Department of Health & Social Care

From James Morris MP
Parliamentary Under Secretary of State for Primary Care and Patient Safety

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[redacted]

Our Ref: PFD - 1404142

Ms Alison Mutch
HM Senior Coroner, Manchester South
Coroner's Court
1 Mount Tabor Street
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27th July 2022

Dear Ms Mutch,

Thank you for your letter of 31 December 2021 to the Secretary of State for Health and Social Care. I am replying as Minister with responsibility for Primary Care and Patient Safety, and thank you for the additional time allowed.

I would like to start by saying how very sorry I was to read the circumstances of the death baby Jos Tartese-Joy. I can appreciate how devastating his loss must be to his parents and all who loved him. It is vitally important that we take the learning from Jos' death to prevent future tragedies.

Therefore, I have outlined below the action we are taking to prevent future deaths and address your concerns outlined in your letter.

I note that it was found that there was no nationally recognised way of flagging in maternity notes that a pregnancy is considered high-risk. As a consequence, the community midwife and GP were not aware that the pregnancy was high-risk, and additionally the mother herself was not explicitly counselled about this.

To improve women's access to maternity records, in June 2021 an additional £52 million was announced to fast track the provision of online maternity records. This backs the long-term plan commitment to ensure everyone has access to their maternity notes and information electronically by 2023/24. An initial component of this was to create an agreed upon format for the notes both in terms of layout and content. This then has been taken to ensure "*interoperability*" – that is that the notes will be shared irrespective of clinical system.

Not only will this aid communication between healthcare professionals in different parts of the system. It will also allow women to have easy access to their maternity records to take full control of their pregnancy by having information and decisions about their care readily available. The current format of having handheld notes, hospital notes and GP records does not allow for this single combined source of information.

I note that as this pregnancy was not documented or communicated as being high-risk and steps were not taken to create a safe plan for management of the pregnancy and delivery. This included no consultant review and consequently no decision for induction.

The Maternity Transformation Programme led by NHSE, is committed to ensuring that all women have a Personalised Care and Support Plan in place, where risks are identified and discussed and where the principle of fully informed consent is central. A Personalised Care and Support Plan is a series of facilitated conversations in which the person actively participates to explore the management of their health and well-being so that all considerations that might impact on safe care are accounted for. The agreed personalised care and support plan is a live document that should reflect new risks that are identified through the pregnancy and the decisions the woman makes about the care and support she wants to receive as she moves through her pregnancy. Those decisions should be informed by the discussions she has with her healthcare professional about the benefits and harms of the evidence-based options available.

To improve communication and consistency of care for individuals, the NHSE are working with Trusts to roll out midwifery Continuity of Carer. The Midwifery Continuity of Carer model is a way of delivering maternity care so that women receive dedicated support from the same midwifery team throughout their pregnancy.

This relationship between carer giver and receiver has been proven to lead to better outcomes and safety for woman and baby. Continuity of carer promotes closer relationships, with women more likely to disclose health concerns to a midwife they know and trust. Access may also be quicker, which means that care and treatment may be expedited. Therefore, this model of care improves communication between the women and healthcare professionals as women are receiving care from the same midwifery team throughout their pregnancy. In high-risk pregnancy, this model of care is particularly important.

NHSE are working towards achieving the ambition that 75% of women from ethnic minorities and deprived areas receive continuity of carer by 2024.

In October 2021, guidance[1] was published to support Local Maternity Systems and Integrated Care Systems to deliver continuity of carer at full scale, following an extensive process of listening to trusts, services and staff.

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[1] https://www.england.nhs.uk/publication/delivering-midwifery-continuity-of-carer-at-full-scale-guidance-21-22/

I note that an admission CTG was not used for this mother and that slowing of fetal growth while noted on scans was not acted on.

Every maternity service in the NHS is actively implementing elements of the Saving Babies' Lives Care Bundle which comprises four key elements of care: reducing smoking in pregnancy; risk assessment and surveillance for fetal growth restriction; raising awareness of reduced fetal movement; and effective fetal monitoring during labour.

The package was developed by groups brought together by NHS England, including midwives, obstetricians and representatives from stillbirth charities. Though the NHS already follows much of this best practice, this is the first time that guidance specifically for reducing the risk of stillbirth and early neonatal death has been brought together in a coherent package.

Version two of the Saving Babies Lives Care Bundle has been produced to build on the achievements of the version one. This version aims to provide detailed information for providers and commissioners of maternity care on how to reduce perinatal mortality across England. It provides detailed information on risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction. The updated element seeks to focus more attention on pregnancies at high-risk of fetal growth restriction and underlines the importance of properly training staff to carry out symphysis fundal height measurements.

In addition, the bundle provides detailed information on effective fetal monitoring during labour such as trusts must be able to demonstrate that all qualified staff who care for women in labour are competent to interpret CTGs, always use a buddy system and escalate accordingly when concerns arise or risks develop. The bundle has developed a standardised risk assessment tool that all trust should use at the onset of labour.

NHSE has published updated guidance in June 2022, "*Supporting pregnant women using maternity services and access for parents of babies in neonatal units*"[2]. This guidance provides detailed actions for NHS providers of maternity services to facilitate pregnant women having a support person of their choosing with them at all antenatal appointments and during labour and parents of babies on neonatal units having access to their babies.

All maternity units should be allowing all partners and support people to attend all appointments and scans. Health and care settings should continue to maintain appropriate infection prevention and control processes. Related guidance will be kept under review and updated based on the latest clinical evidence where appropriate.

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[2] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/12/C1659-using-maternity-services-and-access-for-parents-of-babies-in-neonatal-units-action-for-nhs-trusts-v2.pdf

Thank you for bringing these important issues and this tragic case to my attention. I hope this letter offers you reassurance that action is being taken in relation to the issue that you have highlighted.

Yours sincerely,

[redacted]

JAMES MORRIS MP
PARLIAMENTARY UNDER SECRETARY OF STATE FOR PRIMARY CARE AND PATIENT SAFETY