NHS
Royal Berkshire
NHS Foundation Trust

Private & Confidential
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By email:
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29 September 2022

Response to Regulation 28 Report to Prevent Future Deaths

Dear Mrs Connor

Thank you for granting us additional time to consider and provide our response to your Regulation 28 Report dated 20 June 2022, following the inquest into the death of Adele Massoudi which took place on 25-27 May and 10 June 2022. I would like to begin by offering my sincerest condolences to the parents of Adele, [redacted]

In summary, your matters of concern related to two areas; training for staff who attend homebirths and the retention of all placentas for an extended storage period, including in uncomplicated births. I will address each matter in turn below.

Midwifery Training

In considering whether the midwifery training provided to date is sufficient and safe, the Trust commissioned an external midwifery report from a Consultant Midwife, to review the midwifery and maternity support worker training provided at the Trust.

The review took into account a wide variety of resources including training policies and guidelines, lesson plans and training evaluations. It also considered national publications and evidence, as well as conducting interviews with members of maternity practice development, matron teams and the South Central Ambulance Service clinical education team.

The following eight recommendations were made for future training provision and the Trust are developing an action plan to address the recommendations. The proposed actions can be summarised as follows:

1. *Review the maternity Training Needs Analysis [TNA] document to better reflect training undertaken;*
   The expectations of staff members, educators and managers are clearly detailed within the TNA and include the management of non-attendance. This, along with the interviews undertaken, gave the reviewer a very positive indication of the Trust's commitment to training. To give further quality assurance the TNA is being reviewed to provide details of the varied ways in which education is delivered.

2. *Increase access to accredited Resuscitation Council UK [RCUK] neonatal life support training for midwives delivering community intrapartum care;*
   The Trust have increased funding for an additional 15 places every year with priority spaces being given to community midwives who provide intrapartum care.

3. *Introduce extended newborn resuscitation in house for midwives and maternity support workers delivering community intrapartum care;*
   Skills drills in the community are run by the education team one or twice a month and are attended by midwives and support workers. Enhanced training sessions are in development alongside the Trust's resuscitation team, and are being written into the TNA with timeframes on when this must be achieved and how often staff will need to attend.

4. *Make attendance at PROMPT [Practical Obstetric Multi-Professional Training] training annual for all community staff;*
   The Trust are exploring increasing capacity to enable community staff to attend the PHONE or PROMPT training day annually, whichever is considered the most appropriate for multidisciplinary neonatal resuscitation training.

5. *Consider strengthening competency assessment within mandatory training;*
   A formal assessment of neonatal resuscitation is now included during induction (delivery of inflation breaths, calling for help and SBAR handover). The practice development team are also undertaking training with RBFT resuscitation team to ensure consistency of informal assessments.

6. *Undertake a survey of maternity staff working in community settings to assess their training and development needs for intrapartum care;*
   Two surveys are in development for community midwives and maternity support workers to assess their knowledge and confidence.

7. *Consider offering opportunities for community staff to work in acute site with support, to enhance their clinical skills and confidence;*
   All new midwives have shifts within the maternity unit as part of their induction. The survey above will also identify whether any further training is indicated for acute site placements to be facilitated, alongside the new homebirth competency/confidence documents which all maternity support workers are required to complete annually with their line managers.

8. *Greater MDT collaboration in the design and delivery of training for staff providing intrapartum care in community settings;*
   The neonatal team are currently involved in delivering skill drill training within the unit and discussions are taking place to ensure their involvement in training in community settings.

9. *Purchase of additional equipment to support community birth and training.*
   Safety requirements around community staff keeping drugs at home prevents it being possible for all community on-call midwives to carry a full range of drugs. The only piece of emergency equipment which is not carried is a suction, and the Practice Development team are reviewing the use of handheld/portable suckers. A bid has also been made for more diverse training equipment.

Overall, the external Consultant Midwife concluded that the current training offer for community staff providing intrapartum care at the Trust appears sound and effective and no gaps in training topics were identified. In conclusion she reported that we have many successes in the training we offer, with the service being open to feedback and actively developing in response to multiple drivers, including past incidents. The recommendations made within this review aim to support the service to clarify and consolidate this work, and we are committed to delivering accessible and relevant training on the management of intrapartum emergencies.

For additional reassurance and alongside this external review, our Chief Nurse commissioned an internal review of the Trust's action plan in response to the Healthcare Safety Investigation Branch (HSIB) investigation into this case. This was undertaken by a senior member of RBFT staff working outside of maternity to provide assurance that lessons were being learnt and improvements made, in light of the recently nationally published Ockenden report, March 2022. This review was presented to the RBFT Urgent

Care Group Board and concluded that the action plan has been delivered and addresses all of the recommendations made in the HSIB report. The evidence supported the green RAG (red/amber/green) rating, which is the rating process used by NHS England for the NHS Performance Framework.

Placenta Retention

Previously, placentas in uncomplicated cases were being disposed of on a daily basis but I can confirm that the Trust have implemented processes to ensure that all placentas are stored for 48 hours from the time of birth. We are advised by the Pathology team that retaining placentas beyond this time would not provide reliable histology findings.

In practical terms, placenta fridges have now been placed in the Delivery Suite and Birth Centre, and homebirth placentas will be placed in the Birth Centre fridge (the Homebirth Operating Procedures have been updated to reflect this). Tutela temperate monitors are operating in the fridges, which provide connected automated monitoring and alerts the clinical areas if there are any concerns with the temperature of the fridge.

The Standard Operating Procedure (SOP) for placenta retention will be ratified at the Maternity Clinical Governance Meeting in October 2022 and will go live on 10 October 2022; it provides guidance on which placentas need to be sent to histology for pathological examination, as well as storing and retaining all placentas for 48 hours before disposal in uncomplicated cases. In order to disseminate this information, all of the Trust's Band 7 midwives and Unit Coordinators will be trained on the new SOP to ensure compliance throughout maternity, and in particular the midwives and maternity support workers. We are also working with Waste Management to ensure that their team are fully aware of the new process, as they now need to request that a member of the midwifery team attends with them to ensure that the correct procedures are followed.

As an additional assurance, the safety huddle templates on our electronic patient record system will be updated to prompt the team to ask whether any babies have deteriorated or been admitted from other areas in the last 24 hours to the pediatric ward, who are less than 48 hours of age and require ventilation, cooling or neonatal death. This measure will be introduced to ensure that placentas are not erroneously disposed of due to any lack of communication between the maternity unit and paediatric ward.

I hope this response provides you and the parents of Adele with assurance that the Trust have taken your concerns for future patients' safety seriously by implementing further actions to ensure that all community midwives and maternity support workers feel confident in delivering community intrapartum care. In addition, we endorse your view that storing all placentas for at least 48 hours will assist in providing crucial evidence as part of death investigations and therefore will provide an opportunity to improve our services as a result of these actions taken.

If you require any further information or evidence, please do not hesitate to contact us.

Yours sincerely

[redacted]

Chief Executive Officer