NHS Resolution

# Midlands & East Of England

## Regional Safety and Learning Networking Forum

26 November 2025
12:30 – 14:00

@NHSResolution

Advise / Resolve / Learn

# Agenda

| Time | Item | Speaker |
|---|---|---|
| 12:30 | Introduction to the forum (2 mins) | Chair, Safety & Learning Lead – Midlands and East, NHSR |
| 12:32 | Learning from claims data on VTE (3 mins) | Sam Thomas, Safety & Learning Lead – Midlands and East, NHSR |
| 12:35 | Maternity related VTE claims data (15 mins) | Dr Bethan Percival, EN Obstetric Fellow – Midlands and East, NHSR |
| 12:50 | Nurse led scanning within a DVT clinic (20 mins) | Liz Murray, Anticoagulation Nurse Practitioner/Sonographer and Service Manager, University Hospitals of Northamptonshire NHS Group |
| 13:10 | Improving Safety & Quality in VTE Through Targeted Projects (15 mins) | Emma Gee, Nurse Consultant – Thrombosis & Coagulation, King's College Hospital NHS Foundation Trust |
| 13:25 | Medico-legal insights from VTE claims (15 mins) | Helen Thackwray, Partner, Capsticks |
| 13:40 | Panel Q&A | Maria Yousif, Associate Safety and Learning Lead – Midlands and East, NHSR |
| 13:55 | Summary and Close (5 mins) | |

# Venous thrombosis/embolism CNST claims 2015 to 2025

## National and regional overview

Safety and Learning team: nhsr.safety@nhs.net

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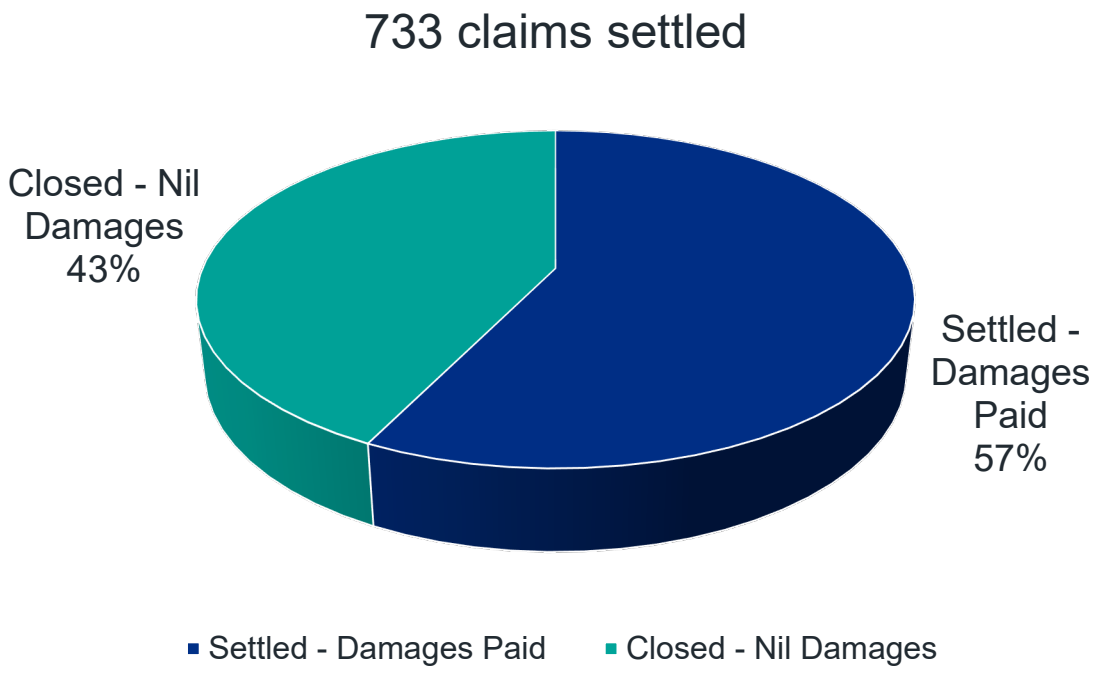
From 1 April 2015 until 31 March 2025 NHS Resolution documented 733 closed claims relating to VTE injuries across the clinical negligence indemnity schemes nationally. The sum of total damages paid was £27,593,056

**1016**

Total volume of claims received between 2015 -2025

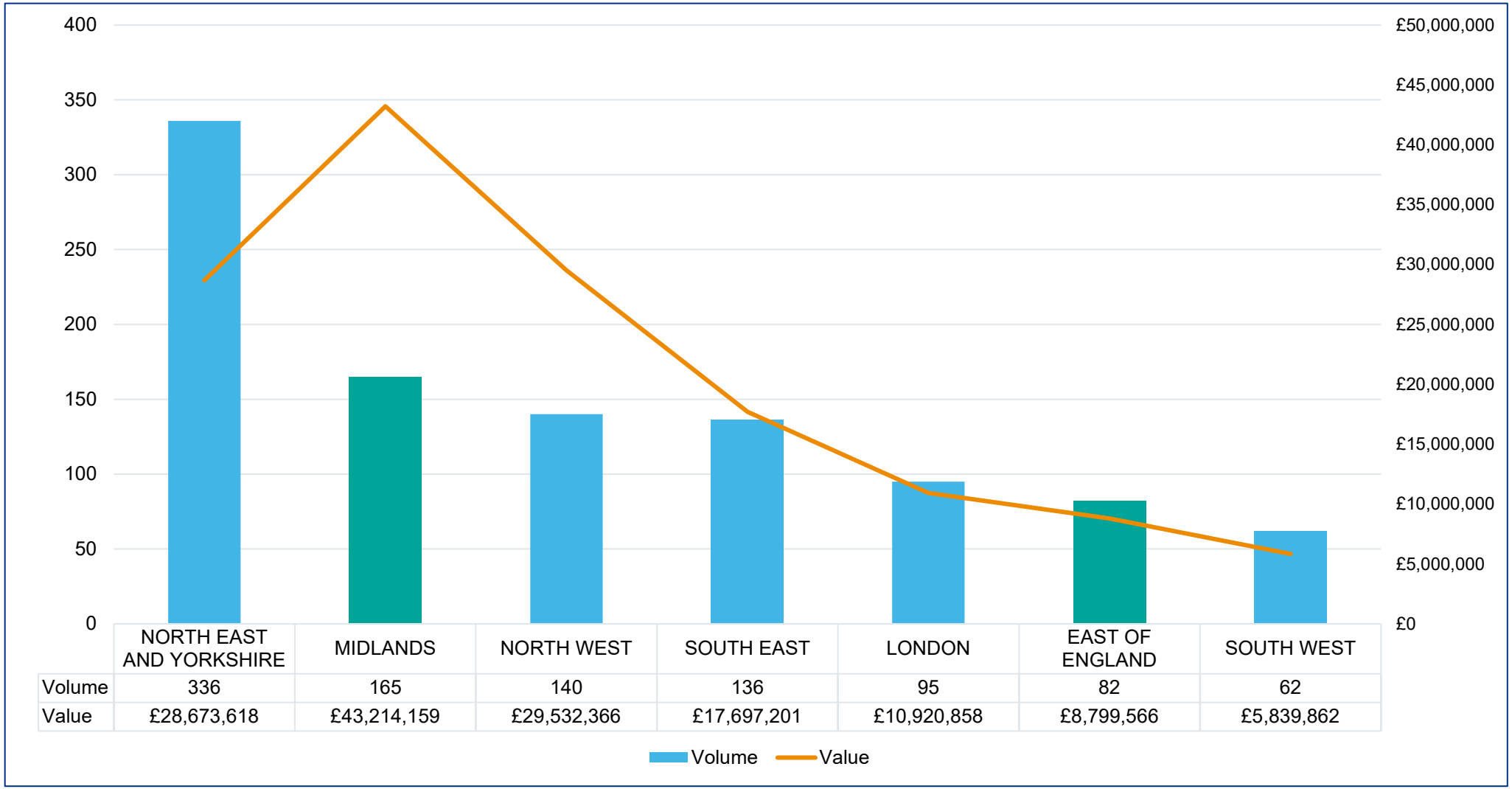
- 418 claims were settled with damages paid
- 313 claims were settled with no damages paid






