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Having read the Department of Health and Social Care paper on "Appropriate clinical negligence cover" in full, my view is that the Department's proposal to require regulated insurance for clinical negligence is by far the best option for patient safety and, ultimately, regulated healthcare professionals as well.

The Medical Defence Organisations emerged from 1885 around the Gentlemens' Clubs of the Victorian Age. Their origins were to defend the Doctors, rather than ensure the care of injured patients – in short, these entities really emerged to provide support for disciplinary and criminal proceedings against Doctors. In today's world by far the most significant cost is to rectify injury and provide care for patients rather than disciplinary proceedings. The professional indemnity market in insurance emerged around the 1700s to provide protection against negligence for all other professions. Medical indemnity is the only profession which is out of line with the approach of professional indemnity insurance which has worked well over time and through significant change in the insurance markets.

Today all regulated healthcare professionals in private practice require indemnity which has an administrative cost associated with it. Moreover, many regulated healthcare professionals practice through a partnership or company, which requires additional insurances that are currently purchased in the traditional insurance market. Acquiring regulated insurance to cover professional indemnity will not add a significant overhead above these requirements. Additional work might be required to provide a more detailed evaluation of the risks involved in order to make a fair presentation of the risk to insurers, which will be beneficial on all fronts.

The only option that is not considered is for the Government to provide a State backed indemnity for Private Healthcare which is not equitable or politically expedient. Private Healthcare should cover its full costs.

I agree with the Department that the best option is to require all regulated healthcare professionals working in private practice in the UK to hold appropriate clinical negligence cover that is subject to appropriate supervision by the FCA and PRA. There are two benefits with this approach. Firstly, PRA regulation ensures that the indemnity provider has appropriate financial resource to cover claims. Secondly, and just as important, is that the FCA supervision ensures that the indemnity provider honours its commitments to provide cover and pay legitimate claims. I have clients who have simply been told by an MDO that their membership has been suspended. This provides too much uncertainty for healthcare professionals, let alone injured patients.

I believe that the best approach is to make clinical negligence cover for private practice a statutory insurance, like motor insurance and employers' liability insurance. If the regulation were changed to require a regulated healthcare professional to hold a regulated insurance contract it would allow sensible approaches such as having an entire group of regulated healthcare professionals acting through a company to purchase insurance for the company. The NHS itself takes this entity approach in CNST which has a number of benefits including covering the vicarious liability between regulated healthcare professionals and allowing for run off cover as the entity can persist after an individual regulated healthcare professional retires.

As this is a pressing patient safety issue the Government should seek to introduce these regulations as soon as possible. Regulated healthcare professionals' indemnity generally renews annually. Rather than force

mass cancellation and acquisition of indemnity on a single date, the regulations should require all renewing indemnity to comply by the new rules with an absolute requirement that all indemnity comply twelve months after the introduction.

The risks identified in paragraphs 5.32-5.35 can be mitigated.

The most significant risk in the transition from discretionary to contractual cover is to ensure that claims that emerge from incidents immediately prior to the transition remain covered. If the existing discretionary mutual are not going to provide indemnity under the new framework there is no incentive for these organisations to continue to provide indemnity for claims that emerge. This risk could be mitigated by requiring the existing discretionary mutual to contribute to a pool, that is managed by NHS Resolve, that will cover emerging claims that are on the account of the discretionary mutual on a contractual basis. The Government might need to provide an ultimate backstop on this, but this should only be at the point where all of the assets of the existing discretionary mutual are exhausted.

Regulated insurance is priced on an evaluation of the risks. Moving indemnity for private practice into a regulated insurance contract will mean that it is all priced on an individual evaluation of the risks presented by each medical professional. My own brokerage seeks to obtain a complete list of all the procedures undertaken by a medical professional in the previous twelve months and then analyses the risks that these pose from academic research and studies. On this basis the cost of indemnity is not systematically higher, it is simply more appropriate to the presented risks. In some cases the risk posed by individual regulated healthcare professionals undertaking certain procedures is deemed to be very high and priced accordingly - this is actually supportive of patient safety. Moreover, as the risks are priced effectively and adequately, there is pricing stability. Pricing in the discretionary mutual market can simply reflect a lack of funds rather than any increase in the risk. This difference in pricing stability is exacerbated as a regulated insurer must account for unreported claims (incurred but not [yet] reported – IBNR). I have seen accounts for the discretionary mutual which are specifically endorsed to state that they do not include IBNR. This can lead to significant loss volatility and, therefore, pricing uncertainty.

The insurance broking business is there to provide advice to clients on the scope and risk of their business, the terms and conditions of their contract of insurance, that their insurance does not exclude any relevant activities and that the limit of cover is appropriate. Whilst few in number there are insurance brokers with a specialism in medical indemnity and this market will grow with the change in regulation. Insurance broking itself is a regulated activity and is required to carry professional indemnity insurance adding an extra layer of protection.

Most regulated contracts of insurance for medical indemnity include run-off cover. A specialist broker can advise on the adequacy of this cover. The best mitigation, to my knowledge, is for private medical services to be provided through a company and for that company to purchase indemnity. This means that the company can persist after an individual retires creating a continuity in cover. This is how professional indemnity for other professions such as architects or lawyers works. Very occasionally, some claims can emerge decades after an incident. The Government could introduce a small levy on medical indemnity to provide an NHS Resolve manged fund to cover this.

The Government Actuaries Department could assess the reserves required to support the run off of the UK business of the discretionary mutuals. These assets could then be a pool that is managed by NHS Resolve on a non-discretionary basis for UK liabilities. Any residual assets could provide pools for overseas

members. It is my view that UK taxpayers should not support foreign members and, therefore, any shortfall of the foreign member pools should be dealt with by the Government of that country – or through a call on the members of the mutual in that country.

The Government should not specify claims made or losses occurring cover. Both have potential gaps which can be managed through effective advice and structuring. The Government should simply specify adequate cover and suggest that buyers seek professional advice – much like pension fund trustees are required to seek professional advice. This is the case for all other aspects of indemnity. It should be tailored to be appropriate for the particular regulated healthcare professional and their activities.

Medical indemnity is not rated on any of the equality factors noted in the Equality Act 2010 Section 149. My business has certainly negotiated a lower premium for a mother on maternity leave as she was not working for a period of time and, therefore, her risk was lower than a contemporary who would be working all the time.

I do not know of any impact on clinical research. Clinical trials are covered under a separate area on the regulated insurance market. If all of the appropriate regulation is followed for a new clinical procedure and the risk evaluated properly, it will be appropriately prices in the regulated insurance market.

My business gathers significant amounts of data on the indemnity arrangements and clinical practices of regulated healthcare professionals in private practice as part of our everyday business of understanding clinical risks and presenting these to underwriters.

Christopher Cloke Browne

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Director