



NHS CIRCULAR 1989(PCS)32

General Managers of Health Boards
General Manager, Common Services Agency

Your ref

Our ref

Date 21 December 1989

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Dear Sir

MEDICAL NEGLIGENCE: NEW ARRANGEMENTS FOR NHS HOSPITAL AND COMMUNITY HEALTH SERVICE DOCTORS AND DENTISTS

Summary

1. From 1 January 1990 new arrangements will apply to the handling of allegations of negligence against medical and dental staff employed in the hospital and community health services. General medical and dental practitioners are not directly affected by the new arrangements unless they have a contract of employment, for example as a hospital practitioner, with a Health Board. This circular advises Health Boards on the procedures to be followed, and provides information on the financial arrangements.

Action Required

2. With effect from 1 January 1990, Health Boards are asked to:
- (a) assume responsibility for new and existing claims of medical negligence;
 - (b) ensure that a named officer has sufficient authority to make decisions on behalf of the Board on the conduct of cases;
 - (c) cease to require their medical and dental staff to subscribe to a medical defence organisation and cease to reimburse two-thirds of medical defence subscriptions;
 - (d) encourage their medical and dental staff to ensure that they have adequate defence cover as appropriate; and
 - (e) distribute as quickly as is practicable to all their medical and dental staff, including those with honorary NHS contracts, copies of this circular.

Introduction

3. Health Boards, as corporate bodies, are legally liable for the negligent acts of their employees in the course of their NHS employment. Hitherto, however, hospital medical and dental staff have taken separate responsibility for claims of negligence made against them by subscribing

to one of three medical defence organisations (MDOs) and Health Boards have reimbursed staff for two-thirds of the cost of these subscriptions. In the light of the increasing incidence of litigation and the rapidly increasing costs of medical defence subscriptions, Ministers have decided that the NHS should assume direct financial responsibility for claims of negligence against medical and dental staff employed in the hospital and community health services (HCHS). General practitioners are not affected by these new arrangements.

Handling of claims of medical or dental negligence

A. Claims intimated to Health Boards or to the Central Legal Office on or after 1 January 1990

4. From 1 January 1990 Health Boards will be formally responsible for the handling and financing of claims of negligence against their medical and dental staff. At present Health Boards are required to obtain their legal advice on this matter from the Central Legal Office of the Common Services Agency (CLO). CLO liaises with the MDOs who presently provide the necessary medical or dental advice at the initial claim stage. Under the new arrangements Health Boards will continue to be required to obtain their legal advice from CLO but as from 1 January 1990 CLO will be free to seek medical advice from wherever they consider most appropriate, ie from the MDOs or from the other sources they have identified.

B. Claims intimated to MDOs before 1 January 1990

5. Because of the length of time many medical negligence actions take to be resolved, there will be a considerable number of claims and actions outstanding at 1 January 1990. Health Boards will take over financial responsibility for such claims or actions from that date.

6. Health Boards will control the conduct of these claims and actions since they will be liable for the expenses and damages arising. CLO will, however, continue to liaise with the MDOs until such claims or actions have been concluded. This is necessary because the re-insurance cover of the MDOs for claims intimated before 1990 will remain valid only if the MDO currently financially liable for the claim or action continues to control the conduct of the defence of such claims or actions. Since some of the cover is on an aggregate basis, this advice applies to both large and small claims even although the arrangements described in paragraph 12 below for access to a share of the MDOs reserves will only cover awards above a threshold.

C. General Handling Principles

7. Health Boards should take the essential decisions on the handling of claims of medical negligence against their staff in close consultation with CLO. Boards should ensure that they have made effective arrangements to delegate authority appropriately in order to enable decisions to be made promptly, especially where the CLO is negotiating a settlement. Boards should allocate such responsibility to a named officer.

8. In deciding how a claim or action should be handled, and in particular whether to resist a claim or seek an out-of-court settlement, Health Boards and CLO should pay particular attention to any view

expressed by the practitioner(s) concerned and to any potentially damaging effect on the professional reputation of the practitioner(s) concerned. Boards should also have clear regard to any point of principle or of wider application raised by the case and to the costs involved.

