GIRFT for Emergency Medicine

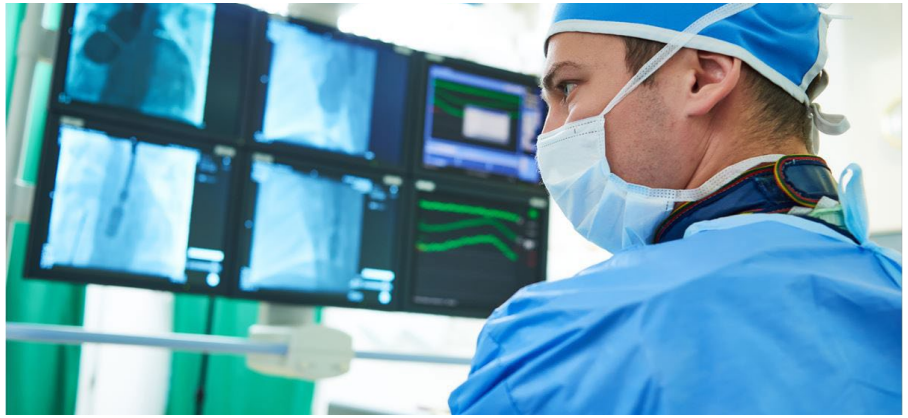
A perfect storm of litigation: an EM weather forecast

Professor Tim Briggs: Consultant Orthopaedic Surgeon, National Director for Clinical Improvement and Elective Recovery, Chair of the GIRFT Programme

Mr John Machin: Consultant Orthopaedic Surgeon, Co-lead for GIRFT Litigation

Dr Sue Greenhalgh: Consultant Physiotherapist

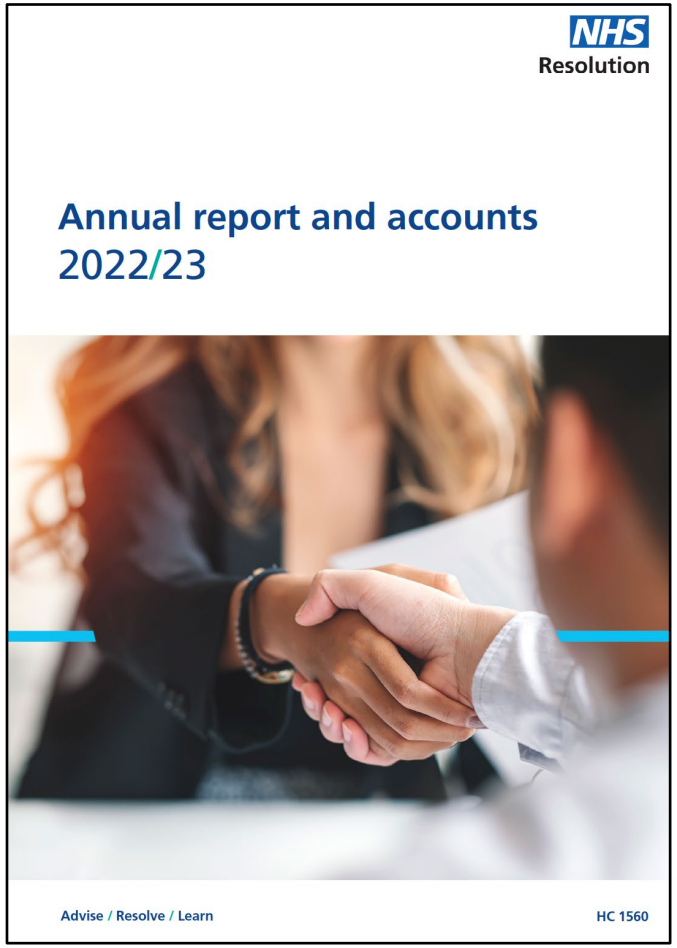
Dr Chris Moulton: Consultant in Emergency Medicine, Clinical Lead for GIRFT for EM



GIRFT priorities in 2023

- Elective recovery
- Surgical hubs
- UEC
- Cancer

The NHS litigation problem



Current provision for liabilities of known claims is £69.6 billion

Total cost of clinical negligence scheme is £2.6 billion for 2022-2023

>85% increase in cost from 2014-2015

>1.25% of NHS budget in England

13,511 claims in 2022-2023

Cost of harm from incidents in 2022-2023 is £6.3 billion

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2022 Litigation Data Pack

Anonymised NHS Trust

This pack provides your benchmarked clinical negligence claims data from the last 5 years to support learning from litigation claims.

Data pack prepared by:

Dr Josh Wall
Specialist Registrar in Anaesthetics and GIRFT National Medical Director's Clinical Fellow

Mr John Machin
Post-CCT Fellow in Trauma and Orthopaedic Surgery and GIRFT Co-lead for Litigation

Professor Tim Briggs
Consultant Orthopaedic Surgeon, Chair of GIRFT and NHS England's National Director of Clinical Improvement

Refresh coming in 2023

Trust overview by specialty

Medical

Specialty	Cost per Activity	National Cost per Activity	Trust Position	Quartile
Acute and General Medicine	£20.65	£23.57	75 of 121	3
Anaesthetic and Perioperative Medicine	£2.86	£5.29	95 of 137	3
Cardiology	£29.41	£52.66	49 of 123	2
Dermatology	£0.62	£1.08	63 of 114	3
Emergency Medicine	£22.66	£19.69	82 of 127	3
Endocrinology	£1.62	£5.12	75 of 124	3
Gastroenterology	**£30.77**	**£16.02**	111 of 126	4
Geriatric Medicine	£8.47	£7.02	76 of 122	3
Intensive & Critical Care (Adult)	£0.00	£12.10	equal 1 of 133	1
Intensive & Critical Care (Children)	£0.00	£48.92	equal 1 of 61	1
Neurology	£15.43	£38.41	53 of 113	2
Paediatric Medicine	£79.04	£249.22	57 of 129	2
Radiology	£1.29	£2.06	70 of 138	3
Renal *	**£1,155.54**	**£535.50**	117 of 128	4
Renal (47 Trusts with dialysis units only) * **	**£1,155.54**	**£653.39**	39 of 47	4
Respiratory	£10.61	£25.16	51 of 122	2
Rheumatology	£0.38	£2.56	70 of 122	3

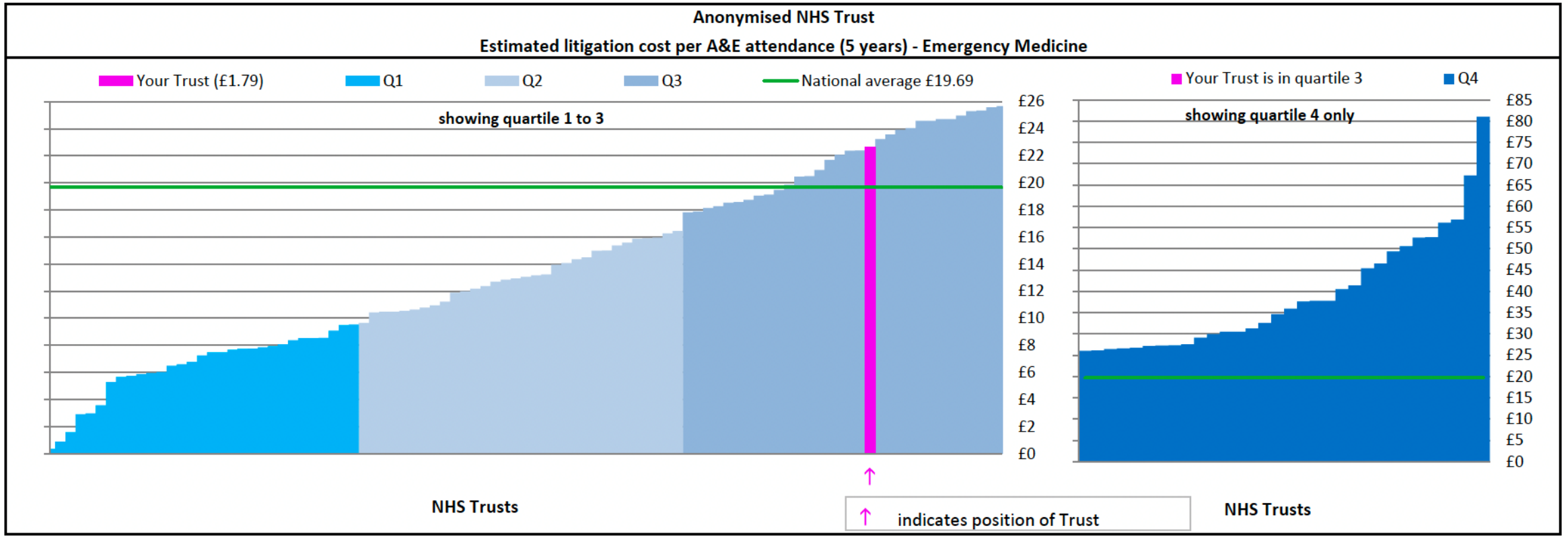
The cost per activity value shown in this table has been rounded to 2 decimal places; trust positions and quartiles are reflective of the actual cost per activity value.

Indicates a value in the 4th quartile

* These specialties show claims costs per £100k of costs incurred in providing the service, not activity

** 47 Trusts due to Trust mergers

Emergency Medicine



Total number of NHS Trusts	127
National minimum estimated cost of claims per activity	£0.36
National maximum estimated cost of claims per activity	£81
National average estimated cost of claims per activity	**£19.69**

Your Trust's estimated cost of claims per activity	**£22.66**
Your Trust's number of claims	72
Your Trust's position	82 of 127

Denominator includes all attendance to an emergency department with consultant led 24hour service, for patients of all ages.

