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12 May 2022

The Rt Hon Sajid Javid MP
Secretary of State for Health and Social Care
39 Victoria Street
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Dear Rt Hon Sajid Javid MP

Ockenden Final Report and NHS Resolution's past and ongoing work

Thank you for your letter requesting NHS Resolution to critically review its activity over the period of the report (between the years 2000 and 2019) with consideration to any changes necessary in light of the findings.

NHS Resolution is committed to supporting the maternity, regulatory and national commissioning systems towards achieving the National Maternity Safety Ambition to halve rates of stillbirth, neonatal and maternal death and brain injuries that occur during or shortly after birth by 2025. We welcome the findings and recommendations of Donna Ockenden's Final Report into the maternity failures at Shrewsbury and Telford NHS Trust and are committed to continuing our work to help ensure that all maternity services are of the highest possible quality for all patients. Our thoughts are with all those that have been affected.

NHS Resolution's Board met on 4 May 2022 to discuss the Ockenden report, its recommendations and how we can continue to support the National Ambition. Furthermore, in 2020 NHS Resolution completed an internal review of its Safety and Learning function in the years 2013 to 2020 to analyse our progress in supporting NHS providers to better understand their claims profiles whilst sharing learning. The review highlighted to us the need for a greater focus on maternity which we have embedded into our new Strategy, as outlined in the accompanying paper.

This work was recently expanded to include consideration of each essential action of the Ockenden Report. Our further review of the Ockenden Report also found that, although we have made good headway in recent years, our planned evaluations of the impact of the Maternity Incentive Scheme and Early Notification Scheme will be important to analyse whether we can further improve both schemes to prevent avoidable harm from occurring in maternity services.

I outline in the following paper progress that has been made during the reporting period, using each essential action as a heading, as well as important work that NHS Resolution is undertaking to further support the maternity ambition in light of the recommendations.

Finally, although the NHS remains one of the safest healthcare systems in the world within which to give birth, avoidable errors within maternity can still occur. As the Ockenden report has illustrated, these incidents can have devastating consequences for the child, mother and wider family, as well as the NHS staff involved. NHS Resolution will continue to identify other opportunities where we can improve with consideration to the Ockenden Report's recommendations. We will also work with our system partners to ensure that the Ockenden Report's actions are understood, disseminated and actioned to try to prevent such harm from occurring again.

If there is any additional information that NHS Resolution can provide to support this work please let me know.

Yours sincerely,

Helen Vernon
Chief Executive, NHS Resolution

Introduction

NHS Resolution, previously known as The NHS Litigation Authority (NHSLA), was established in 1995.[1]

NHS Resolution provides expertise to the NHS on resolving concerns and disputes fairly, sharing learning for improvement and preserving resources for patient care. We have four key service areas:

- Claims Management: delivering expertise in handling both clinical and non-clinical claims to members of our Indemnity Schemes.
- Practitioner Performance Advice: providing advice, support and interventions in relation to concerns about the individual performance of Doctors, Dentists and Pharmacists.
- Primary Care Appeals: offering an impartial resolution service for the fair handling of Primary Care contracting services.
- Safety and Learning: supporting the NHS to better understand and learn from claims, concerns and disputes; to target safety activity while sharing learning across the NHS.

NHS Resolution recognises that more needs to be done to support maternity services to learn from mistakes and prevent harm from occurring. As a result of our increasing focus on and activity in maternity safety and the fact that obstetrics claims remain the most significant driver of the clinical negligence liability, in our new Strategy to 2022-25 we have included a specific priority to collaborate to improve maternity outcomes and continue to support the National Maternity Safety Ambition. Our focus to 2025 is now on the following priorities:

1. **Deliver fair resolution.** All of our services will focus on achieving fair and timely resolution, wherever possible keeping patients and healthcare staff out of formal processes to minimise distress and cost.
2. **Share data and insights as a catalyst for improvement.** Ensuring that our unique datasets help derive usable insights that benefit patients and the healthcare and justice systems.
3. **Collaborate to improve maternity outcomes.** Bringing together key parties to determine what further improvements can be made within our areas of expertise to support the government's maternity safety ambition.
4. **Invest in our people and systems to transform our business.**

Whilst NHS Resolution's principle role is the resolution of claims for compensation, we are aware that the optimum time for learning from an incident is as rapidly as possible after it has happened. Patients generally have three years to bring a claim (this will be longer in claims involving minors or adults without mental capacity), the scope to learn from claims can be impacted by time lags. The average time between incident and notification across all clinical claims is 3.1 years, and across obstetric cerebral palsy and brain injury claims is 5.8 years.[2]

NHS Resolution's Early Notification (EN) Scheme for obstetric brain injury, which has been running since 2017, aims to shorten this timescale for certain types of obstetric injuries and thereby increase the scope for learning from compensation claims. Learning from the EN Scheme[3] has started to play an important role in informing improvements made to the safety of maternity services both locally and nationally.

