Department of Health

Professional insurance and indemnity for regulated Healthcare Professionals – policy review research

June 2010
Final Report - Strictly Confidential

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Section 1

Executive Summary

Executive Summary
Key Highlights

- General agreement amongst regulators that a check on insurance / indemnity coverage at the point of registration was possible and is likely to be a proportionate and cost effective means to achieving the Government's established policy that all registered Healthcare Professionals should have insurance or indemnity cover
- There were no objections to the underlying policy, where redress should be possible in the interests of public protection as far as practicable although this may not be guaranteed
- The context in which Healthcare Professionals work is a key factor in determining the relative risk of unmet negligence claims. Those who work in the independent/private sector, but are self-employed, are likely to pose the most risk of lack of redress
- Several key limitations of linking insurance/indemnity cover to the individual's registration with a regulatory body were highlighted including the tracking of scope of practice, definitions of adequacy and appropriateness, and liability
- The proposed solution may not deal with all circumstances
  (e.g. groups of professionals who cannot obtain coverage or professionals from overseas)
- Implementation issues will need to be resolved including resource / process change requirements within the different regulators. However, means to minimise the cost are available
- Understanding the size of the problem (i.e. the extent of negligence claims against Healthcare Professionals) is complex and the required data is not readily available. However, available data sources may provide an indication of the extent of risk associated with different groups of professionals.
- Several alternative options may be available to help achieve similar goals

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Patients* treated by Healthcare Professionals who are not directly employed or engaged by an NHS provider may not necessarily have access to compensation arrangements for negligence.

There is currently no statutory requirement for independent, self-employed or NHS sub-contracted Healthcare Professionals to have cover in place to compensate patients from harm caused by negligence.

Professional insurance or indemnity cover aims to provide financial compensation in the case of negligence or mistakes on the part of Healthcare Professionals. The compensation arrangements available to patients, the public, and service users vary across the Health Professions, and are influenced by the settings within which Healthcare Professionals work and operate.

The UK Government's current policy is to ensure that, as far as practicable, patients can secure compensation when they suffer harm through negligence on the part of a Healthcare Professional. The UK Government has commissioned a review of the implementation of this policy. This specifically addresses whether the requirement to have professional insurance or indemnity in place, as a condition of registration with a health regulatory body, is the most effective and proportionate way of ensuring that patients can secure compensation when they suffer harm through negligence on the part of the Healthcare Professional.

PricewaterhouseCoopers (PwC) was commissioned by the DH to explore the current arrangements of insurance/indemnity for Healthcare Professionals in the UK, and the issues and potential options for ensuring the provision of insurance/indemnity cover for registered Healthcare Professionals in cases of negligence.

This work focused on two key themes: the frequency and severity of claims for each regulated Healthcare Professional group, and the potential cost of linking insurance/indemnity to the registration process.

The Government policy, currently being explored to provide a proportionate and effective response to some of the risks and deficiencies of the current system, is to link insurance/indemnity cover to the individual's registration with a regulatory body.

However, challenges to introducing a uniform solution of linking insurance/indemnity with registration include variety in the regulatory environment, with nine regulatory bodies regulating 1.4 million Healthcare Professionals in the UK.

Significant process changes, and/or a degree of standardisation across the regulators may carry a degree of extra cost in the system according to the option chosen. The estimated costs of linking insurance with registration and the ability to verify at the point of renewal varies by regulatory body.

Furthermore, the level of confirmation required and detail of the individual's scope of practice at the time of renewal may vary.

In this report, we have examined these issues, amongst others, to explore the degree and costs of the assurance that could be given by linking a check of indemnity/insurance with Health Profession registration.

(*The term "Patients" throughout this report refers to any member of the public who is seen by a registered healthcare professional.)

Executive Summary

In this report, key limitations regarding the linking of a check on insurance/indemnity at registration and renewal are explored, including :

- Changes in the scope of practice of registrants; how this could be monitored and how coverage confirmed at registration may become invalidated between renewals.
- Defining the minimum level of insurance/indemnity which is appropriate and/or adequate for Healthcare Professionals, and the potential risks associated with making this determination.
- Some Healthcare Professionals for whom currently no options for insurance/indemnity exist in the market, e.g. independent midwives.
- Responsibility for Healthcare Professionals who have indemnity or insurance cover from another EU country who come to the UK to practice.

Findings from desk based research (including literature reviews and website searches) and interviews with the regulatory bodies give an understanding of the size and nature of the healthcare workforce and the existing regulatory processes. These also informed an estimate of the (costs and process) resource burden to the regulatory system to implement a link between insurance/indemnity cover and registration process.

The general view of the organisations who participated in this review was that the responsibility for ensuring cover is maintained and should remain with the individual professional. However, a check on this coverage at the point of registration or renewal was possible.

The majority expressed the view that there should be a risk stratification of professions to define individual requirements for coverage which should be proportionate to the profession's perceived risk exposure.

The extent to which professional services are delivered outside of a public (NHS) environment may be an indicator as to the extent to which personal insurance or indemnity provisions are required.

Other options to achieve similar goals were proposed by stakeholders during our research, including:

- Cover through the Healthcare providing organisation rather than the individual professional;
- State subsidisation;
- A pooled online system, shared across all regulators;
- Automatic validation of coverage at registration and renewal, reinforced by penalties.

Any final option would need to consider the limitations and/or unwillingness of the commercial market to provide cover to those who work in professions for which substantial amounts can be awarded as redress such as independent midwives.

We describe a number of options for keeping the cost of linking cover to registration to a minimum. These include moving to online platforms and using other existing communication mechanisms to seek confirmation of coverage at minimum marginal cost.

Further detail is captured in three main sections of this report.
These are:

- (Section 4) The size of the issue;
- (Section 5) Linking indemnity and insurance with registration; and
- (Section 6) 'Wider Considerations' where views expressed by contributors are reflected, and some options/issues and impacts on the healthcare environment are explored.

Section 2

Background

Background

In recent years attention has been drawn to a number of cases of claims against Healthcare Professionals for negligence which, although small in number, have been of a relatively high profile because the professional concerned was uninsured. In such cases the public and patients may be at risk of no, or limited, recourse to compensation.

The public in general may have an expectation that should a healthcare professional be negligent, then there should be some form of redress available to the user of the service and/or their family.

There are approximately 1.4 million Healthcare Professionals in the United Kingdom, these include doctors, dentists, nurses, midwives and professions regulated by Health Professions Council, such as physiotherapists and dieticians. We have defined 'Healthcare Professionals' as those professionals regulated by the regulatory bodies listed in Appendix A.

Depending on the type of employment and the nature of their work, each Healthcare Professional is exposed to different levels of risk, and groups of professionals differ in the frequency and/or severity of professional negligence claims they potentially face in their professional careers.

There are four groups into which Healthcare Professionals in the UK may be broadly divided, to better understand exposure to claims and the nature of indemnity and insurance cover available:

1) Those who are employed or engaged by an NHS hospital/acute trust;
2) Those who work in NHS "branded" care environments, such as primary care;
3) Those who work in the independent/private sector but are employed; and
4) Those who work in the independent/private sector but are self-employed.

For Healthcare Professionals who are employed or engaged directly by a NHS hospital/acute trust, there is provision of indemnity and insurance cover through the National Health Service Litigation Authority (NHSLA) schemes, and similar schemes in Scotland, Wales and Northern Ireland.

However, where Healthcare Professionals are employed by another organisation, or are conducting work on a self-employed basis, either independently or for the NHS (including independent contractors in primary care (e.g. GPs) or through sub contracts), cover is varied.

There is currently no uniform statutory requirement for Healthcare Professionals to declare, or even have access to, appropriate and adequate indemnity or insurance cover. Some professional or regulatory bodies require members to have sufficient cover as part of their registration procedures, but the level of implementation varies.

In 2009, the Secretary of State for Health (SofS) for England instructed officials to establish a review of the policy on professional insurance and indemnity, facilitated through the Review Group and a wider group of stakeholders.

The review process is intended to ascertain whether the requirement to have professional insurance or indemnity in place, as a condition of registration with a health regulatory body, is the most effective and proportionate way of ensuring that, as far as practicable, patients can secure compensation when they suffer harm through negligence on the part of a Healthcare Professional

Background

The Government, through the Department of Health ("DH"), has indicated its wish for all Healthcare Professionals to be covered by suitable insurance or indemnity arrangements.

The Government white paper "Trust, Assurance and Safety – The Regulation of Healthcare Professionals in the 21st Century", 2007 states:

"…In response to a government initiative, indemnity insurance is also becoming a requirement..."

Any policy will also need to meet, as a minimum, the requirements of any EU Directive.

PwC were commissioned by the DH to gain a deeper understanding of current arrangements in the UK with regard to the provision of professional insurance/indemnity cover for registered Healthcare Professionals, and the costs and benefits associated with potentially linking indemnity/insurance requirements to professional registration.

In addition to the work described in this report, PwC is also conducting a stakeholder engagement exercise on behalf of the Independent Indemnity and Insurance Policy Review Group regarding insurance/indemnity of Healthcare Professionals.

In order to explore a link between indemnity/insurance cover to professional registration, we focus on two key questions in this report:

- What is the frequency and severity of claims within an unprotected environment in healthcare in the UK?
- What are the costs associated with linking of insurance/indemnity to registration as a response to the need to have adequate and appropriate indemnity and insurance cover for all registered Healthcare Professionals?

We have sought to answer these questions through a combination of structured interviews with key stakeholders, qualitative and quantitative research, and quantitative analysis (where possible).

Our approach is defined in more detail in the next section.

Section 3

Our Approach

Our approach

In the preparation of this report, in order to determine if linking registration to the requirement to have insurance/indemnity cover is a proportionate and cost effective means to achieving the Government's established policy, we have engaged with a large number of organisations and stakeholders, primarily through semi-structured interviews.

Interviews were structured around:

- Their perception of size of the issue
- Implications for their stakeholders (particularly with regard to a link to registration of indemnity/insurance cover)
- Implications for their processes (particularly the link to registration)

A detailed list of the organisations may be found in Appendix D.

In addition to interviews, PwC undertook desk based research, consultation with PwC Healthcare Professionals, and data analysis to inform the three main sections of the report as outlined below:

Size of the issue

- Research to understand the key professions involved, current registration processes and insurance/indemnity arrangements for each.
- Collating data from existing data sources regarding the number and size of negligence claims from within a managed NHS environment.
- Determining the availability of data to identify the number and size of negligence claims which occur outside of a managed NHS environment.
- Generation of indicative ranking of professions regarding risk of negligence claims which may not be met due to lack of insurance/indemnity cover.

Linking Insurance with Registration

- For each profession, research regarding the current registration processes.
- Estimation of the cost to the registration organisation of administering the process to link insurance with registration, focusing on the cost of the administration process for the types of link which are contemplated.
- Determination of the steps that may be explored to keep costs to minimum.

Wider Considerations

- Alternative and/or additional options for achieving the same goal of achieving coverage for all registered Healthcare Professionals and/or to improve the effectiveness of any existing mechanism.
- Key potential implications of enforcing a link to registration, for patient choice and the perspective of the Healthcare Professional.
- Alternative steps that may be adopted for professions in whose case universal coverage cannot be provided or deemed not to be cost effective (if any).
- Definitions of "appropriate" and "adequate", and who could define or implement these.

