

CLINICAL NEGLIGENCE PROTOCOL

PROVISIONAL FINAL DRAFT

Explanatory note:

This draft is the work of a representative group set up by the Clinical Disputes Forum (CDF) in response to a new invitation to review the Clinical Negligence Protocol, this time from the Law Society at the behest of the Civil Justice Council (CJC). This draft builds on work done by another group of the CDF in 2002-03 in response to the last invitation to do this, the product of which never saw the light of day. CDF wants to thank those who contributed both to that draft and this one.

This draft has been finalised two weeks after publication of Sir Rupert Jackson's monumental Report Review of Civil Litigation Costs (referred to in this draft as Jackson). Several of his proposed reforms will impinge upon the final form of any clinical negligence protocol, and we have footnoted the most obvious of these, indicating where our draft agrees or (occasionally) disagrees with his proposals. This draft does not assume implementation of his recommendations, and what appears here is what we believe could and should be included now.

The purpose of this draft is to circulate it as widely as possible, as well as treating it as a report to the Law Society and Civil Justice Council about where we have reached in our thinking. There will be a debate sponsored by the CJC about the Protocols in March 2010, and any further product from that and from responses to the wider consultation process now afoot can be embodied in any final draft by whoever is given the job of doing this.

Any further responses would be welcomed by the CDF and should be addressed to Tony Allen c/o CEDR, IDRC, 70 Fleet Street, London EC4Y 1EU or e-mailed to tallen@cedr.com.

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8 February 2010

THE CLINICAL NEGLIGENCE PROTOCOL

1 INTRODUCTION

1.1 The first Protocol for the Resolution of Clinical Disputes was produced by the Clinical Disputes Forum, a multi-disciplinary body (now a registered charitable company) which was formed in 1997 in response to Lord Woolf's Access to Justice reports. One of the aims of the Forum is to find less adversarial and more cost-effective ways of resolving disputes about healthcare and medical treatment, and the Clinical Disputes Pre-action Protocol was its first major initiative, drafted after extensive consultation. At the request of the Civil Justice Council and the Law Society, the Forum has again taken the lead in consulting widely to draft this updated Protocol.

1.2 This Protocol (which is set out in Sections 4 to 12 inclusive below)

- encourages a **climate of openness** when something has gone wrong with a claimant's¹ treatment or the claimant is dissatisfied with that treatment and/or the outcome. This reflects the requirements for clinical governance within healthcare;
- provides **general guidance** on how this more open culture might be achieved when disputes arise, in accordance with a "cards-on-the-table" approach;
- recommends a **timed sequence** of steps for claimants and healthcare providers, and their advisers, to follow when a dispute arises. This should facilitate and speed up exchanging relevant information and increase the prospects that disputes can be resolved without resort to legal action.

1.3 This new version of the Protocol also takes into account developments in civil procedure since the Civil Procedure Rules 1998 (the CPR) were implemented, and in particular the terms of the Pre-Action Conduct Practice Direction introduced in April 2009 (the PACPD)².

2 THE AIMS OF THIS PROTOCOL

2.1 The **general** aims of the Protocol are –

- to maintain and/or restore the claimant/healthcare provider relationship; and
- to resolve as many disputes as possible without litigation.

2.2 Its **specific** objectives are –

Openness

- to encourage early communication of the perceived problem between claimants and healthcare providers;

¹ Although no assumption can or should be made that a patient will definitely turn into a claimant, we have chosen to use the word "claimant" (instead of "patient") throughout this Protocol, which is after all about behaviour in relation to the bringing of claims. It must be remembered that the claim may be on behalf of a patient without capacity, or be triggered by the death of the "patient", so that a litigation friend or relative will be the "claimant".

² Jackson recommends repeal of the PACPD. If this happens, references will have to be deleted or amended to refer to any replacement PD.

- to encourage claimants to voice any concerns or dissatisfaction with their treatment as soon as practicable;
- to encourage healthcare providers to develop systems of early reporting and investigation for serious adverse treatment outcomes and to provide full and prompt explanations, including an apology where appropriate, to dissatisfied claimants; such expressions of regret do not constitute an admission of liability in part or in full.
- to ensure that sufficient information is disclosed by both parties to enable each to understand the other's perspective and case, and to encourage early resolution;

Timeliness

- to provide an early opportunity for healthcare providers to identify cases where an investigation is required and to carry out that investigation promptly;
- to encourage primary and private healthcare providers to involve their defence organisations or insurers at an early stage;
- to ensure that all relevant medical records are provided to claimants or their appointed representatives on request within 40 days as required by the Data Protection Act 1998;
- to ensure that relevant records which are not in healthcare providers' possession are made available to them by claimants and their advisers at an appropriate stage;
- to identify a stage before issue of proceedings at which the parties should consider whether settlement discussions, whether by alternative dispute resolution or otherwise, are appropriate;
- where a resolution is not achievable, to lay the ground to enable litigation to proceed on a reasonable timetable, at a reasonable and proportionate cost and to limit the matters in contention;
- to discourage the pursuit of unmeritorious claims and the prolonged defence of meritorious claims.