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[1] NHSLA establishment legislation

[2] NHSR (2021). Annual Statistics (Supplementary Annual Statistics, Table 16.A). London. NHSR. Available online at: https://resolution.nhs.uk/wp-content/uploads/2021/11/NHS-Resolution-Supplementary-Annual-Statistics-2020-21.xlsx.

[3] NHSR, The Early Notification scheme progress report: collaboration and improved experience for families (2019)

NHS Resolution's Safety and Learning function and internal review

In 2013, NHS Resolution established the Safety and Learning function with the primary aim of supporting members to learn from claims, identify areas for local improvement in patient, staff and public safety, and help them to reduce avoidable harm.

In March 2017, we published our Strategy to 2022 which included a commitment to "*provide analysis and expert knowledge to the healthcare and civil justice systems, to drive improvement*". Our refreshed 2019-2022 strategic plan *Delivering fair resolution and learning from harm* (February 2020) updated the Strategy across our four strategic aims.

To further embed our Safety and Learning function, Directions came into force on 5 December 2019 which enabled NHS Resolution to carry out its safety and learning functions as part of administering indemnity schemes.[4]

NHS Resolution completed an internal review of its Safety and Learning function from its establishment in 2013 to 2020 to analyse our progress in supporting NHS providers to better understand their claims profiles whilst sharing learning.

This review found evidence of success in meeting the aims of the Safety and Learning function, including:

- The launch of the extranet secure web portal in 2013 for Clinical Negligence Scheme for Trusts (CNST) members to help them improve safety by giving them more information about their claims and providing learning materials.

- The establishment of the Early Notification (EN) Scheme in 2017. NHS Resolution's EN scheme proactively investigates specific brain injuries at birth for the purposes of determining if negligence has caused the harm. We do this by requiring our Clinical Negligence Scheme for Trusts (CNST) members to notify us of maternity incidents which meet a certain clinical definition.[5] The Scheme aims to accelerate liability investigations, improve the patient experience and provide eligible families with faster access to appropriate support.

  Although in its early years, the EN scheme has already achieved reductions in the time between an incident occurring, an investigation into eligibility for compensation being initiated and admissions of liability being made. Seeking earlier notification of incidents means not only that NHS Resolution can proactively investigate liability, but also that trusts are encouraged to be open about incidents, be candid with families and maximise opportunities to learn from them.

  The EN approach has led to rapid learning and recommendations for safety improvement which have been implemented by maternity units to prevent a recurrence. The Year One EN scheme progress report (2019) recommended six key areas for national maternity care improvement based on the findings of the first year of the EN scheme, all of which have progressed. For example, THIS

[4] DHSC, The National Health Service Litigation Authority (Safety and Learning) Directions 2019
[5] NHSR, Early Notification Scheme, Support for NHS trusts or member organisations

Institute are working with RCOG and RCM to develop ways for improving detection and response to fetal deterioration and to improve management of impacted fetal head.[6]

- The first CNST maternity incentive scheme (MIS) was launched in 2017, designed to financially reward trusts who demonstrate full compliance with ten safety actions. Our Maternity Incentive Scheme has nationally agreed safety actions, which have been agreed by the two national maternity champions - Professor Jacqueline Dunkley-Bent, Chief Midwifery Officer in England and Dr Matthew Jolly, National Clinical Director for the Maternity Review and Women's Health. Our interim evaluation of the MIS, published in 2020, suggests that individual trusts have been encouraged to implement safety actions and treat maternity services as high priorities.[7]

- We regularly collaborate and share learning with maternity stakeholders, CQC, GIRFT, NHSE/I, Royal Colleges, and others. For example, we have ccollaborated with Getting It Right First Time (GIRFT) to share data on claims costs with trusts with a view to influencing clinical practice.

