

Clinical negligence claims in
Emergency Departments in England

Report 1 of 3:

High value and fatality related claims





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Foreword

For the past 10 years, Emergency Medicine (EM) as a specialty has occupied either first or second position each year in terms of the highest number of new claim notifications to NHS Resolution¹. Each claim represents an episode of harm with associated financial cost to the NHS together with an immeasurable impact on patients, their families and the healthcare staff involved. The demand on emergency medicine is high and continues to grow year on year^{2,3}. These claims are a valuable source of learning within the wider NHS⁴.

Thankfully, while the figures for EM are high in the context of claims, they are very low in relation to overall activity in the Emergency Department (ED), with a claim occurring for only one in every 17,000 episodes of ED care.

Emergency Departments in England are very safe but clearly face unique challenges. They are the NHS’s ‘always open’ service and must meet the health needs of a population that is both growing and ageing⁵. The needs of this patient population are increasingly complex⁵. Patients presenting to ED will often have comorbidities in addition to the problem they are attending for.

Despite this large and increasing demand on Emergency Departments the number of claims have risen broadly in line with the rising number of attendances to ED (17% rise in attendances, 23% rise in EM claims between 2010/11 and 2019/20, Figure 1). While this should be treated with caution due to the lagged nature of claims and the influence of the legal market (with claims overall peaking in 2013 due to legal reforms), the trend observed does not give reason to suggest a deteriorating picture in regards to either patient safety or claims risk in this area.

Every claim is an opportunity for learning, whether successful or not, and provides a unique lens through which to view the causes of harm; therefore it is important to consider claims both locally and nationally as a resource for improvement.

This report aims to provide clinical staff working in EDs with national learning from what NHS Resolution sees in claims across EM in England.

Given the full spectrum of care provided and the diverse patient group in EM it is not surprising that a range of themes emerged from this review. These are presented to the right in Table 1. However, there was a smaller group of consistent themes that occurred frequently and were associated with high levels of harm, namely: failings in the investigations process leading to missed or delayed diagnosis; and recognising and responding to both deteriorating and re-attending patients. Across these themes there was also an overarching issue with the provision of timely and appropriate senior review.

This report would not have been possible without input from the members of our Clinical Advisory Groups, none more so than Dr Cliff Mann OBE, GIRFT Clinical Lead for Emergency Medicine. Dr Mann sadly died in February 2021 and as an advocate for the speciality of Emergency Medicine and a leader in the NHS he will be sorely missed.

Helen Vernon
Chief Executive, NHS Resolution

Table 1. Key conclusions across three reports from Emergency Medicine series following a thematic review of NHS Resolution claims.

No.	Conclusion	Theme occurs in
1	Diagnostic errors including missing signs of deterioration, particularly for spinal and cerebral injury.	• high value and fatality related
2	Failures in the investigation process leading to missed or delayed diagnosis.	• high value and fatality related
3	Failure to recognise the significance of re-attendance to ED.	• high value and fatality related
4	Delay in accessing senior and specialty reviews, leading to missed therapeutic options.	• high value and fatality related • missed fractures
5	Communication issues impacting the escalation and handover of care and cross specialty team working.	• high value and fatality related • falls/pressure ulcers • missed fractures
6	Absence of standardised risk assessments.	• falls/pressure ulcers
7	Failure to deliver proactive nursing interventions in ED, leading to harm.	• falls/pressure ulcers
8	Inconsistent use of incident reporting and investigations as tools for learning from harm to make care safer.	• falls/pressure ulcers
9	Diagnostic error, specifically where early incorrect diagnosis prevented further investigation.	• missed fractures
10	Obtaining images to support diagnosis, including requesting, reporting, interpretation and follow up of images.	• missed fractures

The Royal College of Emergency Medicine (RCEM) welcomes these reports as learning opportunities to reduce the tragedy of preventable harm to individuals and their families as well as the staff involved. No clinician goes to work meaning to make a medical error. As specialty leaders and standard setters, we must use the stories and themes identified in these reports to focus our guidance and teaching and sharpen our advocacy for a better system of care modelled to deliver patient needs.

As well as making sure common errors are widely known about, we need to break down barriers in clinical pathways that can lead to difficult communication and delays. Emergency Departments are under pressure and fulfil every definition of an environment where there is a risk of making a mistake. It is of enormous credit to Emergency Department staff that for the most part they are so safe but as frontline clinicians we want the best care for everyone and know at times we fail.

The Emergency Department sees a greater range of clinical presentations than any other area of the hospital and the patients who present are unselected and most often unannounced. The work is high intensity both by patient volume and also often by severity and complexity. Job demands are high and frequently resources are lacking – despite Covid rules, Emergency Departments are still viewed as having elastic walls and end up holding patients until a hospital bed can be found often many hours later. Crowding is associated with patient harm and dilutes the staff resources to care for new patients. The risk of overwhelming the cognitive resources of the senior staff and demotivating all staff because they feel they cannot deliver the quality care they want to is real.

Reports like these have a responsibility to recognise the gap between what should be the standard of care and the operational pressures a service is working under in the real world. The responsibility for ensuring an adequately qualified staffed Emergency Department with the equipment needed and access to relevant inpatient specialties lies with those who plan healthcare services, but every clinician must look through a report like this. We must all think how we can eliminate patient harm by improving our knowledge and skills, teach others, advocate for better diagnostic pathways and safety net systems.

We must also get better at communicating risk and uncertainty realities to patients, so they feel involved and confident to return for review if things do not seem to be following the expected plan. We need to make sure we are following guidance that already exists, so we balance the hope of picking up atypical, rare but devastating diagnoses and the harms of over-investigation. RCEM is committed to doing everything it can to improve patient safety and reduce the use of resources needed to manage patient harm.

Dr Katherine Henderson

Royal College of Emergency Medicine President

For many patients the Emergency Department is the front door they pass through on a journey through health and care services. When things go wrong there, the impact can follow them on every step of that journey, and affect short-term and long-term outcomes. This set of reports is a valuable source of learning for health and care services, and for nursing, beyond the front door, as the themes identified here resonate more widely.

Every nurse and health care professional will have been involved in an instance when things have gone wrong for their patients; a mistake, an omission, a missed opportunity to intervene. In the majority of cases this will not go on to become a claim, but it is essential to learn from those that do.

Risk is inherent in all settings in which health care is delivered, and the need for robust, documented risk assessment is emphasised, not only to prevent harm coming to patients, but also to support staff in their practice. As this series of reports recognises, current risk assessments are all too often burdensome and time consuming, with duplicated information in a range of paper and electronic tools. A contemporary digital risk assessment as recommended in this series of reports requires true collaboration and co-creation to ensure that it reflects practice at all stages of the patient journey.

When harm does occur, the need for effective incident reporting is highlighted as essential for learning, but so too are failings in current processes, and the impact on those involved – patients, families and healthcare staff. This series of reports reference work being done in NHS England to make this process more effective, and recommends the inclusion of significant information currently lacking on the context in which incidents happen, including staffing levels, skill mix and patient acuity.

The third report in this series focuses on pressure ulcers and falls, which are recognised as nurse-sensitive indicators of quality care, and highlights a lack of proactive nursing interventions. While none of these reports explicitly examine staffing levels, they highlight other publications which have done so. The link between poor patient outcomes and the number of admissions managed by each registered nurse in the Emergency Department is in line with the strong evidence base which links nurse/patient ratios within in-patient settings.

The Royal College of Nursing (RCN) has published Nursing Workforce Standards⁶ which apply across all settings, and are designed to support a safe and effective nursing workforce wherever care is delivered. Implementation of these standards within the emergency care setting would support the recommendation of this report for dedicated nursing time to deliver high quality nursing interventions.

Rachel Hollis

Chair of RCN's Professional Nursing Committee

Executive Summary

NHS Resolution is an arm’s length body of the Department of Health and Social Care. Our purpose is to provide expertise to the NHS to resolve claims fairly, share learning for improvement and preserve resources for patient care. Annually NHS Resolution is notified of circa 11,000 clinical negligence claims with an estimated value of £4.5 billion.

RATIONALE

In 2020/21, clinical negligence claims associated with the Emergency Department (ED) accounted for 11% of the total number of claims notified to NHS Resolution and 5% of the total estimated value of all claims notified. In total the value of notified claims equated to £321.98 million including both estimated damages and the legal costs. The reported value of these claims is third next to obstetrics and paediatrics⁷.

The impact of harm to these patients together with the volume and value of these claims have driven this deep dive into Emergency Department claims to identify common issues. Many who attend ED also have other health issues that may affect diagnosis and management and Emergency Departments provide open access to the public. These departments are often the only part of a hospital that many will see. They play an important part in caring both for those with acute illness and those with injury. Public expectation is high and increasing. Furthermore, this is a specialty that has seen a significant growth in demand with further demand anticipated in view of an increasingly ageing population and in the context where EDs are seen as a primary source of help.

