SCOTTISH EXECUTIVE

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Health Department
Directorate of Finance

Dear Colleague

21st December 1999

CLINICAL NEGLIGENCE AND OTHER RISKS (NON-CLINICAL) INDEMNITY SCHEME (CNORIS)

Purpose

1. The purpose of this letter is to inform the NHSiS that from 1st April 2000 there will be new financial risk sharing arrangements for clinical negligence awards and certain non-clinical risk categories. It provides an outline of the future arrangements and a note of action to be taken in that regard.

Detail

2. The attached Appendix summarises the background to the development and outlines the new scheme that will be developed between now and the April start date. A key point summary is provided below.

3. Given the need for specialist skill in the fields of risk management and actuarial advice, the design, implementation and certain management elements of the new scheme are being outsourced. Following a competitive tender process the contract for the required management services has been awarded to Willis Corroon for an initial three-year period.

Addressees

For action
Chief Executives, NHS Trusts

General Managers, Health Boards
Common Services Agency
Scottish Ambulance Service Board
State Hospitals Board for Scotland
Directors of Finance
Health Boards and NHS Trusts

The Director,
Mental Welfare Commission

For information
Chief Executive, Clinical Standards Board for Scotland

General Manager, Health Education Board for Scotland

Executive Director, SCPMDE

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Summary of New Risk Pool Arrangements

4. The following is a summary of the key points.

- The financial risk pool will initially cover all NHS Trusts and Health Boards, the State Hospital and Ambulance Service Boards for Scotland, the Common Services Agency and the Mental Welfare Commission.

- Membership to the scheme will be mandatory and cover, as appropriate for each of the above bodies, stemming from:

  - Clinical Negligence

  - Non-Clinical Risks
    - Employer's Liability
    - Public and Product Liability
    - Cash Loss and Fidelity Guarantees

- The financial risks will be managed within a single pool with separate arrangements applying for incidents occurring or reported from 1st April 2000 and for pre 1st April losses.

- The pool will operate on a 'pay as you go' basis, i.e. members' contributions for any one year will be based on the expected level of demand on the pool in that year.

- The contribution structure will offer members a choice of deductibles which will determine the level of financial risk they carry.

- Contributions will be set in part on the member's effectiveness in establishing and operating appropriate risk management procedures, i.e. an incremental rate of discount will be applied if centrally set performance standards are achieved. Achievement of the standards will be subject to an annual independent assessment.

- A Committee comprising NHSiS representatives and Willis Corroon will set the risk management standards (clinical and non-clinical) against which performance is assessed and contributions are set.

- A Joint Administration Group will be established to represent members' interests and to review the operational effectiveness of the scheme on a regular basis.

- Willis Corroon will run at least one seminar or workshop before April 2000 to introduce the standards and provide guidance on how the risk management controls can be implemented.

Action

5. Chief Executives and General Managers should:

- note the development and alert their Risk Directors and/or Managers accordingly;
- be prepared to co-operate with Willis Corroon and their associates when contacted for appropriate information and advice required to develop the scheme's criteria;
- ensure that no further post 1st April 2000 insurance policy renewals are effected for the non-clinical risk items listed above: policies still in force at that date should be allowed to complete their term;
- ensure that, where existing policies are on a 'claims made' basis, the insurance companies are timeously notified of **all** known incidents up to the policy's expiry date, which have any possibility of giving rise to a claim or claims.

6. Also, to assist the development and implementation process, please provide details of:

- the preferred/ initial contact point for Willis Corroon representatives, including full postal address, telephone and fax numbers and e-mail address;
- personnel employed for, or actively involved in, risk management functions.

7. The above information should be sent to Colette Gilchrist, SEHD Finance Directorate, Room 250 St. Andrew's House, for 5th January 2000 at the latest.

Yours sincerely

JOHN ALDRIDGE
Director of Finance

APPENDIX

CLINICAL NEGLIGENCE AND OTHER RISKS (NON-CLINCIAL) INDEMNITY SCHEME (CNORIS): INTERIM EXPLANATORY NOTE

Background

1. Since 1990, Health Boards and latterly Trusts have had a scheme under which they receive financial assistance towards the cost of any relatively large clinical negligence awards they have to meet. The assistance has been funded from a Reserve held on behalf of the Management Executive by the Medical & Dental Defence Union (MDDU). The Reserve, which is not Voted money, was initially £5m but this will probably be exhausted next year. With this in prospect, a cross-Service review Group was convened to consider the need and potential for future financial risk pooling arrangements.

