IFF Research

Clinical Indemnity – Survey of Regulated Healthcare Professionals with Private Cover

Commissioned by Department of Health & Social Care (DHSC)

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Contents

1 Executive Summary

Introduction

In the UK, there are over 1 million registered regulated healthcare professionals, all of which are legally required to hold appropriate indemnity or insurance cover. Most staff in the NHS in England and Wales benefit from state indemnity for clinical negligence. Many of those who do not, including many private practitioners and dentists around the UK, and GPs in Scotland and Northern Ireland, hold either insurance through an insurance provider or discretionary indemnity through membership of an MDO (Medical Defence Organisation) or other discretionary indemnity provider.

Providers of insurance products are regulated by the Financial Conduct Authority (FCA) and Prudential Regulation Authority (PRA). Discretionary indemnity arrangements are not subject to this regulatory oversight. [Some discretionary indemnity providers choose to follow the Association of Financial Mutuals (AFM) Governance Code and/or the Wates Principles.

The Department of Health and Social Care commissioned IFF to undertake research to better understand the medical indemnity markets and the impact of current arrangements on HCPs.

This report covers the findings from both an online survey of 1,235 respondents and 20 in-depth interviews with a range of HCPs in the UK who are either working in private practice or in the NHS with non-state indemnity cover.

As some of the HCPs surveyed may have had a limited understanding of the product they held, some responses received appeared to be inaccurate – for example the name of the provider HCPs gave did not always match the type of indemnity they said they held. All findings in this report are based on the information given by HCPs, with no adjustments made to ‘correct’ for inaccuracies.

Margins of error are larger for smaller sample sizes. Caution is needed interpreting the results pertaining to nurses and midwives due to a small sample size for these professions. The same applies to questions which were asked of a small proportion of HCPs for example those around experience of claims.

HCPs cover arrangements

State and private cover

This research focussed on HCPs in the UK who are either working in private practice or in the NHS with non-state indemnity cover.

Those HCPs covered solely by a state indemnity scheme were not covered in the research. There are seven state clinical negligence indemnity schemes largely covering hospital staff in England delivering NHS care, as well as the NHS work of GPs and their staff. Other HCPs, whether delivering private or NHS care, tend to have indemnity cover from private insurers or indemnity providers, or their professional body or union. HCPs who are fully covered by a state scheme for their NHS work may also have private indemnity cover for their private work or for additional advisory services such as for fitness to practise hearings.

Of surveyed HCPs who work at least partially in the NHS, the vast majority (84%) said they are covered by private regulated insurance or discretionary indemnity for their NHS work and almost half

(47%) said they are covered by a state indemnity scheme e.g. the Clinical Negligence Scheme for Trusts (CNST) for their NHS work.

In terms of why HCPs have both private cover and state cover for their NHS work, most HCPs say it's because private indemnity products cover aspects that state indemnity doesn't cover, such as employer disputes or because it was included in their professional body/union membership.

Arranging cover separate from state indemnity

Overall, HCPs are most likely to arrange individual cover or receive their insurance through their membership of a professional association. However, doctors and dental professionals are more likely to hold individual cover with an indemnity or insurance provider, with very small numbers obtaining cover through membership of a professional association. In contrast, nurses and midwives are much more likely than other HCPs to arrange their cover through membership of a professional association.

Many HCPs found the process of obtaining their cover easy and straightforward, however some identified that the process was lengthy and laborious given the amount of documentation that was required by providers.

Understanding of cover

Whilst almost half of HCPs reported a good understanding of their cover, one in five HCPs reported a poor or very poor understanding. Doctors are more likely than other HCPs to feel their understanding of their cover is good.

Frequency of review

The majority of HCPs review their cover annually, but many have never reviewed their cover. Doctors are more likely to review their cover annually. In contrast, the direct engagement of nurses and midwives with their cover is low, with just over a third having never reviewed their arrangements.

Type of cover

Over one third of HCPs have discretionary indemnity, slightly fewer than hold regulated insurance. However, over a quarter of HCPs do not know what type of cover they hold[1].

Around half of dental professionals and doctors reported that they hold discretionary indemnity, compared to less than one in three nurses. Of the HCPs surveyed, nurses were most likely not to know what type of cover they held - higher than doctors and dental professionals but broadly in line with other professions.

[1] During quality assurance, a number of inconsistencies were identified in individuals' selection of their type of indemnity cover. No adjustments were made to account for these inconsistencies and the data presented in the report is as reported by survey participants. However, given the relatively high level of uncertainty around cover type, we checked what HCPs told us about their type of cover against the name(s) of their provider. Using knowledge of what type of cover each provider offers, we can estimate that, in fact, almost half (47%) of HCPs hold regulated insurance and just over a quarter (27%) hold discretionary indemnity, with the remainder unsure or preferring not to say.

The surveyed HCPs most commonly hold occurrence cover, claims made, run off cover and claims paid cover. However, there was again evidence of low understanding of cover types among HCPs, with many not knowing what elements are included in their private cover.

Doctors and dental professionals who responded were more likely to hold occurrence policies than nurses and other professionals. Doctors were also more likely to hold run off cover than other professions.

Premium costs

The majority of HCPs surveyed paid for their indemnity cover annually, with just over a quarter paying monthly. Doctors, dental professionals and 'all other professions' are more likely to pay their premium costs annually than nurses / midwives.

The mean average annual premium costs paid by HCPs for their clinical negligence cover is £2,467 (or £420 as a median) and around two thirds pay less than £1,000. Doctors pay the highest premium costs on average and nurses the lowest.

Cover value

The average value of indemnity cover held by HCPs is £7.9 million, with a median value of £5 million. Limited knowledge is again a factor, with a third of HCPs not knowing the value of their cover.

Doctors on average had the highest level of cover, with a mean value of £9.9 million against £6.33 million for dental professionals, £6.98 million for nurses and midwives and £6.74 million for 'all other professions'.

Policy limitations

Most of the HCPs surveyed didn't know what the limitations of their policy were, and a significant minority stated that their cover does not have any limitations. Limitations of their cover raised by HCPs include the value of their cover, that certain procedures are excluded, that the cover excludes certain claims, that cosmetic procedures are excluded and (particularly for physiotherapists) that professional sports patients are excluded.

Reason for selecting provider for individual cover

The majority of surveyed HCPs with individual cover were driven by satisfaction with cover levels and price when selecting their indemnity provider. The other reasons discussed by HCPs were based on a recommendation, because of past experience, the certainty of cover and that it was required for a change in role/employer.

Switching providers

More HCPs surveyed had thought about switching from discretionary indemnity to regulated insurance, than vice versa.

Price is key in considering switching, with the cost of premiums being a key reason for almost three quarters of those who have considered switching providers. Just under a fifth are considering switching providers based on recommendations, and smaller proportions considered switching to ensure predictability of cover from their provider or because of a poor experience with their existing provider.

Claims and contacting their provider

Most professionals surveyed had not spoken to their provider for matters other than a clinical negligence claim, so had not discussed for example the type, cost or limitations of their cover, in the last 5 years.

The majority of HCPs surveyed had never had a claim made about them, with one in ten having experienced one claim and just 7% having experienced more than one claim made against them.

Almost half of cases result in damages being awarded to a claimant. The average pay-out for those claims that resulted in damages was £26,170 with a median pay-out of £13,000.

More than one in ten HCPs surveyed who have had a claim made against them have had difficulties with determining responsibilities for covering costs.

Refused claims

Around one in twenty of the HCPs surveyed (6%) who have had clinical negligence claims made against them have had a provider refuse to cover the claim.

The reasons given to those HCPs who have had a regulated insurance or discretionary indemnity claim refused were that:

- Conditions imposed by the cover have not been met;
- Claim occurred while doing work beyond remit included in cover;
- Claim was not notified within the period required by the relevant policy or terms of membership;
- Claim occurred because the nature of the work differed to that included in the cover; or they
- Decided to pay/pay additional costs out of pocket.

The value of the claims refused were most commonly £25k or less, reflecting the value of claims overall.

After having their clinical negligence claim refused, it was relatively common for HCPs to appeal, which typically did not change the outcome. One in five also changed provider.

There was a range of final outcomes for refused claims. While some claims were deemed to have no merit and did not proceed, others resulted in claims settled by indemnifiers or out of pocket payments by HCPs.

Views of improvements

Training / guidance

Some HCPs interviewed as part of the qualitative phase had previously received training on indemnity cover from providers, employers or professional organisations. However, such training was not universal, with some HCPs relying on personal experience or that of their peers for their knowledge on indemnity arrangements.

Most felt that training would be beneficial to all HCPs and that it would be a good idea to make such training mandatory. Some HCPs acknowledge that the legal element of their cover is a grey area for them and that the insight required for greater understanding is something that can only be provided by experts.

Compensation safety net for criminal acts

In the discussions surrounding a proposed compensation safety net for criminal acts, many felt that this did not actually deal directly with the issues they faced and instead that there needs to be two separate processes for clinical negligence claims and those deemed criminal.

Many HCPs felt that these criminal offences were few and far between and fell under the scope of the criminal justice system. With regards to the current clinical negligence compensation system, some HCPs suggested, a no-fault compensation route would be the most suitable. However, this view was not universal: one HCP expressed reservations about introducing a no-fault compensation route.

In terms of funding the proposed safety net, where they were able to comment, those HCPs suggested that it should be funded out of the public purse – either by the DHSC or the NHS.

Other improvements to the claims process

Respondents outlined the impact of the claims process on HCPs and a number also held views on the proposed reforms to indemnity cover within the healthcare sector.

Some HCPs suggested a process involving arbitration would be most suitable. Others would like to see action taken on no win no fee lawyers who are felt to encourage patients to make baseless claims.

2 Introduction

Background to the study and research objectives

Professional indemnity is a security or protection for professionals against claims for loss or damage made by clients or third parties as a result of the impact of negligent services provided or negligent advice offered. HCPs are legally required by their professional body or regulator to have in place such arrangements, so they can meet the costs of claims and damages awarded to patients in cases of clinical negligence. Such incidents arise when a professional, who owes a duty of care to a patient, breaches that duty of care (by an act, or omission to act) and that breach causes the patient harm (personal injury or loss).

Most HCPs working for the NHS in England and Wales will have some form of state provided cover. Many of those who do not, including HCPs who work in the independent sector, are required to have in place their own indemnity cover. Products available can be broadly categorised into:

- **Regulated insurance** – whereby coverage and payments are bound by a contract. This is usually provided by a commercial insurer and most of these contractual policies work on a claims-made basis, covering any claim made during the active time of coverage. The terms of an insurance policy specify with certainty the nature of cover provided to the HCP and in what circumstances. Cover is generally subject to caps, and frequently excesses and deductibles, on the value of claims that the HCP is covered for (e.g. up to £10m) and may exclude particular clinical activities. When an insurance provider does not support a claim based on insurance policy terms, the HCP will be personally liable for any claim-related costs.

- **Discretionary indemnity arrangement** – whereby coverage is provided by a Medical Defence Organisation (MDO) or another discretionary indemnity provider. There is no explicit limit on the cover and financial support to cover a claim is at the discretion of the provider. If the provider exercises discretion to not support the claim, the HCP will be personally liable for any claim-related costs.

Providers of discretionary indemnity schemes are not subject to financial conduct or prudential regulation, unlike regulated insurance providers which are bound by strict reporting and other requirements.

Policy types vary significantly and include:

- **Occurrence based/claims occurring**: provides cover for any claim relating to an incident that occurred while the membership was active, even if the policy/membership has since expired or the individual has ceased practicing by the time the claim becomes known;

- **Claims made**: provides cover for any claim made and reported during the existing policy/membership period relating to incidents that occurred during that period of practice;

- **Claims paid**: provides cover for any claim made, reported and settled during the existing policy/membership period relating to incidents that occurred during that period of practice; and

- **Run off cover**: provides cover for claims made and reported after a claims made/paid indemnity policy/membership has expired, relating to incidents that occurred during the policy/membership period. This is not required for HCPs who have occurrence-based protection against claims.

Due to concerns about discretionary indemnity arrangements, particularly the rising costs of discretionary indemnity for doctors in General Practice, in 2016 the government conducted a General Practice Indemnity Review (GPIR). The GPIR was established as a short-term, focused piece of work which sought to establish the extent of inflation in GP discretionary indemnity, the root causes of this, and to identify proposals for improving the situation[1]. Later in 2018, the government conducted a consultation on appropriate clinical negligence cover.

The consultation[2] aimed to collect stakeholders' views on government proposals on how to address their concern about the stability of the current forms of indemnity cover. These options were:

- leave arrangements as they are (option 1); or
- change legislation to ensure that all regulated professionals in the UK not covered by a state-backed indemnity scheme hold appropriate clinical negligence cover that is subject to appropriate supervision (option 2).

The majority of respondents to the consultation were in support of the government's preferred option, option 2, with greatest support coming from insurance and finance-related associations, lawyers and law firms, the general public, public sector organisations, and independent providers.

In February 2020, the Paterson Inquiry highlighted serious concerns with the current system of clinical negligence cover for healthcare professionals, outlining that *"the discretionary nature of the cover, combined with the lack of clarity about whether private healthcare providers are vicariously liable for healthcare professionals' actions, means that there are potential gaps in clinical indemnity in the independent sector which do not exist in the NHS. This risk does not appear to be transparent to private patients at the point that they choose to have their treatment in this sector"*[3].

The Inquiry recommended that the government "*reform the current regulation of indemnity products for healthcare professionals, in light of the serious shortcomings identified by the inquiry and introduce a nationwide safety net to ensure patients are not disadvantaged"*[4].

