NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

Trust Board

Agenda Item	11b.	**Date: 26.07.17**	
Title of Report	Legal Services Annual Report 2016/17		
Purpose of the report and the key issues for consideration/decision	The Committee is asked to review the contents and note progress during 2016/2017 following presentation to Audit Committee in May 2017.		
Prepared by: Name & Title	Jennifer Hovington, Trust Solicitor Dawn Sharples, Legal Services and Inquest Liaison Assistant		
Presented by:	Pauline Law, Director of Nursing		

Action Required (please X)					
Approve	**x**	**Adopt**		**Receive for information**	

Strategic/Corporate Objective(s) supported by this paper	Governance

Is this on the Trust's risk register?					
No	x	**Yes**		**If Yes, Score**	

Which Standards apply to this report?	
CQC	x
NHSLA	x
BAF Objectives	x
WWL Wheel	x

Have all implications related to this report been considered?

	Yes/No/NA	Any Action Required		Yes/ No/NA	Any Action Required
Finance Revenue & Capital	Y		Equality & Diversity	Na	Na
National Policy/Legislation	Y		Patient Experience	Y	
NHS Contract	Na	Na	Governance & Risk Management	Y	
Human Resources	Na	Na	Terms of Authorisation	Y	
Consultation / Communication	Na	Na	Human Rights	Na	Na
Other:	Na	Na	Carbon Reduction	Na	Na
If action required please state:					

Previous Meetings

Please insert the date the paper was presented next to the relevant group

ECC	Audit Committee	Quality & Safety Committee	Finance & Investment Committee	Management Board	IM&T Strategy Committee	HR Committee	NED	Other
Na	May 2017	Na	Na	Na	Na	Na	Na	Na

Wrightington, Wigan and Leigh NHS Foundation Trust

LEGAL SERVICES ANNUAL REPORT 2016/2017

your hospitals, your health, our priority

Contents

1. EXECUTIVE SUMMARY

The Legal Services Annual Report 2016/2017 for Wrightington, Wigan and Leigh NHS Foundation Trust ("the Trust") will be submitted to the May 2017, Audit Committee.

The information contained within this report comprises the period from 1 April 2016 to 31 March 2017 in respect of claims, litigation and HM Coroner's Inquests. The report contains an analysis of the data during the 2016/2017 financial year, and where appropriate, uses comparative data from previous years.

The purpose of the Legal Services Annual Report is to feed this data back into the organisation to see what lessons can be learnt, and where appropriate changes can be made. This is to ensure that the Trust develops an ability to learn from claims, litigation and HM Coroners Inquests trends and themes, with the aim of reducing both harm to patients and litigation costs.

The report will also provide an update on the progress made by the Legal Services Department itself during 2016/2017, along with proposals for change within the next financial year.

2. INTRODUCTION

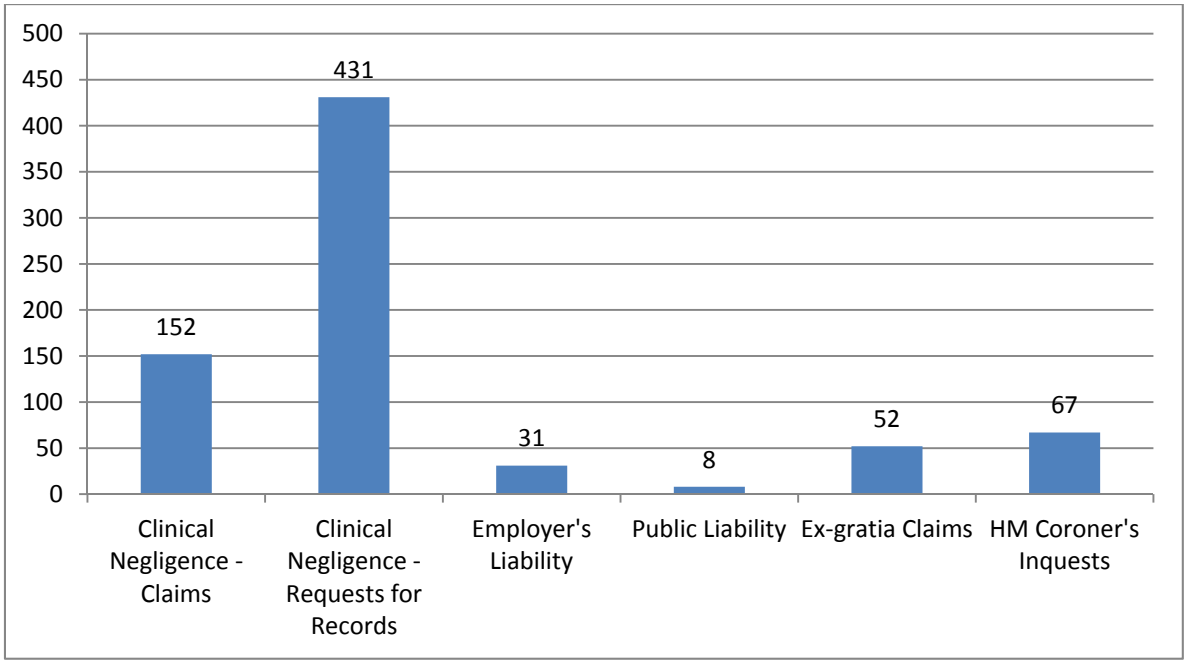
The Legal Services Department ("the Department") is responsible for the management of:

- Clinical negligence claims;
- Employers and public liability claims;
- Ex-gratia requests for compensation; and
- HM Coroner's inquests.

