

**Independent review of the requirement  
to have insurance or indemnity as a  
condition of registration as a  
healthcare professional**

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**Finlay Scott**

# Independent review of the requirement to have insurance or indemnity as a condition of registration as a healthcare professional

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## **Independent review of the requirement to have insurance or indemnity as a condition of registration as a healthcare professional**

### **Issue**

1. I was asked to examine, and to offer recommendations on, whether making insurance or indemnity a condition of registration is the most cost effective and proportionate means of achieving the policy objective that all registered healthcare professionals must have cover<sup>1</sup>.
2. I was not asked to examine whether the policy objective itself was proportionate. The policy objective was a given. During the review, there was clear support for the policy objective.
3. I was assisted by the Review Group whose membership is at Annex A; and by Kat Caldwell, Mike Lewis and Niall McDermott as the able and enthusiastic secretariat from the Department of Health. I am grateful for their support and contributions.

### **Conclusions and recommendations**

4. In my judgement, making insurance or indemnity a statutory condition of registration is the most cost effective and proportionate means of achieving the policy objective. The main reasons are:
  - 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 registrant 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.

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<sup>1</sup> For the purposes of this report, the term 'cover' denotes 'insurance or indemnity'

5. In my judgement, it would not be cost effective or proportionate if healthcare professional regulators, system regulators, primary care organisations and others were required to undertake wholesale compliance testing in pursuit of the policy objective. There is an opportunity for cooperation among various organisations that require insurance or indemnity to be in place. The aim should be a coordinated approach to risk assessment and compliance testing. This would be consistent with the principles of good regulation, and with the approach described in the Hampton Report<sup>2</sup>. There may be scope for greater harmonisation of respective requirements for insurance and indemnity.

6. My conclusions have taken into account that employees in the NHS and independent sector will 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. Personal cover, from a defence organisation, trade union or other body, will not be required in relation to practice as an employee. Personal cover will only be required in relation to self-employed practice. In my judgement, this is the correct approach. However, the role of corporate cover, as a means of satisfying the condition of registration, is not well understood and needs to be explained to registrants and others. It will be important to counter any impression that the policy objective, and the condition of registration, signal a shift of responsibility from employers to employees.

7. If Ministers accept my conclusions, they may wish to take into account the following recommendations:

**Recommendation 1:** There should be a statutory duty upon registrants to have insurance or indemnity in respect of liabilities which may be incurred in carrying out work as a registered healthcare professional.

**Recommendation 2:** In relation to the condition of registration, the roles of healthcare professional regulators should be supported by powers not duties; and those powers should include:

- a. A power to require relevant information to be provided to the Registrar in order to determine whether a registrant, or applicant for registration, has cover.
- b. A power to require registrants to inform the Registrar if cover ceases.
- c. A power to refuse to grant registration to an applicant who fails to comply with a request for information or fails to demonstrate that they have, or will have, cover.

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<sup>2</sup> Report on Regulatory Inspections and Enforcement, HM Treasury, March 2005. Accessible at:  
[http://webarchive.nationalarchives.gov.uk/+http://www.hm-treasury.gov.uk/bud\\_bud05\\_hampton.htm](http://webarchive.nationalarchives.gov.uk/+http://www.hm-treasury.gov.uk/bud_bud05_hampton.htm)

d. A power to withdraw registration from a registrant who fails to comply with a request for information or fails to demonstrate that they have, or will have, cover.

e. A power to refer a registrant into fitness to practise procedures if the cover is alleged to be inadequate or inappropriate to the registrant's practice.

**Recommendation 3:** Relevant legislation should be harmonised across healthcare professional regulators, with common duties on registrants and common powers for healthcare professional regulators.

**Recommendation 4:** There should be a review of existing legislation, including that in force for the General Chiropractic Council, General Optical Council and General Osteopathic Council.

**Recommendation 5:** Within a harmonised framework, it should be for each healthcare professional regulator to decide, using a risk based approach, how best to exercise its powers.

**Recommendation 6:** Healthcare professional regulators should cooperate with system regulators, primary care organisations, and the independent sector to maximise coordination and minimise duplication.

**Recommendation 7:** Healthcare professional regulators should work with employers, trade unions and other representative bodies, and defence organisations to communicate to registrants the importance of insurance or indemnity and to explain how the condition of registration can be satisfied .

**Recommendation 8:** Healthcare professional regulators should explore, for example through pilot studies, how best to introduce the statutory condition of registration in a way that secures registrants' support and compliance rather than resistance.

**Recommendation 9:** Healthcare professional regulators should be given adequate time to prepare but Ministers should set a target date by which the statutory condition of registration has been implemented for all registrants.

**Recommendation 10:** To maintain and enhance public confidence, the Council for Healthcare Regulatory Excellence should report on each healthcare professional regulator's use of the relevant powers, as part of its annual performance review.

**Recommendation 11:** In consultation with insurers and indemnifiers, healthcare professional regulators should consider the case for communicating to patients, clients and the public, for example through regulators' websites, the value of insurance and indemnity, when they can assume it is in place, when they may need to check and how they would do so.

**Recommendation 12:** For the minimisation of doubt, the legislation should ensure, and make clear, that healthcare professional regulators are not liable for a breach of duty by a registrant provided that the regulator has acted reasonably.

**Recommendation 13:** In relation to personal cover required for self-employed practice, there should be a duty upon registrants to provide full disclosure of relevant facts to their insurer or indemnifier.

**Recommendation 14:** When personal cover for self-employed practice is alleged by a healthcare professional regulator to be inadequate or inappropriate, enforcement action should be through fitness to practise procedures, not administrative procedures.

**Recommendation 15:** Provided that there has been full disclosure of relevant facts, in the event that personal cover for self-employed practice is alleged to be inadequate or inappropriate, registrants should be entitled to rely on the defence that they have acted in accordance with the proposals of their insurer or indemnifier.

**Recommendation 16:** Healthcare professional regulators should make clear that, if registrants wish to change the scope of their practice, they should first have, or acquire, adequate and appropriate insurance or indemnity.

**Recommendation 17:** In relation to self-employed practice, healthcare professional regulators should consider their requirements for run-off cover and how to deal with past periods when the statutory condition of registration had been breached.

**Recommendation 18:** Healthcare professional regulators should explain to registrants that Good Samaritan acts fall outside the requirement to have insurance or indemnity as a condition of registration; and should provide guidance to registrants on good neighbour acts.

**Recommendation 19:** When implementing the condition of registration, healthcare professional regulators should seek to ensure, as far as they can, that they do not inadvertently jeopardise the availability of personal cover through membership related schemes provided by trade unions and others.