GIRFT litigation five-point plan

1. Assess department's benchmarked position compared to other departments nationally.
2. Confirm correct coding to that specialty with trust legal team and inform NHS Resolution of any changes. nhsr.claimsenquiries@nhs.net
3. Detailed review of claims including witness statements, panel firm reports and patient records.
4. Triangulate claims with learning themes from complaints, inquests and patient safety incidents. Where a claim has not been investigated as a patient safety incident already this should be considered. Learning to be shared at departmental clinical governance or multidisciplinary meetings.
5. Trusts outside the top performing quartile to be supported by GIRFT and NHS Resolution through regional teams and national guidance.

Feedback to 2022 litigation data pack so far….

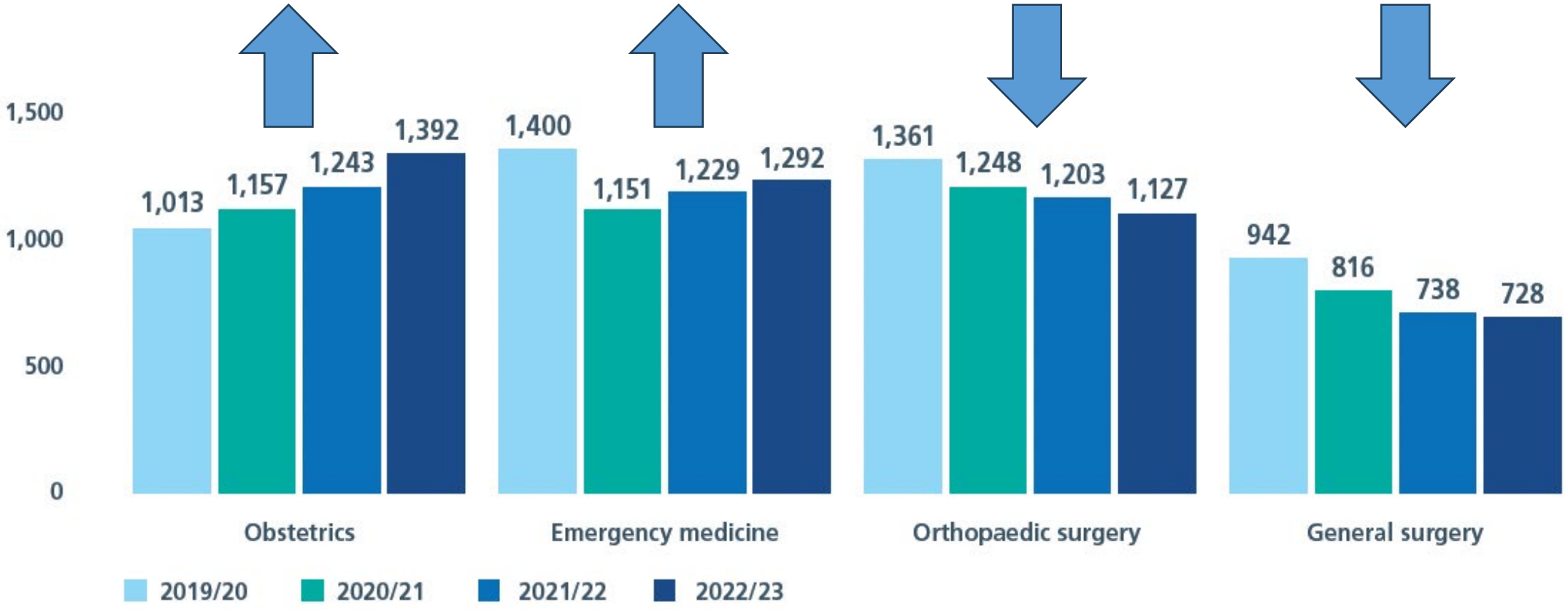
- 122 trusts (88%) have acknowledged receipt and are reviewing the data

- 97 trusts (70%) have completed the feedback

- Many examples of improvement in clinical governance or change in clinical practice – key themes include: communication, documentation and consent

Trends in the top four specialties

Figure 8: The top four categories of clinical negligence claims reported in each financial year between 2019/20 and 2022/23



From NHS Resolution Report & Accounts 2022-23
N.B. Orthopaedic surgery includes orthopaedic spinal surgery

Reduction in T&O litigation claims

- NHS-R 2020 report - Reduction in T&O litigation claims since 2014
- T&O dropped from number 1 to number 3 most litigated speciality
- T&O dropped from 10% to 3% of costs
- Bucking the trend in other specialities - overall cost of clinical claims rising by 95% to £2.3bn

Year of claim Notification	No. of claims	% change in claim volume	Estimated cost of claims end of 2019/20	% change in cost of claims
2012/13	1467		£173.0 M	GIRFT VISITS BEGAN
2013/14	1617	10.22	£175.9 M	1.65
2014/15	1519	-6.06	£147.7 M	-16.04
2015/16	1395	-8.16	£146.3 M	-0.92
2016/17	1268	-9.10	£163.5 M	11.71
2017/18	1206	-4.89	£138.7 M	-15.16
2018/19	1144	-5.14	£139.6 M	0.62
2019/20	1253	9.53	£166.3 M	19.17

- New estimated cost saving of £145.4m since 2013/14 (reduction in claims number of 1174 claims) N.B. A rise in ALL clinical claims in CNST of 9.35% in 2019/20
- NHS-R premium 2017/18 - RNOHT down by £650,000
  - St Georges down by £900,000

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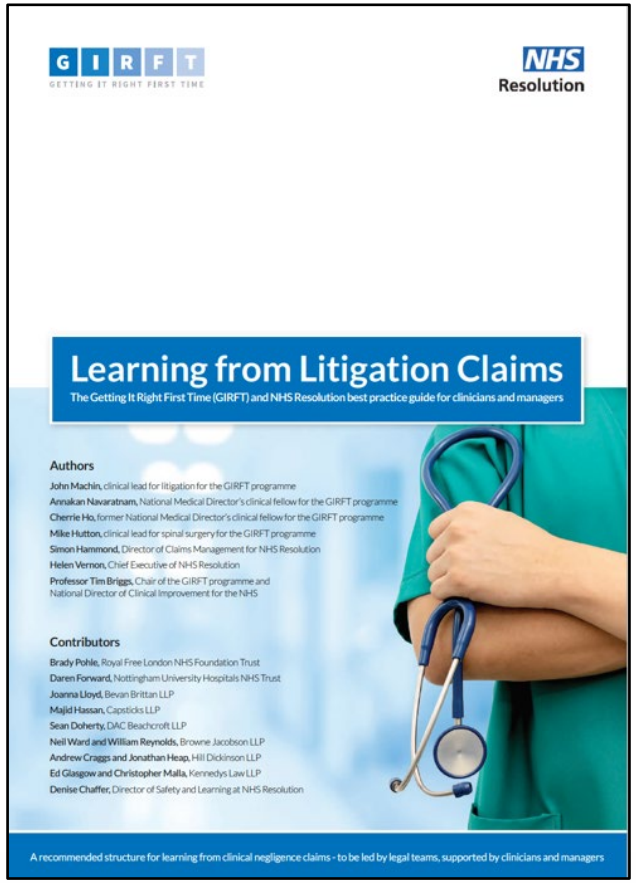
Learning from claims best practice guidance

1. Appointing dedicated clinical staff to assist trust legal teams to highlight patient safety issues with sessions incorporated into job plans
2. Regular discussion of claims with clinicians in forums such as clinical governance or multidisciplinary meetings to introduce focused improvement
3. Making clinicians more aware of the claims process and ensuring legal teams are more visible to clinical staff at all times
4. Ensuring clinical staff are aware when a claim has been initiated and are fully supported through the process
5. Working in partnership with patients, families and carers, and involving them in investigations, to ensure openness



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GIRFT Documentation Guides in HVLC

GIRFT BHS and BOA NHS

GIRFT, BHS and BOA Best Practice for Hip Arthroplasty Surgery Documentation

Background and Justification:

This guidance has been produced by GIRFT in partnership with the British Hip Society and is aimed to provide advice on various aspects of surgery which should be available and clearly documented in a hip arthroplasty operation record. The document is not a comprehensive guide to hip surgery, however it is hoped that surgeons will find the advice it offers helpful.

It is expected that the standards listed would be included within the documentation of patient care and although the majority will be included in the operation note, the information could be contained elsewhere in the patient record including and not limited to pre-surgery documentation from outpatient and pre-assessment clinics, MDT meeting documentation, ward round entries, a separate WHO Surgical Safety Checklist and drug charts. The documentation where appropriate may be made by other members of the surgical team apart from the operating surgeon. However, it is the operating surgeon's responsibility to ensure that appropriate documentation has occurred.

It is important to note that the information in this document was produced from the analysis of medical negligence claims notified to NHS Resolution by NHS trusts, the experience of leading expert witnesses in orthopaedic surgery and a review of existing guidance. The complete document including case studies should be read in parallel with this summary.

