Isle of Wight NHS Trust

CLAIMS HANDLING & MANAGEMENT POLICY

Including Clinical Negligence, Liabilities to Third Parties and Property Expenses Scheme Claims

During the COVID19 crisis, please read the policies in conjunction with any updates provided by National Guidance, which we are actively seeking to incorporate into policies through the Clinical Ethics Assurance Group.

Document Author	Authorised
Written By: Clinical Risk & Claims Manager **Date:** October 2014	**Authorised By:** Chief Executive **Date:** 18th November 2014
Lead Director: Programme Director and Company Secretary	
Effective Date: 18th November 2014	**Review Date:** 17th November 2017 **Extension date:** 17th December 2017 **Extension date:** 17th January 2018 **Extension date:** 28th February 2018 **Extension date:** 16th May 2018 **Extension date:** 29th June 2018 **Extension date:** 15th November 2018 **Extension date:** 30th November 2019 **Extension date:** 31st January 2020 **Extension date:** 30th June 2020
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DOCUMENT HISTORY

(Procedural document version numbering convention will follow the following format. Whole numbers for approved versions, e.g. 1.0, 2.0, 3.0 etc. With decimals being used to represent the current working draft version, e.g. 1.1, 1.2, 1.3, 1.4 etc. For example, when writing a procedural document for the first time – the initial draft will be version 0.1)

Date of Issue	Version No.	Date Approved	Director Responsible for Change	Nature of Change	Ratification / Approval
14 Nov 12	3.1		Executive Director of Finance and IM&T	Put into new template and few minor amendments for approval	
21 Nov 12	3.1		Executive Director of Finance and IM&T		Ratified by Risk Management Committee
28 Nov 12	3.1		Executive Director of Finance and IM&T		Ratified at Policy Management Group
3 Dec 12	4	3 Dec 12	Executive Director of Finance and IM&T		Approved at Executive Board
26 Aug 14	4.1		FT Programme Director and Company Secretary	Reviewed	Ratified by Risk Management Committee
17 Oct 14	5	17 Oct 14	FT Programme Director and Company Secretary		Approved at Policy Management Group
14 Nov 17	5		FT Programme Director and Company Secretary	Policy review date extended by one month	Corporate Governance & Risk Sub-Committee
12 Dec 17	5		FT Programme Director and Company Secretary	Policy review date extended by one month	Corporate Governance & Risk Sub-Committee
9 Jan 18	5		FT Programme Director and Company Secretary	Policy review date extended until the end of Feb 2018	Policy Management Group
13 Feb 18	5		FT Programme Director and Company Secretary	Policy review date extended until the 16th May 2018	Policy Management Sub-Committee
08 May 18	5		FT Programme Director and Company Secretary	Policy review date extended until the end of June 2018	Policy Management Sub-Committee
14 Aug 18	5		FT Programme Director and Company Secretary	Policy review date extended until the 15th Nov 2018	Policy Management Sub-Committee
24 June 19	5		FT Programme Director and Company Secretary	Policy review date extended until the 30th Nov 2018	Policy Management Sub-Committee
9 Dec 20	5		FT Programme Director and Company Secretary	Policy review date extended until the 31st Jan 2020	Policy Management Sub-Committee
26 Mar 20	5		FT Programme Director and Company Secretary	Policy review date extended until the 30th June 2020 via Chairs Action during COVID 19 period	Policy Management Sub-Committee

NB This policy relates to the Isle of Wight NHS Trust hereafter referred to as the Trust.

Contents **Page**

Appendices:

1. EXECUTIVE SUMMARY

1.1 This policy explains the current procedure and operating systems for the handling and management of all claims received by the Organisation. These include clinical negligence, employers and public liability, property expenses claims, employment tribunal and/or personal injury claims relating to employment tribunals and ex-gratia payments.

1.2 It sets out the duties of all staff members at the Organisation to ensure that all claims processes are undertaken effectively and efficiently (see Appendix A).

1.3 The Organisation is a member of the National Health Service Litigation Authorities (NHSLA) Risk Pooling Schemes, which provide indemnity to all member Trusts.

2. INTRODUCTION

2.1 The handling of claims is a fundamental principle of risk management – whereby the extent of the risk can be measured against the likelihood of its occurrence and lessons can be learned across the Organisation.

2.2 The Organisation is a member of the Clinical Negligence Scheme for Trust's (CNST), for clinical negligence claims; the Liabilities to Third Party Scheme (LTPS), for employers and public liability; and the Properties Expenses Scheme (PES) for damage to properties.

2.3 This policy sets out the procedures for the handling of clinical negligence claims, employers and public liability claims and others, along with the processes and contacts for managing claims made from employment tribunals and/or personal injury claims and ex-gratia payments.

2.4 Following the conclusion of the NHSLA risk management programme of inspection visits the Organisation is currently looking into how we can implement the newly introduced "Sign up to Safety" campaign

2.5 This policy also demonstrates how and who in the Organisation will liaise with third parties outside the Organisation where necessary. These include the claimant, the Coroner, the National Health Service Litigation Authority and Solicitors.

3. SCOPE

3.1 This Policy applies to all claims received by the Organisation.

3.2 This Policy applies to all staff and extends to cover all areas where the Organisation owes a statutory duty of care and responsibility to employees, patients and visitors and the public in general.

4. PURPOSE/PRINCIPLES OF HANDLING A CLAIM

4.1 The basic principle is that the Organisation should maintain an open and honest stance with all persons wishing to make a claim for compensation (claimants). This includes patients, relatives, carers, staff, visitors, litigation friends and personal representatives in the case of deceased patients.

