Royal College of Nursing response to Department of Health and Social Care consultation on Appropriate Clinical Negligence Indemnity Cover

Introduction:

With a membership of around 435,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

RCN members enjoy a range of benefits of membership, including an entitlement to benefit from the RCN's discretionary indemnity scheme. Having paid the subscription fee (just under £200 for a full registered nurse member), our members will have indemnity cover for clinical negligence for their self-employed nursing work and student placements, as well as for voluntary and good Samaritan nursing. There is a cap on each claim of £3 million, which is a higher figure than that for the other healthcare unions that nurses might join. Also included in member benefits is access to legal advice and full representation for a range of workplace issues, including employment and regulatory concerns (most commonly NMC cases).

We know that our members place great value both upon the RCN indemnity scheme and access to legal representation. These are significant factors for many in deciding to join the RCN. The cover is low cost for our members, compared with commercial alternatives, and straightforward for members to join. Though we don't have accurate figures on those who rely on the RCN's scheme, we do receive over 8000 calls to our support service (RCN Direct) annually about indemnity. An analysis of the last quarter of calls about indemnity in 2018 revealed that 61% of the callers identified themselves as agency, bank or self-employed workers.

The cover enables nurses to work flexibly and undertake voluntary work. This is particularly important given current nursing shortages and of benefit to public health. For example, we know that some nursing homes and other social care providers rely on agency staff to operate and that this indemnity allows nurses to engage in this type of agency work.

In addition self-employed members, who join primarily for indemnity cover, gain access to all of the RCN's professional support which enables them to practise more safely and effectively.

We agree that health professionals should feel confident that they have sufficient indemnity cover for the healthcare tasks that they undertake, and that members of the public must have the same access to compensation no matter which professional is treating them.

Accordingly, we contend that the RCN indemnity scheme is of great value to our members and to the public, and we ask that any future path adopted in relation to discretionary schemes enables the RCN to continue to provide this cost-effective, flexible arrangement.

6. Consultation questions

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

We appreciate that the Government wish to support the most transparent and stable arrangements for the provision of such important cover for healthcare professionals and the public. However, no evidence has been presented to suggest that the current arrangements have caused difficulty to those two groups.

We cannot speak for other organisations providing discretionary schemes, but the RCN has provided a dependable scheme for its members that has operated well. The RCN has been financially stable throughout its 100 year history. Being a membership organisation, any decisions about the application of discretion in relation to the scheme are made with acute awareness of our overriding requirement to serve that membership.

The RCN has a strong vested interest in the scheme being run fairly and in accordance with the terms of the published scheme. If it was run unfairly, there would be the risk of reputational damage that could undermine our critical relationship of trust with our members. We are not aware of any criticism from members of the RCN scheme in recent years for exercising the indemnity scheme unfairly or outside the published terms. The RCN has a set of values that is ethical and we are here to serve our members, a different relationship to that between an insurer and a policy-holder. This is set out in our mission statement.

The RCN mission statement:

The Royal College of Nursing represents nurses and nursing, promotes excellence in practice and shapes health policies.

Insurers have exclusions and terms, such as strict notification requirements. These may not breach the requirements of a regulator like the FCA. However the terms may be restrictive and therefore more likely to frustrate the core objectives of this consultation. The RCN works hard to ensure that the needs of its members are central to our indemnity scheme.

We have seen an example of an insurance policy delivering an unfortunate outcome recently where an insurer provided cover to a clinic offering fertility treatments, but the cover excluded a certain type of injury to patients. Unfortunately, a patient then did suffer that injury and the insurer refused cover, leaving the clinic uninsured for that incident.

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?

We have undertaken some investigation into the feasibility of purchasing insurance-backed cover for our membership. Insurance market providers consider such schemes purchasable, but are less clear on costs. The cost is likely to be higher than the RCN's current arrangements. The RCN scheme is occurrence-based, so there are issues of run-off, depending on the rules adopted.

