

MDU response to Department of Health and Social Care consultation:

Appropriate clinical negligence cover

1 What are your views on the proposed options for meeting the Government's policy objectives (please see paragraph 4.1)?

Summary

The principal policy objective is that 'patients who are harmed by the negligence of regulated healthcare professionals can access appropriate compensation.'

In light of that principal policy objective the consultation material is fundamentally flawed for a number of reasons. These include the following:

- First, it fails to explain properly why the existing discretionary method of indemnity provision, which has provided indemnity for clinical negligence claims to hundreds of thousands of doctors and dentists for well over 100 years, does not meet that objective. The established discretionary method of indemnity provision already meets the principal policy objective, because doctors who are members of medical defence organisations can access indemnity and patients harmed by their negligence can access appropriate compensation. Without such a fundamental explanation and reasoning, the whole basis of the consultation exercise is flawed.
- Second, it fails to provide any reliable or meaningful evidence that the preferred option of insurance would provide the same or, more importantly, greater protection for patients than the status quo.
- Third, it underestimates significantly the number and types of healthcare practitioners who would be affected by such a change and the detrimental consequences for them.

Any proper or lawful consultation would need to present all factors relevant to the objective of ensuring patients who are negligently harmed can access compensation (often many years after the incident) in a fair, balanced and correct way which this consultation does not. It is also critical that any such consultation should address fully how any change of the type the Government favours, or any other option, would deal with obvious situations which will arise under the preferred option and meet the principal policy objective, such as:

- Where insured practitioners cannot afford to continue a policy and/or pay for run-off cover to provide the necessary compensation required by patients.

- Where insured practitioners did not purchase indemnity with sufficient limits (money and/or time) to provide the necessary compensation required by patients.
- Where a regulated insurer suddenly leaves the market and large numbers of practitioners are then not able buy and/or could not afford run-off cover.
- Even if practitioners are theoretically able to buy some run-off, what will happen where such run-off cover is limited in money and/or time as it inevitably will be, leaving practitioners without cover to provide the necessary compensation required by patients?
- The basic lack of insurers in the regulated market with an appetite to write cover (or cover that is available at an accessible premium for practitioners) for business that will not be capable of meeting shareholder returns

The consultation fails to address any of these points. This is unacceptable as it is clear that the Government's proposed form of regulation does not protect against any of these eventualities and will fail to deliver the principal policy objective. That is in stark contrast with the existing situation where the principal policy objective has been delivered through the provision of discretionary indemnity.

There is a conspicuous absence of meaningful evidence to back up many of the consultation document's implicitly pejorative assertions about discretionary indemnifiers and the indemnity they provide. There is a very clear misunderstanding of the nature of such discretionary indemnity and the way it has enabled healthcare practitioners to meet the principal policy objective for so many years. If there is any evidence to back up the assertions or basic contentions, this should be provided so that those seeking to respond to the consultation are properly informed. Moreover, the document does not consider the failures of insurers and insurance (outlined in detail in our response) which, for the preferred option to compensate patients in many clinical negligence claims, would need to be in place and adequate 10, 20, 30 or more years ahead.

These failures, along with the unevidenced basis for a very clear predisposition towards the Government's option which is based on basic misunderstandings and failures set out above have resulted in a flawed consultation. There is an inherent bias towards a predetermined option and a failure to present a balanced and impartial assessment of the available options. We set out immediately below a summary of our main concerns and comments in this respect. We then also address all these points in greater detail in responding to the consultation's questions. However this is entirely without prejudice to our very clear view

that the consultation material and the exercise is not fit for purpose and is inherently unlawful for the reasons we have summarised. Any fair, transparent and lawful consultation on options for change needs to provide a proper and balanced assessment of the status quo and any options for change which this consultation does not.

Regulated insurance provides no greater protection than discretionary indemnity for patients with long tail claims

The consultation document asserts, and is based on the mistaken premise throughout, that because discretionary indemnity providers have no legal obligation to ensure they have reserves to cover the cost of claims, this creates a real risk in practice of a patient being unable to access appropriate compensation. However, no evidence is supplied to support this assertion that the risk is real, let alone a risk which would be addressed by the Government's preferred alternative. The assertion simply disregards the basic facts which contradict the assumption. To take by way of example only (in circumstances where the consultation material ignores the wide range of contradictory evidence available):

- In 2001 there was a surprise withdrawal of the insurer the St Paul from the worldwide clinical negligence indemnity market. Despite the fact the St Paul was a regulated insurer, it was able to withdraw from this market in the UK, after just over two years of operation, leaving thousands of UK GPs and dentists without any tail cover (ie for claims arising from incidents that occurred while they had a policy with the St Paul). Patients would have been left uncompensated if these GPs and dentists had not been able to access discretionary indemnity for their uninsured tail from the medical defence organisations (MDOs). Such events demonstrate how unprincipled the consultation document is in making claims about the benefits of insurance cover over discretionary indemnity when there is clear evidence that discretionary indemnity was able to meet the principal policy objective where insurance cover did not.
- In dramatic contrast to the longevity of the MDOs and discretionary indemnity provision, there are numerous examples, both in the past and in the present, of well-documented failures in the insurance market by regulated insurers that have either withdrawn a line of business with no notice, with no arrangements made for cover, or failed altogether and/or ceased to exist (for whatever reason), leaving those who believed themselves to be insured without cover. This is a well-established and repeating problem: See eg [FCA announcement of 21 August 2018](#): 'Our main

concern is the risk to customers in the event the insurer fails and are unable to pay claims. The failures of Alpha, Enterprise and Gable, demonstrated the harm that can be caused to customers as over 1 million policyholders had to find alternative insurance cover.'

- By contrast to the insurance market, the consultation fails to address the compelling position that MDOs have a long track record of indemnifying their members without disappearing from the market. Indeed, the MDU has been in business for 133 years. It continues to pay out on claims many years after the incident. By way of example only of the potency of this:
 - A member reported a 1959 incident in 1989 which the MDU settled for £866,000 in 1998.
 - A member reported a 1965 incident in 1991 which the MDU settled for £515,000 in 1996.
 - A member reported a 1966 incident in 1992 which the MDU settled for £130,000 in 1997.

The consultation fails to grapple with the basics of medical negligence liability, where claims may often be made many, many years after the provision of the healthcare and where such claims are not time-barred. Moreover, such claims often present very large liabilities.

- The examples above illustrate the basic need for clinical negligence indemnity provision to be in place to provide compensation to meet the principal policy objective of the Government in respect of all claims, including those that may only be notified, 10, 20, 30 or more years after the incident. A simple example of this is in respect of claims in respect of incidents that occur to children where one would expect the Government's principal policy objective to be as relevant, if not more so. The ability to seek and receive compensation of a patient who experienced healthcare negligence as an infant or child should be unimpeded. The law generally recognises this by suspending the limitation period to bring a claim until the child reaches adulthood. Yet the Government's consultation fails to deal with this sort of common event, where the claim will often be made 10 years or more after the event. Insurers do not provide effective indemnity on a true occurrence basis, as the MDOs do. If they were to attempt to cover all claims on an occurrence basis at an acceptable level, they would inevitably need to increase their solvency and capital requirements and reserves, and premiums would very quickly become unaffordable.

The Government's proposal is setting up a system which must necessarily fail and which is based on a misunderstanding of how and why regulated insurance of the type that is suggested cannot fulfil the principal policy objective.

- By stark contrast, a practitioner with discretionary occurrence indemnity from an MDO is able to approach that MDO for assistance with a claim arising from an incident when they were a member, whenever that claim is made, even after retirement, or their estate may do so even after the member's death. This clearly fulfils the Government's principal policy objective, particularly for the most vulnerable of patients where claims may often be made many years after the event itself.
- The Government's consultation also fails to address the fact that for those insurers that currently purport to provide 'occurrence' indemnity (ie with policies where there are no time limits), such indemnity is almost invariably subject to a monetary limit, eg £10 million. The consultation fails to deal with the fact that such cover will often be seriously inadequate. Just one high value claim against a healthcare practitioner in the current climate where the discount rate dropped in 2017, may result in settlement or establishment of liability at levels well over £20 million. Given that the financial value of the claim is intended to reflect what the law regards as fair compensation for the patient, an inability to meet such claims from insurance cover will leave patients exposed to inadequate compensation, along with healthcare practitioners exposed to financial ruin.
- The consultation does not deal with the fact and evidence that insurers are subject to the same 'external shocks or changes in the market' that providers of discretionary indemnity experience. This is evidenced by [the reaction of the ABI](#) (representing insurers) to the announcement of what the ABI itself described as the 'crazy' decision by the then Lord Chancellor, Liz Truss, to cut the discount rate by 3.25%: 'Cutting the discount rate to -0.75% from 2.5% is a crazy decision by Liz Truss. Claims costs will soar, making it inevitable that there will be an increase in motor and liability premiums for millions of drivers and businesses across the UK. We estimate that up to 36 million individual and business motor insurance policies could be affected in order to over-compensate a few thousand claimants a year.' Insurers providing claims-made indemnity inevitably seek to address such changes by either raising premium costs at the end of a year in order to react to 'external shocks' such as the discount rate, or by exiting the market. But they are in a different and no better position than discretionary indemnity providers. Indeed, if they are to provide indemnity for claims that need to be met 10, 20, 30 or more years after the incident,

their insurance premiums will inevitably reflect this or, as will often be the case, they will simply exit the market. As the experience of the St Paul demonstrates, major insurers have no difficulty in quitting markets that are volatile and expensive, such as that for clinical negligence claims, in very short order. Both the insurance market and the discretionary indemnity providers face the same challenges, but the resulting reactions are very different. The insurance market will inevitably be driven by the economics of those changes and either exit the market, or impose unaffordable premiums or unacceptable limits on cover. The discretionary indemnity providers will continue to provide discretionary indemnity to their members.