Standards for documentation of practice in all patients undergoing hip arthroplasty surgery:

1. If used, record the results of preoperative templating and the outcomes of any MDT meetings used to discuss complex cases including who was present and the agreed actions.
2. Documentation of the informed consent process should be available, including the choice of implants, the potential use of bone graft or any other additional procedures as relevant.
3. Safety briefing, sign in, time out, and sign out as part of WHO Surgical Safety Checklist . The presence of required prostheses and any equipment required for their insertion should be confirmed .
4. Record names of all surgeons with name/grade of lead surgeon and assistants.
5. Record names and grades of anaesthetist(s) and type(s) of anaesthetic used.
6. Record patient position, skin preparation, surgical approach.
7. Identify steps taken to protect critical structures e.g. sciatic nerve in the posterior approach.
8. Record the preparation of the acetabulum including maximum size of reamer used, the quality of bone stock and then the cup size used and its orientation as well as commenting on stability and the use of screws and augments.
9. For uncemented cups: a confirmation of liner material, size and accurate seating.
10. Record the broach size used for femoral preparation and any details regarding abnormal alignment or version.
11. With cemented stems record use of cement restrictor and implant centraliser as relevant .
12. Record the use of a trial of implants, the sizes involved, and the findings and plans made from that trial.
13. There should be a record, readily available from the patient's notes, of the implanted acetabular, femoral and femoral head components. The information required includes component, size, taper details, manufacturer, and expiry date.
14. The manufacturer's unique identifier label for the prosthesis should be attached for all components and uploaded to the National Joint Registry.
15. Record the type of cement used e.g. brand, use of antibiotics, quantity, and methods used to optimise cementation.
16. It is preferable to use implants that manufacturers identify as compatible. A justification should be documented if ignoring manufacturer's guidance, e.g. in revision surgery.
17. For the second procedure in bilateral hip arthroplasty, knowledge of the previous implants and sizes is required, and any reason for deviation from these should be clearly documented.
18. Document positioning of final components, assessment of stability of hip and range of movement achieved before dislocation both in extension with external rotation and flexion with adduction and internal rotation.
19. Record all details of intra operative concerns or complications e.g. fracture and their management.
20. Record clear details of closure.
21. Record drugs given during surgery e.g. antibiotics, tranexamic acid.
22. Record leg lengths and vascular status at end of procedure, and neurologic status once regional anaesthesia has worn off.
23. The post-operative plan for antibiotics, haemoglobin, AP and Lateral X-rays, and VTE thromboprophylaxis (including risk assessment and deviations from local protocol) should be documented.
24. Clear instructions should be given regarding post-operative mobilisation strategy and any concerns or deviation from standard practice should be identified.

New for 2024

- Shoulder arthroscopy for all indication – BESS
- Shoulder arthroplasty - BESS
- ACL - BASK
- Knee arthroscopy - BASK
- Unicompartmental knee replacement - BASK
- Bunion / SCARF surgery – BOFAS

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HVLC Standardised Consent forms (total = 59)

NHS England London

1. ENT **Total: 6**	1.1 Tonsillectomy 1.2 Myringoplasty 1.3 Functional Septorhinoplasty 1.4 Inferior Turbinate Reduction 1.5 Septoplasty 1.6 Endoscopic sinus surgery
2. General Surgery **Total: 9**	2.1 Laparoscopic cholecystectomy 2.2 Inguinal hernia 2.3 Paraumbilical hernia 2.4 Fermoral Hernias 2.5 Haemorrhoidectomy 2.6 Fistulo in Ano 2.7 Anal Fissure 2.8 Pilonidal Disease 2.9 Anal Skin / Fibroepithelial polyps
3. Gynaecology **Total: 9**	3.1 Diagnostic Laparoscopy 3.2 Endometrial Ablation 3.3 Outpatient Endometrial Ablation 3.4 Laparoscopic Sterilisation 3.5 Outpatient Hysteroscopy 3.6 Outpatient Operative Hysteroscopy 3.7 Operative Hysteroscopy 3.8 Total Laparoscopic Hysterectomy 3.9 Vaginal Hysterectomy and Repair
4. Orthopaedics (Limbs) **Total: 6**	4.1 Anterior cruciate ligament reconstruction 4.2 Therapeutic shoulder arthroscopy 4.3 Total hip replacement 4.4 Total knee replacement 4.5 Unicompartmental knee replacement 4.6 Scarf Osteotomy (Bunions)
5. Ophthalmology **Total: 1**	5.1 Cataract Day Surgery
6.Urology **Total: 28**	6.1 Rigid cystoscopy 6.2 Cystoscopy and insertion of suprapubic catheter 6.3 Rigid cystoscopy and cystolithalopaxy 6.4 Cystoscopy and bladder Botox injections 6.5 Meatotomy 6.6 Cystoscopy and retrograde studies 6.7 Vasectomy 6.8 Circumcision 6.9 Transurethral resection of prostate (TURP) 6.10 Dorsal slit 6.11 Frenuloplasty 6.12 Endoscopic treatment of a urethral stricture 6.13 Holmium laser enucleation of prostate (HoLEP) 6.14 Bladder Neck Incision 6.15 Holmium laser Bladder neck incision 6.16 Prostatic urethral lift (Urolift) 6.17 Simple orchidectomy 6.18 Telescopic Insertion or Removal of a Stent from the Ureter 6.19 Diagnostic ureteroscopy 6.20 Orchidopexy for an Undescended testis 6.21 Excision of epididymal cyst 6.22 Epididymectomy (Removal of Part or all of the Epididymis) 6.23 Transurethral resection of bladder tumour (TURBT) 6.24 Radical inguinal orchidectomy 6.25 Hydrocele repair 6.26 Ureteroscopy for stone removal 6.27 Photovapourisation of the prostate (PVP) 6.28 Flexible cystoscopy

Our objectives and the future

- National programme for learning from clinical negligence claims
  - GIRFT litigation collaborating with NHS Resolution
  - Contribution to National Patient Safety Strategy – Parity with incident learning
  - Litigation sections in each GIRFT National Specialty Report

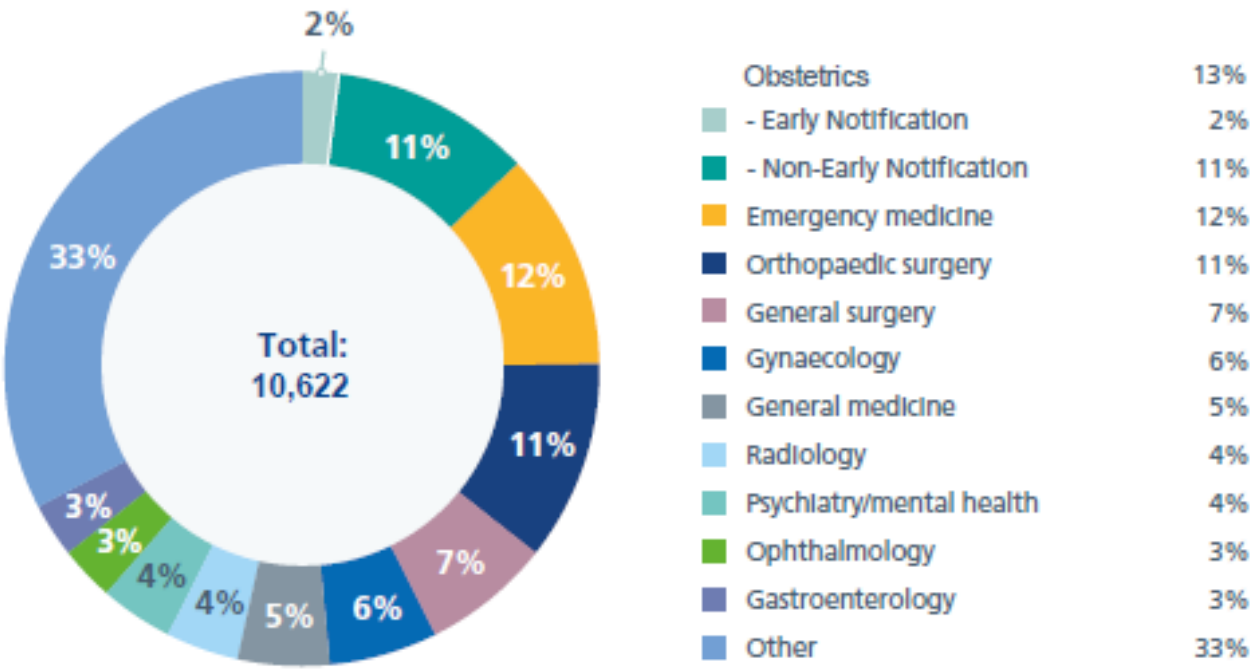
- Best practice guidance in claims learning
  - Learning from claims best practice guide – 2021

- Measure of hospital performance and incentives for best practice
  - Litigation data packs - Refresh in 2023

- Guidance for front line clinicians
  - Guidance for documentation in hip and knee arthroplasty – 2019
  - General surgery 2022
  - Guidance to follow across HVLC surgical procedures 2023-24
  - Standardised consent forms for HVLC – 2023-24

The ED litigation problem in financial terms [1]

Figure 17: Total number of clinical claims received in 2022/23 by speciality[1]



EM has the second highest number of clinical claims

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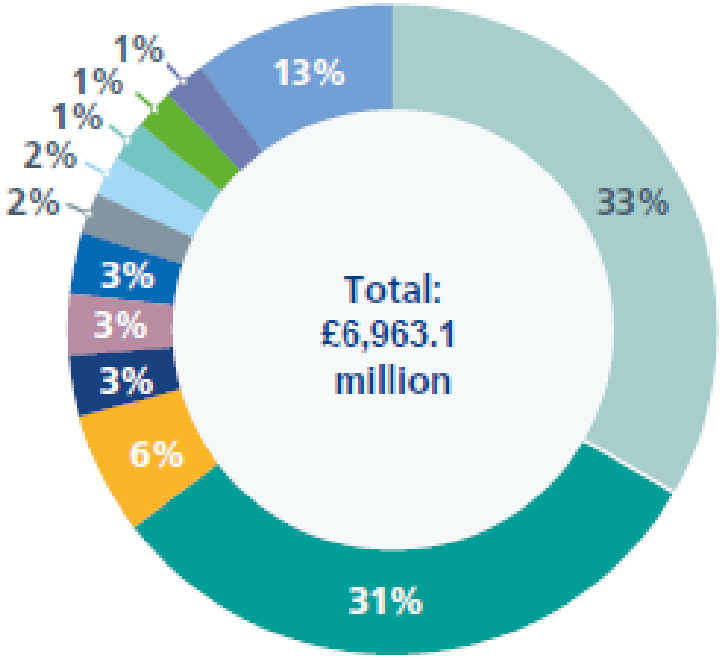
NHS Resolution Annual report and accounts 2022/23

The ED litigation problem in financial terms [2]

Figure 18: Total value of clinical claims received in 2022/23 by speciality[2]



Obstetrics	64%
- Early Notification	33%
- Non-Early Notification	31%
Emergency medicine	6%
Orthopaedic surgery	3%
General surgery	3%
Gynaecology	3%
General medicine	2%
Radiology	2%
Psychiatry/mental health	1%
Ophthalmology	1%
Gastroenterology	1%
Other	13%

EM has the second highest cost of clinical claims

NHS Resolution Annual report and accounts 2022/23

NHSE litigation liabilities for EDs exceed £350 million a year

Average ED costs	Mean	Lower quartile	Upper quartile	Range
Per attendance	£19.50	£10.50	£24.80	£2.90 to £67.30
Per claim	£203k	£110k	£249k	£3k to £3million

Average costs of litigation attributed t

Data source: Claims notified to NHS Res

Unwarranted variation!!

