

General Practice Indemnity and Learning from claims

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Advise / Resolve / Learn

- Introduction to NHS Resolution and the GP indemnity scheme
- Highlights from the year one CNSGP report
- The national picture and value from learning from claims and complaints
- Culture and its impact on patient safety
- Practicing safely with proactive risk management
- NHS Resolution learning resources

Enabled by:

Claims Management

Delivers expertise in handling both clinical and non-clinical claims through our indemnity schemes.

Primary Care Appeals

Offers a quasi-tribunal service for the fair handling of primary care contracting disputes.

Practitioner Performance Advice

Provides advice, support and interventions in relation to concerns about the individual performance of doctors, dentists and pharmacists.

Safety and Learning

Supports the NHS to better understand their claims risk profiles, to target their safety activity while sharing learning across the system.

Finance and
Corporate
Planning

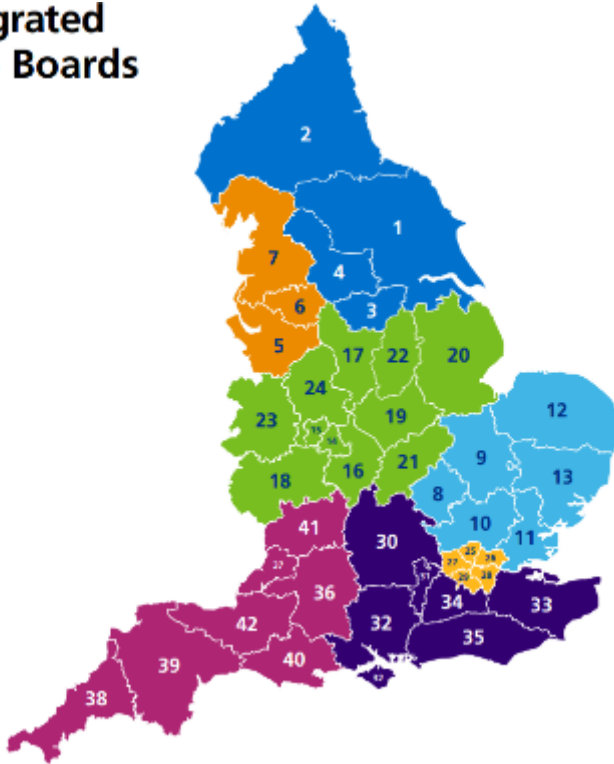
Digital, Data and
Technology

Membership
and Stakeholder
Engagement

Policy,
Strategy and
Transformation

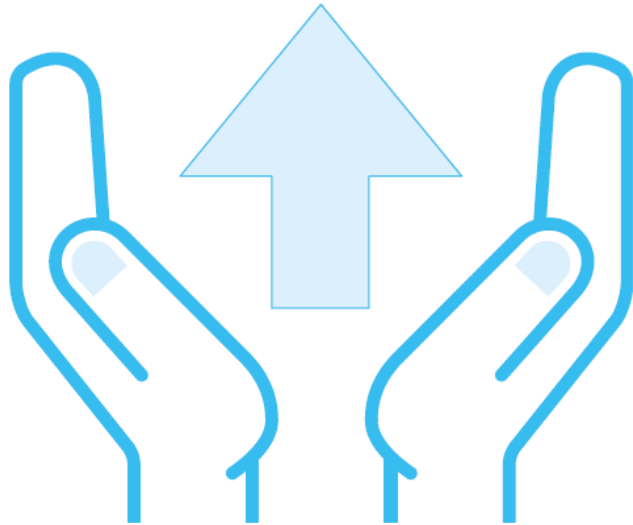
Role of Safety and learning in GP

Integrated Care Boards



- Build relationships with Primary Care Networks, GP federations, training hubs and Local Medical committees
- Offer learning sessions on supportive learning from risks and claims in general practice
- Support collaborative regional learning from claims
- Thematic analysis of delayed cancer diagnosis claims
- Promote and disseminate NHS Resolution resources for learning and QI

We launched three new indemnity schemes which work to a different model to our membership schemes