Awareness of Options

- to ensure that claimants and healthcare providers are made aware of the available options to pursue and resolve disputes and what each might involve.

2.3 This Protocol does not attempt to be prescriptive about a number of related clinical governance issues which will have a bearing on any healthcare provider's ability to meet the standards within the Protocol. Good clinical governance requires the following to be considered:

- (1) **Clinical risk management:** the protocol does not provide any detailed guidance to healthcare providers on clinical risk management or the adoption of risk management systems and procedures. This is a matter for the National Health Service Litigation Authority, individual trusts and providers, including GPs, dentists and the private sector, including the Medical Defence Organisations. Effective, co-ordinated and focused clinical risk management strategies and procedures are essential for the management of risk and the early identification and investigation of adverse outcomes.

- (2) **Adverse outcome reporting:** the Protocol does not provide any detailed guidance on which adverse outcomes should trigger an investigation. However, healthcare providers should have in place procedures for such investigations, including recording of statements of key witnesses. These procedures should also cover when and how to inform claimants that an adverse outcome has occurred. Providers should also work with the National Patient Safety Agency on data collection on adverse incidents.
- (3) **The professional's duty to report:** in his final report, Lord Woolf suggested that the professional bodies might consider changes to their codes of conduct to impose duties to report adverse incidents.. The General Medical Council has published guidance to doctors about their duties to report adverse incidents to the relevant authorities and co-operate with inquiries.

Where the Protocol fits in

2.4 Protocols serve the needs of potential litigants in setting out a code of good practice, and assisting with:

- predictability in the time needed for necessary steps early in a dispute;
- standardisation of the requirements for relevant information, including records and documents to be disclosed;
- creating an expectation that steps will be taken before issue of proceedings to facilitate early resolution of cases and/or to minimise the number of issues to be litigated.

2.5 It is recognised that contexts differ significantly. For example:

- claimants tend to have an ongoing relationship with a general practitioner, more so than with a hospital;
- clinical staff in the National Health Service are often employees, while those in the private sector may be contractors;
- providing records quickly may be relatively easy for GPs and dentists, but can be a complicated procedure in a large multi-department hospital.

2.6 This Protocol is intended to be sufficiently broadly based and flexible to apply to all sectors of healthcare, both public and private.

3 ENFORCEMENT OF THE PROTOCOL AND SANCTIONS FOR NON- COMPLIANCE³

3.1 This Protocol – when read with the CPR and the PACPD - is now regarded by the courts as setting the standard of normal reasonable pre-action conduct for clinical disputes.

³ Jackson proposes pre-action applications to allege non-compliance. Such a move would apparently need primary legislation. If introduced, this will need amendment.

3.2 If proceedings are issued, it is for the court to decide whether non-compliance with a Protocol merits sanctions. The PACPD explains and supports the Protocols, and sets out a list of sanctions which might be considered for non-compliance with any Protocol (see Section II paragraph 4 of the PACPD).

3.3 If the court has to consider the question of compliance after proceedings have begun, it may be less concerned with minor infringements, e.g. failure by a short period to provide relevant information. One minor breach will not entitle the ‘innocent’ party to abandon the procedure set out in this Protocol. The court looks at the effect of non-compliance on the other party when deciding whether to impose sanctions. Additionally, the court can itself order a stay of proceedings where **both** parties have failed to observe the requirements of any Protocol, for example by failing unreasonably to consider ADR.

4 THE PROTOCOL

4.1 This Protocol is not a comprehensive code governing all the steps in clinical disputes. Rather it attempts to set out **a code of good practice** which parties should follow when litigation might be a possibility.

4.2 The **commitments** section (Section 5) of the Protocol summarises the guiding principles which healthcare providers and claimants and their advisers are invited to endorse when dealing with claimant dissatisfaction with treatment and its outcome, and with potential complaints and claims.

4.3 The **steps** section (Section 6) sets out a recommended sequence of actions to be followed if litigation is in prospect, in a more prescriptive form.