Although these are the main areas of work within the Department, this list is by no means exhaustive. The Department is also responsible for providing advice on a wide range of legal issues; including healthcare advisory work, contractual matters and Freedom of Information requests.

It is accepted that there will be times when the Department may have to instruct external solicitors to provide specialist advice on various healthcare / contractual issues. The Head of Legal Services is responsible for determining when external solicitors should be instructed to deal with any relevant matters to the organisation; at all times ensuring that legal costs are proportionate to the particular matter at hand. (Further details regarding legal spend for 2016/2017 is provided under section 7 of this report).

The graph 1 below demonstrates the number of on-going / "live" claims and inquests the Department was dealing with as at 31 March 2017.



Graph 1

Graph 1 shows the number of "*live*" clinical negligence claims the Department was managing as at 31 March 2017 compared to previous financial years (in 2013/2014 there were 104 "live" claims, in 2014/2015 there were 140 and in 2015/2016 there were 151). The most significant rise has been in the number of requests for disclosure of medical records from claimant solicitors. There were 254 in 2013/2014, 338 in 2014/2015 and 409 in 2015/2016. In 2016/2017 there were 431 live requests for medical records at 31 March, 2017, and several of these requests will result in clinical negligence claims, however, the Department is unable to predict the exact figure at present. The requests for records continue to have a huge impact on the resources within the Department which is responsible for reviewing all medical records requests and the copying of notes.

With regards to non-clinical claims (Employers and Public liability claims) there has not been a significant change from the last financial year, but the number of "*live*" inquests the Department was managing at 31 March, 2017, has increased.

3. CLINICAL NEGLIGENCE CLAIMS

All clinical negligence claims brought against the Trust are managed in accordance with Trust policy and the terms and requirements of the NHS Resolution Clinical Negligence Scheme for Trusts (CNST).

CNST is a contributory scheme which funds all damages and solicitors' costs in cases which have been referred to the NHS Resolution. The Department is responsible for handling claims prior to referral and for ensuring appropriate preliminary investigations are carried out. Once a referral to the NHS Resolution has been made, the Department is responsible for ensuring the case is appropriately managed and to assist in obtaining information relevant to the claim (such as clinician's statements, protocols, medical records etc.).

In March 2016 the NHS Resolution opened a **Consultation into the CNST scheme** for all member Trusts to put forward their views on how their financial contributions should be managed. Currently CNST operates as a pay-as-you-go basis, which means the NHS Resolution collects in every year what they expect a Trust to pay out.

The significant and rising cost of clinical negligence is driven by the rising number and value of claims against the NHS. The NHS Resolution wanted to hear from member Trusts as to how they might better develop the CNST scheme. The Head of Legal Services worked with the Finance Department, Governance Leads and the Trust's external solicitors to provide a response to the Consultation by the deadline of 17 May 2016. It was the NHS Resolution's intention to then review all member responses, and look to provide a formal report by the end of the year, setting out how the CNST scheme will be run in the future. This information is still awaited.

3.1 New Clinical Claims

The number of clinical negligence claims brought against the Trust since 2012/2013 is displayed in Table 1. For the second time in four years the Department has seen a reduction in the number of clinical negligence claims as shown below.

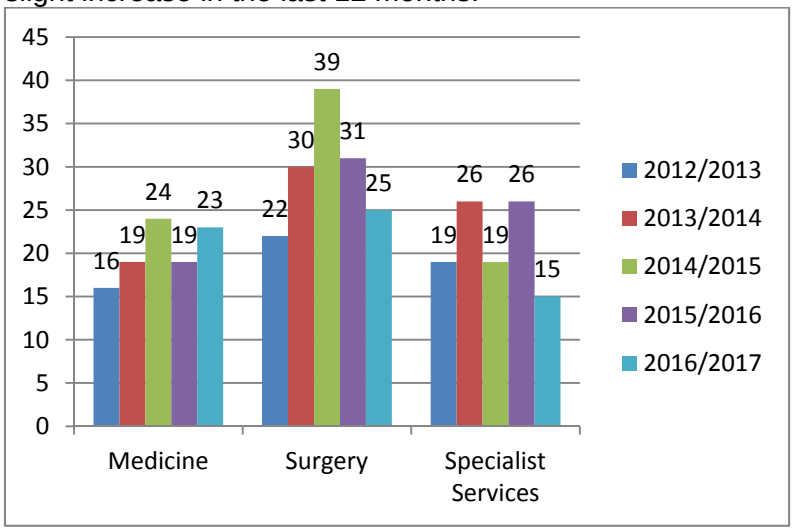
Reporting Year	New Clinical Negligence Claims Received
2012/2013	56
2013/2014	75
2014/2015	81
2015/2016	75
2016/2017	**63**

Table 1

Whilst there has been a steady increase in the number of claims from 2012/2013 to 2014/2015, it was expected that the rate of increase would slow down eventually in the wake of changes to funding arrangements for civil litigation, introduced by the Legal Aid, Sentencing and Punishment of Offenders Act (LASPO) on 1 April 2013. LASPO reformed funding arrangements and has prevented claimant solicitors from recovering success fees of up to 100% of their base costs from the defendant, making bringing claims slightly less attractive.

The NHS Resolution has also seen a reduction in the number of clinical negligence claims in recent years and they too have put this down to the changes brought by LASPO.