- We have published several thematic reports[8] alongside 'Being Fair' guidance and products, to promote a just and learning culture.

- In 2020 additional Safety and Learning posts were established to support each of the seven regions across England. Our claims scorecards form the basis of regional discussion. These are provided to our members annually via our Extranet. The scorecards are designed to help members better understand their claims profile down to a specialty level which allows them to target interventions aimed at improving patient safety.

Alongside successes, the review highlighted a number of areas of potential development and improvement that we considered when creating our new Strategy from 2022. These included NHS Resolution's evolving role in driving improvements to the safety culture of the NHS and an exploration of how we further build on work with our key partners to make sense of our data, including how we work in partnership with others to identify future priorities for learning. We have implemented these reflections in our new Strategy. Consideration of how integrated care systems and new models of care could impact on our work, and the need for NHS Resolution to continually evolve to meet the changing needs of the health and care system was also considered.

We have taken the learning from the review and expanded it over each Essential Action of the Ockenden Report to identify progress that has been made during the reporting period and areas where NHS Resolution might be able to do more.

NHS Resolution's activity in the period 2000 to 2019 relating to the Essential Actions of the Ockenden report and future work plans in light of those recommendations

Our ongoing and future planned work, organised by Essential Action, is outlined below.

[6] https://www.thisinstitute.cam.ac.uk/research-projects/avoiding-brain-injury-in-childbirth-collaboration/
[7] NHSR, Maternity incentive scheme – an interim evaluation (April 2020)
[8] For example: Five years of cerebral palsy claims (2017), Learning from suicide-related claims (2018), Three reports which explore clinical issues that contribute to compensation claims within Emergency Departments (2022)

1. Workforce planning and sustainability

a. Financing a safe maternity workforce

Although NHS Resolution is not responsible for financing and resourcing the NHS workforce, we will continue to support the retention of staff and help to ensure that resources are preserved for healthcare, as outlined below.

Past and ongoing work includes:

- **Support to DHSC:** Work to address the challenge of the rising cost of clinical negligence continues across government and NHS Resolution continues to support this work. We also continue to support the DHSC with the development of its Patient Safety Action Plan, with its response to the Health and Social Care Committee's report into NHS Litigation Reform (2022) and other initiatives. This work aims to ensure that eligible patients and their families get financial compensation in a way that is sustainable for the NHS.

- **Practitioner Performance Advice (PPA)**: Our PPA service works to help to ensure that the NHS workforce is supported and concerns resolved to preserve resources for patient care. Recognising that the data gathered by PPA might have useful learning for the system, especially in terms of the management of the workforce, we have identified opportunities to expand the insights function as outlined below.

- **Just and learning culture:** NHS Resolution is committed to working with our system partners to create a just and learning culture in the NHS. Creating such a positive culture can play a role in tackling a variety of workplace issues such as retention and is key to improving patient safety. In 2018, we released a leaflet entitled *'Saying Sorry'* as part of our work on Duty of Candour. This resource for the workforce highlights that saying sorry meaningfully when things go wrong is vital for everyone involved in an incident, including the patient, their family, carers, and the staff that care for them. In 2019, we published *'Being fair'*; a report which sets out the argument for organisations adopting a more reflective approach to learning from incidents and supporting staff which includes a 'Just and Learning Culture Charter' for organisations to adapt and adopt.

Future work plans include:

- **Managing practitioner performance concerns**: Our PPA service will continue to share more research and insights from our work to manage practitioner performance concerns. We will also continue to improve the management and local resolution of practitioner performance concerns. We will do this by strengthening our approach to the management of behavioural concerns and delivering a range of multi-format learning programmes to upskill the NHS workforce and extending the reach of our Assisted Mediation service through targeted awareness raising. Furthermore, we will work to strengthen our interventions where concerns arise about a team which is not functioning as a result of interpersonal conflict.[9] The Practitioner Performance Advice team has started to explore with the Maternity Safety Support Programme (MSSP) how we might be able to complement existing services to support maternity teams which are experiencing dysfunction owing to poor interpersonal relationships. We also see the opportunity to tailor our team review intervention

[9] NHSR Business Plan 2022/23

specifically for the context of maternity services and are beginning to explore how this might be best taken forward.