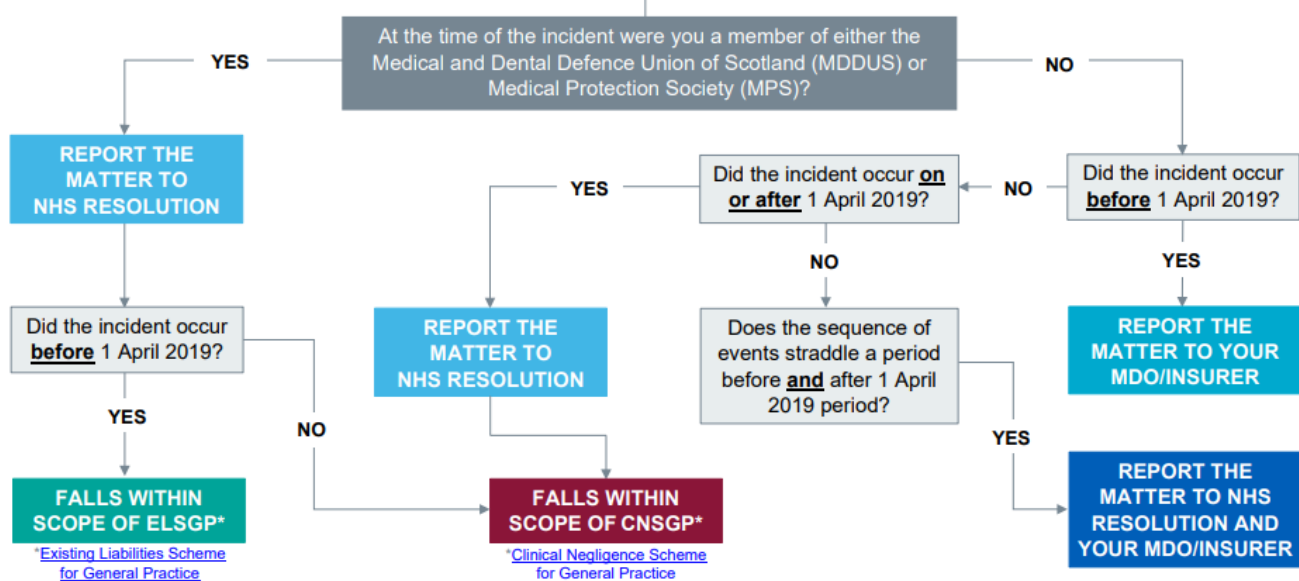
Clinical Negligence Scheme for General Practice (CNSGP) which covers clinical negligence claims for incidents occurring in general practice on or after 1 April 2019.

Clinical Negligence Scheme for Coronavirus (CNSC) launched on 3 April 2020.

Existing Liabilities Scheme for General Practice (ELSGP) is a new scheme launched on 6 April 2020. Medical and Dental Defence Union of Scotland (MDDUS) claims fully transferred to NHS Resolution on that date.

How claims will be managed

I HAVE BEEN NOTIFIED OF A CLAIM OR POTENTIAL CLAIM ARISING FROM NHS CARE, DIAGNOSIS OR TREATMENT – DO I REPORT IT TO NHS RESOLUTION OR MY MEDICAL DEFENCE ORGANISATION (MDO)?
<https://resolution.nhs.uk/wp-content/uploads/2021/03/GPI-Reporting-guidelines-1.pdf>



Excluded under ELSGP and CNSGP:

- Non-NHS work
- Disclosure of record requests from patients (where there is no intimation of a claim and it is not a request from the patient's solicitor)
- Complaints (where there is no intimation of a claim)
- GMC inquiries and representation
- CQC investigations
- Inquest Representation
- Disciplinary proceedings against you or your staff
- Ex-gratia payments
- Defamation claims
- Awards made by the Parliamentary and Health Service Ombudsman (unless there is an overlap with compensation payable for an injury resulting from clinical negligence)
- Claims arising from non-compliance with any legislation e.g. breach of data protection legislation; Equality Act (2010); Human Rights Act (1998)
- Employers' liability claims
- Public liability claims
- Property liability claims
- Cyber liabilities (for example, costs resulting from system shut down as a result of a cyber-attack).

This is not an exhaustive list. Please report any of these to your MDO/Insurer.

Further details can be found: <https://resolution.nhs.uk/services/claims-management/clinical-schemes/general-practice-indemnity/clinical-negligence-scheme-for-general-practice/>

Year one Clinical Negligence Scheme for General Practice (CNSGP) report

CNSGP year one report claims

11,682
total
claims
(2019/20)

401 GP
claims

Common Themes:

1

Failure to investigate and/or
diagnose, and missed, wrong and
delayed diagnoses

2

Medication errors

3

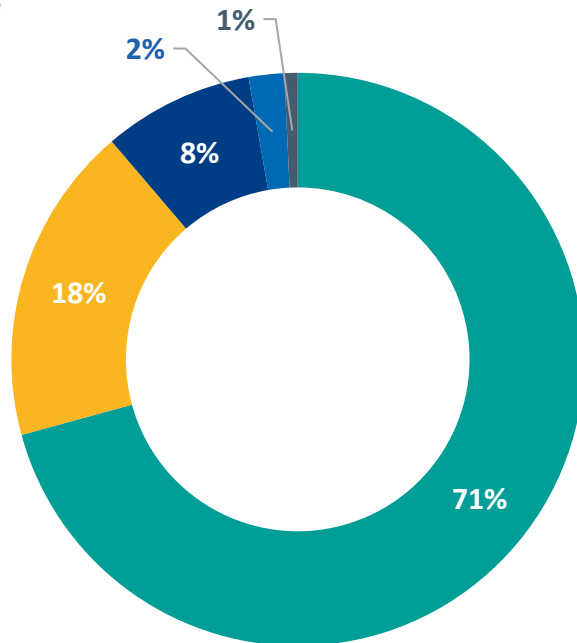
Delays in care, including specialty
reviews and referrals

