Clinical Negligence Scheme for General Practice

NHS Resolution

An overview of the first year of the Clinical Negligence Scheme for General Practice (CNSGP) including a high level thematic analysis of the cohort of cases from year one of the scheme, 2019–2020.

Advise / Resolve / Learn

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Contents

NHS Resolution

Foreword

General practice is the bedrock of the NHS. It is the first point of contact with the health service, with general practice teams carrying out over one million consultations every day. General practitioners (GPs) provide high-quality, person-centred, relational care which is rooted in local communities. This is the foundation for good health outcomes for our patients and an efficient, cost-effective NHS. Yet general practice is under immense pressure. Alongside workforce shortages, demand continues to grow year-on-year and our patients have growing and increasingly complex needs.

In recent years these challenges have been exacerbated by rising indemnity costs cutting into tight practice budgets. I was pleased, therefore, when in April 2019, the Department of Health and Social Care responded by introducing a state-backed clinical negligence indemnity scheme for general practice.

This report provides an overview of the first year of that general practice indemnity scheme and an insight into the claims made in that time. Each of these individual claims represents not just a financial cost to the NHS but more importantly an episode of possible harm. GPs and the wider general practice team, along with staff across the NHS as a whole, work incredibly hard to provide the best possible care for their patients. We are always devastated to learn of complaints and possible errors.

As such, the Royal College of General Practitioners (RCGP) welcomes this report as a valuable learning opportunity. The themes identified, including missed or delayed diagnoses and medication errors, are not challenges unique to general practice, but ones which resonate across the healthcare system. They will prove useful to general practice and the wider health service in planning guidance and care.

One of the most crucial areas highlighted by this report is the importance of communication. GPs know that good communication with our patients is critical; communicating risk and safety-netting when diagnoses are uncertain. Effective communication between primary and secondary care is also critical to keeping our patients safe and ensuring a smooth journey through the health service. As system working develops further, the RCGP looks forward to continuing to engage with NHS Resolution and other key partners to consider the interface between primary and secondary care.

Similarly, the importance of the wider general practice team cannot be overstated, and the report quite rightly focuses on the range of healthcare professionals and the variety of settings within general practice care.

This year, the RCGP celebrates 70 years of best practice in our role representing GPs across the UK. As primary care continues to rise to the challenge of meeting rising demand in a changing landscape, I welcome this report as a valuable contribution to the important work of ensuring patient safety.

Professor Martin Marshall CBE FRCGP
Chair of RCGP

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 concerns and claims fairly, share learning for improvement and preserve resources for patient care. A total 11,682 new clinical claims and reported incidents were recorded in 2019/20. The cost of settling claims in 2019/20 reduced by £103 million, to £2.3 billion on longstanding schemes. An additional £61.4 million was spent on settling general practice claims[1].

Rationale

Rising indemnity costs and the impact on general practice led the Department of Health and Social Care (DHSC) to announce in October 2017 the introduction of a state-backed clinical negligence indemnity scheme for general practice from April 2019. The introduction of a state scheme reduces the risk of rising indemnity costs for medical and healthcare professionals (see glossary) working in general practice. The CNSGP scheme launched in April 2019.

This report has been produced further to NHS Resolution's functions under paragraphs 3-5 of the Safety and Learning Directions 2019. These require NHS Resolution to disseminate information it obtains and generates in the exercise of its functions, and undertake research, particularly as regards safety, quality and scheme management, and to encourage members of its schemes to improve the quality and safety of services they provide.

Clinical negligence claims associated with general practice accounted for 401 (3.4%) of the 11,682 new claims notified to NHS Resolution in the first year of the scheme. This number is expected to increase as claims are often reported many years after the incident has taken place. To put these figures in context, 90% of patient contact with the NHS takes place in general practice.[(i)(ii)]

The report explores the clinical issues within general practice that contribute to compensation claims. The preliminary data and findings extracted focus on identifying common themes from claims reported to the scheme. By providing practical recommendations to respond to initial themes, this analysis aims to improve patient safety and avoid harm and thereby drive down the number and cost of general practice claims.

Aim

This report is aimed at understanding the causes of claims that occur in general practice and identifying common themes and claims with secondary care providers.

Method

A total 401 cases were reported to the CNSGP between 1 April 2019 and 31 March 2020. Both open and closed cases were evaluated to form this report; previous thematic reviews have focused on learning from closed cases. The review includes potential claims such as patient safety incidents and complaint responses amounting to an admission of breach of duty. Information from letters of claim, serious incident investigation reports, defence expert witness reports and some clinical records were repetitively and thoroughly scrutinised to extract the clinical themes.

[1]NHS Resolution's Annual report and accounts 2019/20

NHS Resolution recognise that the first year of CNSGP is likely to be a skewed sample as by definition, it concerns incidents which have converted rapidly into a claim. We know from our experience of managing other schemes that incidents which result in ongoing needs such as care (and which are therefore of high financial value), generally take longer to be reported as a claim.

The most frequent case notifications were as follows: cancer (9.3%), cardiac (7.3%) and sepsis (5.3%). The most commonly reported cause code was delay/failure to diagnose which features in 43.5% of CNSGP cases, followed by medication errors (18.5%) and delay/failure to refer (10%). The number of formal claims (where a letter of claim has been received or formal proceedings have started) notified over this period was 81.

There are some limitations to the conclusions we can draw as some claims may not ultimately result in a finding that negligently caused harm has occurred. Irrespective of this, we recognise that in each case someone has been harmed and understanding why this has occurred provides an opportunity for improvement. Therefore we have included them in this report.

Results

Three initial themes were identified; delay/failure in diagnosis, medication errors and issues arising in prison healthcare.

Many of these claims relate to systems and processes which influence delivery of effective care in general practice and communication was contributing factor in some of the incidents for both claims arising in general practice and secondary care.

Key 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 system[2]) assessment tool for use in general practice to assist earlier identification of deteriorating patients.

2

Recommend that NHSX with NHS Digital GP IT[3] (see footnote) and NHS England continue to promote existing safety netting tools (including minimising 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

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.

Part 1

CNSGP: Overview and reporting

The Clinical Negligence Scheme for General Practice

This report reviews the first year of the Clinical Negligence Scheme for General Practice (CNSGP), the indemnity scheme which covers the NHS work of general practice in England for incidents occurring after 1 April 2019.

1. Background

As part of the Department of Health and Social Care's commitment to provide a more stable and affordable system of indemnity for general practice, and to support the commitments set out in the NHS Long Term Plan, the CNSGP was launched on 1 April 2019. It covers all clinical negligence claims for compensation arising from NHS services provided by general practice in England and covers all incidents occurring on or after 1 April 2019 relating to care provided under GP contracts. It was a key part of the five-year framework for GP contract reform to implement the NHS Long Term Plan. The purpose of the state scheme is to provide a more stable, affordable system of indemnity which supports general practice recruitment and retention, protects patients and ensures access to fair compensation where appropriate.

Alongside NHS Resolution's other indemnity schemes, CNSGP allows us to understand why harm occurs and share that knowledge with the clinical and non-clinical staff so healthcare can be improved. Operating CNSGP means that for the first time, one organisation, NHS Resolution, holds information on the majority of claims made against NHS providers of healthcare in England. This will facilitate system-wide learning in a way that has not been possible before.

Together with the introduction of CNSGP, we have supported the Department of Health and Social Care to bring historic (pre 1 April 2019) general practice liabilities under the same roof as CNSGP. The Existing Liabilities Scheme for General Practice was established in April 2020. It currently covers liabilities previously covered by the Medical and Dental Defence Union of Scotland and as of 1 April 2021, those of the Medical Protection Society.

2. Introduction to the scheme

Prior to CNSGP, those working in general practice were required to put in place their own indemnity arrangements. A survey carried out by Ipsos MORI, a market research company, on behalf of the Department of Health and Social Care in November 2018 concluded that the average cost of indemnity cover for GPs in 2018/19 was £7,452 and this had gradually increased over the previous few years. This was understood to be having a negative impact on general practice recruitment and retention.

CNSGP provides a similar approach to that taken by secondary care for process of claims and learning within NHS Resolution. Mistakes in healthcare are often multi-factorial and systemic rather than due to individual failings. CNSGP promotes joined up working between primary and secondary care with a reduction in any gaps and boundaries. This supports the Cumberlege report[v] recommendations, the NHS Long Term Plan, the commissioning of care across multi-disciplinary teams and development of Integrated Care Systems.

CNSGP was a key part of the five year framework for GP contract reform to implement the NHS Long Term Plan. CNSGP provides an assurance of comprehensive and unlimited cover not just to general practitioners themselves but also to registered nurses, front of house (receptionists) and back-office staff, pharmacists working in general practice and indeed anyone who plays a part in providing services and delivering care to patients within general practice. A suite of supporting material is available on the NHS Resolution website[vi].

This is particularly pertinent with the intended expansion of the workforce cited in the NHS Long Term Plan, as general practice evolves with the creation of Primary Care Networks and the overall aim and recruitment of 26,000 additional roles working in general practice by 2023/24.

The Medical Defence Organisations and other indemnity providers remain particularly important partners for NHS Resolution and have been instrumental in making the new arrangements a success, with the interface between the CNSGP and other indemnity and advice products working well.

3. Our focus during the first year

Although indemnity within general practice was new for the organisation in 2019, NHS Resolution already had a strong presence within primary care. The Practitioner Performance Advice and Primary Care Appeals services have served NHS primary care since 2001 by respectively resolving performance concerns of individual doctors, appeals and disputes between primary care contractors and NHS England.

Our focus for the first year of CNSGP was to ensure this new way of providing indemnity was widely understood among the general practice community and the scheme was fully integrated within our broader resolution frameworks.

Although the volume of cases[4] notified under the CNSGP in its first year of operation has been relatively low, during the first year we dealt with over 3,000 individual queries from practitioners, practice managers and others. Many of these queries were around contracting arrangements, which is the key component for provision of indemnity under the scheme.

As part of our external engagement activities, we ran regional primary care roadshow events across the seven NHS regions in conjunction with NHS England. These provided an opportunity for providers and commissioners of primary care to hear about NHS Resolution's full range of services and to engage with delegates from across the primary care community, including practice managers, general practitioners, clinical commissioners, representatives from Local Medical Committees and other healthcare organisations.

We have drawn on the knowledge and expertise of those already well established within general practice, including the British Medical Association and the Royal College of General Practitioners, both of whom are key stakeholders and trusted advisors.

We have established a sounding board with representation from the various professions that make up NHS general practice to advise on and inform our publications and engagement with the professions. We have also launched a range of digital products including podcasts, animations, resource videos and webinars[5].

Where applicable, NHS Resolution worked in partnership with the Medical Defence Organisations to ensure a seamless transition in indemnity provision, a clear interface between state and Medical Defence Organisation provision of services and smooth transfer of responsibility of historic liabilities. Medical Defence Organisations continue to provide support to their members for matters that fall outside the scope of CNSGP, such as complaints handling, inquests, disciplinary and regulatory matters and those services for which their members are privately paid. Members will be signposted to CNSGP when a relevant claim or potential claim is identified.

One of the biggest benefits of having all clinical negligence cases together is the opportunity this presents for learning. We are already beginning to look across pathways to identify local and regional trends and are embarking on an ambitious strategy to transform the way in which we use the data we hold to drive improvements in healthcare. As the general practice workforce grows and new, emerging professional groups take a greater role in care delivery, they will all be covered under the CNSGP regardless of their location or shift patterns.

[4] See glossary

[5] See: https://resolution.nhs.uk/services/claims-management/clinical-schemes/general-practice-indemnity/clinical-negligence-scheme-for-general-practice/ and https://resolution.nhs.uk/resources/?fwp_resources_type=podcast

The cases in this report consist of both open and closed cases. This means there are some limitations to the conclusions that can be drawn as some claims may not ultimately result in a finding that negligently caused harm has occurred. Irrespective of that, we recognise that in each case someone has been harmed and understanding why that has occurred provides an opportunity for improvement and therefore we have included open cases in this report.

The end of the first year of CNSGP coincided with the start of the Covid-19 pandemic and the greatest challenge faced by the NHS and society at large for decades. At the time of writing this report, the pressures continue. There will however be longer term impacts as the country recovers. NHS staff have been on the frontline throughout providing expert care with professionalism and determination. NHS Resolution have supported where we can, ensuring that indemnity was not a barrier to that response. NHS Resolution have developed new schemes, adapted existing ones and provided guidance where needed[6]. As we move forward, our key priority will be to make sure that our services continue to support healthcare delivery through the pandemic and recovery.

CNSGP: The first year in numbers

Between 1 April 2019 and 31 March 2020 a total of 401 cases were reported to the CNSGP. These include potential claims such as patient safety incidents and complaint responses amounting to an admission of breach of duty. The number of formal claims (where a letter of claim has been received or formal proceedings have started) notified over this period was 81.

Table 1: The classification of cases reported

Request for Records for Potential Claim	177
Patient safety incident	89
CNSGP Claim	81
Complaint with Admission of Breach of Duty	47
Communication from the Parliamentary and Health Service Ombudsman	3
Intended Offer of Compensation/ Other Redress	3
Panel Instruction*	1

[6] Clinical Negligence Scheme for Coronavirus – NHS Resolution

* Panel instruction is a temporary code used until a case is reallocated

4. CNSGP notifications

Identifying and reporting claims to the CNSGP in a timely manner allows us to provide support to the staff involved and ensure any protocol or procedural deadlines are met. Reporting patient safety incidents which have a high potential to become claims provides the opportunity for early investigation and early resolution. For both patients and healthcare providers the claims process can be stressful, time intensive and expensive. Beneficiaries of the CNSGP are asked to notify NHS Resolution of claims in line with our published reporting criteria to meet these aims[7].

A claim can be defined in broad terms as one where either a formal legal process has been started (e.g. a letter of claim or proceedings have been served) or where we accept a payment of compensation is likely to be made (even if a formal process has not been commenced). These must be reported to NHS Resolution under the CNSGP in line with our published reporting criteria.

Over the first year of CNSGP, NHS Resolution have been notified of both claims and potential claims. Claims are progressed to resolution which can either be a payment of damages or denial of liability followed by file closure.

- Potential claims are usually managed by providing scheme beneficiaries with advice.
- Where these are high risk, they may turn into claims and progress to resolution.
- Potential claims in their early stages are often closed after advice has been provided to the beneficiary and may be reported back if there are any further developments.

We have seen a higher number of potential claims rather than actual claims reported in the first year. Where harm has occurred, patients have at least three years from the date of an incident to start court proceedings in relation to personal injury. Our experience across other clinical negligence schemes is that we are routinely notified of claims many months, if not years, after the incident.