2. The Group reported to Ministers last year. Their recommendations, which Ministers accepted, were:

- the establishment of a new scheme for the financial risk pooling, not only for clinical risk liabilities but also for certain categories of non-clinical liability;

- the pool should be funded by contributions from the scheme's members with the amount chargeable related in part to the member's performance in managing clinical and health and safety risk (as appropriate);

- given the need for certain specialist skills (e.g. risk management and actuarial services), the design, implementation and certain management elements of the scheme should be provided from an external source.

3. The required management services were put out to competitive tender and resulted in the appointment of Willis Corroon, for a three-year period, to:

- provide the actuarial services (through Lane Clark and Peacock) for determining the risk pool's annual resource requirement;

- establish an appropriate contribution structure for the scheme;

- set appropriate risk management standards for both the clinical and non-clinical components of the new scheme;

- arrange for an independent assessment and report on each member's performance in achieving the set standards;

- provide loss adjuster (through Cunningham, Ellis & Buckle) and claim handling services for the non-clinical component of the scheme;

- promote and assist in the develop of risk management and its application within the NHSiS.

Key Points to Note

4. The **scope of the new scheme** is detailed below. In the case of clinical negligence the cover is extended to include staff in the nursing and professions allied to medicine (PAM) sectors.

- Clinical Negligence
- Non-Clinical Risks
  - Employer's Liability
  - Public and Product Liability
  - Cash Loss and Fidelity Guarantees

5. Items currently **excluded from the scheme** are insurance cover for motor vehicles, income generation and PFI developments.

6. The **membership** will comprise all NHS Trusts and Health Boards, the State Hospital and Ambulance Service Boards for Scotland, the Common Services Agency and the Mental Welfare Commission. Membership will be mandatory to ensure a sound financial base and remove the threat of wide fluctuations in contribution levels.

7. The **Central Legal Office** (CLO) will remain the sole provider of legal services for clinical negligence claims.

8. Loss adjuster costs for non-clinical claims below the deductible point will remain the member's responsibility. It is expected that the scheme's loss adjusters will provide a fixed costing structure to handle 'below deductible' claims should this be required.

Development and Future Administration

9. Paragraphs 13 to 27 below provide an outline of the possible structure of the new pooling arrangements. It reflects the framework developed by Willis Corroon but will be subject to enhancement and change in light of a development process that will involve a short life steering group with cross-Service representation.

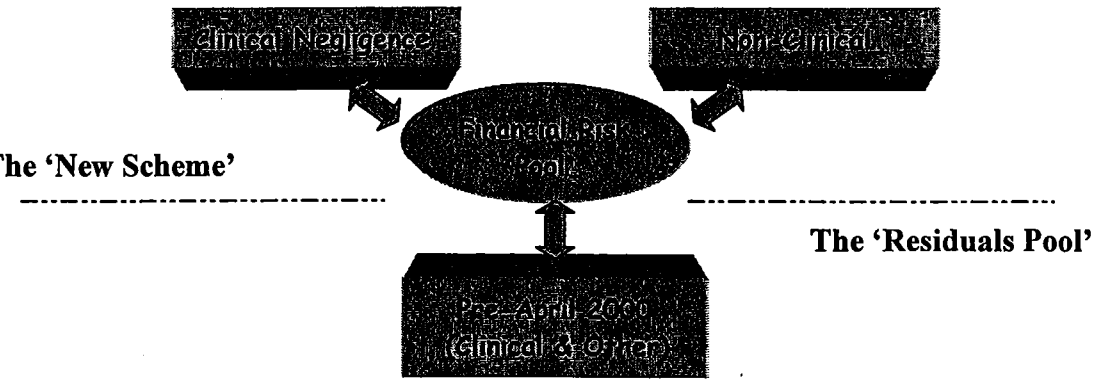
10. Two other groups will be established. Firstly a Standards Committee. A key aim for the clinical component of the new scheme is that it complements and facilitates the development of other initiatives to improve clinical standards and performance. It is also important that the standards developed are generic to the NHSiS and reflect the structure and relative risks of the scheme's members. To that end the Standards Committee will draw its representation from the NHSiS to work with Willis Corroon in developing, reviewing and updating the core and specific standards for the clinical and non-clinical components of the risk pool.

