Care Quality Commission

Response to our consultation on our proposed approach to regulating

Independent doctor services

December 2016

About CQC

The Care Quality Commission is the independent regulator of health and adult social care in England. We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role

- We register health and adult social care providers.
- We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.
- We use our legal powers to take action where we identify poor care.
- We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

Our values

- Excellence – being a high-performing organisation.
- Caring – treating everyone with dignity and respect.
- Integrity – doing the right thing.
- Teamwork – learning from each other to be the best we can.

Contents

Introduction

CQC's consultation on our proposed approach to regulating and inspecting independent doctor services ran from August to October 2015. We engaged directly with the independent doctor services sector to gain a better understanding of the services provided and the issues around quality and safety of care that are most relevant for them.

We are grateful to all who responded for the valuable feedback, which will help us to understand more about independent doctor services and help us in developing our approach.

Following the consultation, we tested our proposed approach in pilot inspections of 40 independent doctor services between November 2015 and April 2016, to identify learning in relation to regulating these services.

In May 2016, after the consultation and pilot inspections, CQC published *Shaping the future,* our new strategy for 2016 to 2021.

In this consultation response, we now present the key points from the feedback from those who responded to the consultation and the learning from our pilot inspections of independent doctor services, and explain how this fits in with CQC's vision as set out in our new strategy for 2016 to 2021.

The private healthcare sector is diverse, ranging from slimming clinics to cardiology, with providers delivering services from many different settings and in a number of ways. Independent doctor services operate under different contractual arrangements from NHS services, for example, through insurance companies and direct arrangements with business and individual clients. If independent doctor services are within the scope of CQC registration – and are therefore required to be registered with CQC – they must meet the fundamental standards and other relevant legislation, including demonstrating how they are providing evidence-based care.

However, not all medical practitioners in independent practice are required to be registered with CQC (although all are subject to professional regulation, for example, through the General Medical Council for doctors). Some providers are exempt from regulation (see the exemptions in our Scope of Registration (March 2015), and the exemptions set out in Schedule 2 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

Alignment with CQC's strategy for 2016 to 2021

CQC's strategy for 2016 to 2021, *Shaping the future*, sets out an ambitious vision for a more targeted, responsive and collaborative approach to regulation. Among our priorities are encouraging improvement, innovation and sustainability in care, and promoting a single shared view of quality. Our strategy sets out how we will regulate the quality and safety of care in a changing context, where providers are increasingly innovative in how they deliver healthcare, for example, through developing new models of care or using new technologies.

Our new strategy was developed to respond to the way that health and social care providers and services are changing by having greater alignment across the different health and social care sectors. We are therefore consulting on the detail of our proposed changes in the next phase of our regulatory approach across all sectors that CQC regulates.

Firstly, in December 2016, our formal consultation on our next phase of regulation will focus on our proposed revised assessment frameworks and the way in which we will monitor, inspect and rate NHS trusts and also our approach to inspecting new and complex types of providers. Then in Spring 2017, we will consult on our proposed approach to regulating adult social care and primary medical services. We encourage providers of independent doctor services and other interested stakeholders to participate in both these consultations, as the regulatory approach outlined will be relevant to them.

You can respond to this consultation online at: www.cqc.org.uk/nextphase.

What we will do going forward

The proposals in the next phase consultation aim to reduce complexity for providers by replacing the existing 11 sector-specific handbooks and sets of KLOEs and prompts and having only two assessment frameworks: one for health care services and one for adult social care services, but continuing to provide sector-specific guidance where necessary.

The strong message from feedback on the consultation on independent doctor services was that these services should meet the same standards as NHS and private hospitals. In other sectors, for example adult social care and mental health services, CQC's regulatory approach does not distinguish between services based on whether the provider is in the NHS or independent sector. This means that we use the right regulatory approach for the service, rather than the type of provider.

We intend to align our approach to independent doctor services with this principle. Instead of taking a separate approach to independent doctor services, we will re-categorise these services to fit with equivalent service types that are provided in the NHS. Subject to the outcome of the next phase consultation, this would mean using the health care assessment framework to assess independent doctor services. For example, independent GPs would be categorised with NHS GPs, and we would inspect them using the same approach.