Graph 2 below shows a comparison of the number of claims brought against each Division between 2012/2013 and 2016/2017. The graph demonstrates a reduction in the number of claims for Surgery and Specialist Services; however the Division of Medicine has seen a slight increase in the last 12 months.



Graph 2

3.2 Summary of Clinical Negligence Cases 2016/2017

The information in Table 2 below shows how many new clinical negligence cases (per quarter) where brought against the Trust during the period of 1 April 2016 and 31 March 2017, and what payments were made to both the claimant and their solicitors (where available).

Report Quarter	New	Closed	Cases Resulting in Payment to the Claimant	Total Value Settled Claims	Total Value Claimant's Solicitors Costs	Highest Payment Made
Q1 April to June 2016	14	28	15	£292,373	£332,150 *7 not yet paid	£75,000
Q2 July to September 2016	13	19	12	£526,250	£342,226 *4 not yet paid	£350,000
Q3 October to December 2016*	18	37	11	£4,643,500*	£75,600 *9 not yet paid	£2,000,000* x 2
Q4 January to March 2017	18	26	7	£82,250	£151,000 *3 not yet paid	£30,000

Table 2

The NHS Resolution arrange the payment of damages, claimant's solicitors' costs and defence solicitors' costs relating to the clinical negligence claims. These costs are reflected in the Trust's annual premium payments.

The claims above, which resulted in damages being made to the claimant, fell within the following Divisions:

(It is noted in bold what claim the highest payment per quarter related to)

<u>Surgical Division</u>:

General Surgery

- During operation for hiatus hernia a surgical instrument was dropped on patient's abdomen causing a burn which will leave scarring
- Patient had poor outcome of breast reconstruction surgery
- Failure to image the appendix on two occasions and a failure to investigate symptoms of appendicitis.
- Claimant alleges failure to provide post-operative fragmin.
- Patient suffered a fractured tibia following a fall whilst mobilising on the ward.
- Damage to aorta at groin level during a laparoscopic nephrectomy for renal carcinoma.
- Failure to provide a reasonable standard of care in the treatment of an aortic aneurysm.
- Following an operation to remove a cancerous tumour, the surgeon failed to remove all swab remnants from the wound.
  A wound infection followed and a further procedure under General Anaesthetic with a prolonged period of recovery, wound healing and pain and suffering.

Child Health

- Delay in diagnosing hypothyroidism. Claimant suffered extended pain and suffering and symptoms of lethargy, general ill health and deterioration in school attendance and weight gain.

Breast Surgery

- Patient fell when mobilising to the toilet unaided.

ENT

- Whilst undergoing an operation for a perforated left eardrum non-surgical material was used in place of self-absorbent medical material over the ear drum to aid healing resulting in unnecessary pain, suffering.
- Patient was given calcium by way of intravenous drip following surgery which resulted in Trousseu and Chvosteks and was not informed of the risks of the operation.

Urology

- Perforation of bowel during op to remove kidney which led to peritonitis and emergency ileostomy.
- Claimant suffered stress and anxiety following an unwanted pregnancy, which resulted in a termination following her husband's unsuccessful vasectomy (linked to claim below).
- Vasectomy not performed satisfactorily as the left vas deferens had not been cut but instead a blood vessel had. A second procedure was required and claimant sustained some nerve damage. Claimant's wife became pregnant.

Gynaecology

- Filshie Clip was dropped and left in situ during sterilisation procedure resulting in the patient becoming pregnant a few months following procedure.
- Following a smear which resulted in severe bleeding, claimant developed an infection for which surgery was required to remove fallopian tubes.
- Poor outcome following surgery for hysterectomy. Failure to investigate fall in haemoglobin levels on discharge. Patient was readmitted for pelvic hematoma and small bowel perforation, suffered incurable infection and died.

Maternity

- Child sustained brain damage including visual and development impairment following delay in diagnosing infantile spasms prior to and subsequent to birth. Mother claimed psychiatric damage. **(resulted in a lump sum payment of £1,000,000; the joint highest for Q3 – this claim was also the subject of a structured settlement whereby the claimant will receive an annual sum of £95,000 up to the end of 2023 and following this the sum of £108,000 annually for life).**

Of the above claims, the highest number related to general surgery. (In 2015/2016 the highest number of surgical claims also related to anaesthetic and maternity services).

<u>Medicine Division:</u>

Acute/General Medicine/Care of Elderly

- Death of an 18 year old female presenting with "sore throat" and identified as a + Glandular fever.

- Patient in stage 4 chronic renal failure developed haematoma, had poorly controlled anti-coagulant therapy and patient passed away. **(resulted in a payment of £30,000; the highest for Q4)**
- Patient prescribed drug to treat tumour at the side of their head but it was discovered the tumour was benign. The patient died before being weaned from the drug. **(resulted in a payment of £75,000; the highest for Q1)**
- The patient fell in the shower and sustained bruising to back when left unattended.
- Patient treated for with botulium toxin injection to right shoulder. It was subsequently noted that the injection had been given to the wrong patient.
- Failed discharge of patient with end stage COPD, patient died.