We are very disturbed that the consultation document contains a misleading assertion that MDOs 'do not have to disclose their full financial position, meaning that healthcare professionals may be unaware of the extent of their financial cover'. This is incorrect and leads to a number of important misapprehensions:

- MDOs do disclose their full financial position in relation to their known liabilities. Incidents that have occurred that will turn into claims are accounted for when they do so. Similarly, claims made insurers do not account for claims arising from incidents in the policy year which are not reported in the policy year. Assessing incurred but not reported incidents (IBNR) for claims which may not materialise for many years is highly dependent on assumptions. Small changes to the assumptions can change the figure substantially, as can any change in the legal, medical, social and/or economic environments with a retrospective effect on long-tail clinical negligence claims.
- In any event, regulation of insurance, with a requirement on insurers to disclose their full financial position, does not serve the principal policy objective. Such disclosure has not stopped insurers withdrawing lines of business (such as the St Paul withdrawing clinical negligence cover worldwide in 2001 and leaving thousands of UK GPs and dentists to make their own arrangements for tail cover), or failing and leaving policyholders without cover and needing to make urgent, alternative arrangements (for example [Independent](#), [Alpha](#), [Enterprise](#) and [Gable](#) – [here is a link to the FSCS list of insurance insolvencies](#)).
- Moreover, regulation of an insurance company in 2019 is no guarantee it will still be in business many years in the future when a claim is actually made relating to an allegedly negligent incident that occurred in 2019.

The consultation document also contains the misleading and unsubstantiated assertion that because MDOs are not subject to independent regulation on financial conduct and fair treatment, this somehow leaves healthcare professionals at risk of unfair treatment. This is misleading and again results in a number of errors in the consultation because:

- Any MDU member who believes he or she has been treated unfairly has recourse to the courts and such claims can be funded, affordably, on a CFA basis. Only a handful of members have ever considered it necessary to pursue this option, and no case was successful, demonstrating an enviable track record of the provision of fair treatment. By contrast, the consultation document fails to identify how many regulated insurance providers have been found to have acted unfairly in order to provide a fair comparison. We request that this information is provided.
- The concept of fairness is confused with the principal policy objective outcome: for example, regulated insurance is subject to the restrictive nature of contractual insurance products (including the voiding of cover for the assured's failure to make relevant disclosures to the insurer); it may be fair for the insurer not to provide cover in these circumstances, given the contractual terms. By contrast, discretionary indemnity has protected patients by allowing the MDU flexibility to agree to provide retrospective indemnity in appropriate cases even when, for example, members have made an inadvertent mistake with their subscription declaration. The consultation document does not address this difference properly.
- Since the MDU stopped providing members with an insured indemnity with discretionary wrap around, from April 2013, the number of doctor and dentist members has grown substantially. This suggests that doctors and dentists saw no particular benefit from insured indemnity, but that they do have a continuing appetite for indemnity on a discretionary basis as it provides effective indemnity for them.
- We are regularly contacted by a growing number of former members who are now unhappy about the way they have been treated by their insurer and want to return. Concerns relate to matters such as dramatic rises in premium costs, policies that are voided mid-term, and material conditions and exclusions that were not explained to them. We provide details in response to question 6.5. The consultation is flawed as it fails to identify or to provide any such evidence which would allow a meaningful comparison between the fairness of the two products, for healthcare practitioners and for patients alike. We would like to see any evidence the Department has

available, or has taken into account, about the way insured doctors and dentists are treated by their insurance provider. If such material has been taken into account, basic principles of fairness and transparency require it to be made available so that we can comment upon it. If there is no such material, then there is no evidential basis for the consultation assumptions which do not reflect our own knowledge. In this respect we are aware the Department conducted a survey about indemnity in primary care, where the majority of respondents were practice managers. It is not clear if any material was collated about other doctors and healthcare practitioners' attitude to their insurers. This information should be provided. In addition, we need to know whether it sought the views of insured doctors or dentists in order to inform the assertions that are now made about clinical negligence insurance in the consultation document. We request that this information and material be provided as a matter of urgency.

- Other mutual organisations continue to provide discretionary products to thousands of clients with no concerns raised. There are also new entrants to the market, such as the Local Government Mutual, providing discretionary indemnity to local government service providers, and the Fire and Rescue Indemnity Company. This contradicts the assumption that there is some underlying issue with discretionary indemnity or its fairness in contrast to insurance.
- We also note that where insurance has been provided, our subsidiary, MDU Services Ltd, is a regulated insurance intermediary for our insured legacy product and subject to the prudential requirements for insurance intermediaries set by the FCA.
- We are also subject to the [FCA expectations](#) on fair treatment of customers in relation to insured claims, which outcomes we also strive for in our discretionary interactions with all MDU members.

In addition to the points above, the assumptions made in the majority of the consultation document are inconsistent with the known evidence available to the Government. In particular, the consultation document includes a statement that the Government is only aware of a limited number of cases where MDOs have exercised discretion not to support a member. The fact that the Government is only aware of a limited number of cases is not surprising, as the MDU itself is a not-for-profit mutual with the aim of supporting members facing the stress of a clinical negligence claim, not avoiding it. However, this point is not properly explained or dealt with in the remainder of the consultation document. There is no reference to the fact of avoidance of policies by insurers and how often this occurs. The

consultation document is both unfair in approach and misleading, as it implies that MDOs are more likely than insurers not to assist doctors or dentists, whereas there is no evidence to support this contention. If the Government has any evidential basis for such a contention, that evidential basis should be disclosed for comment.

It is a basic failing in the consultation document, that there is no attempt to explore what occurs in practice with insurers. The Government should have collated proper evidence about insurance practice, including what we know to be the significant concerns about avoidance of policies, and the widespread use of terms and conditions that would result in patients not receiving adequate or any compensation (see for example [FCA complaints register](#) and [FOS complaints data](#) and our response to Q6.5 for details).

The evidence that is available to us shows that the MDOs have been successfully providing indemnity to hundreds of thousands of members for well over 100 years each. By contrast, regulated insurers acting in a manner that is legal and doesn't breach any regulatory requirements (because of the terms of the policy), can pull out of the clinical negligence professional indemnity market in short order, leaving their insureds without tail cover and needing to find other indemnity providers to take them on.

The consultation document is not based upon a proper understanding of the way in which discretionary indemnity works and has worked for so many years. For example:

- While the MDU cannot fetter its discretion by saying in advance whether and in what circumstances it will assist a member, our Member Guides provide a clear indication of the circumstances [in which we are likely to help](#) and [when we are unlikely to provide support](#). For example, we are unlikely to provide support with matters arising from a deliberate intent to cause harm, or malicious, reckless or criminal acts. These are all exclusions also contained in insurance policies. Our discretion has been exercised in a way consistent with the Member Guide.
- The consultation paper fails to identify any cases where discretionary indemnity is likely to be refused, but where it would be likely to fall within the terms of a typical insurance policy.
- In the absence of proper evidence provided as part of the consultation, we have done our best to collate some evidence of what happens in practice. This is outlined in our response to Q6.5 where we provide numerous examples, given to us by our members, of exclusions and conditions in insurance policies that are intended to result in, or have resulted in, indemnities not being provided by insurers to doctors

or dentists for clinical negligence claims. There is not yet a mature market in clinical negligence insurance, but there are already numerous examples in circumstances where only a small percentage of doctors and dentists have been indemnified by insurers for a just a few years. This is alarming. It is also disturbing that there is no analysis of this problem in the consultation document.