Reporting of potential claims resulting from patient safety incidents does not replace the need for a local learning investigation. It is essential that causes of harm are explored and healthcare providers are open and transparent with patients at the time the incident occurs, providing an apology where appropriate[8].

[7] When and how to report a claim – NHS Resolution

[8] Saying sorry (duty of candour) - NHS Resolution

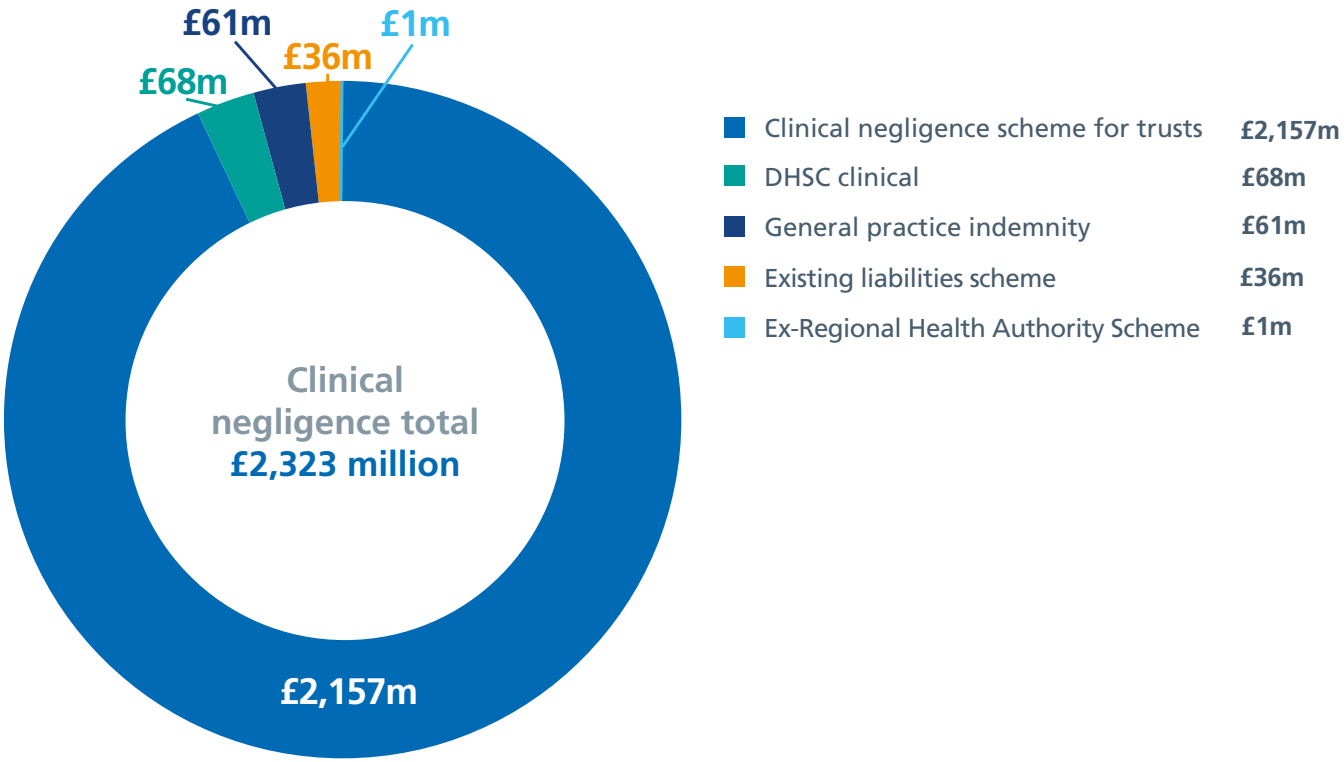
CNSGP: First year in figures

There can be a time lag of several years between incidents occurring and notification of claims being received and settled, particularly in relation to clinical negligence. We therefore engage actuarial advisers (Government Actuary's Department) to assist in developing estimates for the cost of clinical negligence.

It is estimated that the cost of clinical negligence claims under the CNSGP scheme arising from incidents in 2019/20 was £307m[9]. Almost all of this is an actuarial estimate of the volume and value of claims we expect to receive in the future[vii].

The actual amount spent on handling and settling CNSGP claims in 2019/20 was £59,000[10]. This is only a small proportion of the total value of payments (£61 million) for general practice indemnity as a whole, referenced in Figure 1. The £61 million includes the related cost for pre-1 April 2019 claims migrated to NHS Resolution from medical defence organisations. The £59,000 is reflective of the time lags referred to above, and it is expected that in-year payments will increase in years to come.

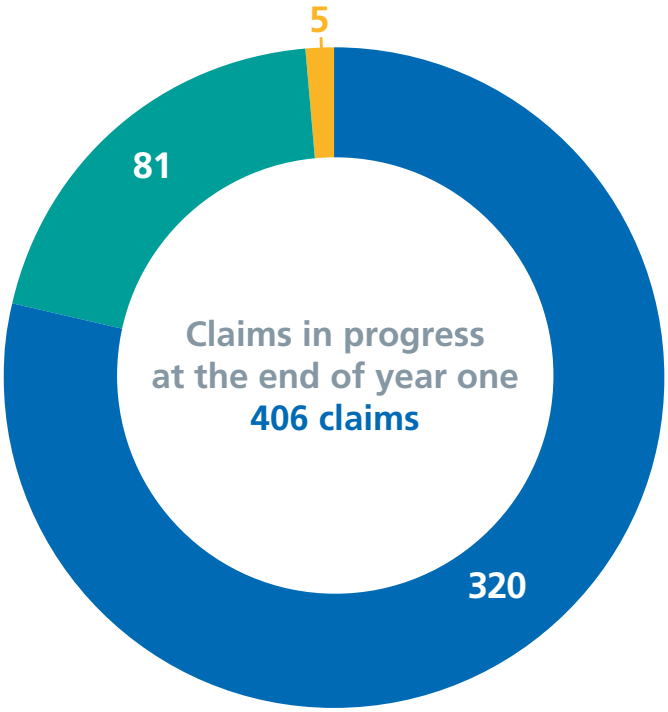
Figure 1: The value of payments (damages, claimant and NHS legal costs) for General Practice Indemnity 2019/20



[9] Note 2.1 Financial Statements in NHS Resolution annual reports and accounts 2019/20

[10] Note 7 Financial Statements in NHS Resolution annual reports and accounts 2019/20

Figure 2: CNSGP: A year in numbers



Number of potential claims notified	320
Number of claims notified	81
Number of claims paid	5

193 CNSGP cases (48.1% of total notifications) have been closed to date with nil damages.

Due to the maturing nature of the CNSGP scheme, only a few claims were resolved within the first year, and many claims are currently open. No conclusions can currently be drawn from this data due to the immaturity of the scheme.

5. CNSGP claims with linked Clinical Negligence Scheme for Trusts claims

One of the overarching benefits of the CNSGP commencing was the opportunity to have both primary and secondary care claims managed by the same organisation and to identify possible trends and themes for improvement. In the first year, 14 CNSGP claims (3.5% of total claims) were linked with a Clinical Negligence Scheme for Trusts (CNST) claim. The CNST is NHS Resolution's indemnity scheme for clinical negligence claims made against NHS Trusts.

Part 2

Clinical findings

Overview of general practice

Primary care services are at the heart of healthcare in many countries. They provide an entry point into the health system and directly impact on people's well-being and their use of other health and care resources. Thus, improving safety in primary care is essential when striving to achieve both equal access and the sustainability of healthcare[viii].

We already know general practice is an efficient and cost-effective way of delivering healthcare within communities to the majority of the population. The Five Year Forward View highlighted that general practice provides over 300 million patient consultations each year[ix].

Despite high patient satisfaction levels[x], recurring, common errors occur within general practice. Avery et al identify the key incident themes in general practice as: diagnosis 61%, medication-related 26% and delayed referrals 11%[xi]. Carson-Stevens, Hibbert and Williams et al[xii] categorised them into five underlying reported causes for safety incidents in general practice. The five categories of incident type, were:

1. **Communication with and about patients.**
2. **Medication and vaccine provision.**
3. **Errors in investigative processes.**
4. **Treatment and equipment provision.**
5. **Timely diagnosis and assessment.**

The initial CNSGP findings outlined in this report paralleled these five categories of incident types in the initial themes and recommendations for future work.

Methodology

This review identifies the initial top themes that have arisen in general practice during the first year of CNSGP.

This is a preliminary review of the available data following a high-level data extraction in May 2020. Extracting themes at this stage, in categories such as the most common injuries and errors, will guide a detailed investigation into the potential learning from future general practice claims.

The CNSGP indemnity scheme is based on occurrence, with numbers of claims reported expected to see a gradual increase, allowing for the time lag between incident occurring and a claim being pursued.

This review will culminate in more detailed analysis with the aim of improving patient safety and reducing the volume of future claims from general practice. Of particular interest is likely to be the overlap and integration of primary and secondary care services, which suggests a greater understanding of the risks for those providing and receiving GP services could help improve patient safety and patient pathways in general practice, community or hospital settings.

The data extraction in May 2020 identified 401 CNSGP cases using a creation date search criteria between the start of the scheme on 1 April 2019 to the 31 March 2020.

The CNSGP data was interrogated using the claims management classification categories under the scheme and in parallel, drawing on an internal thematic taxonomy paper exploring whether an updated coding system may better stratify general practice cases. Subsequent analysis revealed a duplicate claim, which was removed from the data set therefore 400 CNSGP cases were analysed and divided into top themes.

NHS Resolution has a responsibility to maintain the integrity of patient data and confidentiality under data protection laws and we have supressed low figures as we believe that disclosure of information with this level of granularity would contravene one or more of the data protection principles. The data protection principles are set out in Article 5 of the General Data Protection Regulation.

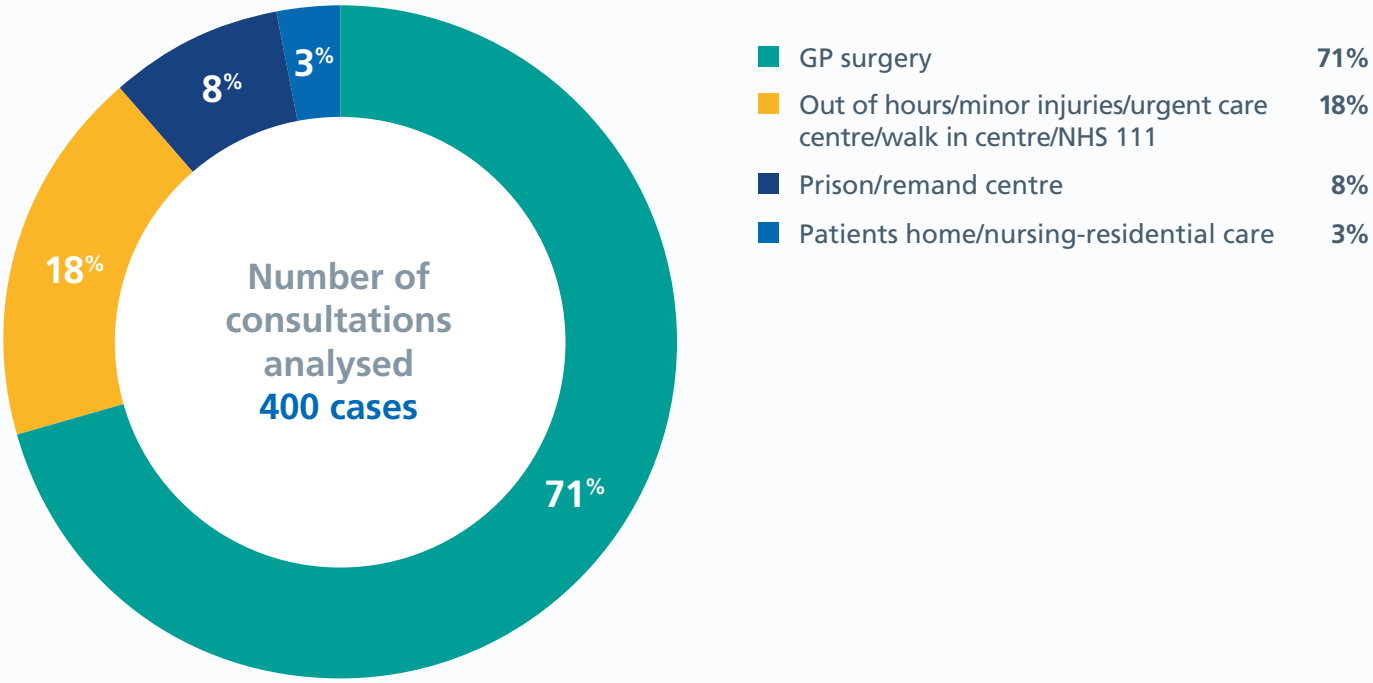
The majority of CNSGP cases are open cases, therefore this review provides a high-level analysis with limited interrogation of the data to ensure the claim and patient confidentiality are not prejudiced. More frequent clinical themes were identified as speciality themes, whilst the remaining data was further sub-divided into categories incorporating ‘under ten’ notifications and ‘fewer than five’ notifications.

Initial findings arising from the first year of CNSGP

General practice: Attendance demographics

Analysis of consultation data available showed 71% (n=283) of patient consultations took place within the general practice setting. Out of hours settings saw 18% of consultations, with prison/remand settings seeing 8.5% of consultations. As this is the first year of the scheme, there is currently no comparator.

Figure 3: Location of attendance



The NHS Long Term Plan 2019[xiii], the Five Year Forward View[xv] and the General Practice Forward View[xv] all have a clear commitment to multi-professional teams practising clinically in the general practice setting offering patient choice. A clinician overview has been included within the speciality themes later in the report.

6. Most frequent notification by patient condition

The most frequent notifications by patient condition are listed in order of occurrence; the most common case notifications were cancer (9.3%), cardiac (7.3%) and sepsis (5.3%).

The most commonly reported cause code is *delay/failure to diagnose* which features in 43.5% of CNSGP cases, followed by *medication error* (18.5%) and *delay/failure to refer* (10%). Due to the nature of the risk profile with healthcare, a number of cause codes can be applied to one case.