Accident & Emergency

- Delay in escalation of patient who developed sepsis after being treated for liver damage and jaundice. Patient died.
- Failure to control ascites, patient died of cirrhosis of the liver.
- Failure to diagnose ankle fractures, which were noted at re-attendance.
- Failure to diagnose broken wrist.
- Failure to remove foreign body from cut hand.
- Failure to diagnose/treat a broken achilles tendon.
- Following repeated prolonged inhalation of Entonox patient sustained a vitamin b12, deficiency which resulted in both physical and psychological injury. **(resulted in a payment of £2,000,000; the joint highest for Q3)**

The majority of these claims relate to Accident and Emergency and specifically are failure to diagnose cases. (In 2015/2016 six of the claims also related to failure to diagnose/misdiagnosis).

<u>Specialist Services Division</u>:

Rheumatology

- Misdiagnosis of rheumatoid arthritis.
- Misdiagnosis of rheumatoid arthritis.
- Misdiagnosis of rheumatoid arthritis.
- Erroneous diagnosis and treatment for lupus.
- Wrongful diagnosis and treatment with medication of psoriatic arthritis.
- Incorrect medications prescribed for treatment of rheumatoid arthritis.
- Incorrect diagnosis of rheumatoid arthritis.
- Misdiagnosis of and treatment for psoriatic spondyloarthropathy.

Orthopaedic

- Patient had operation for repair of fracture cancelled on two occasions. Following operation patient was re-admitted with deterioration and died.
- Failure to note that fracture was not healing following surgery, failure to refer for second opinion and treatment, failure to note fracture was progressing towards non union, as no evidence of callus formation and there was a progressive drift of fracture into recurvatum and valgus malalignment.
- Out of area patient referred for operation to insert an ulna head which has an lead to an unsatisfactory result.
- Poor outcome following hip surgery. **(resulted in a payment of £350,000; the highest for Q2)**
- Following bilateral hip replacement/revision there was a failure to carry out timely repair of snapped wires, leading to muscle wastage.

When any claim is settled a briefing report is prepared by the Head of Legal Services or the Legal Services and Inquest Liaison Assistant. The report provides a synopsis of the claim, the reasons for settlement, and where lessons can be learnt. These reports are then discussed at the weekly Executive Scrutiny Committee and shared with the appropriate Divisions via the Corporate QEC agenda. On occasions the Head of Legal Services will attend the Divisional DQECs to present these reports. The reports are also issued weekly with the Teleconference notes by the Patient Safety Manager.

4. EMPLOYERS AND PUBLIC LIABILITY CLAIMS

The Trust is a member of the NHS Resolution Liabilities to Third Parties Scheme (LTPS); a contributory scheme which provides financial assistance to Trust's in meeting damages and solicitors' costs in respect of Employers and Public Liability claims. Unlike CNST, all cases are referred to the NHS Resolution at the outset of the claim and the Trust itself is responsible for meeting the first £10,000 of each claim (including defence costs in cases successfully defended).

4.1 Employers Liability Claims

Table 3 provides details of new Employers Liability claims notified to the Trust since 2012/2013. Over the last few years the number of Employers Liability claims has been steadily increasing, however for the first time in four years we have seen a significant reduction in the number of claims brought against the Trust. This is also reflected in Graph 2 above which shows a reduction in the number of non-clinical claims received by the NHS Resolution.

Reporting Year	Number of Cases
2012/2013	17
2013/2014	20
2014/2015	31
2015/2016	16
2016/2017	14

Table 3

The reason for the reduction in non-clinical claims is likely due to the introduction of the NHS Resolution's online portal system for Employers Liability and Public Liability claims. The portal brought about fixed costs for claimant lawyers, making these claims less attractive as they can no longer claim hourly rates and excessive charges.

Table 4 below shows the number of Employers' Liability claims (per quarter) against the Trust during for the period of 1 April 2016 and 31 March 2017, and the total payment to the claimants and their solicitors.

Report Quarter	New	Closed	Cases Resulting in Payment to the Claimant	Total Value Settled Claims Damages	Total Value Claimant's Solicitors Costs	Total Value of Payment made by The Trust
Q1 April to June 2016	4	1	0	0	0	0
Q2 July to September 2016	4	3	1	£2,000	£1,560	£3,560

Q3 October to December 2016	4	9	4	£10,050	£16,596	£26,646
Q4 January to March 2017	2	6	1	£2,650	£7,131	£9,781

Table 4

The majority of cases where payment was made related to the following:

- Slips/Trips/Falls (20%) – *down from 33% in 2015/2016*
- Injuries caused by object / equipment (40%) – *up from 20% in 2015/2016*
- Lifting/handling/manoeuvring (20%) – the same as in 2015/2016
- Sharps Injuries (20%) – nil in 2015/2016

Although there has been a slight reduction in the number of non-clinical claims brought against the Trust in 2016/2017, the amount of damages (and claimant solicitor's costs) paid has reduced by over £200,000 due to a number in the reduction of settled claims in the last financial year. It is therefore crucial that we continue to learn lessons wherever possible.

When a claim is settled a briefing report is prepared by the Head of Legal Services or the Legal Services and Inquest Liaison Assistant. The report sets out the reason for settlement, and where lessons can be learnt. These reports are discussed at the weekly Executive Scrutiny Committee and then sent directly to a delegated person within the Division for action to be undertaken, and assurance provided that risk of future injury has been mitigated. They are also shared on the Corporate QEC agenda. Employers Liability claims will also now be monitored through the Occupational Safety and Health Committee.

4.2 Public Liability Claims

Table 5 indicates the number of Public Liability claims received by the Trust since 2012/2013.