In order to support its membership, the RCN could face the prospect of needing to maintain its current scheme for the run-off, whilst also commencing an insurance-backed regulated scheme. We would request close consultation in the event of the introduction of new rules, and that priority is given to maintaining the viability of an RCN scheme that can be low cost and straightforward to access.

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

We believe that the assumption that individual professional practitioners must take all the responsibility for holding adequate indemnity cover is misplaced. Since 2014, as noted in the consultation document, there has been a requirement on professionals to hold adequate indemnity cover following an EU Directive. The advice on the NMC website states:

"Each nurse, midwife and nursing associate is responsible for making sure they have the appropriate cover for their role and scope of practice. 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."

Without this, nurses are warned that they will be breaking the law and will be removed from the register. However, as noted in the consultation document, no guidance is given to nurses by the NMC about what amounts to 'appropriate cover'. We argue that nurses would need to have knowledge about the current clinical negligence landscape to understand their risk. It is quite possible for a single error like an unreturned call by a nurse to lead to a missed diagnosis, which could have catastrophic consequences for the patient and potential damages that exceed the cap on damages in most schemes, including those of financially regulated insurers.

In our experience, most responsible employers and providers of healthcare services do not rely upon arrangements made by their nursing staff individually. This enables us to offer a good value scheme to our members, since most employers and those who hire locums and agency staff make arrangements for adequate indemnity.

However, we have numerous experiences where our members have discovered that their employers made a mistake when arranging their cover and informed our member they had appropriate cover in place when they did not. We have also had disputes with employers who have then resisted purchasing retrospective cover. Our members have been in the unenviable position of discovering that they inadvertently misled their regulator by signing the indemnity declaration incorrectly. The regulator

can remove the nurse from the register at that point, and whilst they are likely to be returned, the disruption can be damaging to that nurse, their family and their employer. It appears to us that mandating indemnity cover through the route of regulation is inefficient and often places the onus on the wrong person to evaluate the appropriateness of the cover.

We have also encountered institutions offering private clinic services whose owners appear to see their own role as little more than that of a landlord. These type of institutions appear to rely upon the indemnity cover of the staff who cover their clinics. In our view, this results in a loss of oversight and commitment to safe practices and we have identified weaker processes at such institutions.

We have experienced the consequence of litigation involving multiple defendants represented by different indemnifiers. We are often involved in such litigation, as many injuries to patients result from a series of missed opportunities to refer a patient for further investigation in a timely, relevant manner. For example, our member may have covered one appointment among many, and we are then involved in gathering evidence about which of the defendants involved was more responsible for the injury. This requires expensive reports from nursing experts and causation experts by all the different defendants. It might be clear that the claimant should recover damages, but the costs involved and time before settlement are driven upwards. There would be a significant costs saving if a single indemnifier, representing the whole institution and all who work there, took responsibility for the entirety of the claim.

We suggest the need to revisit the principle that an employer required to meet a claim by reason of vicarious liability can seek recovery from their employee, arising from the 1957 House of Lords case of *Lister v Romford Ice and Cold Storage Ltd.* If this change was made, vicariously liable employers, including those that have hired agency staff, would not be able to subsequently seek a contribution from their staff. In reality, the vast majority of employers and all responsible employers never do so, but the reassurance that this would give would be valuable and would remove the uncertainty that leads to many nurses purchasing unnecessary additional cover. Again, this would create certainty about which indemnifier will meet the claim.

We are assisting a member who does not qualify for our scheme because she was employed at the time of the incident. Her employer purchased inadequate insurance cover due to the nature of one of the exclusions in the policy. The employer did not require our member to purchase her own cover because the employer mistakenly believed that the cover was adequate. The employer is now seeking a contribution from our member personally. While this is an isolated case the damage done to our member is significant; this has been hanging over her for a number of years and it has greatly impacted her mental wellbeing. We are attempting through legal action to bring the matter to a close. This could have been prevented if employers were prevented from seeking a contribution in these situations, where there has been no question of recklessness or deliberate action, and, in fact, it is denied that the nurse has even made an error.