- **Exclusions**: In response to the Report of the independent inquiry into the issues raised by Paterson (2020), we have recently published an *Insight* paper looking at ten years of medical exclusions cases reported to the Practitioner Performance Advice service, which captures our learning from exclusions (published 2022). The *Insight* paper is accompanied by a number of resources to aid fair and effective decision making in respect of exclusions.[10] We will continue to disseminate this learning.

- **Just and learning culture:** NHS Resolution will continue to help build a just and learning culture. Key areas of focus for 2022/23 include: delivering training modules on giving meaningful apologies; further promoting our *Being Fair* charter and Duty of candour animation (2022) which offers guidance on the importance of being open and honest; developing the next iteration of the *Being Fair* guidance which will consider response to behavioural concerns; and, working in partnership with key stakeholders including patient representative groups.[11]

b. Training

NHS Resolution will continue to identify opportunities for learning, share our insights and promote best practice.

Past and ongoing work include:

- **Maternity Incentive Scheme (MIS):** NHS Resolution's interim evaluation of the MIS, published in 2020, suggests that individual trusts have been encouraged to implement the safety actions and treat maternity services as high priorities.[12] The MIS is now in its fourth year.

  Since its inception, MIS has had safety actions relating to workforce safety and training. Safety Action 8 of MIS Year Four states: "*Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?"*

  The results of MIS for Years 1 to 3 can be found here. In Year 1, 48 Trusts out of 131 did not meet Safety Action 8's requirements. In Year 2, only nine Trusts did not meet the requirements and in Year 3, three Trusts did not meet the Safety Action 8's requirements. This shows some improvement in meeting this MIS Standard.

[10] https://resolution.nhs.uk/2022/04/28/resources-to-support-the-right-decisions-on-excluding-doctors-and-dentists-published/
[11] NHSR Business Plan 2022/23
[12] NHSR, Maternity incentive scheme – an interim evaluation (April 2020)

- **Resources for learning:** NHS Resolution has produced a range of quality learning resources. The new online Faculty of Learning provides access to a range of learning resources and materials. Current modules within the Faculty include: consent; learning from inquests; point of incident resolution for families and carers; and point of incident resolution for staff. Our thematic review on cerebral palsy has cross system recommendations which have been widely shared and referenced. We will continue to develop the learning resources available. We also regularly collaborate and share learning with maternity stakeholders, CQC, GIRFT, NHSE/I, Royal Colleges, and others.

Future work plans include:

- **Case stories and immersive learning:** To improve how we share our learning from high-value maternity claims, NHS Resolution is currently working collaboratively with academic partners to develop an immersive e-learning module based on common themes identified from our Early Notification (EN) Scheme's clinical reviews. We have written three illustrative case stories, all of which are being developed to provide learners with the opportunity to make decisions about care based on the information they are provided with a view to receiving feedback on the decisions and facilitate learning. The learning will also include information to support learning on the way these incidents are managed from a legal perspective and we plan to publish this on Health Education England's website to increase the reach of these resources to clinicians in training.

- **Compassionate Conversations**: Compassionate Conversations, run by our Practitioner Performance Advice service, is a new, half day, evidence-based learning programme, which is being piloted in 2022. It aims to develop the confidence and capability of managers and clinicians to have a compassionate conversation that is honest and engages with challenging subjects, particularly in relation to practitioner performance. It recognises a recurrent theme, namely that there are ways of approaching performance conversations that make discussions more effective for everyone involved, including the practitioner.

2. Safe staffing: All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals

The reasons behind an incident and claim are often multi-factorial. However, we recognise that safe staffing is important to ensure high-quality maternity care at all times.

Past and ongoing work includes:

- **Maternity Incentive Scheme (MIS):** Safety Actions 4 and 5 state: "Can *you demonstrate an effective system of clinical workforce planning to the required standard*?" and "*Can you demonstrate an effective system of midwifery workforce planning to the required standard?*" Workforce has been a consistent part of the MIS Safety Actions since it was established in 2017. We will continue to assess the Safety Actions each year to help to drive improvements needed in terms of workforce planning where possible.

  In terms of Safety Action 4, in Year 1, one Trust did not meet the Action's requirements compared to four in Year 2 and six in Year 3.

