

Reference Number: UHB 332 Version Number: 1	Date of Next Review: 13 Sep 2019 Previous Trust/LHB Reference Number: T/3
--	--

Claims (Clinical Negligence, Personal Injury and redress) Management Policy

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will manage all claims in accordance with the policy.

Policy Commitment

To provide a transparent, equitable and proactive approach to the management of claims. To ensure that learning is identified and actioned at the earliest opportunity.

Supporting Procedures and Written Control Documents

Other supporting documents are:

Responsibilities & Accountability Framework

Scheme of Delegation

Claims Handling Escalation Procedure

Standing Orders and Standing Financial Instructions

WHC (97) 17 - CN & PI : Claims Handling

WHC (97) 7 - CN & PI: Structured Settlements

WHC (98) 8 – NHS Indemnity – Arrangements for Handling CN Claims against NHS Staff

WHC (99) 128 – Handling CN Claims: Pre-Action Protocol

WRP Claims Management Standards (April 2007)

WRP Reimbursement Procedure & other Procedures

Civil Procedure Rules 1998

Putting Things right Regulation 2011 (Guidance amended November 2013)

With thanks to Betsi Cadwalder Health Board who shared their revised Claims policy to inform this policy

Scope

This policy applies to all of our staff in all locations including those with honorary contracts

Equality Assessment

Impact

An Equality Impact Assessment (EqIA) has / has been completed and this found there to be a positive. No key actions have been identified

Health Assessment	Impact	An Equality Health Impact Assessment (EQIA) has been completed and this found there to be a potential positive impact on equality as the policy as it provides a transparent and equitable process.
Policy Approved by	Quality and Safety Committee September 2016	
Group with authority to approve procedures written to explain how this policy will be implemented	To be ratified at the Quality and safety Executive Meeting	
Accountable Executive	Executive Nurse Director	

[Type text]

Document Title: Claims (Negligence , Personal Injury and Redress) Management Policy	2 of 38	Approval Date: 13 Sep 2016
Reference Number: UHB 332		Next Review Date: 13 Sep 2019
Version Number: 1		Date of Publication: 11 Oct 2016
Approved By: Quality, Safety and Experience Committee		

or Clinical Board Director	
<u>Disclaimer</u> If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Concerns Department	

Summary of reviews/amendments				
Version Number	Date Approved	Review	Date Published	Summary of Amendments
1	13/09/2016		11/10/2016	New Policy superseding UHB 107,108,109

Document Title: Claims (Negligence , Personal Injury and Redress) Management Policy	3 of 38	Approval Date: 13 Sep 2016
Reference Number: UHB 332		Next Review Date: 13 Sep 2019
Version Number: 1		Date of Publication: 11 Oct 2016
Approved By: Quality, Safety and Experience Committee		

1. POLICY STATEMENT

1.1 This document describes the Policy of the Cardiff and Vale University Health Board for the management of clinical negligence and personal injury claims made against the Health Board.

1.2 Both the human costs of things going wrong and the financial costs of providing redress are powerful incentives for effective risk management. It is acknowledged that funds that are spent on addressing and compensating could otherwise contribute to the continuous improvements of healthcare services and working environments. Therefore, this Policy forms an integral part of the Health Board's Risk Management Strategy and is intrinsically linked into the Health Board's systems for managing and learning from adverse incidents and complaints.

1.3 The Health Board aims to deal with all claims made against it proactively, in an equitable, efficient and timely manner.

1.4 The Health Board will adopt a common and standardised approach in dealing with litigation claims for both clinical negligence and personal injury. The Health Board aims to gather all evidence as quickly as possible and, where liability is admitted, will seek to negotiate settlement in the shortest possible time therefore minimising unnecessary legal costs.

1.5 The Health Board will defend claims where appropriate. We will make every effort to resolve a claim before the issue of court proceedings and will explore the option of alternative dispute resolution methods when appropriate. However, where formal legal action or Court proceedings is required the Health Board will ensure that it conducts its defence of the Claim in a fair and timely manner, ensuring that legal costs are incurred appropriately and proportionately.

1.6 The Health Board acknowledges the importance of the claims management process within its organisation and will ensure that the process is supported by a robust escalation policy. The weekly executive meetings enable the timely consideration of identified legal cases.

1.7 The Health Board will comply with the Pre-Action Protocols laid down by the Civil Procedure Rules in dealing with all legal claims ensuring a constructive and open approach to claims that reduces delays and costs and the need for formal legal proceedings.

1.8 The Health Board is committed to learning lessons from claims to ensure the continued improvement in standards of patient and staff safety and services.

2. INTRODUCTION

2.1 This Policy has been produced in accordance with the references contained in Appendix 1 for the management of the following:

Document Title: Claims (Negligence , Personal Injury and Redress) Management Policy	4 of 38	Approval Date: 13 Sep 2016
Reference Number: UHB 332		Next Review Date: 13 Sep 2019
Version Number: 1		Date of Publication: 11 Oct 2016
Approved By: Quality, Safety and Experience Committee		

- clinical/medical negligence claims;
- personal injury claims;
- Redress claims

It does not cover Employment or Estates issues.

2.2 The Health Board has a legal duty of care towards those it treats, together with members of the general public and its staff. People who consider they have suffered harm from a breach of this duty can make a claim for compensation and damages against the Health Board.

2.3 For a claim to be successful, a claimant must prove:

- that he/she was owed a duty of care;
- that the duty was breached;
- that the breach of duty caused, or contributed materially to, the damage in question; and
- that there were consequences and effects of the damage.

2.4 The Limitation Act 1980 requires that claims be made within three years of the date of the incident or three years from the date a claimant became aware that he/she had suffered from an episode of negligence. With minors, the three-year limitation period becomes effective once they have reached the age of 18. However, there are no time limits for people with a disability who cannot manage their own affairs. Claims exceeding the three-year limitation period can, however, still be brought against the Health Board at the discretion of the Court.

3. DEFINITIONS

The following provide definitions for clinical negligence, personal injury.

3.1 Clinical/ Medical Negligence

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

3.2 Personal Injury

“Any disease or impairment of a person’s physical or mental condition.”

4. RESPONSIBILITIES

4.1 The Chief Executive is the Board member with overall responsibility for issues relating to clinical negligence and personal injury and for keeping the Health Board informed of major developments. This responsibility has been delegated to the Executive Director of Nursing.

Document Title: Claims (Negligence , Personal Injury and Redress) Management Policy	5 of 38	Approval Date: 13 Sep 2016
Reference Number: UHB 332		Next Review Date: 13 Sep 2019
Version Number: 1		Date of Publication: 11 Oct 2016
Approved By: Quality, Safety and Experience Committee		

4.2 All Executive Directors and Clinical Board Directors, Directors of Nursing and Directors of Operations have delegated accountability and responsibility within their designated areas for the implementation and adherence to this policy.

4.3 The Concerns Managers are accountable to the Executive Nurse Director via the Assistant Director of Patient Experience for the management of claims for ensuring compliance with policy, including compliance with delegated authority limits and for securing the most cost-effective resolution of claims.

4.5 All members of staff are encouraged to report adverse incidents, including those that may lead to claims for compensation, in line with the Health Board's promotion of a just, blame free culture.

4.6 Staff also have a duty towards the Health Board in the investigation and, where appropriate, defence of all claims and will assist all claims staff, as necessary during the claims management process.

4.7 Approval of this strategic Claims Management Policy will rest with the Health Board or delegated committee; although the approval of subsequent claims management procedures setting out the detailed operational arrangements for complying with this policy will be delegated by the Health Board to the appropriate committee.

5. DELEGATED LIMITS

Delegation of Out of Court Settlement

5.1 The Health Board acknowledges that the Welsh Assembly Government has delegated its responsibility for the settlement of claims to a limit of £1 million to the Health Board and that the Health Board continues to exercise this discretion subject to satisfaction with minimum requirements and standards:

- That it adopts a clear policy for the handling of claims which satisfies the requirements of WHC(97)17
- That the requirements of WHC(97)17 form the basis of the procedure for the day to day management of claims.

Internal Delegated Limits

5.2 The Health Board has formal delegated responsibility from the Welsh Assembly Government for the management of clinical negligence and personal injury claims valued up to £1million.

5.3 The levels of delegated authority within the Health Board are those contained within the Health Board's Scheme of Delegation.

6. USE OF LEGAL ADVISORS

6.1 The Health Board will use legal advisors in the defence or settlement of significant clinical negligence and personal injury claims. Small to moderate value

Document Title: Claims (Negligence , Personal Injury and Redress) Management Policy	6 of 38	Approval Date: 13 Sep 2016
Reference Number: UHB 332		Next Review Date: 13 Sep 2019
Version Number: 1		Date of Publication: 11 Oct 2016
Approved By: Quality, Safety and Experience Committee		

claims of modest complexity may be managed in-house by the Health Board's Concerns/Claims Managers. The legal process of claims will be managed by Welsh Health Legal Services.

6.2 Where external legal advice is sought, the Health Board will retain the responsibility to direct its solicitors in respect of liability admission, defence, settlement and general strategy. However, the Health Board will always take due account of qualified legal advice in making such decisions. Legal advice will cover:

- Liability and causation; with the exception of some redress cases
- An assessment of the strength of the available defence and probability of success;
- The likely valuation of quantum of damages including best and worst case scenarios; and Estimates of legal costs for claimant and defendant

6.3 For claims managed in-house, advice will be provided by the Health Board's Concerns Managers. In all such cases, advice will be recorded on the case file satisfying the same requirements for the provision of legal advice as are set out in paragraph 6.2 above.

6.4 The decision to settle a claim or to continue with its defence will be on the basis of legal advice of Counsel and/or WHLS, in conjunction with Concerns Managers.

7. THE ROLE OF THE CONCERNS/ CLAIMS MANAGERS

7.1 The Health Board will employ dedicated Concerns Managers, who can demonstrate sufficient experience in the management of Clinical Negligence and Personal Injury claims.