*Data correct as of 30.06.25

# Regions – VTE CNST claims per year 2015 to 2025 via claims notification date




| | NORTH EAST AND YORKSHIRE | MIDLANDS | NORTH WEST | SOUTH EAST | LONDON | EAST OF ENGLAND | SOUTH WEST |
|---|---|---|---|---|---|---|---|
| Volume | 336 | 165 | 140 | 136 | 95 | 82 | 62 |
| Value | £28,673,618 | £43,214,159 | £29,532,366 | £17,697,201 | £10,920,858 | £8,799,566 | £5,839,862 |



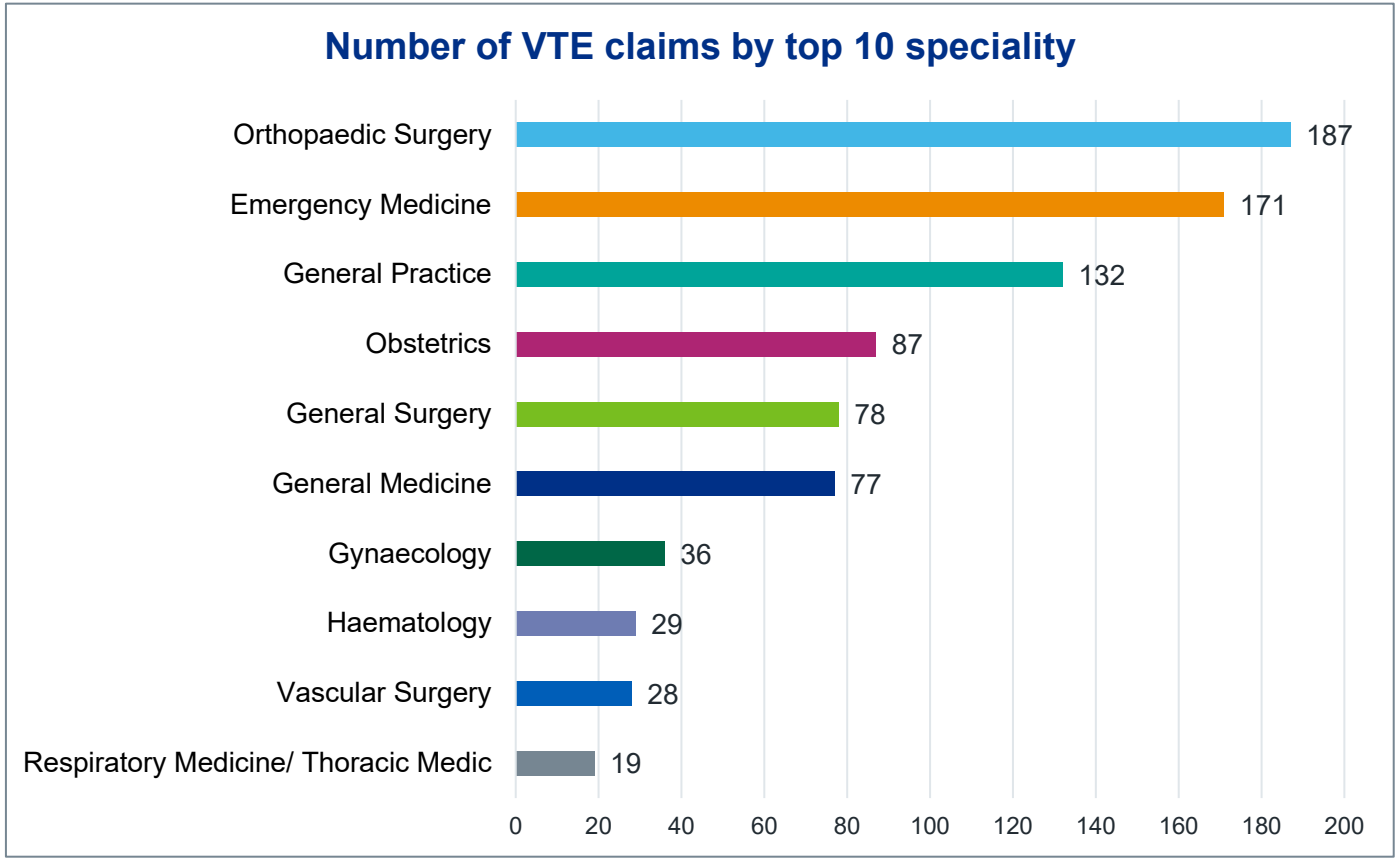
*Data correct as of 30.06.25

# Specialities involved in VTE claims

The top specialities involved in VTE claims continue to be

- orthopaedic surgery (18%)
- emergency medicine (17%)
- general practice (13%)

There has been an increase in obstetric claims from 42 in 2022 to 87 in the 2025 data. Obstetrics has now surpassed general surgery.



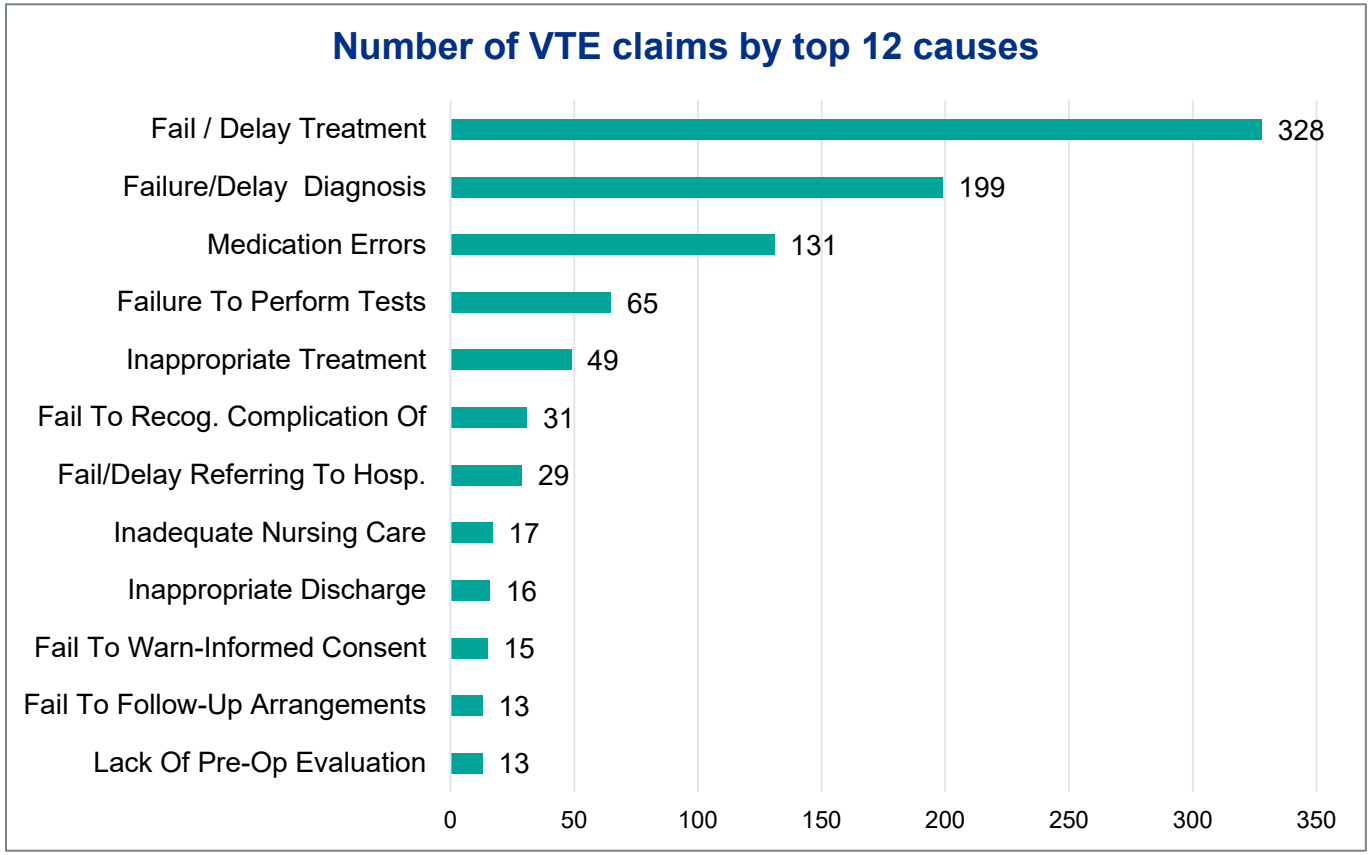



*Data correct as of 30.06.25

# Causes reported in VTE claims

Of the claims received, 12.89% were related to a medication error. This is an increase of 2.29% from 2022. The themes seen within the data were the same as those seen in the previous review;

- Failure to prescribe or administer anticoagulant
- Failure to carry out a VTE risk assessment
- Incorrect dose of anticoagulant administered






*Data correct as of 30.06.25

# AIM: reducing VTE (venous thrombosis embolism) in pregnancy

Presented by:

- Bethan Percival, Obstetric Clinical Fellow
- Prima Shah, Obstetric Clinical Fellow
- Victoria Wilkins, Associate Safety and Learning Lead

# NHS Resolution – our strategy at a glance

## Who we are

We are part of the NHS, operating at arm's length from the Department of Health and Social Care.

