The emergency department or the emergency medicine service? Redefining the boundaries of responsibility for emergency care litigation in England

Clinical negligence claims allocated to emergency medicine (EM) now account for the equal-highest volume notified to NHS Resolution (NHS-R), the body responsible for handling negligence claims on behalf of NHS organisations, sponsored by the Department of Health and Social Care.[1] NHS-R mandates the allocation of a responsible specialty within 48 hours of claim receipt, mostly allocated by medicolegal departments without clinician involvement.[1] In England, >75% of acute admissions present via an emergency department (ED).[2] Therefore, there is a risk that the ED (as a location) is used synonymously with EM (the specialty), resulting in misallocated claims impeding the process for accurate system improvement. The Getting It Right First Time programme recognises that litigation reflects poor patient outcomes and uses EM-allocated claims as a comparative metric to rate and explore variations across organisations.[3] The aim of this study was to report the true proportion and cost allocation of negligence claims initially attributed to EM at a large tertiary hospital with a high litigation burden.

A retrospective observational study was performed at Cambridge University Hospitals NHS Foundation Trust (CUHNFT). CUHNFT is the regional major trauma centre for the East of England with an ED attendance of >120 000 patients per year, operating a 'single front door' for unscheduled care: undifferentiated patients are seen by EM clinicians, and referred patients are seen in the ED by in-hospital specialties. Data were obtained from NHS-R for all claims allocated to EM, 2011–2020. Clinical and medicolegal records were interrogated by two emergency physicians (JP and EBGB) and independently reviewed by an acute medicine physician (CA) to determine the causative incident, nature and value of the claim, and the attributable specialty. Equivocal cases were arbitrated by a senior emergency physician (SMR). Data are described as 'allocated' when referring to initial NHR-R notification and 'attributed' when referring to the result of case review. Data are reported as number (percentage) and median (IQR).

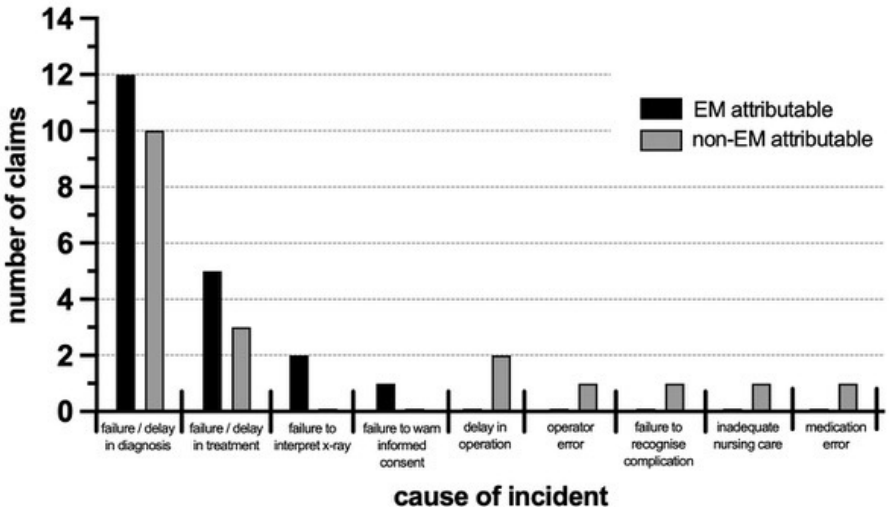

Figure 1 EM NHS Resolution allocated clinical negligence claims according to cause of incident at Cambridge University Hospitals NHS Foundation trust (2011–2020), presented as EM attributable and non-EM attributable. EM, emergency medicine.

During the study period, 39 EM-allocated claims were notified to NHS-R (median/year 3.5 (2.0–6.8)) with a value of £22.2 million (median/year £1.0 million (£80.0 k–£3.7 million)). There were seven 'high-value' (>£1 million) claims totalling £19.6 million, and 32 'low-value' claims totalling £2.6 million. Medical cases were responsible for the largest proportion of high-value claims (71.4%). The largest proportion of low-value claims was minor injury cases (53.1%). Case reviews identified a single specialty responsible for each claim, of which n=20 (51.3%) were attributable to EM, with a total value of £4.4 million (19.9%). Non-EM specialties were found to be responsible for 48.7% of claims that were initially allocated to EM, with a total value of £17.8 million (80.1%), including six out of seven high-value claims (table 1).

The median value per claim for EM-attributable cases compared with non-EM attributable cases was £41.8 k (£17.3 k–£114.6 k) and £97.4 k (£43.7

Table 1 Total value of all NHS Resolution EM-allocated claims according to cause of incident at Cambridge University Hospitals NHS Foundation Trust (2011–2020) following case review, presented as 'correctly allocated to EM' and 'incorrectly allocated to EM'

	Total claim value (%)			
Cause of incident	Correctly allocated to EM	Proportion of total claim cost (%)	Incorrectly allocated to EM	Proportion of total claim cost (%)
Failure/delay in diagnosis	£3 855 817.05	17.37	£12 262 261.69	55.23
Failure/delay in treatment	£502 076.20	2.26	£357 110.84	1.61
Failure to interpret X-ray	£61 717.06	0.28	£0.00	0.00
Failure to warn informed consent	£8243.70	0.04	£0.00	0.00
Delay in operation	£0.00	0.00	£47 600.00	0.21
Operator error	£0.00	0.00	£39 071.61	0.18
Failure to recognise complication	£0.00	0.00	£3 470 000.00	15.63
Inadequate nursing care	£0.00	0.00	£0.00	0.00
Medication error	£0.00	0.00	£1 600 000.00	7.21
Total	£4 427 854.01	19.9	£17 776 044.14	80.1

EM, emergency medicine.

k–£1.5 million), respectively. The greatest proportion of claims was due to 'failure or delay in diagnosis' (figure 1). The most prevalent EM-attributable claims were minor injuries with either delayed diagnosis/treatment or misinterpretation of X-rays, resulting in unnecessary pain.

This study provides evidence that approximately half of all NHS-R EM-allocated claims are not attributable to EM and that litigation allocated to the ED is not the same as litigation generated by EM clinicians. Furthermore, owing to the significantly lower value per claim of EM-attributable claims, only one-fifth of total claim value initially allocated was found to be attributable to EM. These misallocations are likely due to a combination of the synonymous use of ED and EM and current NHS-R time constraints for notification. The Royal College of Emergency Medicine and NHS-R encourage the sharing of data and insights as a catalyst for improvement.[1 4] However, without accurate data on how to attribute clinical negligence claims, this process will be impeded. EM leaders are encouraged to review their own litigation cases and collaborate with medicolegal departments to ensure correct coding is applied at the point of NHS-R notification and to update historical claims where inaccuracies have become evident.

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