4.2 A claim is defined as any request by a claimant for compensation for either an act or omission of a duty of care.

4.3 Apologies and explanations are to be encouraged and frequently may satisfy the claimant and thus prevent further action. The National Health Service Litigation Authority document Apologies and Explanations (updated 1 May 2009) gives further guidance on apologies and explanations (see Appendix B). It is recognised that it is both natural and desirable for those involved in any adverse incident to sympathise with the patient/claimant, or their relatives and to express regret at the outcome. Such apologies or expressions of regret would not normally constitute an admission of liability, either in part or in full.

4.4 Following the Francis Report the Organisation has implemented a process to implement the "Duty of Candour" and staff should also adhere to the "Being Open" policy to discuss potential claims with claimant, families and or carers.

4.5 Patients and/or their relatives increasingly ask for detailed explanations of what led to the accident or incident. It is a frequently expressed view that their desire for information will help them feel some consolation if lessons have been learned for the future. The Organisation is keen to discuss any issues regarding any accident or incident with patients and/or their families and encourages its staff to use appropriate channels of communication where applicable.

5. ROLES AND RESPONSIBILITIES

5.1 The majority of claims handled at the Organisation fall into one of six categories below. The Organisation's officers who are directly responsible for investigating each type of claim are as listed below and Appendix A.

- **Clinical Negligence**
  Clinical Risk & Claims Manager (ext 4099)

- **Employers Liability (E/L)**
- **Public Liability (P/L)**
- **Property Expenses**

  } Risk Administrator (ext 2137)

- **Employment Tribunal and/or Personal Injury Claims relating to Employment Tribunals**
  Deputy Director of Workforce (ext 3261)

- **Ex-gratia Payments**
  Risk Administrator (ext 2137)

Specific Roles and Responsibilities of Claims Handlers:

5.1.1 Clinical Risk & Claims Manager

- To place a copy of this policy onto the Trusts intranet site.
- To manage clinical negligence claims locally on behalf of the NHSLA.
- To manage clinical negligence claims and provide and collect information for the Claimant, the Organisation, Solicitors and Litigants in Person.
- To work in accordance to the timescales as set out in the Civil Procedure Rules 1998.
- To enter claims onto the risk management database.
- To provide claims reports to the Directorates, Risk Management Committee, Trust Executive Committee and Trust Board; on claim trends, claim categories and Consultant data.
- To attend various Committees to present claims reports where required.

5.1.2 Risk Administrator

- Local Management of all Public Liability claims (including collection and processing of all information relating to the claim)
- Local Management of all Employers Liability claims (including collection and processing of all information relating to the claim)
- Local Management of all Property claims
- To handle all ex-gratia claims and payments
- To enter claims onto the risk management database
- To provide EL, PL and Ex-Gratia claims reports to the Directorates, Risk Management Committee, Trust Executive Committee and the Trust Board

5.1.3 Deputy Director of Workforce

- To manage all claims relating to Employment Tribunals

5.2 Responsibilities of other individuals, departments, committees and staff at the organisation are shown separately below.

5.2.1 Chief Executive

The Chief Executive is ultimately responsible for ensuring that all claims made to the organisation are dealt with effectively and efficiently.

5.2.2 The Trust Board

The responsibility of the Trust Board is to endeavour to be informed and ultimately assured that the claims management system within the organisation is working effectively.

5.2.3. FT Programme Director/Company Secretary and the Executive Director of Nursing and Workforce

Both designated Board Members are responsible for compliance with the claims handling procedures within their own areas of responsibility.

They should both monitor the process and report directly to the Chief Executive and the organisation's Board on the effectiveness of the policy.

5.2.4 Policy Management Group

The Policy Management Group is a Sub-committee of the Organisation's Board.

This Sub-Committee has been delegated the authority to approve this policy on behalf of the Trust Executive Committee.

5.2.5 Trust Executive Committee

Trust Executive Committee links directly with the Risk Management Committee and the SEE Committee to share information and lessons learned**.**

The purpose of Trust Executive Committee is to maintain a constant review of all governance and assurance arrangements to ensure all the threads of quality, performance and governance are aligned and integrated.

The Trust Executive Committee will review and monitor all settled claims to ensure lessons are learned and future potential for similar claims is reduced.

5.2.6 Directorates

Both of the Directorates will review claims information on a quarterly basis, to ensure lessons are learned and future potential for similar claims is reduced.

5.2.7 Associate Directors/Managers/Consultants

All senior managers will ensure that their staff are aware of this policy and understand where to forward relevant communication/documentation.

5.2.8 Role of clinicians/specialist advisors at the Organisation

At the request of the investigating person a clinician/specialist advisor may be asked to give comments, and provide or clarify a witness statement; or advise regarding correspondence including Letters of Claim, Responses and Defences etc.

5.2.9 Executive Director of Nursing and Workforce, Executive Medical Director and Lead for SEE

Review on a weekly basis all new clinical negligence claims received by the Organisation.

5.2.10 Information Governance Team

Undertake all subject access requests for disclosure of medical records and other tests and investigations.

5.3.11All staff

All staff when requested or on receipt of a claim or request for ex-gratia payment must forward this to the correct department (see above) so that the claim is dealt with in a timely manner.

6. POLICY DETAIL/COURSE OF ACTION

In the event of a claim the following procedures should be commenced.

7. TRIGGERS FOR INVOKING A CLAIM

7.1 For patients, relatives and carers the initial contact with the Trust is usually via the Patient Experience Officers (PEOs**) or** the Complaints process, and many issues are resolved to the claimants' satisfaction at this stage.

7.2 However, If the concern/complaint cannot be resolved through either the PEOs or the Quality Department and the patient (claimant)/or staff member (employment related) is adamant that they wish to pursue an action for compensation then the appropriate Trust lead officer should be immediately informed and the claims process invoked.

8. CLINICAL NEGLIGENCE SCHEMES FOR TRUSTS (CNST)

8.1 Clinical negligence claims are claims for compensation in respect of adverse clinical incidents which lead to a personal injury.

