

NMC response to the Department of Health and Social Care consultation on Appropriate Clinical Negligence Cover

1. We're the independent regulator for nurses, midwives and nursing associates. We hold a register of the 690,000 nurses, midwives and nursing associates who can practise in the UK.
2. Better and safer care for people is at the heart of what we do, supporting the healthcare professionals on our register to deliver the highest standards of care.
3. We make sure nurses, midwives and nursing associates have the skills they need to care for people safely, with integrity, expertise, respect and compassion, from the moment they step into their first job.
4. Learning does not stop the day nurses, midwives and nursing associates qualify. To promote safety and public trust, we require professionals to demonstrate throughout their career that they are committed to learning and developing to keep their skills up to date and improve as practitioners.
5. We want to encourage openness and learning among healthcare professions to improve care and keep the public safe. On the occasions when something goes wrong and people are at risk, we can step in to investigate and take action, giving patients and families a voice as we do so.
6. We welcome the opportunity to respond to this consultation on the appropriate clinical negligence cover for healthcare professionals practising in the UK. Our responses to some of the specific consultation questions are below.
7. In summary, although we believe that the status quo arrangements for indemnity cover may not be sufficient, the current consultation does not sufficiently consider the needs of, and impact on, healthcare professionals on our register. Our response will therefore focus on sharing our experiences and relevant data on the indemnity arrangements of people on our register; this will include analysis of the groups who are most likely to be affected as they rely on indemnity cover through membership of a professional body. We will also set out the impact on the NMC of the specific option of changing our regulation to require people on our register to hold regulated indemnity cover.

Consultation questions

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

Do you agree with the Government's preferred option (ii) 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?

8. We believe it would be helpful if we set out the details of the indemnity requirements that currently apply to people on our register. As part of their application to join our register or renew their registration (revalidate), nurses, midwives and nursing associates need to self-declare that they have in place, or will do when practising, an indemnity arrangement that provides appropriate cover for their role and scope of practice when they practise in the UK. The cover they have in place should be relevant to the risks involved in their practice, so that it is sufficient if a claim is successfully made against them. They must inform us whether their indemnity arrangement is through their employer, membership of a professional body or a private insurance arrangement. If their indemnity arrangement is provided through membership of a professional body or a private insurance arrangement they need to provide the name of the professional body or provider. In support of this requirement we also ask for their scope(s) of practice and work setting(s), and any person, body or organisation by whom they are employed, intend to be employed or have an arrangement to provide services as a nurse, midwife or nursing associate.
9. As part of our reporting on revalidation we ask registrants who actively lapse from our register why they have chosen to do so. In the first year of revalidation (April 2016-March 2017) eight people cited 'no professional indemnity arrangement' as their reason for lapsing from the register (which is 0.1% of active lapsed who gave a reason for lapsing). In the second year of revalidation (April 2017-March 2018) five people cited 'no professional indemnity arrangement' as their reason for lapsing from the register (which is 0.1% of active lapsed who gave a reason for lapsing). These data suggest that the current requirement for professional indemnity is not an impediment to remaining on our register.
10. However, if it is discovered that a nurse, midwife or nursing associate is practising without an appropriate indemnity arrangement in place, they will ultimately be removed from the register and no longer be able to practise as a nurse, midwife or nursing associate. This includes registrants who cancel their indemnity cover after registration or renewal and fail to put alternative cover in place while still practising. We will also consider taking fitness to practise action if we discover that a registrant has made a false declaration that they have professional indemnity cover in place. If someone who wishes to practise as a nurse, midwife or nursing associate is unable to secure appropriate indemnity cover this therefore jeopardises their registration, practice and livelihood.
11. We also believe it would be helpful for the Government to carefully consider the NMC's recent decision regarding the indemnity arrangements for independent midwives offered by the organisation Independent Midwives UK (IMUK). Our actions in this case were motivated by our concern that mothers and babies who

suffer injury through the negligence of an attending midwife might not be properly compensated for their injury.