- The medical and dental professions are relatively small environments and information travels swiftly within and between them. The MDU's membership would not have continued to rise over the last 5 years if, as implied, doctors and dentists thought we exercised our discretion inappropriately.
- The consultation paper fails to address the fact that NHS Resolution is also a discretionary provider of occurrence indemnity. We know that it has exercised its discretion, no doubt appropriately. The consultation paper does not suggest there is a problem with this discretionary provider exercising its discretion. Please confirm that is the case. If that is the case, the Government needs to provide meaningful, clear and transparent evidence of why it is contending (if it is contending) that there is or will be a problem with MDOs exercising their discretion.
- The only specific example referred to in the consultation paper relating to the exercise of discretion is of a decision by the MDU not to exercise its discretion to assist some of its obstetric members in Ireland. However, reference to this case in this way in the consultation paper is misleading. It fails to note that this exercise of discretion occurred in circumstances where there was a guarantee from the Irish Government that practitioners would not be left unindemnified or patients left uncompensated. It also provides no information about the well-documented Irish Department of Health's interference in the market that led to this. This basic information is omitted from the consultation paper. Quite apart from the fact that this will inexorably create a misleading impression for consultation responses from those who are not aware of the facts, it reflects a mistaken basis for the views being expressed in the consultation document itself.

Detailed response to Q6.1

6.1 What are your views on the proposed options for meeting the Government's policy objectives?

Clinical negligence claims are long tail – indemnity must respond at notification

The consultation document fails to explain adequately the material impact on the provision of indemnity, no matter what supplier, of the fact that clinical negligence cover is very different from other types of indemnity. Unlike claims for fire damage, theft or car accidents (where when the incident happens the insured knows about it straight away and can make a claim in the policy year), nearly all clinical negligence claims are made years after the incident. They may be made within 3-5 years, but they are often made after longer periods of time. The general limitation period of 3 years runs from the date of the incident, or the date of relevant knowledge. The latter can be long after the incident itself. Very often neither the doctor nor the patient knows that anything has gone wrong, or that any damage has occurred that may be ascribed to negligence, before a considerable amount of time has lapsed. For example, this happens in cases where delayed or failed diagnosis is alleged and cases of this type are a frequent source of claims. There are other factors that affect the limitation period, such as the ability of child claimants with earlier knowledge to claim any time up to their 21st birthday, and the ability for a claim to be made on behalf of patients with mental incapacity at any time.

In 2017, the MDU told NHS England that since 1995 the MDU had well over 1,000 claims notified more than 10 years after the incident, and some of them were 20-30 and even 40 years afterwards. Again, by way of a recent current example, in 2018 the MDU received a claim arising from medical treatment provided in 1984, where the date of knowledge (ie the patient's realisation there may have been damage caused by negligence) was 2015. The doctor was an MDU member in 1984 (when the annual subscription was £264) and was able to seek our assistance with the claim in 2018.

The consultation document inexplicably fails to consider what the position would be with an insurer in such circumstances. We have outlined the main points of concern in our response to this first question. But in general, the position is that the doctor would have had to have held clinical negligence insurance cover continuously for a long period that had no exclusions or conditions and was truly unlimited in terms of time and money, or have made a run-off payment to ensure access to unlimited cover with no exclusions or conditions.

The main objective of the consultation is said to be that 'patients harmed by the negligence of regulated healthcare professionals can access appropriate compensation'. If this objective is to be satisfied, it means healthcare practitioners need access to the sort of indemnity that will respond when the claim is made to an incident which occurred previously. This will very often be many years in the future, and not when the allegedly negligent incident happened.

Adequate and appropriate indemnity needs to be provided to healthcare practitioners on an occurrence basis as the MDOs do principally. By contrast, most insurance providers only offer claims-made insurance that is limited by the terms of the policy and limits cover to the period of the insurance when the claim is made, not when the incident occurred.

One or two insurers claim that their policies are 'occurrence' policies, but our experience is that there are significant monetary limits on such policies which will still mean claimants may be insufficiently compensated, if at all. Moreover, in the whole insurance market, the number of insurers willing to write long-tail business is very limited.

The MDU is in a unique position in having experience of providing members with discretionary and insured indemnity. This allows the MDU to assess and provide reliable evidence on the advantages and disadvantages of both methods of delivery. From 2000 until 2013 MDU members were provided with a claims-made insurance policy, supplemented, necessarily, by discretionary indemnity for matters outside the policy. Despite what this unparalleled experience and evidence on the part of the MDU demonstrates, the consultation proceeds to favour insurance alone in a way which flies in the face of the available evidence as to the basic problems with insurance, and in a way which is unsupported by any other contrary evidence made available for comment. More fundamentally, it will be incapable of meeting the principal policy objective set out above, let alone in a way which is better than the current status quo.

Claims made insurance requires the practitioner to notify the claim while the policy is in force

One of the basic problems of claims-made insurance is that if healthcare practitioners with such insurance wish to retire, or change insurer, they will need to make separate arrangements for indemnity if they want cover for claims from incidents that happen while they are or were insured, but which claims are only notified after the policy has ceased. Unless such cover is obtained, the healthcare practitioner will be exposed to unaffordable liabilities, and the principal policy objective identified in the consultation will not be met, namely the ability for patients to obtain compensation in respect of negligent incidents.

Such cover usually has to be obtained through what is known as 'run-off' cover. However even if run-off cover is theoretically available, it can be priced so high that healthcare practitioners cannot realistically afford it. And even where it is affordable, it will almost always be subject to an overall policy limit (for example some current policies have limits of

only £5 million or £10 million). Such policy limits will not provide sufficient amounts to meet the principal policy objective, given that a significant number of claims already exceed these sums now. In addition, there may also be a time limit on run-off cover (we have seen insurance policies with limits of 3-5 years).

Consequently, even if practitioners can afford run-off payments, the cover is likely to be limited in monetary value and in terms of time covered, and these policies may well not be able to respond in 10, let alone 20, 30 or more years later when a claim is made and when a patient is actually seeking compensation. Even if the cover is applicable, the financial limit of the policy issued in the last policy year will apply and will generally be inadequate because annual claims inflation means damages awards are doubling in size every seven years.

As noted above, there are some insurers currently offering policies that are described as providing 'occurrence' indemnity, but in practice these policies have very significant financial or other limits, such as deadlines for reporting claims, which make them unable to meet the principal policy objective.

Insurers have to put a limit on these policies because they need to have certainty and to be able to quantify their liabilities accurately, not least for their shareholders and investors who are seeking returns from the insurance market. What is treated in the consultation document as an advantage of such insurance in terms of regulatory protection, namely a requirement for appropriate solvency margins, in fact has the consequence of requiring insurers to calculate their liabilities accurately if they are providing cover in a particular area so that they can ensure the appropriate solvency margin. In a theoretical sense, this does not prevent the insurance market from issuing policies that are truly unlimited in time and/or money in this sector after carrying out an appropriate solvency assessment, but in practice this does not happen. That is because the insurers would have to charge such high premiums to cover future, essentially unquantifiable risks, that the insurance would be unaffordable.

To put this in the context that insurance cannot fill this void, we return to the 1984 example that we identified above (where we are assisting a doctor for an incident that occurred as long ago as 1984): all doctors paid the MDU a subscription of £264 at that time. The MDU had at that time never seen a claim for even £1 million. No one then could have forecast that 34 years later we would see a claims environment where, in just two days in October 2018, NHS Resolution would agree settlements of two claims: one with a reported potential total value of £37 million and the other, £27 million. It is only discretionary indemnity that is

likely to serve healthcare practitioners and patients in these circumstances. In reality, the insurance market is unable to fill this gap. Generally it does not provide occurrence based cover; but where it does, the requirements to calculate the liabilities will either mean limits are imposed which make the cover inadequate, or the cover would be unaffordable.

There are very few insurers providing clinical negligence indemnity to doctors in the UK that have a track record of doing so for more than a few years. They do not know what claims will cost in the medium to longer term, let alone an indefinite number of years in the future. Despite these obvious problems, the consultation suggests it will be possible in some way to require insurers to set adequate limits. This demonstrates a deeply concerning lack of understanding of clinical negligence claims and of the likely appetite of insurers to underwrite it at all, let alone at an affordable cost. It is an irrational suggestion. Moreover, it is not evidenced or supported by any material. Once again, we request transparent and fair disclosure of any work and calculations or analysis the Department has done to satisfy itself that insurers would agree to mandatory conditions that somehow guaranteed that patients would always be compensated, whenever they made a claim, no matter the size of award sought.

The MDU's own experience is that the suggestion is fanciful. The MDU's believes that a regulated insurer, which needs to be able to quantify its liabilities accurately in order to have in place appropriate solvency margins, would not be in a position to provide an affordable policy that would guarantee what effectively needs to be unlimited indemnity in order to ensure that patients would be compensated very many years after an incident with an unknown, but what is likely to be a very high, award. Absent some way of securing the availability of such cover, there is the very obvious risk that many patients will go uncompensated because any policies that are offered to provide cover for healthcare practitioners will inevitably have limits in terms of time and/or money (including sunset clauses which state that the insurer will respond only to losses reported before a predetermined future date, usually a set period after the expiration of the policy). We consider it is a fundamental and serious omission that the consultation document does not address this basic point, nor does it provide any material to demonstrate what (if any) analysis has been done in respect of it.

