

Ongoing clinical themes from Early Notification (EN) Scheme cases

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Introduction

The NHS remains one of the safest healthcare systems in the world to give birth. However, avoidable errors within maternity still occur and can have devastating consequences for the child, their mother, their wider family, and the NHS staff involved. As well as the significant human impact for everyone involved, such incidents also result in a significant financial cost. The estimated clinical negligence cost of harm was £13.3 billion with maternity claims making up 60% of this (2021/22.¹)

The EN Scheme was created by NHS Resolution to improve claims resolution but also to support learning from incidents. Ongoing clinical themes from EN cases include delay in birth, problems with fetal monitoring, vaginal breech births, suspected intrapartum infections and uterine rupture during vaginal birth after caesarean section (VBAC.)

The EN scheme aims to have the following impacts:

- Investigate potential eligibility for compensation and reduce legal costs
- Perform an early assessment of risk closer to the time of incident
- Build on the principles of Saying Sorry and Being Fair 2. 2,3,4.
- Provide a unique contribution to the patient safety landscape
- Improve the experience for the family and affected staff
- Share learning with individual trusts.

Design

The EN Scheme was established in 2017 and at the end of 2022 we published “The second report: The evolution of the Early Notification Scheme.” We reviewed a cohort of incidents occurring in Year 2 of the EN Scheme. These incidents occurred between 1 April 2018 and 31 March 2019.⁵

We randomly selected 100 cases that were referred to NHS Resolution and our commissioned panel of solicitors with an instruction to undertake a liability investigation. 7 cases were excluded as they were duplicates which led to 93 cases being analysed.