7.2 The Concerns Managers will be required to demonstrate on-going updating and continuing professional development in the area of claims management.

7.3 There must be demonstrable communications, as necessary to achieve the objectives of WHC(97)17 for effective claims management.

7.4 The Concerns Managers will ensure that all members of staff and/or their line managers involved in a claim are kept informed of the progress and outcome of the claim.

8. REPORTING REQUIREMENTS

8.1 The Health Board delegates its responsibilities to the Concerns, Claims and Compliments assurance group, the duly authorised committee. The group will receive and review quarterly progress reports on the management and status of claims against the Health Board, in the format specified by WHC (97)17.

8.2 The delegated committee will receive a quarterly report, reporting upon comparative issues.

Document Title: Claims (Negligence , Personal Injury and Redress) Management Policy	7 of 38	Approval Date: 13 Sep 2016
Reference Number: UHB 332		Next Review Date: 13 Sep 2019
Version Number: 1		Date of Publication: 11 Oct 2016
Approved By: Quality, Safety and Experience Committee		

8.3 The Terms of Reference of the delegated committee as the duly authorised Committee will reflect its role in relation to claims.

8.4 The Executive Nurse Director retains responsibility for claims management within the Health Board and will ensure that the Health Board is kept informed of significant and major developments.

8.5 It is acknowledged that where a claim has been identified as a Patient Safety Incident but that it was not previously reported through the incident reporting process, the Health Board will ensure that a procedure exists which is set out in the Claims Management Written Control Document, to support the objective that the person with responsibility for Risk Management within the Health Board, is informed, and a retrospective report is sent to the National Patient Safety Agency by the National Reporting and Learning System as appropriate following a review.

8.6 The reporting requirements relating to the reimbursement process managed by the Welsh Risk Pool

8.7 The reporting requirements to the Welsh Assembly Government are set out in this policy.

9. CLAIMS MANAGEMENT WRITTEN CONTROL DOCUMENT

9.1 The Health Board will ensure that a Claims Management Written Control Document is developed which supports and embraces the objectives contained in this Policy and WHC(91)17.

10. INVOLVEMENT OF STAFF

10.1 The Health Board recognises that the co-operation of all staff involved in the incident leading to a claim is crucial to the early collation of information to that case. The Health Board will ensure that staff are encouraged to support the Concerns Managers and any duly appointed legal advisors, in the handling of that claim. All staff are required to fully and openly co-operate with the investigation of any legal claims and to comply with this Policy and the Claims Management Written Control Document.

10.2 Once a claim has been received, the Concerns Managers will establish an objective account of the original incident at the earliest available opportunity.

10.3 Unless there are exceptional circumstances, any member of staff asked to do so should provide the Concerns Managers with a witness statement and information regarding the investigation of the relevant claim in a timely manner.

10.4 The Health Board recognises that providing a statement and giving evidence can be a stressful experience and will ensure that full support and guidance is

Document Title: Claims (Negligence , Personal Injury and Redress) Management Policy	8 of 38	Approval Date: 13 Sep 2016
Reference Number: UHB 332		Next Review Date: 13 Sep 2019
Version Number: 1		Date of Publication: 11 Oct 2016
Approved By: Quality, Safety and Experience Committee		

provided to members of staff who are asked to give evidence on behalf of the Health Board.

10.5 The Health Board will support an escalation procedure to be contained in the Health Board's Claims Management Written Control Document to secure this objective.

10.6 The Health Board will take full responsibility for managing and, where appropriate, settling claims in clinical negligence cases, meeting all its financial obligations and will not seek to recover any costs from health professionals. In very exceptional cases, where the health professional was legally found to be acting outside of his/her remit, the matter will be referred to the appropriate Clinical Board or Executive Director.

11. NUISANCE CLAIMS

11.1 The Health Board will not settle claims of doubtful merit, however small, purely on a 'nuisance' value basis. Similarly claims will not be inappropriately defended.

11.2 The decision to settle a claim will always be based upon an assessment of the Health Board's legal liability and the risks and costs associated with the defence of that claim, including the prospects of recovering those costs in the event that the defence is successful.

12. REPORTING OF CLAIMS TO WELSH ASSEMBLY GOVERNMENT

12.1 Novel, Contentious or Repercussive Claims

The Concerns Managers will monitor the nature and type of claims received to highlight any claims which are considered to be novel, contentious or repercussive. In such cases the Concerns Managers will liaise with the designated Solicitors/Legal Advisors, to ensure that the Welsh Assembly Government are duly made aware or advised. The Director of Governance and Communications will be kept informed throughout.

12.2 Claims Exceeding the Delegated Authority

The Concerns Managers will ensure that any claims with damages estimated to exceed the Health Board's delegated authority of £1 million are reported to the Welsh Assembly Government and prior approval is obtained in advance of liability being conceded and the claim being settled.

12.3 The Annex form will be signed by the Clinical Board lead, Executive Nurse Director and /or Chief Executive prior to the matter being reported to the Welsh Assembly Government and a copy will be presented to the Quality and Safety Committee for information purposes only.

13. DATABASES

13.1 The Health Board will maintain a Claims Handling database via datix :

Document Title: Claims (Negligence , Personal Injury and Redress) Management Policy	9 of 38	Approval Date: 13 Sep 2016
Reference Number: UHB 332		Next Review Date: 13 Sep 2019
Version Number: 1		Date of Publication: 11 Oct 2016
Approved By: Quality, Safety and Experience Committee		

- The Health Board’s claims data-base will contain the information given in the Claims Management Written Control Document. All Clinical Negligence and Personal Injury claims will be entered onto the database by the Legal Services Manager or by an authorised member of staff.
- The Health Board will ensure that patient and staff confidentiality is maintained.

14. LINKS BETWEEN CLAIMS, COMPLAINTS, INCIDENTS AND OTHER RISK INFORMATION

14.1 The Health Board recognises the need for close connections between risk management, complaints, incidents and the management of claims. It appreciates the need for close and co-operative working between these functions and will ensure that appropriate linkages are in place to facilitate this objective.

Linkages

14.2 Adverse incidents or outcomes which could lead to a claim for negligence should be identified and reported to the Concerns Managers at the earliest possible opportunity, either through the provision of a serious incident report sent to the Welsh Assembly Government or Regional Office or by the provision of the relevant documentation.

14.3 The Concerns Managers will work together to identify complaints which involved potential breaches of the legal duty of care by the Health Board. An appropriate investigation will be undertaken to enable the Health Board to adopt a pro-active stance to the management and resolution of potential claims identified through the complaints procedure. Never events will be discussed with the concerns team to establish if redress is appropriate for early and effective litigation resolution.

14.4 Appropriate systems will be established by the appointed deputy, to enable the lead members of staff for complaints, risk and claims to meet on a regular basis through an appropriate forum to ensure the identification of any trends and remedial action that may be required. Appropriate and relevant staff will then implement any recommendations arising from complaints, claims, experts’ reports and investigations.

14.5 The Claims Handling Database system identifies where a potential claim has previously been reported as an incident or complaint. This facilitates the gathering of information to comply with the relevant Pre-Action Protocols.

Committee Structure

Document Title: Claims (Negligence , Personal Injury and Redress) Management Policy	10 of 38	Approval Date: 13 Sep 2016
Reference Number: UHB 332		Next Review Date: 13 Sep 2019
Version Number: 1		Date of Publication: 11 Oct 2016
Approved By: Quality, Safety and Experience Committee		

14.6 Summaries of claims and trends will be routinely provided for information and management action as necessary to such committees as requested.

14.7 the special losses panel will routinely report the value and incidence of Claims, payments to the Audit Committee.

Controls Assurance

14.8 The Concerns Managers are the Lead Officers for the Welsh Risk Management Standard for Claims Management and are responsible for provision of the evidence against this standard which relates to matters within their jurisdiction.

15. LEARNING LESSONS FROM CLAIMS AND IDENTIFYING CLAIMS FROM INCIDENTS AND COMPLAINTS

15.1 The Health Board is committed to learning lessons from claims, complaints and adverse incidents.

15.2 It is important that wherever possible lessons are learnt following an incident. It is the responsibility of Concerns manger to ensure that any lessons learnt from claims are communicated to the relevant staff in the Clinical Board structure and that any action plans are implemented and monitored in a timely manner.

15.3 The Health Board, via the Clinical Boards, will ensure that a formal process and procedure to support the learning of lessons, monitoring of implementation of lessons learned, evaluation of the efficacy of lessons learned and thereafter the auditing of each component, is developed.

15.4 The Concerns Managers will identify the potential for ‘learning lessons’ from claims. This information will be routinely reported to the appropriate committee in accordance with the formal procedure for learning lessons as set out in the Claims Management Written Control Document.

15.5 The Concerns Managers will identify the potential for the use of alternative dispute resolution before considering litigation. In addition, the established NHS Complaint’s procedure will be used to ensure that patients receive, where appropriate, an apology and a full explanation of what went wrong to reduce the potential for complainants to take legal action to achieve such a remedy.

15.6 The Concerns Managers will produce an Annex form Checklist and an associated Action Plan for all claims exceeding the Health Board’s excess of £25,000. This will be used as the basis for learning, monitoring and evaluating the efficacy of the lessons learned from claims.

CPG

Document Title: Claims (Negligence , Personal Injury and Redress) Management Policy	11 of 38	Approval Date: 13 Sep 2016
Reference Number: UHB 332		Next Review Date: 13 Sep 2019
Version Number: 1		Date of Publication: 11 Oct 2016
Approved By: Quality, Safety and Experience Committee		

16. LIAISON WITH THE WELSH RISK POOL

16.1 The Health Board is assessed annually against the Welsh Risk Pool Standard for Claims Management.

16.2 The Health Board will comply with the various rules and procedures of the Welsh Risk Pool. The Concerns Managers will ensure the Health Board's adherence to the same.

