East Kent Hospitals University NHS Foundation Trust

READING THE SIGNALS OVERSIGHT GROUP

TUESDAY 16 JULY 2024 11:10 – 13:00 HRS
BOARD ROOM, KENT & CANTERBURY HOSPITAL,
ETHELBERT ROAD, CANTERBURY
AND BY WEBEX TELECONFERENCE

This meeting will be conducted in line with the Trust Values below:

- People feel cared for as individuals
- People feel safe, reassured and involved
- People feel teamwork, trust and respect sit at the heart of everything we do
- People feel confident we are making a difference.

AGENDA

24/

OPENING/STANDING ITEMS

No.	Item	Time	Purpose	Type	Presenter
009	Welcome, Introductions and Apologies	11:10	To Note	Verbal	Claudia Sykes Chair/Non-Executive Director
010	Minutes from the last meeting held on the 14 May 2024	11:15	Approval	Enclosure	Claudia Sykes Chair/Non-Executive Director
011	Matters Arising from the Minutes	11:20	Discussion	Enclosure	Claudia Sykes Chair/Non-Executive Director

ITEMS

012	Maternity IPR Update	11:25	Discussion	Enclosure	Sarah Hayes / Des Holden CNMO / CMO
013	Specific response to the issues in the RtS report "You said, we did"	11:40	Discussion	Enclosure	Sarah Hayes CNMO
014	Review of Terms of Reference	12:00	Discussion	Enclosure	Claudia Sykes Chair/Non-Executive Director

015	Feedback from East Kent MNVP on Their “15 Steps”	12:15	Discussion	Enclosure	Sarah Hubbard MNVP Lead
016	Family Representative Feedback	12:30	Discussion	Verbal	Claudia Sykes Chair/Non-Executive Director

CLOSING MATTERS

017	Any Other Business	12:45	Discussion	Verbal	Claudia Sykes Chair/Non-Executive Director

Date of next meeting: **Tuesday 17 September 2024 @ 11:10 hrs**

UNCONFIRMED MINUTES OF THE READING THE SIGNALS OVERSIGHT MEETING TUESDAY 14 MAY 2024 13:10 – 15:00 HRS BOARDROOM, KENT AND CANTERBURY HOSPITAL, ETHELBERT ROAD, CANTERBURY VIA WEBEX TELECONFERENCE

PRESENT

Claudia Sykes	Non-Executive Director (Chair)	CS
Stewart Baird	Interim Chair & Non-Executive Maternity Safety Champion	SB
Tracey Fletcher	Chief Executive Officer	TF
Des Holden	Chief Medical Officer	DH
Sarah Hayes	Chief Nursing and Midwifery Officer	SHa
Ben Stevens	Chief Strategy and Partnerships Officer	BS
Andrea Ashman	Chief People Officer	AA
Sarah Hubbard	MNVP Lead for East Kent	SH
Bernie Mayall	Lead Governor/Elected Public Governor - Dover	BM
Alex Ricketts	Elected Governor - Canterbury	AR
Derek Richford	Family Representative	DR
Tanya Linehan	Family Representative	TL
Linda Dempster	Family Representative	LD
Helen Gittos	Family Representative	HG
Yvette Sampson	Family Representative	YS
Caroline Potter-Edwards	Family Representative	CPE

Attendees

Natalie Yost	Director of Comms and Engagement	NY
Khaleel Desai	Director of Corporate Governance	KD
Fay Corder	(on behalf of Kaye Wilson)	FC
Becky Collins	Director of Maternity & Neonatal Services, Kent & Medway	BC
Bill Kirkup	Investigator into East Kent Maternity Services	BK
Edile Murdoch	Chair Maternity & Neonatal Outcomes Group	EM
Ann Ridley	Formerly Family Liaison Contact for EK Independent Panel	ARi

AGENDA ITEM NO		ACTION
24/001	**WELCOME AND INTRODUCTIONS AND APOLOGIES** Apologies were received from: Carl Shorter - Elected Governor - Folkestone & Hythe/Deputy Lead Governor Kaye Wilson - Regional Chief Midwife for SE Region	
24/002	**MINUTES FROM THE LAST MEETING HELD ON THE 12 MARCH 2024** The minutes from the previous meeting were **APPROVED.**	
24/003	**MATTERS ARISING FROM THE MINUTES** **RSOG/07 - Your Voice is Heard Feedback - The Trusts' target needed to be changed to reflect the national average FFT percentage - Update 14.05.24 –** BC gave an update, there was an ambition to complete a piece of system work to look at the national averages and response rates. There were some differences in the localisation of how the FFT report was being completed in some fields. The national team had stopped producing a national average response rate. Rather than aligning all four of the maternity service providers, they would be working with individual service providers to make sure that they were hearing from all of the groups of people that used their services.	

BC stated that it was important for the group to understand how widely promoted the *Your Voice is Heard* approach was already in operation within the organisation as an exemplar model. The information gathered was reported in a really useful way and then reported through good governance. The *Friends and Family Test* (FFT) had many more limitations, and from across the country had a much lower response rate, than what was being achieved by *Your Voice is Heard*.

Regarding the timeline, BC confirmed that her team were focused on other providers within the Kent & Medway system, and bringing these up to the standards that were already seen in East Kent. To CLOSE.

RSOG/11 - Family Representative Feedback - The trust to take feedback received by family reps and look at how these could be addressed - **Update 14.05.24** – CS confirmed that this was an ongoing area of discussion that needed to be kept open. The Terms of Reference were to be reviewed at the next meeting, along with a review of the progress that had been made in the past year or so. To remain OPEN.

RSOG/12 - Family Representative Feedback - TF to follow up issues regarding the legal process - Update 14.05.24 – TF stated that subsequent to the last meeting, she and SHa had met with NHS Resolution again, around the support provided to the Trust. NHS Resolution picked up the management of support when cases progressed. TF & SHa had been discussing with NHS Resolution as to what the future arrangements looked like. SHa confirmed that it was a very detailed discussion, and one that would continue. It was difficult to give a time-scale, but it was agreed that this could be discussed again at future meetings for an update. It was agreed that this would be put on the agenda as a standing agenda item, along with any other items that required transparency, or learning from lessons. To CLOSE.

RSOG/13 - Maternity Update - BS to amend the IPR report to explain/remove any jargon used - Update 14/05/2024 - The Chair informed the reports were being read through to ensure jargon was removed, or explained. There was still a need to ensure that any board reports, and any reports available to the public, were easy to read. To CLOSE.

