



Department of  
**Health, Social Services  
and Public Safety**

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AN ROINN

**Sláinte, Seirbhísí Sóisialta  
agus Sábháilteachta Poiblí**

MÄNNYSTRIE O

**Poustie, Resydènter Heisin  
an Fowk Siccar**

## **POLICY CIRCULAR**

**Subject:**  
**Handling Clinical and Social Care Negligence and  
Personal Injury Claims**

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**For Action by:**

Chief Executives, HSC Trusts  
Chief Executive, NI Blood Transfusion Service  
Directors of Finance, HSC Trusts

**For information to:**

Chief Executive, HSC Board  
Chief Executive, Public Health Agency  
Chief Executive, Business Services Organisation  
Chief Executive, Patient and Client Council  
Chief Executive, RQIA  
Chief Executive, NI Fire and Rescue Service  
Medical Directors, HSC Trusts  
Directors of Nursing, PHA and HSC Trusts  
Directors of Social Care, HSC Board and Trusts  
Directors of Pharmacy, HSC Trusts  
Family Practitioner Services  
Independent GP practices

**Summary of Contents:**

This Circular provides guidance on how clinical and social care negligence and personal injury (excluding employment law) claims should be managed within Health and Social Care organisations.

**Enquiries:**

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

Involvement and Learning Quality Unit  
DHSSPS  
Room D1  
Castle Buildings  
Stormont  
BELFAST  
BT4 3SQ

Tel: 028 9052 8322

**Related documents:**

HSS(F) 19/2000

**Superseded Documents:**

HSS(F) 67/2006  
HSS(F) 61/2005  
HSS(F) 20/2002  
HSS(F) 28/1999  
HSS(F) 28/1999 Supplement 1  
HSS(F) 21/1998  
HSS(F) 20/1998

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[qualityandsafety@dhsspsni.gov.uk](mailto:qualityandsafety@dhsspsni.gov.uk)

## **CONTENTS**

Covering Letter .....	3
Definitions .....	5
Governance and Risk Management .....	5
Delegated Limits and Minimum Standards for Handling Claims .....	8
Procedure for Handling Claims .....	9
Compliance with Protocols .....	10
Protocol for the Resolution of Clinical Disputes .....	13
Apologies and Explanations .....	13
Settlement of Claims .....	14
Confidentiality .....	14
Records Management .....	15
Clinical Negligence Central Fund and Accounting Arrangements .....	17
Multiple HSC Defendants .....	18
Structured Settlements .....	18
Review of Cases .....	18
Annex A .....	20
Annex B .....	24
Annex C .....	26
Annex C (Appendix 1) .....	28
Annex D .....	29
Annex D (Appendix 1) .....	36

**Dear Colleague**

## **GUIDANCE ON CLAIMS HANDLING IN HSC ORGANISATIONS**

As part of the programme of work to improve regional arrangements for handling claims made against Health and Social Care organisations, the Department of Health, Social Services and Public Safety established in 2008 a Project Group made up of Governance representatives from all HSC Trusts, DHSSPS personnel and a representative from the Legal Directorate of the Central Services Agency. This group carried out a review of all existing Departmental guidance circulars on managing claims, and this review has informed the development of the attached guidance which is intended to consolidate all existing requirements in respect of handling claims into one central point of reference.

This circular therefore supersedes all existing Departmental circulars on this subject, with the exception of HSS (F) 19/2000, which will continue to provide guidance on the accounting arrangements for the Clinical Negligence Central Fund. Work to review these arrangements in light of the revised structures post – RPA is continuing, and further revised guidance on this will be issued in due course.

This guidance aims to advise HSC organisations of the procedures that should be followed in the management of all negligence and other personal injury claims. It excludes all employment law claims. It is not intended to be exhaustive, but rather to provide a code of best practice for dealing with the great majority of cases where litigation is a possibility. It does not prejudice existing financial control and monitoring processes, nor any future work which may be carried out to review claims management, risk sharing and accountability arrangements.

Good practice guidance is provided throughout this circular which includes, inter alia, guidance on:

- (i) how to better handle cases that have the potential to become claims and;
- (ii) how to manage claims data and claims investigations more effectively and efficiently.

This circular also provides a set of steps to be followed by organisations in the management and exchange of claims related information/records where litigation is in prospect.

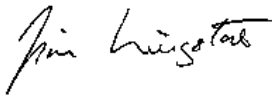
It will be important that HSC bodies are able to demonstrate, as a minimum, that they are meeting the following mandatory requirements:

1. The identification of a Board member with clear responsibility for clinical and social care negligence issues and with clear responsibility for personal injury claims who will report to the Board on a regular basis (para 16);
2. The organisation's claims handling procedures are in compliance with all extant NI Court Service Protocols or Practice Directions (para 24);
3. The organisation maintains a database of comprehensive, up-to-date information on all claims to support claims management (para 39);
4. An annual review is carried out of all of the organisation's clinical and social care negligence cases with a view to:
  - avoiding record duplication;
  - considering closure of cases static for 3 or more years;
  - evaluating expected compensation, associated costs and date of settlement (para 51).

Verification that the above requirements have been met will take place as part of the Controls Assurance process. The relevant Standards will be amended to reflect this.

You are asked to ensure that this circular is widely communicated to staff.

Yours sincerely



**Dr Jim Livingstone**

**Director Safety, Quality and Standards Directorate**

# Guidance on Claims Handling in Health and Social Care (HSC) Organisations

## Definitions

1. For the purposes of this circular, clinical and social care negligence is defined as:  
*“a breach of duty of care by members of the health care and social professions employed by HSC organisations or by others consequent on decisions or judgements made by members of those professions acting in the course of their employment, and which are admitted as negligent by the employer or determined as such through the legal process”.*
2. The term ‘health and social care professional’ includes hospital doctors, dentists, nurses, midwives, health visitors, pharmacists, social workers, registered ophthalmic or dispensing opticians (working in a hospital setting), members of the Allied Health Professions and dentistry, ambulance personnel, laboratory staff and relevant technicians.
3. Personal injury claims are defined as:  
*“Any claim in respect of injury to any person including bodily injury, psychiatric injury or death for which an HSC body is legally liable and which does not fall within the definition of clinical and social care negligence as set out above.”*

## Governance and Risk Management

4. HSC organisations need to recognise the close connections between risk management, complaints, adverse incident reporting and the management of claims. Where these are the responsibility of separate individuals, consideration should be given to what arrangements are needed to ensure the fullest possible co-ordination. HSC organisations should:
  - Ensure key staff are appropriately trained;
  - Develop a coordinated and integrated approach to governance, including links to external agencies as appropriate;
  - Set up an adverse incident reporting system;
  - Operate a system that derives learning from the results of adverse incidents and complaints positively;
  - Ensure that patients/service users are fully aware of how to raise their concerns or complaints;
  - Establish efficient and effective systems of recording and storing patient/service user records;
  - Advise patients/service users of a serious adverse outcome.