Figure 4: Most frequent notification by patient condition

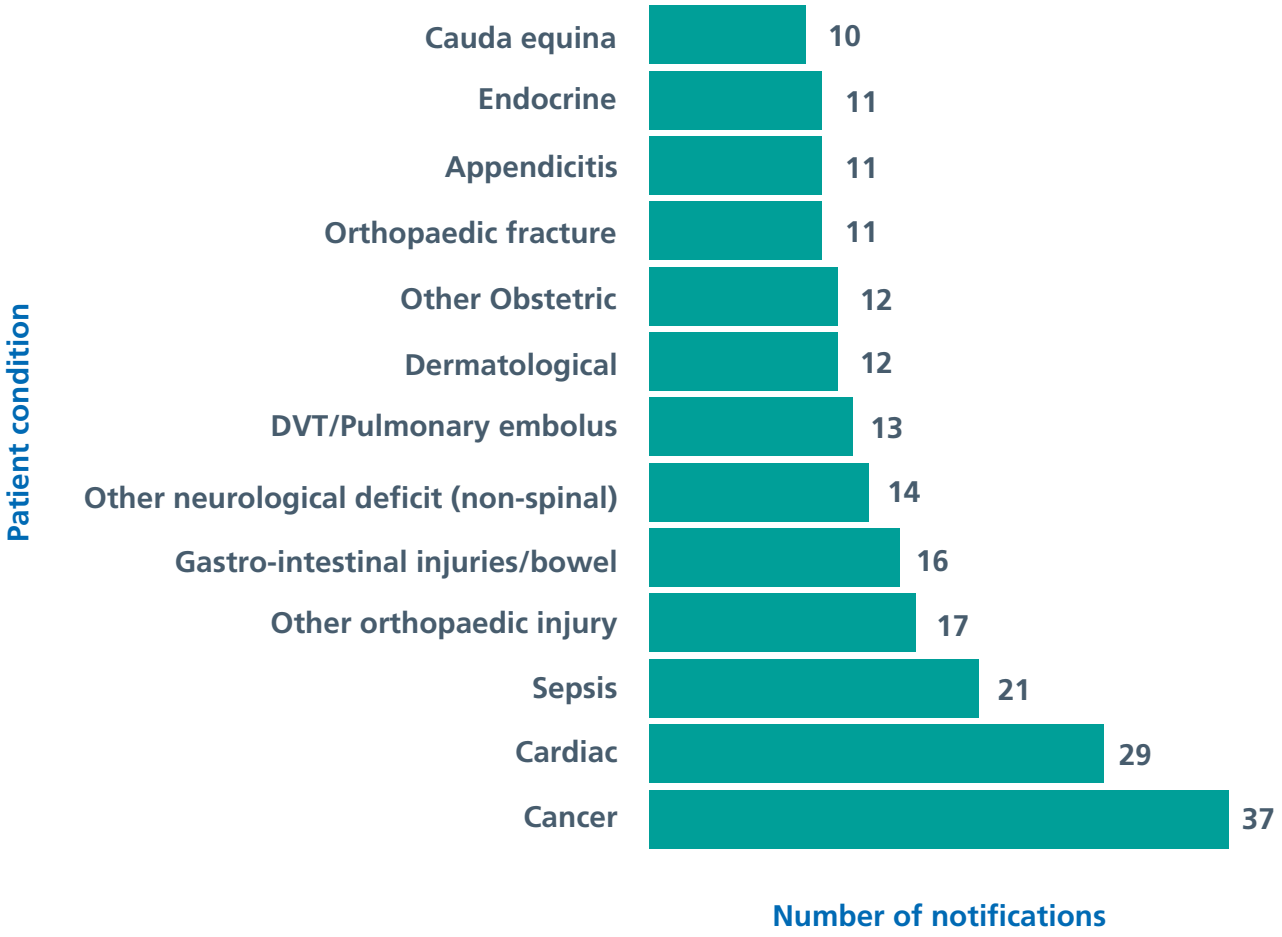


Table 2: Stratification of common cause codes of CNSGP notifications in year one

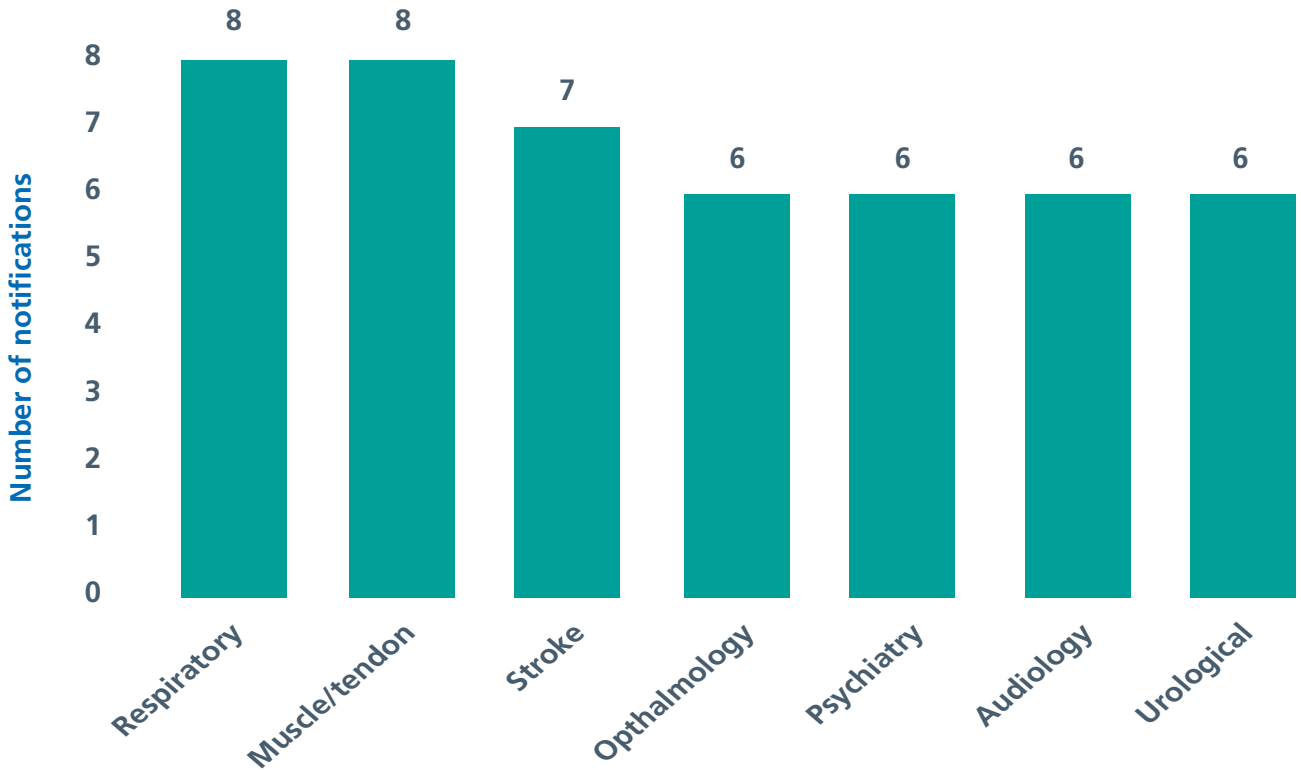
Cause codes	Cases
Delay/Failure to diagnose	174
Medication error	74
Delay/Failure to refer	40
Failure to monitor	27
Failure of follow up arrangements	26
Failure to recognise complication in treatment	21
Other (consent/delegation/tests)	18
Administrative/practice error	12
Failure to act on test result/report	8

7. General practice: CNSGP cases by patient condition

The data covers over 160 varieties of patient conditions across 34 injury/condition notification categories recorded in the first year of the CNSGP scheme (Appendix 1). The range of patient conditions highlights the broad spectrum of knowledge and expertise that underpins those healthcare professionals working in general practice. A separate notification category was recorded for medication errors which is discussed as an individual theme later in the report.

Less frequent clinical themes were sub-divided into categories incorporating 'under ten' notifications and 'fewer than five' notifications. The report will not contain reference to any notifications 'fewer than five' due to the risk of possible patient identification.

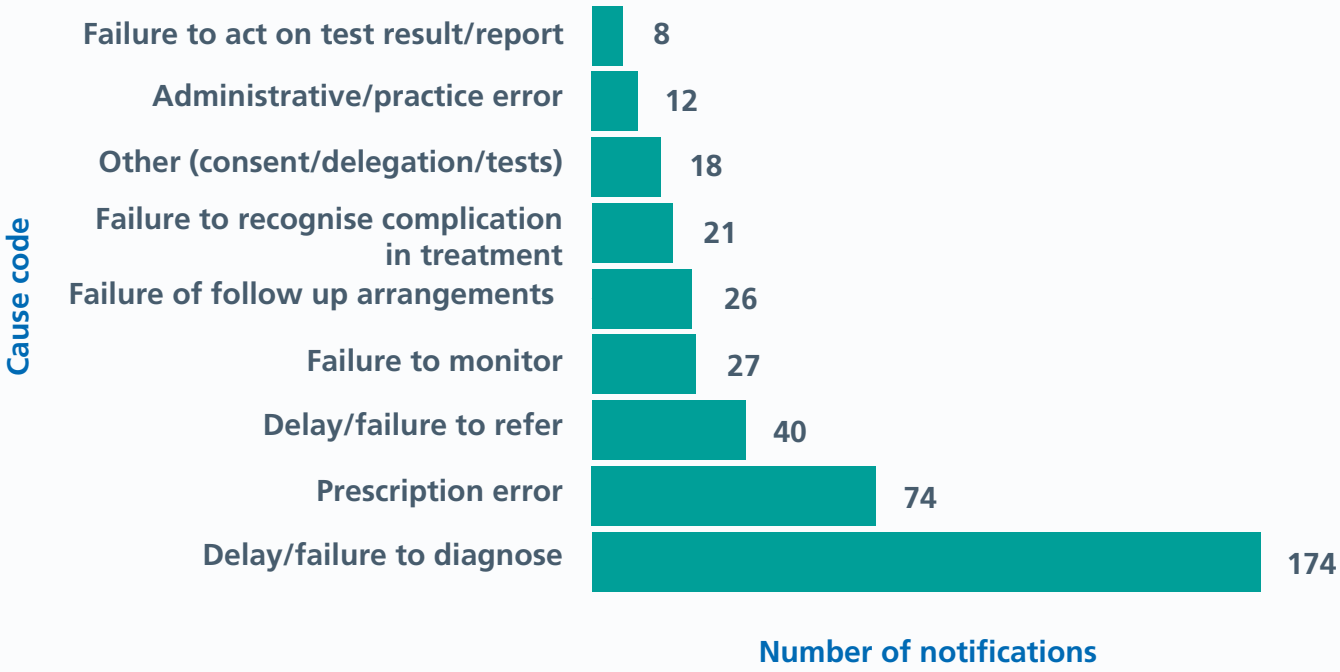
Figure 5: Specialties with fewer than 10 notifications



8. General practice: CNSGP cases by cause

The data is classified by ten primary cause codes across all the CNSGP cases. As highlighted earlier the most common are shown below, with a failure/delay in diagnosis accounting for 174 (43.5%) of CNSGP claims, followed by *medication error* (18.5%) and *delay/failure to refer* (10%).

Figure 6: Number of notifications per cause code



9. Delay/failure to diagnose

Missed/delayed diagnosis featured as an issue in general practice and appears to be a common patient safety concern. It is not a new issue and has been highlighted in published articles and reports external to NHS Resolution[11]. There is an overlap between *delay/failure to diagnose* and failure to refer.

The role of the general practice in diagnosis is one of problem recognition and decision-making.

A crucial aim of the general practitioner or healthcare professional in this regard is to minimise danger by recognising and responding to signs and symptoms of possible serious illness. The objective is not always to reach a definitive conclusion in general practice – the diagnostic process can also act as a gateway to further management of the patient's complaint[xvi].
It is important to recognise that diagnosis is a complex area of clinical activity that does not often follow a simple linear sequence.

[11] The global burden of diagnostic errors in primary care | BMJ Quality & Safety

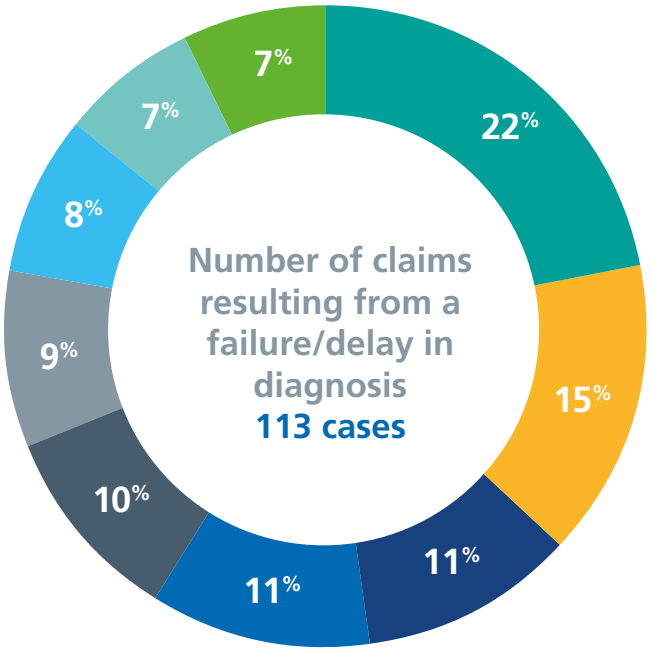
The need for radical investment and reform of diagnostic services to support clinical diagnosis has been recognised in the NHS Long Term Plan published in 2019. The Report of the Independent Review of Diagnostic Services for NHS England[12] published in October 2020 reiterated the need for investment into localised diagnostic services to deliver safe, high-quality diagnostic services to support clinical diagnosis.

Continuity of care may have been a factor in some delays as there was some evidence in the data of patients seeing multiple clinicians both in general practice and in out of hours settings prior to diagnosis. Continuity of care is described as the extent to which a series of healthcare services is experienced as connected and coherent and is consistent with a patient's health needs and personal circumstances[xvii].

Car et al (2016) argue strategies for measurement and monitoring the *delay/ failure to diagnose* are underdeveloped and underutilised and suggested solutions include development of a more rigorous system for communicating abnormal results to patients, direct hotlines to specialists to discuss patient problems and clear referral guidelines and pathways for common conditions[xix].

Reviewing the most common patient conditions and cross referencing against the most common cause codes provides another perspective. *Delay/failure to diagnose* was found in higher volumes in clinical areas such as cancer, 68% (n=25) and sepsis, 81% (n=17), and also had a high correlation in lower volume areas such as Deep vein thrombosis/ Pulmonary embolism and Other obstetric[13].