We acknowledge the multi-faceted nature of emergency care; that ED claims include incidences of harm across a range of specialities and that claims are not restricted to care provided by Emergency Medicine teams. We also recognise that current coding systems do not always capture this detail. However, all claims allocated represent an incident of harm to a patient regardless of attribution and therefore these key messages apply to all emergency care settings and all emergency care teams rather than the Emergency Departments in isolation.

AIMS

EDs have a number of unique challenges and the Getting It Right First Time (GIRFT) report from NHS England and NHS Improvement³ has provided an excellent analysis of the operational issues. This series of thematic analyses complements that report by exploring the clinical issues that contribute to compensation claims. By providing practical recommendations for clinical care, we aim to improve patient safety, which will help prevent harm and ultimately reduce the number and cost of ED claims.

METHOD

We undertook a thematic analysis of Emergency Department claims. A total of 220 claims were included in the analysis.



RESULTS

The complexity of this specialty required wider and more complex analysis than NHS Resolution has previously published. For this reason we are delivering the various themes as a series of reports, which include high value (in excess of £1 million) and fatality claims; missed fractures (report number 2); and hospital acquired pressure ulcers and falls (report number 3).

For this report (number 1 of the ED series – high value and fatality related claims) the numbers are as follows:

- **High value claims:** 16 closed claims (from the period between 2014 and 2018) were analysed with a total value of £33 million. Missed diagnosis was a key theme common to all the incidents, particularly for spinal and cerebral injury.
- **Fatalities:** 86 claims were evaluated with a claims cost of £5.8 million. The most common causes of death were related to misdiagnosis of infection or sepsis, pulmonary embolus, suicide, acute coronary syndrome and aortic disease, including dissection and ruptured abdominal aortic aneurysm.

COMMON THEMES:

Common themes emerging from thematic review included:

- Diagnostic error including missing signs of deterioration.
- Failure to investigate and/or diagnose, and missed, wrong and delayed diagnoses.
- Failure to recognise the significance of repeat attendance and/or patient not re-attending when advised to.
- Delays in care, including specialty reviews and missed therapeutic options.
- Problems with communication, escalation and cross specialty team working.

Recommendations

The recommendations are grouped under those for national action and those requiring local action.

Recommendation 1:

Diagnostic error including failure to investigate and/or missed, wrong and delayed diagnoses

National

- This report supports the findings of previous publications including the Independent Review of Diagnostic Services for NHS England⁸ that highlight the need to ensure that imaging is available without delay in ED. NHS Resolution will convene a meeting to explore with NHS England and NHS Improvement (NHSE/I), supported by RCEM, The Royal College of Radiologists (RCR) and College of Radiographers (CoR) the feasibility and cost benefit analysis of increasing MRI so that it is available 24/7 in all EDs.
- The organisations listed above to explore a range of possible system level options to support staff accessing local multi-professional training with tools to implement existing national guidelines and recommendations, for example from Royal Colleges, GIRFT, Care Quality Commission (CQC) and National Institute of Clinical Excellence (NICE).

Local

- Consistent use of the national early warning system scoring to identify deteriorating patients and take effective action.
- Provider trusts to implement multidisciplinary training programmes supported by Royal Colleges and Health Education England (HEE) programmes, with a focus on preventing and reducing diagnostic error.

Recommendation 2:

Recognition of the significance of repeat attendance or patient not reattending when advised

National

- NHSEI together with other partners and stakeholders to highlight both nationally and through regional structures the importance of recognition of risks associated with repeat attenders and the need for systems to ensure access to senior clinical review for this group of patients.

Local

- Providers of ED services to implement the RCEM recommendations and agreed pathways for patients that re-attend Emergency Departments on a number of occasions with the same condition to ensure a senior level clinical review takes place.

Recommendation 3:

Delays in care, including specialty reviews and missed therapeutic options

National

- Royal Colleges and national bodies to mandate professional standards such as those that are published by NHSEI.

Local

- Introduce regular multidisciplinary team (MDT)/wider specialty clinical governance meeting to regularly meet to discuss cases such as specialty reviews and action plans for improvement. These should include ED senior clinicians and radiology/diagnostics to discuss cases, build trusting relationships and support effective team working.

Recommendation 4:

Communication and escalation

National

- Promotion of resources to support and improve safety and learning cultures and team working, that support both effective escalation cross specialty and access to senior level support.

Local

- Implement the CQC's 'Patient FIRST' principles⁹ and professional standards from its 2018 report 'Under pressure: Safely managing increased demand in emergency departments'¹⁰ to include development of supportive escalation pathways to improve cross specialty and senior level support.



Introduction

Since 2017/18, Emergency Medicine as a clinical specialty has been one of the specialities associated with the largest number of clinical negligence claims made to NHS Resolution, accounting for 11% of the total claims notified in 2020/21⁷. The estimated cost of these claims was valued at £321.91 million, including damages and legal costs⁷.

This accounted for 5% of total NHS claim legal costs; the second highest number of any specialty and third in value only to obstetrics and paediatrics. Emergency care in England is generally very safe and the overall claim rate in proportion to Emergency Department (ED) episodes is very low: < 0.005% (~1400 claims for 23.8m; in major EDs the figure is closer to 16 million ED episodes per year or less than one claim for every 17,000 attendances).

There are a number of unique challenges in Emergency Medicine, including the requirement to provide care for undifferentiated acute and urgent aspects of illness and injury for patients of all age groups with a full spectrum of physical and psychological disorders. In addition, patients presenting at the ED are often characterised by multiple morbidities and polypharmacy with complex clinical presentations that require sophisticated diagnostic input and multidisciplinary care¹¹ connecting with almost every other inpatient speciality. Furthermore, the demand on ED and acute medical services is increasing¹².

This report complements NHS England and NHS Improvement's GIRFT EM report³. Their report highlights the operational challenges EDs face to deliver optimum care and treatment, including: demand, activity, safe staffing and appropriate estate resource³. These issues contribute to the variation in outcomes identified by the GIRFT EM report (2021).



Summary of the key findings from the GIRFT EM report³

The GIRFT team visited a range of emergency departments (EDs) between 2017 and 2020, and observed a high level of variation – both unwarranted and warranted. Some of the variation they found was due to geographic, social and demographic factors. Some was also due to historical and funding issues. However, much was believed to be a result of system and operational processes, and a failure to meet the local demand for emergency care. Unfortunately, the EDs with the largest burden of deprivation and disease often had the poorest facilities and the fewest staff³.

The GIRFT Emergency Medicine report (2021)³ focuses on giving providers accurate information to identify how best to meet the demand for emergency care from the catchment population. The GIRFT team developed some new metrics to interpret the data and some different ways of representing it. One such metric, the aggregated patient delay (APD), has already been adopted by NHS England and NHS Improvement's Model Hospital portal and some other metrics are also entering common usage. The Summary ED Indicator Table (SEDIT) that was developed is now available online and updated monthly, thus providing a readily available source of current and comparative information for all EDs. Additionally, the Covid-19 situation has further stress-tested emergency care provision, throwing a national spotlight on many of the issues found in the course of GIRFT team visits to EDs over the past three years and making the case for change more urgent than ever before.

The key messages of relevance to ED claims were³:

- There is enormous unwarranted variation in Emergency Departments throughout England.
- There is variation in the four main GIRFT-EM domains of demand, capacity, flow and outcomes. Most of the variation in demand is due to geographical and demographic factors and is very difficult to change but variation in capacity is usually amenable to improvement.
- Flow and outcomes are dependent to some extent on the demand and capacity profile of an ED but the GIRFT-EM quadrants offer a graphical way of representing a considerable amount of ED data showing that there are many more factors at play.
- The GIRFT-EM SEDITs (Summary ED Indicator Tables) give a good oversight of the comparative metrics for every single ED in England and can be used to guide investment and improvement.