4

Problems with communication,
between primary and secondary
care

Location of Attendance

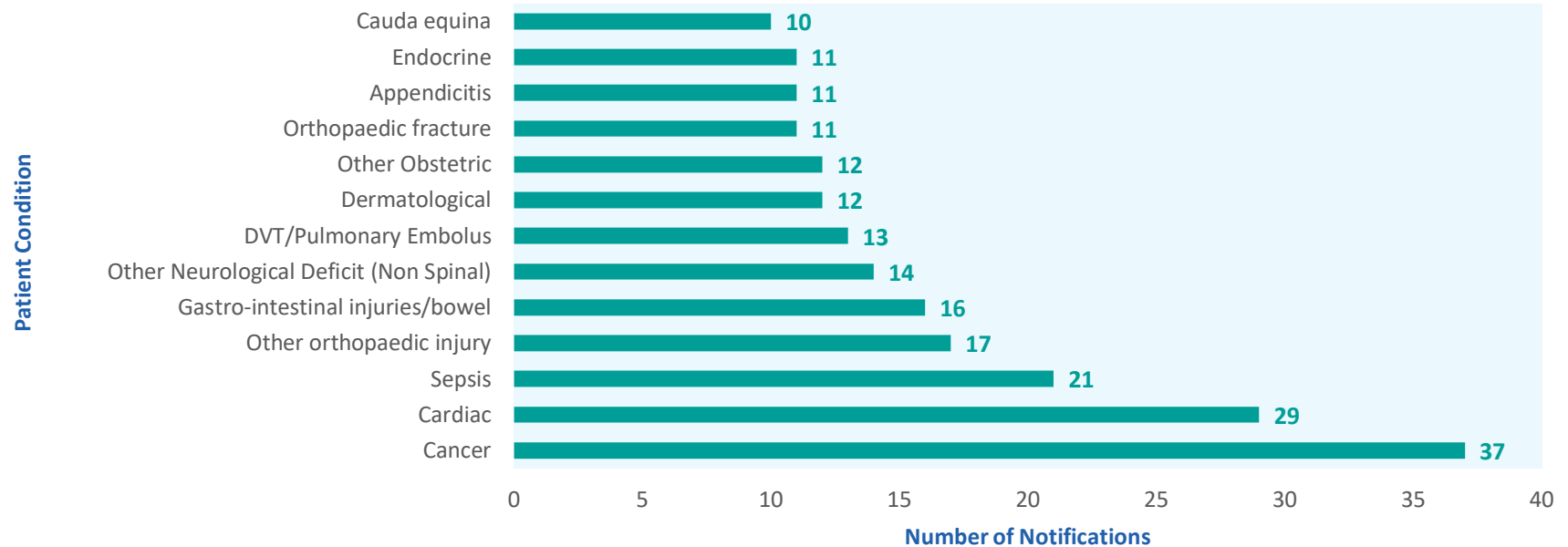
Location of Attendance



- GP Surgery
- Out of Hours/Minor Injuries/Urgent Care Centre/Walk In Centre/NHS 111
- Prison / remand centre
- Patients Home
- Nursing/residential care home

