East Kent Hospitals University NHS Foundation Trust

East Kent Hospitals Update for Health Overview and Scrutiny Committee Maternity Services Update: January 2025

1. Introduction

1.1. 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.

1.2. The 'Reading the Signals' report in 2022 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 accepted all that the report said, apologise unreservedly for the pain and suffering caused, and are continuing to use the lessons to put things right.

1.3. We want to provide great care for everyone using our maternity and neonatal services. We are also clear that there is learning from the lessons in the report for every area of our organisation; these are not just confined to maternity.

1.4. 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, and the wider Trust-wide improvement work underway.

2. Two years on from Reading the Signals

2.1 In October 2022, Dr Bill Kirkup published 'Reading the signals', his report of the independent investigation of maternity and neonatal services in East Kent Hospitals between 2009 and 2020. Of the 202 cases that agreed to be assessed by the panel, the outcome for babies, mothers and families could have been different in 97 cases, and the outcome could have been different in 45 of the 65 baby deaths, if the right standard of care had been given. The report found that women, babies and their families had suffered significant harm and loss because of poor clinical care but also that we did not listen to women, their families and indeed at times, our own staff. The experience those families endured was unacceptably and distressingly poor, it repeatedly lacked kindness and compassion, both while families were in our care and afterwards.

2.2 We continue to make significant changes to our maternity and neonatal services, for example - successful recruitment of two Consultant Midwives working cross-site supporting women and birthing people with personalised care planning with a key focus on health inequalities and equitable access to maternity care. We have also recently recruited a Multiple Pregnancy Midwife, Fetal Medicine Lead Midwife, and a Maternal Medicine Midwife to provide specialist care during the maternity journey. In addition, there have been medical appointments including consultant obstetricians with plans in place to

recruit to further doctor posts to enhance our medical workforce, including targeted training for succession planning; recruitment processes continue to focus on appointing high quality candidates.

2.3 Recruitment and retention is one example of how we are committed to addressing the key areas for action in 'Reading the Signals', which include: monitoring safe performance; standards of clinical behaviour; flawed team working, and organisational behaviour. In addition, a recommendation specifically for the Trust is to 'embark on a restorative process addressing the problems identified in partnership with families, publicly and with external input'.

2.4 Our Maternity and Neonatal Improvement Programme (MNIP) was developed throughout Spring and Summer 2023 and involved bringing together people who use the service, the maternity leadership team, all grades of midwifery, obstetric and neonatal staff, Kent & Medway Local Maternity and Neonatal System (LMNS), Maternity and Neonatal Voices Partnership (MNVP) and members of NHS England's regional maternity team to ensure it was truly co-produced. The programme was also benchmarked against, and aligned to, requirements of our Reading the Signals report, CQC requirements, the Three-Year Single Delivery Plan for Maternity and Neonatal Services and ultimately the national maternity and neonatal safety ambition to halve the number of stillbirth rates, neonatal deaths, brain injury and maternal deaths compared to the 2010 rates by 2025.

2.5 Within MNIP was a requirement to develop a Quality & Safety Framework (QSF) to set out governance systems and processes to ensure that quality and safety of maternity services had robust oversight and scrutiny. The Maternity QSF was published in February 2024 and is routinely reviewed and updated as required in-line with internal and external assurance requirements. For example, as of April 2025, the service will move to a Maternity and Neonatal Quality Board with an open-door structure to which families will be invited to join and will be able to engage with the executive team. Working with families will be further reflected in the QSF and Terms of Reference (ToR) for this forum with standing agenda items to be developed in collaboration with service user representatives.

2.6 We continue to report on our progress and you can read more here www.ekhuft.nhs.uk/about-us/maternity-report/

2.7 The Care Quality Commission (CQC) visited our maternity services in early December as part of the national maternity inspection programme. The team consisted of a pharmacy inspector, maternity specialist advisors, obstetric specialist advisor and supporting inspectors. Following the inspection, no immediate safety actions or concerns were identified and the inspection team commented on notable improvements since their previous visit in 2023. The formal publication date is to be confirmed.