Background



NHS RESOLUTION AND CLAIMS COSTS

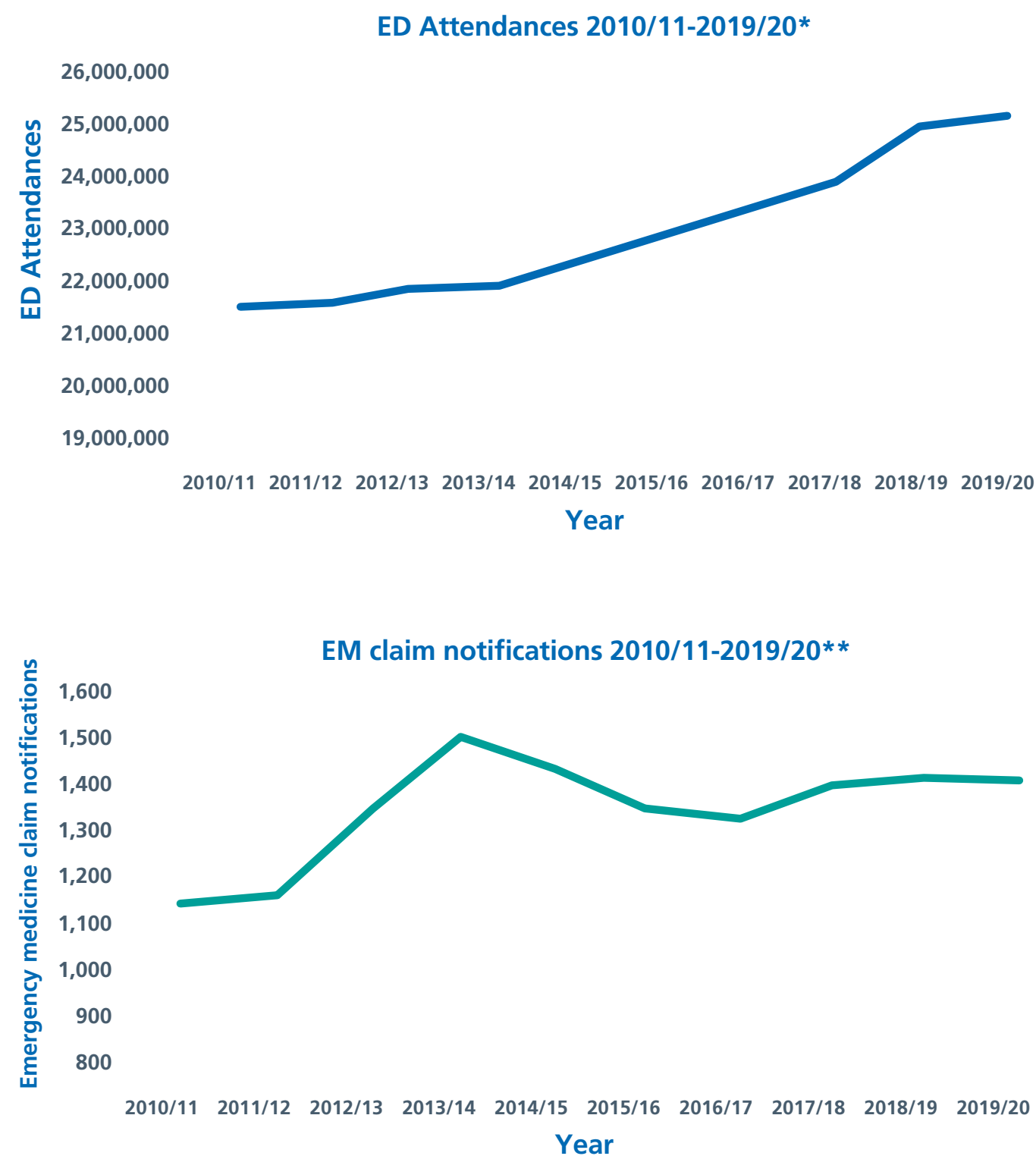
NHS Resolution aims to resolve and learn from clinical negligence claims, so that trusts and the wider NHS can learn from these incidents sooner to implement change and therefore mitigate future risk of harm and claims.

In 2020/21, NHS Resolution received 10,816^a clinical negligence claim notifications⁷. Emergency Medicine accounted for 1,151⁷ notifications, which is similar to the previous year's claims notifications at 1,401¹.

As NHS clinical activity has continued to rise this represents a fall in claims proportionate to clinical episodes. It is important to note that initiatives over previous years in other specialties, in particular orthopaedics, to improve safety have had some positive impact by reducing claims in those areas. This makes EM now appear high, whereas the reality is that despite increasing patient numbers visiting EDs the number of new notifications is fairly consistent (see Figure 1).

^aExcludes data from general practice indemnity schemes

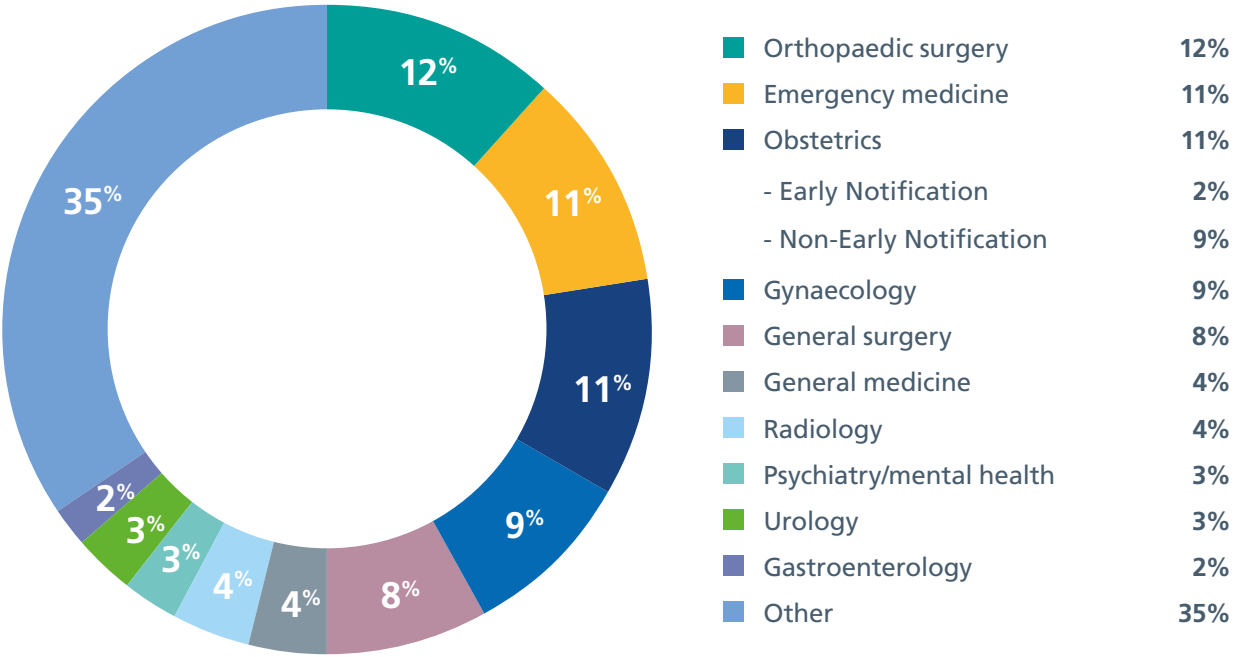
Figure 1: ED attendances and EM claim notifications 2010/11 to 2019/20



* ED attendances (MSitAE data published by NHS England and NHS Improvement¹²)

**EM claim notifications (volume of claims notified to NHS Resolution¹¹)

Figure 2: The total number of clinical negligence claims received in 2020/21, broken down by specialty from a total of 10,816⁷



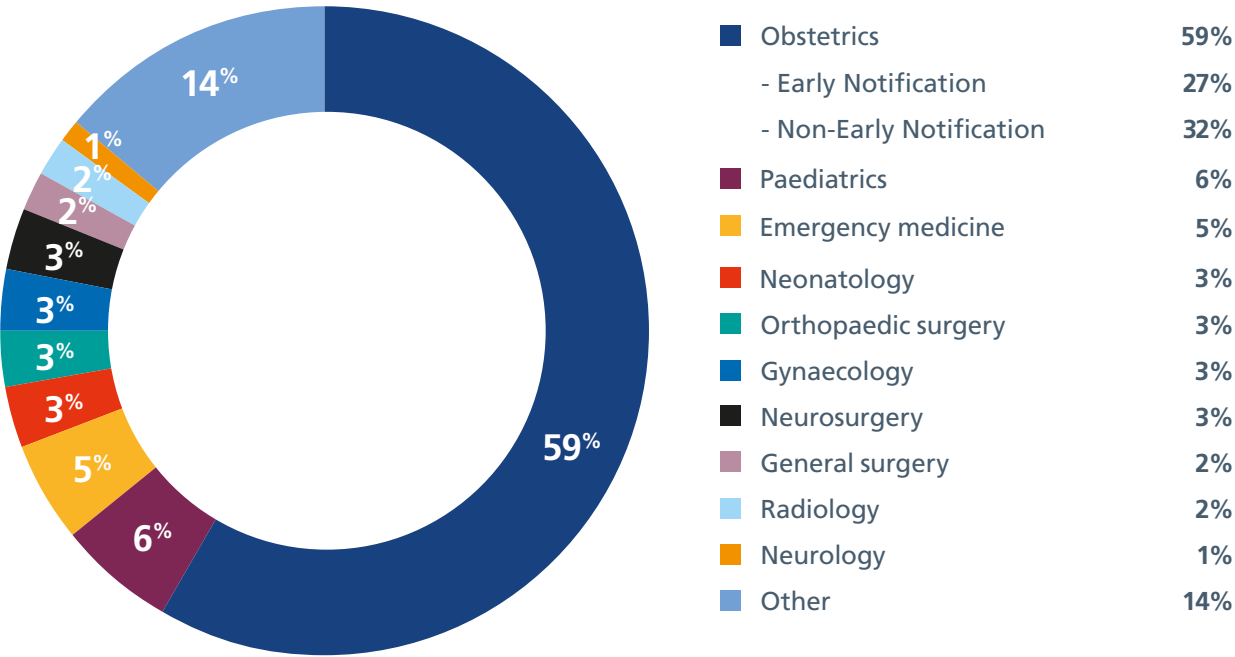
Investigating claims related to Emergency Medicine within the ED provides an important vehicle to identify learning to share with EM services and the wider NHS. Moreover, the investigation aims to identify areas and priorities for research in ED system level organisation and care provision.

