Browne Jacobson

Shared Insights: Implementing learning from claims to help improve patient safety - focus on diabetes and lower limb complications

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Introduction

We were pleased to welcome speakers Dr Nigel Ineson, General Practitioner, and Nicole Mottolini, Podiatrist and Clinical Fellow at NHS Resolution, to talk about diabetes and lower limb complications, and NHS Resolution's recent thematic review of clinical negligence claims arising from these. You can find the full review here.

The thematic review, written by Nicole, is accompanied by a short video summary.

View video
https://resolution.nhs.uk/resources/diabetes-and-lower-limb-complications-a-thematic-review-of-clinical-negligence-claims/

The video highlights two key points that NHS Resolution want to understand:

1. Why principles of care that are well-reported in literature and guidance are not consistently applied; and
2. How those care principles and the thematic review recommendations can be implemented more consistently to improve patient safety and care.

In particular, this session focused on:

- the context of diabetic lower limb claims
- the Review findings, and how to implement them to drive changes for patient safety, as well as reducing the costs of claims.
- sharing examples and experiences of best practice for learning from claims
- what good implementation looks like and how to overcome barriers to that

Our speakers:

William Reynolds, Partner →

Rebecca Coe, Senior Associate →

Diabetes Mellitus and care of feet in General Practice

Dr Nigel Ineson, GP

Before we considered the findings of the Review, Dr Ineson explained why it is important to take the care of diabetic feet very seriously, both in general practice and in the multidisciplinary footcare clinic.

Diabetes UK data

- Prevalence of diabetes in the population is 7% (with at least 1-2% of the population being undiagnosed)
- There are over half a million diabetics in the UK
- Diabetes causes 24,000 premature deaths per year
- Treating diabetes costs £10 billion per year – equating to 10% NHS expenditure
- 8-10% of over 65s have diabetes

Diabetic footcare data

- Diabetes is the most common cause of non-traumatic limb amputation
- Diabetic foot ulcers precede more than 80% of amputations
- After a first amputation there is double the risk of a second
- Up to 70% of diabetics die within 5 years of having an amputation
- 50% die within 5 years of developing a foot ulcer

In Korea, where there is a high prevalence of diabetes, they have taken the approach of raising public awareness in innovative ways including art installations in public spaces.

Guidelines have been in place since 2000 (updated 2004 (NICE CG10) and 2015 (NG19)) as put together by RCGP, BDA, RCP and RCN. Under those Guidelines, referral to a multidisciplinary footcare team within 24 hours is mandatory where there is:

- New ulceration, new swelling or new discolouration
- Cellulitis

Examples of limb and life-threatening diabetic foot problems include ulceration with fever, signs of sepsis or limb ischemia; clinical concern of a bone or deep- seated soft tissue infection and gangrene.

The Guidelines recommend the provision of a multidisciplinary foot care service and clear local pathways. The Getting It Right First Time (GIRFT) programme reinforces this. However, not everywhere has a specialist care team accessible within 24 hours and the Guidelines are not consistently followed.

NHS Resolution's recent thematic review of clinical negligence claims found:

- 64% of patients did not having ongoing consistent reviews by specialist footcare team (even once referred and reviewed)
- 52% of patients reviewed had no MDFT input at any stage
- 54% who had a major amputation were not decisions reached through MDFT

Dr Ineson explained that as a medico-legal expert he has reported on multiple cases involving diabetic feet with many proving indefensible. One of the challenges lies in following the guidelines where there is no or limited service provision.

Learning from Claims: Diabetes and lower limb complications – a thematic review of clinical negligence claims

Nicole Mottolini, NHS Resolution

Nicole gave an overview of the aims and findings of her thematic review and the recommendations. The practicalities of implementing the recommendations translate to other areas of medicine.

Aims

- Reduce variation of practice
- Improve standards of care for patients and staff
- Learn from harm, share learning, prevent future harm

~ 90 closed clinical negligence claims were reviewed by thematic analysis to:

- Identify qualitative themes and recurrent clinical patterns. A high level overview can help highlight issues and drive recognition of clinical and financial risk.
- Produce a report and recommendations including why issues are occurring and what can be done about it.
- Work collaboratively to implement changes and monitor their impact

Findings

Common issues seen in claims included problems with:

- Preventative care
- Pathways between primary care and specialist footcare teams
- Management of diabetic foot disease and specifically diabetic foot ulcers
- Biomechanics and offloading (pressure relief)
- Emergency Department attendance, admission into and discharge from hospital
- Management of peripheral arterial diseases
- Education, psychological support and patient compliance

Recurrent themes that arose out of the review were:

- Missed recognition of severity
- Lack of urgency in providing care

Contributed to by:

- Inconsistent use of terminology and non-descript language making it difficult to ascertain if situation improving or deteriorating
- Lack of pain response from patients resulting in lack of urgent response from clinicians
- The involvement of multiple disciplines not always resulting in integrated multi-disciplinary team working
- This resulted in a change in clinical picture not leading to a change in management plan.