8.2 All Clinical Negligence Claims are managed centrally on behalf of the NHS through the Clinical Negligence Schemes for Trust's (CNST) through the office of the Trust's Clinical Risk & Claims Manager.

8.3 All Clinical Negligence cases are managed in accordance with the CNST Clinical Reporting Guidelines with the Clinical Risk & Claims Manager remaining involved in the management of the claim. The Clinical Risk & Claims Manager is responsible for providing and gathering information for both the Claimants and the Trust's Solicitors, for example organising the copying of medical records, (via the Information Governance Team) preparing evidence and witness statements, and investigating claims made by Litigants in Person. This work is undertaken in accordance with the timescales as laid out in the Civil Procedure Rules 1998

and the Clinical Negligence Pre-action Protocol. Where the claim has not reached the protocol stage the Clinical Risk & Claims Manager will deal with the claim in a timely manner and provide all Litigants in Person with deadlines in which they can expect a reply to their claim.

8.4 A summary of these reporting requirements is detailed below.

- Acknowledge a potential claim and forward request for disclosure of medical records to Information Governance
- Register the claim on the Claims part of the Datix Risk Management System
- Have system in place for identifying adverse incidents, significant litigation risks etc; and complete a Claims Notification Form to notify Directorates of claims
- Report actual cases to the NHSLA (using the Claims wizard on the NHSLA intranet site) and completed Clinical Claims Report Form
- All Letters of Claim and Part 36 offers to be notified to the NHSLA as soon as possible within 14 days;
- Acknowledge Letters of Claim within 14 days;
- Detailed response due within 3 months;
- All legal proceedings to be notified immediately.

9. LIABILITIES TO THIRD PARTIES SCHEME (LTPS)

9.1 Liabilities to Third Parties includes compensation for injuries to staff following an accident at work and public liability claims relating to compensation for injuries to patients/visitors following an accident on the Trust's premises.

9.2 All LTPS Claims are managed centrally on behalf of the NHS by the NHSLA and locally via the Corporate Governance & Risk Management Department. As with Clinical Negligence Claims the Trust's officers remain involved in the management of the claim and have a particular role in gathering information, evidence and witness statements etc. The management of Employers and Public Liability claims is the responsibility of the Head of Governance and Assurance and the Risk Administrator.

With effect from 1 August 2006 all new claims reported to the NHSLA must include the following documentation:

- NHSLA LTPS Report Form
- Letter of Claim
- All documents relating to the type of claim being reported. Sample lists taken from the *Pre-Action Protocol for Personal Injury Claims* are enclosed in the form of a new 'NHSLA Disclosure List'. A completed 'NHSLA Disclosure List' must accompany all reported claims, indicating which documents are enclosed by means of a tick in the appropriate box.

10. PROPERTY EXPENSES SCHEME (PES)

10.1 Property Expenses claims are in respect of damage to the Trust's property, for example accidental loss or damage to the Trust's property from fire, flood or subsidence, etc.

10.2 Investigations are carried out by the Corporate Governance & Risk Management Department and all claims for Property Expenses are submitted to the NHS Litigation Authority as part of the Trust's Scheme Membership arrangements.

11. EMPLOYMENT TRIBUNAL AND/OR PERSONAL INJURY CLAIMS

11.1 This category of claim covers employment tribunals and/or personal injuries relating to Employment Tribunal Claims – e.g. Unfair Dismissal, claims under the Sex Discrimination Act, Race Relations Act or the Disability Discrimination Act. All claims within this category are the responsibility of the Trust's Human Resources Department.

12. EX-GRATIA PAYMENTS

12.1 Ex-gratia payments are 'goodwill' payments, made without the acceptance of liability, and tend to be for either very minor injuries or in most cases for loss of or damage to property, patients belongings, etc.

12.2 All Ex-gratia payments are handled by the Trust's Corporate Governance & Risk Management Department.

12.3 If any member of staff receives either verbal or written requests for ex-gratia payments they should relay the request with as much background detail as possible, to the Corporate Governance & Risk Management Department without delay. The relative merits of any claim will then be assessed as quickly as possible and the claimant advised of the outcome. In all cases the final decision on whether any claim should be paid is the responsibility of the Risk Administrator. At no time should a member of staff agree an ex gratia payment without referring to the Corporate Governance & Risk Management Department for advice and guidance.

13. INVESTIGATION AND ROOT CAUSE ANALYSIS

13.1 As with serious untoward incidents, now known as Serious Incidents Requiring Investigation (SIRI's), it is important that all claims against the Trust are fully investigated so that changes/improvements can be made and the risk of similar, future claims reduced. Where appropriate, detailed Root Cause Analysis investigation, including the conducting of interviews, along with the involvement of any external agencies, will be undertaken in accordance with the Trust Incident Reporting and Management Policy, SIRI Procedure and the Being Open Policy

13.2 It is the responsibility of the claims handler as detailed in 5.1 to decide on the nature of the investigation of any particular incident/claim in accordance with the Trust Incident Reporting and Management Policy, SIRI Procedure and the Being Open policy.

13.3 Where deemed appropriate and after a discussion with the NHSLA, and/or the Executive Medical Director, the Clinical Risk & Claims Manager may appoint a third party to investigate a clinical claim. This would normally only apply either when there is insufficient expertise within the Trust or a totally independent view is required.

13.4 At the conclusion of each clinical negligence claim, where possible and applicable the root cause and any lessons to be learnt are identified. Lessons learnt are also shared in the quarterly learning lessons bulletin, which is distributed Trustwide and in the Community.

14. TIMESCALES AND PROCEDURES FOR THE EXCHANGE OF INFORMATION WITH OTHER PARTIES

14.1 In accordance with the Civil Procedure Rules (CPR) 1996 the timescales for the disclosure and exchange of information should be met in a timely and just manner.