For Safety Action 5, seven Trusts did not meet the requirements of the Action in Years 1, 2 and 3 (please note that the Trusts now did not meet the Action varied from year to year).[13]

Future work includes:

- **Educating the workforce on litigation:** Recognising that in some cases fear of litigation can impact upon recruitment and retention of staff, NHS Resolution's Safety & Learning (S&L) team are currently exploring opportunities where we might be able to change the perception of litigation to ensure that it is not a barrier to learning and does not prevent NHS staff from joining a particular specialty.

3. Escalation and accountability: Staff must be able to escalate concerns if necessary

In terms of escalation and accountability, NHS Resolution considers that its Duty of Candour work is, and continues to be, important.

Past and ongoing work includes:

- **Just and Learning Culture:** As noted above, the importance of a just and learning culture is emphasised in our Duty of Candour work including *Saying Sorry* and *Being Fair* to ensure the process to obtain compensation is not a barrier to openness, candour and learning.

- **Early Notification (EN) Scheme:** The importance of a just and learning culture is also encouraged through our EN Scheme. Early Notification has helped to encourage trusts be open about incidents, be candid with families and maximise opportunities to learn from the incident.

- **Thematic reviews:** Thematic review of claims identify escalation as a key theme and recommend it as an area of improvement in a range of their recommendations. For example, escalation pathways and training is identified in recommendation three and six in our Early Notification Scheme progress report published in 2019. These recommendations were distributed widely across maternity networks.

Future work includes:

- As well as continuing with its Duty of Candour work, NHS Resolution plan to establish a Clinicians' Advisory Group in quarter two of 2022 to support learning organisation principles for clinicians involved in incidents.

4. Clinical governance – leadership: Trust boards must have oversight of the quality and performance of their maternity services

Past and ongoing work includes:

- **Sharing claims information:** NHS Resolution launched the extranet secure web portal in 2013 for Clinical Negligence Scheme for Trusts (CNST) members to help them improve safety by giving them more information about their claims and providing learning materials.

[13] NHSR, Maternity Incentive Scheme Results

NHS Resolution has also collaborated with Getting It Right First Time (GIRFT) to share data on claims costs with trusts with a view to influencing clinical practice. We have coproduced a best practice guide to help trusts learn more from NHS negligence claims in order to drive patient safety for the benefit of patients - Learning from Litigation Claims (2021) – and contributed to GIRFT's 2021 report on Maternity and Gynaecology: GIRFT Programme National Specialty Report.

- **Scorecards**: As noted above, claims scorecards are provided to our members annually via our Extranet. The scorecards are designed to help members better understand their claims profile down to a specialty level which allows them to target interventions aimed at improving patient safety.

  Year 4 MIS Safety Action 9 includes a requirement for Trusts to review NHSR scorecards regarding maternity ("Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?"). To meet the Safety Action, we ask that the Trust provides, as a minimum, "e*vidence that the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions to help target interventions aimed at improving patient safety at least twice in the MIS reporting period at a Trust level quality meeting. This can be a board or directorate level meeting*."

  In Year 1 of MIS, nine Trusts did not meet Safety Action 9. In Year 2, this reduced to five Trusts and in Year 3 rose to 19 Trusts.[14]

Future work includes:

- **Developing internal systems:** Although we have made progress to share our data with system provides with, for example, claims scorecards, one area of improvement for NHS Resolution is to be more data driven. We are therefore developing our capability to derive insights from our unique data sets. Our Core System Programme (CSP) is our largest ever technology transformation which will replace our existing three bespoke legacy core business platforms with one new sustainable platform for the future. We are also making operational changes to ensure we are in a position to share those insights with the system in a more effective way, including by aligning our teams with the NHS' new regional structures.

5. Clinical governance – incident investigation and complaints: Incident investigations must be meaningful for families and staff, and lessons must be learned and implemented in practice in a timely manner

NHS Resolution is not directly involved in complaints or incident investigations. However, given that these can, in some cases, lead to a claim, NHS Resolution works closely with NHS England, the Parliamentary and Health Service Ombudsman and the Healthcare Safety Investigation Branch to try to prevent incidents from reoccurring and to improve the response to complaints which might, if poorly handled lead to claims.[15] When a claim does occur, we aim to deliver fair and timely resolution for all patients and their families whilst sharing data and insights as a catalyst for improvement.