Figure 7: Claims resulting from a failure/delay in diagnosis



Cancer	22%
Sepsis	15%
Deep vein thrombosis/pulmonary embolism	11%
Other obstetric	11%
Cardiac	10%
Appendicitis	9%
Gastro-intestinal/bowel	8%
Cauda equina	7%
Orthopaedic fracture	7%

[12] DIAGNOSTICS: RECOVERY AND RENEWAL – Report of the Independent Review of Diagnostic Services for NHS England – October 2020

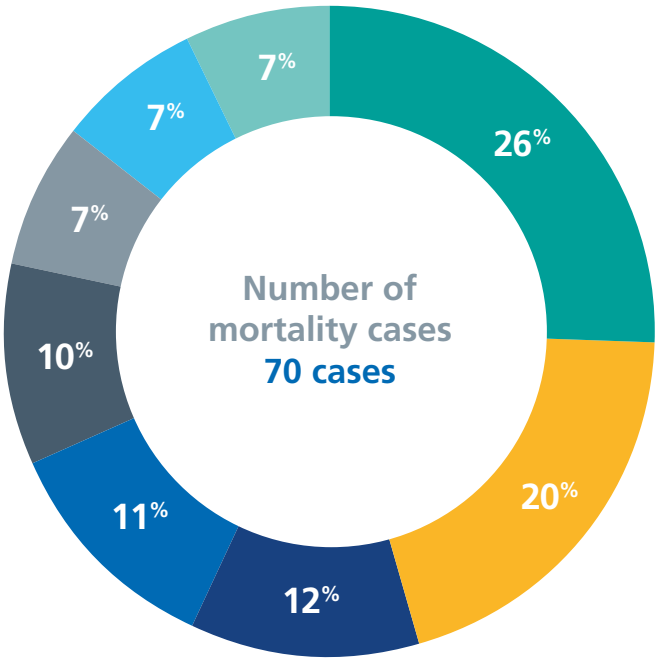
[13] See glossary

10. Mortality

70 incidences of mortality within the CNSGP notifications were identified between 1 April 2019 and 31 March 2020. This equates to 18% of the total CNSGP notifications. Of the 70 notifications, cardiac deaths account for 26% (n=18), with both medication error and Deep vein thrombosis/Pulmonary embolism accounting for 11% (n=8) each of total deaths.

These findings should be treated with caution as mortality may not indicate clinical negligence and the findings may alter as the data becomes more mature.

Figure 8: Mortality by injury/condition



Cardiac	26%
Other	20%
Prescription error	12%
Deep vein thrombosis/pulmonary embolism	11%
Sepsis	10%
Psychiatric	7%
Respiratory	7%
Gastro-intestinal/bowel	7%

Findings by theme

The findings are divided into clinical themes to provide further analysis. The first four themes provide an overview of the most common clinical cases, whilst theme five scrutinises medication errors and theme six draws attention to the role general practice has in delivering prison healthcare.

21 cases were of other notifications which do not currently fit into an injury classification[14], either because insufficient information is currently held in the claims record or because they do not relate to an injury.

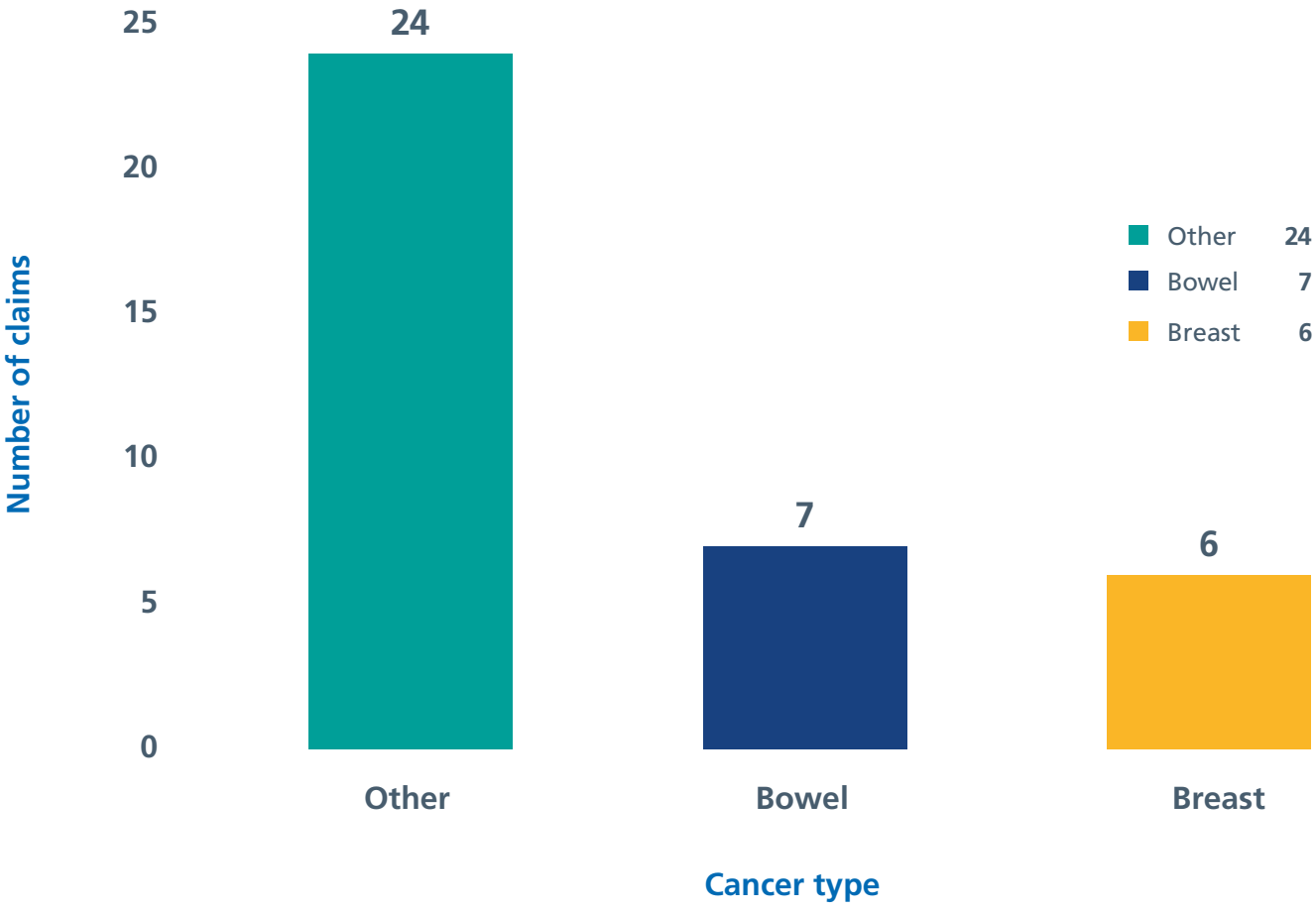
Theme 1: Cancer

One in two people will develop cancer at some point in their lives, according to forecasts from Cancer Research UK. As a result of a growing population, referrals are increasing pressure on cancer services. Reducing delay in the general practice cancer care pathway is likely to improve cancer survival.

During the first year of CNSGP, 37 cancer notifications were noted. This amounts to 9.3% of the total notifications. Within these notifications, 19 categories of cancer were identified.

Bowel cancer accounted for 18% (n=7) of the total cancer notifications during this time, followed by breast cancer 16% (n=6). The category 'other' was the largest group and compromises of small incidences of varying cancers, but due to small numbers were grouped together.

Figure 9: Cancer claims by type of cancer



11. Cancer group claim notification

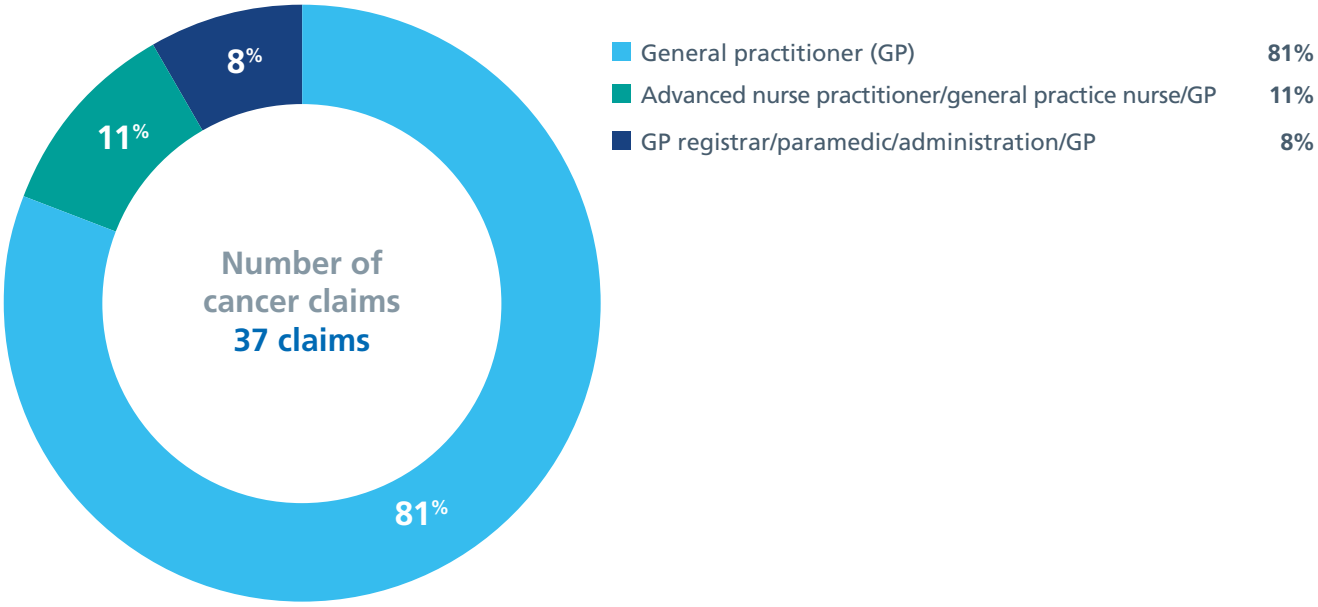
The most common grouped claim notification was request for *records for potential claim*. A patient's medical records are usually a vital tool in establishing whether they might have a claim for negligent medical treatment. A request for records may indicate a claim will be pursued, but not all requests for records will result in an eventual claim being made.

Delay/failure to diagnose in cancer is the most common cause code accounting for 67.6% (n=25) of cases. Failure/delay to refer accounted for 10.8%. Taken together they amounted to 78.4% of all cancer cases. There were a small number of claims that related to a failure to refer, failure to perform the appropriate test or act on a test result, administrative errors and failure of follow up arrangements.

12. Clinician/non-clinician involvement

While statistics are not available for all of the CNSGP themes, clinicians involved in the cancer cases were categorised. All notifications had general practitioner involvement with 11% involving registered nurses and 8% involving a variety of other clinicians including GP registrars, paramedics and administrators.

Figure 10: Cancer claims by clinician involved



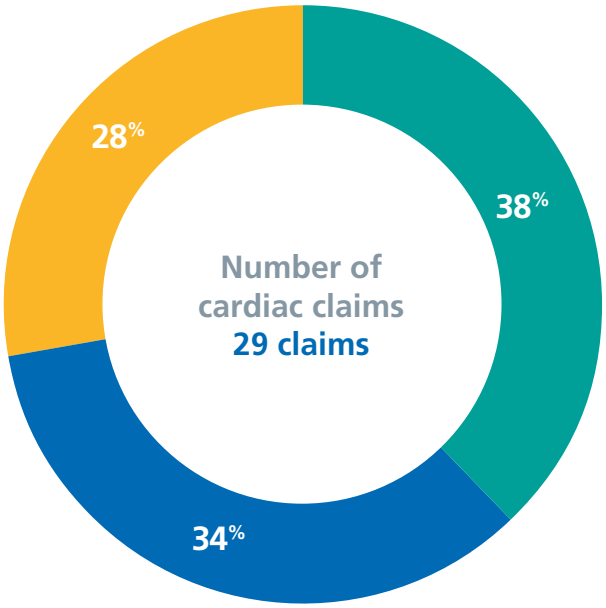
Theme 2: Cardiac

In the UK, deaths from heart and circulatory diseases average one in every three minutes. Heart and circulatory diseases accounted for 167,116 deaths in 2018, just over 27% of total deaths in the UK that year[xx].

Within the CNSGP data set, there were 29 cardiac notifications and eight categories of cardiac diagnosis were identified. Of the 29 cardiac cases, the most common events were myocardial infarction at 38% (n=11) and cardiac arrest at 28% (n=8).

The most common grouped claim notification was request for records for potential claim at 38% (n=11) followed by Patient safety incident at 34% (n=10).

Figure 11: Cardiac claims by type



Myocardial infarction	38%
Other: Incl heart failure, hypertension, angina, aortic anuuerysm, cardiomyopthy, cardiac wound infection	34%
Cardiac arrest	28%

13. Cardiac grouped claim notification

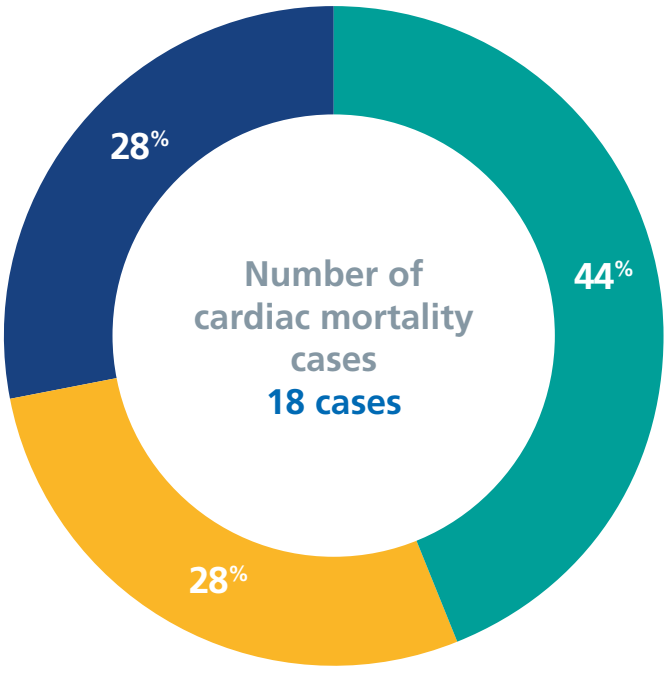
Delay/failure to diagnose in cardiac claims is the most common cause code accounting for 38% (n=11) of errors. *Failure of follow up arrangements* accounted for 24%. There were a small number of claims that related to a failure to monitor, failure to refer, administrative errors and failure to recognise a complication in treatment.

14. Cardiac mortality

In England there are approximately 30,000 out-of-hospital cardiac arrests each year. In terms of mortality in the NHS Resolution data, cardiac arrest was the most likely cause of death 44% (n=8) followed by a myocardial infarction 28% (n=5).