14.2 This should reflect the requirement of the CPR in the following ways and ensure that claims are settled as soon as possible:

- Encourage more pre-action contact with claimants;
- Better and earlier exchange of information;
- Improve investigation;
- Earlier settlement without the need for expensive litigation; and
- Court proceedings to run smoothly where there is a need for litigation.

15. SUPPORT MECHANISM FOR PATIENTS/RELATIVES/CARERS AND STAFF

15.1 It is imperative that all patient/relatives/carers who bring a claim feel supported throughout the claims process. The Trust supports an open and honest approach to any claim investigation and a commitment to sharing the lessons learned with patients, relatives, carers and staff.

15.2 It is especially important when the claimant wishes to act as a Litigant in Person that the Trust treats them fairly and provides guidance to them regarding the processes and procedures and gives them clear timescales as to when they can expect a response to their correspondence.

15.3 It is equally important that staff who are involved in any claim feel supported and aware of where to seek help and advice both within and outside the Trust. The Trust's managers have a responsibility to ensure that their staff are appropriately supported. The principles for supporting staff are contained in the Being Open Policy.

15.4 In the case of clinical negligence claims the Clinical Risk & Claims Manager will discuss individual cases with the staff involved and they will also be asked to approve all documents, for example responses, draft defences and all settlements prior to a case settling.

15.5 If a case is to go to trial, staff giving evidence will receive support from the Clinical Risk & Claims Manager, or an appropriate manager and their line manager both in pre trial meetings and at the trial itself. Additionally staff may wish to be accompanied by their union representative.

16. CLAIMS DATA COLLECTION AND ANALYSIS

16.1 On receipt of a claim, information including the details of the claimant, the incident date and allegation will be entered onto the Claims module of the Datix Risk Management system.

16.2 This system will be updated as the case proceeds through the relevant stages and will in turn be used to provide data for reports.

16.3 An analysis of claims to incident ratio is undertaken every quarter to identify whether or not an incident form has been completed prior to the incident becoming a claim, (where applicable). Trends and themes of claims are also assessed along with an analysis of Consultants in settled claims where damages paid.

17. REPORTS TO RELEVANT COMMITTEES

17.1 Claims data will be provided to Directorate Board meetings on a monthly basis by the Corporate Governance & Risk Management Department.

17.2 The Patient Safety, Experience and Clinical Effectiveness Committee, and the Risk Management Committee will also receive information on all claims received and closed within the quarter, as part of the Governance & Assurance quarterly report.

17.3 Regular claims reports will be produced for review at the Trust's Board as instructed by Executor Director of Finance.

17.4 Ad hoc reports can be requested from the Corporate Governance & Risk Management Department by any Manager if there is a concern regarding trends of claims etc.

18. LINKS WITH INCIDENT MANAGEMENT AND COMPLAINTS MANAGEMENT

18.1 There is a close working relationship between the Quality Department and the Corporate Governance & Risk Management Department to ensure that information regarding claims, complaints and incidents is effectively managed and regularly reviewed to identify trends and risks.

18.2 It is recognised that most claims will come from incidents and complaints and for this reason both incidents and complaints are linked to claims via the Datix system and shared with the Quality Team for their weekly meeting.

19. LIAISING WITH THIRD PARTIES

19.1 National Health Service Litigation Authority

The relevant claims handler will refer the claim in accordance with the NHSLA reporting guidance.

19.2 Claimants

19.2.1 Where claimants choose to act as 'litigants in person' the Trust will correspond with them personally at their chosen address.

19.2.2 In the case of claimants who are represented by Solicitors the Trust will deal directly with the firm of Solicitors and will not write directly to the claimant.

19.3 Solicitors

On the appointment of a panel firm by the NHSLA the claims handler at the Trust will deal directly with the named Solicitors to manage the claim.

19.4 Coroner

The Clinical Risk & Claims Manager will be the first point of contact for the Coroner. In their absence the Head of Corporate Governance & Risk Management will either contact the Coroner directly or nominate a deputy to liaise with the Coroner.

19.5 National Counter Fraud Service

The Trust is totally committed to maintaining an honest, open and well-intentioned culture and is therefore dedicated to the elimination of any fraud within the Trust.

If Fraud or Corruption is suspected please report to the Local Counter Fraud Specialist or Director of Finance or ring the National Fraud and Corruption reporting line on 0800 028 40 60

Please refer to the Trust's Fraud and Corruption Policy and Reporting Procedure for details, the policy is available on the Countering Fraud Intranet Page.

20. LESSONS LEARNED

20.1 Lessons learned from incidents and any subsequent investigation/enquiry will be shared across the Trust through the quarterly Learning Lessons bulletin (produced via the Clinical Risk and Claims Manager)

20.2 Individual lessons for groups of staff/specialities/directorates for example will be discussed at relevant review meetings where applicable.

21. CONFIDENTIALITY

All claims documents and correspondence should be treated in a confidential manner in accordance with the Trust's Confidentiality Policy.

Claims documents should be retained in accordance with the NHS Retention and Storage Policy.

22. CONSULTATION

This document will be reviewed at Risk Management Committee prior to it being sent to Policy Management Group for approval and ratification, in accordance with the Trust's Policy Management Document.

23. TRAINING

This Claims Handling policy has a mandatory training requirement as part of Investigation of Incidents and Complaints and Claims training which is detailed in the Trusts mandatory training matrix and is reviewed on a yearly basis.

24. DISSEMINATION PROCESS

24.1 When approved this document will be available on the Intranet and will be subject to document control procedures. Approved documents will be placed on the Intranet within 5 working days of date of approval once received by the Risk Management Team.

