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Dear Colleague

MEDICAL INDEMNITY: ARRANGEMENTS FOR CENTRAL REIMBURSEMENT OF COSTS FOR LARGE DAMAGES AWARDS

Summary

1. This letter updates the financial thresholds above which Health Boards and NHS Trusts can seek assistance towards the costs and expenses of large damages awards arising from successful medical negligence claims.

2. It also provides details of actions being taken towards the introduction of a new scheme from April 2000.

Background

3. The scheme under which employing health authorities may receive financial assistance towards the cost of relatively large medical negligence awards was introduced in 1990. It is funded from a reserve held on behalf of the Management Executive by the Medical & Dental Defence Union (MDDU). Access to the fund is dependent on the size of an award relative to the employing authority's HCHS allocation (Health Boards) or annual level of contract income (Trusts).

4. In brief, the terms of the scheme are that employing authorities are responsible for meeting the costs of awards that are less than 0.15% of their allocation/expected annual income or £450,000, whichever is the smaller. Once above that threshold the authority may access funds, but still remain responsible for meeting the first 25% of the amount claimed against the reserve. Further safety nets exist to protect employing authorities against really large awards or a substantial accumulation of awards in any one financial year. Fuller details were provided in Appendix 1 to NHS Circular MEL(1996)12 which remains extant.

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5. This letter details the revised threshold points for individual Health Boards and Trusts based on their 1999-00 HCHS allocations or contract income as appropriate. Both the percentage limits and cash ceiling remain unchanged. The thresholds apply to awards that fall payable from the date of this circular.

General

6. Circular NHS MEL(1996)12 dated 7 February 1996 provided a summary check for clinical risk management standards. It did so against the need for employing authorities to have appropriate risk management procedures in place. This is re-issued as Appendix 3. It is not definitive and should be regarded as guidance only. It was drawn from the 1993 SCOTMEG/CRAG report 'Medical Claims' and Appendix A of a NHS Executive (England) publication which outlined their clinical negligence scheme for Trusts (CNST). Both remain useful sources of reference and advice.

Future Arrangements

7. The MDDU reserve from which the central contributions are paid has now almost expired. The options for extending the operation of the scheme, and widening its scope to include certain non-clinical areas of liability, were considered by a cross-Service review Group that reported to Ministers last year. In summary those recommendations were as follows.

Clinical Negligence

- *Continuation of a central pool to aid the management of financial risk from large clinical negligence awards.*

- *Clinical activity by nurses and professions allied to medicine (PAMs), should be formally added to the cover (it currently lies outside the central scheme arrangements).*

- *Any revision of the scheme must encourage the use of 'structured settlements' given the potential VFM benefits for the Service.*

- *Funding of the pool should be by levies on individual Trusts based on a system of financial incentives or penalties that encourage sound risk management procedures and improved clinical performance.*

- *The presumption is that all Trusts will participate in the new scheme with exemption being agreed only on the presentation of a strongly based case.*

- *The scheme must be cost efficient in both administration and management terms.*

Other Risks

- *The possible establishment of one or more risk pools for non-clinical liabilities.*
- *Funding of the pool(s) should be by levies on individual health bodies based on a system of financial incentives or penalties that encourage sound risk management procedures appropriate to the areas covered.*
- *Ideally all Trusts, and other health bodies as determined by the Management Executive, should subscribe to the scheme(s).*
- *The scheme(s) must be cost efficient in both administration and management terms.*

8. In light of the Group's recommendations, Ministers agreed to a competitive tender exercise for the design, implementation and subsequent management of a risk pool scheme or schemes to cover both clinical and non-clinical risks.

9. Invitations to tender issued in July with a submission date of 20 August. A tender evaluation panel that comprises Management Executive, Trust, Health Board and CLO representation, is currently considering the submissions. Subject to Ministers' views any final appointment of scheme managers will be made in November. This will allow an initial development period of 4 months to the introduction of a new scheme, or schemes, on 1 April 2000. Any such scheme(s) will be covered by Regulations.