Of the 29 cardiac notifications, 62% (n=18) either led to or contributed to a cardiac fatality, with cardiac arrest scoring highest at 44% (n=8) of the total, followed by myocardial infarction at 28% (n=5). The category 'other' also had 28% mortality, but due to small numbers of specific cardiac incidences they were grouped together.

Figure 12: Cardiac mortality by type

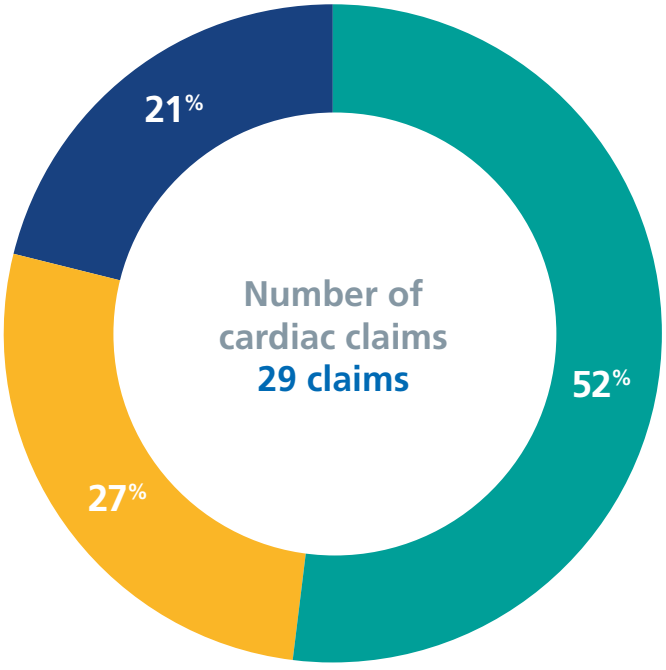


Cardiac arrest	44%
Myocardial infarction	28%
Other	28%

15. Clinician/non-clinician involvement

Whilst statistics are not available for all of the CNSGP themes, clinicians involved in the cardiac cases were categorised. 52% of notifications had general practitioner involvement with 28% (n=8) involving call handlers or practice reception staff. The Darnley[xxii] ruling in 2018 highlights the importance of understanding what information patients are entitled to receive when they present to reception and other 'first contact' staff in a clinical setting.

Figure 13: Clinicians involved in cardiac claims



GP	44%
Reception/call handler	28%
Registered nurse/paramedic/ GP registrar, unknown	28%

Theme 3: Sepsis

The World Health Organization, in its first report on the global epidemiology and burden of sepsis, estimates that the life-threatening reaction to infection causes one in five deaths worldwide[xxiii]. The UK Parliamentary and Health Service Ombudsman enquiry[xxiv] and UK National Confidential Enquiry into Patient Outcome and Death highlighted sepsis as being a leading cause of avoidable death that kills more people than breast, bowel and prostate cancer combined (NICE NG51)[xxv]. An estimated 37,000 deaths are associated with this the condition in England[xxvi]. The RCGP Sepsis Toolkit[xxvii] was developed to assist clinicians in recognising that an early warning score can help escalate a sepsis concern rapidly.

There were 21 sepsis notifications, within which ten categories of sepsis were identified. Of the 21 sepsis cases, the most common forms of sepsis were undefined sepsis and urological sepsis at 19% each and respiratory sepsis at 14%.

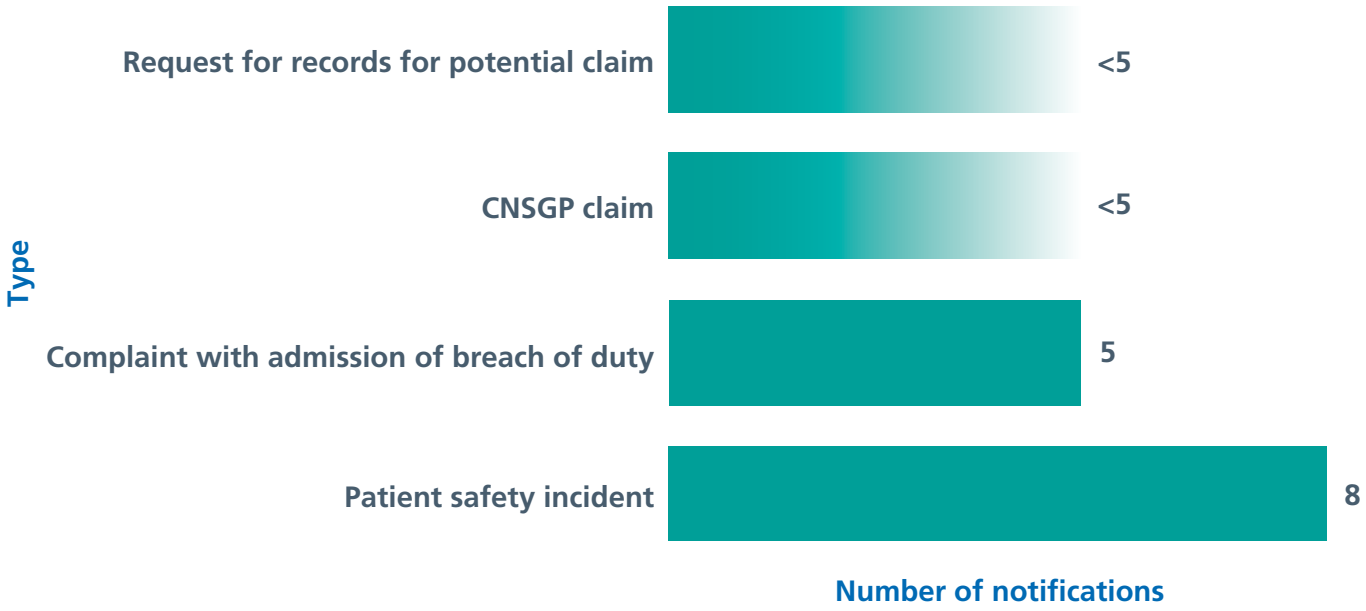
The most common sepsis grouped claim notification was a *patient safety incident* in 38.1% (n=8) of cases. Every day over a million NHS patients are cared for by dedicated teams of general practitioners and practice staff. The majority of patients are treated safely and effectively, but unfortunately sometimes things can and do go wrong, no matter how caring and competent staff are.

Practice staff were previously encouraged to use National Reporting and Learning System e-forms[xxviii] to report all patient safety incidents and near misses whether they resulted in harm or not. The new NHS 'Learn from patient safety events' (LFPSE) service[xxix] replaces the National Reporting and Learning System in 2022.

16. Sepsis grouped claim notification

The most common cause was a *Delay/failure to diagnose* in 81% (n=17) of cases. There were a small number of claims that related to a failure to refer, failure to monitor and failure of follow up arrangements.

Figure 14: Number of grouped claim notifications regarding sepsis



17. Sepsis mortality

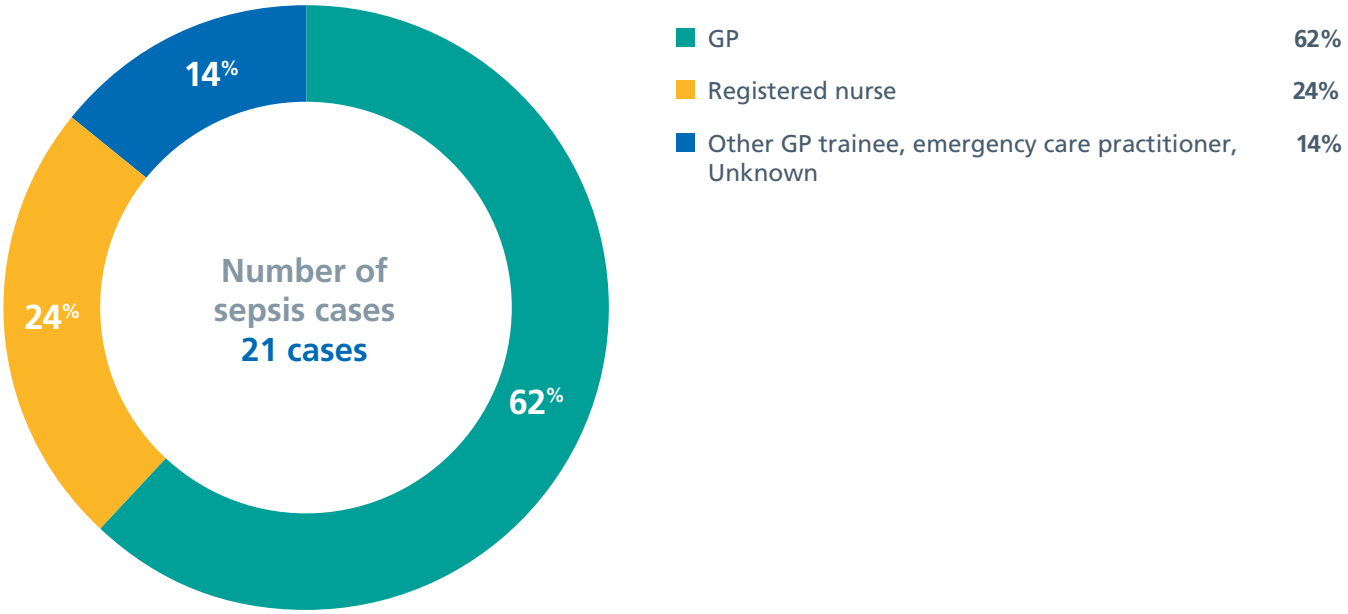
There were 21 sepsis notifications with a 33% (n=7) mortality rate noted. In 2017, an estimated 11 million sepsis-related deaths were reported worldwide, representing 19.7% of all global deaths[xxx]. Detailed guidelines exist for the management of sepsis in adult and paediatric intensive care units, and by intensive care clinicians called to other settings. The Sepsis Trust have produced a General Practice Sepsis Decision Support Tool to aid early identification of adults and older children with systemic response to infection[15].

[15] GP-adult-NICE-Final-2.pdf (sepsistrust.org)

18. Clinician/non-clinician involvement

Whilst statistics are not available for all of the CNSGP themes, clinicians involved in the sepsis cases were categorised. 62% (n=13) of notifications had general practitioner involvement with 24% (n=5) involving registered nurses.

Figure 15: Clinicians involved in sepsis claims



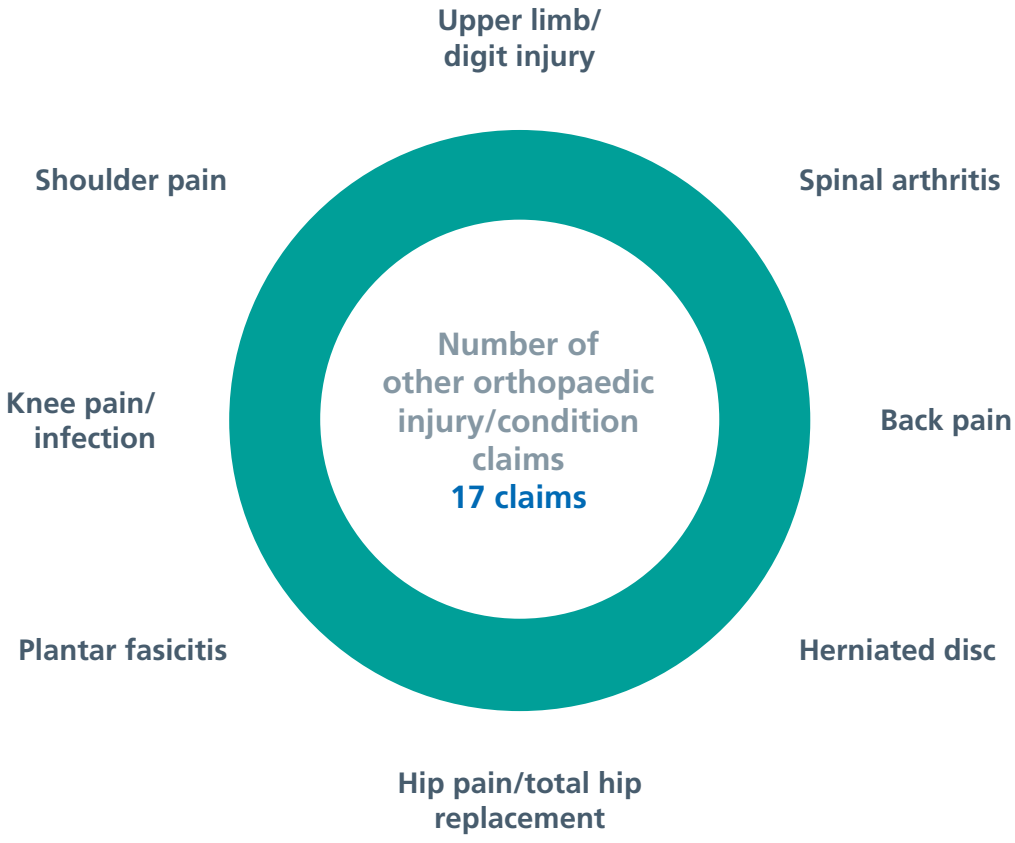
Theme 4: Other orthopaedic injury/infection

Musculoskeletal conditions are the world's fourth largest burden of disease, accounting for more than 50% of chronic health conditions in the population aged >50 years (2018) and are a common reason for patients to engage with general practice or emergency department visits[xxxi,xxxii]. This increasing burden is due to an increasingly overweight, sedentary and ageing population and is often poorly recognised as a priority globally with the majority of claims built around misdiagnosis, dissatisfaction with treatment, or most worryingly a preventable iatrogenic injury[xxxiii].

The category 'Other orthopaedic injuries' includes any injury to the musculoskeletal system excluding orthopaedic fractures, which is a separate category. Treatment of an orthopaedic injury often encompasses a range of specialisms within the NHS, including general practice, emergency department, radiology, orthopaedics, surgery, anaesthetics, nursing, district nursing and physiotherapy. NICE has produced a musculoskeletal conditions overview to aid clinicians[xxxiv].

There were 17 cases of other orthopaedic injury/infection, resulting in ten categories. Upper limb/digit injury/infection was the most common at 23%. Due to small numbers, no further categorisation has been undertaken.