Building on the information collected through the consultation and the Paterson Inquiry, the Department of Health and Social Care (DHSC) is now carrying out a programme of evidence gathering. As part of this, DHSC commissioned IFF to undertake research to better understand the

[1] Department of Health. GP Indemnity Review. 2016. Available at: gp-indemnity-rev-summary.pdf (england.nhs.uk)
[2] Department of Health & Social Care. Appropriate clinical negligence cover: Summary of responses. 2019. Available at: Appropriate clinical negligence cover: summary of responses - GOV.UK (www.gov.uk)
[3] Report of the Independent Inquiry into the Issues raised by Paterson. 2020. Available at: Report of the Independent Inquiry into the Issues raise by Paterson (publishing.service.gov.uk)
[4] Report of the Independent Inquiry into the Issues raised by Paterson. 2020. Available at: Report of the Independent Inquiry into the Issues raise by Paterson (publishing.service.gov.uk)

complexities of the medical indemnity market and to inform future policy decisions. The research set out to:

- Understand the discretionary indemnity and/or regulated insurance arrangements HCPs have in place for clinical negligence cover – separate from any state indemnity they may be covered by; and
- Explore their experience in relation to clinical negligence claims related to these discretionary indemnity and/or insurance arrangements.

Methodology

The research involved both a quantitative survey to gather robust nationally representative evidence and qualitative research (in-depth interviews) to add further insight and nuance to the findings. The approach to each element is set out in further detail below.

Survey of healthcare professionals

IFF Research conducted a 15-minute online survey with 1,235 HCPs. The survey was disseminated through a range of channels including professional bodies, regulators and independent providers. In addition, some sample was purchased from a commercial sample provider. Mainstage fieldwork took place between 1st September and 14th October 2022.

Prior to the mainstage launch, the survey was cognitively tested and then piloted to ensure the questions being asked were relevant and easy to understand. The final breakdown of interviews achieved (unweighted) split by profession was as follows:

Table 1: Profile of achieved quantitative participants split by profession

Grouped profession	Profession	Number of respondents
Doctor (primary and secondary care)	Doctor - Primary care (GP)	39
	Doctor - Secondary or tertiary care	397
	Total doctors (primary and secondary care)	**436**
Nurses and midwives	Nurse / nursing associate	56
	Midwife	7
	Total Nurses / Midwives	**63**
Dental professionals (Dentists and DCPs)	Dentists	270
	Dental care professional	39
	Total dental professionals (Dentists and DCPs)	**309**
All other professions	Psychologist / psychiatrist / psychotherapist	117
	Pharmacist / pharmacy technician	65
	Optometrist / dispensing optician	37

	Physiotherapist	32
	Chiropractor	24
	Osteopath	15
	Other	110
	Total all other professions	**400**
	Unspecified (preferred not to say)	27
Total		**1,235**

Data weighting was applied to the dataset to ensure the results were, as far as possible, representative of the healthcare professional population in the UK who are either working in private practice or in the NHS with non-state indemnity cover.

Quality assurance processes identified that survey respondents' answers appeared to be inaccurate – for example the name of the provider they gave did not always match the type of indemnity they said they held. All findings in this report are based on the information given by HCPs, with no adjustments made to 'correct' for inaccuracies.

Please see the Technical Appendix for further information on survey methodology including sampling and weighting, as well as further detail on the demographic profile of the final sample.

Qualitative research

Following the quantitative survey, IFF Research carried out 20 in-depth interviews with a range of HCPs. Qualitative fieldwork took place between 16th January and 21st February 2023, and interviews were carried out via Microsoft Teams or via the telephone.

The main aims of the qualitative phase were to get a clearer picture of HCPs understanding of their cover arrangements, why they chose them, and their experiences of the claims process when it comes to clinical negligence claims.

All participants had already completed the survey and had consented to taking part in further, qualitative, research.

In-depth interviews took place with HCPs with a range of claims experience; 14 had a clinical negligence claim made against them without difficulties, 6 experienced difficulties when determining who was responsible for covering the costs of the claim and 2 respondents had a clinical negligence claim refused.

Table 2 shows a breakdown of the final profile for the in-depth interviews by profession.

Table 2: Profile of qualitative participants split by profession

HCP type	Number of respondents
Doctor (primary and secondary care)	9
Dental professionals (Dentists and DCPs)	8
All other professions	3

Total	**20**

Please see the Technical Appendix for information on the demographic profile of the qualitative respondents.

Reporting conventions and interpretation

Professional groupings

For the purpose of analysis due to small base sizes, professions were grouped together as follows:

- Doctors (including primary, secondary or tertiary care);
- Nurses and midwives (including nursing associates);
- Dental professionals (including dentists and dental care professionals such as dental nurses, hygienists, dental technicians etc.); and
- All other professions (including chiropractors, pharmacists, pharmacy technicians, optometrists, dispensing opticians, physiotherapists, osteopaths and those coded from 'other').

Healthcare professionals as a group are often abbreviated to HCPs throughout this report.

Those who work solely in the NHS and who are covered by a state indemnity scheme only were not relevant for the research, so they were screened out. When this report uses the term HCPs it is referring to those in scope for the research, so those who hold some private insurance or indemnity arrangement for clinical negligence claims.

Significance testing and rounding

All differences stated in this report between sub-groups are statistically significant at the 95% confidence level, and are demonstrated in the tables using an asterisk (*).

For multi-response questions, the sum of the total responses may exceed 100%. This is because a healthcare professional could provide more than one response, and responses are not mutually exclusive. For single-response questions, the sum of all responses may not add up to 100% due to rounding. For example, a response may represent a percentage of 65.54% and this will be rounded up to 66%.

Effective sample size and margins of error

Data weighting reduces the effective sample size from 1235 to 685. The table overleaf shows that for an effective sample size of 685, where a finding is 50% (the worst case scenario from a statistical perspective), we can be 95% confident that the 'real' figure is +/-3.14 percentage points from 50% i.e. it could be anywhere between 46.86% and 53.14%. For a finding of 10% or 90% the margin of error is reduced to just +/-1.89 percentage points.

As data weighting does not affect the results by profession, the effective sample sizes for each grouped profession are the same as the number of survey completes.

Margins of error are larger for smaller sample sizes and caution is needed interpreting the results pertaining to nurses and midwives.

Table 3: Margins of error for healthcare professionals overall and by grouped profession

	Base size (n)	Margin of error with findings at 50%	Margin of error with findings at 90%
Doctors	436	+/-4.69	+/-2.82
Nurses and midwives	63	+/-12.35	+/-7.41
Dental professionals	311	+/-5.56	+/-3.33
All other professions	400	+/-4.9	+/-2.94
Overall HCPs (effective sample size)	685	+/-3.14	+/-1.89

Qualitative reporting uncertainty

The purpose of the qualitative research is to provide an in-depth understanding of HCPs' own understanding of their discretionary indemnity and/or regulated insurance arrangements. It is not intended to be statistically representative, and therefore findings should not be generalised to the population of HCPs either working in private practice or in the NHS with non-state indemnity cover.

3 Healthcare professionals cover arrangements

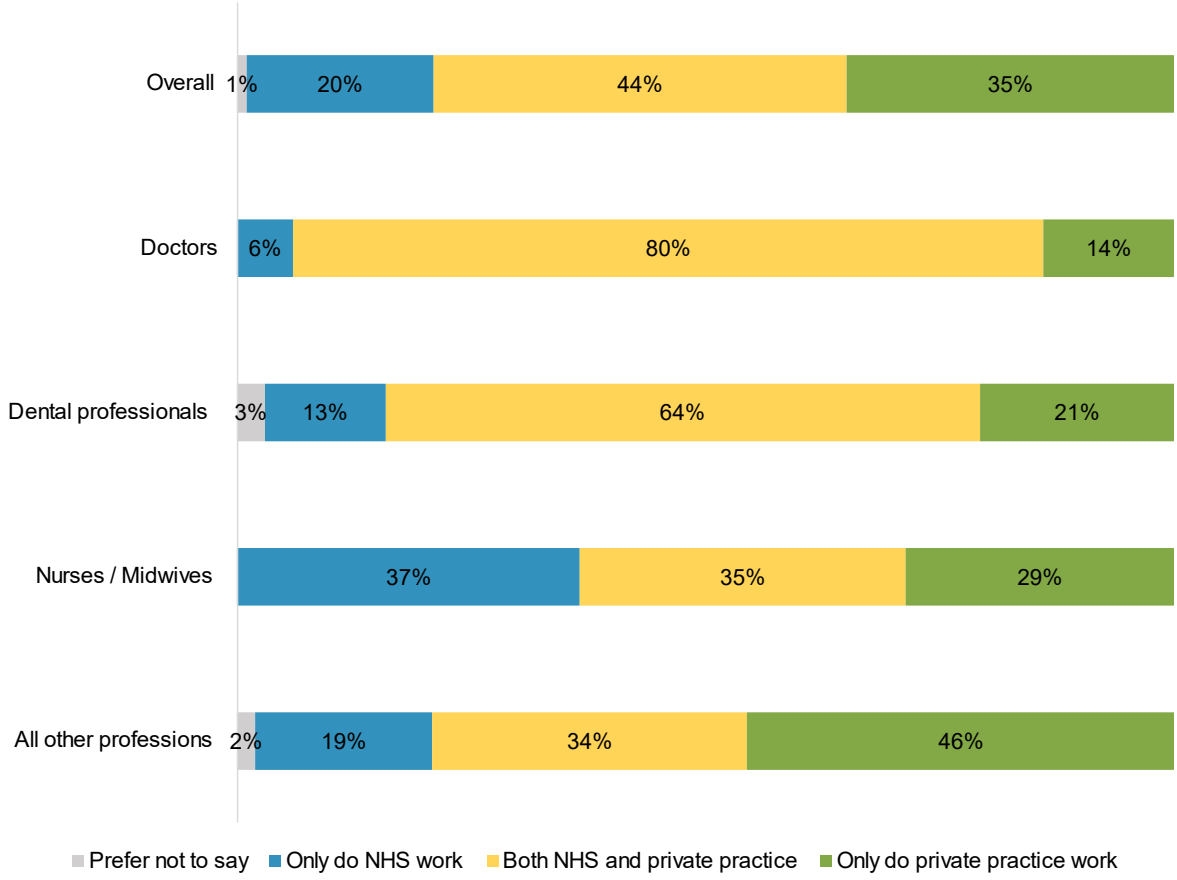
This chapter covers the working arrangements of HCPs, how they arrange their clinical negligence cover, their understanding of their cover, how often they review it and the type of cover they hold. It goes on to cover average premium costs and cover value, the limitations of HCPs' cover and whether they have considered switching providers.

Working arrangements

Those who work solely in the NHS and who are covered by a state indemnity scheme only were not relevant for the research, so they were screened out. Of the remainder, working in both the NHS and private practice is common, with just under a half (44%) of HCPs doing so. Smaller proportions of HCPs either only do NHS work (20%) or only private practice work (34%).

Doctors are most likely to split their time across both types of work, four in five (80%) of whom do so, compared to just under two thirds of dental professionals (64%) and around one third of nurses (35%) and 'all other professions' (34%). Nurses are most likely to work only in the NHS (37%) and those HCPs grouped under 'all other professions' are most likely to work only in private practice (46%).

Figure 1: HCP working arrangements



A1a: How is your working time split between the NHS and private practice? Base: All HCPs (n=1235); Doctors (n=436), Nurses and midwives (n=63), Dental Professionals (n=309), Other (n=400)

HCPs work an average of 31.5 contracted hours per week, with a third (33%) saying they work between 30-39 hours and just over a quarter working less than that (28%).

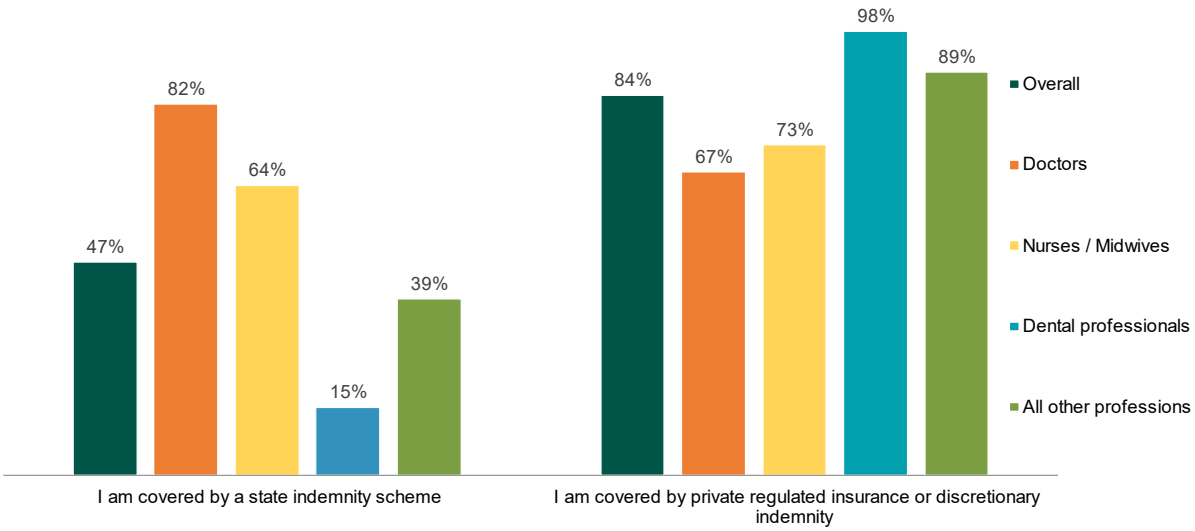
Doctors, on average, work the longest hours (37.3 hours), considerably longer than nurses (32.3 hours), dental professionals (31.5 hours) and 'all other professions' (30 hours).

State and private cover

Of the surveyed HCPs who work at least partially in the NHS, the vast majority (84%) are covered by private regulated insurance or discretionary indemnity for their NHS work and almost half (47%) are covered by a state indemnity scheme e.g. Clinical Negligence Scheme for Trusts for their NHS work.

Dental professionals (98%) and 'all other professions' (89%) are more likely to be covered by private regulated insurance or discretionary indemnity for their NHS work than nurses (73%) or doctors (67%). This is likely due to state indemnity schemes not applying to these professionals. In contrast, of the doctors and nurses surveyed, far more are likely to be covered by a state indemnity scheme, such as CNST and CNSGP (82% and 64% vs 47% average).