## Our services

**Indemnity and Claims Management:** Comprehensive cover and claims management for NHS services.

**Advice:** Supporting the NHS with concerns about practitioner performance.

**Appeals:** Offering impartial resolution of primary care contracting disputes.

**Safety and Learning:** Using the information we hold to support improvement.

## Our priorities

### Fair resolution

All of our services will focus on fair and timely resolution, keeping patients and healthcare staff out of litigation and other formal processes to minimise distress and cost.

### Data and insights

We will contribute our unique data and insights to learn from harm and the response to harm across the health and justice systems.

### Maternity and neonatal

We will draw on our unique position and work with our system partners to support maternity and neonatal safety improvements.

**Our strategy is driven by our priorities, supported by our people and systems.**

## Our values

**Professional:** we are dedicated to providing a professional, high quality service.

**Expert:** we bring unique skills, knowledge and expertise to everything we do.

**Ethical:** we are committed to acting with honesty, integrity and fairness.

**Respectful:** we treat people with consideration and respect and encourage supportive, collaborative and inclusive team working.

# Background

- Pregnancy elevates venous thromboembolism (VTE) risk by a factor of 4 to 6 compared to the non-pregnant state.
- It is associated with significant morbidity, mortality and psychological distress for families.
- This poses a substantial financial burden onto the NHS.
- National discussions on VTE in maternity have highlighted a potential disconnect between primary and secondary care, prompting action to improve prevention.

# Objective

To identify contributory factors in the occurrence and management of VTE in maternity by analysing NHS Resolution claims data, with a view to promote consistency and excellence in risk assessment and prophylaxis throughout the duration of maternity care.

# Methodology

- A retrospective thematic analysis of NHS Resolution claims related to VTE
- Inclusion criteria (Total 51 Claims):
  - Settled maternity claims with damages paid
  - All VTE during pregnancy up until 6 weeks postnatal.
  - Incidents occurring between April 2016 - March 2025.
- Themes from 43 open claims were identified but not analysed.

# Results

- 1 in 2 suffered with a **Pulmonary Embolism (PE)**
- 3 in 4 developed a VTE in the **postnatal period**, most commonly between 11-42 days.
- 3 in 5 delivered **vaginally**

# Results - diagnosis

- **1 in 2** presented more than once before a diagnosis was made.
- For those who presented more than once, the average time from presentation to diagnosis was **9 days**
- The longest time from presentation to diagnosis was **102 days***
- **2 in 5** presented to **Urgent Care or Emergency Departments** between 24 weeks to 10 days postnatal
- **3 in 5** presented to a **GP** > 11 days postnatal

# Results - risk assessment

- Of the claims with no VTE risk assessment it was apparent from the letter of claim that risk factors were present
- **3 in 4** women had a completed VTE risk assessment, however only **1 in 3** were completed **correctly**
- **3 in 4** women had a **change** in risk factors from booking
- This led to VTE prophylaxis not being prescribed in several cases where it was required (58%)

# Results - risk assessment

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| Booking | Antenatal | Postnatal |
| --- | --- | --- |
| • Maternal Age<br>• BMI 30-40<br>• Parity<br>• Family History<br>• Smoker | • Hospital Admission<br>• Current Systemic infection<br>• Immobility | • Caesarean Section<br>• Parity<br>• Maternal Age<br>• BMI<br>• VTE in antenatal period |

# Illustrative case story – postnatal

NHS Resolution

## Situation:

- Presented four days post forceps delivery to emergency department with shortness of breath and chest pain
- Discharged home after one dose of treatment for assumed pulmonary embolism (PE). No diagnostic testing performed.
- Five days later patient collapsed and was admitted.
- Diagnosis was confirmed pulmonary embolism and respiratory infection
- Patient deteriorated and required admission to ITU
- Patient went on to develop pulmonary oedema and cardiomyopathy

## Background:

- G5 P3 – 1 singleton, 1 set of twins
- Deemed low risk pregnancy
- Late booker
- Previous LETZ procedures
- BMI of 35
- Smoker
- Maternal age 34 at booking – turned 35 during pregnancy

## Assessment:

Breach of duty:

- Wrong pathway of care from booking
- Antenatal VTE assessment incorrect
- Postnatal VTE assessment incorrect
- No prophylaxis given

## Recommendations:

Causation:

- Correct VTE assessment was required in the antenatal and postnatal periods which would have triggered the prescribing of prophylaxis which should have prevented the initial PE on a balance of probabilities

# Illustrative case story – surgical admission for non-obstetric procedure

NHS Resolution

## Situation:

- Patient, 25+3 weeks pregnant, had an accident whilst gardening and scraped leg on a piece of rotten wood with rusty nails protruding
- Patient attended emergency department 2 days later with grazing, cuts and weeping wounds
- Cellulitis diagnosed and antibiotics required IV
- Wound unclean therefore decision made for surgical wash out and for admission
- Patient went on to develop a PE whilst an inpatient
- Patient was seen daily for FH monitoring whilst an inpatient but remained under surgical care

## Background:

- G2 P1 – previous SVD
- Maternal age 37
- No prior medical conditions

## Assessment:

Breach of duty:

- VTE assessment not completed as an inpatient or after surgery
- When symptoms arose, although a VTE assessment carried out, this was not maternity specific.

## Recommendations:

Causation:

- Correct VTE assessment was required on admission, prior to surgery and after surgery.
- A maternity VTE assessment and re-assessment would have triggered the prescribing of prophylaxis which should have prevented the PE on a balance of probabilities

# The cost of claims

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The total cost of closed with damages paid claims was £3.5m

The average cost of a claim was £68,793

Other associated costs included increased medication needs for longer duration, increased inpatient stays, longer term ongoing follow up care

