NHS Resolution

A summary of:

The Early Notification scheme progress report

An overview of the scheme to date together with thematic analysis of a cohort of cases from year one of the scheme, 2017–2018

September 2019

Advise / Resolve / Learn

''We welcome the publication of this report from NHS Resolution's Early Notification scheme and in particular the benefits that the Early Notification scheme may provide for the system, maternity teams and families. In addition to the tragedy of avoidable harm for individuals and their families, the increasing costs of clinical negligence in maternity care are an enormous financial drain on NHS healthcare resources. Furthermore, we must not overlook the fact that every incident of patient harm is distressing for the maternity staff involved.''

Gill Walton
Chief Executive of the Royal College of Midwives

Professor Lesley Regan
President of the Royal College of Obstetricians and Gynaecologists

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

- **key findings of the report;**
- **six recommendations;**
- **information on our collaborative partners; and**
- **other resources available on our website including information on supporting staff and families**

The report is aimed at multiple levels of the system, including staff and clinical teams, trust boards and policymakers. We encourage you to read the full report which can be found at: *https://resolution.nhs.uk/resources/early-notification-scheme-progress-report.*

The findings of the report and recommendations have been developed in partnership with members of the Early Notification scheme's clinical advisory group. We are grateful for their ongoing support and commitment to the scheme. NHS Resolution is also committed to cross-system working and the advisory group plays a major part in achieving that.

Members of the clinical advisory group include senior representatives of:

- NHS England and NHS Improvement
- The National Maternity Safety Champions
- Healthcare Safety Investigation Branch
- The Care Quality Commission
- The Royal College of Obstetricians and Gynaecologists
- The Royal College of Midwives
- The British Association of Perinatal Medicine
- Department of Health and Social Care
- Health Education England
- Clinical experts in midwifery, neonatology, obstetrics and paediatric neuroradiology

Key findings

The Early Notification scheme is a national programme for the early reporting of infants born with a potential severe brain injury following term labour to NHS Resolution.

It aims to support the government priorities to halve the rate of stillbirth, neonatal death and brain injury and improve the safety of maternity care, while also responding to the needs of families where clinical negligence is identified including the early admission of liability, where appropriate. The scheme also aims to improve the experience for NHS staff by speeding up the legal process and rapidly sharing learning from avoidable harm.

The report describes the development and progress of this innovative scheme to date with an overview of the cases reported in year one from 1 April 2017 to 31 March 2018. It includes an analysis of the issues identified in a cohort of cases with recommendations for future work.

In its first year of operation – April 2017 to March 2018 – 746 qualifying cases were reported to the Early Notification scheme.

To date, 24 families have received an admission of liability, formal apology and in some cases, financial assistance with their care and other needs within 18 months of the incident. There are a further number of cases currently being reviewed. This short duration is unprecedented for claims related to brain injury and/or cerebral palsy.

An analysis of a sample of 96 of the total 197 cases where NHS Resolution panel solicitors were instructed to investigate liability identified the following clinical issues:

- Key themes in investigations included limited support to staff, insufficient family involvement, and confusion over duty of candour
- Issues with fetal monitoring were a leading contributory factor in 70% of cases. In 63%, at least two or more factors were identified; a delay in acting on a pathological CTG was the most common factor
- Impacted fetal head and/or difficult delivery of the head at caesarean section was a contributory factor in 9% of cases in this cohort. This is a high incidence for a problem that has not previously been reported by NHS Resolution
- Concurrent maternal medical emergencies in labour occurred in 6% including significant maternal hyponatraemia and were important contributors to neonatal seizures and encephalopathy
- Immediate neonatal care and resuscitation remains an important but an under-recognised factor affecting 32% of the cohort

Recommendations

1

All families, whose baby meets the Early Notification criteria and requires treatment and separation from them for a potentially severe brain injury, should be offered a full and open conversation about their care.

This should include an apology in accordance with the statutory duty of candour, a description of the intended investigation process and options for their involvement in investigations.

2

An independent package of support should be offered to all NHS staff to manage the distress that can be associated with providing acute health services and in particular to those involved in incidents.