Figure 2: State and Private Cover



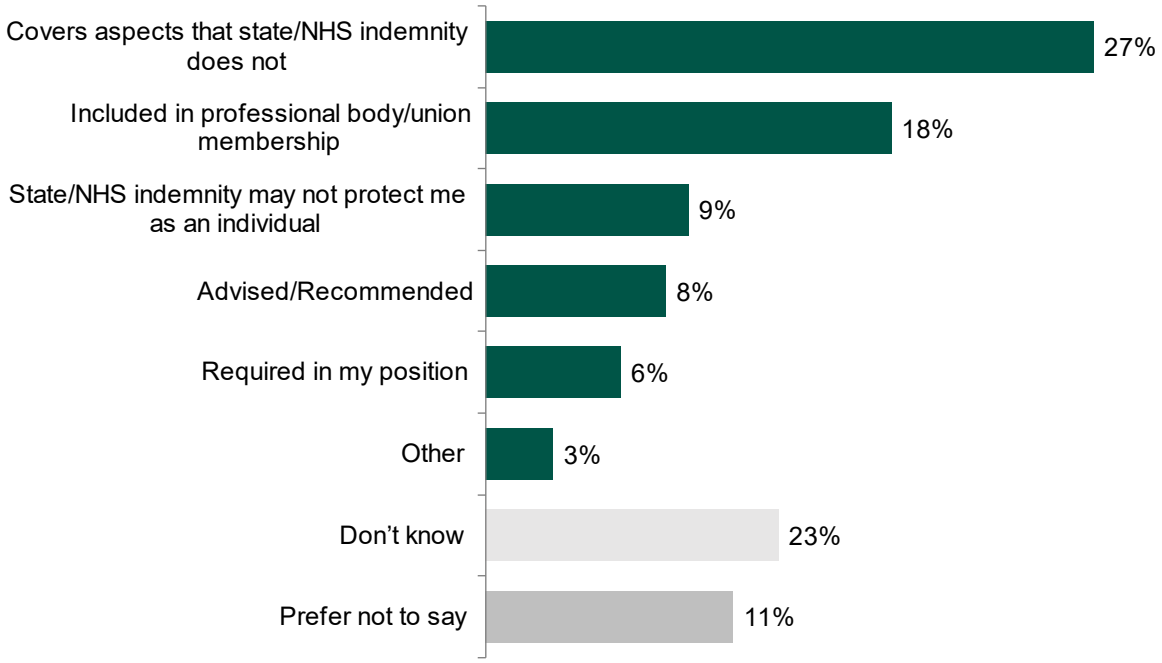
A1c: What are your indemnity arrangements in relation to clinical negligence claims for your NHS work? Base: All (n=902); Doctors (n=377), Nurses and midwives (n=45), Dental Professionals (n=245), Other Professionals (n=218)

In terms of why they have state and private cover for their NHS work, most HCPs say it's because private indemnity arrangements cover aspects that state indemnity doesn't cover, such as employer disputes (27%) or because it was included in their professional body/union membership (18%).

Other reasons discussed by HCPs were that state/NHS indemnity may not protect them as an individual (9%), that they were advised/recommended to do so (8%) or that it was required in their position (6%).

Almost a quarter of HCPs (23%) said they don't know why they hold both state and private cover for their NHS work or were unwilling to say – a lack of understanding / engagement with indemnity which can be seen throughout this research.

Figure 3: Reasons for holding both state indemnity and private indemnity for NHS work



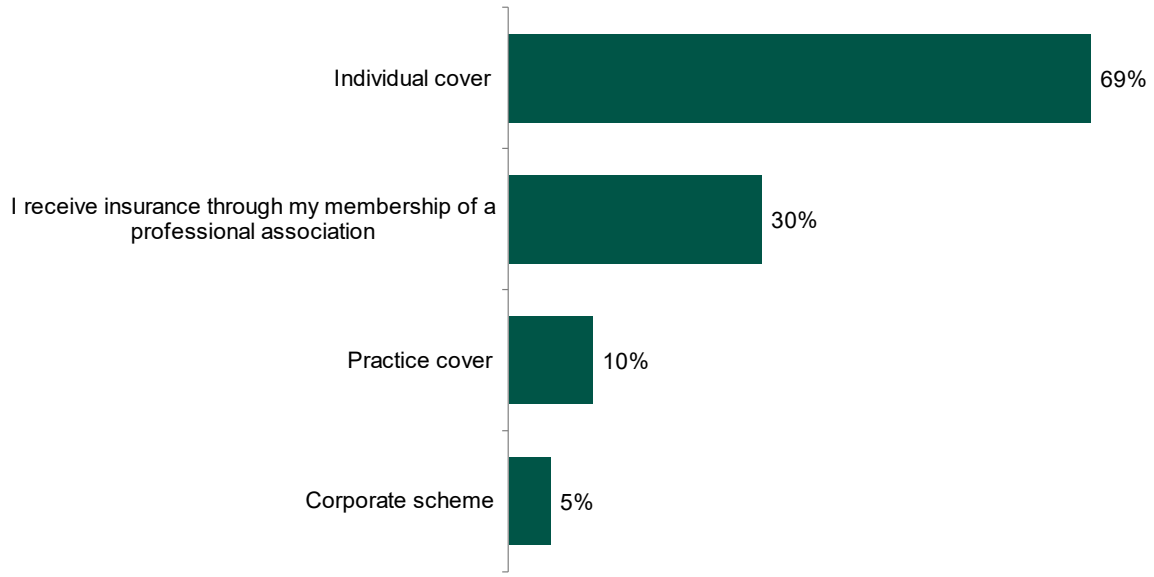
A1d: Why do you have both state indemnity and private indemnity for your NHS work? Base: All (298)

Those with individual cover were more likely to have taken an active interest in what they are covered for: they are more likely to hold private cover to fill gaps that state indemnity doesn't cover (34% vs. 27% average).

Arranging cover separate from state indemnity

HCPs are most likely to arrange individual cover - over two thirds of whom do so (69%) - followed by just under one third (30%) who receive their insurance through their membership of a professional association. One in ten HCPs (10%) have practice cover and 5% have their cover through a corporate scheme.

Figure 4: Cover arrangements



B2: Thinking about your private practice work, how do you currently arrange your cover? Base: All (1050)

Many HCPs found the process of obtaining their cover easy and straightforward, however, there were several HCPs who identified that the process was lengthy and laborious given the amount of documentation that was required by providers. One HCP compared the process to that of obtaining home or car insurance and felt that the process was easy despite the standard of bureaucracy expected when taking out insurance of any nature.

Many expressed a feeling of entrapment when it comes to choosing their cover, given that they are unable to practice without obtaining cover.

"Feels like we are at the mercy of the industry giving insurance because I cannot work without it."

Doctor, Regulated insurance

"The insurance company decides who can and cannot work as a doctor."

Ophthalmologist, Regulated insurance

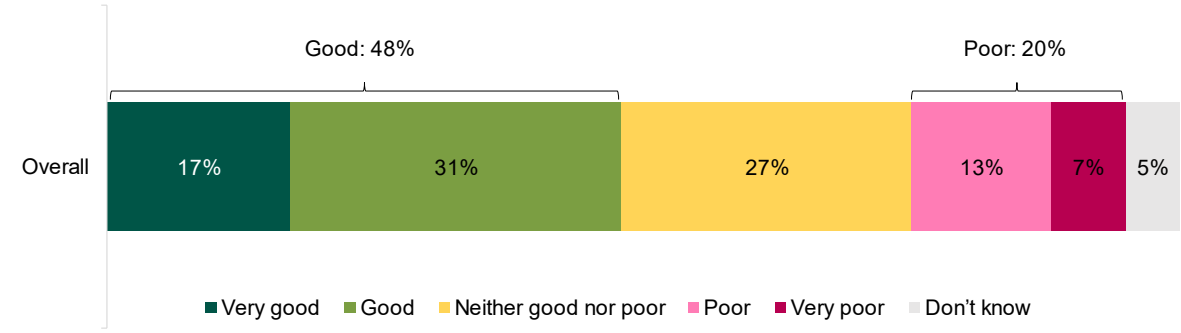
Understanding of cover

Whilst many of the HCPs surveyed reported a good understanding of their cover (48%), including a substantial minority who have a very good understanding (17%), a significant minority of HCPs we spoke to had a poor (13%) or very poor (7%) understanding of their cover.

Fewer than half of those with professional association cover claimed to have a good understanding (40%), significantly lower than those with individual cover (53%), corporate cover (64%) or practice cover (65%).

Those with regulated insurance were more likely to report a good understanding of their cover than those with discretionary indemnity (62% vs. 52%).

Figure 5: HCPs' understanding of their cover



B1: Overall, how would you rate your understanding of your discretionary indemnity and/or regulated insurance arrangements, and the types of products and policies available (e.g. claims made vs. occurrence, insurance caps/exclusions): Would you say it was? Base: All (1235)

In the qualitative interviews, most HCPs were introduced to indemnity cover arrangements at university, with most dentists reporting staying with the insurer they were introduced to at university.

Those who had an active involvement in obtaining cover – for example undertaking their own research online, speaking to providers and peers within the field - expressed a greater understanding of their cover.

"So my knowledge was through speaking to colleagues and then approaching these organisations."

Doctor, Regulated insurance

"*I found out about it at Medical School and have updated my knowledge about it ever since."*

Doctor, Discretionary indemnity

Some identified that the accessibility and clarity of information provided by their cover was hindered by the language used, particularly the prevalence of legal jargon.

"It's like all these insurances - with car insurance, house insurance, there's a lot of legalese around the terminology, its not really in plain English […] you don't actually know what you are covered for until you make that claim."

Ophthalmologist, Regulated Insurance

Frequency of review

The majority of HCPs (71%) review their cover annually, but one in five (21%) have never reviewed their cover. A very small proportion said they were not responsible for their indemnity arrangements (4%), while even fewer said they reviewed their arrangements every 2-5 years, every 2-6 months or as circumstances change (1% each).

Those with individual (84%) or practice cover (84%) are more likely to review it annually than those with corporate (56%) or professional association (50%) cover. They are also less likely to have never reviewed their cover than those with professional association cover (12% and 9% vs. 39%).

Despite having a greater understanding of their cover, those with regulated insurance are no more likely than those with discretionary indemnity to review their cover annually.

Most HCPs reported that they revisit their cover on renewal. Many felt that there was no need for revision as they ensured upon purchase that the policy was all encompassing for the nature of their work. Some HCPs reported having made minor changes to their policy throughout the year which included elements like changing the number of hours worked or the number of staff registered at the practice. Those who had made additions felt that the process was simple.

"It was very easy to add the staff on. It is really easy."

Dentist, Discretionary indemnity

Those who took an active approach to renewing their insurance tended to be those with a better understanding of their cover. Those who took a more passive approach to renewal tended to ascribe this to the restraints of their job namely time pressure and prioritisation of more important tasks. One HCP reported having taken a passive approach when looking at other providers as they felt the cover would not be too dissimilar to their existing cover.

"I didn't really look into it that much as I knew it would be similar cover to Dental Protection."

Dentist, Discretionary indemnity

Arranging and reviewing cover by profession

Doctors and dental professionals are more likely to hold individual cover (93% each vs 69% average), with very small numbers getting cover through membership of a professional association (both 5% respectively).

Doctors are more likely to feel their understanding of their cover is good (55% vs. 48% average) and almost nine in ten (88%) review their cover annually, more than dental professionals (80%), other professions (76%) or nurses (43%).

Meanwhile the understanding of dental professionals is in line with average (50% claimed a good understanding) but they are more likely to review cover annually (80% vs. 71% average).

Nurses are much more likely than other HCPs to arrange their cover through membership of a professional association (73% vs. 30% average). This means their direct engagement with their cover is low, with 38% having never reviewed their arrangements. In line with average, under half (46%) of nurses rated their understanding of their cover as good, with one in five (19%) rating it poor.

Other professions are a diverse group. In line with average, they are most likely to hold individual cover (69%) but just under one in three (31%) obtained cover through a professional association. They are slightly more likely than average to hold practice cover (14% vs 10%). Three quarters of other professionals (76%) review their cover annually – slightly above the average of 71% - but their understanding of their cover was in line with average (47% reporting a good understanding).

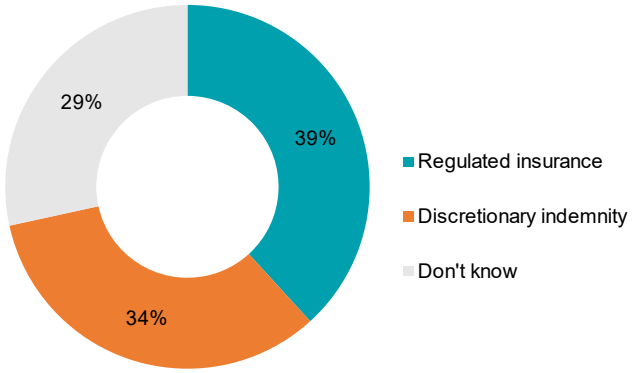
Type of cover

Over one third (34%) of HCPs in the research reported holding discretionary indemnity, slightly fewer than hold regulated insurance (39%). However, over a quarter of HCPs (29%) do not know what type of cover they hold.

Those with professional association cover are most likely not to know what type of cover they hold (41% vs 22% of those with individual cover and 12% of those with practice cover).

During quality assurance, a number of inconsistencies were identified in individuals' selection of their type of indemnity cover. No adjustments were made to account for these inconsistencies and the data presented in the report is as reported by survey participants.

