Kennedys

NHS Resolution

Maternity Claims Data & Early Notification Case Themes

@NHSResolution

Presentation Overview

1. NHS Resolution: our priorities and services
2. Data Caveats
3. National claims (All claims & Specialities).
4. Obstetric Claims – National & Regional volume.
5. Obstetric Claims & Causes – National, South East & London.
6. Obstetric Injuries & Injuries – National, South East & London.
7. Summary of Obstetric claims for the South East & London Region.
8. Themes from Early Notification Scheme cases
8. Questions.

NHS Resolution: our priorities and services

New strategic priorities

Deliver fair resolution

Share data and insights as a catalyst for improvement

Collaborate to improve maternity outcomes

Invest in our people and systems to transform our business

Our services

Claims Management
Delivers expertise in handling both clinical and non-clinical claims through our indemnity schemes

Primary Care Appeals
Offers an impartial resolution service for the fair handling of primary care contracting disputes.

Practitioner Performance Advice
Delivering expert advice, support and interventions on the fair management of concerns about the performance of doctors, dentists and pharmacists

Safety and Learning
Supports the NHS, our members and beneficiaries to better understand their claims risk profiles, to target their safety activity while sharing learning across the system to improve patient care

Data caveats

Source

- NHS Resolution Supplementary Account Stats dataset.
- Snapshot date 31.03.23.

Inclusion

- All Clinical Negligence Scheme for Trusts (CNST) claims as of 1st April 2013 to 31st March 2023 in England by incident date.
- All open & closed claims.

Exclusions

- Claims where the injury is yet to be defined, i.e., injury code ‘Not Specified’.
- Claims from the independent sector.
- 12 claims with a NULL region - where the region was not identified at the time of the data was extracted.

Volume & value of all claims in England 2013/14 to 2022/23

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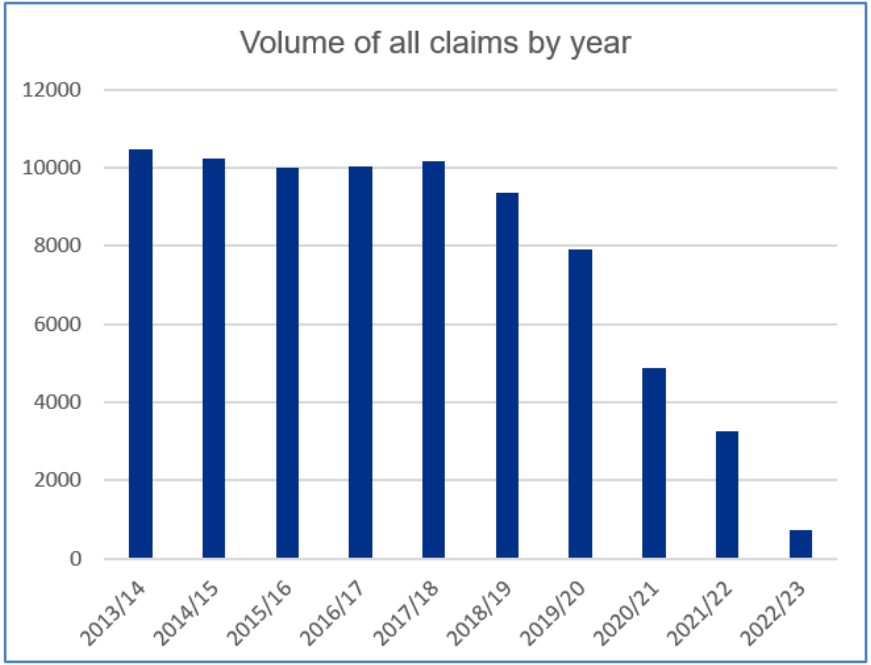
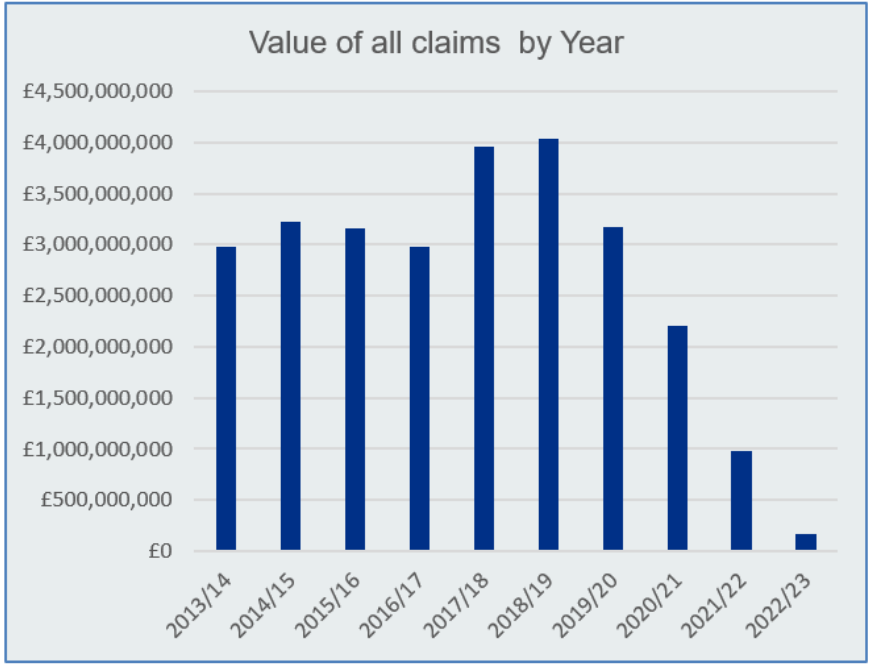
Volume - 77,075 claims