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The ED litigation problem in patient terms [1]

Litigation is just the tip of an iceberg of patient dissatisfaction with their ED care.

FFT - ED Friends & Family: % positive	%	72.9
NHS Staff Survey: Happy with standard of care for a relative/friend	%	53.3
NHS Staff Survey: Recommend as a place to work	%	49.2

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The ED litigation problem in patient terms [2]

- There is a tragic human story behind almost all litigation.
- The tax-payer wants patient care not medico-legal fees and compensation awards.
- People who have suffered from clinical negligence “want to….. make sure that avoidable harm does not occur in the future, so that others do not suffer in the same way”.

House of Commons

Health and Social Care Committee

NHS litigation reform

Thirteenth Report of Session 2021–22

Report, together with formal minutes relating to the report

Ordered by the House of Commons to be printed 20 April 2022

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The emergency care litigation problem in staff terms [1]

The lived experience of physiotherapists involved in Cauda Equina Syndrome litigation

Dr Sue Greenhalgh OBE

Consultant Physiotherapist Bolton NHS FT

Clinical Fellow Manchester Metropolitan University

Funded by

The CSP Charitable Trust
Registered Charity No. 279882

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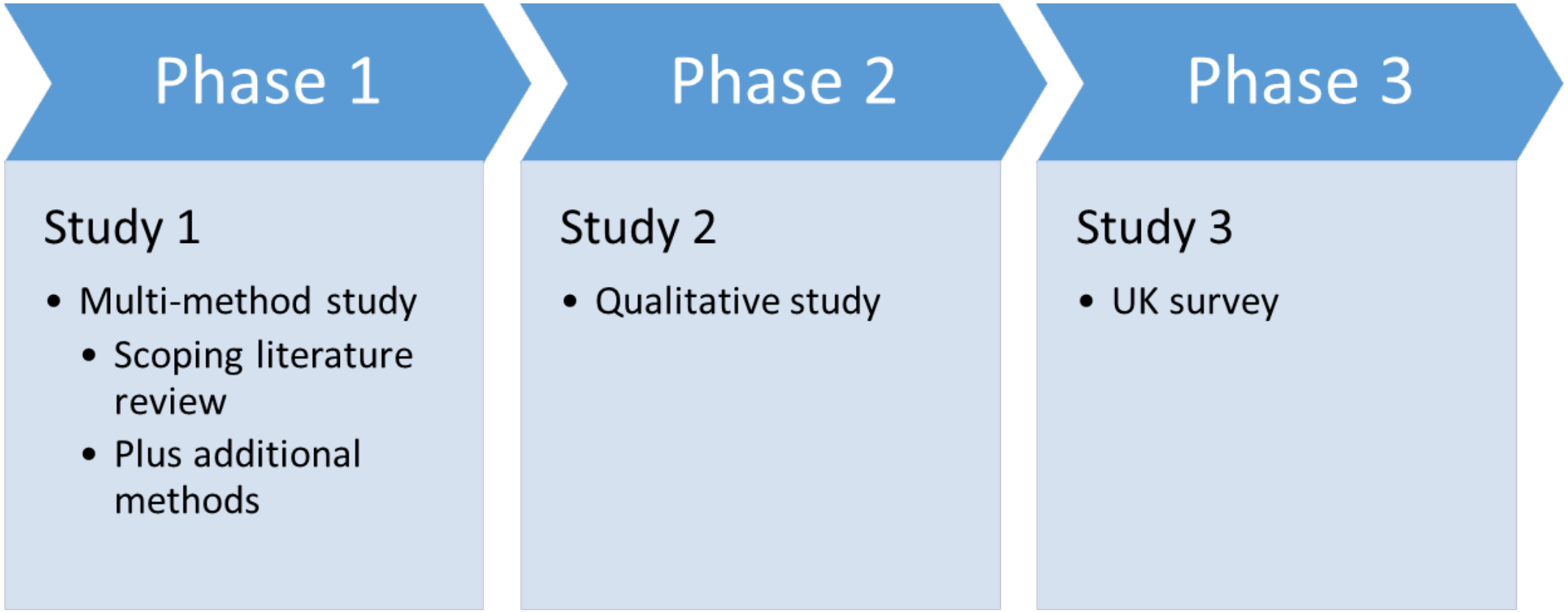
Project overview: phases of research



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Phase 2: Qualitative study

- The first study to investigate the lived experience of litigation in UK physiotherapists
- Affected physical and mental wellbeing
- Impacted on clinical practice
- Personal attack on professional competency
- Increased sickness absence, changed roles, reduced hours, left the profession or retired
- Blame culture
- Stigma surrounding litigation
- Significant learning need

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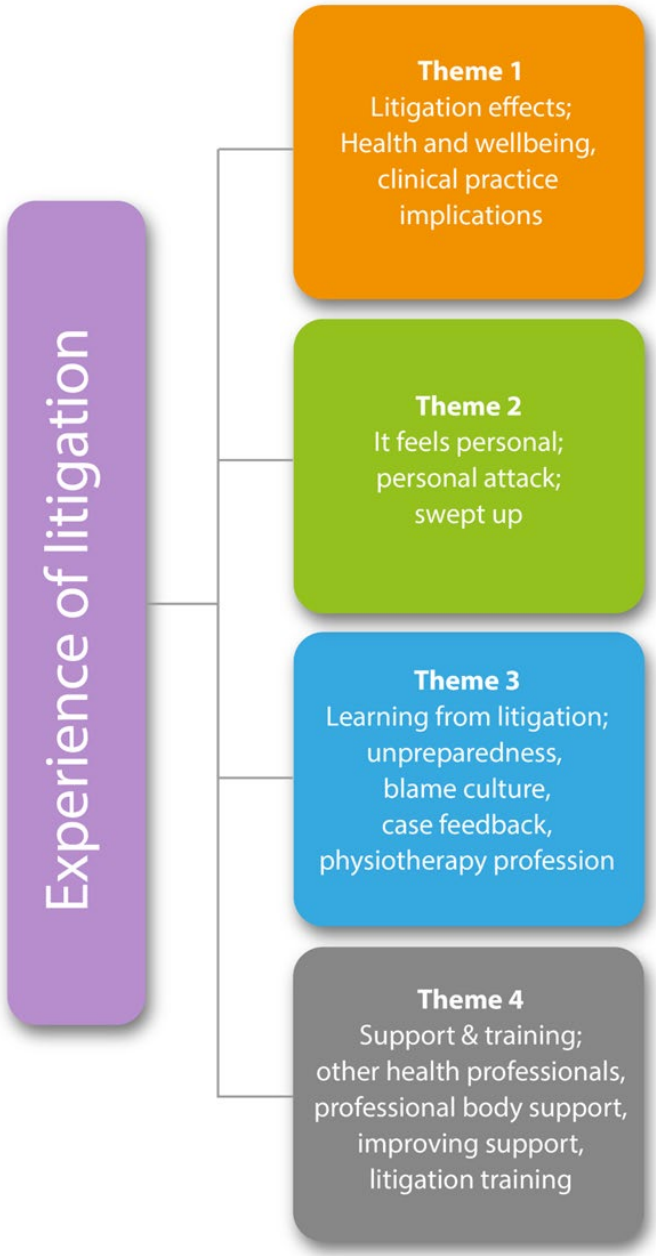
Staff experience of litigation



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Phase 3: UK survey demographics

688 responses (minimum target sample = 383)

- 73% female (n=503)
- 45% qualified > 20 years (n=306)
- 62% worked in MSK (n=408)
- 25% did not work in NHS (n=181)

- 128 claims were reported
- 11% of participants had been cited in a litigation case
- 8% of participants had been cited in four or more claims

The emergency care litigation problem in staff terms [2]

Evidence was submitted to the Health and Social Care Committee.