[14] NHSR, Maternity Incentive Scheme Results
[15] NHSR, Behavioural insights into patient motivation to make a claim for clinical negligence (2018)

Past and ongoing work includes:

Early Notification (EN) Scheme: As noted above, NHS Resolution's EN Scheme aims to share learning rapidly with the individual trust and the wider system in order to support safety improvement and prevent the same things happening again.

- **Maternity Incentive Scheme**: Safety Action 10 of MIS states: *"Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) scheme for 2021/22?"*
  In Year 1 of the MIS, two Trusts did not meet Safety Action 10. In Year 2, all Trusts reported full compliance with the Safety Action and in Year 3 two Trusts did not meet the requirements of that Safety Action.[16]

Future work includes:

- **Early Notification (EN) Scheme:** A report evaluating the second year of the scheme is due to be published in May 2022. NHS Resolution will also conduct an assessment of the impact of the scheme to date which will help us to improve and maximise the effectiveness of the existing scheme. Key areas of focus for 2022/23 include: establishing a methodology for evaluating the scheme and developing our approach to assessing and delivering compensation packages in consultation with patients, their representatives and wider system partners.[17] The EN team will continue to work with its Maternity Voices Advisory Group (MVAG) to support developments to the scheme (further information about the MVAG is provided below).

- **2022-2025 Strategy and 2022/23 Business Plan:** Although our primary focus is on investigations to inform an entitlement to compensation, recognising that we can do more in this area, our new Strategy includes the following aim: "*supporting the planned improvements to deliver independent, standardised and family-focused maternity incident investigations that provide learning to the health system at local, regional and national level and help build local capacity and capability to respond to such incidents*". Furthermore, NHS Resolution's 2022/23 Business plan includes the following area of focus: "*supporting the work to establish a new Special Health Authority to deliver independent, standardised and family-focused maternity incident investigations*".

- **Improving written communication with patients who complain:** NHS Resolution is conducting research to provide NHS Resolution's members with practical, evidence-based advice to improve written communication with patients. NHS Resolution will share the findings of the research in Q3 2022/23 with the NHS and will work with the Parliamentary and Health Service Ombudsman to embed the findings into the NHS Complaint Standards Framework in 2023.

6. Learning from maternal deaths: Nationally, all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy-related pathologies

[16] NHSR, Maternity Incentive Scheme Results
[17] NHSR Business Plan 2022/23

NHS Resolution supports this action via its Maternity Incentive Scheme. As part of Safety Action 1 of MIS, Trusts are required to: "*Use the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard."* The aim of the Tool is to support standardised perinatal mortality reviews across NHS maternity and neonatal units in England, Scotland and Wales.

Furthermore, the EN concerns group has membership from the Healthcare Safety Investigation Branch (HSIB) which shares any maternity investigations highlighting concern regarding trusts, which includes still births, neonatal death and maternal deaths.

7. Multidisciplinary training: Staff who work together must train together

As noted above, NHS Resolution encourages appropriate maternity training through the Maternity Incentive Scheme requirements. We will continue to review and improve the MIS Safety Actions annually with our partners.

8. Complex antenatal care: Local maternity systems, maternal medicine networks and trusts must ensure that women have access to pre-conception care

As part of Safety Action 6 of MIS, Trusts are required to "*demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two*." NHS England's care bundle was produced to help reduce perinatal mortality across England. It includes recommendations including to provide 'Safe and Healthy Pregnancy Information' to help women reduce the risks to their baby and to encourage women to take a vitamin supplement before conception and during pregnancy as appropriate, for example folic acid.

9. Preterm birth: The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth

As noted above, NHS Resolution incentivises this recommendation as part of Safety Action 6 of MIS. Trusts are required to "*demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two*."

10. Labour and birth: Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary

As recommended in our EN Scheme Progress Report, THIS Institute are working with RCOG and RCM to develop ways for improving detection and response to fetal deterioration and we continue to identify opportunities for fetal monitoring improvements and the advice provided to women.

11. Obstetric anaesthesia: In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm

An analysis of our claims has shown that anaesthesia remains a medico legally low risk specialty. However, NHS Resolution recognises the importance of obstetric anaesthesia care. Ongoing work in this area includes:

- **Research**: NHS Resolution recently released a paper on Litigation related to Anaesthesia (2022).[18] The analysis provides important insights into current and changing patterns in claim distributions that may aid improvements in quality of patient care and reduce future litigation. The review concludes with a recommendation of the establishment of a structure for national review and learning from all cases of litigation. NHS Resolution will continue to promote the findings of this research.

