

A grayscale background image showing a pair of hands, one larger and one smaller, gently cupping each other. The hands are positioned in the center of the frame, with the fingers slightly curled. The lighting is soft, highlighting the texture of the skin.

Learning from Maternity and Reducing Harm

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Moving upstream – the traditional model

Current

Incident



*Might be a failure
to be open
Potential loss
of trust*

Complaint



*Search for an
explanation
Sometimes blame
takes hold*

Claim

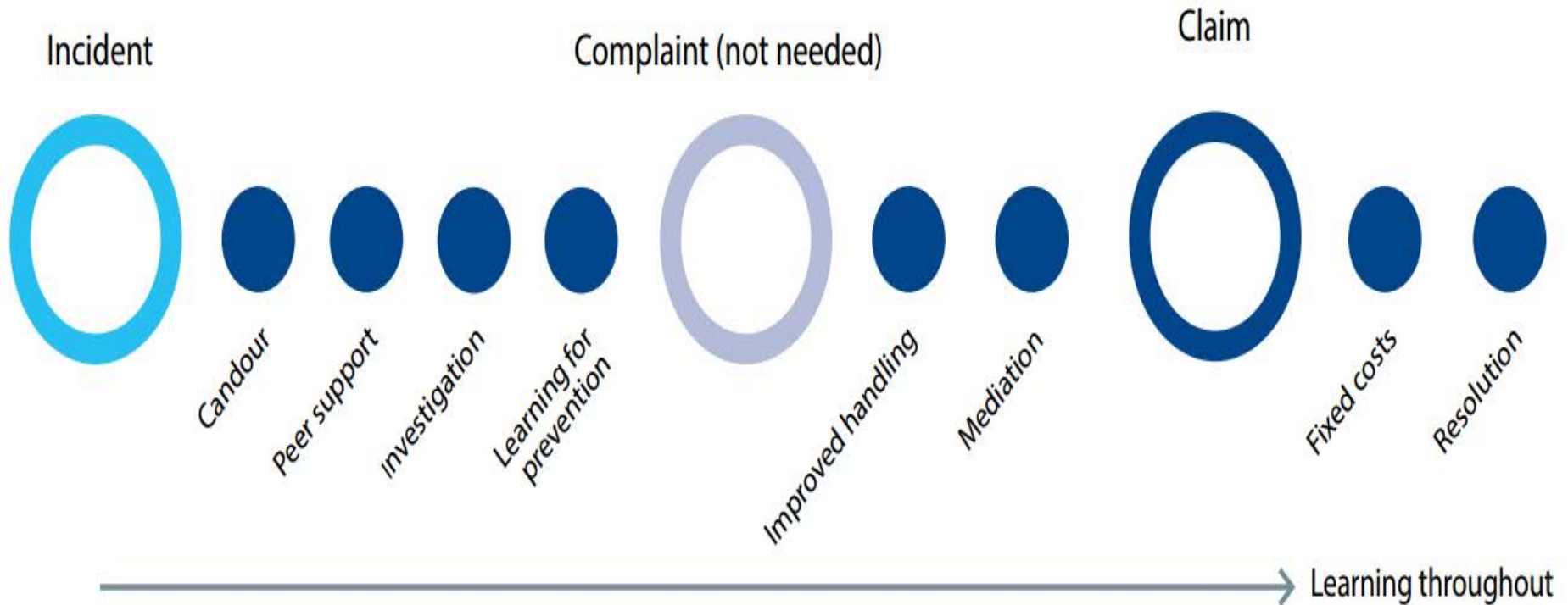


*Lawyers to get