10. We shall keep the Service informed of progress and developments. Additionally, as part of the tender submission, bidders have been asked to provide details of how they will lead-in to the implementation date. This is expected to include seminars for the Service that will explain and detail the proposals/future arrangements. In this regard it should be noted that it has been made clear to potential bidders that **an important element of the clinical risks scheme is that it must complement and facilitate the development of other initiatives to improve clinical standards and performance, and risk management procedures in general**. In particular we have advised bidders to have special regard to:

- programmes of clinical audit at local and national levels throughout Scotland led by the Clinical Resource & Audit Group (CRAG);
- the newly introduced clinical governance requirements which place an explicit responsibility on Trust Boards for the quality of clinical care they provide: Annex 3, NHS MEL(1998)75 on 'Clinical Governance', provides further information on this issue: included within that guidance is a recognition of the need for the NHSiS to address specific approaches to Clinical Risk Management;
- the future work of the Clinical Standards Board for Scotland (CSBS) and the Scottish Health Technology Assessment Centre (SHTAC), who will develop standards for care and treatment in the NHSiS;

- controls assurance statements in Boards/Trusts' Annual Accounts and Reports.

Action

11. Health Boards and NHS Trusts should note the revised thresholds above which contributions towards the cost of medical indemnity awards are payable, and that they come into effect as of now. The criteria for making claims are set out in Appendix 1.

12. Health Boards and NHS Trusts should also note the content of paragraphs 7 to 10 and, in particular, the intention for there to be a clear interface between the new clinical negligence scheme and other initiatives to improve clinical standards and performance.

JOHN ALDRIDGE
Director of Finance

APPENDIX 1

ARRANGEMENTS FOR REIMBURSEMENT OF COST OF LARGE AWARDS FOR MEDICAL NEGLIGENCE

1. Health Boards and NHS Trusts (employing authorities) are responsible for meeting the costs of all awards which are less than 0.15% of their base revenue allocation (Boards) or expected annual income (Trusts), up to a maximum of £450,000.

2. For awards above the calculated sum, employing authorities will additionally pay one quarter (25%) of the amount by which the award exceeds the calculated sum, thereafter the balance will be met centrally. This is subject to maxima rules, i.e. the employing authority will not be liable to meet the costs:

- for any one award where their contribution exceeds 0.3% of their allocation/income figure;
- where the total payments by employing authorities on all awards in one financial year exceeds 0.5% of their allocation/income figure.

The excess in each case will be met centrally.

3. In calculating the cost of an award, the employing authority should include both the payment to the Pursuer and the adverse legal expenses of the Action. Once a settlement is reached, Central Legal Office will advise the employing authority and the Management Executive of the amounts which fall to be paid.

4. Thereafter, the employing authority should notify the Management Executive of the amount it wishes to reclaim, under the above formulae, using the form attached as an Annex to this Appendix. Once checked and agreed, the Management Executive will arrange for the appropriate sum to be transferred from the Medical and Dental Defence Reserve to the employing authority.

SEHD Finance Directorate

NHS
MEL(1999)63

IN CONFIDENCE

ANNEX A

HEALTH BOARD/ NHS TRUST REFERENCE:	HD REFERENCE: .....

APPLICATION FOR REIMBURSEMENT OF PART OF COSTS INCURRED IN A CASE OF MEDICAL NEGLIGENCE

Name of Health Board/NHS Trust:	
Name(s) of pursuer(s):	

Name(s) of Health Board/NHS Trust employee(s) whose negligence has been established or admitted:	

Nature of negligence established:	

Cost to Health Board/Trust of award:	£

Adverse legal and associated costs incurred by Health Board/NHS Trust (as certified by Central Legal Office):	£

Amount of reimbursement sought:	£

(Signed):	
(Position):	
(Date):	

Notes:	
1.	This form should be returned to Colette Gilchrist, Scottish Executive Health Department, Management Executive, Room 250, St Andrew's House, Edinburgh, EH1 3DE, telephone 0131-244 2271.
2.	If there is likely to be a delay in establishing the legal costs, Health Boards/Trusts may wish to submit an initial application for the cost of an award and a subsequent application for the legal costs; in calculating the final sum due to a Board/Trust, the various costs will be added and the sum to be reimbursed calculated from that total.