**Recommendation 20:** In relation to groups for whom the market does not provide affordable insurance or indemnity, the four health departments should consider whether it is necessary to enable the continued availability of the services provided by those groups; and, if so, the health departments should seek to facilitate a solution.

## Background to the Review

8. There are about 1.4 million registered<sup>3</sup> healthcare professionals in the UK. They span some 30 separate groups and are regulated by nine healthcare professional regulators<sup>4</sup>. The regulators range in size from the General Chiropractic Council and the Pharmaceutical Society of Northern Ireland, each with about 2,000 registrants, to the Nursing and Midwifery Council, with over 670,000 registrants.

9. Healthcare professional regulation in the UK is a success story. The great majority of registered healthcare professionals practise to high standards and consistently deliver good quality healthcare. Effective regulation makes an important contribution to ensuring that this continues.

10. Regrettably, however, despite generally high standards, things do sometimes go wrong as a consequence of negligence on the part of a registered healthcare professional.

11. The previous Administration's position was clear - when harm has been caused through negligence on the part of a registered healthcare professional, the patient or client<sup>5</sup> should receive any redress to which they are entitled.

12. For this to be possible, there must be sufficient assets to enable the payment of compensation that is due. There is a risk that compensation will not be paid, or will not be paid in full, because assets are insufficient.

13. To minimise this risk, the previous Administration's policy objective was that all registered healthcare professionals must be covered by insurance or indemnity.

14. This policy objective was fully consistent with the position of seven of the nine regulators. They insist that their registrants should have insurance or indemnity. For example, the General Dental Council's *Standards for Dental Professionals* includes:

*'Make sure your patients are able to claim any compensation they may be entitled to by making sure you are protected against claims at all times, including past periods of practice.'*

15. The policy objective was the end to be achieved. As a means of achieving that end, the previous Administration concluded that insurance or indemnity should be made a condition of registration as a healthcare professional; and that, where necessary, legislation should be amended to achieve this.

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<sup>3</sup> 'registered' in this context means 'registered with a healthcare professional regulator and holding a licence to practise where that is appropriate'.

<sup>4</sup> Unless otherwise specified, the term 'regulator' means 'healthcare professional regulator'.

<sup>5</sup> Not all users of healthcare services are patients, hence the term 'patients and clients'.

16. 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.

17. All employers are vicariously liable for the negligent acts of their employees, provided that the employee was acting in the course of their employment. This principle applies across all settings in which healthcare is delivered, regardless of who is the employer.

18. For the NHS in England, cover is provided through the Clinical Negligence Scheme for Trusts, which is administered by the NHS Litigation Authority. The NHSLA handles claims against its NHS member bodies. Claims are against the NHS body concerned, in their capacity as employer and provider of healthcare. There are equivalent schemes in Scotland (the Clinical Negligence and Other Risks Indemnity Scheme), Wales (the Welsh Risk Pool) and Northern Ireland.

19. CNST does not extend to NHS primary care unless the services are or were delivered by an NHS body. Primary care contracts such as the general medical contract and general dental contract require providers to hold adequate insurance. Failure to do so would be a breach of those contracts. In Scotland, the position under the new General Dental Services regulations is that providers are not required to hold indemnity insurance but they are required to state to the relevant Health Board whether they hold cover.

20. The NHSLA does not handle claims against individual employees and individuals are currently unable to be members of its schemes. NHS bodies should accept full financial responsibility where they are vicariously liable for the negligence of their employees and thus claims are appropriately directed against the NHS body rather than the employee.

21. Significant numbers of employees, who could rely on corporate cover, choose to have personal cover (possibly as part of a package of other services) although they have no self-employed practice

22. Insurance or indemnity is already a statutory requirement for three regulators. They are the GCC (since 10 November 1999) and the General Osteopathic Council (since 9 May 1998), whose legislation contained the necessary provisions from the outset; and the General Optical Council (since 1 July 2005) whose legislation was amended in 2005.

23. Legislation is in place for three further regulators but has not been commenced. They are the GDC, the General Medical Council and the Royal Pharmaceutical Society of Great Britain. The General Pharmaceutical Council, which will assume the RPSGB's regulatory role in 2010, has similar powers in place but not in force.

24. There were preliminary discussions on proposed changes to the NMC's legislation, to make insurance or indemnity a condition of registration. During those discussions concerns were expressed that the market was unable to offer cover to some groups of self-employed registered healthcare professionals and that, without cover, they would lose their registration and livelihood.

25. In the light of those concerns, Ministers concluded that there should be an independent review. The purpose of the review was to examine, and to offer recommendations on, whether making insurance or indemnity a condition of registration is the most cost effective and proportionate means of achieving the policy objective that all registered healthcare professionals must have cover.

26. I was invited to undertake that review, supported by a Review Group. Meanwhile, the GDC, GMC and RPSGB were advised by the Department of Health to put implementation on hold until the review had concluded and decisions had been taken.

## Discussion

### ***Healthcare professional regulation***

27. The purpose of healthcare regulation, broadly speaking, is to protect, promote and maintain the health and safety of the public by ensuring proper standards in healthcare practice<sup>6</sup>.

28. This purpose is generally supported by four regulatory functions: registration, education and training, standards and ethics, and fitness to practise (sometimes misleadingly labelled the disciplinary function).

29. Three of the four functions have their main effects before the event. Registration, education and training, and standards and ethics, all aim to minimise the risk that things will go wrong. For example, education and training, combined with registration procedures, are designed to ensure that only properly qualified individuals obtain and retain registration.

30. In contrast, fitness to practise procedures have their main effects after the event. Fitness to practise procedures are engaged if something has gone wrong or has allegedly gone wrong. The burden of proof lies with the regulator. When fitness to practise is found to be impaired, the regulator can impose sanctions, for example conditions on registration, suspension of registration, or erasure from the register. Those sanctions protect the public interest for the future but they cannot put right something that has already gone awry.

### ***Advice and guidance***

31. The regulators provide general and specific advice and guidance for their registrants. This shapes and encourages good practice and helps to ensure that professional practice keeps pace with the public's expectations.

32. The regulators' guidance significantly influences registrants and their practice. In general, however, compliance with the principles of good practice can only be evaluated after the event.