12. Following introduction by the UK Government of the requirement for all healthcare professionals to hold an appropriate indemnity arrangement in 2014, from mid-2015 around 80 midwives who were members of IMUK relied on indemnity cover provided by a small limited company set up specifically for this purpose. It relied solely on the premiums paid by the individual members and a personal guarantee from its managing director. Its financial assets were limited and it was not backed by any additional policy of insurance.
13. When a concern was raised with the NMC about the indemnity cover held by IMUK midwives the Registrar investigated the appropriateness of this arrangement. In August 2016 the NMC wrote to all the midwives affected to tell them our provisional decision that that the scheme did not provide appropriate cover as it had inadequate funds to settle significant claims should harm come to a woman or their baby during childbirth. It was not able to call upon sufficient financial resources to meet the costs of a successful claim for damages for a range of situations. These included the rare cases of catastrophic injury, such as cerebral palsy.
14. We made clear to IMUK that if the provider did not increase its available resources, then its member midwives would have to secure an alternative arrangement or they would face removal from the NMC's register. As we did not receive adequate further assurances we wrote to IMUK and all the affected midwives in December 2016 to tell them our final decision that their scheme was not appropriate.
15. A number of the affected midwives brought a judicial review claim against the NMC and in December 2017 a [High Court Judge upheld our decision](#). She recognised that while the risk of a high value claim was low, the risk was real and the nature of the risk was very severe. IMUK members have all now confirmed to the NMC that they will not rely on the IMUK indemnity scheme.
16. The IMUK case demonstrates how the current situation can lead to uncertainty for people on our register and patients they care for. The case led to direct costs for the midwives involved, and for the NMC in investigating, acting and defending our decision (and therefore indirect costs for the people on our register).
17. However, before the Government comes to a decision on this issue, it needs to carefully consider the rationale for any changes to the status quo in this complex area that spans both health and social care provision, and financial services.
18. A move to requiring regulated indemnity cover might not prove to be a straightforward solution. Unlike discretionary cover, insurance products typically come with strict terms and conditions, and the Government needs to consider whether these will deliver the benefits to patients, the public and regulated healthcare professionals that it is seeking.
19. We provide further examples of the areas that the Government needs to investigate, analyse and monitor in our responses to subsequent questions.

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?

20. As set out in Article 3(4) of the Nursing and Midwifery Order 2001¹ ('the Order'), the over-arching objective of the Council is the protection of the public. It is vital that those who suffer due to negligence by regulated healthcare professionals (in our case nurses, midwives and nursing associates) have recourse to any required compensation, particularly in rare cases of substantial harm.
21. For patients and members of the public, these changes could provide more certainty that they would be adequately compensated if they are unfortunate enough to require long term care or other significant ongoing medical support following a clinical injury resulting from negligence. However, as noted above there may be some disadvantages of relying on insurance products rather than indemnity cover from well-established and well-funded discretionary schemes. The Government needs to consider to ensure that the proposed change does in fact deliver the benefits to patients, the public and regulated healthcare professionals that it is seeking.
22. Knowing that adequate compensation is available could also lead to the secondary benefit of increased public confidence in regulated healthcare professionals who provide services outside existing or proposed state-backed schemes. The current approach to this issue is to require individual regulated healthcare professionals to hold appropriate indemnity arrangements. We welcome further consideration of the policy approach, given the shortcomings in the current approach exemplified above.
23. For people on our register the main benefit would be to increase certainty that their cover is appropriate. We currently advise registrants that while they do not need to individually hold their indemnity arrangement, it is their responsibility to ensure that whenever they practise they will have an appropriate indemnity arrangement in place. Supervision by the FCA and PRA should provide some assurance for people who provide services outside state-backed schemes that their cover is appropriate. Healthcare professionals need protection from the potential burden of being required to provide compensation as an individual in the event of substantial harm, which is particularly likely for those with self-organised cover for small groups.
24. We are aware that there might be some negative impact for some people on our register. Bringing cover into regulation might lead to cover becoming more expensive or difficult to source. In extreme circumstances those who cannot obtain cover cannot be on our register and practise their profession. A 2011 report commissioned by the NMC and Royal College of Midwives into the feasibility of a model for supporting the continuity of independent midwifery found a viable solution for securing insurance using a social enterprise or corporate structure.
25. A benefit for the NMC comes from the avoidance of potential costs stemming from investigations such as the IMUK case. This also has an indirect benefit for people on our register whose fees pay for our work. However, if the change is implemented via an amendment to our legislation this brings a higher cost in the short-term (see below).