16.3 The Concerns Managers will report details of claims settled with a quantum of under £25,000 to the Welsh Risk Pool using the WRP 3 form or such other format as may be required by the Welsh Risk Pool.

16.4 In order to be reimbursed by the Welsh Risk Pool, the Health Board is required to submit a WRP 1, Costs Schedule and Annex form Checklist, in a format consistent with that set out in the Welsh Risk Pool reimbursement procedures.

16.5 The Health Board acknowledges that the Welsh Risk Pool will periodically undertake reviews of claims managed by the Health Board. The Health Board will ensure the co-operation of its members of staff with such reviews through the development of a formal review process to be contained in the Claims Management Procedure.

17. NHS REDRESS ACT 2006

17.1 The Health Board appreciates and is committed to the objectives of the NHS Redress Act 2006 which provides for the development of a small value clinical negligence scheme for Wales.

17.2 The Health Board will undertake such action as it deems appropriate to support the introduction of such a scheme following the development of detailed regulations and which will be included in its Claims Management Procedure.

REFERENCES

This Policy complies with the following references:-

- The Civil Procedure Rules 1998
- WHC(97) 7 – Clinical Negligence and Personal Injury Litigation: Structured Settlements
- WHC(97)17 – Clinical Negligence and Personal Injury Litigation: Claims Handling
- WHC(98)8 - NHS Indemnity – Arrangements for Handling Clinical Negligence Claims against NHS Staff
- WHC(99)128 – Handling Clinical Negligence Claims: Pre-Action Protocol
- The Welsh Risk Pool Claims Management Standard (April 2007)
- The Welsh Risk Pool Reimbursement Procedure and other Procedures
- The Health Board's Standing Orders and Standing Financial Instructions

Documents to be read alongside this policy:

Document Title: Claims (Negligence , Personal Injury and Redress) Management Policy	12 of 38	Approval Date: 13 Sep 2016
Reference Number: UHB 332		Next Review Date: 13 Sep 2019
Version Number: 1		Date of Publication: 11 Oct 2016
Approved By: Quality, Safety and Experience Committee		

- UHB Claims Handling Statement of Intent
- UHB Claims Handling Policy & Procedure
- UHB Responsibilities & Accountability Framework
- UHB Scheme of Delegation
- Claims Handling Escalation Procedure Standing Orders and Standing Financial Instructions
- WHC (97) 17 - CN & PI : Claims Handling
- WHC (97) 7 - CN & PI: Structured Settlements
- WHC (98) 8 – NHS Indemnity – Arrangements for Handling CN Claims against NHS Staff
- WHC (99) 128 – Handling CN Claims: Pre-Action Protocol
- WRP Claims Management Standards (April 2007)
- WRP Reimbursement Procedure & other Procedures
- Civil Procedure Rules 1998

Review

CLAIMS HANDLING PROCEDURE

INDEX

1. Pre-Litigation Procedure
2. Definitions
3. Handling Clinical Negligence Claims
4. Handling Personal Injury Claims
5. Court Proceedings
6. Claims Handling - General Information
7. Welsh Risk Pool Requirements
8. Concluded Claims

Appendix

9. General Information

1. PRE-LITIGATION PROCEDURE

1.1 Reporting and investigation of incidents (see Appendix 1: Flowchart – Claims Procedure)

The principal benefit of untoward incident reporting is that it provides a means of identifying claims at an early stage. In practice, years can pass between the date of medical treatment, giving rise to a claim or accident and a letter of claim, or a request for disclosure of medical notes and records. In the interim, key witnesses could have moved away or have little recollection of any particular case over and above the contents of a note or usual practice.

Early investigation into circumstances surrounding an alleged breach of duty is essential if the chances of successfully defending a claim are to be increased. In addition, work carried out at this stage is an investment if viewed as a means of identifying problem cases where an early conclusion would minimise legal costs.

Document Title: Claims (Negligence , Personal Injury and Redress) Management Policy	13 of 38	Approval Date: 13 Sep 2016
Reference Number: UHB 332		Next Review Date: 13 Sep 2019
Version Number: 1		Date of Publication: 11 Oct 2016
Approved By: Quality, Safety and Experience Committee		

Completion of the accident book and incident report should be undertaken as soon as practicable after the incident occurs and all the requisite documentation should be completed as comprehensively as possible, signed by the reporting officer and providing all relevant information and details of witnesses.

All witnesses should be asked to provide a statement to include those named in the incident report and other relevant parties. The manager should not simply rely on the names of witnesses given by the injured person but should make their own investigations to find out whether or not other witnesses exist. Brief statements should be taken from the witnesses and should include details of the witnesses name, address and job description and all information relevant to the allegation. There should be an investigation of the site of the incident, for example in slipping/tripping cases the location of the incident should be considered along with the floor surface or ground in question. Investigations should be carried out as to whether or not there have been previous incidents or complaints and consideration should be given to obtaining photographs of the area at an early stage.

In relation to manual handling claims or incidents the risk assessment, injured persons training record and availability of other staff to assist with the manoeuvre should be obtained and considered. Particular note should be made of exactly who was on duty at the time and who could have been contacted.

The patient’s details should be considered if injury were caused as a result of lifting or assisting a patient, with details of the patient’s dependency level at the time of the incident should also be considered.

Consideration should be given to any possible element of contributory negligence on the part of the injured person.

The Concerns Manager should be notified immediately of any reported incidents or complaints that could potentially result in a claim.

2. DEFINITIONS

2.1 Timescale for bringing a claim

A patient contemplating an action must act relatively promptly. The general rule is that all actions for clinical negligence or personal injury must be brought within three years of the infliction of the relevant injury or the date of knowledge of the injury.

This is known as the limitation period and is laid down in the Limitation Act 1990. In the case of a minor the three-year period runs from the date that the child attains the age of 18. The claimant must demonstrate that it is more likely than not that his or her deterioration in health or the injury resulted from the negligence of the defendant.

2.2 Clinical Negligence

Clinical negligence is defined by the Welsh Risk Pool (hereinafter referred to as the WRP) as: -

Document Title: Claims (Negligence , Personal Injury and Redress) Management Policy	14 of 38	Approval Date: 13 Sep 2016
Reference Number: UHB 332		Next Review Date: 13 Sep 2019
Version Number: 1		Date of Publication: 11 Oct 2016
Approved By: Quality, Safety and Experience Committee		

“A breach of duty of care by members of the Healthcare Professions (including medical practitioners, nurses and midwives, professions allied to medicine, laboratory staff and relevant technicians) or by others consequent on decisions of judgments made by members of those professions acting in their professional capacity on relevant work, and which are admitted as negligent by the employer or are determined as such through the legal process.”

In as much as a breach of duty of care is alleged, the Health Board will need to seek legal advice in individual cases. In general terms however the following must apply before liability for negligence exists: -

- There must have been a duty of care owed to the patient by the relevant professional(s)
- The standard of care appropriate to such duty must not have been attained and therefore the duty breached whether by action or inaction, advice given or failure to advise
- It must be demonstrated that the breach caused the injury and therefore the resulting loss about what the patient complains
- The loss must have been reasonably foreseeable

2.2.1 Private work

Consultants providing care under private arrangements with their patients, or Consultants or other clinical staff treating patients in connection with voluntary work or “Good Samaritan” act, are not covered by these arrangements or the WRP. Instead, consultants or other clinical staff should take out their own medical defence insurance. However, the WRP cover does apply where medical or other staff working under their NHS contract provide care for a consultant’s private patients.

Any incident arising as a result of private work, which involves other staff, facilities or equipment, must be reported in the usual way.

2.3 Personal injury

Personal injury litigation can be defined as action taken (often through solicitors) by an individual who has sustained an accident or contracted a condition as a consequence of alleged exposure to a harmful substance and **not** as a result of clinical intervention, treatment or lack of treatment. The Health Board receives such claims from staff, visitors and patients who have suffered an injury related to the premises. The majority of cases brought against the Health Board are union funded and the union solicitors will inevitably advise the claimants. In the absence of legal advice a claimant can of course bring a claim without legal assistance, known as a ‘litigant in person’. This occurs rarely. For the purpose of this document, reference will be made to claimants who are being represented by solicitors. Not every incident gives rise to litigation, but for those incidents that do, it is essential that the Health Board have in place a co-ordinated system that firstly examines issues of liability and causation which ultimately results in a claim being settled or defended. If the claimant is unable to adduce sufficient evidence to prove his or her case, a further possibility is that the claim may be discontinued.

Document Title: Claims (Negligence , Personal Injury and Redress) Management Policy	15 of 38	Approval Date: 13 Sep 2016
Reference Number: UHB 332		Next Review Date: 13 Sep 2019
Version Number: 1		Date of Publication: 11 Oct 2016
Approved By: Quality, Safety and Experience Committee		

To be successful, the claimant must prove, on the balance of probabilities (i.e.>51%) the following three things:

- That the Health Board had a duty of care to staff, visitors or patients to ensure that every precaution is taken to prevent personal injury
- That the duty of care had been breached by not complying with any standards set to safeguard the person
- That the breach of duty caused the damage to the person

2.4 Pre Action Protocols

The claimant or his/her solicitors should provide full details of the intended claim pursuant to the Pre Action Protocols contained in the Civil Procedure Rules, which arose from Lord Wolf's Access to Justice Report (July 1996). The Pre-Action Protocols were introduced on all proceedings that commenced after 26 April 1999 and impose challenging targets for the Health Board. The only way to avoid increased litigation costs and court imposed financial penalties is to ensure that a clear view about any alleged incident is reached quickly and effectively. This requires commitment from all staff involved to report adverse incidents and to respond quickly and clearly to allegations.

A detailed response to the letter of claim must be given within 3 months. These Protocols encourage early exchange of and full information to be given about a claim, with a view to trying to avoid litigation by agreeing a settlement before the commencement of proceedings. If the claim cannot be agreed, proceedings are issued and a claim form and particulars (or statement) of claim are served upon the Health Board. This document sets out the details of the allegations against the defendant/Health Board, together with a medical report as to the claimant's condition and statement (or schedule) of special damages (financial loss said to have been suffered as a consequence of injury and future losses). The Protocols support efficient management of proceedings where litigation cannot be avoided.