9. It is open to the practitioner concerned to employ at his or her expense an expert adviser, but the practitioner can be defended separately in court only with the agreement of the Court. The pursuer and the Health Board may agree to separate defence for the practitioner; under normal circumstances the Health Board should do so unless it considers that this would lead to additional expenses or damages falling on the Health Board.

10. Where a case involves both a Health Board and a general medical or dental practitioner (or any other medical or dental practitioner in relation to work for which the Health Board is not responsible), the Health Board through the CLO should consult with the practitioner(s) cited or their representative to seek agreement on the conduct of the claim or action. Where a Health Board (or its employees) alone is cited, but there is reason to believe that the action or inaction of a practitioner outside the Health Board's responsibility was a material factor in the negligence concerned, the Health Board through the CLO should actively seek a contribution to any eventual costs and damages. Conversely, in cases where such a practitioner alone is cited, there may be circumstances in which an MDO asks the Health Board to make a similar contribution, as if it were a defender. In any such circumstances, Health Boards through the CLO should co-operate fully in the formulation of the defence and should seek to reach agreement with the MDO out of Court on the proportion in which any expenses and damages awarded to the pursuer should be borne.

Coverage of the Scheme and Arrangements in Practice

11. The Health Departments' views on some of the questions that have arisen about the practical operation of the new arrangements are given in the Annex to this letter. The indemnity scheme applies to all staff in the course of their employment in the hospital or community health services, including those engaged through private agencies.

Financial Arrangements

Funding of Claims

12. Subject to final agreement with the MDOs, the public sector will have access to a share of the MDOs' reserves in respect of the hospital and community health services. It is expected that the MDOs will each establish a fund to be drawn on according to criteria set by the Health Departments. The Health Departments will be introducing a transitional scheme under which these reserves will be made available to assist Health Boards to meet the costs of particularly large settlements. These will usually, but not necessarily, be cases which arose from claims or actions which were intimated before 1 January 1990. Details of the financial arrangements and of the means of access to these funds will be given later.

NHS Trusts

13. NHS Trusts will be responsible for claims of negligence against their medical and dental staff. The Health Departments are considering what arrangements will apply to NHS Trusts and further guidance will be issued in due course.

Monitoring

14. In order to assess the resource consequences of these changes, the Health Departments will need to have information on the costs incurred by Health Boards following the assumption of direct financial responsibility for medical and dental negligence. The information required will include (for each financial year):

- i. the number of claims of medical or dental negligence against the Health Board and/or its employees, including the number of cases brought forward from an earlier period;
- ii. the number of such cases settled during the period, with the Health Board's expenses, including damages payable, in the following cost bands:

Number of Cases

(a)	£0 - £100,000
(b)	£100,000 - £200,000
(c)	£200,000 - £300,000
(d)	£300,000 - £500,000
(e)	over £500,000

iii. the total cost of the settlements reached or awards made; distinguishing between:

- a. the Board's costs and the costs of the payment of the pursuer's expenses and damages; and
- b. an estimate of expenses and damages attributable to medical and dental negligence as distinct from negligence of other staff.

15. The Department will request this information from CLO at the end of each financial year, starting with 31 March 1990 in order to obtain an early indication of the costs of the scheme.

Review

16. The Health Departments plan to review the operation of these arrangements in 1992. The review will include examination of the effect of the arrangements on individual practitioners.

Summary

17. Health Boards are asked to introduce the arrangements described above from 1 January 1990. Sufficient copies of the circular are being sent to Boards to allow them to distribute it to all medical and dental practitioners in their employment, including those with honorary contracts; Health Boards are asked to make arrangements for this distribution as soon as practicable.

18. Since Health Boards will be taking financial responsibility in claims and actions of medical negligence it will no longer be necessary for them to require employed staff to subscribe to a recognised professional defence organisation, as in the recommended form of consultant contract set out at Annex C of NHS Circular 1979(PCS)55. New contracts should not contain this provision. Boards should inform their medical and dental staff that the provision no longer applies. They should, however, encourage such staff to ensure that they have adequate defence cover for activities not covered by the Health Board indemnity. The Annex to this letter discusses these points more fully.