Reporting Year	Number of Cases Notified
2012/2013	2
2013/2014	4
2014/2015	7
2015/2016	4
2016/2017	3

Table 5

The Table above shows that there has also been a reduction in the number of Public Liability claims over the last twelve months (for the second time in four years). The likely reason for the reduction is attributable to the introduction of fixed costs via the NHS Resolution portal.

Table 6 details new and settled Public Liability claims from 1 April 2016 to 31 March 2017 including the value of the claim and the Claimant's Solicitors costs.

Report Quarter	New	Closed	Settled	Total Value Settled Claims	Total Value Claimant's Solicitors Costs
Q1 April to June 2016	0	0	0	0	0

Report Quarter	New	Closed	Settled	Total Value Settled Claims	Total Value Claimant's Solicitors Costs
Q2 July to September 2016	0	0	0	0	0
Q3 October to December 2016	0	1	0	0	0
Q4 January to March 2017	3	2	1	£1,200	£5,551

Table 6

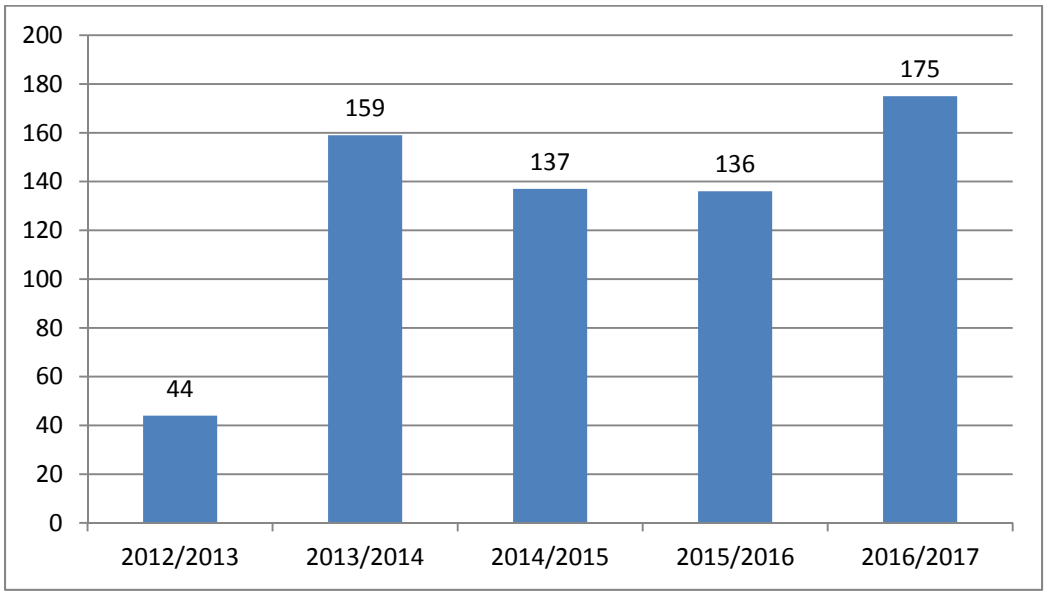
5. HM CORONER'S INQUESTS

HM Coroner will notify the Department of any upcoming inquests where the death of the patient occurred in the Trust, or where the patient had been treated by the Trust prior to death. Upon request by HM Coroner, the Department is responsible for obtaining statements from relevant members of staff and for these to be submitted to the Coroner's office. HM Coroner will then decide if that clinician is required to be present at the inquest itself, or if their statement can be read as documentary evidence under Rule 37 of the Coroner's Rules.

The Head of Legal Services is responsible for assisting members of staff in the preparation of those statements and attendance at inquest if necessary. However where it is felt that there may be potential issues which could affect the Trust, or attract adverse publicity, the Head of Legal Services is obliged to notify the NHS Resolution of the upcoming inquest and can request NHS Resolution funding. If approved, the NHS Resolution will then instruct external solicitors to represent the Trust at the hearing. The Head of Legal Services may also seek specialist advice from external solicitors on other issues relating to upcoming inquests, at all times ensuring the legal costs are propionate to the advice sought.

Graph 3 below provides a breakdown of the number of inquests received by the Trust during the period of 1 April 2012 to 31 March 2017.

New Inquests Received



Graph 3

The above graph indicates that the number of new inquests the Department has received remains consistent from last year, however the number of Trust staff required to attend and give evidence at inquest hearings has increased (further details regarding this is provided under section 8 below).

Table 5 below demonstrates the number of inquests that were held each quarter during the 2016/2017 financial year.

Report Quarter	New Inquests Notified	Inquests Held	Inquests Attended by Head of Legal Services / External Solicitors
Q1 April to June 2016	37	32	4
Q2 July to September 2016	44	27	3
Q3 October to December 2016	49	36	4
Q4 January to March 2017	45	50	5

Table 5

Every inquest that is held is reported to the weekly Executive Scrutiny Committee where the Head of Legal Services will highlight any actions or concerns that arise out of the hearings. There are a number of common themes, regularly addressed by HM Coroner, which include the following:

- Nursing documentation – writing in retrospect
- Observations not being carried out accurately.
- Failure to perform neuro observations
- Falls Risk Assessments not being calculated properly / not being done
- Poor communication with relatives
- Clinicians failing to accurately record the date and time next to their entries
- Failure to detect signs of sepsis
- Lack of joined up working with external organisations

Regulation 28 Prevention of Future Death Reports (PFDs)

The Trust received two PFD's in 2016/17. The action plans following a PFD are monitored by the Quality and Safety Committee which is chaired by a Non-Executive Director and attended by several members of the Executive team, including the Director of Nursing.

