AvMA's response to the DHSC consultation:

Appropriate clinical negligence cover

February 2019

Action against Medical Accidents

1. Action against Medical Accidents (AvMA) was established in 1982. It is the UK patient safety charity specialising in advice and support for patients and their families affected by medical accidents. Since its inception AvMA has provided advice and support to over 100,000 people affected by medical accidents throughout the United Kingdom. As an organisation our aims are to champion patient safety and access to justice.

2. AvMA offers specialist services to the public, free of charge across the United Kingdom. This includes a helpline and an individual casework service. AvMA also operates a pro bon inquest service in England and Wales, providing advice and representation for families who have lost loved ones.

3. AvMA provides specialist support services for legal professionals through our Lawyers Resource Service including the recommendation of expert witnesses. We organise specialist training courses and conferences for health and legal professionals, advice agencies and members of the public.

4. AvMA operates a specialist accreditation scheme for clinical negligence lawyers. The AvMA Specialist Clinical Negligence Panel has been running since the early 1980's and is the longest running clinical negligence accreditation scheme as well as being the first accreditation scheme of its kind. We re-accredit our panel solicitors every 5 years to ensure that they are maintaining standards. As part of the accreditation and reaccreditation process, solicitors are required to submit reports on cases they have conducted as a claimant practitioner. This gives AvMA a unique overview of the difficulties faced by patients and their legal advisors in obtaining redress following an avoidable injury.

Executive Summary

1. Regulatory oversight: AvMA would support bringing the medical defence organisations (MDOs) within the regulatory framework of the Financial Conduct Authority (FCA) and Prudential Regulation Authority (PRA). With general practice about to move over to an NHS backed indemnity scheme, there are likely to be financial implications for the MDOs which would suggest that regulatory oversight will be even more important.

2. Professional regulators and indemnity arrangements: it is essential that a practitioner's professional indemnity arrangements, past and present, are verified and held centrally on the relevant professional register and for those details to be made available to the patient

and their representatives where a claim is being intimated. Any proposed changes to indemnity arrangements would be seriously undermined if patients do not have ready access to this information. As set out below, AvMA is regularly notified about difficulties in identifying a practitioner's indemnity arrangements, particularly where there are no current contact details for the practitioner. It is arguable that these problems are more likely to be encountered where 'rogue' practitioners who are inherently at greater risk of causing harm are involved. Given it is a requirement that practitioners hold professional indemnity cover, then regulators need to ensure that details of that cover can be readily accessed otherwise the requirement is in effect meaningless.

3. Independent hospitals and clinics: should be vicariously liable for all treatment carried out within their premises or as part of their regulated activities. Whilst developments in case law are increasingly making it more difficult for independent hospitals and clinics to avoid liability for treatment provided by clinicians with practising rights, the statutory regulation of independent hospitals needs to be amended to reflect this. This avoids the invidious position where independent hospitals argue against any liability for avoidable harm on the basis that their role is just to provide the 'facilities' and that the treatment and any adverse outcome is the sole responsibility of the private practitioner even though it is rarely the case that failures are just down to the individual practitioner. This fundamentally goes against the principles of clinical governance particularly in the context of some of the inherent weaknesses in the safety of provision of healthcare in independent hospitals. By making hospitals legally liable will also help ensure that they also take full responsibility for clinical standards.

4. Approved list of providers: it should be a requirement that clinical negligence indemnity cover is sourced from an approved UK based provider. One of the potential risks of a sudden shift in the indemnity market will be the rapid entry and exit of new providers into the market and so it is important that a list of approved providers is created.

5. Essential criteria and standards for indemnity cover: whilst different professional roles will require different levels of cover, it is essential that professional indemnity cover is required to comply with a set of core requirements to ensure it provides adequate protection for patients as well as the practitioner. This would include issues such as run off cover, what happens in the event of the death of the practitioner, limiting the number of exclusions within the policy, multiparty actions, and ensuring that any financial limits on the cover will not leave patients under-compensated.

6. Uninsured practitioners: given one of the stated aims of the proposals is to provide assurance for patients that they can obtain financial redress following avoidable harm, then an organisation similar to the Motor Insurers' Bureau (MIB) needs to be established to provide cover for clinical negligence claims where a practitioner is found to be either uninsured or without adequate cover for the treatment or injury in question. The professional regulators should take a strong line with respect to any practitioner who fails to comply with their respective professional regulator's requirements in relation to indemnity cover. This body could also provide a safety net where the limits of indemnity are insufficient for the claim in question.