19. The two-thirds reimbursement of medical defence subscriptions ends on 31 December 1989. Paragraph 310 of the Terms and Conditions of Service for Hospital Medical and Dental Staff and paragraph 289 of the Terms and Conditions of Service for Doctors in Community Medicine and the Community Health Service shall not have effect after 31 December 1989.

Enquiries

20. Any enquiries regarding this Circular should be directed to Mrs L Middleton, Room 155 (Ext 2828) or Miss M Glen, Room 130C (Ext 2475) St Andrew's House, Edinburgh EH1 3DE.

Yours faithfully



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MEDICAL NEGLIGENCE: NEW NHS ARRANGEMENTS FOR NHS HOSPITAL AND COMMUNITY HEALTH SERVICE DOCTORS AND DENTISTS

Introduction

1. New arrangements for dealing with medical and dental negligence claims in the hospital and community health services are being introduced from 1 January 1990. Subject to final agreement with the medical defence organisations on the financial arrangements, Health Boards will take direct financial responsibility for claims and actions initiated before that date as well as for new claims. In future, medical and dental staff employed by Health Boards will no longer be required under the terms of their contract to subscribe to a medical defence organisation. The Health Board indemnity will, however, cover only Health Board responsibilities. The Health Departments advise practitioners to maintain their defence body membership in order to ensure they are covered for any work which does not fall within the scope of the indemnity scheme.

Set out below are the Health Departments' replies to some of the questions most commonly asked about the operation of the new arrangements.

2. Why is this change necessary?

Medical defence subscriptions rose rapidly in the 1980s because of growth both in the number of medical negligence cases and in the size of the awards made by the courts. Subscriptions tripled between 1986 and 1988, and the Doctors' and Dentists' Review Body concluded that to take account of the increase in subscriptions through practitioners' pay would lead to distortions in pay and pensions. The pressure to relate subscription rates to the practitioner's specialty underlined the difficulty of maintaining the system. The Health Departments issued in March 1989 a proposal for a health authority indemnity. The new arrangements follow discussions with the medical defence organisations, the medical and dental professions, health authority management and other interested bodies.

Coverage

3. Who is covered by the Health Board indemnity scheme?

Health Boards as employers are liable at law for the negligence (acts or omissions) of their staff in the course of their NHS employment. The legal position is the same for medical and dental staff as for other NHS employees, but for many years doctors and dentists have themselves taken out medical defence cover through the three medical defence organisations (MDOs). Under the indemnity scheme, Health Boards will take direct responsibility for expenses and damages arising from medical negligence where they as employers are vicariously liable for the acts and omissions of their medical and dental staff.

4. Does this include clinical academics and research workers?

Health Boards are vicariously liable for the work done by university medical staff and other research workers under their honorary contracts in the course of their NHS duties, but not for pre-clinical or other work in a university or research institute.

5. Is private work in NHS hospitals covered by the indemnity scheme?

Health Boards will not be responsible for a consultant's private practice, even in an NHS hospital. Where junior medical staff are involved in the care of private patients in NHS hospitals, however, they would normally be doing so as part of their contract with the Health Board. It remains advisable that any junior doctor who might be involved in any work outside the scope of his or her employment should have separate medical defence or insurance cover.

6. Is Category 2 work covered?

Category 2 work (eg reports for insurance companies) is by definition not undertaken for the employing Health Board and will, therefore, not be covered by the Health Board indemnity scheme; separate medical defence cover would be appropriate.

7. Are GMC or other disciplinary proceedings covered?

Health Boards will not be financially responsible for the defence of medical staff involved in GMC or other disciplinary proceedings. It is the responsibility of the practitioner concerned to take out separate medical defence cover against such an eventuality.