11. And, secondly, there will be a Joint Administration Group whose membership will be drawn from senior staff in Trusts, Health Boards, the CLO, the Health Department and Willis Corroon (as scheme managers). It will meet regularly to review the scheme's structure and effectiveness and, more generally, to reflect members' interests.

12. Willis Corroon will run at least one seminar or workshop before April 2000 to introduce the initial scheme standards and provide guidance on how the contribution/risk management assessment arrangements will link and operate.

Scheme Outline

13. The scheme will operate as a single Pool with three main components, viz:



14. For Trusts' and other Members who provide clinical services, the New Scheme will cover claims for incidents occurring from 1st April 2000 and 'incidents incurred but not reported' (IBNR), i.e. pre-April 2000 incidents. Health Boards' IBNR will be managed through the Residuals Pool. For the Other Risks component, the New Scheme will cover all claims from 1st April 2000 and all IBNR for all Members.

15. The Residuals Pool will provide a mechanism for dealing with all Clinical and Other Risk claims known at 31st March 2000. It will also cover IBNR for Health Boards, i.e. pre-April 2000 incidents.

Contributions: New Scheme

16. Contributions for the component categories of the pool will be calculated annually and notified to Members before the start of the financial year to which they apply. The policy is to keep the calculation of contributions for the New Scheme relatively simple at the outset. For both the clinical and non-clinical risk components the 1st year's contribution calculations will be based on factual data and an assessment of associated risk, e.g. (not comprehensive):

Clinical

- Type of Trust
- Number of WTEs in the various clinical specialities
- Activity levels within clinical specialities (banded and weighted for clinical risk)

Other Risks

- Type of Trust
- Insurance position since formed (claims made, occurrence, self funded)

- Premiums paid and cover taken

17. For the 1st year no account will be taken of the Member's (or in the case of Trust's their predecessor's) previous claims history or risk management performance.

18. Contribution calculations for subsequent years will take account of the Member's performance in establishing and operating appropriate risk management procedures. There will be three levels of standard for risk management that will equate to a contribution discount in the following year. For example only, these may be ~ Level One 10% ~ Level Two 15% ~ Level Three 20%.

19. Additionally, a financial penalty may apply for lack of progression through the standards, e.g. if Level One is not achieved within two years a 10% loading will be applied.

20. Members will be able to influence their contribution by their choice of deductible, i.e. the 'excess' they will meet over and above the base amount that Members will be required to meet. The deductible levels can only be set following an actuarial review and assessment of future liabilities. However, the intention is to limit the deductible to three levels. These could be set (for example) at £25,000 ~ £50,000 and £75,000.

The Standards (New Scheme)

21. For the *Clinical Negligence* component of the scheme, Willis Corroon propose using (initially at least) the standards used in England for their Clinical Negligence Scheme for Trusts (CNST). A summary of these standards, and where they fit into the three level structure outlined above, is provided at Annex 1. However, the intention is to develop standards that are unique to Scotland. Accordingly, the Health Department will establish a Standards Committee, with clinical representation from the NHSiS, to work with Willis Corroon to that end.

22. The risk management standards for *Non-Clinical Risks* will be developed on the European Quality Model. This will include a requirement to establish a core risk management system that is supplemented by organisational risk control standards for a range of key areas. These are listed at Annex 2, which also summarises the three Standard Levels for this category of risk.

23. The initial standards will be issued to all Members prior to 1st April 2000 to allow them to work on compliance with Level One. An independent assessor (still to be appointed) will visit each member between April 2000 and February 2001 to establish if the Level One standards are being met and determine the contribution discount for Year 2 of the scheme. Reports will be issued to each Member following their assessment to allow them to work on any revisions or improvements.

Contributions: Residuals Pool

24. The concept here is to be subject to further consideration and development. However, the intention is that the Residuals Pool will deal with known losses pre 1st April 2000, and Health Boards' clinical IBNR, on a 'cost over time' basis, i.e. a spreading mechanism compared with the New Scheme's cost sharing mechanism.