24.2 When submitted to the Risk Management Team for inclusion on the Intranet this document will have fully completed document details including version control with the actual hard copy signed by the relevant Lead Director. Keywords and description for the Intranet search engine will be supplied by the author at the time of submission.

24.3 Notification of new and revised documentation will be issued on the Front page of the Intranet, through e-bulletin, and on staff notice boards where appropriate. Any controlled documents noted at the Trust Executive Committee will be notified through the e-bulletin.

24.4 Staff using the Trust's intranet can access all procedural documents. It is the responsibility of managers to ensure that all staff are aware of where, and how, documents can be accessed within their areas of work.

24.5 It is the responsibility of each individual who prints a hard copy of any document to ensure that the printed hardcopy is the current version. Current versions are maintained on the Intranet.

25. EQUALITY ANALYSIS

25.1 This procedure has undergone an equality analysis please refer to Appendix F.

26. REVIEW AND REVISION ARRANGEMENTS

26.1 This policy will be ratified in accordance with the Trust's Policy Management Document.

26.2 The Clinical Risk & Claims Manager will be responsible for reviewing the policy within 3 years from the updated policy.

26.3 Superseded documents will be retained by the Clinical Risk & Claims Manager and can be retrieved by contacting the Corporate Governance & Risk Management Department.

27. MONITORING COMPLIANCE AND EFFECTIVENESS

27.1 Quarterly reports are now available via the NHSLA intranet site. The relevant claims handlers will check and agree these quarterly reports with the NHS Litigation Authority.

27.2 Any Claim made to the Employment Tribunal is responded to in conjunction with advice from the Trust's appointed legal representatives. Each claim has its own unique detail which means that there is no one prescribed route that it will follow. As appropriate it will be necessary to approach either the Audit and Corporate Risk Committee or the Remuneration and Nomination Committee. Progression of Tribunal cases needs to be made in a timely manner, and it is not possible to predict when approvals might be required. To that end extraordinary meetings will be called as necessary.

28. LINKS TO OTHER TRUST POLICIES/DOCUMENTS

- Being Open Policy
- Civil Procedure Rules 1998
- Incident Reporting and Management Policy
- Serious Incidents Requiring Investigation (SIRI) Procedure
- Standing Orders and Standing Financial Instructions
- Mandatory Training Policy
- Disciplinary and Dismissal Policy and Procedure
- Equality and Diversity Policy

29. REFERENCES

- Department for Constitutional Affairs, 1998. Pre-action Protocols for the Resolution of Clinical Disputes 1998/183 [online]. London: The Stationary Office. Available from: www.dca.gov.uk
- Department for Constitutional Affairs, 1998. Pre-Action Protocol for Personal Injury Claims [online]. London: The Stationary Office. Available from www.dca.gov.uk
- Department for Constitutional Affairs, 1998 Pre-Action Protocol for Personal Injury

Claims [online]. London: The Stationary Office. Available from www.dca.gov.uk

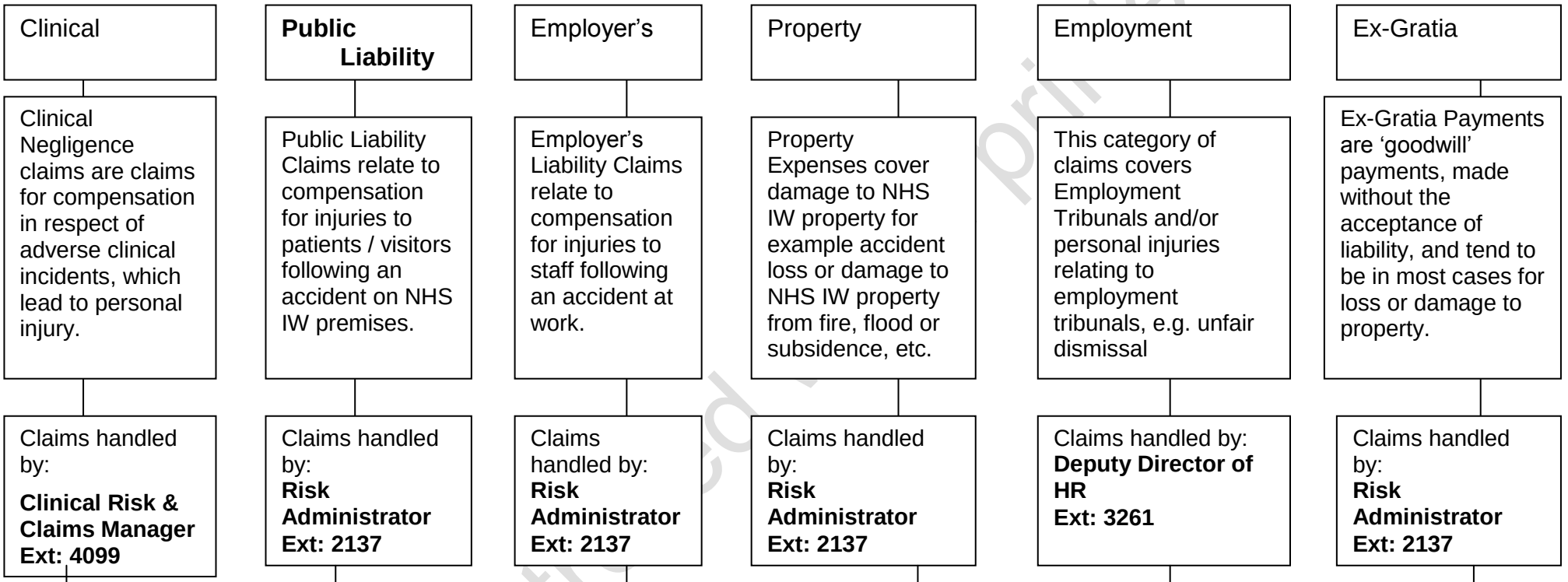
- The National Health Service Litigation Authority Framework Document. Available from www.nhsla.com (Publications - Claims publications)
- Clinical negligence reporting guidelines fourth edition – January 2007. Available from www.nhsla.com (Publications - Claims publications)
- Non-clinical claims reporting guidelines Available from www.nhsla.com (Publications - Claims publications)
- NHSLA Disclosure List. Available from www.nhsla.com (Publications - Claims publications)

30. DISCLAIMER

It is the responsibility of all staff to check the Trust intranet to ensure that the most recent version/issue of this document is being referenced.