¹ SI 2002/253 (as amended)

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

26. As the holder of the largest register of healthcare professionals in the UK (over 690,000 as of September 2018²), we have data on the indemnity arrangements of all of the nurses, midwives and nursing associates currently registered to practise in the UK.
27. The vast majority of people on our register employed in both the NHS and the independent sector are covered by their employer's indemnity arrangements (91 per cent of those who had submitted a revalidation application by mid-January 2019). A small number of people on our register work on a self-employed basis and are responsible for securing their own professional indemnity arrangement: 1 per cent of those who had submitted a revalidation application by mid-January 2019 had indemnity cover through a private insurance arrangement and 7 per cent had indemnity cover through membership of a professional body. It is the approximately 49,000 people whose indemnity cover comes through membership of a professional body who are most likely to be affected by this change.
28. People whose practice is in certain areas are more likely to rely on membership of a professional body for their indemnity cover. 13 per cent of those whose scope of practice is 'direct clinical care or management – occupational health', and 11 per cent of those whose scope of practice is 'quality assurance or inspection', rely on membership of a professional body (compared to 7 per cent of all people on our register). Similarly, 31 per cent of those who work in a private domestic setting, 26 per cent of those who work in consultancy, 19 per cent of those who work in insurance or legal settings and 17 per cent of those who work in prison rely on membership of a professional body (compared to 7 per cent of all people on our register).
29. In particular our data indicate that those who practise more independently from other healthcare professionals, or in non-standard settings, are more likely to seek indemnity cover from a professional body. In addition to the practice areas where we know that cover via a professional body is more common, we believe there are also other groups whose independent practice in non-standard settings means they are more likely to be affected, such as some of those undertaking cosmetic or aesthetic nursing practice. The consultation document indicates that the Government is aware of the indemnity arrangements of midwives practising independently but our data show that these proposals are also likely to impact other groups.
30. In our analysis above we have focused on those groups who are disproportionately likely to be affected by the proposed change. However, we would expect the Government's full impact assessment to drill into the details of all those likely to be affected, particularly the nature of their practice. The size of a group is not necessarily a guide to the impact of their practice on patients, service users and members of the public, as the IMUK case involving 80 people on our register demonstrates.

² <https://www.nmc.org.uk/globalassets/sitedocuments/other-publications/nmc-big-picture-september-18.pdf>

31. It is vital that, before making any policy decision regarding these arrangements, the Government considers all these data to fully understand the impact of any changes for individual practitioners and those for whom they provide services, alongside similar data from other healthcare professional regulators and other sources of evidence.

If the Government pursues option (ii): 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.**

Option (a)