There is a further problem that is not addressed. It arises because of the long-tail nature of clinical negligence, from date of incident to date of notification and also, once notified, to date of settlement. This process gives rise to exposure to substantial defence costs arising

from claims which may ultimately settle for no damages. For most insurers, the latency in realising the ultimate claim settlement value is the key consideration in determining whether their reserves are sufficient to deal with significant material adverse deviation from their original estimates of the claim. This results in uncertainty which does not apply to short-tail business (eg house insurance) where losses are paid out quickly. In these circumstances, insurers can use prompt feedback to adjust premiums. However, long-tail clinical negligence claims mean it could take years for an insurer to estimate its ultimate claims accurately once an exposure period expires. If its reserves were deficient, and required strengthening, the insurer's financial results could suffer from under-pricing for several years making this market unattractive to their shareholders. Once again, this point is not considered in the consultation document and there is no analysis or evidence provided about this problem, creating a further element of irrationality and unlawfulness in the consultation approach and procedure.

Regulation does not address insurers leaving the market and/or withdrawing clinical negligence cover

There is no recognition in the consultation document that insurance companies come and go, and many withdraw from lines of business, or exploration of the consequences of that happening. By contrast MDOs have been in business since the late 1800s, providing indemnity to their members and compensating patients on their behalf.

This creates a real problem for patients in respect of insurance as a preferred option. Patients need to be sure of the availability of compensation at the time they make a valid claim. The consultation appear to be suggesting that comfort is provided by regulation, but in practice that is a false comfort. Regulation may impose requirements that govern what cover is provided, but this simply gives rise to limits on the cover that is then available for healthcare practitioners. Regulated insurance will only provide compensation within the policy limits which is not what patients actually require with long-tail and/or high value claims. Regulation does not give any guarantees that an insurer will continue in business and/or still provide that type of insurance, let alone insurance with adequate financial limits to provide the necessary compensation when it will be required, often many years ahead when patients need the compensation.

The consultation document fails to explain how it will ensure there will always be insurance providers of clinical negligence cover, meeting policies in full, at the time patients are awarded compensation. It does not mention, let alone deal with, the fact there are no

guarantees that insurers will be around and/or providing sufficient clinical negligence indemnity for prolonged periods in circumstances where there is a well-documented history of insurers in other sectors that have left the market for a variety of reasons, leaving insureds without cover (see, for example, the [Financial Conduct Authority warning of August 2018](#) about 'the failures of [Alpha](#), [Enterprise](#) and [Gable](#)', that 'demonstrated the harm that can be caused to customers as over 1 million policyholders had to find alternative insurance cover'. There are many other examples).

This is all the more surprising where there is a prominent example within this sector of the insurance market (which the consultation does not mention) of such a departure. The surprise announcement from the St Paul Insurance company in December 2001 that it was withdrawing from providing clinical negligence cover worldwide at the end of that year, just over two years after it had announced its intention of taking a dominant stake in the market, illustrates what can happen over which regulation has no control. The effect of the St Paul's sudden withdrawal of clinical negligence cover in the UK was to leave thousands of GPs and dentists (who had claims-made insurance) with no tail cover.

These healthcare practitioners were fortunate in that the MDOs, the not-for-profit mutuals providing discretionary indemnity, agreed to provide retrospective tail indemnity. Had this not happened, thousands of GPs and dentists would have been exposed to such liabilities and unindemnified, and the practical consequence is that many patients would have gone uncompensated while healthcare practitioners faced potential financial ruin.

There is nothing about regulation which prevents this from happening. There would have been no recourse to the FSCS, or the ability to make a complaint to the FOS, as none of the terms of the St Paul policy were breached. They just withdrew from the market without providing any continuing coverage. Insurers were not then, and are not now required, to provide continuing coverage.

The St Paul was operating as a regulated insurance company. Regulatory protections similar to those referred to in the consultation document were in place, but were of no practical use. They did not, and do not, guard against an insurer deciding to quit the market and/or to stop providing clinical negligence cover, for example because it becomes too expensive, or because they can make a better return on capital with other lines of business. The protections then and now would only apply to claims made within the terms of the policy. They do not provide for any claims made against practitioners once the policy ceases to exist, and with clinical negligence claims there is always a time lag between the

incident giving rise to the claim and notification. Once again, the consultation documents fails to deal with this sort of basic evidence and problem in what it is proposing.

Conditions, limits and exclusions

The consultation document says, at 5.34: 'regulated healthcare professionals need to ensure that the scope and risk of their practice is reflected in the terms and conditions of their contract of insurance – that it does not exclude any relevant activities and that the limit of cover is appropriate.' It is not clear what is envisaged, but there are again some basic problems which are not addressed.

The Prudential Regulation Authority (PRA) does not address the adequacy of the cover sold but only the adequacy of reserves to back the policy and this does not provide any regulatory protection that such cover will be available or required. And, despite regulation of insurance by the Financial Conduct Authority (FCA), in the current market doctors and dentists can and do buy insurance policies with a wide range of conditions, limits and exclusions – for example, financial limits of only £5 million (for orthopaedic surgeons – including legal costs) and conditions such as a requirement to notify all claims and circumstances within 30 days; that the doctor 'must always act honestly', and exclusions for clinical matters such as failure to recognise oral cancer. The consultation document does not explain what assumptions it is making. It cannot rationally be assuming that such cover is adequate to address the principal policy objective that is said to underpin the consultation. Yet it then fails to explain how the large gaps in the cover will be provided, let alone what that will cost and how it can be secured. If there is any such analysis, it has not been disclosed in a fair and transparent manner.

We address this point in more detail in our response to Q6.5. We give details of limits, exclusions and conditions of which we are currently aware on insurance policies that have the potential for patients to be inadequately compensated, or to receive no compensation at all. However, in answering question 6.1 we also set out here important respects in which insurance gives no greater certainty than discretionary indemnity. In particular, it is a fact that insurers can and do lawfully avoid policies and refund premiums. For example, insurers can and will do this if they find out that not all relevant information has been provided, or the policy conditions have not been adhered to, even if inadvertently. Moreover, if insurers were required to provide adequate and appropriate tail coverage for long-tail clinical

negligence claims, they may well consider the regulatory, solvency and capital requirements too onerous and leave, or decide not to enter, the market.

Insurers will insist on some exclusions as they are common within the insurance market. They are basic terms of all policies, and not negotiable. There are exclusions in current medical and dental insurance policies in respect of criminal acts and wilful misconduct and alleged sexual relations or conduct on behalf of the insured. In this respect, the insurance market offers no benefits over discretionary indemnity. The MDU also makes it clear to members that we are unlikely to be able to provide support in similar circumstances. This sort of exclusion, whether contractual or discretionary, is reasonable. The point is that insurance offers no greater protection in these circumstances and this would not be expected to change. Insurers will retain the ability to refuse to renew or to avoid policies mid-term, and policy exclusions for matters such as claims arising from criminal acts or sexual relations or misconduct such as malicious, fraudulent, dishonest or reckless acts by the insured. To do otherwise would constitute a moral hazard and be contrary to public policy.

In discussions and correspondence, the Department of Health and Social Care has not provided the MDU with any rationale as to why there is perceived to be any problem with discretionary occurrence indemnity provided by the MDOs in this or any other regard. To date no concerns have been raised about discretionary indemnity, yet there have been plenty of opportunities to do so.

For example, in his 2010 analysis (for the Department of Health) *Independent review of the requirement to have insurance or indemnity as a condition of registration as a healthcare professional* Finlay Scott stated that the Department of Health's officials had confirmed discretionary indemnity was acceptable:

'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.'

From 2015, NHS England (with the knowledge and agreement of the Department of Health) has been content to reimburse the cost of GPs' MDO subscriptions for additional out-of-hours work they have undertaken. In order to ensure that NHS patients are compensated in future from incidents that have occurred during these sessions, NHSE specifies that the indemnity must be provided on a discretionary occurrence basis.

And in 2016, in response to repeated concerns about the unaffordable cost of indemnity raised by the GP profession's leaders, the Department of Health undertook a review of GP indemnity. That review, published in July 2016 stated at paragraph 3.6:

'The review did not find evidence to suggest that market inefficiency is a cause of rising indemnity premiums. The increases in the costs of indemnity are due to factors largely out of the control of the medical defence organisations.'

This begs a question which is not answered by the consultation document: if there is or was a problem with discretionary indemnity, why wasn't it identified previously and action taken and what exactly is that problem? The answer is that there wasn't and isn't a problem, as was evidenced by (among other things) the interim solution adopted by the Department of Health and NHS England, of reimbursing GPs for the inflation element of their MDO subscription, retrospectively for two years from April 2017.

As we have noted above, this consultation document does not identify or discuss the disadvantages of insurance as a means of indemnifying long-tail clinical negligence claims. Nor does it not contain any coherent arguments in support of the proposal to change the way in which clinical negligence indemnity is provided. When the MDU provided insurance policies to members, they were not 'stand-alone' but insurance was wrapped round with discretion. This was, and is, needed by members so they will be in a position to compensate patients who are negligently harmed, no matter how long after the incident the claim is made.