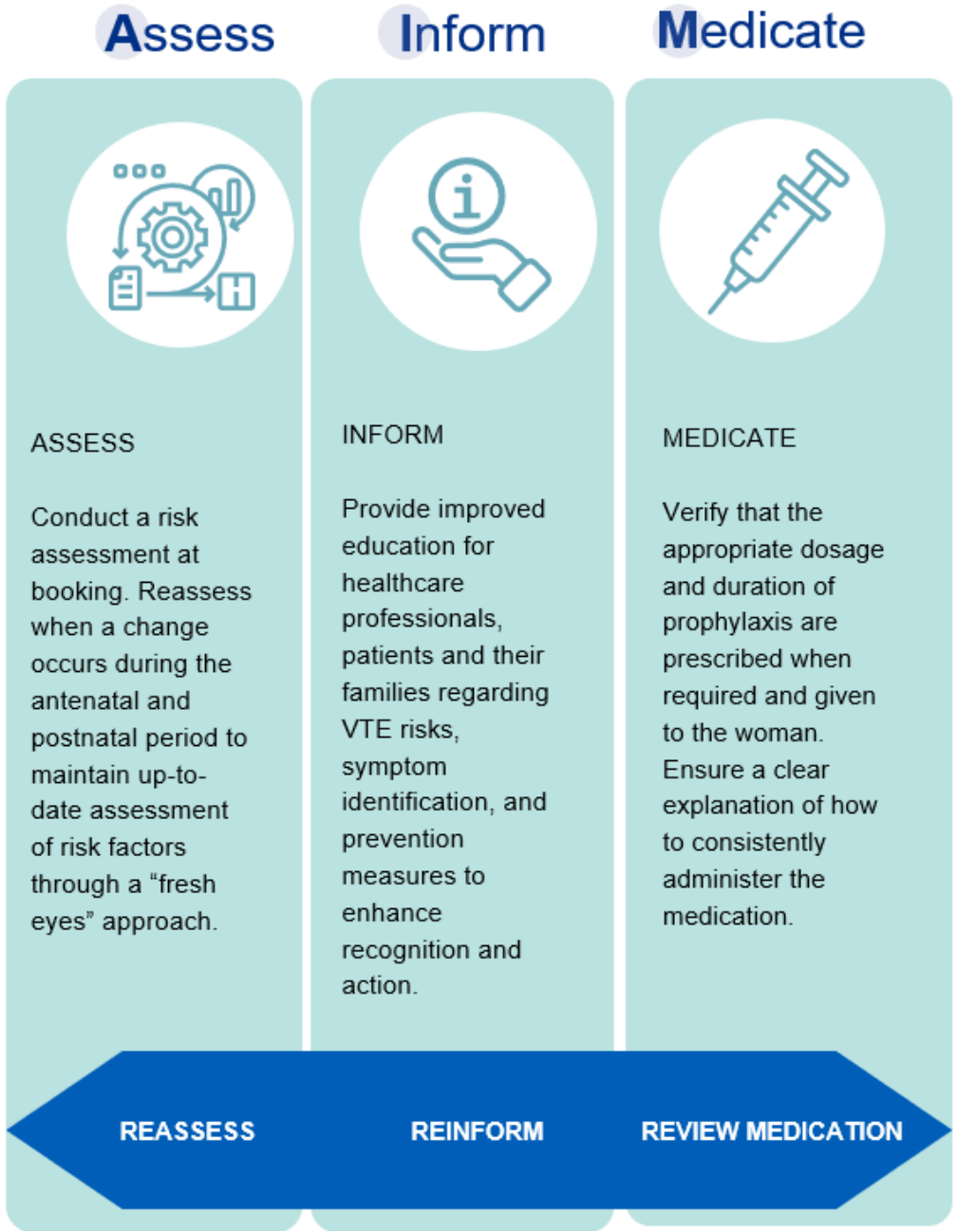
Other 'costs' to the patient are detriments to physical, emotional and mental health in the short, medium and long term

# Limitations

- Assumptions made when:
  - Spontaneous vaginal delivery when no other type of delivery is noted
  - Low risk when no risk factors have been noted
- Compliance to prophylaxis remains unknown throughout pregnancy and the postnatal period.
- Retrospective – basing on available documentation
- Health inequalities were not analysed with this data

# The influence of health inequalities on receiving care and making a claim

| |
|---|
| Ethnicity – multifactorial |
| Social and economic deprivation – ability to attend appointments/hospital |
| Language – ability to understand information and provision of information in appropriate language |
| Working pregnant people – ability to attend appointments/hospital |
| Vulnerabilities – learning disabilities, migrants/asylum seekers, safeguarding concerns, teenagers- multifactorial |
| Rural communities – ability to attend appointments/hospital |

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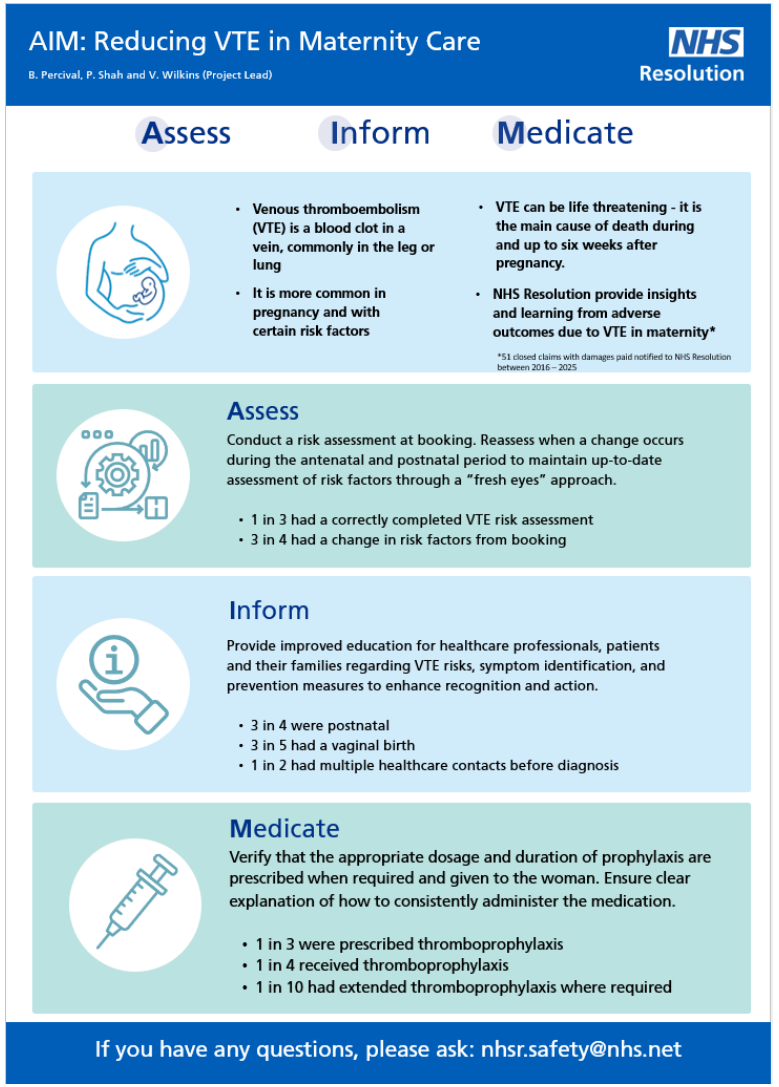
# Information poster for clinicians

NHS Resolution

## Inform

INFORM

Provide improved education for healthcare professionals, patients and their families regarding VTE risks, symptom identification, and prevention measures to enhance recognition and action.



# Information poster for patients and families

NHS Resolution

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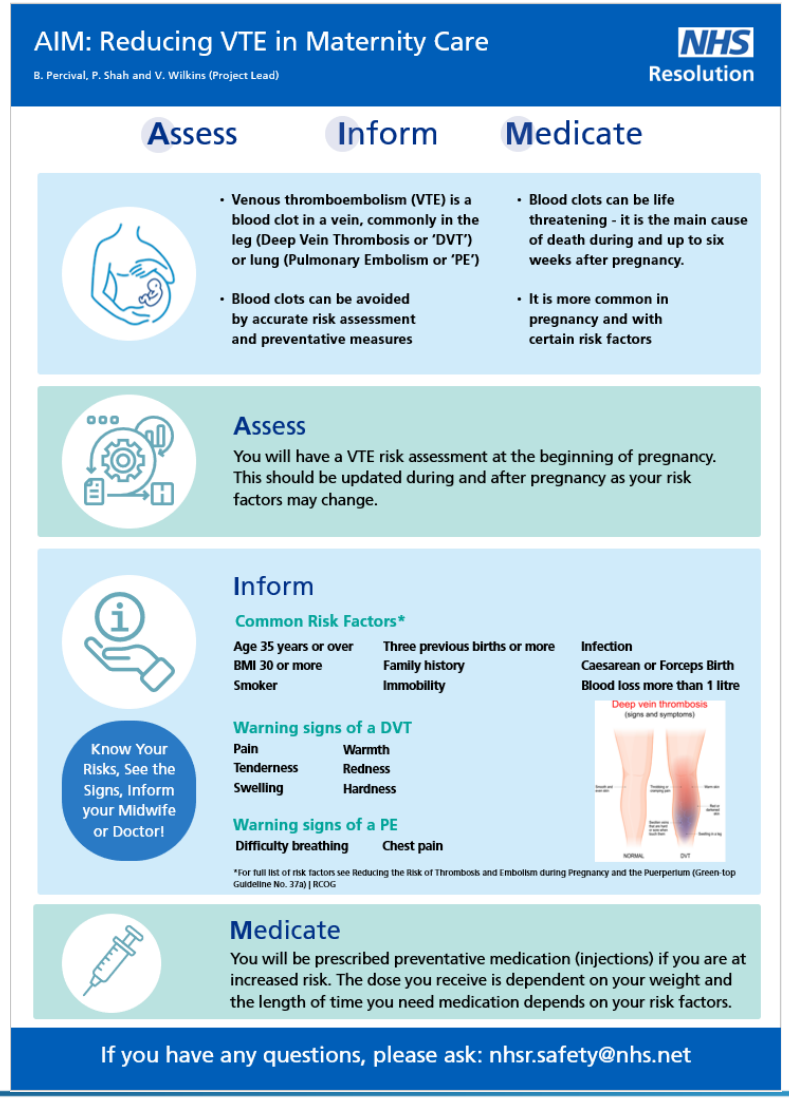

