

Appropriate Clinical Negligence Cover Consultation

Acute Care and Quality Directorate, Fifth Floor
Department of Health and Social Care
39 Victoria Street
London
SW1H 0EU

Sent by email: clinicalnegligenceregulationconsultation@dhsc.gov.uk

27 February 2019

Dear Sir/Madam

The BMA is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives.

We welcome the opportunity to respond to the consultation on appropriate clinical negligence cover. We hope that our submission is useful. Please do not hesitate to contact us for more information if required.

If you have any enquiries about the response or require further information, please do not hesitate to contact Reena Zapata, Senior Policy Advisor (rzapata@bma.org.uk)

Yours sincerely,



Raj Jethwa
Director of policy



The BMA firmly believes that patients who suffer harm through negligence on the part of a clinician should have recourse to compensation. The BMA wants to encourage a safe environment for patients with less emphasis on litigation and more focus on shared responsibility for safe healthcare culture, outcomes and delivery. However, the BMA believes that before any wholesale changes are proposed, there is a need to quantify:

- 1) The number of cases annually, both within the NHS and in the independent sector, involving harm caused to patients through negligence by a clinician;
- 2) The number of those cases in which the patient was unable to secure adequate and appropriate compensation;
- 3) The number of those cases where the failure to secure adequate and appropriate compensation was due to a lack of insurance or indemnity, inadequate cover or where discretionary indemnity has been declined to the clinician concerned.

We do not believe that the consultation document has fully examined the current system or makes the case for change and therefore we believe that arrangements should stay as they are until further analysis is undertaken, including a regulatory impact assessment. As noted in the consultation document, the proposed changes could result in an increase to the cost of indemnity and the impact that this might have on different groups of doctors needs further consideration.

Mutual basis and discretionary system

The Medical Defence Organisations (MDOs) have historically always reported that their processes provide the most comprehensive cost-effective indemnity cover. This position has been achieved by working on a mutual basis and via a discretionary system, that allowed them the flexibility to work to the member's best interests. The BMA believes that in general the MDOs have been successful at defending claims, and in negotiating settlements prior to court hearing where a claim was not defensible. The down side of this process is the rising cost of litigation which has resulted in a requirement to increase subscriptions year on year. The BMA believes the Government should focus its efforts in regulating the clinical claims environment, instead. England and Wales have amongst the highest level of personal injury damages awards in the world. Damages inflation far exceeds other inflation measures and now runs at about 10% a year.¹In Scotland, where the costs of claims to MDOs are lower, doctors have not seen the same rapid increase in the cost of indemnity, however, these proposals risk undermining that market.

Although the BMA recognises that there are risks in remaining in the current structure and that the discretionary structure does in theory provide MDOs the freedom to decline cover to a member, we understand that this has happened in only a very small number of cases. Before proceeding with wholesale changes, the BMA would advise gathering evidence on whether the discretionary MDO structure is really unfit for purpose and the extent that this is the case.

Cost

The BMA firmly believes that the rising cost of indemnity needs to be addressed urgently. Anecdotally, we have observed that some doctors are moving to non-mutual/for profit insurance as the cost of indemnity is becoming too expensive, particularly for those in specialties where practising outside of state backed schemes is prohibitive.

¹ Reform is needed now - <https://www.themdu.com/guidance-and-advice/journals/mdu-journal-april-2013/reform-is-needed-now>

Furthermore, as noted in the consultation document, there is a risk that a move to regulation might lead to an increase in costs. The BMA would urge the government to carry out a comprehensive cost analysis and regulatory impact assessment, so clinicians are made aware of the overall cost of moving to a regulated insurer. We have particular concerns about the impact of this on GPs in Northern Ireland and Scotland who don't have access to state backed indemnity schemes and the knock-on effect that this may have on recruitment and retention in those countries. An analysis of the likely impact on medical recruitment and retention of any increased costs should also be carried out, with a particular focus on GPs in Scotland and Northern Ireland. A letter that we have sent to the Secretary of State for Scotland outlining these concerns is enclosed (appendix 1).

Equally, increased indemnity costs could make undertaking some medical practice unsustainable and an analysis should be undertaken on the impact of the proposals on the private healthcare market and other areas of work which have not been identified in the consultation document, such as medical cover provided at sporting events. There is also a risk that an increase in the cost of individual personal indemnity cover which doctors purchase in addition to clinical negligence state backed schemes could ultimately increase the risk to the public, and we would encourage research in this area.

It is also important to note that regulated insurers would not remain immune to crises/fluctuations in the financial market. For example, in 2017, when the Lord Chancellor cut the discount rate by 3.25%², the Association of British Insurers stated that claim costs would soar, making it inevitable that there would be an increase in motor and liability premiums for millions of drivers and businesses across the UK.

Run-off

The consultation document does not address how the government would resolve a situation whereby an insured practitioner could not afford to continue an insurance policy and/or run-off cover³ or where a regulated insurer suddenly leaves the market as happened with St Paul in 2001.⁴ US insurer St Paul left the UK medical indemnity market, only two years after announcing its intention to take a dominant stake in the sector. This resulted in large numbers of practitioners who could not buy/could not afford run-off cover and even if they could afford run-off cover, it was limited by caps on money and time.

The BMA believes the requirement to purchase 'run-off' for any claims brought after cessation of clinical practice would be an enduring liability arising from the regulated option.

