Title: Amendment to Healthcare Regulatory Bodies legislation to require registrants to hold professional liability cover as a condition of registration **IA No:** 8037 **Lead department or agency:** Department of Health **Other departments or agencies:** Scottish Government, Welsh Government, DHSSPSNI	**Impact Assessment (IA)** **Date:** 01/11/2012 **Stage:** Consultation **Source of intervention:** EU **Type of measure:** Secondary legislation **Contact for enquiries:** **Mike Lewis 0113 2546146** **Mike.Lewis@dh.gsi.gov.uk**

Summary: Intervention and Options

RPC Opinion: RPC Opinion Status

Cost of Preferred (or more likely) Option				
Total Net Present Value	**Business Net Present Value**	**Net cost to business per year** (EANCB on 2009 prices)	**In scope of One-In, One-Out?**	**Measure qualifies as**
£0m	£m	£1m	No	NA

What is the problem under consideration? Why is government intervention necessary?

Currently not all statutorily regulated healthcare professionals are required to have in place indemnity arrangements in respect of their practice. Some patients, members of the public and service users might be unable to seek redress in the event of experiencing negligent care from a healthcare professional.

Recent European legislation requires Member States to legislate in relation to indemnity arrangements to be transposed into domestic law by October 2013. Intervention is necessary to implement the legislation as it relates to an individual registered healthcare professional. Failure to transpose could lead to heavy fines for the UK Government. As this is driven by EU legislation, it is out of scope of One-In, One-Out.

What are the policy objectives and the intended effects?

The policy objective is to put in place a system that complies with Directive 2011/24/EU and in doing so, to ensure that, when harm has been caused through negligence on the part of a healthcare professional, patients, the public or service users should have means of redress. The intended effect is to require all healthcare professionals to have an indemnity arrangement in place (either arranged personally or in place as a result of their employment status). Unless healthcare professionals can demonstrate that such arrangements are in place they will be unable to register as a healthcare professional and so be unable to practise.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

Option 1: Introduce new, consistent, legislative requirements across the regulators requiring registrants to have an indemnity arrangement in place as a condition of registration.

Three further options were considered: 'Do nothing', rely on regulators' guidance to registrants to have indemnity arrangements, and repealing existing legislation; or rely on existing legislation and introducing new legislation for Regulators who do not currently have it.

Only the option above delivers the policy objectives of meeting the obligations placed on Member States under Article 4 (2)(d) of the EU Directive on Patients Rights in Cross Border Healthcare in respect of individual healthcare professionals, as well as implementing the recommendations of the Independent Review Group (IRG)

Will the policy be reviewed? It will be reviewed. **If applicable, set review date:** 10/2018

Does implementation go beyond minimum EU requirements?			No		
Are any of these organisations in scope? If Micros not exempted set out reason in Evidence Base.	**Micro** No	**< 20** No	**Small** No	**Medium** No	**Large** No
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)			**Traded:** NA	**Non-traded:** NA	

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible SELECT SIGNATORY: ..... Date: .....

Summary: Analysis & Evidence

Policy Option 1

Description:

FULL ECONOMIC ASSESSMENT

Price Base Year 2012	PV Base Year 2012	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: Optional	**High:** Optional	**Best Estimate:** 0

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	Optional		Optional	**Optional**
High	Optional		Optional	**Optional**
Best Estimate	0		1.0	**8.6**

Description and scale of key monetised costs by 'main affected groups'

The chief costs are to individual practitioners who do not already have indemnity cover in obtaining cover..

An estimated 4195 practitioners will be impacted, each incurring an estimated average cost of £240 per year, a total cost of £1m per year. Given that costs will be incurred by self-employed individuals, it is possible that these additional costs will be passed on to patients.

Other key non-monetised costs by 'main affected groups'

Small impact to employers due to administrative costs of providing evidence of cover to regulatory bodies.

Regulators will incur compliance, compliance testing and enforcement costs. Consultation seeks data to quantify these costs.

Transaction costs of insurance/indemnity provision (chiefly administrative) will be incured by registrants and providers of cover

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	Optional		Optional	**Optional**
High	Optional		Optional	**Optional**
Best Estimate			1.0	**8.6**

Description and scale of key monetised benefits by 'main affected groups'

Additionally, on the assumption of an actuarially fair market, the costs to individuals of obtaining cover will be offset by the benefit received by patients in claims, together with the benefit to the providers of insurance and indemnity in terms of the increased income from premiums, with the profit that ensues. thus resulting in an overall cost neutral transaction. The consultation invites respondents to provide data to test and validate these assumptions.

Other key non-monetised benefits by 'main affected groups'

Patients will benefit from recourse to redress in the event of experiencing negligent care and from the general assurance that will result from the knowledge that all practitioners have appropriate cover in place.

Professionals will experience the benefits that result from insurance cover.

Tax payers will benefit through not having to meet costs incurred due to negligent care provided by professionals operating without cover.

Key assumptions/sensitivities/risks **Discount rate (%)** 3.5

Assumptions made for estimation of impact will be tested and validated by consultation.
All employed individuals covered by employers arrangments, including CNST and equivalent schemes.
Self employed individuals without cover estimated to be 4195, with proxy cost of cover estimated at £240 - the average costs of obstaining cover via professional body membership.
Costs balanced by benefits resulting in a net present value of zero.

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			In scope of OIOO?	Measure qualifies as
Costs: 1	**Benefits:** 1	**Net:** 0	No	NA

References

(1) Directive 2011/24/EU Of The European Parliament And Of The Council Of 9 March 2011 On The Application Of Patients' Rights In Cross-Border Healthcare

(2) Independent review of the requirement to have insurance or indemnity as a condition of registration as a healthcare professional - Government response: DH, July 2010
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117454

(3) Response to the Independent Review of the requirement to have insurance or indemnity as a condition of registration as a healthcare professional; DH, December 2010
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122611

Notes

RPC Opinion Status

A Regulatory Triage Assessment (RTA) was submitted to the Regulatory Policy Committee to seek fast track clearance as "deregulatory" representing an overall simplification of legislation being across the healthcare professional regulatory bodies.

The Regulatory Policy Committee commented that the

> 'RTA does not appear to provide sufficient evidence that the proposal is deregulatory. There is evidence to suggest that this proposal instead represents an increase in regulatory requirements with direct costs to business of over £1m and therefore appears to require a full IA to be submitted instead of a RTA.'