MS (Q2 2016/17)
The PFD in Q2 brought to light failings that had occurred in the management of a patient during the weekend. During the inquest evidence was heard that at weekends the surgical on call team were extremely busy which led to patients, on occasions, not always receiving the standard of treatment they should expect. The Directorate of General Surgery recognised the variation in patient care that existed between weekends and weekdays, and action has been taken accordingly.

The Action Plan details that the Surgical Division has now allocated a middle grade surgeon to undertake a 4 hour ward round for elective patients during weekends.

This means that a middle grade clinician (such as a clinical fellow or surgical registrar) will now perform additional duties at weekends to check on patients who have undergone elective surgery. These middle grades will review the patients and report any concerns to their on-call Consultant. These changes have been made to ensure that the surgical rota for doctors is robust, and also to ensure that these patients receive a daily senior review. By making these changes elective surgical patients are guaranteed to be seen by more experienced clinicians at weekends, thereby allowing junior doctors more time to undertake their other duties. To ensure there are sufficient clinicians to cover the additional ward rounds, the Trust is in the process of recruiting 2 clinical fellows. The changes regarding additional weekend working is being monitored through the Trust's Surgical Clinical Cabinet. The Cabinet is chaired by the Trust's Medical Director and is attended by senior representatives of the Surgical Division responsible for implementing these changes.

In addition to the above, it was evident at inquest that staff did not appear to understand how the MEWS chart should be scored, and additional training for nursing staff would be required.

Since the conclusion of the inquest the Trust has provided extensive training programmes both in the accuracy and recording of MEWS and fluid balance, but also in recognising and responding appropriately to the early signs of deterioration in patients, including sepsis. The Action Plan provides extensive evidence of the teaching sessions held to date, and those sessions will continue on a monthly basis for all Trust staff involved in patient care.

Firstly, with regards to training of the MEWS tool this has been led by the Trust's Critical Care Outreach Lead, through the QUEST programme. This programme trains nursing staff on the use of the MEWS Tool, and highlights the importance of accurate scoring. A dedicated Critical Care Outreach Nurse also undertakes monthly audits of compliance with MEWS standards. The results are fed back to Ward Managers and Heads of Nursing for action to be taken, wherever necessary. They are also monitored through the Trust's Harm Free Care Board.

In addition to this, the Trust's Director of Nursing, has established since the inquest, and is currently chair of, a dedicated Task and Finish Group to oversee the use of the MEWS Tool. The Group meets on a monthly basis to discuss the audit findings and to monitor compliance and accuracy of scoring.

Secondly, extensive training programmes have also been held in recognising and responding appropriately to early signs of deterioration in patients, including sepsis. This training has been led by the Trust's dedicated Sepsis Specialist Nurse through attendance at the Trust's Sepsis Study Day and arrangements are in place to make this training mandatory for all nursing staff.

A number of Sepsis 'Drop-In' sessions were arranged specifically for nursing staff. These sessions have focused on sepsis recognition, understanding the sepsis screening tool and sepsis management.

In addition to the above, the Trust also has in place the Acute Illness Management (AIMS) course that focuses on the recognition of the acutely unwell deteriorating patient, and how they should be managed. Training on sepsis is also contained within this course.

Management of sepsis is audited on a monthly basis and the results are contained within the attached Sepsis Dashboards. These audits show improvements in sepsis screening, and also with the use of the Sepsis Six pathway within the Trust's A&E Department.

PS (Q3 2016/17)
In respect of the PFD in Q3, HM Coroner requested that a review was undertaken of policies and procedures in place at Wrightington, Wigan and Leigh NHS Foundation Trust dealing with communication between doctors caring for a patient, when there is shared care in place between the Cardiology and the Surgical teams.

Since the conclusion of the inquest the Trust has worked to ensure lessons have been learnt from the events surrounding this patient's death. A copy of PFD report was sent in the first instance to the Trust's Acting Medical Directors and the treating Consultant. The concerns raised in respect of shared care were also discussed at the Trust's Clinical Advisory Board (CAB) on 7 December 2016. In addition the Acting Medical Director asked a Cardiology Consultant colleague, to review the care provided to the patient, and to consider whether the lack of communication between the surgical and cardiology teams had had any detrimental impact. A formal response was provided to the Trust's Medical Directors following examination of all the handwritten and electronic clinical records. (Unfortunately it is clear from the audio transcript of the hearing that the treating Consultant did not have access to the CCU (Coronary Care Unit) records at the inquest, as these are held electronically).
The Consultant Cardiologist confirmed that the patient received daily reviews from both teams (surgical and cardiac), however no direct communication between the two teams was documented to have taken place, nor was there any documentation to indicate that either team had encountered any difficulties in attempting to contact the other. Both teams were able to review and comment on each other's documented management plans.
Having reviewed the records, the Consultant colleague was satisfied that the absence of direct communication between the two clinical teams did not contribute to the deceased's demise. It appears that both teams were satisfied with each other's management plans and documentation, and therefore there was no indication to have a direct discussion.

