26 March 2015

Strategy and Policy Board

To consider

Insurance and indemnity: changes to the Licence to Practise and Revalidation Regulations 2012

Issue

1. Following approval of the consultation documentation by the Strategy and Policy Board on circulation in October 2014, we consulted from October to December 2014 on proposed amendments to the Licence to Practise and Revalidation Regulations 2012. These amendments will enable us to implement the recommendations of an independent review of insurance and indemnity for healthcare professionals, commissioned by the Department of Health in 2009.

2. Responses to the consultation indicated a high level of support for our proposals. Subject to the Board’s approval, we propose to seek Council’s approval for the amended Regulations at its meeting on 23 April 2015.

Recommendations

3. The Strategy and Policy Board is asked to:

   a. Consider the proposed amendments to the Licence to Practise and Revalidation Regulations 2012 following the public consultation.

   b. Note that the amended Regulations, at Annex A, will be considered by Council for approval at its meeting on 23 April 2015.
Insurance and indemnity: changes to the Licence to Practise and Revalidation Regulations 2012

Issue

4 The Department of Health commissioned an independent Review Group in 2009 to look at the issue of insurance and indemnity for healthcare professionals. It reported in 2010 and recommended that making insurance or indemnity a statutory condition for access to a profession is the most cost effective and proportionate way of ensuring that all healthcare professionals have adequate insurance or indemnity cover.

5 The report also recommended that, while legislation should be harmonised across healthcare professional regulators, it should be for each healthcare regulator to decide how best to exercise its powers.

6 In July 2014, Parliament passed the Health Care and Associated Professions (Indemnity Arrangements) Order 2014, which implemented the recommendations of the independent Review Group and created a new Section 44C of the Medical Act 1983. This new section of the Act gives the GMC powers to make Regulations to assure itself about a doctor’s insurance and indemnity arrangements.

7 From 15 October to 10 December 2014 we publicly consulted on amendments to the Licence to Practise and Revalidation Regulations 2012, which mean that:

a There will be a requirement to include a declaration* on insurance and indemnity in any application for a licence in order for it to be complete.

b We will have the power to request information from the practitioner or another party to satisfy ourselves that the declarations are accurate and to determine whether the practitioner has appropriate cover in place.

c We will have the power to require a licenced practitioner to inform us if they have appropriate cover provided under an indemnity arrangement by an employer and to inform us if their indemnity cover ceases.

d We will have the ability to refuse to grant, or to withdraw, a licence for failure to have appropriate cover or failure to comply with our requirements to provide the declaration or further information we might request.

* The declaration was introduced as part of the application process on 30 August 2014. It states ‘I have in place, or will have in place, at the point at which I practise in the UK, insurance or indemnity arrangements appropriate to the areas of my practice’.
Consultation responses

8 The consultation sought views on the main effects of the proposed changes to the Licence to Practise and Revalidation Regulations 2012.

9 We received 31 responses to our consultation: 16 from individuals and 15 from key interest organisations.

10 The consultation outcome report is at Annex B. The report highlights that there was a high level of support for our proposals from both individuals and key interest organisations. Respondents in favour of the proposals felt they were ‘reasonable’ and ‘appropriate’ and that the changes highlighted the importance of appropriate indemnity cover for both the doctor and their patients.

11 A number of respondents commented that we should:

   a Explain what is meant by ‘appropriate’ and ‘sufficient’ cover, for example what value of cover is required for a particular area of practice.

   b Clarify that doctors do not need to arrange private insurance cover where their employers’ indemnity or indemnity provided by an NHS employer is sufficient.

12 Our current position is that the definition of ‘appropriate’ and ‘sufficient’ cover is a complex area and is very much dependent on each doctor’s individual circumstances. We feel that this is a matter for a doctor to discuss with a relevant insurance provider or other appropriate professional who will be able to provide specialist advice.

13 We do not therefore intend to provide guidance on what is meant by ‘appropriate’ and ‘sufficient’ cover. However, we will review and update our existing guidance in the light of the consultation feedback, including clarification that most doctors who are covered by their employer’s insurance and indemnity (and those working in the NHS) will not usually need to arrange their own cover if they do not do any other medical work elsewhere. We will publish this revised guidance when the new Regulations come into force.

External audit

14 We commissioned an external audit of our consultation report which provided assurance that the report covered all the key points in the responses we received and was accurate. The audit also confirmed that all the substantive points raised by respondents had been correctly interpreted in the report. The audit report is available on request.

Amendment to the draft Regulations

15 Following our public consultation on the Regulations we had discussions with colleagues at the Department of Health to agree the final Regulations.
We have subsequently decided to remove Regulation 4A(2)(a) and (b) which would have given us the power to require a licenced practitioner to inform us if they have appropriate cover provided under an indemnity arrangement by an employer and to inform us if their indemnity cover ceases. This is because we already have a general power to request information under Regulation 4A(a) and (b). A further specific provision is unnecessary.

**Next steps**

Subject to any comments from the Board on the amended Regulations, we propose the following next steps:

- **a** Invite Council to agree and make the amended Regulations on 23 April 2015.

- **b** Implement the changes on 1 August 2015 (when the amended Regulations will take effect). This is contingent on Privy Council approval of the regulations. The general election in May 2015 might impact on that timetable. We will therefore keep the implementation date under review.

- **c** Publish revised guidance when the new Regulations come into force, provisionally 1 August 2015.
Supporting information

How this issue relates to the corporate strategy and business plan

18  Strategic aim 1: to make the best use of intelligence about doctors and the healthcare environment to ensure good standards and identify risks to patients.