8. Is a hospital doctor doing a GP locum covered?

This would not be the responsibility of the Health Board. The hospital doctor and the general practitioners concerned should ensure that there is appropriate medical defence cover.

9. Is a GP seeing his own patient in hospital covered?

A GP providing medical care to patients in hospital under a contractual arrangement, eg where the GP was employed as a clinical assistant, will be covered by the Health Board indemnity. On the other hand, if the Health Board is essentially providing only hotel services and the patient(s) remain in the care of the GP, the GP would be responsible and separate medical defence cover would be appropriate.

10. Are GP trainees working in general practice covered?

In general practice the responsibility for training and for paying the salary of a GP trainee rests with the trainer (with funds from the Health Board). Where the trainee's medical defence subscription is higher than the subscription of an SHO in the hospital service, he or she may apply through the trainer for the difference in subscription to be reimbursed. While the trainee is receiving a salary in general practice, it is advisable that both the trainee and the trainer, and indeed other members of the practice, should have separate medical defence cover.

11. Are clinical trials covered?

The proposed arrangements do not alter the current legal position. If the Health Board was responsible for a clinical trial authorised under the Medicines Act 1968 or its subordinate legislation and that trial was carried out by or on behalf of a doctor involving his or her NHS patients, such a

doctor would be covered by the indemnity scheme. Similarly, for a trial not involving medicines, the Health Board would take financial responsibility unless the trial were covered by such other indemnity as may have been agreed between the Health Board and those responsible for the trial. In any case, Health Boards must take steps to make sure that they are informed of clinical trials in which their staff are taking part in their NHS employment and that these trials have the required approval of the local ethical committee concerned with research applications.

12. Would a doctor be covered if he was working other than in accordance with the duties of his post?

Such a doctor would be covered by the Health Board indemnity for actions in the course of NHS employment, and for this purpose the Department expects Health Boards to interpret the scope of this employment liberally. For work not covered in this way the doctor personally may have a civil, or even in extreme circumstances criminal, liability for his actions.

13. Are doctors attending accident victims ("Good Samaritan" acts) covered?

By definition, "Good Samaritan" acts are not part of the doctor's work for the employing Health Board. Medical defence organisations are willing to provide low-cost cover against the (unusual) event of a doctor performing such an act being sued for negligence.

14. Are consultants in public health medicine doing work for local authorities covered? Are occupational physicians covered?

Consultants in public health medicine carrying out local authority functions under their Health Board contract would be acting in the course of their NHS employment. They will therefore be covered by the Health Board indemnity. The same principle applies to occupational physicians employed by Health Boards.

15. Will NHS hospital doctors working for other agencies, eg the Prison Service, be covered?

In general, Health Boards will not be financially responsible for the acts of NHS staff when they are working on a contractual basis for other agencies. Conversely, they will be responsible where, for example, a Ministry of Defence doctor works in an NHS hospital. Either the agency commissioning the work would be responsible or the doctor should have separate medical defence cover. Health Boards' indemnity should, however, cover work for which they pay a fee, such as domiciliary visits and family planning services.

16. Are retired doctors covered?

The Health Board indemnity will apply to acts or omissions in the course of NHS employment regardless of when the claim was notified. Health Boards will thus cover doctors who have subsequently retired or left the service for events which took place before their retirement, but will seek their co-operation in the defence of a claim or action. Retired doctors will not be covered for "Good Samaritan" acts or for work for voluntary bodies; for these reasons they may wish to maintain separate medical defence cover.

17. Are doctors offering services to voluntary bodies such as the Red Cross or hospices covered?

The Health Board would be responsible for the doctor's actions only if the Board were responsible for the medical staffing of the voluntary body. If not, the doctors concerned may wish to ensure that they have separate medical defence cover as at present.

18. Will a Health Board provide cover for a hospital locum doctor?

A Health Board will take financial responsibility for the acts and omissions of a locum doctor whether "internal" or provided by an external agency.

19. Are private sector rotations for hospital staff covered?

The medical staff of independent hospitals are responsible for their own medical defence cover, subject to the requirements of the hospital managers. If NHS staff in the training grades work in independent hospitals as part of their NHS training, they would be covered by the Health Board indemnity provided that such work was covered by an NHS contract.