Following discussions at the Trust's Clinical Advisory Board, it was agreed that much of the requirement for communication within shared care falls under the remit of the GMC's (General Medical Council) 'Good Medical Practice' which all clinicians are required to adhere to. Under section 11, in respect of communication within and between teams, the GMC states as follows:

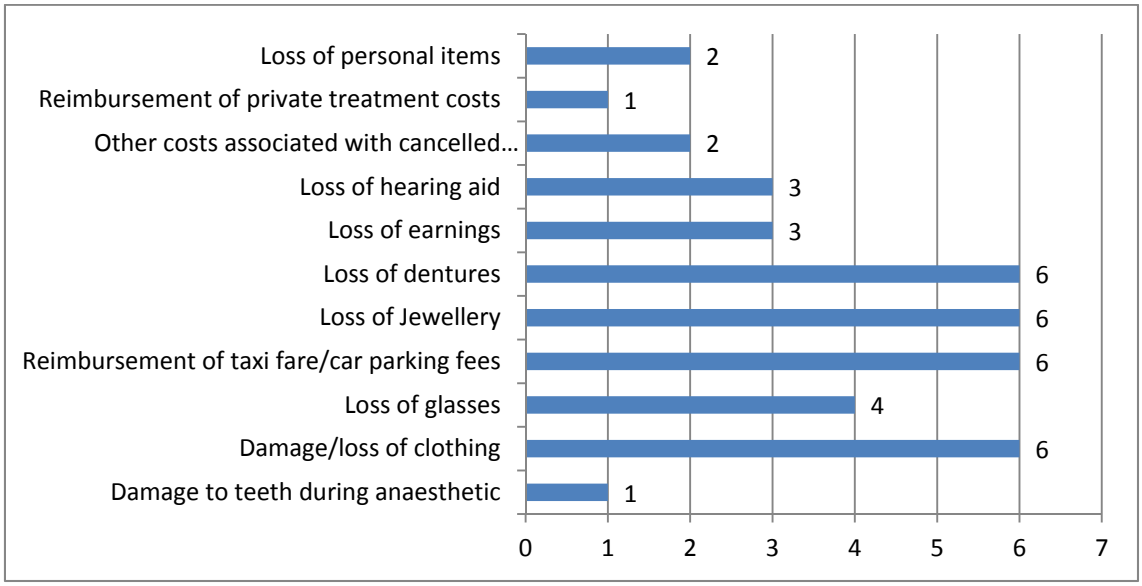
"You must make sure that you communicate relevant information clearly to:
a. colleagues in your team
b. colleagues in other services with which you work
c. patients and those close to them in a way that they can understand, including who to contact if they have questions or concerns. This is particularly important when patient care is shared between teams."

However it is accepted that there are occasions when shared care is not as easy, particularly when Consultant cover changes on a daily basis. This can be challenging in terms of communication between teams, and it is then crucial that teams agree some fundamental principles such as ceilings of care, and who communications directly with the patient and their families.

In that respect the Trust's Responsible Officer was asked to draft a guidance note in respect of shared care for circulation within the Trust to remind clinical staff of their responsibilities. This was distributed amongst clinical staff and uploaded to the Trust's policy library for future reference. This will ensure that there is consistent communication between healthcare professionals when dealing with patients under shared care, such as cardiology and surgery.

6. EX-GRATIA PAYMENTS

In 2016/2017 the Department received 40 ex-gratia payment requests. A breakdown of the reason for the request for payment is provided in Graph 4.



Graph 4

Table 6 below provides a breakdown of the requests made and settled since 2012/2013. There has been a reduction in the number of ex-gratia claims in the last two years, and also a reduction in the amount of reimbursements made.

Year	Number of Requests	Number of Requests Paid	Percentage	Total Paid
2012/2013	35	14	40%	£4,247.33
2013/2014	41	22	54%	£10,277.94
2014/2015	32	10	32%	£2,100.62
2015/2016	24	9 (1 item located)	37.5%	£1,682.00
2016/2017	40	13 (17 closed and 23 still live)	32.5%	£3,095.99

Table 6

From the information above it is evident that the majority of ex-gratia claims relate to items that have gone missing or lost on the wards (primarily clothing, jewellery and dentures). The Department cannot begin to defend these claims if patients have not signed disclaimers on admission (see section 8 below for further details).

7. HEALTHCARE ADVISORY WORK

The Head of Legal Services also provides advice on a wide range of legal issues, including healthcare advisory matters, disclosure of records, contract law and Freedom of Information Requests. Lectures have also been given recently on the issues flowing from the High Court ruling on Montgomery.

Healthcare advisory work will be kept “in-house” and dealt with by the Head of Legal Services. If more specialist knowledge is required, it may be necessary at times to refer work to the Trust’s external solicitors. At all times the Head of Legal Services will ensure the fees incurred are proportionate to the work undertaken.

In 2015/2016 there has been a significant reduction in the amount of money spent on instructing external solicitors as shown in Table 7 below. The Head of Legal Services has endeavoured to keep costs to a minimum by dealing with matters in-house wherever possible. The Head of Legal Services has also developed a Standard Operating Procedure (SOP) for the instruction of external legal advice. This is to ensure there is a centralised approach that can be managed and monitored more closely.

Legal Spend

	Healthcare Advisory	**Commercial and Property**	**Employment**	**Grand Total**
2013-2014	£89,545.44	£84,240	£24,818.57	**£198,604.01**
2014-2015	£60,279.37	£161,243.30	£18,072.48	**£239,595.15**
2015-2016	£41,172.06	£44,002.70	£21,221.40	**£106,396.16**
2016-2017	£22,725.73	£50,915.61	£8,436.76	**£82,078.10**

Table 7

8. RISK MANAGEMENT ISSUES

The three key risk management issues have been identified as follows:

8.1 Increased Attendance at Inquests

Although the number of new inquests received by the Department has remained consistent from last year, the number of Trust staff required to attend and give evidence at inquest hearings has decreased, which is likely due to the ongoing discussions with the Coroner regarding witness attendance.