Other relevant background information

19  Article 4(2)(d) of the European Union Directive 2011/24/EU on the application of patients’ rights in cross-border healthcare has now been implemented into national law. The Directive requires Member States to have systems of professional liability insurance or similar arrangements in place in relation to provision of cross border health care, and had to be transposed into domestic law by 25 October 2013. The Directive does not explicitly state how this should be achieved, and it is for each member state to decide how it should implement the requirements of the Directive.

20  The UK government complied with the Directive in July 2014 when it passed the Health Care and Associated Professions (Indemnity Arrangements) Order 2014. Additionally, we introduced a declaration about insurance and indemnity as part of the application for a licence to practise on 30 August 2014. We anticipate that (subject to approval by Council and, subsequently, the Privy Council) the amendments to the Regulations will be implemented on 1 August 2015.

What engagement approach has been used to inform the work (and what further communication and engagement is needed)

21  We publicly consulted between October and December 2014. We also plan to communicate with all registered doctors to remind them of their statutory duty (to have appropriate cover in place), when we implement the amended Regulations.

What equality and diversity considerations relate to this issue

22  We have not undertaken an equality analysis. However, we have taken into account that a doctor’s registration and licensing requirements can change with their personal circumstances, such as periods of ill health, pregnancy or career breaks. For this reason, although we will have the power to do so, we will not routinely require doctors to inform us each time their cover ceases or employment status changes, for example due to reasons associated with the characteristics of disability, gender, and pregnancy and maternity which are protected under the Equality Act 2010.

If you have any questions about this paper please contact: Jane Durkin, Assistant Director - Registration, Jdurkin@gmc-uk.org, 0161 923 6685.
9 - Insurance and indemnity: changes to the Licence to Practise and Revalidation Regulations 2012

Regulations
2015 No.****

HEALTH CARE AND ASSOCIATED PROFESSIONS

DOCTORS

The General Medical Council (Licence to Practise and Revalidation) (Amendment) Regulations Order of Council 2015

Made - - - - ***2015
Laid before Parliament ***2015
Coming into force - - ***2015

At the Council Chamber, Whitehall, the *** day of ***

By the Lords of Her Majesty’s Most Honourable Privy Council

The General Medical Council has made the General Medical Council (Licence to Practise and Revalidation) (Amendment) Regulations 2015 which are set out in the Schedule to this Order, in exercise of the powers conferred by sections 29A(2) to (4), 29B(1), (2), (3), 29D(1) and (2), 29J(3) and 44C(4) and (5) of the Medical Act 1983(a).

The General Medical Council has consulted with such bodies of persons representing medical practitioners, and such medical practitioners, as appeared to the General Medical Council requisite to be consulted in accordance with section 29J(5) of that Act.

By virtue of sections 29J(4) and 44C(10) of that Act the Regulations shall not have effect until approved by order of Privy Council.

Citation and commencement

1. This Order may be cited as the General Medical Council (Licence to Practise and Revalidation) (Amendment) Regulations Order of Council 2015 and comes into force on xxx 2015.

Privy Council approval

2. Their Lordships, having taken these Regulations into consideration, are pleased to and do approve them.

Name
Clerk of the Privy Council

SCHEDULE
Article 2

The General Medical Council (Licence to Practise and Revalidation) (Amendment) Regulations 2015

These Regulations are made by the General Medical Council in exercise of the powers conferred by sections 29A(2) to (4), 29B(1), (2) and (3), 29D(1) and (2), 29J(3) and 44C(4) and (5) of the Medical Act 1983.

The General Medical Council has consulted with such bodies of persons representing medical practitioners, and medical practitioners of any such description, as appeared to the General Medical Council requisite to be consulted in accordance with section 29J(5) of that Act.

Citation and commencement

1. These Regulations may be cited as the General Medical Council (Licence to Practise and Revalidation) (Amendment) Regulations 2015 and come into force on 1st August 2015.

Amendments to the General Medical Council (Licence to Practise and Revalidation) Regulations 2012

2.—(1) The General Medical Council (Licence to Practise and Revalidation) Regulations 2012 (a) are amended as follows.

(a) in paragraph (2), after the definition of “the Act” insert—

“appropriate cover” in relation to practice as a medical practitioner, means cover against liabilities that may be incurred in practising as such which is appropriate, having regard to the nature and extent of the risks of practising as such;”; and

(b) after paragraph (3), add—

“(4) For the purposes of these Regulations, an indemnity arrangement may comprise—

(a) a policy of insurance;
(b) an arrangement for the purposes of indemnifying a person;
(c) a combination of the two.”.

(3) In regulation 3(b) (grant or refusal of a licence)—

(a) in paragraph (1), for “paragraph (1A)” substitute “paragraphs (1A) and (1C),”;

(b) after paragraph (1B), insert—

“(1C) The Registrar may refuse to grant a licence under paragraph (1) to a medical practitioner who has failed to provide—

(a) confirmation that they have in force or will have in force in relation to them by the time they begin practice as a licensed practitioner, an indemnity arrangement which provides appropriate cover; or

(b) any other evidence or information requested by the Registrar under regulation 4A.”;

and
c) after paragraph (3)(d), insert—

“(da) a statement by the practitioner that the practitioner has in force, or will have in force in relation to them by the time the practitioner begins to practise as a licensed practitioner in the UK, an indemnity arrangement which provides appropriate cover;”.

(a) Scheduled to S.I. 2012/2685.

(b) Amended by S.I. 2014/1273.
(4) In regulation 4 (withdrawal of a licence) after paragraph (3)(f) insert—

“(fa) failed, without reasonable excuse, to provide any evidence or information to the Registrar in accordance with regulation 4A;

(fb) failed, when practising as a licensed practitioner, to have in force in relation to them an indemnity arrangement providing appropriate cover;”.

