GETTING IT RIGHT FIRST TIME

NHS Resolution

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Learning from Litigation Claims

The Getting It Right First Time (GIRFT) and NHS Resolution best practice guide for clinicians and managers

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With supporting statement from

Sir Robert Francis QC, Chair of Healthwatch England

A recommended structure for learning from clinical negligence claims - to be led by legal teams, supported by clinicians and managers

Foreword

We are delighted to recommend this Getting It Right First Time (GIRFT) and NHS Resolution best practice guide to claims learning. As GIRFT clinical leads have visited trusts across England it has been clear that many clinicians and managers are unaware of the claims against their department. Across the system claims learning has not had the attention required to achieve the potential improvements in patient safety and the resulting reduction in costs.

It is important that trusts recognise the direct link between clinical incidents, claims for compensation and their financial contribution to the Clinical Negligence Scheme for Trusts (CNST). Nowhere is the business case for investment in safety improvement clearer. With some trusts paying over £40m in yearly contributions and the annual cost representing around 2% of the NHS budget, it is clear that board-level attention on claims is essential and should be part of the effective governance of any organisation.

In response, we have worked together and alongside other stakeholders to ensure that claims learning and management have parity to incident learning and complaints. An excellent example of this has been our work across maternity services. Obstetrics accounted for 9% of clinical negligence claims but represented 50% of the total incoming claims value in 2019/20. The introduction of two initiatives by NHS Resolution in recent years – the Maternity Incentive Scheme and the Early Notification scheme – has helped to ensure that learning is shared across departments to improve safety and drive better patient outcomes.

Another example of the GIRFT approach has been demonstrated through the improvements in orthopaedic surgery. Following the orthopaedic visits to all trusts in England, orthopaedic surgery moved from 15% of claims in 2013/14 to 12% in 2019/20, second to Emergency Medicine, having previously been the highest volume specialty. At the same time there has been a corresponding fall in the share of clinical negligence costs in the specialty from 10% in 2013/14 to only 5% in 2019/20. Trusts with large orthopaedic departments have also been able to report reductions in their contributions to CNST. This demonstrates that the GIRFT methodology can make a difference to this complex problem. We are conscious that the achievements over this six-year period can only be sustained by trusts continuing to review their data and learn from their claims with the support of frontline clinicians.

More recently the GIRFT, NHS Resolution, the British Hip Society (BHS), the British Association for Surgery of the Knee (BASK) and the British Orthopaedic Association (BOA) best practice guidance for hip and knee arthroplasty documentation has provided specific guidance to help colleagues record the required documentation of operations, to allow good clinical practice to be more easily defended and claims to be resolved quickly for the benefit of both patients and clinicians. The aim is that learning from claims in this way will reduce the highest volume areas in orthopaedic surgery and in future other specialties.

In the post-COVID-19 world getting our approach to claims and resulting learning right is now more important than ever. We hope that clinicians and managers will be able to use this best practice guidance as the impetus to improve the management of claims and patient care.

Professor Tim Briggs CBE
GIRFT programme Chair
National Director of Clinical Improvement, NHS

Helen Vernon
Chief Executive, NHS Resolution

Statement of support

Successful medical treatment requires many things to go right. As this welcome guidance emphasises, among the very first requirements is to provide the patient with a comprehensive understanding of the choices available, and the risks and benefits for the individual patient of each possible course of action. The range of outcomes has to be explained and all the patient's questions answered honestly. In the end the decision what to do is the patient's to make, not the doctor's. When properly handled this process develops that most basic of requirements of successful medical treatment – trust. The patient is then a truly willing participant in the process of treatment, not merely a body to whom things are done.

Parallel requirements exist at the end of treatment. The patient needs to be fully involved in the assessment of the outcome whether successful or not, and decisions about further action. This is particularly important when the outcome has been unexpected, unwanted and harmful. Patients are then entitled to an immediate honest and open explanation of the position, if available, and an honest admission of any limits of what is currently known. They should be offered meaningful involvement in the processes of investigation and review. The relationship of trust will be lost if candour is absent, if appropriate apologies, empathy and a promise of learning are not offered, or there is a delay in providing any of these. There is a real imperative to get this right first time as soon as possible.

When the outcome of medical treatment is unwanted and unexpected and results in harm, the first priority should be the patient, or, in the case of a fatality, the bereaved. The doctor/patient relationship does not end because something has occurred which everyone would have preferred had been avoided. So many victims of medical accidents I have met wanted, but were denied, honest explanations, appropriate apologies, and timely support for their needs. They would have welcomed being involved in working out how their experience could be used to avoid others suffering as they had. Many such victims would have been satisfied with being treated with respect in this way and would not have gone on to sue for damages.

I look forward to a day when all patients who have suffered unexpected and unwanted harmful outcomes will have the chance to be part of the learning from incidents. They should be treated in this way regardless of whether the incident has been the subject of a complaint, an incident report, concerns expressed by a member of staff speaking up, or a claim. I believe that this approach offers the best chance of maintaining the patient's confidence in the service, promoting the best remediation for any injury, avoiding a fruitless hunt for unfortunate staff to blame and punish, and improving safety through learning. Not least it is likely to reduce the inexcusable cost of negligence claims.