Appendix A

KEY DEFINITIONS FOR DOCUMENTATION
Claims Handling Overview



If any staff member receives any correspondence (letters of claims, solicitors letters, ET1 (Employment Tribunal) claim forms, requests for ex-gratia payments, etc) these must be passed on immediately to the appropriate person above

Any staff member discovering or suspecting any loss or incident, which could lead a claim, should immediately report this to their Head of Department and complete an incident report form. (See standing orders/standing financial instructions for further details).

Throughout the claims processes the claims handler will need to communicate with all those involved in the incident / claim e.g. the Organisation's Managers and staff, claims handlers at the NHSLA, Solicitors or legal representatives, prison staff, General Practitioners, Claimants, staff from other Hospitals.

May 1st 2009

To: Chief Executives and Finance Directors
All NHS Bodies

NHS
Litigation Authority

Napier House
24 High Holborn
London
WC1V 6AZ

Tel: 020 7430 6700

Dear Colleagues

Apologies and Explanations

I am pleased to report that the Authority's letter of 15 August 2007, on providing apologies and explanations to patients or their relatives, has been updated and endorsed widely by other organisations, so it seemed appropriate to reissue it with those endorsements included. To ensure the widest possible distribution to staff in the NHS and beyond, the co-signatories have all incorporated links to this letter on their own websites. To reduce the possibility of misunderstandings by front-line staff, the original letter has been reworded slightly in places.

Apologies

It is both natural and desirable for clinicians who have provided treatment which produces an adverse result, for whatever reason, to sympathise with the patient or the patient's relatives; to express sorrow or regret at the outcome; and to apologise for shortcomings in treatment. It is most important to patients that they or their relatives receive a meaningful apology. We encourage this, and stress that apologies do not constitute an admission of liability. In addition, it is not our policy to dispute any payment, under any scheme, solely on the grounds of such an apology.

Explanations

Patients and their relatives increasingly ask for detailed explanations of what led to adverse outcomes. Moreover, they frequently say that they derive some consolation from knowing that lessons have been learned for the future.

In this area, too, the NHSLA is keen to encourage both clinicians and NHS bodies to supply appropriate information whether informally, formally or through mediation.

Explanations should not contain admissions of liability. For the avoidance of doubt, the NHSLA will not take a point against any NHS body or any clinician seeking NHS indemnity, on the basis of a factual explanation offered in good faith before litigation is in train. We consider that the provision of such information constitutes good clinical and managerial practice.

To assist in the provision of apologies and explanations, clinicians and NHS bodies should familiarise themselves with the guidance on Being Open, produced by the National Patient Safety Agency and available at www.npsa.nhs.uk/nrls/alerts-and-directives/notices/disclosure/

Formal Admissions

In keeping with our financial and case management responsibilities, the NHSLA will make or agree the terms of formal admissions within or before litigation. This circular is intended to encourage scheme members and their employees to offer the earlier, more informal, apologies and explanations so desired by patients and their families.

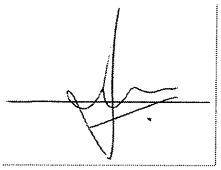
Medical Defence Organisations

It is critically important to note that all of the above applies to the provision of NHS indemnity to NHS bodies and employees. Should any individual clinicians wish to adopt a particular policy vis a vis apologies and explanations, in a matter which might expose them to an action brought against them as an individual, they should seek the advice of their medical defence organisation and/or professional body.

Staff Support

We should not lose sight of the traumatic effect that adverse outcomes, and their aftermath, might have on NHS staff as well as on patients and their relatives. Some may find compliance with these recommendations cathartic or therapeutic; others will not. None will find compliance easy. Recognising this, employers should do whatever is necessary by way of offering training, support, counselling or formal debriefing.

Yours sincerely

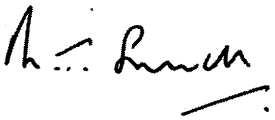


Stephen Walker CBE
Chief Executive

We endorse the NHSLA guidance on apologies and explanations.

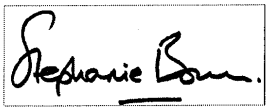
For many years we have advised our members that, if something goes wrong, patients should receive a prompt, open, sympathetic and above all truthful account of what has happened. Any patient who has had the misfortune to suffer through an error of whatever nature should receive a full explanation and a genuine apology. We encourage members to adopt this approach. There are no legal concerns about taking this course of action: it is quite different from admitting liability.

Dr Michael Saunders
Chief Executive
Medical Defence Union



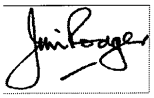
THE
MDU

Dr Stephanie Bown
Director of Policy and Communications
Medical Protection Society



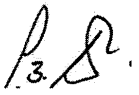
MPS

Dr Jim Rodger
Head of Professional Services
Medical and Dental Defence Union of Scotland



MDDUS

Dr Peter Carter
Chief Executive and General Secretary
Royal College of Nursing

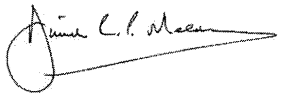


Royal College of Nursing

Martin Fletcher
Chief Executive
National Patient Safety Agency

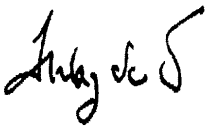
NHS
National Patient Safety Agency

Dr Hamish Meldrum
Chairman of Council
British Medical Association



The GMC fully supports this advice from the NHSLA. If something goes wrong, patients deserve an apology and a full explanation. In *Good Medical Practice* we say 'if a patient under your care has suffered harm or distress, you must act immediately to put matters right, if that is possible. You should offer an apology and explain fully and promptly to the patient what has happened and the likely short-term and long-term effects.'

