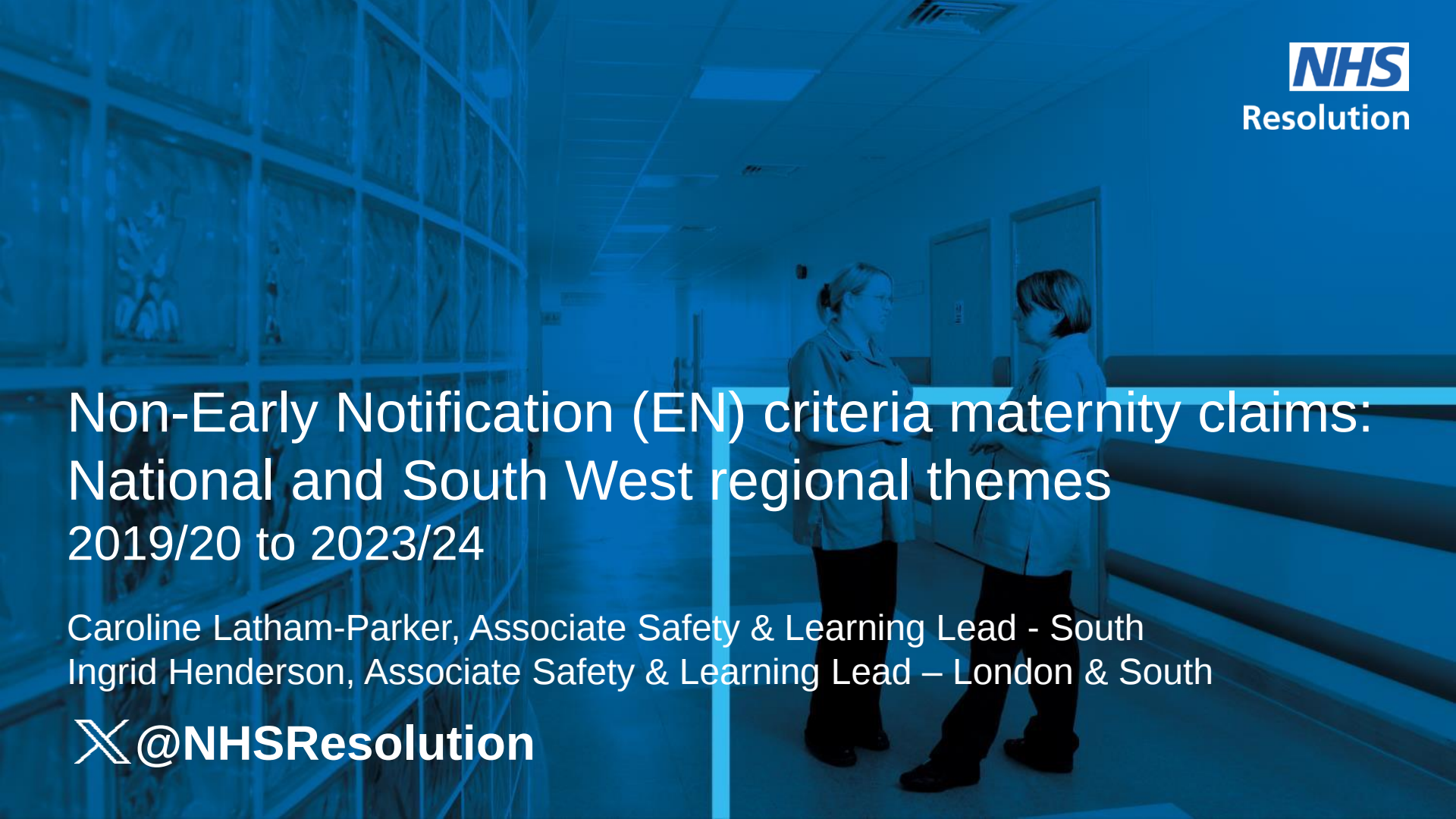




Non-Early Notification (EN) criteria maternity claims: National and South West regional themes 2019/20 to 2023/24

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Presentation Overview

1. NHS Resolution: our priorities and services
2. Data Caveats
3. National - Volume & value of maternity Clinical Negligence Scheme for Trusts (CNST) claims per year.
4. Regional – Maternity CNST claims by volume
5. Regional – Maternity CNST claims Value
6. National & South West (SW) region – Maternity CNST Cause codes & claims volume rate per 1000 births.
7. National & South West (SW) region – Maternity CNST Injury codes & claims volume rate per 1000 births.
8. Summary of Maternity claims.
9. Questions.



