

The Clinical Negligence Scheme for Trusts – why CNST rules

The NHS pays out £800 million each year in clinical negligence payments, so avoiding litigation is a major concern of health service managers. Here Gillian Fletcher, an antenatal tutor, explains how this affects maternity services.

A significant cost for the health service is payments for clinical negligence claims. At the RCM Legal Birth conference in July this year, John Mead, the NHS Litigation Authority's technical claims director, reported that the number of obstetric cases receiving a compensation pay-out represents 20.58% of all claims. Much more startling is the fact that these represent 60.9% of the value of all compensation awards.¹

When maternity care is sub-optimal and results in a damaged baby or an injured mother, the family is able to make a claim for compensation. The consequences of clinical errors and omissions of care can lead to immense physical and emotional harm. Some mistakes can be resolved with further treatment but others have a life-long impact on quality of life and opportunities. If a baby is severely disabled and likely to need constant care and special facilities for many years, the claim an NHS trust has to settle can be huge.

This is the background to a concerted effort to ensure that maternity care is of a consistently high quality and that all staff see it as one of their concerns to keep

women and babies safe.² It also provides the rationale for all NHS trusts belonging to the Clinical Negligence Scheme for Trusts (CNST).

The independent inquiry into the safety of maternity services by the King's Fund in England said:

'Discussion on safety should not only focus on risk and harm but also on the causes of success and the positive actions that create and maintain a system that achieves maximum reliability and resilience'.²

The NHS Litigation Authority (NHSLA), established in 1995, indemnifies English NHS bodies against claims for clinical negligence through CNST, and aims to promote effective risk management to minimise harm to patients and the cost of claims. A separate set of CNST standards was developed for maternity services in 2003, because of the disproportionate scale of maternity claims. These were revised in 2007/8 and will be updated annually following the issue of national guidelines and reports.

The five standards, applying to antenatal, intrapartum and postnatal services, including care of the newborn,

midwifery led-care, obstetrics, anaesthetics and ultrasonography, are:

- Organisation
- Clinical care
- High risk conditions
- Communication
- Postnatal and newborn care.

Each standard covers an area of risk and has ten specific underpinning criteria, each with detailed breakdown, against which Trusts are assessed. There are three progressive levels of assessment and for each level minimum requirements are set (see table below).

All services must be regularly assessed, as follows:

- Level 0 maternity services must be assessed annually until such time as they achieve Level 1.
- Level 1 services must be assessed at least once in any two-year period
- Level 2 and 3 must be assessed at least once in any three-year period.

An incentive scheme, in the form of a discount for achieving each level, intended to drive up the standard of

Level	Basis of assessment	Method of assessment
1- Policy Documentation	Processes for managing risk are described and documented.	Review of documents.
2- Practice Implementation	Processes for managing risk as described in Level 1 documentation is in use and has been implemented throughout the service.	Majority of level 2 criteria are assessed by assessors reviewing health records. Assessors review a minimum sample size of health records agreed in advance.
3. Performance Monitoring	Monitoring whether or not processes for risk management, as described in Level 1 approved documentation, are working across the organisation. Action plans must be developed for any failings identified and changes made to reduce risk.	Monitoring should reflect all care settings (including home births), all staff and all patient groups.

maternity care, has had insufficient impact in practice. So, it has been suggested that the Department of Health create further financial incentives to promote the safest care, and to develop commissioning and patient choice as drivers for improvement.²

Recent changes to CNST have affected assessment processes and scoring tables, the layout of standards and criteria. A number of new criteria and minimum requirements have been introduced, as well as a clear rationale for each criterion.³

'Risk management should be seen in the context of the woman's whole journey through pregnancy'

NCT and many midwives are concerned that implemented rigidly and without due regard for the individual circumstances and preferences of each pregnant woman, a focus on safety can be reduced to routine use of restrictive care protocols aimed at avoidance of risk. However, the King's Fund report highlighted the importance of women's experiences and the impact that the quality of the birth experience can have on individuals and families. Risk management should be seen, therefore, in the context of the woman's whole journey through pregnancy and the couple's transition to parenthood, and an appropriate balance should struck when considering risk management in maternity care.

However, there is still plenty of scope for creativity and innovation. I know of

one hospital that is applying for level three CNST alongside all their current work on preventing unnecessary caesareans and promoting normality.⁴

For more information, see www.nhsla.com. Please feedback to me at gillian.fletcher4@btinternet.com any experience you have had of CNST.

References

1. Legal birth conference 2010. Available from: <https://www.rcm.org.uk/login/?ReturnUrl=/midwives/news/legal-birth-conference-2010/>
2. O'Neill O. *Safe births: everybody's business. An independent inquiry into the safety of maternity services in England*. London: King's Fund; 2008. Available from: http://www.kingsfund.org.uk/publications/kings_fund_publications/safe_births.html
3. NHS Litigation Authority. *Clinical negligence scheme for trusts maternity clinical risk management standards: version 1 2010/11*. Available from: <http://www.nhsla.com/RiskManagement/>
4. NHS Institute for Innovation and Improvement. *Delivering quality and value. Pathways to success: a self-improvement toolkit. Focus on normal birth and reducing Caesarean section rates*. Coventry: NHS Institute; 2006.

Actions for maternity services reps

If you are a rep on a maternity services liaison committee or labour ward forum, it is a good idea to find out whether your Trust has policies and guidelines reflecting good practice and, if so, whether it follows them:

- Familiarise yourself with the CNST standards and the level at which your trust operates or is applying for.
- Talk to midwives to explore the potential implications for the service.
- Suggest reviewing (or discussing) CNST standards as an agenda item.

Examples of CNST standards

Standard 2 - Criterion 2: Auscultation

The maternity service must have an approved system for improving the care and learning lessons relating to auscultation of the fetal heart in labour that is implemented and monitored.

The rationale states: 'Intermittent auscultation of the fetal heart rate is recommended for low risk women in established labour in any birth setting.'

Would this help you in challenging the routine use of admission traces still occurring on all women in many units despite the evidence?

Standard 2 - Criterion 10: Vaginal Birth After Caesarean Section (VBAC)

The maternity service must have approved documentation for the management of VBAC, which as a minimum must include:

- 1.2.10 (c) documented individual management plan for labour
- 1.2.10 (f) documented plan for monitoring fetal heart in labour.

How much do the management plans in your trust promote maintaining upright positions whilst being monitored? Manage risk by all means, but also ensure the highest chance that the woman might achieve a normal birth.

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