# Key messages

VTE assessment is essential in pregnancy and the postnatal period

Risk should be reassessed with every change, using the correct maternity VTE assessment tool

This will allow for the correct prophylaxis at the right dosage for the right amount of time

# Thank you for listening

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**@NHSResolution**

**Project Lead - Victoria Wilkins**
Associate Safety and Learning Lead (North)

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# Nurse sonography in a DVT clinic – an innovative approach

**Liz Murray**

**Manager of Anticoagulant & DVT Service**
**Northampton General Hospital**

# 2015

1. Couldn't get enough scans
2. Patients on interim anticoagulation for 7/7 (or more) waiting for scans
3. Served notice by DVT scan provider

# Solution

Business case to buy ultrasound machine – approved March 2016

US Machine bought May 2016 (the easy part)

Find someone to scan

- Locum Agency but delays in finding sonographer trained in DVT scanning & willing to work in a DVT service – finally started scanning 16th December 2016

# In the beginning……

- Scanned 2 days per week – 18 per day
- Quickly moved to 3 days per week, 4 days per week on completion of training
- Constantly evolving service
- Extremely challenging

# Today……

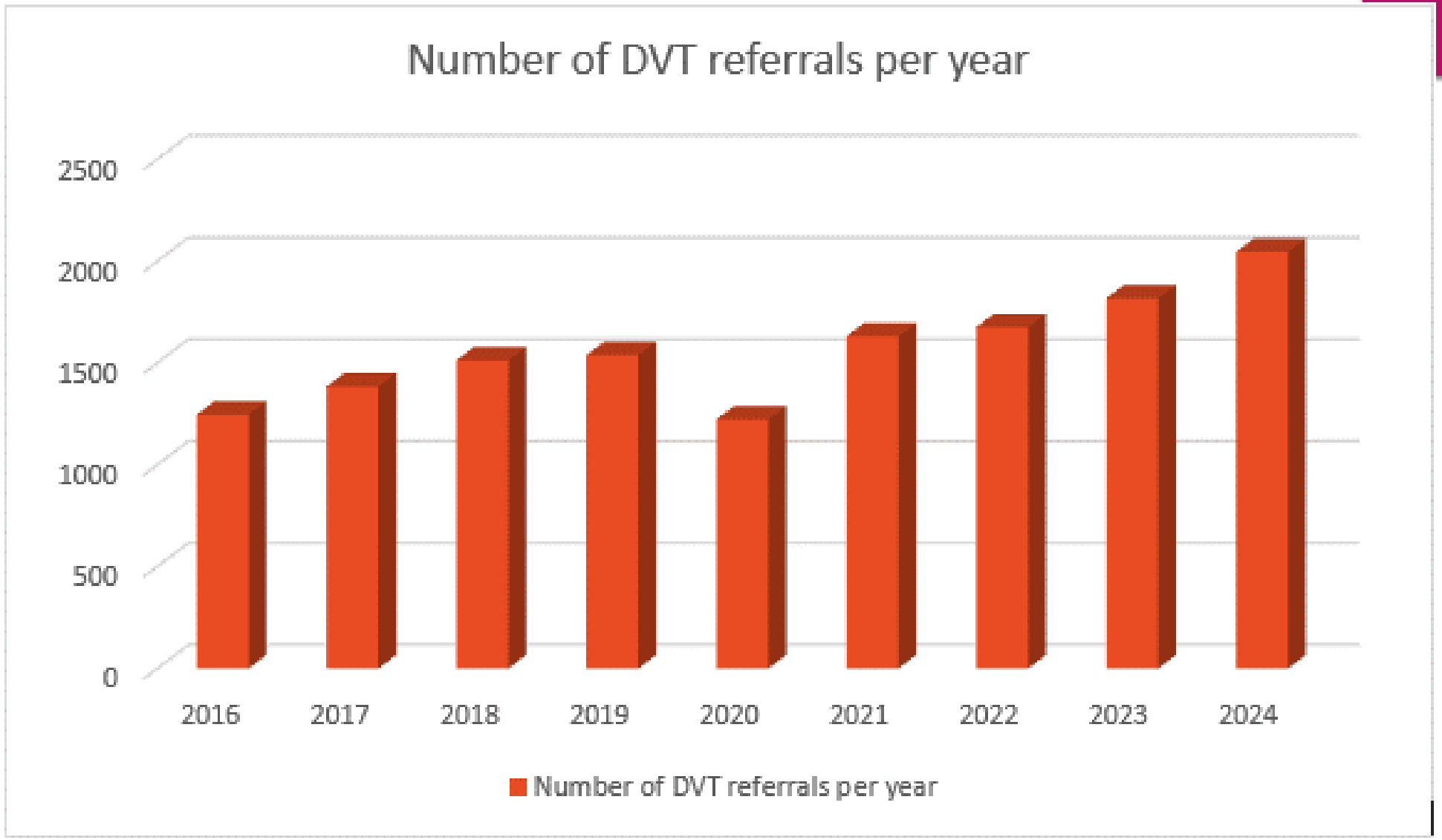
- 3 nurses scanning
- Scanning 5 days per week
- Complete control over lists & can scan later in the day, can add extras in depending on clinical need
- Adapt to changes without waiting for other parties to agree
- Working to NICE guidelines, providing same day scanning (depending on capacity)
- Able to use d-dimers to exclude unnecessary scanning
- Professional development & autonomous practice
- Training radiologists, A&E/SDEC consultants/registrars & Sonographers
- Service user & patient satisfaction is high