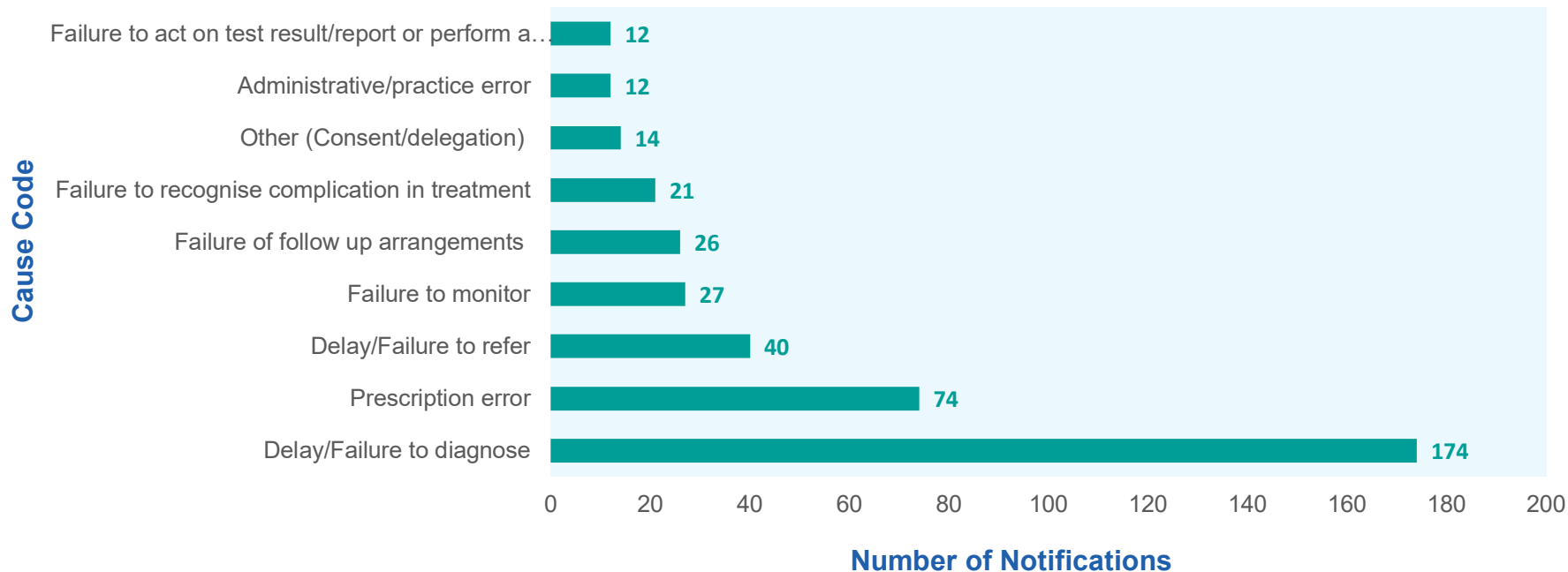
Most Frequent Notifications by Patient Condition

Most Frequent Notification by Patient Condition



CNSGP notification causes

Number of Notifications per cause code



Recommendations

1

- Recommend NHS England, the Royal Colleges, Getting It Right First Time and Professional Regulators work together to explore the feasibility of a patient acuity risk (track and trigger system²) assessment tool for use in general practice to assist earlier identification of deteriorating patients

2

- Recommend that NHSX with NHS Digital GP IT³ (see footnote) and NHS England continue to promote existing safety netting tools (including minimizing inequalities e.g. enhancing easy reading, translation and digital exclusion) such that they are available nationally.

3

- Recommend that policy makers, academic partners and NHS bodies explore feasibility of further development of advice and guidance service that enables improved communication and collaboration between general practice and secondary care.

4

- Recommend that NHS bodies, Royal Colleges and associated stakeholders consider collaboration to support introduction of Protected Learning Time across general practice teams.

² [Guidance | Acutely ill adults in hospital: recognising and responding to deterioration](#) | [Guidance | NICE](#)

³ NHS England have now created a Transformation Directorate, incorporating [NHSX](#) and [NHS Digital](#)

Recommendations (continued)

5

- Recommend that professional regulators consider using the Royal Pharmaceutical Society (RPS) competency framework as a benchmark when reviewing prescribers and prescribing in conjunction with National Institute of Clinical Excellence (NICE) guidance on medications management.

6

- Recommend that NHSX, as part of its Digital Clinical Safety Strategy, consider research into why clinicians override adverse drug reaction system prompts and how this may be minimised.

