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GP Indemnity Review

GP Indemnity Review

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Introduction

- 1.1. General practice is the foundation of the NHS, internationally renowned with high levels of patient satisfaction. But it is under unprecedented pressure and as the BMA says, 'if general practice fails, the NHS fails'.
- 1.2. The General Practice Forward View recognises this and sets out a plan, backed by a multi-billion pound investment, to stabilise and transform general practice – to start to put funding on a proper footing with the rest of the NHS, enabling more self-care, managing demand on services and expanding the workforce.
- 1.3. One of the key concerns within general practice in recent years is the ongoing rise in the costs of indemnity. GPs have made clear that they feel they have been subject to unsustainable, above-inflation rises in the amount they must pay to buy indemnity against clinical negligence. Concerns have also been raised about the potential for rising indemnity costs to discourage GPs from providing certain services including out-of-hours care.
- 1.4. The General Practice Forward View recognised these concerns and committed NHS England and the Department of Health to bringing forward proposals to address the rising costs of indemnity in general practice. A General Practice Indemnity Review was established in May to form an initial view of the issue, and this document sets out the findings of the review, and the actions to be taken forward.

Approach of the GP Indemnity review

- 2.1. The GP Indemnity Review was established as a short-term, focussed piece of work which sought to establish the extent of inflation in GP indemnity, the root causes of this, and to identify proposals for improving the situation.
- 2.2. The General Practice Indemnity Review was an eight-week focussed exploration of a complex area. The approach taken involved a number of steps:
 - a) Develop a full understanding of the structure of the medical indemnity market, through desk research and dialogue with the three main medical defence organisations, the NHS Litigation Authority, commercial specialists, and a commercial insurer.
 - b) Develop a realistic view of the extent to which indemnity costs have been rising, understand the impact of this on the general practice workforce to date, including carrying out a survey of nearly 4,500 GPs, and through conversation with the profession's representatives.
 - c) Consider the implications of future developments through dialogue with commissioning specialists, a patient advocate group and teams involved with developing new models of care in NHS England.
 - d) Identify the factors driving the increase in indemnity costs.

- e) Investigate potential solutions, including those used internationally, to identify those that can lessen the immediate pressure on general practice; and to carry out an initial investigation of longer-term solutions, to identify ways forward which merit further exploration.

Our objectives in approaching this work were:

- To consider how to bring down the overall costs of indemnity, wherever it is funded
- To minimise the risk that indemnity costs distort personal choices about working in general practice

Findings

The medical indemnity market

3.1 The review set out to understand the structure and model of the current indemnity market, which is arranged in different ways for primary care compared to NHS Trusts and Foundation Trusts.

3.2 It is a requirement of registration with the GMC that all doctors have adequate and appropriate indemnity for their work. The main providers of medical indemnity in England are the Medical Defence Union, the Medical Protection Society, and the Medical and Dental Defence Union of Scotland. These medical defence organisations provide cover on behalf of their respective members. They offer indemnity cover to all doctors for any private work, good Samaritan acts, and for representation for professional regulatory issues. They also provide clinical negligence cover relating to NHS work to over 99% of GPs¹. By contrast, clinical negligence cover for the NHS work of hospital doctors is purchased on their behalf by their employers from the NHS Litigation Authority.

3.3 There can be a long lag between the point at which clinical negligence occurs, and when damages are eventually paid to the recipient. This gap is on average 5-8 years, but in some cases involving children it can take 10-20 years for the extent of the damage to become clear. It is not uncommon for a GP to have ceased practising, and be no longer contributing to a medical defence fund by the time a claim relating to their practice is settled. Equally, doctors can face claims at other stages in their career when they are not contributing to a fund covering UK liability, for example if they are on maternity leave or working overseas.

3.4 For this reason, the medical defence organisations provide clinical negligence cover to GPs on an 'occurrence' basis – meaning the amount charged in a given year is priced to reflect the cost of a payout that results from care provided in that

¹ According to returns from the survey of GPs carried out by the review team in June

year, but which may not be decided until several years later. The medical defence organisations commonly operate a large reserve fund to cover the costs of these as-yet unsettled or un-notified cases.