Paragraph 64 reflected the evidence of academic staff at Manchester Metropolitan University:

> *"It is very difficult for NHS Trusts to be able to share experiences and whilst one Trust may learn from reflection on the litigation incident, this learning is then not shared with other Trusts who may repeat the same mistakes"*

House of Commons

Health and Social Care Committee

NHS litigation reform

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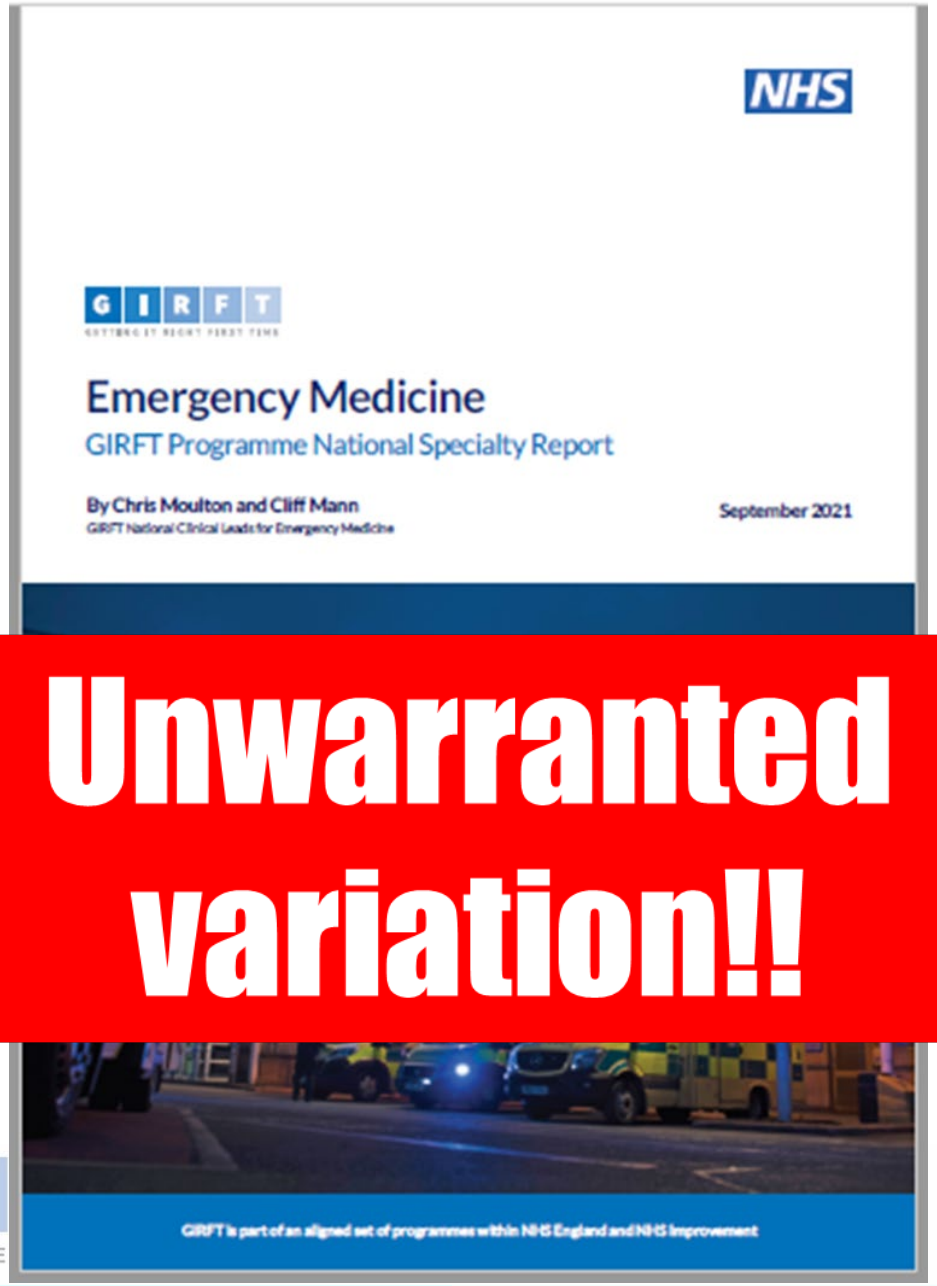

Unwarranted variation!!

Published:
Thursday 9th
September 2021

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Unwarranted variation in emergency care

There is a huge amount of unwarranted variation in the EDs of England. This is the variation in staffing, facilities, processes and outcomes that is bad for patients, bad for staff, bad for the health service and bad for the economy. It also creates the perfect environment for ED litigation.....

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A perfect storm of emergency care litigation

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17 recommendations to address three key priorities:

17a. Trusts to review their ED-attributed litigation, to identify recurrent themes and to take action accordingly.

17b. Commissioners and providers to ensure 24-hour availability of urgent cross-sectional imaging (both computed tomography and magnetic resonance scanning), rapid reporting of imaging and senior clinical advice to reduce patient harms.

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The most surprising thing is that….

When we visit trusts as GIRFT for EM:

- The clinicians have a high lev
- Nobody has ex

Knowledge of the costs and the types of claims is the first step to addressing the problem.

We have all been so busy trying to sort out ED crowding and staffing, that we have neglected litigation. NHS-R Claims Score Cards are available and so are NHS-R experts…..

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* For further information on the trends and themes within your ED's litigation data, please contact: nhsr.safety@nhs.net

Domains - Benchmarked metrics

1st quartile | 2nd quartile | 3rd quartile | 4th quartile

Demand (-10)

Metric Name		Site Value
Proportion of catchment population attending ED per y..	%	32.5
ED admissions aged 75+	%	27.9
ED attendances in the highest quintile of deprivation	%	53.1
GIRFT-EM ED Acuity Index		1.7
Conversion rate (proportion of ED attendances admitted) [A..	%	52.8
Proportion of all emergency admissions that occur via ED	%	90.8
Proportion of all hospital admissions that are elective p..	%	8.1
Trauma status of the ED		TU

Capacity (-5)

Metric Name	Site Value
Annual ED attendances per ED consultant	6,888.4
Annual ED admissions per ED consultant	3,235.5
Annual ED attendances per ED registered nurse	916.1
Annual ED admissions per M&R cubicle	1,527.9
Annual ALL overnight admissions per G&A bed	56.8
Annual acute overnight admissions per G&A bed	50.8
Annual elective overnight admissions per G&A bed	6.0
Annual trust admissions per WTE trust consultant	347.4
ED estate adequacy	

Flow (1)

Metric Name		Site Value
Emergency ambulance handover delays > 30 minutes	%	21.6
DAT-2 (patients discharged, admitted or transferred <= 2 hours of arrival)	%	24.5
APBR-6 (admitted patient breach rate > 6 hours)	%	58.9
APD-6 (aggregated patient delay > 6 hours)		1,704.1
SDEC (same day emergency care): emergency admissions with Zero LoS	%	48.8
Admissions via A&E with LoS > 0 and < 2 days	%	13.8
Admissions via A&E with LoS > 6 days	%	18.7

Outcomes (-7)

Metric Name		Site Value
APBR-12 (admitted patient breach rate > 12 hours)	%	44.3
APD-12 (aggregated patient delay > 12 hours (admissions)		1,582.3
ED-DRH (estimate of annual number of ED patients with delay-related harm)		237.8
Litigation liability per ED attendance *	£	49.4
NHS Staff Survey: Recommend place to work or receive treatment		4.2

For queries, or to update your workforce and/or cubicle numbers, please email england.analyticsproductsteam@nhs.net

* For further information on the trends and themes within your ED's litigation data, please contact: nhsr.safety@nhs.net

But lots of specialties work in the ED…..

NHS Resolution mandates the allocation of a responsible specialty (e.g. emergency medicine) within 48 hours of claim receipt.

Clearly, EM-attributed litigation is not the same as claims generated by the staff of the ED.

Recent research from Cambridge (single site) has suggested that:

- Approximately **half** of all NHS-R EM-allocated claims are not attributable to EM (i.e. the staff of the ED).
- Sole EM (ED staff) liability is around **20%** of the total value.

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Five main conditions leading to litigation attributed to EDs

Medical condition leading to claim	Number of claims in three-year period	Average cost per claim	% of total ED claims cost in three-year period	Total cost over three-year period
Meningitis	32	£2,880,000	9.4%	£92.2 million
Cauda equina syndrome	123	£810,000	10.2%	£99.7 million
Intracranial bleed	67	£742,000	5.1%	£49.7 million
Infection / sepsis	303	£472,000	14.6%	£143.1 million
Fractures	1,055	£77,250	8.3%	£81.5 million

The ED litigation costs of five main conditions over three years

Data source: NHS Resolution, 2015 to 2018

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CES is a recurrent theme

The Healthcare Safety Investigation Branch

And so it is a good sentinel condition for ED litigation….

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CES litigation for EDs

- Failure to scan
  accepted are th
  EDs - not failur
- Therefore, edu
- Radiologists and neurosurgeons need clarity.
- With a suspicious history, clinical examination, rectal examination and bladder scanning should not delay MR imaging.

We must re-engineer the system for patients with possible CES: we need local MR imaging 24/7.