25. In brief, the annual payment pattern for known losses (and Health Boards clinical IBNR) would be predicted by the scheme's actuaries and contributors to the Residual Pool would benefit by spreading their costs in any one year and not having to meet substantial costs on their own. Over time the contributors would end up meeting all their known liabilities but the total would be spread over the life of the pool. An initial period of 5 years has been suggested.

Contributions: Collection

26. This is another area where the detail has still to be determined. The likelihood is that the contribution, covering all the component parts (as appropriate) and possibly an element of the management costs, will be collected by means of allocation adjustments.

Claims Handling

27. The process for seeking access to the main pool for *Clinical Negligence* awards will be similar to that at present i.e. a claim for reimbursement of the award and expenses (less the deductible) will be submitted to a central point. Reimbursement to the Member is likely to be through an allocation adjustment process.

28. Claims for *Other Risks* above a pre-set value (possibly £1,000) will be submitted to Willis Corroon and hence the loss adjuster to assess/determine whether the settlement value is likely to fall within the scope of the Pool. For cases below that value the Member will decide whether they still wish the scheme's loss adjuster to handle the claim (for a fee) or to refer it on to CLO or another firm of loss adjusters. Where the claim is chargeable to the Pool, Members will pay the agreed settlement to the claimant direct and Willis Corroon will certify the sum reclaimable from the Pool. Reimbursement to the Member is likely to be through an allocation adjustment process.

29. Where possible the handling process will allow for the electronic transfer of data.

Scottish Executive Health Department
Finance Directorate
December 1999

ANNEX 1

	Summary of Standards and Features	L1	L2	L3
	An asterisk indicates that to achieve compliance this feature must be met.			
1.0	***Board Clinical Risk Management Strategy***			
1.1.1	There is a Board minute with date accepting the Strategy.	*	*	*
1.2.1	The Strategy has been promulgated to all staff via handbooks and other information.		*	*
1.2.2	The Strategy is available to the public via publications, Notice Boards etc.			*
1.2.3	The Strategy is available local purchasers.			*
1.2.4	The Trust can produce documentary evidence demonstrating that the Board's strategy is being implemented.		*	*
1.3.1	The Trust can produce documentary evidence demonstrating that the Board's strategy is being implemented and is subject to continuing review.			*
2.0	***Executive Director and Clinical Risk***			
2.1.1	An Executive Director has been appointed to be responsible for clinical risk management.	*	*	*
2.1.2	The Strategy makes clear the responsibility of the Executive Director for risk management clear.	*	*	*
3.0	***Clinical Risk Manager/Group***			
3.1.1	One or more persons is charged with responsibility for co-ordination of clinical risk activities.	*	*	*
3.1.2	Post-holder(s) accountable to the Executive Director responsible for risk management.	*	*	*
4.0	***Clinical Incident Reporting System***			
4.1.1	Policy / procedure document on IR is available in 10% of Directorates.	*		
4.1.2	IR form gathers significant data about the event (date and time, patient identifiers, outline of incident, staff involved).		*	*
4.1.3	IR form requires fact not opinion			*
4.1.4	The IR form requires immediate reporting of unexpected death / serious injury.			*
4.1.5	IR form or other records first aid for non-patients.			*
4.1.6	IR form or other allows for notification of equipment failure.			*
4.1.7	IR form allows "near misses" to be recorded.			*
4.1.8	Summarised IR are provided regularly to relevant bodies for review and action.		*	*
4.2.1	There is a process in place for detailed investigation of major clinical incidents.			*
4.2.2	Clinically related are events being reported as they occur and before claims are made.			*
4.2.3	There is evidence of management action arising from IR.		*	*
4.2.4	Implementation of incident reporting is operating in 25% of all Directorates.		*	
4.2.5	Person receiving IRs has written instructions on action to be taken.			
4.2.6	Incidents are graded for their degree of risk upon receipt of a form and guidance is given for this.			*
4.3.1	Implementation of incident reporting is operating in all specialties.			*
4.3.2	Incident Reporting is part of induction training for all clinical staff.			*
5.0	***There is a policy for rapid follow-up of major clinical incidents***			
5.1.1	The policy covers responsibility for management of the incident.		*	*
5.1.2	The policy is explicit about responsibility for informing patient(s) and relative(s).	*	*	*
5.1.3	The policy covers record-keeping about the incident.			*
5.1.4	The policy is explicit about individuals in the Trust who must be informed.			*
5.1.5	The policy details which other interested parties need to be informed of the event, e.g. GPs, purchasers, CHC.			*
5.1.6	The policy makes it explicit that patients must be notified before the media.			*
5.2.1	The policy covers media relations and who will be responsible for them.		*	*
5.3.1	For serial incidents there is a strategy for dealing with multiple enquiries.			*