## Risk Management

5. HSC organisations are expected to have the basic building blocks in place for managing risk through the development and implementation of a comprehensive risk management system, in line with the requirements of the DHSSPS Risk Management, Governance and Finance core Controls Assurance Standards.<sup>1</sup>
6. Accounting officers of all HSC bodies should ensure that the controls listed in [Annex B](#), or an acceptable equivalent, are in place. They should also make sure that they are in compliance with all extant Departmental guidance. Independent assurance of the effectiveness of controls and the adherence to guidance should be obtained periodically.

## Corporate Governance

7. The boards of HSC organisations should satisfy themselves that they have properly identified and suitably addressed all relevant governance and internal control requirements incumbent upon them, including the statutory duty of quality. Whilst the Governance Controls Assurance Standard describes the overarching approach boards of HSC organisations should take to governance, internal control and management of principal risks, the Risk Management Controls Assurance Standard should be consulted regarding the more detailed processes for addressing risk throughout the organisation.
8. In addition, when assessing risks to the organisation – in particular those deemed to pose a high/extreme threat to the achievement of key objectives – the relevance of other controls assurance standards<sup>2</sup> should be considered.
9. Adoption and operation of an Assurance Framework is mandatory for boards of HSC organisations. The Assurance Framework provides members of the board of an HSC body with a mechanism for identifying and understanding both the principal risks to achieving its principal objectives, and the key controls to manage those risks. It also provides a mechanism for collecting and marshalling evidence, as required for the Statement on Internal Control, that the board is aware of the totality of its organisational risks and has based its decisions on all the material evidence.

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<sup>1</sup> <http://www.dhsspsni.gov.uk/index/hss/governance/governance-controls.htm>

<sup>2</sup> <http://www.dhsspsni.gov.uk/governance-controls.htm>

## Complaints

10. Competent handling of complaints can assist in improving the quality of care and minimising claims by listening to the voice of service users and using this as an opportunity for the organisation to learn from complaints. Complaints and claims, when examined in conjunction with reported adverse incidents, accidents and near misses, can enable trends, clusters, contingencies and other possible relationships to be identified at both a local and regional level. This will serve to minimise the possibility of recurrence, or of more serious incidents and complaints occurring in the future.
11. DHSSPS has developed new guidance on complaints "*Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning*". This replaces the HPSS Complaints Procedures (1996) and came into effect on 1 April 2009. HSC organisations are required to take action to ensure that these new arrangements are implemented in full by that date. If the complainant has either instigated formal legal action or advised that he or she intends to do so, the complaints procedure should cease.
12. This new guidance provides a streamlined process that applies equally to all HSC organisations. As such it provides a simple, consistent approach both for staff who handle complaints, and for people raising complaints across all health and social care services. The standards and guidelines have been developed in conjunction with HSC organisations, following public consultation. They reflect the changing culture across health and social care with an increasing emphasis on the promotion of safety and quality and the need to be open, to learn and, as a consequence, take action in order to reduce the risk of recurrence.

## Communication in relation to claims handling

13. There will be appropriate linkages for claims handling to:
  - (a) operational directorates;
  - (b) audit; and
  - (c) risk management (including compliance with health and safety at work legislation).
14. Many clinical and other operational directors will already appreciate the importance to the Trust's reputation of the effective handling of claims. Nevertheless, the Trust must ensure that all directorates are fully consulted on the Trust's claims handling policies and that appropriate arrangements are in place to enable them to support the Claims Manager in the day-to-day handling of claims. All directors must also consider how

the results of retrospective review of claims can be used as input to identifying organisational learning and audit arrangements.

### **Delegated Limits and Minimum Standards for Handling of Claims**

15. The delegated limit for Trusts' clinical and social care negligence out of court settlements is £250,000. Settlements above this limit must be submitted to DHSSPS Finance Policy and Accountability Unit for prior approval. Procedures for doing so are set out in **Annex C** below. HSC organisations are responsible for the handling of all negligence and personal injury claims. HSC bodies are directly responsible for payments in respect of all personal injury claims (claims which do not involve clinical and social care negligence).

### Board Level Responsibility

16. There will be a board member / board members with clear responsibility for clinical and social care negligence issues and personal injury claims who will keep the board informed of major developments. This may be the same individual who has overall responsibility for risk management.

### Experienced Claims Manager

17. The Trusts will have in place a claims manager (or equivalent) with a line of accountability to the board member(s). This is the manager responsible for the day to day management of the claims caseload within the Trust and/or with a delegated authority in accordance with the Trust Standing Financial Instructions. Trusts must ensure that their claims manager:
  - i. is of sufficient seniority to carry influence within the organisation and is given the status to do so; and
  - ii. has sufficient experience of, and/or training in, handling clinical and social care negligence claims and personal injury claims.

### Qualified Legal Advice

18. The Trust will have a clear policy on the circumstances in which qualified legal advice will be obtained. Whatever the locally determined policy, qualified legal advice must always be obtained at an appropriate stage for all claims involving potential expenditure above the standard delegated limit for *ex gratia* payments (£10,000) and, in any case, before making any firm offer to settle the claim. This advice will include:
  - i. liability and causation;
  - ii. an assessment of the strength of the defence on the balance of probabilities;

- iii. the likely quantum of damages, including best and worst case;  
and
  - iv. the likely legal costs of defending the claim.
19. Legal advice may also be helpful in deciding which expert witness to call, and whether the dispute could be resolved in other ways, e.g. through mediation.
20. Nevertheless, the final decision whether to seek to negotiate a settlement of the case or to continue defending the case should be taken by the appropriate delegated officer(s), within delegated limits.
21. Where advisers other than self-insured public bodies are engaged, Trusts should seek to ensure that such advisers carry a significant level of professional indemnity insurance.

#### Involvement of Front-Line Staff

22. There should be clear procedures for involving relevant front-line staff, whose co-operation is essential if claims are to be successfully defended. In clinical and social care negligence cases, where appropriate, the view of those involved in the incident which has given rise to a claim will be considered by the delegated officer before a decision is made to settle or defend the claim.

#### **Procedure for Handling Claims**

23. There should be a well-understood and clearly documented policy and procedure for handling claims. This will include:
- i. Setting up a record of the claim and maintaining a claims review system;
  - ii. Establishing, when needed, an objective account of the original incident - the incident must be properly investigated in a timely manner. Such investigation is vital to allow liability to be properly assessed in all cases and can often be crucial to the successful defence of claims;
  - iii. Identifying and securing all records related to the incident;
  - iv. Establishing and maintaining contact with all staff involved in the original incident;
  - v. Obtaining an in-house “expert view” of the claim and, if appropriate, securing suitable external expert witness; this must entail a timely, robust and appropriate investigation of the claim;
  - vi. Initial valuation of the claim;
  - vii. Instructing solicitors, briefing counsel and monitoring their costs;
  - viii. Negotiation of out of court settlements within delegated limits which apply;

- ix. (For large settlements, in particular those over £250,000 where the plaintiff is agreeable) evaluation of the costs and benefits of structuring the settlement, negotiation of the details, and preparation of the Value For Money report for DHSSPS;
- x. Procedures to identify any processes or aspects of practice requiring remedial action, including systematic review of all cases after closure;
- xi. Clear allocation of responsibility for carrying through any remedial action required and for disseminating any wider lessons, both within the trust and (where appropriate) more widely;
- xii. Arrangements for analysis of claims against the HSC organisation; in particular the analysis of trends and emerging patterns, and the implications for any policies of the HSC organisation;
- xiii. Arrangements for regular reporting to the board or to a group or subgroup of the board, both in aggregate and on individual claims; and
- xiv. Trust policies taking account of any relevant Protocols or Practice Directions issued by the Courts in Northern Ireland in relation to personal injury claims and/or clinical negligence claims.