In light of these comments, the enclosed consultation paper has been amended and this supporting consultative Impact Assessment has been prepared, which acknowledges that there is a shortage of reliable data with regard to the extent of indemnity cover and cost in the private sector. Accordingly a series of assumptions have been made to estimate the impact of the proposals. Respondents to the consultation are invited to provide data to test and validate the assumptions in order to complete a full Impact Assessment. Following consultation this will be submitted for clearance before publication.

Organisations in Scope

It should be noted that, as the legislation relates to requirements for individual healthcare professionals to hold an indemnity arrangement, organisations are not considered to be in scope of the legislation.
Whilst there may be a direct impact on the affected healthcare professional regulatory bodies, the consultation seeks additional information to quantify this and to test and validate the assumptions relating to the costs and benefits to business.

Evidence Base

PROBLEM UNDER CONSIDERATION

1. The four UK Health Departments are aware of concerns that have arisen about the fact that some healthcare professionals currently practice without indemnity or insurance cover, or with insufficient cover, and that in such circumstances those whom they treat may be left without means to seek redress in the event of a negative incident negligently caused by the activities of a healthcare professional(s). Individual tragedies caused by negligence should not be compounded by this.

2. Recent European legislation requires Member States to have in place requirements in relation to indemnity arrangements in the health sphere. Member States are required to transpose this legislation into domestic law by October 2013. Meeting this requirement subsumes the existing policy objective set out above.

3. Therefore, the problem under consideration is how to put in a place a system to ensure that those harmed by the negligent activities of healthcare professionals have a means to redress, that meets the requirements of European Law.

BACKGROUND

EU DIRECTIVE 2011/24/EU ON PATIENTS RIGHTS IN CROSS BORDER HEALTHCARE

4. Following negotiation across Europe, the European Union Commission, Parliament and European Council formally adopted Directive 2011/24/EU on the application of patients' rights in cross-border health care (the Directive), via the co-decision process. Member States now have until October 2013 to transpose the Directive's requirements into their national laws. Negotiation around the content of the Directive was taking place whilst an Independent Review Group was reviewing the domestic policy, although the Directive was not formally approved until after it reported.

5. The Directive sets out at Article 4(2)(d) that Member States shall ensure:-

   'systems of professional liability insurance, or a guarantee or similar arrangement that is equivalent or essentially comparable as regards its purpose and which is appropriate to the nature and the extent of the risk, are in place for treatment provided on its territory'

6. In its definitions, the Directive sets out that:

   Article 3(a) '**healthcare'** means health services provided by health professionals to patients to assess, maintain or restore their state of health, including the prescription, dispensation and provision of medicinal products and medical devices;

   And that:

   Article 3(f) '**health professional'** means a doctor of medicine, a nurse responsible for general care, a dental practitioner, a midwife or a pharmacist within the meaning of Directive 2005/36/EC, or another professional exercising activities in the healthcare sector which are restricted to a regulated profession as defined in Article 3(1)(a) of Directive 2005/36/EC, or a person considered to be a health professional according to the legislation of the Member State of treatment.

DOMESTIC CONCERNS ON LACK OF INDEMNITY COVER FOR HEALTHCARE PROFESSIONALS

7. Domestic concerns about professional indemnity predate the introduction of European requirements in this area. In May 2003, Des Turner MP introduced a Ten Minute Rule Bill to require professional indemnity, following a case where a dentist who had harmed a patient had failed to take out indemnity. The Bill was rejected, but Rosie Winterton, then Minister of State for Health, wrote to Des Turner committing to explore options to address his concerns.

8. In March 2004, the then Minister of State for Health decided to proceed with compulsory indemnity on the basis that it was unreasonable for individual tragedies to be compounded by the injustice of being unable to secure compensation. Accordingly legislation began to be introduced on a regulator by regulator basis.

9. In another case, in 2005, harm was caused to a mother and baby by an independent midwife, resulting in permanent disability for the child and reconstructive surgery for the mother. In seeking redress subsequently, it became apparent that the midwife had failed to inform her clients that she had no cover. As she had no assets, any attempt to seek redress in court would not have resulted in compensation to the patients.

10. There are 32 groups of healthcare professionals (the Healthcare Professionals) who must be registered by one of nine statutory healthcare professional regulatory bodies in order to practise their profession.[1]

11. There is currently no consistency across the healthcare professional regulatory bodies with regard to legislation or guidance on the need for individual regulated healthcare professionals to hold insurance or indemnity cover (an indemnity arrangement).

12. Therefore, in terms of the current position on insurance and indemnity, the healthcare professional regulatory bodies fall into three groups:
    A. Those whose guidance insists on insurance or indemnity (when in active practice in the case of the General Chiropractic Council) and it is a statutory requirement: the General Chiropractic Council (GCC), the General Optical Council (GOC) and the General Osteopathic Council (GOsC) and the General Pharmaceutical Council (GPhC);
    B Those whose guidance insists on insurance or indemnity and a statutory requirement has been approved by Parliament, but is not yet in force: the General Dental Council (GDC), the General Medical Council (GMC) and the Pharmaceutical Society of Northern Ireland (PSNI); and
    C Those whose guidance does not insist on insurance or indemnity, nor is it a mandatory requirement: the Health and Care Professions Council (HCPC) - previously the Health Professions Council - and the Nursing and Midwifery Council (NMC), although the NMC recommends it.

13. It should be noted that legislation in respect of the Pharmaceutical Society of Northern Ireland is devolved to the Northern Ireland legislature and is not addressed in this Order.

14. The four UK Health Departments believe that it is unacceptable for individuals not to have access to recourse to compensation where they suffer harm through negligence on the part of a healthcare professional.[2]

[1] Annex A of this consultation paper details the Regulators and which groups of healthcare professionals they regulate, together with number of registrants and indemnity provision.

15. In 2009, the previous administration sought to introduce requirements to have an indemnity arrangement in place to nurses and midwives, but concerns were raised about the proposed model of implementing such a requirement.

16. In response, an Independent Review Group (made up of representatives from healthcare professional regulatory bodies, professional bodies, patient/public representatives and other interested parties) was established by the then Secretary of State for Health in England, with the support of Ministers in Northern Ireland, Scotland and Wales to take forward work arising from the Review. The Independent Review Group was led by Finlay Scott, the former Chief Executive of the GMC.