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. Since that date, to the end of December 2024, we have spoken to 10,771 women.

3.2 Between January and December 2024, we heard from 4,327 women, who have given birth in our hospitals, and from birth partners, too, an average 75.7% response rate. These 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. Of the 4,327 women spoken to:

- 90.5% would be happy to return
- 91.2% were positive about their antenatal care
- 92% were positive about their care during labour
- 85.5% were positive about their postnatal care

3.3 From its launch in 2022 to the end of December 2024, almost 5,000 compliments from families had been shared directly with staff. We have extended 'Your Voice is Heard' to include families whose babies have been in neonatal care and we are exploring how best to extend this service to include bereaved families, in addition to other support in place for them.

3.4 Some of the changes we have made are small but practical and important to people using our services. Such as: introducing soft-close bins to reduce noise on the postnatal wards, re-commencement of drug rounds on the post-natal wards, offering snack boxes and hot drinks for birthing partners and installing new sleeper chairs for birthing partners at the WHH. The YVIH service was used to conduct the Surgical Site Infection (SSI) audit with a wealth of information being gathered from women who gave birth via caesarean section from August-October 2024. We also run a 'guest question' each month for specific areas of maternity to gather information about an area that may require improvement.

3.5 Feedback has also assisted with:

- Creating a postnatal care / discharge planning group to assess the issues we frequently hear about postnatal ward care and look at the discharge process
- Mapping the new antenatal education programme from direct service user feedback
- Looking at the induction of labour pathway and the information provision around this
- Creating a 'family bathroom' for women and support partners to access whilst on our maternity wards
- Creating a 'welcome booklet' for our women and families with useful information about their stay in hospital (1st draft due to be in use by the end of

January 2025). This will become a fully co-produced leaflet for postnatal women to take home by Spring/Summer 2025

3.6 The annual CQC Maternity Services Survey, conducted in early 2023, had a response rate of 41%. It showed East Kent maternity services as having lower than average scores for antenatal care and postnatal care, but improvements in people feeling they received help and advice about feeding their baby in the first six weeks after birth, in partners being able to stay as long they wanted, support for mental health in pregnancy and a choice of where to have their baby. We are awaiting the results of the follow up CQC inspection in December 2024.

4. Improvements initiatives relating to engagement

4.1 The Director and Deputy Director of Midwifery Walk the patch, which involves regularly walking around the maternity units to listen to people who use our services, and their families/carers to hear directly about their experiences of maternity care. Feedback is then used to share good news stories and areas for improvement.

4.2 In order to improve the quality of our Triage service and identify any training requirements, all calls to maternity triage are now recorded and monitored. In this way, not only the quality of information and care can be monitored, but also how service users are spoken to and involved in decisions about their care.

4.3 *Leave your troubles at our door*, is as an additional patient experience service providing women and birthing people in hospital with direct access to a senior member of the midwifery team, as someone to speak to if they wish to talk about their care.

4.4 We have increasingly innovative ways of involving people who use our services, in partnership with the Maternity and Neonatal Voices Partnership, including holding Facebook “Live” sessions, appointing a midwife specifically to lead work on reducing health inequalities and focussing on under-served communities, for example we held an event with Lithuanian families and are seeking funding for a community bus to go out to our communities.

4.5 We also involve families in investigations from the outset; have co-produced our maternity and neonatal improvement programme and new pathways of care; and we are working with families directly involved in Dr Kirkup’s investigation.

4.6 We want our service to be welcoming, safe, clean, professional, friendly, calm and well organised. The Maternity and Neonatal Voices Partnership led a ‘15-Steps challenge’ with service users on both units. This sees the service through the eyes of people who use it and what they see and experience within 15 steps of entering a department. Improvements include making the

units more welcoming, murals on walls, soft lighting in labour rooms and improved information about leaving hospital.