Value - £26.87 Billion



Top 20 Specialities by volume & value 2013/14 to 2022/23

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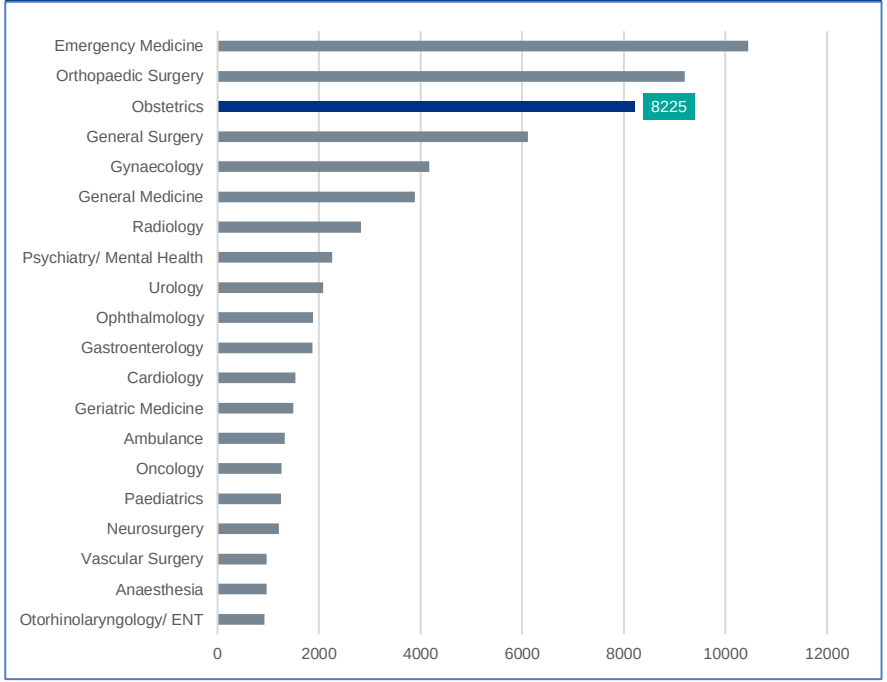
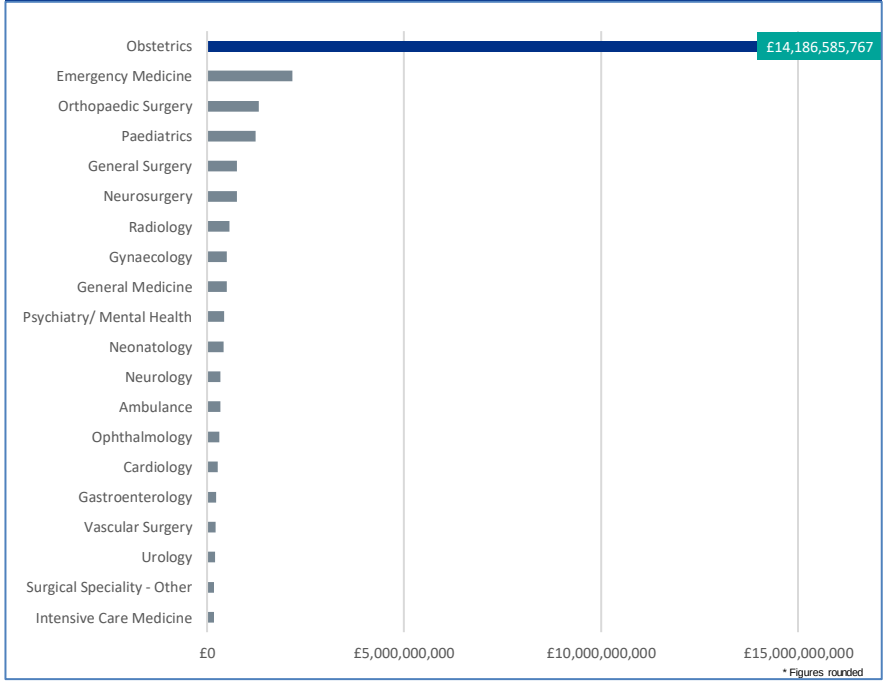
Top 20 by Volume = 63,890 claims