17. The specific purpose of the Independent Review Group's work was to make recommendations to Government as to whether requiring healthcare professionals to have an indemnity arrangement in place as a condition of their registration was the most cost effective and proportionate means of achieving the policy objective.

18. In order to asses the comparative costs and benefits of a statutory condition of registration, the Independent Review Group commissioned research from Pricewaterhouse Coopers to:
    - assess the scale and seriousness of incidence.
    - examine the costs and benefits of options for introducing insurance or indemnity as a condition of registration for regulated healthcare professionals.
    - identify the practicalities of minimising associated costs to ensure that the impact is as proportionate as possible.

19. However, as set out in the Independent Review Group Report,

    'it proved impossible to formulate conventional cost benefit analysis….. There was an almost complete absence of reliable data on the incidence and scale of failures to secure compensation because adequate assets were not available.'[3]

20. Pricewaterhouse Coopers also found that details of insurance and indemnity cover premiums are not widely available, due to its "commercial in confidence" nature.

21. In light of this the Independent Review Group considered an alternative cost basis of:

    a. Compliance – the costs incurred by registrants in satisfying the requirement to have insurance or indemnity.

    b. Compliance testing – the costs incurred by regulators in determining whether registrants satisfy the requirement to have insurance or indemnity.

    c. Enforcement – the costs incurred by regulators when the requirement to have insurance or indemnity is not satisfied. [4]

22. After consideration of the issues the Independent Review Group concluded that:

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[2] The NHS Constitution in England reinforces this by including the "right to compensation where you have been harmed by negligent treatment".

[3] Independent review of the requirement to have insurance or indemnity as a condition of registration as a healthcare professional - Government response: DH, 2010 page 13

[4] Independent review of the requirement to have insurance or indemnity as a condition of registration as a healthcare professional - Government response: DH, 2010 page14

'making insurance or indemnity a statutory condition of registration is the most cost effective and proportionate means of achieving the *policy* objective' [5]

23. The Independent Review Group also concluded that such a requirement would best work as follows:-

    a. A statutory condition of registration would apply equally and unequivocally to all registered healthcare professionals; would be seen by patients and the public to do so; and would enhance patient and public confidence.

    b. A statutory condition of registration has the unique advantage that, when supported by appropriate powers, enforcement action can be taken through low cost administrative procedures rather than high cost fitness to practise procedures.

    c. As a result, a statutory condition of registration would reduce enforcement costs compared with alternatives, without increasing compliance costs or the costs of compliance testing.

    d. A statutory condition of registration would require the healthcare professional to be able to prove a positive, namely the presence of cover, rather than the regulator to prove a negative, namely the absence of cover.

    e. A statutory condition of registration creates the opportunity for action by the regulator before the event, through registration procedures, to ensure that insurance or indemnity is in place."[6]

24. The Independent Review Group reported shortly after the General Election in May 2010. The incoming Government and the Devolved Administrations welcomed the findings of the Independent Review Group and accepted its conclusions and recommendations.

25. Subsequently the Government stated in its Command Paper Enabling Excellence (published in February 2011)[7] that:-

    'The Coalition Government and the Devolved Administrations believe that the requirement that healthcare professionals should hold insurance or indemnity cover should be consistent across health regulation, and that introduction of any requirements should not be framed so as to require individual employees to obtain personal cover themselves when they are already covered by corporate or employer cover.'

26. The Independent Review Group recommendations provide a framework within which the provisions of Article 4(2)(d) of Directive 2011/24/EU can be implemented, without going beyond the requirements of the Directive.

27. The consultation which this impact assessment supports does not, therefore, consider the appropriateness of a requirement for healthcare professionals to have in place an indemnity arrangement as a condition of registration. The reason for this is that the four UK Health Departments, cognisant of the need to implement the Directive and after consideration of the work of the Independent Review Group, believe that it is right and proper to introduce such a requirement to provide better and more consistent protection to patients and the public. Instead, this consultation focuses on assessing the implementation and impact of the policy.

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[5] Independent review of the requirement to have insurance or indemnity as a condition of registration as a healthcare professional - Government response: DH, 2010 page 3

[6] Independent review of the requirement to have insurance or indemnity as a condition of registration as a healthcare professional - Government response: DH, 2010 page 3

[7] Enabling Excellence: Autonomy and Accountability for Health and Social Care Staff DH 2011, p20

28. The Impact Assessment has been drawn up using the best available data to make a series of assumptions. However, it should be emphasised that, in the absence of reliable data as indicated above, there is a need to source further information, if available, and refine the data in order to test and validate the assumptions. Accordingly, the consultation asks a series of questions inviting respondents to provide information to assist in the development of a full Impact Assessment.

29. As the scope of the Order is limited to individual regulated healthcare professionals, it does not address the question of indemnity cover for corporate health providers. Issues around corporate health providers will be addressed as part of the transposition of the other elements of the Directive, which will be consulted on separately.

30. The Scottish Government has recently completed a public consultation on the recommendations of the No-fault Compensation Review Group which was established in 2009. The Review Group recommended that all clinical treatment injuries that occur in Scotland; (injuries caused, for example, by the treatment itself or by a failure to treat, as well as by faulty equipment, in which case there may be third party liability) should be covered by the scheme. The Review Group also recommended that the scheme should extend to all registered healthcare professionals in Scotland, not simply to those employed by NHS Scotland. The responses to the consultation are currently being considered.

RATIONALE FOR CHANGE

31. Because of the multiple ways in which healthcare is delivered in the UK, there is a mixed economy in terms of ways in which redress might be sought in the event of negligent harm. As research commissioned by the Independent Review Group stated:

> 'For Healthcare Professionals who are employed or engaged directly by a NHS hospital/acute trust, there is provision of [an indemnity arrangement] 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…
>
> …Some professional or regulatory bodies require members to have [an indemnity arrangement] as part of their registration, but the level of implementation varies.'[8]

32. Tying registration as a healthcare professional to possession of an indemnity arrangement is a proportionate way in which to achieve the policy objectives.

ASSUMPTIONS, RISKS, AND ISSUES

Who will be impacted?