2013/2014: 188 staff attendances
2014/2015: 215 staff attendances
2015/2016: 223 staff attendances
2016/2017: 140 staff attendances

We will continue to monitor the number of witnesses required to attend an Inquest. From a financial perspective, every clinic or theatre list that is cancelled results in a financial loss to the Trust. More importantly from a patient safety perspective, increased attendance at inquests has resulted in more clinical staff having to be away from the hospital site.

A meeting with HM Coroner was held in April 2017 with the Associate Medical Director for Paediatrics during which it was noted that there has a been a significant decrease in staff attending Inquests relating to fractured neck of femurs, there was also discussion regarding the use of HIS by both Coroners and Trust staff in the Courtroom. Discussions are ongoing on the use of HIS at Inquests and a further update can be provided in due course.

8.2 Learning Lessons

In 2016/2017 the Department has seen a reduction in the number of clinical and non-clinical claims for the second time in four years. Nevertheless it is essential that we continue to learn lessons wherever possible to try and reduce the number of claims brought against the organisation.

As indicated above, a briefing report is prepared for every claim that is settled providing a synopsis of the claim, reasons for settlement, and where lessons can be learnt. These are distributed to the Divisions accordingly.

The Department would like to seek assurance that these reports are discussed at a divisional level and actions put into place to learn from wherever possible.

8.3 Completion of Disclaimers

The Department has seen an increase in the number of ex-gratia payments in 2016/2017, the majority of reimbursements made relate to items that have gone missing or lost on the wards. The Department is unable to attempt to defend these claims if disclaimers have not been signed by the patient or their relatives. The Trust will therefore be ultimately liable for these items to be reimbursed.

The average payment for replacement dentures is in the region of £500, and the Department has seen recent requests for replacement hearing aids in the value of £2,000. In addition, there has been a rise in patients claiming for lost jewellery and taxi fares/parking fees due to mix up in appointments.

Better care of patient's belongings is the priority as this will ultimately result in a better patient experience. However even when the Trust considers it is not responsible for the missing items, these claims are very difficult to defend without a properly completed disclaimer.

The Head of Legal Services has highlighted this risk to the Heads of Nursing who have agreed to communicate this throughout the wards.

9. IMPROVEMENTS IN 2016/17

The following actions have been implemented in 2016/17 in order to progress and sustain the development of the Department:

- The Trust procured Hempsons as its Trust Solicitors in July 2016 (Weightmans remain the Trust's NHS Resolution Panel Solicitors). There was a smooth transition and a positive change in the provision of legal advice. Hempsons supported the Trust to cover the maternity leave of the Head of Legal Services.

- The Legal Services Department has been working closely with the Patient Relations Team and the Patient Safety Teams to ensure triangulation between Inquests, Complaints and internal Trust Investigations to ensure a joined up approach and to enable issues to be investigated in a thorough and expeditious manner.
- Within the Legal Services Annual Report 2014/2015 one of the risk management issues identified was the increase in claims and litigation. The number of clinical claims and litigation in 2016/2017 has remained constant from the previous year.
  The Legal Department will continue to endeavour to reduce the number of clinical and non-clinical claims brought against the Trust.
- The Head of Legal Services (and in her absence the Legal Services and Inquest Liaison Assistant) continues to attend the weekly Executive Scrutiny Committee. At this meeting all new and held HM Coroner's inquests, as well as all new and settled clinical and non-clinical claims are discussed, so that appropriate action can be taken. The Heads of Governance now also attend these weekly meetings to ensure that actions can be escalated straight to the appropriate Divisions without delay. Briefing reports for all settled clinical and non-clinical claims are now shared directly with the Divisions for learning.

10. LOOKING AHEAD TO 2017/2018

- Datix training is being provided to the Legal Services Department to promote better understanding of the electronic incident, complaint and claims processes. There will continue to be strong collaborative working between the Department, Patient Relations and Patient Safety team.
- The Head of Legal Services will now be attending the Occupational Safety and Health Committee to ensure key themes from non-clinical claims are discussed, so that lessons can be learnt wherever possible.
- In light of the increased attendance of staff at inquests, the Head of Legal Services is also looking to hold a Trust wide training day specifically around inquest attendance. The Department will look to invite external legal providers, as well as local HM Coroners, to present and provide updated legal training.
- The Head of Legal Services and Associate Director of Governance and Assurance will be reviewing the SOP for the handling of Ex-Gratia claims, Employer's Liability claims and Clinical Negligence claims to ensure that these are fully up to date. These policies will then be put before PARC for approval.
- The Legal Department is moving towards a more paper light based system where all correspondence and documentation is scanned electronically or saved to disc to reduce the number of paper files requiring storage.
- The Department aims to support the facilitation of the use of HIS at Inquests.
- Following communication from the NHS Resolution in October, 2016, in respect of an Early notification scheme for maternity incidents and maternity contributions whereby the NHS Resolution were working with Trusts to identify suitable indicators to incentivise improvements in maternity safety, they indicated that no changes would be made to maternity contributions for 2017/2018. However, the NHS Resolution continued to work on potential indicators, along with the development of a scheme in relation to early notification of brain injury at birth. This scheme is now up and running and the Legal Services Department has notified the NHS Resolution of a potential claim.