Figure 6: Regulated insurance vs. Discretionary indemnity Cover

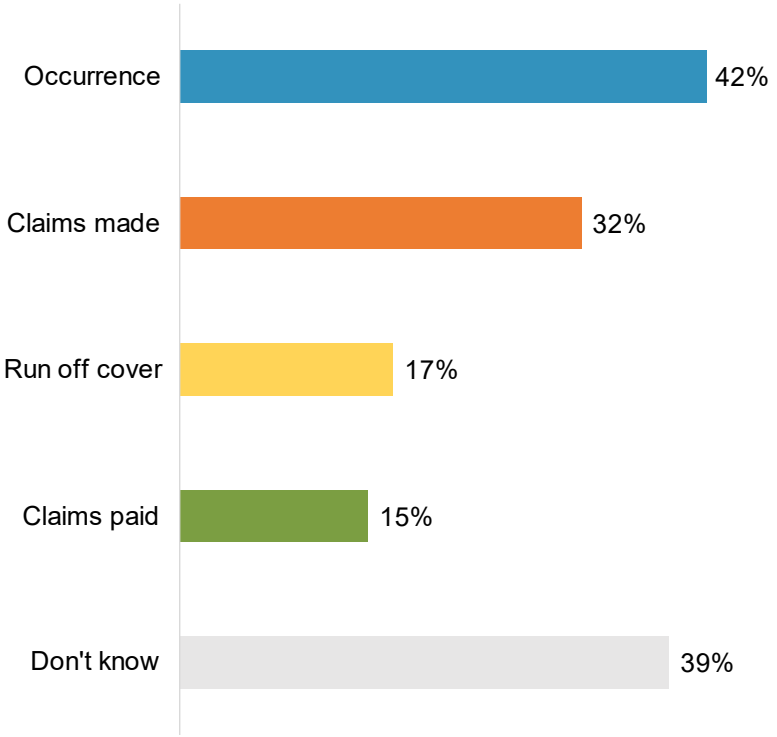


B3 Summary: Percentage who have regulated insurance vs. discretionary indemnity cover across arrangements. Base: All (1235)

HCPs most commonly hold occurrence cover (42%), claims made (32%), run off cover (17%) and claims paid (15%). However, there was again evidence of low understanding of cover types among HCPs, with two in five (39%) not knowing what elements are included in their private cover[1].

[1] The sum of the total responses here exceed 100% as this was a multi-response question, HCPs could provide more than one response, and responses were not mutually exclusive.

Figure 7: Type of private sector cover



B4 Summary: What type of private sector cover do you currently hold? Base: All (1235)

Those with regulated insurance are more likely to have claims made cover (42% vs 33% for discretionary indemnity) as well as run off cover (24% vs 16%).

Table 4: HCPs private sector indemnity coverage by type of cover

Type of Indemnity	Regulated insurance	Discretionary indemnity
Occurrence	52%	51%
Claims made	42%	33%
Run off cover	24%	16%
Claims paid	20%	17%
Don't know	27%	28%

* excludes those with >1%.

Those with professional association cover are more likely not to know what type of cover they hold than those with individual or practice cover (58% vs 30% and 25%).

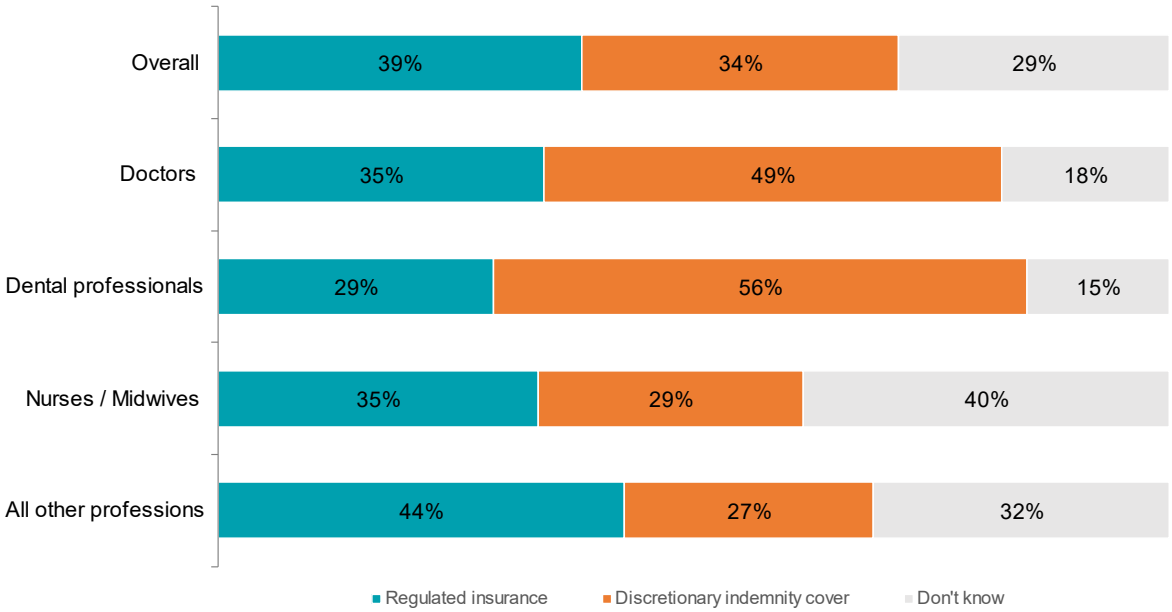
Type of cover by profession

Around a half of dental professionals (56%) and doctors (49%) reported that they hold discretionary indemnity, compared to less than one in three nurses (29%) or other professions (27%).

Other professions are more likely than doctors or dental professionals to hold regulated insurance (44% vs. 35% and 29% respectively).

Nurses are most likely not to know what type of cover they held (40%) - higher than doctors (18%) and dental professionals (15%) but broadly in line with other professions (32%).

Figure 8: Regulated insurance vs. Discretionary indemnity



B3 Summary: Percentage who have regulated insurance vs. discretionary indemnity cover across arrangements. Base: All HCPs (1235); Doctors (n=436), Dental professionals (n=309), Nurses and midwives (n=63), Other professionals (n=400)

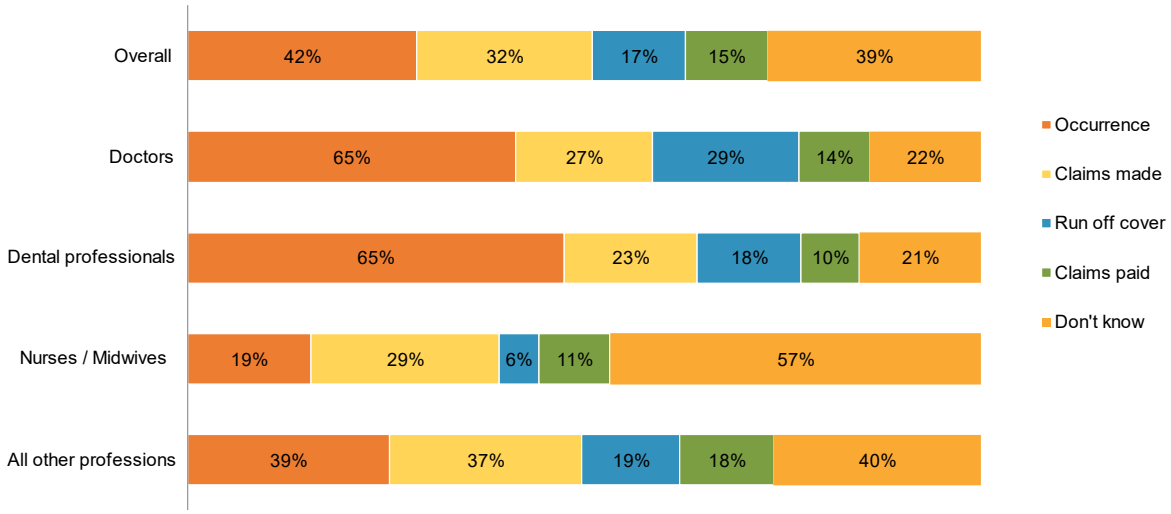
Almost two thirds of doctors and dental professionals (65% each) hold occurrence policies. This makes them more likely to do so than nurses (19%) and other professions (39%).

Doctors are also more likely to hold run off cover than other groups (29% vs. 19% other professions, 18% dental care, 6% nurses).

Other professions are more likely than doctors and dental professionals to have claims made policies (37% vs. 27% and 23% respectively) and more likely than dental professionals to have claims paid (18% vs. 10%).

Almost three in five nurses (57%) did not know what type of policy they hold.

Figure 9: Type of private cover policy split by profession



B4 Summary: What type of private sector cover do you currently hold? Base: All HCPs (1235); Doctors (n=436), Dental professionals (n=309), Nurses and midwives (n=63), Other professionals (n=400)

Doctors with regulated insurance are more likely than doctors with discretionary indemnity to have claims made cover (42% vs. 33%).

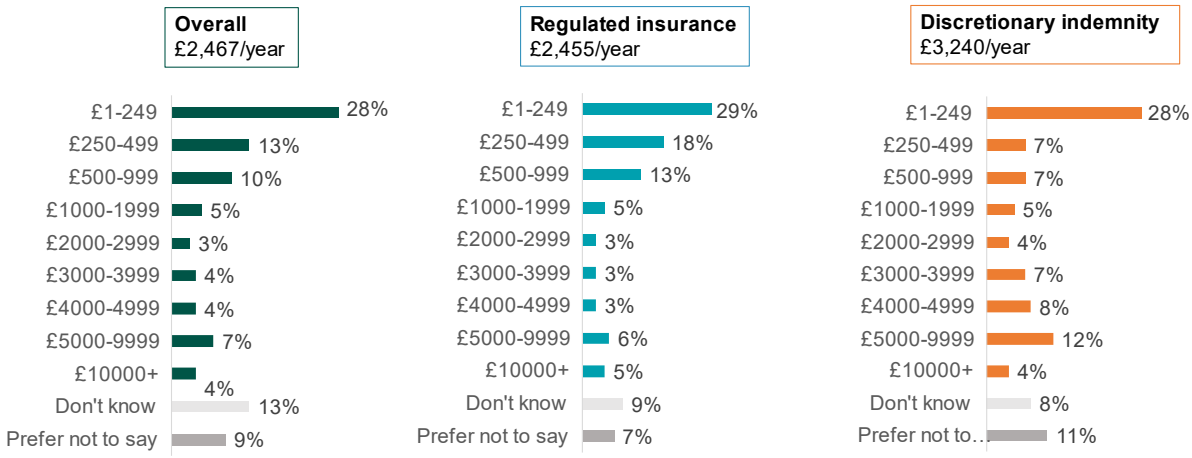
Premium costs

The majority of HCPs surveyed pay for their indemnity cover annually (52%), with just over a quarter (27%) paying monthly and the remainder unsure (13%) or unwilling to say (9%). Those with regulated insurance are more likely to pay annually (64%) than those who hold discretionary indemnity (52%).

Of those surveyed, HCPs on average pay £2,467 per year in premium costs for their clinical negligence cover, with a median value of £420.

Mean premium costs are higher for those with corporate cover (£4,482), individual cover (£3,007) or practice cover (£2,360) than for those with professional association cover (£840). The median values across the cover arrangements for HCPs are £1,390 for corporate cover, £698 for individual cover, £650 for practice cover and £312 for professional association cover.

Figure 10: Premium costs



B5 Annual Summary: How much do you pay for your subscription or premium costs for you discretionary indemnity cover or regulated insurance arrangements? Base: All (707)

In the qualitative interviews, some believed that the premiums they were paying were too high, based on an incorrect assessment of their risk profile, so they negotiated with insurers to bring down the costs.

"Historically there has been little choice in terms of insurance providers, and previously aesthetic surgeons were being charged fortunes."

Doctor, Discretionary indemnity

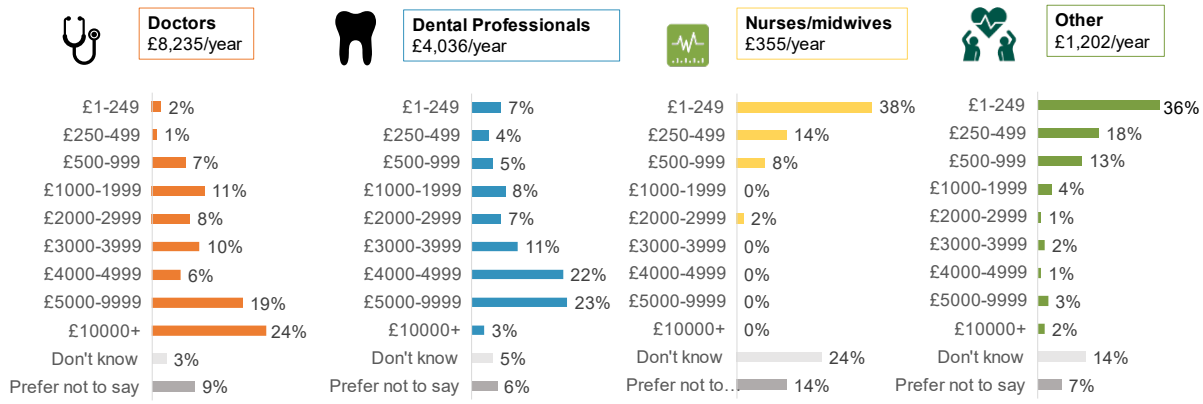
Premium costs by profession

Doctors, dental professionals and 'all other professions' are more likely to pay their premium costs annually than nurses / midwives (61%, 55% and 61% vs. 25%). Nurses and midwives are more likely to pay their premium costs monthly (41%), linked to the fact that they are more likely to hold cover through a professional association.

Doctors pay the highest premium costs on average and nurses the lowest. For doctors the mean of annual premium costs is £8,235, for dental professionals its £4,036, £355 for nurses / midwives and £1,202 for 'all other professions'. The median across professions is £4,800 for doctors, £4,000 for dental professions, £204 for nurses / midwives and £250 for 'all other professions'.

Just under a quarter (24%) of doctors pay more than £10,000 in annual premium costs compared to 3% of dental professionals, 0% of nurses and 2% of 'all other professions'.