Although it makes sense to adopt the same approach for NHS and independent services, there are some differences that we will need to reflect in our regulatory approach. We know from the pilot inspections that independent providers frequently provide services that are outside the scope of regulation alongside regulated activities. We do not currently have a duty to rate independent doctor services, whereas we do rate the majority of NHS services. We will ensure that these differences are clearly reflected in our guidance documents and in our inspection reporting.

Our approach would also mean not providing a separate handbook (including separate KLOEs and prompts) for independent doctor services. However, our health care assessment framework will be available on our website in the sections of the website for each type of service we regulate.

Our next phase consultation proposes new KLOEs and prompts in the assessment framework for health care services that reflect key issues in the quality of care for independent doctor services, for example, covering medicines management and new technology.

Subject to feedback from our consultations, we will begin the next phase of inspections under the new assessment frameworks for health care and for adult social care services in 2017. We aim to implement our new approach to assessing hospitals from April 2017, and then start the approach for assessing primary medical services from October 2017. Independent doctor services will be inspected alongside other services as we introduce this approach. In the interim, we will carry out focused inspections where necessary (for example, in response to a concern about safety or quality of care) using the approach and methodology that we have piloted.

We will be clear in our reports about what we inspected and how we report our findings. We will ensure that our inspection reports identify the elements of a provider's service that are out of the scope of regulation by CQC, so that the public understand what we are unable to check.

Our pilot inspections included services whose main purpose was to provide digital online consultation and treatment. Such newer, innovative technologies present a challenge for regulators and we found that we need to further develop our inspection approach for these services. We will therefore consult on new prompts for inspecting digital health services.

We do not currently have a duty to rate independent doctor services, although we may be given the power to rate them in the future. In the feedback to our consultation on these providers, the majority of respondents thought that we should rate independent doctor services. Based on the findings of our pilot inspections, we think it may be possible to provide a rating for some or all of the five key questions that we ask (are they safe, effective, caring, responsive and well-led?). We will undertake further work to consider how we could rate these services if we are given the power to rate them in the future.

Key findings

We asked six questions relating to our approach, with the overall aim of determining whether our proposed approach was the right one. We asked:

1. Whether the KLOE would enable us to comment on independent doctor services and identify poor quality care.
2. Whether the examples of intelligence we plan to look at were appropriate.
3. Whether CQC should rate independent doctor services and what approach we should take.
4. Whether independent doctors should remain within the scope of regulation by CQC.
5. How could CQC recognise 'notable practice' for this sector?
6. Whether our proposed methods are the right ones.

Overall feedback to the consultation from providers was positive and agreed with our proposed approach. Following the pilot inspections, the feedback from the services, our staff and the specialist advisers who participated also supported the approach.

There was agreement that the proposed methods would enable us to identify poor quality care and that providers should remain within the scope of CQC regulation. In responses to many of the consultation questions, people told us that independent doctor services should meet the same standards as the NHS and private hospitals.

In relation to how we could best recognise 'notable practice' and whether we should give a rating to independent doctor services, many respondents suggested that a rating would help to publicly acknowledge the work they are doing. Most respondents to this question felt we should rate across all of the five key questions, with others suggesting different options, such as an overall rating.

Respondents suggested that CQC should share examples of good practice on our website, to enable independent doctors to share and learn from the examples.

What we learned from our pilot

We tested our new approach in pilot inspections of 40 independent doctor services. Although the pilot included a relatively small number of registered providers, we believe they reflected the diversity of the sector.

In many areas we found that the private sector is not as different to the NHS as we may have anticipated. The same regulations apply to both NHS and the independent sector. Where we asked providers to improve, it was often as a result of misunderstandings of the scope of those regulations and other relevant legislation. Further messaging to the sector is needed around some key risk areas to help clarify expectations.