2.5 Methods of reaching a settlement

Every effort should be made to discuss and negotiate settlement prior to court proceedings. This may include:

- Mediation/face to face discussion with the claimant regarding the claim
- Early evaluation of the claim by legal expert
- Internal arbitration
- Determination by an expert
- Alternative Dispute Resolution

3. HANDLING CLINICAL NEGLIGENCE CLAIMS

3.1 Notification of a claim

There are several ways in which the Health Board may be notified of a claim:

- Letter of claim

Document Title: Claims (Negligence , Personal Injury and Redress) Management Policy	16 of 38	Approval Date: 13 Sep 2016
Reference Number: UHB 332		Next Review Date: 13 Sep 2019
Version Number: 1		Date of Publication: 11 Oct 2016
Approved By: Quality, Safety and Experience Committee		

- Request for medical records from a solicitor where it is stated that action against the Health Board is contemplated
- Verbal
- During the complaints process
- Direct contact

3.2 Initial stage of the claim

When notification of a claim is received, usually in the form of a letter of claim, and it is stated that there is a potential or actual threat of litigation as a result of negligence; certain action will then need to be undertaken immediately. An assessment of the claim is required to ascertain what information will be required.

The claim will be acknowledged in an appropriate manner within 14 days, using the standard form letter available for use at the relevant time. The Health Board's solicitors are also notified, and formally requested to act on behalf of the Health Board, usually by sending to them a copy of the letter of claim.

3.3 First steps

Upon receipt of the claim for compensation, the details must be entered onto the Claims database.

The database is the Health Board's own record of new and ongoing claims and must be maintained and updated throughout the life of the claim.

The following information is recorded:

- Name of claimant
- Name of second person, if the claim is on behalf of a child or patient who has died
- Unique reference number
- Type of claim
- Whether it is a Health Board or Health Authority claim
- Whether the claim has previously been the subject of an internal complaint
- Whether a clinical adverse incident form was completed at the time of the event
- Date of incident
- Date of letter before action
- Directorate and specialty
- Ward or department
- Consultant
- Other Consultant or named staff
- Allegations
- Injury sustained
- Claimant's Solicitors
- Stage of the claim
- Quantum damages
- Quantum costs

Document Title: Claims (Negligence , Personal Injury and Redress) Management Policy	17 of 38	Approval Date: 13 Sep 2016
Reference Number: UHB 332		Next Review Date: 13 Sep 2019
Version Number: 1		Date of Publication: 11 Oct 2016
Approved By: Quality, Safety and Experience Committee		

- Compensation recovery unit
- Estimated date of settlement
- Compensation paid including interim payments
- Actual costs - claimant and defendant
- Additional costs

The former Health Authorities were abolished on the 31st March 2003. Powys Local Health Board has responsibility for accounting for the residual liabilities arising from legal claims against the former Health Authorities. Management is directly by the WRP on behalf of Powys HB.

Any queries in relation to these procedures should be directed either to the WRP's Senior Claims Support Officer or Finance Development Officer.

A file is then created to keep the documentation relevant to the claim such as:

- Correspondence to/from the Health Board's solicitors
- Risk management issues
- Copies of proceedings and expert opinions
- Witness statements
- Internal correspondence
- Financial documents

3.4 Information required at the start of the claim

The standard information required at the start of the claim and the reasons for this, are detailed below:

a) Full names and titles of all staff involved

It is useful at the outset if the consultant/manager in charge of the patient's care can list the staff involved so that statements can be obtained from all necessary parties.

b) Identity of the Doctors' defence organisations and membership numbers

Doctors no longer need to subscribe to a recognised defence organisation following the guidance given in circular WHC (89) 70. However, many doctors still pay a lower rate subscription to a defence organisation for personal advice. It is often found that the junior medical staff involved in treatment, which is later the subject of a legal claim, are no longer in post. If the Health Board has no forwarding address, the defence organisation can be engaged to locate Doctors and obtain statements when required.

c) Two copies of the case notes

When considering whether the claimant has a claim in respect of negligence, the patient and his legal advisors will clearly benefit by gaining access to the patient's notes, reports and X-rays and other test records. Disclosure of the records can be mutually beneficial to the other side and the Health Board, as a claim is often found

Document Title: Claims (Negligence , Personal Injury and Redress) Management Policy	18 of 38	Approval Date: 13 Sep 2016
Reference Number: UHB 332		Next Review Date: 13 Sep 2019
Version Number: 1		Date of Publication: 11 Oct 2016
Approved By: Quality, Safety and Experience Committee		

to have no merit or an individual's actions may be exonerated. Money and effort can be saved by prompt disclosure.

Upon receipt of the medical records, the Concerns/Claims Managers shall check that the records are complete. Once copied, the notes shall be checked to ensure that the standard of photocopying is satisfactory and that the information is appropriate. At the start of a claim, two copies of the claimant's case notes are required for use by the Health Board's solicitors - disclosure to the "other side's" solicitors (if an authority to disclose has been obtained) and for a nominated expert adviser. The copy notes should be made available within 40 days of the letter of claim, if practicable to do so.

Delays in the initial investigation of a claim are often caused by the poor standards of photocopied case notes, which are disclosed to the "other side", and criticism is often aimed at the presentation, clarity and format of copy case notes. It is therefore helpful if staff could ensure that they make comprehensive legible entries in the case notes, use a black pen at all times and ensure that case note sheets are filed in chronological order.

d) One copy of any relevant X-rays

X-rays form part of the medical records and are usually asked for in the list of documents requested from the claimant's solicitors. These will be disclosed through the Health Board's solicitors. Additional sets may be required depending on how many expert reports are commissioned.

e) View of the Consultant concerned upon the disclosure of the case notes to the other side's expert advisors

The Consultant will need to give his/her views upon the disclosure of case notes as soon as possible. If disclosure is not given promptly the claimant may apply for a court order requiring the Doctor or the Health Board to disclose any records or notes likely to be relevant in forthcoming proceedings under Section 33 of the Supreme Court Act 1981 or under the Access to Health Records Act 1990 / Data Protection Act 1998. If an application is made for pre-action disclosure then additional costs may be incurred.

However, in view of the effects of the Access to Health Records Act 1990 / Data Protection Act 1998 and subsequent Welsh Assembly Government clarification, objections to disclosure of the case notes can only be made where there is something in the notes that could cause serious mental or physical harm to the patient or a third person, as defined in the relevant legislation.

f) Initial statements from the identified staff regarding their involvement in a claim

The Health Board will require co-operation if cases are to be defended. Statements will therefore be required to assist in investigating or defending a claim. Failure

Document Title: Claims (Negligence , Personal Injury and Redress) Management Policy	19 of 38	Approval Date: 13 Sep 2016
Reference Number: UHB 332		Next Review Date: 13 Sep 2019
Version Number: 1		Date of Publication: 11 Oct 2016
Approved By: Quality, Safety and Experience Committee		

without good cause to provide a statement could result in the Health Board being unable to defend an allegation of negligence.

At the start of each claim it is necessary that good preliminary reports be obtained from **all** the staff involved. Such statements, if adequate, provide invaluable information as to whether a claim has any foundation and its future management can be assessed. Until such statements are received it is difficult to proceed past the investigatory stage of a claim.

It is necessary, therefore, that the staff concerned, are informed of a claim as soon as possible and a copy of the claimant’s solicitors letter outlining allegations is made available to them.

g) Member of staff with primary involvement

The member of staff who has primary involvement will need to be identified so that s/he can provide a detailed report.

h) Views of the clinical board as to whether he/she considers the claim to have any merit.

The Clinical Director and Consultant responsible for the patient should be informed about the claim by way of notice, with relevant documents attached. The Clinical Director and/or the Consultant will need to provide a preliminary report outlining the background of the case, involvement of his/her department as a whole, guidance on any areas of importance, identify the staff involved and finally offer any views as to whether the claim has any merit.

i) Any other background information

Any additional information available surrounding a legal claim, such as previous documentation at a complaints stage or untoward incident report should be considered.

3.5 Escalation procedure

Should the Concerns/Claims Managers encounter difficulties in obtaining comments from any members of the Health Board’s staff, the matter shall be escalated to the attention of the, Clinical Board Director, Director of Nursing or Director of Operations. If there is still difficulty in obtaining comments, the Concerns/Claims Managers will escalate matters initially to the assistant director of patient experience and ultimately the lead Executive will be informed.

3.6 Progress of the claim – expert advice

The claimant’s claim will be reliant upon expert testimony to prove negligence. Expert medical evidence can be obtained to comment on many issues including causation, condition and prognosis and life expectancy. When a suitable expert has been determined, the lead Clinician involved in the litigation claim will be invited to approve the appointment.

The Health Board may also wish to commission its own expert reports, particularly in relation to multi-track claims, which may lead to conflicting accounts as to the proper standard of care in the procedure in issue. In certain circumstances the Health Board

Document Title: Claims (Negligence , Personal Injury and Redress) Management Policy	20 of 38	Approval Date: 13 Sep 2016
Reference Number: UHB 332		Next Review Date: 13 Sep 2019
Version Number: 1		Date of Publication: 11 Oct 2016
Approved By: Quality, Safety and Experience Committee		

may agree to the use of a joint expert. Given the complexity of clinical negligence claims, reports from Counsel are sometimes sought by the Health Board’s legal advisors to consider the future management of the claim and to comment specifically on issues relating to liability and quantum.

The Clinical Board and lead Clinician shall be kept updated as to the progress of the claim at all times.

3.7 Assessment of the claim

An assessment of the claim will need to be made by the Concerns Manager and Health Board’s solicitor, by examining expert legal and medical reports and the views of the staff involved. Although the views of the staff directly involved are considered, it is not appropriate that they are involved in the decision making process as this requires an independent role. These will need to be authorised by the concerns team staff, a second Executive Director, and Chief Executive.