This welcome guidance is a promising advance towards that goal.

Sir Robert Francis QC
Chair, Healthwatch England

Executive summary

Purpose

- This guide gives a recommended structure for learning from clinical negligence claims that should be led by trust legal departments, supported by clinicians and managers.
- Claims learning should have the same parity as learning from clinical incidents. It is a rich resource to help improve patient safety in addition to learning from complaints, incidents and inquests.

Claims handling to facilitate learning

- Claims reporting should include **relevant clinical details** to facilitate learning on a local and national level. This is better achieved when a clinician has time allocated in their job plan to review claims and integrate the learning into the clinical governance of their department.
- Reporting of a claim should contain a minimum dataset including relevant patient diagnosis, patient age, patient sex, procedure or operation (including laterality and site), date of incident, time of incident, causes which have led to the claim, incident description containing an explanation of litigation claim, injury due to incident, reference to relevant clinical coding, location in the hospital and parent medical specialty, as well as other medical specialties involved with the incident and if the incident was associated with a previous complaint, incident or inquest.

NHS Resolution

- **NHS Resolution claims handler.** Trusts will have a named claims handler at NHS Resolution who they can liaise with for updates as well as for feedback after closure of priority claims. After reviewing the GIRFT and NHS Resolution litigation data pack, trusts can take the opportunity to update their trust's own claims with NHS Resolution.
- **NHS Resolution Safety and Learning team.** NHS Resolution provides online learning materials and runs educational events that trust legal teams and clinicians can utilise. Details can be found on their website: https://resolution.nhs.uk/services/safety-and-learning/

Panel law firms

- Trusts should make use of the **value added services** from NHS panel legal firms in seeking feedback from claims, as well as making the most of other educational offerings.

Complaints, patient safety and clinical teams

- Learning from clinical negligence claims should involve the legal, complaints, patient safety and clinical teams. Quarterly reviews of claims, complaints and incidents is beneficial.
- Work in partnership with patients, families and carers and involve them with safety investigations, ensure openness and candour, signpost to support and commit to share learning.
- Frontline clinical staff are often unaware of the claims within their department unless they are directly involved. A **clinical department's claims should be discussed** on a regular basis in a formal governance structure on **at least a quarterly basis in departmental meetings**.

Resources to guide claims learning

- Utilisation of claims learning resources helps trusts identify areas of high performance, targets for improvement and benchmarking against other trusts. These include the **GIRFT NHS Resolution litigation data pack** and resources on the **NHS Resolution extranet**.

Impact of claims learning on clinical practice

- Learning from clinical negligence claims influences and improves clinical practice especially in the consent process, pre-procedure patient education and clinical documentation.

Monitoring of claims learning

- Trusts should monitor their claims learning practices to ensure the maximum is gained for the improvement of patient care.

Guidance

Background

Clinical negligence claims are an ever-increasing burden in the NHS, with the annual cost of harm amounting to £8.3 billion in 2019/20[1]. The GIRFT litigation workstream has collaborated with NHS Resolution to engage with trusts and share data regarding their own claims on a speciality specific basis in bespoke data packs. GIRFT has also conducted litigation deep dives in high priority specialties: maternity and gynaecology, trauma and orthopaedic surgery and spinal surgery, involving trust legal, complaints and clinical staff as well as senior management. These meetings have enabled us to better understand the processes that facilitate effective claims prevention, management and learning.

We have produced this guidance to enable clinicians and managers to understand the multifaceted process of learning from clinical negligence claims (Figure 1). The role of the trust legal team has expanded from facilitation of claims management with NHS Resolution to include claims learning. Our intention is to support the engagement of clinicians in this process to maximise patient safety and curb the increasing cost of litigation. This guidance will provide a framework to deliver this.

Engaging clinical staff

Dedicated clinical staff to assist trust legal teams

- Trust legal teams benefit hugely from clinical input in claims management and with further engagement with clinicians. Formal roles with dedicated sessions that are incorporated into job plans enable this work to be given protected time without detrimental effect on clinical services. Usually the clinician acting as the clinical governance lead for each department would be best placed to undertake this role and to triangulate learning from claims, complaints and patient safety incidents.

Discussion of claims in clinical departments

- Clinical negligence claims should be discussed regularly in meetings attended by clinical staff (e.g. clinical governance or multidisciplinary meetings) led by senior clinicians with support from trust legal teams.
- The frequency of these discussions.
    - *Quarterly* with a review of complaints and incidents with a focus on high priority specialties e.g. obstetrics, emergency medicine, orthopaedic and spinal surgery
    - *Annually* at regional level especially in clinical specialities where regional networks exist
- Claims learning discussions for clinicians should target high value learning areas:
    - Closed cases with admission of liabilities using case summaries from the trust legal team
    - Open cases with high potential costs using updates from panel law firms and expert witness
    - Benchmarking of trust litigation activity using the GIRFT & NHS Resolution litigation data pack
    - Clinically relevant legal talks using invited speakers from panel law firms.