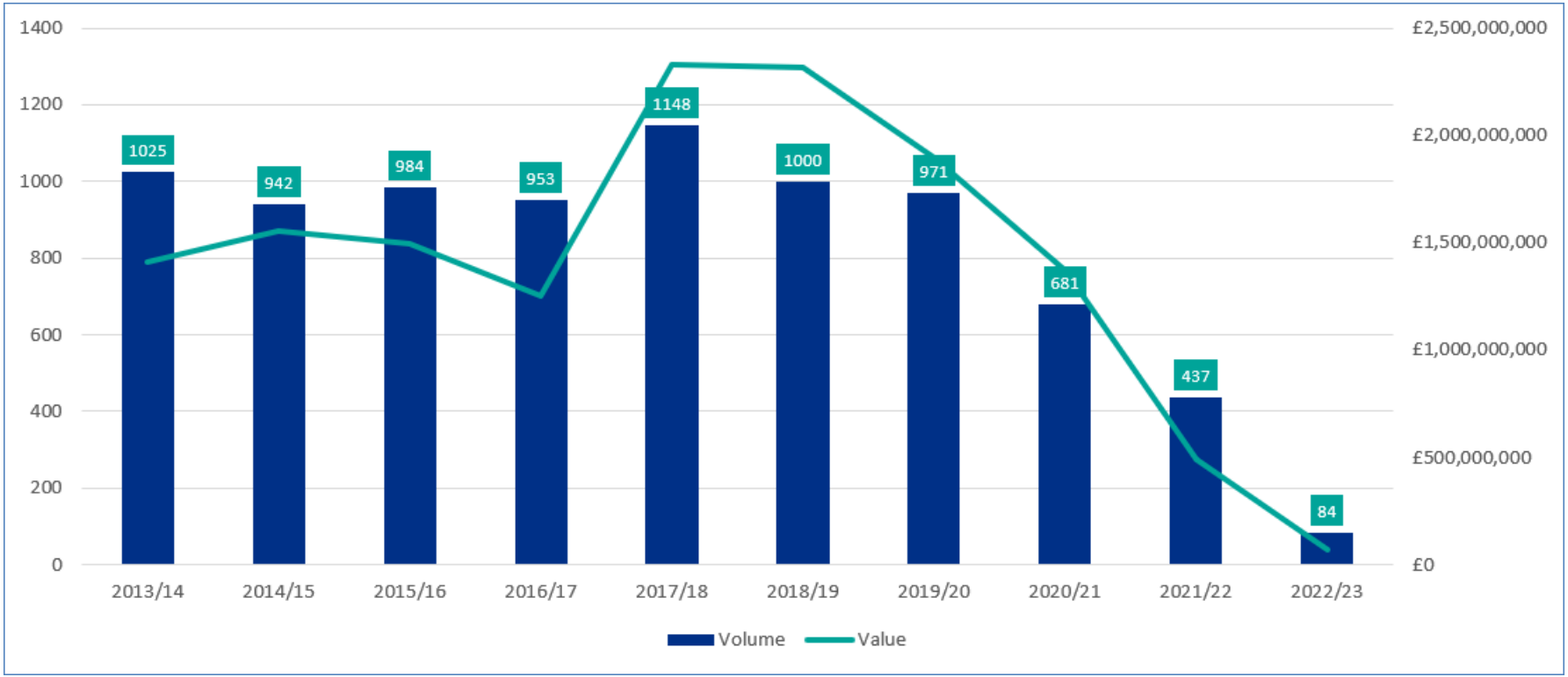


Top 20 by Value (Total claim) = *£25.1 Billion

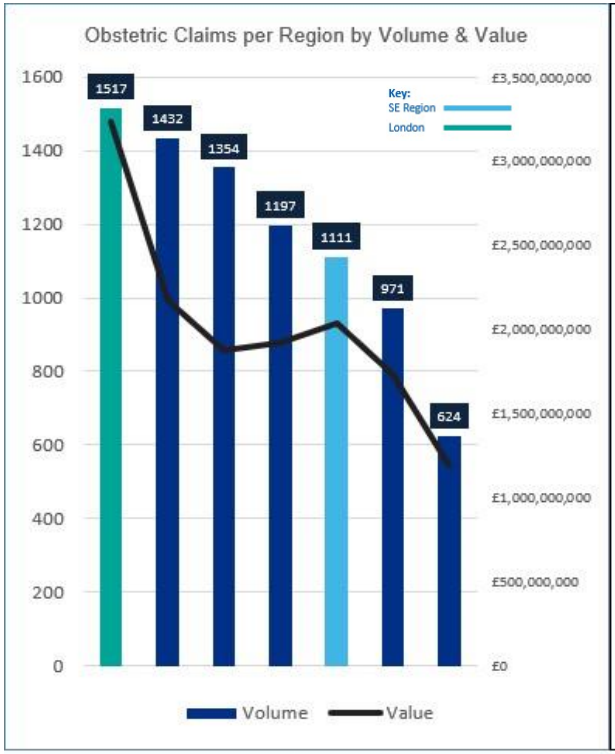


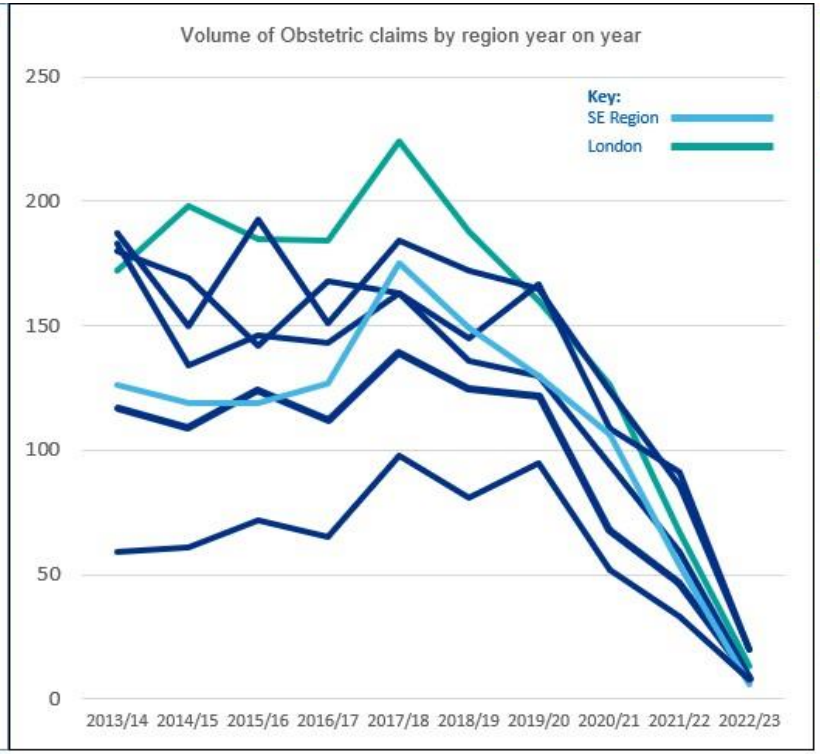
Volume & value of Obstetric claims 2013/14 to 2022/23

NHS Resolution



Regional – Obstetric CNST claims 2013/14 to 2022/23





Region	Population Footprint *	Births 2021**
LONDON	10,579,509	115,279
MIDLANDS	10,658,558	106,696
SOUTH EAST	9,1851,22	88,976
NE & YORKS	8,535,263	86,080
NORTH WEST	7,693,574	76,568
EAST OF ENGLAND	7,082,155	67,551
SOUTH WEST	5,665,799	52,708