Health Board approval will be sought as required. A broad guideline to the information usually required is:

- An objective account of the incident
- An explanation of the basis and background of the claim
- The views of the Welsh Government if the case involves novel, contentious or precedent setting issues
- A balanced view of the likely defence, including legal and medical opinion when available
- Clarification of the basis on which damages have been estimated
- A legal opinion of the likely outcome of any court hearing
- Assessment of quantum including, if applicable, the reason for the proposed settlement
- An estimate of the possible savings for the public purse if a payment is made
- Details of the proposed approach to negotiations with the claimant, including the initial offer and proposed upper limit
- Details, where applicable, of structured settlements/periodical payments
- Details of any systematic failings on the part of; the clinical or other front line staff, operational or risk management procedures, claims handling staff or claims handling procedures. If so, what action is intended to remedy the identified deficiencies, including the timetable for implementation of any changes or improvements and identify how the proposed improvements will be monitored

3.8 Settle or defend

Upon receipt of the Health Board’s instruction, the Health Board’s solicitors will either prepare the case for Court or attempt to secure a settlement, which can either be accompanied by an admission of liability on a “without prejudice” basis.

4. HANDLING PERSONAL INJURY CLAIMS

4.1 Notification of a claim

Document Title: Claims (Negligence , Personal Injury and Redress) Management Policy	21 of 38	Approval Date: 13 Sep 2016
Reference Number: UHB 332		Next Review Date: 13 Sep 2019
Version Number: 1		Date of Publication: 11 Oct 2016
Approved By: Quality, Safety and Experience Committee		

There are several ways in which the Health Board may be notified of a claim:

- Letter of claim
- Verbal
- During the complaint process
- Direct contact

4.2 Initial stage of the claim

When notification of a claim is received, usually in the form of a letter of claim, and it is stated that there is a potential or actual threat of litigation as a result of an alleged breach of duty of care, then certain action will need to be undertaken immediately. An assessment of the claim is required to ascertain what information will be required. The claim will be acknowledged in an appropriate manner within 21 days, using the standard form letter available for use at the relevant time. The Health Board's solicitors are also notified, usually by sending to them a copy of the letter of claim.

4.3 First steps

Upon receipt of the claim for compensation, the details must be entered onto the claims database.

The database is the Health Board's own record of new and ongoing claims and must be maintained and updated throughout the life of the claim.

The following information is recorded:

- Name of claimant
- Name of second person if the claim is on behalf of a child or patient who has died
- Unique reference
- Type of claim
- Date of letter of claim
- Whether a clinical adverse incident form was completed at the time of the event
- Date of incident
- Date of letter before action
- Department
- Location of incident
- Head of department
- Witness names
- Brief description of incident
- Injury sustained
- Claimant's solicitors
- Stage of the claim
- Quantum damages
- Quantum – claimant's and defendant's costs
- Compensation recovery unit
- Estimated date of settlement/closure

Document Title: Claims (Negligence , Personal Injury and Redress) Management Policy	22 of 38	Approval Date: 13 Sep 2016
Reference Number: UHB 332		Next Review Date: 13 Sep 2019
Version Number: 1		Date of Publication: 11 Oct 2016
Approved By: Quality, Safety and Experience Committee		

- Compensation paid including interim payments
- Actual costs - claimant and defendant
- Additional costs

A file is then created to keep the documentation relevant to the claim such as:

- Correspondence to/from our solicitor
- Risk management issues
- Copies of proceedings and expert opinions
- Witness statements
- Internal correspondence
- Financial documents

4.4 Action to be taken and information to be gathered

The standard action and information required at the start of the claim and the reasons for this are detailed below:

a) Notify the appropriate Clinical Board lead requesting, amongst other things:

- Incident documentation (report and check list)
- Accident book entry
- RIDDOR form
- Initial witness statements
- Documented training (if member of staff)
- Initial investigations
- Details of the patient (if involved)
- Photographs and plans
- Documentation re: repairs, staffing levels etc.
- Details of previous similar incidents
- Risk assessment
- Local procedures and protocol
- Personnel file (if member of staff)
- If the action concerns a member of staff, write to the Payroll Department, seeking details of the claimant's earnings and statutory sickness details
- Establish contact with the Head of Risk Management, seeking details as to any investigation or review undertaken in respect of the incident, establishing an objective account of the original incident, ascertaining the incident has been duly reported:
- Adverse Incident Report
- All meetings with complainants/Claimants can be audio recorded and a copy of the recording provided to all parties

Documentation to be accessed to include, but not limited to;

- Datix
- RIDDOR
- Ad Hoc Reports

Document Title: Claims (Negligence , Personal Injury and Redress) Management Policy	23 of 38	Approval Date: 13 Sep 2016
Reference Number: UHB 332		Next Review Date: 13 Sep 2019
Version Number: 1		Date of Publication: 11 Oct 2016
Approved By: Quality, Safety and Experience Committee		

- Risk Register

If not so reported, the Concerns/Claims Managers will link with the Risk Manager to ensure that a retrospective report is presented to the NPSA upon any and all Claims/Incidents as of 1st January 2004.

b) Notify the Compensation Recovery Unit, if the case is being dealt with internally.

c) Obtain Emergency Unit cards.

d) Ask the claimant to sign a form of authority for the release of his/her GP notes, Medical Notes, X-rays and Occupational Health Records

e) If the claimant's solicitors request copies of the A&E, hospital notes or Xrays, obtain the claimant's signed form of authority for the disclosure of these notes to the solicitors and check the quality and accuracy of the photocopied records before sending them to the solicitors (see 3.4.c).

f) Review the Directorate's response to the standard letter, payroll information and further information from the claimant's solicitors and obtain any further comments/statements required.

g) Establish an objective account of the original incident, which gives appropriate weight to the recollection of the staff originally involved.

h) At this stage, a decision will be made by the Executive Nurse Director or Concerns/Claims Managers regarding the handling of the claim internally or by reference of the file to one of the firms of solicitors duly appointed by the Health Board. For the purpose of this document, reference will be made to the Health Board's solicitor.

4.5 Gathering the evidence

Staff should be aware that certain type of information is subject to confidentiality. In the past, statements have been received from staff, which makes reference to patients and their medical conditions. This is of course confidential to the patient.

In cases where staff have injured themselves when lifting a patient it is usual for the claimant's solicitors to seek information in respect of the patient, normally the care plan, giving details as to weight and medical condition. The Health Board's legal **advisor** will ensure that any information will be subject to the removal of the patient's identification details thus anonymising the records.

It is a legal requirement, once legal action has been initiated, that we are bound to disclose any notes, memoranda etc. that relates to a specific incident that were in existence prior to the commencement of an action. It is therefore essential to instigate and maintain a system, which will ensure the ability to file and recall appropriate records.

Document Title: Claims (Negligence , Personal Injury and Redress) Management Policy	24 of 38	Approval Date: 13 Sep 2016
Reference Number: UHB 332		Next Review Date: 13 Sep 2019
Version Number: 1		Date of Publication: 11 Oct 2016
Approved By: Quality, Safety and Experience Committee		

The claimant's solicitors may request access to an area where their client allegedly sustained their accident. Whilst this request cannot normally be denied, it is important to place the request in the context of the proceedings. For example, if the Health Board's position in respect of liability and causation is a foregone conclusion in favour of the claimant then an inspection of the site in question would be an unnecessary addition to the costs of the action.

Where a site inspection has been agreed, the name of the appropriate contact officer should be given to the Concerns/Claims Managers or Health Board's solicitors, who will relay this information to the claimant's solicitors.

Should equipment be involved in an accident, this will have to be retained for inspection, if practicable, and if not, appropriate steps should be taken to provide a brief note as to its reason for disposal. Although not every accident leads to litigation, some incidents will prompt the senior manager responsible to ask for photographs to be taken, which of course will aid the Health Board, should the claim be initiated at a future date.

4.6 Expert evidence

Expert advice, such as engineer or medical evidence can be obtained to comment on many issues including liability, causation, condition and prognosis and life expectancy.

The Health Board may also wish to commission its own experts reports, particularly in relation to multi-track claims, which may lead to conflicting accounts as to the proper standard of care in the procedure in issue. In certain circumstances the Health Board may agree to the use of a joint expert. Given the complexity of some claims, in particular clinical negligence claims, the Health Board's solicitors to consider the future management of the claim and to comment specifically on issues relating to liability and quantum and will seek advice from Counsel when appropriate. The Clinical Board shall be kept updated as to the progress of the claim at all times.

4.7 Assessment of a claim

Following the receipt of the evidence, the Health Board's solicitors will provide an initial assessment and valuation of the claim, together with recommendations for future management within three months of the notification of the claim. Although the views of the staff directly involved are considered, it is not appropriate that they are involved in the decision making process. This requires an independent assessment of the available evidence and a consideration of the Health Board's position on the balance of probabilities.

The Health Board's solicitors will then prepare a summary of the claim by examining expert legal and medical reports and the views of the staff involved. A broad guideline as to the information usually required is:

- An objective account of the incident
- An explanation of the basis and background of the claim

Document Title: Claims (Negligence , Personal Injury and Redress) Management Policy	25 of 38	Approval Date: 13 Sep 2016
Reference Number: UHB 332		Next Review Date: 13 Sep 2019
Version Number: 1		Date of Publication: 11 Oct 2016
Approved By: Quality, Safety and Experience Committee		

- The views of the Welsh Government if the case involves novel, contentious or precedent setting issues
- A balanced view of the likely defence including legal and medical opinion when available
- Clarification of the basis on which damages have been estimated
- A legal opinion of the likely outcome of any court hearing
- An assessment of quantum including, where applicable, the reason for the proposed settlement
- An estimate of the possible savings for the public purse if a payment is made
- Details of the proposed approach to negotiations with the claimant (Including the initial offer and proposed upper limit)
- Details, where applicable, of structured settlement/periodical payments
- Details of any systematic failings on the part of clinical or other front line staff, operational and risk management procedures, claims handling staff, claims handling procedure. If so, what action is intended to remedy the identified deficiencies, including the timetable for implementation of any changes or improvements. It should also be identified how the proposed improvements will be monitored

4.8 Settle or defend

Depending on each individual case, the Health Board's Solicitor may be able to conclude the matter swiftly or else seek further expert opinion from suitably qualified experts. If the Health Board's solicitors advise that the allegations cannot be defended, then authorisation for an out of court settlement will be sought within delegated limits and agreed levels of authority. Alternatively, the Health Board's solicitors will prepare the case for court.