5 GOOD PRACTICE COMMITMENTS

5.1 **Healthcare providers** should –

- (1) ensure that **key staff**, including complaints, claims and risk managers, are adequately trained and have knowledge of healthcare law, complaints procedures, risk management and civil litigation practice and procedure appropriate to their roles;
- (2) develop an approach to **clinical governance** that ensures that clinical practice is delivered to commonly accepted standards and that this is routinely monitored through a system of clinical audit and clinical risk management (particularly adverse outcome investigation);
- (3) set up **adverse outcome reporting systems** in all specialties to record and investigate unexpected serious adverse outcomes as soon as possible. Such systems can enable evidence to be gathered quickly, which makes it easier to provide an accurate explanation of what happened and to defend or settle any subsequent claims;
- (4) use the results of **adverse incidents and complaints positively** as a guide to how to improve services to claimants in the future;

- (5) ensure **that claimants receive clear and comprehensible information** in an accessible form about how to raise their concerns or complaints;
- (6) establish **efficient and effective systems of recording and storing claimant records**, notes, diagnostic reports and X-rays, and to retain these in accordance with Department of Health guidance (currently for a minimum of eight years in the case of adults, all obstetric and paediatric notes for children until they reach the age of 25, and indefinitely for claimants lacking mental capacity);
- (7) **advise claimants** of a serious adverse outcome and provide on request to the claimant or the claimant's representative an oral or written explanation of what happened, information on further steps open to the claimant, including where appropriate an offer of future treatment to rectify the problem, an apology, changes in procedure which will benefit claimants and/or compensation.

5.2 **Claimants and their advisers** should –

- (1) **report any concerns and dissatisfaction** to the healthcare provider as soon as is reasonable to enable that provider to offer clinical advice where possible, to advise the claimant if anything has gone wrong and take appropriate action;
- (2) consider the **full range of options** available following an adverse outcome with which a claimant is dissatisfied, including a request for an explanation, a meeting, a complaint, and other appropriate dispute resolution methods (including mediation) and negotiation, not only litigation;
- (3) **inform the healthcare provider when** the matter will not be pursued further or has been concluded: legal advisers should also notify the provider when they are no longer acting for the claimant, particularly if proceedings have not started.

6 **OBTAINING THE HEALTH RECORDS⁴**

6.1 Any request for records by the claimant should

- **provide sufficient information** to alert the healthcare provider where an adverse outcome has been serious or had serious consequences;
- be as **specific as possible** about the records which are required.

6.2 Requests for copies of the claimant's clinical records should be made using the Law Society and Department of Health approved **standard forms** (Annex A to this Protocol), adapted as necessary.

6.3 The copy records should be provided **within 40 days** of the request and for a cost not exceeding the charges permissible under the Access to Health Records Act 1990 and the Data Protection Act 1998.

⁴ Note that Jackson proposes financial penalties where healthcare providers delay in providing records.

6.4 The claimant may also make a request under the Freedom of Information Act 2000.

6.5 Disclosable documents include those created by the healthcare provider in relation to any relevant adverse incident or complaint made by or on behalf of the claimant. They also include any relevant guidelines, protocols or policies. The claimant should make a specific request for all documents reasonably required for the initial investigation of the case.

6.6 In the rare circumstances that the healthcare provider is in difficulty in complying with the claimant's request within 40 days, the **problem should be explained** quickly and details given of what is being done to resolve it.

6.7 It will not be practicable for healthcare providers to investigate in detail each case when records are requested. But healthcare providers should **adopt a policy as to which cases will be investigated** ******(see paragraph 5.1 above on clinical governance and adverse outcome reporting and note also the provision regarding commencing investigations in sections 7 and 8 below).

6.8 If the healthcare provider fails to provide the health records within 40 days, the claimant can then apply to the court under the CPR Part 31.16 for an **order for pre-action disclosure**. The court has the power to impose costs sanctions for unreasonable delay in providing records. The claimant may also refer the matter to the Information Commissioner for a potential breach of the Data Protection Act 1998.

6.9 If either the claimant or the healthcare provider considers that **additional health records are reasonably required from a third party**, in the first instance these should be requested by or through the claimant. Third party healthcare providers are expected to co-operate. The claimant should provide to the defendant, within 40 days of a request, copies of relevant third party records in their possession. The CPR Part 31.17 enables claimants and healthcare providers to apply to the court for pre-action disclosure by third parties.

6.10 Legible copies of the claimant's medical records should be placed in an indexed and paginated bundle by the claimant at the earliest opportunity and kept up to date. If the healthcare provider requests copies of the claimant's records including copies of relevant third party records the claimant should where requested provide the healthcare provider with a copy of the indexed and paginated bundle. The healthcare provider should agree to pay a reasonable copying charge in respect of the provision of the bundle.