answers
Money to recognise that
something went wrong*

.....> Learning fragmented

Moving upstream

Future



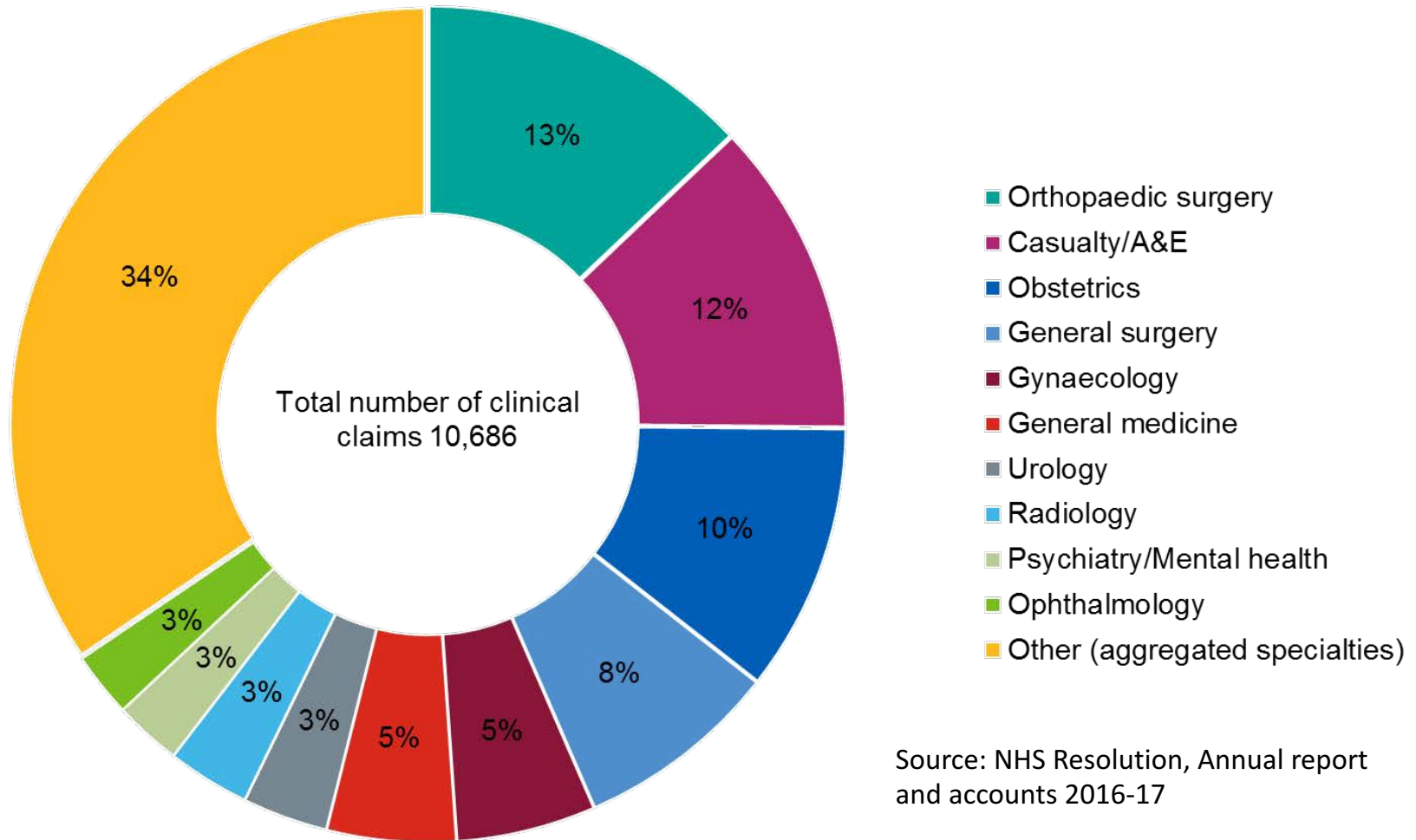
Human perspective

“Knowing our son has cerebral palsy from medical negligence when my wife looked after him so well while he was still in the womb is very difficult to deal with. He was a healthy boy until 10 minutes before he was born and the events that happened in the hospital still haunt me and my wife every day, reliving the moment that his ‘normal’ life was taken away from him by people not doing their job correctly will never escape our memories”.