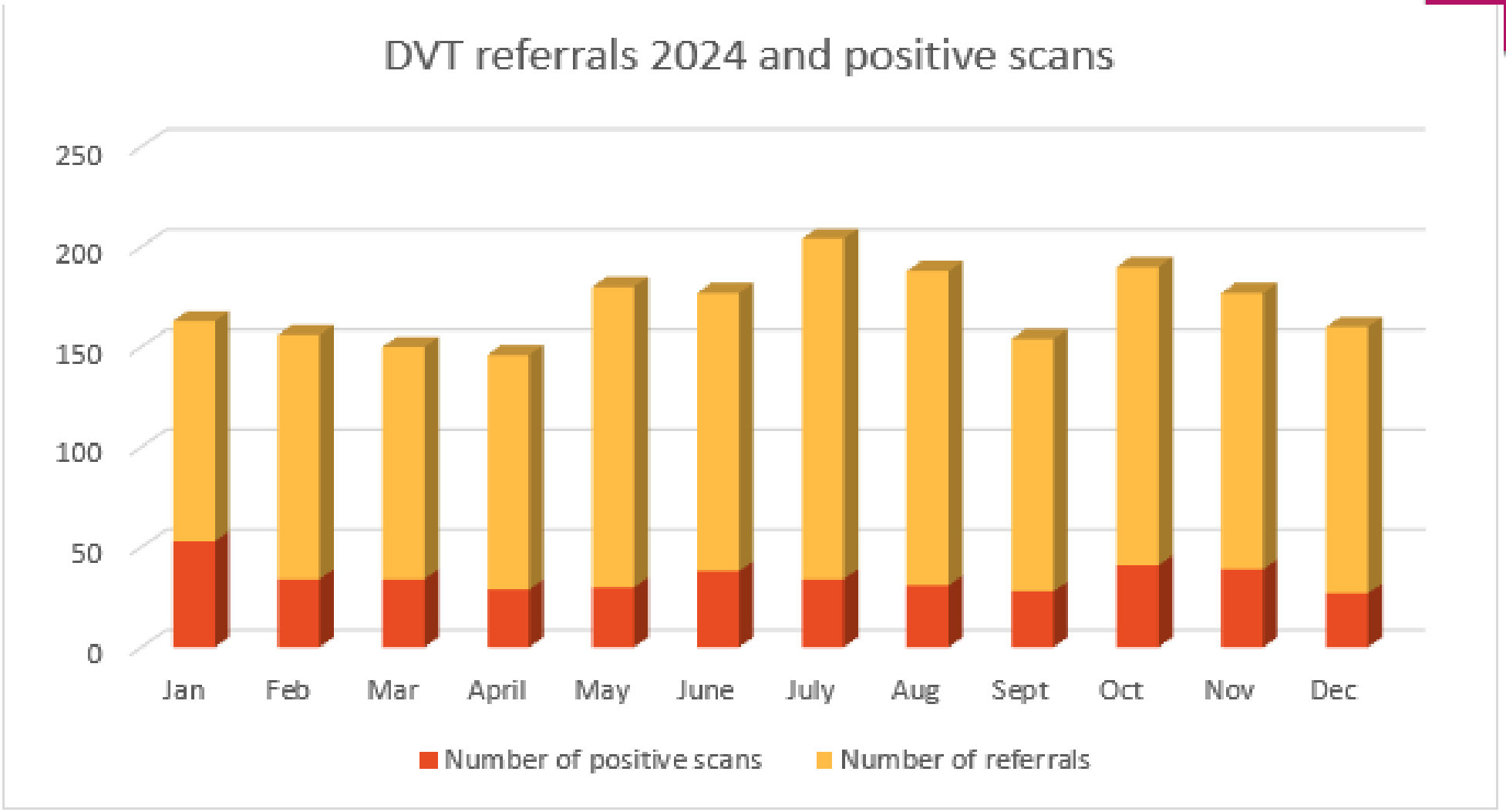
# Training

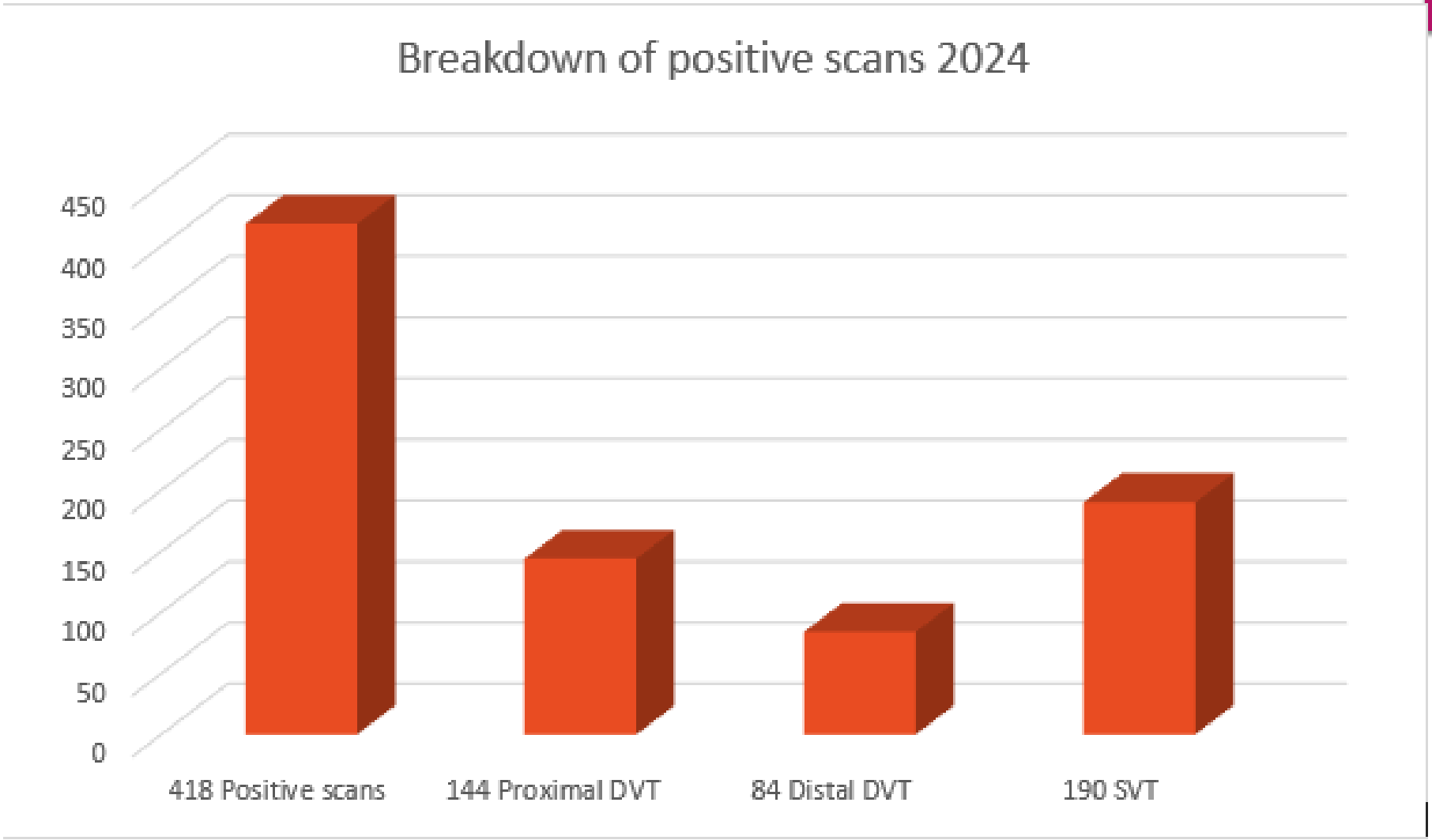
- Full academic year
- 2 x Level 7 modules at Derby University
- Core module - Principles of Medical Ultrasound (exam & written assignment)
- Specialised Focused Module (portfolio)
- 2 days scanning per week

# Tips

- Be tenacious, it's challenging!
- Business case - machine, staff etc
- Get your current US provider on board right at the start
- Advice re buying/leasing an US machine
- Can they provide the in-house training? If not, look for sonographer (? locum)
- Access to radiology systems (CRIS, PACS, e-rad reporting)
- RCR Standards for the provision of an ultrasound service (www.rcr.ac.uk)
- Suitable room for equipment (machine, couch, lighting etc)
- What university – speak to T&D re funding
- Find staff willing/capable of training
- Think about what your ideal service will look like


Number of DVT referrals per year
2500
2000
1500
1000
500
0
2016
2017
2018
2019
2020
2021
2022
2023
2024
Number of DVT referrals per year


DVT referrals 2024 and positive scans
250
200
150
100
50
0
Jan
Feb
Mar
April
May
June
July
Aug
Sept
Oct
Nov
Dec
Number of positive scans
Number of referrals


Breakdown of positive scans 2024
450
400
350
300
250
200
150
100
50
0
418 Positive scans
144 Proximal DVT
84 Distal DVT
190 SVT

# Pros & cons

- Extremely challenging!
- Has given us complete control of our service
- No waiting list
- High patient satisfaction
- Efficient & safe DVT scanning service

- Extremely challenging!
- Keeping enough staff trained


VTE AWARDS 2025
WINNER
NORTHAMPTON GENERAL HOSPITAL

# Improving Safety & Quality in VTE Through Targeted Projects

Emma Gee

Nurse Consultant, Thrombosis & Coagulation

King’s College Hospital NHS FT

# Warfarin Optimisation Clinic

## Background

Poor warfarin control

frequent INRs

↑ bleeding/thrombosis risk

huge impact on the patient

heavy HC resource use


## Method

- Warfarin optimization clinic established to case find & review patients with poor warfarin control
- Evidence and experience-based protocol developed with PROMs assessment
- Virtual patient review by an anticoagulation specialist to identify potential determinants, lifestyle, behaviour and belief factors, collaborative action planning