Figure 16: Breakdown of the 'other orthopaedic injury/condition' category

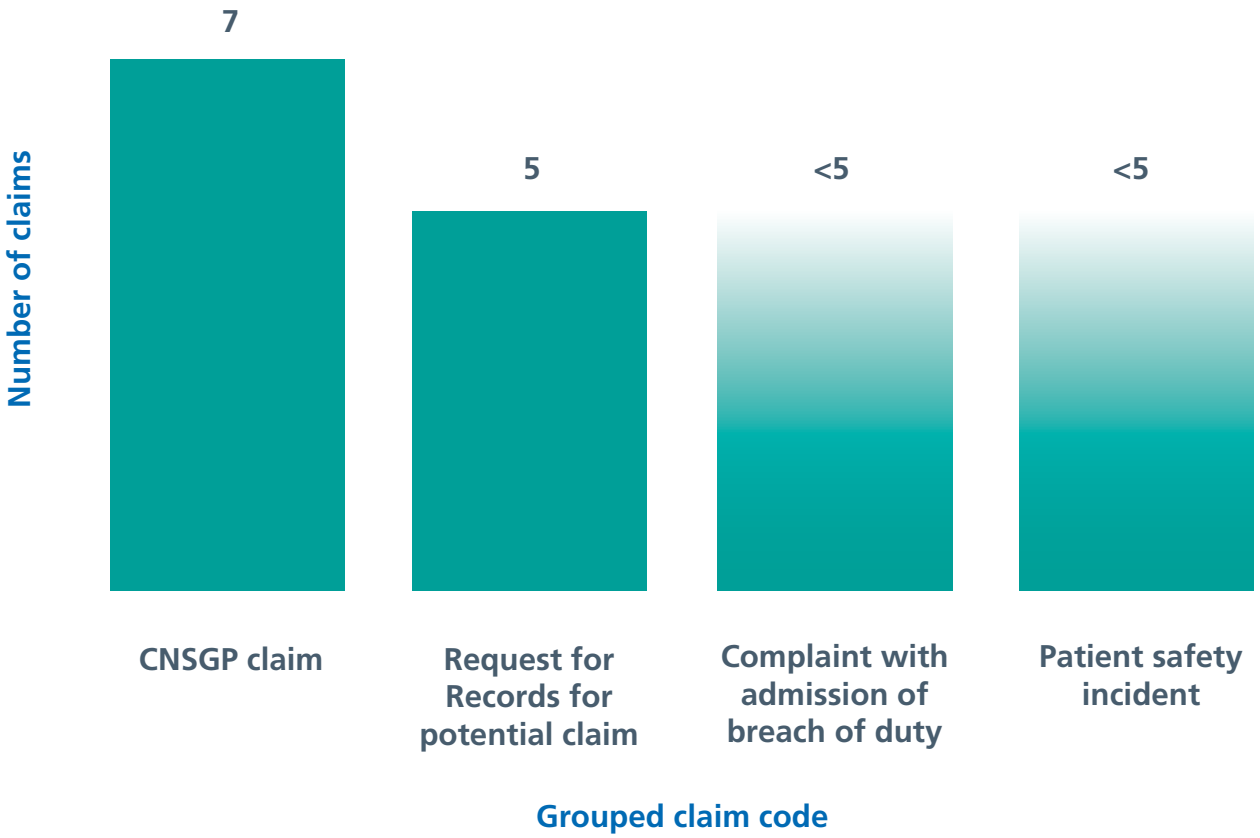


19. Other orthopaedic grouped claim notification

The most common cause was a *Delay/failure to refer* in 35.3% (n=6) of cases with *delay/failure to diagnose* in 29.4% of cases.

There were a small number of claims that related to a failure to diagnose, failure of follow up arrangements, failure to act on a test result/report and consent concerns.

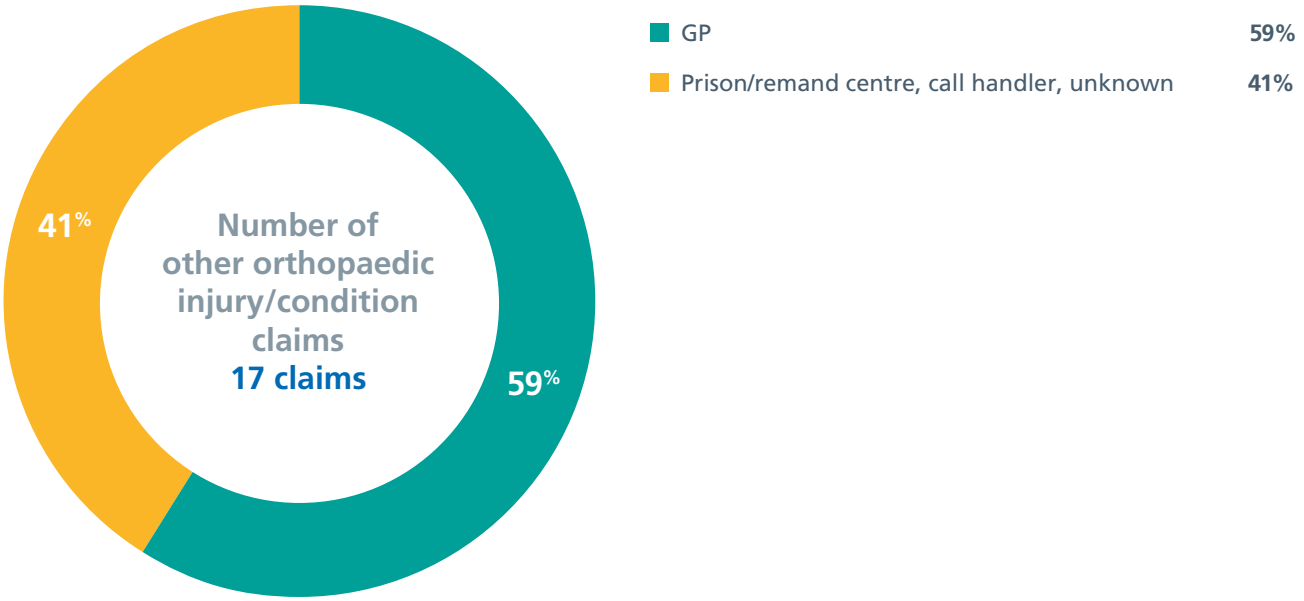
Figure 17: Number of claims by grouped claim code



20. Clinician/non-clinician involvement

Clinicians involved in the other orthopaedic injury/infection cases were categorised. 59% (n=10) of notifications had general practitioner involvement with 41% (n=7) involving prison healthcare teams.

Figure 18: Clinicians involved in 'other orthopaedic injury/condition' claims

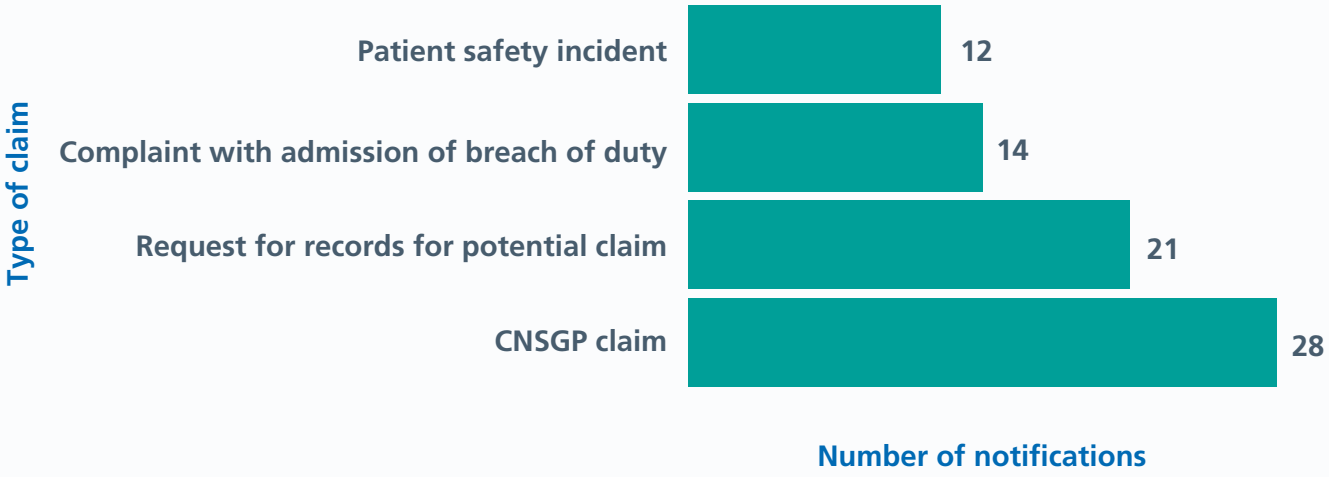


Theme 5: Medication errors

Medication errors are relatively common but preventable events. Most of these errors result in no harm or low-to-moderate harm; however, some result in severe harm or death[xxxv]. Medication error rates of 4.9% of all prescription items have been observed in general practice[xxxvi, xxxvii].

Within the CNSGP data, 74 medication errors were identified, accounting for 18.5% of the total CNSGP notifications within year one of the scheme.

Figure 19: Types of claims where there was a medication error

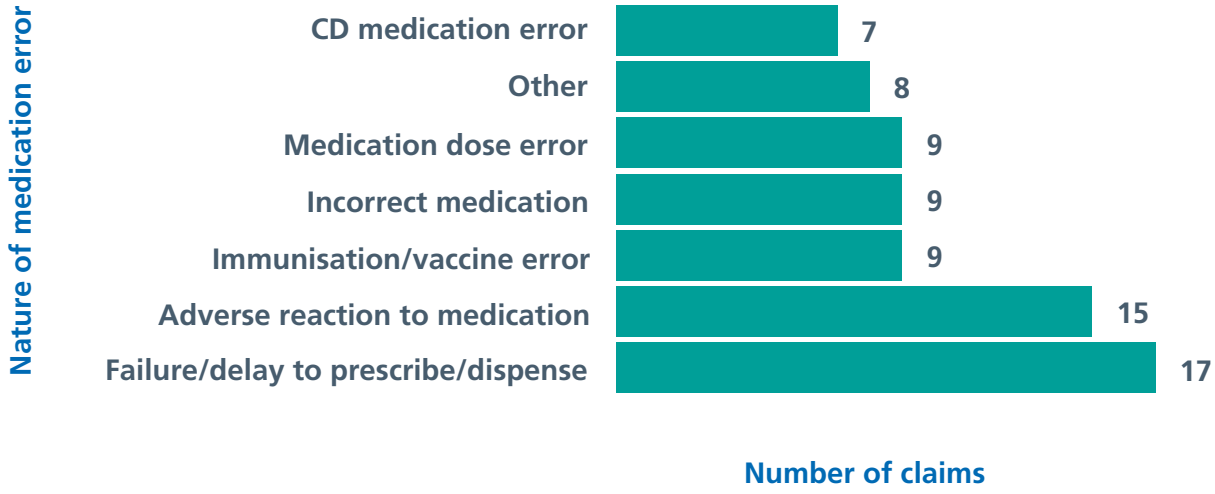


Medication error coding was developed based on recurring themes to identify the common areas with medication error:

- Failure/delay to prescribe/dispense
- Adverse reaction to medication
- Immunisation/vaccine error
- Incorrect medication
- Medication dose error
- Controlled drug medication error
- Failure to monitor medication
- Incorrect prescription dispensed
- Failure to perform injection technique correctly
- Other.

Failure/delay to prescribe/dispense accounted for 23% (n=17) of medication errors followed by adverse reaction to medication 20.3% (n=15). Immunisation/vaccine error, incorrect medication and medication dose error each accounted for 12.2% (n=9) of the total prescribing error notifications.

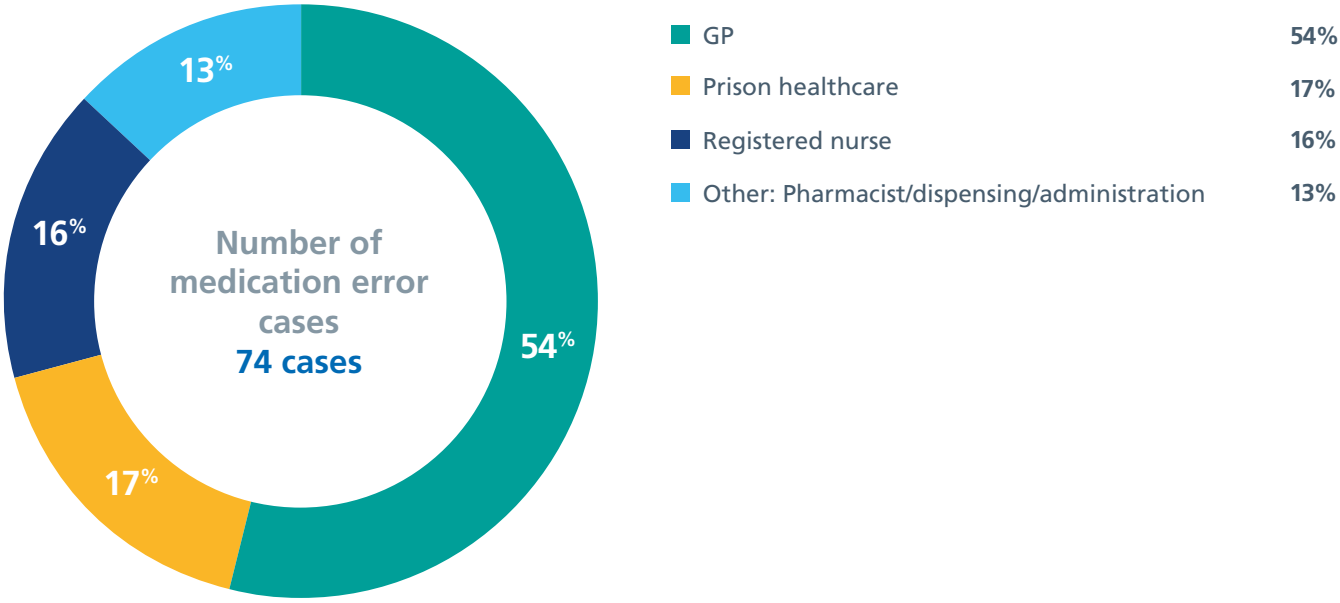
Figure 20: Number of claims by nature of medication error



21. Clinician/non-clinician involvement

Medication errors involved medical, non-medical professionals and non-clinical staff. The inclusion of non-medical professionals i.e. nursing, pharmacy reflects extended prescribing rights outlined in section 63 of the Health and Social Care Act (2001) which enabled the government to extend prescribing responsibilities to non-medical health professions[xxxviii].