Section 4

Size of the Issue

Size of the Issue

This section explores the healthcare regulatory environment in the United Kingdom and the size of the issue with regard to the number and size of complaints and claims against different categories of Healthcare Professional. Appreciating the relative risk of different categories of Healthcare Professionals as defined above is an essential first step to determine if linking registration to the requirement to have insurance/indemnity cover is a proportionate and cost effective means to achieving the Government's established policy,

This includes:

- The professions and example protected titles under each regulator;
- The size of the issue in terms of the number of claims made by specialties within a NHS environment (NHSLA data); and
- A description of the risk exposure of individual professions.

Regulated professions and protected titles

In the UK, healthcare is provided by Healthcare Professionals working in different environments.

The nature and extent of regulation varies between, and sometimes within, these professions. Some professions (e.g. medical practitioners, nurses) have had a long history of being regulated while some professions, like some of those regulated by the Health Professions Council ("HPC"), are relatively new to regulation.

To understand the implications of linking registration with a requirement for adequate and appropriate indemnity/insurance cover, it is necessary to understand the regulators, the professions which are regulated, and the numbers of individuals within these professions.

There are currently 9 regulatory bodies for Healthcare Professionals. (The Royal Pharmaceutical Society of Great Britain (RPSGB) became the General Pharmaceutical Council on the 1st April 2010. Throughout this report we have made reference to the RPSGB, to which our data relates.)

The table below summarises regulation of Healthcare Professionals in the UK.

Regulatory Body	Professions	Example Protected Titles
General Chiropractic Council (GCC)	Chiropractors	Chiropractor
General Dental Council (GDC)	Dentists, Dental Hygienists, Dental Therapists, Dental Technicians, Clinical Dental Technicians, Orthodontic Therapists	Dentist (equivalent to Dental Surgeon, Dental Practitioner), Dental Care Professional
General Medical Council (GMC)	All doctors with approved medical qualification	Registered Medical Practitioner
General Optical Council (GOC)	Optometrists, Dispensing Opticians	Registered Optometrist, Registered Ophthalmic Optician, Registered Dispensing Optician
General Osteopathic Council (GOsC)	Osteopaths	Osteopath
Nursing and Midwifery Council (NMC)	Nurses, Midwives, Specialist Community Public Health Nurses (SCPHN). SCPHNs include: Community Staff Nurse, District Nurse, Practice Nurse, Community Matron, Health Visitor, School Nurse (Note: All SCPHNs must be registered as a nurse or midwife)	Registered Nurse, Midwife
Pharmaceutical Society of Northern Ireland (PSNI)	Pharmacist	Registered pharmaceutical chemists
Royal Pharmaceutical Society of Great Britain (RPSGB)	Pharmacist, Pharmacy Technicians	Pharmacist (it is not compulsory for technicians to register)

Source: DH background data and regulator websites

Regulated professions and protected titles – continued

Regulatory Body	Professions	Example Protected Titles
Health Professions Council (HPC)	Practitioner psychologists	Practitioner psychologist Registered psychologist Clinical psychologist Counselling psychologist Educational psychologist Forensic psychologist Health psychologist Occupational psychologist Sport and exercise psychologist
	Prosthetist / orthotist	Prosthetist, Orthotist
	Radiographer	Radiographer, Diagnostic Radiographer, Therapeutic radiographer
	Biomedical scientist	Biomedical scientist
	Chiropodist / podiatrist	Chiropodist, Podiatrist
	Clinical scientist	Clinical scientist
	Dietician	Dietician
	Occupational therapist	Occupational therapist
	Operating department practitioner	Operating Department Practitioner
	Orthoptist	Orthoptist
	Paramedic	Paramedic
	Arts therapist	Art Psychotherapists, Art Therapist, Drama Therapist, Music Therapist
	Physiotherapist	Physiotherapist, Physical Therapist

Source: DH background data and regulator websites

Current registration process and size of register

Findings from desk based research and interviews with the regulatory bodies give an understanding of the size and nature of the healthcare workforce and the existing regulatory processes, to inform an estimate of the (costs and process) resource burden to the regulatory system to implement a link between insurance/indemnity cover and registration process.

We have documented the number of registers and registrants within each regulator, with the registrant population split between those that work within a protected NHS environment and those that work outside in a non-NHS environment, where known. (In some cases this split figure is an estimation provided by the regulators.) This information can be found in Appendix A. We highlight that the NMC regulates the largest number of Healthcare Professionals (665,704), followed by the GMC (231,291). In addition, unlike all other regulatory bodies, the HPC regulates 14* different types of Healthcare Professionals ranging from physiotherapists (the largest with 44,734 registrants) to prosthetists (the smallest with 865 registrants).

Most regulators do not capture information regarding working environment(s) at the point of registration. Many Healthcare Professionals work in the NHS and independent sectors at the same time, and the work environment of a Healthcare Professional may change between contacts with the regulatory body; therefore the figures quoted in the next page are only indicative.

In our research, insurance/indemnity provider organisations and regulators each considered it the responsibility of the individual professional to adhere to rules governing their own 'fitness to practise' status, including informing the regulator/insurer/indemnifier of a relevant change in the nature of their practice.

Source: *From 1 April 2010 the HPC became responsible for the regulation of approximately 1500 hearing aid dispensers

Split between NHS and non-NHS staff

We have been provided with information that gives an indication of the split for different professions for those individuals who declare their main area of work as being in the public or private sectors. The table on the right provides an overview in the UK of this split for those professions where data is readily available.

We note that the information in this table may be subject to some double counting of figures, where an individual may be employed in both the public and private sector. We also note that this data only relates to the respondents to the relevant ONS Surveys and may not reflect the full registered population.

Individuals who work as dentists or therapists work predominantly in the private sector. In each instance, over 80% of the individuals work within the private sector. We understand from discussions with the appropriate regulatory bodies that dentists currently have an ethical requirement to hold insurance/indemnity cover, however there is no requirement for therapists.

In contrast, we highlight that eight professions, including midwives and paramedics, predominantly have employment within the public sector. In these cases, less than 10% of individuals are employed in the private sector.

The extent to which professional services are delivered outside of a public (NHS) environment may be an indicator as to the extent to which personal insurance or indemnity provisions are required. This provides some anecdotal evidence as to which professions are at greater risk of having a lack of cover to meet potential negligence claims as they fall outside of the blanket cover provided by agencies such as the NHSLA.

We note that the definition of NHS and non NHS work within this data may not be consistent with our categorisation. For example, some professionals working in an NHS 'branded' environment (i.e. category 2), such as the majority of GP's, may have been recorded as working in the NHS, whilst others may have been recorded as working outside the NHS.

Profession	Non NHS (private sector)	NHS (Public Sector)	Total	% working in non -NHS sector
Chiropodists	7,497	3,594	11,091	67.6%
Dental nurses	25,498	13,767	39,265	64.9%
Dental practitioners	30,048	4,364	34,413	87.3%
Medical and dental technicians	9,711	16,691	26,402	36.8%
Medical practitioners	55,228	150,128	205,357	26.9%
Medical radiographers	2,452	20,027	22,479	10.9%
Midwives	1,196	34,801	35,997	3.3%
Nurses	54,204	407,013	461,462	11.8%
Occupational therapists	1,975	20,225	22,200	8.9%
Ophthalmic opticians	1,212	1,081	2,293	52.9%
Paramedics	885	18,535	19,543	4.6%
Pharmacists & pharmacologists	923	6,852	7,775	11.9%
Physiotherapists	8,171	23,281	31,452	26.0%
Psychologists	4,299	18,073	22,372	19.2%
Speech and language therapists	271	7,968	8,239	3.3%
Therapists n.e.c.	37,040	8,581	45,754	81.2%

Source: ONS 4 Quarter Average July 2008 – June 2009

Complaints by profession – NHS and non-NHS

Regulators capture data regarding the number of cases referred to them on their registrants. We have collectively referred to these cases as complaints for the purpose of this report but note that there are a variety of interchangeable definitions regarding this term. We note that these are Fitness to Practise complaints and may not result in compensation claims been pursued.

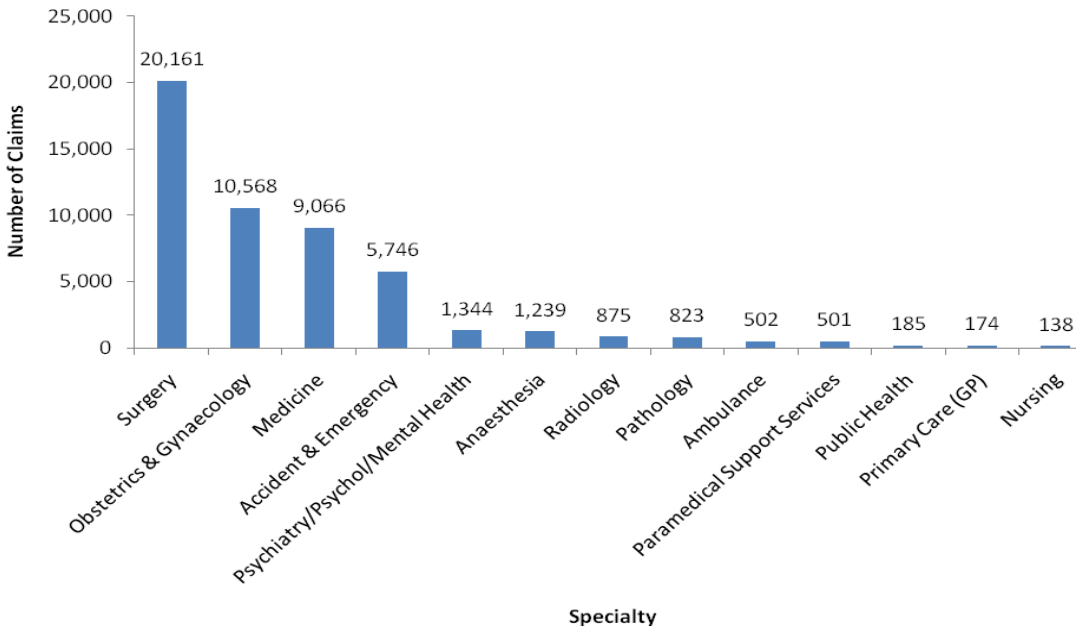
The number and size of complaints that Healthcare Professionals face may give an indication of risk associated with each profession, although we were not able to determine a "conversion rate" of complaints to claims for negligence, or the size of any subsequent awards. We note that not all complaints made to each regulatory body are related to the negligence of a Healthcare Professional. We comment that whilst all of the regulatory bodies we spoke to recorded the number of complaints, they did not record any claims data in relation to the number of claims. Therefore we have been unable to draw any conclusions about the number of negligence claims for each Healthcare Profession and the final cost of these claims.

