NHS Resolution

A summary of: Five years of cerebral palsy claims

A thematic review of NHS Resolution data

September 2017

Advise / Resolve / Learn

Our report ***'Five years of cerebral palsy claims'***, provides an in-depth examination of the causes of these rare but tragic incidents and the investigations that follow them. For the purposes of this study we focused on 50 cases of cerebral palsy where the incidents occurred between 2012 and 2016 and a legal liability has been established.

This leaflet has been produced as an overview to highlight the:

- aims of the review;
- key findings; and
- the seven recommendations in the report.

We would encourage you to the read the full report which can be found online at www.resolution.nhs.uk/five-years-of-cerebral-palsy-claims

Working in partnership with other organisations, including the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives, NHS England and NHS Improvement, we have highlighted areas for improvement and made clear recommendations to help trusts prevent further incidents.

The study draws upon the unique dataset held by NHS Resolution to address two key areas for improvement; training to prevent future incidents and the quality of serious incident investigations.

Aims of the review

1. Identify the clinical and non-clinical themes from cerebral palsy claims that resulted in a claim for compensation.
2. Disseminate the shared learning and use this as a driver for change and quality improvement.
3. Highlight areas for improvement and evidence of good practice, signpost potential solutions and make recommendations for change.

Key findings

- The potential financial liability of the 50 cases examined could be greater than £390 million, which excludes the defence costs and the wider healthcare costs to the NHS;
- Evidence of poor quality serious incident investigations at a local level;
  - The patient and family were only involved in 40% of investigations
  - Only 32% had a review that involved an obstetrician, midwife and neonatologist
  - Only 4% had an external reviewer
  - Reports focused too heavily on individual errors
- Breech births were over-represented within this cohort, compared to the national average
- Errors with fetal heart rate monitoring was the most common theme. However, the underlying causes were often not related to individual misinterpretation but to systemic and human factors
- Inadequate staff training and monitoring of competency were identified as an important issue.
- Shortcomings in informed consent were evident
- Although this review analyses a small number of specific claims, the findings resonate with other reports with similar findings (1-3).
- Unfortunately, the evidence suggests there has been little improvement in these areas in recent years (1, 4-6).

References

1 Care Quality Commission. *Briefing; learning from serious incidents in NHS acute hospitals.* 2016.
2 Royal College of Obstetricians and Gynaecologists. *Each Baby Counts. Key messages from 2015*.2016.
3 *Mothers and Babies Reducing Risk through Audit and Confidential Enquiries across the UK. Perinatal Confidential Enquiry Report.* 2015 [Available from: https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UKPerinatal Report 2015.pdf Accessed 15th March 2017].
4 Parliamentary and Health Service Ombudsman. *Learning from mistakes.* 2016.
5 Parliamentary and Health Service Ombudsman. *A review into the quality of NHS complaints investigations where serious or avoidable harm has been alleged.* 2015.
6 House of Commons Public Administration and Constitutional Affairs Committee. *Will the NHS never learn?* Follow-up to PHSO report *'Learning from Mistakes'* on the NHS in England. 2017.

Recommendations

1. Women and their families offer invaluable insight into the care they received. To ensure this is included in all serious incident investigations, commissioners should take responsibility by ensuring serious incidents are not 'closed' unless the woman and her family have been actively involved throughout the investigation process.

2. The quality of serious incident investigations has repeatedly been found to be poor with very little or no training for investigators across the NHS. A working party, involving, and possibly led by the Healthcare Safety Investigation Branch should discuss creating a national standardised and accredited training programme for all staff conducting serious incident investigations. This should focus on improving competency of investigators and reduce variation in how investigations are conducted.

3. In line with the Kirkup and Royal College of Obstetricians and Gynaecologists Each Baby Counts reports, all cases of potential severe brain injury, intra partum stillbirth and early neonatal death should be subject to an external or independent peer review. However, the most appropriate model requires further national clarification.

4. Adverse events within maternity can have serious negative effects on staff, who are often provided with inadequate support. Trusts' obstetric and midwifery leads, with support from their board level maternity champion, must ensure that improving emotional support for staff throughout an investigation, irrespective of whether it becomes a compensation claim, is a priority.

5 Trust boards, alongside their obstetric and midwifery leads, must ensure that all staff undergo annual, locally led, multi professional training, which includes simulation training for breech birth. This training should focus on integrating clinical skills with enhancing leadership, teamwork, awareness of human factors and communication. Staff should not provide unsupervised care on delivery suite until the competencies have been achieved.

6 Cardiotocograph interpretation should not occur in isolation. It should always occur as part of a holistic assessment of fetal and maternal well being. Cardiotocograph training should incorporate risk stratification, timely escalation of concerns and the detection and treatment of the deteriorating mother and baby.

7 Trusts should monitor the effectiveness of their training by linking it to clinical outcomes. Trust boards should encourage units to publish their local indicators, which can then be subject to benchmarking and external scrutiny.

Other resources

Early Notification

From 1 April 2017 providers of NHS maternity care are required to report to NHS Resolution all incidents of potentially severe brain injury arising from birth which meet the criteria identified by the Royal College of Obstetricians and Gynaecologists through their independent Each Baby Counts Programme.

The support services we provide include peer support for affected healthcare staff; advice and practical help on delivering candour in practice; point of incident mediation; aiding the preservation of records and other evidence; analysis of cases for learning and where indicated, a preliminary investigation of legal liability. For more about the scheme visit: www.resolution.nhs.uk/early-notification-scheme or if you have any questions contact the Early Notification Team at: ENTeam@resolution.nhs.uk

Saying Sorry

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 these instances you may find our Saying sorry leaflet useful. www.resolution.nhs.uk/saying-sorry-leaflet

If you would like to get in touch with our Safety & Learning Team, email: safetyandlearningenquiries@resolution.nhs.uk or to see more of our resources please visit: http://bit.ly/NHSResolutionResources

Notes

To read the full review:
www.resolution.nhs.uk/five-years-of-cerebral-palsy-claims/

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