East Kent Hospitals University NHS Foundation Trust

East Kent Hospitals Update for Health Overview and Scrutiny Committee

Maternity Services Update: April 2023

1. Introduction

1.1. This paper updates the Committee on work underway to improve maternity and neonatal services at East Kent Hospitals to implement the actions in the Reading the Signals report, published by Dr Bill Kirkup on 19 October 2022, and the wider Trust-wide improvement work underway.

1.2. Reading the Signals found that women, babies and their families had suffered significant harm because of poor care in our maternity and new-born services, between 2009 and 2020. We accept all that the report says, apologise unreservedly for the pain and suffering caused, and are using the lessons to put things right.

1.3. We provide a range of maternity care services in hospital, at birthing units at William Harvey Hospital and Queen Elizabeth Queen Mother Hospital (QEQM). We also provide antenatal and postnatal services in the local community and the home birth service, with around 6,500 births a year.

2. Implementing the recommendations from Reading the Signals

2.1 We have made significant changes to our maternity and neonatal services, for example by investing more than £3m in more midwives and doctors for the service, improving Board oversight of performance, ensuring serious incidents are reviewed rapidly and immediate safety actions taken, and improving training compliance and progress against national standards.

2.2 Despite these changes we acknowledge there is much more work to do. The long-standing cultural issues identified in Dr Kirkup's report will take time to resolve, and the lessons are relevant to all our services. We are committed and working hard to tackle those issues so we can provide the consistently high standard of care that women and families deserve.

2.3 We are committed to addressing the five key areas for action in Reading the Signals which are:

1) Monitoring safe performance;
2) Standards of clinical behaviour;
3) Flawed team working;
4) Organisational behaviour;

5) And, a recommendation specifically for the Trust, to embark on a restorative process addressing the problems identified in partnership with families, publicly and with external input.

2.4 In February we published details of the five programmes of work to address these actions, which we have called our Pillars of Change, together with an open letter to our community, apologising for our failures in care and making a commitment to change. Our Pillars of Change apply across our whole Trust and set out the practical short, medium, and long-term goals to be delivered over the next three years.

- Pillar 1: Reducing harm and safe service delivery
- Pillar 2: Care and compassion
- Pillar 3: Engagement, Listening and Leadership
- Pillar 4: Organisation Governance Development
- Pillar 5: Patient, Family and Community Voices

2.4 Some of this work is new and some of it builds on work that has already begun. Some of this work can be implemented quickly, but some outcomes will take longer to achieve. For example, the sustained culture change we need to see.

2.5 We monitor this work closely and report on it and the progress we are making regularly and publicly. The Board is responsible for overseeing this major transformation programme with day-to-day responsibility for delivery and monitoring progress taken forward by our Clinical Executive Management Group. Specific improvements in maternity and neonatology services continue to be overseen by the Maternity and Neonatal Assurance Group, again reporting to Trust Board.

2.6 We have established a Reading the Signals Oversight Group which includes representatives from patients and families, the Maternity Voices Partnership, our Council of Governors and Trust Board, and will provide oversight of the programme, making sure there is engagement with those who use our services and that steps are taken to address the issues identified in the report. The group meets in public and reports directly to the Board of Directors.

2.7 Maternity is a key priority in our Integrated Improvement Plan which sets out how we will drive forward Trust-wide improvements over the next 12-18 months in six key areas: Trust leadership and governance; Maternity; Performance (e.g. emergency, cancer and planned care); Quality and safety; People and culture and financial sustainability.

3. Listening to women and their families

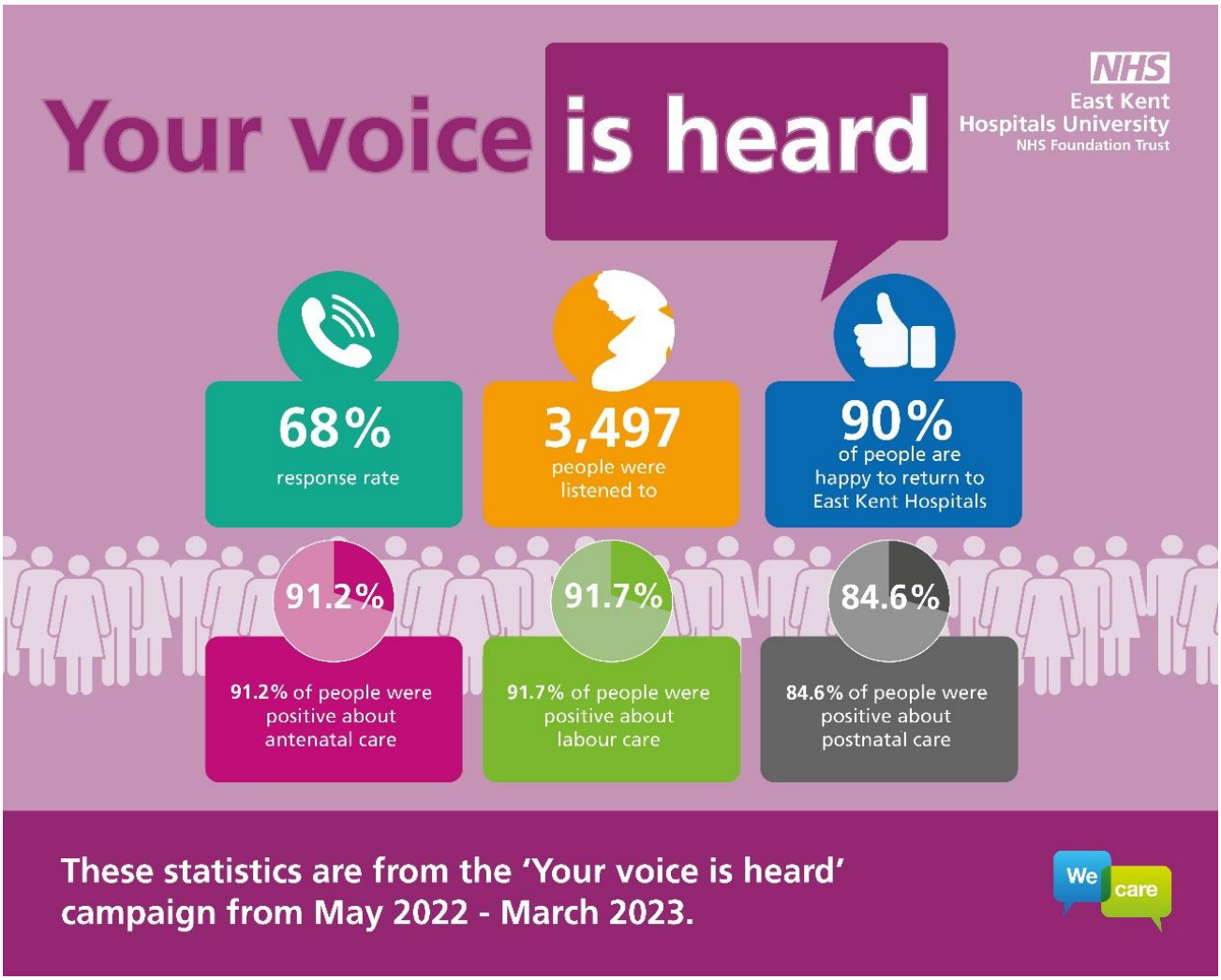
3.1 In May 2022 we launched Your Voice is Heard, an essential part of our work to better listen to families whose babies are born in our care. We

offer a follow-up call to discuss their experiences six weeks after giving birth, including partners, so we can act on feedback and make changes.

3.2 Between May 2022 to end March 2023 we have heard from almost 3,500 women, during 30-minute phone calls, which allow time for a detailed conversation about all aspects of their and their baby's care, giving opportunities for staff recognition, learning and action.

3.3 Of the 3,497 women spoken to between May 2022 and March 2023:

- 90% would be happy to return
- 91% were positive about their antenatal care
- 91% were positive about their care during labour
- 84% were positive about their postnatal care



3.4 Key themes for improvement raised include facilities for partners and pain relief. There are clear action plans for each of these areas as part of the overarching maternity transformation plan which is overseen by our

Maternity and Neonatal Assurance Group which reports to the Quality and Safety Committee and to the Trust Board.

3.5 We have developed a new bereavement pathway with families and charity SANDS. Building on their feedback, the new pathway will improve and expand the emotional and practical support we provide families who have experienced pregnancy loss and the death of a baby, with care provided throughout any subsequent pregnancies, including throughout labour and delivery. The new model also includes a new team, which has now been recruited to and provides a 7-day service for bereaved families.

4. Care Quality Commission (CQC) Inspection

4.1 While we have made changes to improve our services, we know we have much more work to do, as evidenced in the initial feedback from the Care Quality Commission inspection of maternity services at QEQM and WHH on 10 and 11 January 2023. We anticipate the CQC will publish a report for maternity services at each hospital soon and we will provide the Committee with a further update at this time.

4.2 Following this inspection, in February, the CQC imposed Section 31 conditions on the Trust's registration to ensure processes are in place to assess, manage and monitor the safety of the environment and equipment in the maternity departments and for regular updates to be provided to CQC on a monthly basis.

4.3 We acted immediately on the CQC's concerns:

- We increased doctor staffing in the antenatal triage service at WHH, which has improved the time in which women are seen by a doctor. The same antenatal triage service is being implemented at WHH that has been successfully put in place at QEQM Hospital, which will ensure women are cared for in the appropriate environment.

- We introduced electronic alerts for staff when fetal monitoring indicates a risk to a baby or that a check is due.

- We increased the frequency of daily cleaning and are making daily checks on cleanliness and emergency equipment and are increasing the number of support workers to ensure high cleaning standards are maintained.

- We implemented weekly formal IPC environmental audits in each unit, which are done in partnership with infection prevention and control, clinical and facilities colleagues.

- We had already appointed a new dedicated fetal heart monitoring midwife who in February joined us to work alongside our clinical teams to ensure safe monitoring is consistently completed.

4.4 Some of the areas of concern identified by the CQC are a direct consequence of the old buildings we are delivering services from, which are not fit for purpose. For example, birthing rooms are small and many lack ensuite facilities.

4.5 We have developed building plans with clinical teams to create a second obstetric operating theatre at QEQM, additional training facilities, more birthing rooms for families at each hospital, and improved facilities to meet the needs of our women, families and staff and meet modern compliance standards. We seeking ways to fund these improvements.

4.6 We are investing £1.6m from the Trust's limited capital allocation, however, we need almost £60m (£38m QEQM and £21m WHH) to carry out this work and expand and refurbish both units.

5. Midwifery education at William Harvey Hospital

5.1 In February, Canterbury Christ Church University withdrew student midwives on placement at WHH in Ashford. Some of the students have been placed in our community teams. Our student midwives remain at QEQM hospital in Margate.

5.2 Our students are valuable members of our team as well as our future workforce and we have been working hard to support them. Student midwives are supernumerary and are not included in our staffing rota. We are working closely with the university to restore midwifery education to William Harvey Hospital as soon as possible.

5.3 Five internationally educated midwives joined in March and 23 out of 25, 3rd year students, have indicated their intention to take up positions as newly qualified midwives across East Kent when they complete their training.

6. Staff engagement

6.1 We are involving all staff in our Maternity Transformation Plan. Since March, daily staff forums have been held to give all staff the opportunity to discuss improvements.

6.2 Fortnightly staff forums are held for all staff groups to meet and talk with the care group's senior leaders and lunch and learn sessions are one of the ways we are listening to and sharing learning with front-line staff.