Written evidence submitted by NHS Resolution (RTR0060)

About NHS Resolution

NHS Resolution is an arm's-length body of the Department of Health and Social Care. We provide expertise to the NHS on resolving claims, concerns and disputes fairly, sharing learning for improvement and preserving resources for patient care.

Our main functions are:

- **Claims Management**: dealing with claims for compensation on behalf of the NHS in England. The bulk of our workload is handling negligence claims on behalf of the members of our indemnity schemes: NHS organisations and independent sector providers of NHS care in England and since April 2019, beneficiaries of state-backed indemnity for general practice;
- **Practitioner Performance Advice**: supporting the management of concerns raised about the performance of doctors, dentists and pharmacists. In addition, NHS Resolution's Advice function is responsible for the management of the Healthcare Professional Alert Notices (HPANs) system. This is a system where notices are issued by us to inform NHS bodies and others about health professionals who may pose a significant risk of harm to patients, staff or the public. More information about HPANs can be found here;
- **Primary Care Appeals**: dealing with appeals and disputes between primary care contractors and NHS England; and
- **Safety and Learning**: helping providers of NHS care to understand their own claims risk profiles to target safety activity and share learning across the health service nationwide.

Response to the consultation

Introduction

1. NHS Resolution welcomes this consultation at a time where healthcare practitioners continue to face significant challenges, especially in the midst of the coronavirus pandemic. Exploring the ongoing challenges with recruitment, retention and training in the health sector is important to ensure high-quality care for patients and to improve the experiences of medical professionals.

2. We will only comment on matters relating to the healthcare sector as our remit does not extend to social care.

3. The below response to this consultation aims to:
    - Demonstrate what NHS Resolution has learnt from our unique data with regards to workforce challenges;
    - Outline our work to support organisations to resolve concerns about practitioners in a fair and timely way, including our Practitioner Performance Advice function; and emphasise the importance of robust and effective inductions.

Learning from claims – workforce levels and training

4. It is important to note that the NHS remains one of the safest healthcare systems in the world. However, avoidable errors still occur and can have devastating consequences for patients and their wider family, as well as the NHS staff involved.

5. Where clinical negligence does occur, in some cases workforce pressures and training requirements are identified as important contributing factors leading to patient harm. For example, in our thematic review of suicide-related claims (2018), we found that, albeit not a root cause in any of the serious incident reports used for our analysis, a third of the investigations reported lower staffing levels. Indeed, of these, 70% determined that staffing levels were lower than required for optimal working.[1]

6. NHS Resolution works closely with medical Colleges including the Royal College of Obstetricians and Gynaecologists, Royal College of Midwives, Royal College of Anaesthetists and the Royal College of Paediatrics and Child Health. NHS Resolution continues to highlight the importance of a sustainable workforce and robust training.

7. NHS Resolution supports training and incentivises the actions of the medical and midwifery workforce through our Maternity Incentive Scheme (MIS). See in particular Safety Actions four, five and eight of the ten Safety Actions:[2]

    - Can you demonstrate an effective system of clinical workforce planning to the required standard?
    - Can you demonstrate an effective system of midwifery workforce planning to the required standard?
    - Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?

Role of NHS Resolution's Practitioner Performance Advice

8. NHS Resolution's Practitioner Performance Advice Service ("Advice function") provides impartial advice to healthcare organisations to effectively manage and resolve concerns raised about the practice of individual doctors, dentists and pharmacists. Cases reflect a range of issues relating to clinical capability, performance, workplace behaviour and conduct. [3]

9. This helps to ensure that practitioners can return to safe and effective practice quickly and efficiently where appropriate whilst ensuring patient safety.

10. In order to understand trends in our data, and in doing so, ascertain how our Advice function can proactively support more healthcare organisations and their staff, we have expanded our data analysis, business intelligence and evaluation of the Advice function services.

11. For example, Advice function insights publications share analysis and research which draw on our in-depth experience providing expert, impartial advice and interventions to healthcare

[1] NHSR, Learning from suicide-related claims: A thematic review of NHS Resolution data (2018) page 83
[2] NHSR, Maternity Incentive Scheme – Year Four (2021)
[3] NHSR, Annual report and accounts 2020/21 (2021) page 19

organisations to effectively manage and resolve concerns raised about the practice of individual healthcare practitioners.[4]

12. We have commissioned external research to better understand the lived experiences of ethnic minority and international medical graduate practitioners who are subjects of Advice function cases. The purpose of this work is to guide the continuous improvement of the service which will allow us to improve how we manage cases and help us interact with practitioners in a more compassionate way by ensuring they feel heard, supported and understood. NHS Resolution will share this analysis once concluded with the wider system.