RSOG/20 – Team Working Across Disciplines – MC to circulate the scorecard/CNST document to the group after the meeting – Update 14/05/2024 - SHa confirmed that this was to have been circulated prior to the meeting (JA gave apologies and circulated the CNST document following the meeting). The document that had been circulated was the public board paper, although it did contain some complicated jargon. The Director of Midwifery was happy to meet with anyone to talk it through with them if this would prove to be helpful. To CLOSE

RSOG/21 – Team Working Across Disciplines – Updated MNIP Metrics data to be seen at the next meeting. Update 14/05/2024 – This item was on the agenda. To CLOSE

RSOG/22 – Family Representative Views – Reputational Management in SI criteria to be looked at to see if it could be removed – SHa confirmed that she had had several conversations with the Chief Midwifery Officer for England. There was a national commitment, with the PSIRF methodology, that the reputational management aspect, that was currently included within the SI, was removed. The Trust was in the process of moving over to PSIRF. DR confirmed that he had also had conversations with the Chief Midwifery Officer for England and that she confirmed that there was nothing to be done regarding reputational damage, as far

as investigations of problems was concerned. **Action: SHa** was to circulate the new PSIRF Proforma. BC added, that within the ICB there was the responsibility to oversee the process of declaration, investigation and closing of Serious Incidents, under the Serious Incidents Framework. A decision had been made (quite a while ago) to move the maternity and neonatal incidents into a bespoke panel. The panel included service users as decision makers. During the period, since this was introduced, there had not been a signal incident that had been reported in the category of reputational issues, for the reporting organisation. To CLOSE.

RSOG/23 – Family Representative Views – HG requested a conversation to be had at the next meeting around the implementation of the Kirkup recommendations. This was on the agenda – to CLOSE.

24/004 **MATERNITY IPR**

In the interest of time (as time was required for Dr Kirkup's and Edile Murdoch's presentation) the Chair suggested that the reports were reviewed on an exception basis and to take any questions.

SHa confirmed that this was a data driven report and that she was happy to take any questions that anyone had.

HG raised a question regarding the report being split into incidents rated as "severe" and "moderate" and whether this was a new way of reporting? BS confirmed that there had been a change in the way that the data was being reported. The change occurred in February 2024 and, therefore, the current report was showing a crossover of the data from the old method to the revised method during the month of February.

Discussions took place regarding the way in which the data was reported. The information provided only showed the numbers within each category, there was no explanation as to what these referred to. **Action: SHa** was to have a discussion with the governance team as to how the data could be presented in future, to give a better understanding of the figures that were being presented and the themes that were occurring.

Action: SHa and DH were to have a discussion with their teams around the data within the reports and to present it with some additional information for the group to review. The wording within the report also needed to be reviewed.

24/005 **PRESENTATION FROM NATIONAL TEAM**

BK thanked the group for being invited to the meeting and the opportunity to update the group as to what has happened since the initial report was published. BK thanked the families who had participated in the forming of the report.

EM presented the Maternity Outcome Signal System (MOSS). EK thanked BK for the recommendations that were made to NHS England and the Department of Health, which meant that the actions were going to be applied to all maternity units.

One of the slides showed the analysis of trends using a CUSUM chart (a cumulative sum chart, used to monitor small shifts in the process mean). Towards the end of 2016 the outcomes crossed the threshold. In this system, this could indicate an area requiring investigation to determine what the reasons were for this. BK stated that even if the line started to approach the threshold, this would be an indication that a more thorough review would be required. There were indications in 2011/12 that there was a potential issue.

EM confirmed that back in 2011/12 no real time information was available. Any information that the Trust and Boards were given, was very retrospective. Data

would have been generated via the Datix system (in terms of major harm), but unless it was generated in the cumulative way of trends (CUSUM), the changes would not have been visible.

One of the slides showed the CUSUM chart along side a VLAD (Variable Life Adjusted Display) chart and also a Date of Event chart (which displayed the data in clusters). The VLAD was a different way of expressing the CUSUM data. It was thought that the VLAD presentation was easier to interpret. The plan was to present all three charts for the testing of the data.

The analysts were working with the NHS England technical team to create a live dashboard, which would display the three charts.

The NHS England, Single Notification Portal was being moved to SPEN. The plan was for significant safety events to be reported into the SPEN portal, from which it would be forwarded to other platforms that required the data. This was to reduce the number of times that staff had to submit the same information to different organisations. This would allow a live feed for the signal system. It was hoped that this was to go live by the end of 2024, beginning of 2025.

It was noted that maternal deaths were not yet being captured on this system. BK confirmed that this data was not being captured on the first tranche, due to the small numbers (along with other areas, eg anaesthetic awareness).

It was confirmed that neonatal deaths were recorded at place of birth, when there had been a transfer.

The intention was to have a system that when a signal was seen, there would be a Standard Operating Procedure (SOP) to follow. This would give a guide as to what had to be done and would remove any need for interpretation. These reports would go to the Board and would be recorded. Over time, if there were repeated signals this would indicate that some additional support or help was required. The intention was to make the process as robotic as possible and to take out any requirement for interpretation.

There were concerns about the lack of awareness of the work had already taken place and the lack of visibility.

Dr Kirkup had identified seven actions that would help with compassion care and team work. The next step was to try to work out how best to get people onboard, who had the control to make the changes.

BC stated that herself and the Regional Chief Midwife, champion the good work that had happened in East Kent and would support the team in promoting the good work that had been done. CS stated that East Kent would like to be a flagship within Kent & Medway and the ICB. Not only in what has been achieved, but also for what the ambition was and how it had been achieved. There had been some real learning as to how to make some substantial improvements that have been made.

24/006 **UPDATE ON TRUST RESPONSE TO KIRKUP**

DR stated that there would be a point in time where the local community, and certainly the families that had been involved, should know that what they had input to had resulted in national recognition. As a result of the Reading the Signals Report that happened around the events in East Kent, there has been a national effect regarding the outcomes learnt. A level of positivity was required to embrace the amount of good work that had already taken place. There was still more work to be done.

SB confirmed that there was a need to start building the learnings for other maternity services. A lot had been learnt at East Kent, which would be invaluable to other services.

NY stated that there needed to be a balance between the good and not so good experiences that patients are experiencing. There needed to be an honest conversation, publicly, about the challenges that still remained, but also what had also been achieved.

BK stated there was also a need to get the regulators onboard (GMC and NMC) to deal with transgressive behaviour, as the current HR processes were not robust enough to deal with this.