The consultation document at 4.17 refers to a 'risk that a provider of discretionary indemnity may not be able to meet the cost of future claims'. This is misleading in principle as a basis for preferring insurance over discretionary indemnity. As we have pointed out above (but it is not addressed in the consultation document) the risk of providing indemnity for long-tail claims sits equally with insurers. Patients are no more likely (indeed they are less likely) to be protected by a regulated insurer for such claims. In addition, insurers can easily exit the

market leaving the 'incurred but not yet reported' claims unindemnified and claimants uncompensated in the future. The risk for all providers is the spiralling cost of claims, whose principal drivers are legal and economic, and squarely in the control of the Government. The Department has been aware of this for many years and has failed to address it effectively. (We address this in response to question 6.3.)

In summary, the consultation document omits many material considerations, including the omission of several significant disadvantages and inherent problems in attempting to rely on insurance as a vehicle for indemnifying clinical negligence claims. In cases where these shortcomings leave insured practitioners with inadequate cover, or no cover at all, claimants' solicitors might seek to advise their NHS patient clients to sue NHS England on the grounds of vicarious liability for NHS treatment which would only serve to make such claims more complicated and expensive. But this would not provide redress for patients treated in the independent sector. The consultation response does not explain what would happen in that situation.

As noted above, the basic point (reflected in the principal policy objective) is that patients need potential access to appropriate compensation for a negligent incident which they may not know about until very many years later. The only proven way to provide adequate and appropriate indemnity which is affordable and which does respond in such circumstances, is discretionary occurrence indemnity. We support consultation policy option:

- i) Maintaining the existing legislation and arrangements related to clinical negligence cover.

Response to Q6.2

6.2 What are your views on the potential costs and benefits of these options, for example the familiarisation and administrative costs for individuals, businesses, and other groups, in complying with potential changes to regulation?

Additional costs burden of insurance

The consultation document recognises (at 5.31 and 7.23) that introducing a requirement for insured indemnity is likely to increase the cost to healthcare practitioners. We strongly agree, but we have also explained above that there is no evidence to suggest this would be in return for increased protection for patients or healthcare practitioners. What is more,

there is no assessment in the consultation document of that increase in cost (ie its amount) and how it would be affordable. This is a glaring omission. The consultation document also claims mandatory insurance would increase competition but no evidence is provided of this. We assume there must have been an impact assessment of competition and would like to see it.

As stated above, the MDU provided members with claims made insurance previously (wrapped around with discretionary indemnity for matters outside the policy) because it was thought at that time it was the best way to ensure our members had access to the advantages of insurance and discretionary indemnity when they needed it. However regulated insurance came with premiums that increased substantially over the 13 years. It is clear that insurance premiums cost considerably more than discretionary indemnity because:

- Insurers need to make a profit for their shareholders, whereas MDOs are mutual not-for-profit organisations owned by their members
 - The fact that insurers need to make a profit for their shareholders means they need to leave lines of business or markets that become uneconomic. See example above of the St Paul exiting the clinical negligence market worldwide in 2001, leaving thousands of doctors and dentists in the UK without cover for historic claims.
- The insurance chain often includes brokers' fees which will increase costs for healthcare professionals.
- Insurers incur additional regulatory costs – eg levies by the Financial Services Compensation Scheme.
- Insurance incurs insurance premium tax (IPT). The standard rate is currently 12%. It doubled from 6% to 12% from 2015 to 2017, and a rate of 20% already applies to some classes of UK insurance.
- Around 55% of insurance premiums relate to claims costs and 45% relate to expenses
 - To cover £100 worth of claims, a policyholder would have to pay £100 claims cost plus £82 expenses plus £22 IPT: £204 in total.
 - In contrast, for £100 of indemnified claims the MDU charges £27 for claims handling, legal costs and overheads: £127 in total.
- Because discretionary indemnity does not attract these additional costs, MDOs can ensure a far higher proportion of members' subscriptions are used directly for their benefit, including contributing to funds to pay for future claims.

- By way of comparison and as an example of the problem, the Law Society advised its members in 2019 about the 'hardening' market for solicitors' indemnity insurance which is seeing 'contraction', with insurers leaving that market and costs of remaining providers increasing substantially: 'In addition to professional indemnity claims, insurers have also been exposed to losses from natural disasters, such as earthquakes and hurricanes, and significant losses have also been experienced in the Directors and Officers insurance market. For insurers writing all classes of business, this will impact their overall profitability, causing rates to increase.'

The need to set up and run a body to oversee clinical negligence insurers and policies

The current market for indemnity for solicitors is a useful example to understand the minimum issues with clinical negligence insurance and the many points that the consultation document has failed to address. We say minimum because the principal policy objective in the case of clinical negligence insurance is the ability of patients to have access to adequate compensation and this objective is arguably more fundamental than that which applies in other sectors.

Solicitors buy insurance principally so they are able to compensate their clients. It would not be appropriate simply to require solicitors to have suitable cover without it being heavily prescribed. The policies they are allowed to hold are subject to requirements specified by the Solicitors Regulation Authority (SRA) in order to ensure their clients do not go uncompensated. The SRA needs to have adequate resources to undertake this.

Drawing on the experience of solicitors' insurance, it must follow that, in order to ensure patients are appropriately compensated, whenever a legitimate claim is made and settled, insured healthcare practitioners must have to have in place insurance that meets all the required terms and conditions and limits and is provided by insurers that are approved for the purpose. The consultation document does not address this. Currently there is no such body for clinical negligence claims, and setting one up for this specialist market would be a considerable undertaking. It is likely the setting up and running costs would be substantial, especially as the body would need to continue to review all requirements regularly to ensure they would continue to provide adequate and appropriate compensation many years hence. Such costs would have to be borne by insured healthcare practitioners, either directly or indirectly, but the consultation document is silent on all this, as well as what would the requirements of cover.

UK-wide impact of mandatory insurance on all healthcare practitioners engaging in any 'private' work

The impact of the increased cost of insurance, with the many potential disadvantages we have outlined above, would fall on all NHS dental, private medical and many other practitioners. Every healthcare practitioner, across every discipline, even those who are state-indemnified, would require insurance for claims arising from the parts of their work that fall outside state indemnity arrangements. Practitioners, including those providing services to NHS patients, will have to absorb the additional costs of insurance themselves. This may cause difficulties in terms of recruitment and retention if the Government does nothing effective to address claims inflation and their remuneration continues not to keep pace with it. For example, if NHS dentists could not afford the ever-increasing costs of insurance, they might find themselves in a position, as GPs are currently, where they could not afford to pay for indemnity insurance and/or for run-off cover when they left practice.

In order to identify all practitioners who would be affected by the proposed change in indemnity arrangements we would expect the Department to undertake a comprehensive survey of all healthcare practitioners who might be affected in order to understand the work they undertake and the indemnity arrangements they have in place. There are likely to be many thousands of practitioners who would be affected professionally and financially by the proposed change whom the Department should have made aware of the consultation and whose responses should be sought. This has not been done.

For example, the consultation does not mention NHS hospital doctors and GPs who undertake private work that is not, or will not be, NHS indemnified. Even if they are NHS indemnified, doctors need to arrange their own indemnity for a wide range of additional, non-NHS work – for example writing reports and medico-legal work as well as professional attendance at private, events including charity and sporting events, from which negligence claims can and do arise.

Here are some other types of work that doctors can carry out in circumstances where the doctor is not the patient's own doctor. The list below is not comprehensive and we can provide many more examples. It includes:

- Statements of fact
- Signing photo card driving licences
- Attendance at airports

- Attendance at a patient's request at a police station
- Completing cremation forms
- Removal of a pacemaker before disposal of a body
- Court exemption from attending as a witness on medical grounds
- Drivers: full medical examination and completion of forms for a vocational drivers licence (large goods vehicles and passenger carrying vehicles, taxi etc)
- Fitness to drive for insurance purposes (elderly driver, racing driver etc)
- Aviation licence (pilots)
- Fitness for sports
- Patients with self-referral overseas
- Seatbelt exemptions
- Doctors can charge for private prescriptions for private patients or drugs required for travel abroad (private or NHS patients)
- Abortion (confirmatory) certificate; second certificate under the Abortion Act 1967 in cases where the patient is not on the GPs NHS list
- Vaccinations and immunisations to travel abroad

The fact that doctors will have to bear the additional cost of insurance may affect their willingness to undertake any additional work, especially if it is unpaid. It is not just GPs and hospital doctors, but other healthcare practitioners who provide healthcare services (on a paid or unpaid basis) outside their NHS work throughout the UK. They too should have been made aware of this consultation because of its potential impact on them.

There are other groups of healthcare practitioners who rely on discretionary indemnity for their regular work. For example, we believe nurses who are members of the Royal College of Nursing (RCN) have discretionary indemnity. Requiring nurses to hold individual insurance policies will only increase the cost.