33. For example, the Health Professions Council's *Standards of Conduct, Performance and Ethics* includes:

*'You must treat information about service users as confidential and use it only for the purposes they have provided it for'.*

34. This is a powerful message; and the HPC's registrants understand that the possible consequences of non-compliance include action on their registration. However, neither the HPC, nor any other regulator, can ensure confidentiality. Regulators can act, through their fitness to practise procedures, when a breach of confidentiality has been alleged but this would be after the event, not before.

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<sup>6</sup> Adapted from the statutory and charitable purpose of the General Medical Council.

35. There are exceptions to this general rule. In principle, it would be possible for a regulator, whose guidance insisted on insurance or indemnity, to test whether cover was in place; and, if there was no cover, to take action through fitness to practise procedures. However, the regulator would require appropriate statutory powers if registrants were to be required to provide relevant information and, as with fitness to practise procedures generally, the burden of proof would remain with the regulator, not with the registrant.

### **Conditions of registration**

36. In contrast, a condition of registration, implemented as an express or implied statutory duty, shifts the onus to the registrant. When appropriate powers have been granted to the regulator, a breach by the registrant can be addressed through administrative procedures rather than fitness to practise procedures.

37. For example, registered medical practitioners are required to maintain an effective address to enable the GMC to communicate with them. Under section 30(5) of the Medical Act 1983:

*'The Registrar may, by letter addressed to any person registered in the register at his address on the register, inquire whether he has changed his address and, if no answer is received to the inquiry within six months from the posting of the letter, may erase from the register the entry relating to that person.'*

38. In line with general public law principles, powers must be exercised reasonably; and regulators incorporate safeguards into their procedures before taking administrative action that has an impact on registration. The GMC, when it has reason to believe that a doctor's registered address is now incorrect, follows a four stage process before erasure from the register under section 30(5). The stages are designed to maximise the opportunity for doctors to respond; and include the use of email and text messages where possible.

### **Current position on insurance and indemnity**

39. The regulators fall into three groups:

- a. Group A: GCC, GOC and GOsC: their guidance insists on insurance or indemnity (when in active practice in the case of the GCC) and it is a statutory requirement.
- b. Group B: GDC, GMC, PSNI and RPSGP: their guidance insists on insurance or indemnity but a statutory requirement is not yet in force.
- c. Group C: HPC and NMC: their guidance does not insist on insurance or indemnity.

40. The HPC does not offer guidance on the need for insurance or indemnity. However, the HPC made clear during the review that it stands ready to implement a statutory condition of registration if the HPC's legislation is amended.

41. The NMC's guidance recognises the importance of insurance or indemnity but stops short of making it a requirement. Since the discussions that prompted this review, the NMC has reaffirmed that protection of the public interest is the NMC's main obligation and that this principle will be central to the NMC's formal decision on the issue of cover in July 2010.

### **How to answer the question?**

42. The question at the heart of the review is narrowly focussed. However, it became clear from early contributions to the review that there was a range of associated issues that would need to be addressed if Ministers decided to proceed with the condition of registration. Some are strictly outside the terms of the review but the Review Group suggested that I should include them and, if appropriate, offer recommendations.

43. I concluded that to answer the question posed by the review, and to address some of the issues that had arisen in the early discussions, it was necessary to pose the following:

Question 1: What would be the comparative costs and benefits of a statutory condition of registration?

Question 2: How could regulatory costs be contained or reduced?

Question 3: What should be expected of the regulators?

Question 4: Would there be a risk of unintended consequences and how could they be managed?

Question 5: What supplementary points have arisen in the course of the review?

### ***Question 1: What would be the comparative costs and benefits of a statutory condition of registration?***

44. The principles of good regulation are integral to the work of all Government departments and regulators. Regulation should be:

- a. Proportionate: regulators should only intervene when necessary. Remedies should be appropriate to the risk posed, and costs identified and minimised.
- b. Accountable: regulators must be able to justify decisions, and be subject to public scrutiny.
- c. Consistent: rules and standards must be joined up and implemented fairly.

- d. Transparent: regulators should be open, and keep regulations simple and user friendly.
  - e. Targeted: regulation should be focused on the problem, and minimise side effects.
45. When the review was established, there was an expectation that the question posed could be answered, or would be informed, by cost benefit analysis.
46. Conventionally, cost benefit analysis would look at the cost effectiveness of various approaches to addressing the relevant mischief in order to identify where the optimum balance lay between costs and benefits.
47. The primary mischief in this case is failure, through the absence of adequate resources, to secure compensation that is due as the result of negligence on the part of a registered healthcare professional. The Review Group, therefore, agreed to the commissioning of research:
- a. To assess the scale and seriousness of incidence.
  - b. To examine the costs and benefits of options for introducing insurance or indemnity as a condition of registration for regulated healthcare professionals.
  - c. To identify the practicalities of minimising associated costs to ensure that the impact is as proportionate as possible.
48. One aim of the research, the report of which is at Annex B, was to inform a comparison of different approaches to addressing the primary mischief.
49. In the event, it proved impossible to formulate conventional cost benefit analysis in relation to the primary mischief. 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.
50. There is a further consideration. The issue at the heart of the policy objective is not how to reduce negligence on the part of registered healthcare professionals and, hence, reduce costs. Rather, given that negligence will regrettably occur, the issue is where the costs of that negligence should fall.
51. I have, therefore, adopted a different approach to costs and benefits, based on a comparison, in principle, between a statutory condition of registration, supported by appropriate powers, and a notional, at least equally effective, alternative means of delivering the policy objective, whatever form it might take. Both approaches – the condition of registration and the notional alternative – would require registrants to have cover, in line with the policy objective: the difference between them would be how the requirement is expressed.

## *Costs and benefits*

52. Potential costs fall under three headings:

- 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.

### Compliance

53. The compliance costs of a regulatory requirement are the incremental costs that arise from that requirement. They do not include the costs of activities that would have been carried out anyway or of meeting requirements that were already in place.

54. In this case, the requirement to have insurance or indemnity arises from the policy objective, not from the means of achieving it.

55. A statutory condition of registration requires no more of the registrant than any other means of achieving the policy objective. As it happens, it also requires no more than is already required, through guidance, by seven of the regulators.

56. It follows that no incremental compliance costs arise as a result of making insurance or indemnity a statutory condition of registration.

### Compliance testing

57. Regulators will incur costs if, for example, they are required, or choose, to check that registrants have cover. This will be true whether the requirement for cover is expressed as a statutory condition of registration or is expressed in some other way.

58. There is no self evident reason why a regulator should undertake more compliance testing, or more expensive compliance testing, because insurance or indemnity is required as a statutory condition of registration and not as the result of a notional alternative. Whatever means has been adopted to deliver the policy objective, regulators should do what they judge to be required to encourage or ensure compliance.