## **Compliance with Protocols**

- 24. HSC organisations should ensure that their procedures comply with any current Protocols or Practice Directions which may be applicable. The Northern Ireland Court Service worked with the Law Society of Northern Ireland to introduce a local protocol for handling personal injury cases<sup>3</sup>. This protocol refers only to cases heard in the High Court. A clinical negligence protocol<sup>4</sup> has also been developed, and came into operation on 20<sup>th</sup> April 2009.
- 25. Both protocols aim to improve the pre-action communication between parties by establishing a timetable for the exchange of relevant information and by setting standards for the contents of correspondence. Compliance with the protocol timetable should assist parties in making an informed judgment on the merits of their case earlier than usual and will provide an opportunity for improved communications between the parties, intended to lead to an increase in pre-action settlements.

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<sup>3</sup> The current version of this protocol is available at;  
[http://www.courtsni.gov.uk/en-gb/judicial+decisions/practice+directions/j\\_j\\_preactionprotocol.htm](http://www.courtsni.gov.uk/en-gb/judicial+decisions/practice+directions/j_j_preactionprotocol.htm)

<sup>4</sup> The current version of this protocol is available at;  
[http://www.courtsni.gov.uk/en-GB/Judicial+Decisions/Practice+Directions/j\\_j\\_Clinical+Negligence+protocol.htm](http://www.courtsni.gov.uk/en-GB/Judicial+Decisions/Practice+Directions/j_j_Clinical+Negligence+protocol.htm)

## Pre action Protocol for Personal Injury Litigation

26. The contents of this protocol state that:
- i. The plaintiff's solicitors shall send to the proposed defendant a letter of claim as soon as sufficient information is available to substantiate a realistic claim and before issues of quantum are addressed in detail.
  - ii. The letter of claim includes a request to the defendant to pass the letter to any relevant insurer to enable acknowledgement of the correspondence within 21 days, failing which legal proceedings may be issued without further warning.
  - iii. The fundamental purpose to be served by the letter of claim is to provide sufficient information for the defendant's insurer/solicitors to commence investigations, assess liability and at least put a broad valuation on likely "risk".
  - iv. The defendant should reply within 21 days of the date of posting of the letter of claim identifying his insurer/solicitors (if any). If there has been no reply by the defendant or any solicitor or insurer within 21 days, the plaintiff will be entitled to issue proceedings.
  - v. The defendant's solicitor/insurers will have a maximum of three months from the date of acknowledgement of the letter of claim to investigate. The defendant's insurer/solicitors shall reply no later than the end of that period, stating whether liability is denied and, if so, providing reasons for the denial of liability. If contributory negligence is being alleged by the defendant, details should be provided of what is alleged and upon what basis.

## Pre action Protocol for Clinical Negligence Litigation

27. The contents of this protocol state that:
- i. Where litigation is appropriate, it should be conducted economically, efficiently and in accordance with a realistic and flexible timetable set by the court.
  - ii. Requests for health records should be as specific as possible about the records that are required. Section 7 of the Data Protection Act 1998 provides a right of access to health records by a patient or certain other parties on behalf of a patient in respect of living patients, while Article 5 of the Access to Health Records (Northern Ireland) Order 1993 applies in respect of deceased persons.
  - iii. Copies of any records sought should be supplied by the relevant healthcare provider within 40 days or such other relevant requisite period at the relevant fee specified in the 1998 Act or the 1993 Order.

- iv. In the event that a healthcare provider encounters difficulty in complying with the relevant timetable for disclosure of medical notes and records, the provider should provide the patient and/or his representative with an explanation of the problem together with details of the resolution proposed by the provider.
- v. Healthcare providers should make arrangements to ensure that they are able to react positively and expeditiously to inquiries and requests in accordance with the simplified statutory procedure available under the provisions of the 1998 Act or the 1993 Order.
- vi. If either the patient or the healthcare provider considers that additional health records are required from a third party in the first instance, these should be requested in writing by or through the patient or his or her representatives. The relevant third party health provider should reply in writing within 40 days either disclosing the records sought or, if a difficulty is encountered, providing a written explanation of the difficulty and the resolution proposed.
- vii. Once a decision has been taken by the patient and/or his or her advisors that there are grounds for a claim, as soon as practicable, a letter of claim should be sent to the relevant healthcare provider/potential defendant.
- viii. Unless there is a limitation problem or some other issue as to why the plaintiff's position needs to be protected by early issue, proceedings should not generally be issued until 3 months after the date of the letter of claim.
- ix. The relevant healthcare provider should acknowledge the letter of claim within 14 days of receipt and should identify the solicitor or other legal representative who will be dealing with the matter. Trusts should instruct Directorate of Legal Services (DLS) immediately on receipt of correspondence, and should ensure that the matter is investigated and all relevant information provided to DLS as expeditiously as possible to enable a response to be provided within the stipulated timeframe. No later than 3 months from the letter of claim the relevant healthcare provider should write to the plaintiff's solicitors stating whether liability, breach of duty or causation are denied or admitted. Thereafter it will be appropriate for the plaintiff to issue proceedings.

### Alternative Dispute Resolution

28. Both protocols also include guidance on alternative approaches to settling disputes ("Alternative Dispute Resolution"). They refer to alternative approaches to settling clinical negligence disputes including arbitration, mediation and determination by an expert. The use of 'mediation' in

particular has found favour in Great Britain as a method that will work in certain cases. It should be explored as a possible option in any instances where ongoing negotiations with the plaintiffs suggest that it would work. Information on its use is available on the NHS Litigation Authority website<sup>5</sup> and on the Law Society of Northern Ireland website<sup>6</sup>. In judging whether to try this option or other alternatives, regard should be given to the likelihood of success, as otherwise it may become just another step in the process with both consequential delay and generation of additional cost.

### **Protocol for the resolution of Clinical Disputes**

29. At present, HSC organisations are encouraged to comply with the protocol developed by the Clinical Disputes Forum in Great Britain<sup>7</sup>. This protocol was developed to find less adversarial and more cost-effective ways of resolving disputes about healthcare and medical treatment. Compliance is not mandatory for the legal profession in Northern Ireland although compliance with its basic principles and timescales is encouraged. Under this protocol, HSC organisations are asked to:
- i. Ensure that all claims managers and other relevant staff have access to relevant protocols, and;
  - ii. Examine their caseload to check the level of compliance with the time limits specified in it and rectify instances where these limits have been exceeded.
30. Governance arrangements implemented in pursuance of the obligations within the protocol must integrate fully with the clinical and social care governance framework envisaged within “Best Practice – Best Care<sup>8</sup>”. In March 2006, DHSSPS also issued “The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS<sup>9</sup>”. The frameworks and themes in these documents are designed to ensure that high quality, effective care is delivered and that when things go wrong they are quickly put right and lessons are learned to help minimise recurrence. This will require HSC organisations to put and keep in place arrangements for monitoring and improving the quality of health and social care services that they provide in line with the statutory duty of quality.