Figure 1: *Internal trust teams and external organisations involved in claims learning*

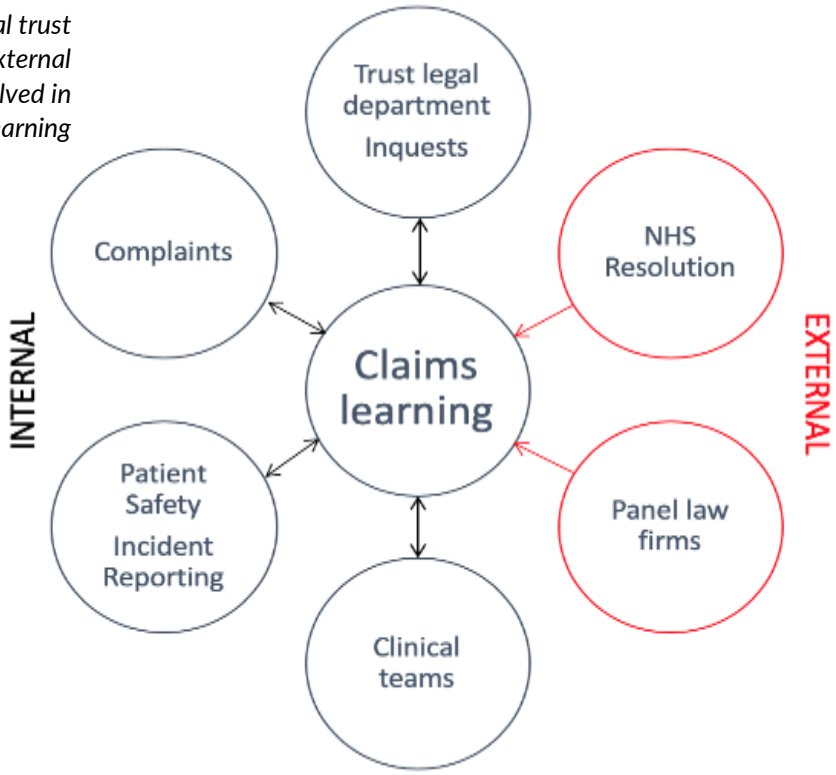


Table 1: *Potential clinical forums for clinician engagement*

Clinical meetings	Collaborative events
Mortality and morbidity	NHS Resolution
Multidisciplinary team	events
Grand rounds	Member trust forums
Clinical governance	Regional meetings
Teaching	

Making clinicians aware of clinical negligence claims process

- Trust legal teams need to increase their visibility to clinical staff at times when they are not involved in a claim. This will reduce the stigma around discussing claims to improve patient care. Legal teams will need to be supported by senior clinicians to gain engagement and enable them to effectively communicate with clinical teams through the appropriate forums (Table 1). The emphasis should be on avoiding the attribution of blame and instead focus on the analysis of claims to determine the cause and the focused improvement that could prevent the incident arising in the future.

Case study

Kingston Hospital NHS Foundation Trust orthopaedic department

- **Litigation claims are reviewed on a monthly basis** at the departmental governance meeting. These meetings are attended by all clinical staff and management in the department and if claims are discussed learning is supported by the trust legal team.
- **Learning themes** are brought out from the clinical negligence claims.
- **Claims learning promoted among clinical staff.** Importantly, this involves junior members of the team who may be unfamiliar with clinical negligence claims.

Claims handling to facilitate learning

Claims reporting

- Claims reporting should include relevant clinical details to facilitate learning on a local and national level. This would benefit from a clinician with time allocated in their job plan for this.
- Reporting of a claim should contain a minimum dataset (Table 2). There should be a recognition of areas of ambiguity or uncertainty and the patient's point of view, including their reported injury.

Patient	Clinical details	Claim details
Age at the time of incident **Sex**	**Diagnosis** at the time of the incident both primary, secondary and relevant diagnosis either acute or chronic **Procedure or operation** (laterality and site) index procedure and subsequent procedures. Identify which procedures the claim is directed against. **Medical specialty/specialties** against which the act of negligence is alleged. **Date of incident** **Clinical coding** both diagnostic and treatment codes related to the incident **Job title and grade of clinical staff or allied health care professional** involved to identify level of support provided and not to identify individuals	**National Claim reference number** **Claim status** – incident, open or closed **Incident description** containing an explanation of claim **Cause** which have led to the claim **Injury** due to incident **Location** in the hospital **Complaint, incident or inquest** associated with claim **Existing claim(s)** which relate to the claim **Date of notification of claim**

Table 2: *Minimum dataset for entry onto claims database*

Internal claims management

- In the management of clinical negligence claims, a case file is opened and used to organise all case documents including information from complaints, incident reporting and inquests.
- Ensuring that a claim summary is updated and maintained as the claim progresses ensures this resource can be easily accessed and disseminated for learning purposes. Expert witness statements and panel law firm summaries should be referenced in these summaries.