- **Maternity Incentive Scheme**: There is a requirement for appropriate anesthetic staffing within MIS Safety Action 4: "*Can you demonstrate an effective system of clinical workforce planning to the required standard?*" The required standard for this safety action is for "A *duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (ACSA standard 1.7.2.1)"*

12. Postnatal care: Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review

As noted above, NHS Resolution continues to support safe staffing and the retention of staff, especially through the Maternity Incentive Scheme. In particular, the required standard of Safety Action 4 regarding the Obstetric medical workforce is stated as:

- "*The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service."*
- *"Units should monitor their compliance of consultant attendance for the clinical situations listed in this document when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. Trusts' positions with the requirement should be shared with the Trust board, the board-level safety champions as well as LMS."*

13. Bereavement care: Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services

Since its creation in 2017, the EN Scheme directs patients and families to organisations that can offer support, including Bereavement care.[19] NHS Resolution continues to expand its patient-centered webpages where appropriate.

NHS Resolution is currently exploring a Family Liaison Service role for the Early Notification Scheme to help improve the experience of families who are embarking on a clinical negligence claim. This will focus on families in the EN process and not parents who have suffered pregnancy loss at this stage.

[18] NHSR, Litigation related to Anaesthesia Analysis of Claims report published (2022)
[19] NHSR, Support for Patients, Families or Carers.

14. Neonatal care: There must be clear pathways of care for provision of neonatal care

Recognising the importance of neonatal care, NHS Resolution's ongoing and future work includes:

- **Maternity Incentive Scheme (MIS):** As noted above, the MIS has several actions relating to safe staffing and training in maternity. Two of the required standards for Safety Action 4 ("*Can you demonstrate an effective system of clinical workforce planning to the required standard?*) are:

    - **"*Neonatal medical workforce**: The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If the requirements had not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies. If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies".*

    - ***"Neonatal nursing workforce**: The neonatal unit meets the service specification for neonatal nursing standards. If the requirements had not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies. If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies and share this with the Royal College of Nursing, LMS and Neonatal Operational Delivery Network (ODN) Lead".*

- **Early Notification (EN) Scheme:** Neonatal expertise membership is included in our EN Collaborative Group which is held to share learning for improvement of the scheme.

- **Collaboration**: NHS Resolution is a member of the British Association of Perinatal Medicine's group looking at sudden unexpected collapse of the newborn where we share learning and insights.

- **Thematic reviews:** A thematic review is underway regarding neonatal claims related to Group B Strep. When published, recommendations and learnings from the report will be disseminated.

15. Supporting families: Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provision

One of NHS Resolution's strategic goals is to reduce the distress caused to patients, their families and staff involved when a claim or concern arises. To this end, our ongoing and future work includes:

- **Early Notification (EN) Scheme:** We are currently exploring including a Family Liaison Service role as a part of the EN Scheme to help improve the experience of families whose cases are being progressed within the Early Notification scheme.

    The EN Maternity Voices Advisory Group (MVAG) provides external partners with a forum through which they can share the views of families and support future service developments within the EN scheme. Through this group, families are helping to co-produce patient-facing products or materials

such as template letters for families which provide accessible, sensitive updates that will be tailored to each case and recipient.

- **Alternative dispute resolution (ADR):** NHS Resolution's claims mediation service and use of ADR are designed to support patients, families and NHS staff in working together towards the resolution of incidents, legal claims, costs disputes, and to avoid the potential emotional stress and expense of going to court. They also provide a helpful forum for candid conversations to take place and explanations and apologies to be provided to patients and their families. We have been testing a wide range of alternative dispute resolution (ADR) techniques including 'resolution meetings' and 'stock-take' processes and we will continue to expand and evaluate alternative dispute resolution offers in Claims Management.

Other work

As illustrated above, NHS Resolution as a contributor to supporting harm reduction has developed a range of resources and engagement events with the aim of raising awareness of the impact of claims and to share learning. Other ongoing activities which, although do not fall directly into any of the Ockenden Report's essential actions, are important to support system wide improvement are outlined below.

