Consultation Response

07 May 2013

MPS's response to the Health Care and Associated Professions (Indemnity Arrangements) Order 2013

About MPS

The Medical Protection Society is the leading provider of comprehensive professional indemnity and expert advice to doctors, dentists and health professionals around the world.

MPS is not an insurance company. The benefits of membership are discretionary - this allows us the flexibility to provide help and support even in unusual circumstances.

Consultation Questions

Q1: Do you agree that the requirement for healthcare professionals to have an indemnity arrangement in place should match the requirements set out in the Directive and place an obligation on healthcare professionals themselves to ensure that any indemnity arrangement in place is appropriate to their duties, scope of practise, and to the nature and the extent of the risk?

The Medical Protection Society (MPS) is a mutual membership organisation of doctors, dentists, dental care professionals (DCPs) and other healthcare professionals. We have over 280,000 members around the world, including nearly half the doctors and more than two thirds of the dentists in the UK. Benefits of membership include access to an indemnity for clinical negligence claims as well as wide ranging professional support and advice.

Whilst most of our indemnity experience relates to doctors, dentists, DCPs and to a lesser degree nurses, we believe our comments apply generically as the principles span all regulated healthcare professionals.

We strongly agree that the requirement for healthcare professionals to have an indemnity arrangement in place should match the requirements set out in the Directive. Placing an obligation on healthcare

professionals to ensure the appropriateness of their indemnity arrangements is the right approach. In fulfilling this requirement, healthcare professionals (whose practice is not fully indemnified by their employing Trust or other employer) must understand their duty to fully disclose the nature, scope and extent of their practice to their indemnity provider. Full disclosure must occur both at the time of taking out indemnity protection and whenever the scope of their practice changes.

We believe that healthcare professional regulators should make it clear to registrants that they must fulfil this responsibility for full disclosure and remind them of the importance of doing so on an ongoing basis.

Q2: Do you agree with the proposed definition of an indemnity arrangement?

Yes. We are pleased that the definition of an indemnity arrangement includes the type of indemnity protection offered by MPS to healthcare professionals.

MPS offers occurrence-based indemnity which means members can seek assistance for any adverse incident that occurs during their membership of MPS – even if the claim is brought years later and assistance is not conditional on their remaining a member of MPS at the time of the claim being made.

MPS indemnity is comprehensive and discretionary. Because we are not restricted by detailed terms and conditions and other constraints found in insurance policies, we are often able to help members with unusual problems. MPS indemnity rests on the Memorandum and Articles of Association, which specifies that all the benefits of membership are to be granted at the discretion of MPS Council. This discretion allows us to respond to changes in the medicolegal environment and assist members with emerging problems that may not have been foreseen – and therefore not included in a contract of insurance – at the time it was taken out. MPS indemnity for healthcare professionals is not limited by financial caps– nor do we impose a system of excesses. When we take on a member's case, we can take care of all the legal costs and compensation payments.

Advances in clinical practice, changing social expectations and political agendas all influence the medicolegal environment to varying degrees. Therefore it is important that indemnity arrangements for healthcare professionals are both robust enough to accommodate escalating costs and flexible enough to adjust to new and unusual demands.

Q3: Do you agree with the proposed provisions that set out:

(a) What information needs to be provided by healthcare professionals, and when, in relation to the indemnity arrangement they have in place;

Allowing each regulatory body the power to make rules on what information needs to be provided by healthcare professionals and when it must be provided is a sensible approach. The regulator needs to know that the indemnity arrangements are adequate to cover the risks posed by the nature and extent of the registrant's professional practice. Provision for this should be a central feature of the rules issued by each regulator with the onus for providing the information placed on the practitioner.

The rules should also state that the information should be provided by the practitioner at the time he or she commences practice and when there is a material change in their practice.

We agree with the principle that individuals should not have to take out personal indemnity for the sole purpose of registration before acquiring employer's cover after taking up a job. However the consultation paper assumes that healthcare professionals registering for the first time will always seek an employed role. This is not always the case; a dentist from Europe for example might start his or her first role in the UK within a primary dental care practice setting which is unlikely to be subject to NHS indemnity. Any UK dental graduate (dentist and DCP alike) entering Foundation Training in primary care will not be subject to NHS indemnity. This is different to medical graduates entering their first employment which will be within the NHS. MPS does not provide indemnity until a professional is registered with a healthcare regulator but the approach outlined in this consultation would mean that the professional could not gain registration without securing indemnity and a catch 22 situation would ensue. Regulators and indemnity providers will need to work together to investigate a satisfactory solution that can respond to this type of scenario.

(b) The requirement to inform the Regulator when cover ceases; and,

We agree with the suggested approach that registrants should have an obligation to inform their regulator when cover ceases. Again, we believe that regulators should be tasked with reminding registrants of this duty on a regular basis.