Source: * 2023 NHSE Board Paper - Assessment of system readiness * * Perinatal mortality data viewer | MBRRACE-UK (le.ac.uk)

Top 5 Obstetric causes by volume 2013/14 to 2022/23

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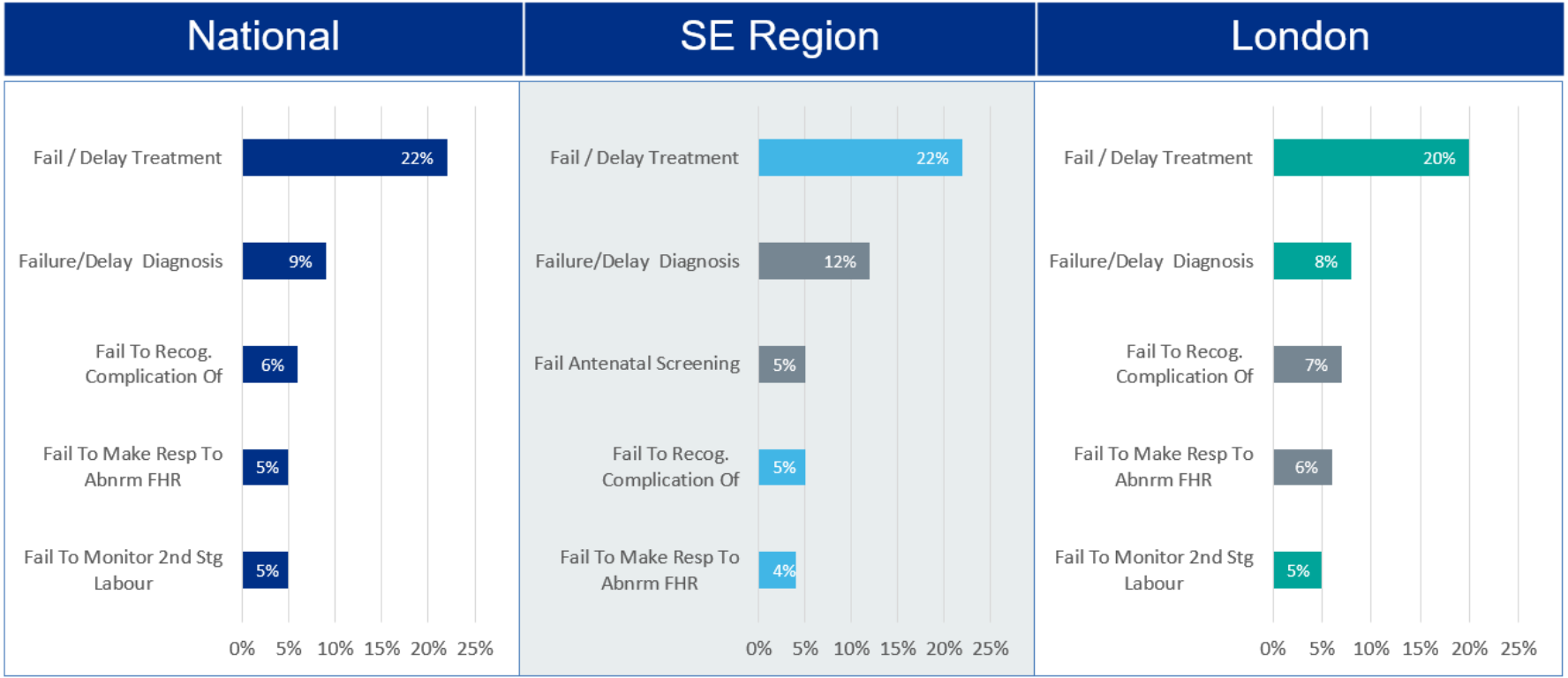