Size and frequency of negligence claims – NHS Litigation Authority

The NHS Litigation Authority (NHS LA) is responsible for managing all negligence claims made against NHS bodies in England. As such, most negligence events which occur in an NHS environment in England are automatically covered by the NHSLA and so do not contribute to the scope of un-met claims which is the focus of this review. However, the claims statistics from the NHSLA can provide useful insights into the propensity for claims to occur from certain specialties. This can provide a useful indicator of the riskiness of various professional activities. This coupled with an awareness of the extent to which these activities occur outside of an NHS managed environment, can help indicate those groups of Healthcare Professionals at highest risk of resulting in un-met claims.

The NHSLA only captures claim data by the specialty under which care was being delivered at the time of the negligence event. This reflects the fact that often several professionals from different disciplines will be working together to deliver this care. As such, the graph to the right provides a summary of the profile of the number of claims received by specialty which were dealt with by the NHSLA since 1995 to 2009.

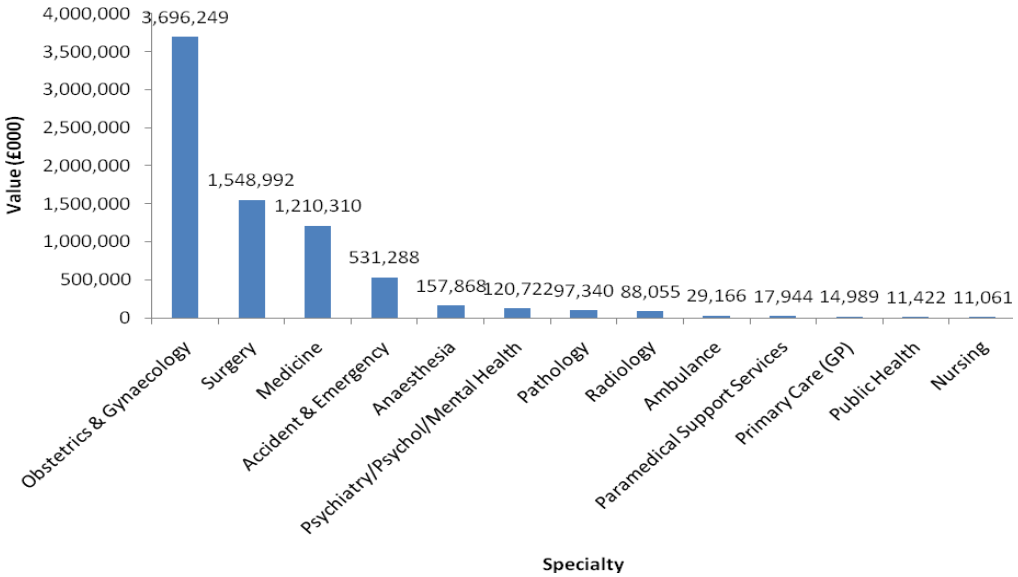
Total number of reported CNST claims by specialty as at 31 March 2009 (since the scheme began in April 1995, excluding "below excess" claims handled by trusts)



Source: NHS LA NHS Indemnity Arrangements for Clinical Negligence Claims in the NHS, The NHS Litigation Authority, Factsheet 3: information on claims

Size and frequency of negligence claims – NHS Litigation Authority

Total value of reported CNST claims by specialty as at 31/03/09 (since the scheme began in April 1995, excluding "below excess" claims handled by trusts)



Source: NHS LA NHS Indemnity Arrangements for Clinical Negligence Claims in the NHS, The NHS Litigation Authority, Factsheet 3: information on claims

This graph provides an indication of the absolute amounts of compensation paid out by the NHSLA for each specialty. This clearly shows the higher amounts paid out by Obstetrics and Gynaecology compared to other specialties. This is a reflection of the significantly higher claim payments for this specialty at approximately £3.6 million compared to a range of payouts of £11K to £1.5million for all other specialisms.

The lack of claims data by Healthcare Professions limit the ability to draw conclusions regarding the relative claim frequency and severity for Healthcare Professionals in an NHS environment. However, these graphs do provide a confirmation of the types of activities which can lead to the largest frequency and severity of claims.

In addition to the NHSLA, we held discussions with other providers of healthcare indemnity or insurance in the UK. As these organisations provide protection to individuals, they record claims data by profession. However, due to the commercially sensitive nature of this information, we were not able to obtain this data to use as a basis for our analysis.

Size and frequency of negligence claims – Wales, Scotland and Northern Ireland

Similar to the NHSLA, the Welsh Risk Pool (WRP) also collects claims data by speciality. The table (right) shows the split of the number of claims and value of claims by specialty.

Although year-on-year fluctuations in a particular speciality may simply reflect the timing of ongoing claims, obstetric claims remain the single largest speciality in terms of claims value, reflecting high costs associated with providing long-term care and support. This is echoed in the NHSLA claims data (albeit over a longer time frame).

Within Obstetrics, the main issue remains the failure to recognise and act upon fetal distress resulting in cerebral palsy and/or brain damage (WRP).

Specialties including Accident and Emergency, Orthopaedics and General Surgery are consistently within the highest level of reimbursements and numbers of claims.

Although there is very little commonality between the claims themselves common themes include (WRP):

- Failure to act upon test results
- Failure to follow up (e.g. appointment not issued)
- Failures in the induction and supervision of new staff
- Failure to supervise junior members of staff
- Failures in the record keeping
- Failures in communication

The Clinical Negligence and Other Risks Scheme (CNORIS), the Scottish equivalent of the NHSLA and WRP, does not publish claims information at the same level of granularity. There is no current equivalent risk pooling scheme in Northern Ireland.

Value and number of reimbursements by speciality (WRP)

Specialty	2008/2009 £000	Number	2007/2008 £000	Number	2006/2007 £'000	Number
Obstetrics	5,609	28	28,440	34	20,172	33
Trauma and Orthopaedics	3,853	28	2,589	26	2,447	22
General Surgery	1,868	18	1,394	17	2,076	27
Accident and Emergency	1,529	12	1,880	19	1522	21
Ambulance	863	2	349	3	55	1
Mental Health	861	6	670	6	142	3
General Medicine	730	14	880	12	839	7
Neurology	622	4	507	3	230	4
Anaesthetics	438	3	260	2	68	11
Cardiology	360	1	65	2	246	4
Pathology	287	4	1,418	7	750	7
Gynaecological	273	7	204	2	290	2
Ear Nose and Throat (ENT)	220	1	87	3	474	5
Radiology	197	3	71	1	0	0
Gastroenterology	153	3	763	9	0	0
Paediatrics	152	2	3,343	8	8,328	7
Ophthalmology	98	2	231	8	149	5
Urology	95	2	6	1	9	1
Other	24	3	2	1	145	12
Grand Total	18,232	143	43,159	164	94,237	172

Source: Welsh Risk Pool annual report 2008/09

Size and frequency of negligence claims – continued

As described, NHSLA and WRP schemes extend to negligence within the “NHS directly employed or engaged” category of Healthcare Professionals only. These are categorised by speciality rather than by registered Healthcare Profession.

This reinforces the view of these organisations’ regarding the nature of healthcare and claims relating to it, including that failure is often multi-factorial rather than resulting from negligence of a particular individual.

Furthermore, membership of these schemes is of the organisation providing healthcare, rather than the Healthcare Professionals employed or engaged within them.

Non- NHS

Because of the commercially sensitive nature of claims data, provider organisations were not in a position to share regarding negligence outside of the NHS; this has been a constraint in terms of this report exploring the extent of claims against Healthcare Professionals outside NHS environments.

However, some information on risk stratification was provided, for example one provider has supplied their risk bandings; in hospital practice, physicians working in obstetrics are given the highest risk, and those in ENT the lowest.

Some risk stratification is implied in the differences in membership premiums for different specialities which may indicate comparative risk.

The HPC also indicated that certain members of their register may carry higher risk profiles than others i.e. operating department practitioners (ODP's), paramedics and prosthetists.

Size of the issue – Key conclusions

There are 1.4 million registered Healthcare Professionals regulated by nine regulatory bodies.

Based on data provided by the ONS as at June 2009, on average there is a relatively even split, between individuals that work in the public sector and those that work in the private sector for the key health professions we have examined. However, for professions such as dentists and therapists, a high proportion of individuals work within the private sector (i.e. are not employed directly by the NHS). Conversely, for professions such as midwifery and paramedics, there is only a small proportion of individuals who work within the private sector.

Claims within the NHS are covered by various clinical negligence risk pooling schemes. Whilst data is captured on all claim activity it is only held by speciality and not by profession. NHSLA data confirms that claims from obstetrics and gynaecology have the highest average cost. However, claims from surgery have the highest frequency, although no meaningful split of the professionals involved is captured.

The number of Fitness to Practise complaints relative to the number of registered Healthcare Professionals for each regulated body is small. For different regulatory bodies the proportion of complaints against registrants varies between 0% and 3%, based on the data we have received.

We were not able to infer from the number of complaints, the number of claims for negligence or the size of any subsequent award.

Claim frequency and severity data could not be extrapolated from an NHS environment to independent/private sector environment. This was due to NHS claims data not being captured by profession and no available robust data on the proportion of professional activity which occurs inside and outside of a NHS environment. We understand that some private sector organisations may capture some of this information, but due to commercial sensitivity could not disclose this to us. In addition, we explored potential alternative sources of information (e.g. court data). However, there are no centralised readily accessible information sources on the frequency and severity of medical negligence claims through the court system. A policy which is being currently explored and could address some of the risks and deficiencies of the current system is to link insurance/indemnity cover to the individual's registration with a regulatory body.

Relative risk indication

Category of Healthcare professional	Number of registrants	Estimated proportion who work outside the NHS**
Registered with GMC	231,291	
Registered with GDC	92,976	
Registered with NMC	665,704	
Registered with GOC	23,319	
Registered with GOsC	4,187	
Registered with GCC	2,489	
(Previously) Registered with RPSGB	58,220	
Registered with PSNI	2,200	
Arts therapist	2,768	
Biomedical scientists	21,786	
Chiropodist/podiatrist	12,876	
Clinical scientist	4,394	
Dietician	7,137	
Occupational Therapist	30,127	
Operating Department Practitioner	10,048	
Orthoptists	1,263	
Paramedic	15,589	
Physiotherapist	44,734	
Practitioner psychologists	15,244	
Prosthetist / orthotist	865	
Radiographer	26,319	
Speech and language therapists	12,298	

** * ONS 4 quarter average July 2008 – June 2009 and from interviews with regulatory bodies, where available.*

Table key

Rating	Proportion working outside of NHS
	0 – 10%
	10 – 75%
	75 – 100%

This table provides an indication of the relative risk of unmet negligence claims based on the estimated proportion of professionals who are generally considered to work outside the NHS. This includes categories 2, 3 and 4 of our classification:

•Those who work in “NHS branded” care environments like Primary care (e.g. GPs)

•Those who work in the independent/private sector but are employed; and

•Those who work in the independent/private sector but are self-employed.

When relating this to the potential for claims account should be taken of the extent of indemnity cover pertaining to each of these groups. Interviewees reported that, for example, registered medical professionals are likely to have adequate indemnity cover to compensate for negligence or for other support offered. In addition, within these groups, there may be high risk subgroups who either undertake particularly risky activities, or who work to a greater extent than their peers outside of an NHS environment.

The greater the risk of negligence claims, the greater the need to establish a link between registration and the requirement to have insurance/indemnity cover . A focus on establishing a link for higher risk groups will lead to a more proportionate and cost effective means to achieving the Government’s established policy.

Section 5

Linking insurance cover with registration

An overview of the registration process for each regulatory body

The costs and barriers to establishing a link between registration and the requirement to have insurance/indemnity cover will be dependent on the nature and application of this link and the existing processes. Effective implementation of the link, leveraging existing infrastructure, will be key to ensuring a cost effective means to achieving the Government's established policy,

Through our discussions with a number of the regulatory bodies, we have been able to gain an insight to the different types of registration process currently employed. This information about the registration processes can help to identify any future potential costs that may be associated with linking the verification of insurance or indemnity coverage to registration.

This section summarises the key points raised by the regulatory bodies from these discussions.

For most bodies, the process of initial registration is a paper based process, reflecting the need to gather key documents as evidence of qualifications or fitness to practise. Approximately half of the bodies we spoke to also had some form of online service to capture the information from registrants.

The majority of regulatory bodies have an annual registration process, with some notable exceptions running a bi or tri annual process for different elements of their membership (e.g. annual maintenance of registration; renewal every 3 years). The nature of this process varies considerably. At one end of the spectrum there is the basic need to pay a renewal subscription, which is often done through direct debit. In these instances, written confirmation of the renewal fee is sent to each registrant and the amount collected. However, there is no requirement for the registrant to acknowledge or respond to this apart from ensuring payment is made.

However, some regulatory bodies have a more detailed process, whereby some form of acknowledgement is required, either paper based or online, to confirm the desire to renew cover and reconfirm some basic details about the scope of practice of the registrant. In addition, Continuing Education and Training (CET) and Continuing Professional Development (CPD) returns are also gathered, either as part of or as a related process, which provides a further existing link between registrants and the regulatory body.

For those regulatory bodies without an online registration process, the majority of them are considering the benefits that an online system may have to their processes.

We understand that most regulatory bodies, including those who currently have an online registration process, feel that it is appropriate to maintain some paper based registration processes. In particular, for first time registration, it has been a common theme raised that the registration process should be paper based to ensure the correct identification of an individual and verification of their qualifications.

In addition, several regulatory bodies have also highlighted the importance of the use of a paper based registration process for those registrants whose membership has previously lapsed. We understand that in these cases identification of the registrant is particularly important.

An overview of the registration process for each regulatory body

Summary of key features of the registration processes for each of the regulatory bodies interviewed:

Regulatory Body	Renewal Process	Paper Based Renewal	Online Renewal	Comment
General Chiropractic Council (GCC)	Annual	✓	X	
General Dental Council (GDC)	Annual	✓	X	Renewal is automatic on payment of renewal fee
General Medical Council (GMC)	Annual	✓	X	Renewal is automatic on payment of renewal fee
General Optical Council (GOC)	Annual	✓	X	Plans to move online
General Osteopathic Council (GOsC)	Annual	✓	X	
Health Professions Council (HPC)	Every 2 years	✓	✓	Online pilot currently being trialled
Nursing and Midwifery Council (NMC)	Annual maintenance of registration; renewal every 3 years	✓	X	Annual maintenance on payment of registration fee; full renewal every 3 years provided satisfactory evidence of CPD and practice requirements in previous 3 years.
Pharmaceutical Society of Northern Ireland (PSNI)	Annual	✓	X	
Royal Pharmaceutical Society of Great Britain (RPSGB)	Annual	✓	X	Anticipated that GPhC will be more web-based - but some like overseas qualified applicants will be required to attend with original documents

Source: Regulator meetings

Current links of registration to requirement for indemnity and insurance cover

Most regulatory bodies have a requirement for registered professionals to be 'fit to practise', which may include an explicit requirement to have adequate and appropriate indemnity and/or insurance cover to protect the public. Currently the responsibility for acquiring this cover lies with the individual professional for all professional groups.

Through our discussions with regulatory bodies and Healthcare Professionals, we have explored the nature of this link. Understanding of the current requirements allows consideration of the potential additional resource implications for regulatory bodies (and individuals) of establishing or strengthening the link between registration and insurance/indemnity.

Regulatory Body	Current links between registration and indemnity/insurance cover
General Chiropractic Council (GCC)	Insurance/indemnity is compulsory for all registrants. Detailed provider information is collected by the regulator. Professional indemnity insurance cover of at least £3million is compulsory for all registrants while practising. The insurance must provide perpetual cover in relation to things done (or negligently omitted to be done) after the policy is first in place. Further detail is provided in the Statutory Instrument 1999 No. 3071 The General Chiropractic Council (Professional Indemnity Insurance) Rules Order 1999 (GCC meeting). Insurers include: H & L Balen, WR Berkley and Royal & Sun Alliance (GCC).
General Dental Council (GDC)	GDC does not collect any information on insurance cover. Currently it is an ethical requirement that registrants have insurance/indemnity cover but this is not compulsory. At the moment, insurance/indemnity providers ask for proof of registration before individuals can get cover. The GDC would consider checking directly with insurance/indemnity providers if registrants are covered by them, although there may be practical and consent implications of this, even were it to be backed by statute (GDC)
General Medical Council (GMC)	GMC does not collect any information on insurance cover. Insurance/indemnity providers that are referenced on the GMC website are the MPS, MDDUS and MDU.(GMC)
General Optical Council (GOC)	Insurance/indemnity is compulsory for all optometrists and dispensing opticians. The GOC collates details on the provider, the policy type and number. Insurance/indemnity coverage for Optometrists and Dispensing Opticians is provided through different organisations including: Association of Optometrists (9,036), Association of British Dispensing Opticians (3,351), Federation Of Ophthalmic and Dispensing Opticians (1,875), D&A (343), Boots (191) and Specsavers (2,044), 80-85% optometrists on the register are insured by the Association of Optometrists (main professional organisation and trade union). It is a requirement under clause 18 of the GOC Code of Conduct for Individual Registrants to " be covered by adequate and appropriate insurance for practice in the United Kingdom throughout the period of your registration" (GOC)

Source: Regulator websites and meetings

Current links of registration to requirement for indemnity and insurance cover

Regulatory Body	Current links between registration and indemnity/insurance cover
General Osteopathic Council (GOsC)	Registrants need to obtain professional indemnity/insurance that meets the Professional Indemnity Insurance Rules, with a minimum cover of £2.5 million. (GOsC) (http://www.osteopathy.org.uk/practice/how-to-register-uk/)
Health Professions Council (HPC)	HPC does not collect any information on insurance cover. Further, they do not endorse any indemnity/insurance providers, and are unlikely to do so in the future even if the requirement becomes mandatory. As part of its "grand-parent" application process, registrants are required to demonstrate proof of practice including declaration of adequate professional insurance/indemnity cover. (HPC)
Nursing and Midwifery Council (NMC)	NMC does not collect any information on insurance cover. In 2002 a public consultation took place which considered linking registration with professional insurance or indemnity cover. In the interests of safety for all sections of the public who benefit from nursing or midwifery care the resulting policy was not to make this a requirement of registration. A review of the current NMC position is being scoped and will take place late in 2010. (NMC)
Pharmaceutical Society of Northern Ireland (PSNI)	The PSNI asks that each new or retained registrant self certify that they have insurance/indemnity cover provided by (1) the registrant themselves, or (2) an employer – It is a professional requirement in the PSNI's code of ethics that all professional activities are indemnified. (PSNI)
Royal Pharmaceutical Society of Great Britain (RPSGB)	There is currently no confirmation of existence of insurance or indemnity coverage as part of the registration process with the Royal Pharmaceutical Society of GB. Although Article 38 of P&PTO provided that registrants on the practising register must have 'adequate and appropriate indemnity arrangements' rules have not yet been made about what is an adequate and appropriate indemnity arrangement. Additionally the requirement for registrants to have appropriate professional indemnity arrangements is covered in Principle 7.7 of the Code of Ethics for Pharmacists and Pharmacy technicians and also in Professional Standards and Guidance documents which support the Code of Ethics - see Paragraph 9 of Professional Standards for Pharmacists and Pharmacy Technicians in positions of authority (http://www.rpsgb.org/pdfs/coepsposauth.pdf). At registration and renewal of registration all registrants must declare that they have in place 'appropriate indemnity arrangements'. As regulation will transfer to the GPhC at some stage during 2010(parliamentary timetable permitting) it will be up to the GPhC to take this forward in accordance with Article 32 of the PO 2010 (RPSGB)

Source: Regulator websites and meetings

Estimation of the cost to link insurance with registration – first order costs

Each regulatory body has provided us with information about their current registration process and whether it captures the insurance or indemnity coverage that is held by each of their registrants. Where a regulatory body does not obtain this information, we have asked it to provide an estimate to the cost of updating its registration process to capture this information.

We asked organisations to consider the costs of only requiring registrants to confirm the existence of coverage at the point of registration (a basic 'tick box' exercise) where this link did not already exist.

Currently the GDC and GMC do not have an online renewals process and there is no requirement for registrants to submit anything to the regulator at renewal. As such, the costs of requesting confirmation of coverage would require the creation of a new communication mechanism (either online or paper based) to gather this information.

Renewals for most registrants with the NMC would also be along the same lines as the GDC and GMC, but the costs are larger due to the larger registrant population covered by the NMC.

The HPC do have an online renewal process and so can request confirmation of cover with relatively little cost in updating the online renewal form.

Regulatory body	Existing link to insurance?	Estimated cost of link to registration
General Chiropractic Council (GCC)	✓	n/a
General Dental Council (GDC)	X	Currently looking into costs and in discussions with providers to perform automatic validation
General Medical Council (GMC)	X	£370k to collect and collate information with no verification. Additional ongoing costs will be required
General Optical Council (GOC)	✓	n/a
General Osteopathic Council (GOsC)	✓	n/a
Health Professions Council (HPC)	X	£40K for updating registration/online renewal system to support registrants self-declarations (one off cost). Analysis or verification may be linked to ongoing CPD audits reducing ongoing expenditure
Nursing and Midwifery Council (NMC)	X	£100k - £500k for tick box exercise for 3 yearly renewals reflecting the development and implementation of this registration process only
Pharmaceutical Society of Northern Ireland (PSNI)	✓ self certification only	n/a if self certification adequate – additional specialist resource would be required to test appropriateness or adequacy at renewal estimated at £30K or £15 per registrant (additional 4% on annual fee). Further cost would be incurred if it were necessary to update information during a registration year
Royal Pharmaceutical Society of Great Britain (RPSGB)	X	This has not been posted

Source: Regulator meetings

Linking insurance/indemnity with professional registration

Our research has given insight into how the various organisations, regulators and providers, consider a link between registration and insurance/indemnity cover.

Awareness, recognition of the issue and activity to find solutions

For a few of the regulatory bodies (e.g. GOC, GCC), it is already mandatory that Healthcare Professionals are covered by insurance/indemnity before they can register.

Other regulatory bodies acknowledge the importance of insurance/indemnity cover of their registrants, and are considering systems to ensure this.

These are at various stages of development. For example, the GDC has commissioned work to investigate the costs of capturing insurance details.