- 3.5 The model of indemnity provided to hospitals by the NHS Litigation Authority works in a different way. Hospital trusts cover clinical liabilities under the Clinical Negligence Scheme for Trusts (CNST), which is a “pay as you go” risk pool. Annual contributions from Trusts generally match payments out during that year, although such payments usually relate to incidents that occurred in previous years. The NHS Litigation Authority therefore does not save up a large fund to cover future payouts, but the amounts Trusts pay in to the scheme would need to rise if the liabilities increased in any one year (or could fall if the liabilities fall). This approach is suitable for hospitals due to the relatively small number of payers in the pool and the low likelihood that a Trust will exit the scheme and leave it underfunded in future.
- 3.6 The medical defence organisations are not-for-profit organisations. The subscriptions they charge go towards the payment of damages, defending doctors, and on general running costs. The review did not find evidence to suggest that market inefficiency is a cause of rising indemnity premiums. The increases in the costs of indemnity are due to factors largely out of the control of the medical defence organisations.
- 3.7 There is price variation in the market, and it is possible for GPs to switch between indemnity providers, and the market overall provides enough variety and transparency to encourage GPs to shop around to get the best deal. The survey of GPs carried out by the review showed around 40% have switched indemnity provider. The medical defence organisations assert that this competition requires them to keep the costs for their members as low as possible (whilst still maintaining the ability to meet the costs of future payouts to patients who have suffered damage).
- 3.8 The existence of parallel indemnity systems for hospitals and general practice reflect the historic structural differences between the two sectors. Both areas are subject to similar annual inflation in cost, and the expectation is that these costs will continue to increase over time.
- 3.9 The emergence of new models of care poses a different challenge for an indemnity market that has evolved to serve the traditional GP practice model. The new models of care are embryonic, and vary in shape, size and approach across the country, so it is not possible to define what a coherent and sustainable approach to indemnity may look like for those models at this point. The medical defence organisations are working with the new models of care pilots to identify the most appropriate indemnity arrangements, and it is clear that any new

approaches to indemnity need to be developed in a way that neither destabilises the wider market, or is unfair on those members of the general practice workforce who have not had the opportunity to be involved in a new care model. The Department of Health and NHS England will keep the functioning of the indemnity market under review as these changes take hold.

The reality of indemnity inflation, impact on GPs and implications for primary care

4.1 The review team circulated a survey to GPs, with the help of the GPC, from 8th – 16th June 2016. This generated nearly 4,500 responses, and was particularly useful in capturing changes in the out-of-pocket payments made by GPs for the period from 2010 to 2016. Alongside this, the review team held discussions with the medical defence organisations and explored their observations on the extent of indemnity inflation, as well as considering the information they had published previously. This information allowed the review to develop a view of the extent to which GPs have been subject to inflation in their indemnity costs over recent years.

4.2 According to the survey the average payment for indemnity for in-hours/scheduled care in 2010 was approximately £5,200, rising to £7,900 in 2016, an increase of more than 50% in 6 years. This suggests that indemnity costs rose, on average, by around 7% per annum in the same period (Figure 1), although it may understate real inflation as it does not allow for reductions in average numbers of sessions worked by GPs over this period.