Human perspective

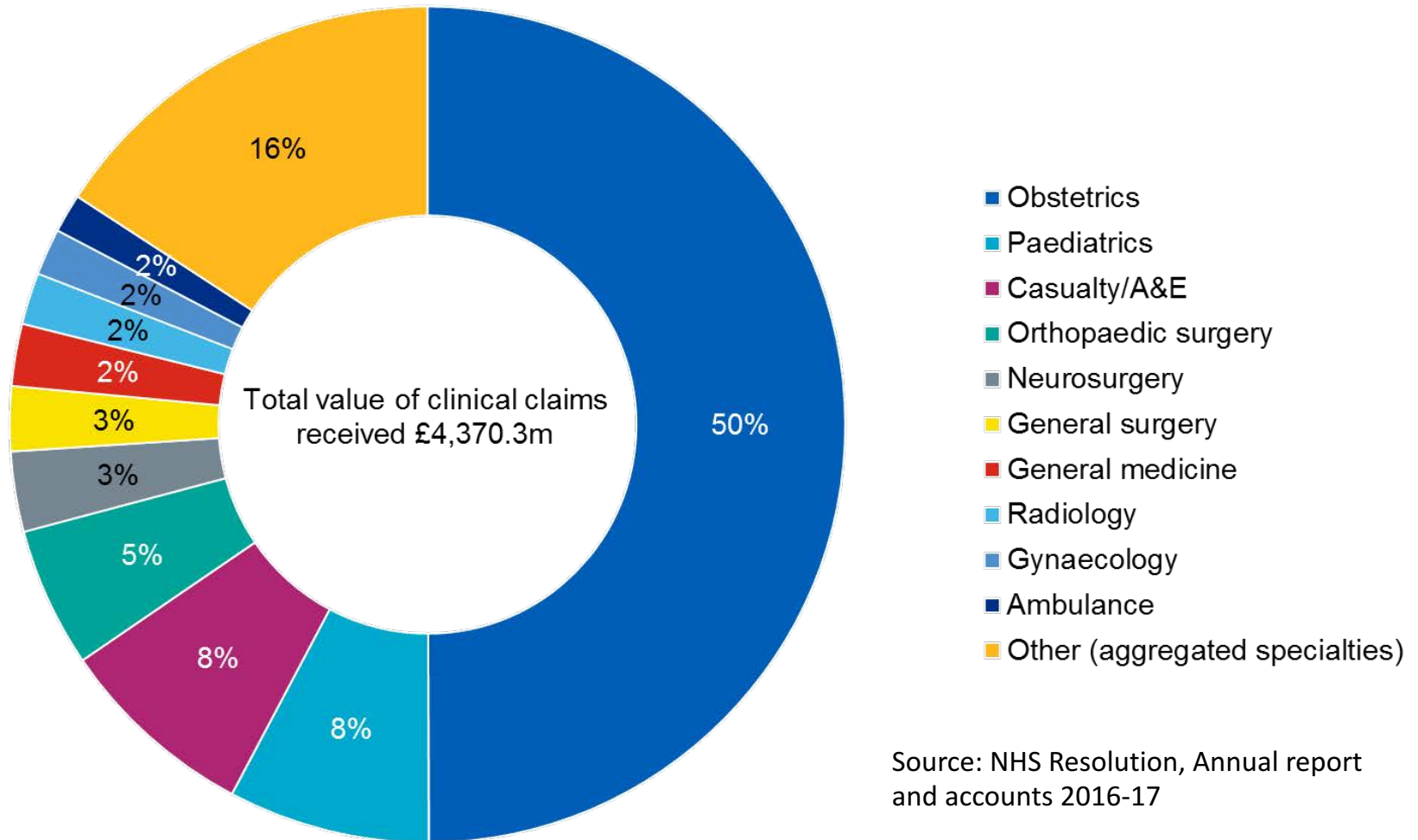
- Evidence suggests there is a significant effect on staff after adverse maternity events
- Common to experience guilt, fear, anxiety, anger, depression and insomnia
- Can lead to Post Traumatic Stress Disorder (PTSD - 1 in 20 midwives have PTSD after exposure to adverse event)
- 1 in 5 UK Obs & Gynae specialist trainees leave the profession – a key reason is lack of support and supervision.

