NHS
East Kent
Hospitals University
NHS Foundation Trust

East Kent Hospitals Update for Health Overview and Scrutiny Committee Maternity and Neonatal Services: 21 November 2022

1. Introduction

1.1. This paper summarises the work underway to improve maternity and neonatal services at the Trust and the key findings and actions arising from the *Reading the signals*: maternity and neonatal services in East Kent report, published on 19 October 2022.

1.2. The report follows an investigation into maternity and neonatal services at the Queen Elizabeth The Queen Mother Hospital (QEQM) in Margate and the William Harvey Hospital (WHH) in Ashford, between 2009 and 2020. Some 202 cases were assessed by the panel, led by Dr Bill Kirkup.

1.3. While this paper focuses on maternity and neonatal services, we recognise that learning from this report is relevant to every part of our Trust. We recognise themes, such as workplace culture and listening to patients, are areas we need to improve across all our services and we are committed to addressing this.

2. 'Reading the signals: maternity and neonatal services in East Kent'

2.1. This report details systemic failures in care that led to significant harm, a failure to listen to families and staff, actions which made families experiences unacceptably and distressingly poor, and a series of missed opportunities to tackle the problems effectively.

2.2. It finds that had care been given to the nationally recognised standards, the outcome could have been different in 97 of the 202 cases assessed by the Panel (48% cases) and the outcome could have been different in 45 of the 65 baby deaths (69% cases).

2.3. The panel was unable to detect any discernible improvement in outcomes or suboptimal care, as evidenced by the cases assessed over the period from 2009 to 2020.

2.4. The report identifies four areas for action for the Trust and wider NHS:

- identifying poorly performing units
- giving care with compassion and kindness
- teamworking with a common purpose
- responding to challenge with honesty

2.5. In addition, a key recommendation for the Trust is to accept the reality of these findings; acknowledge in full the unnecessary harm that has been caused; and embark on a restorative process addressing the problems identified, in partnership with families, publicly and with external input.

2.6. We fully accept the report's findings and apologise unreservedly for the harm and suffering experienced by women and babies who were within our care, together with their families. We recognise that families came to us expecting that we would care for them safely, and we failed them.

2.7. We are determined to learn from and act on this report; for those who have taken part in the investigation, for those who we will care for in future, and for our local communities.

3. Improvements to date

3.1. Around 6,500 women give birth each year at maternity units at QEQM and WHH and at home.

3.2. Below are some of the improvements that we have been working on since 2021. We recognise there is much more for us to do, as outlined in sections 4 and 5.

Listening to women and families

3.3. Since May 2022, women are offered a follow-up call with a midwife six weeks after delivery to ask them what went well and what needs to improve. Calls last approximately 30 minutes to enable sufficient time for a detailed conversation about all aspects of their and their baby's care, with birthing partners also invited to participate.

3.4. We have spoken to 1,770 women between May and October 2022, in October:

- 90% would be happy to return to the Trust
- 90% were positive about their antenatal care
- 91% were positive about their care during labour
- 82% positive about post-natal care.

3.5. This approach provides rich and detailed feedback which enables both opportunities for staff recognition and learning. Key themes for improvement raised include delays to care, improving access to pain relief, being listened to by staff, feeling looked after and having enough staff. There are clear action plans for each of these areas as part of the overarching maternity improvement plan, examples include reviewing the bereavement and antenatal pathways.

Listening to our staff

3.6. We have introduced a dedicated Freedom to Speak Up Guardian for maternity and neonatal services, providing a dedicated route for staff to voice concerns in a confidential and supportive manner.

3.7. The Executive Maternity Safety Champion visits labour wards weekly and staff forums, including for community staff, and Band 7 midwives, take place monthly.

More staff available to run services

3.8. We have invested £1.6m in midwifery staffing since 2021 which, combined with additional national funding, resulted in an additional 38 midwife and 11 specialist/leadership midwife posts, including specialist bereavement midwives and a dedicated neonatal bereavement key worker.

3.9. We offer permanent posts to all our student midwives following completion of their training - 22 newly qualified midwives joined us last year and a further 18 started in September 2022.