7

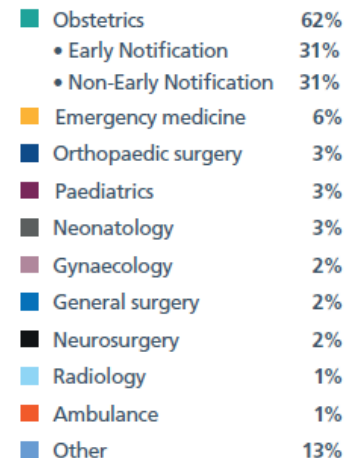
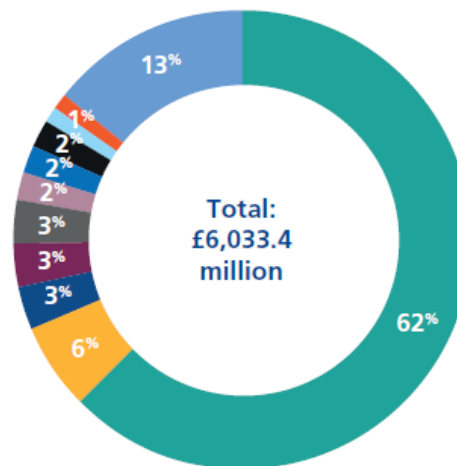
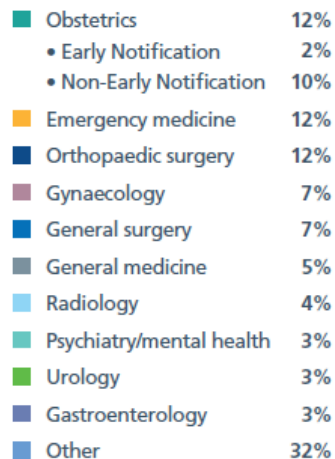
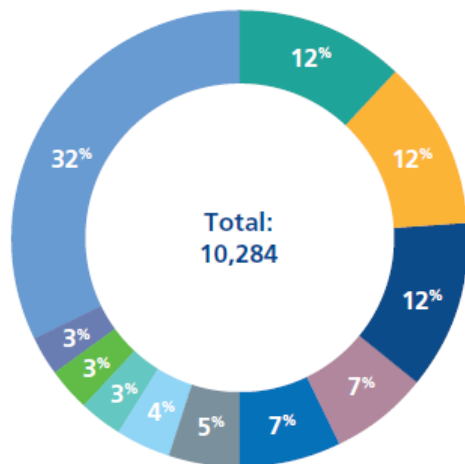
- Recommend that NHS England suggest Integrated Care Systems appoint a Designated Medication Safety Officer supporting clinicians in adhering to the Green Book recommendations on the handling and storage of vaccines and to share any learning from error.

8

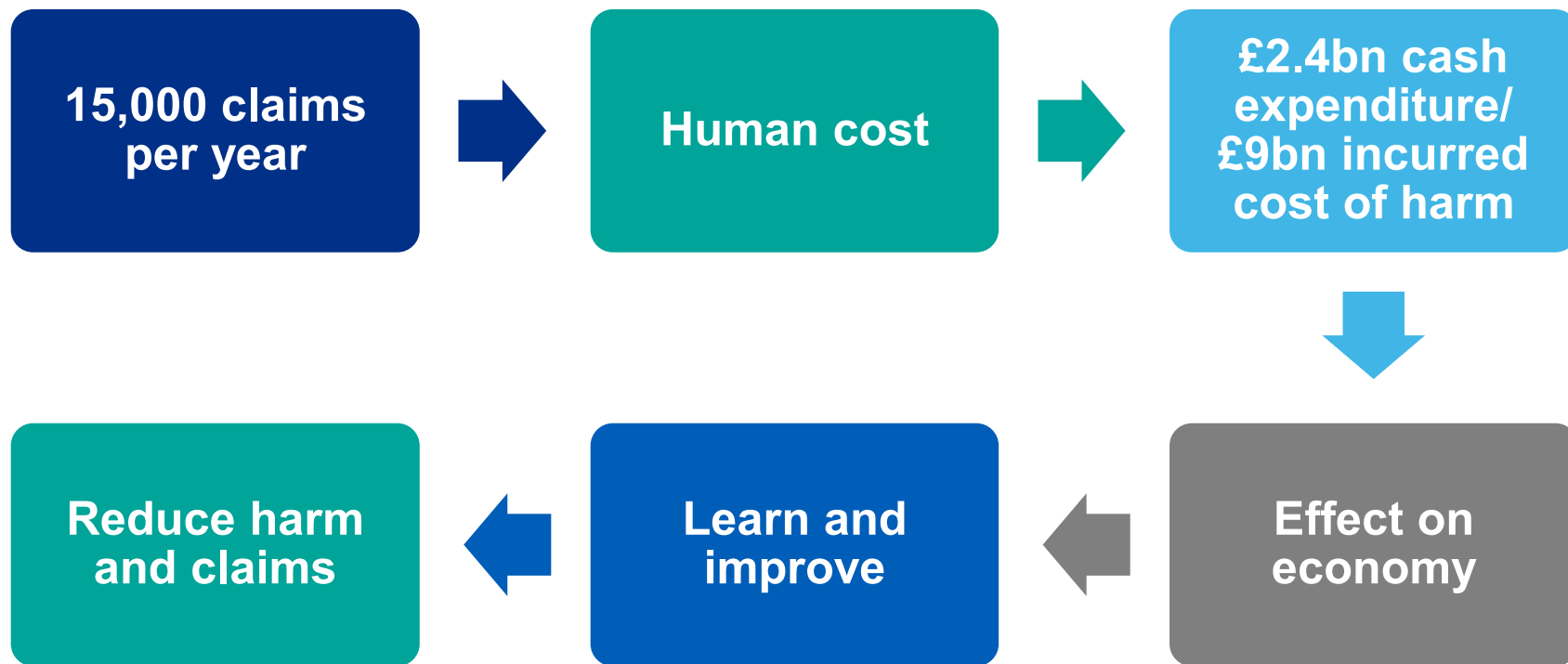
- Recommend that commissioners, providers and Integrated Care Systems who oversee prison services, consider increasing the use of the telemedicine across the estate working to support primary and secondary care appointments as well as improving continuity of care with community services.