TF said that we would want to look at implementing the recommendations BK referred to and thanked BK and EM for attending and their contribution to the discussions.

It was noted that the representation at the meeting had changed. TF confirmed that it was felt that the focus of the meeting needed to be shifted and as a result the list of invitees had been amended. The CEO and CNMO now had a better focus for these meetings and were able to have wider, more detailed, discussions with their teams, outside of this group.

SHa stated that she did have an update on the Maternity Improvement Programme. A discussion needed to take place as to what routine reporting should come to the next meeting. BC confirmed that she would be happy to support those conversations. Prior to the next meeting SHa would like an indication as to what the group thought would be the useful topics to discuss and also what should be included on the agenda.

SHa also offered for some of the family representatives to be invited to the Maternity and Neonatal Assurance Group (MNAG) meetings. SHa was happy for anyone to email her with their suggestions.

CS also mentioned that there was the East Kent Maternity Voices group, which family representatives were welcome to join. It was agreed that it was time to take the Reading the Signals Group to the next level and have family members more involved in other appropriate meetings.

Action: SH offered to bring a summary of the findings from the 15 Steps visit. Over the last two months both WHH and QEQM were visited.

24/007 **FAMILY REPRESENTATIVE FEEDBACK**

Due to the presentation from BK and EM, there was not enough time to discuss this agenda item in detail.

HG stated that she would like to see a proper discussion about what was being implemented following the Kirkup Recommendations.

SB stated that a lot of the data that was presented was NHS data. There was a need to consolidate and interpret it to ensure that it was written in plain English for easier interpretation and for people to understand.

BS was looking at the way that some of the information was presented.

SH stated, that it would be good if it could be shown how the data fed back into the recommendations. This would help with the reading and interpretation of the progress, and whether the recommendations were being met.

24/008 **ANY OTHER BUSINESS**

There was no any other business.

24/009 **DATE OF NEXT MEETING –** Tuesday 16 July 2024

SIGNED: _____

DATED: _____

EAST KENT HOSPITALS UNIVERSITY FOUNDATION TRUST READING THE SIGNALS OVERSIGHT GROUP ACTION LOG

RSOG/07	08/08/2023	23/032	Your Voice is Heard Feedback	The Trusts' target needed to be changed to reflect the national average FFT percentage	19/09/2023	MC	Open	Update - MC to email the Regional Chief Midwife for her perspective. **Update 19.09.23 -** MC informed there had been a conversation regarding this at the Maternity & Neonatal Assurance Group (MNAG) and it was felt that the regional average would be looked at. BC commented this would be discussed at a Performance and Quality meeting during this week and it was hoped an agreement would be made across Kent and Medway by this next meeting.**Update 31.10.23 -** MC updated on this action in BC's absence - It was not possible for this to be discussed at the LMNS meeting as planned and the team were undertaking a piece of work to review the differing reporting of this important metric across the four maternity services in K&M with a view to aligning the reporting and agreeing targets and thresholds. To remain OPEN. **Update 16.01.2024 -** MC informed the Regional team were discussing what the regional average would look like and feedback was awaited, however, 12% was the national average. JHa was now dealing with the FFT for a system wide agreement on an improvement projectory - a meeting was being arranged - To remain OPEN **Update 02/02/2024 -** Email sent on behalf of MC to support this action. Update 12.03.24 - JHam informed a working group had been set up to look at the FFT. A cohesive approach was needed as individual trusts were conducting the FFT in different ways and this would take some time to agree. The meetings were ongoing and once a standardised approach had been agreed then the improvement of response rates and trajectories could be looked at. DR asked if there was a timescale around this. JHam responded it needed to be understood how complex the issue was. To remain OPEN.
RSOG/11	31/10/2023	23/054	Family Representative Feedback	The trust to take feedback received by family reps and look at how these could be addressed	Jan-24	CS	Open	**Update 16.01.2024 -** The Chair advised this would remain open as there was a lot of work still to be done by the trust. **Update 12.03.24 -** To remain OPEN
RSOG/12	31/10/2023	23/054	Family Representative Feedback	TF to follow up issues regarding the legal process		TF	Open	**Update 16.01.2024 -** SH commented on the comment made at the last meeting by PL in regards to the "win" over his family was that was used as an advert. This had been looked at, and was visible on a related companys website in New York. Work was being done with Katy White - Director of Quality Governance to try and get this removed. SH apologised to the family involved, and an apology had also been issued by the company who were also working to try and resolve this. The Chair asked if there was anyway the trust could stop this happening again. SH responded it would be very difficult as this had been picked up by a search engine, however, the trust were keeping a close eye on things with the help of Comms & Engagement. AA asked if the company was a sister company. SH responded, it was a different entity. To remain OPEN. **Update 12.03.24 -** PL commented an apology still had not been received by the company, only by the trust. This was still very distressing for the family and more representation was needed around this. SH gave re-assurance this was being persued. A discussion was due to be had with NHS Resolutions and TF gave assurance there was ongoing work around this. TL described how the process over the last few years had made her feel. To remain OPEN
RSOG/13	16/01/2024	23/061	Maternity Update	BS to amend the IPR report to explain/remove any jargon used.	Mar-24	BS	Open	**Update 12/03/2024** - The Chair informed the reports were being read through to ensure jargon is removed or explained in reports ? To remain open?
RSOG/20	12/03/2024	23/070	Team Working Across Disciplines	MC to circulate the scorecard/CNST document to the group after the meeting	May-24	MC	Open	
RSOG/21	12/03/2024	23/070	Team Working Across Disciplines	Updated MNIP Metrics data to be seen at the next meeting	May-24	MC	Open	
RSOG/22	12/03/2024	23/071	Family Representative Views	Reputational Management in SI criteria to be looked at to see if it could be removed		SH	Open	
RSOG/23	12/03/2024	23/071	Family Representative Views	HG requested a conversation to be had at the next meeting around the implementation of the Kirkup recommendations	May-24	SH/MC	Open	