33. The following categories of groups will potentially be impacted by these proposals:-
    - **Healthcare Professionals:** This group would be required to be sure that indemnity arrangements are in place. Some of them would bear the cost of obtaining cover;

[8] Source: Independent review of the requirement to have insurance or indemnity as a condition of registration as a healthcare professional, 2010, Annex B Pricewaterhouse Coopers Report: *Professional insurance and indemnity for regulated healthcare professionals – policy review research,* p 13

- **Employers of Healthcare Professionals:** A limited impact is assumed, due to the administrative costs of providing evidence of cover to the regulatory bodies;
- **Patients and Service Users:** This group would benefit by assurance that, should a negligent action by a healthcare professional cause harm, recourse to redress was available, which may include financial compensation. Indeed research on public opinion commissioned by the Independent Review Group found that the majority of respondents thought that healthcare professionals were already required to hold an indemnity arrangement;
- **The Public and Taxpayers:** In addition to the benefits for patients and service users, this group would benefit by reduced costs to the public purse of meeting certain care and support services that are provided on a means tested basis for patients following adverse incidents due to the negligent actions of healthcare professionals who do not have an indemnity arrangement in place; and
- **The Healthcare Professional Regulatory Bodies:** As the Independent Review Group envisaged, there might be compliance testing and enforcement costs resulting from these policy proposals. With regard to compliance testing, these have not as yet been quantified. The report however indicated that the impact associated with enforcement would be minimal or reduced as action could be taken via low cost administrative measures as opposed to high cost fitness to practise procedures.
- **Providers of Indemnity cover:** These would benefit from the increased business received due to the policies that individual healthcare professionals would be required to obtain.

Proportionality

34. When considered in isolation, the introduction of a requirement for all 1.4 million healthcare professionals to have an indemnity arrangement in place as a condition of their registration might raise significant concerns as to cost implications. However, it is vital to stress that there is no intention to introduce duplication through these proposals. That is, for instance, if a healthcare professional benefits from an indemnity arrangement as provided through their employer this would be sufficient to meet the requirement for registration as a healthcare professional. As the Independent Review Group put it:-

> 'From the outset, there was an important distinction to be drawn in how the condition of registration could be met. For employees in the NHS or independent sector, it was intended that they should be able to satisfy the condition of registration by dint of the corporate cover that arises from an employer's vicarious liability for the acts or omissions of employees. As a result, personal cover, from a defence organisation, trade union or other body, would not be required in relation to practice as an employee. Personal cover would only be required in relation to self-employed practice.' [9]

35. Furthermore, where individuals are covered through membership of a professional association which provides an indemnity arrangement that fully covers their scope of practice, this also would be sufficient to meet the requirement for registration as a healthcare professional.

36. Therefore, for avoidance of doubt, the draft legislation to which this impact assessment refers does not intend, or require, individuals to take out additional or duplicate cover when a sufficient indemnity arrangement is already in place. Clearly, this would be disproportionate.

[9] Independent review of the requirement to have insurance or indemnity as a condition of registration as a healthcare professional - Government response: DH, 2010 p 8

Alternatives to Regulation

37. In line with cross-Government initiatives to reduce regulatory burdens, the Department of Health, on behalf of the four UK Health Departments, has fully explored whether non-legislative steps might achieve the same ends as is intended. Principally, we have explored whether or not the healthcare professional regulatory bodies' guidance to their registrants could require them to hold an indemnity arrangement. This would mean that a failure to do so would be treated as a fitness to practise matter and the healthcare professional regulatory body would respond accordingly.

38. This proposal was regarded as flawed as it did not ensure that a system of indemnity was in place and that failure to hold such cover would only be addressed in cases where its absence came to light. In light of this, the view was that this solution did not meet either the requirements of the Directive or the policy objective.

OPTIONS APPRAISAL

39. Consideration was also given at the options analysis phase to both a 'do nothing option' and the use of existing legislation with the introduction of new legislation for the HCPC and NMC.

40. The 'do nothing' option is not feasible as it would not meet the requirements of the Directive. There would be no means of the member state ensuring that a system of professional indemnity cover was in place for all healthcare professionals and the UK Government would be at risk of infraction by the European Court of Justice. Therefore, in line with guidance from the Department of Business, Innovation and Skills, the 'do nothing' option has not been included in this consultative Impact Assessment.

41. The use of existing legislation would have perpetuated a piecemeal approach to the issue and would lack consistency across the healthcare professional regulatory bodies. It would also mean that an absence of cover might only be discovered after an incident occurred. This would not meet either the policy objective or the requirements of the Directive. Accordingly further work was not undertaken on the proposal.

42. As a result only one option remains feasible and has been appraised.

Option 1: Introduce new, consistent, legislative requirements across all the healthcare professional regulatory bodies to require Healthcare Professionals to have an indemnity arrangement in place as a condition of registration.

43. This Option implements the key recommendations of the Independent Review Group through new legislation, consistent across all the healthcare professional regulatory bodies, which:-
    - Introduces a requirement for healthcare professionals to have an indemnity arrangement in place (as required by Article 4(2)(d) of the Directive);
    - Provides healthcare professional regulatory bodies with a power to make rules on:-
        - What information needs to be provided by healthcare professionals, and when, to demonstrate that they have an indemnity arrangement in place in order to practise;
        - Requirements for healthcare professionals to inform their healthcare professional regulatory body should cover under an indemnity arrangement cease; and,
        - Requirements for healthcare professionals to inform their healthcare professional regulatory body if the source of their indemnity arrangement is one provided by an employer;
    - Gives healthcare professional regulatory bodies the ability to refuse to allow a healthcare professional to join, remain on, or return to, their register; and,
    - Permits healthcare professional regulatory bodies to either administratively remove a healthcare professional from their register, or take fitness to practise action against them, in the event of there not being an indemnity arrangement in place.

Estimating the number of healthcare professionals impacted by the policy

44. It is difficult to estimate the number of healthcare professionals who are currently covered by an indemnity arrangement, and the source of that indemnity (e.g. an employer, professional body, or personally held cover). As has been set out above, there is an absence of reliable data. For the purposes of this consultative Impact Assessment, a series of assumptions have been made using the best available data from a range of sources. The consultation document specifically invites respondents to submit further information to test and validate these assumptions.

45. In order to estimate the number of practitioners potentially impacted by the policy change, the following methodology has been used:
    i. Identify those professional groups which are most likely to be impacted by the policy change.
    ii. Identify the number in each professional group working in the private sector, based on data from the Office of National Statistics, supported by registration data from healthcare professional regulatory bodies.
    iii. Separately identify employees / employed staff, based on data from the Office of National Statistics and registration data from healthcare professional regulatory bodies.
    iv. For each group, estimate the proportion of staff who are members of a professional body which provides indemnity cover, based on membership data of professional bodies as a proportion of total registrants.
    v. Identify the groups of staff where coverage at step (iv) is not 100%
    vi. Estimate the number of individuals impacted, i.e. self-employed and not otherwise holding an indemnity arrangement, using proportions calculated at step (iv).