We found that some registered services carried out a range of care and treatment that is outside of the scope of CQC regulation. For example, the provider may offer both occupational health services to people under arrangements made by their employer (these are outside of the scope of CQC regulation) and private GP services open to the public (which are within our scope). This highlighted the challenge of reporting on quality of care in services that are in scope, while being clear that other services outside of the scope of regulation are also provided.

In relation to our regulatory findings, breaches of regulations were minimal. In some cases we did say that providers should make improvements across one or more of the key question areas, mainly for safe, effective and well-led. We made no requirements under the key question areas of caring and responsive.

The following summarises the areas for improvement that we identified in the pilot inspections:

Safe:

- Ensuring appropriate arrangements for managing emergencies if they arise, including out of normal working hours.
- Supplying unlicensed medicines only where there is a valid special clinical need of an individual patient and where there is no suitable licensed alternative.
- Having safeguarding systems and processes in place, including training for adult and child safeguarding.

Effective:

- Patients fully understanding the treatment they are consenting to receive and how that differs from available NHS care and treatment.
- Having a clear policy that sets out arrangements to share information about any consultation and treatment prescribed. For example, with the patient's NHS GP (if they have one), as this is often left for the patient to share.

Well-led:

- Underdeveloped governance arrangements and limited quality improvement processes.

Our consultation

We consulted from 24 August to 19 October 2015 on our proposed inspection method for the following types of services:

- Specialists providing consultation and/or treatment, who are on the GMC's specialist register or have completed further Certificate of Completion of Training (CCT) and who are **not** exempt from CQC registration, and would ordinarily provide the same or similar services in an acute/community or mental health hospital.
- Specialists providing consultation and/or treatment remotely, for example by telephone or internet (including FaceTime or Skype), who are on the GMC's specialist register or have completed CCT and who would ordinarily provide the same or similar services in an acute/community or mental health hospital.
- Travel or other vaccination clinics. Note: it is possible that some of these services may not be operated by an independent doctor but if travel vaccination is the main purpose of the service it will come under this approach.
- Slimming clinics where the regulated activity of services in slimming clinics is the main purpose.
- Vasectomy carried out under local anaesthesia.
- Private GP services, including medical agencies that carry out visits to people in their homes or other places that they are staying such as hotels or care homes, non-NHS primary medical type services, including online consultation with or without prescribing.
- Private GPs or Registered Medical Practitioners providing consultation and/or treatment remotely, for example by telephone or internet (including FaceTime or Skype).
- Endoscopy restricted to nasopharyngoscopy, colposcopy and use of auroscope.
- Health screening (only if undertaken in a primary care service).
- Gynaecology, dermatology, cardiology or other healthcare or diagnostic services that do not involve any treatment that falls under the acute or single specialty category.
- Family planning services – only if operated by a medical practitioner and where the regulated activity of family planning is the main purpose.

The consultation did not include:

- Private independent healthcare providers of hospital services (secondary and tertiary care) or single specialty services such as termination of pregnancy or in vitro fertilisation (IVF).
- Any residential services.
- Independent community services.

- NHS GP and GP out-of-hours services even though these are often provided by independent organisations.
- Private dentists.

How we engaged and who we heard from

We promoted the consultation to all registered independent consulting doctor providers (who provide services at approximately 1,000 locations) in our August and September 2015 provider bulletin, and also informed our independent consulting doctors stakeholder group (15 members, including representatives of people who use services, providers, professionals and commissioners).

The consultation was also promoted on our website, through our social media channels, and on our online community for providers and professionals (around 7,500 members) and the public (around 2,600 members).

We advertised a conference call with interested stakeholders to discuss our proposals, and answer questions.

We directly contacted 130 national organisations that represent people who use services to let them know about the consultation and highlighted it in our bulletin for the public and in newsletters to local Healthwatch and overview and scrutiny committees.

We also received additional feedback from CQC's public online community, and from a variety of events organised by both CQC and external groups.

From a total of 56 responses, 39 were through the webform, 12 were written or email responses and five responses were through a teleconference.

