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Clinical Negligence Scheme for Trusts: a briefing paper for costing practitioners

Costing extension

Version 1, March 2022

Introduction

The Clinical Negligence Scheme for Trusts (CNST) is a payment made to NHS Resolution as a premium for the insurance product covering NHS organisations for claims against clinical negligence. The cost of the premium is set by NHS Resolution annually for each organisation, based on a range of historic and controllable factors.

The value of this premium is material for acute trusts and some integrated trusts, and so requires specific guidance on allocation during the patient level costing process. The calculation of this premium is complex and was considered during the establishment of the costing rules.

The paper aims to clarify the current costing allocation description of the CNST premium.

Calculation of the premium

The largest portion of the premium relates to **maternity services**. Of this, the calculation is based on the number of births and historic claims against the trust.

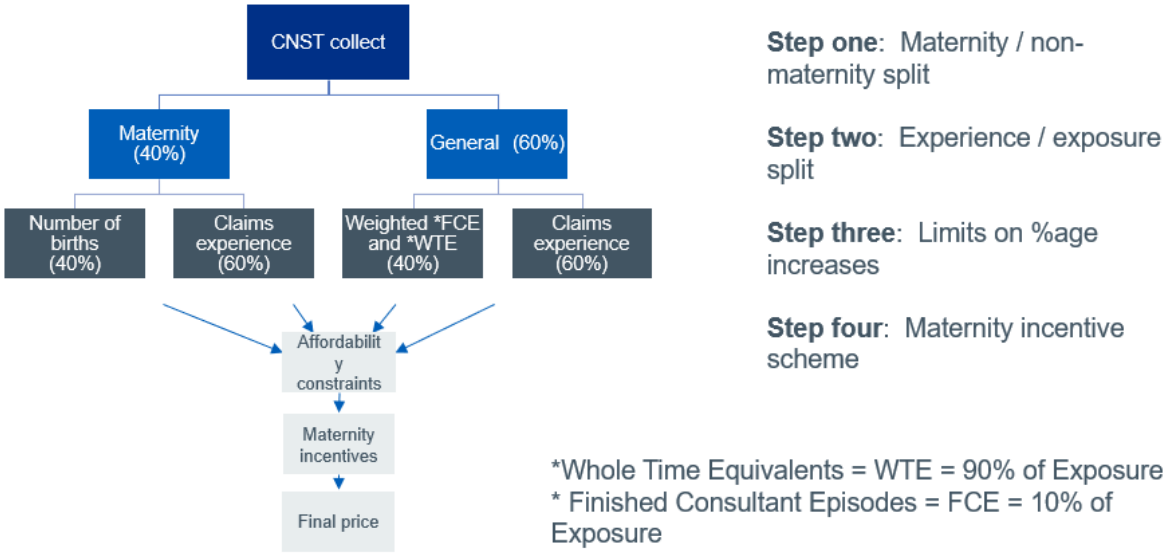
The rest is based on the number of admitted patient care (APC) episodes and outpatient attendances (OPAs) attendances, factoring in:

- the size of service in each organisation
- the number of staff (whole time equivalent, WTE) (on the basis that more staff make more mistakes balanced with the fact that more staff is safer than fewer staff)
- the claims history.

Further adjustments are made to smooth the year-on-year change to the claims history and activity/staff changes, and to incentivise high quality services.

Within **the 'non-maternity' category**, complex risk analyses by government actuaries provide weightings for different services. These are reviewed occasionally on a rotational basis.

Figure 1: Breakdown of CNST categories



Every year each trust receives a breakdown of the financial premium value allocated to services– this is called 'The Schedule'. There is some finished consultant episode (FCE), OPA and WTE information on the schedule, but this should not be used for costing purposes, as it comes from manual collections (not from hospital episode statistics (HES) or other national source data) and are not reconcilable to the information used in patient level information costing systems (PLICS).

Outpatients note. No premium is included for maternity service outpatients, but other outpatient face-to-face NAPC contacts should have some premium allocated as shown in the schedule.

Approach

The CNST premium will be identifiable in the general ledger. You should map to the cost centre XXX203 CNST and the expense code 7137 CNST contributions in the cost ledger.

Resources

The CNST premium is a resource, so it can be identified as part of the patient event cost.

- Costing Resource ID: SPR105 CNST payment
- Collection Resource ID: CSC006 CNST payment.

This resource should be allocated across service areas in the proportion of the values shown in the schedule sent annually.

Use the following steps to create **relative weight values (**RWVs) for CNST.

1. Identify the proportion of the premium that relates to maternity services.

2. Identify the remaining services in the schedule that are at treatment function code (TFC) level. Then identify services where the schedule does not show a valid TFC. For example, 'Cardiothoracic Surgery' may include cardiac surgery, thoracic surgery and vascular surgery or 'Trauma & Orthopaedics' may include spinal surgery. Costing practitioners should use their local knowledge of the services to split the cost to TFC level. The activity in the TFC areas may also be used.

3. The schedule does not include detailed point of delivery (POD) information, so costing practitioners should use the mapping template for weightings of all services except maternity. The mapping should be based on the average time in minutes for the different POD across all specialties.

   For example: the weighting between inpatient/outpatient/emergency department (ED) activity could be 48:1:8 assuming an inpt is 24 hours, outpatient is 30 mins, ED is 4 hours.

   Also for example: the template shows how for the emergency department, you should use specialty 180 and separate the premium between the ward activity of clinical decision units (etc) and the main A&E department. There is no inclusion of CNST for urgent treatment centres, minor injury units or walk-in centres

Activities

The resource of CNST should be allocated to the following activities:

Point of delivery	Costing activity ID	Costing activity title	Collection activity ID	Collection activity title
Admitted patient care (APC)	SLA097	Ward care	WRD001	Ward Care
Critical care	SLA107	Critical care ward care	WRD001	Ward care
	SLA135	Outpatient care	OUT001	

Non admitted patient care (NAPC)	SLA136	Outpatient procedure and treatment room care	OUT001	
Emergency department attendances	SLA121	A&E – medical care	EMC001	Emergency Care

Notes on activity combinations

For APC patient events, the resource of CNST should be allocated to the Ward care costing activity and the Ward care collection activity as this is the only collection activity guaranteed to appear on every APC episode. Not all patient events will have theatres or delivery activities.

A&E medical care has been chosen as the prescribed activity as all attendances to a 24-hour unit will receive input from a doctor, so this activity identifies where the clinical risk is higher. Lower risk units such as minor injury units and walk in centres have less doctor input, and if the service has no doctor input, there is no CNST element in the premium.

Allocating resource/activity combinations to patients

1. Within maternity:

   - The proportional cost of the premium should be allocated across all births, whether they are theatre births, delivery suite or home births, and include obstetric and midwife-led care. Occasionally a birth may be in another TFC, if the birth was in main theatres for a highly complex case. Therefore, you should identify births by the healthcare resource group HRG rather than the TFC.
   - Non-birth APC HRGs should not be allocated CNST premium costs.
   - NAPC contacts for maternity should not be allocated CNST premium costs.

   As a superior method, costing practitioners can work with their maternity teams to set weightings for different types of delivery event. We will take feedback on this area in the next year and look at the options for publishing a national weighting table.
2. Within other services, the cost can be added equally to all patients in the relevant TFC and POD.

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