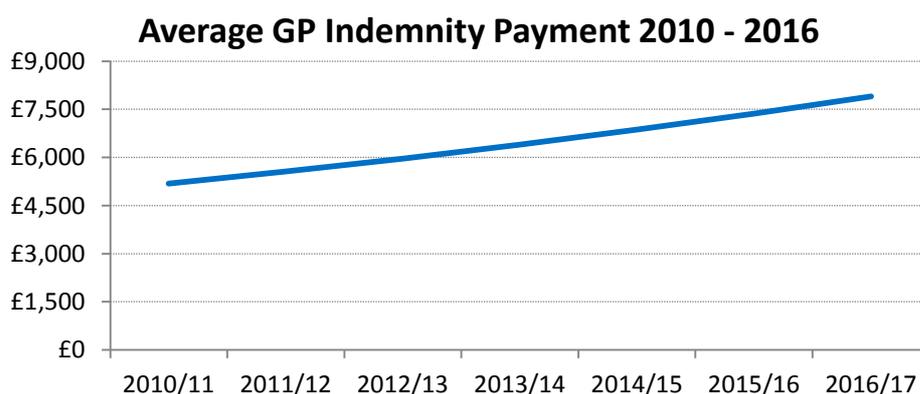


Figure 1 – Average GP Indemnity Payment (in hours) 2010 – 2016, according to GP survey

4.3 Data published by the Medical Defence Union in its 2014 Annual Report suggests indemnity inflation is around 10% per annum. This is broadly corroborated by discussions with the other MDOs. The review judges this figure to be a more

reliable indicator of inflation than the figure obtained in the survey of GPs as it is for the same number of clinical sessions worked.

- 4.4 The inflation in out of hours/unscheduled care sessions is likely to be higher than for in hours sessions, but has been harder to establish due to data availability. Using data from the survey of GPs, and discussions we held with stakeholders, the review estimates the average annual indemnity cost inflation in out-of-hours to be around 20% per year.
- 4.5 Indemnity costs have risen as a proportion of GP income over the last five years. These costs are considered an expense for GPs, and funding for expenses has increased via the contract. An additional £33m was included in 2016-17 specifically to reflect indemnity inflation rises in the last year.
- 4.6 The survey also provided information about the extent to which issues with indemnity are a concern for GPs, and what the consequences are for some individuals. It showed that 95% of GPs surveyed have experienced a rise in their indemnity costs in the recent years and that 88% of GPs surveyed pay this from their own pockets.
- 4.7 When asked about whether they have been deterred from taking certain types of clinical sessions due to the rise in their indemnity costs, four fifths of GPs responded² that they had been deterred in some way. The results are summarised in Table 1 below.

Percentage of GPs deterred from taking on more clinical sessions, per type of sessions

Type of session	Number of responses	Percentage
In-hours sessions	1,155	36%
Out-of-hours sessions	2,299	72%
Evening sessions	1,057	33%
Weekend sessions	1,263	39%
Indemnity has not deterred me from taking on additional sessions	682	21%
Total number of respondents to the question *	3,232	

* Total number of respondents does not sum up as more than one answer was allowed.

- 4.8 Examples have been cited in the press of GPs paying up to £30,000 per year. The review found no evidence of this being a widespread phenomenon.

² 70% of the sample responded to the question whether they were deterred from taking any additional sessions due to rising indemnity costs

However, GPs told us that that if indemnity costs continue to rise at recent rates, this may act as a break on the willingness of GPs to join the profession, to remain in the profession, or to increase their workload.

Drivers of indemnity inflation

5.1 The increases in costs experienced by GPs reflect the fact that the amount of damages being awarded to victims of clinical negligence is increasing year on year, and that the medical defence organisations expect this trend to continue. The review considered all of the potential drivers of this “indemnity inflation”, and found that there are likely to be a number of root-causes, firstly related to the volume of cases, and secondly, related to the costs of damages.

Volume

5.2 It is clear that there has been no material deterioration in the quality and safety standards within primary care in recent years - by objective measures the quality and safety of care provided by GPs has never been higher³. 85% of the respondents to the GP survey had not had a claim brought against them in recent years (2014 – 2016). So it is unlikely that the increase in indemnity costs is reflective of the safety of care being provided.

5.3 However it is possible that indemnity inflation bears some relation to the fact that GPs are seeing a higher volume of patients than previously. Even if the overall likelihood of an incidence of clinical negligence occurring in any given interaction remains static, a higher volume of patients being seen would mean a higher number of incidents occurring. Some medical defence organisations also suggest that patients are more likely to take legal action against a GP they don't know, and that GPs working under pressure are more likely to leave patients dissatisfied.

