

Introduction

The NHS remains one of the safest healthcare system in the world to give birth in. However, avoidable errors within maternity still occur and can have devastating consequences for the child, their mother and their wider family, as well as the NHS staff involved. Although secondary to human impact, such incidents can result in significant financial cost to the NHS. Obstetric claims accounted for 59% of the total estimated value of new claims reported to our clinical schemes in 2020/2021, despite only representing 11% of the number. (Figure 1)

NHS Resolution is committed to supporting the National Maternity Safety Ambition¹ to halve maternal and neonatal deaths and reduce significant harm. In order to support achieving this, the Early Notification Scheme (ENS) is an innovative national program by NHS Resolution undertaking early liability investigations for infants with intrapartum hypoxia related brain injury.

The ENS aims to have the following impacts:

- Investigate potential eligibility for compensation and take proactive action to reduce legal costs and improve the experience for the family and affected staff;
- Share learning rapidly with the individual trust and the wider system in order to support safety improvement and prevent the same things happening again;
- Build on our **Saying Sorry**² and **Being Fair**³ work to ensure the process to obtain compensation is not a barrier to openness, candour and learning;
- Preserve evidence to ensure we are able to respond to cases that a family may choose to bring at a later date; and
- Improve the process for obtaining compensation for families, meeting needs in real time where possible to reduce the risk of claims increasing in value due to inflation or unmet needs (such as psychological support) translating into larger losses.



Getting closer to the incident

Although financial compensation is one reason for bringing a medical negligence claim, our experience suggests that in addition to this, for many claimants and their families, the primary litigation aim is to prevent a similar incident happening to others and a proportion of claimants have reported they felt preventative actions had not been appropriately taken.⁴

One of the key benefits of the ENS, in comparison to the usual route a litigation investigation usually takes, is the ability to identify learning in a timely way, which can then be shared at local, regional and national level, reducing the potential for future harm. This is demonstrated in the graphic below:

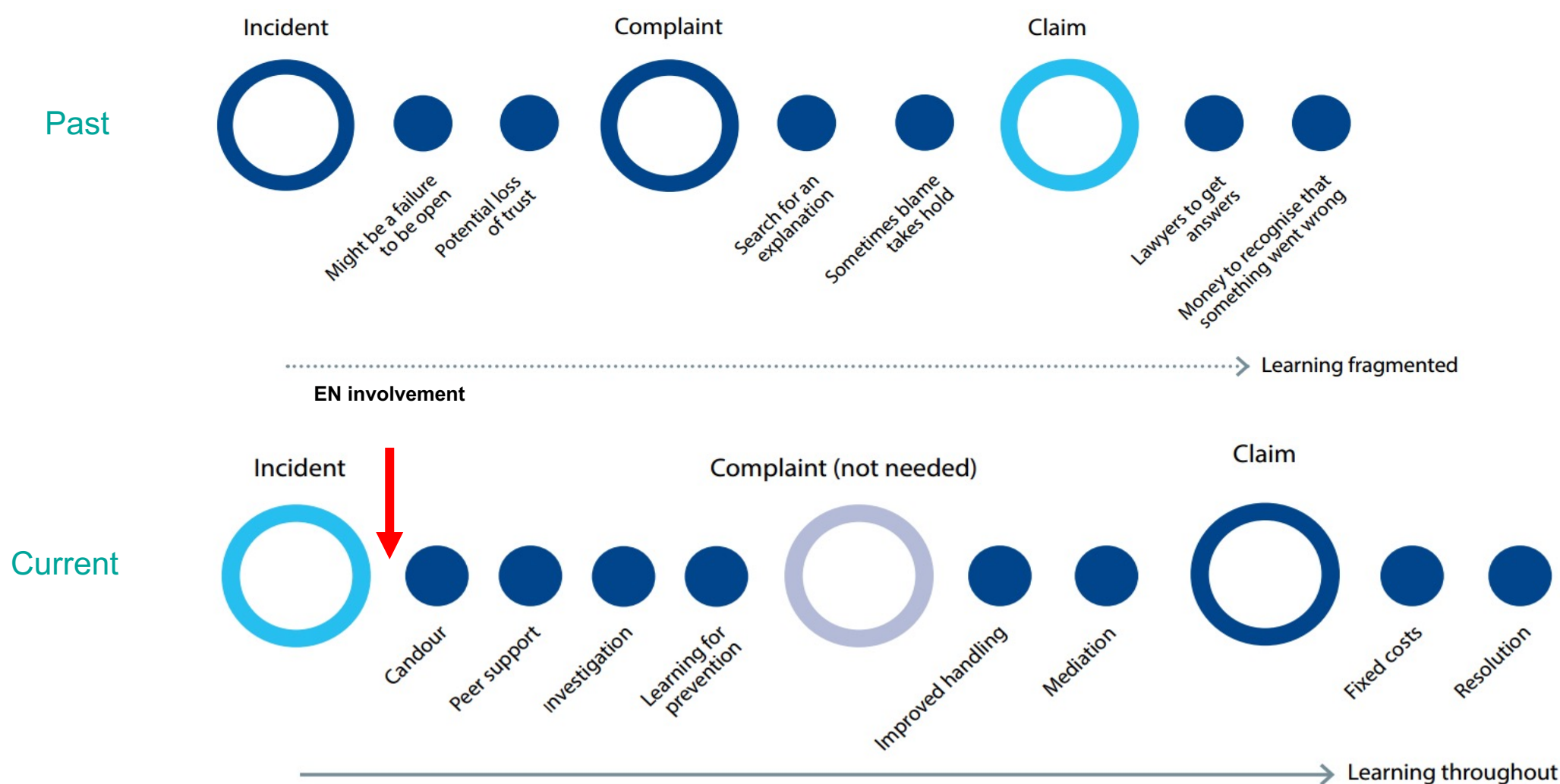
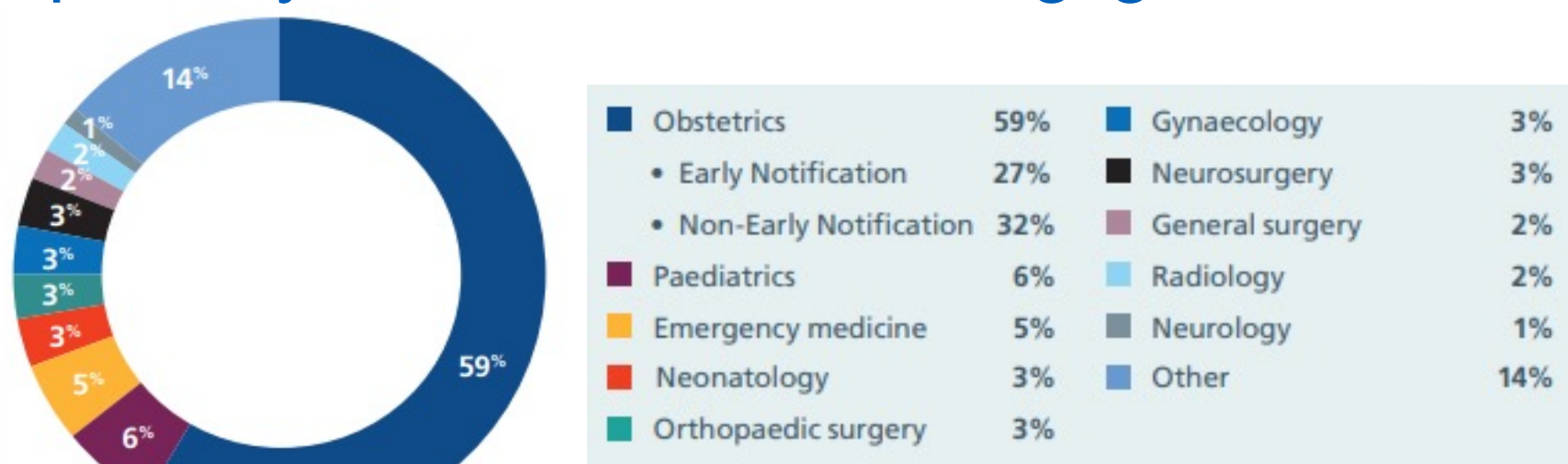