(5) After regulation 4 (withdrawal of a licence), insert—

“Request for information: indemnity arrangement

4A. For the purposes of determining whether in relation to a licensed practitioner there is in force, or in the case of a person seeking a licence to practise, there will be in force, an indemnity arrangement which provides appropriate cover, the Registrar may by notice —

(a) require that licensed practitioner or that person, to provide, within 28 days of the date of the notice such evidence or information as it appears reasonable to the Registrar to request;

(b) require evidence or information to be provided by that licensed practitioner on such dates and at such intervals as the Registrar may specify in the notice.”.

(6) In regulation 5 (restoration of a licence after withdrawal), after paragraph (2)(d) insert—

“(da) a statement by the practitioner that the practitioner has in force, or will have in force in relation to him by the time the practitioner begins to practise as a licensed practitioner in the UK, an indemnity arrangement which provides appropriate cover.”.

Transitional provisions

3. The amendments made by regulation 2(3) and 2(5) do not apply in relation to—

(a) any application for registration as a medical practitioner, or

(b) any application for a licence to practise,

received by the General Council before the day on which these Regulations come into force and which has not been determined before that date.

Given under the official seal of the General Medical Council this 23rd day of April 2015.

[Terence Stephenson]
Chair

[Niall Dickson]
Chief Executive and Registrar
EXPLANATORY NOTE
(This note is not part of the Order)

This Order approves the Regulations set out in the Schedule to it which amend the General Medical Council (Licence to Practise and Revalidation) Regulations 2012 (scheduled to S.I 2012/2685) (“the 2012 Regulations”).

Regulation 2(2) amends regulation 1 of the 2012 Regulations providing a definition of appropriate cover and specifying what an indemnity arrangement may comprise for the purposes of the 2012 Regulations.

Regulations 2(3)(a) and (b) amend regulation 3 of the 2012 Regulations enabling the Registrar to refuse to grant a licence if the practitioner has failed to: (a) provide confirmation that they have, or will have by the time they begin practice, an indemnity arrangement in force providing appropriate cover, or (b) provide any information requested by the Registrar in connection with an indemnity arrangement.

Regulation 2(3)(c) also amends regulation 3 of the 2012 Regulations requiring an applicant for a licence to provide a statement that they have, or will have, an indemnity arrangement in force providing appropriate cover.

Regulation 2(4) amends regulation 4 of the 2012 Regulations enabling the Registrar to withdraw a practitioner’s licence where they have failed to: (a) provide any information requested by the Registrar, without reasonable excuse, or (b) have an indemnity arrangement in force providing appropriate cover when practising.

Regulation 2(5) inserts a new regulation 4A in the 2012 Regulations enabling the Registrar to request information from a practitioner to determine whether they have, or will have, an indemnity arrangement in force providing appropriate cover.

Regulation 2(6) amends regulation 5 of the 2012 Regulations to require an applicant seeking restoration of a licence to provide a statement that they have, or will have, an indemnity arrangement in force providing appropriate cover.

Regulation 3 makes transitional provisions in relation to the amendments made by regulation 2(3) and 2(5).
Consultation report

Insurance and Indemnity: a consultation on changes to the Licence to Practise and Revalidation Regulations 2012

Introduction

1. From 15 October 2014 to 10 December 2014 we consulted on changes to the Licence to Practise and Revalidation Regulations 2012 which will:
   
   a. enable the Registrar to ask for information about a doctor’s professional indemnity arrangements
   
   b. enable the Registrar to withdraw a doctor’s licence to practise if they don’t provide the information when requested or if they have failed to obtain, or maintain, an indemnity arrangement which provides appropriate cover
   
   c. confirm the change we have made to the declaration section of new applications for registration with a licence to practise and restoration of a licence to practise, to include a statement about professional insurance and indemnity.

2. This document sets out a summary of the responses to our consultation.

Background

3. There is currently no statutory requirement for doctors to have professional indemnity or insurance arrangements in place to provide cover for liabilities incurred in their practice. However, Good medical practice places a professional duty on doctors to do so. Paragraph 63 states ‘You must make sure that you have adequate insurance or indemnity cover so that your patients will not be disadvantaged if they make a claim about the clinical care you have provided in the UK.’ The duties of a doctor set out in
*Good medical practice* apply to all doctors registered with the GMC, whether or not they hold a licence to practise.

4 An independent review group headed by Finlay Scott was commissioned by the Department of Health in 2009 to look at the issue of insurance and indemnity. It reported in 2010 and recommended that making insurance or indemnity a statutory condition for access to the profession is the most cost effective and proportionate way of ensuring that all healthcare professionals have adequate insurance or indemnity cover.

5 The report also recommended that there should be a review of all existing legislation in this area and that the relevant legislation should be harmonised across healthcare professional regulators. It also recommended that within that framework it should be for each healthcare regulator to decide how best to exercise its powers.

6 The Department of Health has drafted and Parliament has now passed a new Health Care and Associated Professions (Indemnity Arrangements) Order 2013, which implements the recommendations of the independent review group and creates a new S44C of the Medical Act 1983.

**The new S44C of the Medical Act 1983**

7 This provides the GMC with powers to make regulations to:

   a request information from or in relation to a licensed doctor or a doctor seeking a licence to practise to demonstrate that they have appropriate cover under an indemnity arrangement, or will have appropriate cover, by the time they begin to practise

   b require a doctor to inform us if they cease to have appropriate cover

   c require a doctor to inform us if they have appropriate cover provided by their employer.

8 Additionally the new S44C will enable us to refuse to grant a licence to practise where a doctor fails or refuses to comply with these requirements.