Figure 11: Premium costs by profession



B5: How much do you pay for your subscription or premium costs for your discretionary indemnity cover or regulated insurance arrangements? Base: All HCPs (1235); Doctors (n=436), Dental professionals (n=309), Nurses and midwives (n=63), Other professionals (n=400)

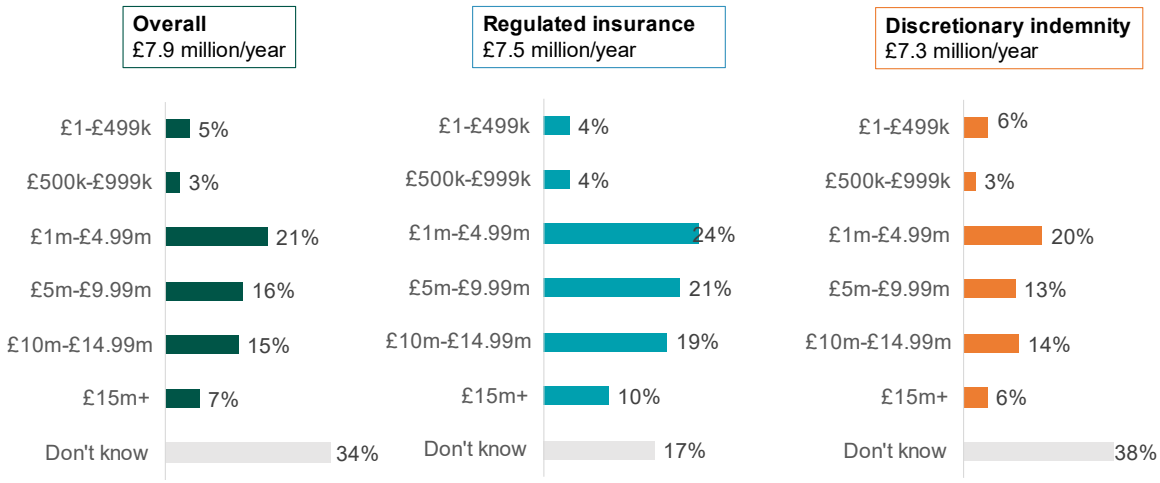
Cover value

The average value of indemnity cover held by those HCPs surveyed is £7.9 million, with a median value of £5 million. Small proportions have cover of less than £1 million (8%) or over £15 million (7%) with a relatively even spread between these extremes: 21% covered for £1-5m, 16% for £5-10m and 15% for £10-15m. Limited knowledge is again a factor, with a third (34%) of HCPs not knowing the value of their cover.

The average value of cover for those that hold corporate cover (£15.3 million) and practice cover (£13.2 million) is higher than the average cover held by those that have professional association (£9.2 million) or individual cover (£6.7 million).

Those with regulated insurance had the highest level of cover, with a mean cover value of £7.5 million, against the mean cover value of £7.3 million for those with discretionary indemnity and £5.7 million for those who didn't know what type of cover they hold.

Figure 12: Cover value



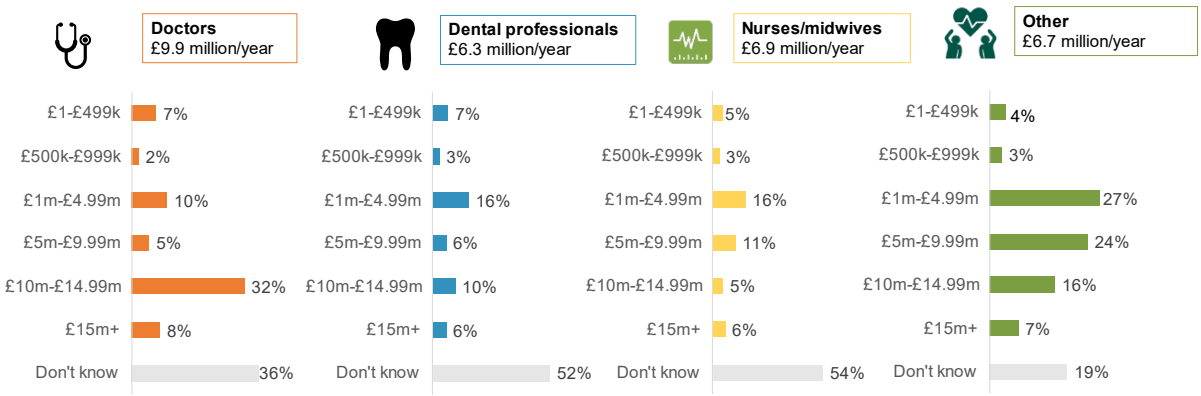
B6/B7 Summary: For the current year, what is the value of the cover provided by your discretionary indemnity cover or regulated insurance provider? Base: All HCPs (1235); Doctors (n=436), Dental professionals (n=309), Nurses (n=63), Other professionals (n=400)

Cover value by profession

Across professions the level of cover varied:

- Doctors on average had the highest level of cover, with a mean of £9.9 million and median value of cover of £10 million;
- 'All other professions' had a mean of £6.7 million and a median of £5 million;
- Dental professionals had a mean of £6.3 million and a median of £3 million; and
- Nurses and midwives had a mean of £6.9 million and a median of £3 million.

Figure 13: Cover value by profession



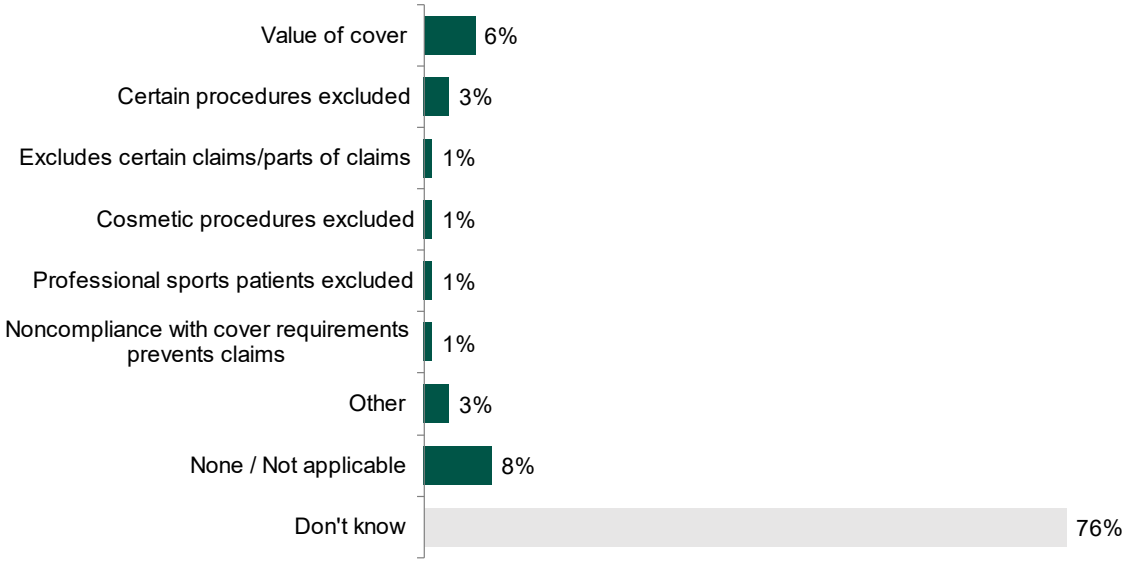
B6/B7: For the current year, what is the value of the cover provided by your discretionary indemnity or regulated insurance provider? Base: All HCPs (1235); Doctors (n=436), Dental professionals (n=309), Nurses and midwives (n=63), Other professionals (n=400)

*The above figure is based on the responses of those HCPs who took part in the survey and may not provide an accurate representation across all indemnity policies.

Policy limitations

Most surveyed HCPs (76%) didn't know what the limitations of their policy are, and a significant minority (8%), including both regulated insurance and discretionary indemnity holders, stated that they do not think they have any. Limitations of their cover that were raised HCPs were; the value of their cover (6%), that certain procedures are excluded (3%), that the cover excludes certain claims (1%), that cosmetic procedures are excluded (1%) and that professional sports patients are excluded (1%).

Figure 14: Policy limitations



B7a: What are the limitations of your cover (if anything)? Base: All (1235)
NB. Categories of <1% are not charted.

When looking at the limitations of their cover, doctors (18%) are more likely to think there are no limitations to their cover than dental professionals, 'all other professions' or nurses and midwives (18% v. 12%, 6% and 3% respectively).

Nurses and midwives surveyed were more likely not to know what the limitations of their cover are, over three quarters (83%) of whom said so, against around two thirds of doctors (62%), dental professionals (70%) and three quarters of 'all other professions' (77%).

Dental professionals are more likely to experience a limit on workloads/hours worked (3% vs 0% for doctors, nurses and midwives or 'all other professions'). Doctors and nurses and midwives are more likely than 'all other professions' to have certain procedures excluded (6% and 8% vs 2%). The exclusion of cosmetic procedures is more likely to be a limitation for dental professionals (3%) and doctors (1%) than nurses and 'all other professions' (0%). Doctors and dental professionals are also more likely to express that the limitation of the cover is that it is discretionary than 'all other professions' (1% and 2% vs 0%).

Doctors with discretionary indemnity are more likely not to know limitations of their cover than doctors with regulated insurance (63% vs 52%).

In the qualitative interviews, most HCPs reported that their cover did not have any impact on the way in which they practice. This was largely attributed to taking out cover that fully encompassed the nature of their practice.

Current provider

As discussed earlier in this chapter, over one third (34%) of HCPs in the research reported holding discretionary indemnity, slightly fewer than hold regulated insurance (39%), and over a quarter of HCPs (29%) do not know what type of cover they hold. Given the relatively high level of uncertainty around cover type, we checked what HCPs told us about their type of cover against the name(s) of their provider.

The providers of clinical negligence cover that doctors reported currently using were most commonly the large medical defence organisations (MDOs) in the UK, namely the Medical / Dental Protection Society, the Medical / Dental Defence Union and the Medical and Dental Defence Union of Scotland (MDDUS).

Dentists predominantly utilised these same large MDOs. However, 7% did receive their clinical negligence cover through the British Dental Association (BDA) who offer only regulated insurance.

In contrast, more than a third (38%) of nurses and midwives had the Royal College of Nursing (RCN) as their provider, receiving their clinical negligence cover in the form of discretionary indemnity as part of membership of that association.

For 'all other professions' providers of regulated insurance were more common as well as professional associations like the Association of Optometrists (6%) and Pharmacist Defence Association (6%).

Using knowledge of what type of cover each provider offers, we can estimate that, in fact, almost half (47%) of HCPs hold regulated insurance and just over a quarter (27%) hold discretionary indemnity, with the remainder unsure or preferring not to say. To note, due to the weighting we have applied to the calculation to enable the survey sample to be representative of the total HCP population, these overall figures (compared to the responses breakdown below) have been heavily influenced by the high percentage of 'all other professions' in the HCP population as a whole[1].

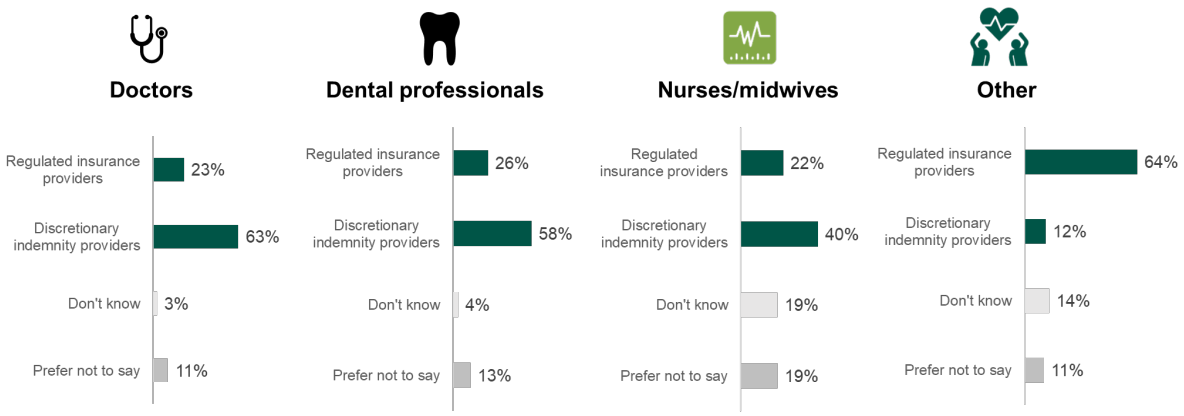
When looking across HCP professions we can see that doctors (63%), dental professionals (58%) and nurses and midwives (40%) were all more likely to mention discretionary indemnity providers when discussing their current providers than 'all other professions' (6%). Doctors and dental professionals were also more likely to mention discretionary indemnity providers than nurses and midwives, who were more likely to be unsure of their provider.

Conversely, 'all other professions' (64%) were more likely than doctors (23%), nurses and midwives (22%) and dental professionals (26%) to mention having regulated insurance providers as their current provider.

Please note that the rest of the report uses the information on cover type given directly by HCPs with no adjustments made to 'correct' for inaccuracies.

[1] 53% of all HCPs are 'all other professions' compared to 11% doctors, 21% nurses and midwives and 15% dental professionals.

