:

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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Superseded Documents: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

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Department of Health, Social Services & Public Safety
An Roinn Sláinte, Seirbhísí Sóisialta agus Sábháilteacht Phoiblí

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 ([redacted]1 or email Adrian.Murphy([redacted]

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 number [redacted]) or by e-mail to adrian.murphy([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.

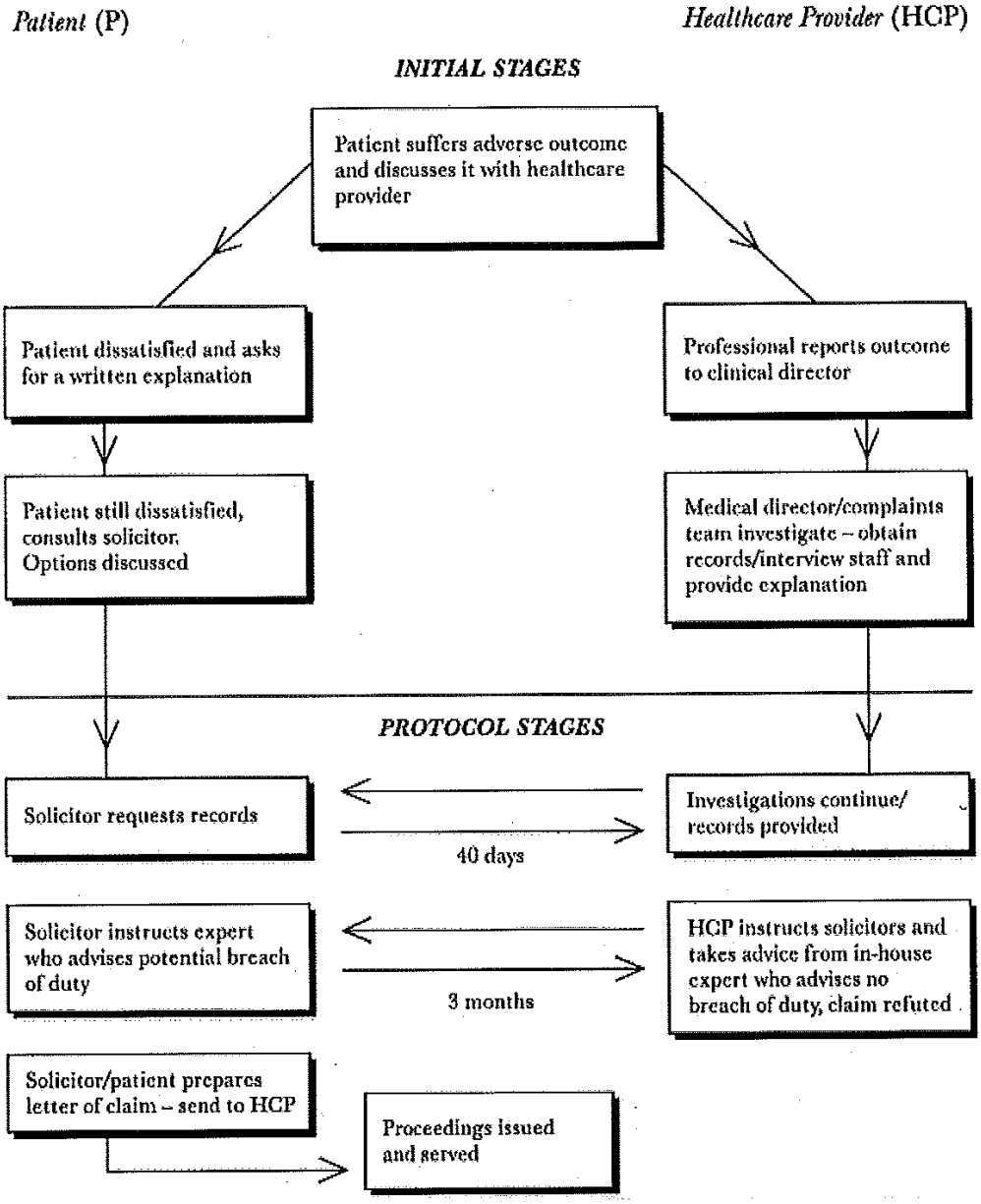
5.2 Most disputes are resolved by **discussion and negotiation.** Parties should bear in mind that carefully planned face-to-face meetings may be particularly helpful in exploring further treatment for the patient, in reaching understandings about what happened, and on both parties' positions, in narrowing 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 0171 320 5739, or to the NHS Management Executive, Quarry House, Quarry Hill, Leeds LS2 7UE.

The Law Society

May 1998

Appendix A

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

Appendix A

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	

Appendix A

SECOND RESPONSE ENCLOSING PATIENT'S HOSPITAL MEDICAL RECORDS

Address

Our Ref.
Your Ref.

1	NAME OF PATIENT: 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
[redacted]

Telephone [redacted]

Appendix B

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

Appendix C

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

Appendix C

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)

Appendix C

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

Appendix D

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

Annex E

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