Finlay Scott
Chief Executive
General Medical Council



Appendix C

CHECKLIST FOR THE DEVELOPMENT AND APPROVAL OF CONTROLLED DOCUMENTATION

To be completed and attached to any document when submitted to the appropriate committee for consideration and approval.

Title of document being reviewed:		Y/N/ Unsure	Comments
1.	**Title/Cover**		
	Is the title clear and unambiguous?	Y	
	Does the title make it clear whether the controlled document is a guideline, policy, protocol or standard?	Y	
2.	**Document Details and History**		
	Have all sections of the document detail/history been completed?	Y	
3.	**Development Process**		
	Is the development method described in brief?	Y	
	Are people involved in the development identified?	Y	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Y	
4.	**Review and Revision Arrangements Including Version Control**		
	Is the review date identified?	Y	
	Is the frequency of review identified? If so, is it acceptable?	Y	
	Are details of how the review will take place identified?	Y	
	Does the document identify where it will be held and how version control will be addressed?	Y	
5.	**Approval**		
	Does the document identify which committee/group will approve it?	Y	
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	N/A	
6.	**Consultation**		
	Do you have evidence of who has been consulted?	Y	
7.	**Table of Contents**		
	Has the table of contents been completed and checked?	Y	
8.	**Summary Points**		
	Have the summary points of the document been included?	Y	
9.	**Definition**		
	Is it clear whether the controlled document is a guideline, policy, protocol or standard?	Y	
10.	**Relevance**		
	Has the audience been identified and clearly stated?	Y	
11.	**Purpose**		
	Are the reasons for the development of the document stated?	Y	
12.	**Roles and Responsibilities**		
	Are the roles and responsibilities clearly identified?	Y	
13.	**Content**		
	Is the objective of the document clear?	Y	
	Is the target population clear and unambiguous?	Y	

Title of document being reviewed:		Y/N/ Unsure	Comments
	Are the intended outcomes described?	Y	
	Are the statements clear and unambiguous?	Y	
14.	**Training**		
	Have training needs been identified and documented?	Y	
15.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	Y	
	Does the plan include the necessary training/support to ensure compliance?	Y	
16.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or Key Performance Indicators (KPIs) to support the monitoring of compliance with and effectiveness of the document?	Y	
	Is there a plan to review or audit compliance within the document?	Y	
	Is it clear who will see the results of the audit and where the action plan will be monitored?	Y	
17.	**Associated Documents**		
	Have all associated documents to the document been listed?	Y	
18.	**References**		
	Have all references that support the document been listed in full?	Y	
19.	**Glossary**		
	Has the need for a glossary been identified and included within the document?	N	
20.	**Equality Analysis**		
	Has an Equality Analysis been completed and included with the document?	Y	
21.	**Archiving**		
	Have archiving arrangements for superseded documents been addressed?	Y	
	Has the process for retrieving archived versions of the document been identified and included within?	Y	
22.	**Format and Style**		
	Does the document follow the correct style and format of the Document Control Procedure?	Y	
23.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the documentation?	Y	

Committee Approval			
If the committee is happy to approve this document, please sign and date it and forward copies for inclusion on the Intranet.			
Name of Committee	Policy Management Group	Date	
Print Name	CLAIRE WILLIS	Signature of Chair	

Appendix D

IMPACT ASSESSMENT ON DOCUMENT IMPLEMENTATION

Summary of Impact Assessment (see next page for details)

Document title	**Claims Handling and Management Policy**

Totals	**WTE**	**Recurring £**	**Non Recurring £**
Manpower Costs	**NIL**	**NIL**	**NIL**
Training Staff	**NIL**	**NIL**	**NIL**
Equipment & Provision of resources	**NIL**	**NIL**	**NIL**

Summary of Impact:

This policy sets out the process for Claims Management within the Trust

Risk Management Issues:

There are no risk management issues associated with this policy

Benefits / Savings to the organisation:

The main benefits to the Trust will be to inform all staff about the process for receiving and investigating a claim. It will ensure the well established processes detailed in the policy can continue to be used across the Trust.

Equality Impact Assessment

- Has this been appropriately carried out? YES
- Are there any reported equality issues? NO

If "YES" please specify:

Use additional sheets if necessary.

IMPACT ASSESSMENT ON POLICY IMPLEMENTATION

Please include all associated costs where an impact on implementing this policy has been considered. A checklist is included for guidance but is not comprehensive so please ensure you have thought through the impact on staffing, training and equipment carefully and that ALL aspects are covered.

Manpower	**WTE**	**Recurring £**	**Non-Recurring £**
Operational running costs	NIL	NIL	NIL
Additional staffing required - by affected areas / departments:	NONE	NONE	NONE
Totals:	NIL	NIL	NIL

Staff Training Impact	**Recurring £**	**Non-Recurring £**
Affected areas / departments	NONE	NONE
e.g. 10 staff for 2 days		
Totals:	NIL	NIL

Equipment and Provision of Resources	**Recurring £ ***	**Non-Recurring £ ***
Accommodation / facilities needed		
Building alterations (extensions/new)	NONE	NONE
IT Hardware / software / licences	NONE	NONE
Medical equipment	NONE	NONE
Stationery / publicity	NONE	NONE
Travel costs	NONE	NONE
Utilities e.g. telephones	NONE	NONE
Process change	NONE	NONE
Rolling replacement of equipment	NONE	NONE
Equipment maintenance	NONE	NONE
Marketing – booklets/posters/handouts, etc	NONE	NONE
Totals:	NONE	NONE

- Capital implications £5,000 with life expectancy of more than one year.