Figure 15: Current provider type by profession

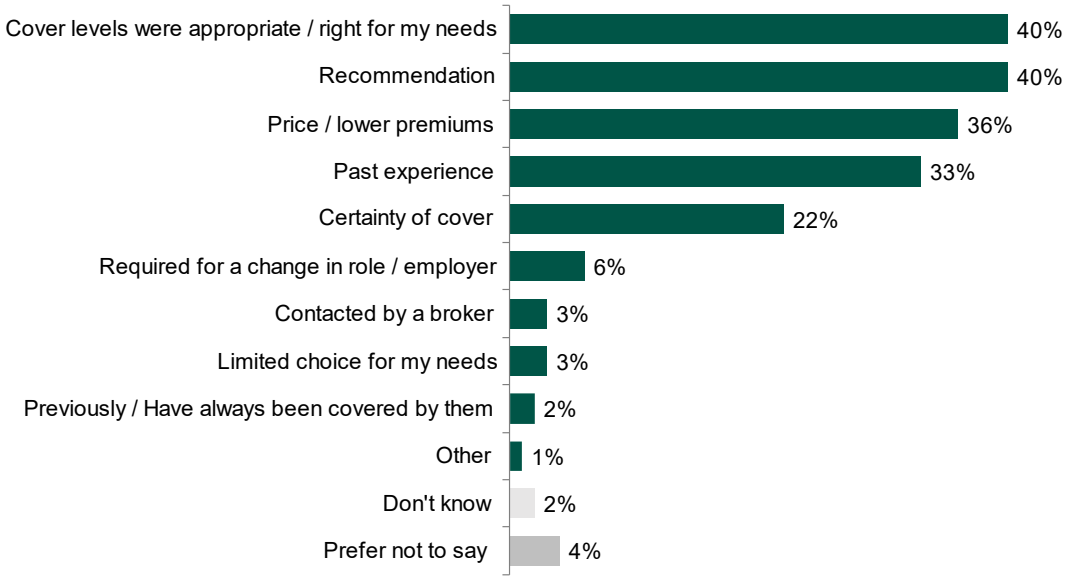


B8: Who is your current provider? Base: All HCPs (1235); Doctors (n=436), Dental professionals (n=309), Nurses and midwives (n=63), Other professionals (n=400).

Reason for selecting provider for individual cover

The majority of HCPs with individual cover are driven by satisfaction with cover levels (40%) and price (36%) when selecting their indemnity provider. The other reasons discussed by HCPs were based on a recommendation (40%), because of past experience (33%), the certainty of cover (22%) and that it was required for a change in role/employer (6%).

Figure 16: Reason for selecting provider for individual cover



B9 Summary: What were your reasons for selecting your current discretionary indemnity cover or regulated insurance provider? Base: HCP who have arranged cover themselves (983)

Those with regulated insurance are more likely to select their provider because cover levels were appropriate than those with discretionary indemnity or those that don't know what type of cover they hold (50% vs 35% and 29%).

There are few differences by profession in terms of reasons for selecting provider. However, dental professionals are less likely than doctors, nurses and other professionals to have chosen on the basis of cover levels being appropriate (33% vs. 42% vs. 41% and 44%) and less likely to have been contacted by a broker than doctors (2% vs. 6%).

Doctors and dental professionals are more likely to be driven by price/lower premiums than 'all other professions' (48% and 43% vs 28%) and this was the same for certainty of cover (30% and 28% vs 19%).

Doctors are also more likely to be driven by past experiences than 'all other professions' (42% vs 31%).

As mentioned earlier in this report, many HCPs were introduced to indemnity cover at university, and some chose to stay with the insurer they were introduced to at university (particularly dentists).

For most HCPs, the most important aspect when choosing an insurance provider was ensuring that their insurance was all encompassing.

"The cover meets the scope of my practice."

Doctor, Discretionary indemnity

"I know my limitation in terms of what kind of work I can provide, and I cannot and based on that I took out the coverage accordingly."

Ophthalmologist, Regulated insurance

However, for some HCPs, they reported that cost was the most important element when selecting a provider.

"Tended to look at how much the insurance was going to cost me per month or per year rather than what they were actually going to cover."

Ophthalmologist, Regulated insurance

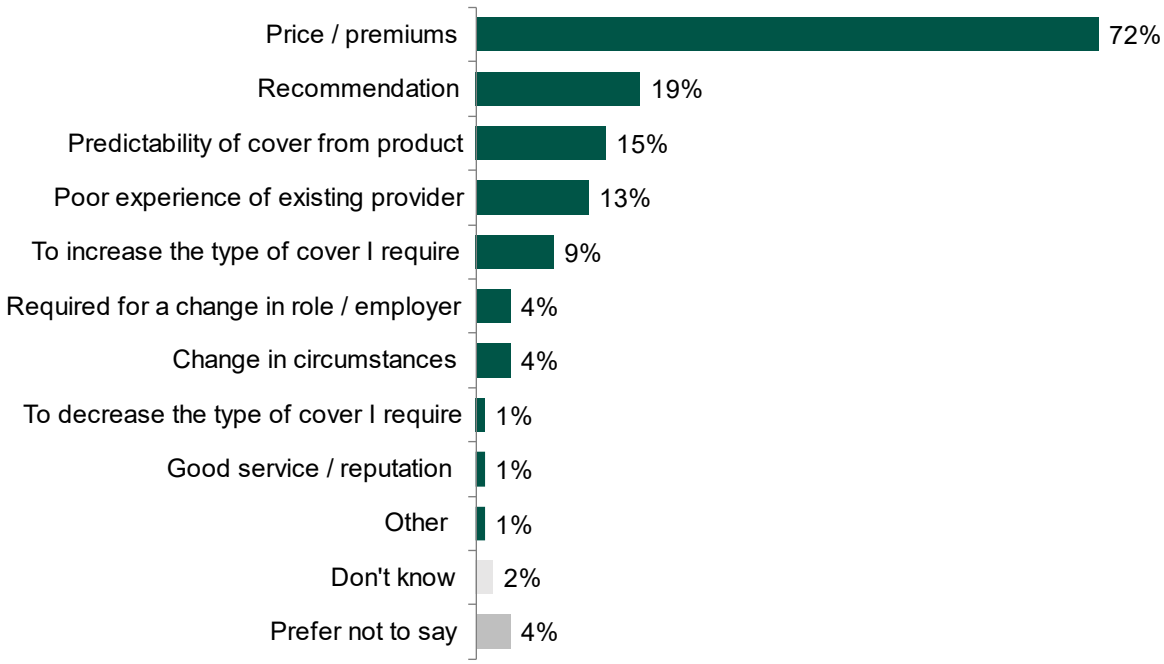
Switching providers

More have thought about switching from discretionary indemnity to regulated insurance (36%) than vice versa (22%).

The type of cover and how HCPs arrange their cover plays no significant role in determining the relative importance of reasons for switching providers.

Price is key in considering switching, with the cost of premiums being a key reason for almost three quarters (72%) of those who have considered switching providers. Just under a fifth (19%) are considering switching providers based on recommendations, 15% to ensure predictability of cover from their provider and 13% because of a poor experience with their existing provider.

Figure 17: Reasons for considering switching provider



B11: Why have you considered switching provider? Base: All HCPs who considered switching provider (271)

For those who have considered switching their provider, price is a more important reason for switching providers for 'all other professions' than for dental professionals (80% vs 64%).

The predictability of cover from their indemnity product is more important as a reason for switching providers to doctors and dental professionals than for 'all other professions' (21% and 27% vs 5%).

Where HCPs had had a claim made against them, their experience with their provider was critical in terms of deciding whether to stick with them or switch to a competitor. For those who faced no difficulties, most respondents reported no desire to change from their current provider.

"If anything it's made me stick with [provider] more because they were so good."

Doctor, Regulated insurance

"All those problems are hazards of practice but actually changing provider would be the silliest thing to do."

Doctor, Discretionary indemnity

Whereas, for those individuals who faced difficulties, some expressed a desire to change or update their cover on the grounds of their experience with the provider. One HCP who experienced a denied claim, changed provider due to their claims experience, which they felt was unsatisfactory.

"Even though it goes nowhere because six months later they decide you are right, it's got nothing to do with you […] nonetheless I am out of pocket a huge amount of money because they wouldn't cover me."

Ophthalmologist, Regulated insurance

4 Claims and contacting their provider

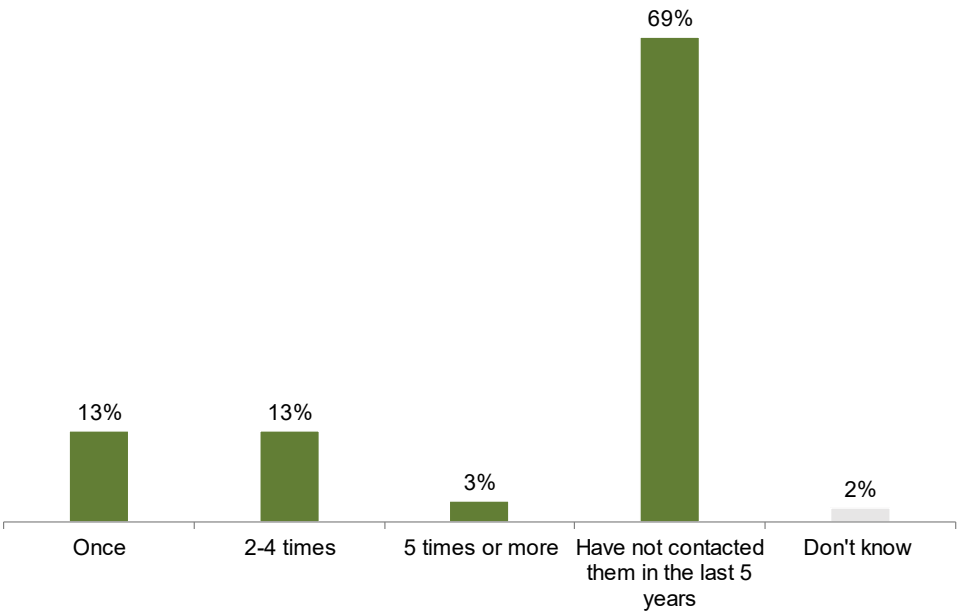
This chapter covers how frequently HCPs have contacted their indemnity provider, their experience of claims, the damages awarded for those that have claims made against them, whether they experienced any difficulties with the claim, the value of any refused claims and steps taken after a claim was refused.

Contacting their provider

Most professionals (69%) have not spoken to their provider about matters other than clinical negligence claims in the last 5 years, with 13% having spoken to them once, 13% having spoken to them between 2-4 times and 3% having spoken to them 5 times or more (at least once a year on average).

Dental professionals are the group most frequently contacting their provider: over one in ten (12%) had done so 5 times or more in the last 5 years, compared to smaller proportions of doctors (5%), nurses and midwives (2%) and other professionals (1%). Dental professionals are also the group most likely to have contacted their provider at all. Only 31% of dental professionals had *not* contacted their provider in the last 5 years, compared to over half (53%) of doctors and to over three quarters of other professionals (76%) and nurses and midwives (86%).

Figure 18: Contacting their provider in the last 5 years for matters unrelated to clinical negligence claims



C1: How many times have you contacted your discretionary indemnity or regulated insurance provider in the last 5 years for matters other than regarding a clinical negligence claim? Base: All HCPs (1235)

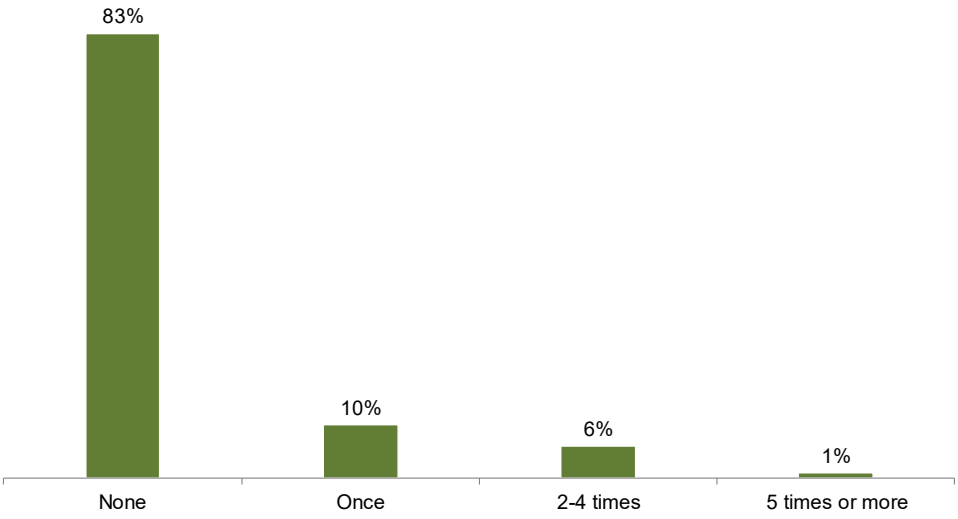
Those with regulated insurance are more likely not to have contacted their provider in 5 years than those with discretionary indemnity (69% vs 58%). Perhaps unsurprisingly, HCPs who don't know their type of cover are the most likely not to have contacted their provider within 5 years (79%).

Also those who have professional association cover are more likely than those who hold individual or practice cover to have not contacted them over the last 5 years (79% vs 62% and 51% respectively).

Experience of claims

The majority of HCPs (83%) have never had a claim made against them, with one in ten (10%) having experienced one claim and just 7% having experienced more than one claim made against them.

Figure 19: Experience of clinical negligence claims



C2: How many, if any, clinical negligence claims have ever been made against you? Base: All HCPs (1235)

Those HCPs with professional association cover are more likely than those with individual cover or practice cover to have never had a claim made against them (93% vs 78% and 82% respectively).

Those who don't know what type of cover they hold are also more likely to have never had a claim made against them, more than nine in ten (91%) of whom said so, compared to more than three quarters of those regulated insurance (82%) or those with discretionary indemnity (78%).

Nurses and midwives and 'all other professions' are the least likely to have experienced claims with over nine in ten (94% and 92% respectively) never having had a claim made against them, compared to 70% of doctors and 50% of dental professionals.

Dental professionals are more likely to have had claims made against them than doctors, nurses and midwives or 'all other professions' with 50% having had one or more claims made against them, compared to 30% of doctors, 6% of nurses and 8% of 'all other professions'.

In the qualitative interviews, most HCPs recalled similar processes in terms of being made aware of a claim made against them. The process is as follows: the patient files the claim, the HCP receives a notice of their claim and immediately informs their insurer of the claim.