5. Reducing harm and delivering safe services

5.1 Following the CQC inspection in January 2023 which found the Trust was 'not consistently providing the standards of maternity care women and families should expect', We acted at once to respond to the CQC's concerns. For example, by increasing doctor cover in the triage service at William Harvey Hospital and introducing additional training and electronic alerts for staff when a fetal monitoring check is due.

5.2 Out of the 40 actions recommended by the CQC, 38 had been fully completed by summer 2024. The remaining two: a second obstetric theatre at QEQM, is subject to a bid for national capital funding (funding has been provided to do the initial work), and moving the Twinkling Stars bereavement suite which will be completed in 2025.

5.3 Other immediate changes included improving access to and regular checking of emergency equipment and increased cleaning of the environment and the equipment. We continue to monitor these standards daily, alongside hand hygiene and PPE compliance. Data is collected weekly, monitored by the Director and Deputy Director of Midwifery and shared with the CQC on a monthly basis, with the results consistently showing high compliance.

5.4 To improve the safety of our triage service, we implemented the Birmingham Symptom Specific Obstetric Triage System. The service was shortlisted for a Royal College of Midwifery Award for Outstanding Contribution to Midwifery Services: Digital, for this work.

5.5 To improve the quality and safety of care we have increased the numbers of midwives and doctors, including specialist roles. We are also developing our existing workforce, for example by using the NHS Health Education England Maternity Support Worker Competency Framework to upskill the maternity support workforce and provide a clear pathway for career progression.

5.6 Medical staff have developed and trained 200 midwives in enhanced maternity care, allowing patients who need enhanced care to remain on the labour ward with their babies in dedicated enhanced maternity care rooms at both William Harvey Hospital and Queen Elizabeth the Queen Mother Hospital.

5.7 In December 2023 we reopened the Singleton Midwife-led Unit at William Harvey Hospital as a place of birth, offering more choice to women in relation to their preferred place of birth. By September 2024, 183 babies have been born in the unit.

5.8 Following the withdrawal of the Nursing and Midwifery Council (NMC) approval for the midwifery programme at Canterbury Christ Church University, we

worked closely with the University of Surrey to enable student midwives to return to their placements with us in September 2023. They will qualify in January 2025 and have all been offered and accepted placements with us.

6. Staff engagement

6.1 Regular staff training and reflection on clinical practice is a crucial part of delivering safe services. We have a monthly staff Safety Summit to share key safety learning. At this forum cases are discussed, themes and learning identified and solutions discussed and shared.

6.2 We also have a number of ways to regularly share learning across maternity:

- ‘Hot Topics’ that require immediate dissemination
- ‘Safety Threads’ used in safety huddles and handovers
- ‘Lunch and Learn’ sessions to share learning in a relaxed space
- Monthly ‘Safety Summit’ with Board maternity safety champions, Chief Nursing and Midwifery Officer and Non-Executive Director
- ‘We Hear You’ and consultant forums, which give staff direct access to the senior leadership team.

6.3 We are one of the first Trusts to adopt Martha’s rule in our acute hospitals in Ashford and Margate, which gives patients, families, carers and staff round-the-clock access to a rapid review from a separate care team if they are worried about a person’s condition. This follows the national initiative ‘Call 4 concern’ which is run by our Critical Care Outreach Team (CCOT), and continues at Kent and Canterbury Hospital.

7. Caring with Compassion

7.1 We co-produced a new bereavement care model in our maternity and neonatal service with families who wanted to ensure other families did not experience a lack of care and compassion. Specialist bereavement midwives worked with families and the Saving Babies Lives charity (SANDS) to improve and expand the emotional and practical support available to families who have tragically experienced baby death or severe injury or illness.

7.2 The remodelling of our bereavement service includes the relocation and refurbishment of the Twinkling Stars bereavement suite (a dedicated area for families) at William Harvey Hospital to a location outside of the Labour ward so that women, babies and their families can be cared for in a more considerate and suitable setting. This is being funded by East Kent Hospitals Charity and will be completed in 2025.