7 THE LETTER OF NOTIFICATION⁵

7.1 This section of the protocol introduces a new intermediate stage, which follows on from obtaining the medical records, but is likely to arise before the claimant is in a position to send a Letter of Claim in accordance with Section 8 of this protocol. This section recognises that a healthcare provider may not be in a position to investigate every potential claim where the records have been requested. The aim of this new intermediate stage is to provide the claimant with an opportunity to send to the healthcare provider a Letter of Notification confirming that the case is one which is proceeding and to enable the provider(s) to

⁵ Jackson decided not to recommend a stage like this: see Final Report chapter 23, para 4.10 (p.240). We had already decided to propose it, and after debate still think that such a step will indeed be a good way for reducing both unnecessary defence investigation while promoting timely responses from the defence where claimants do decide to proceed with a case, even if they cannot yet compile a comprehensive Letter of Claim.

consider whether this is a case in which they should now commence their investigations if they have not done so already.

7.2 Annex B1 to this protocol provides **a template for the recommended contents of a Letter of Notification**. The level of detail will need to be varied to suit the particular circumstances.

7.3 Following the receipt and analysis of the records, and the receipt of an initial supportive medical report dealing with breach of duty and causation, the claimant should give consideration to sending a Letter of Notification to the healthcare provider as soon as practicable.

7.4 This letter should confirm that the case is one which is still being investigated and that it is premature to send a Letter of Claim in accordance with section 8. It should however advise the healthcare provider that this is a case where the claimant has obtained supportive medical evidence about breach of duty and causation and that the case is one which is likely to result in a Letter of Claim being sent in due course in accordance with section 8. The claimant should at the same time send a copy of the Letter of Notification to the NHSLA or other relevant medical defence organisation or indemnity provider (where known).

7.5 The healthcare provider (and any defence organisation sent a copy of the Letter of Notification) should **acknowledge** any Letter of Notification **within 14 days of receipt** and should identify who will be dealing with the matter.

7.6 On receipt of a Letter of Notification the healthcare provider should then consider whether or not to undertake its own investigations into the case and whether or not to obtain its own evidence in anticipation of having to respond to a Letter of Claim in due course⁶.

7.7 When subsequently considering whether any request by a healthcare provider for an extension of the time limit for a Letter of Response under section 8 is reasonable, the claimant should have regard to whether a Letter of Notification was sent to the provider.

7.8 When considering the extent to which either party has complied with its obligations under the Protocol including the extent to which it is reasonable for a healthcare provider to have an extension of time for its Letter of Response, the court should have regard to whether or not the claimant sent a Letter of Notification and to whether or not the healthcare provider initiated investigations upon receipt of a Letter of Notification. There should be a reasonable lapse of time between a Letter of Notification, which should only be sent where supportive expert evidence as to breach of duty and causation has been obtained) and any later Letter of Claim. Attempts to misuse this two-stage process may be met with costs sanctions.

8 THE LETTER OF CLAIM

8.1 Annex B2 to this Protocol provides **a template for the recommended contents of a Letter of Claim**. The level of detail will need to be varied to suit the particular circumstances.

8.2 If, following the receipt and analysis of the records, and the receipt of any further advice (including from experts if necessary – see Section 11 below), the claimant/adviser decides that there are grounds for a

⁶ Jackson suggests that receipt of a Letter of Claim should trigger independent expert advice being sought by the defence. The purpose of a Letter of Notification is to bring the start of defence investigations earlier, for the benefit of both sides.

claim, they should then send, as soon as practicable, to the healthcare provider/potential defendant, a **Letter of Claim**. The claimant should at the same time send a copy of the Letter of Claim to the NHSLA or other relevant medical defence organisation or indemnity provider (where known).⁷

8.3 This letter should contain a **clear summary of the facts** on which the claim is based, including the alleged adverse outcome, and the **main allegations of negligence and causation. i.e. the nature of the alleged breaches of duty and their causative effect**. It should also describe the **claimant's injuries**, and present condition and prognosis. The **financial loss** incurred by the claimant should be outlined with an indication of the heads of damage to be claimed and the scale of the loss, unless this is impracticable.

8.4 In lower value claims where total damages are likely to be less than £25,000, particularly where the claimant has recovered from her injuries, details of the injuries and losses should be provided as soon as is practicable, including where appropriate an expert's condition and prognosis report.

8.5 In more complex cases a **chronology** of the relevant events should be provided, particularly if the claimant has been treated by a number of different healthcare providers.

8.6 The Letter of Claim **should refer to any relevant documents**, including health records, and if possible enclose copies of any of those which will not already be in the potential defendant's possession with an index of those records, e.g. any relevant general practitioner records if the claimant's claim is against a hospital.

8.7 Sufficient information must be given to enable the healthcare provider defendant to **commence investigations** (if not already started following a Letter of Notification) and to put an initial valuation on the claim.