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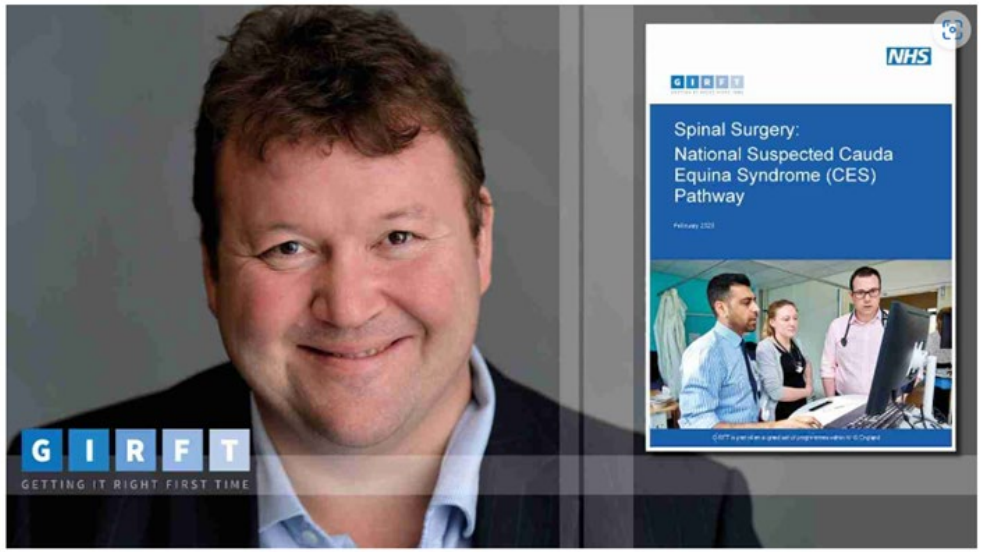
Manchester Metropolitan University

GIRFT: National Suspected Cauda Equina Syndrome Pathway [1]

Pathway supports clinicians to diagnose and treat Cauda Equina Syndrome without delay

February 22, 2023 | News, Publications



GIRFT is pleased to co-badge the Suspected Cauda Equina Syndrome pathway with:

- British Association of Spine Surgeons
- British Association of Urological Surgeons
- British Orthopaedic Association
- British Society of Skeletal Radiologists
- Cauda Equina Champions Charity
- Chartered Society of Physiotherapy
- National Spine Network
- The Royal College of Radiologists
- The Society of Radiographers
- Society of British Neurological Surgeons
- Spinal Injuries Association

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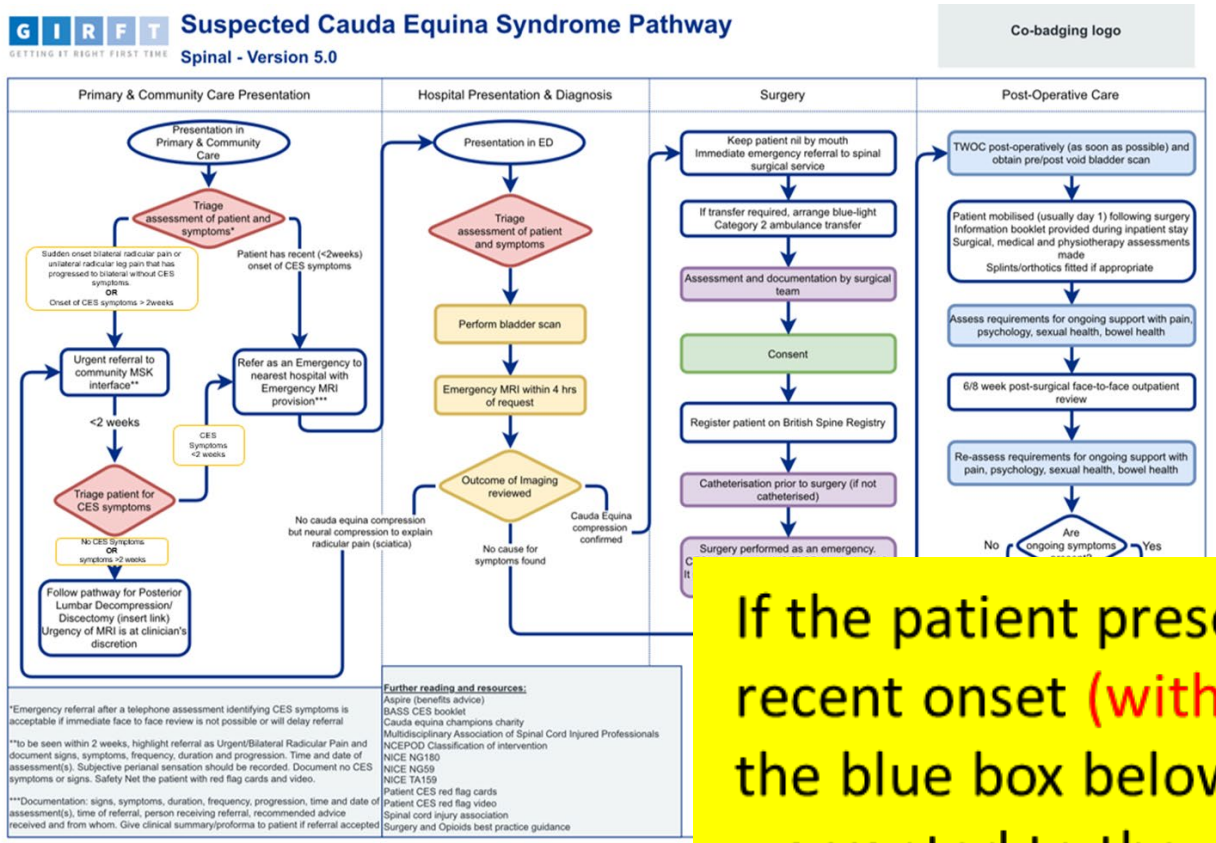
National-Suspected-Cauda-Equina-Pathway-February-2023-FINAL-V2.pdf (gettingitrightfirsttime.co.uk)

GIRFT: National Suspected Cauda Equina Syndrome Pathway [2]



- CES does not have a set clinical pattern.
- No single red flag or combination of flags has good diagnostic accuracy.
- Negative physical tests do not rule out CES if positive subjective symptoms present.

If the patient presents with leg and/or back pain and recent onset (within 2 weeks) of any of the symptoms in the blue box below then an emergency referral is warranted to the nearest facility with emergency MRI.

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Capstick's Solicitors (Discussion Clinical Negligence Scheme for Trusts): The CES two-week window?

- Entry should be by one route.
- Where more optic es, more scope for getting it wron
- Err on the side of caution to avoid patient harm.
- Care
- If va ses will b
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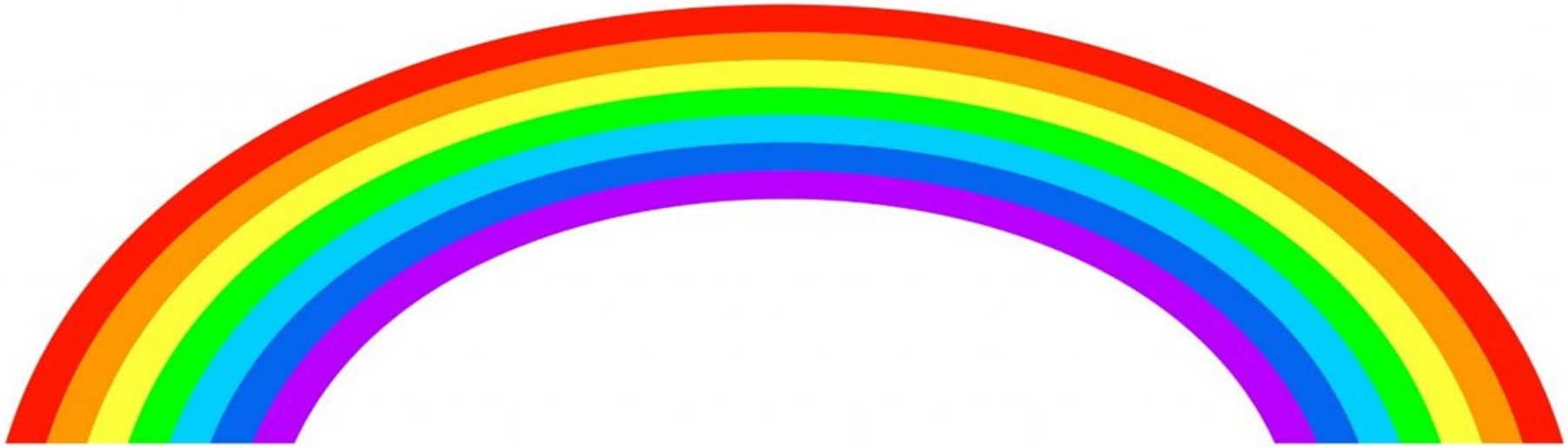
- Cons
- Mini
- Safe
- They

The Perfect World



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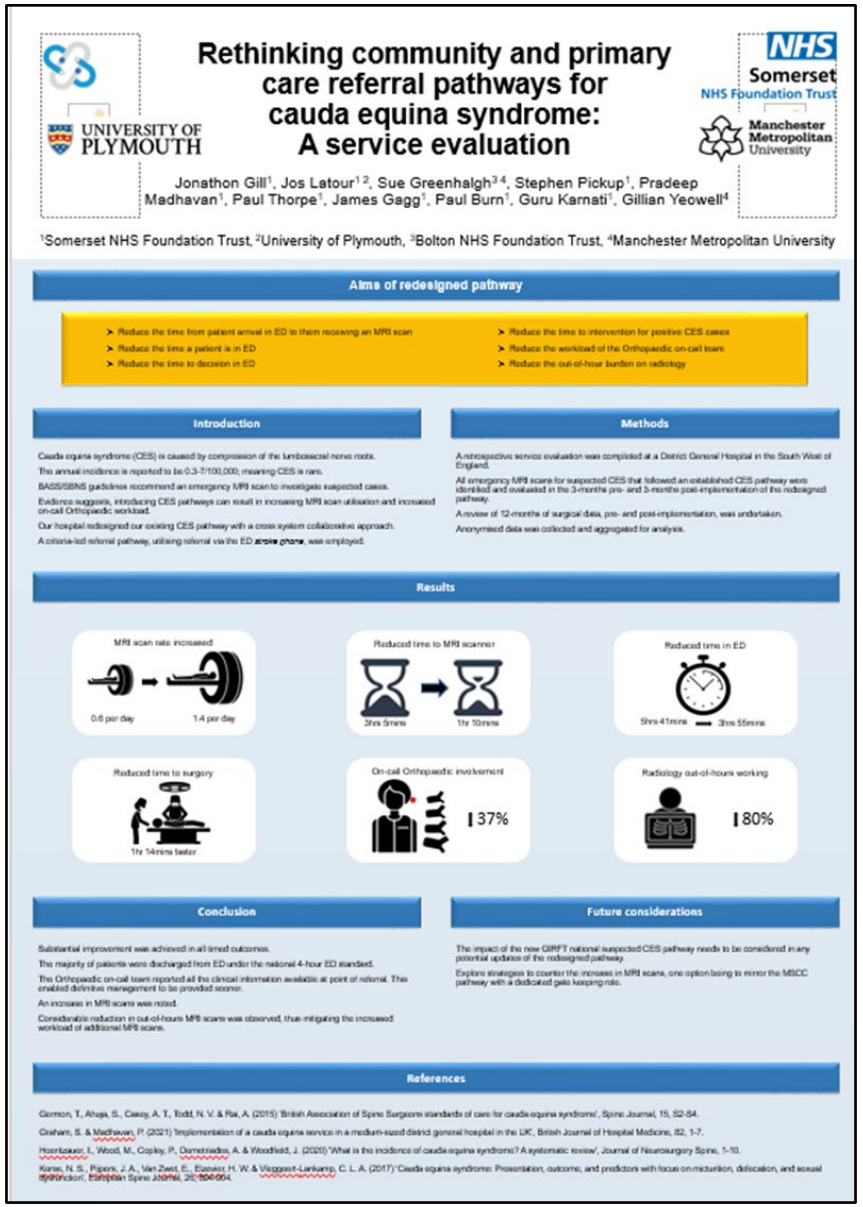
An innovative approach