The responses were from:

- 26 healthcare professionals
- 5 providers of services
- 2 members of the public
- 3 recipients of health and social care
- 2 voluntary and community sector representatives
- 16 stakeholders*
- 2 CQC staff members.

* One stakeholder is a representative organisation for many independent doctors registered with CQC. As such, we feel we should give more prominence to its feedback and have therefore included all of these comments in our response.

We commissioned Quality Health, an external organisation, to support the consultation process. Quality Health reviewed, analysed and reported on all the feedback collected from the consultation which we have included below.

What you told us and our response

Consultation question 1

- **Do you agree that the key lines of enquiry (KLOEs) will enable us to comment on independent doctor services under the five key questions?**
- **Is there anything else we should include?**
- **We have provided examples of the evidence we may look for during our inspections. Do you agree that this will identify any areas of poor quality care?**

What you said

We received 48 responses to this question. Of these, 39 agreed that the KLOEs will enable us to comment on independent doctor services under the five key questions.

We received a range of feedback on other things that we could include. The following examples best reflect this:

- Provide guidance in relation to online or remote consultations that includes a recommendation for the independent doctor to hand over to the patient's GP.
- Place more emphasis on patient responses, and take these into account during inspections.
- Review the prompts under the five KLOEs by looking into whether a service meets the minimum standard expected. Compared to the NHS, the private sector may be lacking in areas such as: provision of multidisciplinary teams, discharge planning, treatment protocols, and root cause analyses.
- Hold independent doctors to the same standards as the NHS and private hospital sectors.

How CQC can ensure good care

- Tailor the inspection process to each provider, taking into account that some providers are offering a whole service, while many operate as part of a group of healthcare professionals in a hospital that is already inspected by CQC.
- Inspect healthcare companies with head offices and satellite clinics using a similar model to OFSTED.
- Recognise any whistleblowing activity within a provider as an important indicator of patient safety concerns.
- Acknowledge, record and mitigate any conflicts of interest in accordance with GMC guidance (http://www.gmcuk.org/guidance/ethical_guidance/21161.asp).

- Continue to avoid duplicating data by allowing doctors to provide data in the same format for both their appraisal and revalidation, and for CQC inspections.

In addition, 34 out of 42 people agreed that the examples of evidence provided will identify areas of poor care.

Our response

In our pilot inspections we found that the private sector is not as different to the NHS as we had anticipated. The same regulations apply to both NHS and the independent sector, which was reflected in the strong views of respondents that independent doctors should meet the same standards as the NHS and private hospital sectors.

These responses supported the overall content of our KLOEs. Although we are proposing not to publish separate KLOEs and prompts for independent doctor services as we move to one assessment framework for the health care sector, we have taken account of feedback and learning from both the consultation and from our pilot in developing the approach. We have also ensured that the proposed KLOEs and prompts specific to independent doctor services are included in the new assessment framework, which we are consulting on in December 2016. For example, in the assessment framework for health care services, we have introduced a separate KLOE and prompts for medicines management to reflect the importance of proper and safe handling of medicines in delivering safe care. We have also strengthened our prompts on the use of technology.

Our pilot inspections included services whose main purpose was to provide digital online consultation and treatment. For these newer, innovative technology types of services, we found that we needed to further develop our inspection and regulatory approach, and we will be consulting on an additional set of specific prompts for digital health services as a result.

Consultation question 2

- **Do you agree that the examples of intelligence we plan to look at will identify both good practice and risks of poor quality care?**

What you said

We received 48 responses to the question. Of these, 39 respondents agreed that the examples of intelligence CQC plans to look at will identify both good practice and risks of poor quality care.

There is some concern that the intelligence will not be applicable to all practices. Some people took the view that patient questionnaires were useful, although did not see the value of having patient groups in the independent sector.

Our response

We have reviewed the feedback from respondents, including providers, our staff and specialist advisors, and we do not propose to make any changes to the types of intelligence we use before an inspection.

We are developing our approach to how we reach out to patients to obtain their feedback about certain types of provider. For example, we used comment cards in the pilot, but we are testing a wider range of feedback approaches in other sectors.

