BMA

Cymru Wales

Indemnity

Concerns relating to indemnity costs for GPs have escalated over the last few months and are now being raised by individual practitioners and whole practice teams covering both in and out of hours General Practice on a regular basis.

There is a pressing need to urgently find solutions to prevent services from collapsing given we are now in the winter pressure period.

Overview

- Increasing reports that rising indemnity costs is making some work, especially Out of Hours work (OOH), prohibitive for GPs. *Consequent impact of this will be on the sustainability of GP services across the 24/7 period.*
- Welsh Risk Pool is available for OOH clinicians working in Health Board run OOH services and has been offered to sessional doctors working in Health Board managed practices. In some cases this has led to lower indemnity premiums, but not in all cases - and it does not cover other private organisations providing some OOH care in Wales i.e. ShropDoc. However, it must be noted that the Welsh Risk Pool does not cover the individual, it covers the organisation that is funding it for its vicarious liability in clinical incidents arising out of a complaint. That means that there other important areas that clinical practitioners need covered, as outlined below, and the frequent comment that "Welsh Risk Pool" is the solution is not as straightforward as it seems.
- Some specific initiatives in England have offered to cover rising indemnity fees:
    1. Clinician presence in 111 call centres – however not all Clinical Commissioning Groups (CCGs) availed themselves of this, and of those that did, it is not known what the impact was on the OOH centres. It is important that careful evaluation of these is carried out given the potential for OOH sessions to be cancelled to enable GPs to work in these pilot services and the subsequent impact of that on the running of OOH Services. One service should not be destabilised to staff another. This is something that Wales needs to be aware of given the development of the 111 service. One positive of GPs working in English 111 centres, however, is that at least one medical defence organisation (MDO) is able to highlight the additional cost of doing unscheduled work in various settings versus scheduled in-hours GP work.
    2. £30 million commitment has been made available each year for two years towards the costs of GP practice indemnity, through a payment to practices of 52p/patient to recognise the increase in indemnity premiums (further details on this scheme can be made available).
- Out Of Hours services have seen little or no investment in Wales since 2004 and this has been widely reported as impacting on the ability to reconfigure services / enable more acceptable terms to be offered to doctors willing to work in OOH centres. This negative impact needs to be reversed.

- Issues of escalating indemnity costs have been long known, and for some time expected to rapidly increase, and we are now seeing the stark reality of that as subscription renewals are received – i.e. doctors are unable to undertake more clinical sessions as it is unaffordable to cover the indemnity costs, or take on additional roles if it adversely affects their premiums. To date, despite representations there has largely been a closed door to addressing this but that now appears to be changing, and the First Minister has made a commitment to work on a solution for GP practices[1].
- It is important to note that while indemnity costs are increasing, this should not be conflated with a decline in patient safety and overall standards. There is clear evidence that the costs of payouts in cases where a patient is awarded damages are increasing. Medical defence organisations have to collect enough money from their members to ensure these pay outs can be made, so it is highly likely that the rises in cost experienced by GPs is related to the increases in damages being awarded. The intention of awarding damages is to put the victim back in a position they were in had the clinical negligence not occurred, which can include loss of earnings and cost of future treatment. These costs are increasing due to factors such as increasing life expectancy and advances in medical treatment. Also, under our present legal system (in England and Wales), each time a novel payout is made, the bar for all future payouts increases.
- The workforce is changing with new, and greater use of, other health professionals in primary care, and thus the risk of their attracting claims has increased due to the rise in consultations they have with patients. ***This changing workforce profile is particularly relevant in Wales with the current recruitment / retention issues and implementation of new models of working in primary care.*** This shift in the workforce has significantly affected group indemnity subscriptions and premiums for individual roles within a practice which again adversely impacts upon practice income. Particular concern has been raised around physician's associates and what level of cover they would attract.
- There is an issue around ensuring the nomenclature and description of these roles is consistent across the board in order that correct subscription rates are applied. There is a need to move away from in hours / out of hours to scheduled / unscheduled care and the environment within which such individuals work (i.e. own patients / other patients with or without access to records).
- It is unlikely that the Medical Defence Organisation costs will reduce, especially as they base costs on actuarial proof of rising claims (for all OOH clinicians). Without tort reform then the costs of each claim is not going to reduce. In addition, there are concerns that the impact of the reduction of the discount rate consultation being undertaken by Westminster will mean higher costs of claims, and thus premiums will have to rise even further.
- There is a need to educate and update doctors in how the defence subscriptions are calculated with respect to assessment of risk and factors that are taken into consideration.
- Expenses are no longer being covered by the Doctors & Dentists Review Body (DDRB) remuneration awards – up until 2 or 3 years ago, the indemnity expense would be largely covered.
- In England, the NHS Litigation Authority and Medical Defence Organisations are reporting liabilities of up to £28.6 billion for claims already in the pipeline. We are not aware of what the figure is in Wales.