7. Criminal offences: there needs to be protection for patients where a practitioner has been found guilty of a criminal offence that directly relates to the treatment in question which could result in the indemnity cover being voided.

8. Patient safety: in the event that the medical indemnity market is opened up to multiple providers, it would be important that patient safety data from claims can still be collated

and lessons disseminated to the professions and to healthcare organisations. The MDOs have traditionally shared lessons from cases with the medical profession - learning from the mistakes of others being an important way of understanding why mistakes have happened and prevent a repetition. There should be a duty placed on approved indemnity providers to enhance patient safety.

9. Future proofing: indemnity arrangements need to be future proofed in terms of validity of the cover as well as any limits on damages to be paid particularly given past as well as future anticipated rises in care and accommodation costs.

AvMA's experience of problems with current professional indemnity arrangements

Through our advice services to patients and their legal advisors, AvMA not infrequently receives reports about failures in the current protections afforded to patients with respect to treatment that falls outside of the NHS indemnity scheme (CNST)[1]. The current consultation document has tended to focus on issues around the discretionary nature of the indemnity cover provided by the MDOs and that is clearly a very significant issue in those instances where a patient finds they potentially have no recourse to financial redress. Certainly AvMA is notified of instances where MDO cover has been denied in a particular case e.g. in the past we often saw examples where indemnity was denied in instances where the practitioner had died or where the actions are deemed to have crossed the criminal threshold.

In addition to instances where cover is refused, there are also issues in relation to the level of indemnity cover and this sometimes being insufficient to cover a claim, particularly those claims involving catastrophic injuries where an injured patient may require 24 hr care throughout their lifetime. Any changes need to ensure that potential loopholes around discretionary cover and limits on cover that prevent a claimant being adequately compensated, are addressed.

There are additional circumstances where patients are at risk of going uncompensated. An issue regularly reported to AvMA is the inability to identify the provider of a practitioner's indemnity arrangements, if such cover even exists in some instances. A common example is where a practitioner is either untraceable or is simply failing to respond to any correspondence including failing to provide details of their indemnity arrangements. This is usually compounded by the MDOs refusing to confirm or deny that a practitioner is indemnified by them. This has been particularly prevalent but certainly not exclusively so in the field of cosmetic surgery where surgeons may for example be operating in the UK for a limited period of time making it difficult if not impossible to track down the doctor's current whereabouts and therefore the identify of their professional indemnity provider. However, this can equally apply to UK based doctors and in other specialities.

The simplest way of addressing this particular issue is to require professional regulators to hold details of a practitioner's professional indemnity arrangements on the relevant professional register. Without this protection, the requirement to hold professional indemnity cover will on its own fail to protect patients.

AvMA has also seen reports of doctors whose insurance cover has been sourced from their home country, most often within the European Union, where the insurance company has

[1] https://resolution.nhs.uk/wp-content/uploads/2018/10/NHS-Indemnity.pdf

refused to cooperate or respond to approaches from the patient's legal advisors. So whilst the doctor may have been able to tick the box confirming that they have indemnity cover, this cover may in practice provide little protection for their patients.

There are also examples where there has been an apparent misunderstanding about whether a practitioner is covered by their employer, particularly where there is a chain of sub-contractors involved in the provision of care. Where there is a chain of providers and subcontractors, indemnity arrangements can become very complex. This needs to be addressed in terms of whether there needs to be greater statutory regulation with the aim of simplifying where liability rests.

There are clearly issues around the discretionary nature of professional indemnity provided by medical defence organisations but there may prove to be equal concerns about 'exclusions' within insurance policies and how you ensure that patients don't find themselves facing the same difficulties with insurers. This goes back to setting statutory standards and essential criteria for indemnity cover.

The insurance industry is one of the most powerful lobbying groups when it comes to influencing government policy. We would be concerned about any undue influence brought to bear by the insurance industry in relation to patients and their rights to be fairly and adequately compensated.