Once a claim is lodged NHS Resolution will investigate by obtaining witness statements and expert advice to establish firstly whether there has been a breach of the duty of care owed by the NHS trust to the patient and secondly whether that breach has caused an injury which means that the claimant is entitled to compensation. Forty-four per cent of claims resolve without compensation being paid.

Compensation is assessed and negotiated according to established legal principles. NHS Resolution aims at all times to keep cases out of formal litigation which can be distressing for patients and clinical staff. Seventy-five per cent of claims resolve without formal proceedings and only 0.4% go to trial.



Figure 3: The total potential value of clinical negligence claims received in 2020/21, broken down by specialty from a total of £7,113.8 million



Source: NHS Resolution Annual report and accounts 2020/21 (both Figure 2 and 3)
These figures exclude data from our general practice indemnity schemes (both Figure 2 and 3)

Human cost

Over and above the financial cost of claims, each successful claim represents a patient journey or experience where the NHS has failed to meet expectations or standards and patients have come to preventable harm or suffering. Patient outcomes and experiences are also highlighted as a major concern of the GIRFT-EM (2021) report³. Each claim is a human story and is inadequately captured in the collection and interpretation of data alone.

Although the effects of clinical negligence are primarily felt by patients and their families, the impact on staff involved can also be significant and long-lasting¹⁵. Clinical staff strive to provide the best possible care and the discovery that an error or omission, often made as part of a wider systemic failure, has caused a patient harm can have far-reaching consequences for frontline teams and individual staff members^{15,16,17}. This can include short term effects on practice and changes to area of practice and/or career as well as contributing to some clinicians leaving the profession completely¹⁷. The current difficulties with recruitment and retention of health professionals, particularly in acute specialties, underline the need to provide a supportive and compassionate environment for clinicians when they are involved in a clinical negligence case¹⁵.

Nevertheless, there is a need for clinical accountability and a parallel 'system level' requirement to address weaknesses in policies and processes, practices, training and education, while striking a balance between accountability and a just and fair culture of learning¹⁵. This allows the greatest opportunity across the wider NHS to learn when things go wrong, and mitigate future risk.

Methodology and approach

The objective of the analysis was to identify a representative cohort of NHS Resolution claims where ED care was deemed not to have met the required standard, resulting in patient harm, with the goal of identifying areas of potential improvement relevant to the practice of Emergency Medicine, and the service more widely.

It is important to acknowledge that claims relating to ED include incidents of harm that relate to a range of specialties. While the coding system may not always capture this in detail, all claims allocated represent an incident of harm and therefore the key messages apply to all areas within the emergency care setting.

The NHS Resolution Claims Management System (CMS) holds information for clinical negligence claims received since 1995 concerning incidents dating back to the formation of the NHS. The CMS was interrogated, and an initial search identified 6,412 Emergency Medicine clinical negligence claims with a notification, incident or closure date between 1 April 2015 and 31 March 2018.

Open claims pending resolution (1,564) and unsuccessful closed claims (1,715) were excluded. There were 3,133 completed claims where damages were awarded to the claimant between 1 April 2015 and 31 March 2018.

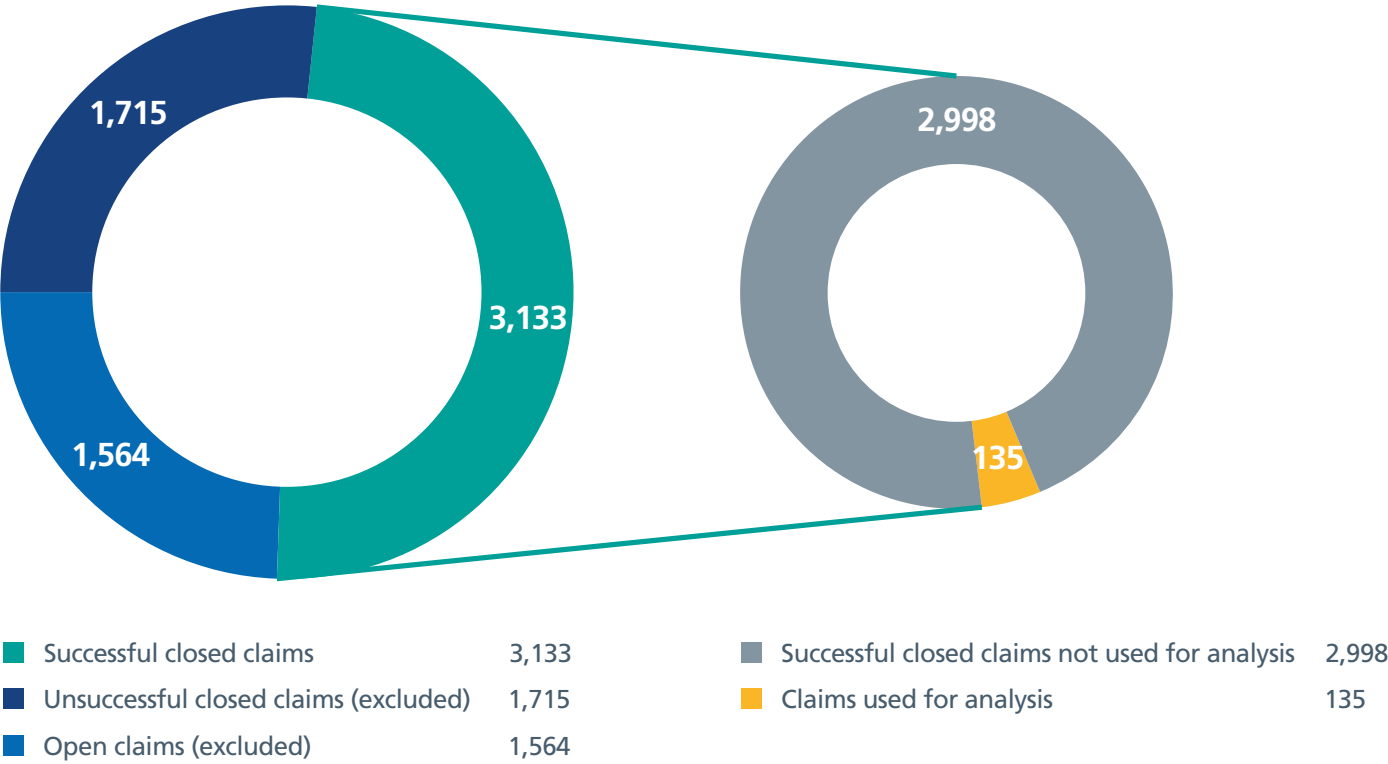
There were 135 closed claims from two complete years of claims – 2016 to 2018 – that were both suitable for analysis and deemed most relevant to current practice. Catastrophic injury/high value cases (with a value of over £1 million) prior to this date were also checked to ensure that the 135 were a representative sample.

A detailed pilot review of 30 cases was used to develop a database that was subsequently populated by complete review of the CMS data for the 135 claims (see Figure 4). Wherever possible further information from NHS Resolution's panel of solicitors was included within the review. Two claims were excluded after detailed review because they had been wrongly coded to EM, leaving a total of 133 claims.

This report in the series presents an analysis of a subset of the 133 claims relating to 86 fatality cases and 16 high value claims – claims valued in excess of £1 million.

We will present the review of claims related to missed fractures, falls and hospital acquired pressure ulcers separately in the series of related EM reports.

Figure 4: Emergency Medicine claims^b, showing the proportion of open, unsuccessful and successful claims, and the proportion of successful claims used for analysis



^b **All Emergency Medicine claims:** Emergency Medicine clinical negligence claims with a notification, incident or closure date between 1 April 2015 and 31 March 2018.
Successful closed claims: Completed claims where damages were awarded to the claimant between 1 April 2015 and 31 March 2018.
Open claims: Open claims pending resolution (excluded).
Unsuccessful closed claims: Unsuccessful closed claims (excluded).
Claims used for analysis: A sample of 135 claims selected from the 'Successful closed claims' data for analysis.

Limitations

There are a number of limitations to the analysis. There are 1,300–1,400 notifications to NHS Resolution each year for claims in Emergency Medicine and a pragmatic approach was employed to identify claims that could be investigated within the resource available. High value claims were identified and analysed separately.