Where we receive intelligence from other organisations, we will use that information to inform our inspections. It will be treated in line with our Privacy Statement and associated policies.

Consultation question 3

- **Should CQC rate independent doctor services?**
- **If CQC are granted the powers to rate independent doctor services in the future, which of the approaches below should we take?**
  - **Inspect and rate across all of the five key questions in line with our current model for other services we rate.**
  - **Inspect against all of the five key questions but only rate against certain key questions.**
- **If you think we should only rate against some of the key questions, which key questions should we rate against?**
- **If you think we should consider other options, please tell us what these are.**

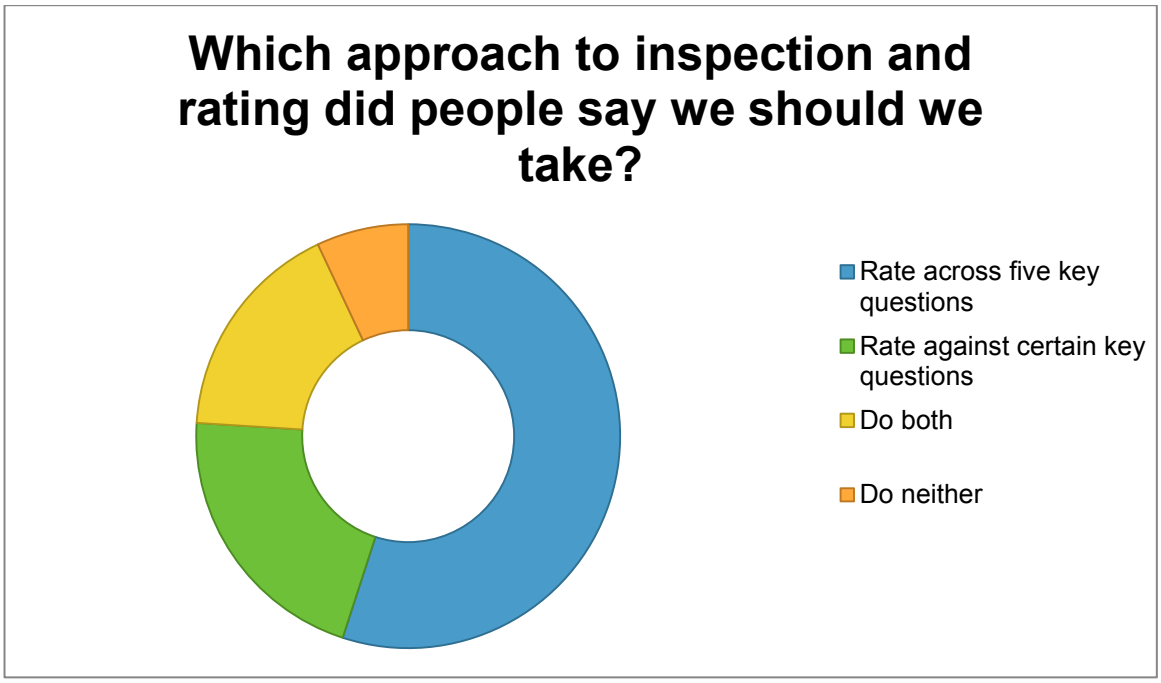
What you said

Should CQC rate independent doctor services?

We received 48 responses to this question. Thirty one respondents said CQC should rate independent doctor services. Some felt that CQC should rate independent doctor services if we use a fair and transparent system that takes into account the many different types, sizes and resources of practices/specialties being inspected. There were other people who did not agree.

Which approach to inspection and rating did people think we should we take?

We received 23 responses to this question. Of these, 13 respondents said that, if CQC is granted the powers to rate independent doctor services in the future, we should inspect and rate across all of the five key questions in line with our current model for other services that we rate. Five respondents said we should only rate against certain key questions. Others took a different view, with two people agreeing with both options, and four people disagreeing with both options.