For HPC, under the "grand parenting" rules for newly regulated professions, a registrant is required to declare the nature and adequateness of indemnity and insurance cover in order to be deemed 'fit to practise'.

Data sharing between insurance providers and regulatory bodies

Regulators indicated that the scope and implementation of a link between registration and indemnity/insurance may depend on data sharing between the providers of indemnity/insurance and the regulatory bodies.

Providers questioned generally expressed a willingness to share data on a voluntary basis, subject to consent.

Tracking scope of work changes

The regulatory bodies generally consider their registers to be historical records. This has its limitations. For example, at a particular point in time, an individual may be shown as 'active' on a register but it doesn't mean that they are actually practising; the data is not necessarily reflecting current practice.

Information captured at registration/renewal, at a point in time, may not ensure adequacy or appropriateness of cover, particularly for subsequent change in circumstances or practise of the Healthcare Professional.

The organisations interviewed stressed the desirability of a "real time" solution to this practical problem, to more accurately reflect current practice which could potentially be applied to adequacy of insurance/indemnity cover for current practice.

Responsibility to inform the regulatory body and insurance/indemnity provider of relevant changes in practice currently universally rests with the individual Healthcare Professional.

Willingness of registrants to disclose insurance and indemnity information

Most organisations interviewed stressed that a very high proportion of their registrants and members already have cover and are likely to be willing to disclose information on insurance and indemnity coverage. However, individual consent will be required for any disclosure.

"…The challenge is that even if you confirm insurance coverage, this is only as good as the date that data has been inputted. It is not an issue of whether [Health Professionals] have insurance, but how you regulate it i.e. what about lapses in insurance renewal."

"…[checking insurance/indemnity coverage] could be incorporated into CPD requirements"

"…but how would CPD appraisers evaluate this at other than a high level? would they be liable?…"

(Regulatory bodies)

Further considerations around the link to registration

In addition to the basic need to confirm the existence of coverage, several of the regulatory bodies highlighted a range of concerns and wider considerations around this process. Much of this stemmed from the fact that almost all of these organisations had been considering the requirement to confirm the existence of coverage prior to this review and so had some thoughts and concerns relating to this. Our key observations are:

- **Verification.** Where a regulatory body does ask for confirmation of the existence of coverage, this information is not often independently verified by the body. As such, any requirement to seek confirmation of coverage would need to also consider the costs of verifying this coverage did exist, albeit for a sampled subset of the population.
- **Cost.** Many regulatory bodies considered the cost of analysing and verifying any information obtain from such an exercise to be likely to outweigh the cost of obtaining the information.
- **Changes in practice.** There was considerable concern as to how changes in scope of practice of registrants may be monitored and how the appropriateness of coverage confirmed at registration may become invalidated between renewals, although there was recognition that the onus regarding maintaining appropriate coverage for ones activities remained with the registrant at all times. As such, a 'spot check' on this coverage at the point of registration was considered an appropriate balance.
- **Adequacy.** Each regulatory body may need to form an opinion as to whether it believes the level of insurance or indemnity cover is adequate and appropriate. This was one area which most regulators were most uncomfortable with as they did not feel they had the right skills and experience to make this determination. In addition, concerns were also raised about the risks which the regulator may be exposed to if subsequently, coverage was not deemed to be appropriate or adequate.

Further considerations around the link to registration

Enforcing the requirement to confirm insurance coverage as part of the renewal or registration process assumes that registrants are able to obtain coverage or evidence of coverage. For the vast majority of professionals, coverage is available, either through a range of commercial providers, or through coverage provided by the registrants employer (both within the NHS and in a private care setting).

However, there are some groups of registrants for whom no commercial coverage is currently available in the market. The most significant of these are independent midwives operating outside of the NHS. From our discussions with representatives from the insurance and broking industry, our understanding of some of the reasons for the lack of commercial coverage include:

• **Viability.** Too small a number of members to make insurance a viable option – insurance works on the basis of pooling risks across a large group of policy holders, such that the average expected cost of claims for each policy holder is a reasonable and affordable amount. The numbers of independent midwives are too small to allow effectively pooling of risk and reduce average costs (and therefore premiums) to an affordable level.

• **Quantification of risk.** The nature of the work performed by independent midwives, for example, is such that there is considered to be a relatively small probability of an event which may lead to a claim, but that the average size of each claim is expected to be significant. As such, the quantification of the total expected cost of claims for all independent midwives is highly uncertain, resulting in insurance providers requiring additional premiums accept this uncertainty of outcome. Again, this would increase premiums beyond affordable levels.

Given the above, it is important to recognise that simply creating a link between the confirmation of coverage and the registration or renewal process would not provide a viable option for all groups of registered Healthcare Professionals.

In conclusion there are four groups into which Healthcare Professionals in the UK may be broadly divided:

1) Those who are employed or engaged by an NHS hospital/acute trust;
2) Those who work in NHS “branded” care environments, such as primary care;
3) Those who work in the independent/private sector but are employed; and
4) Those who work in the independent/private sector but are self-employed.

The likelihood of non-existent or inadequate insurance/indemnity coverage is greatest with group 4, of which independent midwives are an example.

Alternative solutions should be sought for these groups. We are aware of attempts being made by the British Insurance Brokers Association to create and facilitate such a solution.

Keeping the cost of linkage to a minimum

Several regulatory bodies have considered how the link between coverage and the registration process may be created in an efficient manner. Key to keeping costs down, is the need to leverage off the back of existing communications between registrants and the regulator. Key observations from our discussions with regulatory bodies include:

- **An online platform.** Most regulators are considering moving to an online platform where one is not used currently. Whilst the costs of creating this platform may be significant, the incremental cost of requesting confirmation of cover as part of this process may be marginal.
- **Using other existing communication mechanisms (e.g. revalidation).** For several regulatory bodies, there is no or limited dialogue between registrants and the regulator at renewal. Often the payment of fee's by direct debit means no formal response is required from registrants at renewal. The confirmation of coverage would require some form of response from registrants. To the extent that other mechanisms exist to gather information from registrants on a periodic basis (e.g. confirmation of CPD completion for members of the GDC, the imminent revalidation process for doctors registered with the GMC), this mechanism could be used to seek confirmation of coverage at minimal marginal cost.
- **Direct verification.** Costs, however, of verifying coverage would be much greater than currently and still incurred regardless of the route to seek confirmation. Some regulators currently do verify coverage with the main providers of indemnity cover. Others are currently in discussions with the main providers to develop some form of automatic verification of coverage. Whilst this may provide further comfort that the registrant has cover in place, there still remain uncertainties regarding the appropriateness and adequacy of cover.
- **Targeting.** In addition, it was recognised that those registrants who solely work in a managed NHS environment or are directly employed by an NHS body, will not require independent insurance cover as their activities under this employment will be covered by the NHSLA. As such, any confirmation and verification process should seek to identify and exclude these individuals.

Section 6

Wider considerations

“Appropriate” and “adequate” cover?

A theme across a number of regulators that were interviewed in this review is a lack of common understanding of ‘appropriate’ and ‘adequate’. This was highlighted as a particularly challenging area and a key gap. Many regulators welcomed the opportunity to discuss and define their responsibilities in this regard.

Most regulators have started exploring a potential requirement for universal indemnity/insurance cover of registrants as part of the registration (and/or revalidation) process.

One regulatory body raised the question of how 'adequate and appropriate cover‘ could be ensured, particularly with limited regulator resource and/or capabilities to track any changes in scope of practice.

Further concern was raised by the participants in this review regarding the liability or responsibility of the regulatory bodies, or those involved in the renewal/revalidation processes, should they be obliged to confirm the existence of adequate and/or appropriate indemnity/insurance cover.

Currently, responsibility to be insured/indemnified rests with the individual practitioner. The organisations which participated in this review generally felt that there should not be any shift from individual professional responsibility to ensure cover.

Is existence of coverage enough?

A Healthcare Professional not having indemnity or insurance coverage at all may be more significant than them having inadequate or inappropriate cover.

By implementing a system which requires confirmation of the existence of coverage, it may be possible to substantially achieve the aim of the Government’s policy, whilst also addressing some of the concerns noted above regarding definitions around adequacy and appropriateness of cover. To enhance the effectiveness of this process, further confirmation from the individual that their scope of practice is within the coverage of their insurance / indemnity.

Healthcare Professionals from abroad

A further point highlighted by several registration bodies related to the need to register Healthcare Professionals who wish to work in the UK, having qualified, or who predominantly work, in other EU countries. Often these professionals will have the necessary qualifications but may have insurance or indemnity coverage from a provider in their home country.

Regulators raised concerns regarding the appropriateness or adequacy of this coverage on several grounds:

- Will the financial limits and scope of coverage be suitable to activities which are typically performed in the UK? There was an expectation that coverage by UK providers would be expected to cover those core activities commonly performed by the profession in the UK. However, differences in custom and practice between countries may lead to foreign cover proving to be inadequate in the UK.
- In addition, the mechanisms and typical level of compensatory awards may vary between countries. As such, to the extent that UK awards are typically higher than awards in the professionals home country, the financial limits of coverage may prove to be inadequate.
- It was also felt that there may be issues with regard to the assessment of adequacy and appropriateness of coverage, especially if the translation and interpretation of overseas insurance documents was required.

This is particularly an issue with those who work in the UK outside a managed NHS environment, where schemes such as the NHSLA do not operate. Professionals involved include out-of-hours GP's or temporary independent midwives.

Additional options for universal coverage of insurance for Healthcare Professionals

Some additional options to individual universal coverage for Healthcare Professionals were suggested by interviewees. These are:

Organisational cover

A few organisations suggested that insurance/indemnity could be linked to healthcare provider organisations rather than individuals; this will enable costs to be kept to a minimum and will potentially allow for a wider and more appropriate coverage.

This is consistent with the practice and spirit of current NHSLA schemes, and cover could be linked with the registration of the healthcare organisation with the Care Quality Commission.

However, practitioners who provide care outside of an organisation (e.g. sole practitioners delivering care at home) may not fit this model.

State subsidisation

Subsidisation by the State to allow for universal coverage without additional burden to individual registrants or to the public, was suggested as a solution.

This may operate with the State providing a basic level of cover up to a cap for all registered Healthcare Professionals with the need for some professionals who provide higher risk services to purchase top-up cover independently.

Alternatively, the State could provide top-up cover in circumstances where full cover is not otherwise available to certain groups of Healthcare Professionals. As such, individuals would need to obtain a basic level of cover which would be more affordable when coupled with a State funded top-up cover.

It was felt that the commercial insurance market was more inclined to support the second of these proposals.

Pooled online system

A pooled, online system for capturing information on insurance coverage of professionals that is shared between regulators and providers has been suggested. An electronic pooled process would rationalise costs and would make it easier to check, and to monitor practice changes, if applicable. Currently, the HPC model may be considered as a basis for this to help reduce initial costs for other regulators.