**Our consultation**

9 In accordance with the powers set out in S44C of the Medical Act 1983 we have drafted amendments to the * Licence to Practise and Revalidation Regulations 2012*, which mean that:
a there will be a requirement to include the declaration* in the application for a licence in order for it to be complete

b we will have the power to request information from the practitioner or another party to satisfy ourselves that declarations are accurate or otherwise to determine whether the practitioner has appropriate cover in place

c we will have the power to require a licensed practitioner to inform us if they have appropriate cover provided under an indemnity arrangement by an employer and to inform us if their indemnity cover ceases

d we will have the ability to refuse to grant or to withdraw a licence for failure to have appropriate cover or to comply with our requirements to provide the declaration or any further information.

10 The consultation sought views on the main effects of the proposed changes to the Licence to Practise and Revalidation Regulations 2012.

11 The consultation documentation included the draft General Medical Council (Licence to Practise and Revalidation) (Amendment) Regulations Order of Council 2015.

Our approach

12 We asked four questions about the proposals. Respondents were asked to answer yes or no to each question to indicate whether they agreed or disagreed with each question. Respondents were asked to provide further comments for each question. An analysis of the responses to the questions is set out later in the document.

13 The following methods were used to publicise the consultation:

- A web story and a registration news article with a link to the consultation was published on the GMC’s website
- An email with an invitation to take part in the consultation was sent to 150 selected stakeholders (including medical employers, organisations representing doctors and medical defence organisations).

Breakdown of responses

1 We received a total of 31 responses to our consultation. Table 1 shows the breakdown of responses according to source. Most responses were received via our
e-consult survey tool. However some respondents preferred to complete offline responses and send them separately.

2 We also received an email from the Southern Health and Social Care Trust in Northern Ireland. This set out two general comments from consultants working at the Trust. As the comments were quite general and could not be considered to be either positive or negative, I have not added them as an offline response and have added them as examples of general comments under that section.

Table 1

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<tbody>
<tr>
<td>E-consult site responses</td>
<td>22</td>
</tr>
<tr>
<td>Offline responses</td>
<td>9</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>31</strong></td>
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3 Table 2 below provides a breakdown of the types of respondents. We received 16 responses from individuals and 15 responses on behalf of organisations. A list of organisations who responded is at Annex A.

Table 2

<table>
<thead>
<tr>
<th>Organisations</th>
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<tbody>
<tr>
<td>Medical royal college or faculty</td>
<td>5</td>
</tr>
<tr>
<td>Body representing doctors</td>
<td>3</td>
</tr>
<tr>
<td>NHS organisation</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
</tr>
<tr>
<td>Locum agency</td>
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<tr>
<td><strong>Total organisations</strong></td>
<td><strong>15</strong></td>
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<table>
<thead>
<tr>
<th>Individuals</th>
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<tbody>
<tr>
<td>Doctor (other- grade/status provided)</td>
<td>1</td>
</tr>
<tr>
<td>Doctor (other- grade/status not provided)</td>
<td>2</td>
</tr>
</tbody>
</table>
Summary of findings

General
14 There was a high level of support for our proposals from both individuals and stakeholder organisations. Respondents in favour of the proposals felt they were ‘reasonable’ and ‘appropriate’ and that the changes highlighted the importance of appropriate indemnity cover for both the doctor and their patients.

15 A small number of respondents felt that the proposals were insufficient and suggested that the GMC should both request and check evidence of indemnity cover. They felt that this was the best way of ensuring that patients will be able to make a claim should the need arise.

Conclusions and next steps
16 Our proposals were supported by both individuals and stakeholder organisations.

17 Many respondents commented that guidance should be available for both doctors and stakeholder organisations to provide clarity on the following issues;

- we should explain what is meant by ‘appropriate’ and ‘sufficient’ cover, for example what value of cover is required for a particular area of practice.

- we should clarify that cover provided by NHS trusts will be adequate as long as the doctor practises in the NHS.
we should clarify that Doctors do not need to arrange private insurance cover where their employer’s indemnity is sufficient.

18 Our current position is that the definition of ‘appropriate’ and ‘sufficient’ cover is a complex area and is very much dependent on each doctor’s individual circumstances. We feel that this is matter for a doctor to discuss with a relevant insurance provider or other appropriate professional who will be able to provide them with specialist advice. We will however, take into account this feedback as we develop our communications and guidance.

Question by question analysis

19 The questions and comments sections were mandatory (a respondent needed to answer yes or no to each question and provide comments in order to move onto the next section).

20 We asked a number of preliminary questions

a Name.

b Are you either a medical student or a doctor? (if a respondent answered yes to this question we asked them to indicate their level or grade from a list we provided).

c If you are responding on behalf of an organisation, please state the name of the organisation.

d We may want to contact you to discuss your comments. If you are happy to be contacted please provide your email address and/or contact telephone number below.

21 We then set out key questions about the proposals.

22 We have set out each question followed by the breakdown of responses, a summary of the themes and selected comments both supportive and unsupportive.

Applications for a licence to practise and for restoration of a licence to practise

23 As part of the introduction to the first question we explained that we are proposing an amendment to regulation 1(2) to include definitions of ‘indemnity arrangement’ and ‘appropriate cover’.

* An ‘indemnity arrangement’ may comprise, a) a policy of insurance; b) an arrangement for the purposes of indemnifying a person; c) a combination of the two.
24 We are also proposing amendments to Regulation 3(3) and 4(3) which will provide that an application (for both new applications and applications for restoration) must include a statement that the practitioner has in place, or will have in place at the point at which the practitioner practises in the UK, an indemnity arrangement† which provides appropriate cover*. ’

25 This means that all applications for a licence to practise (both new applications and applications for restoration) will include a declaration. The declaration will form part of the online application form (a mandatory tick box as part of the final declaration) which will be a required field in order to submit the application.