8.8 Letters of Claim are **not** intended to have the same formal status as particulars of claim, nor should any sanctions necessarily apply if the Letter of Claim and any subsequent statement of claim in the proceedings differ.

8.9 **Proceedings should not be started until at least [three/four]⁸ months from the letter of claim**, unless there is a limitation problem and/or the claimant's position needs to be protected by early issue.

8.10 The claimant or their adviser may want to make an **offer to settle** the claim at this early stage by putting forward an amount of compensation which would be satisfactory (possibly including any costs incurred to date). If an offer to settle is made, generally this should be supported by a medical report which deals with the injuries, condition and prognosis, and by a schedule of loss and supporting documentation. The level of detail necessary will depend on the value of the claim. Medical reports may not be necessary where there is no significant continuing injury, and a detailed schedule may not be necessary in a low value case. CPR Part 36 sets out the legal and procedural requirements for making offers to settle.

⁷ Sending copies of any Letter of Notification and Claim to the NHSLA or relevant MDO was something we had already suggested before it was recommended in Jackson.

⁸ This time limit tallies with the issue of 3 or 4 months after Jackson, and what should be the right figure in para 9.3 below. This is open for consultation, as the CDF Working Group did not achieve unanimity on this point.. Much depends upon whether the Letter of Notification procedure we suggest is adopted..

8.11 Every claimant who has Legal Services Commission funding, or has entered into any funding arrangement, should comply with the obligations to serve notices thereof as set out in the CPR and Practice Directions.

9 THE RESPONSE

9.1 Annex B3 provides a template for the suggested contents of the **Letter of Response**.

9.2 The healthcare provider (and any defence organisation sent a copy of the Letter of Claim) should **acknowledge** any Letter of Claim **within 14 days of receipt** and should identify who will be dealing with the matter.

9.3 The healthcare provider should, **within [three/four⁹] months of the Letter of Claim** (or such other further period as may be agreed with the claimant provide a reasoned answer. The claimant should generally agree to a reasonable extension of time if the healthcare provider puts forward good reasons for such an extension, particularly in a claim that is of high value and/or of a complex nature.

9.4 If the **claim is admitted** the healthcare provider should say so in clear terms and in particular which alleged breaches of duty and causation are admitted and why;

9.5 If only **part of the claim is admitted** the healthcare provider should make clear which issues of breach of duty and/or causation are admitted and which are denied and why. CPR Part 14.1A applies to the status of admissions made before commencement of proceedings.

9.6 If a healthcare provider wishes to explore **settlement without any admission of liability**, then this should be conveyed to the claimant and/or his/her representatives, who should consider agreeing a reasonable request for a period of time in order to try to resolve the claim without the need for legal proceedings to be issued¹⁰.

9.7 If the **claim is denied**, this should include specific comments on the allegations of negligence, and if a synopsis or chronology of relevant events has been provided and is disputed, the healthcare provider's version of those events;

9.8 The Letter of Response is not intended to have the same formal status as a defence, nor should any sanctions necessarily apply if the Letter of Response and any subsequent defence in the proceedings differ.

9.9 Where additional documents are relied upon, e.g. an internal protocol or documents in relation to an adverse incident or a relevant complaint concerning the same claimant/ incident, copies should be provided.

9.10 If the claimant has made an offer to settle, the healthcare provider should **respond to that offer** at the same time as the response letter, preferably with reasons. The healthcare provider may make its own offer to settle at this stage, either as a counter-offer to the claimant's, or of its own accord, but should

⁹ The CDF Working Group debated the Jackson recommendation and found unanimity elusive on whether the period should be 3 or 4 months. This is a matter upon which we welcome views from consultees. Much depends on whether our proposal for a prior Letter of Notification is implemented.

¹⁰ We inserted this before Jackson proposed it and agree with his recommendation, though we have not proposed his suggested three month moratorium

accompany the offer with any supporting medical report which deals with the injuries, condition and prognosis, and/or with any counter-schedule of loss and supporting documents which are in the healthcare provider's possession.

9.11 If the parties do not reach agreement on liability they should discuss whether the claimant should start proceedings and whether the court might be invited to direct an early trial of a preliminary issue or of breach of duty and causation.

9.12 If following receipt of the Letter of Response the claimant and their adviser is aware that there may be a delay of six months or more before the claimant decides if, when and how to proceed they should keep the healthcare provider generally informed.

9.13 If the parties reach agreement on liability, but time is needed to resolve the value of the claim, they should aim to agree a reasonable period.

9.14 In any event, where comprehensive settlement (as to breach of duty, causation and quantum) does not take place as a result of receipt of the Letter of Response and before the issue of proceedings, the parties should consider the use of ADR.