Learning objectives: To provide an overview of the national and SW regional themes seen in non-EN criteria claims brought under the CNST scheme.

1. How does these themes compare with what you see in your local claims via the Trust scorecard?
2. Do they align with your current quality metrics, e.g. complaints and patient safety events data?
3. How can this help you formulate priorities for future patient safety improvement?

NHS Resolution: our priorities and services

New strategic priorities



Deliver fair resolution



**Share data and insights as
a catalyst for improvement**



**Collaborate to improve
maternity outcomes**



**Invest in our people and
systems to transform our
business**

Our services

Claims Management

Delivers expertise in handling both clinical and non-clinical claims through our indemnity schemes

Primary Care Appeals

Offers an impartial resolution service for the fair handling of primary care contracting disputes.

Practitioner Performance Advice

Delivering expert advice, support and interventions on the fair management of concerns about the performance of doctors, dentists and pharmacists

Safety and Learning

Supports the NHS, our members and beneficiaries to better understand their claims risk profiles, to target their safety activity while sharing learning across the system to improve patient care

Data caveats – slide 6 onwards

Sources

- NHS Resolution Supplementary Account Stats dataset - Snapshot date 31.03.24.
- MBRRACE - [Perinatal mortality data viewer](#) | [MBRRACE-UK \(le.ac.uk\)](#)

Inclusion

- Maternity (Obstetric) Clinical Negligence Scheme for Trusts (CNST) claims as of 1st April 2019 to 31st March 2024 in England. All by clinical incident date with exception of table 1 on slide 5 which is by claims notification date.
- All open & closed claims.
- Incidents or Letter of Notification.
- MBRRACE - Total Births in 2022 only

Exclusions

- EN criteria claims.
- Claims where the injury is yet to be defined, i.e., injury code 'Not Specified' are excluded on charts referring to Top 5 but are included in overall total figures.

National volume & value of maternity CNST claims per year from 2019/20 to 2023/24