32. Option (a) has the advantage of directly addressing the issue at hand by ensuring that all those who wish to practise as a nurse or midwife in the UK, or as a nursing associate in England, must have regulated clinical negligence cover, which means it must be subject to appropriate supervision by the FCA and PRA.
33. However, there would be an impact on the NMC of the short-term resources we would need to dedicate to changing all relevant parts of our legislation through a section 60 Order, plus associated activities.
34. The requirement for indemnity cover for individuals is integrated into several pieces of NMC legislation. It stems from EU Directive 2011/24/EU³ which requires healthcare professionals, including in the UK, to have an appropriate indemnity arrangement in force appropriate to their role. The Nursing and Midwifery Order 2001⁴ ('the Order') sets out how this requirement applies to nurses, midwives and nursing associates in relation to their initial registration, retention of registration, renewal of registration and for readmission or restoration to the register.
35. In particular, Article 12A of the Order sets out the requirement for each registrant to have an indemnity arrangement that provides appropriate cover. It states that an "indemnity arrangement" may comprise:
- 35.1. a policy of insurance;
 - 35.2. an arrangement made for the purposes of indemnifying a person;
 - 35.3. a combination of the two.
36. Article 12A(2) of the Order also provides for the NMC's Council to make rules for the information to be provided by registrants about their cover and action if that requirement is not met. These Rules are the Nursing and Midwifery Council

³ Directive 2011/24/EU 'on the application of patients' rights in cross border healthcare'

⁴ SI 2002/253 (as amended)

(Education, Registration and Registration Appeals) Rules 2004⁵ (the Registration Rules). Schedules 3 and 4 of the Rules require those applying to register or retain their registration to provide details of the nature and scope of their practice, and of those for whom they are or intend to be employed by or provide services with.

37. Initially NMC legal and policy staff would need to work with the Government to identify all of the relevant parts of our legislation that would require amending, and consider any unforeseen consequences and mitigating actions. We would then work with government lawyers on the drafting of any necessary changes and related public consultation. The full parliamentary process typically takes 18-24 months to complete. Alongside this would be a communications programme to set out the impact on people on our register and other stakeholders. Internally we would need to ensure our systems, processes and guidance reflect the legislative changes, and that staff were suitably prepared for any change in approach.
38. Any activities we undertake are directly funded by the fees paid by people on our register. The Government must ensure that the indirect impact on those on our register from short-term resources commitments is balanced by longer-term benefits
39. This option would mean that people on our register would become responsible for ensuring that their indemnity cover was regulated. However, people on our register are not necessarily insurance experts, and it is important that those who have to source alternative cover do not affect their registration by inadvertently continuing to rely on unregulated cover.

Option (b)

40. This option would place less onus on people on our register as providers of discretionary products used by those whose indemnity is not backed by a government scheme would be subject to financial regulation. They would therefore be less likely to inadvertently rely on products offered by organisations that were not authorised to do so.
41. Another benefit to both people on our register and the NMC would be the reduced short-term costs to the NMC, as we would not need to be heavily involved in these legislative changes.
42. However, this option does not directly address the concern that individuals must hold appropriate indemnity cover. By instead indirectly addressing the issue by changing the financial regulation of indemnity products it exposes a potential gap relating to the UK jurisdiction of financial regulation. If the financial regulation of indemnity providers is amended this could still allow people on our register to buy discretionary cover from non-UK based providers who are not subject to UK financial regulation, which could leave gaps in patient access to compensation.
43. This option is also potentially less future-proof as it relies on bringing the current suite of providers and products into regulation.
44. Whether the Government chooses to pursue option a, b or c we believe it will be critical for its success to conduct a full impact assessment prior to any change. It

⁵ SI 2004/1767 (as amended)

must consider the views and evidence of those with expertise in both financial and healthcare professional regulation to avoid unintended consequences in the short and long term.

45. For example, there is an unanswered question relating to those who practise outside the jurisdiction of UK financial regulators. We know that a small proportion of people on our register practise mainly outside the UK; this was 1.4 per cent of people on our register in April 2017-March 2018.⁶ It is not clear with any option whether these people would be required to hold indemnity regulated by UK financial regulators, whether regulated cover in their country of practice would suffice, or whether this requirement would not extend to them as it only extends to practice in the UK or in England for nursing associates.

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?