Figure 21: Clinicians involved in medication error claims



Theme 6: Prison healthcare

NHS England Health and Justice is responsible for commissioning healthcare for children, young people and adults across secure and detained settings. It commissions to the 'principle of equivalence' meaning the health needs of a population constrained by their circumstances are not compromised and they receive an equal level of service as that offered to the rest of the population. Their report 'Strategic Direction for Health Services in the Justice System 2016-2020'[xxxix] highlighted seven priority areas, focusing on improving access to services and bridging the divide between those provided in community settings and those provided in justice settings to ensure an integrated focus on service delivery which emphasises prevention, rehabilitation and recovery and addresses the health drivers of criminal behaviour.

The Care Quality Commission states that people who use services in secure settings are generally more vulnerable because they rely on authorities for their safety, care and wellbeing, and they are unable to choose their place of care[xl].

The Prison Reform Trust[xli] has reported that whilst in prison, inmates are more likely to suffer ill-health, physical injury and mental health problems than those outside, as well as recording that a third of people (34%) assessed in prison in 2017-18 reported that they had a learning disability or difficulty. In its 2017 report, HM Chief Inspector for Prisons for England and Wales[xlii] highlighted that many prisons struggle to recruit healthcare staff of the right calibre and that health services in prisons were repeatedly impeded by the unavailability of prison officers and restrictive regimes.

The CNSGP data found 34 notifications from the prison healthcare sector, accounting for 8.5% of the total CNSGP notifications within year one of the scheme. The proportion of cases received does not suggest there is a particular problem and the data is insufficient to draw any conclusions at present.

Figure 22: Number of prison healthcare claims by grouped claim code

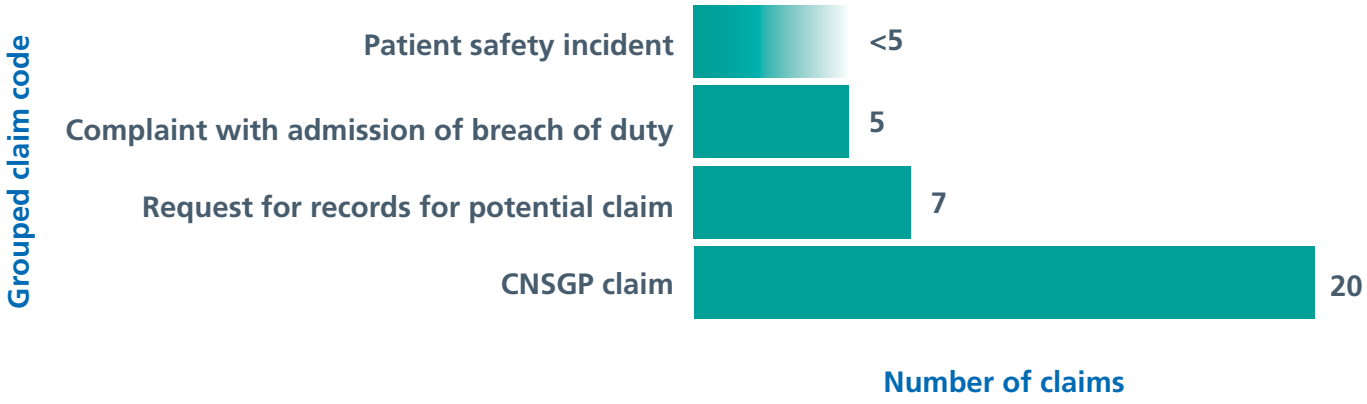
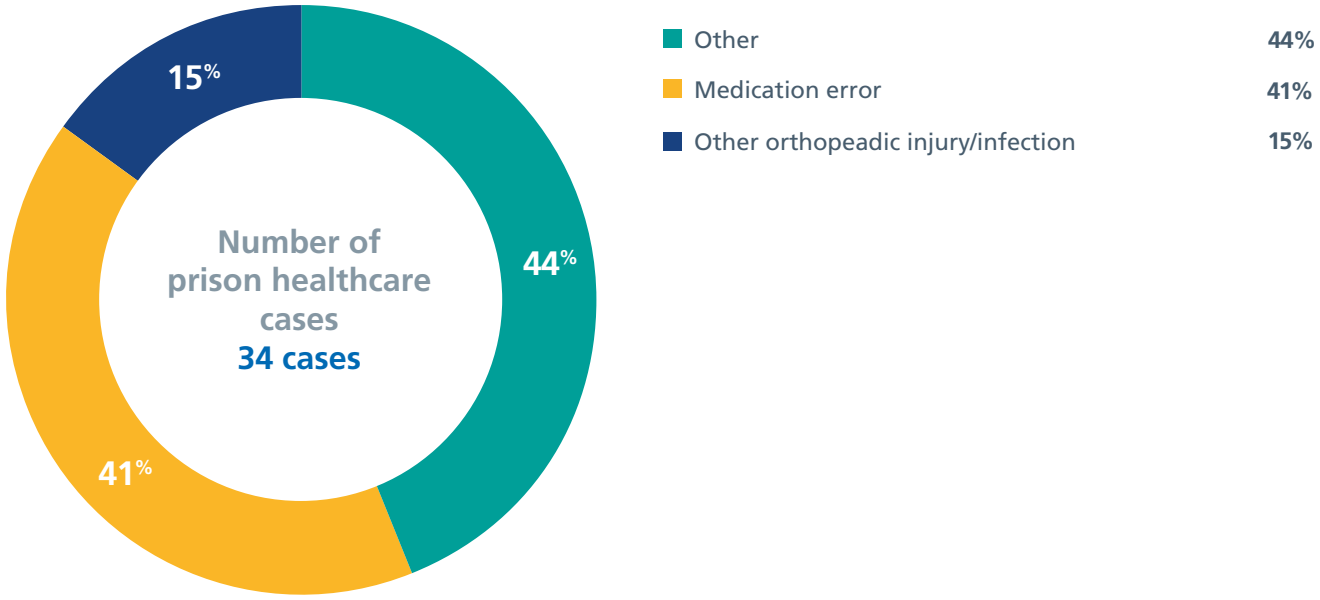


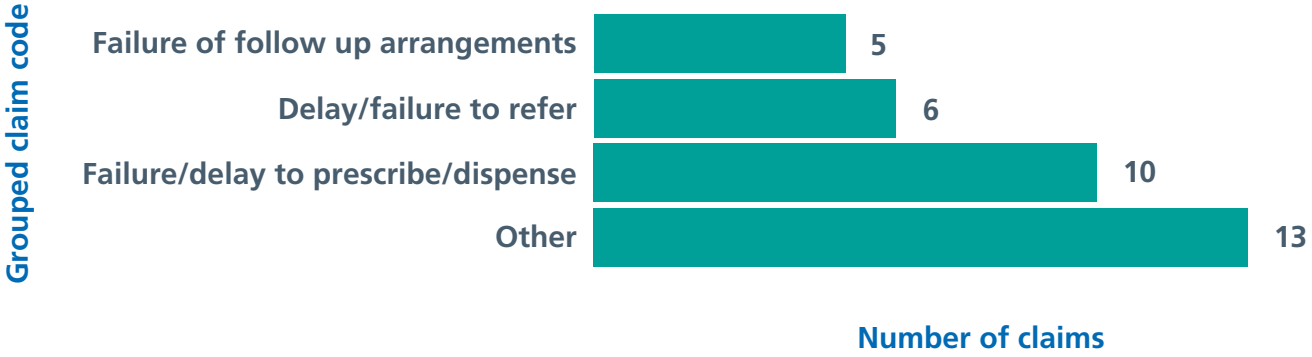
Figure 23: Prison healthcare claims by nature of injury



41% (n=14) of nature of injury notifications were medication errors and 44% (n=15) collated a number of small injury categories. The most common classification error was *Failure/delay to Prescribe/dispense* at 29.4% (n=10) followed by *Delay/failure to refer* 17.6% (n=6).

Failure of Follow Up Arrangements 14.7% (n=5) was noteworthy, this cohort had missed outpatient appointments due to lack of availability of escort on the day of their appointment, reflected in the 2017 report of the HM Chief Inspector for Prisons for England and Wales.

Figure 24: Number of prison healthcare claims by cause code



Recommendations

The next section discusses the conclusions and the recommendations from the three key initial themes:

Recommendation 1: Delay/failure in diagnosis

Recommendation 2: Medication errors

Recommendation 3: Prison healthcare.

Recommendation 1: Delay/failure in diagnosis

Delay/failure to diagnose is a common theme emerging from the analysis across the general practice data. This topic is well recognised by clinicians working in general practice and across academic literature.

This is a broad spectrum topic encompassing many facets. For the purposes of this report, the recommendations were divided into three underlying codes seen across the initial data analysed:

Sub-theme 1. Diagnostic tools and risk assessments

Sub-theme 2. Cross system communication and research

Sub-theme 3. Cross system education.

The report supports the need to improve communication across the NHS systems. Good clinical relationships facilitate information exchange, provide learning opportunities and underpin high-quality diagnosis and referral. Good relationships may also make it easier for general practice to seek informal advice, reducing the need for making formal referrals and avoiding duplication of test[16].

[16] The quality of GP diagnosis and referral. The King's Fund. 2010. Diagnosis and referral.pdf (kingsfund.org.uk)

Sub-themes

1. Diagnostic tools and risk assessments

Diagnostic tools and risk assessments

National	Local
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 system[17]) assessment tool for use in general practice to assist earlier identification of deteriorating patients.	Recommend local systems have access to implement a national digital template on general practice and out of hours software for clinical use with a local governance audit process in place to monitor effectiveness.
Recommend that NHSX with NHS Digital GP IT[18] (see footnote) and NHS England and NHS Improvement continue to promote existing safety netting tools (including minimising inequalities e.g. enhancing easy reading, translation and digital exclusion) such that they are available nationally.	Use of digital text or app facility providing patients with advice and safety netting, and clinicians with assurance that patients and their families have access to recall safety netting information if they require clarification.
Consideration by NHS England of a patient escalation decision support tool and responsibility hierarchy to identify and manage multiple attendances by a patient with the same complaint across general practice settings over a short time frame.	Local systems to co-create monitoring and governance strategies which identify and ensure patients who have multiple attendances for a similar problem over a short time span, have been thoroughly evaluated.
	Practice development teams and trainers to consider what local multidisciplinary training programmes and guidance are in place to support reduction of diagnostic error and support learning from incidents and significant events.

[17] 1 Guidance | Acutely ill adults in hospital: recognising and responding to deterioration | Guidance | NICE

[18] NHS England have now created a Transformation Directorate, incorporating NHSX and NHS Digital

2. Cross system communication and research

There are multiple points in a patient's journey to and through general practice where communication can break down, and the claims review has identified problems with both communication and escalation that reduce the quality of care.

The patient-clinician relationship and the quality of the consultation are crucial for high-quality diagnosis and referral. There are a variety of ways that patients consult with a clinician; face to face, remote or virtual consultations are now readily available. There is also the question whether longer consultation times for specific conditions or access via remote consultation may support or reduce improved decision-making and patient satisfaction around diagnosis and referral.

Schemes such as an advice and guidance system, the GP-Consultant[19] scheme or Clinical Interface Committee[20] enhance cross sector communication and were highly valued by the CNSGP clinical focus groups. We suggest that the hybrid approach developed in the Covid-19 pandemic could ensure that general practice has opportunity for more accessible two-way communication between general practice and secondary care.

Additionally, the data showed a range of clinicians involved in cases beyond the current NHS Digital general practice workforce appointment classifications[21]. There would be value in further identification of clinical and non-clinical groups as the diversification of roles in general practice moves forwards.

Cross system communication and research

National
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.
Recommend NHS England and NHS Digital progress work to identify further general practice workforce groups (for example pharmacy, nursing, paramedic) beyond the current NHS Digital[22] workforce data classification, to facilitate improved understanding of the composition of consulting professional and clinical consultations.
Recommend that NHS England considers commissioning research to look at whether variation exists between face to face, remote and virtual consultations across the general practice team.

[19] NHS England » GP Consultant Liaison – Southampton City Clinical Commissioning Group

[20] NHS England » Clinical Interface Committees (CICs) at Frimley Health NHS Foundation Trust

[21] Appointments in General Practice report - NHS Digital

[22] General practice data hub - NHS Digital

3. Cross system education

Patient care activity has increased without a proportionate rise in workforce numbers. Stakeholders have identified the need to increase general practice workforce numbers and have put proactive schemes in place such as Newly Qualified Fellowships for GPs, general practice nurses and the Primary Care Network Additional Roles Reimbursement Scheme. The implementation of key policies such as extended general practice hours, Primary Care Networks and Integrated Care Systems and the Covid-19 pandemic may impact on regular professional education and will continue to remain a key priority for safe patient care and professional development. Value placed on staff development is a useful barometer to the culture and outlook of an organisation as cited in the Culture of Care Barometer (2017)[23].

Cross system education

National	Local
NHS bodies, Royal Colleges and associated stakeholders to consider collaboration to support introduction of Protected Learning Time across general practice teams.	Consideration of Integrated Care Systems, Primary Care Network and general practice multidisciplinary team clinical governance meetings to discuss relevant cases and action plans for improvement.
Royal Colleges to promote awareness of clinical and non-clinical development plans; all staff to have mandated opportunity to attend a range of multi-disciplinary meetings: mandatory, professional and clinical education, consider recommending for inclusion in annual appraisal.	

[23] Culture of Care' Barometer (2017) ccb-barometer-rep-guide.pdf (england.nhs.uk)

Recommendation 2: Medication errors

The CNSGP report identified a range of medication errors, including failure/delay to prescribe or dispense, adverse reaction and vaccination/immunisation errors amongst other themes in the analysis. Whilst anecdotal evidence from medical defence organisations[24] indicates damages payments for these claims are not high, and many medication error claims notified don't result in ongoing harm to the patient, occasional cases can be catastrophic and any error can nevertheless cause significant anxiety for both the patient and the prescriber.

A set of prescribing indicators have been developed nationally as part of a programme of work to reduce medication error and promote safer use of medicines, including prescribing, dispensing, and administration and monitoring. The programme of work is in response to the World Health Organization global challenge – Medication without Harm[25].

This is a broad spectrum topic encompassing many facets. For the purposes of this report the recommendations were divided into three underlying codes seen across the data analysed:

Sub-theme 1. Competency and complaints

Sub-theme 2. Adverse reactions

Sub-theme 3. Vaccine/Immunisations errors.

[24] Prescription errors (themdu.com)

[25] Medication Without Harm (who.int)

Sub-themes

1. Competency and complaints

Competency and complaints

National	Local
Recommend at system level that NHS England promote and include the Royal Pharmaceutical Society (RPS) competency framework in its upcoming publications relating to prescribing.	Employers to have processes in place to continuously assure the competence of their staff in accordance with the RPS competency framework.
Recommend that professional regulators consider using the RPS competency framework as a benchmark when reviewing prescribers and prescribing in conjunction with NICE guidance on medications management.	
Professional bodies promote medication safety as being one aspect of their revalidation processes, therefore professional bodies to consider including as an optional focus of audit or improvement work.	