26 Although we will require all applicants to complete the declaration, we do not intend routinely to ask for evidence of insurance and indemnity at the point of registration. However the Registrar will have powers to request evidence of arrangements that are in place or steps taken to make arrangements to provide cover at the point the applicant will begin practising, and to determine whether the arrangements are appropriate. We are likely to exercise those powers only where we become aware of information which may raise concerns about the validity of the original application declaration completed by the doctor.

27 We do not plan to ask for ongoing declarations on a routine basis.

<table>
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<th>Question 1</th>
<th>Yes</th>
<th>No</th>
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<td>Are the arrangements set out in section 1 above appropriate and reasonable?</td>
<td>Organisations</td>
<td>Individuals</td>
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<tr>
<td></td>
<td>9 (64%)</td>
<td>9 (56%)</td>
</tr>
<tr>
<td>Total</td>
<td>18 (60%)</td>
<td>12 (40%)</td>
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</table>

NB – 1 organisation replying offline did not provide a yes or no answer to this question

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<th>Question 1 – part 2</th>
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<tr>
<td>Please give reasons</td>
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</table>

28 The majority of respondents (60%) agreed with the proposals set out in this section.

* ‘appropriate cover’ in relation to practice as a medical practitioner, means cover against liabilities that may be incurred in practising as such which is appropriate having regard to the nature and extent of the risks of practising as such.
Respondents provided additional comments to support their responses to question 1. These can be broadly categorised as follows.

Evidence of indemnity cover

A number of respondents considered that we should request evidence of indemnity cover. In particular:

- One respondent stated that doctors should be required to provide a membership number to demonstrate that they hold appropriate cover.
- Two respondents felt that the arrangements were not adequately robust as only a declaration was required.
- One respondent stated that the GMC should consider whether the cover is appropriate and we should also look at the appropriateness of the organisation providing the cover.
- One respondent stated that LRMP should show whether insurance is up to date and when it expires.
- One respondent felt that the declaration should be added to the annual NHS appraisal (in the same way as health conditions must be declared).

Guidance on ‘appropriate cover’

A number of respondents felt that the GMC should provide guidance on what we consider to be ‘appropriate’ and ‘sufficient’ cover in particular;

- One respondent felt that we should provide a definition of ‘appropriate’ and ‘sufficient’ for example what value of cover is required, and what is acceptable in terms of the limit of indemnity.
- One respondent noted that doctors may be unsure how and where to find out what level of cover is deemed appropriate for their area of practice.
- One respondent felt that we should highlight to doctors the importance of reconsidering their cover when undertaking any new area of practice.

Sufficiency of employers’ indemnity cover

Two respondents suggested that we should clarify that;

- Cover provided by NHS trusts will be adequate as long as the doctor practises in the NHS.
Doctors do not need to arrange private insurance cover where their employer’s indemnity is sufficient.

**General**

33 One respondent suggested that a declaration confirming that the doctor holds appropriate indemnity cover should be required at the point of applying to join the specialist register and at the point of revalidation.

34 One respondent commented that it was unclear why a change in the regulations was required.

35 One respondent felt that the arrangements were too onerous and that the GMC was overextending its powers. They highlighted that employers are already under an obligation to ensure that adequate arrangements are in place.

36 One respondent felt that it is unfair to require a declaration at the application stage. They felt that doctors should have a personal choice whether to opt in for private medical cover.

**Comments**

**Individual response – GP partner**

37 ‘I do not think it is unreasonable to ask this question as part of an application, given that this is a long standing duty as laid out in "good medical practice". However I do not see why a change in the regulations is needed for this’.

**Individual response – Medical Director**

38 ‘This has always been something of a grey area and providing clarity can only be a good thing for practitioners and hosting organisations’.

**Stakeholder response - Royal College of Physicians and Surgeons of Glasgow**

39 ‘These controls should also apply to any interim period where the doctor usually relies on indemnification by the employer but for whatever reason, may not be practising independently 'between employers'. Locum work done in the private sector, for example may not be indemnified by the hospital group for which the work is done. It should be stated explicitly that any NHS hospital doctor working in the private sector is not covered by Crown Indemnity. As Crown Indemnity covers being sued for negligence but not disciplinary, GMC or Court proceedings it would be helpful to promote the possessing of indemnity cover to address these other aspects. For some doctors who hide from the probability that they will be sued or involved in GMC cases this would prevent hardship for them - and if they are in the wrong there will be
adequate insurance for patients. For clinicians practising as GPs or in the private sector, a system of sampling of evidence in respect of both the existence and appropriateness of the indemnity arrangement could be considered’.

Stakeholder response - Medical Protection Society

40 ‘The arrangements outlined are in general reasonable and appropriate. However, the GMC should be aware that MDOs will be unable to be specific about the indemnity individual registrants can request until a licence is granted and they are consequently accepted as a member of that MDO’.

Stakeholder response – Action against Medical Accidents (AvMA)

41 ‘The arrangements do not go far enough. As set out in our summary above, in order to protect the interests of patients, there need to be additional safeguards in order for the proposals to be in any way meaningful. AvMA would therefore make the following recommendations: 1. A doctor’s indemnity arrangements, past and present, should be held on the GMC register and be made available in the event that there is a potential legal claim against the registrant. This is essential in order for the proposed changes to be meaningful. 2. A doctor’s indemnity arrangements should be sourced through or associated with a UK based insurance or professional indemnity organisation. This is to avoid the difficulties created by cross border arrangements that may not be workable in the event that the doctor leaves the United Kingdom and/or their European or overseas insurers refuse to cooperate. 3. The GMC should undertake due diligence to confirm that the indemnity arrangements are fit for purpose. The GMC should ensure that guidance is available for doctors to assist them in ensuring their indemnity arrangements are adequate. 4. A doctor who is or has practised within the United Kingdom should be required to ensure that their contact details as held by the GMC are kept updated. 5. The GMC should take a strong line on any doctor who fails to comply with the requirements over indemnity arrangements’.