- **Sharing concerns:** On very rare occasions, we may identify a significant concern and have a duty to share information externally, for example, with other NHS bodies or those with responsibility for regulation within the healthcare system. NHS Resolution has a system in place to identify and manage significant concerns. This is known as the Significant Concerns Framework and is run by our Significant Concerns Group.

  We will also continue to work with key stakeholders such as NHSE/I to contribute to insights and intelligence regarding maternity safety and work with other key stakeholders such as HSIB, CQC and to share insights and intelligence at regional meetings and the National Perinatal Safety Surveillance and Concerns Group. The EN Maternity Risks and Concern Group ensures that there is a consistent and coordinated process for how risks (at Trust level) are identified, managed and escalated.

- **Maternity Incentive Scheme (MIS):** We will continue to develop the MIS to support the delivery of the national maternity strategy. Key areas of focus for 2022/23 include exploring the best approach for evaluating the scheme including the timing of when such an evaluation should take place. This evaluation of years one to four will incorporate learning from the Ockenden Report.

  Year 4 safety action leads were asked to consider anything from the Ockenden Report that may impact their actions in the immediate term. Year 4 has now been re-launched with strengthened conditions. This includes the following condition to increase ownership and accountability of MIS: by the accountable officer for the lead commissioner: *"The CEO of the Trust will ensure that the Accountable Officer (AO) for their Clinical Commissioning Group/Integrated Care System (CCG/ICB) is apprised of the MIS safety actions' evidence and declaration form. The CEO and AO must both*

sign the Board declaration form as evidence that they are both fully assured and in agreement with the evidence to be submitted to NHS Resolution".[20]

NHS Resolution will also review the actions and develop them for Year 5 of MIS. This will involve having a Collaborative Advisory Group (CAG)[21] workshop in the late autumn of 2022 to consider the findings of the Ockenden Report in relation to MIS, alongside the evaluation of the scheme in years one to four. This work will help us develop and refine the MIS further for Year 5.

Further information about how we continue to improve how we identify and address safety risks in Trusts related to MIS is provided below.

- **Continuing to identify and address safety risks in Trusts related to MIS:** Whilst the maternity incentive scheme is a self-certified scheme, with all scheme submissions requiring sign-off by trust Boards following conversations with trust commissioners, all submissions also undergo an external verification process and are sense-checked by the Care Quality Commission (CQC).[22]

  In response to a small number of NHS Trusts mis-declaring compliance with the MIS safety actions over the years that the scheme has been in operation, the conditions of the scheme continue to be revised and strengthened to reduce the risk of future mis-certifications. The scheme's conditions now include:
  - HSIB are now members of the MIS collaborative group, and are able to support with the sense check process of submissions.
  - Trusts are required to declare compliance against each safety action's sub-requirements.
  - The Trust Chief Executives are required to sign the declaration form in three places and confirm compliance, that a discussion with commissioners has occurred and that there are no reports covering two previous financial years that relate to the provision of maternity services that may subsequently provide conflicting information to Trusts' declaration.
  - CQC explore compliance with elements of the MIS during inspections of maternity services via their Key Lines of Enquiry. Ongoing discussions with the CQC regarding inspection findings.
  - Regional Chief Midwives provide support and oversight to Trusts when reviewing Trusts' update at LMS and regional meetings.
  - HSIB and NHS Resolution are jointly responsible for safety action 10; as part of the national perinatal safety surveillance work, HSIB, NHSR, CQC and NHSEI, RCOG share safety intelligence and insights in relation to Trusts.

CNST standards scheme discontinued

Page 50 of the Ockenden report references NHS Resolution's CNST standards scheme.

This scheme was discontinued in 2014 due to recognition by NHS Resolution (formally NHS Litigation Authority) of its limitations. This was informed by a consultation at the time with the NHS and others and a review undertaken by the then risk managers for the scheme, Det Norske Veritas. It was established that there was insufficient correlation between achievement against the standards and the claims experience of

[20] NHSR, Maternity incentive scheme – year four, Conditions of the scheme (May 2022)
[21] Key members of the CAG include: DHSC, NHSD, NHSE/I, RCOG, RCM, MBRRACE, RCoA, CQC and HSIB
[22] Maternity Incentive Scheme

NHS Trusts to justify continuance. In addition, CQC inspections had by then progressed to a point where there was considerable overlap.