East Kent Hospitals Update for Health Overview and Scrutiny Committee Maternity Services Update: December 2023

1. Purpose

To update HOSC on work undertaken by maternity and neonatal services and wider Trust initiatives one year on from the publication of *Reading the Signals*, the independent report into maternity and neonatal services in East Kent.

2. Background

On October 19 2022, Dr Bill Kirkup published his independent investigation into maternity and neonatal care provided from 2009 to 2020 in East Kent.

The report found that women, babies and their families had suffered significant harm and the experience they endured was unacceptably and distressingly poor. Care repeatedly lacked kindness and compassion, both while families were in our care and afterwards, when families were coping with injuries and deaths. We did not listen to women, their families and indeed at times, our own staff.

The investigation found at least eight opportunities where the Trust Board and other senior managers could and should have acted to tackle these problems effectively. 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 Trust Board has apologised unreservedly for the pain and devastating loss endured by the families and for the failures of the Board to effectively act. Losing a baby has an immeasurable impact on women and their families and whilst the Trust Board has apologised, the impact of these outcomes can never be altered and for this we are truly sorry.

We remain determined to use the lessons in *Reading the Signals* to put things right, to make improvements and make sure that we always listen to patients, their families and staff when they raise concerns.

3. Acting on the key areas for action

One year on from the publication of *Reading the Signals*, the importance of the report and its findings remains just as profound and significant.

We have taken each of Dr Kirkup's key areas for action and adopted them as five of our seven organisational objectives, we call these:

- Patient, family and community voices
- Reducing harm and delivering safe services
- Care and compassion
- Engagement, listening and leadership
- Developing our organisation.

Our maternity service is working to embed the changes that are needed with families and staff to make continued and sustained improvement in care and outcomes for women, babies and their families. We recognise there is much more we need to do. This work is ongoing and we need to involve more people as we continue our work to develop safer and more compassionate services.

We are grateful to the families, and colleagues, who are giving their time to the Reading the Signals Oversight Group and for their challenge and involvement. The purpose of the group is to ensure there is appropriate engagement with patients, their families and the community to oversee, challenge and advise on how the Trust embarks and embeds the restorative process required to address the problems identified in the report.

4. Patient, family and community voices

Dr Kirkup's investigation found that we did not listen to women, families and at times our own staff, and this contributed significantly to the poor experience of families and in some cases to clinical outcomes.

We are working hard to change this in both our maternity and neonatal services and as a Trust. There is much more we want and need to do in this area. To help us achieve this we have recruited a patient experience team specifically to work with women, birthing partners and families and staff to improve patient and staff experience.

The Director and Deputy Director of Midwifery have introduced *Walk the patch*, regularly walking around the units to listen to women and birthing people and directly hear about their experiences of their maternity care. By doing this they are also assessing that the environment is safe and clean, are observing what staff are doing well and what needs improving. The Maternity and Neonatal Voices Partnership will continue to take this work forward.

The team has also launched *Leave your troubles at our door*, as an additional patient experience service to provide women and birthing people in hospital with direct access to a senior member of the midwifery team, as someone to speak to about their care.

We want our service to be welcoming, safe, clean, friendly, calm and well organised. The Maternity and Neonatal Voices Partnership are to lead monthly '15-Steps challenges', which see the service through the eyes of people who use it and what they see and experience within 15 steps of entering a department.

The age and quality of our buildings across the Trust, and a lack of capital funding available, is an ongoing challenge. We are working with the Kent and Medway Integrated Care Board, local MPs and NHS England regionally to identify sources of funding, including to enable us to deliver much-needed expansion and refurbishment of our maternity units.