CENTRAL CONTRIBUTION TO DAMAGES AWARDS: 1999/2000

HEALTH AUTHORITY	GENERAL REVENUE ALLOCATION	MINIMUM AWARD FOR CENTRAL CONTRIBUTION 0.15% OF Col (2) WITH £450,000 CEILING	AWARD ABOVE WHICH ADDITIONAL COSTS MET CENTRALLY 0.3% OF Col (2)	MAXIMUM EXPENDITURE BY EMPLOYING AUTHORITY IN FINANCIAL YEAR (0.5% of Col (2))
COL (1)	COL (2) £M	COL (3) £	COL (4) £	COL (5) £
HEALTH BOARDS				
ARGYLL & CLYDE	257.700	386,550	773,100	1,288,500
AYRSHIRE & ARRAN	218.600	327,900	655,800	1,093,000
BORDERS	66.300	99,450	198,900	331,500
DUMFRIES & GALLOWAY	92.800	139,200	278,400	464,000
FIFE	192.800	289,200	578,400	964,000
FORTH VALLEY	152.100	228,150	456,300	760,500
GRAMPIAN	280.700	421,050	842,100	1,403,500
GREATER GLASGOW	567.700	450,000	1,703,100	2,838,500
HIGHLAND	126.000	189,000	378,000	630,000
LANARKSHIRE	304.800	457,200	914,400	1,524,000
LOTHIAN	420.200	450,000	1,260,600	2,101,000
ORKNEY	12.500	18,750	37,500	62,500
SHETLAND	14.800	22,200	44,400	74,000
TAYSIDE	242.100	363,150	726,300	1,210,500
WESTERN ISLES	22.100	33,150	66,300	110,500
OTHER				
STATE HOSPITAL	14.700	22,050	44,100	73,500
CSA	86.000	129,000	258,000	430,000
MENTAL WELFARE COMMISSION	1.500	2,250	4,500	7,500

CENTRAL CONTRIBUTION TO DAMAGES AWARDS: 1999/2000

HEALTH AUTHORITY	ESTIMATES FOR PATIENTS INCOME	MINIMUM AWARD FOR CENTRAL CONTRIBUTION 0.15% OF Col (2) WITH £450,000 CEILING	AWARD ABOVE WHICH ADDITIONAL COSTS MET CENTRALLY 0.3% OF Col (2)	MAXIMUM EXPENDITURE BY EMPLOYING AUTHORITY IN FINANCIAL YEAR (0.5% of Col (2))
COL (1)	COL (2)	COL (3)	COL (4)	COL (5)
NHS TRUSTS	£M	£	£	£
Argyll & Clyde Acute Hospitals	116.500	174,750	349,500	582,500
Ayrshire & Arran Acute Hospitals	134.000	201,000	402,000	670,000
Ayrshire & Arran Primary Care	73.200	109,800	219,600	366,000
Borders General Hospital	32.400	48,600	97,200	162,000
Borders Primary Care	31.200	46,800	93,600	156,000
Dumfries & Galloway Acute & Maternity Hospitals	45.700	68,550	137,100	228,500
Dumfries & Galloway Primary Care	45.700	68,550	137,100	228,500
Fife Acute Hospitals	89.300	133,950	267,900	446,500
Fife Primary Care	80.000	120,000	240,000	400,000
Forth Valley Acute Hospitals	81.900	122,850	245,700	409,500
Forth Valley Primary Care	63.400	95,100	190,200	317,000
Grampian Primary Care	18.800	28,200	56,400	94,000