59. It follows that no incremental costs of compliance testing would result from a statutory condition of registration.

## Enforcement

60. Insurance or indemnity is already a statutory requirement for registrants of the GCC, GOC and GOsC. However, because of the way their legislation is framed, the GCC and GOsC can only address actual or suspected breaches through their fitness to practise procedures. For example, the General Osteopathic Council (Professional Indemnity Insurance) Rules 1998 include:

*'9. Any failure by an osteopath to maintain insurance in accordance with these Rules may be treated as constituting unacceptable professional conduct and dealt with accordingly.'*

61. Registrants of the Group B regulators breach good practice guidance if they do not have cover; and they consequently leave themselves open to action under fitness to practise procedures. This would be true of any notional alternative to a statutory condition of registration.

62. The disadvantages of relying on fitness to practise procedures include that the burden of proof lies with the regulator to prove a negative, namely that cover is absent; and high costs.

63. In contrast, provided that regulators have appropriate powers, a statutory condition of registration would require the registrant to be able to prove a positive, namely that cover was present; and action, when cover was absent, could be taken through low cost administrative procedures rather than high cost fitness to practise procedures.

64. It follows that, when cover is absent, a statutory condition of registration would reduce enforcement costs compared with a notional alternative means of achieving the policy objective.

### *Significant added value*

65. There is little or no point in a free or cheap good if it does not add any or sufficient value. A statutory condition of registration would have the potential to add significant value in a number of ways:

- 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 the alternatives, without increasing compliance costs or the costs of compliance testing.

d. A statutory condition of registration would require the registrant 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.

**Recommendation 1:** There should be a statutory duty upon registrants to have insurance or indemnity in respect of liabilities which may be incurred in carrying out work as a registered healthcare professional.

### *Adjuncts to a statutory condition of registration*

66. A number of other possible approaches to delivering the policy objective were identified in the course of the review. They included further exhortation and guidance by regulators, system regulation, contract management, and market power exercised by patients and clients.

67. For example, in Scotland the provider of a care service regulated by the Care Commission is legally required to have a certificate of insurance in relation to the care service in respect of death, injury, public liability or other loss.

68. In principle, system regulators such as the Care Commission and the Care Quality Commission in England could ensure, in relation to providers regulated by them, that insurance or indemnity is in place appropriate to harm caused through negligence on the part of a registered healthcare professional employed by or associated with the healthcare provider.

69. There are, however, limitations to this approach: in particular, coverage by system regulators is not universal. System regulation alone cannot deliver the policy objective.

70. Similar limitations apply to contract management.

71. System regulation, contract management, patient and client power, and other possible approaches have the potential to add value; and they could play an important part in encouraging registrants to have cover and in reducing the need for, and costs of, compliance testing. They could help to identify and report registrants who were practising without insurance or indemnity.

72. However, with all other possible approaches, if insurance or indemnity were absent, the burden of proof would remain with the healthcare professional regulator to prove a negative; and enforcement action would be through high cost fitness to practise procedures, rather than low cost administrative procedures.

73. Other possible approaches to delivering the policy objective should be seen as adjuncts to a statutory condition of registration, not alternatives.

## **Question 2: How could regulatory costs be contained or reduced?**

### *Duties and powers*

74. Fears were expressed during the review that a statutory condition of registration would lead to substantial additional costs for regulators, out of proportion to the mischief being addressed. I believe this reflected an misinterpretation of the proposals.

75. A duty on registrants to have insurance or indemnity would not, by itself, create a corresponding duty on regulators to check that cover was in place. Having placed a duty on registrants, legislation could create duties, or powers, or a combination of duties and powers, for regulators.

76. The provisions in place, but not commenced, for the GMC and RPSGB are along similar lines. For example, Article 38(1) of the Pharmacists and Pharmacy Technicians Order 2007 places a statutory duty on registrants:

*'A registrant who is registered in Part 1 of one of the Society's registers must have in force in relation to him an adequate and appropriate indemnity arrangement which provides cover in respect of liabilities which may be incurred in carrying out work as a pharmacist or pharmacy technician.'*

77. The remainder of article 38 creates powers to be exercised at the discretion of the RPSGB. No duties are imposed upon the RPSGB.

78. In my view, this is the correct approach.

**Recommendation 2:** In relation to the condition of registration, the roles of healthcare professional regulators should be supported by powers not duties and those powers should include:

- a. A power to require relevant information to be provided to the Registrar in order to determine whether a registrant, or applicant for registration, has cover.
- b. A power to require registrants to inform the Registrar if cover ceases.
- c. A power to refuse to grant registration to an applicant who fails to comply with a request for information or fails to demonstrate that they have, or will have, cover.
- d. A power to withdraw registration from a registrant who fails to comply with a request for information or fails to demonstrate that they have, or will have, cover.
- e. A power to refer a registrant into fitness to practise procedures if the cover is alleged to be inadequate or inappropriate to the registrant's practice.

## *Harmonisation*

79. We have a plural approach to healthcare professional regulation, with nine regulators covering some 30 groups of healthcare professionals. The groups vary greatly in their characteristics and in the circumstances in which they provide healthcare. The plural approach enables individual regulators to judge how best to regulate their registrants.

80. On the other hand, many of the variations evident across the nine regulators are accidents of history, rather than a result of objective analysis. The existing legislation in relation to insurance and indemnity is no exception. There are marked differences across the provisions in force for the GCC, GOsC and GOC; and between those provisions and the provisions in place, but not commenced, for the GDC, GMC and RPSGB.

81. A harmonised framework would benefit patient and client understanding. It would help to ensure that regulators can share best practice based on experience; and that system regulators, and others who could make a contribution to compliance testing, can get to grips with one harmonised framework rather than nine variations on a theme.

**Recommendation 3:** Relevant legislation should be harmonised across healthcare professional regulators, with common duties on registrants and common powers for healthcare professional regulators.

82. I was not invited to review the existing legislation. However, if this report commands support, changes will be required to the legislation already in force, and to the legislation in place but not commenced. My impression is that the legislation in place, but not commenced, for the GMC and RPSGB comes closest to what is required. However, there is room for improvement.

**Recommendation 4:** There should be a review of existing legislation, including that in force for the General Chiropractic Council, General Optical Council and General Osteopathic Council.

## *Risk assessment*

83. The fact that something can be checked does not mean that it should be checked. The cash and opportunity costs of routinely confirming that 1.4 million registrants have insurance or indemnity would be considerable. Even if the resources were readily available, it is probable that they could be spent to better effect.