Top 5 Obstetric causes by value 2013/14 to 2022/23

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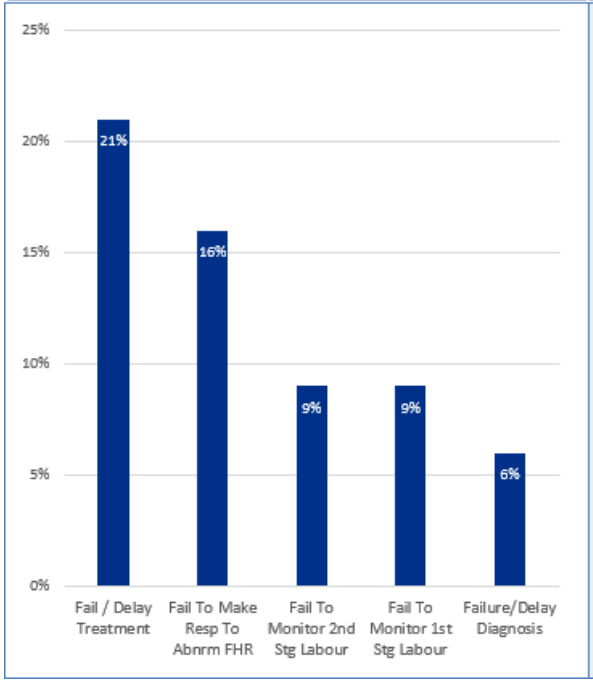
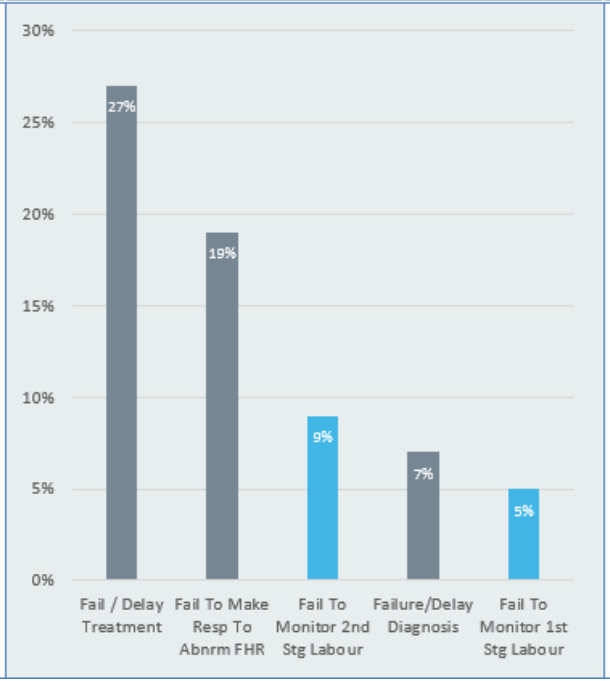
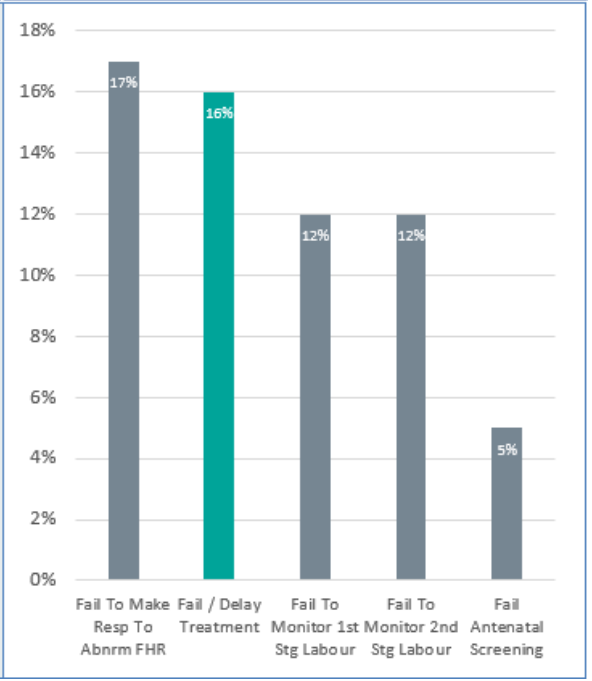
National



SE Region

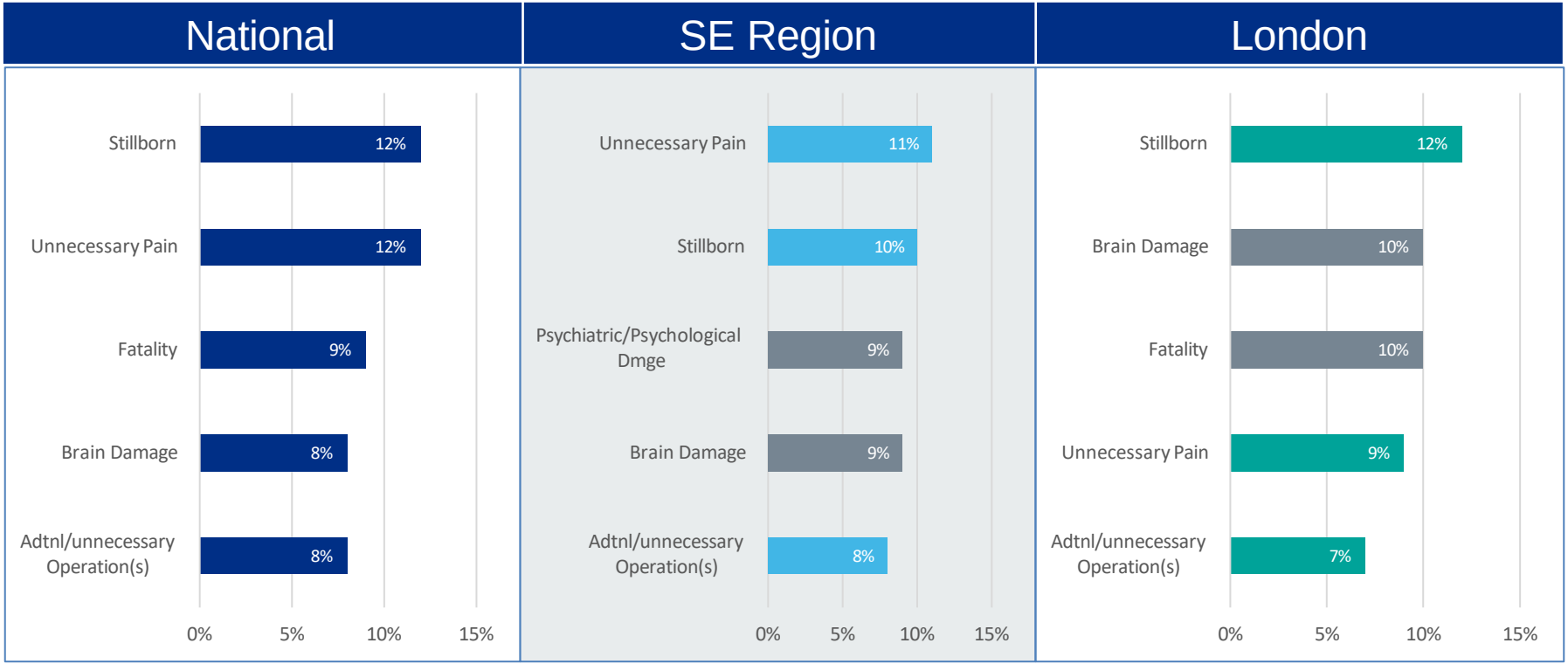


London



Top 5 Obstetric injuries by volume 2013/14 to 2022/23

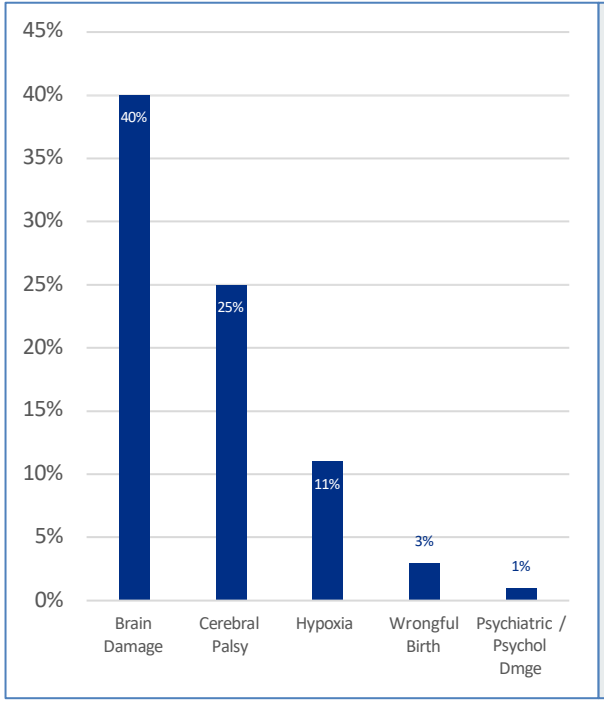
NHS Resolution



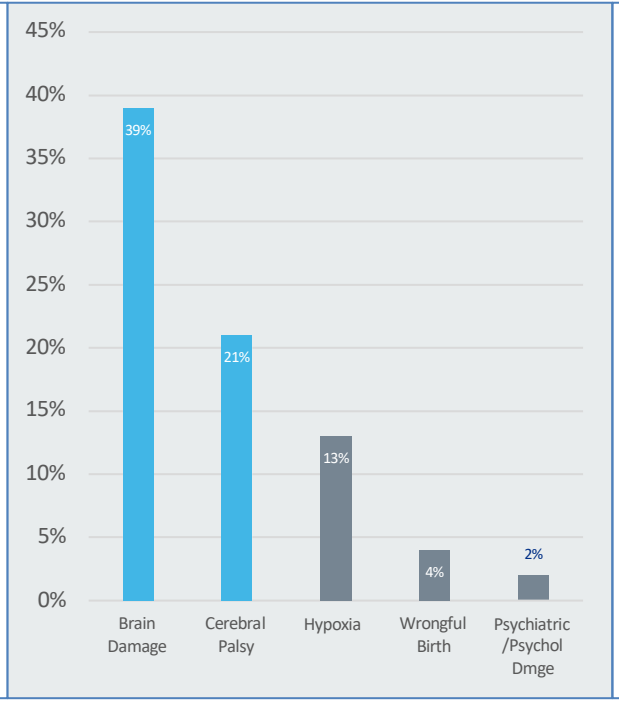
Top 5 Obstetric injuries by value 2013/14 to 2022/23

NHS Resolution

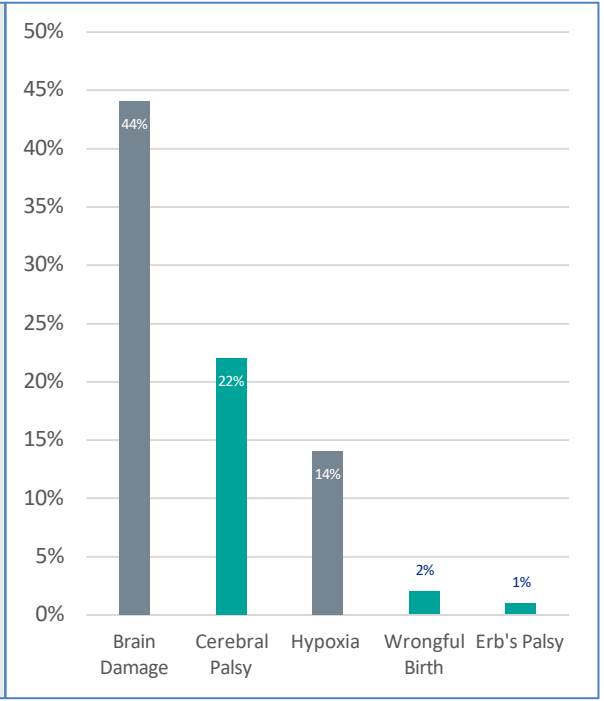
National



SE Region



London



Summary – CNST Obstetric claims

	South East	London
All Claims	Third lowest across all 7 NHS regions, this is contrary to the SE region have the third highest birth & population footprint.	In line with having the highest births & population footprint London also has the highest number of claims in comparison to other regions.
Cause codes	Fail/Delay treatment was the highest cause by volume both for the SE region and nationally, both were 22% of the overall claims. Fail Antenatal Screening' was the third highest cause code by volume in the SE region, this was not in the Top 5 nationally. From a value perspective, there were three cause codes for the SE region that were higher than the national percentage, there were: • 'Fail/Delay treatment', 'Fail To Make Resp To Abnrm FHR' & 'Failure/Delay Diagnosis'.	All Top 5 cause codes align with the national picture for cause of claims. Two cause codes were above the national figure for volume, these were: • Fail To Recog. Complications of. & Fail To Make Resp To Abnorm FHR Fail To Make Resp To Abnorm FHR was also the highest code from a value perspective. This was 17% just above the 16% seen nationally. Both Fail To Monitor 1st and 2nd stage of labour were above the national spend, along with Fail Antenatal screening.
Injury codes	Two injury codes attributed a higher percentage of claims from a volume perspective compared to national claims, there were: • 'Psychiatric/Psychological Dmge' & 'Brain Damage Hypoxia, Wrongful Birth and Psychiartric / Psychological damage were higher than national for the SE region with regards to value	Two injury codes attribute a higher percentage of claims from a volume perspective compared to national claims, there were: • Brain Damage & Fatality And for value Brain Damage and Hypoxia

Next Steps

- Triangulation locally with population heath data and quality metrics.

