Department of Health & Social Care

From Nadine Dorries MP
Minister of State for Patient Safety,
Suicide Prevention and Mental Health

39 Victoria Street
London
SW1H 0EU

020 7210 4850

Your Ref: CEM/00617-2019
Our Ref: PFD-1236272

Professor Catherine E Mason
HM Senior Coroner, Leicester City
and South Leicestershire
HM Coroner's Office
Town Hall
Town Hall Square
Leicester LE1 9BG

11th September 2020

Dear Professor Mason,

Thank you for your letter of 12 May 2020 to Matt Hancock, received by the Department on 26 June 2020, about the death of Harrison Colin Hassall. I am responding as Minister with portfolio responsibility for maternity services and patient safety.

Let me start by saying how deeply saddened I am to learn of the tragic circumstances surrounding the death of baby Harrison. I offer my most heartfelt condolences to Harrison's parents and all those affected by Harrison's death. That Harrison's death was contributed to by the failings of healthcare professionals, as your investigation has concluded, must be particularly distressing and we must do all we can to learn from those failings to prevent future tragedies.

I am advised that investigations conducted by the University Hospitals of Leicester NHS Trust and the East Midlands Ambulance Service NHS Trust into the care provided to Harrison and his mother identified areas for improvement that resulted in recommendations for action. I am further advised that those actions have been implemented and the learning from this incident has been shared widely to support improvements in safety and in particular, the response of multi-disciplinary teams to maternity emergencies. I encourage the NHS organisations involved to reflect fully on the findings of the coronial investigation and to consider if there is more that can be done to learn from the circumstances of Harrison's death.

Your report explains that evidence heard at inquest suggested that midwives are permitted to work in the community too soon after qualification and without adequate experience. In considering those concerns, my officials have taken advice from NHS England and NHS Improvement (NHSEI) and the Chief Midwifery Officer, Professor Jacqueline Dunkley-Bent OBE, and I can provide the following information in relation to the education and training, ongoing professional development and supervision of midwives, including community midwives, in England.

As you will be aware, the Nursing and Midwifery Council (NMC) is the independent regulator of midwives in the UK. Where there are concerns that a midwife is not meeting the standards for skills, education and behaviour required for registration, the NMC can investigate and has the power to impose sanctions on a registrant's practise to protect patient safety.

The NMC sets the standards of proficiency that midwives must demonstrate to enter on its register. Approved Education Institutions (AEIs) develop, deliver and manage educational curricula to meet the NMC's standards. Community midwives, like all midwives, are required to undertake a minimum of three years theoretical and practical midwifery education and training to acquire the skills, competencies and learning required as a practising midwife, prior to entry to the NMC register.

In 2019, the NMC published updated standards of proficiency for midwives[1], setting out the knowledge and skills required to join the register, as well as new standards for pre-registration training and education programmes. The new standards came into effect in January 2020. However, due to the impact of the Covid-19 pandemic, implementation of the new standards by AEIs has been delayed by the NMC.

Preceptorships provide a period of guidance and support to newly qualified practitioners that supplements formal induction and mandatory training and can positively influence a new registrant's career, supporting them to become confident professionals. In July 2020, the NMC published principles for preceptorship[2], to support organisations and employers across the UK to achieve consistently high quality and effective preceptorship for newly registered nurses, midwives and nursing associates in the UK. NHS Trusts and other employers can use the NMC's recently published principles of preceptorship to design and deliver effective, high quality preceptorship programmes.

I am advised that the University Hospitals of Leicester NHS Trust introduced a preceptorship programme in 2019 that requires newly qualified midwives, including those going on to community placements, to take a minimum 12-month period of preceptorship, with clinical competency assessments. I am further advised that following the conclusion of the inquest into Harrison's death, the Trust has indicated that it will not place midwives into the community during their preceptorship period.

In relation to the supervision of midwives, in April 2017, NHSEI published a new model for supervision[3], moving to an employer-led professional model called A-EQUIP (advocating for education and quality improvement). The A-EQUIP model and the associated role of Professional Midwifery Advocate are designed to promote continuous improvement and build the personal and professional resilience of midwives and therefore enhance the quality of care for women and babies.

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[1] https://www.nmc.org.uk/standards/standards-for-midwives/

[2] https://www.nmc.org.uk/standards/guidance/preceptorship/

[3] https://www.england.nhs.uk/publication/a-equip-a-model-of-clinical-midwifery-supervision/

During practice, all midwives, including community midwives, are required to undertake mandatory annual skills training and are expected to take personal accountability for their continuing professional development. This is reinforced by the annual registration process and the requirement for full revalidation every three years to remain on the NMC register. Mandatory annual skills training includes training in emergency situations, such as for the delivery of babies in the breech position. Human factors training and training in simulation-type settings is also recommended by the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists, and providers of maternity services are encouraged to adopt such training as good local practice.

At a national level, there are several measures being taken to drive improvements in maternity quality and safety in the NHS that are relevant to highlight in this response. This includes the Maternity Transformation Programme[4], led by NHSEI, which is focused on the delivery of safer and more personal maternity care. A key part of the Programme is the appointment of Safety Champions in NHS Trusts, who are responsible for providing leadership and oversight for safety improvements in maternity and neonatal services, as well as ensuring that learning from tragic events lead to change and improvements to ensure safer care.

Other aspects of the Programme include a focus on continuity of care, with the same midwife caring for a woman during the antenatal, labour and post-natal period in a team or buddy system. This way of working has been shown to improve outcomes, including for example, women being less likely to experience preterm birth.

The Programme also underlines the importance of multi-disciplinary team working and is developing a new, core competency curriculum that includes multi-disciplinary team training on skills acquisition, including the management of unexpected breech birth. Elements of the curriculum, including breech birth, will extend to that of ambulance personnel and will cover essential elements of escalation, communication and transfer.

Multi-disciplinary team working is further reinforced by the Maternity Incentive Scheme[5], which as part of the Clinical Negligence Scheme, issues financial rebates to NHS Trusts, subject to them meeting 10 safety actions relating to maternity safety. The 10 safety actions include the requirement that Trust Boards evidence that at least 90 per cent of the staff of each maternity unit attend an 'in-house' multi-professional maternity emergencies training session within the last training year.

Phase 2 of the Maternity and Neonatal Safety Improvement Programme[6], includes escalation as a major area of focus through its work in relation to deterioration of mother and baby. Similarly, through the Each Baby Counts Learn and Support Programme[7], led by the Royal College of Obstetricians and Gynaecologists and the Royal College of

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[4] https://www.england.nhs.uk/mat-transformation/

[5] https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/

[6] https://www.england.nhs.uk/mat-transformation/maternal-and-neonatal-safety-collaborative/

[7] https://www.rcog.org.uk/en/guidelines-research-services/audit-quality-improvement/ebc-learn-support/

Midwives, 16 NHS Trusts will pilot innovative approaches to escalation when maternity safety concerns are identified.

Finally, my officials have brought your report to the attention of the Healthcare Safety Investigation Branch, the independent national body which, through its maternity investigation programme, seeks to identify common themes and influence safer maternity care; and also the Care Quality Commission (CQC) as regulator for quality.

The safety of maternity services is a key priority for this Government and I hope this response is helpful in setting out the requirements in place in relation to the education and training, ongoing professional development and supervision of midwives, as well as wider national action to improve maternity safety.

Thank you for bringing your concerns to my attention.

Nadine Dorries

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