Regulatory oversight

AvMA supports strengthening the regulatory oversight of medical indemnity arrangements with respect to the medical defence organisations (MDOs). This is particularly in the light of the proposed changes in GP indemnity due to come into effect in April 2019 in England and Wales, with Scotland and Northern Ireland likely to follow in due course. It would be important to understand the potential impact this may have on the MDOs and their future viability but also in terms of the size and viability of the professional indemnity market overall. Any changes in oversight should be with a view to underpinning the future security of indemnity arrangements and to ensure patients are able to obtain the redress they are entitled to in the event that they suffer avoidable harm. How this is best achieved would be a matter for those who are expert in insurance and indemnity arrangements but we believe that caution needs to be exercised in the introduction of any sweeping changes without first undertaking a detailed analysis of the viability of alternative arrangements and having an understanding of the potential impact those changes may have as well as ensuring there is some form of safety net in place.

It is unclear from the consultation document the full extent of the problem that it is attempting to address and it may in fact be difficult to assess this at the current time given the changes that are taking place but there is a risk of unintended consequences which may negatively impact on both patients and practitioners. The underlying principle of any proposed changes should be that patients who have been harmed are never left without access to appropriate financial redress.

It is reported that the MDOs currently hold over 90% of the medical indemnity market in the UK, which means there will be limited evidence available with respect to the viability of alternatives both in terms of the affordability of premiums and the potential for more exclusions from cover which may in turn have a direct impact on private healthcare and the treatments that are covered. We already have the example of independent midwives who have continued to struggle to find appropriate professional indemnity insurance to allow them to continue

practising[2]. This could be repeated in other specialities which are deemed high risk. However this can also apply to the MDOs with the example of the Medical Defence Union's announcement in 2017 that they would no longer be providing cover for spinal surgery[3]. This is not to say that limiting access to certain treatments may not sometimes afford protection for patients where a treatment is in fact deemed too high risk in a private healthcare setting, but it could also mean patients being denied access to clinically appropriate treatments that might not be available through the NHS. In the event that independent hospitals and clinics are made vicariously liable for treatment carried out within their premises, there are likely to be a different set of insurance considerations that will need to be addressed.

6. Consultation questions

6.1 What are your views on the proposed options for meeting the Government's policy objectives (please see paragraph 4.1)?

AvMA would support strengthening the regulation of professional indemnity arrangements but as set out above, would want to see some key additional changes. This includes requiring professional regulators to hold details of a practitioner's indemnity arrangements on the professional register and for this information to be made available to patients and their legal advisors on request. Only those products that meet essential criteria and standards and sourced from approved providers should qualify to satisfy the requirement to hold 'appropriate and adequate' indemnity cover.

6.2 What are your views on the potential costs and benefits of these options, for example the familiarisation and administrative costs for individuals, businesses, and other groups, in complying with potential changes to regulation?

Questions around the financial implications of the proposed options falls outside AvMA's remit. It is essential that patients are afforded better protection and that failings in the current indemnity arrangements are fully addressed including the recommendations we have made above. However, there will be concerns about the potential for unintended consequences and the need to fully explore the potential consequences of changes to the medical indemnity market. The medical defence organisations have traditionally dominated the medical indemnity market in the UK. We therefore have relatively limited evidence in the UK of the likely impact of the proposed options. If the medical indemnity market becomes more fragmented, it will be important to determine what impact this might have on the viability of indemnity schemes including that provided by the MDOs, having seen the entry and exit of companies like St Paul's into and out of the market within the space of two years.[4][5]

6.3 Are there any other options that the Government should consider?

[2] https://www.nursinginpractice.com/article/independent-midwives-lose-indemnity-appeal-against-nmc
[3] https://www.independent-practitioner-today.co.uk/2017/07/mdu-blasted-for-ditching-back-surgery/
[4] https://www.insuranceage.co.uk/professional-broking/news/1196813/medical-malpractice-st-paul-announces-departure-medical
[5] https://www.nytimes.com/2001/12/13/business/st-paul-cos-exits-medical-malpractice-insurance.html

As set out above, there are some additional changes that need to be made in order to afford better protection for patients. This includes having a statutory requirement to record details of an individual practitioner's indemnity arrangements on their respective professional register and for this information to be made available to a patient and or their legal advisor where a claim is being intimated. The indemnity arrangements should be checked and verified by the professional regulator with the cooperation and assistance of the providers. Qualifying indemnity arrangement should be restricted to approved products and providers based on a set of essential standards.

Independent hospitals and clinics should be required to indemnify any treatment carried out as part of their regulated activities. It is unacceptable that when a patient suffers avoidable harm that the hospital or clinic where their treatment was carried out can deny any responsibility for that treatment on the basis that their role is just to provide the 'facilities' and any treatment is the responsibility of the practitioner concerned. Whilst case law is making it more difficult for private providers to abrogate responsibility in this way, there is a more fundamental issue around clinical governance and the need for organisations to take full responsibility for treatment carried out within their premises.