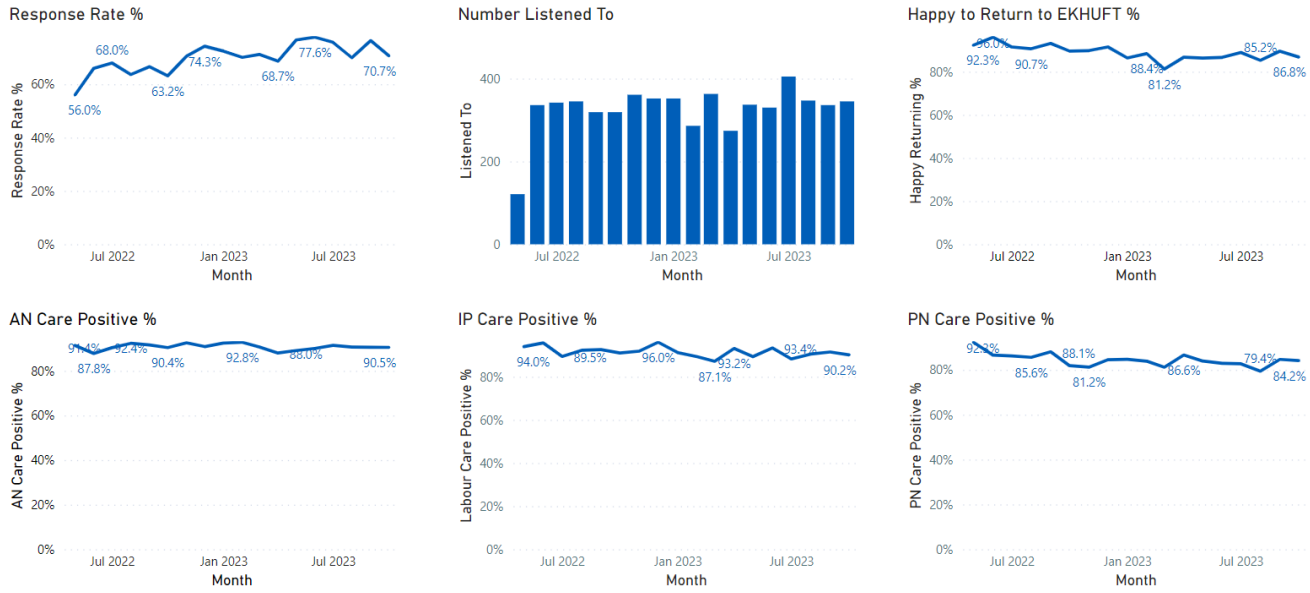
5. Your Voice is Heard

This year the maternity Patient Experience team has focused on embedding 'Your Voice is Heard', which is a feedback service unique to East Kent. This service was co-produced with our local Maternity and Neonatal Voices Partnership, families and a Trust governor.

Introduced in May 2022, this initiative is more than just a survey. People who use our maternity service are contacted by phone six weeks after discharge to discuss all aspects of their and their baby's care. Feedback from these follow-up calls is used to recognise what works well and identify where we need to make changes to improve people's experience.

So far, we have heard from more than 6,000 women who have given birth in our hospitals, and from their partners, too. We want everyone to have a positive experience of all aspects of their care and to be 'happy to return', we still have a lot of work to do to reach this point. We are committed to using the feedback we have from this initiative and other methods to make the necessary changes to achieve this.

Data to October 2023:



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, offering snack boxes and hot drinks for birthing partners and are trialling new sleeper chairs for birthing partners. We need to make sure these are consistently available.

We are refurbishing the postnatal ward at William Harvey Hospital and feedback has also been used to create a pain management working group, to understand and consider how we respond to the pain relief needs and options of our women and birthing people, including providing these in a timelier way.

We have reinstated home visits on the first day home from hospital and we are working with our system partners and the Patient Voice and Involvement team to listen to families about developing improved and accessible antenatal education. We need to do much more to improve people's experiences of postnatal care, including support for infant feeding, discharge processes and partner experiences; choice of place of birth; and consent and communication.

It is important that we also know where things are going well so we can build on them and thousands of compliments from families have been shared directly with staff. Next year we are extending Your Voice is Heard to include the neonatal service, as well as bereaved families, in addition to the support currently in place for them.

We also work closely with and receive feedback from the Maternity and Neonatal Voices Partnership. We look at the themes coming from all the sources of patient feedback to understand what actions we need to take to co-produce improvements with our patients and families.

6. Changes across our Trust: Patient Voice and Involvement

The lessons within *Reading the Signals* apply as much to the rest of our Trust and all our services, as they do in maternity. Within the wider Trust, we have recruited a new patient voice and involvement team to help us involve patients and our communities in our services. The team has been in place for 14 months. The role of the patient involvement officers is to

reach out to local communities and voluntary, community and social enterprise organisations to reach people who may not often get a chance to have their voice heard.

People can get involved on a voluntary basis by becoming a Participation Partner. The Patient Participation and Action Group is co-chaired by a Participation Partner and the Head of Patient Voice and Involvement, and a Non-Executive Director attends as the Board Champion for Patient Voice. Membership of the group is 50% people who use our services or are carers or family members, 30% voluntary community and social enterprise sector representatives and 20% staff.

7. Reducing harm and delivering safe services

Dr Kirkup's investigation identified unacceptable, poor clinical care in our maternity service. We are committed to providing the safe care that our communities need and deserve.

Despite the commitment and hard work of our staff, when the Care Quality Commission (CQC) inspected our maternity service in January 2023, they very disappointingly found that 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.

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.

To improve the safety of our triage service, we have implemented the Birmingham Symptom Specific Obstetric Triage System to ensure women and birthing people are assessed promptly on arrival at either of our maternity units and triaged appropriately according to their clinical need. The aim is for everyone to be assessed within 15 minutes and given a clinical priority using a recognised colour coding system so that people with the most urgent need(s) are treated first.

