NHS
West Lancashire
Clinical Commissioning Group

Claim Management Policy

With you.
For you.

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West Lancashire CCG is committed to ensuring that, as far as it is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on the basis of their age, disability, gender, race, religion/belief or sexual orientation.

Should a member of staff or any other person require access to this policy in another language or format (such as Braille or large print) they can do so by contacting the West Lancashire CCG who will do its utmost to support and develop equitable access to all policies.

Senior managers within the CCG have a responsibility for ensuring that a system is in place for their area of responsibility that keeps staff up to date with new policy changes.

It is the responsibility of all staff employed directly or indirectly by the CCG to make themselves aware of the policies and procedures of that CCG.

Contents

1. Introduction

This policy recognises the need to ensure appropriate management of claims in respect of alleged negligence where compensation is demanded, and the importance of taking action to minimise such claims through effective risk management.

The CCG's Risk Management Strategy should be read together with this policy to ensure that the CCG approach to the management of risks identified as the result of claims is fully understood in context.

2. Purpose

To ensure that an efficient and effective claims management system is in place that will deal with claims fairly whilst safeguarding the interests of staff, patients and the CCG.

The CCG is committed to a fair blame approach when handling claims, which will always be directed at the organisation rather than the individual. This commitment will not, however, prejudice any subsequent disciplinary action where breaches of law, professional misconduct, or unacceptable repetitious acts have occurred.

3. Scope

The policy applies to all staff of the CCG employees, volunteers, visitors and contractors.

4. Principles

Notification of Claims

Notification of claims can come in many forms and it is imperative that the CCG has systems in place to recognise these when they arrive. Once the litigation process has begun tight timescales are imposed.

Any member of staff who receives or opens a notification of claim should pass it to the Head of Corporate Affairs. In their absence it should be passed to the Chief Finance Officer.

Under no circumstances should the claim be acknowledged in writing or by making a telephone call.

The National Health Service Litigation Authority (NHSLA)

The National Health Service Litigation Authority (NHSLA) is a Special Health Authority set up under Section 11 of the NHS Act 1977. The NHSLA is effectively the CCG's "insurance company" and administers the following schemes:

- Existing Liabilities Scheme (ELS) – covering claimed relating to incidents that occurred before 31 March 1995

- Clinical Negligence Scheme for Trusts (CNST) – covering claims relating to incidents that occurred from 1 April 1995

- Risk Pooling scheme for Trusts (RPST) – this is the NHSLA's risk pooling scheme for employer's, public and third party liability claims. It covers claims relating to incidents after 1 December 199. The scheme is split into two parts Property Expenses Scheme (PES) and Liabilities to Third Parties Scheme (LTPS)

The above NHSLA schemes relevant to the CCG cover Clinical Negligence Scheme for Trusts (CNST) and Third Party Liability (LTPS) including:

- Personal injury to employees
- Personal injury to members of the public
- Property belonging to others
- Losses through acts or omissions by Officers

5. Implementation and Responsibility

Chief Officer - is the officer responsible for the management of claims. It is the Chief Officer's responsibility to ensure that claims are managed in compliance with the policy, national guidance and statute.

Chief Finance Officer – is the designated executive lead for litigation and claims and will ensure that all claims are investigated (see appendix ??). The Chief Finance Officer will keep the Quality and Safety Committee and the Governing Body informed of any major developments related to the management of claims and is also responsible for approving the admission of liability or settling of claims.

Line managers - are responsible for the co-operation of staff within their areas of responsibility in providing timely and accurate information.

Staff – any member of staff receiving a claim or potential claim must pass the letter directly to the Head of Corporate Affairs without acknowledgement, as many deadlines run from the date of acknowledgement. All staff are responsible for the prompt supply of all relevant information required in respect of each claim to the Head of Corporate Affairs. Any High Court Writ or County Court Summons received in relation to claims or litigation against the CCG must be forwarded immediately to the Head of Corporate Affairs and under no circumstances should they be acknowledge by any individual.

The co-operation of all staff is essential to allow early assessment of the merits of claims and plan their future management.

Third party correspondence received in respect of claims should be referred to the Head of Corporate Affairs.

6. Triggers for invoking the claims procedure

Should a member of staff feel that the CCG may be subject to a potential claim they should contact the Head of Corporate Affairs immediately.