84. It may be appropriate, from time to time, to remind registrants of the need for insurance or indemnity, for example when registration is due for renewal. It is doubtful whether asking them for confirmation, by ticking a box, adds any or sufficient value.

85. The Hampton Report confirmed:

a. If regulators operate effectively, and use the best evidence to programme their work, administrative burdens can be reduced while maintaining or even improving regulatory outcomes.

- b. Risk assessment is an essential means of directing regulatory resources where they can have the maximum impact on outcomes.
- c. Regulators should use the resources released through ... risk based assessment to provide improved advice, because better advice leads to better regulatory outcomes.

86. The exercise of each regulator's powers should be based on risk assessment that reflects, among other things, the characteristics of registrants and the contexts in which registrants practice. The risk to be assessed would be the regulatory risk that the statutory condition of registration is being, or would be, breached. The risk would not be the risk associated with clinical and other procedures.

87. Risk assessments should be undertaken by each regulator. It would be inappropriate to determine centrally the scale and nature of compliance testing that would be appropriate for particular groups.

**Recommendation 5:** Within a harmonised framework, it should be for each healthcare professional regulator to decide, using a risk based approach, how best to exercise its powers.

#### *Maximising cooperation*

88. A number of bodies, with different roles and responsibilities, have in common that they insist on insurance or indemnity. They include healthcare professional regulators, system regulators, primary care organisations when awarding contracts and independent sector hospitals when granting admitting rights.

89. There is a danger that the same question about insurance and indemnity will be asked many times. There is an equal danger that each organisation will assume that checks are being undertaken by others.

**Recommendation 6:** Healthcare professional regulators should cooperate with system regulators, primary care organisations, and the independent sector to maximise coordination and minimise duplication.

#### *Guidance (and enlightened self interest)*

90. Guidance from regulators shapes their registrants' practice; and all regulators issue targeted advice and guidance from time to time, in the light of changes in the external environment or when an issue is topical.

91. A reasonable hypothesis is that further highlighting the importance of insurance or indemnity would reduce the number and proportion of self-employed registrants who do not have cover or whose personal cover is inadequate or inappropriate. Targeted advice and guidance could explain why insurance or indemnity serves registrants' self interest as well as serving the interests of patients and clients. If explained sensitively, registrants should recognise the advantages for them, as well as for patients and clients.

92. It will be important to explain that personal cover, from a defence organisation, trade union or other body, will not be required in relation to practice as an employee; and that personal cover will only be required in relation to self-employed practice. Opportunities should be taken to counter any impression that the policy objective, and the condition of registration, signal a shift of responsibility from employers to employees.

**Recommendation 7:** Healthcare professional regulators should work with employers, trade unions and other representative bodies, and defence organisations to communicate to registrants the importance of insurance or indemnity and to explain how the condition of registration can be satisfied.

### *Professionalism*

93. A characteristic of registered healthcare professionals in the UK is their professionalism, defined as the set of values, behaviours, and relationships that underpins the trust the public has in them<sup>7</sup>.

94. The February 2007 White Paper<sup>8</sup> on regulation recognised the value to patients of that professionalism:

*'Patients in the United Kingdom rightly have great confidence in their health professionals ...*

*The danger is that ... we risk highlighting too much the poor practice or unacceptable behaviour of a very small number ...*

*... professionalism is an unquantifiable asset ... which rules, regulations and systems must support not inhibit.'*

95. It is possible that making insurance or indemnity a condition of registration will be seen by registered healthcare professionals as yet another unnecessary diminution of their professionalism. This may be a particular risk among groups where personal cover, at the registrant's expense, is already commonplace; and the risk may be increased if regulators adopt an unselective, tick box, approach to compliance testing.

**Recommendation 8:** Regulators should explore, for example through pilot studies, how best to introduce the statutory condition of registration in a way that secures registrants' support and compliance rather than resistance.

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<sup>7</sup> Adapted from *Doctors in Society, Medical professionalism in a changing world* published by the Royal College of Physicians of London in December 2005.

<sup>8</sup> Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century, White Paper published 21 February 2007

### *Timescales and safeguards*

96. Each regulator will need to undertake an informed risk assessment, devise a risk algorithm, decide what compliance testing is required and, if necessary, implement changes to administrative processes and systems.

97. The speed with which regulators can do so cost effectively will be a function of their respective starting points. For some, with more up to date, flexible, systems this should be relatively straightforward. For others, it may take longer.

**Recommendation 9:** Healthcare professional regulators should be given adequate time to prepare but Ministers should set a target date by which the statutory condition of registration has been implemented for all registrants.

98. I am confident that regulators will seek to implement effective, and cost effective, compliance testing that properly reflects their commitment to protecting the public interest. Regulators may consider it advisable to consult on their proposed approaches to ensure that they command the confidence and support of patients, clients and the public. As with other aspects of regulation, there should be a degree of external oversight. The Council for Healthcare Regulatory Excellence reports annually on how each regulator carries out its functions.

**Recommendation 10:** To maintain and enhance public confidence, the Council for Healthcare Regulatory Excellence should report on each healthcare professional regulator's use of the relevant powers, as part of its annual performance review.

### ***Question 3: What should be expected of the regulators?***

#### *Patients and clients: awareness and expectations*

99. The Review Group considered it essential to understand the expectations of patients and clients, the public, and service users regarding insurance or indemnity for registered healthcare professionals. PWC were commissioned to conduct a series of focus groups for this purpose. The report can be found at Annex C

100. The PWC report's first conclusion is:

*'There was an overall assumption that all Healthcare Professionals are covered by insurance and it was felt to be very important for them to have insurance. Only a small minority would use an uninsured professional, and this would only be for treatments perceived to be less risky.'*

101. As Sir Cecil Clothier noted<sup>9</sup>, the determined intelligent criminal mind will defeat even the most effective system of regulation. Despite the statutory condition of registration, a registrant who is determined to practise without cover will almost certainly succeed, at least for a period.

102. It would be wrong to create an expectation among patients and clients that the primary mischief can be completely eliminated. Careful communication should help to enhance awareness among patients and clients without raising unrealistic expectations.

103. In 2005, the HPC first ran a campaign to raise awareness among patients and the public of the importance of registration to safeguarding the public interest and of the value of checking registration. There are opportunities for all regulators to draw on, and build upon, the HPC's experience.