Clinician involvement in claims management

- Continual engagement with clinical teams and provision of support will ensure appropriate and timely input from clinicians in the claims handling process.
- Clinicians should be made aware when the claims process is initiated either from a request for health records or formally with a letter of claim or claim notification. A **statement** from a clinician should be provided, when required, within **two weeks** of the request. (See Appendix 1 for an example of claims management process).
- Clinical staff should be supported appropriately through the claim's management process. This can be a stressful and difficult experience for many healthcare professionals.
- In GIRFT provider visits trusts have reported significant concerns regarding expert witnesses. All experts should include in their formal reports all reasonably possible arguments and literature for and against any proposition relevant to the issues in question. This is a well-established legal

requirement but can be neglected. GIRFT and NHS Resolution support providing recommendations of minimum standards for experts, as offered by BASS and SBNS. GIRFT also recognises that the opportunity to provide learning to improve practice and patient safety is not fully utilised in expert reports. The taxonomy of claims in NHS Resolution's national Claims Management System could be improved by expert witnesses providing information to ensure the summary information held accurately reflects the claim. GIRFT and NHS Resolution are working together on the production of guidance for expert witnesses to address the concerns of trusts and national bodies, in collaboration with both claimant and NHS panel law firms.

NHS Resolution claims handler

- Trusts have a named claims handler at NHS Resolution who the trust legal team can liaise with during the course of a claim for updates as well as for feedback after closure of priority claims.
- After reviewing the GIRFT and NHS Resolution litigation data pack, trust legal teams can take the opportunity to review and update their trust's own claims with NHS Resolution. It is important that the national Claims Management System has the claim allocated to the correct specialty and there is an accurate and precise description of the claim. If the trust believes the specialty is coded incorrectly on NHS Resolution's claims management system, they should liaise with NHS Resolution in accordance with the standard procedures.

NHS Resolution Safety and Learning team

- Regional Safety and Learning leads can provide support to trusts with claims learning.
- Online learning materials are provided including guidance on 'Saying sorry' and 'Being fair' and case stories of previous claims with key lessons. They also provide educational events both regionally and nationally. Details can be found on their website: https://resolution.nhs.uk/services/safety-and-learning/
- Some resources related to 'Point of incident resolution' are available on NHS Resolutions website to assist trusts in supporting patients, families and their carers when incidents occur by encouraging staff to be open, honest and give an apology i.e. 'saying sorry'. Trusts are advised of the importance of ensuring that all concerns of the patient and their family are comprehensively and frankly addressed and that everything possible is done to maintain their trusts in the process. Support needs to be more than the offer of apologies and explanations but should extend to material support, including treatment, advice, equipment and, where appropriate, early resolution of claim where damages are due.
- Sharing learning from published thematic reviews of claims.
- NHS Resolution also provides national initiatives in high priority areas. The Early Notification scheme for maternity has moved upstream to capture incidents before they become claims, share learning in real time and support trusts in their response as well as undertaking an early liability investigation to accelerate the provision of compensation where appropriate.
- The claims scorecard available on NHS Resolution's extranet is an interactive tool looking at clinical and non-clinical claims. NHS Resolution is working with GIRFT to further develop this tool to align the data GIRFT and NHS Resolution use, and to help trusts identify the clinical areas to prioritise for claims learning.

Panel law firms

- The value added services from NHS Resolution panel legal firms can include feedback from individual claims and educational opportunities such as member trust forums, courses and invitations to speak about clinically relevant topics.
- Senior clinicians should contact their trust's panel law firm through the trust legal team to explore learning opportunities.
- Clinicians should be aware that patient feedback and additional learning resources are available from claimant legal firms and various patient-led charities such as Action against Medical Accidents (AvMA). These organisations can contribute to general learning themes from the patient's perspective although they should not be consulted on open claims.

Case example

Member trust forums

- NHS panel law firms are instructed by NHS Resolution to take on clinical negligence claims for NHS trusts.
- Many panel law firms organise a series of forums which member trusts are invited to attend.
- Presentations are given by clinical negligence solicitors and other organisations involved in claims learning including GIRFT and NHS Resolution.
- Theses forums provide an opportunity to receive updates in the clinical negligence field, learn from claims and safety and learning initiatives.

GIRFT resources to guide claims learning

GIRFT and NHS Resolution litigation data packs are a claims learning resource that help trusts identify areas of high performance and targets for improvement by benchmarking against other trusts. GIRFT and NHS Resolution have supplied this data pack to each trust using a speciality specific metric that places the cost of claims in the context of the volume of activity carried out by each specialty. Trust legal teams are supplied with guidance regarding its use and are asked to complete a five-point action plan in response with the support of clinicians and panel law firms (see Appendix 2 for full version).

GIRFT litigation data pack five-point plan (abbreviated)

1. Assess department's benchmarked position compared to other departments nationally.
2. Confirm correct coding to that specialty with trust legal team and NHS Resolution.
3. Detailed review of claims including witness statements, panel firm reports and patient records.
4. Triangulate claims with learning themes from complaints, inquests and patient safety incidents. Where a claim has not been investigated as a patient safety incident already this should be carried out. Learning to be shared at departmental, clinical governance or multidisciplinary meetings.
5. Trusts outside the top performing quartile to be supported by GIRFT and NHS Resolution through regional teams and national guidance.