5.4 Evidence also suggests that patient behaviour has undergone a significant change in recent years, in a way that may lead to an increase in the likelihood of a claim arising. Expectations of care are higher, and the medical defence organisations observe that patients have a different relationship with their GP increasing the likelihood to sue when something goes wrong – something that was just not a feature of primary care 15-20 years ago. This trend has also been observed in secondary care – the NHS Litigation Authority report that there has been an increase in the number of patients claiming compensation as a proportion of reported incidents, and also an increase in low value claims.

5.5 There are a growing numbers of claims companies entering the market and advertising their services to patients. The aggressiveness of the compensation

³ General Practice Forward View, April 2016. NHS England, pp.13 - 14

market is marked in England compared to other countries, and this could be a factor in the increasing volume of claims.

5.6 Despite the increase in volume of claims, in recent years the medical defence organisations have increased the proportion of cases closed with no payment made to the claimant from 70% to 80%⁴. However, the overall number of claims has increased significantly and the associated legal costs are borne by the medical defence organisations and eventually the GPs, even where cases are closed with no damages being paid.

Award of damages

5.7 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 (both volume and cost), particularly for high-value claims.

5.8 In general, the aim of awarding damages is to put the victim back into the position that they would have been in had the clinical negligence not occurred. Damages paid to victims of clinical negligence include in particular, loss of earnings, the cost of future health care treatment and other forms of care and therapies, as well as general damages for things such as pain and suffering. Interest is usually also payable, and the successful claimant's legal costs are generally also recoverable, subject to the rules of court. These costs are increasing due to a number of factors:

- Increased life expectancy (in cases where the damage will last for life, increased life expectancy means the loss of earnings is greater, and the medical expenses are higher)
- Advances in medical treatment – resulting in higher treatment costs
- Rising legal fees charged by claims companies (particularly for low value claims)

5.9 Added to this, the nature of English law means that each time a novel payout is made, the bar for all future payouts increases. This is particularly problematic where a medical defence organisation has an outstanding claim to pay, but where the incident it relates to occurred while subscriptions were priced based on the previous bar.

5.10 These factors relating to cost of damages also apply to clinical negligence claims in secondary care, hence the cost pressures are broadly similar across the board.

⁴ MDU Annual Report 2014, p.4

5.11 Discussion with the medical defence organisations and the NHS Litigation Authority suggests that as things stand, we can expect the cost of indemnity to continue to push upwards at a similar annual rate to that seen in recent years.

Discussion of solutions

6.1 The review carried out an initial exploration of a range of options that had the potential to address the immediate pressure on general practice, and to reduce the overall costs of indemnity by acting on either the volume of claims or amount of damages being awarded.

Addressing pressure in the short term

6.2 It was clear that any actions to address the long-term drivers would not immediately relieve the pressures on GPs. As a result the review concluded that the best way of to alleviate the immediate pressure was through a new and bespoke scheme to **provide direct financial support to general practice**.

6.3 In deciding on the best way to develop such a financial package, the review had several considerations in mind:

- The scheme should provide a financial contribution to alleviate GPs' exposure to indemnity inflation in scheduled work.
- The scheme should reflect the average annual indemnity inflationary pressures faced by GPs.
- The scheme should have an impact on the largest number of GPs, and be transparent, visible and accessible to them.
- The scheme should not distort the market by removing the incentive for medical defence organisations to compete for members, or discourage GPs from shopping around
- The scheme should not introduce perverse incentives for medical defence organisations to increase costs
- The scheme should not disadvantage under-doctored practices
- The scheme should not increase the administrative burden on the profession
- The scheme should be affordable, and not create an undue opportunity cost

6.4 The approach to be taken meets these criteria, and is set out below. Different approaches will be needed for scheduled sessions (in hours) and out of hours sessions, reflecting the different ways these services are contracted for.