## Results

Early results reveal positive outcomes from reviews = improved warfarin control, switching to a DOAC, stopping warfarin, improved patient confidence and QoL

# Mental Wellbeing Assessment in DVT Clinic

## Background

- Detrimental Psychosocial impact of DVT exposed in recent research
- Clinic assessments traditionally focused on physical manifestations of DVT

## Method/Action

- Psychosocial wellbeing assessment implemented to assess how patients were coping emotionally to their diagnosis
- An open question, Distress score (0-10), QoL likert scale were used

## Results

- Median distress score 2/10
- 18% distress score ≥6 (triggered further f/up)
- ¼ had a deterioration in their QoL
- Contributory factors = pain, impaired mobility, fear, inability to perform ADLs
- Now an embedded and valued aspect of DVT care at KCH

# Heavy Menstrual Bleeding on DOACs

## Background

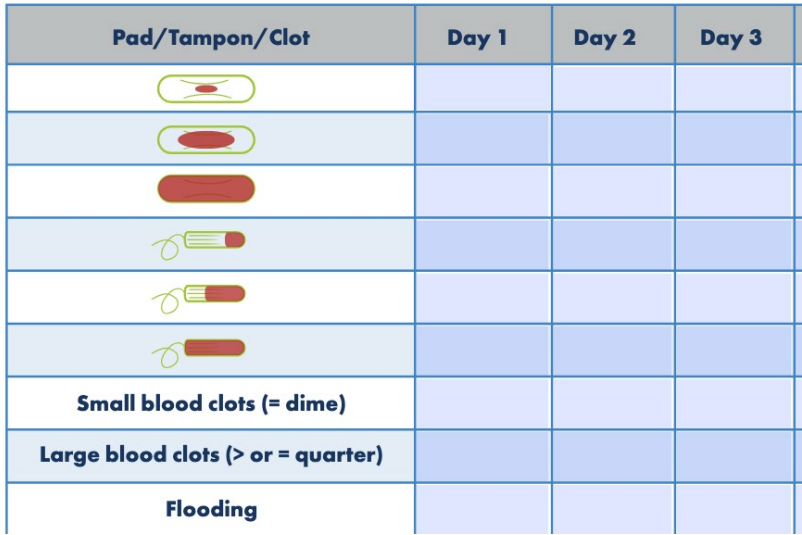
Anticoagulation seemed to have a negative impact on the heaviness and length of women's periods

## Method

Women newly commenced on anticoagulants were studied via questionnaires and interviews and compared to controls

2 instruments completed over 2 consecutive cycles:

- Menstrual bleeding questionnaire
  20 items covering 4 domains:
  Bleeding (heaviness and irregularity), pain, QoL
  Score from 0-100
- Pictorial Blood Assessment Chart (PBAC)



| Pad/Tampon/Clot | Day 1 | Day 2 | Day 3 |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| Small blood clots (= dime) | | | |
| Large blood clots (> or = quarter) | | | |
| Flooding | | | |

# Results

| Reported item | Cycle 1 | | Cycle 2 | |
|---|---|---|---|---|
| | Anticoagulation | Control | Anticoagulation | Control |
| Bleeding soaked through to outer clothes, % | 54 | 22 | 44 | 25 |
| Got out of bed to change sanitary products at night, % | 54 | 28 | 46 | 28 |
| Avoided social activities whether or not they were bleeding, % | 35 | 29 | 30 | 21 |
| End date of the period was not at all predictable, % | 35 | 5 | 33 | 3 |

# Outputs

- Apixaban used first line for menstruating women
- Dedicated patient information developed
- Screening tool used routinely


Thanks to Jig Patel

# Cancer screening in unprovoked VTEs

## Background & Aims

Prevalence of occult cancer in unprovoked VTE is reported as ~ 5%

Assess adherence to and efficacy of the local cancer screening protocol

- CXR
- Bone profile
- PSA
- Abdo & lymph node examination
- Cancer screening questionnaire

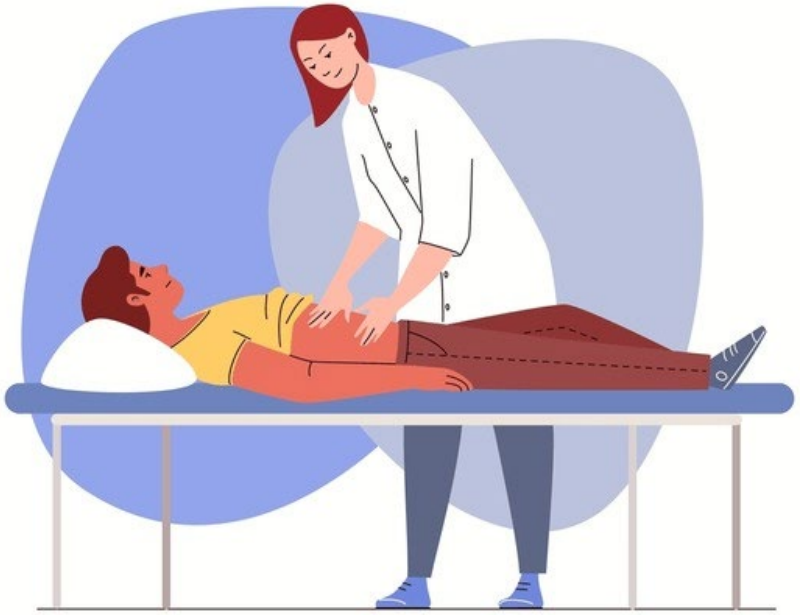
## Methods

Using hospital electronic records, all unprovoked DVT patients for a two-year period were reviewed.

Cancer screening strategies and their outcomes were recorded.

# Results

- Unprovoked DVT n=137 (37% of total DVTs)
- Adherence to screening protocol was 95.5%
- 10 (7.3 %) patients with unprovoked DVT had cancer diagnoses detected by the cancer screening strategy
- 4 cases were detected by CXR, 3 by the CSQ and 3 by PSA
- Abdominal/LN examination and bone profile did not detect any cancer cases



Thanks to Vishaka Gunawardena

# Vit K admin @ home

## Background

Patients with high INRs were spending many hours in ED to get vit K

## Interventions

1. The local out of hours medical service agreed to visit patients to administer Vit K
2. Selected patients were identified to keep vitamin K at home to self administer when necessary

## Results

- Very few patients attending the emergency department for vitamin K administration
- Safer, better value patient care

# Antiembolism Stocking Removal

## Background

Low efficacy, skin damage, costs, time

## Method

Stakeholder engagement (clinical teams, facilities team, stocking company, hospital management, comms team, patients, patient safety team, governance teams, patient outcomes team)

Derogation from NICE guidance

Update policy

Update patient information-electronic and written

Update training materials

## Expected Results (TBC)

Saving of around £80,000/annum, no stocking related skin damage

Staff efficiency savings (nursing & facilities)

Patient satisfaction

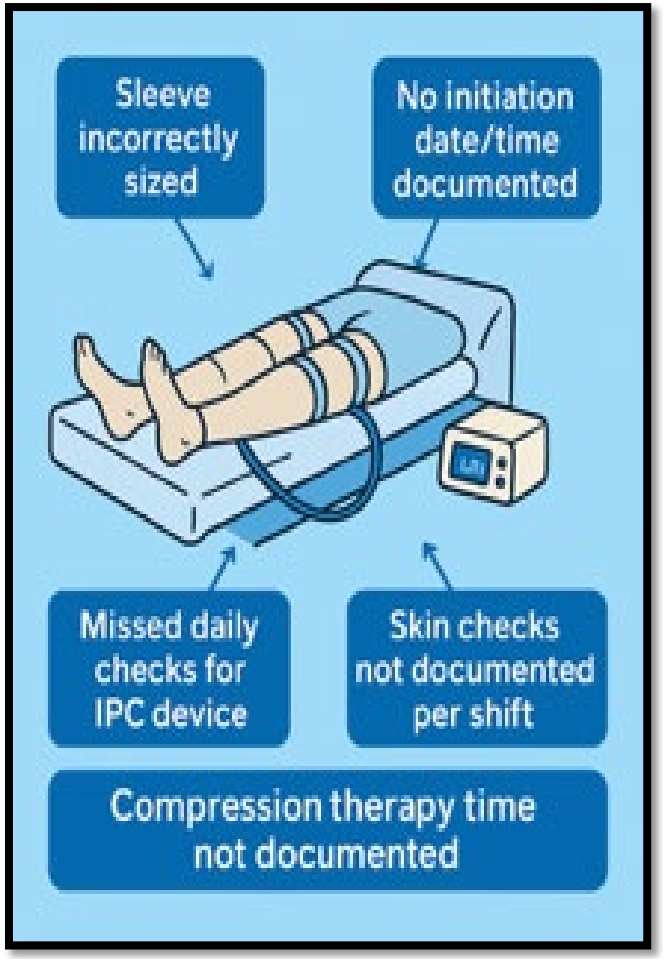
# IPC in stroke

## Background

- IPC devices are effective in reducing DVT risk for immobile stroke patients.
- Documentation and monitoring are essential for patient safety, facilitating continuity of care and preventing adverse outcomes.
- CHEST recommends wearing IPC devices at least 18 hours/day to prevent VTE.