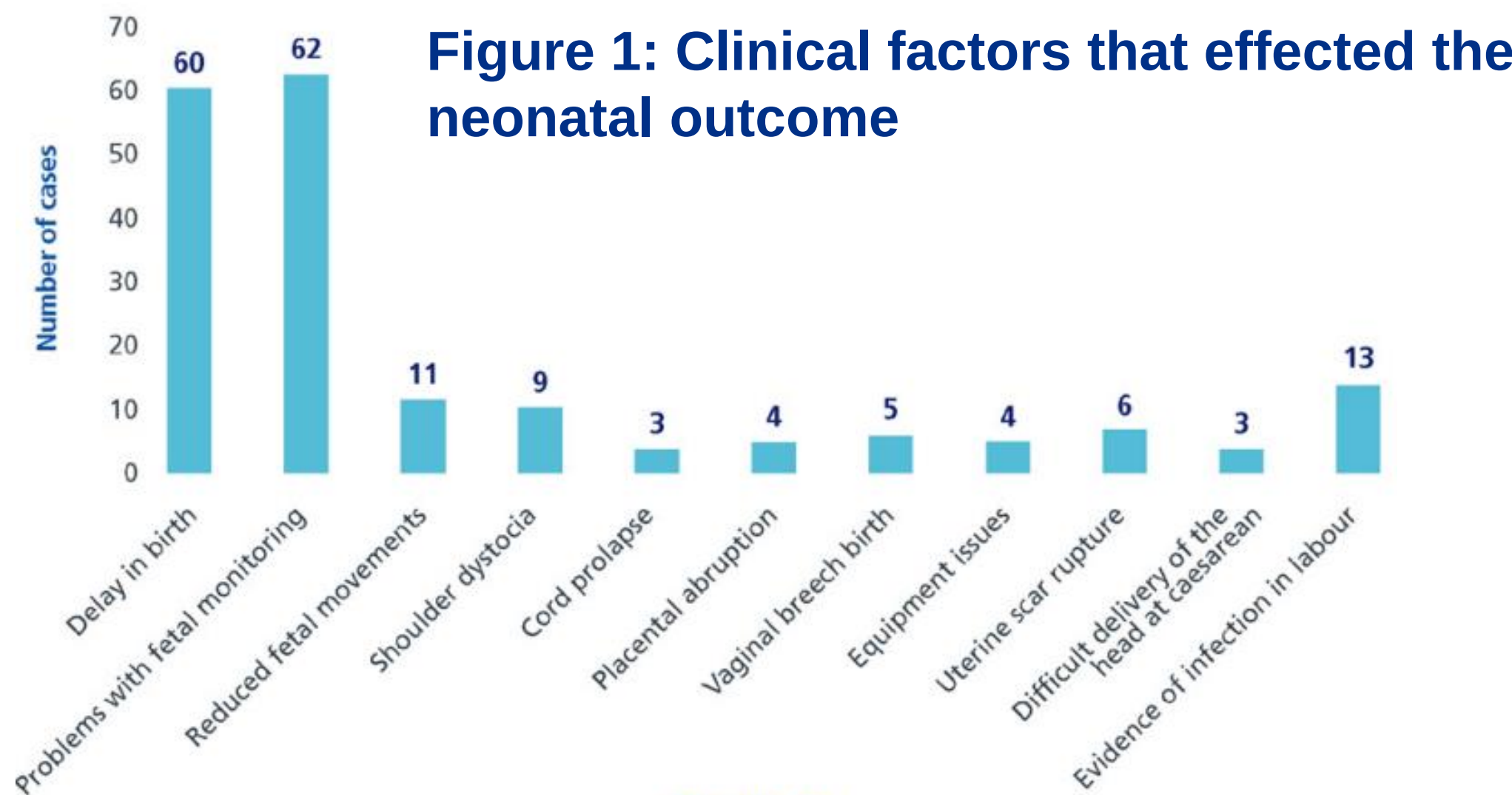


Figure 1: Clinical factors that effected the neonatal outcome

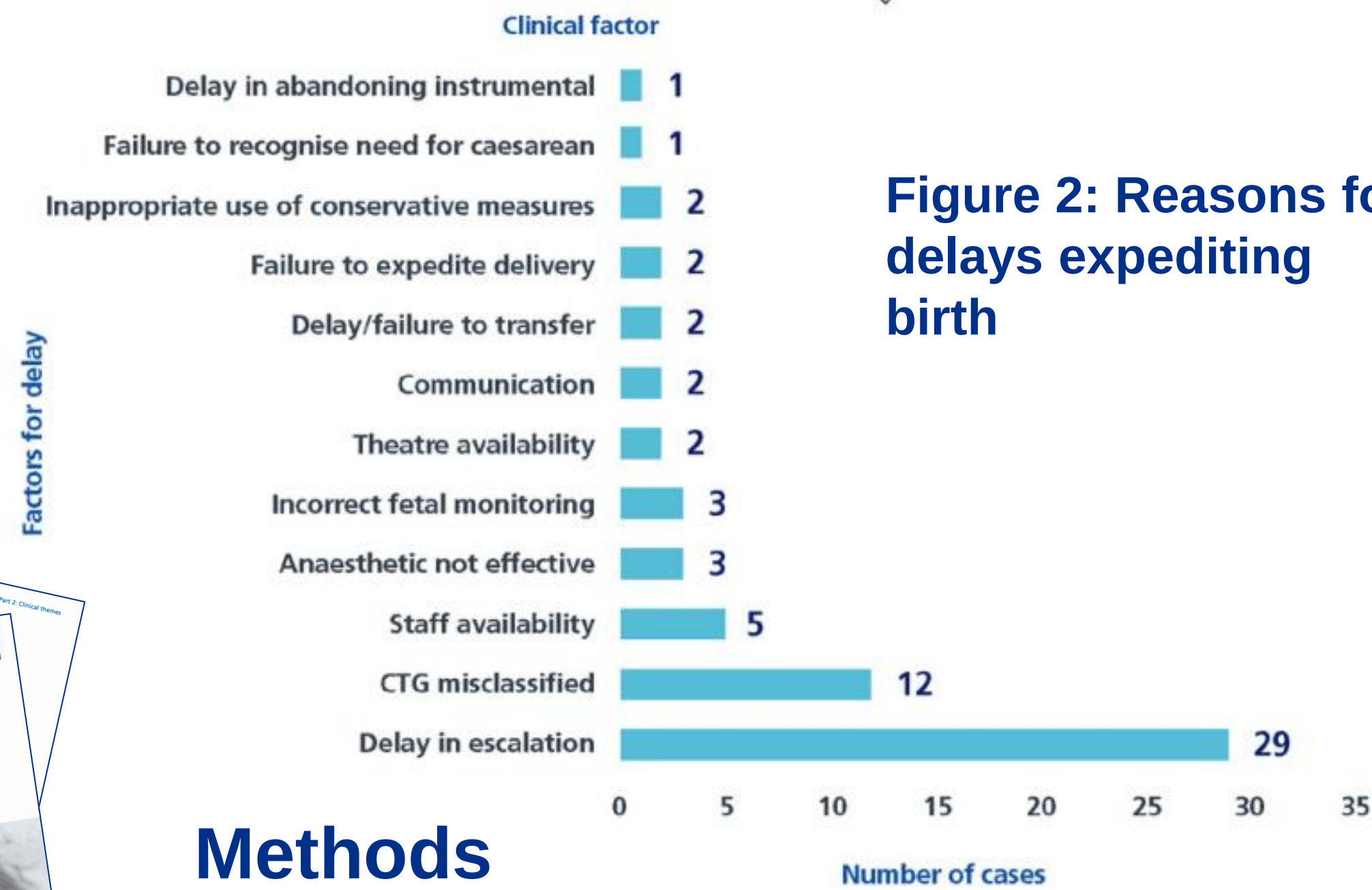


Figure 2: Reasons for delays expediting birth

Methods

Incidents were referred to panel for independent expert review where there was evidence of suboptimal care identified by the Trust or NHS Resolution EN clinical review. The aim of this analysis was to provide a systems based understanding of why harm may have occurred and to look for any common themes.

Results

Mode of delivery varied in this cohort but as expected with cases referred to EN 43% of cases involved an emergency caesarean section. 22% of cases revealed problems with neonatal resuscitation. Specific issues included delay in calling for help and inadequate resuscitation and difficulty intubating. Factors affecting neonatal outcome are summarised in Figure 1.

Key Themes

Problems persist with fetal monitoring which was a feature in 67% of cases and was felt to contribute to the poor outcome. Maternal infection was found in 14% of cases. Vaginal breech birth is overrepresented in our cohort compared to the national average but was seen in 5% of cases.