Case study

Moorfields Eye Hospital NHS Foundation Trust - clinician-led claims learning improvement project

In response to the GIRFT and NHS Resolution Litigation data pack's five-point plan, ophthalmology consultant Melanie Hingorani led a quality improvement project to investigate the clinical negligence claims in the trust. The structure of this project used many elements found in our best practice guidance.

- **Dedicated clinical staff with allocated time in job plan to facilitate claims learning**
  Ms Hingorani had allocated time within her consultant job plan to be involved in significant incident and claims analysis. This enabled her to undertake this work promptly after the distribution of the GIRFT and NHS Resolution litigation data pack in collaboration with Moorfield Eye Hospital's risk manager and claims solicitor.
- **Thorough review of claims including all documentation to facilitate claims learning**
  All documents of claims included in the project were reviewed. Analysis included identification of clinical sub-specialty, stratification of harm and recognition of learning themes.
- **Triangulation with significant events**
  Using trust risk management systems, claims were cross referenced to identify if they had been reviewed by the significant incident panel.
- **Investigation of claims given parity with investigation of serious incidents**
  Claims that were not identified as significant incidents were investigated and learning themes identified.
- **Themes for learning identified**
  From this work, the investigating team produced a report with five key learning themes and action plans to improve patient safety and reduce impact of litigation. These included changes to improve clinical practice which not only reduce exposure to potential litigation but also improve patient care.
- **Dissemination of learning**
  The work has been disseminated across all sites and subspecialties within Moorfields Eye Hospital, but also to other trusts in London and across the UK via the UK Ophthalmology Alliance. This is an excellent example of dissemination of claims learning beyond the hospital trust for system wide learning at both a regional and national level.
- **Co-production**
  The trust has a patient representative on the significant incident investigation panel. This provides an insight from a patient's perspective when discussing serious incidents and this role can be extending to discussing claims and the learning that can be achieved.

Case study

Guys and St Thomas' NHS Foundation Trust – engaging clinicians

- Clinicians are notified on receipt of letters of notification, letters of claim, draft letters of response, proceedings, draft defences, expert evidence and confirmation of settlement or discontinuance.
- Clinicians are asked to provide comments on letters of claim, draft letters of response, particulars of claim, draft defences and, independent experts' reports; prepare witness statements; attend conferences with counsel and experts; and give evidence at trial.
- Involvement of clinicians throughout the process enables the smooth management of the claim so that it progresses quickly and efficiently.
- The trust is holding workshops in 2020 to develop a framework to support clinicians involved in a clinical negligence claim, as being involved in a clinical negligence claim can be very difficult

Impact of claims learning on clinical practice

Claims learning has the potential to inform and improve current clinical practice. We found from GIRFT provider visits and discussions with clinical teams that certain common themes emerge in clinical negligence claims that provide targets for clinical improvement.

Consent for elective procedures

- A significant proportion of clinical negligence claims are directly or indirectly related to the consent process, especially in surgical specialities. It is vital that the consent process is a journey that starts from the moment the patient is first seen for their presenting symptom rather than an isolated event that takes place prior to the proposed procedure.
- Following *Montgomery vs Lanarkshire Health Board*, 2015, the test of materiality was introduced which requires the surgeon to consider the following when contemplating which risk and benefits to discuss regarding a procedure.[(2)] Whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would likely attach significance to it. It is not sufficient to ask the patient if they want to know anything else, as patients cannot be expected to know what they do not know about their condition or treatment options. Further details of this case along with other videos on the issues surrounding consent can be found in the resources section of the NHS Resolution website (https://resolution.nhs.uk/resources/nadines-story-consent/)
- Alternative options must be discussed including the option of no treatment. Elective procedures are at increased risk compared to trauma or emergency surgery from consent claims as the claimant can argue that they would not have had the procedure if they had been advised of alternative options. *Thefaut v Johnston*, 2017, illustrated the necessity of an adequate discussion using language which has been 'de-jargonised.'[(3)] Claims could stand even if the patient sustains a recognised complication which has been included on the signed consent form if the patient can prove that had they been fully informed they would have either delayed their surgery to another day to allow them to think things over or would have cancelled.
- GIRFT supports the principles of the **three legged stool** approach to consent that has been proposed by the British Association of Spinal Surgeons.[(4)] This model consists of three distinct aspects to consent, all of which support the whole consenting process, and none of which are of any value in isolation: information booklets, patient-centred dialogue and procedure specific surgeon guided consent form (see Appendix 3 for more details regarding this approach, and related guidance in Appendix 4 from the Royal College of Surgeons, Consent: Supported Decision-making[(5)]).
- Surgeons should make patients aware of national guidelines on treatment choices, such as NICE (National Institute for Health and Care Excellence) and SIGN (Scottish Intercollegiate Guidelines Network) guidelines. If the recommended treatment is not in keeping with current guidelines, surgeons must explain the reason for not following current guidance. If there is more than one accepted technique for the procedure being carried out the surgeon should explain and document the reason for their chosen technique and how this can vary.
- Written consent itself should be obtained ideally two to four weeks before the procedure in most cases, in order for patients to have a period of time to reflect on the decision prior to date of the procedure. Many surgical departments have set up specific outpatient consultant-led consent clinics to deliver this.