CENTRAL CONTRIBUTION TO DAMAGES AWARDS: 1999/2000

HEALTH AUTHORITY	ESTIMATES FOR PATIENTS INCOME	MINIMUM AWARD FOR CENTRAL CONTRIBUTION 0.15% OF Col (2) WITH £450,000 CEILING	AWARD ABOVE WHICH ADDITIONAL COSTS MET CENTRALLY 0.3% OF Col (2)	MAXIMUM EXPENDITURE BY EMPLOYING AUTHORITY IN FINANCIAL YEAR (0.5% of Col (2))
	COL (1)	COL (2)	COL (3)	COL (4)	COL (5)
NHS TRUSTS		£M	£	£	£
Grampian University Hospitals		170.200	255,300	510,600	851,000
Greater Glasgow Primary Care		153.400	230,100	460,200	767,000
Highland Acute		73.800	110,700	221,400	369,000
Highland Primary Care		56.600	84,900	169,800	283,000
Lanarkshire Acute Hospitals		168.100	252,150	504,300	840,500
Lanarkshire Primary Care		101.000	151,500	303,000	505,000
Lomond & Argyll Primary Care		38.500	57,750	115,500	192,500
Lothian Primary Care		132.700	199,050	398,100	663,500
Lothian University Hospitals		253.700	380,550	761,100	1,268,500
North Glasgow University Hospitals		305.400	450,000	916,200	1,527,000
Renfrewshire & Inverclyde Primary Care		69.000	103,500	207,000	345,000
South Glasgow University Hospitals		150.200	225,300	450,600	751,000
Tayside Primary Care		112.300	168,450	336,900	561,500

CENTRAL CONTRIBUTION TO DAMAGES AWARDS: 1999/2000

HEALTH AUTHORITY		ESTIMATES FOR PATIENTS INCOME	MINIMUM AWARD FOR CENTRAL CONTRIBUTION 0.15% OF Col (2) WITH £450,000 CEILING	AWARD ABOVE WHICH ADDITIONAL COSTS MET CENTRALLY 0.3% OF Col (2)	MAXIMUM EXPENDITURE BY EMPLOYING AUTHORITY IN FINANCIAL YEAR (0.5% of Col (2))
	COL (1)	COL (2)	COL (3)	COL (4)	COL (5)
NHS TRUSTS		£M	£	£	£
Tayside University Hospitals		180.900	271,350	542,700	904,500
Yorkhill		80.000	120,000	240,000	400,000
West Lothian Healthcare		66.800	100,200	200,400	334,000

The Components of Clinical Risk Management

Supervision and Training

- ⇨ Induction or orientation programmes for all new clinical staff.
- ⇨ Early experience in straightforward practical procedures for new clinical staff.
- ⇨ Appropriate degrees of consultant supervision, commensurate with doctor's experience and known capabilities.

Medical Records

- ⇨ Comprehensive system for the completion, use, storage and retrieval of medical records.
- ⇨ Record-keeping standards monitored through the clinical audit process.

Communications with Patients and Relatives

- ⇨ Appropriate information provided on the risks and benefits of proposed treatment or investigation before consent signature sought.

Handling of Complaints

- ⇨ Agreed system in place with clear identification of clinical complaints, as opposed to more general complaints.

Clinical Incident Reporting System (CIRS)

- ⇨ Operated in all medical specialities and clinical support departments.
- ⇨ To record all unexpected events occurring during treatment, or unexpected result of treatment which may, or does, cause harm to the patient.
- ⇨ Essential that all such incidents are recorded to form a database.
- ⇨ Incidents investigated timeously and action taken to limit damage and prevent recurrence.
- ⇨ Regular review of database, practices and protocols with feedback to staff.

APPENDIX 3

CLINICAL RISK MANAGEMENT: STANDARDS CHECKLIST

General

Risk management may be defined as a systematic approach to:

- identifying, classifying, evaluating and reducing or eliminating risks, injuries or infections to patients, staff or visitors;
- administering a cost effective method for handling complaints and claims.

This covers all areas of activity within a Trust or hospital, including accident prevention and loss control. Clinical risk management is primarily concerned with risks, injuries or infections sustained by patients as a result of actions carried out by doctors, nurses or paramedical staff.

Providers should be committed to managing clinical risk throughout their organisation, having:

- a written risk management strategy agreed by managers and endorsed by their Board;
- a clinical risk management system, with an action plan for reducing key risks identified for urgent attention;
- a Risk Manager.

The Risk Manager will have access to clinical information and ideally should report to an Executive member of the Board. Responsibilities of the post might include:

- ensuring appropriate training for new staff;
- development of clinical guidelines and protocols (in conjunction with clinical directors);
- ensuring adequate communication with patients and relatives;
- monitoring adverse occurrence screens;
- handling of complaints;
- arranging continuing education for clinicians.

Techniques of Clinical Risk Management

- Complaints Audit
- Adverse Occurrence Screening
- Clinical Guidelines and Protocols
- Regular Review of CIRS database
- Liaison with Central Legal Office