### **Apologies and Explanations**

31. Based on the experience in Great Britain of dealing with clinical negligence cases where limited injury or loss has occurred, it should not

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<sup>5</sup> <http://www.nhs.uk>

<sup>6</sup> <http://www.lawsoc-ni.org>

<sup>7</sup> The protocol can be accessed at; [www.clinical-disputes-forum.org.uk/files/projectfiles/ProtocolFull.doc](http://www.clinical-disputes-forum.org.uk/files/projectfiles/ProtocolFull.doc)

<sup>8</sup> <http://www.dhsspsni.gov.uk/bestpractice2002.pdf>

<sup>9</sup> [http://www.dhsspsni.gov.uk/qpi\\_quality\\_standards\\_for\\_health\\_social\\_care.pdf](http://www.dhsspsni.gov.uk/qpi_quality_standards_for_health_social_care.pdf)

- be viewed as inevitable that a patient/service user who suffers an adverse effect will proceed to making a claim for compensation the service provider is first made aware by the patient/service user, or vice-versa, of a breach in the expected standard of care, direct open and considered communication may obviate a sense of hurt leading to avoidable litigation.
32. In line with the principle of being as honest and open with patients/service users as possible, it is recommended that the following should be given:
- i. an expression of sympathy and sorrow or regret at the outcome of the treatment. To say sorry to those who perceive a poor outcome is not an admission of liability;
  - ii. as full and factual an explanation as possible, similarly without any admission of liability, of what has happened and its effects;
  - iii. if appropriate, an offer of early corrective treatment and/or rehabilitation; and
  - iv. advice on accessing the complaints system.
33. It is recommended that HSC organisations consider how best this policy may be adopted within each clinical/professional area based on the competence and expertise of the staff involved. HSC organisations should set guidelines for frontline staff who will likely be the first point of contact, supported by guidelines for the involvement of complaints officers or more senior members of staff in fulfilling this obligation on behalf of the HSC organisation. It is acknowledged that staff within HSC organisations may require training and support to put such change into effect.

### **Settlement of Claims**

34. Where a case has progressed to legal process, it is recognised that plaintiffs may not want to settle early in the proceedings. Nevertheless, it is recommended that HSC organisations will seek, with appropriate advice, proactively manage claims including, where appropriate, early settlement negotiations in order to save costs.

### **Confidentiality**

35. All HSC bodies (and those carrying out functions on behalf of the HSC) have a common law duty of confidence to patients/clients and a duty to maintain professional, ethical standards of confidentiality. Everyone working for or with the HSC who records, handles, stores or otherwise comes across personal information has a personal common law duty of confidence to patients/clients and to his/her employer. The DHSSPS guidance, 'Code of Practice on Protecting the Confidentiality of Service User Information'<sup>10</sup>, supports all staff working in health and social care to make good decisions about the protection, use and disclosure of service

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<sup>10</sup> <http://www.dhsspsni.gov.uk/confidentiality-code-of-practice0109.pdf>

user information. The duty of confidence continues even after the death of the patient/client, or after an employee or contractor has left the HSC.

## **Records Management**

36. This common law duty of confidence to patients/clients requires that HSC organisations and those carrying out functions on behalf of the HSC must ensure compliance with legislation, including the Data Protection Act 1998 and the Freedom of Information Act 2000. DHSSPS has produced guidance for HSC organisations in Northern Ireland on managing records called “Good Management, Good Records”<sup>11</sup>. This document offers an overview of the key issues and solutions in relation to the management of records, and best practice guidelines for HSC teams to follow when preparing a records management strategy. It represents the joint DHSSPS and Public Records Office of Northern Ireland (PRONI) view of how records should be administered and sets the standard required of HSC organisations. HSC organisations should have due regard to the requirements of this guidance in their arrangements for handling and retaining records relating to clinical and social care negligence cases.
37. Records in the context of HSC may include:
- Patient/client’s health records (electronic or paper based: including those containing all specialities, but excluding GP medical records).
  - Accident and Emergency, Birth, and all other Registers.
  - Theatre Registers and Minor Operations (and all other related) Registers.
  - Administrative records (including e.g. personnel, estates, financial and accounting records; notes associated with complaint handling).
  - X-Ray and imaging reports, output and images.
  - Photographs, slides and other images.
  - Microfiche/film.
  - Audio and videotapes, cassettes, CD-Rom etc.
  - Computer databases, output and disks etc; and all other electronic records.
  - Material intended for short term or transitory use, including notes and ‘spare’ copies of documents.
38. When copying records, HSC staff should ensure:
- i. All documents are legible and complete, if necessary by photocopying at less than 100% size.

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<sup>11</sup> <http://www.dhsspsni.gov.uk/dhs-goodmanagement.pdf>

- ii. Documents larger than A4 in the original, e.g. ITU charts, should be reproduced in A3, or reduced to A4 where this retains readability.
- iii. Documents are only copied on one side of paper, unless the original is two sided.
- iv. Documents should not be unnecessarily shuffled or bound and holes should not be made in the copied papers.

### Claims Database

39. Each HSC organisation will set up and regularly maintain a database with information on all claims. Detailed guidance on the information that should be captured in the database is set out in [Annex A](#). HSC organisations must ensure that information relating to individuals is processed in accordance with relevant legislation and guidance including the Data Protection Act.
40. Each HSC organisation will be required to submit a summary of this information (relating to clinical and social care negligence claims only) annually to the Department. The required information will be commissioned from organisations by **30<sup>th</sup> June** each year. The information provided will be analysed and an annual report prepared, identifying any trends or regional lessons arising. In addition to this, HSC organisations should provide to the Department, on a quarterly basis, a specified subset of this information relating solely to clinical negligence cases, which the Department will use to ensure that progress on these cases can be effectively monitored and as a cross check to financial monitoring to ensure budgetary projections are accurate. HSC organisations will be advised separately of details of the information required in this return and the arrangements for submitting this to the Department.

### Storage and security

41. The Data Protection Act 1998 places a statutory responsibility on all HSC organisations to protect the personal data which they hold. To support the continuing conduct of business, patient and client care, compliance with the regulatory environment, and to provide necessary accountability, organisations should create and maintain authentic, reliable and usable records and should protect the integrity of those records for as long as required. This is particularly important to ensure that the organisation has access to all relevant information relating to cases where litigation proceedings are likely or underway, and means they must implement measures to:
- i. maintain the accuracy of records held;
  - ii. protect the security of personal data;

- iii. control access to the personal data; and
  - iv. make arrangements for secure disposal once the record is no longer required.
42. As a matter of policy and procedure, all staff should understand their responsibilities when using or communicating personal data and information. HSC organisations should ensure that induction training for staff includes consideration of record management issues and that staff responsibility for managing records that they create or use is documented.