We consider that all institutions providing healthcare should be required to appropriately insure the healthcare treatments provided without recourse to individual practitioners. This would be similar to the legal requirement to have employer's

liability insurance. The provider is in a better position financially to purchase adequate insurance, and to ensure that policies, staff skill sets and the setting is as safe as possible before they provide patient care. Requirement for professionals to have adequate indemnity cover could then be limited to self-employment only.

We also propose that tort reform is another area for investigation by the DHSC. There is limited evidence to suggest that the lack of financial regulation of discretionary schemes has caused significant difficulty in the past, and speculate that the spiralling costs in current clinical negligence claims are likely to have been a driver for this consultation. Therefore we would also support an investigation into the benefits of tort reform, as there is potential for this to bring these costs under control.

We are aware of the harmful effects to those practitioners involved in a clinical negligence case. Nurses, like other healthcare practitioners, often chose their career as a vocation and experience high degrees of distress if their practice becomes the subject of a case, resulting in many leaving practice. In addition practitioners describe defensive practices adopted to mitigate against litigation. Examples include nurses noting that certain treatments might be better provided at home but are being provided in clinic settings due to worries about insurance cover. These result in greater inconvenience to patients and a further strain on the system. These unintended outcomes would also be suitable for consideration under tort reform.

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?

We do not have an adequate knowledge about the difficulties caused by lack of supervision by the FCA and PRA as it might have affected other schemes, but we can draw on our own experience of the RCN discretionary scheme.

During the past 20 years or so there have been no occasions on which the discretion of the RCN was exercised to deny indemnity cover in a manner that was not set out in the Indemnity Scheme document. For over a century the RCN has been a financially stable organisation. The scheme does have a set of exclusions and other terms, clearly stated on our RCN website, we believe these are similar to the types of terms and exclusions that would be found in an insurance scheme regulated by the FCA and PRA.

To our knowledge we have received no complaints from our members on their level of cover over the past 20 years. From this claims history it appears unlikely that being subject to FCA and PRA supervision would have led to any different outcomes.

We are concerned that regulated insurance schemes are just as likely to include exclusions that the regulatory processes outlined in this consultation will not prevent. It may be those exclusions, rather than FCA and PRA supervision, which create outcomes that are contrary to the objectives of this consultation.

The concern for the RCN is that the requirement for such supervision will add to additional cost or lead to unforeseen outcomes that prevent the RCN from offering the coverage as at present.

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

We have looked at the ways in which our members utilise the RCN scheme by undertaking a brief survey of those who rang in to our call centre during the lifetime of this consultation response period. We carried out 13 interviews, and acknowledge this sample, though indicative, is not representative of the views of our membership. Members are most likely to contact us at the outset of self-employed work, to check that they are covered. The details of the 13 members utilising the RCN scheme for self-employed work were as follows:

Four worked full time, nine part time (for as little as four hours per week)

If the RCN scheme were not available, some said that they would seek out commercial cover, others said that they would investigate the cost of commercial cover and would carry on with their nursing duties if cover were affordable, but around a half would probably give up their self-employed work.

The work included acupuncture, occupational health nursing, agency work in care homes and private hospitals (several members), medical screening for insurance companies, care home inspection and menopause support.

Comments about why the member would have to stop the work without the RCN scheme included:

- "*because nursing salaries are not that great"*
- *"it would put the kibosh on my self-employed work' because the income was variable and not guaranteed"*
- [to make other arrangements would be] *"too much hassle*".

We also reached out through our forums to nurses who volunteer. We had comments from nurses volunteering in summer music festivals and at 'Crisis at Christmas'. The festival work actually raises £80,000 a year for charitable causes related to health. Both commented that the invaluable support by RCN members to those events would be threatened if separate commercial arrangements had to be made.

We also spoke to managers of leading nursing agencies, who said that the margins for nurses providing agency nursing care are already very tight, particularly in the independent sector. From their own knowledge of their clientele, they observed that they would see a reduction in nurses working as agency staff if arrangements became more costly or complex. These agencies also indicated that they are struggling to meet demand and are involved in exercises such as facilitating recruitment in the Philippines, which is indicative of the severity of the nursing shortage.