104. The importance of registration, and the value of registers, has been increasingly acknowledged by the media over the past 10 years or so. It is now commonplace to find advice on the need to check registration, for example in articles on plastic surgery. There is the potential to make journalists and other commentators similarly aware of the importance of insurance and indemnity, particularly in relation to self-employed practice.

**Recommendation 11:** In consultation with insurers and indemnifiers, healthcare professional regulators should consider the case for communicating to patients and clients, for example through regulators' websites, the value of insurance and indemnity, when they can assume it is in place, when they may need to check and how they would do so.

#### *Liability in the event of a breach*

105. The regulators expressed concern that they could be liable, in the event of a successful claim for compensation following negligence on the part of a registrant, if it transpired that the registrant did not have insurance or indemnity or that the cover was inadequate or inappropriate.

106. As far as I have been able to establish, there has never been any intention that regulators should be liable for a breach of a statutory duty by a registrant provided, as always, that the regulator had acted reasonably.

**Recommendation 12:** For the minimisation of doubt, the legislation should ensure, and make clear, that healthcare professional regulators are not liable for a breach of duty by a registrant provided that the regulator has acted reasonably.

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<sup>9</sup> *Independent Inquiry relating to deaths and injuries on the children's ward at Grantham and Kesteven General Hospital*. London: HMSO, 1994

## *Adequate and appropriate*

107. The legislation for the GDC, GMC, GOC and RPSGB associates the phrase 'adequate and appropriate' with the requirement to have insurance or indemnity. For example, section 10A(1) of the Opticians Act 1989 stipulates:

*'A registered optometrist or registered dispensing optician must be covered by adequate and appropriate insurance throughout the period during which he is registered in the appropriate register'.*

108. The legislation for those regulators includes the power to make rules on 'adequate and appropriate'. For example, section 26A(2) of the Dentists Act 1984 includes:

*'In this section "adequate and appropriate insurance" means insurance of a type and amount which rules under this section specify as adequate and appropriate.'*

109. There is an obvious circularity in this formulation. The *Interpretation* sections of the respective legislation offer no guidance on the meaning of 'adequate and appropriate'. In the context of insurance or indemnity as a condition of registration, the phrase appears to have its origin in the GOC's response to the consultation on the draft amendment Order in 2005. It is unclear what view a Court would take if the point was tested.

110. The terms 'adequate' and 'appropriate' are relevant only to personal cover required to satisfy the condition of registration in relation to self-employed practice. The issues they raise are not relevant to corporate cover; and they are not relevant to personal cover that is held by employees as a matter of choice and not to satisfy the condition of registration.

111. The interpretation of 'appropriate' is, or should be, relatively straightforward. On the face of it, insurance or indemnity must be appropriate to the nature and scope of the registrant's self-employed practice; and geographical coverage must include the UK.

112. The interpretation of 'adequate' is less straightforward and a recurring question during the review was who should determine what is, or would be, adequate?

113. There are three, not mutually exclusive, candidates for determining adequacy of personal cover in relation to self-employed practice – regulators; registrants; and insurers and indemnifiers.

114. It was common ground throughout the review that regulators are not competent to determine adequacy. Insurance and indemnity are highly technical, complex, areas requiring considerable expertise that regulators could not sensibly be expected to maintain.

115. Regulators would need to take advice from, and depend upon, expertise to be found elsewhere. This happens with the GOC, and with the GCC and GOsC whose legislation imposes an analogous responsibility, albeit expressed differently.

116. It is misleading, and potentially unhelpful, to require regulators to appear to profess a competence they do not possess.

117. It was also common ground that, for the same reasons, registrants are not competent to determine adequacy in relation to any self-employed practice.

118. A tripartite approach, on the following lines, has the potential to balance competences and responsibilities:

- a. Regulators would be responsible for providing advice and guidance to their registrants on when personal cover is required; and on how registrants should satisfy themselves that they have adequate and appropriate cover. Regulators should act when personal cover for self-employed practice is alleged to be inadequate (or inappropriate).
- b. Registrants would be responsible for providing full disclosure of relevant facts to their insurer or indemnifier.
- c. Insurers and indemnifiers would continue to determine what is adequate for individual registrants in the light of information provided by those registrants.

**Recommendation 13:** In relation to personal cover required for self-employed practice, there should be a duty upon registrants to provide full disclosure of relevant facts to their insurer or indemnifier.

119. It would fly in the face of the intention behind the policy objective if, in relation to self-employed practice, the statutory condition of registration could be met through possession of insurance or indemnity whose provisions were inadequate or inappropriate. The regulator must have the power to act.

120. This led to the following distinction: when the registrant has failed to demonstrate that cover is present, the breach should be a matter for administrative procedures; and, when cover is alleged to be inadequate or inappropriate, this should be a matter for fitness to practise procedures.

121. The rationale is that presence or absence is a binary test, whereas adequacy or inadequacy, and appropriateness or inappropriateness, may leave room for argument. When cover is alleged by the regulator to be inadequate or inappropriate, it should be open to registrants to defend their position, with the burden of proof on the regulator. Each party would be able to deploy expert opinion to support its position.

**Recommendation 14:** When personal cover for self-employed practice is alleged by a healthcare professional regulator to be inadequate or inappropriate, enforcement action should be through fitness to practise procedures, not administrative procedures.

122. Having recognised that registrants are not competent to decide what is adequate personal cover for their self-employed practice, it would not be fair to expect them to second guess what the regulator would judge to be adequate. One contribution to resolving this complements the proposed duty on registrants to provide full disclosure of relevant facts to their insurer or indemnifier.

**Recommendation 15:** Provided that there has been full disclosure of relevant facts, in the event that personal cover for self-employed practice is alleged to be inadequate or inappropriate, registrants should be entitled to rely on the defence that they have acted in accordance with the proposals of their insurer or indemnifier.

123. In practice, there will be variations on the administrative action versus fitness to practise action dichotomy. For example, it may be appropriate to enable registrants to address suspected breaches before either administrative or fitness to practise action is taken.

#### *The chicken or the egg?*

124. Fears were expressed that the references in legislation to 'adequate and appropriate' would require regulators to keep track of registrants' practice in order to ensure that the both criteria continued to be met. I believe this reflected a misinterpretation of the proposals; and, if the recommendations above are accepted, those fears will have been addressed.

125. However, there is a risk that, inadvertently or otherwise, registrants may take their practice outside the scope of their current insurance or indemnity in advance of modifying or extending their cover.

126. It is a cardinal principle of healthcare professional regulation in the UK that registrants should practice within their knowledge and skills. For example, the GMC's *Good Medical Practice* includes:

*'3 In providing care you must:*

*(a) recognise and work within the limits of your competence.'*

127. The corollary is that, if registrants wish to change the scope of their practice, they must first have, or acquire, the necessary knowledge and skills. The same principle should apply to insurance or indemnity.