Other suggested options included:

- Adopt the view that independent doctors should be subject to the same standards as other practitioners using the KLOEs, as they are a well-established model.
- Place emphasis on inspecting independent doctors because the nature of solo practice makes it less likely to meet the criteria of the five KLOEs.
- Replace the current rating system with a simple CQC compliance regulation, with either a “yes” or “no” answer.
- Acknowledge the diverse nature of independent doctors’ services, and give them an overall rating based on the findings of the inspection rather than against the five KLOEs.

Our response

We asked people if we should rate independent doctor services because it is important to understand what the sector and public think, and because ratings may help people to choose who provides their care and treatment. In particular, we asked

whether we should rate all or just some of the five key questions (are services safe, effective, caring, responsive and well-led) or take a different approach.

There was broad support from the sector to do this. Currently, the Care Quality Commission (Reviews and performance Assessments) Regulations 2014 do not place a duty on CQC to rate independent doctor services. However, CQC may be given the power to rate independent doctor services in the future, subject to a change in legislation.

From the experience of our pilot, we recognise that there could be benefits to rating independent doctor services and we think it might be possible to rate a provider under three of the five key question areas of: safe, effective and well-led. However, this presents challenges as independent doctors may offer services outside of the scope of our regulation. Therefore, if we did rate them in the future, we would need to be explicit in what the rating covered and what it excluded.

Consultation question 4

- **Do you agree that independent doctors should remain within the scope of regulation by CQC?**
- **If yes, please tell us why you think it should be CQC.**

What you said

We received 33 responses to this question. Of these, 31 respondents agreed that independent doctors should remain within the scope of regulation by CQC.

Of the 33 responses to the second part of the question, the majority took the view that CQC is a well-placed organisation to regulate independent doctors, as it has the necessary expertise and experience to make impartial, validated judgements and to speak with an independent voice.

One recurring view was that independent doctors should be subject to the same regulation as NHS doctors, as patients have a right to the same standard of good quality care across all sectors.

There was also the general view that CQC is able to regulate independent doctors in a different way to the General Medical Council (GMC). The GMC is not able to undertake regulation in the same detail that CQC currently does. Therefore, it is important for CQC to regulate using our model, as this would avoid resource implications for the GMC in terms of time and the level of detail that is needed to inspect within the sector.

We also received the following comments:

- CQC should have an ongoing collaboration with the General Pharmaceutical Council (GPhC). Regulation of independent doctors for prescribing aspects should remain with CQC, and registration of pharmacy premises and pharmacy professionals should remain with the GPhC.
- CQC's process of ensuring compliance with regulations gives confidence to providers in how they manage and deliver services, and promotes a culture in which one 'strives for excellence', rather than just to meet basic requirements.
- CQC is the correct body to regulate independent doctors because it reflects the quality of care expected of a patient-centered approach, rather than setting internal standards for practitioners and organisations.
- The GMC should be responsible for the regulation of independent medical doctors regarding their fitness to practise and clinical skills. CQC should be the regulatory body for the environment in which the doctor practises.
- CQC's findings are fully accessible to the public, and therefore people can exercise their right to know what to expect of their care.
- CQC should not inspect independent doctors because it cannot guarantee that the inspectors will be ex-doctors and therefore fully qualified to carry out inspection.

Our response

We were reassured by the responses to this question that providers believe we are the right organisation to regulate them.

It is clear that those who responded recognise the differences in roles between that of the professional regulator, the General Medical Council (GMC) who regulate medical practitioners and CQC as the regulator of their service. We have a Memorandum of Understanding (MOU) with the GMC, which sets out our respective responsibilities and how we will share concerns.

Where some of the services we inspect offer elements that are outside of our scope of regulation, we will make it clear in our inspection reports that we have no legal remit to inspect those elements.

For example: An online digital consultation and treatment service is often linked to a pharmacy. We have no remit to regulate the pharmacy or their dispensing, as that is the remit of the GPhC. We have a MOU with the GPhC which has this responsibility and we would share any concerns we may identify with them.

During our pilot, our inspection teams all consisted of a CQC inspector and a specialist professional advisor with appropriate skills to carry out the inspection. Most specialist professional advisors who joined our pilot inspections were GPs or pharmacists. Providers should be reassured that teams have the right level of expertise.