	Summary of Standards and Features	L1	L2	L3
6.0	***Managing Complaints***			
6.1.1	The method of dealing with complaints is clear and meets NHSE guidelines.	*	*	*
6.2.1	Examples of 2 changes which reduce risk as a consequence of complaints can be demonstrated.		*	*
6.3.1	Examples of 5 changes which reduce risk as a consequence of complaints can be demonstrated.			*
7.0	***Information on the risks and benefits of proposed treatment or investigation.***			
7.1.1	There is patient information available showing the risks / benefits of 10 common elective treatments.	*		
7.1.2	All Consent Forms used comply with NHSE Guidelines for design and use.	*	*	*
7.2.1	There is patient information available showing the risks/benefits of 20 common elective treatments.		*	*
7.2.2	There is a policy/guideline stating that consent for elective procedures is to be obtained by a person capable of performing the procedure.		*	*
7.3.1	There is a clear mechanism for patients to obtain additional information about their condition.			*
8.0	***Standards, use, storage and retrieval of medical records.***			
8.1.1	There is a unified medical record which all specialties use.	*	*	*
8.1.2	Records are bound and stored so that loss of documents and traces is minimised for in patients and out-patients.		*	*
8.1.3	The medical record contains clear instruction regarding filing of documents.			*
8.1.4	Operation notes and other key procedures are readily identifiable.		*	*
8.1.5	CTG and other machine produced recordings are securely stored and mounted.			*
8.1.6	There is a computer (or other efficient) system for identifying and retrieving X-rays.			*
8.1.7	The storage arrangements allow retrieval on a 24 hour / 7 day arrangement.		*	*
8.1.8	There is clear evidence of clinical audit of record-keeping standards in high risk specialties within the 12 months prior to the assessment.	*		
8.1.9	There is a mechanism for identifying records which must not be destroyed.			*
8.2.1	A&E records are contained within the main record for patients who are subsequently admitted.			
8.2.2	Nursing, medical and other records (e.g. Care Plans) are filed together when the patient is discharged.		*	*
8.2.3	There is a system for measuring efficiency in the recovery of records for inpatients and outpatients.		*	*
8.2.4	The medical record contains a designated place for the recording of hyper-sensitivity reactions.			
8.2.5	A&E records provide for the GP to be sent a copy of the record.			*
8.2.6	There is clear evidence of clinical audit of record-keeping standards in at least 50% of the specialties within the 12 months prior to the assessment.		*	
8.3.1	An author of an entry in a medical record is clearly and easily identifiable.			*
8.3.2	There is clear evidence of clinical audit of record-keeping standards in all specialties within the 12 months prior to the assessment.			*
8.3.3	There is a computer based PAS or HISS.			
9.0	***Induction / Orientation Programmes***			
9.1.1	All clinical (including medical) staff attend a mandatory general induction course on joining the Trust.	*	*	*
9.1.2	All clinical staff (not doctors) attend a specific induction appropriate to the specialty in which they are working.	*	*	*
9.1.3	The Trust has a policy requiring relevant clinical staff to be competent to perform basic life support and can demonstrate there is a system in place that fulfils the policy.		*	*

