Having a baby under the NHS: very safe but more training could reduce accidental injuries

Having a baby while in the care of the NHS is very safe, according to a new report published today (26 October). However, more training, development and support for clinical staff could help to protect mothers and their babies from accidental injury.

The report published today by the NHS Litigation Authority (NHS LA), which manages legal claims made against the NHS in England, examines 10 years of claims arising from NHS maternity care.

While 5.5 million babies were born in England during the decade from 1 April 2000 to 31 March 2010, these resulted in 5,087 maternity claims for injury made against the NHS during the same period – less than one claim per 1,000 births. However, because injuries to mothers and their babies can be so serious, it is important that the NHS learns from these claims.

The report found that in the 5,087 cases that resulted in claims, junior doctors and inexperienced midwives were often involved in the management of labour in these cases without adequate assistance from senior clinicians. Having more senior staff available during labour together with a better understanding among junior staff about when to ask them for help may prevent harm. The report also found that effective multi-disciplinary team working is essential for safe maternity care.

The report, *Ten Years of Maternity Claims, An Analysis of NHS Litigation Authority Data*, is the result of collaboration with a wide range of healthcare and legal experts, including doctors, midwives and lawyers specialising in maternity claims.

(cont.)
NHS LA Chief Executive Catherine Dixon said:

“Having a baby while under the care of NHS doctors and midwives remains very safe. Out of 5.5 million births in England during the decade covered by the report, about one in a thousand result in a legal claim against the NHS.

“However, because maternity claims are so serious as they involve harm to mothers and their babies, it’s vital that we learn and share lessons from them so that professionals can improve their clinical practice in the future and prevent harm. That’s what our report aims to do.”

David Richmond, RCOG Vice President (Clinical Quality), who contributed to the report, said:

“This report has defined why problems occur and provides us with valuable information so that maternity services can put in place robust monitoring and risk identification systems to prevent them from recurring.

“Our most recent reports – High Quality Women’s Health Care and Tomorrow’s Specialist – make a strong case for the NHS to move to a consultant-delivered service so that trainee doctors receive adequate support and women have access to qualified specialists throughout the day and night. Alongside the recommendations from the NHS LA, we now have good information on how we can learn from past mistakes so that new ones can be prevented.”

NHS LA will work closely with the Department of Health and with other professional bodies and organisations in the coming months to share the lessons from the report with NHS clinicians across the country. The report also includes a series of information sheets (appendices 1-19) designed to help clinicians raise the standard of maternity care in a range of specific risk areas. The information sheets, which form part of the 170 page report, are available separately on the NHSLA’s website to make it easier for clinicians to access them.

**Key findings**

The report found that three types of case accounted for 70% of the total value: claims arising from mistakes in cardiotocograph (CTG) interpretation, claims arising from mistakes in the management of labour and cases in which the outcome was that the baby suffered cerebral palsy. There were 542 claims for cerebral palsy with a total value of paid and outstanding payments of £1.3 billion, reflecting the lifelong cost of future treatment and care.

The report looked at claims arising from failures in four key areas in greater depth: antenatal ultrasound investigations; cardiotocograph (CTG) interpretation; perineal trauma and uterine rupture.

The key findings were as follows:

(cont.)
Antenatal ultrasound investigations

- Most failures to detect anomalies from antenatal ultrasound investigations were due to human error, highlighting a need for improved and regular training, team discussion to learn from the findings of difficult scans and regular review of scans.
- In some cases there was evidence of failures to adopt national guidance* in the implementation of local protocols, indicating a need to ensure that local protocols are consistent with national guidance and followed by staff.
  (* UK National Screening Programme and NHS Fetal Anomaly Screening Programme Standards and Policies, http://fetalanomaly.screening.nhs.uk/standardsandpolicies)
- Scanned images made during pregnancy were only saved in half of the claims – making it difficult to establish whether fetal anomalies were visible at the time of the scan and were overlooked or if they were not visible on the scan. National standards introduced in 2010 state that all images should now be captured, stored and archived to provide a complete clinical record which will support improved care.

Cardiotocograph (CTG) Interpretation

- Claims arising from CTG interpretation were mainly as a result of the failure to recognise an abnormal CTG and/or act on it, showing the importance of staff attending and completing training for intrapartum fetal monitoring and ensuring their competence in applying the knowledge to clinical practice.
- The majority of claims arose out of pregnancies and labours assessed as being low risk by those caring for the mothers, indicating a need for effective monitoring of all deliveries.
- As is to be expected, the majority of CTG claims related to pregnancies at term but the highest number of incidents occurred towards the end of the normal gestation period at 40 and 41 weeks.

Perineal trauma

- Claims arising from perineal trauma mainly arose from failure to recognise the severity of injury and to adequately repair it. Both midwives and obstetricians of varying experience misdiagnosed tears. The majority of claims challenging adequacy of repair involved doctors of registrar level or below.
- A number of the claims for perineal trauma arose from a failure to perform a rectal examination on the mother following delivery, emphasising the importance of this procedure.
- To ensure appropriate care, there needs to be a clear process for the review of women who have sustained a perineal tear in an obstetric/gynaecology postnatal clinic and the assessment must be documented.

Uterine rupture

- More than half the claims arising from uterine rupture occurred in a vaginal birth after a previous caesarean section (VBAC).

(cont.)
• Labour was induced or augmented (assisting the start of contractions or increasing the frequency and duration of contractions) in more than 50% of the claims arising from uterine rupture, indicating that for most women with uterine scars where induction and/or augmentation is considered, a consultant obstetrician should be involved in the decision making process. (Royal College of Obstetricians and Gynaecologists: Green-top Guideline No. 45 Feb 2007 Birth After Previous Caesarean Birth http://www.rcog.org.uk/files/rcog-corp/GTG4511022011.pdf)

• Almost 50% of the claims reviewed involved a delay in diagnosis of rupture or impending rupture, showing the importance of undertaking maternal observations in labour, whilst continually monitoring fetal wellbeing in accordance with an approved guideline. The progress of labour must be closely monitored and clinical decisions made by taking the whole clinical picture into account.

Other general learning for maternity services

• The detailed studies show a need for more effective training and development of staff including online learning.
• Effective multi-disciplinary team working, and mutual professional respect, is essential to the provision of safe care.
• Maternity services must ensure that national guidance is considered and reflected appropriately within local guidelines and protocols. Such guidance must be current, accessible, understood and acted on by staff and reviewed regularly.

Learning for the NHS LA

• The claims management process can contribute to safety awareness and understanding. The NHS LA needs to introduce better ways of sharing the information gained with healthcare professionals.
• The coding used by the NHS LA to record claims needs to be revised to assist ongoing analysis and support further learning.
• The report should be used to inform revisions of the NHS LA’s approach to the maternity standards and assessment process.

ends

Notes to Editors

1. The NHS Litigation Authority was created to deal with claims from patients who have been harmed while undergoing NHS treatment. It aims to pay justified claims promptly and fairly and to defend unjustified claims robustly. It also has a role in helping NHS providers to learn lessons from claims, to manage risks and improve patient and staff safety.

2. A full copy of the report is available on NHS LA’s website at www.nhsla.com > Publications > Claims and Risk Management Initiatives > Ten Years of Maternity Claims

3. For further information about this press release, please contact:
Paul Wastell, Head of Communications at NHS LA on 020 7811 2843, paul.wastell@nhsla.com