East Kent Hospitals University NHS Foundation Trust

READING THE SIGNALS OVERSIGHT GROUP

TUESDAY 19 NOVEMBER 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
027	Welcome, Introductions and Apologies	11:10	To Note	Verbal	Claudia Sykes Chair/Non-Executive Director
028	Minutes from the last meeting held on the 17 September 2024	11:15	Approval	Enclosure	Claudia Sykes Chair/Non-Executive Director
029	Matters Arising from the Minutes		Discussion	Enclosure	Claudia Sykes Chair/Non-Executive Director

ITEMS

030	Maternity IPR Update	11:20	Discussion	Enclosure	Sarah Hayes / Des Holden CNMO / CMO
031	Patient Voice Team Update	11:35	Discussion	Enclosure	Adam Littlefield Lead for PV & Involvement
032	Update on MSSP	11:50	Discussion	Verbal	Sarah Hayes CNMO

033	Neonatal Death Review	12:00	Discussion	Enclosure	Sarah Hayes
034	Medical Education Update	12:10	Discussion	Verbal	Des Holden CMO
035	Family Representative Feedback	12:20	Discussion	Verbal	Claudia Sykes Chair/Non-Executive Director
036	Discussion Around Future of the Reading the Signals Group	12:35	Discussion	Verbal	Sarah Hayes CNMO
CLOSING MATTERS					
037	Any Other Business	12:55	Discussion	Verbal	Claudia Sykes Chair/Non-Executive Director

Date of next meeting: **Tuesday 21 January 2025 @ 11:10 hrs**


Our vision
Great healthcare from great people
Our values
People feel cared for, safe, respected and confident we are making a difference
Our strategic themes
Quality and safety
Patients
People
Partnerships
Sustainability
Research
Our strategic objectives
Reducing harm and delivering safe services
Patients, family and community voices
Timely access to care
Care and compassion
Teamwork, trust, respect and inclusion
Improving outcomes and reducing health inequality
Financial sustainability
Centre of research excellence

UNCONFIRMED MINUTES OF THE READING THE SIGNALS OVERSIGHT MEETING TUESDAY 17 SEPTEMBER 2024 11:10 – 13:00 HRS BOARDROOM, KENT AND CANTERBURY HOSPITAL, ETHELBERT ROAD, CANTERBURY VIA WEBEX TELECONFERENCE

PRESENT

Claudia Sykes	Non-Executive Director (Chair)	CS
Tracey Fletcher	Chief Executive Officer	TF
Sarah Hayes	Chief Nursing and Midwifery Officer	SH
Des Holden	Chief Medical Officer	DH
Ben Stevens	Chief Strategy and Partnership Officer	BS
Bernie Mayall	Lead Governor/Elected Public Governor - Dover	BM
Tanya Linehan	Family Representative	TL
Phil Linehan	Family Representative	PL
Helen Gittos	Family Representative	HG
Caroline Potter-Edwards	Family Representative	CPE

Attendees

Khaleel Desai	Director of Corporate Governance	KD
Fay Corder	South East Governance Lead	FC
Jenny Hamilton	Co-Production and Engagement Lead, NHS Kent & Medway	JH
Ben Doble	Administrator	BD

AGENDA ITEM NO | **ACTION**

24/018 **WELCOME AND INTRODUCTIONS AND APOLOGIES**

Apologies were received from:
Kaye Wilson - Regional Chief Midwife for SE Region
Derek Richford - Family Representative
Alex Ricketts - Elected Governor – Canterbury
Carl Shorter - Elected Governor - Folkestone & Hythe/Deputy Lead Governor
Lyn Richardson - Family Representative
Becky Collins - Director of Maternity & Neonatal Services, Kent & Medway
Stewart Baird – Interim Chairman and Maternity Champion
Sarah Hubbard – MNVP Lead for East Kent
Debbie Viner Interim Deputy Chief People Officer
Linda Dempster Family Representative

Prior to reviewing the minutes from the last meeting, CS reminded everyone as to the purpose and value of this meeting. There were some comments and discussions at the last meeting, that were not relevant. This resulted in that some of the items that were on the agenda for discussion, were not addressed. CS gave apologies that this had been the case.

It was noted that if anyone started to discuss any topics that were not relevant to this meeting, it may be necessary for them to be muted, to allow the meeting to continue with discussions of the relevant agenda topics.

24/019 **MINUTES FROM THE LAST MEETING HELD ON THE 16 JULY 2024**

The minutes from the previous meeting were **APPROVED.**

24/020 **MATTERS ARISING FROM THE MINUTES**

RSOG/11 - Family Representative Feedback - The Trust to take feedback received by family reps and look at how these could be addressed. **Update 17.09.24** - This was to be addressed during the discussion of the Terms of Reference, as to

how useful these meetings were. Were items still being covered that people wanted to be addressed? Discussions had taken place at previous meetings as to how long The Reading of the Signals Oversight Group was to continue, as these meetings had been in place for the past two years.

RSOG/13 - Matters Arising from the Minutes - Maternity IPR data to be reviewed regarding the way it was presented. **Update 17.09.24** - Any actions relating to IPR were to be covered by BS during the meeting. **Item closed.**

RSOG/14 – Matters Arising from the Minutes – Maternity IPR data to be reviewed regarding the way it was present. **Update 17.09.24** - Any actions relating to IPR were to be covered by BS during the meeting. **Item closed.**

RSOG/15 – Update on Trust Response to Kirkup – Review of topics for future meetings – Update 17/09/2024 – This action would be addressed when the Terms of Reference were discussed later in the meeting.

RSOG/17 – Maternity IPR – Update 17.09.24 - This action was to be closed, as it would be discussed during today's meeting.