**Recommendation 16:** Healthcare professional regulators should make clear that, if registrants wish to change the scope of their practice, they should first have, or acquire, adequate and appropriate insurance or indemnity.

#### *Run-off cover*

128. Negligence claims can arise years after the relevant healthcare services were provided. Run-off cover provides cover for claims that first come to light and are notified after a policy has ceased to have effect but only in respect of services provided during the life of the policy.

129. The importance of run-off cover is recognised, for example, in the GOsC's Rules:

*'7. Every practising osteopath shall maintain insurance cover for the prescribed risks and in the prescribed amounts to cover any claims in respect of his practice as an osteopath which may arise after the date on which he ceases to practise as an osteopath for whatever reason.'*

130. The regulators will need to consider their requirements for run-off cover. They will also need to address how to deal with situations in which it comes to light that a registrant has practised for a period without cover, for whatever reason. Acquiring or resuming cover for the future will not by itself address the issue for any past period when there was no adequate or appropriate cover in place.

**Recommendation 17:** In relation to self-employed practice, healthcare professional regulators should consider their requirements for run-off cover and how to deal with past periods when the statutory condition of registration had been breached.

**Question 4: Is there a risk of unintended consequences; and, if so, how can they be managed?**

131. As with any policy objective, there is a danger of unintended consequences. In this case, they include:

- a. Inhibiting Good Samaritan acts and good neighbour acts.
- b. Impacting adversely on trade union and similar membership based indemnity schemes.
- c. Denying registration to healthcare professionals for whom, through no fault of their own, the market does not provide cover at affordable cost.

*Good Samaritan acts and good neighbour acts*

132. The majority of registered healthcare professionals are employed by a healthcare provider in the NHS or independent sector. They will be entitled to rely upon corporate cover, by dint of their employer's vicarious liability, to meet the statutory condition of registration. Employed healthcare professionals may choose to have personal cover but they will not be required to do so.

133. The argument in relation to Good Samaritan acts and good neighbour acts is that they fall outside the normal work of a registrant and, hence, outside any corporate cover; or may be perceived as so doing. The result, it is argued, is that individuals, who do not have personal cover, may be reluctant to undertake Good Samaritan acts or good neighbour acts for fear of attracting the wrath of their regulator.

134. It is important that any such risks are addressed by common sense and good communication. For example, section 44C(1) of the Medical Act 1983, which has not been commenced, makes clear that the cover required is '*in respect of liabilities which may be incurred in carrying out work as a medical practitioner*'. Good Samaritan acts do not fall within this definition.

135. Good neighbour acts may be less clear cut. On the one hand, single, unpaid, good neighbour acts are unlikely to be classed as carrying out work as a healthcare professional. On the other hand, repeated acts, over a sustained period, may be classed as work as a healthcare professional even if unpaid.

136. Regulators should make clear that the requirement to have insurance or indemnity as a condition of registration will only apply in respect of the provision of healthcare services by registrants in the course of employment or self-employment.

**Recommendation 18:** Healthcare professional regulators should explain to registrants that Good Samaritan acts fall outside the requirement to have insurance or indemnity as a condition of registration; and should provide guidance to registrants on good neighbour acts.

#### *Trade union and similar schemes*

137. A number of trade unions offer discretionary indemnity as an adjunct to membership; and the evidence presented to the review suggested that such schemes were a valuable, cost-effective, source of personal cover.

138. Fears were expressed that introducing the statutory condition of registration could jeopardise the viability of those schemes. Two particular examples were given - if the interpretation of 'adequate and appropriate' led to a requirement for much higher compensation ceilings than currently in place; and if employers increasingly sought to recover from employees (and their insurers or indemnifiers) some or all of the costs borne by employers as a result of vicarious liability.

139. Strictly, neither example of potential jeopardy arises as a direct consequence of the proposed condition of registration. However, they illustrate the fear of unintended consequences that could jeopardise valued sources of personal cover.

**Recommendation 19:** When implementing the condition of registration, healthcare professional regulators should seek to ensure, as far as they can, that they do not inadvertently jeopardise the availability of personal cover through membership related schemes provided by trade unions and others.

### *Groups who cannot obtain affordable cover in the market*

140. There are groups of self-employed registered healthcare professionals who, through no fault of their own, cannot obtain insurance or indemnity in the market or can do so only at a cost that is unaffordable. It follows that, in the absence of a solution, those individuals would be unable to secure or retain registration.

141. It is important to stress that the impediment to a market solution is not quality of care. The impediment is that the number of individuals is too small to enable the risk to be pooled and spread in a way that produces an affordable premium.

142. The potential problem arises from the policy objective that all registered healthcare professionals must have insurance or indemnity. It does not arise from the statutory condition of registration as the means of delivering the policy objective. To that extent, strictly the problem falls outside the remit of this review.

143. Nevertheless, the position of such groups is relevant to the acceptability of making insurance or indemnity a condition of registration and to securing confidence and support. It will not help if some self-employed registered healthcare professionals, who are providing good quality and valued services, are unable to continue to practise because they cannot, through no fault of their own, meet a condition of registration despite their willingness to do so.

144. It is a well established principle that governments may need to intervene when the functioning of the market does not, or cannot, provide an affordable solution.

**Recommendation 20:** In relation to groups for whom the market does not provide affordable insurance or indemnity, the four health departments should consider whether it is necessary to enable the continued availability of the services provided by those groups; and, if so, the health departments should seek to facilitate a solution.

### ***Question 5: What supplementary points have arisen in the course of the review?***

145. A number of supplementary points arose that fall outside the scope of the review. They do not justify a recommendation but some should be recorded.

#### *Public expectations when receiving NHS care*

146. The PWC research on public expectations indicated that patients and the public assume that cover is available across the NHS:

*“If it says NHS that means National Health, it’s the government so its automatically covered.”*

147. The arrangements for meeting the costs of negligence on the part of a registered healthcare professional are different in NHS primary care compared with most other parts of the NHS. For example, in England, CNST does not extend to independent contractors providing NHS primary care services, except in limited circumstances where the primary care organisation may enter into a centrally approved agreement to take on liabilities.

148. Primary care contracts such as the general medical contract and general dental contract require providers to hold adequate cover; and failure to do so would be a breach of those contracts. The requirement for adequate cover can be met through a contract of insurance or other arrangement made for the purpose of indemnifying the contractor; and this can include aggregation of the individual insurance or indemnity held by the contractor's employees.