Step (i) Professional Groups

46. The Independent Review Group commissioned bespoke research from Pricewaterhouse Coopers in which a relative risk indicator was developed to identify those professions operating predominantly within and outside of the NHS. The areas highlighted in red and amber in the Table 1 are those which might be most likely to need an indemnity arrangement.

Table 1

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%

Source: Independent review of the requirement to have insurance or indemnity as a condition of registration as a healthcare professional, 2010, Annex B Pricewaterhouse Coopers Report: Professional insurance and indemnity for regulated healthcare professionals – policy review research, p 32

47. Of the professions identified as red or amber, only the following are regulated by bodies whose guidance does not already insist on insurance or indemnity, and nor is it a mandatory requirement (as noted in paragraph 12). These categories are in scope for the impact analysis as at step (i):
    - Psychologists
    - Nurses
    - Midwives
    - Paramedics
    - Medical Radiographers
    - Chiropodists

- Physiotherapists
- Occupational Therapists
- Speech And Language Therapists
- Therapists not elsewhere classified (excluding Chiropractors or Osteopaths).

48. In general, healthcare professionals who are employed or engaged by the public sector would have an indemnity arrangement in place through their public sector employer. Therefore, means for redress would naturally exist, so such individuals are considered to be out of scope for the impact analysis.

Step (ii) Individuals working in the private sector
Step (iii) Self employed private sector healthcare professionals

49. Step (ii) was to identify how many individuals work in each of the professional groups within scope in the private sector, with step (iii) refining the data to identify those working in a self-employed capacity. Those who are employed are assumed to have an indemnity arrangement in place through their employer. Data from the Office of National Statistics (ONS) as set out in Table 2 indicates that, of the approximately 1.4 million health and social care professionals, there are around 25,000 self-employed individuals across the UK who are not currently required by statute or by their regulatory body guidance to hold an indemnity arrangement, excluding the ONS classification of "Therapists not elsewhere classified."

Table 2 Public and Private Employment Figures

Annual Population Survey (APS), Jan - Dec 2010

Thousands, not seasonally adjusted

	UK						
	Private				Public		
2. PROFESSIONAL OCCUPATIONS	**ALL**	**Employee**	**Self Employed**		**ALL**	**Employee**	**Self Employed**
221. HEALTH PROFESSIONALS							
MEDICAL PRACTITIONERS	64	12	51		179	179	-
PSYCHOLOGISTS	6	1	5		24	24	-
PHARMACISTS & PHARMACOLOGISTS	29	19	10		13	13	-
OPHTHALMIC OPTICIANS	12	8	4		1	1	-
DENTAL PRACTITIONERS	26	1	25		9	9	-
SOCIAL WORKERS	21	15	6		98	98	*
3. ASSOCIATE PROFESSIONAL AND TECHNICAL							
321. HEALTH ASSOCIATE PROFESSIONALS							
NURSES	83	80	3		426	426	-
MIDWIVES	1	1	-		34	34	-
PARAMEDICS	*	*	-		21	21	-
MEDICAL RADIOGRAPHERS	4	4	-		20	20	-
CHIROPODISTS	6	-	6		5	5	-
DISPENSING OPTICIANS	6	5	1		-	-	-
PHARMACEUTICAL DISPENSERS	33	32	1		13	13	-
MEDICAL AND DENTAL TECHNICIANS	19	14	5		24	24	-
322. THERAPISTS							
PHYSIOTHERAPISTS	14	5	9		32	32	-
OCCUPATIONAL THERAPISTS	3	2	1		30	30	-
SPEECH AND LANGUAGE THERAPISTS	2	1	1		12	12	-
THERAPISTS NEC [1]	48	8	39		21	21	-
6. PERSONAL SERVICE OCCUPATIONS							
611. HEALTH CARE & RELATED PERSONAL SERVICES							
DENTAL NURSES	34	34	-		12	12	-
TOTAL	411	242	167		974	974	
TOTAL SELF EMPLOYED NOT REQUIRED TO HOLD INSURANCE/INDEMNITY EXCLUDING THERAPISTS NEC			25				

Source: Labour Market Survey

Footnotes:

- Estimates have been suppressed due to sample size. Small values are replaced by "*", zero estimates are shown with "-".

- Highlighted cells show groups not currently required to hold indemnity arrangements.

1 Classification of Therapists NEC includes chiropodists and osteopaths who are required by statute to hold indemnity. It also includes non regulated professionals, such as hydrotherapists and aromatherapists.

[2] Estimate of the total number of professionals not required by statute or code of conduct to hold insurance or indemnity.

50. The ONS classification of “Therapists not elsewhere classified” includes Osteopaths and Chiropractors who are already required by statute to hold an indemnity arrangement. It also includes professions such as aromatherapists and hydrotherapists who are not statutorily regulated and who are not affected by the IA classification and are therefore excluded from this analysis.

51. Accordingly, a table for those professional groups in scope has been produced (Table 3). This includes a line for “Therapists not elsewhere classified based on regulator data”. This is based solely on data for regulated healthcare professional therapists who are not currently required to hold an indemnity arrangement. This comprises data for Arts Therapists, Biomedical and Clinical Scientists, Dietitians, Orthoptists and Prosthetists and Orthotists, using registrant data from the HCPC, the healthcare professional regulatory body responsible for these therapists, and identifies 12 thousand self-employed individuals.

Table 3 Public and Private Employment Figures for self-employed Healthcare Professionals not currently required to hold an indemnity arrangement

	UK						
	Private				Public		
PROFESSIONAL GROUP	ALL	Employee	Self Employed		ALL	Employee	Self Employed
PSYCHOLOGISTS	6	1	5		24	24	-
NURSES	83	80	3		426	426	
CHIROPODISTS	6	-	6		34	34	
PHYSIOTHERAPISTS	14	5	9		21	21	
OCCUPATIONAL THERAPISTS	3	2	1		20	20	
SPEECH AND LANGUAGE THERAPISTS	2	1	1		5	5	
THERAPISTS NEC BASED ON REGULATOR DATA [1]	15	2	12		38	38	
	129	91	37		530	530	
TOTAL SELF EMPLOYED NOT REQUIRED TO HOLD INSURANCE/INDEMNITY [2]	-	-	37				

Source: Labour Market Survey and Regulatory Body data

1 Therapists not elsewhere classified includes the following professional groups: Arts Therapists, Biomedical Scientists, Clinical Scientists, Dieticians, Operating Department Practitioners, Orthoptists and Prosthetists/Orthotists. Split based on ONS ratios

[2] Estimate of the total number of professionals not required by statute or code of conduct to hold insurance or indemnity.