This analysis employed the following inclusion criteria:

- The claims reviewed were restricted to closed claims in England with an incident date between 2014 and 2018, coded on the NHS Resolution Claims Management System (CMS) to have originated in the ED.
- These data are limited to those that have been reported, investigated and closed within the defined time frame. This may have the unintended consequence of reducing representation of complex claims that inevitably have a longer lag time before settlement.
- NHS Resolution covers trusts in England only and direct extrapolation to other devolved nations may not be helpful (although they are believed to have similar themes), particularly with different legal systems.
- CMS is a system primarily designed for managing claims, rather than for enabling the NHS to learn from compensation claims. Claims are coded as they come in by claims managers not clinicians, and many codes relate to legal process rather than clinical outcome, which can restrict analysis. Some claims may have different specialty involvement.

We accept that although claims analyses provide a perspective on medical negligence that informs litigation systems, this lens can provide a narrow and often historical view of adverse incidents for clinicians¹⁸. However, it is an important lens for the identification of remediable errors and system learning.

Information governance

All personal data held and used by NHS Resolution is processed in accordance with the UK implementation of General Data Protection Regulation (GDPR) and research ethics committee approval was not required because this was a review of routinely collected data.

Staff involved in this work (and all those who work for NHS Resolution more generally) are subject to confidentiality obligations. Part of NHS Resolution's remit^c is to learn from the information held for claims and to disseminate this learning as widely as possible across the NHS to improve patient safety and reduce harm. This report has used the data held for this purpose and has reduced the use of identifiable material to a minimum during the research process.



^c The National Health Service Litigation Authority (Safety and Learning) Directions 2019⁴.

Thematic review of high value and fatal ED claims

This chapter presents the findings that emerged from the thematic reviews of both high value claims (valued with damages awarded > £1 million and claims where there is severe long-term injury) and a group of fatality claims.

Each one of these claims represents a patient who has suffered life-changing injury or unexpectedly died while accessing care in the NHS. The human cost of harm is high, which impacts patients, families and carers, as well as the staff involved in their care. The aim of these reviews is to develop a better understanding of the contributing factors to these claims to extract learning and develop recommendations to drive improvements in care, and to reduce harm and future claims.



Summary of findings in closed claims 2014–2018

HIGH VALUE CLAIMS

- 16 claims were identified with damages awarded of £1 million or more.
- The average damages awarded were £2,069,029.
- Missed diagnosis (which includes failure to investigate) was common to all the high value claims: spinal (n=8) and cerebral (n=4) related misdiagnoses were the most common clinical areas for claims.
- There were insufficient data to provide any robust demographic conclusions.
- In half of the claims, there was evidence of a local incident report and a complaint, but only 2 (12.5%) cases had been formally reviewed in line with the recommended serious incident (SI) process. The GIRFT teams have observed that ED clinicians need to be more closely involved in these processes.

FATALITIES

- There were 86 settled claims involving the death of a patient with an incident date between April 2014 and March 2018.
- The average damages paid to claimants was £45,284.
- Missed diagnosis was identified in >80% of claims and the remainder were related to iatrogenic harm.
- The most common causes of death related to a missed diagnosis, in descending frequency:
 - Infection or sepsis, particularly due to missed gastro-intestinal diagnoses such as ischaemic, perforated or obstructed bowel (including the use of the correct diagnostic test)
 - Pulmonary embolus
 - Falls (including falls of patients in a hospital setting, i.e. while attempting to walk or move from a bed or trolley; these were generally older patients)
 - Suicide
 - Acute coronary syndrome
 - Aortic disease including dissection and ruptured abdominal aortic aneurysm
 - Fatalities related to iatrogenic harm predominantly due to medication errors and particularly a failure to instigate appropriate Venous Thromboembolism (VTE) prophylaxis
- There was insufficient data to provide any robust demographic conclusions.

High value claims

The low number of claims can make inadvertent patient identification a risk, particularly for individual conditions. Therefore, we have presented a limited summary of aggregated data and the themes identified by our analyses, rather than comprehensive case details.

SPINAL CONDITIONS

This group of patients all had a disease process affecting the spinal cord, including traumatic spinal cord injury, tumour, haematoma, and abscess and cauda equina.

With the exception of a single case all had multiple previous attendances to primary and/or secondary care – ranging from 2–15. Despite this, there was little evidence of senior review for patients presenting for the second, third or fourth time with the same problem.

Missed diagnosis, particularly missing important features of the clinical history and examination, was almost ubiquitously related to a successful compensation claim in these cases. In particular:

- Severe and persistent pain was identified and not given sufficient clinical importance
- Failure to perform the right diagnostic test, i.e. imaging
- Features of systemic illness were either not asked about and/or not recorded
- Referred pain from nerve root compression was misinterpreted as pain related to shoulder, chest or abdominal conditions, which resulted in inappropriate referral to medical or surgical teams
- Documentation of a complete neurological examination was often lacking.

Once the differential diagnosis had been correctly identified there were often further delays in performing an MRI scan to confirm the diagnosis, with additional delay to appropriate management, e.g. reversal of anticoagulation or operative intervention.

In some cases, these post diagnosis delays appeared to be due to lack of awareness of the urgency required, while in others they appeared to be due to system problems delaying urgent intervention. These system problems included access to an MRI scanner. Many hospitals do not have access to 24/7 MRI¹⁹; therefore, if a scan is required outside those hours a transfer to another hospital has to be arranged, which takes time, including the transport required, the patient needing to be clerked by the receiving hospital and a senior review to decide whether to proceed to surgery. All these issues contributed to significant delays to action.

Communication problems particularly around escalation between specialties were also deemed to have contributed to delay in diagnosis.

Illustrative case study related to a spinal claim

This illustrative case study seeks to highlight some of the key themes identified in respect of the spinal claims reviewed. In particular:

- The importance of taking into account previous attendances (including those with primary care).
- Communication problems/escalation between specialties.
- Bilateral sciatica should immediately suggest central prolapse and cord compression.
- Bladder and bowel symptoms often occur when neurological damage is irreversible.

The claimant attended her GP on three occasions over two weeks with concerns about severe back pain, radiating into her legs. The GP diagnosed sciatica and prescribed pain relief with advice to return for review if her symptoms became worse.

A week later, the claimant called NHS 111 with concerns that the back pain she was experiencing had become excruciating with pain radiating to her legs with a pins and needles sensation and some weakness in her left leg. The claimant was advised to attend A&E.

On arrival at A&E, the claimant was seen by a consultant, Dr Red, who noted the history, namely worsening back pain and bilateral sciatica. However, she considered that the left leg weakness was likely to be due to the pain the claimant was suffering. She was also reassured by the fact that the claimant reported normal perineal sensation. A rectal examination identified normal anal and sphincter tone and there was no incontinence. Dr Green thought it was most likely the claimant was suffering from a trapped nerve. The claimant was discharged with advice to see her GP again if her symptoms did not settle.

The next morning, the claimant re-presented at A&E. She was very distressed and reported that she was now also experiencing numbness in her groin area.

The claimant was seen by Dr Green, Specialist Registrar in Emergency Medicine, at 08:45. Dr Green recorded a three-week history of lower back pain with the recent onset of pain radiating into both legs. The claimant was able to pass urine and a bladder scan was normal. In addition, a rectal examination identified normal anal tone. However, Dr Green was concerned by the claimant's saddle anaesthesia. She therefore contacted the orthopaedic/spinal team to discuss the claimant's presentation at 09:00.

The spinal team was extremely busy, and Dr Green left a message, but it wasn't until 10:30 that Mr Orange, Spinal Consultant, telephoned back. Dr Green shared the claimant's history and the findings from her examination. Unfortunately, the precise detail of the information relayed by Dr Green to Mr Orange was not documented. However, Mr Orange did not consider there to be a spinal emergency. In his record of the conversation, he noted that there were no bladder or bowel symptoms and normal anal tone. In his view, there was no red flag to warrant MRI or spinal review.

It was therefore considered appropriate to discharge the claimant home with pain relief and advice to return to hospital if she developed any red flag symptoms. Dr Green recalled that she discussed red flags with the claimant, but she had not documented this in the notes.

The following morning, the claimant re-attended A&E. Her symptoms had deteriorated further. There had been a worsening of her sensation deficit to the back of her legs and she was struggling to mobilise. She also reported a loss of sensation when passing urine.

She was seen by Dr Pink, an A&E Consultant. Examination identified slightly reduced power in the right leg with some reduced sensation. Anal tone was absent. There was urinary incontinence, and a bladder scan revealed a large volume, so a catheter was inserted. Dr Pink made urgent contact with the spinal team who examined the claimant and admitted her. An MRI scan was performed, and the claimant underwent emergency decompression surgery later that day.

The claimant sustained permanent neurological damage and now suffers with bladder, bowel and sexual dysfunction symptoms, as well as loss of mobility.

LEARNING POINTS

This case study identifies the importance of clear communication between specialties and good record keeping. It is based on a number of claims where there was poor documentation, making it difficult to establish precisely what had happened and what information had been shared between specialties and between the clinicians and the claimant.

