avma action against medical accidents

for patient safety and justice

SUBMISSION BY ACTION AGAINST MEDICAL ACCIDENTS ('AvMA') TO HEALTH SELECT COMMITTEE INQUIRY INTO MATERNITY SERVICES FOLLOWING THE PUBLICATION OF THE NATIONAL MATERNITY REVIEW REPORT 'BETTER BIRTHS'

Action against Medical Accidents

1. Action against Medical Accidents (AvMA) is the UK charity for patient safety and justice.

2. Established in 1982, AvMA provides free independent advice and support to people affected by medical accidents through our specialist helpline, written casework and inquest support service. It is our work with patients and their families that informs and drives AvMA's policy work.

3. AvMA also works in partnership with health professionals, the NHS, government departments, lawyers and, most of all patients, to improve patient safety and justice in the widest sense for people affected by medical accidents.

AvMA's response to the Maternity Review report

Introduction

4. The National Maternity Review was born out of the Morecambe Bay inquiry undertaken by Dr Bill Kirkup [i] into the failures in maternity care at Furness Hospital, now part of Morecambe Bay NHS Foundation Trust. The tragic events at Furness had resulted in avoidable deaths and significant harm to both mothers and babies stretching over a decade. The inquiry identified not only that the unit was unsafe and dysfunctional but that there were significant failings in the wider regulatory system. There was much that warranted action both at local and national level.

5. It was anticipated that the focus of the Maternity Review would be about improving safety in maternity care and addressing some of the key findings of the Kirkup report. Whilst there were problems specific to Morecambe Bay, avoidable harm occurs across our maternity services, devastating the lives of many hundreds of families but also impacting adversely on clinical staff.

6. The National Maternity Review touched on issues which impact on safety, but there was not the level of focus on reducing avoidable harm that had been anticipated. This is not to detract from some of the very important recommendations made by the Review, particularly around issues such as continuity of care, multi-professional working and improved mental health care for mothers. If implemented, this will contribute to safer care.

Existing evidence on avoidable harm

7. Maternity care has been amongst one of the most examined areas of healthcare with the confidential enquiry into maternal deaths (CEMD) being established in the 1950s and the confidential enquiry into stillbirths and deaths in infancy (CESDI) in 1992. [These enquiries are now incorporated into MBRRACE (Mothers and Babies – reducing risks through audits and confidential enquiries).]

8. Another potentially important source of data on maternity care is that arising from claims for clinical negligence. These cases will have been subject to detailed analysis by senior consultants in obstetrics and paediatrics. All of this data will have been available to the NHS Litigation Authority which has managed claims on behalf of the NHS since 1995. It is only very recently that attention has been given as to how that data might be used to improve care.

The need to act on the evidence

9. The reality is that there is already a considerable amount of evidence available about some of the common causes of avoidable harm, the failure lies in acting on what we already know. For decades it has been known that a failure to accurately monitor and interpret foetal well-being in labour is frequently a factor in cases of avoidable cerebral palsy along with the overuse use of oxytocic drugs. That continues to be the case. We also know that the failure to identify and respond to foetal growth restriction is a significant factor in avoidable stillbirths. There are many other similar factors that have consistently been identified as contributing to avoidable harm but there has been a failure to drill down to why the same mistakes keep being repeated.

10. Since the seminal patient safety report, An Organisation with a Memory [ii], published by the Chief Medical Officer in 2000, there has been a great deal of rhetoric around the importance of learning and disseminating learning. However, what is becoming increasingly apparent is that the 'learning' that is available has not prevented the same errors being repeated.

11. The best maternity units are implementing change but their needs to be a coordinated and sustained commitment across the board to reduce some of the basic errors that lead to avoidable harm. This means being completely honest and open about the causes of avoidable harm whether it relates to the resourcing and staffing of our maternity services or issues around the quality and nature of professional training. This may require some fundamental changes in the way we organise our maternity services and in the way that we train our healthcare professionals. We can look to examples from other countries where such improvements have been achieved by recognising the need to make that across the board commitment to improving care.

12. We are at a watershed where the inaction and apparent complacency that has allowed failures in maternity care to persist is no longer sustainable. This is particularly important at a time when our maternity services are facing very significant challenges with the highest birth rate in over 40 years and with an increasing caseload of complex and high risk pregnancies.

National strategy on reducing harm in maternity care

13. There are already a number of different initiatives focused on reducing harm in maternity care including 'Each Baby Counts', an improvement programme introduced by the Royal College of Obstetricians and Gynaecologists (RCOG) [iii]. Jeremy Hunt announced in November 2015 [iv] an ambition to reduce stillbirths, neonatal deaths and maternal deaths by 50% by 2030 as well as reducing the number of brain injuries occurring during or after birth. What is less clear is how those improvements are to be achieved. Previous targets have been set but not achieved including in the CMO's report of 2000, with a five year target to 'reduce by 25% the number of instances of negligent harm in the field of obstetrics and gynaecology which result in litigation'. If targets are to be achieved, there needs to be a national coordinated strategy bringing together all the different strands and stakeholders from Government to parents.