The timeliness and assessment of the triage service is monitored, to ensure patients are being cared for appropriately. The number of women and birthing people being seen on time by a midwife has increased from 97.3% in October 2022 when the system was implemented to 99.1% in October 2023.

To improve the quality and safety of care we have invested to increase the numbers of midwives and doctors, including specialist roles. However, filling vacancies has remained challenging this year, particularly in midwifery at William Harvey Hospital. To support our recruitment drive, we appointed ten internationally educated midwives. Once their training is completed they will be added to our rosters to increase our midwifery establishment and capacity.

Midwifery staffing challenges have meant we have been unable to offer women and birthing people the Singleton Midwife-led Unit at William Harvey Hospital as a place of birth. This unit is due to re-open later this month, offering more choice to women in relation to their preferred place of birth.

8. Return of student midwives

We are delighted to have welcomed back midwifery students to the Trust this autumn. In February 2023, student midwives were removed from their placements at William Harvey Hospital due to mounting concerns about how the safety issues identified by CQC and others, including concerns with fetal monitoring, escalation of concerns and checking of equipment, were impacting on the effectiveness of the learning environment.

In May, the Nursing and Midwifery Council (NMC) withdrew its approval for the midwifery programme at Canterbury Christ Church University and students were removed from all Kent and Medway placements.

We have been working closely with the University of Surrey to enable student midwives to return and have increased the practice development team and systems for student support and supervision, as well as increasing the ways students can raise concerns about their clinical placement.

We will continue to work with the NMC and the University of Surrey to ensure the standards students require in order to became safe and effective registered midwives are being met. Students on clinical placement with us are not counted in our staffing numbers, but they are an important part of our team and for our future workforce.

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

We have also introduced five key 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 twice-monthly consultant forums, which give staff direct access to the senior leadership team.

We are changing the way we monitor patient safety and our clinical performance, articulated in the *Reading the Signals* report as ‘finding signals among noise’. We use statistical process charts which plot data over time to help us understand variation and to help us take the most appropriate action. The format of our data is based on best practice, has been externally reviewed and welcomed by NHS England.

9. Changes across our Trust: Call 4 concern

In November we rolled out the national initiative ‘Call 4 concern’ across our main hospital sites following a successful pilot at William Harvey Hospital.

Call for concern is a scheme where patients and relatives can call the Critical Care Outreach Team directly if they are concerned about a patient's condition. If a patient/relative has unresolved concerns, CCOT staff liaise between the patient and or carer/relative and the team/ward staff. Posters and leaflets are provided in and outside ward areas across the hospital giving information and the contact number for the service. Patients and/or carers and relatives can contact the team directly or ask a member of staff for the information.

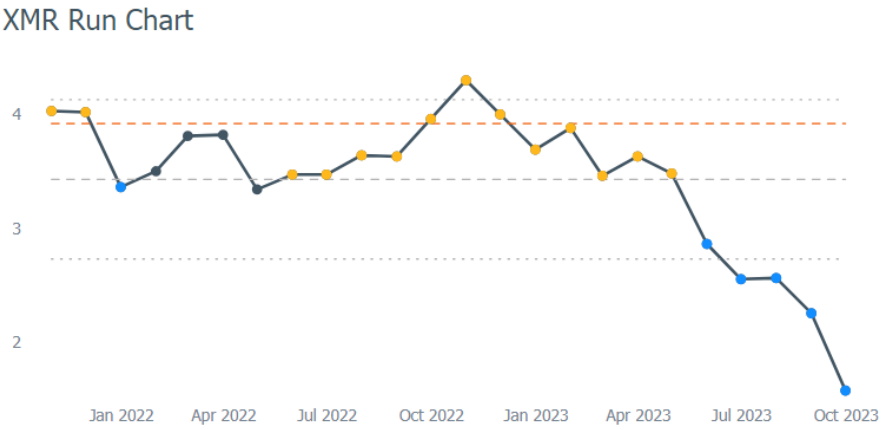
10. Saving Babies Lives

Saving Babies Lives is a government ambition to achieve a national 50% reduction in stillbirth and neonatal mortality by 2025, from 2010 figures. To achieve this the stillbirth rate in the UK would need to decrease to 2.6 stillbirths per 1000 total births and neonatal mortality to 1.2 neonatal deaths per 1,000 total births by 2025.

In October 2023, East Kent had 1.57 stillbirths per 1,000 and 0.87 neonatal deaths per 1,000.