The national picture and value of learning from claims and complaints

The percentage of clinical negligence claims reported in 2021/22 by specialty, with a breakdown by volume and by value



Why learn from claims?



Incidents, complaints and claims

1 April 2021- 31 March 2022



Resolution



15,078

new clinical claims

reported to NHS Resolution

225,570 **complaints**

recorded by NHS Digital

2,345,817 **incidents**

reported to the National Reporting
and Learning System

Make the contact count

- Make this conversation or letter count!
- Thank them for the complaint but apologise for their experience
- Address and deal with any consent issues
- Offer to discuss the handling of and clarify the complaint
- Explain the timeframe for responding and what happens if it takes longer – offer to negotiate
- Explain who investigates and how
- Provide a named contact for the complainant

Saying Sorry

We have never, and will never, refuse cover on a claim because an apology has been given.

Helen Vernon, Chief Executive, NHS Resolution



Duty of candour

I just wanted to hear somebody say 'sorry' and I feel very sad... that it took legal proceedings to prompt such a lovely, thoughtful letter.

Recent patient

Claims related to paediatric medication errors

Claims notified
193
Claims settled with damages
paid
91
Total cost of settled claims
£19,783,043



Illustrative case study

As you read about this incident, please ask yourself;

- Could this happen in my organisation?
- Who could I share this with?
- What can we learn from this?

A child was prescribed an anticonvulsant which is usually prescribed in a 5mg/5ml solution. An error occurred in the community pharmacy and the prescribed dose and 5mg/5ml solution label were applied to a 25mg/5ml bottle of medication.

The error went unnoticed and the child received the increased dose for several weeks before being admitted to hospital with breathing difficulties. On admission, the hospital continued to use the patient's own medicine for further doses. Queries about the discrepancy between the applied patient drug label and manufacturer label did not result in correction until several days after admission.

Points for reflection:

- Do you have a process for checking and use of patient own medicines?
- Do you consider the integrated care system when investigating medicine errors?

What actions can you take as a clinician?

- Facilitate easy access to the British National Formulary for Children (BNFC) for accurate individualised dosing and administration of medicines for children
- Provide prescribers with readily available access to prescribing support and expertise of hospital and/or community pharmacists
- Minimise distractions to those responsible for calculating doses and prescribing medications
- Ensure that the weight of patient is checked regularly for accurate dosing of medication
- Check the allergy status of the patient at each point of the medication administration process
- Maintain awareness and communicate the risk of tenfold dosing errors
- Ensure robust policies and procedures exist around supervision and checking of repeat prescriptions
- Review local protocols to support the correct use of infusion pump settings for drug administration

How might staff feel receiving a claim?

Stress

Anxiety

Confusion

Why me? I did everything and even went the extra mile

Fear

NB

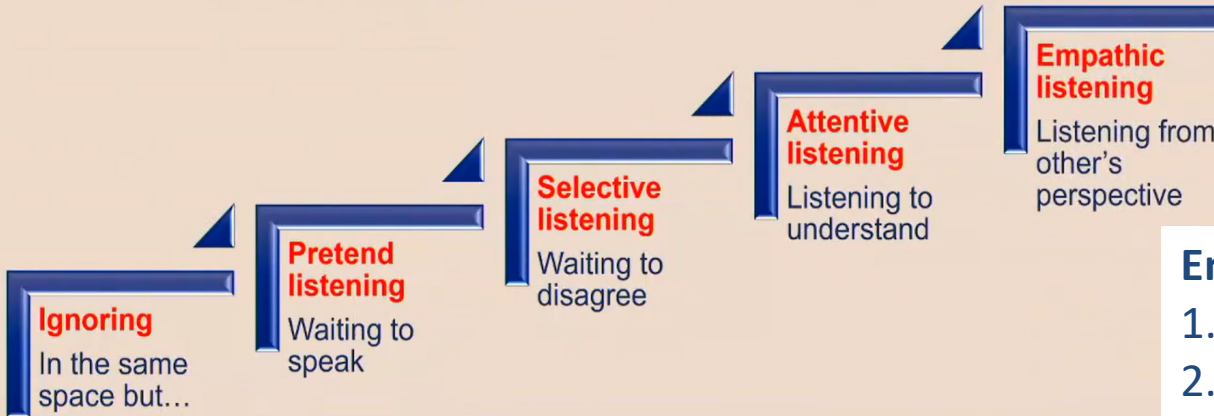
- It is very important to share your thoughts with colleagues, line managers.