Figure 1

The number of clinical negligence claims reported in 2020/21 by specialty from a total of 10,816



Value of clinical negligence claims reported in 2020/21 by specialty across all clinical negligence schemes

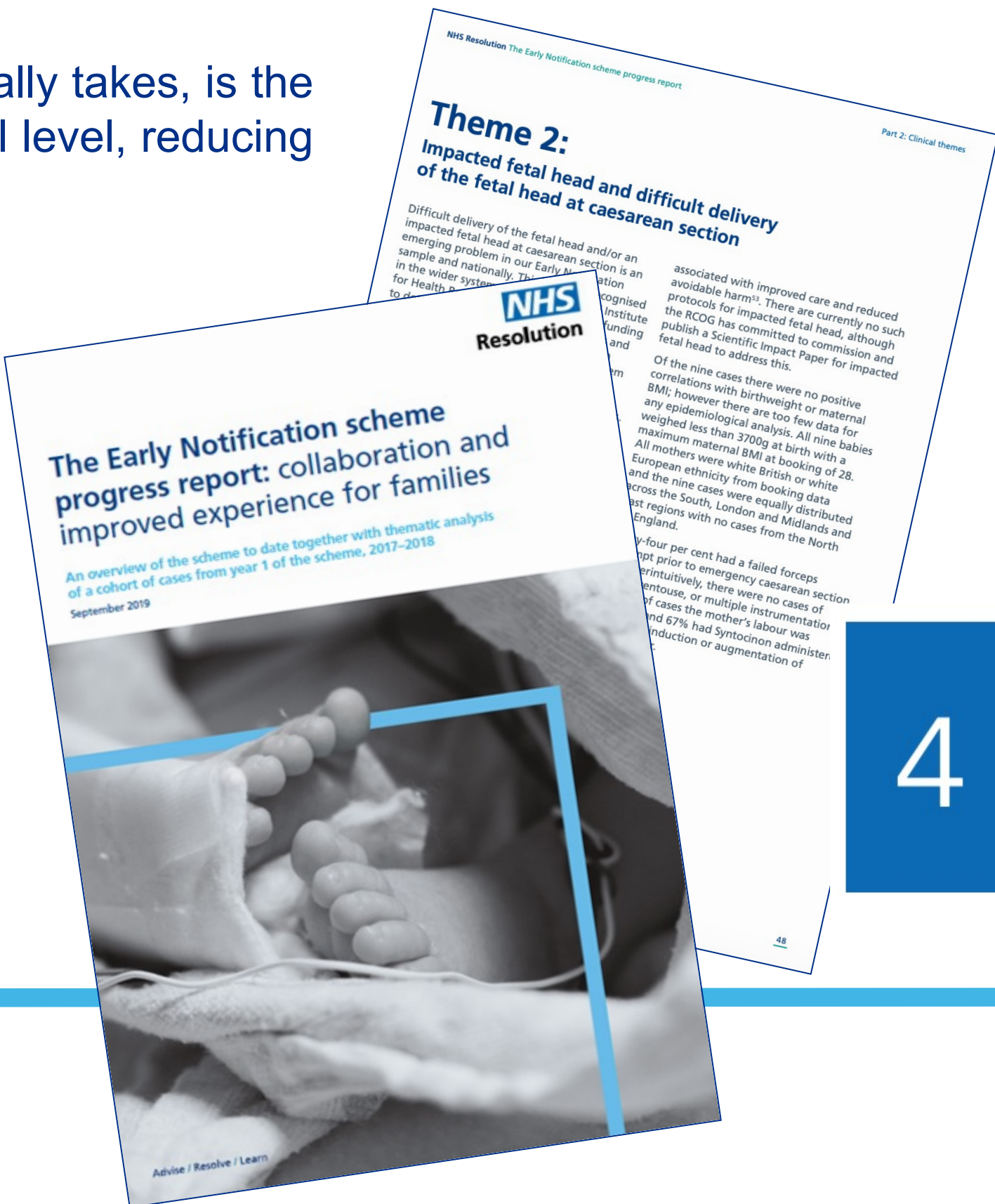


Claims data for learning purposes

Now in its fifth year, the ENS has demonstrated the unique contribution it offers to improve patient safety. In September 2019, NHS Resolution published a year one progress report⁵, and identified an emerging issue of Impacted Fetal Head (IFH) at Caesarean Section occurring in 9% of the ENS cases referred for a full liability investigation. This was a clinical issue that had not been previously recognised in litigation cases, with minimal research and no national guidance in place at the time.

Since then, the EN Report has catalysed a system response to improve care in this area, including a Royal College of Obstetricians and Gynaecologists (RCOG) Scientific Impact Paper and is also included in the Department of Health and Social Care funded Avoiding Brain Injuries in childbirth Project⁶ aiming to develop and produce a national training program.

This is an excellent example of a system level response to an alert from aggregated litigation cases by NHS Resolution, ensuring lessons are learnt, and improvements are made.



Quarterly case stories

As every ENS case represents a baby and family who may have experienced avoidable harm, it is important that all these pregnancies are carefully considered using the lens of both local practice and national policy, as there may be other similar gaps identified that could prevent future harm. To ensure timely feedback of emerging themes, and to highlight areas of suboptimal care that may have led to a brain injury, in contrast to the national report, the ENS clinical fellows produce quarterly case stories.⁷

These case stories are short, illustrative cases based on real events and lessons learnt through ENS incidents. They range from common clinical scenarios to less well-documented areas of maternity care and include areas of good practice. They are designed to encourage reflection or to be used for group discussion. These case stories are produced in an accessible format, published on the NHS Resolution website and aim to provide a regular insight into brain injury cases, providing learning for front line clinicians in a timely way.

Learning at local level