#### Retention and Disposal of records

43. “Good Management, Good Records” (GMGR) provides guidelines for HSC organisations for the retention and disposal of records. PRONI has a legislative responsibility within the public sector in Northern Ireland to ensure that records are managed in accordance with agreed policies and procedures. HSC organisations should use the Disposal Schedule agreed by PRONI in GMGR as the basis for developing their own Disposal Schedules, which must also be agreed with PRONI.
44. Taking account of current guidance in “GMGR” on the retention of files, and in line with DLS guidelines on the retention of medical negligence files, it is recommended that HSC organisations retain all relevant records relating to cases where litigation has commenced (ie when the letter of claim has been received) for a minimum of six years from the date of last action on file. In cases where proceedings related to a minor<sup>12</sup>, records should be retained until their 22<sup>nd</sup> birthday, and in cases involving a person under a disability<sup>13</sup>, records should be retained for a period of six years after the death of the individual concerned.

#### **Clinical Negligence Central Fund and Accounting Arrangements**

45. Arrangements in respect of accounting for clinical and social care negligence and liaison with the Clinical Negligence Central Fund remain under review by DHSSPS. Until further notice HSC organisations should continue with current practice in terms of;
- (i) FRS12 Reporting in Annual Accounts, and;
  - (ii) seeking reimbursement from the Clinical Negligence Central Fund on settlement of a case.

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<sup>12</sup> An individual under the age of 18 years old

<sup>13</sup> A person under a disability is defined here as any person who is incapable by reason of mental illness or disorder from managing their own affairs (crucially whether they are capable of giving instruction to solicitors in relation to the conduct of legal proceedings) – this may be as a result of a pre-existing condition or may have been caused as a result of clinical negligence.

46. Annual returns to the Central Fund and to Finance Policy and Accountability Unit, forecasting clinical and social care negligence payments for the year ahead, are no longer required. Provisions information will continue to be provided to DHSSPS within monthly financial monitoring returns.

### **Multiple HSC Defendants**

47. Where two or more HSC bodies are named as defendants to a claim, the HSC bodies, in conjunction with their legal advisers, should co-operate with a view to reaching an agreed apportionment of liability. Once apportionment has been agreed, the HSC body with the agreed greater proportion of liability with regard to alleged harm will then take over the conduct of the claim to conclusion.

### **Structured Settlements**

48. Structured settlements are the guaranteed payment of a tax-free stream of income over the plaintiff's life. These can offer reassurance to plaintiffs and their carers and offer value for money to the HSC.
49. DHSSPS is aware that it is very rare for structured settlements to be used. Whilst acknowledging that the take-up of such a settlement is a matter for the plaintiffs to determine, DHSSPS would encourage HSC organisations to always consider making use of structured settlements in cases where settlements will be £250,000 or more, or where to do so might also represent good value for money. **Annex D** sets out the guidance for this.
50. Each HSC body is asked to review relevant ongoing cases to ensure that full consideration has been given to the use of structured settlements. It should also be noted that, under the Damages Act 1996, Courts may now sanction structured settlements where the parties consent, and the Act further provides for the Department to guarantee such settlements on behalf of HSC organisations.

### **Review of Cases**

51. HSC organisations are asked to carry out an immediate review of all the ongoing clinical and social care negligence cases they have on record and, as a minimum, to review all ongoing cases on an annual basis. The review must examine cases:
  - a) to review fully the base data held for each to ensure there is no duplication of records (in a number of instances, cases have been registered when a 'letter of disclosure' is received and then again when an actual claim is lodged);

- b) to consider suitability of immediate closure of all cases held without contact/action on behalf of the plaintiff for three years or more; and
- c) to consider the expected value of compensation and associated costs and expected settlement date in line with accounting guidance.

**INFORMATION TO BE MAINTAINED IN DATABASE**

**Initial Screen**

**Patients Reference Number (Health and Care Number)**

**Type of Claim**

- Employers Liability Claim (ELC)
- Occupiers Liability Claim (OLC)
- Professional Negligence Claim (PNC)

**Note:** This list is for codes which are reported to the Department, HSC organisations can still have extra codes for internal use.

**Date of Incident**

**Date of Claim**

**Estimated year of settlement**

**Settled Date (date on letter /document stating terms of settlement)**

- Settled in-court
- Settled out of court

**Closed Date (date on letter / document)**

**Note:** Either settled date or closed date should be completed, not both. Closed date should only be used if claim has not been settled.

**Case Specialty (using following list)**

Amended List of Specialties

**SPECIALTY**

Accident & Emergency  
Allied Health Professions  
Anaesthetics & Pain Management  
Blood Transfusion  
Burns, Plastic and Maxillofacial Surgery  
Cardiac Surgery  
Cardiology  
Child & Adolescent Psychiatry  
Children and Young People Services

Clinical Genetics  
Community Nursing/Midwives  
Community Paediatrics  
Day Care Services  
Dentistry  
Dermatology  
Domiciliary Services  
ENT  
General Medicine  
General Surgery  
Genito-Urinary Medicine  
Geriatric Medicine  
Gynaecology  
Haematology (Clinical)  
Infectious Diseases  
Joint Consultant Clinics  
Learning Disability  
Medicines Management  
Mental Health Acute  
Mental Health Community  
Neonatology  
Nephrology  
Neurology  
Neurosurgery  
Nuclear Medicine  
Obstetrics  
Occupational Health Medicine  
Old Age Psychiatry  
Oncology  
Ophthalmology  
Other  
Paediatric Neurology  
Paediatric Surgery  
Paediatrics  
Palliative Care  
Pathology (Laboratory Services)  
Physical Disability/Sensory Support  
Radiology  
Rehabilitation  
Residential Care  
Supported Living  
Thoracic Surgery  
Trauma & Orthopaedics

Urology  
Vascular

### **Nature of incident**

### **Hospital (if appropriate)**

- Independent provider

### **Last Stage – Legal Process**

1. Letter of claim
2. Investigation
3. Pre-proceedings discovery/disclosure
4. Proceedings issued
5. Counsel's advices
6. Trial date set
7. Appearances (High Court cases)
8. Notice of Intention to defend (County Court cases)
9. Re-activated
10. Repudiation of liability
11. Statement of claim received
12. Notice for further and better particulars
13. Replies to Notices for Particulars
14. Lodgement into court
15. Dismissed by court
16. Judgement entered in favour of the defence
17. Interrogatories/Affidavit
18. Remittal/application removal
19. Discovery
20. Admission of liability
21. Amended statement of claim
22. Case pending appeal
23. Expert Reports
24. Quantum reports
25. Application to strike
26. Set down for trial (High Court cases)
27. Certificate of Readiness (County Court cases)
28. Settled out of court -
  - a) Before proceedings by negotiation
  - b) After proceedings by negotiation
  - c) Damages awarded by the court
  - d) Statute barred
  - e) Court dismissed
  - f) Withdrawn
29. Defence issued
30. Withdrawn – no payment – case withdrawn by plaintiff

- 31. Payment – case withdrawn but Trust bears own costs
- 32. Damages awarded by court
- 33. Statute barred

**Outcome**

- Open
- Settled
- Closed

**Defence Costs**

- Expert reports
- Other Costs
- Loss adjustors/claims investigators
- Junior Counsel
- Senior Counsel

**Plaintiff Costs**

- Damages
- Compensation Recovery Unit (CRU)
- Receipts
- Third Party Costs

**Persons Tab**

- Date of Birth
- Date of Death

**Extra Fields Tab**

- Complaint – Yes or No

**Finance Tab**

- Expected Value Total
- Payments
- Defence Costs
- Plaintiffs Costs
- Reference Number:

**FRS12 Information**

	Forecast Settlement	Probability	Expected Value
Lower			
Middle			
Upper			
Total			

Note for future changes to the system: should provide capacity to enter and record performance against pre-action protocol timeframes.