Induction and Support

13. NHS Resolution would welcome the opportunity to contribute to improving the induction process and programmes for medical staff. It is vitally important to ensure that all staff, and in particular international recruits, are inducted properly to the NHS.

14. The GMC's Fair to Refer Report[5] commissioned to understand why some groups of doctors are referred to them for fitness to practise concerns, highlighted that some doctors are provided with inadequate induction and/or ongoing support in transitioning to new social, cultural and professional environments.

15. More recently, in 2020, the GMC published a paper titled 'Understanding the nature and scale of the issues associated with doctors' induction'.[6] It highlighted that inductions were of a variable quality and that poor inductions can be linked directly to patient safety, e.g. doctors being unaware of emergency procedures/where vital equipment was stored. The report sets out key elements of a safe and effective induction which should be noted.

16. We support the GMC's conclusion that there needs to be improved consistency across all NHS Trusts in relation to induction. Therefore, NHS Resolution recommends that the NHS needs to strengthen or adapt its induction programmes to better support all practitioners particularly those from overseas which, in turn, will aid recruitment and retention. This is evidenced by NHS Employers' case study of University Hospitals Sussex NHS Foundation Trust who have provided robust induction and on boarding for overseas nurses which led to a 100% retention rate.[7]

Exclusions

17. NHS Resolution's Advice function also provides advice to healthcare organisations considering excluding, suspending or restricting a practitioner's practice. Where patient safety is considered to be at risk or where there are allegations of serious misconduct, it is important for healthcare organisations to be able to take appropriate steps so that the situation can be investigated.[8] NHS Resolution provides training to help those involved understand the appropriate thresholds for taking these actions.

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[4] For example: NHSR, Insights: Casework during the Covid-19 Pandemic (2020)
[5] General Medical Council, Fair to Refer (2019)
[6] General Medical Council, Understanding the Nature and Scale of the issues associated with doctors' induction (2020)
[7] NHS Employers, Pastoral support and induction for international recruits (2021)
[8] NHSR, Supporting secondary care organisations in England in dealing with exclusions (2020)

18. As one of the actions from the Government's Response to the Paterson Inquiry, we are producing guidance for employing organisations managing exclusions in England.[9] It highlights that exclusions should be used in a proportionate manner, subject to senior-level oversight and is a measure of last resort. This is to protect against the inappropriate use of exclusions. The Advice function supports clinicians and organisations to mitigate losing clinicians temporarily or entirely from the profession. However, we understand that in a minority of cases, exclusions and restriction of practice can be necessary and, in some cases, immediate exclusion is an appropriate response while an investigation is ongoing. Where exclusion, suspension or restriction is thought to be appropriate, we will continue to work with the healthcare organisation to routinely monitor the position and advise on good practice, taking account of local and national policy requirements.[10]

Just and learning culture

19. NHS Resolution are committed to working with our system partners to create a just and learning culture in the NHS. Creating such a positive culture can play a role in tackling a variety of workplace issues such as retention and is key to improving patient safety. However, it is important that all staff feel able to follow the Duty of Candour principles confidential and consistently. Training and early recognition of the Duty in inductions is vital.

20. While NHS Resolution continue to disseminate the messages of its Being Fair[11] report, Just and Learning Culture Charter and Saying Sorry[12] publication, we recommend that staff receive training for effective, full and open communication, and in particular, how to have 'difficult conversations'.[13] This will help to ensure that the Duty of Candour is not a barrier to learning. NHS Resolution considers that these principles should be embedded into the next iteration of the NHS People Plan.

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[9] NHSR, Supporting secondary care organisations in England in dealing with exclusions (2020) [10] NHSR, Supporting secondary care organisations in England in dealing with exclusions (2020) [11] NHSR, Being Fair (2019)
[12] NHSR, Saying Sorry (2017)
[13] NHSR, The Early Notification scheme progress report: collaboration and improved experience for families (2019) page 32