10 ALTERNATIVE DISPUTE RESOLUTION (ADR)

10.1 Starting proceedings should usually be a step of last resort, and proceedings should not normally be started when a settlement is still actively being explored. Although ADR is not compulsory, the parties should consider whether some form of ADR procedure might enable them to settle the matter without starting proceedings. The court may require evidence that the parties considered some form of ADR.

10.2 It would not be practicable for this protocol to address in any detail how a claimant or their adviser, or healthcare provider, might decide which method to adopt to resolve the particular problem. But the courts increasingly expect parties to try to settle their differences by agreement before issuing proceedings.

10.3 Summarised below are the main alternative processes for resolving clinical disputes:

- The **NHS Complaints Procedure**, which is designed to provide claimants with an explanation of what happened and an apology if appropriate. It is not designed to provide compensation for cases of negligence¹¹. However, claimants might choose to use the procedure if their only, or main, goal is to obtain an explanation, or to obtain more information to help them decide what other action might be appropriate. A complaint may be pursued at the same time as or in addition to a claim for negligence.
- **Discussion and negotiation**, including **round-table meetings**¹²;
- **Mediation**, which is a form of facilitated negotiation assisted by an independent neutral party. It is suitable in many cases, including on occasions pre-action. The Civil Procedure Rules give the

¹¹ Jackson recommends implementation of NHS Redress, and indeed this is due to be introduced in Wales. Future amendment may become necessary to this sentence.

¹² Also often called joint settlement meetings, though sometimes they are convened to debate discontinuance rather than settlement.

court the power to stay proceedings for one month for settlement discussions or mediation and sometimes the courts go further at a case management conference and recommend parties to attempt mediation. The CDF has published a Guide to Mediation which will assist: this is generally available on the CDF website at www.clinicaldisputesforum.org.uk.

- Other methods of resolving disputes include **arbitration, determination by an expert, and early neutral evaluation** by a medical or legal expert.

9.4 The Legal Services Commission has published a booklet on "**Alternatives to Court**" (LSC August 2000, CLS information leaflet number 23) which lists a number of organisations that provide alternative dispute resolution services. The National Mediation Helpline on 0845 603 0809 or at www.nationalmediationhelpline.com. and mediation providers can provide information about mediation.

9.5 The parties should continue to consider the possibility of reaching a settlement at all times. This still applies after proceedings have been started, up to and during any trial or final hearing. Most disputes are resolved by agreement, even after proceedings have been issued. Parties should bear in mind that carefully planned face-to-face meetings, with or without a mediator, may be particularly helpful in exploring further treatment for the claimant, in reaching understandings about what happened and over both parties' positions, in narrowing the issues in dispute, perhaps in involving the relevant clinicians, and, if the timing is right, in helping to settle the whole matter, especially if the claimant wants an apology, explanation, or assurances about how other claimants will be affected.

11 EXPERTS

11.1 In clinical negligence disputes, **expert opinions** may be needed:

- on breach of duty and causation;
- on the claimant's condition and prognosis;
- to assist in valuing aspects of the claim.

11.2 The CPR encourage economy in the use of experts and a **less adversarial expert culture**. It is recognised that in clinical negligence disputes, the parties and their advisers will require flexibility in their approach to expert evidence. The parties should cooperate about decisions on whether and which experts might be instructed jointly, and on whether reports might be disclosed sequentially or by exchange and at what stage. The protocol does not require the claimant to disclose expert evidence with the letter of claim - the claimant and their adviser may choose to do so when they wish to rely upon that evidence, particularly a report on the claimant's condition and prognosis. Sharing expert evidence will often be appropriate on issues relating to the value of the claim.

11.3 Obtaining expert evidence will often be an expensive step and may take time, especially in specialised areas of medicine where there are limited numbers of suitable experts. Claimants and healthcare provider and their advisers, will therefore need to give careful and early consideration as to how best to obtain any necessary expert help quickly and cost-effectively.

12 LIMITATION OF ACTIONS

12.1 If by reason of complying with any part of this Protocol a claimant's claim may be time-barred under any provision of the Limitation Act 1980 or any other legislation which imposes a time limit for bringing an action, the claimant may commence proceedings without complying with this Protocol, but should then apply to the court on notice at the time that proceedings are issued for directions as to the timetable and form of procedure then to be adopted. The court will then consider whether to order a stay of the whole or part of the proceedings pending compliance with the provisions of this Protocol.