## Results

- Most patients assessed for indication, contraindication, and skin integrity; 97% received skin checks, with no major skin issues documented.
- Key areas for improvement: better documentation (initiation date/time, daily checks), consistent use, and ensuring correct sleeve sizing.




Thanks to Loreena Bacarro

# Conclusions

- We work in a very reactive way
- Change is often data, feedback or event driven
- MDT approach is needed to drive continuous improvement
- Patient involvement is key
- Evaluation and adjustment are usually necessary
- Just start somewhere

# Medico-legal insights from VTE cases

26 November 2025

Helen Thackwray, Partner, Claims

# What we will be covering

- Standard of care
- Why VTE generates medico-legal risk
- Case study
- Learning

# Standard of care

# The legal tests

**Breach of duty** occurs when a healthcare professional's actions fall below the standard expected in their field.

Legal test: *The Bolam Test*

A clinician is **not** negligent if their actions are supported by a responsible body of medical opinion.

*The Bolitho Addendum*

The medical opinion relied on must also be logical and defensible

**Causation** – did the breach cause the harm? The patient must show the breach actually caused the injury.

Legal test – *"But for" Test*

But for the clinician's breach, the injury or harm would not have occurred.

# Why VTE generates medico legal risk

VTE can be viewed as preventable = high scrutiny

Rapid deterioration possible → delay in recognition

Increasing expectations for structured risk assessment tools

Legal claims often hinge on process not just clinical decisions

- Documentation
- Communications
- Escalation
- Adherence to local protocols

# Impact

- Unfortunately these cases can result in the patient's death.
- Any unnecessary death is difficult but in the maternity space these cases can be particularly tragic involving the death of mothers (and their babies).
- Failure to identify and treat DVT can lead to limb amputation
- The damages awards can vary → sometimes into the millions

# The role of experts

- VTE claims can happen in a number of specialities and clinical settings.
- As such it can be necessary to obtain independent expert evidence from a large number of expert disciplines (to consider the legal tests):-
  - Emergency Medicine
  - General Practice
  - Haematologist
  - Stroke Physician
  - Vascular Surgery
  - Orthopaedics
    - Etc

# The importance of factual statements

- Obtaining factual statements from clinicians involved is **crucial** in being able to properly investigate a claim.
- It may make a difference between being able to defend a claim, or not.
- Support is available:

Being a witness in a clinical negligence claim - NHS Resolution


This note provides guidance to those who may be approached to give evidence as a witness if you were involved in providing care and treatment to a claimant on behalf of one of our members (for example, a Trust).

**Download Being a witness in a clinical negligence claim (PDF)**

# Case Study

**Presenting complaint**
A woman in her 50s presents for outpatient Orthopaedic review with longstanding symptoms in her left foot and referred for urgent Vascular review and blood test

**Clinical outcome**
Claimant re-presented to hospital and was admitted 7days later and started on IV heparin. She was diagnosed with thrombosis of the left common iliac artery. During the admission she underwent a number of procedures (stenting, popliteal bypass, fasciotomy, embolectomy) but developed thrombocytopenia and required above knee amputation (total period from presentation to amputation was 20 days)

**Vascular Surgery allegations and expert evidence**
It was also alleged that the Claimant was inadequately heparinised and there was delay in performing bypass surgery due to failure to monitor the left calf for compartment syndrome. Unfortunately there were issues about documentation of the heparin dose.

**Index event**
Whilst attending for blood test 2 days later she experienced pain in the left lower calf. She was taken to A&E in a wheelchair. Following assessment and ultrasound she was referred back to her GP for further consideration of DVT investigations and to await Vascular review

**A&E allegations and expert evidence**
Alleged that presentation at A&E inconsistent with a DVT and should have been transferred to Vascular Surgeons urgently. Disagreement between the parties' A&E experts; the Defence said management plan was reasonable as already under the care of GP and appointment to vascular in hand. Claimant said there had been an increase in pain and disability and so urgent review needed.

# Case Study outcome

**The importance of factual evidence**
Breach of duty in relation to the A&E care came down to a factual dispute as to the severity of the C's presentation at A&E. Robust witness statement served by the treating clinician. C said her condition and pain deteriorated.

A Judge would have to make a decision as to whose account they preferred.

**Legal outcome**
Because the Trust were able to serve robust witness statements; it was able to achieve a liability discount and the case resolved for £1.25m. It would have been much more if the Trust was unable to secure a discount.

**Don't forget the second limb of the liability test – Causation**
Not always straightforward but important investigations may include what factually and in reality would have happened at that time, at that Trust e.g. acuity information, availability of services and timescales of the same…

However in this case it was straightforward → if the Claimant had been referred to vascular from A&E, disease in the common ileac artery would have been confirmed and treated with heparin and antiplatelet medication with an endovascular stent. This in turn would have prevented further embolisation and avoided transfemoral amputation.

[there was however no causation from the later allegations in terms of inadequate anticoagulation / delay performing surgery. By the time C re-presented she had unsalvageable limb ischaemia.

# Why are these claims so expensive?

| | Value |
|---|---|
| **A. General Damages** | |
| 1. General Damages | £132,990.00 |
| | |
| **General Damages Total** | **£132,990.00** |
| | |
| **B. Past Losses** | |
| 1. Past Care | £7,445.53 |
| 2. Past Travel | £545.05 |
| 3. Miscellaneous | £682.05 |
| | |
| **Past Loss Total** | **£8,672.63** |
| | |
| **C. Future Losses** | |
| 1. Future Care | £794,760.14 |
| 2. Prosthetics | £681,910.26 |
| 3. Physiotherapy | £167,968.11 |
| 4. Occupational Therapy | £1,050.00 |
| 5. Vocational Rehabilitation | £1,500.00 |
| 6. Travel | £TBC |
| 7. Aids and Equipment | £161,693.32 |
| 8. Miscellaneous | £148,691.00 |
| 9. Loss of Earnings | £TBC |
| 10. Accommodation | £2,038,728.67 |
| | |
| **Future Loss Total** | **£3,996,321.50 + TBC** |
| | |
| **Total** | **£4,137,984.13 + TBC** |

# Learning

*Do engage with Learning Outcomes – it is important to learn from claims to minimize the cost and impact of such incidents*

**The importance of documentation**

- Rationale for decisions (especially if deviating from guidelines)
- Communication records – who patient discussed with and time/plan recorded
- Patient refusal – counselling process
- Stamp? Signatures difficult to read

***If its not written down, it didn't happen***

***(or at least it then falls to a Judge to determine what happened and that is a risk)***

*Creating safer pathways – standardized risk assessment tools, encouraging a culture of escalation, involving patients in signs and symptoms*

# There is a claim, now what?

- Who is the claim against?
- Legal Department will receive claim and report it to NHS Resolution.
- In some cases NHS Resolution will instruct external solicitors.
- In most cases; comments will be sought from you as clinicians.
- In the first instance the comments can be ‘informal’ but if the case proceeds we will need a formal witness statement.
- Timescales for response.
- Why are you so important as clinicians in a legal claim?

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