149. There is no reason to believe, or evidence to suggest, that the arrangements fail to provide compensation when it is due. However, when the contracts are next reviewed, it may be appropriate to consider whether the current provisions remain the best way of expressing the insurance and indemnity requirement.

#### *Uninsured or unindemnified claims*

150. Making insurance or indemnity a condition of registration will not guarantee that every registered healthcare professional will at all times have adequate and appropriate cover. There will be a residual risk, probably small, that a patient or client may not receive redress to which they are entitled.

151. In the course of the review, it was suggested that the residual risk could, or should, be addressed by arrangements analogous to the Motor Insurance Bureau, which is funded by the insurance industry for the purpose of meeting claims from innocent parties in relation to damage, injury or death caused by uninsured drivers.

#### *Insurance versus indemnity*

152. In the course of the review, one defence organisation argued that only insurance should be accepted as meeting the condition of registration because discretionary indemnity, by its nature, did not provide the guarantee associated with a contract of insurance. Officials confirmed that both insurance and indemnity were acceptable and I did not consider the issue further.

#### *Research and innovative practice*

153. In the course of the review, fears were expressed that insurers and indemnifiers would become increasingly cautious in order to reduce and minimise their exposure; and that, as a result, they would be tempted to exclude research and innovative practice from scope of cover.

154. It is not clear that the statutory condition of registration would bring about, or accelerate, change in this respect. However, it would be a matter of considerable concern if, for other reasons, lack of insurance or indemnity inhibited good quality research or well-founded innovative practice.

### *Catch 22?*

155. It was suggested that the condition of registration would create a situation in which newly qualified healthcare professionals would not be able to secure registration until they have cover; and yet they would not have cover until they have a job, which depends on registration.

156. In my view, any such potential problem is easily resolved: applicants who intend only to seek employment can be granted registration on the basis that they will enjoy corporate cover when they have a job; and applicants who intend to be self-employed, or wish to have the option of self-employment, can acquire adequate and appropriate personal cover.

### *European Union*

157. The Review Group was aware that a draft EU Directive on cross-border healthcare secured political agreement on 8 June 2010. It will now be considered by the European Parliament for its second reading. The earliest date for a final Directive is January 2011, with an implementation date some two years later. One of the provisions of the Directive requires that:

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

158. The Review Group was advised that the effect will be to require all healthcare professionals offering services to be covered by some form of indemnity or insurance so that patients from EU countries have clarity about liability and redress when deciding which provider to use.

159. As far as I am aware, none of the conclusions or recommendations in this report run counter to the principles of the draft Directive.

## **List of Abbreviations used in this report**

CHRE	Council for Healthcare Regulatory Excellence
CNORIS	Clinical Negligence and Other Risks Indemnity Scheme
CNST	Clinical Negligence Scheme for Trusts
CQC	Care Quality Commission
EU	European Union
GCC	General Chiropractic Council regulates chiropractors.
GDC	General Dental Council
GMC	General Medical Council
GOC	General Optical Council
GOsC	General Osteopathic Council
HPC	Health Professions Council
NHS	National Health Service
NHSLA	NHS Litigation Authority
NMC	Nursing and Midwifery Council
PSNI	Pharmaceutical Society of Northern Ireland
PWC	Pricewaterhouse Coopers llp
RPSGB	Royal Pharmaceutical Society of Great Britain

## Annex A

### Membership of the Review Group

Finlay Scott	Chair of the Indemnity Policy Review Group
Sally Taber (Alternate Andrew Wilby)	Head of Operational Policy, Independent Healthcare Advisory Service
David Grantham	Head of Programmes, NHS Employers
Paul Philip/ Una Lane	General Medical Council
Steve Walker (Alternate – Helen Vernon)	Chief Executive, NHS Litigation Authority
Christina McKenzie Carmel Lloyd	Nursing and Midwifery Council
Louise Silvertown	Royal College of Midwives
Janet Davies (alternate Howard Richmond)	Royal College of Nursing
Sally Brearley	Chair of Health Link
Dian Taylor	Chief Executive, General Optical Council
Sheila Tunstall-James	Patient & Public representation from Scotland
Kevin Milsom	President, Association of British Dispensing Opticians
Andrea Holder	Care Quality Commission

### Observers

Kat Caldwell	Secretariat for the Indemnity Policy Review	Department of Health
Mike Lewis	Secretariat and Policy Lead on Professional Standards Indemnity Review	Department of Health
Niall McDermott	Section Head, Professional Standards	Department of Health
Rona McCandlish	Midwifery Professional Officer	Department of Health
Paul Whitbourn	System Regulation on EU Policy	Department of Health
Michael C Wright	Clinical Governance Team	Department of Health,
Mark D Bennett	Policy Manager - System Regulation	Department of Health
Rob Oldham	Policy Manager – Indemnity	Department of Health
Sandra Ince	Solicitor, NHS Primary Care and Professional Regulation	Department of Health Legal Services
Anne Rees	Solicitor, Public Health and Medical Ethics	Department of Health Legal Services
Joyce Cairns	Head of Workforce Planning	Department of Health, Social Services and Public Safety, Northern Ireland

Barbara Bale	Head of Workforce Regulation, Education, Training and Development Health and Social Care Directorate	Welsh Assembly Government
Alexandra Watson	Senior Medical Officer Scottish No Fault Compensation Group	Scottish Executive
Catherine Clark	Head of Regulatory Unit	Scottish Government Health Directorates

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

**Insurance and Indemnity Policy Review Stakeholder Engagement  
Exercise – Key findings**

**Respondents to the Review Group**

British Medical Association  
Chartered Society of Physiotherapy  
Department of Health  
Department of Health, Social Services and Public Safety, Northern Ireland  
General Chiropractic Council  
General Dental Council  
General Medical Council  
General Optical Council  
General Osteopathic Council  
GMB  
Health Professions Council  
Independent Healthcare Advisory Services  
Independent Midwives (UK)  
Medical and Dental Defence Union of Scotland  
Medical Defence Union  
Medical Protection Society  
NHS Employers  
NHS Litigation Authority  
Nursing and Midwifery Council  
Pharmaceutical Society of Northern Ireland  
Pharmacists Defence Association  
Royal College of Midwives  
Royal College of Nursing  
Royal Pharmaceutical Society of Great Britain  
Scottish Executive  
Society of Chiropractors & Podiatrists  
Society of Radiographers  
Unison  
Welsh Assembly Government