3.10. Obstetric consultants are resident in the hospital and available to the labour ward 24/7 at WHH and until at least 22.00 at QEQM Hospital, supported by 24/7 on call. WHH has more births and takes known complex deliveries as it hosts East Kent's Neonatal Intensive Care Unit.

3.11. We have invested in additional paediatric and neonatal consultant posts and improved cross-site working, for example, with a "grand round" where complex cases are regularly discussed to ensure better oversight of patients' care.

Staff training

3.12. We have improved mandatory training compliance. Monthly multidisciplinary teaching takes place with a focus on communication, team working, recognition of the deteriorating patient and escalation.

3.13. All locum doctors undertake introductory training and supervised day shift.

Improving our culture

3.14. A culture and leadership programme is underway which includes vision and values workshops, staff drop-in sessions and a leadership development programme where teams learn together.

3.15. We have appointed a Lead Professional Midwifery Advocate to support and guide midwives to provide high quality safe care and support service users

Improved governance and learning from incidents

3.16. The Trust Board has oversight of performance, learning from serious incidents, training compliance, progress against national reviews and Care Quality Commission actions.

3.17. The Board reviews key quality and performance data monthly using the nationally-recognised perinatal quality surveillance tool to monitor serious incidents, training compliance (e.g. fetal monitoring and newborn life support) and feedback from families, as well as staff.

3.18. A strong culture of reporting incidents is important for the safety of our patients and to this end we are encouraging staff to report all incidents, regardless of their severity.

3.19. We have strengthened the quality of investigations and learning from incidents. For example, we have introduced a rapid review process to review potential serious incidents and ensure immediate safety actions have been taken.

Investing in our estate

3.20. We are currently investing £1.6m in maternity services at WHH and QEQM and £1.7m in the Special Care Baby Unit at QEQM.

3.21. We are seeking additional investment to expand and refurbish both units, including for a second obstetric theatre at QEQM hospital and to increase the number and size of rooms available for women and their families.

4. Next steps – implementing the recommendations

4.1. While progress has been made, we recognise that there is much more for us to continue to do. The Board is determined to use the report's recommendations to make lasting changes to ensure that we are providing the safe, high-quality care our patients expect and deserve.

4.2. This includes work to tackle our culture and behaviours, upholding professional standards, team working, listening to and acting on patient feedback and responding to challenge with honesty.

4.3. The Board will ensure progress against the five key action areas set out in the report, which include 1) reducing harm and monitoring safe performance 2) upholding standards of clinical behaviour 3) team working 4) organisational behaviour and 5) patient and family voices.

4.4. This will include obtaining assurance in relation to the delivery, evidence, sustainability and impact of the implementation of the report's recommendations, including a clear timeline for completion, which will be scrutinised in public. Operational oversight for the development and delivery of this work will be through the Trust's Clinical Executive Management Group

4.5. Listening and working with families, patients and staff to co-design solutions is at the heart of our approach. We have started with listening events with maternity and neonatal staff and we are in contact with a number of families who have told us they would like to be part of developing long-lasting solutions.

4.6. The Board of Directors will dedicate sufficient time at its Board meetings to enable this work to be appropriately considered in keeping with its critical importance.

5. Independent care reviews

5.1. Prior to the publication of the report, we wrote to all families registered with our maternity services, notifying them of the publication of the report and providing contact details in the event of any immediate concerns or questions. This included details of a dedicated enquiries line to which we have received 54 responses to date.

5.2. There is an open invitation to families to meet with representatives of the Trust about their care, regardless of whether or not they participated in the investigation. If any families have concerns, we invite them to contact us and we will support an independent review of their care.

5.3. An independent panel is being established to undertake care reviews requested by families, regardless of whether their care has been previously investigated by the Trust.

5.4. Cases will be reviewed by a panel comprising three independent expert clinicians, including a Consultant Obstetrician and Gynaecologist, Consultant Neonatologist and Director of Midwifery. Executive oversight will be provided by the Chief Nursing and Midwifery Officer supported by the Strategic Maternity Programme Director, reporting monthly to the Trust Board.