Case study

Guys and St Thomas' NHS Foundation Trust – consent

- The department has developed a practice of consenting in the outpatient clinic two weeks prior to surgery for open spinal surgical procedures. If patients do not have their surgery within six weeks of signing the consent form, they are asked to attend outpatients again to repeat the consent.
- Physiotherapists offer pre-operative spinal education (POSE) classes prior to surgery to better understand the operation and the post-operative recovery period. Patients therefore have more realistic expectations, and this greatly informs the patient's consent.

Pre-procedure patient education

- It is vital that patients' expectations of treatment outcomes are realistic and that they are fully informed regarding the restrictions in day to day life they will experience following a procedure. There are many clinical negligence claims coded as 'unsatisfactory outcome to surgery' for cause and frequent injuries in claims coded as 'unnecessary operation.'
- Patient education through communication by clinicians and validated information leaflets and digital resources provide a good base of knowledge for patients.
- Since the COVID-19 pandemic many clinicians have found ways to offer this patient education and even consent discussion online in advance of the day of surgery to minimise additional patient visits to hospital. A record of the online discussion is documented, requiring only confirmation of consent on the day. Consent for procedures to be carried out during the COVID-19 pandemic should include discussion of the additional risks and proposed mitigations.

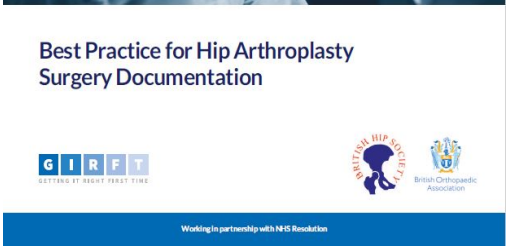
Case study

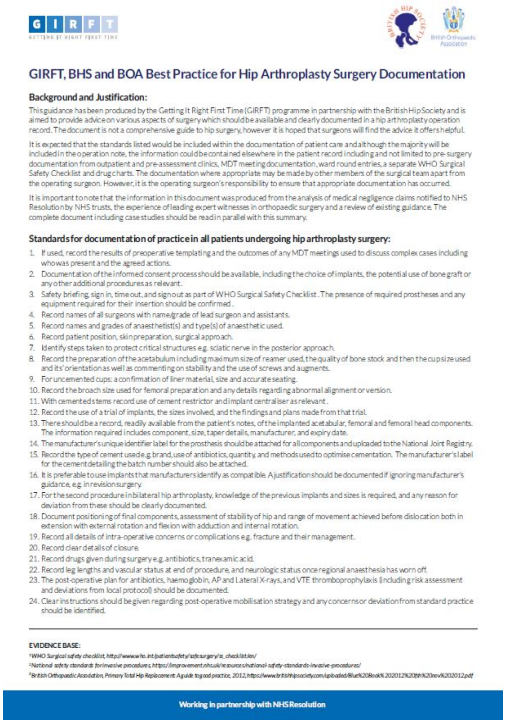
East Lancashire Hospital NHS Trust – 'hip and knee school'

- This initiative provides pre-operative educational sessions with senior nurses, physiotherapists and occupational therapists for patients due to undergo hip and knee arthroplasty surgery.
- Patients are taught about the operation they are due to undergo, logistics for the day of surgery, what to expect post-operatively and ongoing rehabilitation.
- This, integrated with the trust's enhanced recovery programme, provides the patient with the opportunity to have a full informed shared decision throughout the course of their treatment.

Clinical documentation

- Panel law firms can find it difficult to defend trusts in clinical negligence cases due to poor or incomplete documentation by clinicians. In a busy clinical role, it can be difficult to always ensure that documentation is sufficiently robust for legal scrutiny.
- To guide this process GIRFT, in partnership with NHS Resolution, the British Orthopaedic Association and its specialist societies, has produced guidance for primary hip and knee arthroplasty documentation[6],[7]. Many clinicians also use operation note templates to ensure documentation standards are maintained. GIRFT is preparing documentation guidance for other high volume or high-risk procedures.