The Early Notification Scheme

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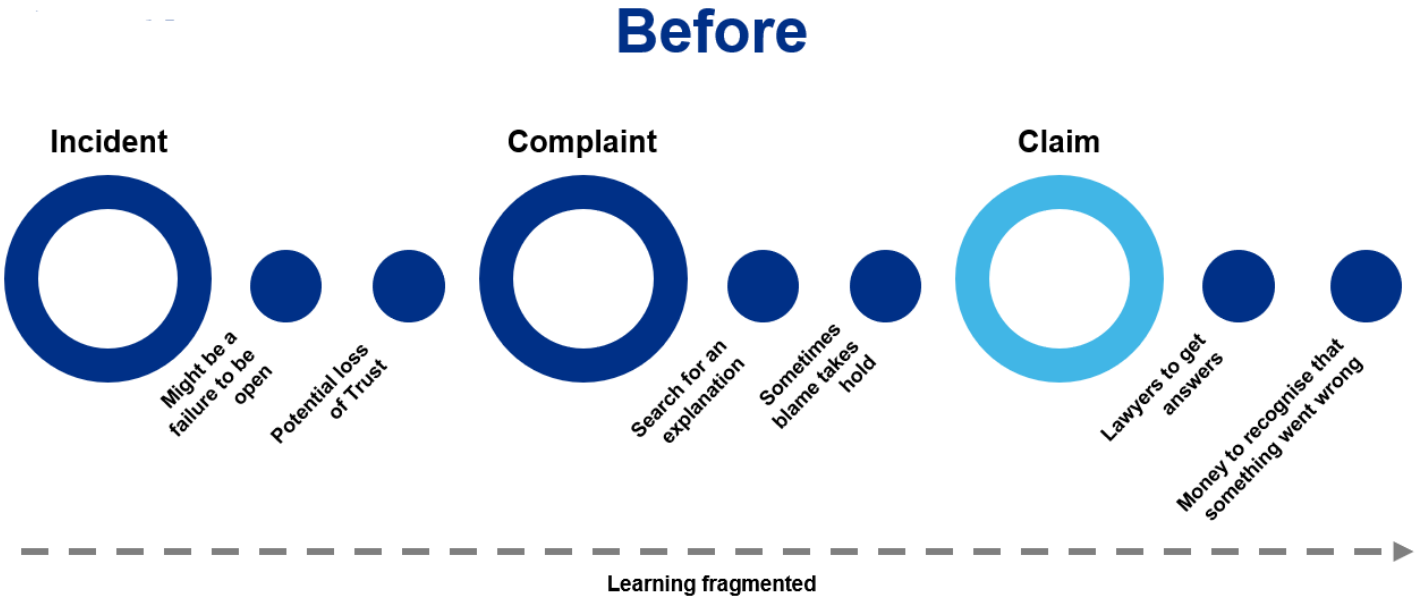
NHS Resolution's EN Scheme proactively investigates specific brain injuries at birth for the purposes of determining if negligence has caused the harm.

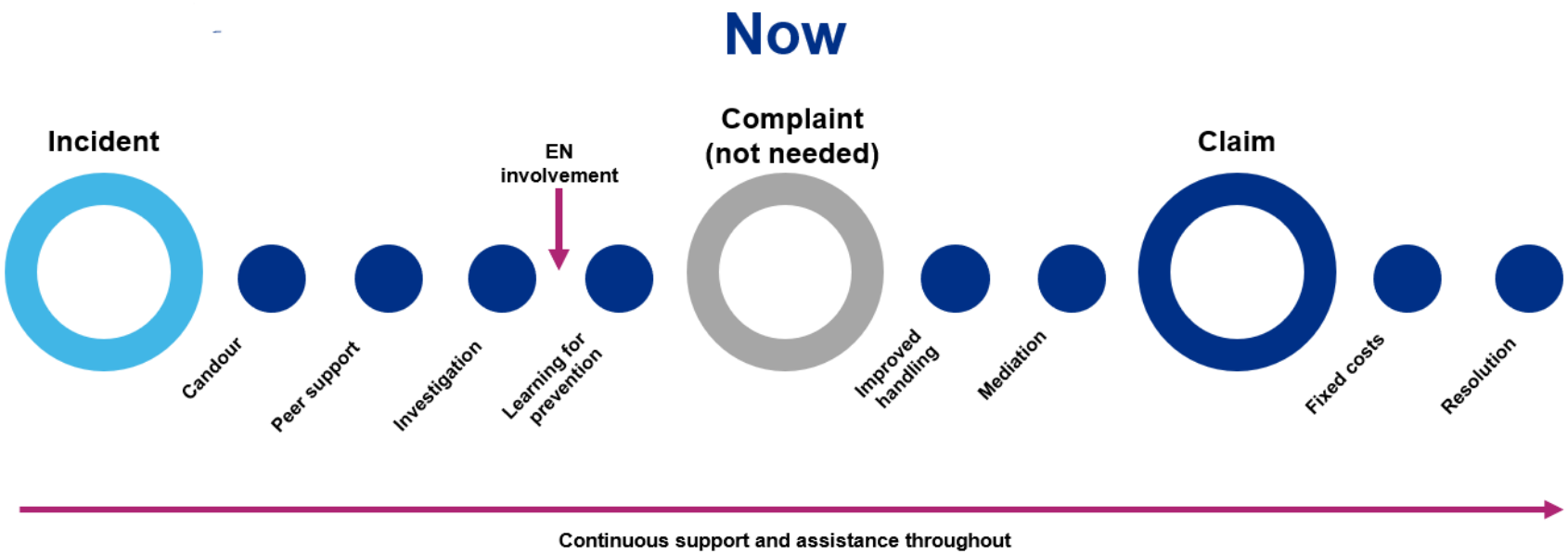
The scheme was established in April 2017 and aims to:
1. Respond to the needs of families where clinical negligence is identified, through the early admission of legal liability and provision of timely compensation where appropriate, and