East Kent Hospitals University NHS Foundation Trust

Improving maternity services in East Kent

Michelle Cudjoe Director of Midwifery

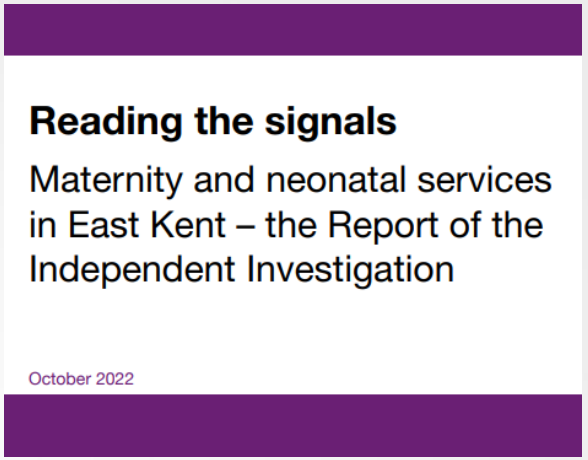
Sarah Hayes CNMO

We care

Vision for maternity

East Kent Hospitals University NHS Foundation Trust

Taking learning from ‘Reading the Signals’, our vision is aligned with the national vision outlined in **Better Births**:



- ‘To become a service that is safer, more personalised, kinder, professional and family friendly’

Maternity and Neonatal Improvement Programme

- “Empowering our staff to work with women and their families to make a difference in outcomes for maternity and neonatal care”

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East Kent Hospitals University NHS Foundation Trust

Key Action Area 1

- Monitoring safety performance – finding signals amongst the noise

We care

Safety performance – work complete

Finding signals amongst noise

East Kent Hospitals University NHS Foundation Trust

- New maternity dashboard to identify trends

"The improvement dashboard developed by East Kent effectively uses Statistical process control (SPC) to monitor the progress of KPIs. We would consider East Kent's use of summary icons and drill-down ability an **example of best-practice reporting**. I am certain the reporting set-up will benefit the wider project"

NHS Making Data Count

- National, regional and local benchmarking
- MNIP measurable outcomes observe the **impact** of change
- Patient Voices Model to receive and act on feedback

We care

Safety performance – outcomes
Stillbirths

NHS
East Kent Hospitals University
NHS Foundation Trust

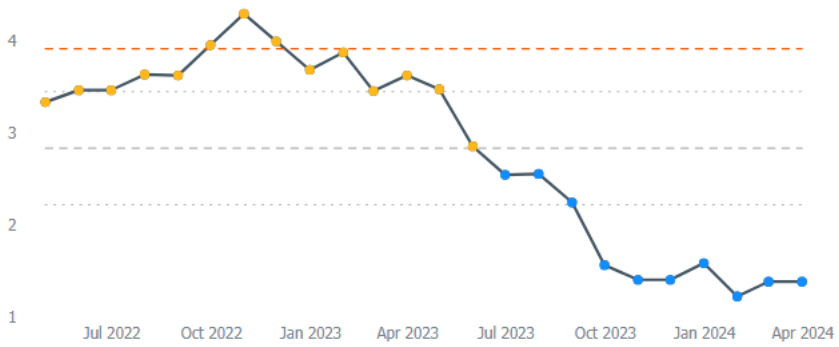
New Maternity Dashboard
Patients | Maternity & WH

Period: Month
Sliced By: TOTAL
Domain, KPI: Morbidity & Mortality (Domain) + MBRRACE Stillbirth 12m Rate (KPI)

MBRRACE Stillbirth 12m Rate

Timescale	Value	SPC
May-23	3.48	
Jun-23	2.86	
Jul-23	2.55	
Aug-23	2.56	
Sep-23	2.25	
Oct-23	1.57	
Nov-23	1.41	
Dec-23	1.41	
Jan-24	1.59	
Feb-24	1.23	
Mar-24	1.39	
Apr-24	1.39	

XMR Run Chart



Understanding the most recent data point

Performance

1.39 — Variation indicates consistently passing the target

Variation

Variation: Special cause of improving nature or lower pressure due to lower values

Flags: Below Mean Run Group; Astronomical Point; Two Out Of Three Beyond Two Sigma Group

M_01204_SB_Rate

Updated | 02/05/2024 09:01:00

Metric Definition

MBRRACE methodology used. Stillborn babies born 24+0 weeks gestation at EKHUFT, reported by birth month. Denominator is all live and stillborn babies 24+0w. Terminations excluded

Rolling 12 month rate. Target is set at the average of Trust's comparator group from the latest MBRRACE report (2021) Average was 3.92

UK ambition to half stillbirths by 2025 to 2.6 per 1,000 births.
East Kent: 1.39 per 1,000 births in April 2024.

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Safety performance – outcomes

Extended Perinatal Mortality

East Kent Hospitals University NHS Foundation Trust

New Maternity Dashboard

Patients | Maternity & WH

Period: Month

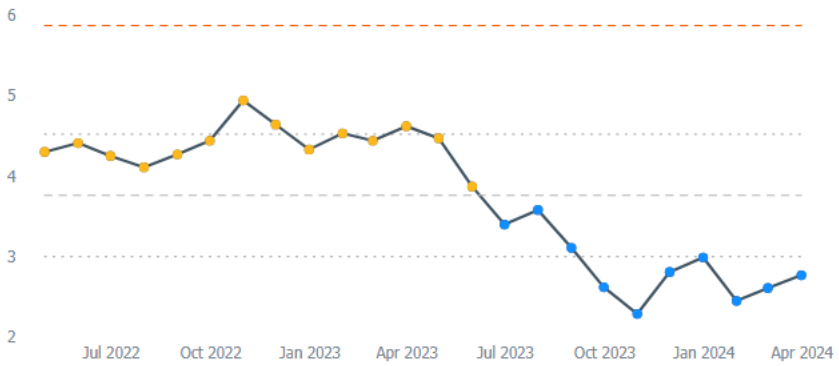
Sliced By: TOTAL

Domain, KPI: Morbidity & Mortality (Domain) + MBRRACE Ext Perinatal Rate 12m (KPI)

MBRRACE Ext Perinatal Rate 12m

Timescale	Value	SPC
May-23	4.47	
Jun-23	3.87	
Jul-23	3.40	
Aug-23	3.58	
Sep-23	3.11	
Oct-23	2.62	
Nov-23	2.29	
Dec-23	2.81	
Jan-24	2.99	
Feb-24	2.45	
Mar-24	2.61	
Apr-24	2.77	

XMR Run Chart



Understanding the most recent data point

Performance

2.77 — Variation indicates consistently passing the target

Variation

Variation: Special cause of improving nature or lower pressure due to lower values

Flags: Below Mean Run Group; Astronomical Point; Two Out Of Three Beyond Two Sigma Group

M_01206

Updated | 15/05/2024 08:02:00

Metric Definition

MBRRACE methodology used. Stillbirths and Neonatal deaths up to 28 days

Rolling 12 month rate. Target is set at the average of Trust's comparator group from the latest MBRRACE report (2021).