Timely access to diagnostic investigations

- Cause codes: 'failure or delay in diagnosis' and 'interpretation of clinical picture' are commonly seen in clinical negligence claims. Often this can be attributed to investigations not being performed in a timely manner. In spinal surgery, missed cases of cauda equina syndrome are a significant cause of litigation with 25% of projected claims costs between 2014-2016 (£68 million) being related to this.
- These cases can be missed due to lack of availability of a MRI scanner outside normal working hours. Consequently, GIRFT is supporting the British Association of Spinal Surgeons (BASS) guidance advising the availability of access to MRI 24 hours a day. As most trusts have MRI scanners already, many are now evaluating their workforce capabilities to ensure availability of
a suitably qualified radiographer outside normal working hours to provide this service.[8],[9]

Safety checklists

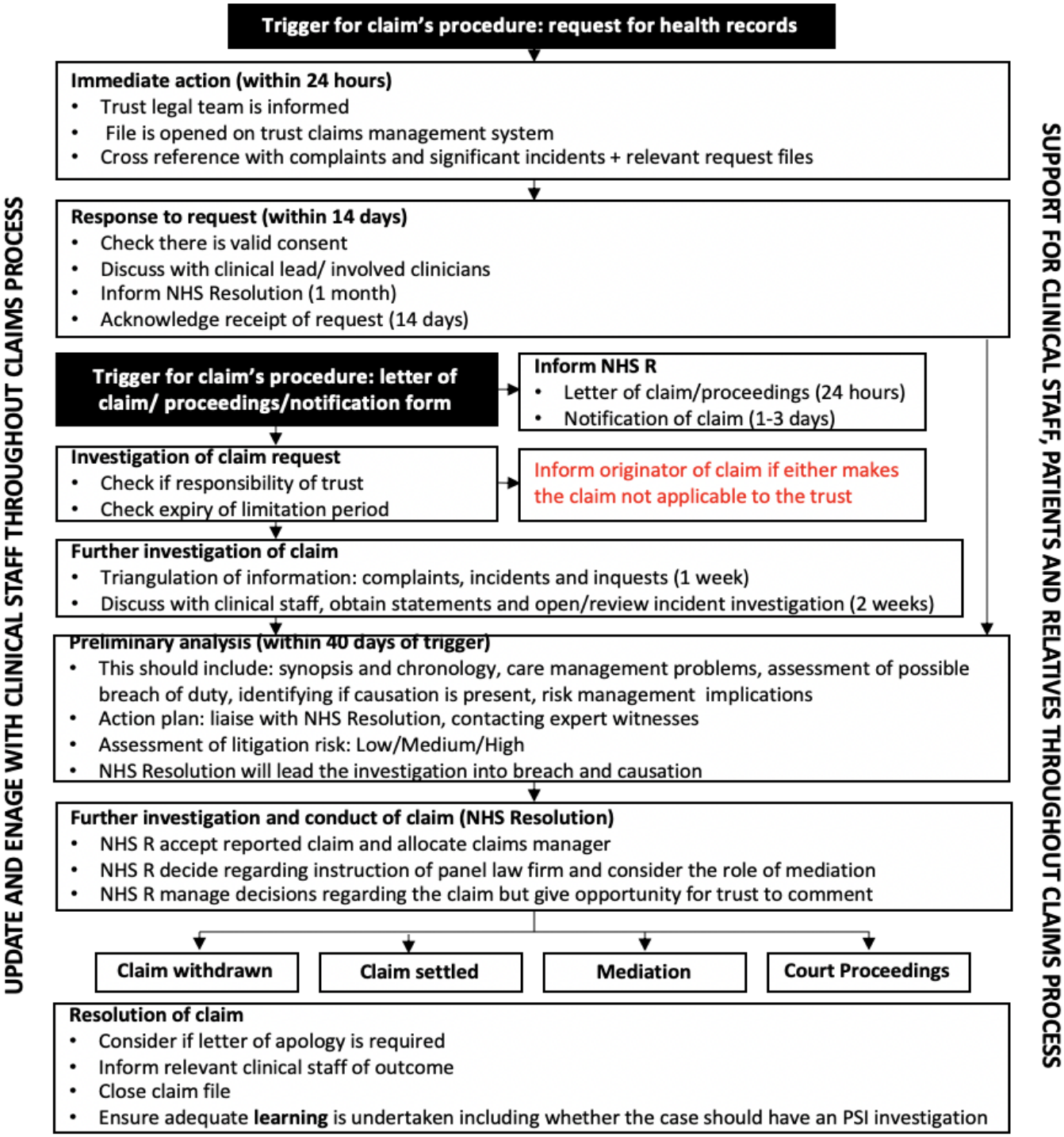
- Never events such as 'wrong site surgery' and 'retained foreign body post procedure' still feature in clinical negligence claims and are significant incidents. Most trusts now incorporate patient safety checklists such as the WHO surgical checklist in their practice to avoid these types of occurrences. It is clear that it is not just the implementation but the consistent strict adherence to these checklists that is critical to avoid never events.

Monitoring of claims learning

Trusts should monitor their claims learning practices to ensure the maximum is gained from this crucial source of education. We have included a structured format for claims learning to be delivered and monitored in Appendix 5.

Appendices

Appendix 1: Example of claims management process



Appendix 2: GIRFT litigation five-point plan for litigation data pack

GIRFT litigation data pack five-point plan

1. Assess benchmarked position compared to the national average and the top quartile (lowest cost) when reviewing the estimated litigation cost per activity (whether it be admissions or deliveries etc.)