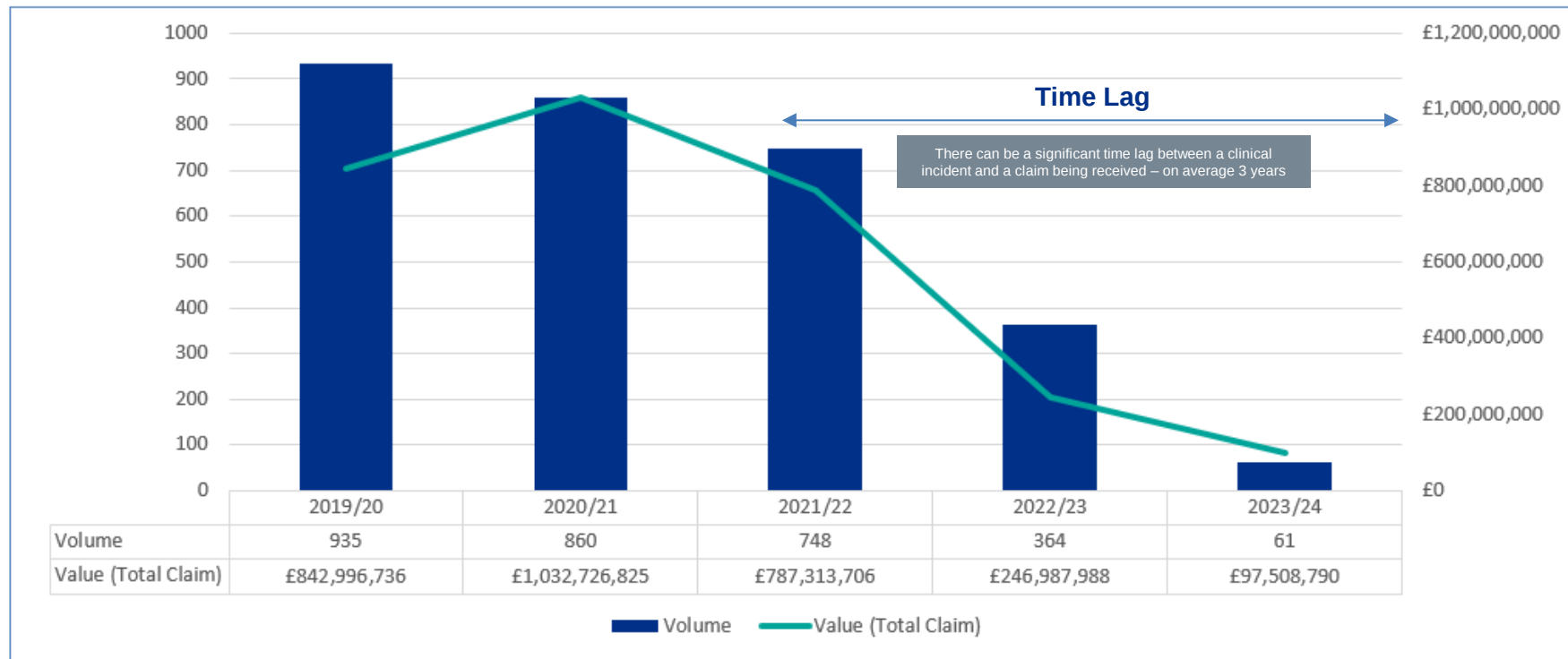
Claims notification date	Volume of claims	Total claim costs	Average of total claims costs
	5462	£9.756 Billion	£1.786 Million

Clinical incident date	Volume of claims	Total claim costs	Average of total claims costs
	2852	£2.935 Billion	£1.029 Million

National volume and value of maternity CNST claims per year 2019/20 to 2023/24 by clinical incident date