Extended perinatal mortality refers to all stillbirths and neonatal deaths.
MBRRACE methodology used. The rate is per 1,000 total births.
Comparator group: 5.87 per 1,000 births. East Kent: 2.77 per 1,000 births.

We care

Safety performance – outcomes

Moderate / severe brain damage

NHS
East Kent Hospitals University
NHS Foundation Trust

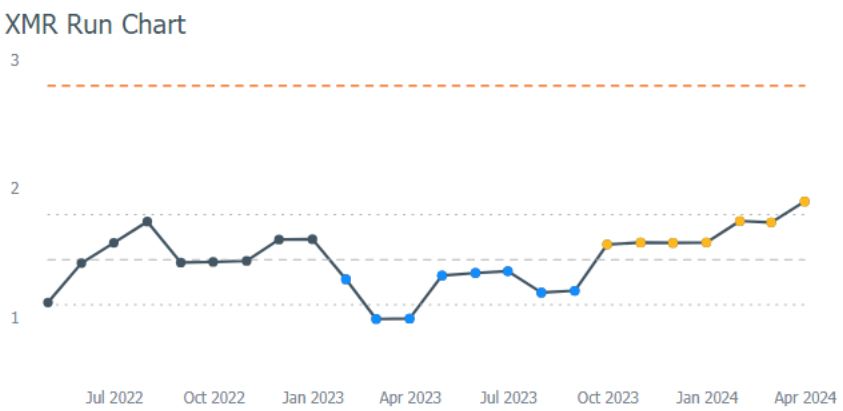
New Maternity Dashboard

Patients | Maternity & WH

Period: Month | Sliced By: TOTAL | Domain, KPI: Morbidity & Mortality (Domain) + HIE Rate Rolling 12m (KPI)

HIE Rate Rolling 12m

Timescale	Value	SPC
May-23	1.3	
Jun-23	1.3	
Jul-23	1.4	
Aug-23	1.2	
Sep-23	1.2	
Oct-23	1.6	
Nov-23	1.6	
Dec-23	1.6	
Jan-24	1.6	
Feb-24	1.8	
Mar-24	1.7	
Apr-24	1.9	



Understanding the most recent data point

Performance

1.9 — Variation indicates consistently passing the target

Variation

Variation: Special cause of concerning nature or higher pressure due to higher values

Flags: Above Mean Run Group; Astronomical Point; Two Out Of Three Beyond Two Sigma Group

M_01158_HIE_mm

Updated | 15/05/2024 10:00:00

Metric Definition

Moderate and Severe HIE rate. Rolling 12 month rate
Numerator: Number of moderate and severe (maximum recorded for each baby) admissions each month to NICU/SCBU. Includes all babies, inborn and outborn, any gestation. Data taken from principal diagnosis at discharge
Demoninator: All livebirths born at EKHUFT

Target range is 2.4 - 2.8 rate per 1000 livebirths as per Chris Gale's research paper " Neonatal brain injuries in England: population-based incidence derived from routinely recorded clinical data held in the National Neonatal Research Database" https://fn.bmj.com/content/103/4/F301#ref-7

Target range is 2.4 per 1,000 live births. East Kent: 1.9 in April 2024. Includes babies of all gestation.

We care

Safety Performance – next steps

Using data to highlight improvement needs/success

East Kent Hospitals University NHS Foundation Trust

- ‘You said, we did’ – continuing to act on service user feedback and co-produce services.
- Monitoring of MNIP outcome measures
- Embedding quality improvement tools for designing new ways of working (PSIRF, We Care)
- Maternity dashboard reporting
- Participate in pilots of new systems for critical safety data oversight to ensure early identification of warning signals that can be used to prompt timely intervention.

Key Action Area 2

- Standards of clinical behaviour – technical care is not enough

Positive culture – work complete

Kindness and compassion

East Kent Hospitals University NHS Foundation Trust

- NHSE Perinatal Culture and Leadership Programme / substantive ‘Quad’
- SCORE Survey
- New team of perinatal culture ‘Change Agents’
- Frontier Leadership:
  'The Strength of the Pack: The Fundamentals of Teamship’
- Civility Saves Lives training
- Compassionate care eLearning
- Introduction of Team of the shift (Escalation toolkit)
- Staff who work together, train together (PROMPT)
- EKHUFT Inclusion and Respect Charter
- EKHUFT Leadership Behaviours Framework
- ‘Leading with kindness’ training
- Practice Assessor / Practice Supervisor training
- Relaunch of Professional Midwifery Advocate (PMA) team
- Freedom to Speak Up Guardian dedicated to Maternity
- Maternity & Neonatal Safety Champions gemba walks
- ‘We hear you’ local initiative
- ‘You said, we listened’

We care

Positive culture - outcomes

Kindness and compassion

NHS
East Kent Hospitals University
NHS Foundation Trust

Your Voice is Heard Feedback

Category	Target (%)	April 2023	April 2024
Response rate	70%	68.7%	72.9%
Happy to return to return for maternity care	90%	86.7%	88.8%
Positive about antenatal care	90%	88.0%	91.3%
Positive about labour care	90%	93.2%	90.4%
Positive about postnatal care	90%	86.6%	82.6%
Felt listened to throughout	90%	86.3%	86.1%

We care

Positive Culture– outcomes

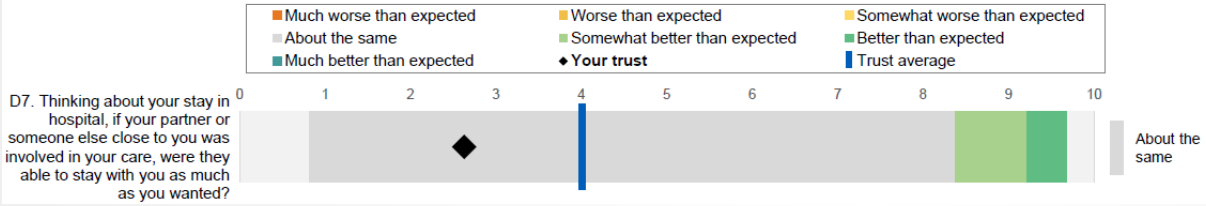
CQC Maternity Services Survey: Partner length of stay

East Kent Hospitals University NHS Foundation Trust

2022 Results – Score of **2.6**

Benchmarking - Labour and birth (continued)