Culture and patient safety

“Be a good listener. Your ears will never get you into trouble”

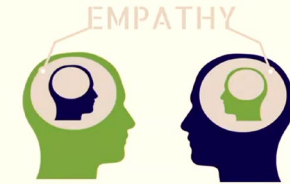
- Frank Tyger

The Listening Staircase



Professor Graham Easton

Empathy



Empathy:

1. Cognitive (understanding)
2. Affective (emotional resonance)
3. **Behavioural (showing)
4. Moral (urge to help)

Taking action

Dimension	Take stock	Take action
Your business or function	Do you understand the current performance and capabilities?	Have you aligned and mobilized your team and organization on the future aspiration and priorities?
Culture	Do you understand the current culture and any shifts required to improve performance?	Are you influencing those shifts with all levers available?
Team	Do you have the right team with the right skills and attitudes and the right structure?	Have you together embarked on a structured journey to become a high-performing team?
Yourself	Have you done what it takes to get up to speed, set boundaries, and consider your legacy?	Do you spend your time wisely by assuming roles only you can play?
Other stakeholders	Do you understand your mandate and the other expectations of major stakeholders?	Have you established a productive working rhythm and relationship with them to shape their views?

McKinsey & Company

Characteristics of a troubled practice

Patients

- Unable to get an appointment
- Referrals take a long time
- Results are not easily accessible
- Premises are out of date
- Staff appear unhappy

Staff

- Unsupported
- Poor governance
- Lack of necessary equipment
- Lack of leadership
- High turnover

• Practitioner

- Isolation
- Inability to keep on top of things
- Out of date
- Stress

Just culture

Just and learning culture charter



Our organisation accepts the evidence that we will provide safer care and be a healthier place to work if we address all of the components of a learning organisation.

Organisations are invited to consider adopting the suggested 'Just and learning culture charter'.

This charter is from our Being fair 2 report



Being fair 2

[Click to see the report](#)

[Advise](#) / [Resolve](#) / [Learn](#)



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Share on LinkedIn

Practicing safely with pro-active risk management

- Accept that uncertainty is a normal part of primary care.
- Good clinician-patient relationship is vital.
- Involve patient in decision-making.
- Discuss probabilities including degree of uncertainty.
- Safety netting
- Consider each patient as an individual.
- Use external evidence.
- Consider use of checklist.
- Maintain good records.

- If you are unsure of something do not plough on regardless. You have a professional responsibility to recognise and work within the limits of your competence and experience, and a duty to seek the advice of a senior or more experienced colleague.
- If you seek a colleagues' advice, make sure this is documented in the records.

- Write legible and detailed notes. The medical notes are essential evidential documents which can help to demonstrate that the standards of care were appropriate in all the circumstances.
- This is especially important as clinical negligence claims can be made years after the events and when your contact with the patient has ended.
- Always keep in mind what your colleagues would do in a given situation.
- Of course your clinical judgment is important, but departing from guidelines or policy without a clear and documented reason can leave you with a heavy burden of demonstrating that it was a reasonable course of action if something goes wrong.

“You *should* usually include the following information when discussing benefits and harms...any risk of serious harm, however unlikely it is to occur.”

GMC –Decision Making and Consent(2020)