DVLA model

Of considerable interest with interviewees was a possible model that would reinforce the responsibility of the individual Healthcare Professional by the making of a declaration of continuing cover, similar to DVLA schemes. Several aspects of the process employed by the DVLA to seek confirmation of insurance at the point of road tax renewal were highlighted including:

- the ability to automatically validate coverage if providers were able to pool or make available coverage information to regulators (subject to seeking consent from registrants);
- the need for penalties for false declarations, including the threat of being struck off the register.

However, it was recognised that there would need to be some standardisation of the nature of professional activities which a registrant declared at registration or renewal. This would allow these to be mapped to levels of insurance coverage and allow automatic confirmation of the appropriateness of coverage for these activities.

Section 7

Appendices

Size of registers

Regulatory Body	No. of Registrants	Workforce split: NHS/non NHS
General Chiropractic Council (GCC)	• 2,489 (GCC annual report, Dec 2008)	All chiropractors work in private practice. Some of them treat patients that are referred and funded by the NHS i.e. Chiropractors who are contracted to the NHS (The GCC do not have statistics on the numbers of these). (GCC)
General Dental Council (GDC)	• 36,360 Dentists • 56,616 Dental Care Professionals Total of 92,976 on the register (GDC, 24 March 2010)	The GDC believes that there are approximately 7000-8000 NHS/Mixed dental practices and 300-400 that are private only. Most practices treat both NHS and private patients. (GDC)
General Medical Council (GMC)	• 58,304 GPs • 172,987 non-GP Medical Practitioners Total of 231,291 registered practitioners (GMC, May 2010)	Of the 231,291 registered medical practitioners; 12,507 doctors have registration status only and are not licensed to practice, 218,784 have a licence to practice and can treat patients. There are approx. 58,304 GPs registered (56,776 licensed) and 65,184 specialists registered (mainly NHS Consultants; 62,223 licensed). The specialist register currently has 57 specialties, (expanded beyond traditional UK categories to allow for EU countries which may have various combinations of the specialties). Of the 218,784 registrants that are licensed to practice, 178,681 work in clinical practice in the NHS (with or without some private work), and 6,604 work privately exclusively (GMC)

Source: Regulator websites and meetings

Size of registers – continued

Regulatory Body	No. of Registrants	Workforce split: NHS/non NHS
General Optical Council (GOC)	•23,319 Registrants (11 Aug 2009, customised GOC annual report 2008/09). Approximate breakdown: Optometrists (12500); Dispensing opticians (5500); Registered students (4500); and Body corporates (1500) (GOC)	Approximately 5% of optometrists work in the NHS (GOC)
General Osteopathic Council (GOsC)	•4,187 (GOsC annual report, Aug 2009)	Approximately 95% of Osteopaths are self employed and 5% work in the NHS. (GOsC)
Nursing and Midwifery Council (NMC)	Registration data as of 01/05/2010 : Nursing only: 596,221 Midwifery only: 26,236 Nursing + Midwifery: 12,498 Nursing + Scphn 25,073 Midwifery + Scphn 212 Nursing + Mid+ Scphn 646	There is no NMC information available on splits of the workforce by sector (NHS/private). The NMC has obtained the following statistics from the Local Supervising Authorities(LSAs) to whom all registered midwives send their annual 'Notification of Intention to Practise' forms issued by the NMC regarding the number of Independent Midwives in the UK: (290 independent midwives (275 notified in England, 12 in Scotland, 1 in Wales and N Ireland) notified their intention to practise for 2008-2009.) *Source: Regulator websites and meetings*

Size of registers – continued

Regulatory Body	No. of Registrants	Workforce split: NHS/non NHS
Pharmaceutical Society of Northern Ireland (PSNI)	• Approximately 2,200 pharmacists (PSNI) and 530 premises	For outside the NHS environment, this is reliant on annual returns and situations may change during a registration year – broadly the PSNI can group them into three categories – Primary, Secondary Care and Other (PSNI) roughly 18% are in secondary care (NHS) at any time
Royal Pharmaceutical Society of Great Britain (RPSGB)	• 49,269 Pharmacists (Part 1 Practising:41,860, Part 2 Non-practising: 7,409) • 8,573 Pharmacy Technicians (Part 1 Practising: 8,424, Part 2 Non-practising: 149) (RPSGB, 31 March 2010)	Approximately 71% pharmacists work in the community sector, 21.4% in hospital, 7.2% primary care, 4.1% in industry, 2.8% academia and 3.8% other (http://www.rpsgb.org/pdfs/census08.pdf, 2008)

Source: Regulator websites and meetings

Size of registers – continued

Regulatory Body	Profession	No. of Registrants (HPC, Jan 2010)	Workforce split: NHS/non NHS
Health Professions Council (HPC)*	Speech and language therapist	12,298	ODP's are likely to be working in a managed environment, even if they are "independent" e.g. through an agency. Prosthetists are usually contracted. Paramedics are normally directly employed by NHS Ambulance services / Trusts (HPC)
	Arts therapist	2,768	
	Biomedical scientist	21,786	
	Chiropodist / podiatrist	12,876	
	Clinical scientist	4,394	
	Dietician	7,137	
	Occupational therapist	30,127	
	Operating department practitioner (ODP)	10,048	
	Orthoptist	1,263	
	Paramedic	15,589	
	Physiotherapist	44,734	
	Practitioner psychologists*	15,244	
	Prosthetist / orthotist	865	
	Radiographer	26,319	

Source: Regulator websites and meetings

*From 1 April 2010 the HPC became responsible for the regulation of approximately 1500 hearing aid dispensers

Indemnity and Insurance Cover in England – NHS Litigation Authority

The NHS Litigation Authority (NHSLA) was established on 20 November 1995 to indemnify English NHS bodies against claims for clinical negligence. The NHSLA is a Special Health Authority and, therefore, part of the National Health Service, not an insurance company. (NHSLA)

Initially, their sole function was to administer the Clinical Negligence Scheme for Trusts (CNST), a risk-pooling scheme in respect of clinical claims arising from incidents on or after 1 April 1995. Almost immediately, however, the role increased significantly in order to cover claims arising from incidents occurring before April 1995. This was achieved through the creation of two separate schemes: the Ex-RHAS, a scheme which covers claims against the former Regional Health Authorities and the Existing Liabilities Scheme (ELS) which covers all other clinical negligence claims arising from pre-April 1995 incidents. (NHSLA)

From 1 April 1999, responsibilities were expanded to include non-clinical claims under the Liabilities to Third Parties Scheme (LTPS) and Property Expenses Scheme (PES).

More recently, the Authority has acquired further, more diverse, functions: the provision of an information service to the NHS on the impact of the Human Rights Act 1998 (from January 2003), the functions of the former Special Health Authority, the Family Health Services Appeal Authority (from April 2005), the provision of advice and assistance with litigation on equal pay (from August 2005) and the provision of advice and assistance in relation to age discrimination claims (from April 2009). (NHSLA)

"We manage three main schemes (CNST, ELS & LTPS) to indemnify NHS bodies against clinical and non-clinical negligence claims, together with a fourth scheme (PES) which covers NHS bodies for property losses. All claims under these four schemes (with the exception of some low-value non-clinical claims) are handled internally, whilst DNV (Det Norske Veritas), working closely with and overseen by our internal risk management team is responsible for the risk management aspects. In each of the three main negligence schemes, the NHS body concerned remains the legal defendant in all claims. The Authority is the defendant for claims made under the Ex-RHAS, a scheme dealing with the clinical liabilities of the former Regional Health Authorities."

Source: The NHS Litigation Authority Factsheet 1: background information

Indemnity and Insurance Cover in England – NHS Litigation Authority (continued)

Who is covered

All NHS professionals directly employed and engaged by NHS; NHSLA also covers some Independent Sector Treatment Centres and Waiting List Initiatives contracted by the DH (refer to fact sheet on NHSLA website for further details). Does not provide cover for sub contracted organisations like private laboratory facilities used by NHS for a service. (NHSLA meeting)

It also covers people in certain other categories whenever the NHS body owes a duty of care to the person harmed, including, for example, locums, medical academic staff with honorary contracts, students, those conducting clinical trials, charitable volunteers and people undergoing further professional education, training and examinations. This includes staff working on income generation projects. GPs or dentists who are directly employed by Health Authorities, e.g. as Public Health doctors (including port medical officers and medical inspectors of immigrants at UK air/sea ports), are covered*.

Who is not covered

NHS Indemnity does not apply to medical and dental practitioners working under contracts for services. General Practitioners are responsible for making their own indemnity arrangements, as are other self-employed Healthcare Professionals such as independent midwives. Neither does NHS Indemnity apply to employees of general practices, or to employees of private hospitals (even when treating NHS patients) local education authorities or voluntary agencies*.

Following various discussions with NHS LA we have found that data relating to claims/incident data by 'profession' is not recorded i.e. NHSLA record by specialty rather than by profession.

*"…In 2008/09, the NHSLA received 6,088 claims (including potential claims) under its clinical negligence schemes and 3,743 claims (including potential claims) in respect of its non-clinical schemes. The figures for 2007/08 were 5,470 and 3,380 respectively. The Authority had 17,899 "live" claims as at 31 March 2008, and CNST claims are now settled in an average of 1.56 years, counting from the date of notification to the NHSLA to the date when compensation is agreed or the claimant discontinues their claim…" ***

*Source: *NHS LA NHS Indemnity Arrangements for Clinical Negligence Claims in the NHS, **The NHS Litigation Authority, Factsheet 3: information on claims*

Indemnity and Insurance Cover in England – NHS Litigation Authority (continued)

Type of Cover

NHSLA covers the organisation and not the individual professional (including because environmental factors are important, as are the difficulties of identifying individuals in a multidisciplinary context). Risk, and premiums, are related to the size of the organisation, and other factors including governance.

NHSLA do not record claims information by professional group but by specialty (organisational structure) of the service provided (since maybe multi-factorial failures result in clinical negligence claims).

Claims

The legal defendant is the employing NHS organisation. Non-clinical claims are covered by RPST scheme. The RPST is the Risk Pooling Scheme for Trusts, which is composed of LTPS and PES.

Other comments

NHSLA may expand its schemes to cover private sector healthcare (under provisions of the Health and Social Care Act) for those providing NHS services; these organisations will be eligible for the CNST scheme; this is under consideration and consultation. There is a grey area where services are subcontracted - i.e. they are not directly engaged or employed by the organisation which is a member (this may be clinical e.g. labs/radiology, or operational e.g. cleaning). The determination whether coverage exists here depends on the amount of "control" that the member has over the activity - e.g. do they direct the work, or do they have control over who is employed by the subcontractor; generally cover (and responsibility/governance) is not delegable.

Source: NHSLA

Indemnity and Insurance Cover in Wales – Welsh Risk Pool

The Welsh Risk Pool (WRP) is the body which indemnifies Welsh healthcare organisations against losses.

It performs an essential function for its members in both:

- Managing the claims reimbursement process effectively
- Seeking to support the NHS in Wales in improving risk management and thus enhancing patient safety.

The Welsh Risk Pool (WRP) is a mutual, self-insurance scheme designed to cover member NHS bodies in Wales. The pooling scheme covers both clinical and non-clinical risks such as staff injuries and physical assets.

The Pool has a well established set of Welsh Risk Management Standards with which all members are expected to comply in pursuit of improving safety for patients, visitors and staff.