2. Financial perspective



Source: NHS Resolution, Annual report and accounts 2016-17

2. Financial perspective



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2. Financial perspective

- The projected spend for the Clinical Negligence Scheme for Trusts (CNST) in 2018/19 - £1.984bn
- CNST provision rising - £59.8bn as at 31st March 2017 from £50.8bn as at 31st March 2016
- External factors e.g. change in the personal injury discount rate from 2.5% to minus 0.75% announced in March 2017

Collaborative working across the maternity system

- **Five years of cerebral palsy claims**
A thematic review of NHS Resolution data
September 2017 - <https://resolution.nhs.uk/five-years-of-cerebral-palsy-claims/>
- Early notification scheme for maternity (launched 1 April 2017), aligned with Royal College of Obstetricians and Gynaecologist (RCOG) Each baby counts reporting criteria
- Utilising CNST pricing to incentivise and support improvement

Early Notification – Year 1 review and reflection

1. How it all began: the birth of NHS Resolution
2. Focus on maternity: the rationale
3. The old and the new
4. Early Notification scheme
 - Learning
 - Accelerated liability investigation
 - Improved experience
5. Year two

Early Notification scheme (ENS)

All trusts required to notify NHS Resolution, within 30 days, any babies born at term, following labour, with a severe brain injury diagnosed in the first seven days of life.

Aims

- **Identify learning** and share at a national, regional and local level;
- **Improve the experience** for both the families and staff affected; and
- **Accelerated liability investigation** allowing contemporaneous collation of evidence and early admissions of liability

Early Notification process

- Trust:
 - Notification
 - Candour
 - Provision of records and investigation documents to NHS Resolution
- NHS Resolution:
 - Internal review / triage
 - Instruction of legal advisors
 - Advice to trusts on liability and learning
 - For families - explanation and, where indicated, admission of liability

Learning

- Capturing data on: clinical outcomes, good investigative practice
- Working collaboratively with royal colleges and arms length bodies to improve patient safety
- Disseminating learning on a national, regional and local level
- Unique opportunity for trusts to receive timely, specific feedback on their incidents and investigations.