"My first port of call would be to make contact with Dental Protection, and they would advise as to what to do next."

Dentist, Discretionary indemnity

Of those who reported challenges with the claims process, most HCPs reported that the communications between different entities was poor. Some struggled to get in touch with their insurers on a regular basis and other cases were complicated by the different systems of different providers who did not communicate effectively with one another when responding to claim which affected several HCPs.

"The only difficulty we had was that some of the respondents had cover with different organisations that approached things in different ways. "

Dentist, Discretionary indemnity

Many respondents felt ostracised from the process and felt that the lack of communication added to the stress and emotional toll of the situation. In addition, several HCPs reported that they were not informed of the outcome of the claim against them.

"Their communication skills… they don't understand clearly what effect it is having on a clinician… it is an anxious time, and it is very very upsetting and emotionally charged."

Osteopath, Regulated insurance

Another HCP also expressed that the process itself is lengthy, alongside communication issues, and that this further heightened the emotional intensity of the entire process.

"I think that was the main challenge, emotional stress and the exhaustion of going through all the bits and bobs of the process really."

Ophthalmologist, Regulated insurance

Many felt that the way in which indemnifiers made the decision to provide cover and/or whether to fight the claim was a commercial one. Some felt that their professional opinion was often ignored in favour of commercial interests. The extensive patient notes required of HCPs were not deemed satisfactory to insurers and some felt had no implications on the outcome of the claim.

"Whatever you write in your notes is never enough, if someone decides they want to sue you.. it's demoralising."

Dentist, Discretionary indemnity

"Having to defend my own actions… whereas my indemnifier was more keen on settling and just accepting liability for it"

Dentist, Discretionary indemnity

One of those interviewed expressed their experience of making an ongoing claim with her previous provider and felt that they were treated with secondary importance and largely ignored when it came to communications with their previous provider.

"Despite paying £9,000 pounds a year, when push comes to shove, you are left feeling on your own and cannot get through to anyone"

Doctor, Discretionary indemnity

Another individual who experienced a denied claim, report being audited by their insurer prior to the insurer confirming whether they would cover the claim, which was frustrating when it did not result in the claim being covered.

"In the meantime, they want a breakdown of what you've earnt in the year so they can do an audit"

Doctor, Regulated insurance

Some expressed that the nature of the claims process has made them practise a more defensive style of medicine due to the costs and implications of claims made against them. This has an impact for patients who might find it harder to access riskier treatments.

"I have now decided not to treat anyone under 18 for fear that they could sue me for a treatment they say has damaged them."

Osteopath, Regulated insurance

"There are hidden costs in the health systems. Doctors are less likely to offer you a treatment that you might need because it comes with a risk […] You are less likely to be sued for not doing something then you are for doing something."

Ophthalmologist, Regulated insurance

The attitudes of HCPs towards having had claims made against them differed, some felt that it was part and parcel of the role and that nowadays you should expect to have claims made against you.

"You basically have to accept as a doctor these days that you are going to be sued."

Doctor, Regulated insurance

Others felt that regardless, having had a claim made against them had an emotional toll and saw them questioning their ability to do their job where they believed they were liable or not.

"It made me really reflect on how well I was doing the job and questioned myself and also question how well I'd communicated with their patient."

Dentist, Discretionary indemnity

"I was very sad that something I'd done had not gone well."

Doctor, Regulated insurance

Many participants highlighted the impact that having had a claim made against them had on their life. Some expressed that having their ability to do their job questioned made the situation very emotionally charged.

"Obviously it's upsetting when all I try and do is my best for people"

Dentist, Discretionary indemnity

"It is a hurtful process… you are treating people and then they come back in your face and say you damaged me… it is a very emotionally charged upsetting process"

Osteopath, Regulated insurance

Other HCPs reported that the implications of having a claim made against them spilled over into their personal life in a negative manner.

"It also spills over into your personal life at home and my partner could see that I am very worried about it and they are obviously concerned."

Dentist, Discretionary indemnity

"It's quite overwhelming and I am sure I went through a phase where it does affect you and you are not the person you otherwise would be."

Dentist, Regulated insurance

One reported that trying to clear their name overtook their free time, and they spent the majority of their time communicating with solicitors rather than spending time with their family.

Damages awarded

Almost half of HCPs (43%) reported having had a claim or claims made against them which resulted in damages being awarded to a claimant:

- 30% had one claim made against them resulting in damages awarded;
- 12% had 2-4 such claims;
- 1% had 5 or more claims made against them where damages were awarded.

Doctors and dental professionals are more likely to have had more than one case against them resulting in damages being paid. Almost a sixth (14%) of doctors and a fifth (19%) of dental professionals who have had clinical negligence claims brought against them, have had damages paid for 2-4 of these claims, against 0% of nurses or 'all other professions'.

The average pay-out for those claims that resulted in damages was £26,216 and a median pay-out of £13,000.

The average pay-out of damages awarded for the most recent settled clinical negligence claim was considerably larger for doctors at £48,710, than for dental professionals who had an average pay-out of £16,885. There are no significant differences in the average rate of pay-out across the types of cover HCPs hold or how they arrange that cover.

The legal costs HCPs faced arising from defending their clinical negligence claims were on average £17,967, with a median cost of £7,500. There are no significant differences for the legal costs involved across profession, the type of cover they hold or how they arrange their cover.

Disputed claims

More than one in ten HCPs (15%) who have had a claim made against them have had difficulties with determining responsibilities for covering costs against just over three quarters (76%) of HCPs who have not experienced difficulties.

Doctors are more likely not to experience difficulties determining who was responsible for covering the costs associated with the claim than dental professionals (84% vs 74%) and dental professionals are more likely to experience difficulties than 'all other professions' (18% vs 3%).

There are no significant differences by type of cover held.

Around one in twenty HCPs (6%) who have had clinical negligence claims made against them have had a provider refuse to cover the claim.[1]

There are no significant differences across professions or type of cover (regulated insurance vs. discretionary indemnity) in terms of whether HCPs have had providers refuse to provide cover.

Reasons given for providers refusing to cover a claim

Due to a small base size (n=25) the findings from those who have had a claim refused will be reported qualitatively. The reasons given for providers refusing to cover a claim were that:

- Conditions imposed by the cover have not been met (n=4);
- Claim occurred while doing work beyond remit included in cover (n=3);
- Claim was not notified within the period required by the relevant policy or terms of membership (n=2);
- Claim occurred because the nature of the work differed to that included in the cover (n=2); and
- Decided to pay/pay additional costs out of pocket (n=2).

In addition, some of those who have had a claim refused were not provided with a reason for the refusal by their provider (n=5).

The breakdown by type of cover is shown in the table below. Due to the small base sizes, any patterns between different cover types can only be indicative.

Table 5: Breakdown of reasons for HCPs providers refusing to cover a claim

Reasons given for providers refusing to pay	Discretionary indemnity	Regulated insurance	Don't know
Conditions imposed by the cover have not been met	3	1	0
Claim occurred while doing work beyond remit included in cover	1	1	1

[1] There was an effective sample size of 191 healthcare professionals answering the question on whether their provider has ever refused to provide cover for the costs associated with a claim. For this sample size, we can be 95% confident that the 'real' figure (taking account of possible sampling effects) is between 2.6% and 9.4%.

Claim was not notified within the period required by the relevant policy or terms of membership	2	0	0
Claim occurred because the nature of the work differed to that included in the cover	0	1	1
Decided to pay/pay additional costs out of pocket	0	0	2
No cover in place at the time of the incident	0	0	0
Other	0	1	0
Not provided with a reason	2	3	0
Prefer not to say	2	3	1
Total	**10**	**10**	**5**

One of those interviewed expressed their frustrations that their insurer had denied the claim as it was not a medical negligence claim, it instead fell under the Sale of Goods Act as the claim was to do with the equipment rather than the work they carried out. Eventually, the insurer determined it was nothing to do with the individual as a professional and discontinued the claim but at this point the individual had paid thousands of pounds in legal fees.

Value of claim refused

The value of the claims refused were usually £25k or less (reflecting the value of claims made overall) (n=12) or between £25,001-£100,000 (n=4) and between £100,000-£250,000 (n=2). A group of HCPs said that they didn't know the approximate value of claim refused (n=7).

The table below outlines the value of refused claims across cover type.

Table 6: Breakdown of the value of clinical negligence claims refused across cover type

Approximate value of the clinical negligence claim refused	Discretionary indemnity	Regulated insurance	Those who don't know their indemnity arrangements
£1 - £25,000	6	3	3
£25,001 - £100,000	1	3	0
£100,000 - £250,000	1	1	0
£250,000 - £500,000	0	0	0
£500,000 - £1mil	0	0	0
£1mil - £3.5mil	0	0	0
£3.5mil+	0	0	0
Don't know	2	3	2
Prefer not to say	0	0	0

Total	**10**	**10**	**5**

Steps taken after refused claim

After having their clinical negligence claim refused, HCPs said that they:

- appealed (n=9);
- changed provider (n=5);
- paid out of pocket (n=3); or
- took other steps (n=1).

Similarly a group of HCPs across all types of cover said they didn't know what steps they took (n=5), indicating that their claims might have been some time ago.

The table below outlines the steps taken after refused claim across cover type.

Table 7: Breakdown of the steps taken after clinical negligence claims were refused across cover type

Steps taken after the clinical negligence claim was refused	Discretionary indemnity	Regulated insurance	Those who don't know their indemnity arrangements
Appealed	4	4	1
Changed provider	1	3	1
Paid out of pocket	1	1	1
Something else	1	0	0
Don't know	2	2	1
Prefer not to say	1	0	1
Total	**10**	**10**	**5**

Outcome of refused claim

The final outcome of the refused claims was predominately:

- Claim was unsuccessful/Did not proceed (n=5);
- Paid out of pocket/defended myself (n=5);
- Claim was settled (n=4);
- Claim is ongoing (n=3); or
- That the HCP was not covered (n=3).

Similarly a group of HCPs across all types of cover said they didn't know what the final outcome of the claim was (n=4). The breakdown by cover type is shown below.

Table 8: Breakdown of final outcomes of refused clinical negligence claims across cover type

Steps taken after the clinical negligence claim was refused	Discretionary indemnity	Regulated insurance	Those who don't know their indemnity arrangements
Claim was unsuccessful/Did not proceed	2	3	0
Paid out of pocket/defended myself	1	2	2
Claim was settled	1	2	1
Claim is ongoing	2	0	1
That the HCP was not covered	1	2	0
Other	1	0	0
Don't know	2	1	1
Prefer not to say	0	0	0
Total	**10**	**10**	**5**

One HCP who reported having a claim refused reported studying for a Postgraduate degree in Law in order to better understand, what they described, as the rules of the game. They felt that this gave them an insight into the process from a legal perspective.

"It gave me a better idea of how the lawyers might work."

Ophthalmologist, Regulated insurance

5 Views of improvements

This chapter covers HCPs' views on improvements to the claims process, including training / guidance, perceptions of a possible compensation safety net for criminal acts and other improvements.

Training / guidance

Some HCPs interviewed as part of the qualitative phase had previously received training on indemnity arrangements from providers, employers or professional organisations. However, such training was not universal, with some HCPs relying on personal experience or that of their peers for their understanding of indemnity arrangements.

Most felt that training would be beneficial to all HCPs and that it would be a good idea to make such training mandatory because of the importance of understanding your cover arrangements to safe practising. A few HCPs suggested that training on indemnity arrangements would be more beneficial than existing mandatory training on other topics.

"It's essential to safe practicing, it's a requirement so therefore you should have full knowledge of the ins and outs and what you are paying for really."

Doctor, Discretionary indemnity

Training on policy limitations and the legal aspects of clinical negligence claims was raised by a group of HCPs who acknowledged their limited understanding of these areas. They also highlighted that they felt less able to teach themselves these elements and therefore that they would benefit from training or guidance.

HCPs felt that the delivery of this training would require a hybrid approach. They discussed wanting courses of different lengths so as to enable HCPs to participate in longer training if they have the time but also offer more bitesize elements as an alternative if they don't. HCPs also discussed the potential benefits of the training reflecting the complete claims process from start to finish

"Certainly from the point of view of time, economy webinars would be helpful, but I think a Q&A thing is really helpful."

Doctor, Discretionary indemnity

"I think a webinar would work for me… an hour would work if the person knew their stuff and is able to give advice."

Dentist, Discretionary indemnity

"Multifunctional, you can do online training like you do for everything else […] but also small groups training with realistic cases are also very useful so you can discuss your experience."

Ophthalmologist, Regulated insurance

Some HCPs called for greater transparency throughout the entire claims process, which they felt would help improve the system. Those HCPs felt that it would be of significant benefit to them for indemnity providers to publish data on what cases have had claims for, what types of claims are

rejected, and the amounts paid out for those claims. This would help to improve HCPs' awareness and understanding of the system and inform their own cover arrangements.

"Doctors have to give insurance companies bank details and earnings but there is no requirement on insurance companies to publish any data whatsoever on how much they paid out, how much profit they are making on this."

Ophthalmologist, Regulated insurance

Compensation safety net for criminal acts

One of the potential solutions being explored by DHSC is the introduction of a compensation safety net for criminal acts. Such a safety net would ensure that patients can be compensated for harm arising from criminal or intentional acts or omissions in the context of clinical care.

When asked whether the system needs a safety net to cover compensation for personal injuries resulting from criminal acts some HCPs felt that this did not actually deal directly with the issues they faced and that instead that there needs to be two separate processes for clinical negligence claims and those deemed criminal.

Whilst HCPs approved of those guilty of criminal offences being held to account, many felt that these cases were few and far between and fell under the scope of the criminal justice system.

"Criminal negligence in the medical profession is quite rare."

Doctor, Regulated insurance

"Criminal cases aren't what the system should be for, they should go through the [criminal] courts."

Ophthalmologist, Regulated insurance

Other HCPs expressed apprehensiveness about the implementation of a compensation safety net and outlined how the targeting of criminal acts specifically does not address the root of the problem for patients and could cause significant challenges for HCPs.