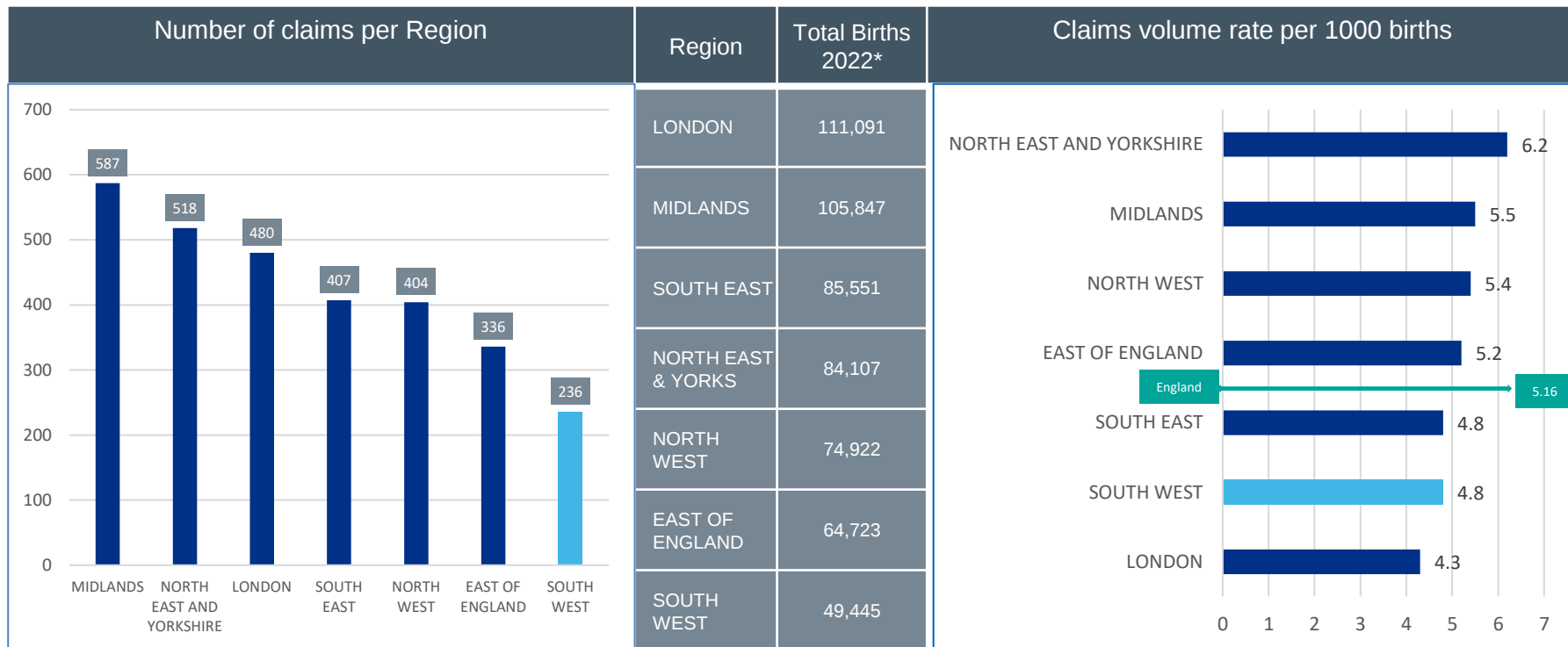


Resolution



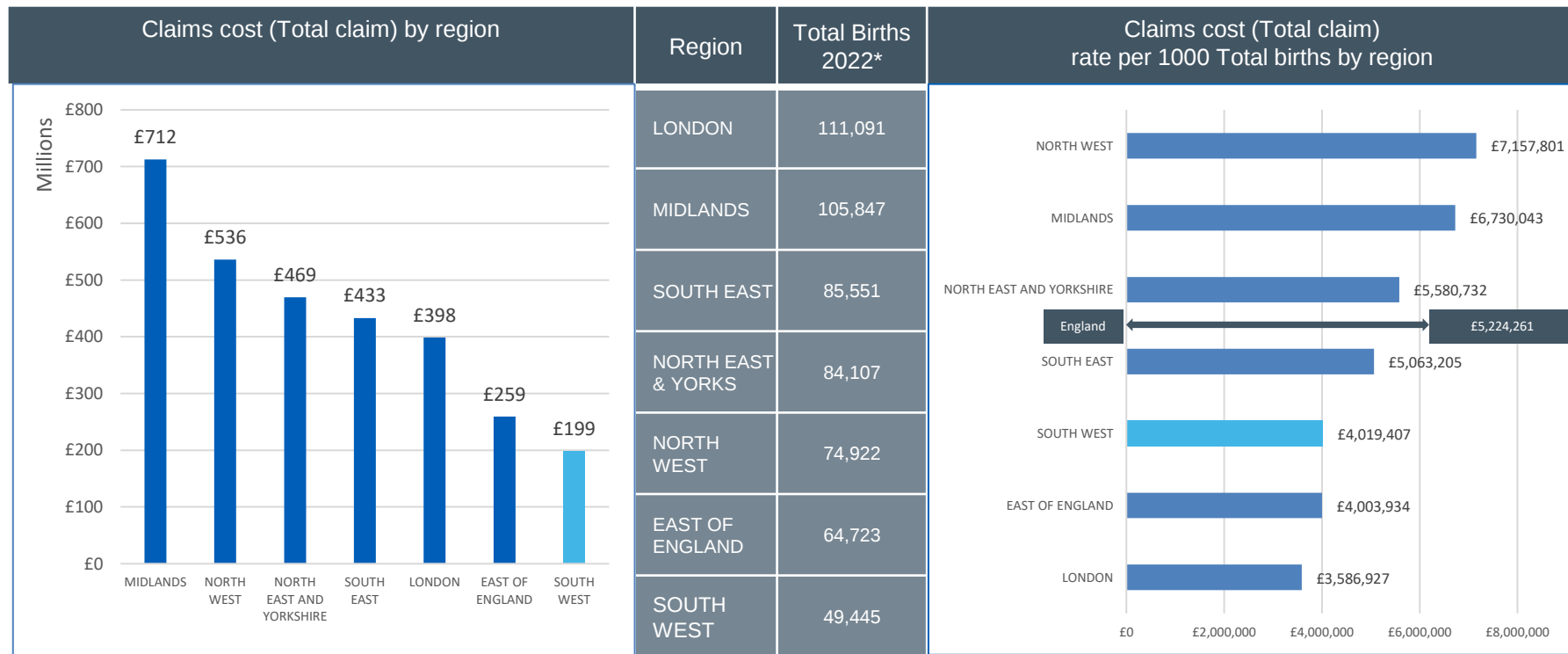
*Data correct as of 31.03.24 and exclude EN criteria claims