The following events are regarded as potential claims against the CCG:

- Receipt of legal proceedings, a letter of claim or a letter indicating a likely claim from a patient, member of the public or employee or from a solicitor;
- Receipt of a request for disclosure of records:

    a) made by a solicitor which is not made for the purpose of a claim against another party
    b) made by a patient/relative who state that they intend making a complaint or claim against the CCG or
    c) made by a patient/relative who does not give a reason for the request; in which case every effort should be made to ascertain the reason, either by review of the records or by asking the patient (however refusal to give a motive does not remove the patient's right to receive a copy of the records)

- An adverse event which may generate substantial compensation
- Receipt of a serious complaint letter containing threats of legal action
- A verbal accusation of negligence/liability from a patient or relative

7. Process

When a claim is received it should be referred immediately to the Head of Corporate Affairs who will ensure that the claim is notified to the NHS Litigation Authority (NHSLA).

The NHSLA have a maximum of three months from the date of acknowledgement of the claim to investigate. No later than the end of that period the NHSLA will reply, stating whether liability is denied and, if so, giving reasons for their denial of liability including any alternative version of events relied upon.

According to each individual case, the Head of Corporate Affairs will need to gather information for the case, for the NHSLA and the instructed solicitor. Time frames are usually reasonable and staff who have been requested to provide information should ensure that they keep to the deadlines.

Staff must not enter into any correspondence directly with the claimant, their solicitors or any other third party.

It will be the responsibility of the Chief Finance Officer to complete all official insurance claim forms.

The Head of Corporate Affairs will support the Chief Finance Officer and ensure that all claims are dealt with promptly and efficiently and in accordance with agreed procedures. Claims falling under the NHSLA schemes will be dealt with in accordance with scheme rules which are available on www.nhsla.com

8. Confidentiality and information governance relating to claims handling

It is essential that the duty of confidentiality the CCG has to all patients/service users and employees is maintained. Anyone involved in a claim, at any level, has an obligation to comply with this policy and to ensure confidentiality of information at all times. The CCG will ensure that all claims are handled in accordance with the requirements of Caldicott and the Data Protection Act 1998 and in respect of deceased patients the Access to Health Records 1990.

Any requests made for claims-related information under the Freedom of Information Act 2000 will be subject to the normal range of absolute and qualified exemptions under the Act. Particular attention will be given to safeguarding person-identifiable information within claims files (section 40).

9. Use of Legal Advisors

For all claims the responsibility for instruction of solicitors will rest with the NHSLA through the panel arrangements.

The CCG will continue to manage its own solicitors in respect of other matters requiring specific legal advice.

The CCG will ensure that legal advice is obtained as necessary from solicitors with appropriate expertise. Steps will be taken on behalf of the Governing Body to ensure that such legal advisors have adequate professional indemnity cover, bearing in mind the potential value of claims resulting from actions taken as a result of advice received.

10. Learning from Claims

Following the resolution of a claim a report will be prepared for the Quality and Safety Committee to identify the key issues to be learned.

11. Compliance

The Chief Finance Officer will be responsible for ensuring that this policy is implemented amongst all staff and has overall responsibility for monitoring the policy.

The Quality and Safety Committee will monitor the effectiveness of the CCG's claims handling arrangements.

Appendix 1

Local Investigation Procedure

All claims will be investigated, but the scope of investigation will depend upon the type and seriousness of the claim and its impact or potential risk to the CCG.

Claim investigations will not always follow the exact same processes. This is because some things are obviously more serious than others, so they require more urgent and immediate action. Sometimes claims are much more straightforward and can be dealt with through less urgent processes. What is important is that all claims are investigated and that the same principles for investigation are applied to each individual situation.

Basic Principles

The basic requirements for any investigation are the following:

- Establish the sequence of events
- Review records/gather evidence
- Interview those involved
- Analyse findings of investigation
- Draw conclusions
- Make recommendations
- Suggest actions
- Identify lessons
- Review outcomes

Who Should Investigate

The Head of Corporate Affairs will take overall responsibility for co-ordination of investigations in liaison with the Chief Finance Officer.

Responsibility for undertaking investigations may be delegated to specific managers depending on the nature of the claim. For particularly serious claims the Chief Finance Officer will oversee the investigative process. It may be that, at the discretion of the Chief Officer a manager of another work area which is not involved in the claim will conduct the investigation to ensure objectivity.

For some particularly serious claims the Head of Corporate Affairs may convene an investigation panel at the discretion of the Chief Officer or Chief Finance Officer.

The panel will be led by a Chief Finance Officer (or nominee) and usually involve the manager for the work area the claim is being made against, Head of Corporate Affairs, other designated managers/staff officers and perhaps an external person to reinforce the impartiality of the process.

If it is considered that external solicitors are required to assist in the investigation or for additional specialist advice they will only be approached on the direction of the Chief

Executive or Chief Finance Officer. Contact will be made through the Head of Corporate Affairs.

Root Cause Analysis

Root Cause Analysis involves looking for the underlying failures in the system that might have led to the event happening. A whole chain of events that might have been thought to be of little significance can sometimes become a big problem that could lead to a mistake happening. It is the investigation of these underlying causes that can help to learn a great deal from an incident.

It is not always necessary to undertake a full Root Cause Analysis as part of an investigation.

Record Keeping

Accurate records are fundamental to any investigation. The Head of Corporate Affairs will ensure that all documentary evidence is kept in a specific file for each claim.

Any evidence gathered from interviews or factual reports must follow these guiding principles:

Records need to be:

- Accurate and contemporaneous
- Legible
- Identifiable
- Well organised
- Easily located

and include the following:

- A signature that is legible
- The status of the signatory

All internal investigations must be completed within 20 working days of the receipt of the claim unless circumstances make it impossible.

APPENDIX 2

Claims Handling Procedure

Introduction

The number of complaints against the NHS is growing as patients become more prepared to question the treatment that they are given, to request an explanation of what happened, and to seek appropriate redress. Generally, they may seek further treatment, an apology, assurance about future action or compensation.

On occasion, patients may feel that it is necessary to go to litigation by pursuing a claim against the NHS and, prior to April 1999, this meant a long, drawn out process and substantial legal costs, leading up to the court hearing stage.

It was recognised that a pre-action protocol which sets out "ground rules" for the handling of disputes at an early stage was required and to this end Lord Woolf produced a report, "Access to Justice", in 1996. Following extensive consultation new Civil Procedure Rules were laid before Parliament and published in January 1999. These rules are supplemented by Practice Directions and Pre-Action Protocols (one Protocol deals with clinical negligence and the other deals with personal injury claims).

- Pre-Action Protocol for the Resolution of Clinical Disputes. The protocol encourages a climate of openness when something has gone wrong with a patient's treatment or the patient is dissatisfied with that treatment or outcome. This reflects requirements for clinical governance in healthcare, provides guidance on how an open culture may be achieved (see Being Open guidance) and recommends a timed sequence of steps for healthcare providers.

- Pre-Action Protocol for Personal Injury Claims. The protocol aims to achieve more pre-action contact between parties, better earlier exchange of information and investigation which puts the parties in a position to enable early settlement before litigation or for proceedings to run more efficiently. This reflects a desire to build on and increase the benefits of early but well informed settlement which genuinely satisfy both parties.

All NHS Authorities and CCGs are required to comply with the Protocols.

Once the litigation process starts tight timetables are imposed.

There are financial penalties for delays, in some instances defense cases may even be struck out as a penalty for undue delay.

The rules are designed to encourage early settlement and provide for the claimant to make an offer to settle. The CCG will need to be in a position to respond very quickly to such requests; if not there are substantial penalties for delay in accepting a reasonable offer.

Where the court decides that one of the parties has been unreasonable in their conduct the court may impose penalties in cost or interest on damages. The possibility of cost or interest penalties means that the pre-action protocol must be complied with. The claim must be thoroughly and speedily investigated at an early stage. The relative merits of defending or settling must be considered early. This means that persons requested to provide information must do so promptly.

Pre-action protocols

The CCG recognises and will at all times adhere to the pre-action protocols for the resolution of clinical disputes and personal injury claims, in the interests of:

- Encouraging a climate of openness when something has "gone wrong" with a patient's treatment or the patient is dissatisfied with that treatment and/or the outcome.

- Encouraging the adoption of a constructive approach to complaints and claims, and accepting that concerned patients are entitled to an explanation and an apology if warranted, and to appropriate redress in the event of negligence.