Additional insurance costs are also likely to affect patients in the private sector as there will be no option but for private practitioners to pass these costs on. There is no assessment in the consultation document of this impact, or its anticipated effect.

Limits and exclusions keep down costs of policies

Another basic consideration which is not addressed in the consultation in terms of the additional financial cost burden of insurance is that currently insurers keep costs down by

using limits, warranties, exclusions and conditions. For example (as noted above), there are policies currently with a financial limit of only £5 million (for orthopaedic surgeons) and conditions that specify exactly how a practitioner will act – for example, they must use a rubber dam to ensure instruments are not lost, or have an exclusion for failure to recognise breaking of the skin, or for specific conditions such as meningitis. If insurers are required in future to have in place specified limits, in terms of time and money, and to not to have in place specified conditions and exclusions, it follows that the cost of insurance will rise. An orthopaedic surgeon who negligently damaged an otherwise fit young person who was left immobile and so physically impaired that he needed round the clock care and treatment, with a predicted life expectancy of 40 years or more, could be looking at an award at today's rates of well over £20 million. However, the fact and extent of such damage may not be immediately apparent and a claim may ensue many years later with, as we have mentioned, claims inflation meaning that compensation awards are doubling in size every seven years (without the added effect of the discount rate).

Assuming insurance became a requirement, and there was a structure in place for setting appropriate limits and terms and conditions, whichever body had responsibility for this would need to ensure the limits it required ensured the policy met the full value of the claim at the time it was made. Five million pounds would not be enough. What sum would provide adequate and appropriate compensation in 10, 20, 30 or more years in future, and what effect would that have on the cost of an insurance policy today? The consultation document does not address this in principle, let alone purport to answer it in practice. If indemnity is unaffordable for consultants in the private sector, they will have to stop providing those services which will fall back on the NHS. We have seen this already, for example with spinal surgeons and, given the uncontrolled rise in claims costs (and therefore in insurance premiums) it is likely that insurance for other 'high risk' specialties in the private sector will soon become unaffordable. The speed at which this happens would increase if mandatory indemnity was in place at increased cost, because of the need for insurers to agree to specified limits and terms and conditions. Even if these were in place, they are still unlikely to adequately anticipate all future eventualities. That would inevitably have an adverse impact on the numbers of unmet claims for matters that were not anticipated and fell outside the coverage provided by the policy. Once again, this is not addressed in the consultation document.

We have referred above to the fact that the increased cost of insurance may result in healthcare practitioners withdrawing from discretionary activities, such as assisting at

sporting events or undertaking medico-legal work. The increased cost of insurance, which will rise substantially over time as a claims-made policy matures, and if run-off cost is factored in (assuming it is available), is also likely to result in healthcare practitioners ceasing practice because they cannot afford premiums. Practitioners with claims-made insurance are unlikely to be able to source affordable ongoing cover if they experience claims.

Response to Q6.3

6.3 Are there any other options that the Government should consider?

Yes, the problem is not with the discretionary providers of indemnity, but with the clinical negligence claims environment. There is no need to introduce mandatory insurance. It will not provide any greater degree of certainty that compensation will be available for patients many years after an incident resulting in negligent harm, but it will increase the cost substantially for practitioners. It has the potential to damage what is already an efficient market. The only solution that will address the problem effectively is tort reform (see [NHSE and DoH GP Indemnity Review 2016](#) and [NAO 2017 report *Managing the costs of clinical negligence in trusts*](#)). The consultation document fails to address this and is flawed in consequence.

MDU ensuring that ministers, officials and others are aware of the extent of the clinical negligence claims problem

When discussing the particular problems of providing indemnity for long tail claims in response to Q6.1, we stated that the current crisis in indemnity costs that has resulted in the need for the Government to introduce state indemnity for primary care is not a new problem. It is no surprise to ministers and officials. The MDU has drawn it to the attention of each government since 1997 and continues to suggest solutions to it. Over that time we have repeatedly raised concerns in consultation responses, and in discussions and correspondence with government bodies such as the Department of Health, the Ministry of Justice (and its predecessors) and the Treasury. For example, we outlined the problem and our proposed solution in our consultation response to the 2007 Ministry of Justice consultation on *The Law of Damages*.

In more recent years, the problem was exacerbated by an unintended consequence of the changes introduced by the Legal Aid, Sentencing and Punishment of Offenders Act 2012. This resulted in a rapid rise in the number of claims from 2012, in anticipation of the Act

coming into force on 1 April 2013, which was also noted and reported on by the (then) NHS Litigation Authority in its Annual Reports. For example the NHSLA's **Annual Report for the year ending 2014/5** set out the main drivers on rising claims costs and numbers and stated: 'The NHSLA is working closely with members to learn from claims in order to reduce harm however, many of the drivers identified lie in the legal environment'.

The dramatic rise in the cost and number of claims, which was beyond their control, hit GPs particularly hard as their remuneration failed to keep pace with claims inflation, which the MDU has seen rise at a constant 10% (combination of frequency and severity) each year over the last few years, and they have been struggling to pay for indemnity for some years. In November 2015 our Chief Executive gave a presentation on behalf of all three MDOs to a meeting sponsored by NHS England at which government and other organisations, including the Department of Health, attended. She outlined the crisis in GP claims, including its drivers, and identified measures of tort reform as the only effective solution.

In 2016, the growing crisis in clinical negligence indemnity was exacerbated by the action of a Government minister, the then Lord Chancellor, who caused the personal injury discount rate to be decreased by a massive 3.25% with effect from 20 March 2017. This has a retrospective effect on long-tail clinical negligence claims as it applies to all claims settled after that date, no matter when the incident occurred, as well as to future claims. The practical effect of the drop in the discount rate is to inflate damages very substantially. It has the effect of doubling and sometimes trebling the cost of high value claims where patients have a long life expectancy; and it is the reason for the two separate compensation awards made in October 2018 by NHS Resolution (NHSR) which may amount to £27 million and £37 million each. Mr Ian Dilks, NHSR Chair, noted in his report in the Annual Report for the financial year ending 31 March 2017 that the reduction in the discount rate: '... added £4.7 billion, approximately 7.5%, to our claims provisions at March 2017...' and, in the **NHS Resolution Annual Report for the year ending 31 March 2018**: 'A further £4.5 billion results from the decrease in the personal injury discount rate (PIDR) that occurred in March 2017 and is a real increased cost to the NHS.'

The dramatic rises in claims costs are no more the making of NHSR than they are of the MDOs; but NHSR can ask the Government for more money to pay costs that are increased because of Government action or inaction because NHSR as a discretionary, claims paid indemnifier is not required to reserve for future claims. It is funded on a 'pay as you go'

basis by the taxpayer. GPs are not in the same position and, if the MDOs had charged them a subscription to reflect the additional cost of the 3.25% reduction in the discount rate, GPs would have been unable to pay it and would have had to stop working. Therefore on 12 October 2017 the Secretary of State for Health gave an undertaking on behalf of the Government to work towards developing a state backed indemnity scheme for general practice, which is planned for April 2019. This is intended to provide financial support for primary care providers; but even if the state takes on indemnity costs for this NHS sector, this will not address the underlying problem of spiralling claims costs and the adverse effect this has on NHS funding. It will, however, increase substantially the already massive NHS total estimated liabilities bill of £77 billion just for NHS hospitals in England.

The Department of Health and Social Care has not been inactive in terms of considering policy to address some of the causes of rising claims costs. There have been some initiatives in respect of negligent birth injuries and fixed costs, but they are yet to bear fruit in terms of costs reduction. For example, in the summer of 2015 the Department held an initial consultation on fixed costs proposals; that was followed in April 2017 by a formal consultation on fixed recoverable costs. This took place after Lord Justice Jackson had conducted a review of fixed costs earlier that year. He recommended in July 2017 that the Civil Justice Council set up a working group with the Department of Health to consider fixed costs for clinical negligence cases up to £25,000. Seven months later, in February 2018, the Department announced: 'The Secretary of State for Health has accepted the proposal to set up a working group to develop a bespoke process for clinical negligence claims and a grid of costs, and work has already begun with the CJC to establish this working group.' Initially the CJC working group was to report and make recommendations in autumn 2018, but this has been postponed. Even if the CJC is able to agree a regime of fixed costs that is acceptable to all parties (four years after the first Department consultation), fixing costs for claims up to £25,000 will not address the overall problem of unaffordable indemnity which sits with high value awards.

The need for concerted action by Government departments to control clinical negligence costs was one of the main findings and recommendations of the National Audit Office's 2017 report on *Managing the costs of clinical negligence in trusts*. It concluded at paragraph 21:

'The cost of clinical negligence in trusts is significant and rising fast, placing increasing financial pressure on an already stretched health system. NHS Resolution

and the Department are proposing incremental measures to reduce existing costs. But expected savings from these schemes are small compared with the predicted rise in the overall costs and liabilities of clinical negligence. The government needs to take a stronger and more integrated approach to fundamentally change the biggest drivers of increasing cost across the health and justice systems. It will require significant activity beyond my scope, in the areas of policy and legislation.'