The redesigned pathway resulted in:

- Increased MRI scan utilisation (pre-implementation n=50; post-implementation n=128)
- Reduction in time to MRI (2 hours)
- Reduction in time spent in ED (1.5 hours)
- Reduction in time to surgery; reduction in out-of-hours scanning (80%)
- Reduction in orthopaedic involvement (38%) (Prior to implementation 97% of suspected CES cases presenting to ED were referred to orthopaedics)



Rethinking community and primary care referral pathways for cauda equina syndrome: A service evaluation

Jonathon Gill[1], Jos Latour[1,2], Sue Greenhalgh[3,4], Stephen Pickup[1], Pradeep Madhavan[1], Paul Thorpe[1], James Gagg[1], Paul Burn[1], Guru Karnati[1], Gillian Yeowell[4]

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Aims of redesigned pathway

- Reduce the time from patient arrival in ED to them receiving an MRI scan
- Reduce the time a patient is in ED
- Reduce the time to decision in ED
- Reduce the time to intervention for positive CES cases
- Reduce the workload of the Orthopaedic on-call team
- Reduce the out-of-hour burden on radiology

Introduction

Cauda equina syndrome (CES) is caused by compression of the lumbosacral nerve roots.

The annual incidence is reported to be 0.3-7/100,000; meaning CES is rare.

BASS/SBNS guidelines recommend an emergency MRI scan to investigate suspected cases.

Evidence suggests, introducing CES pathways can result in increasing MRI scan utilisation and increased on-call Orthopaedic workload.

Our hospital redesigned our existing CES pathway with a cross system collaborative approach.

A criteria-led referral pathway, utilising referral via the ED *stroke phone*, was employed.

Methods

A retrospective service evaluation was completed at a District General Hospital in the South West of England.

All emergency MRI scans for suspected CES that followed an established CES pathway were identified and evaluated in the 3-months pre- and 3-months post-implementation of the redesigned pathway.

A review of 12-months of surgical data, pre- and post-implementation, was undertaken.

Anonymised data was collected and aggregated for analysis.

Results

MRI scan rate increased: 0.6 per day → 1.4 per day

Reduced time to MRI scanner: 3hrs 5mins → 1hr 10mins

Reduced time in ED: 5hrs 41mins → 3hrs 55mins

Reduced time to surgery: 1hr 14mins faster

On-call Orthopaedic involvement: ↓37%

Radiology out-of-hours working: ↑80%

Conclusion

Substantial improvement was achieved in all timed outcomes.

The majority of patients were discharged from ED under the national 4-hour ED standard.

The Orthopaedic on-call team reported all the clinical information available at point of referral. This enabled definitive management to be provided sooner.

An increase in MRI scans was noted.

Considerable reduction in out-of-hours MRI scans was observed, thus mitigating the increased workload of additional MRI scans.

Future considerations

The impact of the new GIRFT national suspected CES pathway needs to be considered in any potential updates of the redesigned pathway.

Explore strategies to counter the increase in MRI scans, one option being to mirror the MSCC pathway with a dedicated gate keeping role.

References

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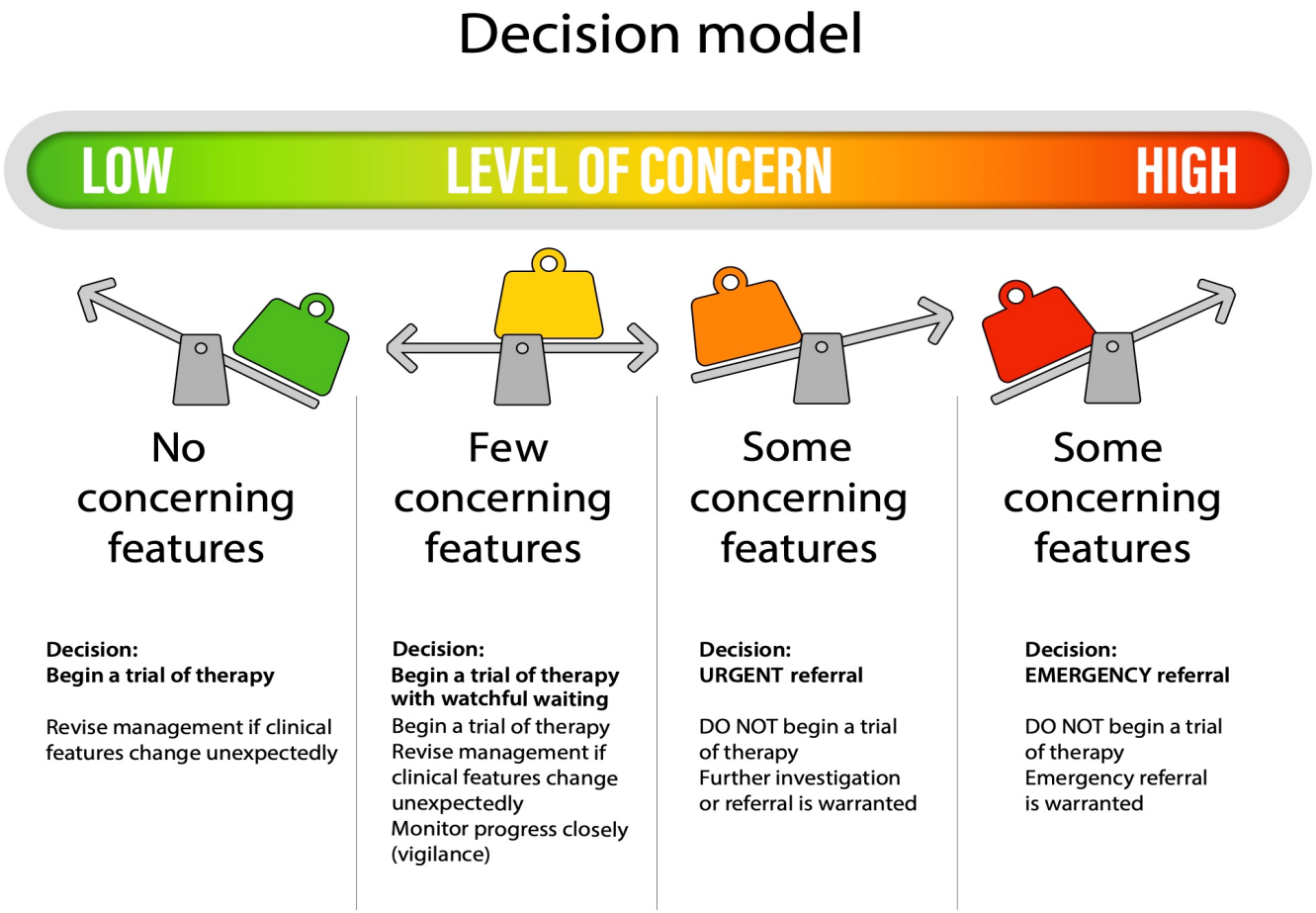
Decision model for possible Cauda Equina Syndrome



- **Emergency Referral** on the same day
- **Urgent Referral** Static CES symptoms within two weeks

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Safety netting for possible Cauda Equina Syndrome [1]

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Professional issue

Safety netting; best practice in the face of uncertainty

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ABSTRACT

Safety netting is a recognised General Practitioner (GP) diagnostic strategy often used in the face of uncertainty to help ensure that a patient with unresolved or worsening symptoms knows when and how to access further advice. It is an important way of reducing clinical risk. In the context of the COVID-19 pandemic and the rapid move to mainly remote consultations within the musculoskeletal field, safety netting is an important strategy to embed within all consultations. Only those presenting with potentially serious conditions are offered face to face consultations. Screening for Red Flags and any indication of a serious cause of symptoms is always first line in any consultation, however, clinical presentations are not always black and white with patients falling into a clear diagnostic category. With patients minds more focussed on COVID-19 symptoms this can be problematic. With the additional ramifications of public health social restrictions, onward management can be a conundrum. Many people with risk factors of serious pathology are also as a consequence, vulnerable to contracting COVID-19. In situations of uncertain clinical presentations, to avoid unnecessary social contact, safety netting can help to monitor symptoms over time until the clinical context becomes more certain. Embedding safety netting within physiotherapy best practice could be a silver lining in this pandemic black cloud.

