2 June 2011

SHA & PCT Chief Executives

Room 229
Richmond House
79 Whitehall
London SW1A 2NS

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Dear Colleague

Guidance Note for use of Clinical Negligence Scheme for Trusts (CNST) cover for the management of the clinical negligence risks of qualified independent sector providers of treatment delivered to NHS Patients under the standard contract for acute services.

Subject

1. This letter provides instructions on how the clinical negligence risks associated with NHS-commissioned elective activity undertaken by IS-providers can be covered by the CNST when the ECN/FCN contracts expire at the end of June 2011, and are replaced by standard contracts for acute services let to independent sector providers that meet the relevant qualification criteria. These cover arrangements are also to apply on "Progression" ISTC procurements that are planned or are underway, where clinical negligence risks are to be covered by the CNST.

2. Whilst it is currently the intention that this apply to contracts referred to in paragraph 1 above, there is nothing to prevent the parties to a contract applying this solution to other contracts for commissioned NHS activity. However, they must first seek DH and SHA approval and notify the NHS Litigation Authority.

3. This is an interim solution, and has been put in place because IS providers are not yet able to become members of the CNST. This solution was informed by discussions with IS providers, the NHS Litigation Authority and other stakeholders.

Immediate Actions

4. This letter sets out the action you need to take immediately, with local IS Providers, to ensure there is clinical negligence cover for their NHS patients when ECN/FCN contracts expire.

5. If Providers elect to use the PCT Indemnity to satisfy their obligations under clause 26 of the Contract:

   (a) the form of PCT Indemnity to be used by Commissioners and IS Providers is as set out in Annex A to this Guidance; and
   (b) the level of contribution to be charged by Commissioners to IS Providers is as set out in this Guidance.

6. Commissioners must work with their Providers immediately to execute the revised form of PCT Indemnity.

7. Once the indemnity is in place, the monthly calculation of contribution should begin from the date of the first invoice under the Contract. If there is a Co-ordinating Commissioner,

each Commissioner should provide the information required under paragraph 14 below. If there is a single Commissioner, each monthly invoice must include the CNST contribution as a separate identifiable sum and reports provided to the Co-ordinating Commissioner as required under the indemnity.

The Interim Solution

8. Clause 26.2 of the NHS Standard Contract for Acute Services (*Liability and Indemnity)* requires the all Providers to put in place appropriate indemnity arrangements or commercial insurance in relation to clinical negligence. These instructions describe the arrangements to be put in place where an indemnity backed by CNST cover is to be used. This does not prevent Provider's from obtaining their own insurance cover that satisfies the Commissioner's requirements under clause 26.2 of the NHS Standard Contract. Commissioners should seek their own advice to determine what is appropriate if IS Providers take out commercial insurances for clinical negligence.

9. The choice between the two approaches is at the election of the IS Provider. Where an IS Provider elects to put in place a PCT indemnity rather than commercial insurance, then the PCT must follow this Guidance.

Updated PCT indemnity

10. If an IS Provider elects to take up the option of the PCT indemnity, then the form of indemnity that must be entered into is attached at Annex A, and IS providers and Commissioners must comply with the requirements set out below with respect to the contribution charged to IS Providers for using the PCT Indemnity.

11. The revisions to the local PCT indemnity include that:

    a) It **may be** entered into by a Co-ordinating Commissioner (the PCT that is signatory to the Contract on behalf of itself and its Associate Commissioners). Commissioners can join the PCT Indemnity for more than one Contract with each IS Provider. This means that where PCTs have entered into a "Cluster" arrangement, they may appoint the PCT Cluster lead as their CNST Co-ordinating Commissioner for the purposes of the PCT indemnity. If PCTs wish to have the PCT Indemnity apply to more than one Contract with the same IS Provider, then the Agency Agreement must also be entered into. The Agency Agreement differs from the Consortium Agreement required under the standard contract because the parties to the Agency Agreement may differ and the "Cluster" arrangement may well be wider in relation to the PCT indemnity arrangements.

    b) The IS Provider must pay a monthly contribution for the indemnity, and this must be set according to methodology set out below.

Charges for the PCT indemnity and associated CNST cover

12. CNST Contributions have already been notified to Commissioners for the current year, 2011-12, and these include a separately identified amount that has been based on each PCT's 2010-11's activity commissioned from IS Providers.