Request for information: indemnity arrangement

42 We are proposing the addition of a new regulation (suggested new regulation 4A) which will provide that:

- The Registrar may ask medical practitioners holding a licence, and other parties, to provide information about the practitioner’s indemnity arrangements.

- The Registrar will have power to request information regarding a licensed medical practitioner’s indemnity arrangements, in order to satisfy himself that indemnity arrangements are in place and to determine whether those arrangements are appropriate.

43 This will give the Registrar power to request information regarding a licensed medical practitioner’s insurance and indemnity arrangements, to ensure that appropriate
arrangements are in place or will be at any time the applicant is practising, and to
determine whether the arrangements are appropriate (this includes the power to
request information within a specified timescale to be determined by the GMC).

44 We will have the power to require a licensed practitioner to inform us if they have
appropriate cover provided under an indemnity arrangement by an employer and to
inform us if their indemnity cover ceases.

45 We are likely only to exercise those powers where we become aware of information
which may raise concerns about the validity of the original declaration completed by
the doctor or which suggests that the practitioner may not have appropriate cover in
place.

46 If it becomes clear that a licensed medical practitioner has not complied with the
regulations (by providing the declaration or further information requested) or has not
maintained appropriate insurance or indemnity arrangements, the Registrar will have
the power to withdraw their licence to practise, or to treat the matter as misconduct
and to refer it to the GMC’s Fitness to Practise directorate for consideration.

<table>
<thead>
<tr>
<th>Question 2</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you think it is reasonable that the Registrar will have power to request information regarding a licensed medical practitioner’s indemnity arrangements?</td>
<td>Organisations: 13 (100%)</td>
<td>Individuals: 11 (69%)</td>
</tr>
<tr>
<td>Total</td>
<td>24 (83%)</td>
<td>5 (17%)</td>
</tr>
</tbody>
</table>

NB – 2 organisations replying offline did not provide a yes or no answer to this question

Question 2 – part 2

Please give reasons?

47 There was a very high level of support for this proposal with 83% of respondents
agreeing that it is reasonable that the Registrar will have power to request
information regarding a licensed medical practitioner’s indemnity arrangements.

48 Five individual doctors disagreed with the proposal.
Respondents provided additional comments to support their responses to question 2. These can broadly be categorised as follows:

**Further information/assurance**

50 A number of respondents felt that the GMC should request additional information or assurance regarding a doctor’s indemnity cover:

- One respondent stated that we should request information about a doctor’s indemnity cover in all cases rather than when we become aware that a doctor may not have cover.

- Two respondents felt that there should be an annual assurance to the GMC that appropriate cover continues to be in place.

- One respondent stated that the GMC should hold details of doctors current and previous indemnity arrangements.

**Guidance and clarification**

51 A number of respondents reiterated suggestions to provide guidance, in particular:

- One respondent felt that we should provide explicit guidance that doctors employed in the NHS and undergraduate medical students will have indemnity cover and do not need to arrange it themselves.

- Two respondents stated that we should provide clarity about indemnity requirements, so that doctors can ensure they have appropriate indemnity before we start asking for further information or withdrawing a doctor’s licence.

- One respondent felt that it would be helpful for the public to know that there is a minimum level of cover in place for all doctors. They highlighted that the GMC should explain that appropriate cover is related to practice and cannot be easily specified for each doctor in regulations.

52 A number of respondents agreed with the proposal but suggested that certain caveats should apply. In particular:

- We should ensure that the source of information is reliable.

- Where there is no complaint or concern we should rely on a doctor’s professionalism to ensure that they are complying with *Good medical practice*.

- There should be a valid reason to ask.

- That withdrawal of a licence should only be after issue of a reminder and only apply to the area of practice that did not have cover.
The GMC should not be able to request information on a doctor’s income (which may be required if there is a need to check not just if cover is in place but that it is appropriate for level of income from practice).

General

53 One respondent stated that this proposal is unnecessary as most doctors will cooperate and provide details or the information can be obtained from the doctor’s employer.

54 One respondent felt that indemnity cover should not be linked to the licence to practise as this would lead to the Registrar being able to demand the type of indemnity that a doctor holds.

Comments

Individual response - Consultant

55 ‘I think you need to be careful to go about this in a measured and reasonable way, however….just how many doctors will have a clear idea of what you expect regarding cover. You could end up withdrawing lots of licences to practise simply because doctors were not fully informed or did not understand what you expect of them’.

Individual response – GP partner

56 ‘Under the current regulations I understand that if the GMC is investigating a complaint against a doctor they can ask for this information. If there is no complaint or concern I think the GMC should rely on doctor’s professionalism to ensure that they are complying with Good medical practice’.

Stakeholder response – Royal College of Radiologists

57 ‘Declarations of insurance/indemnity cover should be required at initial registration and annually thereafter. An analogy is that of a car licence whereby it can only be renewed with evidence of the following year’s insurance cover. We feel patients’ protection should at least match that afforded to road users’.

Stakeholder response – Royal College of Physicians and Surgeons of Glasgow

58 ‘We believe that withdrawal should be only after issue of a reminder and only apply to the area of practice that did not have cover, e.g. if a hospital doctor is working in both the NHS and private sector but does not have private indemnity for non-NHS work. Similarly, we believe that provisions should be made for those practitioners who make a positive declaration in good faith and are thereby accepted onto the register but whose cover is later discovered to be inadequate or not appropriate’.
Stakeholder response – AvMA

59 ‘If patients are to be protected, the Registrar requires greater powers than those proposed in the consultation. It is essential that the Registrar has the powers to require all registrants to provide details of their indemnity arrangements in order to obtain and renew their licence to practise and for these details to be updated annually. These details should be held on their GMC record and should include where appropriate, both current and previous indemnity arrangements, and for these records to be held for the purposes of any future claim that might arise’.