Its recommendation was set out on page 13:

'The Department, together with the Ministry of Justice and others, should, by September 2018, clearly set out a coordinated strategy to manage the growth in the cost of the Clinical Negligence Scheme for Trusts. The strategy should:

- set out what it hopes to achieve, for example, by identifying the balance that government wants to strike between access to justice and access to health services, and what is a proportionate response to harm;
- address all factors contributing to the costs of rising clinical negligence claims that can be influenced by the government, including the number of claims, legal costs and damages awarded;
- and assign accountabilities and set realistic performance measures for organisations for achieving these ambitions.'

This recommendation gained the support of the [Public Accounts Committee in December 2017](#). The Department and the Ministry of Justice are taking a cross-governmental approach which includes 'reviewing whether current legislation remains adequate' as the PAC specified. Publication of their findings was due by September 2018, but it has been delayed. It is important that they do so urgently, especially as, although the Civil Liability Act 2018 now allows changes to the way in which the discount rate is set, the [Ministry of Justice has made it clear](#) it is unlikely that any new rate (which is unlikely to be implemented before September 2019) will restore the discount rate to 2.5%. Clinical negligence costs will continue to spiral out of control.

In summary, the Department of Health and Social Care should drop its proposals to introduce a requirement for insured indemnity for clinical negligence claims. This consultation has demonstrated no need for any change, and the change proposed will only worsen matters by increasing costs of indemnity for doctors, dentists and other healthcare practitioners with no greater protection for patients. Moreover, claims costs will continue to spiral out of control until the problem is addressed satisfactorily. The consultation document

omits to deal with fundamental points and options which have either not been considered properly or fairly, or ignored. The consultation itself, and the proposal it favours, is flawed.

Response to Q6.4

6.4 Do you agree with the Government's preferred option (ii), set out from paragraph 5.15, of ensuring that all regulated healthcare professionals in the UK hold appropriate clinical negligence cover that is subject to appropriate supervision by the FCA and PRA?

No, we do not. We do not repeat all of the many points above again, but we have explained (among other things) that regulation and supervision by the FCA and the PRA will not address the problems of ensuring an insurance company is still trading and/or that there is indemnity available to provide appropriate compensation when exclusions and/or limits apply or, as is the usual reporting pattern, a claim is notified years after an incident that may have been caused by negligence.

We have also explained that regulation by the FCA does not currently prevent insurers providing policies with terms and conditions that leave patients at risk of not receiving compensation – for example, policies with a limit of £5 million for orthopaedic surgeons or containing exclusions for meningitis. The consultation suggests it will be necessary to set limits and criteria in future to in order to define appropriate indemnity but it does not explain which body will bear this responsibility or what limits will be set and their consequences. As well as necessitating a thorough understanding of insurance in this sector (which is not contained in the consultation document) it would require an in-depth understanding of the problems and risks associated with the delivery of medical, dental and wider healthcare services in the NHS and independent sectors and a proper and fair analysis of the basic problems with insurance as compared with discretionary indemnity. The insurance proposal would also require policies that caught unanticipated future developments in healthcare, and allowed for unexpected changes in the legal and economic environments impacting on claims arising from past incidents. The consultation document does not address how this would be achieved, let alone assess the consequences of imposing requirements of this type. Regulators such as the GMC and GDC currently do not have the powers nor do they possess the skills, experience or understanding of the complexities of clinical negligence indemnity and insurance necessary to perform such a function. Further, to fund regulators to perform such a role would add considerably to the financial burden on registrants through their annual registration fee.

Response to Q6.5

6.5 Do you have further insight or data into the types of indemnity/insurance cover held by healthcare professionals?

Yes – we are aware of examples of exclusions and conditions provided by members who have left the MDU for insurers and have got back in touch as they are unhappy with the terms of their cover. There are some terms and conditions that insurers may consider non-negotiable, such as exclusions for criminal acts or wilful misconduct (which in some policies is not defined and in others extends to malicious, fraudulent, dishonest or reckless acts), but there are many that are in force currently, or that have been applied, and where there is the potential for the insured doctor or dentist not to receive an indemnity. All these policies are provided by insurers who are appropriately regulated to conduct insurance business in the UK, but regulation has not prevented them from including terms in policies that may result in patients going uncompensated.

These policies are only those that the MDU is aware of because former members have shared the details with us. They must be only an indication of the sorts of restrictive terms and conditions that are applied currently, and others may only come to light as they are applied. Proper assessment is something that should have been done by the Government before carrying out any consultation, leave aside a consultation which expresses a preferred view. It is notable that, although the consultation document proposes mandatory insurance it does not seek to identify or to provide information about any current insurance terms and conditions that may result in uncompensated patients. Information about the conditions and exclusions in current insurance policies is readily available from insurers and/or insured healthcare practitioners. It is an important factor. It should have been considered as part of any decision about how realistic it would be to expect to impose terms and conditions on the scope of cover that would avoid any risk of insured practitioners being unindemnified and patients going uncompensated. It would also be necessary to inform decisions about which body, if any, would be competent to understand the market well enough and have the authority to mandate the scope and cover of indemnity that will be appropriate to ensure patients are compensated.

A second consultation proposes to look at what types of insured indemnity may be considered acceptable for healthcare practitioners, but this is the wrong way around. Before that stage is reached, it is essential for there to be research, analysis, and then consultation on what is or is not available, and what sort of body (if any) could perform the role of

setting the requirements, how it would do so and the cost of doing so. We expect that such a cost would be an additional expense to be borne by insured healthcare practitioners or possibly additionally by NHS-indemnified registrants if the task were given to one or more of the healthcare regulators. It would make no sense for a Government to decide on a policy to mandate insurance (as this document seemingly proposes) only to find it was not feasible in practice, or because, among other factors, the cost of setting up an authoritative body – to identify acceptable insurers as well as mandating policy limits, and terms and conditions – and of providing it with appropriate expertise and resources was considered prohibitive.

Here are examples of restrictive terms and conditions taken from policies that have been shared with the MDU (appropriately anonymised):

Strict reporting conditions

Must notify all claims & circumstances within 30 days

Duties of insured

Must not admit responsibility or make an offer or promise or payments without written consent of insurer

Dr must always act honestly (or no indemnity) - eg amends records or changes account of events etc

Exclusions

Meningitis

Instruments must be handled, used, stored, sterilised in accordance with manufacturers' instructions and other guidelines

Dr must fully cooperate with insurer (and provide records etc)

Must undertake a medical and/or drug history and a basic periodontal examination for all new patients

Must keep records of periodontal status

Must take a pre-op and post-op periapical radiographic film of any tooth when root canal work is undertaken

Must use a rubber dam to ensure instruments are not lost

Claims brought in other countries / jurisdictions

Any claims associated with a clinical trial

Any contractual liabilities

Breach of confidentiality / DPA claims

Claims relating to CJD or asbestos exposure or HIV/AIDS or meningitis or OOH work

Failure to recognise oral cancer, hepatitis, HTV III or LAC or breaking of the skin

Any claims arising out of dishonesty or fraud

Any claims brought against a Dr as a director, officer or trustee

Criminal acts or wilful misconduct

Reckless, malicious, fraudulent or dishonest acts

Known circumstances on application - policy excludes circumstances or incidents that could give rise to a claim that you might reasonably have foreseen - includes clinical complications

Known circumstances at annual renewal

Product liability (includes products supplied, altered or repaired in any way)

Insured not taking reasonable precautions to prevent an event or loss

Any claims arising from alleged sexual relations or conduct

Direct and vicarious allegations of sexual impropriety and criminal activity

Cancellation clause and cancellation

Mid-term cancellation clause (30 days' notice) - pro-rata refund of premium less any claims payments made

Claims made policy - cancelled mid-term by insurer and individuals left without indemnity and no retroactive cover

Policy voided by any material inaccuracy

Dr must repay any benefit received under the voided policy

Insurer/indemnifier clash

Insurer declines insured cover as believes other indemnity with MDO in place

Limited scope of cover

Claims for 'bodily injury' only

Low indemnity limits single claim

£1m for a GP / £5m orthopaedics

Policy eroded by defence costs

Insurer to withdraw if doctor declines to settle

Liability limited to amount insurer would have been prepared to offer

Policy covered agency not individuals

Doctors left without indemnity or retroactive cover

Insurer failed to tell insured of need for run-off

A number of practitioners who were unhappy with insurance policies they had purchased were surprised to learn they needed run-off if they wanted to leave. They chose to return to DDU, making a payment for tail cover

Conditions on run-off

Run-off only provided if insured no longer practises

Doctor told run-off included in policy. Premium increased and wanted to leave but had to pay run-off as only included on death or retirement.