13. Therefore, Commissioners need to charge a contribution to their IS Providers. These contributions are to be calculated by each PCT taking the undisputed value of the amount invoiced by the Provider under the relevant Contract by each IS Provider in accordance with clause 7 of the Standard Contract and multiplying this amount by 0.85% (being the percentage for 2011-2012). The PCT will then raise an invoice for this amount and the contribution will be charged monthly in arrears. When disputed amounts are subsequently reconciled and become payable, then an appropriate addition, separately

identified, should be made to the subsequent month's contribution. This mechanism is already contemplated under clause 7 of the Standard Contract.

14. This CNST contribution invoice will either be:

    a) Issued to the IS Provider for payment; or
    b) passed to the CNST Co-ordinating Commissioner (if there is one). The CNST Co-ordinating Commissioner will consolidate all contributions to be levied on an IS Provider and invoice the IS Provider with a single invoice.

15. The 0.85% is a level determined by the Department by dividing the total of the contributions notified by the NHSLA for all PCTs' IS activity, by the total value of that activity. By setting the charge centrally, the Department is ensuring that charges to IS Providers will be set according to a consistent methodology by all PCTs. The CNST contributions for the purposes of the PCT Indemnity when calculated using this methodology may be more or less than the amount charged by NHSLA to individual PCTs for their individual IS activity.

16. Where the PCT Indemnity is contracted for and administered on a CNST Co-ordinating Commissioner basis under an Agency Agreement, the CNST Co-ordinating Commissioner should invoice the IS Provider for CNST usage for its own activity and that of CNST Associate Commissioners. The CNST Associate Commissioners must deliver to the Co-ordinating Commissioner the information necessary to make an accurate and timely charge for CNST to the IS Provider within five (5) Business Days of receipt of a monthly activity statement and invoice from an IS Provider under the relevant Contract.

17. Where CNST Co-ordinating Commissioner arrangements are planned, an Agency Agreement in the form set out at Annex B should be completed by the planned CNST Co-ordinating Commissioner and CNST Associate Commissioners. This document is in addition to the Consortium Agreement required under the standard contract.

Removal of the right to charge termination / "run-off" sums

18. Contributions to the CNST are set at a level to cover amounts that are expected to be paid out by the CNST in the year for which the contributions are charged. There is a time-lag in payment of claims that means that at the end of any year there are unpaid liabilities that have to be paid by participants in the scheme in subsequent years. This "overhang" could be removed by charging termination or run-off payments when annual contracts expire. However, in practice, NHS providers are not subject to such charges unless they choose to leave CNST altogether and it is not therefore intended that IS Providers should be subject to them.

19. Termination sums are not therefore to be charged to IS Providers upon expiry of contracts let to supercede existing ECN/FCN arrangements and ISTC progression contracts, and no right is included in the PCT Indemnity or any other contract to make such a charge.

Possible Longer term arrangements:

20. There is currently a central review of the CNST arrangements and the rules for membership of that scheme, so these arrangements have been put in place as an interim arrangement only. One possibility is that membership of CNST is extended to be available to IS Providers. If so, all PCT Indemnities will terminate and IS Providers will become fully responsible for their fair share of the liabilities that remain to be settled or notified in the same way as any NHS member of CNST.

21. The charging arrangements set out above are fixed for 2011-12 only. There could be changes in the basis for the charge if interim arrangements are still in place for 2012-13. If so, these will be notified to Commissioners in the Autumn.

Termination of indemnities issued under these interim arrangements

22. These indemnities will terminate the earlier of:

    (a) the date on which the IS Provider is no longer providing services under any Contract within the CNST Co-ordinating Commissioner's region, if the indemnity has been provided by a CNST Co-ordinating Commissioner on behalf of itself and others, or
    (b) the date on which the IS Provider has ceased providing services for an individual Commissioner, if the indemnity has been issued by a single Commissioner; and
    (c) the date 3 months after the date on which the IS Provider becomes a member of the CNST Scheme.

Next Steps

23. Where Providers elect to take up the option of a PCT Indemnity, it is the intention to have all updated PCT Indemnities in place before the end of June 2011, when ECN/FCN contracts will expire. Commissioners should work with their IS Providers immediately to put in place the above arrangements as quickly as possible.

24. Commissioners are reminded that the arrangements are mandatory where the IS Provider of NHS-commissioned elective services elects to choose cover through a PCT indemnity and the CNST.

Contact at the DH

25. Please do not hesitate to contact either myself for policy issues (bob.ricketts@dh.gsi.gov.uk and on 020 7210 27886) or Ben Masterson on 0113 254 5550 for technical issues (ben.masterson@dh.gsi.gov.uk).

Yours sincerely

Bob Ricketts CBE
Director of Provider Policy

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Annex A: Updated Standard Form Indemnity Agreement
Annex B: Coordinating Commissioner Agency Agreement