In particular, Mr Orange documented that there were no red flags to warrant MRI scan or spinal review because the claimant had no bladder or bowel symptoms and there was normal anal tone.

The patient had bilateral leg pain and perineal paraesthesia. Like many neurosurgeons, Mr Orange wanted a full bladder, a lack of anal tone or double incontinence to confirm the diagnosis. However, while bladder scans and rectal examinations are often requested by neurosurgeons they can often be misleading.

Many patients may present to ED with relevant neurological symptoms but do not have cauda equina syndrome. The correct action would have been for the patient to have had a diagnostic MR scan at the hospital where they first presented.

If Dr Red had been able to arrange an urgent MR scan, harm could have been avoided.

It was also not documented whether Dr Green discussed red flag symptoms with the claimant at the point of discharge and there was therefore no contemporaneous evidence that the claimant had been advised of the need to return if she developed further symptoms.

High value claims

CEREBRAL CONDITIONS

This group of patients had conditions affecting the brain: stroke due to carotid artery dissection, cerebral haemorrhage and a rare case of meningitis.

Again, missed diagnosis was deemed to be related to missing important features of the clinical history and examination albeit for rare conditions, often with atypical presentations. None of the patients presented with a classical history, but if all available sources of the history had been taken into account it was accepted by clinical experts that the diagnosis should not have been missed. In particular:

- GP letters accompanying patients were sometimes not available or read by treating clinicians.
- Information from the ambulance sheet or triage notes was not available or missed.
- Alternative diagnoses were attributed to presenting symptoms leading to missing the correct diagnosis.
- Again, even after a suspected diagnosis, there were prolonged waits of several hours for specialty and/or senior review that resulted in delays to imaging and subsequent interpretation. In at least one case there were delays related to admission to the EAU rather than an area with more specialist care.

LOWER LIMB CONDITIONS

Two of these cases involved patients presenting with knee pain, but the hip was not examined and the correct diagnosis was missed. Neither injury was subsequently identified for several months, with resultant permanent anatomical change and disability.

Fatalities

Although there were more fatal cases analysed, the same caveat for the low numbers of claims and inadvertent identification applies. Therefore, we have presented a limited summary of aggregated data and the themes identified by our analyses, rather than comprehensive case details.

DEATHS DUE TO PULMONARY EMBOLUS

There were two main categories of substandard care identified in the eight deaths from pulmonary embolism: iatrogenic harm and missed diagnosis.

For those who suffered iatrogenic harm, the majority of patients had sustained lower limb injuries requiring immobilisation, which is associated with increased risk of thromboembolism.

VTE risk assessment tools or any risk assessment, including the RCEM recommendations²⁰, were not recorded to have been employed in any of the cases related to iatrogenic harm.

In a minority of cases there was an additional failure to recognise symptoms of potential DVT/PE (n=7), prior to the pulmonary embolus that caused the patient's death.

DEATHS DUE TO SEPSIS

Analysis of fatal claims included seven claims fatalities out of 23 claims relating specifically to sepsis.

Comorbidities relating to sepsis

Underlying medical conditions can make patients more susceptible to infections. Although information was limited for patient comorbidities, the following were reported:

- Six patients had profound respiratory problems such as COPD, asthma and bronchiectasis.
- Four patients had Type 2 diabetes.
- Two patients were immuno-compromised.

Contributory factors

Contributory factors leading to delays in the diagnosis of sepsis included:

- Prolonged wait for assessment despite having been given opiates for pain relief.
- Patient with a neutrophil count of 0.1 not considered to be at risk.
- Abdominal x-ray was incorrectly considered as normal providing incorrect reassurance. CT scan would have been indicated for these cases.
- Even when the patient had a significantly raised CRP this was not escalated as the white cell and neutrophil counts were normal.
- Assumption at triage that the presenting complaint was due to trauma, so no temperature taken.
- ED doctor reviewed the chest x-ray (CXR) and reported it as normal when there were clear indications of pneumonia.
- Patient thought to have a urinary tract infection (UTI); however, also presented with vomiting and diarrhoea which are not typical of a simple UTI.
- No tests or investigations undertaken, only a urinary dip stick.
- At handover from paramedic crew to ED staff, patient was pyrexial, tachycardic and hypotensive. None of these observations were acted on.
- Failure to escalate to Intensive Care Unit.
- Delay in administering timely antibiotics due to the clinicians not considering a sepsis diagnosis.
- Lack of a prioritisation system for patients referred from GPs/the possibility that National Early Warning Scores (NEWS) or physiology is not communicated by the GP
- Whether ED or a direct specialty referral was the correct pathway for these patients. E.g. deaths due to aortic disease

DEATHS DUE TO AORTIC DISEASE

Three patients died after a ruptured abdominal aortic aneurysm (AAA) and two after an aortic dissection. It is well recognised that these conditions are linked to high mortality, which requires prompt investigation, identification and treatment to allow the greatest chance of survival²¹.

Abdominal aortic aneurysm (AAA)

In the patients that died from AAA in this cohort there were a number of clinical themes identified in the claims, including:

- Misunderstanding the high risk and significance and/or differential diagnoses of abdominal pain in older patients.
- Poor awareness, communication and escalation of the symptoms relevant to potential AAA.
- Failure to inform the consultant on call in a timely fashion to allow prompt intervention.

There are two relevant RCEM documents that aim to reduce the chance of missing serious and potentially life-threatening conditions in older patients with abdominal pain. They recommend senior review of patients over the age of 70 presenting with abdominal pain before discharge²² and imaging to exclude AAA in patients over the age of 60 presenting with symptoms of renal colic²³.

Neither of these recommendations were followed in the index fatalities. Although there are no denominator data, a better understanding of effective implementation of national guidelines and strategies to improve their implementation in EM is likely to be a useful strategy to improve care.

Aortic dissection

Aortic dissection can be a challenging diagnosis to make, and may present with collapse, chest or back pain or with neurological symptoms and signs. Chest pain pathways contain a prompt to consider dissection as a possible cause, and as a result of incident reporting, RCEM produced a 'Think Aorta' poster campaign²⁴. The RCEM chest pain standard requires senior review before discharge of patients over 30 years of age with this presentation²².

This did not occur in one case in our cohort and in the other there was no early senior involvement and the diagnosis was only being made at the point of the patient's deterioration.

The review identified poor awareness and recognition of the significance of the presenting symptoms along with evidence of lost opportunities to use information from the ambulance and triage notes.

DEATHS DUE TO CARDIAC CONDITIONS

Seven patients died from acute coronary syndromes or ventricular tachycardia. All had abnormal ECGs or biochemical investigations that were either not recognised, not reviewed and/or not acted on.

The deaths occurred at different times in the care pathway: prior to clinical assessment, after a prolonged stay in ED and after being discharged.

The review identified possible high acuity and unit level activity as contributing factors, with the patients being cared for outside of the recommended environment and with delays to appropriate care.



DEATHS DUE TO SUICIDE

Five patients died due to suicide: three left the ED prior to being assessed and subsequently died by suicide; one died by suicide within the ED; and one patient absconded from the department while receiving medical treatment. Four patients were identified to have had a prolonged wait for assessment.

All these patients arrived in the evening or at night and some evidence of overcrowding was identified by the claims investigations, which was deemed to have contributed to the failure to provide the correct environment and care for the needs of these patients.

Communication problems between ambulance and ED staff; between ED staff themselves; and between ED staff and the patient were identified along with poor records of capacity assessments.

The 2018 NHS Resolution thematic review ‘*Learning from suicide related claims*’²⁵ examined a much larger number of suicide related claims (n=101) between 2015 and 2017. This analysis extends both before and after the time period for deaths investigated by the suicide report. Our current findings with communication, risk assessments and observations were three of the clinical themes reported in that publication.

The last RCEM national audit of care provided to mental health patients in 2014/15 identified that less than 5% of patients were seen by a mental health practitioner within one hour of referral²⁶. The audit investigated the care of mental health patients within the ED itself: not all mental health patients who present to ED need to be seen by a mental health practitioner, but of those who were referred to the mental health team by ED fewer than 5% were seen by that team within an hour of referral. This audit was repeated in 2019/20 and the results are not yet published.

DEATHS DUE TO BOWEL CONDITIONS

The deaths in this category were related to three main bowel conditions: ischaemic bowel, bowel obstruction and bowel perforation/peritonitis.

Once again, the case reviews identified missed opportunities to order the correct investigation and make accurate diagnosis, and substandard delays with care. In particular, the recurring themes were:

- Failure to recognise the significance of severe pain.
- Missed requests for and missed abnormalities in diagnostic tests.
- Delay in acting or escalating deteriorating patients with high NEWS.
- Delay in specialty review.
- Poor communication of management options with the patient.
- Poor discharge diagnoses and planning.

MEDICATION ERROR

There were four medication errors that accounted for the majority of the rest of the fatalities. These included:

- Administering inappropriately high doses of morphine.
- Administering a drug to which the patient was allergic.
- Administering medication to the wrong patient.
- Failing to provide regular prescription drugs and subsequently failing to appropriately manage the resultant deterioration.