Question scores: Care in hospital after birth

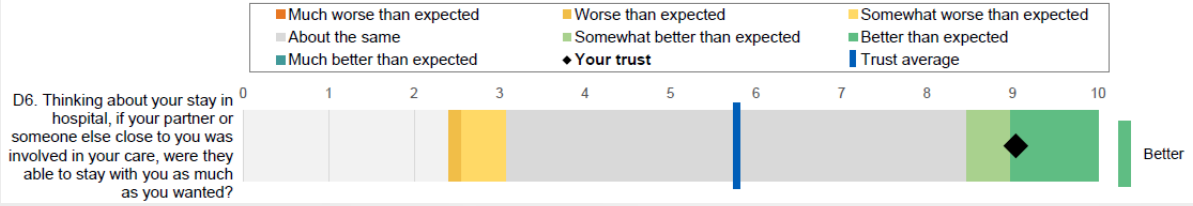


		All trusts in England		
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
214	2.6	4.0	0.8	9.7

2023 Results – Score of **9.0**

Benchmarking - Labour and birth (continued)

Question scores: Care in the ward after birth



		All trusts in England		
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
223	9.0	5.8	2.4	10.0

Source: [NHS Maternity Services Survey 2022 Benchmark Report]

We care

Positive culture - outcomes

Kindness and compassion

East Kent Hospitals University NHS Foundation Trust

My friend, my rock and my midwife Emma. On the 11th November 2022, you held my hand and stayed by my side for the labour of my son, my angel baby- Oliver 👶 💙. On that day although I was ever so grateful to you for the support and care you gave me. I never fully appreciated at the time the type of person it takes to guide and support a birth for parents who are having to say goodbye to their baby. That type of strength and love is not something we are all capable of and you give that to every family you meet. You are rare, a one in a million. You walked through fire with me and never left and there are no words that can ever thank you enough for that 💗

In April 2023 I fell pregnant with my rainbow baby George 🌈. The 9 months of carrying George felt like a lifetime. A lifetime of worry, anxiety and hope. However I was lucky to have you apart of this journey with me. You have been my only constant during that time. You are the person
and hope throu
appointments.
met. You want
and that is exa
You have held
boys 💙💙. Y
moments of m
to me 💗 You
everything x

10 hours ago

"My friend, my rock and my midwife Emma…In April 2023 I fell pregnant with my rainbow baby George. The 9 months carrying George felt like a lifetime…of worry, anxiety and hope…You have been my only constant during that time…You have been there at the worst and best moments of my life and you will always be so so special to me…"

'Small Steps'
specialist bereavement team

Positive culture - next steps

Using feedback to shape ways of working

East Kent Hospitals University NHS Foundation Trust

- Postnatal Care Pathway – area of priority
- Improved equity and equality
- Frontline ‘culture conversations’
- Manager training and development
- Cultural Allyship training
- De-biasing processes/ EDI Ambassadors

We care

Key Action Area 3

- Flawed teamworking – pulling in different directions

Safety Culture – work complete

Teamworking

East Kent Hospitals University NHS Foundation Trust

- Clearly defined team objectives
- New substantive ‘Quad’ leadership team
- Labour Ward Forum
- Team of the shift (Escalation toolkit)
- Strength of the pack training
- Monthly Quality Boards
- Cross Site Working
- Staff who work together, train together (PROMPT)
- EKHUFT Inclusion and Respect Charter
- ‘Leading with kindness’ training
- Practice Assessor / Practice Supervisor training
- Relaunch of Professional Midwifery Advocate (PMA) team

We care

Safety culture - outcomes

Clinical Negligence Scheme for Trusts (CNST)

10 x Safety Actions

NHS
East Kent Hospitals University
NHS Foundation Trust

Section A : Maternity safety actions - East Kent Hospitals University NHS Foundation Trust

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes
2	Are you submitting data to the Maternity Services Data Set to the required standard?	Yes
3	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?	Yes
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate compliance with all four elements of the Saving Babies' Lives V2 ?	Yes
7	Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?	Yes
8	Can you evidence that the maternity unit staff groups have attended as a minimum an half day 'in-house' multi-professional maternity emergencies training session, which can be provided digitally or remotely, since the launch of MIS year three in December 2019?	Yes
9	Can you demonstrate that the Trust safety champions (obstetric, midwifery and neonatal) are meeting bi-monthly with Board level champions to escalate locally identified issues?	Yes
10	Have you reported 100% of qualifying incidents under NHS Resolution's Early Notification scheme? a) Reporting of all outstanding qualifying cases to NHS Resolution EN scheme for 2019/2020 b) Reporting of all qualifying cases to Healthcare Safety Investigation Branch (HSIB) for 2020/21	Yes

We care

Safety culture - outcomes
Teamworking: national benchmarking

East Kent Hospitals University NHS Foundation Trust

Eight out of ten (80%) trainees said that their working environment is a fully supportive one, although… 11% (as 2022) of obstetrics and gynaecology trainees disagreed with this statement

Trainees – Supportive environment questions

Trainees	Positive			Neutral			Negative		
	2021	2022	**2023**	2021	2022	**2023**	2021	2022	**2023**
The working environment is a fully supportive one	81%	79%	↑ **80%**	13%	14%	↓ **13%**	6%	7%	→ **7%**
Staff, including doctors in training, are always treated fairly	70%	67%	↑ **68%**	18%	18%	→ **18%**	12%	15%	→ **15%**
Staff, including doctors in training, always treat others with respect	79%	76%	↑ **77%**	13%	14%	↓ **13%**	8%	10%	→ **10%**
My department/unit/practice provides a supportive environment for everyone regardless of background, beliefs, or identity	89%	88%	→ **88%**	8%	8%	→ **8%**	3%	3%	↑ **4%**