5. COURT PROCEEDINGS

Should court proceedings be commenced in relation to clinical negligence or personal injury claims, the Health Board's solicitors shall take the following actions:

5.1 The procedure

a) Claim form and particulars of claim

The claim form and particulars of claim will be served either directly on the Health Board or the Health Board's solicitors, together with the acknowledgment of service. The acknowledgement of service must be filed within 14 days, indicating whether the claim is to be defended. If the claim is to be defended a defence must be filed within 28 days of service of the particulars of claim.

Therefore, it is essential that any information requested is supplied promptly and forwarded without any unnecessary delays to the Concerns/Claims Managers for onward transmission to the Health Board's solicitors.

b) Development of a case

Court proceedings will be run in accordance with the Civil Procedure Rules and directions given for the conduct of the action at any Case Management Conferences.

c) Directions

Document Title: Claims (Negligence , Personal Injury and Redress) Management Policy	26 of 38	Approval Date: 13 Sep 2016
Reference Number: UHB 332		Next Review Date: 13 Sep 2019
Version Number: 1		Date of Publication: 11 Oct 2016
Approved By: Quality, Safety and Experience Committee		

- **Disclosure**

The parties to an action will have to serve Lists of Documents giving details of all documentary evidence relevant to the claim, not including those documents, which are privileged. Such documentation would include incident reports, risk assessments, claimant’s training records, occupational health records etc.

- **Exchange of evidence**

The parties to the action will have to exchange witness evidence, to include lay witness and medical or other expert evidence prior to the trial.

Exchange of witness evidence is carried out on a simultaneous basis so each side receives the others evidence at the same time. The court at a Case Management Conference determines the time frame.

d) Trial/settlement

Following the completion of the above stages, the claimant will seek to push the matter towards trial, unless a decision is made by the Health Board to settle the claimant’s case or, on rare occasions, the claimant discontinues his/her action against the Health Board.

In readiness for the final hearing, the Concerns/Claims Managers shall arrange for the Health Board’s witnesses to attend court and ensure that they have been briefed about court procedure.

The Health Board’s position is determined after careful consideration of the evidence by the Health Board’s solicitors, backed up by an opinion from Counsel, if necessary. The Health Board will request advice as to the likelihood of successfully arguing, on the balance of probabilities, that the Health Board was not liable for the claimant’s injuries. At this stage it may be necessary to arrange a conference to include officers of the Health Board, usually the Concerns/Claims Managers, with the required level of Executive authority, the Health Board’s legal advisors, experts, Counsel and witnesses in order to consider the available evidence and make a decision on the best options available to the Health Board.

Depending upon the level of quantum, the decision as to whether or not to proceed to trial or negotiate a settlement will be made by the Executive Nurse Director or the Board itself, depending on the level of delegated authority required. Upon receipt of the Health Board’s instructions, the Health Board’s solicitors will either prepare the case for final hearing or attempt to secure a settlement which can either be accompanied by an admission of liability or on a without prejudice basis. Once a decision is taken to settle a claim, the Health Board is committed to payment of those damages to the claimant, whether or not the Health Board admits liability.

On the advice of the Health Board’s solicitors, the Health Board may wish to make a payment into court (Part 36 payment). This would protect the Health Board’s position should the claim proceed to Trial.

6. CLAIMS HANDLING - GENERAL INFORMATION

Document Title: Claims (Negligence , Personal Injury and Redress) Management Policy	27 of 38	Approval Date: 13 Sep 2016
Reference Number: UHB 332		Next Review Date: 13 Sep 2019
Version Number: 1		Date of Publication: 11 Oct 2016
Approved By: Quality, Safety and Experience Committee		

6.1 The role of the Health Board’s Solicitors

Once the Health Board’s solicitors have been notified of a claim, they will then act on the Health Board’s behalf in conducting the claim as set out above. They will keep in regular contact with the Concerns/Claims Managers and give an expert opinion of the strengths and weaknesses in the Health Board’s defence. The solicitor shall also keep the Concerns/Claims Managers fully briefed on all stages of the claim throughout its lifetime.

6.2 Authorisation

a) To take certain action

Authorisation may be requested at any time during the life of a claim. This may be for:

- Authority to admit liability
- Authority to take certain action
- Authority to make an offer of settlement
- Authority to settle damages or costs for a certain amount

To obtain authority to take certain action, all the authorised signatories must sign an ‘Authorisation Request Form’ which is supported by evidence and then retained on the Health Board’s claim file. All claims of £1 million and over have to be submitted to the Welsh Assembly Government for approval.

b) To make payments

Payments may be requested at any time during the life of a claim. These may include:

- Fees to expert witnesses
- Fees to Counsel
- Payments into court
- Interim/full and final settlements of the claimant’s damages and costs
- Legal fees to the Health Board’s solicitors (Personal Injury Cases)

A request for authority to make a payment is made on a ‘Finance Request Form’ to which the invoice/request for payment is attached. All the authorised signatories must sign this form. The form is then handed to the Finance Analyst who arranges for the cheque to be issued and then forwarded to the Concerns/Claims Managers for distribution. The Health Board’s file must have a copy of the finance request form showing all required signatures.

6.3 Delegated financial limits

Document Title: Claims (Negligence , Personal Injury and Redress) Management Policy	28 of 38	Approval Date: 13 Sep 2016
Reference Number: UHB 332		Next Review Date: 13 Sep 2019
Version Number: 1		Date of Publication: 11 Oct 2016
Approved By: Quality, Safety and Experience Committee		

It is the responsibility of the Board to agree the circumstances, including delegated financial limits, in which various requests may be approved by authorised signatories being:

- a) The Chief Executive,
- b) The Board itself
- c) The Executive Directors
- d) Other

6.4 Structured settlements/periodical payments

At times, it may be appropriate for alternatives to a single lump sum payment to be considered.

In the event of a lump sum award, it is assumed that the claimant invests the money in a suitable mix of equities, gilts and cash and pays for the care costs out of these investments. These investments are subject to taxation and professional fees. A lump sum, prudently invested, will provide regular income for the claimant. However, there is also the possibility that the money awarded runs out before the claimant dies. In this case it is assumed that the claimant falls back on the State who pays for their care costs although it is recognised that Free State care may not compare with that purchased by the claimant.

A structured settlement (which is a periodical payment funded by an annuity) is an alternative to a lump sum payment made to a claimant. A structured settlement involves a number of payments at different times in the future. The amount of money required at the present time to provide these payments in the future is known as the present value of the future payments. A structured settlement allows for part of the damages to be paid in the form of annual tax free instalments for the duration of the claimant's life.

The courts are now able to order structured settlements for future loss and care costs without the consent of the parties. It also gives the Lord Chancellor a power to enable such awards or agreements to be varied under specified circumstances, and prevents the assignment of the right to receive payments unless the court is satisfied that there are special circumstances, which make this necessary.

The structured settlement may be for the life of the claimant, for a specified period or of a specified number or minimum number or include payments of more than one of those descriptions. If the recipient of a structured settlement dies, the payments will cease. Therefore, there is a chance that the next payment may not be made. Each year, there is a chance that the recipient of the periodic payment could die. In high value claims a large proportion of the compensation is associated with future loss as a result of the injury. The Health Board will provide these payments either by means of an Annuity backed structured settlement or a self funded structured settlement. Welsh Assembly Government guidance (WHC (97) 17) states that structured settlements must be considered for any settlement of £250,000 or more.

Document Title: Claims (Negligence , Personal Injury and Redress) Management Policy	29 of 38	Approval Date: 13 Sep 2016
Reference Number: UHB 332		Next Review Date: 13 Sep 2019
Version Number: 1		Date of Publication: 11 Oct 2016
Approved By: Quality, Safety and Experience Committee		

The Health Board will depend upon the guidance of its legal advisors and the finance department as to whether to enter into a structured settlement.

In the event that a structured settlement is considered/may be made, the Health Board should notify the WRP as soon as possible. This is essential as the WRP is responsible for setting up and maintaining the structured settlement schedule of payments once agreed by the Court. Once the claim has been settled and the Court has approved the structured settlement, the court order should be submitted to the WRP within 14 days of the order being approved.

Structured settlements are administered in the main by the Health Board's solicitors, Welsh Health Legal Services.

6.5 Quantum reports

On a quarterly basis the Concerns/Claims Managers shall prepare an up to date quantum report, which shall be forwarded to the WRP and to the finance department. The report will give quantum figures to enable the finance department to calculate the Health Board's total liabilities and also probability of loss. The quantum may change during the course of the claim. The following information will also be noted by reference to the numbers 1-5.

Probability of loss

1 - 95%-100% certain

- The Health Board has been proven negligent and will have to compensate

2 - 50%-94% Probable

- There is evidence of negligence, but the Health Board may be able to prove some contributory negligence on the part of the Claimant or extenuating circumstance

3 - 06%-49% Possible

- The Health Board has a good defence and may be able to defend the claim

4 - 0%-06% Remote

- The Health Board has not been found to be negligent and the Claimant has no case

5 – 0%-06% Remote

- The Health Board has not been found to be negligent and the Claimant has no case

5 TETA – Too early to assess - New claim that is too early to assess

On receipt of quantum reports the Concerns/Claims Managers shall confirm the current status of the claim to ensure that it is active. Consideration should be given to the closure of a file if it has been inactive for a period of 18 months.