In addition to utilising claims data to produce national reports and published learning resources, the EN team also provides feedback to individual trusts when concerns are identified during the litigation process. As the EN team review Health Safety Investigation Branch(HSIB) investigations soon after the event has occurred, patterns or trends of concern may be identified that should be raised with the trust at local or regional level. This could include identifying local policies which are not in line with national guidance or identifying similar themes from cases which could help focus future training and resources at trust level.

Our role is to highlight concerns and work in partnership with trusts, empowering them to take ownership of the issue and implement their own escalation through appropriate channels when required. Depending on the nature of the concern, we may undertake a detailed thematic analysis of ENS cases reported by the trust, with feedback in the form of a meeting to facilitate discussions around the findings of the review directly to the clinical teams. We also work closely with other external stakeholders such as the HSIB, Care Quality Commission, Regional Chief Midwives and attend the regional Perinatal Quality and Surveillance meetings and the National Perinatal Safety Surveillance and Concerns Meeting, to ensure all concerns are triangulated.

Conclusion

Litigation can be a narrow lens with retrospective data. However, NHS Resolution is uniquely placed to join up families, local practice and national policy. Aggregating incidents into issues and identifying gaps in current guidance are both useful approaches and although already influencing change, more work is currently being undertaken to maximise the positive impact of litigation data.

References:

- <https://www.longtermplan.nhs.uk/online-version/chapter-3-further-progress-on-care-quality-and-outcomes/a-strong-start-in-life-for-children-and-young-people/maternity-and-neonatal-services/>
- <https://resolution.nhs.uk/resources/saying-sorry/>
- <https://resolution.nhs.uk/resources/being-fair/>
- <https://resolution.nhs.uk/wp-content/uploads/2018/10/Behavioural-insights-into-patient-motivation-to-make-a-claim-for-clinical-negligence.pdf>
- <https://resolution.nhs.uk/wp-content/uploads/2019/09/NHS-Resolution-Early-Notification-report.pdf>
- <https://www.thisinstitute.cam.ac.uk/research-projects/avoiding-brain-injury-in-childbirth-collaboration/>
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