Response to Q6.6

If Government pursues option (ii)

6.6 In order to achieve this aim, what would be the benefits or implications of introducing regulation via?

a) changing professional standards so that professionals have to hold a regulated product in order to practise;

b) changing financial regulation so that any organisation offering clinical negligence cover would need to be authorised to do so;

c) changing both financial and professional regulation.

We have explained in our answers above that the consultation document is flawed and misleading in a number of respects, including the fact that it is silent on a number of matters relating to the disadvantages of clinical negligence insurance now and in future (if it were to be mandatory). There is plenty of information available that explains why insurance is an imperfect means of providing indemnity that can guarantee to be available whenever a claim is made at whatever value, in whatever circumstances. We would have expected to see this explored thoroughly in a balanced consultation and assessed. For this reason it is inappropriate to seek views now on the assumption that option (ii) will be pursued, because the consultation document is misleading and incomplete and cannot be relied upon. We suggest the Department either withdraws the proposals or, if it wishes to pursue this expensive and unnecessary option, it carries out the research and provides the necessary information in a fairer and more balanced way, and that nothing material is withheld to enable a fair consultation to take place. It must also make sure that the hundreds of thousands of practitioners who would be affected by the proposals are made aware of the consultation and are able to consider the full implications and respond if they choose.

We do not see any benefits in any of the options in question 6.6 because to introduce a requirement for mandatory insurance would make indemnity far more expensive for healthcare practitioners. There is no evidence it would provide greater protection for patients and no guarantee that appropriate indemnity will be in place when it is needed. Further, no evidence has been provided to substantiate the claim that discretionary indemnity does not meet the principal policy objective of compensating patients.

Response to Q6.7

6.7 Do you have a view on when regulations should come into force and should these involve a transitional period, considering the potential impact on indemnity providers and healthcare professionals?

Although the consultation recognises a move to mandatory insurance would have a disruptive effect on the market, it has not made the case to support the proposition that insurance provides greater protection for patients than discretionary indemnity. Because clinical negligence claims are long-tail, one of the important factors is the need to set a

scope and limits of cover that would ensure patients were compensated for clinical negligence at any time in the future they made a successful claim. The consultation document does not address this and makes no provision for it. In addition, we have explained why there would need to be a body in place capable of understanding this specialist market and with appropriate authority, all of which will take some time to set up, especially as the body will need to continue in existence to ensure the scope and limits are always appropriate. We are not aware of any alternative being proposed by the Government in the consultation document. Setting up of this body and ensuring it had access to all appropriate information would take a considerable time and would require a long transitional period of many months and probably years. Such a body would be responsible for any decisions it makes on the scope and limits of cover and may be held liable should it turn out in future that requirements it set were inadequate to ensure appropriate compensation for patients who were negligently damaged by a healthcare professional in the NHS or independent sector. (We have commented elsewhere about the cost of such a body, which cost we expect insured healthcare practitioners, at least, would have to bear.)

Response to Q6.8

6.8 Are there any measures that could mitigate the potential risks to introducing regulation as set out in paragraphs 5.32-5.35 (in terms of a stable transition for regulated healthcare professionals and indemnity providers, mitigating potential cost impacts, and run-off cover)?

No. One of main risks of indemnifying long tail clinical negligence claims is that a subscription (or premium) has to be calculated and charged in the knowledge that the claims environment will certainly change in unpredictable ways and that, predictably, compensation will cost substantially more at the time a claim is settled, potentially tens of years after the incident and sometimes, for example when the prognosis is uncertain, years after notification. The only way to mitigate the funding risks that this creates would be to provide legal certainty about compensation levels and to introduce through tort reform legal safeguards that would control claims costs effectively. In addition there would need to be closer control of future legal policy to guard against unintended consequences of other legal changes, such as the effect on claimants solicitors of the Legal Aid, Punishment of Offenders Act 2012 which was responsible for the dramatic rise in claims notifications from 2012 and for the next few years as claimants' solicitors sought to bring cases under the old CFA rules.

Response to Q6.9

6.9 Specifically, on the transition risk, are there any measures that could support the run-off of indemnity providers' existing liabilities on a discretionary basis, and given the potential interaction with overseas business set out in paragraph 5.21?

The MDU is not affected by overseas business. However, any run-off would be discretionary and would involve claims arising from the practice of existing and past members, including those who have retired or died and who paid a subscription for the benefits of membership in the year the incident occurred. We see no practical way of addressing this if the market is deliberately disrupted through mandatory insurance.

Response to Q6.10

6.10 Specifically given the potential risk with claims-made and claims-paid policies and indemnity arrangements as set out in 5.35, should Government specify the type of insurance or regulated product required for regulated healthcare professionals? This could take the form of a) claims-occurring cover, b) claims-made cover, c) claims-made cover with built-in run-off cover on either death or retirement from clinical practice, or d) a combination of these.

Given the principal objective of this consultation is to ensure that 'patients harmed by the negligence of regulated healthcare professionals can access appropriate compensation' and because clinical negligence claims are long-tail, the only way to mitigate the risk of uncompensated patients is to require true occurrence indemnity. That is indemnity that is not limited in time or money (as the MDOs have provided satisfactorily for years) and not insured indemnity that calls itself occurrence but that does have limits. We have explained above the many disadvantages of claims-made insurance for long-tail claims. We expect that claims-made cover with built in run-off on death or retirement (where insurers will want premiums paid up front) will still have limits in time and money and it would not guarantee that indemnity was available when it is needed.

Response to Q6.11

6.11 Related to the above, should the Government and/or the professional healthcare regulators specify a minimum standard of insurance or regulated cover that should be

required for regulated healthcare professionals (for example, a minimum level of cover for each claim and in the aggregate, depending on the regulated healthcare professional)?

In order to ensure indemnity is available to provide adequate compensation whenever patients make claims, no matter how many years after a negligent incident, there has to be indemnity available that is not limited in time and money, written on a true occurrence basis. That is the nature of the indemnity provided to members by the MDOs. However, if the Government begins to put limits on time and money, even if they are considered generous at the time, the MDU's lengthy experience of this market has demonstrated that those limits will be inadequate in very many cases where claims are notified and eventually settled after an incident attaching to the year of the policy. The more 'generous' the Government is with time limits (mandating ability to report for each policy year in, say, 10, 20 or 30 years) and financial limits (say £30 or even £40 million – see the two recently agreed NHR cases described above), the more expensive the insurance policy, assuming the insurance market would ever be prepared to write such business.

The higher the limits, the more likely insurers are to exit the medical indemnity market, and the less likely they are to enter it in the first place. They must use their capital to get the best return they can for their shareholders. This is unlike the MDOs that operate on a mutual not-for-profit basis using members' funds solely to provide the benefits of membership for members. Experience of the insurance market shows that insurers, which must make a profit, fail and/or exit markets that become too expensive, creating the potential for unindemnified practitioners if there are no arrangements in place, such as run-off, to cover the tail of claims not already notified. Having in place regulation and setting minimum standards won't prevent this.

We have provided details in our response to question 6.5 of the conditions and exclusions on practitioners' policies that members or former members have shared with us (to which neither FSCS nor FOS remedies apply) over the period there has been just a small market in insured indemnity for clinical negligence claims. If the Government intends to ensure that patients are compensated appropriately it will need to make it clear which exclusions and conditions it considers appropriate in the context of the objective of adequate compensation. These will have to be tailored to the specific needs of any and every clinical specialty and sub-specialty and situation, and be future-proofed.

We have explained above that there is no regulatory body that currently has powers to set minimum limits and eliminate exclusions from clinical negligence insurance policies. The

Government would need to set up such a body. Even then, as we have explained above, even setting minimum limits will not ensure that policies respond adequately. Nor will it ensure that the insurer is still in place and/or still providing clinical negligence insurance. The FSCS can only respond in the case of an insolvency, and only if there was a policy in place. If a policy limit has expired, it has no remit.

6.12 Are there any equality issues that arise (positive or negative) in relation to each of the options but, in particular, in relation to the Government's preferred option (ii) which is set out from paragraph 5.15? In particular:

Responses to Q6.13 and 6.14

6.13 Is there any discriminatory impact (direct or indirect) arising from any of the proposed options that would engage the Equality Act 2010 and Section 75 of the Northern Ireland Act 1998?

6.14 What is the impact, if any, on any group of persons who share one or more of the protected characteristics set out in section 149 of the Equality Act 2010 when compared with persons who do not share the protected characteristic(s)? Section 149 of the Equality Act 2010 is set out in full in Annex C.

Yes there are many equality issues and potential discriminatory impacts that will arise from what is proposed. Again, we do not repeat all the points we have set out above, but it is clear that the impacts will affect various groups in many different ways which have not been assessed in the consultation document.

6.15 What are the potential consequences to the conduct of clinical research of the proposals set out in this document?

MDU contact details

Mary-Lou Nesbitt

Head of Governmental & External Relations

mary-lou.nesbitt@themdu.com