2. Adverse drug reactions

Adverse drug reactions are harmful events caused by medication. Adverse drug reactions are a significant problem in patients who are on multiple medications such as the elderly. Studies have reported medication discrepancies after the transition from hospital to general practice setting[26] and association with medication errors in general practice[27].

There is also concern that since the introduction of point of care decision support within computerised provider order entry systems, drug-drug interactions have been among the most frequent alerts presented to clinicians writing prescriptions. Presentation of any warning if given too frequently may result in what has been termed "alert fatigue," and concern has risen that this may cause clinicians to override or ignore clinically important warnings[28].

Adverse drug reactions

National	Local
NHSX as part of its Digital Clinical Safety Strategy to consider research into why clinicians override adverse drug reaction system prompts and how this may be minimised.	
NHS England to consider designating within the Integrated Care Systems remit, a senior clinician as a Medication Safety Officer (2014 National Patient Safety Agency guidance[29]) to promote reporting of medication safety incidents and support system-wide learning from incidents, complaints and claims in general practice.	As part of the delivery of Structured Medication Review within the Primary Care Networks Directed Enhanced Service, recommend that patients receiving drugs such as cardiovascular drugs, antipsychotics and opioids are prioritised for review[30,31].

[26] Medication misadventures in the elderly: A year in review - ScienceDirect

[27] Avoiding medical errors in general practice - Coxon - 2015 - Trends in Urology & Men's Health - Wiley Online Library

[28] Tiering Drug–Drug Interaction Alerts by Severity Increases Compliance Rates | Journal of the American Medical Informatics Association | Oxford Academic (oup.com)

[29] npsas-guide2.pdf (england.nhs.uk)

[30] NHS England » Network Contract Directed Enhanced Service (DES) Guidance 2020/21

[31] NHS England » Structured medication reviews and medicines optimisation 2021/22

3. Vaccine/Immunisation errors

Errors in the administration, storage or handling of vaccines cause concern both for the patient/parent/carer and immuniser and can generate cost implications. Whilst it is accepted that cold chain breaches and administration errors can occur in even the most meticulously run organisations/clinics, when they do occur, an informed decision needs to be made as to whether the vaccine has been compromised and, if so, whether it presents a risk to patients.

The effective management of errors is therefore essential to ensure patient safety, to maintain public confidence in immunisation programmes and to minimise vaccine wastage[32]. Recommendations for the storage, distribution and administration of vaccines are detailed in The UK Health Security Agency 'Immunisation against infectious disease' (Green Book)[33].

Vaccine/Immunisation errors

National	Local
Recommend that NHS England suggest Integrated Care Systems appoint 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.	Recommend each general practice should evidence clear processes and protocols from medicines management of prescription only medicines including use of patient group directions and prescriptions / patient specific directions compliance to vaccine management.
NHS England with relevant Royal Colleges to consider updating Immunisation and Screening National Delivery Framework & Local Operating Model[34] guidelines for immunisation and vaccination clinics across England.	
Suggest that NHS England and NHS Improvement local immunisation co-ordinators consider a standardised time allocation for vaccine clinics to minimise risk of vaccine error.	

[32] Vaccine Incidence guidance (publishing.service.gov.uk)

[33] Immunisation against infectious disease - GOV.UK (www.gov.uk)

[34] del-frame-local-op-model-130524.pdf (england.nhs.uk)

Recommendation 3: Prison healthcare

Prisoners tend to have much poorer physical, mental and social health than the population at large. Health promotion and the prevention of disease for this group should be based on an assessment of health needs. The quantity and quality of service should be at least equivalent to services offered in the outside community[35]. During discussions with providers of prison healthcare services, it was noted that variation is present in the provision of services across the sector. It was also recognised that the prison healthcare claims seen within the first year of CNSGP are part of the wider prison healthcare claims received by NHS Resolution.

Prison Healthcare

National
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.
Recommend NHS England and NHS Improvement and the Ministry of Justice consider implementation of Patient Safety Incident Response Framework (PSIRF) to promote best practice and innovation amongst the prison healthcare provider sector.

[35] Prisons and Health, 21 Promoting health in prisons a settings approach (who.int)

Summary

This report provides a preliminary exploration of the first year of the CNSGP scheme. This initial data over one year only provides an indication of the cases NHS Resolution may expect to see in the coming years and no firm conclusions can be drawn from the first year's data. We are also conscious that it is difficult to predict what may arise in the second year, as the Covid-19 pandemic may have altered how general practice care is provided to patients. We hypothesise that the Covid-19 pandemic may result in longer delays for referral or treatment, but may also have made general practice more accessible to the public through the use of remote consultations. It may also result in altered volumes of some clinical cases, for example, fewer cases of orthopaedic injuries may be seen in 2020/21 due to the national lockdown. The increased reliance on remote consultation may mean guidance being developed on their positive and negative influences on patient care.

The opportunity to review cases from primary and secondary care allows NHS Resolution to look across clinical pathways and identify trends. It is embarking on an ambitious strategy to transform the way in which data is used to drive improvements in healthcare.

NHS Resolution is committed to developing existing databases and governance processes, promoting work with academic partners and others to improve the access to and quality of claims data for learning. NHS Resolution will continue to drive timely and early resolution of claims to benefit both families and staff, translating data into information for the wider NHS to ensure general practice is aware of the categories of claims.

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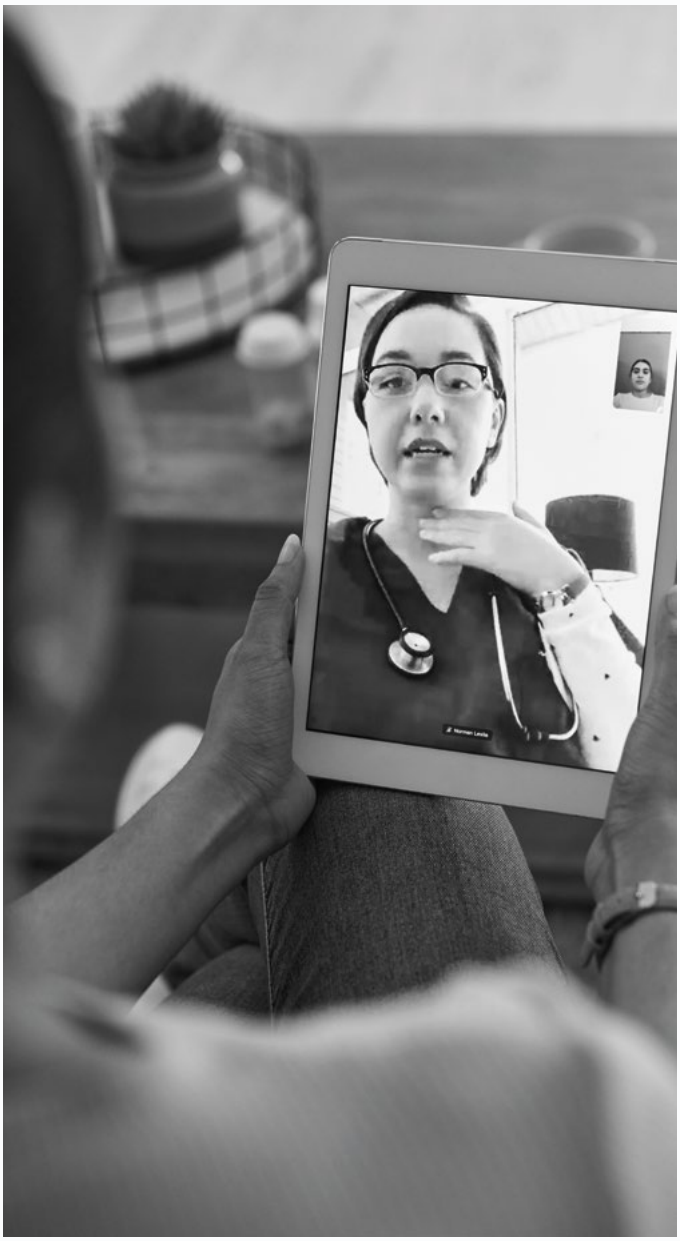

Glossary

Case
Any claim or potential claim (see below).

Claim
A clinical claim can be described as any formal request for compensation as a result of alleged negligence (e.g. a letter of claim or proceedings have been served) or where we accept a payment of compensation is likely to be made (even if a formal process has not been commenced). Claims that fall within the CNSGP are claims arising from the care, diagnosis and treatment of NHS patients under a primary care contract, or ancillary health service.

Healthcare professional
This is an umbrella term referring to non-medical professionals, such as nurses, physiotherapists, paramedics or occupational therapists. This list is not exhaustive.

Potential claim
The following situations are considered 'potential claims' under the scheme and the general practice community is asked to notify NHS Resolution of these:

- A notifiable **patient safety incident** which has or may have resulted in severe harm. Severe harm could include the following resulting from any care, diagnosis and treatment:
  - the death of a patient
  - shortening of a patient's life expectancy
  - impairment of a patient's sensory, motor or intellectual functions which is likely to last for a continuous period
  - prolonged psychological injury.
- A **request for disclosure of patient records** which indicates a claim will be pursued, or some other indication is being considered, such as patient or solicitor's request for an extension of time to pursue a claim.
- Any complaint response which amounts to an **admission of breach of duty**, for example, any omissions or delays in care. Medical Defence Organisations continue to provide support for handling complaints.
- Any communication received from the **Parliamentary Health Service Ombudsman**.
- Any intended offer of **compensation or other redress**.

Appendix I: Injury/Condition Reference Guide

Injury/ Condition	Includes (unless category is a stand-alone)	Excludes
Appendicitis	Stand-alone	
Audiology	Audiometry, Hearing loss, Tympanic Membrane Perforation, Unilateral loss of hearing.	ENT.
Cancer	Appendix, Breast, Basal cell, Bowel, Cholangiocarcinoma, Hepatic, Leukaemia, Lung, Melanoma, Non-Hodgkin's Lymphoma, Oropharynx, Ovarian, Prostate, Renal, Sarcoma, Skin, Thyroid, Unknown causation of cancer, Wrong diagnosis of cancer.	
Cardiac	Angina, Aortic Aneurysm, Cardiac arrest, Cardiomyopathy, Congestive Cardiac Failure, Cardiac Wound Infection, Heart Failure, Hypertension, Ischaemic Heart Disease, Myocardial infarction, Pacemaker, Pericarditis.	
Cauda equina	Stand-alone.	
Dermatological	Abscess, Bruising, Cellulitis, Cryotherapy scarring, Excision of Lipoma, Lower limb abscess, Mole removal, Suture removal, Ulcerated Legs, Wart.	
Dental	Dental Infection, Lack of Treatment.	
DVT/Pulmonary embolus	Stand-alone.	
Endocrine	Charcot Foot, Diabetes Mellitus, Hyperparathyroidism, Thyrotoxicosis.	
ENT	Foreign body in auditory canal, Ear Infection, Ear irrigation, Foreign body in nostril, Mastoiditis, Pain, Polyps in auditory canal, Sore Throat.	Audiology.
Gastro-intestinal/ bowel	Abdominal pain, Abdominal post-op wound Infection, Anal Abscess, Cholecystitis, Colo-vesical fistula, Crohn's Disease, Gastro-intestinal haemorrhage, Helicobacter Pylori, Hernia, Mesenteric ischaemia, Pancreatitis, Perforated bowel, Perforated Diverticulum, Peritonitis.	
Gynaecological	Cervical Cytology, Infertility, IUD insertion complications, Menstrual disorder, Perforated Uterus, Sexual Health.	Other Obstetric.

Injury/ Condition	Includes (unless category is a stand-alone)	Excludes
Haematological	B12 Deficiency, HIV, Hyperkalaemia, Steven Johnson Syndrome.	
Hepatic	Alcoholism.	
Infectious Disease	Scarlet fever, Hand, foot and mouth.	
Limb Ischaemia	Acute limb ischaemia, Gangrene.	Endocrine (Diabetes).
Meningitis	Stand-alone.	
Men's Health	Phimosis, Testicular torsion, Testicular abscess.	
Muscle/tendon rupture	Ankle Tendon Injury, Meniscus tear, Phlebotomy Injury, Ruptured Achilles tendon, Upper limb/digit tendon injury.	
Ophthalmology	Detached Retina, Deteriorating sight, Eye Test, Uveitis, Ophthalmic Referral, Unilateral loss of vision.	
Orthopaedic fracture	Stand-alone.	Other orthopaedic injury.
Other	Includes anything not covered in other categories, e.g. Consent, Data protection, GDPR, Records and where cause is unknown.	
Other neurological deficit (non-spinal)	Aphasia, Benign brain tumour, Cerebral Abscess Cerebellar ataxia, Dysphasia, Fall, Head Injury, Loss of consciousness (cause unknown), Ramsay Hunt Syndrome, Subdural haemorrhage, Subdural haematoma, Vaso-vagal episode.	Stroke, Sub arachnoid haemorrhage.
Other neurological deficit (spinal)	Cervical cord compression, Cervical Myelopathy, Disc Protrusion, Spinal arthritis, Spinal cord compression, Spondylosis, Traverse Myelitis.	Cauda equina.
Other obstetric	Unwanted pregnancy, ectopic pregnancy.	Gynaecology.
Other orthopaedic injury/Infection	Abscess, Amputation of digit, Back Injury/Pain, Dislocation, Herniated Disc, Hip Pain, Knee Pain/infection, Lower limb/digit injury, Osteomyelitis, Plantar Fasciitis, Shoulder Pain, Spinal Arthritis, Swollen Ankle, Total Hip Replacement, Upper limb/digit injury/infection.	Orthopaedic fracture.

Injury/ Condition	Includes (unless category is a stand-alone)	Excludes
Medication error	Stand-alone.	
Psychiatric	Suicide, attempted suicide, delusion.	
Renal	Deteriorating eGFR, Renal Failure.	
Respiratory	Asthma, Bronchopneumonia, COPD, Idiopathic pulmonary fibrosis, Pneumonia.	Sepsis.
Sepsis	Abscess, Biliary Sepsis, Intra-abdominal, Multi-focal Sepsis, Necrosing fasciitis Sepsis, Paediatric Sepsis, Peritonitis, Pneumonia, Respiratory, Septicaemia, Undefined Sepsis, Urosepsis.	
Stroke	Stand-alone.	
Subarachnoid haemorrhage	Stand-alone.	
Urological	Urinary Tract Infection (UTI), Lack of Catheter.	Sepsis.

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