Stakeholder response – Medical Protection Society

60 ‘We think that the powers are reasonable if they are used as described in the consultation document. The powers in relation to requesting information. Specifically, they will allow the GMC to ‘require evidence or information to be provided by or in respect of a licensed practitioner’. We would be concerned if the GMC were to adopt a different approach and were to start either routinely requesting evidence or asking MDUs or indemnity providers directly for it. This would place a disproportionate administrative burden on registrants and MDUs or indemnity providers and could cause significant delays in the registration process for doctors applying to be registered with the GMC’.

Withdrawal of a licence to practise

61 We are proposing an amendment to Regulation 4(3) to enable the Registrar to withdraw a practitioner’s licence to practise if they have:

a failed, without reasonable excuse, to provide any evidence or information to the Registrar in accordance with [regulation 4A] or

b failed to have appropriate cover in place when practising as a licensed practitioner.

62 This will enable the Registrar to take action to withdraw a practitioner’s licence to practise if they have failed to provide information or evidence in accordance with regulation 4A regarding their cover when requested by the Registrar, or where it becomes clear that they have failed to obtain or maintain an indemnity arrangement which provides appropriate cover.

<table>
<thead>
<tr>
<th>Question 3</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you think it is reasonable that the Registrar will have power to withdraw a practitioner’s licence to practise in these organisations?</td>
<td>Organisations</td>
<td>Individuals</td>
</tr>
<tr>
<td></td>
<td>11 (85%)</td>
<td>8 (50%)</td>
</tr>
</tbody>
</table>
The majority of respondents (66%) agreed with this proposal. Of those respondents who disagreed, most were individual doctors.

Respondents provided additional comments to support their responses to question 3. These can broadly be categorised as follows.

**Comments in support of our proposal**

- One respondent stated that any doctor giving false statements is not taking their duty of care to the patients seriously and contravening GMP section 63 so withdrawing their licence to practise is reasonable.

- One respondent considered that it is reasonable to withdraw a practitioner's licence in the above circumstances.

**Guidance**

- One respondent reiterated that the GMC should provide guidance as to what constitutes ‘adequate’. Additionally they stated that the GMC should provide clarity about what cover a doctor should reasonably be expected to have in relation to a ‘good Samaritan’ act should also be provided.

**Support with caveats**

A number of respondents agreed with our proposal subject to the caveats described below:

- There should be a short but specified period of grace for a practitioner to demonstrate that he/she has complied with the requirements of the GMC.

- We should provide the doctor with plenty of time to respond to take account of pressure of work and possible illness.

- The doctor should initially be suspended to allow them time to produce evidence of cover or for cover to be secured. Only if the doctor refuses to take out cover
should his licence be revoked. Knowingly practising whilst not insured should be a matter for consideration under fitness to practise processes.

- The registrar should not be able to withdraw a licence unless the doctor is wilfully negligent in ensuring appropriate cover. It is quite possible that a doctor will think he has the correct level of cover for his usual practice, but it may be identified that elements of his practice require enhanced cover. He should be permitted to remedy deficiencies in cover before any threat to withdraw has licence to practise.

- In some cases, doctors may genuinely have trouble finding appropriate cover on the current insurance market. Provided that the doctor gives notice of the situation, a temporary suspension of the licence would be more appropriate than the withdrawal.

- It would be reasonable for the registrar to withdraw a licence to practise for repeat offenders or where the doctor has deliberately not obtained cover. Otherwise, a temporary suspension, until indemnity cover is obtained would be a more measured response.

Comments not in support of our proposals

69 Two respondents provided comments disagreeing with our proposals for the following reasons:

- As long as there are no concerns about the doctor and they promise to arrange appropriate cover, it is not appropriate to withdraw their licence to practise.

- Doctors employed in the NHS will be covered, so private insurance should not be compulsory.

Comments

Individual response – doctor

70 ‘In some cases, doctors may genuinely have trouble finding appropriate cover on the current insurance market. Provided that the doctor gives notice of the situation, a temporary suspension of the licence would be more appropriate than the withdrawal’.

Individual response – Consultant

71 ‘It is essential that cover be appropriate to the doctor’s practice. The registrar should not be able to withdraw a licence unless the doctor is wilfully negligent in ensuring appropriate cover. It is quite possible that a doctor will think he has the correct level of cover for his usual practice, but it may be identified that elements of his practice require enhanced cover. He should be permitted to remedy deficiencies in cover before any threat to withdraw has licence to practise’.
Stakeholder response – Royal College of Physicians and Surgeons of Glasgow

72 ‘We believe that withdrawal should be only after issue of a reminder and only apply to the area of practice that did not have cover, e.g. if a hospital doctor is working in both the NHS and private sector but does not have private indemnity for non-NHS work. Similarly we believe that provisions should be made for those practitioners who make a positive declaration in good faith and are thereby accepted onto the Register but whose cover is later discovered to be inadequate or not appropriate. However we do appreciate the need to take a strong line on this and ultimately the responsibility lies with the doctor in keeping their indemnity cover up to date’.

Stakeholder response - Royal College of Surgeons of Edinburgh

73 ‘It is the duty of a good doctor to have indemnity but my only concern is there is no guidance as to what constitutes "adequate". Given sufficient guidance as to what constitutes “adequate”, RCSEd believe that it is the duty of a doctor to have indemnity. The GMC should provide clarity on this question. Clarity about what requirement a doctor should reasonably be expected to have in relation to a "good Samaritan" act should also be provided. By simply stating employed work/self-employment only needs to be covered fails to give guidance on this topic to healthcare professionals’.