As set out above, we recommend setting up a body similar to the Motor Insurers' Bureau (MIB) to cover claims where a practitioner is found not to have appropriate professional indemnity arrangements in place.

Consideration should also be given as to whether it would be feasible to further open up NHS indemnity schemes to allow non-NHS providers to join the NHS scheme. This has been done in the past in relation to independent healthcare providers of NHS funded care.

Professional regulators should ensure that detailed guidance is available to their registrants to assist them in ensuring their professional indemnity arrangements are fit for purpose. Whilst insurance has the benefits of having clearly defined terms, the complexity of insurance in this area can also mean that a practitioner may find that the treatment provided has inadvertently fallen outside the terms of their cover, providing neither protection for the practitioner nor their patients. Having an approved list of providers and products that have to comply with essential standards will help mitigate against some of these difficulties.

6.4 Do you agree with the Government's preferred option (ii), set out from paragraph 5.15, of ensuring that all regulated healthcare professionals in the UK hold appropriate clinical negligence cover that is subject to appropriate supervision by the FCA and PRA?

Yes but with the additional safeguards built in as set out above. In particular, ensuring information about a practitioner's indemnity cover is publicly available on request. This will be even more important if the number of potential organisations providing professional indemnity cover is expanded.

6.5 Do you have further insight or data into the types of indemnity/insurance cover held by healthcare professionals?

As above.

If Government pursues option (ii)

6.6 In order to achieve this aim, what would be the benefits or implications of introducing regulation via:

a) changing professional standards so that professionals have to hold a regulated product in order to practise;

b) changing financial regulation so that any organisation offering clinical negligence cover would need to be authorised to do so;

c) *changing both financial and professional regulation*.

As set out above, AvMA would support changing both financial and professional regulation and bringing MDOs within the regulatory framework but with additional recommendations around statutory standards for indemnity products and having an approved list of providers as well as making details of a practitioner's indemnity arrangements accessible to potential claimants.

6.7 Do you have a view on when regulations should come into force and should these involve a transitional period, considering the potential impact on indemnity providers and healthcare professionals?

This potentially represents a significant shift in indemnity arrangements for private care in the UK particularly in the context of GP indemnity moving out of the MDOs' basket into a state backed indemnity scheme. This may in itself lead to some uncertainty in relation to the MDOs and the insurance market more widely and there will inevitably need to be a transitional period for the full effect of the current changes to be understood. The most immediate change would be to bring the MDOs under the regulation of the FCA and PRA.

6.8 Are there any measures that could mitigate the potential risks to introducing regulation as set out in paragraphs 5.32-5.35 (in terms of a stable transition for regulated healthcare professionals and indemnity providers, mitigating potential cost impacts, and run-off cover)?

Outside AvMA's remit to comment.

6.9 Specifically, on the transition risk, are there any measures that could support the run-off of indemnity providers' existing liabilities on a discretionary basis, and given the potential interaction with overseas business set out in paragraph 5.21?

Outside AvMA's remit to comment.

6.10 Specifically given the potential risk with claims-made and claims-paid policies and indemnity arrangements as set out in 5.35, should Government specify the type of insurance or regulated product required for regulated healthcare professionals? This could take the form of a) claims-occurring cover, b) claims-made cover, c) claims-made cover with built-in run-off cover on either death or retirement from clinical practice, or d) a combination of these.

Yes. The Government through statutory regulation should set out essential criteria for indemnity products and providers that will best safeguard the interests of patients.

6.11 Related to the above, should the Government and/or the professional healthcare regulators specify a minimum standard of insurance or regulated cover that should be

required for regulated healthcare professionals (for example, a minimum level of cover for each claim and in the aggregate, depending on the regulated healthcare professional)?

Yes. See comments above. If the market is opened up, it will become even more important to have regulated products and providers that meet essential standards. This is both to ensure practitioners are able to easily identify the most appropriate cover as well as to ensure that patients can be assured of adequate protection.

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Contact details:

Liz Thomas
Policy & Research Manager
Action against Medical Accidents (AvMA)
Freedman House
Christopher Wren Yard
117 High Street
Croydon
CR0 1QG
policy@avma.org.uk
www.avma.org.uk