(Capita Consulting report, see source below)

Source: Welsh Risk Pool - Risk Management Standards and Advice, Capita Consulting, ***Performance Report;*** *A report discussing the performance of Powys (t)LHB in the recent Welsh Risk Pool Audit and the actions required to support compliance*

"The Welsh Risk Pool provides indemnity for all Welsh NHS bodies in respect of claims for negligence (i.e. both clinical negligence and personal injury). The indemnity is subject to a £25k excess in respect of all claims. The indemnity provided covers all activities undertaken by NHS bodies subject to specific exclusions including motor insurance (except ambulances), income generation activities and PFI schemes. As bodies are vicariously liable for the actions of their staff, the indemnity includes the actions of staff deemed to be employees.

"One of the main differences between [the WRP] and the NHSLA is that in Wales there is a separation between the legal management of the claim and the payment of damages and costs. In Wales, the claim is legally managed by Welsh Health Legal Services whilst the payments are made by the body against whom the claim has been made. In turn NHS bodies reclaim amounts over £25k from the WRP. However, reimbursement is only made once the body demonstrates that it has identified the weaknesses giving rise to the claim and put actions in place to reduce the risk of recurrence. This is undertaken on a claim by claim basis."

(WRP)

Indemnity and Insurance Cover in Scotland – CNORIS

CNORIS is a risk transfer and financing scheme for NHS Scotland, which was first established in 1999 by the Scottish Government Health Directorates in partnership with Willis Ltd, the appointed scheme manager. Its primary objective is to provide cost-effective risk pooling and claims management arrangements for Scotland's NHS Boards and Special Health Boards. CNORIS work closely with these organisations and their legal advisors to provide a seamless risk transfer solution.
Scheme's basic objectives

- To provide advice on clinical and non-clinical scheme coverage to all parts of the NHS in Scotland
- To support scheme Members in an advisory capacity in order to reduce their risks
- To indemnify Members against losses which qualify for scheme cover
- To allocate equitable contributions amongst Members to fund their qualifying losses
- To provide Members with scheme financial updates throughout the year to help with end-of-year budgeting
- To help manage risk by providing Members with clinical and non-clinical loss analysis throughout the year

How does the scheme work?

The Scottish Government Health Directorates (SGHD) fund all large losses (i.e. those which breach CNORIS scheme deductibles) during each financial year. At the end of the financial year, CNORIS collect funds from Members to pay back the deficit accrued in-year by SGHD.

In order to share the cost fairly between Members, CNORIS create clinical and non-clinical risk profiles which determine relative risks for each organisation.

The total annual deficit is then shared between Members according to their proportion of the overall risk. In eliminating the need to forecast losses, or to reserve funds within the scheme.

Members contribute to losses only during the period in which they have settled, enabling the service to retain funds for investment in healthcare for the longest possible period.

Who is covered

CNORIS provides a wide range of cover, similar to traditional insurance packages, for each of its Members within NHS Scotland.

These include, amongst others, core Clinical Negligence cover, but also Employers Liability and Public / Product Liability.

Members of Health Professions covered include:

Medical and Dental Practitioners, Nurses and Midwives, Health Visitors, professions allied to medicine, ambulance personnel, hospital pharmacy practitioner, registered ophthalmic, or registered dispensing opticians working in a hospital setting, laboratory staff and relevant technicians.

This includes holders of Honorary contracts on NHS premises by invitation, although the NHS may seek to recover damages if an incident involving an Honorary Contract holder occurs whilst the individual is outwith their agreed terms of reference.

Who is not covered

Negligence arising out of the actions of contracted professionals in primary care, but include General Practitioners when they are in the employment of an NHS Board.

Source: http://www.cnoris.com/

Indemnity and Insurance Cover in Scotland – CNORIS

Further Developments

A No Fault Compensation Review Group was established last year by the Cabinet Secretary for Health and Wellbeing Chaired to consider the benefits of a no-fault compensation scheme and whether such a scheme should be introduced in Scotland alongside the existing clinical negligence arrangements. The Group, Chaired by Professor Sheila McLean, Director of the Institute of Law and Ethics in Medicine at Glasgow University, is looking at the cost implications; the consequences for healthcare staff; the quality and safety of care; the wider implications for the system of justice and personal injury liability and evidence on how no-fault compensation has operated in other countries. The Group has been asked to report by October 2010 and to make recommendations, including advice on the key principles and design criteria that could be adopted for a no-fault compensation scheme

Source: http://www.cnoris.com/

Indemnity and Insurance Cover in Northern Ireland – HPSS Comparisons between UK Countries

Northern Ireland

Claims made against NHS Healthcare Professionals in Northern Ireland are submitted to the Health and Personal Social Services (HPSS) in Northern Ireland.

The Northern Ireland Audit Office carried out a review of Compensation Payments for Clinical Negligence (July 2002). The report included a review of the incidence and nature of known clinical negligence, based on claims made in the health and personal services.

The report found there were 23,000 outstanding claims in against the NHS in England in March 2000. The equivalent figure for Wales was 1,600 claims and 708 in Northern Ireland in 2000-01. In the context of HPSS activity levels, the number of claims made in Northern Ireland is relatively small and many claims do not lead to a financial settlement.

There is a lack of publically available information on clinical negligence in the HPSS; this was also highlighted by the Northern Ireland Audit Office report.

"During the 10 year period from 1991 to 2001, £55 million was paid in compensation. The annual number of new claims raised has remained relatively static over the six years from 1999-2000, although there was an increase in 2000-01."

Source: Compensation Payments for Clinical Negligence, Northern Ireland Audit Office, July 2002

Comparison of Clinical Negligence provisions at 31st March 2000

	Total Provision £ m
Northern Ireland	100
England	2,600
Wales	111
Scotland*	38

Source: Compensation Payments for Clinical Negligence, Northern Ireland Audit Office, July 2002

*Please note, during a symposium on medical practice and growth of litigation, June 2000, the Royal Society of Edinburgh submitted the view that 'the lower number of claims in the NHS in Scotland as compared to England might be due to a number of factors including the fact that it is more difficult to obtain legal aid for medical negligence claims in Scotland than in England, the fact that medical practices tend to be smaller in Scotland, the fact that there are relatively more General Practitioners per head of population than in England, and the fact that there may be less of a 'claims culture' north of the border".

The MDDUS has also highlighted the trend of a lower number of claims made in Scotland when compared to England.

Provider organisations – Medical Defence Union (MDU)

Membership

The MDU is a mutual membership organisation which provides cover for 50% of UK medical practitioners and 30% dentists and dentist practice teams. It provides cover to medical students, trainee doctors (FT1 - ST6), and other professions (e.g. paramedics through a marketing link with British Assoc of Paramedics). Other professions are provided with cover, as demonstrated in the table (right), but cover is not provided for Midwives in independent practice.

The MDU provides medical members with a policy of insurance that covers them for claims arising from their provision of professional services. This policy is for £10 million. For claims that are not covered by the policy, (which includes claims notified when the member is no longer a member but was in benefit at the time of the incident giving rise to the claim) members can seek assistance on a discretionary basis.

For dental members, the MDU provides a policy of insurance on the same terms as that for medical members. In addition, dental members are provided with a 10-year run off policy which provides cover in the event of a dental member's ceasing to practise because of death, disability or retirement. For claims that are not covered by the policy, (which includes claims notified to the MDU when the member is no longer a member but was in benefit at the time of the incident giving rise to the claim) dental members can also seek assistance on a discretionary basis.

There are also corporate (e.g. for private hospitals to cover RMOs/nurses) and other schemes.

Cover is not based on environment/organisational factors, but there is risk stratification between and within professions with banding of premiums.

Individual members are responsible for keeping the MDU updated with regard to changes in practice.

Healthcare Professional Membership categories provided by the MDU, in addition to medical practitioners

Nurses	Others	Dental Professional Members
Practice nurse	Practice manager	Dental Hygienist/Therapist
Healthcare assistants	Phlebotomist	Clinical Dental Technicians
Employed nurse	Operating department practitioner	Orthodontic Therapist
Health visitor	Perfusionist	Dental Practice Manager
NHS nurse	Physiotherapist	Dental Technician
Nurse practitioner	Paramedic	Dental Nurse
NHS nurse practitioner	Emergency care practitioner	
Scheme nurse (BT, clinical research, family planning)	Radiographer	
Occupational health nurse	Sonographer	
	Physician assistant	

Source: MDU

Claims

MDU record claims information by profession and by specialty/ profession, but claims information could not be shared as it is commercially sensitive.

Provider organisations – Medical Protection Society (MPS)

Membership

The MPS is a mutual medical defence organisation, offering more than 260,000 members help with legal and ethical problems that arise from their professional practice. This includes clinical negligence claims, complaints, medical council inquiries, legal and ethical dilemmas, disciplinary procedures, inquests and fatal accident inquiries.

Membership includes doctors, dentists, practice nurses, dental hygienists, therapists, ODPs, radiographers, physiotherapists.

Type of Coverage

The MPS provides discretionary indemnity and other benefits to its individual members.

Claims

MPS record claims information by profession and by specialty/ profession, but claims information could not be shared as it is commercially sensitive.

Source: MPS

Provider organisations – Medical and Dental Defence Union of Scotland (MDDUS)

Membership

MDDUS (Medical and Dental Defence Union of Scotland) is an independent mutual organisation offering expert medico-legal advice, dento-legal advice and discretionary professional indemnity for doctors, dentists and other Healthcare Professionals throughout the UK.

Professional Category	MDDUS Membership
General Medical and Dental Practitioners and GP Registrars	MDDUS membership is open to all medical and dental general practitioners (GPs and GDPs) and GP Registrars working in the UK (excluding the Channel Islands and the Isle of Man), subject to registration with the General Medical Council (GMC) or General Dental Council (GDC) and acceptance by our Board of Directors.
Doctors in Private Practice	The MDDUS provides UK physicians in private practice access to the full range of benefits including expert medico-legal advice and discretionary indemnity for claims of medical negligence.
Hospital and Community Doctors and Dentists	Membership provides doctors and dentists with access to an independent source of advice for professional concerns not covered under NHS crown indemnity, including GMC/GDC matters. This type of membership is also available to practitioners within the Armed Forces and Prison Service.
Medical and Dental Students	The MDDUS offers free Student Membership to undergraduates studying in medical and dental schools throughout the UK.
New Graduate Membership	MDDUS membership is open to graduates from all UK medical & dental schools. Not only will we provide members with a joining gift but you will also benefit from discounts with a variety of publishers.
Practice Managers	Associate Membership is available to medical practice managers, providing you with access to advice and support if a claim is made against your practice.
Dental Hygienists, Dental Therapists and Orthodontic Therapists	Associate Membership is available to dental hygienists, dental therapists and dental orthodontic therapists, providing discretionary indemnity for clinical work and access to the range of benefits and services enjoyed by all members.
Other Healthcare Professionals	MDDUS provides assistance, advice, representation (including legal representation) and discretionary access to indemnity for the following doctors, dentists and allied professions: Occupational Health Physician, Pharmaceutical Physician, Hospice Doctor, Palliative Care, Ophthalmic GP, Doctors working for Atos Origin, Disability Analysis, Non Clinical, Physician Assistant

Source:http://www.mddus.com/mddus/become-an-mddus-member/who-can-join-mddus.aspx

Provider organisations – MDDUS (continued)

Claims

MDDUS captures data on frequency and severity of claims for all professionals on their membership and can profile claims by every feature i.e. claims made by profession, speciality, where they work.