Support should address mental health, wellbeing and post-incident care with access to referral for psychological assessment and intervention where required. This should be confidential and independent of appraisal or the revalidation processes.

3

There is an urgent need for an evidence-based, standardised approach to fetal monitoring in England.

Effective improvement strategies for fetal monitoring require in-depth understanding of the social mechanisms underpinning the process, not just the technical issues. Research in this area should be prioritised urgently.

4

Increase awareness of impacted fetal head and difficult delivery of the fetal head at caesarean section, including the techniques required for care.

Research to understand the prevalence, causes and management of impacted fetal head is a priority, along with effective training in the management techniques.

5

Work with existing national programmes to improve the detection of maternal deterioration in labour, including monitoring as well as the implementation of evidence-based guidance in all birth settings.

Research to understand the prevalence and cause of significant hyponatraemia in labouring mothers in England should also be prioritised.

6

Increase awareness of the importance of high-quality resuscitation and immediate neonatal care on outcomes for newborn babies.

This requires collaboration between the whole multi-professional team.

Other resources

For up to date information on the Early Notification scheme including reporting form, case stories and support services please see our website below:

- *https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/early-notification-scheme/*

In addition case stories can be accessed at the following links:

- *https://resolution.nhs.uk/wp-content/uploads/2019/02/Case-story-Hyponatraemia.pdf*
- *https://resolution.nhs.uk/wp-content/uploads/2019/02/Case-story-Learning-lessons-from-Darnley-revised.pdf*
- *https://resolution.nhs.uk/wp-content/uploads/2019/02/Case-story-Sepsis.pdf*
- *https://resolution.nhs.uk/wp-content/uploads/2018/10/Case-story-Fetal-heart-rate-monitoring.pdf*
- *https://resolution.nhs.uk/resources/good-practice-management-of-the-antenatal-ctg/*
- *https://resolution.nhs.uk/resources/fetal-surveillance/*

Supporting families

Bliss

Bliss provides emotional and practical support to the families of babies born prematurely or sick. Their helpline is open Monday to Friday between 10am and 12pm and again between 7pm and 9pm. Call 0808 801 0322 for information and support. Support is also available via email *hello@bliss.org.uk*.

Alternatively, visit *https://www.bliss.org.uk/parents/support/support-in-your-area/support-in-your-area-map* to see what face-to-face support is available in your area.

Sands

Sands provides support to anyone affected by the death of a baby. Their helpline is open from 9.30am to 5.30pm Monday to Friday and also between 6pm to 10pm on Tuesday and Thursday evenings. Call 0808 164 3332 or email *helpline@sands.org.uk*. Sands also provides an app, designed to provide bereaved families with information and support.

Action against Medical Accidents (AvMA)

AvMA is a charity focusing on patient safety. Self-help guides are available on its website, including information about how to make a legal claim for compensation, including a specific guide to birth injuries available at *https://www.avma.org.uk/?download_protected_attachment=Claims-for-birth-injuries.pdf*. AvMA can also put families in touch with solicitors specialising in clinical negligence. Their helpline is open between 10am and 3.30pm, Monday to Friday. Call 0845 123 2352.

Additional organisations for supporting families can be found within the report

Supporting staff

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. This leaflet is part of our work on duty of candour.

- *https://resolution.nhs.uk/wp content/uploads/2017/04/NHS Resolution Saying Sorry 2017.pdf*

Supporting staff involved in Early Notification cases

Staff involved in serious incidents can suffer effects on mood, health and in some cases post traumatic stress disorder (PTSD) requiring therapeutic intervention. NHS Resolution recognises how distressing it can be for staff to be involved in such incidents and are acutely conscious that the stress may be a result not only of their involvement in the direct incident but also subsequent investigation processes. We are committed to supporting staff and have a list of services and information available that can be found at the link below:

- *https://resolution.nhs.uk/services/claims-management/clinical schemes/clinical negligence scheme for trusts/early notification scheme/early notification scheme support for staff/*

If you would like to get in touch with our Early Notification team, please email: *ENteam@resolution.nhs.uk*

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