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Learning from Emergency Medicine compensation claims

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Every year a high number of patients attend Emergency Departments (EDs) in England, often presenting with complex and wide-ranging symptoms. Indeed, EDs are often the first port of call for many patients seeking medical attention, providing a high-quality service to patients under increasingly challenging circumstances. Many of these challenges were explored in the Getting It Right First Time Emergency Medicine Report, published in 2021.

In 2020/21 NHS Resolution received 10,816 clinical negligence claim notifications, of which 1,151 related to Emergency Medicine/attendances at EDs. The cost of these claims (damages and legal costs) is estimated at £321.91 million. Whilst these claims represent 11% of claims notified overall, the number of claims is low in relation to overall activity in the ED, with a claim occurring for only one in every 17,000 episodes of ED care.

Every claim, regardless of outcome, offers a unique opportunity for learning. NHS Resolution has recently undertaken a thematic review of Emergency Medicine claims, looking at 220 cases relating to incidents which occurred between 2014 and 2018 and where liability had been established. The findings are set out in three reports which focus on the following areas:

- High Value and fatality related claims (over £1million);
- Missed fractures; and
- Hospital-acquired pressure ulcers and falls (HAPU).

Key themes identified and discussed in the three reports include:

- Diagnostic errors as a result of not spotting signs of deterioration;
- Delayed or missed diagnosis due to failures to investigate patients' symptoms / signs;
- Failing to recognise the importance of patients repeatedly attending ED or when patients do not attend when advised to;
- Delay in referring patients for senior review;
- Communication issues;
- Lack of standardised risk assessments;
- Issues surrounding the use of incident reporting and investigations;
- Incorrect diagnosis resulting in a delay or failure to perform further investigations; and
- Issues surrounding diagnostic imaging i.e. requesting, reporting, interpreting and the follow up of imaging.

In addition to highlighting the key clinical issues and common themes, each report provides clear and concise practical recommendations to support Trusts offering acute services in learning from harm to improve patient safety and ultimately reduce the cost of claims in this area.

EDs and acute medical services are under intense pressure following the Covid-19 pandemic alongside demand for services growing each year.

Against this background, NHS Resolution's reports are a helpful resource highlighting the key issues and themes arising from clinical claims associated with EDs and setting out recommendations on how stakeholders can work together to bring about meaningful change to improve patient safety and reduce harm.

This is important. As set out in the National Patient Safety Strategy, a patient safety culture needs to be embedded within a patient safety system. Recognising the issues and working together with other stakeholders to improve patient safety in EDs at both the local and national level is a key part of this journey.

Alongside the information and recommendations from the thematic review, Trusts can use the NHS Resolution scorecard to look at their own claims data to better understand their ED claims (and other specialities). This can help target interventions aimed at improving patient safety.

GIRFT also provides helpful resources and information including a useful Summary ED Indicator Table (SEDIT) which provides current comparative information for ED Trusts including; (i) demand; (ii) capacity; (iii) the patient flow; and (iv) outcomes.

The GIRFT Litigation pack also provides Trusts with benchmarking data on individual claims experience relative to levels of activity. All these resources provide a rich source of data alongside learning from complaints, incidents and inquests to help Trusts (and the Emergency Departments within) identify any themes and trends within their own organisation and plan quality improvement work to improve patient safety.

NHS Resolution have recently announced a Safety and Learning Emergency Department Virtual Forum for NHS staff on Monday 30 May 2022 between 12:30 and 13:40. This forum will explore the key themes and recommendations from the ED Reports. You can register for the forum here.

For further information about how we can support you in learning from ED claims alongside data from incidents and/or inquests please contact Jennifer Fagin, Senior Associate, at Jennifer.fagin@brownejacobson.com or Amelia Newbold, Risk Management Lead at amelia.newbold@brownejacobson.com

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