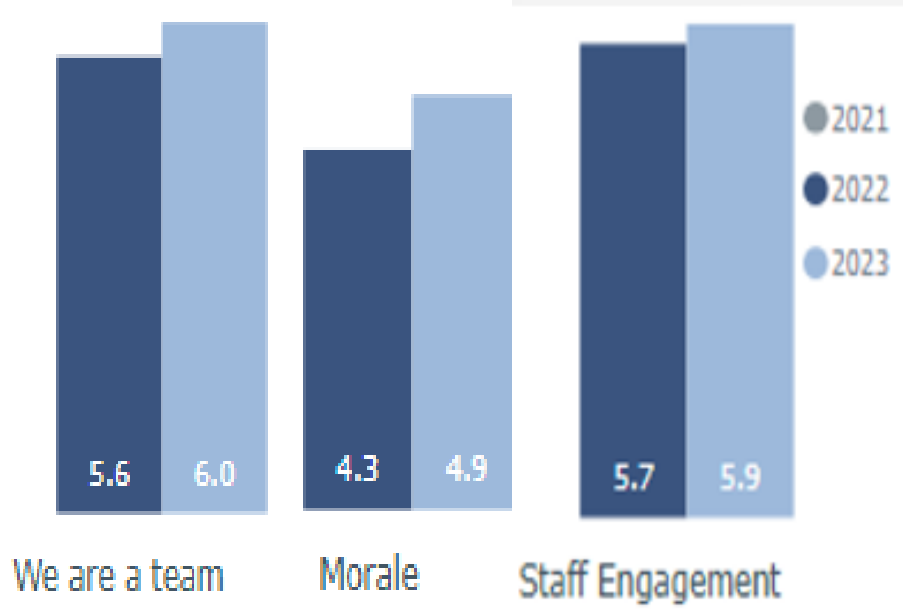
We care

Safety culture - outcomes

Teamworking: local benchmarking

East Kent Hospitals University NHS Foundation Trust

NHS Staff Survey Results: Maternity



All-round improved results 2023 v 2022

(144 responses 2022 / 138 responses 2023)

We care

Safety culture - next steps

Using feedback to shape ways of working

East Kent Hospitals University NHS Foundation Trust

- Ongoing multidisciplinary opportunities
  - Training
  - Improvement projects
- Restorative Clinical Supervision
- Trauma Informed Care- responding to the Birth Trauma Inquiry
- Restoration – Families and Staff

We care

East Kent Hospitals University NHS Foundation Trust

Key Action Area 4

- Organisational behaviour – looking good while doing badly

We care

Listening and engagement – work complete

Honesty and openness

East Kent Hospitals University NHS Foundation Trust

- Substantive leadership teams: Executive / Care Group levels
- Quality and Safety Framework / Governance Structure in place
- All SIs and neonatal death reviews include independent panelists as recommended by the Ockenden Inquiry
- Duty of Candour processes in place and monitored
- Ongoing monitoring and oversight of governance processes by ICB and Regional teams
- Unit currently on sustainability phase of MSSP programme
- Implementation plan for PSIRF
- Coproduction events (Small Steps, MNIP, Postnatal Booklet)
- Engagement meetings / forums
- MNIP Communications Plan

We care

Listening and engagement – next steps
Restoration for families and staff involved in the Kirkup Inquiry

East Kent Hospitals University NHS Foundation Trust

- Independent team of restorative practitioners commissioned to undertake restorative work required for both families and staff
- Project being facilitated in three phases:
- Co-design (in progress)
- Implementation
- Evaluation

We care

NHS
East Kent
Hospitals University
NHS Foundation Trust

TERMS OF REFERENCE

READING THE SIGNALS OVERSIGHT GROUP

1. CONSTITUTION

1.1 The Board of Directors approved the establishment of an Oversight Group which will report to the Trust Board. It will meet in public. The effectiveness of the Group will be reviewed in 6 months' time.

2. PURPOSE

2.1 To provide oversight of the Trust's response to the Reading the Signals report and to make sure there is appropriate engagement with patients, their families and the Community and specifically to oversee, influence, challenge and advise on how the Trust embarks and embeds the restorative process required to address the problems identified in Reading the Signals Report.

2.2 To support the establishment of Community Family Voices meetings to develop the focus of the Trust's response to reflect the issues of importance to families as the organisation transforms its services.

3. OBJECTIVES

3.1. To have oversight of the Trust wide approach to transforming the way the organisation delivers its services through the Five Pillars of Change:

a. Reducing Harm and Safe Service Delivery (Monitoring safe performance)
b. Care and Compassion (Standards of Clinical Behaviour)
c. Engagement, Listening and Leadership (Flawed team working)
d. Organisational Governance and Development (Organisational behaviour)
e. Patient, Family and Community Voices (Listening and Restoration)

3.2 The work programme set out in Pillars of Change details the Trust's transformation ambition over the next 3 years and for year one will predominantly be managed through the Trust wide Integrated Improvement Plan (IIP)which has a set of outcome measures associated with the actions).

3.3 The Clinical Executive Management Group (CEMG) will have day to day responsibility for delivery of the transformation programme and will provide regular updates for the Group using the opportunity to test and refine plans following input from members of the Group. The CEMG will also provide assurance to the Trust Board on the delivery of this restorative process.

3.4 Specific improvements in maternity and neonatal services will continue to be overseen by the Maternity and Neonatal Assurance Group (MNAG) providing assurance to Trust Board.

The Maternity transformation process will be aligned with the national Maternity and Neonatal Delivery Plan focusing on:

Listening to and working with women and families with compassion
Growing, retaining and supporting the workforce
Developing and sustaining a culture of safety and learning and support
Standards and Structure, more personalised and equitable care.

3.5 To receive feedback from the Community Families Voices Meetings on issues of importance to families across East Kent.

3.6 To make sure that evidence of progress is publicly available and reported, and that the Group is consulted and involved in the development of the transformation programme.

3.7 To oversee and provide input into the communications and engagement strategy to support the transformation programme.

3.8 To ensure that the work of the Group is described and presented in a way that is user friendly, concise, meaningful and respectful to families.

4 MEMBERSHIP AND ATTENDANCE

4.1 Members

EKHUFT NED (Chair)

EKHUFT NED (Vice Chair)

Chief Executive Officer

Chief Nurse and Midwifery Officer

Chief Medical Officer

Chief People Officer

Executive Director Strategic Development and Partnerships

Public Governors x 3

Maternity Voices Partnership

Community Representation (1)

Patient and Family Representation (currently 5 -number to be confirmed)

Director of Midwifery

Obstetric and Gynaecology Consultant

4.2 Attendees

Executive Director of Communications and Engagement

Kent and Medway Integrated Care Board (ICB)

NHS England (NHSE) Representation

Quorum

4.3. The meeting will be quorate when one Non-Executive Director and two Executive Directors are present and four members of external representation (including at least one family representative).

Attendance by Members

4.4. The Chair or the nominated deputy of the Committee will be expected to attend every meeting. Other members should attend 75% of meetings and send an alternate on occasions of absence. The alternate should be agreed with the Chair.

Attendance by Officers

4.5. Other staff may be co-opted to attend meetings as considered appropriate by the Group on an ad-hoc basis.

5. FREQUENCY

5.1 The Group shall meet every 6/8 weeks. The Chair may call additional meetings.

6. AUTHORITY

6.1. The Group is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any relevant information it requires from any member of staff or groups/forums and all members of staff are directed to co-operate with any request made by the Group.