Scheduled sessions

- 7.1 For scheduled sessions, NHS England will provide an additional, identifiable payment to each practice.
- 7.2 The first payment will be in April 2017, to address inflation experienced in 2016-17. The scheme will be reviewed in two years.
- 7.3 The overall amount of the contribution will be calculated based on the estimated annual inflationary increase in indemnity costs faced by GPs. This will be based on an agreed and transparent methodology, then multiplied by the expected headcount of GPs.
- 7.4 This will give the total cost of average inflation in indemnity costs for all GPs in England. (Basing the payment on **average** costs rather than actual incurred costs maintains the incentive to shop around for indemnity cover.)
- 7.5 This amount will then be distributed amongst practices based on their list size, not on weighted capitation.
- 7.6 A corresponding payment will be made in April 2018 to cover inflation experienced in 17/18, and the basis of the calculation of inflation will be reviewed as part of this.
- 7.7 The future of the scheme will be reviewed following April 2018, in light of progress made on other aspects of indemnity reform.
- 7.8 By basing payments for practices on the list size, the scheme will include provision for the additional indemnity premiums faced by all GPs at the practice as well as partners. As such, GP practices will be expected to provide an appropriate share of their payment to their salaried GPs and locum GPs.
- 7.9 Further details will be worked up through discussion with the profession.

Unscheduled sessions/ out of hours

- 8.1 Though rises in indemnity premiums are an issue within out of hours work, the local procurement of out of hours, and the variation between CCG areas means the provision of support is more complex than for scheduled work.
- 8.2 In addition, much work is going on locally to re-procure joint NHS 111/ OOH contracts as existing contracts come up for renewal. Because of this complex and variable picture, it is not as easy to implement a quick national solution in the same way as in hours care.

8.3 By the end of the year NHS England will have completed discussions with the profession and CCGs how we can best deliver on the principle set out above, protecting GPs working out of hours from indemnity inflation from 2017-18.

8.4 In the interim, NHS England will put in place another winter indemnity scheme this year to support GPs who are able to carry out more out of hours sessions to help address winter pressures, and this will be published in September.

8.5 General practice is also changing in terms of the types of clinicians employed in the workforce (all of whom have to have clinical negligence cover), the expectations on staff and the demographics of general practitioners themselves. The profession has raised these considerations in respect of indemnity challenges they pose; and have also raised concerns about how to maintain a sense of equity between new care models and those working under traditional contracts. NHS England will take forward discussions on these issues in the coming months.

8.6 The profession has also raised the issue of some atypical and exceptionally high indemnity costs for individual practitioners, or for types of practitioners. NHS England will take forward discussions with the profession to explore these specific cases, and assess whether wider work is needed to tackle them.

Longer term action to reduce costs

9.1 The support scheme outlined above will not of itself help to bring down the long term costs of indemnity in primary care. The review considered a number of other potential solutions, including some suggested by GPs in various forums, and sets out the action that is needed in each area.

Reducing legal costs

9.2 Paragraph 5.7 above indicates that the main driver of increases in the costs of indemnity is increases in the sums being paid out as damages. International evidence suggests that one effective way to significantly bring down indemnity costs over the long term is through reform of the legal system.

9.3 The Department of Health recognises the pressures that growing indemnity costs are placing on the whole NHS, and has already committed to exploring action to fix the amounts that can be recovered in costs by legal firms in certain cases. A further deep dive will be carried out to better understand the options for constraining litigation costs in primary and secondary care