Regional – Maternity CNST claims volume 2019/20 to 2023/24 by clinical incident date



Claims Data correct as of 31.03.24 & exclude EN criteria claims, *[Perinatal mortality data viewer](#) | [MBRRACE-UK \(le.ac.uk\)](#)

Regional – Maternity CNST claims value 2019/20 to 2023/24 by clinical incident date



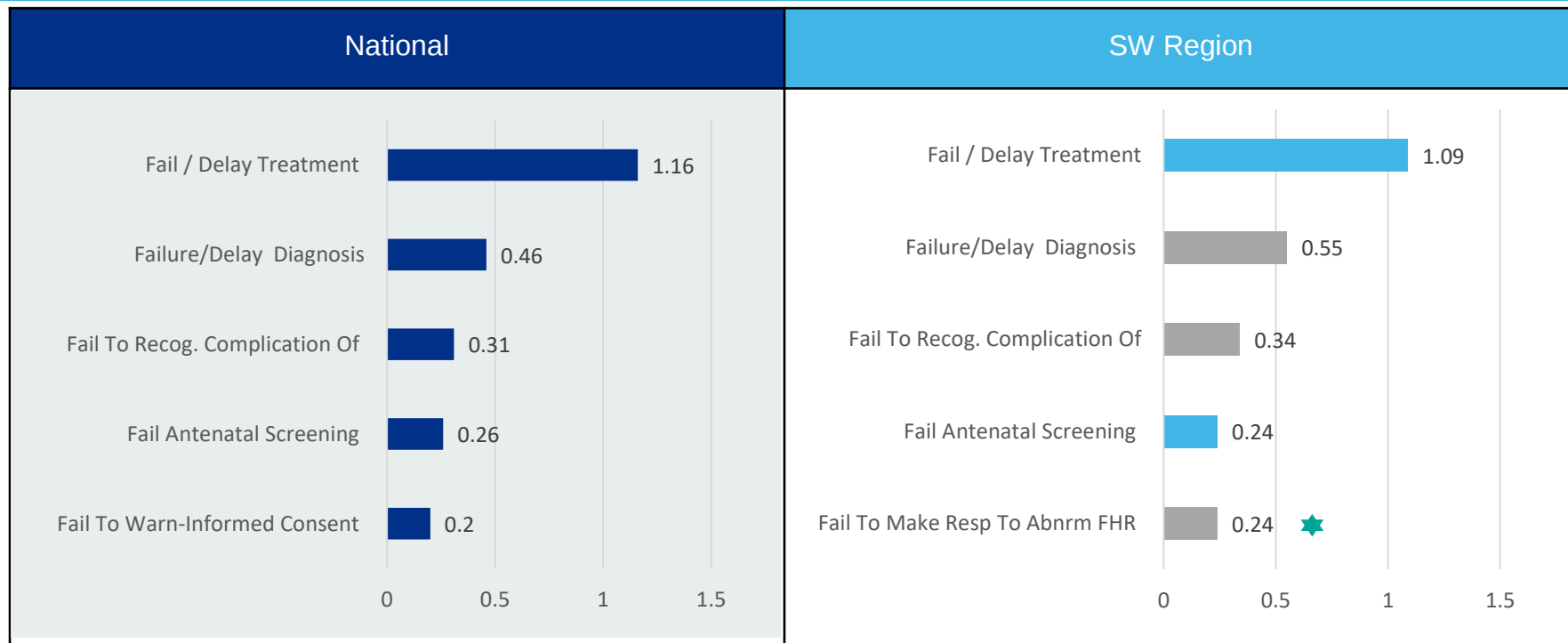
Claims Data correct as of 31.03.24 & exclude EN criteria claims, [*Perinatal mortality data viewer](#) | [MBRRACE-UK \(le.ac.uk\)](#)



Top 5 Cause codes for Maternity CNST claims volume 2019/20 to 2023/24 per 1000 births by clinical incident date



Resolution



★ Not in the Top 5 national causes but seen regionally:

Key



Region > National rate
/100k population

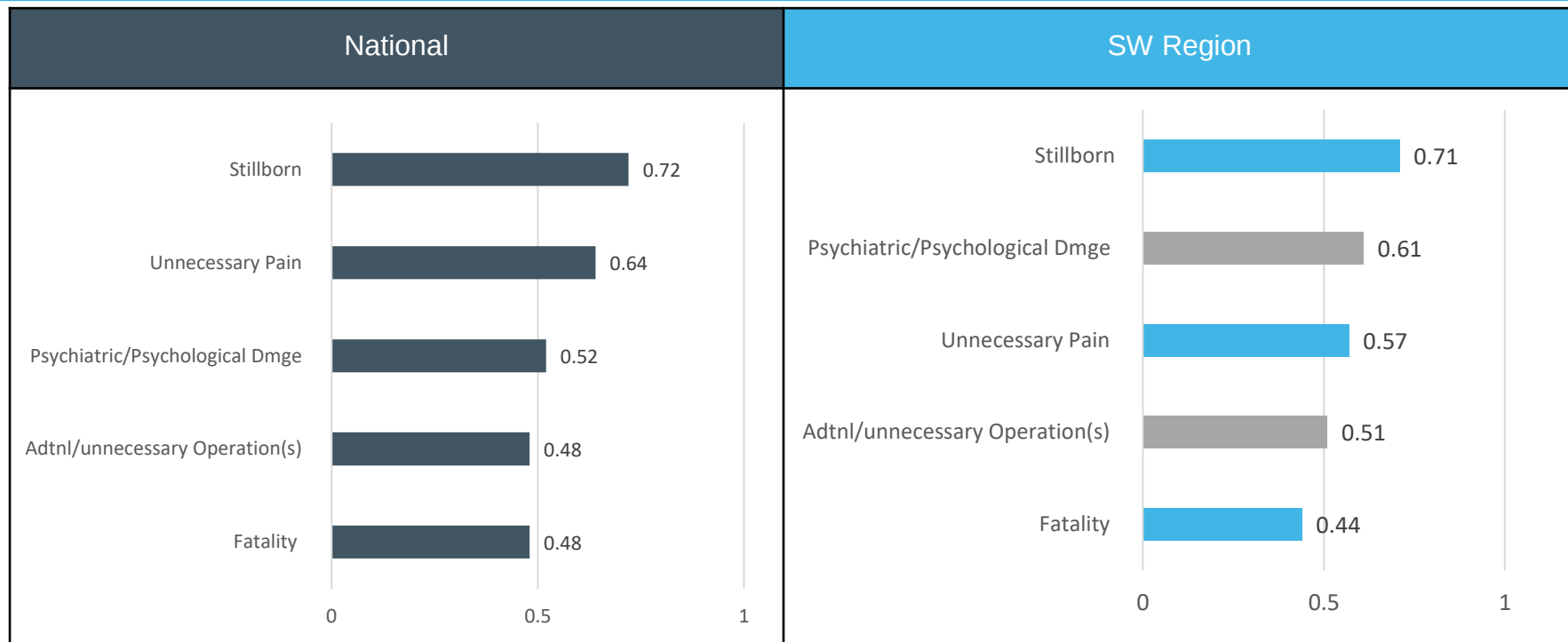
Claims Data correct as of 31.03.24 & exclude EN criteria claims, *[Perinatal mortality data viewer](#) | [MBRRACE-UK](#) ([le.ac.uk](#))