7.3 We recognise that the lessons within Reading the signals apply as much to the rest of our Trust and all our services as they do in maternity and we need to provide care that is more compassionate. Examples of how we are doing this include launching a caring with compassion video in May 2023, which is now part of mandatory training for all Trust staff. The video was developed by the

Supportive and Palliative Care Team and was funded by the East Kent Hospitals charity.

7.4 We introduced a monthly session for Health Care Support Workers focused on 'Seeing the Person' and how they can understand the vital role they play in every patient's experience.

7.5 We have included caring with compassion and respect in routine staff training for maternity and neonatal staff. For example, we have adopted 'Civility Saves Lives', a national project aimed at promoting kindness and respect within teams, based on evidence about the impact this has on patient safety.

8. Leadership, culture and development

8.1 We appointed an experienced, substantive Director, and Deputy Director of Midwifery, in mid May 2023 to strengthen maternity leadership and support improvements to the service across the Trust.

8.2 We recognise the importance of staff feeling listened to, and having easy access to a senior leader if they have any concerns. The leadership team introduced *We Hear You* which gives staff direct access to the Director and Deputy Director of Midwifery, and twice-monthly consultant meetings for colleagues to meet and discuss any concerns they have with the associate medical director for women's health as well as the clinical leads from each hospital site.

8.3 These forums are in addition to regular multi-disciplinary patient safety meetings. Listening events have also been held with the CEO, Chief Nursing and Midwifery Officer and Non-Executive Director lead for maternity.

8.4 As part of the commitment to nurture compassionate leaders and effective teams that work well together, the Trust has adopted NHS England's Culture and Leadership Programme developed by the Kings Fund.

8.5 Changes include introducing a staff council, relaunching our staff wide recognition scheme, developing our organisational strategy and training all staff in essential leadership skills. We are currently reviewing how we deliver our Freedom to Speak Up (FTSU) service to ensure that it is sustainable and meeting the needs of our staff.

8.6 The Maternity and Neonatal Assurance group, chaired by the Chief Nursing and Midwifery Officer and attended by the non-executive director maternity champion (a senior clinician), reports monthly to the Quality and Safety Committee and directly to the Trust Board quarterly and is attended by multiple stakeholders, including the Maternity and Neonatal Voices Partnership.

8.7 We have implemented the nationally-required role of the Maternity and Neonatal Safety Champion. Our multi-disciplinary Maternity and Neonatal Safety Champions are promoted across the units, as a point of reference and contact for the workforce, our families and stakeholders.

9. Governance and Partnership working

9.1 A new governance framework used at all levels of the organisation sets out the Trust's approach to ensuring that roles, responsibilities, reporting and escalation lines are clear and that there are robust systems of governance and accountability in place at all levels to safeguard patients and carers from harm, ensure the care provided by the Trust is in line with regulatory and statutory requirements and provide an effective line of sight from place of care to Board.

9.2 We have embedded the role of Board Safety Champion and Non-Executive Director, and together they work with local maternity and neonatal champions, the care group Director of Midwifery, Associate Medical Director, and executive sponsor for the Maternity and Neonatal Safety Improvement Programme to understand, communicate and champion successes at Board level. With frontline safety champions (who draw on a range of information sources to review outcomes including staff and user feedback), they understand the services they champion and update the Trust Board.

9.3 Examples of opportunities for feedback include Safety Champion listening events, walkarounds, attendance at staff meeting and Safety Summit. In addition, the Maternity and Neonatal team is accountable to the Maternity and Neonatal Assurance Group which reports into the Executive-level Patient Safety Group (PSG), which reports into the Quality and Safety Committee (QSC), which then reports into Trust Board.

9.4 We are working with our partners across the health and social care system in Kent and Medway, to share our learning across the region and to learn from others. Across our Trust we reviewed and restructured our care groups (each responsible for the management of a number of clinical services and sites) to support the delivery of safe, high quality and timely services.

9.5 Overall, we have taken the first significant steps on our journey and we are continuing to review these and make improvements. This is a continual process and will take time to embed, but we give our commitment, that we will not stop until we are offering the safe and compassionate care that all of our service users deserve.

Recommendation
It is recommended that the Committee consider and note the report.