## CONTROLS IN RESPECT OF LITIGATION AND LEGAL PAYMENTS

The following controls are deemed necessary to mitigate potential risks in the payments system; they should be fully implemented:

- i. HSC bodies should reserve the right to randomly check charges for costs incurred by verifying the information held in solicitors' systems and reconciling them to invoiced charges;
- ii. Written approval of an acceptable settlement level from the designated senior authorised officer of the HSC body should be obtained by defence solicitor prior to settlement negotiations;
- iii. Written approval from a duly authorised officer of the HSC body should be obtained prior to defence solicitors engaging counsel/other experts etc;
- iv. Independent confirmation of settlements reached or damages awarded and their amount, e.g. jointly signed statements or Court papers, should be checked prior to payment, where available;
- v. All bills received for Costs and Fee Notes should be on original headed stationery, showing VAT registration if applicable;
- vi. All payments should be authorised by a designated senior officer prior to payment;
- vii. All payment calculations should be checked for accuracy prior to payment;
- viii. Invoices should quote unique case reference numbers that can be matched to HSC records;
- ix. All payments should be attributable to a specific case, and for particular work; no payments should be made for generic, unreferenced or unidentified work;
- x. Effective budgetary controls should be exercised in the monitoring of legal costs, for example "trigger points" could be set to alert budget managers when a predetermined percentage of the budget has been spent;

- xi. A database/checklist should be maintained for all payments made per case, to include information about:
  - settlements/damages
  - defence solicitors' services and outlays
  - defence counsel fees and outlays, where available
  - other defence fees and outlays
  - all relevant plaintiff costs;
- xii. Third party payments should be made directly to third parties if possible;
- xiii. A Form of Receipt should be signed to confirm that payments to third parties have been received, where appropriate;
- xiv. A formal process should be established within each HSC body for opening, closing and reopening case files; such actions should be approved by a designated senior manager;
- xv. An agreed record should be made of meetings between HSC bodies and solicitors about litigation management, either as minutes or action points;
- xvi. Compensation Recovery Unit or DLS will inform the HSC body of any successful appeals against its recovery orders and the amount recovered.

## **PROCEDURES FOR APPROVAL OF CLINICAL NEGLIGENCE SETTLEMENTS ABOVE DELEGATED LIMITS**

1. HSC Bodies hold a delegated limit of £250,000 for the approval of out of court settlements of clinical negligence claims. Clinical negligence claims which are liable to settle in excess of this amount must be notified in advance to Finance Policy and Accountability Unit (FPAU), DHSSPS, using the form attached below at [Annex C Appendix 1](#).
2. Prior approval is required for authority to settle up to a specified amount above this limit. This can only be granted based upon the written advice of Senior Counsel representing the HSC body stating the best estimate of the settlement amount. Should a settlement fail to be reached within the approved amount, further approval must be granted prior to any final settlement.
3. In line with Departmental delegations, FPAU will seek the approval of the Department of Finance and Personnel (DFP) on behalf of HSC bodies in respect of all potential settlements in excess of £1m. DFP requests that all applications for approval to settle above this amount are submitted at least three working days before the case is due to be heard. This allows sufficient time for proper consideration of the case with all relevant papers.
4. All claims involving “novel, contentious or repercussive” expenditure, regardless of the expected settlement figure, should be referred to FPAU for approval, for example:
  - claims involving some unusual and new feature which, if not correctly handled, might set an unfortunate precedent for other litigation; and
  - claims which appear to represent test cases for a potential class action, or cases which, although not formally part of a class action, appear to be very similar in kind to current claims against other HSC bodies.
5. HSC bodies faced with a claim that could fall under either of the above categories are asked to draw the attention of FPAU to the particular feature of the claim at the earliest occasion, usually when first notifying the claim. FPAU will determine whether formal DFP approval to settle the claim is required and inform the HSC body of their decision, and if appropriate take responsibility for seeking authority from DFP.
6. Structured settlements should always be considered for settlements of £250,000 and above and may also represent good value for money for

smaller settlements. Detailed guidance on structured settlements is contained below in [Annex D](#).

7. Requests for approval of clinical negligence settlements must be submitted to FPAU and must include the following:
  - Completed and signed form (attached at [Annex C Appendix 1](#)) containing case information and confirmation of compliance with claims handling procedures.
  - A copy of correspondence received from Senior Counsel advising the HSC body of the potential outcome of the case and the recommended settlement amount. The recommended upper amount, for which approval is being sought for negotiation, must be clearly stated in correspondence from Senior Counsel (as opposed to the Directorate of Legal Services). A copy of any relevant forensic accountant's reports may be requested at the Department's discretion before approval is granted.

*\*NB: Where possible, electronic versions of reports and correspondence are preferred for ease of filing, liaising with DFP etc.*

8. On settlement of a case exceeding delegated limits, the HSC body is required to notify FPAU of the outcome through submitting:
  - a letter from its legal advisor stating its liability and the final settlement amount;
  - the final report of Senior Counsel on the case;
  - evidence of the acceptance of the settled amount, signed by the plaintiff's solicitor.

**Annex C APPENDIX 1**

Request for Approval of Clinical Negligence Settlement above Delegated Limits

Name of HSC Body/Bodies	
Contact name within HSC Body	
Contact telephone number	
Case reference number	
Plaintiff name	
Date of incident	
Summary of incident	
Estimated settlement date	
Estimated settlement figure	
Is the case novel, contentious or repercussive?	
Is structuring feasible/acceptable to the plaintiff?	

I, \_\_\_\_\_, confirm that this case has been handled in accordance with claims handling guidance set out in circular HSC (SQSD) 5 /10

Authorised by: \_\_\_\_\_

Position within Organisation(at least AfC Band 7): \_\_\_\_\_

Date: \_\_\_\_\_

**This form must be submitted to FPAU for prior authority to negotiate clinical negligence claims above £250k.**

**Finance Policy and Accountability Unit  
Room D3  
Castle Buildings  
Stormont Estate  
BELFAST BT4 3SQ**

[fpau@dhsspsni.gov.uk](mailto:fpau@dhsspsni.gov.uk)

## CLINICAL NEGLIGENCE CLAIMS: STRUCTURED SETTLEMENTS

### Background

1. The cost of clinical negligence is an increasing burden on the HSC. Organisations will wish to consider ways to moderate these costs, including as appropriate:
  - i. adopting prudent risk management strategies;
  - ii. adopting a systematic approach to claims handling in line with best current practice..
2. Structured settlements are one way of reducing the financial impact of clinical negligence on the HSC while offering additional security to plaintiffs. A structured settlement cannot be imposed on either party so clearly there needs to be benefit to both parties for it to proceed.