Horizon Scanning



NHS Resolution learning resources

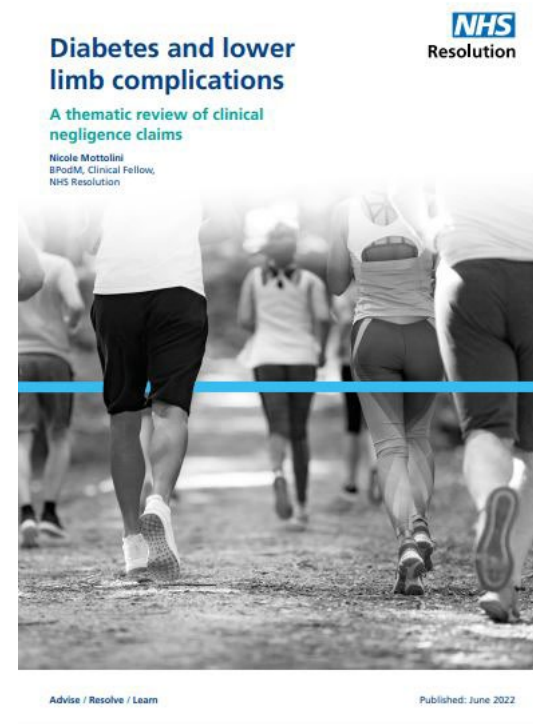
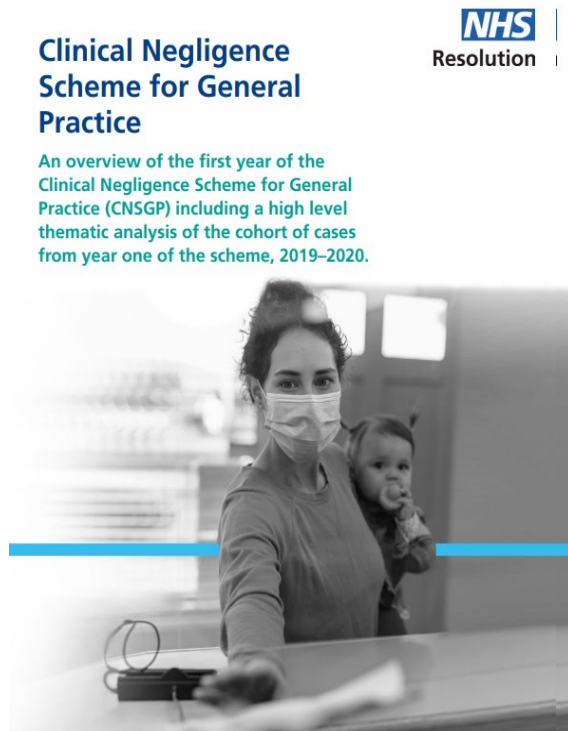
Leadership and Culture Resources

- [Personalised Care institute](#)
- [Advanced Practice Maturity Matrix](#)
- [Primary Care Support](#)
- [NHS Leadership Academy](#)
- [Florence Nightingale Foundation](#)
- [Healthcare Special Safety Investigation Branch](#)
- [Just Culture: Being Fair 2](#)
- [Royal Pharmaceutical Society competency Framework](#)

- Since the launch of our general practice indemnity schemes in April 2019 and April 2020, we have been committed to supporting beneficiaries of these schemes, including through the sharing of learning from claims.
- To do this we continue to grow our digital resource offering. Our focus is on easily accessible content that can be consumed on the go, returned to when convenient, shared with colleagues and used in training.
- Over the summer, we completed our series of 'Supporting general practice' videos. These 8-12 minute videos aim to share learnings from claims to improve patient safety. Each video looks at a particular area that is known to give rise to a number of claims each year and then provides advice on how to prevent such claims arising. They cover:
 - [Medical record keeping](#)
 - [Administrative errors](#)
 - [Consent](#)
 - [What to do if you receive a complaint or claim](#)
 - [Common pitfalls](#)

- We also launched an 8-minute video looking at how to manage clinical risk in general practice and what to do when things go wrong. This is specifically aimed at general practitioners, and especially those new to general practice. In it, three veteran GPs with 80 years general practice experience between them share what they have learned. It is called [Advice for those in General Practice – 80 years](#).
- To outline the parameters of our Existing Liabilities Scheme for General Practice (ELSGP), we also launched a 5-minute animation: [What is the Existing Liabilities Scheme for General Practice?](#)

Thematic reports



Did you know? Medication errors

Click on any of the pictures to read the full leaflet.

You can find other some of our other products for learning via our website [here](#).

Did you know? Insights into medication errors



Did you know? Anti-infective medication errors



Did you know? Heparin and anticoagulants



Did you know? General Practice Medication Errors

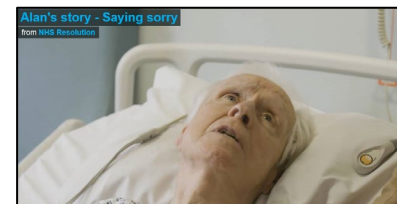
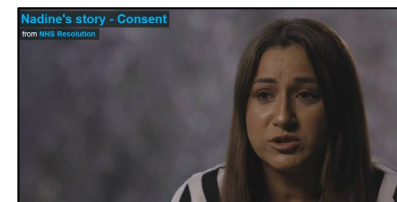


Did you know? Maternity Medication Errors



Did you know? Extravasation





Case story
Better joint working and specialist help benefits patients, families and the NHS

<https://resolution.nhs.uk/resources/>

Learning module: Response to harm - for staff



Treating staff fairly when things go wrong allows staff to be open about their mistakes, feel confident to speak up, without fear of being blamed. A...

Learning module: Response to harm - for patients and their families



How you support patients and their families when an incident occurs is essential part of resolution. On average, every year we are notified of around...

Learning module: Consent



Supporting decision making (consent) is a vital part of patient care. Consent claims often centre on the information, or insufficient information, provided to patients to...

<https://resolution.nhs.uk/facultyoflearning/>

Contact Safety and Learning



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<https://resolution.nhs.uk>

Thank you