(c) The requirement for healthcare professionals to inform their regulatory body if their indemnity arrangement is one provided by an employer?

The registrant must inform their regulator of all indemnity arrangements they have in place. This should include cover from an employing organisation as well as any additional indemnity arrangements they have in place for any otherwise unindemnified practice (including self-employed practice), they undertake.

We would stress again the importance of regulators being aware that the scope of registrants' indemnity arrangements matches the full scope of their practice. A failure to oblige the registrant to disclose the totality of their indemnity arrangements could allow a small number of registrants to under-indemnify. This would mean that any under-declaration might be dealt with as a fitness to practise (FTP) issue.

Q4: Do you agree with the proposal to allow healthcare professional regulatory bodies the ability to refuse to allow a healthcare professional to join, remain on, or return to, their register, or, for the GMC, to hold a licence to practise unless they have an indemnity arrangement in place?

If a registrant suspends clinical practice for whatever reason they should have the ability to suspend their indemnity arrangements. There are circumstances where a registrant might take a break from practice such as for maternity leave, sick leave or for a sabbatical. In these circumstances the requirement for indemnity should be suspended as they are not in active practice and the healthcare professional should not be compelled to go through the process of leaving and then returning to the register with associated costs both for the individuals and regulators, inevitable uncertainties and delay. MPS offers members the facility to move into a non-practising membership category in such circumstances as noted and places an obligation upon that member to declare their return to practice and re-establishment of full indemnity

In respect of the GMC there are already specific rules in place in relation to the retention of a licence to practise.

Q5: Do you agree with the proposal to permit healthcare professional regulatory bodies to remove a healthcare professional from their register, withdraw their licence to practise, or take fitness to practise action against them, in the event of there being an inadequate indemnity arrangement in place?

There should be a reasonable period allowed for healthcare professionals to cooperate with the provisions and there should be an interim step of suspension before substantive removal.

The response should be differentiated according to the circumstances. For example administrative removal might be suitable where no indemnity is in place but questions over the adequacy of a registrant's indemnity arrangements should be considered through some procedure which might include fitness to practise arrangements so the full circumstances can be investigated and considered.

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.

MPS has no comment to provide in response to this question.

Q7: **Do you agree that the provisions in the Draft Order should only apply to qualified healthcare professionals and not students?**

We agree that the provisions of the Draft Order should not apply to students given that they are not registered.

Q8: Are there 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).

In our response to question four, we have outlined situations such as maternity leave or sickness where we believe healthcare professionals would be unfairly penalised if they were compelled to leave and then later return to the register. We believe that the requirement for indemnity should be suspended in these circumstances.

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).

MPS has no comment to provide in response to this question.

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.

MPS indemnity does not extend to public liability, employer liability or product liability and we are unable to provide information on the number of self-employed healthcare professionals in possession of indemnity cover for clinical negligence due to the commercial sensitivity of this information.

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.

We are unable to provide information on the number 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 due to the commercial sensitivity of this information.

We do not possess 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?

MPS has no comment to provide in response to this question.

Q13: Do you think there are any benefits or drawbacks that are not already discussed relating to the proposed changes?

Please provide information/examples in support of your comments.

We strongly support the general approach outlined in this consultation paper and consider it to be in the best interests of doctors, dentists, DCPs and their patients.

MPS believes that patients who have been avoidably harmed through negligence should receive fair compensation. MPS occurrence-based indemnity means that we can assist a member with a claim even if it is brought years after the negligent act occurred. The alternative, known as claims-made indemnity does not provide the same extent of protection unless specific additional arrangements (described as run-off cover) are put in place. Unless regulators require healthcare professionals with claims-made indemnity to have run-off cover in place to cover retirement, career breaks, illness, death or a move abroad, there is a significant risk that patients might not be appropriately compensated.

Q14: Do you have any comments on the draft order itself?

We do not have any comments on the draft order itself but we would like to draw attention to two of the recommendations made by Finlay Scott as part of his Independent Review of the Requirement to have Insurance or Indemnity as a Condition of Registration as a Healthcare Professional.

Recommendation 7 suggested that the regulators should work with employers, representative bodies, and defence organisations to communicate to registrants the importance of indemnity arrangements. Recommendation 11 suggested that consideration should be given to the case for communicating indemnity arrangements to patients and the public.

We believe that for the new arrangements to be successful, regulators must invest in regular promotion of the requirement for indemnity to registrants and spread awareness amongst patients and the public.

We note that the CQC and its equivalent regulators include a review of indemnity arrangements when practices and care establishments are inspected, reducing the risk of registrants operating without adequate indemnity.

Q15: What are your views on extending the requirement to hold an indemnity arrangement as a condition of registration to all professionals statutorily regulated by the Health and Care Professions Council? This would cover social workers in England only.

MPS has no comment to provide in response to this question.

CONTACT

Should you require further information about any aspects of our response to this consultation, please do not hesitate to contact me.

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