MBRRACE Stillbirth 12m Rate

Timescale	Value	SPC
Nov-22	4.30	
Dec-22	4.00	
Jan-23	3.69	
Feb-23	3.88	
Mar-23	3.46	
Apr-23	3.63	
May-23	3.48	
Jun-23	2.86	
Jul-23	2.55	
Aug-23	2.56	
Sep-23	2.25	
Oct-23	1.57	

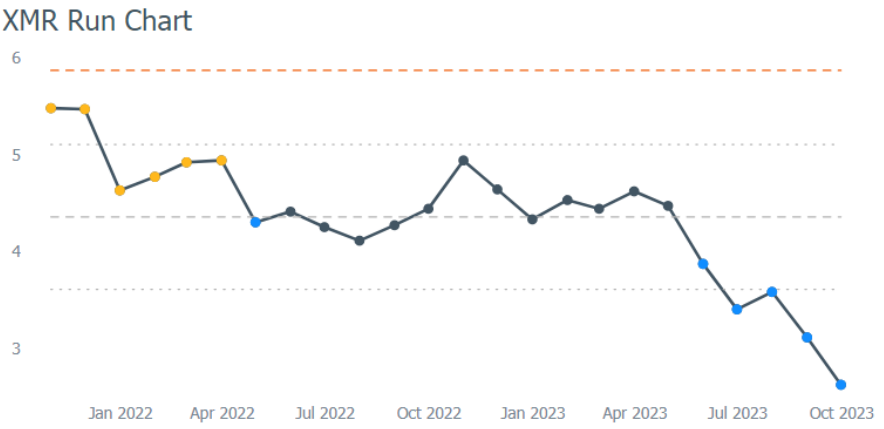


Extended perinatal mortality

Extended perinatal mortality refers to all stillbirths and neonatal deaths. The rate is per 1,000 total births. In October 2023 East Kent had a rate of 2.62 per 1,000 births, compared with our comparator group of 5.87 per 1,000 births.

MBRRACE Ext Perinatal Rate 12m

Timescale	Value	SPC
Nov-22	4.94	
Dec-22	4.64	
Jan-23	4.33	
Feb-23	4.53	
Mar-23	4.44	
Apr-23	4.62	
May-23	4.47	
Jun-23	3.87	
Jul-23	3.40	
Aug-23	3.58	
Sep-23	3.11	
Oct-23	2.62	



11. Care and compassion

The importance of providing compassionate care, not just clinical care, was a theme running through the entire *Reading the Signals* report. We had failed families by not being compassionate when they needed us most.

We have 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 have 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.

This seven-day service model includes continuity of carer for women and their families during a bereavement but also through any subsequent pregnancies, labour and delivery.

The next step in the remodelling of our bereavement service is the relocation next year of the Twinkling Stars bereavement suite (a dedicated area for families) at William Harvey Hospital, to a location which provides improved privacy with its own access so that women, babies and their families can be cared for in a more considerate and suitable setting.

There is evidence that a positive working culture improves the safety and quality of care for service users. 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.

As part of the work to improve the culture in maternity services, service leaders are enrolled onto the NHS Perinatal Culture and Leadership Programme, and across the Trust we have adopted NHS England's Culture and Leadership Programme.

12. Engagement, listening and leadership

We want to have effective, embedded ways of listening to and involving staff, patients and our partners in decisions about services.

We recruited a new experienced, substantive Director, and Deputy Director of Midwifery, who started in post in mid May 2023 to strengthen maternity leadership and support further improvements to the service across the Trust.

The new maternity and neonatal leadership team has worked with families, staff and partners to co-produce a Maternity and Neonatal Improvement Programme for East Kent.

The programme has six priority areas:

1. Developing a positive culture
2. Developing and sustainable culture of safety, learning and support
3. Clinical pathways that underpin safe care
4. Listening to and working with women and families with compassion
5. Growing, retaining and supporting our workforce
6. Infrastructure and digital.

This programme incorporates work developed in March following the publication of the *Reading the Signals* report in October and the Care Quality Commission (CQC) inspection in January 2023. It also reflects the national Three-Year Single Delivery Plan for Maternity and Neonatal Services published in May 2023 – a plan that sets out how the NHS will make maternity and neonatal care safer, more personalised and more equitable.

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 have 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. These forums are in addition to regular multi-disciplinary patient safety meetings.

13. Developing our governance

We want to have effective governance processes which create link throughout the organisation, from frontline staff to the Board, where partnership working is embedded and effective, and leadership is open to challenge.

We established 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). The group 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. It provides specific oversight of maternity and neonatal services, including training compliance, the monthly maternity dashboard, maternity and neonatal improvement programme, progress against Clinical Negligence Scheme for Trusts (CNST), Ockenden and CQC actions.

We have implemented the nationally-required role of the Maternity and Neonatal Safety Champion. Our seven 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. They include consultants, our Chief Nursing and Midwifery Officer, Director of Midwifery and Non-Executive Director Maternity Champion who hold regular walkabouts and monthly listening events.

We have reviewed governance in maternity and developed a maternity risk management strategy in 2022. To support improved governance systems of control across maternity, we appointed several specialist roles, including a head of governance, patient safety matron, a quality governance and education matron and a compliance midwife.

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.