2. Review with the legal or claims department in your trust the claims submitted to NHS Resolution included in the data set to confirm correct coding to that specialty. Inform NHS Resolution of any claims which are not coded correctly to the appropriate specialty via CNST.Helpline@resolution.nhs.uk.

3. Once claims have been verified, we would recommend a further review of claims in detail including expert witness statements, panel firm reports and counsel advice as well as medical records to determine where patient care or documentation could be improved. If your legal department or claims handler needs additional assistance with this, your trust's panel firm should be able to provide support.

4. Claims should be triangulated with learning themes from complaints, inquests and serious incidents (SI)/serious untoward incidents(SUI)/patient safety incidents (PSI) and where a claim has not already been reviewed as a SI/SUI/PSI we would recommend that this is carried out to ensure no opportunity for learning is missed. The findings from this learning should be shared with all front-line clinical staff in a structured format at departmental/directorate meetings (including Multidisciplinary Team meetings, Morbidity and Mortality meetings where appropriate).

5. For those departments outside the top quartile of trusts for litigation costs per activity (as demonstrated in the litigation pack) we will be asking GIRFT national clinical leads and regional teams to follow up and support you in the steps taken to learn from claims. They will also be able to share with your trust examples of good practice where it would be of benefit. This guidance and GIRFT best practice in documentation guidance have been produced as a summary of the good practice for trusts

Appendix 3:
British Association of Spinal Surgeon (BASS) three legged stool model for consent[4]

Three legged stool model for consent

1. **Information booklets**, written and illustrated at a level a reasonable patient can comprehend. In addition, GIRFT recommends where possible some evidence that the patient has read and understood the information be collected by the surgeon.
2. **Patient-centered dialogue** including the risks of the proposed treatment, about which a reasonable patient, in this patient's position, would need and want to know. This dialogue must be documented and recorded in the hospital records and ideally a copy in letter form sent to the patient and General Practitioner. GIRFT would recommend that the dialogue should also include the full list of information which should be provided by the surgeon as listed below which incorporates the recommendations of the Royal of College of Surgeons
3. **Procedure specific and surgeon-guided consent form**, along with the NHS or individual hospital form and to gain consent for use of surgical outcome data where appropriate. This should enable the patient to be aware of factors related to a specific procedure or specific surgical technique for a procedure.

Appendix 4:
Royal College of Surgeon's Consent: Supported Decision-Making checklist[5]

The following information should be provided by a surgeon and recorded:

- The patient's diagnosis and prognosis if untreated
- The right of the patient to refuse treatment and make their own decisions about their care
- Alternative options for treatment, including non-operative care and no treatment
- Advice on lifestyle that may moderate the disease process
- The purpose and expected benefit of the treatment
- The nature of the treatment (what it involves)
- Potential pre-operative or post-operative follow-up treatment
- The likelihood of success
- The clinicians involved in their treatment
- The material risks inherent in the procedure and in the alternative options discussed.
- For private patients, the costs of treatment and potential future costs in the event of complications.

GIRFT further recommendations:

- The advised operation and associated procedures, including the side/level.
- Information booklets or websites provided and, where possible, evidence that the patient has read the resources and understands the information.
- Option for a second opinion or follow-up appointment if the patient is uncertain whether to proceed.
- Date of consent – preferably two to four weeks in advance for elective surgery to allow a cooling off period.
- Discussion of the use of patient's data to collect outcomes e.g. additional consent form or other written evidence of consent for NJR or other registers or registries

Appendix 5: Framework for monitoring of claims learning

Aspect of compliance or effectiveness being monitored	Method of monitoring	Individual(s) responsible for the monitoring	Monitoring frequency
Feedback is sought from NHS Resolution and panel law firms after priority claims		Head of legal team	Quarterly
Clinicians involved in each claim have a dedicated debrief after resolution of a claim where possible		Head of legal team	Quarterly
Attendance at panel law firm forum/ regional meetings		Head of legal team	Annual
Clinical staff offered attendance at available teaching sessions organised by panel	Clinical governance & regional meetings	Head of legal team	Annual
Review of claims with NHS Resolution claims leader or Safety and Learning lead.		Head of legal team	Annual
Review and dissemination of GIRFT and NHS Resolution litigation data pack and responses to five-point plan		Head of legal/department clinical directors or governance leads	Annual
Discussion of claims in a specialty with relevant clinical staff and input from trust legal team	Clinical governance meetings	Relevant directorate/ department clinical directors or governance leads	Quarterly/ 6-monthly dependent on priority of specialty
Clinical staff assisting in claims handling and learning	Suggested job plan 1 PA every 2 weeks for high volume specialties/ to be integrated into clinical governance responsibilities in lower volume specialties	HR / Head of legal/clinical directors	Annual
Were the clinicians informed following the request for disclosure of medical records	All requests for disclosure of medical notes	Head of trust Legal team/ clinical directors	Annual
Interaction from clinician: What percentage of clinician statements were received in 2 weeks from letter of claim (Target >80%)	Request for statements	Head of trust Legal team/ clinical directors	Annual

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