52. This assessment of self-employed regulated healthcare professionals in scope of the consultative Impact Assessment at step (iii) provides a total of 37,000.

Independent Midwives

53. The number of self-employed midwives is suppressed in ONS data due to the small number involved. For 2011-12, 170 individuals have declared their intention to practice to the NMC[10]. Whilst these individuals are currently unable to obtain individual indemnity or insurance cover, independent research commissioned by the Nursing and Midwifery Council and Royal College of Midwives[11] has suggested that independent midwives would be able to obtain insurance as employees within a corporate structure. We know this model of maternity care delivery is viable because midwives operating such models have been able to purchase insurance for the whole of the midwifery care pathway and are delivering maternity services, both inside and outside the National Health Service.

54. It is understood that this model is being explored with a view to encompassing the majority of independent midwives.

[10] Local Supervisory Authority data, NMC 2012

[11] Flaxman Partners: *The Feasibility and Insurability of Independent Midwifery in England* 2011

55. Furthermore, the Department of Health in England is currently reviewing NHS indemnity arrangements with regards to opening up the Clinical Negligence Scheme for Trusts (CNST) to non-NHS bodies delivering NHS care.

56. Accordingly, given the small scale of the professional group, the assumption made for the purposes of the Impact Assessment is that the majority of independent midwives will be able to obtain cover via one of the routes set out above, although it may require midwives to change the governance framework for their care and their delivery practices to comply with an indemnity policy.

57. We will be seeking further information on the validity of this assumption as part of the consultation exercise and are asking a specific question for this purpose. This and other specific questions are set out at Annex B.

Step (iv) Professional body arrangements for cover

58. All the groups in scope have associated professional bodies, many of which provide an indemnity arrangement as a benefit. Analysis in Table 4 of the data at step (iv) shows that all psychologists, chiropodists, physiotherapists and speech and language therapists may be considered to be members of professional bodies that include indemnity cover as a benefit of membership.

59.

Table 4 Professional Body Indemnity coverage

Profession	**Number of Registrants[1]**	**Number registered with professional body offering Indemnity Arrangements (excluding professional bodies where membership is currently unknown)[2]**	**% of practitioners covered via professional body membership (assumed 100% where no. of members exceeds no. of registrants)**
Psychologists[3]	17,864	45,254	100%
Nurses	627,535	410,000	65%
Chiropodists	13,000	17,000	100%
Physiotherapists	46,479	51,250	100%
Occupational Therapists	31,928	29,000	91%
Speech and Language Therapists	13,175	14,000	100%
Therapists not classified elsewhere (exc. chiropractors and osteopaths)	52,314	39,150	75%

Notes:
1 Source HCPC website September 2012
2.Source Relevant professional body websites Summer 2012 – Details in accompanying spreadsheet.
3. Psychologists registered with professional body include a range of disciplines including educational and sports psychiatrists

60. In a number of cases, the number of persons holding indemnity cover with professional bodies exceed the number of registrants in size. This is due to a range of factors, chiefly where non-practising professionals remain part of the professional body or where there are more than one professional association and registrants can be a member of more than one. With regard to Psychologists, there are certain groups who are not subject to

statutory professional regulation, such as educational or sports psychologists , but who may be members of professional bodies.

Step (v) Groups without full cover from professional bodies

61. Accordingly, at step (v) it is assumed that the groups still within scope comprise nurses, occupational therapists and therapists not elsewhere classified.

Step (vi) Estimated number of self-employed healthcare professionals without benefit of indemnity arrangement through membership of a professional body

62. By examining the data from step (iii) in relation to the remaining groups where numbers holding cover from professional bodies was lower than numbers registered with a professional regulator, an estimated total of 16,173 individual self-employed healthcare professionals who currently do not hold any form of indemnity and who will be required to take out insurance or indemnity as a result of the proposed new legislation is reached. This figure is then reduced in line with the estimated proportion of practitioners covered by regulatory body membership (derived from step (iv)) for each professional group, as set out at Table 5.

Table 5 Estimated number of self employed healthcare professionals without an indemnity arrangement.

Profession	**Number of self-employed, private sector practitioners, with therapists based on professional body/regulator data, mid point calculation**	**Estimated % of self-employed practitioners covered via professional body membership**	**Estimated number of self-employed, private sector practitioners not covered via professional body membership, based on ONS data with therapists based on professional body/regulator data**
Nurses	3,000	65%	1,040
Occupational Therapists	1,000	91%	92
Therapists not classified elsewhere remaining in scope	12,173	75%	3,063
TOTAL	**16,173**		**4,195**

Source: DH calculations

63. We therefore estimate the policy will have an impact on up to 4,195 self-employed individuals, who will be required in future to hold an indemnity arrangement who do not currently do so. We will review the assumptions underpinning our analysis following the consultation. It may be for example that, as part of competent business practice, self-

employed individuals are more likely to have some form of public liability insurance or professional indemnity insurance in place.

64. As part of the consultation exercise, respondents are invited to submit further data to test and validate these assumptions, with specific questions as set out in Annex B:

Estimating costs

To Healthcare professionals

65. As has been set out above, data on the cost of insurance and indemnity is not readily available, owing to the ”commercial in confidence” nature. Accordingly, for the purposes of estimating costs in this consultative Impact Assessment, a proxy cost has been used, based on the cost of professional association membership with indemnity cover as a benefit. Using this proxy, should cover not be in place for any of the individuals identified above, we estimate annual costs would be as follows,

Table 6 Estimated cost of obtaining indemnity cover

Profession	**Estimated number of self-employed, private sector practitioners without cover[1]**	**Individual cost of professional body membership**	**Total estimated cost impact of professional body membership for professionals affected by the proposed new requirement**
Nurses	1,040	£195[2]	£203,000
Occupational Therapists	92	£256[3]	£23,000
Therapists not classified elsewhere remaining in scope	3,063	£255[4]	£780,000
TOTAL	**4,195**	**£240[5]**	**£1,006,000**

Notes 1: Source: DH estimates on numbers as calculated above at step (vi)
2.Source. Royal College of Nursing website
3.Source: British Association of Occupational Therapists website
4,Source DH calculation of average cost for Therapists in scope.
5 Mean cost

66. The cost of £1,006,000 does not include the transaction costs to the registrant of obtaining cover, which are assumed to be negligible. The administrative costs of providing cover are included in the overall cost. Ultimately, it is likely that the additional cost to the registrant will be passed on to the patient.