[1] BMJ 'We want the best doctors in Wales, wherever they come from, says first minister' (Oct 2016)

- New potential providers of medical indemnity are emerging – however, the current alternatives to the three main organisations often have limitations to the cover offered and / or exclude certain conditions (e.g. meningitis). The costs of this cover is often prohibitive – some have been quoted upwards of £30k per annum
- The BMA 2016 Annual Representative Meeting voted to request we look into indemnity for whole 24/7 period and it has been suggested that indemnity cover for senior GPs may be a retention "golden egg".

Does the duration of a session affect indemnity?

We are often asked this question, so below we provide an overview of the current situation and the impact it has on clinicians depending on what approach the defence organisations adopt.

- GPC UK and GPC Wales has received many concerns about what constitutes a session for indemnity purposes, in order to ensure that GPs don't inadvertently breach the limitation of their cover. Some MDOs set a fixed or tiered number of sessions, others average the number of hours over the year.
- If doctors are able and willing to do additional sessions, then they need clarity about session duration in order to properly calculate the additional cost to be incurred. It is still unclear whether the MDOs consider a session to be a 4 / 6 / 8 hour shift OR whether one is covered for a "session" irrespective of that duration. The defence organisations need to be clearer on this on their websites and in information sent to GPs.
- The preferred option for GPC Wales is to have an annual rolling average number of sessions to facilitate flexible working. By annualising sessions this will allow holiday periods to be used in calculations, and thus probably reduce costs rather than using weekly session limits. Annual leave would contribute to the number of total sessions you are allowed to work. For example if a doctor works 8 sessions in practice and two in OOH, if their contract / partnership agreement has 8 weeks annual leave (40 days) then this can be taken into consideration in calculating the level of cover for indemnity work and thus put the doctor into a "lower bracket". The Medical Protection Society (MPS) has already adopted this approach. This also ensures that doctors are not over-insuring themselves, which is a concern that has been raised regularly by individual doctors.

Medical Defence Organisations

Below is the information taken from of the three main defence organisations on what they regard as a 'session':

The Medical Defence Union (MDU) website states:

For some members subscriptions are based on sessions. If you are unsure if your subscription is session based or you have any questions about calculating sessions, please contact our membership team on 0800 716 376.

If you do more than one type of GP work, each type of work should be shown on your renewal documents. If we have asked you to calculate an average number of sessions worked per week, please use the following calculation:

Hours per week x *Weeks per year worked* ÷ *52 weeks* ÷ *4 hours in a session* =

Average number of weekly sessions

Please remember it is your average number of weekly sessions across your membership year on which your subscription is calculated.

The Medical Protection Society (MPS) website states:

Scheduled care sessions are defined as work undertaken during the scheduled opening hours of the practice (Mon – Sun, 8.00am – 8.00pm) where registered patients are seen by appointment and where staff have access to the patient's full general practice records. Unscheduled care is anything that falls outside of scheduled care. This includes care given at any time in walk in / urgent care centres. A session will normally be defined as a half-day. Where this is inappropriate, a session can be considered to be a continuous period of work of between 3.5 and 5 hours. When you are employed for a set number of hours each week, this number should be divided by four to obtain the sessional equivalent for subscription calculation.

The Medical and Dental Defence Union Scotland (MDDUS) website states:

MDDUS classifies a session as a half-day, which is normally a morning or an afternoon and should last no longer than five hours. Likewise, those working in the evening or overnight should classify sessions in blocks of five hours. For example, midnight to 8am should be classified as two sessions.

The questions on what constitutes a session for indemnity purposes which we still need clarity on are:

1. If working late into the night doing practice work e.g. administrative work or running late and last patient appointment is after 6.30pm, do these hours require extra cover? Discussions with MDOs have highlighted that if the extra hours are to do normal practice business then additional cover is not needed, but this assurance is required in writing so that GPs have clear guidance going forward.
2. If doing unscheduled care for just your practice population does that count as "sessions" or "hours" within your normal subscription? This will be relevant as clusters begin to look to offer innovative ways of providing access to patients in response to workload demands.
3. If doing unscheduled care for a group of practices with access to the patient record can you include this within your normal "sessions" or "hours"? Again this is relevant as clusters are looking at novel ways of providing additional access to patients.
4. Out of Hours organisations book sessions of varying duration – therefore, if an organisation books 8 hour sessions does that count as one session or two?
5. Some, but not all, MDOs allow annualisation of sessions. This being universally available could potentially be useful in the event of a pandemic outbreak in that would enable clinicians to do some short term additional work

How is a doctor's individual risk assessed?

This again is important and not well understood across the health care arena.