14. AvMA would recommend the need for an independent body to be tasked with coordinating and driving improvements. It would be responsible for bringing together all the different initiatives and ensuring this is translated into real and sustainable change.

15. One of the significant factors in relation to Furness Hospital and that mirrored what happened at Mid Staffs, was the difficulties faced by parents in having their concerns heard. This situation is perhaps never truer than when what patients are saying is incompatible with the image an organisation is trying to present. We are still failing to recognise the important role that patients can play as the real time monitors of standards operating in our health services.

16. Another factor in common with Mid Staffs was the unintended consequences of healthcare policy that meant achieving NHS Foundation Trust status took precedence over patient safety. Patient safety must always take centre stage when policy or structural change is being considered.

Rapid Resolution and Redress Scheme

17. The Maternity Review recommends the introduction of an administrative scheme for compensating babies brain damaged at birth. Whilst AvMA would welcome a scheme that is truly proactive in identifying when treatment has caused avoidable harm and that offers full and prompt compensation in line with a child's legal entitlement to be fully compensated, we have significant concerns with the respect to the scheme as proposed.

18. Firstly, the scheme proposes limiting compensation to a predetermined 'capped' amount regardless of the child's actual needs.

19. It is also proposed that care needs would be met through services on offer from the NHS or local authorities. This would leave families with limited choice or security over services that their child will be reliant on for the rest of their lives. The main motivation for parents in pursuing legal action is to secure their child's future. In effect, they would not be 'compensated', they would simply be accessing the already hard pressed and increasingly limited services available at local level with no guarantee over what will be deemed a suitable care package now or in the future [v] [vi] .

20. The proposals are modelled on the Swedish compensation scheme but this operates within a very different context with high levels of care and support available through the state.

21. It is believed that such a scheme would directly improve safety. Sweden first introduced a 'no fault' compensation scheme in 1975. In 2008, the rates of avoidable harm in Sweden were found to be similar to other equivalent countries. [vii] A second study in 2008 [viii] looked at the causes of avoidable birth asphyxia; this contributed to a major programme of work to improve safety in childbirth. It is clear that we need to focus on a broader range of initiatives to achieve a reduction in harm.

22. One of the biggest improvements which we believe should and could be made which would both help improve learning from incidents in maternity care to improve safety, and also the ability to make speedier decisions about compensating babies, would be to dramatically improve the quality of local investigations. The advent of the Healthcare Safety Investigation Branch may help with the thematic investigation of issues, but does not in any way take away the need to improve the quality of local

investigations. If each serious incident was properly investigated, not only would there be learning but it would also be much more likely that a speedier decision could be made as to whether the case warranted compensation being offered. This would in turn save vast amounts of NHS money wasted due to inappropriate defence of meritorious claims, and the further human agony that this causes. If this happened then a special scheme such as that proposed would not be required.

23. AvMA believes a scheme should only be introduced if it met the following standards:

- The scheme must be sufficiently independent and expert enough to be able to determine whether cases meet the criteria for compensation;
- It should award compensation based on actual need;
- It must guarantee ongoing access to the services that the child needs, be that from the state or private providers;
- The family must have access to specialist advice to empower them in the investigation and determination of their case;
- It is imperative that families retain their right as recommended by the Review to pursue a legal claim for compensation.

24. We believe that if a redress scheme were to be introduced it should base its eligibility criteria on the notion of “avoidability” rather than “negligence”. This would take away the concentration on attributing negligence and blame to individual health professionals which the legal system requires, and be more in tune with patient safety approaches. For example, what were the root causes; how could such incidents be avoided in the future; what went wrong in the organisation/system as opposed to blaming individuals. The test should be: could this harm have been avoided through the provision of reasonable treatment.

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[i] The Report of the Morecambe Bay Investigation, March 2015
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[ii] An Organisation with a Memory
http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4065086.pdf

[iii] Each Baby Counts
https://www.rcog.org.uk/eachbabycounts

[iv] New ambition to halve rate of stillbirths and infant deaths

https://www.gov.uk/government/news/new-ambition-to-halve-rate-of-stillbirths-and-infant-deaths

[v] Disabled claimant given green light to challenge cuts to care package
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[vi] Independent Living Fund: 'Shocking' drop in support after ILF closure
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[vii] Factors influencing patient safety in Sweden: perceptions of patient safety officers in the county councils
http://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-13-52

viii Severe asphyxia due to delivery-related malpractice in Sweden 1990–2005
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