Pre-action protocols for Liabilities for Third Parties Scheme (LTPS) claims

The likelihood of the CCG receiving a claim for clinical negligence is low so this procedure concentrates on Liabilities for Third Parties Scheme (LTPS)

The Liabilities for Third Parties Scheme (LTPS) otherwise known as The Risk Pooling Scheme for CCGs (RPST) covers Employers Liability, Public Liability, Professional Indemnity and the Property Expenses Scheme (PES).

The procedure to be followed for LTPS claims is similar to the procedure for clinical negligence claims, as follows:

Letter of Claim

If the claimant decides that there are grounds for a claim, they or their solicitors will send a letter of claim to the CCG.

The letter of claim should contain a clear summary of the facts on which the claim is based, including the alleged adverse outcome, and the main allegations of negligence. It should describe the patient's injuries, the present condition and prognosis, and the estimated financial loss incurred by the claimant. In more complex cases a chronology of the relevant events should be provided. Sufficient information should be given to enable the CCG to commence investigations if it has not already done so and for the NHSLA to put an initial valuation on the claim.

The letter of claim should be forwarded to the NHSLA within 21 days and all Employer Liability claims must be accompanied by the disclosure list applicable to the particular type of claim (refer to http://www.nhsla.com/Claims/Documents/NHSLA Disclosure List.doc). The CCG should acknowledge the letter and identify that the NHSLA will be dealing with it.

NOTE:
The National Health Litigation Authority (NHSLA) will deal with all claims. They will be notified at the point when all the appropriate documentation is received by the Head of Corporate Affairs. The NHSLA will manage the claim for the CCG, appointing a panel solicitor to defend. The Head of Corporate Affairs will facilitate this approach by providing all necessary information/documents required to defend the claim.

The Head of Corporate Affairs will:

- Notify the Chief Finance Officer within 2 working days that a claim has been received.
- Contact the investigating manager concerned in order to request, within 21 days, an investigation report and copies of any documents and statements in order to assist the defence.

Where it is considered that the claim or part of a claim should be admitted, legal advice should be sought as any admission will be legally binding. This decision/action will be taken by the NHSLA, in consultation with the CCG, in all cases reported to them.

The Head of Corporate Affairs will inform the NHSLA by completing the LTPS report form at http://www.nhsla.com/Claims/Documents/LTPS Claim Report Form.docx. Details of the LTPS Reporting Guidelines can be found at
http://www.nhsla.com/Claims/Documents/Reporting%20Guidelines.pdf

Letter of Response

The NHSLA should investigate the claim and within 3 months of the letter of claim provide a reasoned answer to it in the form of a letter of response. The NHSLA, in consultation with the CCG, will specify which issues of breach of duty and/or causation are admitted and which are denied and why. Documents must be enclosed which are material to the issues in dispute which would be likely to be ordered to be disclosed by the court during proceedings.

The Proceedings Stage

e Proceedings Stage is extremely complex. Any members of staff who may be involved at any time at the Proceedings Stage will be fully informed and supported.

APPENDIX 3

Equality Analysis Checklist

Equality Analysis Checklist	Yes	NO
Does the 'Activity' being considered for equality analysis affect service users, employees or the wider community and therefore potentially be highly significant in terms of equality? ***(Relevance will depend not only on the number of those affected but also by the significance of the effect on them)***		**X**
Is it a major 'Activity' with significant implications for equality? ***E.g. a strategy, commissioning large scale programmes, care pathway re-design, building development etc.***		**X**
Has previous engagement highlighted important inequalities for protected groups?		**X**
Does or could the 'Activity' affect different protected groups differently?		**X**
Does the 'Activity 'relate to a known area of inequalities? ***E.g. access issues for disabled people, services for vulnerable people.***		**X**
If you have answered yes to any of the questions above you need to complete an Equality Analysis. **Focus attention on those aspects most relevant to equality. Which protected groups is it most relevant to?**		
If you answered no to all of the questions above then you don't need to undertake an Equality Analysis. ****When you decide an 'Activity' is not relevant to equality and therefore does not require an Equality Analysis it is important to document the decision and reason for the decision. This ensures that you have not overlooked potential issues relevant to equality which could leave you vulnerable to legal challenge.***		
Decision: No requirement for a full Equality Analysis Assessment	**Reason:** The degree of relevance to individual equality strands will not require a full Equality Analysis Assessment.	
Name: Katie Wightman, head of corporate affairs	**Date: 23.4.15**	