- As soon as a doctor qualifies and is able to write a prescription autonomously they are classified as a "risk".
- When working in a practice environment where governance is good with clear policies, access to records, knowledge of patients then doctors present a relatively low risk.
- When you take the same doctor and put them in a different role their risk changes – although working unscheduled hours for their own patients with access to records is considered no additional risk.
- Working unscheduled hours for a group of practices with access to records is considered a slightly higher risk.
- Working unscheduled hours in an out of hours or other unscheduled care setting with less familiar patients and without full access to full records makes doctors a higher risk. Similarly, if doctors cover unfilled shifts they are considered a higher risk.
- There are further individualised issues for doctors working in relatively unique areas such as medical journalism and elite sports.

What other factors affect an individual / practice's subscription rate?

- Diversity of workforce e.g. practice nurse claims are rising according to MPS[2]. There is currently a difference in approach across the three MDO organisations – some include cover for nurse practitioners as part of a group policy – others don't.

  Practices are reporting significant increases in premiums due to expanded role of other non-doctor clinicians. GPs need to be mindful of the widening skill mix being used in practices – in particular consideration needs to be given to:

  i. Concept of physicians associates as they are currently unregulated and have variable training –would the defence organisations simply cover these practitioners or would there be a limitation on the claim cover provided which could be dangerous to the practice.
  ii. Clinical pharmacists or other healthcare professionals employed by Health Boards, rather than a practice, will have Welsh Risk Pool cover **BUT** GPs need to ensure any additional or extended roles are covered – this needs discussion / clarification with MDOs as to who provides that cover, and where vicarious liability lies in event of an individual working across groupings of practices.
  iii. Ensuring practices inform their defence organisation who is doing what in the practice to ensure they are adequately covered.

- The amount of sessions / hours worked by the range of roles in the practice.
- Previous complaints.

What about the Welsh Risk Pool?

- Welsh Risk Pool cover is already in place for Health Board run Out of Hours Organisations across Wales (private providers excluded). It also covers many GPs working for NHS

[2] MPS Rising Nurse Claims https://www.medicalprotection.org/uk/practice-matters-issue-1/rising-nurse-claims (2012)

organisations in capacity as a *GP with Special Interest* or HB employed salaried GPs. It has recently been extended to some GP sessional doctors working for HB managed practices.

- It has to be made clear that Welsh Risk Pool in itself does not cover everything as it looks after the organisational risk from a complaint, and in particular only the clinical elements of a complaint. It does not cover:
    1. Criminal proceedings
    2. Disciplinary proceedings, including referral to the General Medical Council (GMC).
    3. Coroners court attendance
- The current liabilities of claims that the Welsh Risk Pool is managing is unknown.
- It is important to remember that the Welsh Risk Pool's core function is to reimburse losses incurred by NHS Wales bodies in relation to clinical negligence, whereas Medical Defence Organisations are subscription-based organisations acting in the interest of their individual members.
- Lastly, Welsh Risk Pool cover cannot simply be extended; if Welsh Risk Pool were able to take on covering all GPs, then there needs to be early discussions with MDOs to identify the "run in" and "run off" cover to ensure that an individual GP or claimant is not left in an uncertain position with respect to a claim. This is mainly around commercial business issues but needs to be considered.

The options?

We are aware that NHS Wales recognises indemnity is an increasing problem. Indemnity premiums are likely to rise given that the Welsh Government's prudent healthcare agenda encourages the shift of care into the community and making best use of all healthcare professionals in delivery. If this aspiration is to be realised a solution to indemnity challenges is certainly required.

Options to address and rebalance this could include:

- **A commitment from NHS Wales that individual practitioners should incur no additional indemnity costs for doing unscheduled care work for 111 or an Out of hours organisation.** This would mean a solution found for those working for a private Out of Hours provider (which the Welsh Risk Pool cannot cover as it is not an NHS Body).
- **A commitment to ensure professionals working across a cluster have their indemnity provided by the Welsh Risk Pool via the HB and that any vicarious liability of practices is underwritten by Welsh Government.**
- **NHS Wales to reimburse all / part payment of indemnity fees** (in line with Welsh Local Medical Committee conference policy).
- **Pay an Out of Hours top up premium for OOH work or other work prioritised by NHS Wales**, recognising unique challenges facing GPs now and in the future (e.g. unscheduled work covering clusters or groupings of practices).
- **Block contracts**: It is not clear if Medical Defence Organisations would wish to look at this but is worth pursuing.
- **A hybrid model** of Welsh Risk Pool Indemnity with MDO top-up for in hours as well as OOH GP care. The fact that practices are engaged with Clinical Governance Self-Assessment Toolkit and regularly have clinical governance reviews, means that the Welsh Risk Pool and the defence organisations can be reassured that all practices in Wales should have good governance of their organisations.

- **Pay a contribution towards GP practice and / or individual clinician indemnity.** This is something that has been mentioned in a few arenas including by one MDO which includes up to two sessions OOH in its subscription levies.

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