	Summary of Standards and Features	L1	L2	L3
9.2.1	All medical staff in training attend a specific induction appropriate to the specialty in which they are working.		*	*
9.2.2	Training records of CPR training are kept .			*
9.2.3	Clinical risk management is included in the general induction arrangements for all healthcare staff .		*	*
9.3.1	90% of eligible staff have attended CPR training in the last 12 months.			
9.3.2	There is a section on clinical risk management in the Medical Staff Handbook incorporating key policies and procedures.			*
10.0	***Clinical Risk Management System***			
10.2.1	All clinical risk management standards and processes are in place and operational.		*	*
10.2.2	A formal risk management forum exists where clinical risk related issues are discussed.			
10.2.3	Risk management policy is implemented through the general management arrangements of the Trust.			
10.2.4	A Trust-wide clinical risk assessment has been conducted.		*	*
10.3.1	There is evidence of implementation of recommendations made from the risk assessment.			*
11.0	***Management and Communication in Maternity Care***			
11.1.1	The arrangements are clear concerning which professional is responsible for the care at all times.		*	*
11.1.2	The professional responsible for intra-partum care is clearly identified.		*	*
11.1.3	There are detailed multi-disciplinary policies for management of the following conditions / situations:			
11.1.3.1	Diabetes			*
11.1.3.2	Major haemoglobinopathy			*
11.1.3.3	Severe hypertension			*
11.1.3.4	Multiple pregnancy			*
11.1.3.5	Vaginal breech delivery			*
11.1.3.6	Eclampsia			*
11.1.3.7	Prolapsed cord			*
11.1.3.8	Severe post partum haemorrhage			*
11.1.3.9	Ante partum haemorrhage including placental abruption			*
11.1.3.10	Shoulder dystocia			*
11.1.3.11	Failed adult intubation			*
11.1.3.12	Rupture of the uterus			*
11.1.3.13	Unexplained intra partum/post partum collapse - including amniotic fluid embolism			*
11.1.3.14	Water birth			*
11.1.3.15	Anatomical definition and repair of third degree perineal trauma			*
11.1.4	There is an agreed mechanism for direct referral to a consultant from a midwife.			*
11.1.5	There is a personal handover of care when medical or nursing shifts change.	*	*	*
11.2.1	There is a named consultant with designated responsibility for labour ward matters		*	
11.2.2	There is clear guidance on the transfer of care in the intra partum period.		*	*
11.3.1	A doctor of at least 12 months obstetrics experience should be resident on the labour ward at all times, or available within 5 minutes. A doctor of at least 3 years experience in obstetrics should be available within 30 minutes.			*
11.3.2	The delivery interval in CS for fetal distress is subject to an annual audited standard.			*
11.3.3	There is a personal handover to obstetric locums, either by post-holder, or senior member of the team and vice versa.			

RISK MANAGEMENT STANDARDS FOR OTHER RISKS (NON-CLINICAL)

It is proposed that the standards will be developed on the European Quality Model. This will include a requirement to establish a core risk management system, which is, supplemented by organisational risk control standards for the following areas:

- Building Plant & Equipment
- Infection Control
- Control of Contractors
- Information Management & Technology
- Emergency Preparedness
- Medical Equipment
- Environmental Management
- Professional & Product Liability
- Fire Safety
- Security
- Food Safety & Hygiene
- Transport
- Health & Safety
- Waste Management
- Human Resources

Standard Levels

Level 1

Level 1 standards should represent the basic building blocks required for the implementation and development of effective controls within each risk area. This will involve elements of:

- **Policy:** formal documentation in defining objectives and strategy for managing key risk areas e.g. there is a documented fire safety policy.
- **Organisation:** outlining key responsibilities in a structured form relating to accountability and competence within the framework of total communication e.g. the Chief Executive accepts overall responsibility for fire safety and there is access to competent fire safety advice.
- **Implementation:** systems for identifying, quantifying and controlling risks, setting priorities, generating and implementing risk control plans e.g. suitable fire risk assessments have been carried out and are documented.
- **Cost of Risk:** systems are in place to monitor the overall cost of risk.

Level 2

Level 2 standards should address:

- The quality of management within each risk area.

- The effectiveness of the Level 1 elements noted above.
- The existence of systems to evaluate controls against stated objectives e.g. regular workplace assessments and inspections are carried out.
- The ability to take corrective action where appropriate e.g. following the workplace assessments corrective action is taken to rectify any action.
- The involvement of an effective executive management system e.g. executive management oversees the review of the system of fire safety management at defined intervals.
- The existence of documented action plans.

Level 3

Level 3 standards should be a further progression to include quantitative aspects in relation to the management of risk. The standard should include an ability to demonstrate that:

- There are systems in place to assess the financial impact of risk.
- The process of cost benefit analysis for control measures has been introduced.
- Cost of risk analysis is used to promote risk management.