1. Introduction

The COVID-19 pandemic is arguably one of the greatest global public

netting approach needs to be developed more strongly within physiotherapy generally and it also needs to be firmly embedded in remote consultations to provide appropriate assurances. Safety netting is an

[POSITION STATEMENT]

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International Framework for Red Flags for Potential Serious Spinal Pathologies

Identifying serious pathology as the cause of a person's musculoskeletal presentation is complex. Red flags have historically been used to help clinicians identify serious spinal pathology, and the majority of guidelines recommend the use of red flags. However, guidelines are not consistent about which red flags should be considered when examining people seeking care for musculoskeletal disorders. This has led to confusion and inconsistency in the management of people when there is suspicion of serious pathology, and, in some cases, to unnecessary and worrying medical tests or false reassurance that there is no serious pathology.

We aim to provide clinicians with a more standardized and consistent approach to identifying people with potential serious spinal pathology. This framework has been developed by researchers and clinicians to provide a pragmatic approach for clinicians to screen for serious spinal pathology that can masquerade as musculoskeletal spinal conditions. The framework has been informed by available evidence and augmented by a formal consensus process that included academics and clinicians involved in the management of musculoskeletal conditions.

This framework aims to support a variety of health professionals, irrespective of experience, who provide care for people with musculoskeletal spinal conditions. Clinicians working in musculoskeletal services can play an important role in early identification of serious pathology, ensuring that people achieve the best possible outcome. The prevalence of serious pathology will vary depending on where in the clinical pathway the clinician has contact with the person. Spinal surgeons likely see more cases of serious pathology than general practitioners do, and physical therapists probably see a number in between, depending on where they are on their clinical pathway. Therapists working at an advanced-practice level are likely to see more serious pathology, as the populations they serve are likely to have more complex presentations.[86] Clinicians must consider the context within which red flags exist, and clinically reason the relevance of the information gathered to determine whether any action is required.

SYNOPSIS: The International Federation of Orthopaedic Manipulative Physical Therapists (IFOMPT) led the development of a framework to help clinicians assess and manage people who may have serious spinal pathology. While rare, serious spinal pathology can have devastating and life-changing or life-limiting consequences, and must be identified early and managed appropriately. Red flags (signs and symptoms that might raise suspicion of serious spinal pathology) have historically been used by clinicians to identify serious spinal pathology. Currently, there is an absence of high-quality evidence for the diagnostic accuracy of most red flags. This framework is intended to provide a clinical-reasoning pathway to clarify the role of red flags. J Orthop Sports Phys Ther 2020;50(7):xxx-xxx. Epub 21 May 2020. doi:10.2519/jospt.2020.9971

KEY WORDS: cauda equina syndrome, clinical reasoning, malignancy, spinal fracture, spinal infection

Person-Centered Care

Working with people with possible serious pathology can be challenging, and a collaborative approach is essential. A possible diagnosis of serious pathology can be extremely worrying for people in regard to their families and careers. People must be involved in decision making

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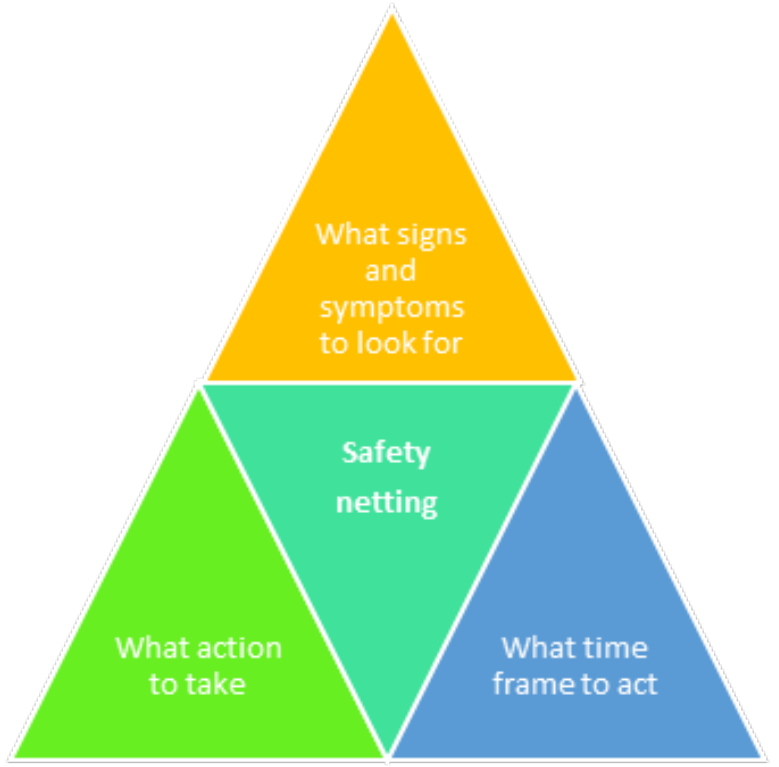
Safety netting for possible Cauda Equina Syndrome [2]

This should include advice to at risk patients on:

- what signs and symptoms to **look out for**
- what **action to take** if symptoms deteriorate and
- the **timeframe** within which action should be taken



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CES credit cards
34 languages

DynamicHealth

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Cauda Equina Syndrome Warning Signs

- L oss of feeling/pins and needles between your inner thighs or genitals
- Numbness in or around your back passage or buttocks
- Altered feeling when using toilet paper to wipe yourself
- Increasing difficulty when you try to urinate
- Increasing difficulty when you try to stop or control your flow of urine
- Loss of sensation when you pass urine
- Leaking urine or recent need to use pads
- Not knowing when your bladder is either full or empty
- Inability to stop a bowel movement or leaking
- Loss of sensation when you pass a bowel motion
- Change in ability to achieve an erection or ejaculate
- Loss of sensation in genitals during sexual intercourse

Any combination seek help immediately

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- Arabic - CES card PDF, 968.47 KB
- Bengali - CES card PDF, 996.36 KB
- Bulgarian - CES card PDF, 159.38 KB
- Cantonese - CES card PDF, 854.92 KB
- Czech - CES card PDF, 776.92 KB
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http://www.eoemskservice.nhs.uk/advice-and-leaflets/lower-back/cauda-equina

อาการปวดหลังโดยทั่วไป (Thai Translation)

ผู้ป่วยจำนวนมากมีอาการร่วมกันของการปวดหลัง ปวดขา ชาขา และอ่อนแรง อาการแสดงเหล่านี้เป็นสิ่งที่น่ากังวลสำหรับคุณ แต่ยังไม่จำเป็นต้องได้รับการดูแลจากแพทย์ฉุกเฉิน **แต่มีผู้ป่วยบางรายที่มีปัญหารุนแรงบริเวณหลัง คือ ภาวะรากประสาทขา ซึ่งสามารถนำไปสู่การบาดเจ็บอย่างถาวร หรือทุพพลภาพ และต้องพบกับกลุ่มผู้เชี่ยวชาญด้านกระดูกสันหลังในภาวะฉุกเฉิน โปรดดูอีกด้านของบัตรเกี่ยวกับสัญญาณเตือนของภาวะรากประสาทขา**

DynamicHealth Manchester Metropolitan University NHS Bolton NHS Foundation Trust

สัญญาณเตือนภาวะรากประสาทขา

- สูญเสียความรู้สึก/รู้สึกเหน็บชาบริเวณขาด้านใน หรืออวัยวะสืบพันธ์
- มีอาการชาบริเวณรอบรูทวาร หรือก้น
- มีความรู้สึกผิดปกติ เมื่อใช้กระดาษชำระเช็ดก้น
- มีความลำบากมากขึ้น เมื่อคุณพยายามที่จะปัสสาวะ
- มีความลำบากมากขึ้น เมื่อคุณพยายามหยุด หรือควบคุมการ ปัสสาวะ
- สูญเสียความรู้สึกขณะปัสสาวะ
- มีอาการปัสสาวะเล็ด หรือปัจจุบันต้องใช้ผ้าอ้อม
- ไม่ทราบว่ากระเพาะปัสสาวะ มีปัสสาวะเต็ม หรือไม่มีปัสสาวะ
- ไม่สามารถหยุดถ่ายอุจจาระ หรือมีอุจจาระเล็ด
- สูญเสียความรู้สึกขณะถ่ายอุจจาระ
- ความสามารถในการแข็งตัวของอวัยวะเพศ หรือการหลั่งน้ำอสุจิเปลี่ยนแปลงไป
- สูญเสียความรู้สึกบริเวณอวัยวะสืบพันธ์ ในขณะมีเพศสัมพันธ์

หากมีปัญหามากกว่า 1 ข้อ ควรขอรับความช่วยเหลือโดยทันที

Bolton: the UK's largest town

- Five CES litigation cases in 10 years (only two involving the ED). This generated litigation costs of over £9 million.
- One solution: Changing the 24/7 CT service to a 24/7 CT and MR service was costed at £148k per annum, plus initial training expenses.
- We began working on learning from litigation in November 2021: Difficulty in getting voice heard at high level, everyone under pressure, departments work in silos, communication across organisations is difficult, big delay waiting for project development team to confirm support (November 2022 to date), activity on pathway only when crisis occurs (i.e. another potential case or national guidelines released), activity began without considering work carried out already or team involved.

Main points from GIRFT:

- Clinical negligence in emergency care and subsequent litigation is bad for patients, staff, the NHS and the economy.
- The current NHS climate - with a large amount of unwarranted variation - creates an environment where clinical negligence can occur too easily.
- It is essential that clinical staff are aware of litigation and then can learn from it.
- The claims score cards and expertise available from NHS Resolution's Safety and Learning Team are of great help in this respect.
- Once problem areas are identified, then the system should be re-engineered to make recurrence much less likely and to make it easy for staff to do the right thing for patients.

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The National GIRFT programme and NHS litigation

- The importance of litigation to GIRFT: a cross-cutting theme and a valuable outcome metric
- The Getting It Right First Time (GIRFT) and NHS Resolution best practice guide for clinicians and managers
- The GIRFT five-point plan to reduce NHS litigation

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