7. WELSH RISK POOL (WRP) REQUIREMENTS

The WRP requires notification of any claim that is estimated to cost more than the Health Board's excess (£25,000). On receipt of the quantum reports from the Health Board and solicitors, on a quarterly basis, the WRP will be updated as to any revaluation or new claims handled by external or in-house solicitor other than the Welsh Health Legal Services that may result in a claim against the WRP.

Document Title: Claims (Negligence , Personal Injury and Redress) Management Policy	30 of 38	Approval Date: 13 Sep 2016
Reference Number: UHB 332		Next Review Date: 13 Sep 2019
Version Number: 1		Date of Publication: 11 Oct 2016
Approved By: Quality, Safety and Experience Committee		

The Concerns/Claims Managers has a duty to:

- Notify the WRP of all claims that are settled
- Claim reimbursement from the WRP within the 56 day rule with the minimum of delay

All claims on the WRP should be made on the appropriate forms. On receipt of the form, the WRP may request additional information. It should also be noted that the claim file might be requested by the WRP for audit purposes.

Claims against the WRP can only be made after the claim has been concluded and the full costs have been paid. However, following an interim payment in excess of £100,000, an immediate claim can be made against the WRP.

The Concerns/Claims Managers and Finance Analyst will work together to ensure that the Health Board complies with the calendar and financial requirements of the WRP, thereby aiming to ensure the efficacy of the Health Board to validate dates, payments made, and reimbursement requests as accurate, appropriate and within the required time parameters.

- **Welsh Risk Pool Assessments**

The WRP periodically undertakes detailed reviews of a sample of claims received by the WRP Advisory Board for reimbursement. The purpose of these reviews is to consider the way in which the claim has been managed with emphasis placed upon the lessons learned and the local procedures that are now in place. The WRP will share the lessons learnt via the networks within the NHS organisations in Wales.

The Concerns/Claims Managers will ensure that upon any request from the WRP for a detailed file review, that access is available, but not limited to, the following:

- Claims File
- Clinical Records
- Policies and Procedures
- Site visit if required
- Directorate staff
- Any or all parties involved in the Claim
- Audit Reports
- Health Board Report etc.

The Concerns/Claims Managers will ensure that all parties are involved in the Claim. All clinical Boards are notified of the Assessment, date, time and venue, and are available for interview if so required. You must ensure that any documentation or any changes instigated since the claim are available for the Assessors review.

Upon conclusion of the Assessment, the WRP Assessor will provide a draft report for comment; the Concerns/Claims Managers will review the said report, consult with

Document Title: Claims (Negligence , Personal Injury and Redress) Management Policy	31 of 38	Approval Date: 13 Sep 2016
Reference Number: UHB 332		Next Review Date: 13 Sep 2019
Version Number: 1		Date of Publication: 11 Oct 2016
Approved By: Quality, Safety and Experience Committee		

Directorate staff and will provide the WRP Assessor with any comments or further information as required, prior to the finalisation of the WRP report.

7.1 Financial Limits and the requirement of an Annex B form

a) Claims not exceeding £1,000 and discontinued claims

There is no obligation to complete an Annex B form in relation to claims where quantum (**damages, claimant's and defendant's costs combined**) does not exceed £1,000 or on claims that have been discontinued. The completion of an Annex B in relation to these claims is at the Concerns/Claims Managers' discretion.

b) Claims exceeding £1,000 but not exceeding £25,000

Annex B's are to be undertaken on all concluded claims where quantum has exceeded £1,000.00. Annex B's with an excess below £25,000.00, are NOT required at the WRP, and will not record in such fine detail the particulars of the administration of a claim.

c) Claims exceeding £25,000

Detailed Annex B's are required whenever quantum on a case exceeds £25,000. When some positive movements towards settlement are made i.e. on acceptance of liability, settlement, an interim payment is made, or earlier if indications show that there will be a need to make a WRP claim, the Concerns/Claims Managers will commence the Annex B for those claims where quantum exceeds £25,000.

The Finance Analyst must be informed of the commencement of the Annex B, where quantum exceeds £25,000.00.

7.2 Procedure for the reimbursement of claims exceeding £25,000

The following documentation should be completed by the Concerns/Claims Managers Litigation, in conjunction with the Finance Analyst, special losses and submitted to the Welsh Risk Pool (WRP) for claim reimbursements:

- WRP1 claim form
- Annex B Checklist
- Schedule of Costs

a) WRP 1 claim form

This form should be:

- An original form
- Signed by an authorised signatory
- Completed in typeface as handwritten forms will not be accepted
- All areas of the claim form should be completed including
- The Claimant's full name including fore name and surname to enable a full search for previous payments
- The name of the lead clinician involved in the claim

Document Title: Claims (Negligence , Personal Injury and Redress) Management Policy	32 of 38	Approval Date: 13 Sep 2016
Reference Number: UHB 332		Next Review Date: 13 Sep 2019
Version Number: 1		Date of Publication: 11 Oct 2016
Approved By: Quality, Safety and Experience Committee		

- Identify correctly the health body who is the Defendant to the claim especially where the claim relates to a former health authority

b) Annex B Checklist/Category 7 Checklist

In accordance with WHC (97) 17, Health Boards and Local Health Boards are required to complete a checklist detailing the nature of the incident, its context, the manner in which it was handled as a claim and changes that have been made to reduce future risk. This is the Annex B Checklist/Category 7 Checklist. The key areas of the Annex B that are reviewed include the remedial action taken to prevent future occurrences and areas where lessons may be learnt. The nature of the alleged negligence should therefore be suitably detailed, as should the breaches of duty of care, to enable the sufficiency of the remedial action to be assessed.

The Annex B should satisfy the following conditions:

- It must be typed, as handwritten Annex B's will not be accepted
- The original Annex B must be submitted for all final and first interim claims as a photocopied Annex B will only be accepted when the checklist has previously been accepted and approved by the Advisory Board and where previous reimbursements have been made against the claim
- It must be signed by authorised signatories, one of whom must always be the Chief Executive

c) Schedule of Costs

A detailed schedule of the costs incurred by the Health Board or health body (i.e. pre Health Board claims), should be attached to the completed WRP 1 claim form.

The schedule should include the following:

- The date that the payment was made
- To whom the payment was payable
- The description of the payment i.e. what it was for
- Where a former health authority has previously managed the claim, the health body that incurred the costs should be specified.

It is also recommended that schedules should have a cumulative running total of expenditure. To ensure compliance of the WRP reimbursement procedures, the Health Board will be required to make a declaration that all items are net of recoverable VAT on each schedule presented.

7.3 Authorised Signatories

Claims for reimbursement can only be considered for approval if authorised signatories have signed the WRP 1 claim form and Annex B checklist. The WRP stipulate that member organisations must supply the WRP manager with sample signatures of at least 3 officers with delegated responsibility for authorising such claims in accordance with the organisation's standing financial instructions. It is the responsibility of all member organisations to update authorised signatories in the event of personnel changes and to ensure that the schedules supplied to the WRP

Document Title: Claims (Negligence , Personal Injury and Redress) Management Policy	33 of 38	Approval Date: 13 Sep 2016
Reference Number: UHB 332		Next Review Date: 13 Sep 2019
Version Number: 1		Date of Publication: 11 Oct 2016
Approved By: Quality, Safety and Experience Committee		

are in accordance with their own standing financial instructions and schemes of delegation. The Chief Executive must always be one of the signatories on the Annex B checklist. Where a health body is aware that its Chief Executive is not going to be available for any reason in the long term, and appoints an Acting Chief Executive, the Acting Chief Executive can complete the signatories forms indicating that he/she is acting up and thereafter may sign the Annex B as Acting Chief Executive.

7.5 Reimbursable Costs – Health Board excess is at £25,000.00

Costs associated with losses will be reimbursed by the WRP subject to compliance with the WRP reimbursement procedures.

Any VAT incurred on costs that can be reclaimed by the Health Board, interest earned from payments into Court or any costs recovered from a claimant, should be deducted from the amount claimed for reimbursement.

Where the WRP has reimbursed the Health Board, any monies returned to the Health Board by either the Courts or the Compensation Recovery unit must be paid back to the WRP within 14 days of its receipt.

7.6 Timing of Reimbursement Claims

Requests for reimbursement must be presented to the WRP Advisory Board, notification of the meeting dates are provided periodically by the WRP. It is preferable that reimbursement claims are submitted 10 days before the due WRP Advisory Board meeting date. Any claims received later than the cut off date will be submitted to the next Advisory Board meeting.

Again, the Concerns/Claims Managers Litigation will contact the WRP by e-mail, within 7 days of forwarding, to confirm their receipt of the said request. WRP acknowledgements to be retained on file accordingly.

7.7 Interim Claims

The Health Board is obliged to submit an interim claim for reimbursement for any claim on which the cumulative balance of all payments, disbursements, costs etc associated with the claim, total £100,000.

The interim claim must be submitted within 56 days of this figure being reached, even where this precedes the resolution of costs. The excess for interim claims for all NHS Health Boards is £50,000.

In the event that a claim is received by the WRP, after 56 days of the expenditure totalling £100,000.00, a penalty will be imposed.

When the unclaimed balance (including the interim excess) again reaches £100,000, a further interim claim should be made. This should continue until the claim is finally concluded.

Document Title: Claims (Negligence , Personal Injury and Redress) Management Policy	34 of 38	Approval Date: 13 Sep 2016
Reference Number: UHB 332		Next Review Date: 13 Sep 2019
Version Number: 1		Date of Publication: 11 Oct 2016
Approved By: Quality, Safety and Experience Committee		

The excess reverts to the standard £25,000 upon conclusion of any claim.