6.2. The Group is authorised to create sub-groups or working groups, as are necessary to fulfil its responsibilities within its terms of reference. The Group may not delegate executive powers (unless expressly authorised by the Board of Directors) and remains accountable for the work of any such group.

7. SERVICING ARRANGEMENTS

7.1. The Group will be serviced by [INSERT]

7.2. Papers will be sent at least five working days before meetings and members will be encouraged to comment via correspondence between meetings as appropriate.

8. ACCOUNTABILITY AND REPORTING

8.1. The Group is accountable to the Trust Board of Directors.

8.2. Minutes will be reported to the Trust Board once they have been approved by the Group Chair along with exception reports as agreed by the membership of this Group.

9. MONITORING EFFECTIVENESS AND REVIEW

9.1 The Role of the Group and its effectiveness will be reviewed by the Group in 6 months' time, making recommendations to Board of Directors where appropriate

East Kent Hospitals University NHS Foundation Trust

REPORT TO READING THE SIGNALS

Report title: **MNVP 15 STEPS VISIT FEEDBACK**

Meeting date: **16TH JULY 2024**

Board sponsor: **East Kent Maternity & Neonatal Voices Partnership Lead**

Paper Author: **SARAH HUBBARD**

Appendices:

MAXIMUM OF TWO APPENDICES *(What are the key appendices that the Board or Committee need to see)*

Executive summary:

Action required:	Sharing the findings of the recently completed 15 Steps visits at EKHUFT.
Purpose of the Report:	*This paper is coming to the board to provide a recent insight into the findings of the recent 15 steps visits to both William Harvey Hospital and Queen Elizabeth the Queen Mother Hospital Maternity departments.* *Fundamentally for the purpose of this board and as an MNVP in general, the question being asked by this paper is; are things improving in EKHUFTs Maternity departments? As you will see below – details in response to this question.*
Summary of key issues:	As you can imagine, the collated reports from all participants observations are lengthy. As such, you will below find a brief summary of the findings from the collated observations from all participants. For more details please see below and beyond that, don't hesitate to request a copy of the full length reports from S Hubbard. Themes noted were: - Friendly & welcoming staff - Signage – to be considered - Consistency in birthing environment no matter where you birthed/ what the outcome may be - Communication wins and improvements - Challenges around estates and restrictions of the buildings as they are. Since the visits, we have been and conducted our regular 'Walk the Patch' visits and begun to witness some of the suggested improvements that were discussed taking place which is encouraging to see.

Key recommendations:	- *Feedback has been shared with the participants and with EKHUFT Maternity DOM, Michelle Cudjoe, DDOM, HOMs.* - *From the feedback debrief and the reports, actions have been taken forward by the Trust to work on and feedback to the MNVP on progress of improvements.*

Implications:

Links to Strategic Theme:	*State which Strategic Theme(s) this report aims to support:* • *Quality and Safety* • *Patients* • *People* • *Partnerships* • *Sustainability* *(*
Link to the Trust Risk Register:	
Resource:	Y/N NHS England – 15 Steps for Maternity document
Legal and regulatory:	Y/N *If yes, state legal or regulatory impact*
Subsidiary:	Y/N *If yes, please indicate the Subsidiary and how its business will be impacted.*

Assurance route:

Previously considered by: *N/A*

East Kent Hospitals University NHS Foundation Trust

REPORT TITLE: **MNVP 15 STEPS VISIT FEEDBACK**
(*Use this template for the detailed report (maximum number of pages in total including the front sheet should be 10)*

1. Purpose of the report

1.1 *The purpose of this report is to share the findings of the 15 Steps for Maternity visits that were carried out. 15 Steps for Maternity visits are designed to look at the... 'quality from the perspective of people who use maternity services' with regard to the maternity services in each trust.*

2. Background

2.1
The visit is led by the Maternity & Neonatal Partnership and is an observational visit whereby the MNVP gathers a number of different stakeholders to visit the maternity departments and observe the four key areas: Welcoming & Informative, Safe & Clean, Friendly & Personal and Organised & Calm. For our visits of both sites we had a wide representation of stakeholders including; Service Users, Community MNVP members, Governors, Non-executive Director, Local Maternity & Neonatal System representation, Maternity & Neonatal Independent Senior Advocate and staff members from the trust. The format of the visit was such that these stakeholders were split into small groups (mixed backgrounds eg. 1 Service User, 1 staff member & 1 LMNS representative) and each group was given 3 areas of the maternity department to visit and make observations in. This method meant that those making observations were able to see more than one area of the maternity service and that each department had been seen by more than one group. This allowed for great discussion when coming together with findings as it showed consistency in the findings across the groups.

3.

3.1 QEQM

Positives:

Reception and Triage now better orientated.

Lovely MLU, although could still feel a bit less clinical. We hope it gets used more.

Generally clean, quiet and bright (with the exception of the Labour Ward rooms re brightness)

Staff we toured with and observed with were friendly and approachable

Bereavement suite was secluded and personal

Suggested Improvements:

Information, such as leaflets, posters and signage could be greatly improved to welcome, orientate, educate and support.

Clinicial feel. Better zoning and decor to feel more at home.

More furniture/equipment/info visible to help with labour (in induction bay especially) and to reference birth preferences.

More suitable staff rooms eg working windows and fans - On Kingsgate Ward it's too small and not very approachable.

Some clutter

Willliam Harvey Hospital

Positives:
Triage felt open and well organised even though it is fairly small.

Generally areas felt welcoming, clean and bright, although certain areas had aged (see below)

Calming MLU with dimmable lights and birth balls to promote active labour

Improvements
Better/more info and signage

Photo boards to be updated

Clean but aged in places so some refurb needed, with thought given to zoning.

Promote sense of calm eg wall decor and discreet clinical items.

Labour ward/Delivery Suite/Induction Bay in biggest need of a refurb to feel fresher and more relaxed (some work underway). Birth preferences could also be referred to more.

Needs of all communities to be considered

4. Conclusion

Overall the visits were encouraging. There were lots of positives to draw from the visits and the way that staff welcomed the visits and have since actioned some of the improvements already continues to strengthen the relationship between the MNVP and the Trust. Since the visits , participants have been happy to hear of a number of improvements already being addressed and felt that the staff who accompanied them on the visit were open to working together and being open and honest about their opinions on what was working well and what may have needed improvement. There is an eagerness from the Trust to address improvements raised from the visits, voices have been heard and we continue to look forward to seeing these come into fruition.