2. Help ensure that steps are taken to learn when things have gone wrong, to improve maternity care as well as sharing good practice.

Our role – getting closer to the incident



Our role – getting closer to the incident



Learning from the Early Notification Scheme

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Delay in birth:

- Loss of situational awareness – loss of sense of accumulation of time
- Impacted fetal head

Fetal monitoring:

- Delay in recognition and/or escalation
- Delay in acting on an abnormal/pathological CTG or abnormal fetal heart on intermittent auscultation
- Guidelines for monitoring not followed

The following slides include vignettes that are examples of these themes and learning identified from legal claims

Source: The second report: The evolution of the Early Notification Scheme (Sept 2022) & Beyond

Trust A: Impacted Fetal Head

Facts:

- P0+0. T+4 low-risk MLC.
- Uneventful 1st stage of labour until 8cm dilated, when oxytocin infusion commenced due to lack of progress
- **2hrs later:** 9cm, contractions 4-5:10. CTG suspicious.
- **2hrs later:** Anterior lip of cervix, contractions 3:10. CTG suspicious. Plan to increase oxytocin and review in 1hr
- **1hr later:** fetal bradycardia on CTG. VE: anterior lip, head 'at spines ++caput' USS confirmed direct OP. FHR recovered after 5 minutes but CTG remained suspicious. Decision for cat 2 C/S
- **Operation commenced:**
- **3 mins:** 1st attempt to deliver head. Attempt to push up head vaginally unsuccessful.
- **8 mins:** GTN administered. Further attempt to push up head vaginally unsuccessful. Consultant bleeped.
- **12 mins:** Consultant attended. Terbutaline given. Uterine incision extended upwards.
- **14 mins:** Baby delivered in breech position.
- Baby diagnosed with HIE and cerebral palsy, with ongoing care needs

Trust A: Impacted Fetal Head

Actions:

1. Importance of whole system approach
2. Skills training
3. Staffing levels

Trust B: Fetal Monitoring; Delay in Escalation

Facts:

- P0+0 39+5. Low risk pregnancy. Admitted to MAU with constant abdo pain. CTG normal, diagnosed early labour and triaged as suitable for care in MLU and intermittent auscultation (IA)
- Labour progressed, continued constant abdo pain; no abdo palpation performed.
- IA identified drop in baseline FHR from 145bpm to 120bpm
- Mother into pool. FHR 90bpm on IA
- Next FHR 90bpm but not auscultated for full minute after contraction. Remained in pool
- Fetal bradycardia ongoing on next IA. Obstetric review required but delay in getting out of pool and transfer to labour ward
- Baby subsequently born in poor condition. Later diagnosed with cerebral palsy

Trust B: Fetal Monitoring; Delay in Escalation

Actions:

1. Abdominal examination on admission to Midwifery Led Unit (MLU) + CTG
2. Deceleration + Further consideration of CTG
3. Prolonged Bradycardia + Prioritising

Trust C: Fetal Monitoring; Incorrect CTG Classification

Facts:

- P0. Uneventful pregnancy. Spontaneous labour at 37+0. Rapid progress in 1st stage. CTG normal throughout
- Delay in 2nd stage: no descent after 1-hour active pushing from onset of 2nd stage:
- CTG difficult to interpret from onset of 2nd stage: Possible FHR 160bpm with decelerations, possible normal baseline with accelerations. Midwife categorised it as normal. Later review identified CTG as pathological
- Oxytocin commenced as contractions reduced. CTG categorised as normal
- Pushing continued for further 1 hour with no further descent. CTG baseline evident as 165bpm with persistent variable decelerations to120bpm.
- Delivered by cat 2 C/S 45 minutes later
- Baby born in poor condition, requiring resuscitation and diagnosed with severe HIE on MRI

Trust C: Fetal Monitoring; Incorrect CTG Classification

Actions:

1. Protected time for learning
2. Improved CTG interpretation training

Themes

Impacted fetal head and fetal monitoring resulting in delayed delivery

Multiple reasons e.g.

- Delay in recognition
- Delay in escalation
- Delivery Units acuity
- Availability of key staff and communication between staff
- Availability of equipment or delay in abandoning instrumental delivery
- Availability of theatres or overuse of conservative measures
- Loss of situational awareness

EN report recommendations and system level work

National and local level approach for the following:

1. Improving antenatal counselling

- Standardised approach to informed decision-making tools
- Tools for intrapartum fetal monitoring

2. Improving response to harm for families and staff

- Combined efforts of NHS Resolution (including Maternity Voices Advisory Group), NHS England, Maternity and Newborn Safety Investigations (MNSI) programme (hosted by the Care Quality Commission (CQC) since October 2023)
- NHS Resolution Patient Safety Events and Publications

3. Improving collaboration between legal services, maternity teams and risk teams

- Insight from Obstetric Clinical Lead and Director/Head of Midwifery
- Adoption of Patient Safety Incident Response Framework (PSIRF)
- Action plans for improvements agreed and put in place

Questions

Thank you for listening

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