"I feel you could run into real problems because I would contend that 99% of medical accidents, they are not criminal and therefore would not be covered by an act of that sort."

Dentist, Discretionary indemnity

Some HCPs felt that it would encourage patients to make baseless claims. They further expressed that any kind of compensation mechanism should require all cases to be properly investigated rather than just paying out to patients regardless of the validity of their claim.

"My worry about that is that it would be an open cheque book for patients to speculatively claim without the claims being investigated and there would be no chance for doctors who haven't actually been negligent to exonerate themselves and clear their name."

Doctor, Discretionary indemnity

In terms of funding such a safety net, where they were able to comment, HCPs suggested that it should be funded out of the public purse, either by DHSC or the NHS.

Other improvements to the claims process

Respondents expressed a range of views about the claims process and made a number of suggestions as to how it could be changed.

Some HCPs instead suggested that to tackle clinical negligence claims, a no-fault compensation route would be the most suitable. One respondent felt that a no-fault compensation model would *"remove the adversarial nature of things".*

It is not criminal acts that are the problem, there needs to be no fault compensation for people that have suffered harm."

Doctor, Regulated insurance

However, this was not universally supported, and one HCP expressed reservations about introducing a no-fault compensation route.

"I want to express in the strongest possible view that a no-fault compensation fund would be very very damaging to healthcare and medical practitioners. It would not help with retention of medical practitioners in this country, it would not help them feel supported. It would be one of the most damaging steps that this government or the health system could take. "

Doctor, Discretionary indemnity

The introduction of arbitration processes to clinical negligence claims was another potential solution suggested by some HCPs, which was thought to better balance the needs of both HCPs and patients.

"[The process should] go through an expert board. They should balance the views of the patients, lawyers and doctors […] It comes to a board early on, there's some sort of arbitration and you come to a reasonable conclusion."

Ophthalmologist, Regulated insurance

HCPs outlined a belief that no win no fee lawyers were contributing to instability in the system through encouraging claims to be made without legal basis. Some HCPs felt that they encouraged patients to make baseless claims as they had little invested in the outcome, with a few suggesting that a small number of clinical negligence claims are speculative. Some HCPs felt that this has led to a current system that benefits those lawyers more than either patients or HCPs.

One HCP expressed an opinion that patients themselves are unaware of the potentially unfavourable terms and conditions of no win no fee lawyers and felt that the legal fees are often disproportionate to compensation. They gave the example of a recent case where the compensation won amounted to £121,000, of which £94,000 went to the lawyers. They felt that even from an HCP perspective, if an error has been made then they would rather the money go to the patient than the lawyers.

"I think that all no win no fee lawyers should be banned to be honest because they throw a spanner in to the system and they abuse the system."

Ophthalmologist, Regulated insurance

6 Technical Appendix

This appendix provides more detail on research approach including information on cognitive interviewing, pilot fieldwork, sampling, weighting, quality control processes and profiles of achieved interviews.

Cognitive testing

Ahead of launching pilot fieldwork, IFF carried out cognitive interviews with 20 healthcare professionals. Fieldwork took place between 12th-28th July 2022 and sample was provided by a panel that specialises in medical and healthcare recruitment.

Respondents were asked to complete the survey 'as live' over video call and asked to comment on clarity, relevance and ease of understanding as they did so. At the end of each section of the questionnaire, respondents were asked about their understanding of certain definitions and if they felt any possible responses were missing from listed answers.

Following this, a few changes were made to the survey questions ahead of the quantitative pilot research phase, including:

- In the screener, a prompt was added "This survey includes a few questions about your cover. You may find it helpful to have your policy document to hand to help you answer these questions."
- A1c was updated to be multi-coded allowing respondents to select both responses.
- In section B, the option 'I receive insurance through my membership to a professional association" was added.
- At B5, the option for paying monthly or annually for subscription costs was added.
- At the beginning of section C, re-emphasise on the anonymity of the survey and explaining it may be dealing with a sensitive subject matter was added.

The table below outlines the profile of respondents for the cognitive interviews.

Table 9: Profile of achieved cognitive interviews

HCP Type	Number of respondents
Consultant	2
General Practitioner	2
Nurse	2
Midwife	1
Dentist	2

Optometrist	2
Pharmacist	2
Chiropractor	2
Other Allied Health Professional (incl. occupational therapist, operating department practitioner, physiotherapist etc.)	4
Osteopath	1

Pilot fieldwork

After the cognitive interviews, the survey was piloted among GPs, hospital doctors, nurses and dentists. This was primarily to test likely response rates, given the unknown proportions among each profession of those working either in private practice or in the NHS with non-state indemnity cover. As a secondary aim the pilot was run to assess survey length and response quality.

Sample was purchased from two commercial sample providers. In total 4100 records were purchased: 2,000 GPs, 1,000 nurses and nursing associates, 500 secondary care doctors and 600 dentists. Any duplicate records were removed (identified using email address), and any individuals that had previously unsubscribed from other IFF Research projects were also excluded. This left 4072 records to approach.

Fieldwork was live from 11th-17th August 2022. HCPs received an initial email invite, followed by a reminder email midway through fieldwork on 15th August 2022.

In total, only nine healthcare professionals completed the survey: 6 GPs, 1 hospital doctor, 1 nurse and 1 dentist. In addition, there were more HCPs who screened out of the survey, stopped midway through or unsubscribed than those who completed the survey. This indicated that purchased sample was going to be of limited use in reaching the most relevant HCPs for the study. As a consequence, IFF and DHSC redoubled efforts to engage regulators and professional bodies to help disseminate and promote the survey and ensure that it was clearly conveyed to potential respondents that the survey was for those with private indemnity cover.

Sampling

Due to anticipated difficulties reaching relevant healthcare professionals a number of approaches were used to reach out to the audience including disseminating and promoting the survey through partners, through a snowballing approach and through additional purchased sample.

IFF Research and DHSC approached a number of regulators, independent providers and professional bodies to ask them to either promote or directly disseminate the survey link to encourage their members to take part. A number of regulators chose to promote the survey on social media including LinkedIn, Twitter and their own websites. Others chose to promote the survey within e-newsletters sent out via email. IFF Research provided suggested examples of social media posts and text to be included within newsletters. We would like to thank the 31 organisations who helped promote this research.

The snowballing approach consisted of HCPs who completed the survey being sent a follow-up email (if they had agreed to be recontacted) requesting them to forward the email on to one or two healthcare professionals within their team that they were aware had private cover for clinical negligence.

Sample was purchased for professions which we had more limited ability to reach through partners. A total of 36,654 records were purchased: 25,167 nurses and nursing associates, 6,081 opticians, 3,721 allied health professionals, 1,106 medical lab professionals, 350 chiropractors and 229 osteopaths. Following the same process at the pilot stage, any duplicate records were removed (identified using email address), and any individuals that had previously unsubscribed from other IFF Research projects were also excluded. This left 36,290 records to approach.

Weighting

The achieved survey data was weighted to make it representative of the underlying population of professionals in the UK working either in private practice or in the NHS with non-state indemnity cover, in terms of the split between doctors, dental professionals, nurses and midwives and other professions.

The total number of registered professionals working in each profession was supplied to IFF by DHSC, who had collected data for each profession from regulators. Due to figures on the proportion of professionals working either in private practice or in the NHS with non-state indemnity cover being unavailable for most professions it was necessary for IFF to estimate these proportions. Estimates were checked with stakeholders who felt these were reasonable / were unable to refine these further.

The figure for independent midwives (150) was taken from the National Childbirth Trust[1].

Final population figures for each (grouped) profession are shown below.

Table 10: Population figures for grouped HCP professions

Grouped profession	Profession	Total by profession	Total by grouped profession
Doctors	GP	7,131	72,426
	Secondary care	65,295	
Nurses / Midwives	Nurse / nursing associate	142,279	142,429
	Midwives / dual registrants	150	
Dental	Dentists	39,580	103,379
	Other dental care professionals	63,798	
All other professions	Chiropractors	3,630	357,362
	Optometrists and opticians	26,532	
	Osteopaths	5,471	

[1] National Childbirth Trust. Choosing an independent midwife. Available at: Choosing an independent midwife | Pregnancy, Your pregnancy week by week articles & support | NCT

	Pharmacists and pharmacy technicians	81,408	
	Other professions including biomedical scientists, occupational therapists, paramedics, physiotherapists, practitioner psychologists, radiographers, chiropodists / podiatrists, arts therapists, clinical scientists, dietitians, hearing aid dispensers, operating department practitioners, orthoptists, prosthetists / orthotists and speech and language therapists	240,322	

The effective weighted sample size is 685 compared to 1235 individuals unweighted. This reduction in effective sample size is a result of the discrepancy between our surveyed completes and the population, which is not unusual for an open link survey which has been distributed through a number of different organisations. This still represents a robust overall base size and allows us to see interesting sub-group differences within the dataset. Weighted and unweighted data profiles are shown later in this chapter.

Quality control

Data set: preparation and checks

A specification for the data set was developed and checked by senior members of the research team.

Once the data set was produced, several rounds of checks were undertaken to ensure data accuracy. We checked the data to ensure no respondents completed the survey in a dubiously quick time. None were identified and so no action was required in this regard.

Where respondents were not able to provide details on their indemnity arrangements, such as cover value because it was arranged through their employer, telephone chasing was used to contact their employers and clarify those elements. In total 170 calls were made to all 42 people and 22 answers were updated with accurate information.

A handful of outliers were identified and so were recontacted to check the figures provided. Most confirmed the figures were correct.

We excluded one record who told us at B5 that their annual premium was £1m as this was far in excess of other figures given and we could not reach them to verify it. Some records were excluded due to the figures provided for the estimates of their cover value at question B6. Records were excluded if they provided a value of less than £1,000 and over £100 million. In total, 16 records were excluded on this basis – so there were 1219 records in the final dataset.

During quality assurance, a number of inconsistencies were identified in individuals selection of their current provider and their type of indemnity cover. Namely, this was the selection of discretionary indemnity providers despite respondents saying they held regulated insurance, or vice versa. No adjustments were made to account for these inconsistencies – instead the data is presented in the report are as reported by survey participants.

Profile of participants in the quantitative stage

The below table shows the number and proportion of completed interviews achieved with healthcare professionals by various factors of interest in the quantitative stage. It also shows the final profile of interviews after weighting was applied to ensure the dataset was representative of the underlying population of professionals working either in private practice or in the NHS with non-state indemnity cover in the UK.

Table 11: Overall healthcare professionals' profile by profession, region, gender, age and ethnicity

	Achieved (n=)	Achieved (%)	Weighted (%)
Profession			
Doctor (primary and secondary care)	436	35%	11%
Nurses / Midwives	63	5%	21%
Dental professionals (Dentists and DCPs)	309	25%	15%
All other professions	400	32%	52%
N/A	27	2%	2%
Region			
East of England	89	7%	7%
East Midlands	65	5%	5%
London	214	17%	17%
North East	42	3%	3%
North West	119	10%	11%
South East	180	15%	13%
South West	139	11%	11%
West Midlands	87	7%	9%
Yorkshire and the Humber	77	6%	5%
Scotland	75	6%	6%
Wales	52	6%	4%
Northern Ireland	64	5%	7%
Gender			
Male	700	57%	40%
Female	487	39%	56%
Other	1	<1%	<1%
Prefer not to say	47	4%	4%
Age			
Under 35	98	8%	10%

36-45	249	20%	21%
46-55	389	32%	30%
56-65	350	28%	28%
65 or over	110	9%	9%
Prefer not to say	39	3%	3%
Ethnicity			
White	889	72%	76
BAME	244	20%	16%
Prefer not to say	102	8%	8%

Profile of participants in the qualitative stage

The tables below show the number and proportion of completed interviews achieved with healthcare professionals by various factors of interest in the qualitative stage.

Table 12: Breakdown of in-depth interviews claims experience

Claims experience	Achieved
HCPs who had claim made against them without difficulties	14
HCPs who have had any difficulties determining who was responsible for covering the costs of the claim	6
HCPs who have had a claim refused	2

Table 33: Breakdown of in-depth interviews claims experience by type of cover

Claims experience	Type of cover	Achieved
HCPs who had a claim made against them without difficulties	Regulated insurance	8
	Discretionary indemnity	6
HCPs who have had any difficulties determining who was responsible for covering the costs of the claim	Regulated insurance	2
	Discretionary indemnity	4

Table 44: Breakdown of in-depth interviews claims experience by profession

Claims experience	Professions	Achieved
HCPs who had a claim made against them without difficulties	Doctors (primary or secondary care)	7
	Dental professionals (including dentists)	5
	All other professions	2
HCPs who have had any difficulties determining who was responsible for covering the costs of the claim	Doctors (primary or secondary care)	2
	Dental professionals (including dentists)	4
	All other professions	0

Table 55: Profile of achieved in-depth interviews

	Achieved
Profession	
Doctor (primary and secondary care)	9
Dental professionals (Dentists and DCPs)	8
All other professions	3
Region	
East Midlands	2
London	1
North East	2
North West	5
South East	2
South West	3
West Midlands	1
Yorkshire and the Humber	3
Wales	1
Gender	
Male	17
Female	2
Prefer not to say	1
Age	

Under 35	1
36-45	1
46-55	2
56-65	9
66 or over	7
Ethnicity	
White	14
BAME	5
Prefer not to say	1

“

IFF Research illuminates the world for organisations businesses and individuals helping them to make better-informed decisions.”

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1. Being human first:

Whether employer or employee, client or collaborator, we are all humans first and foremost. Recognising this essential humanity is central to how we conduct our business, and how we lead our lives. We respect and accommodate each individual’s way of thinking, working and communicating, mindful of the fact that each has their own story and means of telling it.

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IFF Research

5th Floor
St. Magnus House
3 Lower Thames Street
London
EC3R 6HD
Tel: +44(0)20 7250 3035
Website: iffresearch.com

Contact details: