Department of Health & Social Care

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

39 Victoria Street
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[redacted]

Our Ref: [redacted]

Mr Jonathan Stevens
HM Assistant Coroner, Hertfordshire
HM Coroner's Office
The Old Court House
St Albans Road East
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9 February 2021

Dear Mr Stevens

Thank you for your letter of 15 December 2020 to Matt Hancock about the death of Eddie John Coffey. I am responding as Minister with responsibility for maternity care.

Firstly, I would like to say how deeply sorry I was to read of the circumstances of baby Eddie's death and I offer my most sincere condolences to Eddie's parents and family. I appreciate how devastating it must be to lose a child and that the pain must be particularly hard to bear when there are concerns about the care provided.

It is essential that the East and North Hertfordshire NHS Trust (the Trust) takes all the learnings from the circumstances of Eddie's death and the findings of your investigation to prevent future tragedies.

I am advised by the Care Quality Commission (CQC), the independent regulator for quality, that maternity services at the Trust were inspected in April 2018, resulting in an overall rating of Good and Requires Improvement for the safety of care. The CQC has monitored the improvements made by the Trust that include a move to physiological CTG interpretation[1] supported by one full day of CTG training. The CQC was advised by the Trust that as at October 2020, 86 per cent of midwives and 73 per cent of medical staff had received additional training in fetal monitoring during labour.

I am further advised that an inspection of the Trust in June 2019 rated overall leadership as Requires Improvement reflecting that at that time, the Trust was developing its patient safety culture and strengthening its governance processes around incident management to ensure learning.

[1] Physiological interpretation of cardiotocography. A technique used to monitor the fetal heart rate to assess fetal wellbeing.

I welcome the action that has been taken so far and I encourage the Trust to continue to look carefully at what more can be done to improve this important area of patient safety. In line with regulatory processes, I am assured that the CQC will continue to monitor improvements at the Trust and my officials have brought your report to the attention of health system leaders, NHS England and NHS Improvement (NHSEI).

To ensure patient safety, it is vitally important that NHS Trusts encourage a culture of openness and continuous learning. That is why, in 2017, the National Quality Board published national guidance on Learning from Deaths[2], to introduce a more standardised approach to the way NHS trusts review, investigate and learn from deaths thought to be due to problems in care.

From 2017-18, we have required NHS trusts to publish locally the numbers of deaths thought to be due to problems in care on a quarterly basis, and to evidence what they have learned and the actions taken to prevent such deaths on an annual basis in their Quality Accounts. This new level of transparency is fundamental to a culture of learning and ensuring the safety of NHS services. This policy is supported by strengthened inspection assessment of NHS trusts' learning from deaths by the independent regulator for quality, the CQC.

In relation to your findings about the quality of the Trust's investigation of the care and treatment provided to Eddie Coffey and his mother during labour, you may wish to note that a new Patient Safety Incident Response Framework[3], to replace the Serious Incident Framework, is being developed to facilitate examination of a wider range of patient safety incidents in the NHS and to improve the quality of patient safety incident investigation and how organisations can learn and change as a result.

The Framework outlines how NHS organisations should respond to patient safety incidents, including how and when an investigation should be conducted. The Framework supports a systematic, compassionate and proficient response; anchored in the principles of openness, fair accountability, learning and continuous improvement.

NHSEI is currently working with early adopters to pilot the new Framework. The learning from this pilot will be used to inform the final version of the Framework. Until this is finalized, NHS providers and their local health partners should review the introductory framework and Patient Safety Incident Investigation standards[4] and begin to consider what they will need to do to support their implementation.

Turning to your wider concerns about maternity safety, I wish to assure you that there is much being done nationally to improve the quality and safety of maternity services.

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[2] https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

[3] https://www.england.nhs.uk/patient-safety/incident-response-framework/

[4] https://www.england.nhs.uk/patient-safety/patient-safety-investigation/

Following the publication of [redacted] first report, *Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust*, on 10 December 2020, NHSEI wrote to NHS Trust and Foundation Trust Chief Executives and Chairs[5], setting out the immediate response required of all NHS Trusts providing maternity services and next steps to be taken nationally. Despite considerable progress having been made in improving maternity safety, there continues to be too much variation in experience and outcomes for women and their families.

This letter identifies seven priorities and has asked NHS Trusts for immediate actions to implement these, including: enhanced safety; listening to women and their families; staff training and working together; managing complex pregnancy; risk assessment throughout pregnancy; monitoring fetal wellbeing; and informed consent.

In relation to monitoring fetal wellbeing, NHS Trusts are being asked to implement the saving babies lives bundle. Element 4 of the *Saving Babies Lives Care Bundle Version 2* (SBLCBv2[6]) already states there needs to be one lead with the responsibility of improving the standard of fetal monitoring. NHS Trusts are now being asked to ensure that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with the SBLCBv2 and national guidelines.

[redacted] report also identified that safe delivery of maternity services is dependent on a multidisciplinary team approach. The Maternity Transformation Programme[7], led by NHSEI, has implemented a range of interventions to increase numbers of healthcare professionals and support workers including the development of the maternity support worker role; the expansion of midwifery undergraduate numbers; additional maternity placements; and active recruitment.

In addition, £9.4million was awarded in the 2020 Spending Review to support maternity safety pilots that will include fresh learning from recent investigations and academic research to be used to improve clinical practice during childbirth, and cutting-edge training and expert guidance to improve practice and avoid harm to babies.

In relation to guidelines on monitoring fetal heart rate, there are different guidelines for fetal heart rate monitoring that NHS Trusts in England may refer to in developing their local guidelines. This includes:

- NICE (National Institute for Health and Care Excellence) '*Intrapartum care for healthy women and babies*' Clinical guideline [CG190[8]] which includes guidelines on fetal monitoring in labour; and,

[5] https://www.england.nhs.uk/wp-content/uploads/2021/01/Ockenden-Letter-CEO-Chairs-final-14.12.20-1.pdf

[6] https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf

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

[8] https://www.nice.org.uk/guidance/CG190

- FIGO (International Federation of Gynaecology and Obstetrics) '*Consensus guidelines on intrapartum fetal monitoring: Cardiotocography*[9]'.

In addition, there is a third approach called '*Physiological CTG Interpretation*' developed by clinicians from St George's Hospital, Lewisham and Greenwich NHS Trust and Kingston Hospital, led by [redacted][10].
Part of the Spending Review 2020 investment of £9.4million is to pilot an approach to risk assessment and escalation of fetal deterioration, including fetal heart rate monitoring that can be standardised across all maternity providers in England.

Finally, my officials have brought your report to the attention of the Healthcare Safety Investigation Branch (HSIB). HSIB is a key part of our commitment to improve patient safety and the culture of learning in the NHS. The HSIB conduct independent maternity investigations that meet the Each Baby Counts criteria and a defined criteria for maternal deaths so that the NHS learns quickly from what went wrong and uses this to prevent future tragedies. Where HSIB identifies systemic risks, it can consider making national recommendations for system change.

I hope this response is helpful. Thank you for bringing these concerns to my attention.

NADINE DORRIES

MINISTER OF STATE FOR PATIENT SAFETY, SUICIDE PREVENTION AND MENTAL HEALTH

[9] https://www.figo.org/news/available-view-figo-intrapartum-fetal-monitoring-guidelines

[10] https://www.icarectg.com/wp-content/uploads/2018/03/Intrapartum-Fetal-Monitoring-Guideline.pdf