Recommendations to implementation

There are many publications and a significant number of recommendations with similar themes. There needs to be clarity around who is responsible and accountable for implementation and a co-ordinated, consistent and supportive approach. Some key recommendations are as follows:

1. Education / Training

- Nationally, i.e. NHS England and NHS Improvement: footcare component included in all patient diabetes education programmes
- Collaboration with Health Education England and National Wound Care Strategy Programme
- Include consistent training at undergraduate level, thinking about what is taught in theory and how that translates into practice
- Locally: primary care, community podiatry and commissioners ensure education is delivered to patients and recorded and audited

2. Pathways and the provision of consistent services:

Nationally

- NHS England and NHS Improvement work with stakeholders to standardise the remit and function of Multi-disciplinary footcare teams (MDFT) and Foot Protection Services (FPS)
- All guidance and recommendations to include clear definitions and terminology e.g. defining what a diabetic foot ulcer or a limb threatening emergency is
- All guidance and recommendations to be clear, if use “if suspect” or “if clinical concern”, avoid variation in interpretation by specifying what evidence/results should first be gathered, to guide the level of concern or reassurance that follows

Locally

- Streamlined pathways across primary care, community, acute and inpatient teams
- Implementation of a “Pathway Lead” as a link across clinical teams and also between clinicians and commissioners
- Pathways and referral processes clearly documented, promoted and available on intranet/extranet

3. Biomechanics and offloading (pressure relief)

- All services provided evidence-based offloading
- Orthotists to be part of MDFT
- Offloading protocol documented with standard operating procedure.

4. Commissioning of services

- Across a number of services, commissioning teams are key partners to give system level support/oversight to ensure integration of multiple services across jurisdiction
- Integrated care boards: Ensuring a single pathway between primary care, community, acute and inpatient teams
- This includes working with NHS Digital to ensure aligned technology and access to patient notes
- Clinical teams supported to participate in national and local audits

5. Public health campaign

- Working with charities, including Diabetes UK, to promote awareness at local and national level. Promote importance of preventative lower limb care and empower patients
- Encourage open conversations to ensure morbidity and mortality associated with diabetic foot disease is recognised and discussed

6. Leadership and Workforce

- Clarify where decision-making capability comes from. Ensure there is an agreement, as to where overall accountability lies for that patient group. Without it, there can be good intention but a style of healthcare that seems resource-heavy but outcome-light.
- Working with NHS England and NHS Improvement as well as Health Education England, to ensure retention of Podiatrists and Orthotists
- Advancing clinical practice reflected in the remit and roles available – ensure decision making capability
- Clinicians involved in MDFTs have this planned into their roles, with at least one member of the MDFT having admitting rights

7. Participation in NDFA and local service audits

Nationally

- NHS England and NHS Improvement work with Integrated Care Boards to ensure all services participate in the National Diabetes Footcare Audit

Locally

- Reflecting on the care provided following all lower limb amputations and having the ability to capture and feedback learning across all teams involved in the care of the patient.

Quick tips/short term wins

- The International Working Group on Diabetic Feet has clear guidance that does includes terminology which could be included in a glossary
- NHS Resolution are producing a recommendation to implementation template for member Trusts to help track the implementation of recommendations. This practical tool aims to give an overview that can be easily reviewed, presented and escalated. It is hoped this will be published soon. The template will address case of need (where within clinical governance the issue has been identified), with a link to financial risk, quality of care, staff wellbeing and resource management. Once case of need is captured, the most appropriate recommendations can be identified. Trusts can then prioritise recommendations and check whether they are on track.
- NHS Resolution has a catalogue of resources to reflect recommendations – including some ready-made recommendations to be utilised at local level. We have also included a resources page at the end of this note.

Discussion

There was discussion around how Trusts disseminate learning from claims to both clinicians and the board to drive change. A number of examples were given

- Creation of “high-risk claims committee” – raising the profile of claims at board level and providing specific forum to consider learning from claims.

- Creation of “Learning from Litigation” – regular reviews of settled claims with completion and distribution of learning forms to relevant specialities. Then a Trust-wide meeting affording each speciality an opportunity to present their learnings.
- Regular reports submitted at board level covering lessons learned from claims.
- Closure emails to clinicians and relevant service managers highlighting lessons on conclusion of claims.
- Empowerment of clinical teams by sharing individual data around their claims profiles and learning points so they can drive improvements on the ground.
- Legal teams presenting to relevant services with case study slides highlighting common learning themes.

Whilst data can tell the story from a figures/financial perspective, the patient story is powerful and will often impact more at board level. Triangulate data and stories - teams do this on a day to day basis and through governance processes.

A number of resources are available to help Trusts

- Getting It Right First Time - GIRFT– sends claims- based packs to Trusts with information such as how many claims they are getting and how much it is costing. This can be shared with the board.
- Effective use of panel firms and NHS Resolution in terms of reporting – specifics can be drawn out from Panel reports to NHS Resolution on safety and learning aspects of specific claims.

We also discussed the importance of patient empowerment and helping them understand their conditions, and raising awareness of particular conditions within the public and the profession.

NHS Resolution safety and learning resources

NHS Resolution Thematic Reviews

- Five years of cerebral palsy claims - NHS Resolution
- Learning from suicide claims
- Learning from Emergency Medicine claims (3 reports)
- Diabetes and Lower Limb report
- Learning from General Practice claims
- The Early Notification Scheme Second Year Report

Other NHS Resolution Resources

- Duty of Candour animation
- Saying Sorry
- Being Fair
- Learning from medication error claims
- Learning from spinal infection claims
- Extravasation

How we can help

Despite the time lag between incident and claim, claims data provides a source of rich and valuable learning, especially when considered alongside other sources of data such as incidents and complaints.

Claims data can also be used as part of assurance processes to ensure learning has been embedded and to help drive improvements in incident reporting and investigation processes.

We can provide support with analysis of your claims and inquests data to identify key learning to share at Board level and with clinical teams. We also work with Trusts to review data from the NHS Resolution scorecard and GIRFT; information which may also be used to inform your organisation’s patient safety profile and Patient Safety Incident Response Plan.

We also have a team of dedicated specialists who have in depth knowledge of claims involving the treatment of diabetes and lower limb complications. Our experience and awareness of the issues and challenges that Trusts and other health and social care organisations face enable us to deliver pragmatic and practical advice when you need it.

If you would like to discuss how we can support your organisation please contact our dedicated Risk Management Lead, Amelia Newbold.

Key contact

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