ANNEX A: LAW SOCIETY AND DEPARTMENT OF HEALTH STANDARD FORMS FOR OBTAINING HEALTH RECORDS

APPLICATION ON BEHALF OF A PATIENT FOR HOSPITAL MEDICAL RECORDS FOR USE WHEN COURT PROCEEDINGS ARE CONTEMPLATED

Purpose of the forms

This application form and response forms have been prepared by a working party of the Law Society's Civil Litigation Committee and approved by the Department of Health for use in NHS and Trust hospitals.

The purpose of the forms is to standardise and streamline the disclosure of medical records to a patient's solicitors, who are investigating pursuing a personal injury claim against a third party, or a medical negligence claim against the hospital to which the application is addressed and/or other hospitals or general practitioners.

Use of the forms

Use of the forms is entirely voluntary and does not prejudice any party's right under the [Access to Health Records Act 1990^{Acts}](#), the [Data Protection Act 1984^{Acts}](#), or ss. 33 and 34 of the Senior Courts Act 1981. However, it is Department of Health policy that patients be permitted to see what has been written about them, and that healthcare providers should make arrangements to allow patients to see all their records, not only those covered by the Access to Health Records Act 1990. The aim of the forms is to save time and costs for all concerned for the benefit of the patient and the hospital and in the interests of justice. Use of the forms should make it unnecessary in most cases for there to be exchanges of letters or other enquiries. If there is any unusual matter not covered by the form, the patient's solicitor may write a separate letter at the outset.

Charges for records

The [Access to Health Records Act 1990^{Acts}](#) prescribes a maximum fee of £10. Photocopying and postage costs can be charged in addition. No other charges may be made.

The NHS Executive guidance makes it clear to healthcare providers that 'it is a perfectly proper use' of the 1990 Act to request records in that framework for the purpose of potential or actual litigation, whether against a third party or against the hospital or trust.

The 1990 Act does not permit differential rates of charges to be levied if the application is made by the patient, or by a solicitor on his or her behalf, or whether the response to the application is made by the healthcare provider directly (the medical records manager or a claims manager) or by a solicitor.

The NHS Executive guidance recommends that the same practice should be followed with regard to charges when the records are provided under a voluntary agreement as under the 1990 Act, except that in those circumstances the £10 access fee will not be appropriate.

The NHS Executive also advises –

- that the cost of photocopying may include ‘the cost of staff time in making copies’ and the costs of running the copier (but not costs of locating and sifting records);
- that the common practice of setting a standard rate for an application or charging an administration fee is not acceptable because there will be cases when this fails to comply with the 1990 Act.

Records: what might be included

X-rays and test results form part of the patient’s records. Additional charges for copying X-rays are permissible. If there are large numbers of X-rays, the records officer should check with the patient/solicitor before arranging copying.

Reports on an ‘adverse incident’ and reports on the patient made for risk management and audit purposes may form part of the records and be disclosable: the exception will be any specific record or report made solely or mainly in connection with an actual or potential claim.

Records: quality standards

When copying records healthcare providers should ensure –

1. All documents are legible, and complete, if necessary by photocopying at less than 100% size.
2. Documents larger than A4 in the original, e.g. ITU charts, should be reproduced in A3, or reduced to A4 where this retains readability.
3. Documents are only copied on one side of paper, unless the original is two sided.
4. Documents should not be unnecessarily shuffled or bound and holes should not be made in the copied papers.

Enquiries/further information

Any enquiries about the forms should be made initially to the solicitors making the request. Comments on the use and content of the forms should be made to the Secretary, Civil Litigation Committee, The Law Society, 113 Chancery Lane, London WC2A 1PL, telephone 0171 320 5739, or to the NHS Management Executive, Quarry House, Quarry Hill, Leeds LS2 7UE.

The Law Society
May 1998

[Forms below]

4	Details of any records which we are not producing	
5	The reasons for not doing so	
6	An invoice for copying and administration charges is attached	YES/NO
	Signed	
	Date	

ANNEX B: TEMPLATES FOR LETTERS OF NOTIFICATION, CLAIM AND RESPONSE

B1 Template for the Letter of Notification

ESSENTIAL CONTENTS

The Letter of Notification should confirm:

1. Which medical records have been obtained by the claimant. Where possible, details of the medical records obtained should be provided in the form of a document index in accordance with para 6.1 (if not provided previously)
2. That a supportive expert opinion has been obtained on breach of duty or causation or both.
3. That this is a case which is proceeding, but that it is premature for the claimant to send a Letter of Claim at this stage while further investigations remain pending. Where possible the claimant should give an approximate time estimate for provision of the Letter of Claim.
4. That the claimant may have reasonable needs that could be met by rehabilitation treatment or other measures. The Rehabilitation Code may be helpful in considering how to identify the claimant's needs and how to address the cost of providing for those needs.
5. An invitation to the healthcare provider to consider commencing investigations into this case at this stage.
6. That failure to do so will be a factor that can be taken into consideration when considering the reasonableness or otherwise of any subsequent application for an extension of time for the Letter of Response.