Emerging common themes from cases reviewed

Across the range of the cases reviewed within high value claims and fatalities, there were a number of common and recurring themes. The first two of these themes are:

DIAGNOSTIC ERROR - MISSED SIGNS OF DETERIORATION AND FAILURE TO INVESTIGATE; AND MISSED, INCORRECT AND DELAYED DIAGNOSES.

Contributing factors to diagnostics failure included:

- Problems with history taking.
- Too high a threshold for arranging a definitive diagnostic investigation to confirm or refute a suspected or possible severe condition.
- Incorrect weighting of history and findings, particularly the significance of severe pain.
- Important negatives not documented.
- Potential confounding factors not recognised.
- Inadequate or misdirected physical examination.
- Poor documentation.

All of these appear to occur more frequently in respect of patients admitted to an inappropriate or non-standard area of the ED.

FAILURE TO RECOGNISE THE SIGNIFICANCE OF REPEAT ATTENDANCE

A patient presenting to the ED on several occasions is unlikely to see the same clinician each time and this is particularly problematic for patients with repeat attendances across care providers, sometimes in different sites and to different specialties within secondary care.

If the patient presents to different EDs and different primary care settings, the significance of these repeated visits can be further lost. Repeat attendance should be recognised as a red flag.

DELAYS IN CARE

- Delay accessing diagnostic services.
- Delay accessing specialist opinion.
- Delays with transfer.
- Delay resulting in missed therapeutic options.

PROBLEMS WITH COMMUNICATION, ESCALATION AND CROSS SPECIALITY WORKING

- Failure to access information provided in GP letter, ambulance sheet or triage notes.
- Failure to recognise deterioration.
- Failure to escalate.
- Limited or incorrect information provided when escalating care to senior ED doctor or other specialists.

Conclusion

The thematic reviews of both high value and fatalities claims have identified very similar themes across both the categories. These themes are discussed in more detail in the next chapter with a range of recommendations to address these areas. The next chapter proposes strategies to adopt in order to implement improvements nationally, regionally and locally with the aim of reducing harm and improving safety.

Discussion – emerging themes and recommendations

This chapter discusses the emerging themes arising from the clinical review of high value and fatal claims, and proposes recommendations to improve patient safety, in order to lead to a reduction in harm and subsequent claims.

- The common and emergent themes identified were:
- Diagnostic error including missing signs of deterioration.
 - Failure to investigate and diagnose, and missed, wrong and delayed diagnoses.
 - Failures in recognition of the significance of repeat attendance or patient not re-attending when advised.
 - Delays in care, including specialty reviews and missed therapeutic options.
 - Problems with communication and escalation and cross specialty team working.

Theme 1: Diagnostic error

Diagnostic errors are not restricted to ED, but they are widely and consistently reported in ED settings nationally^{27,28} and internationally^{29,30}. It is recognised that EDs are among the most complex systems in a hospital setting with an almost unique set of organisational strains and interdependencies³¹ that may contribute to an increased risk of diagnostic errors²⁸. ED complexity resides in four main areas: the individual patient, the treating clinician, the clinical decision-making process, and the overall ED environment and system issues³². All these elements, individually and collectively, should be considered in potential solutions.

EARLY RECOGNITION OF DETERIORATION

Deterioration is the most important avoidable cause of death and communication is often the root cause. The implementation of NEWS2³³ is recommended for use across the whole country and the whole care pathway (GP, ambulance and all hospitals) to promote the use of same language of sickness in all settings³⁴.

A recent investigation of 2,288 ED diagnostic errors in the UK identified that the majority of diagnoses (86%) were incorrect and/or delayed and only 14% were correctly diagnosed²⁸. There are significant parallels with the NHS Resolution data; fractures were most commonly missed and followed by myocardial infarction, intracranial bleeds, acute abdomen, pulmonary embolus and sepsis^{27,28}. The investigation identified potential contributors to missed diagnosis, were based on professionals, patients and also system factors, as listed in table two.

Table 2: Factors predisposing people to cognitive biases^{28, 29, 30, 31, 35, 36}

Individual factors
High stress
Fatigue
Distraction
Previous experiences affecting interpretation of information
Fear of doing harm or failure
Systemic factors
Workload
Insufficiently staffed clinical area
Not enough time to gather and interpret information
Inadequate teamwork
Lack of available equipment
Patient factors
Multiple risks
Language barriers

These factors resonate with ED where both cognitive and system errors have been identified²⁸. Workload³⁶, possibly including the previous four-hour wait limit, may be a factor³⁴ but there are also data that demonstrate lower-volume EDs have up to twofold higher odds of missed acute myocardial infarctions compared with highest-volume ones after controlling for patient factors³⁷.

Proposed solutions to reduce diagnostic error include the use of checklists³⁸, more staff, a lower threshold for definitive investigations, better implementation of guidelines and teamwork training²⁸. Similar recommendations are common in national reports in other specialties³⁹, but they are not always effective. Moreover, their implementation is complex and often context specific. For example, at least one report of teamwork training in ED was not associated with significant improvements in outcome⁴⁰ and nor was isolated human factors training⁴⁰. Furthermore, checklists are complex systems that require context specific implementation⁴¹ and therefore these solutions are not simple or panaceas.

The Royal College of Emergency Medicine provides relevant guidance for many of the issues identified, including consultant sign off standards⁴². Implementation of national guidance is challenging⁴³ and these challenges are ubiquitous across many healthcare settings and also outside healthcare⁴⁴. However, effective strategies⁴⁵ are also likely to be applicable from other areas to ED.

Research to systemise learning from 'positive deviance' approaches that examine individuals, teams or organisations that show exceptionally good performance⁴⁶ could be scaled across organisations to improve care and outcomes. This approach has been effectively employed in maternity settings⁴⁷. A similar approach has been employed for UK EDs by the Care Quality Commission⁴⁸, but there was no systematic approach to scaling the examples of best practice outside the originator unit, which is an essential bridge to more general improvement⁴⁹.

The RCEM Implementation framework from 2010⁵⁰ recommended that collaborative research bids should be actively developed to foster a better understanding of the barriers and facilitators to implementation including methodological, organisational and clinical issues. We support this aspiration and recommend the formation of a multidisciplinary research group⁵¹ or partnering with other established groups to better understand and identify strategies and tools to improve the use of clinical guidelines⁵² in ED practice.

More and better research to identify the behaviours and practices that appear to be features of good ED care and well-functioning units should be undertaken¹¹, including the structural factors that are likely to impact safety (including staffing levels, quality and availability of equipment and physical environment). Future work should also identify how best to implement best practice and to evaluate how far optimal implementation results in improved outcomes.

Recommendation 1

National

- This report supports the findings of previous publications, including the Independent review of diagnostic services for NHS England⁸, that highlight the need to ensure that imaging is available without delay in ED. NHS Resolution will table a meeting to explore with NHSEI, supported by RCEM, RCR and CoR the feasibility and cost benefit analysis of increasing MRI so that it is available 24/7 in all EDs.
- Explore a range of possible system level options to support staff in accessing local multi-professional training with tools to implement existing national guidelines and recommendations, for example from Royal Colleges, GIRFT, CQC and NICE.

Local

- Early recognition of deterioration: Consistent use of National Early Warning system scoring to identify deteriorating patients and take effective action.
- Provider trusts to implement multidisciplinary training programmes supported by Royal Colleges and HEE programmes, with a focus on reducing diagnostic error.



Theme 2: Recognition of the significance of repeat attendance or patient not re-attending when advised

This report has highlighted the importance of a physical senior review of patients presenting for the second, third or fourth time with the same problem.

Frequent users of the ED often have complex needs and have a higher mortality than those visiting the department no more than once a year. Among those attending the ED two, three or more times in a calendar year, the mortality rate was higher than among those coming only once in a year. The causes of death that led to the highest mortality among frequent users of the ED were neoplasm, ischaemic heart disease and external causes, particularly drug intoxication, suicide and probable suicide^{11,12}.

In 2010, RCEM introduced a Consultant Sign Off standard that was updated in 2016²². This requires review of patients in four high-risk groups by an ED consultant before the patient is discharged. One of the groups of patients identified as high risk are those making an unscheduled return to the ED with the same condition within 72 hours of discharge.

Adherence to this standard should normally include the patient being seen and reviewed in person by the ED consultant. If there is not an ED consultant immediately available to undertake the review, it may be undertaken by an ST4 or higher equivalent member of staff²².

It is already recognised by the RCEM that this standard has been difficult to implement, although it is unclear whether this has improved with recent increases in senior doctor staff numbers in ED. A two-pronged approach may be useful: firstly, to reduce mortality and morbidity with appropriate escalation for senior or specialty review, while also supporting some to reduce the frequency of attendance with integrated care models. Once again, research to identify and scale effective models and good practice would reduce unhelpful duplication and improve care at both unit and patient level.