20. Will academic General Practice be covered?

The Health Departments have no plans to extend the Health Board indemnity to academic departments of general practice. In respect of general medical services, Health Boards will be making payments of fees and allowances which include an element for expenses, of which medical defence subscriptions are a part.

Practical Arrangements

21. How will claims and actions be handled after 1 January 1990?

After 1 January 1990 the Central Legal Office (CLO) of the Common Services Agency will act on the Health Boards' behalf and may seek the necessary medical and dental advice about a case from an MDO or from any other source considered appropriate by CLO.

22. Will doctors be reimbursed by MDOs for the "unexpired" portion of their subscriptions?

This is a matter between each MDO and its members.

23. Will membership of a medical defence organisation continue to be a contractual obligation?

Doctors and dentists may wish to continue their membership on an individual basis in order to receive the cover referred to in paragraphs 5-20 above, as well as the other legal and advisory services provided by the MDOs. The Health Departments are advising health authorities that they should no longer require their medical and dental staff to subscribe to an MDO. A Health Board could require a doctor to be a member of an MDO if the doctor were to be carrying out private work on NHS premises. The two-thirds reimbursement of subscriptions will cease at the end of 1989.

24. Will medical defence subscriptions be tax-allowable in future?

The Health Departments understand that medical defence subscriptions will continue to be allowable under income tax rules.

25. What happens if a doctor wishes to defend a claim which the Health Board would prefer to settle out of court, eg where a point of principle or a doctor's reputation is at stake?

While the final decision rests with the Health Board, it should take careful note of the practitioner's view. Health Boards should not settle cases without good cause.

26. If a doctor wishes to be separately defended in an action, what would be the extent of his liability?

Since it is the Health Board which is normally sued for the medical negligence of its staff and which will in future be solely financially liable, it must have the ultimate right to decide how the defence of an action is to be handled. Subject to this, a Board may welcome a practitioner being separately advised in a case without cost to the Health Board. If a practitioner claims that his interests in any case are distinct from those of the Health Board and wishes to be separately defended in the proceedings, he will normally need the agreement of the pursuer, the defending Health Board and the court. If liability is then established, he would have to pay not only his own legal expenses but also any further expenses incurred by the Health Board as a result of his being separately defended. The Health Board would remain liable for the full award of damages and expenses to the pursuer.

27. Will Health Boards put restrictions on the clinical autonomy of doctors?

Health Boards have a responsibility to organise services in a manner which is in the best interests of patients. In the past, medical defence organisations have advised doctors and dentists on patterns of practice carrying unacceptable dangers to patients. There is, however, no question of Health Boards barring certain services which carry risks but are a high priority for patients.

28. Will Health Board be able to secure statements from doctors for the defence of a claim or action of medical negligence?

Health Boards through the CLO will require statements from medical and dental staff if they are to defend cases. Practitioners have a duty to give the Health Board such assistance as the Board or CLO may reasonably require in investigating or defending any claim or action. A doctor's refusal without good reason to provide a statement could result in the Health Board being unable to defend itself properly and so incurring additional expenses.

29. Will Health Boards be able to trace doctors who formerly worked for them?

It is accepted that Health Boards may have difficulty in tracing the doctors responsible, especially if they were junior medical staff at the time, and in securing statements from them; the MDOs may be able to offer assistance with this matter. Often, however, good medical records kept at the time will be of more value than statements made some years after the event.

30. Will the new arrangements apply to NHS Trusts?

NHS Trusts as employers will be vicariously liable for the acts of their employed medical and dental staff and will take the financial responsibility for negligence. Further guidance will be issued in due course.

31. How can Health Boards meet damages which could be as much as £1 million for a single case?

The Department is making arrangements under which it will provide an element of cost-sharing with Health Boards for medical negligence costs above a certain level. For a transitional period Health Boards will have access under certain criteria to some of the reserves of the MDOs.

Scottish Home and Health Department
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