Top 5 Injury codes for Maternity CNST claims volume in 2019/20 to 2023/24 per 1000 births by clinical incident date



Resolution



Key



Region > National rate
/100k population

Claims Data correct as of 31.03.24 & exclude EN criteria claims, *[Perinatal mortality data viewer](#) | [MBRRACE-UK](#) ([le.ac.uk](#))

Summary – CNST Maternity claims

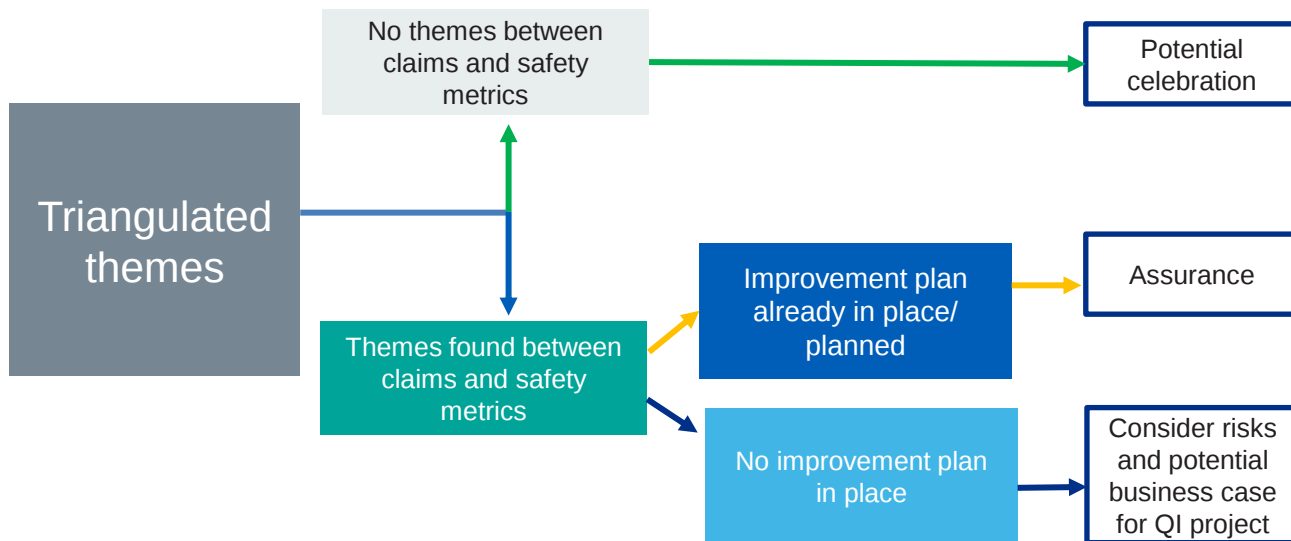
	National	South West
All Claims	The Midlands are the region seen nationally with the highest number of claims, which corresponds with the Midlands also having the highest population footprint. However, they come second to London as the region with the highest number of births.	The South West (SW) has the lowest number of claims across all seven NHS regions, which corresponds with the region having the least number of births and the lowest population footprint.
Cause codes	Fail/Delay treatment was the highest cause by volume both for the SW region and nationally and failure/delay diagnosis was the second highest. Fail to warn-informed consent was the fifth highest cause code by volume seen nationally, this was not in the top five for the SW.	The top four cause codes in volume align with the national picture which are, 'fail / delay treatment', 'failure/delay diagnosis', 'fail to recognise complication of' and fail antenatal screening'. The other cause code was not seen within the national figure for volume, this was: • 'Fail to make resp to abnorm FHR'
Injury codes	The top five injury codes are reflected in both the national and SW picture.	Two injury codes for the SW were higher than the national average, these were: • Psychiatric/ Psychological Dmge. • Adtnl/unnecessary operations.