The Health Board must submit a final claim for reimbursement within 56 days of the case being resolved and the costs being paid in full. Any claims for reimbursement submitted outside of this timescale will be penalised in accordance with WRP provisions.

Claims subject to an outstanding appeal to the Compensation Recovery Unit (CRU) should be considered as a final claim, rather than await determination of the CRU appeal. Following a successful CRU appeal any monies received should be remitted back to the WRP as a Post Closure item.

This is to be monitored by both the Finance Analyst and Concerns/Claims Managers to ensure compliance.

Once again, the Concerns/Claims Managers is to contact the WRP by e-mail, within 7 days of forwarding, to confirm their receipt of the said request. WRP acknowledgements will be retained on file accordingly.

7.9 Penalties

Where a claim for reimbursement is submitted outside of the timescale, will not be paid and the if the delay has been with the Clinical Board thy will be liable for the full cost of the settlement

7.10 Concluded claims: accepted date of closure

The above 'trigger point' practice is also adopted when claims reach their conclusion. The date considered as the final 'done date' is the date of the last cheque request for payment of costs etc., (irrespective of whether they are claimant or defence costs).

The date of settlement is the date the Health Board agreed the terms of the settlement and a cheque request for the amount agreed is prepared and duly authorised. The settlement date is not to be considered as the date when cheques are received from the finance department.

7.11 Annex B process

The Concerns/ Claims managers will complete the appendix form within 6 to 8 weeks of the case closure. The Clinical Board will be given 6 weeks to complete the lesson learned and provide the supporting evidence. The form will then be checked, finance information provided and shared with the Welsh Risk Pool.

7.12 Request for further information and resubmission of rejected claims

If insufficient information is provided in the Annex form, the Advisory Board will request further information. This can delay reimbursement to the Health Board and the Board could reject the claim.

7.13 Post closure payments and receipts

The Health Board may receive late invoices in respect of expert fees and other costs after a claims file has been closed and a final reimbursement has been made by the WRP.

Document Title: Claims (Negligence , Personal Injury and Redress) Management Policy	35 of 38	Approval Date: 13 Sep 2016
Reference Number: UHB 332		Next Review Date: 13 Sep 2019
Version Number: 1		Date of Publication: 11 Oct 2016
Approved By: Quality, Safety and Experience Committee		

For payments made, the WRP will reimburse the additional amount, provided it is satisfied that all reasonable steps were taken by the Health Board to complete all financial transactions prior to submitting a final claim.

The Health Board will need to make a claim using the following documentation:

- WRP 1 claim form
- Updated Schedule of Costs
- Photocopy of the original Annex B

7.14 Notifying the WRP of other claims

In accordance with WHC (2000) 12, the Concerns/Claims Managers is obliged to notify the WRP Manager of the following:

a) WRP 2 Forms

Any existing claim which is likely to become subject to a claim for reimbursement. The WRP acknowledges that it now has available to it, financial information relating to the value of claims from Welsh Health Legal Services ('WHLS'), therefore, this requirement now only relates to claims, which are handled by either external or in-house solicitors, i.e. those other than WHLS. In all such claims, which are likely to exceed excess, the Health Board must lodge a WRP 2 form with the WRP. Failure to notify the WRP of the existence of such a claim, may result in the WRP Advisory Board rejecting the claim.

b) WRP 3 Forms

All claims settled below excess should be notified to the WRP on WRP 3 Forms.

c) WRP4 Forms

WRP 4 forms must be completed and submitted to the WRP by the Legal Services Manager on all claims in excess of £1,000.00 to £30,000.00. The Legal Services Manager sends a hard copy of the signed WRP 4 form to the Finance Analyst.

8. CONCLUSION OF THE CLAIM

8.1 Closed files

There are several ways in which a claim may be closed:

- Discontinued
- Formally withdrawn
- Statute barred
- Settlement
- Nothing further heard

Where settlement has been made, the closure of a claim will include settlement of the claimant's costs. It will also include payment of the Health Board's defence costs

Document Title: Claims (Negligence , Personal Injury and Redress) Management Policy	36 of 38	Approval Date: 13 Sep 2016
Reference Number: UHB 332		Next Review Date: 13 Sep 2019
Version Number: 1		Date of Publication: 11 Oct 2016
Approved By: Quality, Safety and Experience Committee		

and any other outstanding fees. The database should be updated to show the date of closure and the outcome of the claim.

8.1 Closure of files

The Finance Analyst must be advised of the closure of all claims with a monetary value. An Annex form is e-mailed to the Finance Analyst, to enable this information to be recording onto LASPAR. The Finance Analyst also receives a copy of the WRP 4 form.

8.2 Notification to the relevant parties to the claim

At the conclusion of a claim, the Concerns/Claims Managers shall advise the others involved in the Claim, of the outcome of the claim; that the claim is to be closed and thank them for their kind assistance.

8.3 Reviewing files at conclusion

a) Lessons learnt

When the Concerns/Claims Managers identifies or is notified that a claim has been closed, a decision will be made upon whether the preparation of an Annex B is appropriate. This decision is based upon Welsh Risk Pool requirements as set out above or, if an Annex B is not required in accordance with WRP requirements, whether it is felt that the matter has progressed to a stage that an Annex B is justified.

The Concerns/Claims Managers will review all closed files. Once the Annex B has been completed or a decision has been made to close the file without an Annex B, the following actions will be undertaken:

a) The Concerns/Claims Managers will review the file and decide whether to prepare an action plan, identifying the failures, lessons learnt, action to be taken, evidence and audit.

b) If an action plan is appropriate, the Concerns/Claims Managers will then speak to the Clinical Board or other relevant member of staff with conduct of the claim to review the action plan in relation to the failures identified, lessons learnt, action to be taken, evidence and audit.

c) The member of staff with conduct of the claim will then provide the Legal Services Manager with the name of the individual who is responsible for the action and due date.

d) The Concerns/Claims Managers will then finalise the action plan and send a copy to the individual with responsibility for the action, noting the due date.

e) The Lead Officers Group shall consider the action plan and further recommendations may be made. If this is the case, the Legal Services Manager shall discuss these with the member of staff with responsibility for the claim, as set out above.

Document Title: Claims (Negligence , Personal Injury and Redress) Management Policy	37 of 38	Approval Date: 13 Sep 2016
Reference Number: UHB 332		Next Review Date: 13 Sep 2019
Version Number: 1		Date of Publication: 11 Oct 2016
Approved By: Quality, Safety and Experience Committee		

f) The Concerns/Claims Managers will enter the action plan into a bring forward system with a view to monitoring compliance with the due date and collating evidence in relation to each action.

g) Once each action has been addressed and evidence in relation to each action has been collated, the Concerns/Claims Managers will then provide the member of staff with conduct of the complaint with a completed action plan for display/circulation to all staff within the Directorate.

- Facilitating and promoting change within the organisation through the development of the lessons learnt process
- Receiving progress reports on current and recently closed litigation reports
- Receiving annual litigation reports

At every meeting the group will consider in detail the failures identified, lessons learnt, actions to be taken and relevant audits in relation to all relevant claims that have been concluded within the period since the Group last met.

In relation to each claim the Group shall consider the following documents:

- Case Synopsis
- Action Plan
- Concluded action plan together with any relevant documentation in relation to actions taken
- Concluded audits

Having considered the case synopsis and action plan, the group shall:

- Decide whether the failures identified, lessons learnt and actions to be taken are satisfactory
- Decide whether any additional failures, lessons learnt and actions can be identified and make recommendations for amendments to the action plan
- Consider whether the claim should be referred to the Clinical Audit Department for consideration and if so, identify the nature of the audit to be undertaken

It will be noted on all claims files whether a claim has been referred to the Lead Officers Group and if so, the outcome of that referral.

9.2 Compensation Recovery Unit

The rules concerning the repayment of benefits to the Compensation Recovery Unit (CRU) have recently changed under the provisions of the Social Security (Recovery of Benefits) Act 1997.

The main points from the Act are as follows: -

Document Title: Claims (Negligence , Personal Injury and Redress) Management Policy	38 of 38	Approval Date: 13 Sep 2016
Reference Number: UHB 332		Next Review Date: 13 Sep 2019
Version Number: 1		Date of Publication: 11 Oct 2016
Approved By: Quality, Safety and Experience Committee		

- The new rules apply to all claims settled on or after the 6th October 1997, including claims arising out of accidents prior to 1st January 1989 which were not covered by original Compensation Recovery Scheme
- The current small payment exemption for compensation of £2,500 or less will no longer apply from the 6th October 1997, and the CRU must be informed of all claims and a Certificate of Total Benefit obtained before settlement.
- The Health Board repays the full amount of recoverable benefits to the CRU
- No benefits may be taken from the claimant’s general damages i.e. those damages paid for compensation for pain and suffering, loss of amenity, loss of congenial employment
- The Health Board will only be able to reduce the compensation payable to a claimant where DSS benefits have been paid for the same reason that compensation has been awarded e.g. Statutory Sick Pay and Sickness Benefit may be deducted from the compensation award for loss of earnings resulting - from the relevant accident

The new legislation will remove the possibility of a small nuisance settlement in cases where a large amount of benefits has accrued. Further, should the benefits to be repaid to the CRU exceed the special damages claim, the Health Board will have to repay the full amount of benefit to the CRU as well as general damages awarded to the claimant, which will remain ring fenced. This will increase the Health Board’s outlay from the present position whereby any benefits to be recovered in excess of special damages would be recouped from general damages. The Director Governance & Communications’ role in this process is limited. Any documentation received will need to be sent to the Health Board’s legal advisor for action.

9.4 Criminal Injuries Compensation Authority

The Board entertains applications for payments of compensation where the applicant has sustained personal injury attributable to a crime of violence. As with personal injury claims these will only be considered if made within three years of the incident, giving rise to injury. Minor injuries are excluded (i.e. where awards would be less than £1,000 after the deduction of benefits received). A person can simultaneously pursue the Health Board and the Compensation Board, but the individual will not recover a payment in duplicate.