Recommendation 2

National

- NHSEI together with other partners and stakeholders should highlight, through national and regional structures, the importance of recognising risks associated with repeat attenders and the need for systems to ensure access to senior clinical review for this group of patients.

Local

- Implement the consistent use of the National Early Warning Score (2) to identify deteriorating patients and take effective action³³.
- Providers of ED services to implement the RCEM recommendation²² and agreed pathways for patients that re-attend EDs on a number of occasions with the same condition to ensure a senior level clinical review takes place.

Theme 3: Delays in care, including specialty reviews and missed therapeutic options

Once the differential diagnosis had correctly been identified there were commonly delays in arranging, or expediting, imaging to confirm the diagnosis, creating further delays of appropriate management. For example, reversal of anticoagulation, transfer to a specialist unit or operative intervention. In some cases this appeared to be due to a lack of awareness of the urgency required, while in others it appeared to be due to a system problem preventing urgent intervention.

Recommendation 3

National

- Royal Colleges and national bodies to mandate professional standards such as those that are published by NHSEI.

Local

- Introduce regular multidisciplinary team (MDT) wider specialty clinical governance meetings to regularly meet to discuss cases such as specialty reviews and action plans for improvement. These should include ED senior clinicians and radiology/diagnostics to discuss cases, build trusting relationships and support effective team working.

This approach is supported by the previously cited RCEM guidance:

“The Emergency Department and the Radiology Departments are encouraged to hold regular meetings to review requesting protocols, timeliness of reporting and volumes and trends of requests”²² (p.2 Recommendation 8).

Theme 4: Communication and escalation

There are multiple points in a patient’s journey to and through the ED where communication can break down, and we have identified problems with both communication and escalation that reduce the quality of care.

COMMUNICATION

Communication issues are a significant contributory factor in instances where difficulties in staff being able to follow guidelines were identified. This was highlighted across ED during telephone discussions with consultants in other specialties.

Cross-specialty communication

Poor communication between ED staff and other specialties impairs the ability to follow relevant guidelines. Poor communication between department teams regarding the urgency of the situation and of how to escalate to obtain more senior support can impact directly on safe patient care.

If any member of clinical staff feels that the clinical situation needs a more senior team member, or that specialist help is required, they should escalate accordingly.

Team communication

Poor team communication increases risks during emergency situations and can also impact negatively on team performance. This can be compounded by the presence of staff unfamiliar with the local setting and by a lack of knowledge regarding local equipment. ED team members may be aware of the poor communication but not know how to resolve it.

Effective communication strategies for high-risk situations are important and should include every member of the team. Examples include implementation of debrief sessions after high-risk events to examine how well events were handled, where things went well and where improvements might be made in the future. Consultants and senior clinical staff are key role models and one feature of well-performing departments is consultants constructively modelling good communication and behaviours for the team⁵².

Important information can be missed whether conveyed verbally or in written form, and robust systems of communication between GPs and admitting specialties are required to prevent patients ‘defaulting’ to the ED as this delays access to specialty opinion. Improved multidisciplinary communication and a system level change to handovers at high risk ‘check-points’ in patient care can be useful to improve safety at handover.

Moreover, there should also be robust systems to convey and record handover information between ambulance crews and ED triage staff, and ambulance Patient Report Forms (PRFs) should always be available to review, and should be reviewed by, ED staff.

Finally, handover of clinically relevant information about patients from one ED clinician to another, and from ED to ward staff, are further areas of risk, and consideration should be given as to how to minimise the risks.

ESCALATION

Escalation is a complex process and is considered here under two categories, standard escalation and escalation during overcrowding. Barriers to effective escalation were identified from the review of claims – these include:

- Failure to recognise the problem for escalation.
- Staff lack of confidence and/or fear of criticism from colleagues and superiors.
- Staff unfamiliar with processes for escalation.
- Problems with the current process for escalation can be compounded where there are unfamiliar staff, such as locum or agency staff, who need to be provided with an adequate induction to the unit.

Process and cultural issues have been successfully addressed in maternity units by multi-professional level training and it is likely that there would be similar benefits for ED services.

Factors affecting escalation where overcrowding within the ED occurs were identified, which includes:

- Lack of clarity with the escalation protocol.
- Workload.

RCEM and CQC have developed a professional standards report ‘Under pressure: Safely managing increased demand in emergency departments’⁵³. These include the development of supportive escalation pathways to improve cross speciality and senior level support.

Recommendation 4

National

- Promotion of resources to support the improvement of safety and learning cultures and team working that support both effective escalation cross specialty and access to senior level support.

Local

- Implement the CQC’s ‘Patient FIRST’ principles⁹ and professional standards from its 2018 report ‘Under pressure: Safely managing increased demand in emergency departments’¹⁰ to include development of supportive escalation pathways to improve cross specialty escalation and access to senior level support. Actions to include:
 - Agreed robust induction and supervision programmes in place and regularly monitored for temporary staff.
 - Routine use of SBAR processes and early warning resources to underpin pathways.
 - Agreed escalation process in place across organisation supported by senior management, and executive to support ED when indications of unsafe environment identified for patients and for staff.
 - Unit level, multi-professional training to normalize these processes.

Conclusion

This report has identified a number of contributory factors common to both high value and fatality claims. These included:

- Diagnostic error including missing signs of deterioration;
- Failure to investigate and diagnose, and missed, wrong and delayed diagnoses;
- Failure to recognise the significance of repeat attendance or patient not re-attending when advised;
- Delays in care, including specialty reviews and missed therapeutic options; and
- Problems with communication and escalation.

Over the last three years NHS Resolution have undertaken various reviews of claims spanning a number of specialties, including maternity⁵⁴ and mental health services²⁵. The themes identified by these reviews have highlighted a very similar range of contributing factors to this report, which appear to be generalisable across different specialties and settings.

Many of the Royal Colleges have identified similar challenges and we recommend that there should be closer collaboration to share effective strategies to reduce harm, with the aim of developing greater understanding of the human factors and system failures that contribute to harm events while also developing a more evidence-based approach to drive greater improvements in safety.

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Jeannette Beer: Safety and Learning Lead, NHS Resolution.

Professor Tim Draycott: National Senior Obstetric Adviser, NHS Resolution.

Dr Denise Chaffer: Director of Safety and Learning, NHS Resolution.

Dr Alex Crowe: Deputy Director, Incentive Schemes and Academic Partnerships, NHS Resolution

Beverley Hunt: Safety and Learning Lead, NHS Resolution.

Tim Shurlock: Safety and Learning Lead, NHS Resolution.

Dr Chris Moulton: Emergency Care Clinical Lead, GIRFT.

Dr Matt Inada-Kim: Consultant Acute Physician, Hampshire Hospitals NHS Foundation Trust; National Clinical Director – Infection, Antimicrobial Resistance & Deterioration; Chair – Covid pathways group; National Clinical Lead COVID Oximetry@home; NHS England & NHS Improvement.

Case story provided by Amelia Newbold: Risk Management Lead, Browne Jacobson.

The recommendations in this report were co-designed with members of the Emergency Medicine Clinical Advisory Group, including:

Dr Denise Chaffer: Director of Safety and Learning, NHS Resolution.

Tim Shurlock: Safety and Learning Lead, NHS Resolution.

Professor Tim Draycott: Obstetrics and Gynaecology Consultant and Senior Clinical Advisor, NHS Resolution.

Dr Katherine Henderson: President Royal College of Emergency Medicine, Royal College of Emergency Medicine.

Mr John Machin: Clinical Lead for Litigation, GIRFT.

Dr Cliff Mann OBE: Emergency Department National Clinical Lead, GIRFT.

Dr Chris Moulton: Emergency Department National Clinical Lead, GIRFT.

Dr Matt Inada-Kim: Deterioration National Clinical Lead, GIRFT.

Dr Kath Halliday: Radiology National Clinical Lead, GIRFT.

Dr Taj Hassan: Past President Royal College of Emergency Medicine, Royal College of Emergency Medicine. Emergency Medicine Consultant, Leeds Teaching Hospitals NHS Trust.

Dr David Metcalfe: Emergency Medicine Consultant, Oxford Health NHS Foundation Trust.

Dr David Smith: Chair Emergency Medicine, Royal College of Nursing.

Dr Emma Redfern: Emergency Medicine Consultant/Associate Medical Director – Patient Safety, University Hospitals Bristol NHS Trust.

Dr Robin Evans: Consultant Radiologist, Croydon Health Services NHS Trust.

Tracy Regan: Professional Officer, Society of Radiographers.

Claire Land: Policy Manager, Care Quality Commission.

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Available at: <https://resolution.nhs.uk/glossary>



8th Floor
10 South Colonnade
Canary Wharf
London, E14 4PU
Telephone 020 7811 2700
Fax 020 7821 0029

7 & 8 Wellington Place,
Leeds, LS1 4AP
Telephone 0113 866 5500
Fax 020 7821 0029

www.resolution.nhs.uk

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