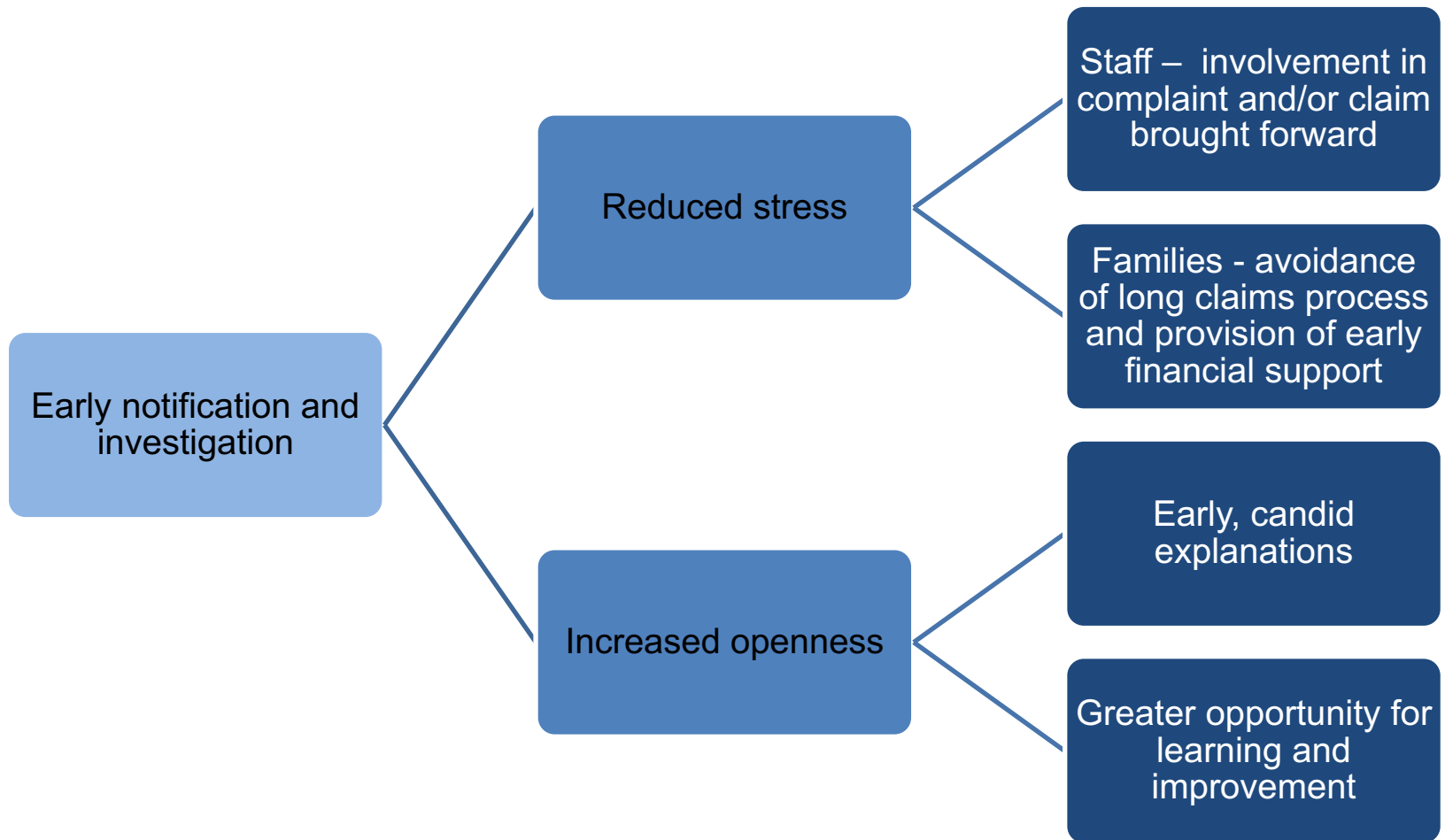
Identifying and sharing learning

- Clinical:
 - Fetal monitoring in theatre / while siting epidural (loss of situational awareness)
 - Intrapartum consent
 - Emergency situation management – breech and impacted head at caesarean section
- Investigative:
 - Variation: notification, candour, form of investigation
 - Innovation: appetite for change
 - Collaboration: system-wide working

Accelerated liability investigation

- Pre-April 2017 process
- Since April 2017:
 - In house reviews
 - Full investigation by independent experts across disciplines
 - Panel review
 - Admissions of liability
 - Financial support provided to families to meet immediate needs
 - Collaborative working with patient representatives

Improved experience



Year two

Continue to:

- Deliver a compassionate response when it matters to patients, families and healthcare staff
- Collate and analyse data to identify areas for improvement
- Reach early decisions on legal liability

And aim to:

- Share learning widely
- Use the opportunity of early involvement to increase support to trusts to improve post-incident management
- Develop EN to best support the implementation of Rapid Resolution and Redress

Developing the 10 maternity actions for CNST incentivisation scheme



Resolution

- Working group convened to deliver. Key players included:
 - National Patient Safety Champions
 - Department of Health and Social Care
 - NHS England
 - NHS Improvement
 - NHS Digital
 - Royal Colleges - RCOG, Royal College of Midwives
 - CQC
 - Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK (MBRRACE-UK)

The maternity incentive scheme explained

10 maternity safety actions:

1. Use of the Perinatal Mortality Review Tool
 2. Submitting data to the National Maternity Services Data Set
 3. Transitional care facilities in place and operational
 4. Appropriate medical workforce planning
 5. Appropriate midwifery workforce planning
 6. Implementation of the *Saving Babies Lives* care bundle (or similar)
 7. Patient feedback mechanism in place
 8. Multi professional training in obstetric emergencies
 9. Effective trust level safety champions
 10. 100% reporting to the Early notification (EN) scheme
- Trusts to self-report progress against 10 actions (Board sign-off required) with cross-checking against some external data sources

Thank you for listening

Advise / Resolve / Learn

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NHS Resolution resources

- Five years of cerebral palsy claims: a thematic review of NHS Resolution data <http://resolution.nhs.uk/five-years-of-cerebral-palsy-claims/>
- NHS Resolution 5 year strategy: Delivering fair resolution and learning from harm <https://resolution.nhs.uk/wp-content/uploads/2017/04/NHS-Resolution-Our-strategy-to-2022-1.pdf>
- NHS Resolution Maternity Incentive Scheme: <https://resolution.nhs.uk/maternity-incentive-scheme/>
- NHS Resolution “Saying Sorry” leaflet <https://resolution.nhs.uk/saying-sorry-leaflet/>