Stakeholder response – Medical Protection Society

74 ‘It is reasonable to remove a practitioner's licence if there has been a persistent refusal to engage with the GMC and to provide information required. This should, however, be the very last step after all other reasonable steps have been taken’.

Stakeholder response – AvMA

75 ‘The GMC needs to send a clear message to the small number of registrants who might otherwise believe they can act with impunity in flouting their professional duty to have in place adequate indemnity cover. As set out above, AvMA has seen a number of examples of doctors who have been found to have inadequate or non-existent indemnity arrangements in place despite this being an existing professional duty’.

Stakeholder response – British Medical Association

76 ‘Provided that the GMC explains in greater detail what is meant by an indemnity arrangement which provides appropriate cover so that doctors can have a greater degree of assurance about the nature of their obligations’.
Question 4

Do you have any other comments about the proposed changes and additions to the Licence to Practise and Revalidation Regulations 2012?

Comments

77 A number of respondents set out additional comments under this section. I have set out below those comments addressing issues which have not been raised elsewhere in the consultation.

Stakeholder response - Royal College of Ophthalmologists

78 ‘Following a withdrawal of LTP, the steps to be reinstated need to be clarified’.

Individual response – doctor

79 ‘This is a sensible development. However, there is a potential problem in that types of indemnity vary. I have occurrence based cover, meaning that even if I have retired and am no longer paying for indemnity cover with the MPS, an event that occurred while I was still practising will still be covered. Cheaper insurance type products require the doctor to maintain premiums even when they have stopped practising in order to maintain cover for events in previous years. There is no method or sanction to ensure that such individuals maintain the payments, and as such their patients could still potentially be disadvantaged under this new regime. Although the GMC does not currently make recommendations about insurance types, unless you mandate that doctors must have occurrence based insurance there will still doctors who may not have adequate cover at the time of the claim, even though they had insurance cover at the time of the event’.

Individual response – consultant

80 ‘Be very careful that these proposed changes apply equally to all doctors practising anywhere for which the GMC has jurisdiction - particularly to doctors (locum or permanent) who have come from abroad (EU or elsewhere) or who usually work abroad (EU or elsewhere). It is particularly important that these proposed changes apply to doctors from EU countries, where there may be attempts to claim that these changes would interfere with free movement. Find some other piece of GMC regulation that can be dropped to prevent the steady increase in bureaucracy. Do not increase GMC fees to pay for any of this proposed change (or for anything else)’.

Individual response – non medical

81 ‘I recently asked the MDU and MPS to provide an online checking facility, like the GMC Register check, but they said it would be a breach of confidentiality. I see that
you are not proposing regular checks but it would be very helpful if Registration could operate like road tax - no tax disc unless insured. These checks are onerous for us, as employers, to complete when we have to ask our doctors for physical evidence of insurance'.

Stakeholder response – Royal College of Radiologists

82 ‘We feel that all doctors who diagnose or care for patients in the UK, whether by teleradiology, telediagnosis, telemedicine or by traditional means, and wherever they are located in the world, should be required to provide the GMC with evidence of insurance/indemnity cover at initial registration and annually thereafter’.

Stakeholder response – Medical Protection Society

83 ‘We note that the consultation document states that the GMC will issue a notification to all registered doctors to remind them of their statutory duty to have an indemnity arrangement. We welcome this proactive communication with registrants regarding their responsibilities. It will be important to stress to registrants whose practice is not fully indemnified by their employer, that in order to fulfil their responsibilities they must fully disclose the nature, scope and extent of their practice to their MDO or indemnity provider. They must do so both at the time of initially making their indemnity arrangements and whenever the scope of their practice changes. MPS welcomes the introduction of these regulations. We think it is important that all practising healthcare professionals are appropriately indemnified and placing an obligation on professionals as part of the registration process with their regulator is the most appropriate way of ensuring this. We welcome the approach adopted by the GMC in applying this policy. This a proportionate and practical way to implement the requirements of the EU Directive (Article 4(2)(d) of the European Union Directive 2011/24/EU on the application of patients’ rights in cross-border healthcare) in relation to doctors. However, it is important to highlight that if the GMC were to change approach in the future this may cause difficulties for registrants. If the GMC were to either start requiring evidence from registrants about their indemnity arrangements on a routine basis or if this evidence were to be requested directly from Medical Defence Organisations (MDOs) this would cause disproportionate administrative burdens for organisations such as MPS and its members. It will be important for the GMC to get its communication programme with registrants right so that they understand their responsibilities, including the need to fully disclose the nature, scope and extent of their practice to their indemnity provider. MPS is willing to assist the GMC in ensuring its communications achieve this’.

Stakeholder response – AVMA

84 The aim of requiring doctors to have adequate indemnity arrangements in place is to protect the interests of patients who have suffered avoidable harm. This will only be achieved if the GMC verifies and maintains records of those arrangements. To reduce
the potential burden on the GMC in maintaining accurate records of doctors’ indemnity arrangements, we would suggest that the GMC enters into discussions with defence organisations and insurers with a view to those organisations assisting with the process of verifying that a doctor has appropriate indemnity arrangements in place'.
Annex A - List of organisations who responded

Locum Agency (not named)

NHS Grampian

NHS England, Thames Valley

NHS (area not stated)

IntraHealth

NHS Education Scotland (NES)

Medical and Dental Defence Union of Scotland (MDDUS)

Royal College of Physicians of Edinburgh

Royal College of Ophthalmologists

Royal College of Radiologists

Royal College of Physicians and Surgeons of Glasgow

Royal College of Surgeons of Edinburgh

Medical Protection Society

Action against Medical Accidents (AvMA)

British Medical Association