Consultation question 5

- **How can CQC recognise and encourage notable practice for independent doctor services?**

What you said

Many people who responded to this question suggested that providing a rating for independent doctors would help to publicly acknowledge their work.

One recurring suggestion was that CQC should share examples of good practice on our website, to enable independent doctors to share and learn from the examples in an open setting. Some felt that CQC should publish these in the same format as our examples of outstanding practice for GPs on our website.

One respondent highlighted that private practice by nature is competitive, and because of this there is less incentive to share examples of best practice (in terms of operational and customer services). Further comments were:

- Encouraging notable practice for independent doctor services is not the responsibility of CQC. Recognition and notable practice should be based on staff and customer feedback through mediums such as surveys and review sites.
- CQC should continue to include notable practice in published inspection reports, as they highlight good practice as well as areas for improvement. This would help change the perception that inspection reports only highlight negative aspects of a service.
- Independent doctors with outstanding practice could receive letters of commendation or certificates of excellence.
- Areas for CQC to consider when inspecting should reflect the enhanced patient experience of the private sector, such as ease of getting appointments, time taken to discuss patient concerns, rapid feedback of results and treatment and referral to named consultants.
- One person suggested that highlighting what we think is 'notable practice' in a commercial environment could be perceived as going beyond our regulatory remit.

Our response

CQC has a responsibility to encourage services to improve and to share and promote the learning. During our pilot inspections, we looked at what providers did over and above meeting the regulations to assure themselves that patients receive good outcomes. We asked providers at the start of an inspection to tell us about this. We also wanted to identify and share 'notable practice'. Our inspectors identify any potential notable practice during their inspections and it is considered as part of our quality assurance process for reports.

As in other sectors, CQC is keen to identify and celebrate notable practice that providers can learn from. We share this in a number of ways, including reports and publications, newsletters and press releases, and an online source of examples of outstanding practice for GPs on our website.

Consultation question 6

- **During our inspections of independent doctor services, we will use a number of methods to gather information from providers, the public and others about their views of the services provided. Do you agree that the proposed methods of doing this are the right ones to use?**
- **Will they enable us to gather views from all of the people we need to hear from?**

What you said

Of the 29 people who responded to this question, over half (18) agreed that the proposed methods are the right ones to use. Some people had reservations about our proposed use of social media to gather information from providers, and felt that this method would only be successful if it was carried out in a relevant, targeted way.

Will the proposed methods enable us to gather views from all of the people we need to hear from?

Of the 24 people who responded, 15 agreed that the methods will enable CQC to gather views from all the people we need to hear from. There was a view that since doctors are already required to provide 360 degree feedback for revalidation purposes, they could share this with CQC.

One person was concerned that we do not prejudice an inspection by contacting organisations for information for example, the GMC.

Our response

We will continue to send a provider information request to all providers to collect evidence about safety and quality of care. Providers can also send us any information they may use for their revalidation as evidence to help show how they provide services and meet regulatory requirements. CQC can use that information in the format that the provider uses.

We will ensure that our inspection teams reflect the scope of the service being inspected, including a specialist advisor or pharmacist with appropriate knowledge and expertise. The size of the team will be proportionate to the size of the service.

We will always review feedback on social media, but ultimately that is only one element of information. The information we receive about services informs our decisions about planning any regulatory action we may take, such as inspection, but on its own is not a basis for making judgements about quality of care.

Further information

To find out about our other consultations, please visit: www.cqc.org.uk/consultations.

Appendix: Organisations that submitted written responses

Patient representative bodies:

- LGBT Foundation
- National LGBT Partnership

Providers and provider representative bodies:

- Independent Doctors Federation
- Lloyds Pharmacy Online Doctors

Professional bodies:

- Association of Anaesthetists of Great Britain and Ireland
- British Medical Association
- Royal College of Surgeons of Edinburgh

Insurance and indemnity providers:

- BLM Law
- Medical Protection Society

National partners:

- General Medical Council