Funding /costs checked & agreed by finance:	NONE
Signature & date of financial accountant:	NONE
Funding / costs have been agreed and are in place:	NONE
Signature of appropriate Executive or Associate Director:	NONE

IMPACT ASSESSMENT ON DOCUMENT IMPLEMENTATION - CHECKLIST

Points to consider

Have you considered the following areas / departments?

- Have you spoken to finance / accountant for costing?
- Where will the funding come from to implement the policy?
- Are all service areas included?
  - Ambulance
  - Acute
  - Mental Health
  - Community Services, e.g. allied health professionals
  - Public Health, Commissioning, Primary Care (general practice, dentistry, optometry), other partner services, e.g. Council, PBC Forum, etc.

Departments / Facilities / Staffing

- Transport
- Estates
  - Building costs, Water, Telephones, Gas, Electricity, Lighting, Heating, Drainage, Building alterations e.g. disabled access, toilets etc
- Portering
- Health Records (clinical records)
- Caretakers
- Ward areas
- Pathology
- Pharmacy
- Infection Control
- Domestic Services
- Radiology
- A&E
- Risk Management Team / Information Officer – responsible to ensure the policy meets the organisation approved format
- Human Resources
- IT Support
- Finance
- Rolling programme of equipment
- Health & safety/fire
- Training materials costs
- Impact upon capacity/activity/performance

Appendix E

Equality Analysis and Action Plan

(This template should be used when assessing services, functions, policies, procedures, practices, projects and strategic documents)

Step 1. Identify who is responsible for the equality analysis.

Name: CLAIRE WILLIS
Role: CLINICAL RISK 8 CLAIMS MANAGER
Other people or agencies who will be involved in undertaking the equality analysis:

Step 2. Establishing relevance to equality

Show how this document or service change meets the aims of the Equality Act 2010?

Equality Act – General Duty	Relevance to Equality Act General Duties

	Relevance		
Protected Groups	**Staff**	**Service Users**	**Wider Community**
Age	√	√	√
Gender Reassignment	√	√	√
Race	√	√	√
Sex and Sexual Orientation	√	√	√
Religion or belief	√	√	√
Disability	√	√	√
Marriage and Civil Partnerships	√	√	√
Human Rights	√	√	√
Pregnancy and Maternity	√	√	√

Eliminates unlawful discrimination, harassment, victimization and any other conduct prohibited by the Act.	Everyone will be treated the same
Advance equality of opportunity between people who share a protected characteristic and people who do not share it	Everyone is aware of the procedures in the policy
Foster good relations between people who share a protected characteristic and people who do not share it.	Everyone is aware of the procedures in the policy

Step 3. Scope your equality analysis

	Scope
What is the purpose of this document or service change?	To set out the policy for claims management within the Trust
Who will benefits?	There will be benefits for patient, carers, relatives, staff and anybody else making a claim
What are the expected outcomes?	To demonstrate the established process for claims handling within the Trust
Why do we need this document or do we need to change the service?	This document sets out the process for claims management

It is important that appropriate and relevant information is used about the different protected groups that will be affected by this document or service change. Information from your service users is in the majority of cases, the most valuable.

Information sources are likely to vary depending on the nature of the document or service change.

Listed below are some suggested sources of information that could be helpful:

- Results from the most recent service user or staff surveys.
- Regional or national surveys
- Analysis of complaints or enquiries
- Recommendations from an audit or inspection
- Local census data
- Information from protected groups or agencies.
- Information from engagement events.

Step 4. Analyse your information.
As yourself two simple questions:

- What will happen, or not happen, if we do things this way?
- What would happen in relation to equality and good relations?

In identifying whether a proposed document or service changes discriminates unlawfully, consider the scope of discrimination set out in the Equality Act 2010, as well as direct and indirect discrimination, harassment, victimization and failure to make a reasonable adjustment.

Findings of your analysis

	Description	Justification of your analysis
No major change	Your analysis demonstrates that the proposal is robust and the evidence shows no potential for discrimination.	This document ensuires that there will be no discrimination within the Claims Policy
Adjust your document or service change proposals	This involves taking steps to remove barriers or to better advance equality outcomes. This might include introducing measures to mitigate the potential effect.	
Continue to implement the document or service change	Despite any adverse effect or missed opportunity to advance equality, provided you can satisfy yourself it does not unlawfully discriminate.	
Stop and review	Adverse effects that cannot be justified or mitigated against, you should consider stopping the proposal. You must stop and review if unlawful discrimination is identified	

5. Next steps.

5.1 Monitoring and Review.

Equality analysis is an ongoing process that does not end once the document has been published or the service change has been implemented.

This does not mean repeating the equality analysis, but using the experience gained through implementation to check the findings and to make any necessary adjustments.

Consider:

How will you measure the effectiveness of this	By reviewing the Equality Act 2010

change	
When will the document or service change be reviewed?	Every 3 years
Who will be responsible for monitoring and review?	Claire Willis
What information will you need for monitoring?	A review of the Equality Act 2010
How will you engage with stakeholders, staff and service users	By the ratification process

5.2 Approval and publication

The Trust Executive Committee / Policy Management Group will be responsible for ensuring that all documents submitted for approval will have completed an equality analysis.

Under the specific duties of the Act, equality information published by the organisation should include evidence that equality analyses are being undertaken. These will be published on the organisations "Equality, Diversity and Inclusion" website.

Useful links:

Equality and Human Rights Commission
http://www.equalityhumanrights.com/advice-and-guidance/new-equality-act-guidance/equality-act-guidance-downloads/