### Features of a Structured Settlement

3. Awards for damages traditionally comprise a single lump sum payment, one element of which (“future loss”) is calculated so that, if prudently invested, it would provide a stream of income representing loss of future earnings and/or the need for continued care for the expected remainder of the plaintiff’s life. The amount of the lump sum is agreed by the court either as a result of a hearing or an out-of-court agreement. Structured settlements on the other hand allow for part of the damages to be paid in the form of annual tax-free instalments for the duration of the plaintiff’s life.

### Forms of Structured Settlement available

4. There are two forms of structured settlement:
  - i. *Annuity-backed structured settlement.* At the point of settlement the HSC organisation makes a lump sum payment to an insurance company to purchase an annuity for the plaintiff. This will guarantee an annual stream of income for the remainder of the plaintiff’s life.
  - ii. *Self-funded structured settlement.* The HSC organisation itself gives an undertaking to make the stream of future payments to the plaintiff out of normal revenue funding.
5. In general, self-funded settlements offer better value for money to the HSC because they avoid paying for the insurance company’s profit

element and secure the benefit of spreading the cash flow impact over time (see paragraph 7 below).

However,

- i. They might, in the past, have been less acceptable to plaintiffs and their solicitors because of the perceived risk that the HSC body might at some future time be wound up or merged. This is considered further at paragraph 9-10 below;
- ii. Many HSC bodies have traditionally been unwilling to take the additional element of risk (i.e. that the plaintiff will in fact live longer than life expectancy assumed in calculating the structure).

### **Advantages of Structured Settlements**

6. The attraction for the plaintiff is that he/she receives a stream of future payments guaranteed for life, usually index-linked to the Retail Price Index. In addition, provided that the paperwork agrees with the procedure set down by the Inland Revenue the instalment payments are free from all taxes. A 1994 Law Commission Report strongly supported the use of structured settlements and its main recommendations have now been taken up in the Damages Act 1996. There was also a specific clause in the 1995 Finance Act giving formal recognition to the structures and their tax-free status, which is now a matter of law. A further advantage for the plaintiff is that the projected settlement can be tailored individually to the plaintiff's needs.
7. The advantage to the HSC is that structured settlements can offer better value for money than a lump sum settlement. Directly, the HSC defendant may be able to negotiate a significant discount (compared with a lump sum comparator) in recognition of the tax and other advantages to the plaintiff. Indirectly, the plaintiff's future needs may be better met by regular payments which are more likely to be spent upon the purposes for which damages were awarded. This should result in a significant reduction in the likelihood of the plaintiff incurring further additional costs to the HSC. A final advantage (self-funded settlements only) is that the damages no longer need to be paid out in one lump sum and thus the cash flow demands will be spread more evenly over time.

### **Funding of Structured Settlements**

8. When details of a structured settlement, either self-funded or annuity-based, have been formally agreed between the plaintiff(s) and the HSC organisation, the latter should make the relevant payment and seek reimbursement from the Clinical Negligence Central Fund, operated by the Business Services Organisation.

## Concerns from Plaintiffs about the security of the arrangement

9. Despite the fact that no public body has ever failed to meet any of its agreed financial obligations, there has been concern amongst plaintiffs and their representatives that structured settlements, which could last 40 to 50 years into the future, may not be fully secure. Plaintiffs may seek a binding guarantee from DHSSPS to underwrite the settlement.
10. The HPSS (Residual Liabilities) (Northern Ireland Order), which came into force on 26 August 1996 requires the DHSSPS to make provision for any residual liabilities of a HSC organisation, which ceases to exist by transferring them to another HSC body or the Department. This removes the perceived problem of security.

## Process for considering and approving Structured Settlements

11. HSC organisations are fully responsible for their decision over the handling of clinical and social care negligence and personal injury litigation although central guidance from DHSSPS must be followed. In particular, HSC organisations are accountable for securing the best possible value for money in any settlement of litigation. **Structured settlements should always be considered whenever the cost to HSC funds is likely to exceed £250,000** and may represent good value for money for lower awards also. This figure may be revised in the light of experience. If, on consideration, a structured settlement does not appear to offer **value for money**, or despite best endeavours the plaintiff is not prepared to accept one, the details should be recorded and made available on request to internal audit and DHSSPS.
12. All structured settlements require approval from DHSSPS. If in view of the HSC organisation a structure might offer value for money (VFM), and it appears that the plaintiff may be agreeable, the HSC organisation should:
  - i. ensure that the Finance Policy and Accountability Unit of DHSSPS is notified at the earliest opportunity;
  - ii. commission or complete a VFM report in the form set out in [Annex D Appendix 1](#) and submit to DHSSPS Finance Policy and Accountability Unit;
  - iii. inform the Business Services Organisation as funding will be required from the Clinical Negligence Central Fund.
13. The VFM report should assess the value for money to the tax payer as a whole as well as to the HSC, comparing the purposed structured settlement with a conventional lump sum award. Both self-funded and annuity-backed structures should be considered. In addition the HSC organisation will need to submit details of:

- i. the statement of claim
- ii. the court order if available
- iii. a legal opinion on causation
- iv. a legal opinion on quantum i.e. the lump sum comparator
- v. a legal opinion that the value of any discount offered on the structure is the maximum that could be achieved in the negotiation or that no discount is appropriate
- vi. the date of any court judgement/settlement

### **Consideration of a Structured Settlement**

14. It is usual to wait until a provisional agreement on the quantum of damages has been reached before considering the case for a structured settlement, even if certain aspects of the proposed settlement are still in dispute. However, a structured settlement can be considered at any stage in the legal process but should certainly be considered with legal advisers before any offer to settle is made.
15. The overall value for money of a proposed structure may depend on whether a suitable discount can be negotiated. It would therefore be wise to tackle this issue at an early stage in the negotiations.

### **Discount and Minimum Guarantee periods**

16. Discounts are received in recognition of the administrative costs of servicing the structure and the tax advantages to the plaintiff. A discount should always be sought in recognition of these additional costs since it may be critical to the overall value for money for the HSC.
17. Minimum guarantee periods (i.e. an undertaking to pay the annuity for a minimum period even if the individual insured dies before the end of the period) are commonly offered by companies when selling annuities. Plaintiffs may therefore ask for similar guarantee periods for structured settlements, whether annuity-backed or self-funded. DHSSPS does not believe that such guarantees are appropriate for most clinical and social care negligence cases where the object is to compensate the plaintiff for loss of earnings or to provide for costs of care during the plaintiff's lifetime. The main exception would be in circumstances in which there are others financially dependent on the plaintiff.
18. Discount and guarantees have often been linked in negotiations (although there is no inherent reason for this). It is common for one to be given up in consideration for the other. Each case should be considered on its own merits; general advice may be obtained on request from DHSSPS.

## **Preparation of the Value for Money Report**

19. The VFM Report should be prepared in-house where possible. However, where specialist advice is deemed necessary by the HSC organisation, external advisers must be employed in accordance with current DHSSPS guidance on the engagement of external consultants.
20. It is essential that the VFM report submitted to DHSSPS is based on a position that has already been conditionally agreed with the plaintiff's advisers. As a structured settlement cannot be imposed by either party in the litigation process on the other, then the plaintiffs must equally be satisfied that this form of settlement represents better value for them. DHSSPS does not have a role in the negotiation.