67. As part of the consultation exercise, respondents are invited to submit further data to test and validate these assumptions as indicated in the questions set out in Annex B.

To Healthcare Professional Regulatory Bodies

68. For the healthcare professional regulatory bodies, estimating the expected cost is complicated given that the draft legislation under consideration provides the healthcare

professional regulatory bodies with enabling powers to make further legislation on how registration as a healthcare professional should be tied to possession of an indemnity arrangement for their particular body. Therefore, as implementation is a matter for each health care professional regulatory body as an independent statutory body, and because they will need to refine their own proposals, consult on them, and assess impact separately, the Impact Assessment cannot be definitive on implementation costs at this stage. The following cost calculations are therefore provided on an indicative basis only.

69. The variety of potential approaches by the healthcare professional regulatory bodies to implementing these proposals is supported by the Research Report of the Independent Review Group. The estimated costs of implementation for the individual healthcare professional regulatory bodies at that time were as follows:

Table 7 Healthcare Professional Regulatory Body –Estimated Cost of implementation of compliance monitoring

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: Independent review of the requirement to have insurance or indemnity as a condition of registration as a healthcare professional, 2010, Annex B Pricewaterhouse Coopers Report: *Professional insurance and indemnity for regulated healthcare professionals – policy review research,* p 39

70. Healthcare professional regulatory bodies may incur additional costs in monitoring compliance, which may be passed on to the individual registrants. Based on data supplied to the Independent Review Group (excluding those bodies who already have a

link to registration) and on recent registration data, the maximum estimated total cost at present is £0.91m, with an estimated minimum of £0.48m.

71. Should these costs be passed on to the registrants, the range of additional costs varies considerably due to the size of the respective healthcare professional regulatory bodies. The additional costs are estimated as follows:

Table 8 Healthcare Professional Regulatory Body - Estimated cost per registrant of implementation of compliance monitoring

Regulatory Body	Cost [1]	No of Registrants[2]	Cost per registrant £
GMC	£370k	246,075	£1.50
HCPC	£40k	219,228	£0.18
NMC	£100-500k	672,095	£0.15 - £0.74

Notes 1 Source: Independent review of the requirement to have insurance or indemnity as a condition of registration as a healthcare professional, 2010, Annex B Pricewaterhouse Coopers Report: *Professional insurance and indemnity for regulated healthcare professionals – policy review research* p 39
2. Source: CHRE Performance Review 2011-12

72. In order to produce a full Impact Assessment, respondents are invited to provide further information to test and validate these assumptions as indicated in the questions set out at Annex B.

To Employers

73. Costs may arise where individual professionals are required by their regulatory body to provide proof of employment and hence cover by some form of indemnity arrangement. Whilst it will be for the healthcare professional regulatory bodies to design their own system, it is anticipated that this will place a minimal burden on employers at negligible cost.

74. As part of the consultation, specific questions are being asked with regard to costs and administrative burdens and respondents are invited to submit further information to test and validate these assumptions as set out at Annex B.

Estimating benefits

To Healthcare professionals

75. Healthcare professionals who are not already covered by an indemnity arrangement will benefit from the assurance that, should a negligent act cause harm, they would be covered by an appropriate indemnity arrangement. Furthermore they, as individuals, would not be financially liable and so would not be in danger of losing personal assets.

76. An additional benefit is that individuals are more likley to ensure that they practise within the scope of their competence and hence their indemnity cover.

To Patients, the Public, Service Users and Tax Payers

77. In terms of Patients, the Public, Service Users and Tax Payers, they are the groups which currently bear the cost of adverse events, either in terms of costs or personal impact, and who would therefore benefit from the implementation of the policy. Pricewaterhouse Coopers, who conducted the research for the Independent Review

Group investigated several potential approaches to try and obtain relevant information to draw conclusions in this regard, but the absence of data made drawing robust conclusions impossible. As the research notes:-

> 'Regulators capture data concerning the number of cases referred to them…We note that these are Fitness to Practise complaints and may not result in compensation claims being pursued…[W]e were not able to determine a "conversion rate" of complaints to claims for negligence, or the size of subsequent awards.'[12]

78. It further notes that:

> '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….
>
> 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.' [13]

79. For patients and service users, as the individuals who will have suffered harm, security would be provided by the clearly delineated legal and financial responsibilities of the indemnity arrangement. In such an instance, there would also be a decrease in legal costs, but as these are a 'transfer payment', there is no overall economic benefit gained. It would however reduce distress on the parties concerned and any associated adverse publicity.

80. In the absence of information on the percentage of overall costs that relate to transaction costs, no correction is made to the estimate of the overall benefit to account for this.

81. For the tax payer, the costs that are liable to be saved are those associated with cases where there is currently no recourse to redress, such as the case cited in paragraph 9. With the provision of cover, costs which might otherwise fall to the public purse can be met from any award. There is limited data on the scale of such costs.

82. As part of the consultation we will be inviting respondents to submit information to validate and test these assumptions, as indicated in the questions set out in Annex B.

To Healthcare Professional Regulatory Bodies

83. By taking administrative procedures (e.g. refusing to grant or renew registration) rather than fitness to practise procedures, the healthcare professional regulatory bodies will be able to deal with issues around a lack of or insufficient indemnity arrangements both quickly and at reduced expense.

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[12] Source: Independent review of the requirement to have insurance or indemnity as a condition of registration as a healthcare professional, 2010, Annex B Pricewaterhouse Coopers Report: *Professional insurance and indemnity for regulated healthcare professionals – policy review research,* p 26

[13] Source: Independent review of the requirement to have insurance or indemnity as a condition of registration as a healthcare professional, 2010, Annex B Pricewaterhouse Coopers Report: *Professional insurance and indemnity for regulated healthcare professionals – policy review research,* p 31

To Employers

84. Employers are likely to benefit from their employees being more conscious of the limits of their scope of practice and accordingly operate within them, hence reducing adverse incidents

To Providers of cover

85. There will be a benefit to the providers of insurance and indemnity in terms of the increased income from premiums and the profit element that will ensue. However, there is also a counterbalancing effect of the changes, where the costs of obtaining cover are offset by the benefit received by patients in claims, thus resulting in an overall cost neutral position. Whilst it is assumed that the net present value is zero, respondents are invited to submit further data to test and validate these assumptions, with specific questions as set out at Annex B.