Occurrence indemnity

MDOs have traditionally provided indemnity cover to members on an occurrence basis which means that a member can seek assistance from the MDO irrespective of the number of years

² <https://www.gov.uk/government/news/new-discount-rate-for-personal-injury-claims-announced>

³ As described in the consultation document, Run-off cover provides cover for claims where the adverse incident has already occurred but has not yet been reported prior to the expiry of the policy or membership period to which the run-off cover relates. The cover could be renewed annually or, for a single payment, cover all past incidents whenever they are reported in the future. This type of cover is required when a member of an MDO or policyholder of an insurer has either claims-made cover or claims-paid cover and either switches indemnifier or ceases to practise.

⁴ <https://www.insuranceage.co.uk/professional-broking/news/1196813/medical-malpractice-st-paul-announces-departure-medical>

since the claim was brought to them and no matter whether they are no longer a member of the MDO. However, some MDOs now only offer claims-based cover and others offer an option between the two. It is important to note that in cases involving children, claims can be made until 3 years after they turn 18 and the MDOs have stated that claims are often submitted many years after the incident happened. Between 1995 and 2016, one MDO has had well over 1000 claims notified more than 10 years after the incident and some of them much later, the longest being 40 years afterwards.⁵ The BMA is concerned that if regulated insurers were to provide insurance on occurrence base, they would have to increase their reserves and as a result, premiums could become unaffordable.

Not for profit vs profit basis

The BMA understands that MDOs operate on a not-for-profit basis. The benefits are provided on an occurrence basis and there is no limit to the indemnity that can be sought. Additionally, there are no excesses to pay or exclusions. Commercial insurers on the other hand operate on a for-profit basis and as such, must guard the interests of their shareholders. We expect that additional competitive pressures on providers, motivated by returning a profit, might lead to greater restrictions on coverage and an incomplete provision, as providers will more likely decline some of the risks currently being undertaken by MDOs. This would have implications for a proportion of clinicians with 'high-risk' specialities or with a claims history that will become unable to buy or afford adequate cover, a situation in which patients could be left uncompensated.

If more commercial for-profit insurers are to join the market, there may be a case for regulation and standardisation of cover, for the protection of the clinician i.e. there should be a minimum standard of cover which all indemnity providers should have to provide. This would ensure an appropriate level of adequacy is in place for clinical support and patient safety.

The need for more transparency and information

The BMA believes it would be helpful to provide assurances and clear information to clinicians as to what may or may not be covered under discretionary indemnity. It is important that doctors are aware of the full extent of their indemnity cover.

In conclusion, the BMA believes that while it believes in plurality of provision, the proposals in the consultation document will not offer greater protection for patients. Instead the BMA would support proportionate reforms that would address the spiralling costs of indemnity. Additionally, the BMA firmly believes that emphasis should be on developing a system where all errors are reported, acted upon, and used to improve the system. Emphasis should be on systemwide lessons, not the individual. Furthermore, it is important to recognise that medicine is an imprecise science requiring a large number of judgement calls and that a wrong judgement is not necessarily negligence. Patient safety will never be improved unless everyone promotes an open learning culture. This issue was recognised by Donald Berwick in his report, *A promise to learn – a commitment to act*⁶ It is crucial that there is a shift from a compensation, blame environment to one where clinicians feel supported when they report their mistakes and the system defects they observe, such that all can learn from them and patients can have recourse to adequate compensation.

⁵ Letter to Dr K Megson, Regional LMC secretary from Dr Christine Tomkins, July 2016.

⁶ ix *A promise to learn – a commitment to act*, Improving the Safety of Patients in England, National Advisory Group on the Safety of Patients in England, August 2013

The Rt Hon David Mundell MP
Secretary of State for Scotland

Dover House
Whitehall
London
SW1A 2AU

Dear Mr Mundell,

Proposed changes to indemnity arrangements affecting GPs in Scotland

I am writing to you in my capacity as chair of the BMA's Scottish GP Committee (SGPC) to seek your assistance regarding Department of Health and Social Care proposals to introduce regulations around clinical negligence indemnity.

What is being proposed in the consultation (available at <https://www.gov.uk/government/consultations/appropriate-clinical-negligence-cover>) is that Medical Defence Organisations become subject to the same regulatory requirements as insurance companies. The likely effect of this is that they will face significantly increased operating costs that would almost certainly be passed on to GPs, who would face higher charges to obtain indemnity cover.

As general practice in England and Wales is about to move to systems of state-backed indemnity, GPs there will be unaffected by these proposals. It is primarily GPs in Scotland and Northern Ireland who would feel the impact of any change, along with doctors practising privately and primary care dentists.

As I am sure you are already aware, general practice in Scotland faces significant difficulties in recruiting and retaining sufficient GPs to meet the needs of Scotland's population. If changes to indemnity result in doctors facing increased costs to practise as a GP in Scotland, then this is likely to further hinder efforts to recruit and retain GPs.

The changes that are being proposed are intended to address an issue that to the best of my knowledge is entirely theoretical. The current arrangements for GP indemnity cover in Scotland work well and GPs in Scotland have not experienced the problems of significant indemnity cost rises faced by our colleagues in England that have resulted in their move to state-backed indemnity. These proposed changes risk fundamentally undermining that market without good reason.

As no regulatory impact assessment has been published to accompany this proposed change, the extent of the impact that these proposals would have on the viability of MDOs and the likely costs to GPs are difficult to establish, but have the potential to be severe.

I would ask that you intervene with your colleagues so that the potential impact on GP recruitment in Scotland is a priority consideration before any substantive action is taken. I look forward to hearing from you in due course.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Andrew Buist'. The signature is stylized with a large, prominent 'B' and 'u'.

Dr Andrew Buist
Chair, BMA Scottish GPC Committee