Overall, the impression that we already had that our scheme is used by our members to enable them to utilise flexible nursing arrangements in a wide variety of settings for the great benefit of the public was reinforced by our very brief project. We would ask that whatever changes are made, priority must be given to maintaining flexible and affordable arrangements that enable this low visibility but important nursing to continue.

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;

We do not consider making individual healthcare professionals responsible for adopting the correct form of clinical negligence cover is the most effective means of operating the current scheme nor for implementing change. Many of our members are confused by both the issues and the terminology, and as a result we would discourage any expectation that they should hold responsibility for their employers making the right choices. As highlighted earlier, employers making mistakes can create a situation where a nurse's ability to earn their living and retain their registration can be threatened, which is a highly undesirable outcome.

Please also refer to our comments and case study under 6.3 above

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

This would be a means for nurses purchasing cover in the open market to know that any clinical negligence cover was compliant with any new rules. This change would require the RCN to offer different cover. There may be ways to do this and retain the benefits of the current RCN scheme, but we would ask that we and other organisations are closely consulted in order that the benefits of our schemes are retained.

• c) changing both financial and professional regulation.

See response to 6.6. a) above

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?

As this consultation makes clear, Scotland currently does not have any stated intent to move to a state-backed scheme. However, the RCN has been in discussion with the Scottish Government around its plans to review current arrangements for indemnity cover. If the result of this UK consultation is a move to financial regulation of indemnity providers the RCN would urge both governments to work together to ensure that unintended consequences in the Scottish market do not expose our

members working in independent providers (including contracted general practice) to the risk of insufficient or non-existent cover. We believe this would be an unacceptable position for our members, who cannot uphold their NMC registration without sufficient cover, or for the general public. We look forward to continuing our engagement with the Scottish Government to shape the future of indemnity provision for Scottish members, taking account of the outcome of this UK consultation.

In Northern Ireland, there is no proposed state-backed scheme for GP services at present, although indemnity cover does include all those who deliver GP services within a provider. As with the Scottish situation, we would ask that the consultation takes into careful account the impact on the arrangements in Northern Ireland.

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)?

As the RCN scheme is claims-occurring cover, we may not have the same issues as other organisations about arranging run-off. However, if there is a new regulatory regime, we believe there will need to be a sufficiently lengthy transition to ensure budgets can be planned to incorporate the cost. We also believe that the RCN membership would need to be consulted if changes to the scheme have to be made, and this would entail the need for a lengthy transition period in order for this consultation to be undertaken.

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?

See response to 6.8

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.

In view of the fact that clinical negligence claims can be made many years, even decades, after the events that led to them, the safest way of ensuring that patients are able to recover compensation (if that remains a priority) and healthcare professionals are able to rely upon their cover, is to require claims-occurring cover.

Claims for children can arrive decades after the original event, and we are regularly contacted about claims relating to events over a decade ago. Contribution claims or Part 20 claims are a particular issue, as the claim can be made for up to 2 years after settlement of the original claim, which will have taken many years to conclude.

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)?

The difficulty of this approach is that the lower level of cover based upon the experience of recent case law suggests that cover could be required in the region of £20m or even more. However, at the RCN, no claim has ever been paid out at the upper level of its cap per claim of £3 million. The danger is that if a minimum level of cover is stipulated, then the cost and risk becomes prohibitive for organisations offering good value flexible cover like the RCN. We believe it would be far better to require that establishments, such as clinics, care homes and private hospitals, are required to have adequate cover for those who work there (including locums and agency staff). Furthermore if minimum levels of cover are required, those organisations should be incorporating the cost and managing the risk as part of their business.

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:

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?

We believe that women would be most likely to be impacted if the cost and complexity of their indemnity arrangements change. Our members who have caring responsibilities often have to manage their work around those responsibilities with part time, self-employed roles, and these are more likely to be female members.