Triangulation of claims

Drivers – patient safety strategy, PSIRF and MIS

Themes in:

- Claims (scorecard)
- Patient safety events
- Complaints
- Safety data (inc. CQC feedback)



Abbreviations: Patient Safety Incident Response Framework (PSIRF), Maternity Incentive Scheme (MIS), Quality Improvement (QI), Clinical Quality Commission (CQC)

Neonatal Jaundice illustrative case story

1. Situation

- Neonatal jaundice leading to kernicterus and subsequent cerebral palsy

2. Background

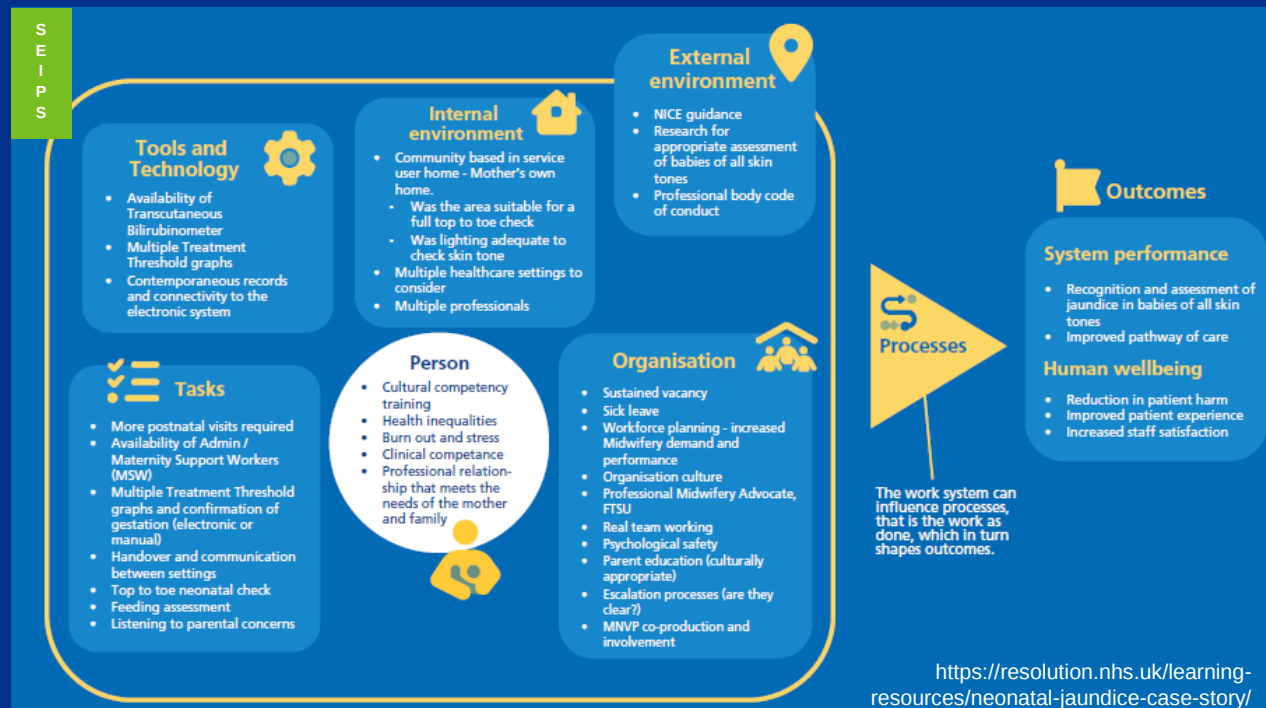
- Black British mother
- No risks identified at booking
- Third baby born by uncomplicated SVD
- Breast feeding

3. Assessment

- Parental concern
- Neonatal Assessment
- Serum Bilirubin Measurement (SBR).
- Urgency of SBR test
- Incorrect chart

4. Recommendation

- SEIPS



Thank you for listening

Any questions?

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