Summary

86. Based on the assumptions applied in this consultative Impact Assessment, the main costs of policy implementation will be borne by self-employed healthcare professionals who currently practise without indemnity cover, These are estimated to number 4,195, with a total cost of an estimated £1m per year. Patients will benefit through access to redress, assumed to equate to the cost of £1m, and the assurance of knowing that all practitioners are operating with cover in place.

87. Through the consultation respondents are invited to provide any information or data which is available to them which would help to refine the analysis above in a post consultation impact assessment to support finalised legislative proposals. As part of the consultation, we will be inviting respondents to submit information to validate and test these assumptions, as indicated in the questions set out at Annex B.

Cost for small firms

88. The assumed cost impact of this policy will be to individual, self-employed contractors. As set out above, we have assumed that small firms' costs may already comprise suitable liability and professional cover. We are aware that independent midwives may be particularly impacted by this. However, we are seeking further information to test and validate these assumptions as part of the consultation exercise.

Equality and Human Rights

Specific impact tests

Equality Impact Assessment

89. By introduction of a requirement to hold an indemnity arrangement, there is the potential for an adverse impact upon independent midwives in that, should they be unable to obtain cover they would be unable to practise.

90. Whilst there are no specific protected characteristics associated with the group, there is a potential impact upon the individuals who make up the group and this is addressed in the consultation document.

91. The consultation exercise asks a specific question with regard to equalities, phrased as follows:

> **Q8: Do you think there are any equalities issues that would result from the implementation of the Draft Order which require consideration? If so, please provide evidence of the issue and the potential impact on people sharing the protected characteristics covered by the Equality Act 2010: disability; race; age; sex; gender reassignment; religion & belief; pregnancy and maternity and sexual orientation and carers (by association).**

Competition

92. The options presented in this impact assessment will apply to all registered healthcare professionals. As such, we do not anticipate that they will disproportionately affect any particular group with protected characteristics.

Summary analysis

93. The following table shows the expected costs and benefits over ten years:

Table 9: Annual profile of monetised costs and benefits of option 1 - (£m) constant (2012/13) prices

	Y_0	Y_1	Y_2	Y_3	Y_4	Y_5	Y_6	Y_7	Y_8	Y_9
Transition costs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Annual recurring cost	1.0	1.0	0.9	0.9	0.9	0.8	0.8	0.8	0.8	0.7
Total annual costs	1.0	1.0	0.9	0.9	0.9	0.8	0.8	0.8	0.8	0.7
Transition benefits	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Annual recurring benefits	1.0	1.0	0.9	0.9	0.9	0.8	0.8	0.8	0.8	0.7
Total annual benefits	1.0	1.0	0.9	0.9	0.9	0.8	0.8	0.8	0.8	0.7
Net present value	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

94. An estimated annual cost of £1 million will equate to total costs (discounted) of £8.6m over ten years. However, the assumption has been made that the overall costs will be balanced by benefits, giving a net present value of zero. The consultation invites respondents to provide further data to test and validate these assumptions.

Annex A

Regulatory Bodies	Professions regulated	No. of Registrants	Professions under the regulatory body	Indemnity Requirements
General Chiropractic Council	1	2,700	Chiropractors	Required for registration by statute
General Dental Council	7	99,518	Dentists Clinical Dental Technicians Dental Hygienists Dental Nurses Dental Technicians Dental Therapists Orthodontic Therapists	In Guidance. Failure to hold indemnity leads to Fitness to Practise proceedings
General Medical Council	1	246,075	Doctors	In Guidance. Failure to hold indemnity leads to Fitness to Practise proceedings
General Optical Council	2	23,935	Optometrists Dispensing Opticians (including student Opticians, student Optometrists and Optical businesses)	Required for registration by statute (not for student or businesses)
General Osteopathic Council	1	4,585	Osteopaths	Required for registration by statute
General Pharmaceutical Council	2	43,756	Pharmacists	In Guidance. Failure to hold indemnity leads to Fitness to Practise proceedings
		12,772	Pharmacy technicians	
Health Professions Council	15	3,127	Arts therapists	No Guidance
		21,886	Biomedical Scientists	
		13,000	Chiropodists/podiatrists	
		4,679	Clinical Scientists	
		7,789	Dietitians	
		1,724	Hearing aid dispensers	
		31,928	Occupational therapists	
		10,929	Operating department practitioners	
		1,286	Orthoptists	
		17,935	Paramedics	
		46,479	Physiotherapists	
		894	Prosthetists/orthotists	
		26,533	Radiographers	
		13,175	Speech and Language therapists	
		17,864	Practitioner psychologists	
Nursing and Midwifery Council	2	627,535	Nurses	Recommended under Code of Conduct
		44,560	Midwives	
Pharmaceutical Society of Northern Ireland	1	2,098	Pharmacists in Northern Ireland	In Guidance. Failure to hold indemnity leads to Fitness to Practise

Annex B Consultation questions inviting respondents to supply additional information to test and validate assumptions

Q6: Please provide any information with regard to the potential barriers to independent midwives moving to alternative governance and delivery practices in order to obtain appropriate indemnity arrangements.

Q9: Please provide comments as to the accuracy of the costs and benefits assessment of the proposed changes as set out in the Impact Assessment (including, if possible, the provision of data to support your comments).

Q10: Please provide information on the numbers of self employed registered healthcare professionals and whether they are in possession of indemnity cover or business insurance which includes public liability insurance and professional indemnity insurance.

Q11: Please provide information on the numbers of employed healthcare professionals who, in addition to working in an employed capacity covered by an employer's arrangement for indemnity or insurance, undertake self-employed practice. Where possible, please provide information as to whether they are in possession of indemnity cover or business insurance which includes public liability insurance and professional indemnity insurance for that self -employed element of their practice.

Q12: Do you have views or evidence as to the likely effect on costs or the administrative burden of the proposed changes set out in the Draft Order? Please provide information/examples in support of your comments.

Q13: Do you think there are any benefits that are not already discussed relating to the proposed changes?
Please provide information/examples in support of your comments.