B2 Template for the Letter of Claim

ESSENTIAL CONTENTS

The Letter of Claim should set out:

1. **The claimant's name**, address, date of birth, etc.
2. **Dates of allegedly negligent treatment**
3. **Events giving rise to the claim**, including:
 - a clear summary of the facts on which the claim is based;
 - details of other relevant treatments to the claimant by other healthcare providers.
4. **Allegations of breach of duty and causal link with injuries**, including
 - an outline of the main allegations or a more detailed list in a complex case;
 - an outline of the causal link between the allegations and the injuries complained of.
5. **Details of the claimant's injuries, condition and future prognosis** with a condition and prognosis report, if appropriate
6. **Request all clinical records (if not previously provided)**
 - use the Law Society form if appropriate or adapt;
 - specify the records required;
 - if other records are held by other providers, and may be relevant, say so;
 - state what investigations have been carried out to date, e.g. information from the claimant and witnesses, any complaint and the outcome, if any clinical records have been seen or experts advice obtained.
7. **The likely value of the claim**, including
 - an outline of the financial loss incurred by the claimant together with the main heads of damage to be claimed;
 - the scale of the loss, or, in lower value claims likely to be under £25,000 particularly where the claimant has recovered from their injuries, details of the injuries and losses should be provided as soon as practicable to enable the healthcare provider to commence investigations and put an initial valuation on the claim..
8. **Documents relied upon**
 - In more complex cases a chronology of the relevant events should be provided particularly if the claimant has been treated by a number of different healthcare providers.
 - Any relevant documents should be referred to, including health records, and if possible enclose copies of those which will not already be in the healthcare provider's possession.
9. **Funding information**

When the claimant has Legal Services Commission funding or has entered into a funding arrangement (a conditional fee agreement within the meaning of CPR43.2(1)) details of this should be provided.

10. Costs incurred

An estimate of the claimants costs incurred to the date of the letter of claim should be included.

OPTIONAL INFORMATION

- What investigations have been carried out
- An offer to settle (open for acceptance until the Letter of Response is due to be served) with supporting medical evidence and / or a schedule of loss with supporting evidence if possible
- Suggestions for obtaining expert evidence
- Suggestions for meetings, negotiations, discussion or mediation
- Any reasonable needs not hitherto notified that could be met by rehabilitation treatment or other measures. The Rehabilitation Code may be helpful in considering how to identify the claimant's needs and how to address the cost of providing for those needs.

Additional enclosures

- Clinical records request form and claimant's authorisation
- Expert report(s)
- Schedules of loss and supporting evidence, even where an offer is not being made.

B3 Template for the Letter of Response

ESSENTIAL CONTENTS

The Letter of Response should:

- 1. Provide requested records and invoice for copying:**
 - explain if records are incomplete or extensive records are held and ask for further instructions;
 - request additional records from third parties.
- 2. Comment on the events alleged and/or chronology:**
 - if events are disputed or the healthcare provider has further information or documents on which they wish to rely, these should be provided, e.g. an internal protocol;
 - details of any further information needed from the claimant or third party should be provided.
- 3. (If this is so) set out that breach of duty and causation are accepted wholly or in part:**
 - this should be set out in clear terms and in particular which alleged breaches of duty and causation are admitted or denied and why;
 - suggestions might be made for resolving the claim and/or requests for further information.
- 4. (If this is so) set out that breach of duty and/or causation are denied:**
 - a bare denial will not be sufficient specific responses to the allegations of negligence should be given. If the healthcare provider has other explanations for what happened, these should be set out as fully as possible;
 - suggestions might be made for the next steps, e.g. further investigations, obtaining expert evidence, meetings/negotiations or mediation, or an invitation to issue proceedings.
- 5. (If this is so) set out that breach of duty and causation are denied but the healthcare provider nevertheless wishes to explore settlement,** together with any proposals for a time period to be agreed by the parties to try and resolve the claim without the need for the issue of legal proceedings
- 6. The response to any offer to settle** made by the claimant's Letter of Claim should be given.
- 7. Costs**

If the claimant has requested details of the healthcare provider's costs incurred to the date of the letter of response the healthcare provider should provide these details

OPTIONAL MATTERS

- Make an offer to settle if the claimant has not made one, or a counter-offer to the claimant's offer with supporting medical evidence and /or a counter-schedule of loss if appropriate

Possible enclosures:

- Clinical records
- Annotated chronology
- Expert reports.

NOTE: We have agreed that the flowchart formerly appended to the Protocol is now redundant.