Other options: risk-sharing and national indemnity schemes

- 10.1 The review considered a number of different ways that the cost of indemnity could be spread differently across the system, to see whether there are any immediate gains to be made from varying the indemnity model currently in operation in general practice.
- 10.2 It would be possible to make changes to spread the risk of indemnification, for example, by transferring some types of activity or claim (e.g. out of hours, minor surgery, claims above a certain amount) to a central, state-run scheme.
- 10.3 A more fundamental change would be to transfer all GP indemnity to a scheme similar to the scheme run for Trusts by the NHS Litigation Authority.
- 10.4 The complexities involved in these kind of scheme, or the transition to them, are immense. Moving to a model that splits the responsibility for indemnity, or moves it entirely to another place would not itself be a more efficient way of meeting the indemnity bill, or of reducing the total amount of money needed to cover the risk.
- 10.5 Separating the responsibility for funding primary indemnity between different parts of the system would almost certainly create the need for an interface between different payers (e.g. medical defence organisation for some claims, the state for other claims), which would be complex given the volume of claims involved, and could introduce perverse incentives for payers to inflate costs in order for them to move off their books. The changes could have knock-on effects for the remaining medical defence market which would need to be fully understood.
- 10.6 There are significant differences between the indemnity models run by medical defence organisations and by the NHS LA, which largely reflect fundamental differences in the structure of the sectors.
- 10.7 Trusts are responsible for paying the indemnity cover for all their activity (and the indemnity costs to Trusts are increasing annually at a similar rate to primary care). This means the cost falls on the Trust rather than the individual employees of the Trust.
- 10.8 Ultimately any move towards adopting a different model of indemnity in primary care would need to reconcile the fact that the cost would not disappear, and would still need to be funded within the overall health expenditure limits.
- 10.9 The review notes that the changing landscape in primary care may ultimately require new models of indemnity to arise in some circumstances, catering for different organisational arrangements, and for this reason suggests it is important to continue to investigate this area, while providing financial support in the short term.
- 10.10 The review notes that some GPs have called for crown immunity or crown indemnity, as possible alternate solutions. Crown immunity does not exist anywhere in the NHS. It would mean that a provider/GP was absolved of any responsibility for providing redress to victims of clinical negligence, which would deny the patient access to justice. Crown indemnity, though often spoken of by

GPs, is not a term associated with any of the indemnity arrangements currently in existence, but is often used to refer to the kinds of risk-sharing models discussed above.

Operational improvements

10.11 The review considered whether there were opportunities to reduce indemnity costs through the provision of support to GPs to reduce the volume of claims at source. Though there is no evidence that claims are driven by worsening safety, there may be potential to reduce the likelihood of some patients taking a legal route, for example through better communication or complaints handling.

10.12 The medical defence organisations already provide advice on the steps GPs can take to make claims less likely. NHS England, other public bodies with a role in safety and quality, the medical defence organisations and the profession have a strong shared interest here. We believe there would be value in a joint exploration of operational measures to reduce negligence claims in primary care.

Conclusions and next steps

11.1 The review concludes that the rises seen in recent years in the cost of indemnity are likely to continue in the future, and that action will be needed in a number of areas to meet the commitments set out in the GP Forward View.

11.2 The review has concluded that in the short term, the best way of reducing the pressure of indemnity in general practice is through a support package that seeks to provide additional funds to offset the inflationary increases seen each year.

11.3 To achieve this NHS England will put in place a financial support package to provide support for in-hours indemnity inflation for introduction in April 2017, as outlined in paragraph 7, building on the extra indemnity expenses funding built in to the 16/17 contract.

11.4 Out of hours/unscheduled care is more complex but NHS England and DH are equally committed to providing additional support in this area. Further work will be carried out this year by NHS England, working with the profession and with commissioners, to establish the best method to achieving this. In the interim, NHS England will run a further year of the winter indemnity scheme for out of hours work.

11.5 Wider work is also being undertaken to consider how indemnity affects GPs considering joining or leaving the profession; and to tackle specific atypically high prices.

11.6 The review concludes that longer-term action is necessary to address the root causes of the rising costs of indemnity. The Department of Health will begin an urgent piece of work to identify the most effective ways of addressing these causes, and continue with the work to cap the amount legal firms can recover in clinical negligence cases.

11.7 The review also concludes that the model of indemnity provision in primary care will face challenges as the primary care environment adapts to deliver the aims of the Five Year Forward View and General Practice Forward View. Further consideration of the options for reform of indemnity arrangements will take place, and NHS England and the Department of Health are committed to continuing exploration of the alternative approaches to indemnity in general practice, including the potential of national clinical negligence schemes.