46. As stated above, we do not believe any changes should be considered without significant further analysis of the likely impact. However, following further consideration and consultation, should the Government decide to implement these proposals we firmly believe there must be a transitional arrangement to allow several key groups to prepare:
- 46.1. Affected healthcare professionals will need sufficient time to become familiar with the new requirements and if necessary source regulated cover to be able to continue to fulfil the registration requirements for practice in the UK. This will also provide them with an opportunity to communicate with those to whom they provide services about any changes that affect them.
- 46.2. It may take some time for indemnity providers to amend their products or develop new ones to fulfil regulatory requirements. We suggest the Government consult directly with those who might provide regulated cover for those whose cover was previously discretionary about the appropriate duration of the transitional arrangement.
- 46.3. Healthcare professional regulators such as the NMC will need time to ensure they have in place communications plans; updated systems, processes and guidance; and that staff are suitably prepared for any change in this requirement.
- 46.4. Those who provide support and advice to healthcare professionals, such as employers and unions, will need time to prepare to play their part.

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https://www.nmc.org.uk/globalassets/sitedocuments/annual_reports_and_accounts/revalidationreports/revalidation-annual-data-report-year-2.pdf

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

47. This change could potentially impact on the ability of some registrants to meet the indemnity requirement and thus risk their registration, practice and livelihood. It is important for the Government to consider the consequences of this decision for individual healthcare professionals and implement mitigating actions.
48. Clear and comprehensive communication with all those affected, particularly healthcare professionals without state-backed indemnity and unregulated providers, will be essential to maximise the opportunity for compliance with the new requirement. Healthcare professionals (and some indemnity providers) will be unfamiliar with insurance regulation, and tailored guidance for non-experts from the financial regulators would be very helpful.
49. For example, it will be important for those moving from a discretionary indemnity arrangement that does not have any excesses, caps and exclusions to understand that these might apply to a future regulated insurance product. Similarly, discretionary indemnity is often provided on a 'claims-occurring' basis, and those moving to the more common 'claims-made' and 'claims-paid' insurance cover need to be informed of the need to purchase run-off insurance if they move provider or cease practising to remain protected.
50. We also urge the Government to work with the devolved administrations to ensure that practitioners in different parts of the UK are not differentially affected.

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)? In particular:

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?

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.

51. Our revalidation data indicate that those from certain ethnic minorities are likely to be disproportionately affected as they are more likely to have indemnity cover through membership of a professional body. 26 per cent of 'black – African' people, 13 per cent of 'black – any other' people, 12 per cent of 'black – Caribbean' people and 19 per cent of 'mixed – white and black African' people have indemnity cover through membership of a professional body, compared with 7 per cent of all people on our register who have indemnity cover through membership of a professional body.
52. Indemnity cover arrangements also vary by age, with the likelihood of cover through membership of a professional body increasing with increasing age. 5 per cent of people on our register aged 21-30 have cover through membership of a

professional body, compared with 10 per cent of those aged 61-65 (and higher percentages for those aged over 65).

53. These statistics can in some instances be explained by the fact that people from certain ethnic minorities and older people are more likely to undertake the types of practice for which practitioners are more likely to rely on cover through membership of a professional body. For example, according to our revalidation data :
 - 53.1. 16 per cent of our people on our register who work in prisons are 'black – African', compared with 6 per cent of all people on our register who are 'black – African'.
 - 53.2. 12 per cent of people on our register who have a scope of practice of 'direct clinical care or management – occupational health' are aged 61 and over and 8 per cent of people on our register who have a scope of practice of 'quality assurance or inspection' are aged 61 and over, compared with 6 per cent of all people on the register who are aged 61 and over.
 - 53.3. Similarly, 14 per cent of those who work in a private domestic setting, 13 per cent of those who work in consultancy and 13 per cent of those who work in insurance or legal settings are aged 61 and over, compared with 6 per cent of all people on the register who are aged 61 and over.
54. It is vital that the Government carries out a full equality impact assessment in addition to a wider impact assessment before coming to any decision regarding the nature of professional indemnity arrangements for healthcare professionals.