## **Factors to be considered in comparing the options**

21. The following factors should be taken into account:
  - i. what investment returns would be available to the plaintiff from a lump sum payment (this is needed to compare any excess HSC care costs for the proposed structure with the lump sum comparator);
  - ii. how long the plaintiff is expected to live;
  - iii. the length of guarantee of payment to the plaintiff;
  - iv. the estimated future costs of care (if any);
  - v. the agreed size of the annual payment under either of the structure options;
  - vi. the size of discount negotiated (if any);
  - vii. the cost of the insurance company quotations (annuity-backed settlements);
  - viii. the estimated loss of taxes to the Treasury under either of the structuring options.

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

22. The cost streams on each option should then be prepared on a net present value (NPV) basis. Sensitivity analysis should be used to test the robustness of the conclusion to the main uncertainties involved (see paragraph 4 of [Appendix 1 to this Annex](#)).

## **Role of DHSSPS**

23. DHSSPS will need to be assured that all relevant factors have been considered and that the preferred option does indeed represent best VFM. If the VFM report is deficient DHSSPS may need to come back to the HSC organisation for additional information. Cases, which exceed the

DHSSPS delegated limits in this area, will also be forwarded to the Department of Finance and Personnel (DFP) for approval.

24. Provided that a VFM report has been submitted, DHSSPS will provide initial comments within 15 working days and a final decision within a further 10 working days from receipt of full replies to any queries. Where DFP approval is also required, this will run in sequence to DHSSPS approval and will operate to the same timescale. The total approval process therefore should be completed within 30 working days provided all information is provided from the outset.
25. Once approval has been given for a structured settlement then
  - i. **for annuity-based settlements**  
The HSC organisation will be authorised by DHSSPS to purchase the annuity (insurance) from one of the particular insurance companies. The insurance company will be selected on the basis of the most cost efficient quotations obtained.
  - ii. **for self-funded settlements**  
Payment and reimbursement procedures should follow current practice, i.e. through the Clinical Negligence Central Fund.

### **Other steps required to implement a Structured Settlement**

26. Preparing the VFM report and securing approval from DHSSPS is only one aspect. Implementing a structured settlement may involve;
  - i. detailed appraisal of the plaintiff's current and future financial needs;
  - ii. formulating a financial package best suited to meet those needs;
  - iii. broking of the markets to identify the most appropriate and the most cost effective annuity and assurance products;
  - iv. negotiating the form of the structure, including the frequency of payments and any guarantee periods;
  - v. assisting in drafting the various orders and agreements for consideration by the lawyers;
  - vi. preparation of all reports required for the approval of the Inland Revenue, the Court and the Court of Protection;
  - vii. attendance at conferences and at court and advising as necessary;
  - viii. appearing in Court to give evidence;
  - ix. preparation of all documentation required for the purchase of the Annuity package;
  - x. monitoring after implementation of the actual working of the structure which has been put in place.

27. Most of these tasks can be subcontracted to specialist accountants. If the HSC organisation chooses to do so they will need to consider whether to pay:
  - I. A fixed fee for specified task whether the work results in a successful structure or not;
  - II. Time related fees for specified tasks whether the work results in a successful structure or not;
  - III. Contingent fixed fee for specified tasks (i.e. no cost if no structure results);
  - IV. Contingent commission (expressed as a percentage of the value of the structure) for specified component.
28. However the work is to be performed, the parties should agree as soon as possible which functions should be carried out by whom and on what basis to avoid unnecessary duplication of costs.
29. Any external advisers must be employed in accordance with current DHSSPS guidance on the engagement of external consultants.

## STRUCTURED SETTLEMENTS: VALUE FOR MONEY REPORT

### Introduction

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

### Documentation Required

2. The following documents are required as well as the VFM report itself:
  - i. the statement of claim
  - ii. copy of the court order if available
  - iii. a legal opinion on causation
  - iv. a legal opinion on quantum i.e. the lump sum comparator
  - v. a legal opinion that the value of any discount offered on the structure is the maximum that could be achieved in the negotiation or that no discount is appropriate
  - vi. the date of any court judgement/settlement

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

### Contents of VFM Report

3. The VFM report must incorporate the following information:
  - I. Quantum – the VFM report figure must be supported by appropriate legal advice and any difference fully explained.
  - II. Discount – full details should be given with an assurance that the Trust has negotiated the maximum possible (or if not discount, that in the overall circumstances of the negotiation why it was not possible to secure one).
  - III. Guarantee period – full details of any guarantee period should be given, especially in the unusual case of a period extending beyond the expected lifetime of the plaintiff.
  - IV. Life expectancy - the figures quoted in the report must correspond with expert opinion from both sides. If there is a significant discrepancy between the two sides the reason for the final weighting (usually by percentage) must be explained.
  - V. The assumed composition of the lump sum comparator. This will in general consist of three elements (bearing in mind that, subject in the

case of patients to any oversight by the Court of Protection, the sum may actually be spent in any way the plaintiff chooses):

- a. An amount to cover capital equipment needs (e.g. **adaptations** to the plaintiff's house);
  - b. A "contingency fund" which (in the case of patients) will be at the disposal of the Court of Protection;
  - c. A sum sufficient to provide for the plaintiff's estimated care needs for his/her expected lifetime (the expiry date for this component must cover the life expectancy and, if it does not, an explanation must be provided).
- VI. The cost of any annuity sufficient to cover the plaintiff's estimated care costs at c. above.
- VII. The proposed self-funded structure – in general the lump sum element will correspond to elements a. and b. above and the annual payments to the estimated care costs at c. Any deviations should be explained.

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

### **VFM Calculations**

4. Once the basic data has been explained, the report should compare the Net Present Value (NPV) of the three options, namely the conventional lump sum settlement and the annuity-backed and self-funded structured settlements. There are certain mandatory parameters, which will be reviewed periodically:
  - I. The discount rate used to calculate the NPV of future cash flows should be set at 6% (unearned return on money);
  - II. The general rate of inflation should be taken as 2.5%;
  - III. Costs of care should be assumed to rise by 2% per annum faster than the general rate inflation;
  - IV. Investment assumptions.

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

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

### **A. Unstructured or Lump Sum Settlement**

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

$$\text{Cost} = \text{A} + \text{B} - \text{C}.$$

### **B. Annuity-Backed Structured Settlement**

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

$$\text{Cost} = \text{D} + \text{E} + \text{F}.$$

### **C. Self-funded Structured Settlement**

The public sector pays a lump sum to the plaintiff **(D)** and makes additional payments until death of the plaintiff (or for the length of any guarantee period).

The public sector self-funds these payments and the expected NPV of these is **(G)**. The public sector also pays for any care costs incurred by HSC, which are not met by the annual payments **(F)**. Fees for the settlement advisors are paid by the public sector **(H)**.

$$\text{Cost} = \text{D} + \text{G} + \text{F} + \text{H}.$$