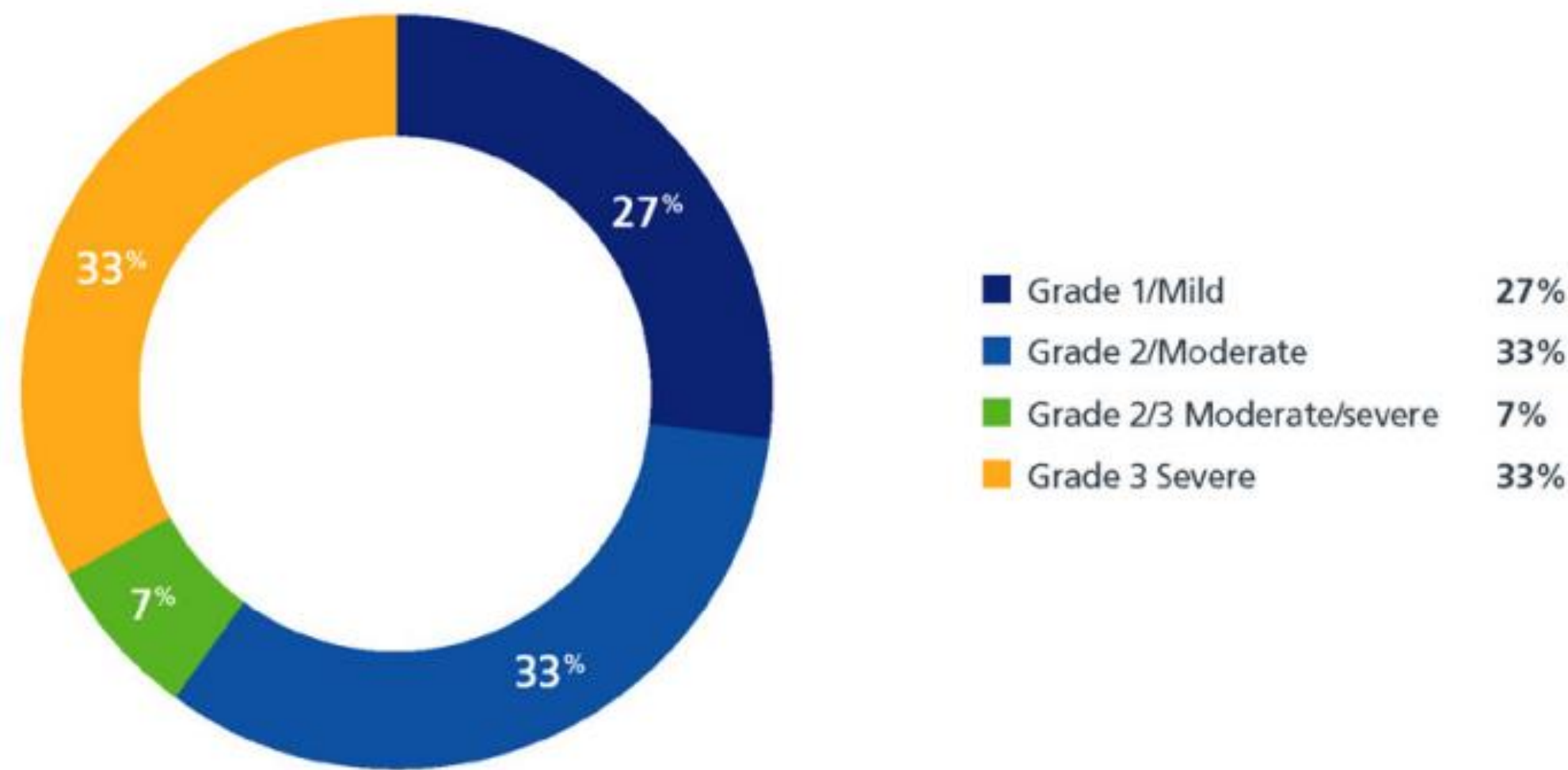


Figure 3: Neonatal outcome by hypoxic-ischaemic diagnosis in babies with delay expediting birth

Several key themes were identified for further focus and these were delay in delivery which was seen in 64% of cases and uterine rupture which was seen in 13% of cases.

Delay in delivery is a multifactorial issue involving delivery unit acuity, availability of key staff members, equipment or theatre and the assessment of the clinical situation (Figure 2.) Delay expediting birth ranged from less than 10 minutes to over 12 hours. The length of delay will have variable effect on neonatal outcomes based on the reason delivery was indicated. The neonatal outcomes are summarised in Figure 3.

Conclusion

This data is based on a potentially narrow lens of litigation and this is a small data set. However there are valuable learning opportunities from these cases and there remains a clear need to progress in these areas to improve care for families.

References:

1. Annual report and accounts. NHS Resolution. [NHS Resolution - Annual report and accounts 2021/22](#)
2. Being Fair. NHS Resolution. [Read the Being Fair report - NHS Resolution](#)
3. Being Fair 2. NHS Resolution. [Being fair 2 - improving organisational culture in the NHS - NHS Resolution](#)
4. Saying Sorry. NHS Resolution. [Read saying sorry \(duty of candour\) - NHS Resolution](#)
5. EN 2nd Report. NHS Resolution. [NHS: The second report: The evolution of the Early Notification Scheme \(resolution.nhs.uk\)](#)