However, claims information could not be shared as it is commercially sensitive.

Risk Stratification

For GMPs and GDPs, the MDDUS stratifies risk based on whether the member is a partner, or employed practitioners, the number of sessions worked, and geographical location.

For hospital practice, the MDDUS categorises doctors into 9 risk bands; obstetrics being the highest, and ENT in the lowest.

In addition to speciality stratification, the number of sessions worked, geographical location, and amount of non-indemnified income are considered in determining premiums.

Source: MDDUS

Examples of other providers – Union bodies

Unions such as UNISON provide professional indemnity cover for health care workers.

Cover is provided for healthcare employees including nurses, health visitors, midwives (except those working outside the NHS), ambulance workers, professions allied to medicine, administrative and clerical workers, managers and ancillary staff.

Most of these organisations provide cover whether you are working inside or outside (with the exception of midwives) the NHS.

There is usually a limit (£1million in the case of Unison) on any individual claim, and is usually what is called “contingent” or “fall back” cover. Therefore this cover is for the rare occasions where the employer’s cover fails to protect the employee (subject to the exemptions listed below).

Some work practices and professional groups may not be covered by this type of cover. In case of UNISON the exemptions are:

- Midwives working outside the NHS
- Medical practitioners
- Expert witnesses
- Self employed independent practitioners and individuals working on a fee for service basis
- Beauty treatments or medico legal work (other than those employed by the NHS)
- All claims relating to transmission of hepatitis non A (outside the NHS).

The Royal College of Nursing (RCN) and Royal College of Midwives (RCM) are both professional membership organisations that also act as union bodies. Members are covered when undertaking a health and social care service acceptable to the RCN and RCM.

The RCN membership includes the indemnity scheme which gives members upto £3 million of financial protection. The RCN indemnity scheme provide public and medical malpractice liability and Professional indemnity (however, this cover is restricted only to nurse expert witnesses and occupational health nurses)

The RCN cover is available to

• full and joint members of the RCN, irrespective of their employment status • student members

• health care assistant and nurse cadet members

• career break members on a reduced annual fee

• who work no more than 37.5 hours a month or five weeks a year.

Joint RCN/RCM members who are full RCM members are not covered by RCN indemnity scheme. The RCM scheme applies for this group.

The RCM medical malpractice insurance cover all full members (including teachers with joint agreement membership) who are registered appropriately with the NMC. This applies to those employed as a midwife and as a nurse if so qualified, (whether full, part time or occasional) - on the condition that the employer accepts liability for the actions of their employees. As the vast majority of midwives are employed by the NHS, they fulfil this criterion. This will also apply to most other midwives in employment, as employers have a legal responsibility for actions undertaken on their behalf. This includes bank midwives, bank nurses, practice nurses, health visitors and midwifery teachers.

International perspectives on insurance/indemnity in healthcare

Healthcare system	Organisational structure
Bulgaria*	The formalising of implementation of risk management in healthcare is only in its infancy in Bulgaria, a comprehensive structure for overall control of the delivery of healthcare is in place. Four institutions are involved. Procedures for litigation by patients are established in law, with the patient being allowed to approach the Regional Health Insurance Fund, the Regional Healthcare Centre or the Regional College of the Union of Bulgarian physicians (BMDU).
Poland*	Poland is undergoing comprehensive healthcare reforms at present. An entirely new legal and organisational approach is required, involving effective instruments to moderate the increasingly problematic nature of risks, accompanying and intensified by these reforms. Risks directly related to the work of medical doctors and healthcare centres are the main areas of concern. Formal structures for monitoring and introducing risk management in healthcare and schemes to bring about improvements that are both sustainable and capable of quantification remain to be introduced.
Ireland*	The national policy envisaged in the Health Strategy, which considers clinical risk management in a unified manner, has now commenced in the Clinical Indemnity Scheme.
Australia	In 2001, the New South Wales Government's reform package went through a public consultation to combat the rise in professional indemnity insurance premiums including a proposal to introduce compulsory professional indemnity insurance for doctors. Prior to this, doctors in New South Wales were not obliged to hold professional indemnity insurance and there was anecdotal evidence to suggest that some doctors are 'going bare', i.e. practising without medical indemnity insurance. (NSW Parliamentary Library Research Service)
New Zealand	NZMP (New Zealand Medical Professionals) in conjunction with Professional Broker Services and NZRDA (New Zealand Resident Doctors' Association) have developed a binding Professional Liability Insurance programme specifically for RMO's which ensures independent representation. The programme provides a comprehensive service enabling RMO's to have more control over events affecting their medical careers. (http://www.nzmpi.co.nz/Site/RMO_Indemnity/Indemnity_Information.ashx)

*Source: * Risk management in healthcare in four European countries - outcomes of the 2003 MORPH survey*

Background information for the current registration processes

Regulatory Body	Registration process
General Chiropractic Council (GCC)	Registrants to the GCC are solely qualified chiropractors. An individual who wishes to describe himself as a chiropractor of any sort in the UK must be registered with the GCC. There is approximately 2,700 registered Chiropractors with the GCC across the UK and some outside the UK (e.g. Australia). There are three categories of registrants: •Those who hold a qualification recognised by the GCC i.e. those with qualifications from the Anglo-European College of Chiropractic, University of Glamorgan and The McTimoney College of Chiropractic; •Foreign qualified applicants who hold an equivalent qualification and pass a test of competence; and •EU nationals or their spouses who meet the requirements of Directive 2005/36/EC. The current registration process is paper based. At initial registration, a registrant must complete a detailed form of statutory declarations, provide the name of the insurance provider and confirm at least £3m coverage. In addition, they are asked to disclose criminal convictions, ethnicity, registered practice address, sex, DOB, provide an original birth certificate. Renewals occur on an annual basis and the registrant must confirm the existence of insurance coverage and provide the date of expiry of the insurance cover at each renewal. The initial registration fee is £1,250. Annual renewal fee is £1,000. For registrants who wish to maintain non practising status, the annual fee is £100 (i.e. call themselves Chiropractors) and complete mandatory requirements of professional development).
General Dental Council (GDC)	The registration process is currently paper based. Each registrant posts application forms, supporting documents and registration fees to the GDC. Currently Dental Care Professionals (DCPs) renew their registration in July and Dentists renew at the end of December. Similar to the GMC, the GDC renewal of registration process simply requires the payment of the renewal fee. Upon payment (which is also predominantly by direct debit) the registrant receives an updated membership certificate. There is no requirement for the registrant to reconfirm registration details at the point of renewal and as such, there is no communication from the registrant to the regulator at this point. *Source: Regulator websites and meetings* In addition, the GDC does require registrants to submit a declaration once a year as to the extent of CPD activities performed by the registrant. This process provides a mechanism to ask for information from each registrant one a year, although it only applies to Dentists and not DCP's.

Background information for the current registration processes – continued

Regulatory Body	Registration process
General Optical Council (GOC)	The registration process is an annual process, which is currently paper based. We understand from our discussions with the GOC that there are plans to change this to an online process. The current annual retention and registration fee for optometrists is £325 and £280 for Dispensing Opticians (GOC).
General Medical Council (GMC)	The GMC has four main categories of registration, each of which indicate the level of recognised qualification held by the registrant. These categories are: provisional; full; specialist; and GP. For each category and speciality, the assessment process at registration is different. Currently, an individual can register either with, or without, a licence to practise (which is subject to revalidation). The annual retention fee for registration with a licence to practise is £420. (GMC website). Once registration has been completed and all identification and qualification checks have been verified, the registrant is able to renew registration simply by making payment of the annual renewal fee. In most instances this is done via direct debit and as such, there is no form of reconfirmation of the registrants details are renewal.
General Osteopathic Council (GOsC)	The registration process is an annual process which is currently paper based. Prior to qualification, an applicant can apply up to three months before graduation, however, the GOsC cannot process the application until after graduation. The fee for registration is: £3750 for the first year, £500 for the second year and £750 thereafter. (GOsC) Renewal of registration is based on payment of a renewal fee and similar to the GCC, registrants are asked to confirm the existence of insurance coverage of at least £2.5m together with the insurance provider both at initial registration and at renewal.
Health Professions Council (HPC)	Any Healthcare Professional practicing a profession regulated by HPC must be registered with the HPC to be able to practice in the UK. First time registration is by a paper process. Online renewal is being currently piloted. Renewal of registration occurs every 2 years. At renewal, personal information is captured, however, key fields such as employment details are not required for regular renewal of registration. There are currently no requirements for revalidation, with the exception of individuals whose membership had previously lapsed. Currently, the registration fee per year is £76. We understand that grand-parenting rules apply for new professions that are added to the HPC register. (HPC)

Source: Regulator websites and meetings

Background information for the current registration processes – continued

Regulatory Body	Registration process
Nursing and Midwifery Council (NMC)	Nurses and midwives can register under multiple categories provided they have completed the relevant pre-registration or post-registration training successfully. All registered nurses and midwives pay an annual retention fee to maintain registration. All renew registration every three years with approximately one third of the number on the register doing so in any given year. As part of the registration process, an applicant must complete and return and Application for Registration form, enclosing the fee. Current fees: UK/EEA applicants – joining the Register - £76; annual registration fee - £76 (NMC) (NMC website)
Pharmaceutical Society of Northern Ireland (PSNI)	The registration process is an annual process, which is currently paper based. The current registration fee is £121 2009/10 from 1st June 09 and is £372 for Pharmacists practising in Northern Ireland. As a GB Registrant (pharmacist who has first been registered with the RPSGB), the fee is £372. (http://www.psni.org.uk/professionals/registration/annual-retention-fees.php). (PSNI website)
Royal Pharmaceutical Society of Great Britain (RPSGB)	The registration process is an annual process, which is currently paper based. The registration fee in 2010 is £202 for a new member and the retention fee is £422 for a practising member (http://www.rpsgb.org.uk/pdfs/2010feesconsultationdoc.pdf). (RSPGB)

Source: Regulator websites and meetings

Participating organisations

We are grateful to the following organisations for their contributions to this report:

Organisation	Organisation
British Insurance Brokers Association	Medical and Dental Defence Union of Scotland
General Chiropractic Council	Medical Protection Society
General Dental Council	NHS Litigation Authority
General Medical Council	National Patient Safety Agency
General Optical Council	Nursing and Midwifery Council
General Osteopathic Council	Pharmaceutical Society of Northern Ireland
General Pharmaceutical Council	Skills for Health
Health Professions Council	Welsh Risk Pool
Medical Defence Union	

This report has been prepared for and only for Indemnity and Insurance Policy Review Group in accordance with the terms of our engagement letter with the Department of Health dated 12 February 2010 and updated on 29 March 2010 and for no other purpose. We do not accept or assume any liability or duty of care for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

PRICEWATERHOUSECOOPERS