RSOG/18 – Specific Response to the issues in the RIS Report - Update 17.09.24 SHa confirmed that she had provided feedback to the Director of Midwifery, regarding the wording in the RIS Report. Action to be Closed.

RSOG/19 - Specific Response to the issues in the RIS Report – Update 17.09.24
SHa confirmed that the dates of the neonatal events had been shared. Action to be Closed. If anyone had not received an invitation to the events, they were to let SHa know. Action to be Closed.

RSOG/20 - Specific Response to the issues in the RIS Report – Update 17.09.24
Anyone who had wanted to take part in the Test and Trial Reporting System, had contacted SHa. Action to be Closed.

RSOG/21 - Specific Response to the issues in the RIS Report – Update 17.09.24
DH was to provide an update at the meeting regarding the medical education and medical trainee perception in line with Bill Kirkup's recommendations. This was on today's agenda. Action to be closed.

RSOG/22 - Specific Response to the issues in the RIS Report – Update 17.09.24
SHa was to produce a slide regarding "Common Purpose". This was then to be circulated to the group. Action to remain open.

RSOG/23 – Post Meeting Request from DR – Update 17.09.24 It was confirmed by SHa that action had been taken in response to DR's email regarding a log to enable someone with responsibility, to review themes and ensure learning from incidents. Action to be closed.

24/021 **MATERNITY IPR**

Comments had been received from DR regarding the content of the Maternity IPR. These had been forwarded by CS to BS for review.

These included observations on the latest IPR:

- Maternity incidents moderate/severe – data missing, a blank area could be a concern.

BS confirmed that there had been a crossover in the change in the reporting system (from Serious Incidents, SIs, to Patient Safety Incident Response Framework,

PSIRF). This was a change that applied to all areas of the organisation, including maternity. February 2024 was when the system crossed over to PSIRF, hence why there were some gaps in the data prior to that time. The change had occurred part way through the month of February 2024. The title had changed to the Maternity Patient Incidences.

Another comment that had been received from DR, was that the maternity response rate appeared to well below the 90% response rate target, but nothing had been highlighted. SHa explained that a lot of work had been done around, not only the complaint responses, but also the quality of the responses. There had been a drop over a number of months due to the work that was being done on the quality of the responses. A trajectory had been set, to make improvements by the end of 2024. Improvement had already been seen over the last couple of months.

DR had also included in his comments; the Friends and Family Test target was 90%. When it dipped below the target, the infographic ignored this fact. BS explained that there were two things that were reviewed regarding representing this data. One was the colour attributed to the "run" figures. An example of this was where the FFT Response rate changed from grey to amber, in December 2023. That was based on that significant statistical change. Included within the report is an assurance column, which showed that if a particular metric was, either consistently "not meeting the target", or whether it was consistently "meeting the target", or at a point where it was consistently "falling below the target".

BS confirmed that, through the Performance Review Meetings, the data was reviewed as to whether targets were hitting their assurance requirements (in terms of the target that had been set).

The colours chosen for the reporting of the data (red, green, amber and blue) had been selected, based on best practice through an organisation called Making Data Count.

What the Trust was doing, was monitoring where things may not yet be statistically significant. Action would be taken early to prevent the event worsening.

The final question from DR, was around the Women's Health Engagement Score. There had been a target of 6.9, but earlier in the year, it was shown as "Blue", even though the result was well below 6.9. There was a thought that the target may have been changed, that would have caused this to have occurred. BS stated that it was most likely to be due to the targets in the background. The data related to the full survey, that was performed once a quarter. Therefore, if data was represented as the same figure for three consecutive months, it was just a representation that the figures were from the last quarterly survey. This was to be changed, so that the figures would be shown for the time period that the survey had taken place, and not for the three months during that period.

In the April score, there was a significant and statistical change (compared to the previous two sets) which meant that the report had changed to "orange". In the most recent engagement score there was a slight improvement to 6.12. There would need to be further improvements, before this would become significant.

CS confirmed that the data within the reports had been an area of ongoing work for improvements. The maternity actions sheet, just below the main dashboard, showed the amount of work that had been undertaken. This was an ongoing area of full focus from the whole Trust.

One of DR's concerns was whether the papers presented to the Board, gave a high level overview of the issues. CS confirmed that this was "work in progress". A lot of the statistical work that was being undertaken, was showing themes over time, which was huge improvement. However, there was still a huge amount of detail

which would make it difficult for Board members to see the main issues, and action being taken, easily. This was a matter of ongoing discussion at the Board as well.

PL commented that discussions had previously taken place to ensure that the charts were readable for the layperson. It was noted that if the targets had changed on the reports, then this should be noted on the reports to make it clear.

ACTION: If a target, on the IPR Dashboard, had been changed on any of the IPR data sets, then this should be clearly noted on the reports. **BS**

SHa gave an update on the Action Plan, around engagement, on the IPR. This was a very large piece of work for the Trust, not just in maternity. There was a Cultural and Leadership Programme that was in place, along with many other actions. The annual Staff Survey had been launched yesterday (16 September 2024). Within the Action Plan, regarding overdue incidents, some improvement had been made, but there was still a long way to go. The governance lead was putting in a lot of work to ensure that improvements were being made, similarly with the improvement in the quality of complaints.

Friends and Family Test (FFT) scores were under target. The Action Plan detailed as to what was being done to improve on this. As well as FFT surveys, the Trust also performed the Patient Voice Surveys, along with other forms of feedback.

At the previous meeting SHa had provided an update on the review of neo-natal deaths. The report showed that the rate of stillbirths, remained within threshold, but there was still a rise within neo-natal deaths. An external review was being conducted, the results of which were to be available at the end of September 2024. The team were also in discussion with Regional colleagues, as there appeared to be a trend across the country regarding increased in delivery at an early stage.

DH stated that every month the Trust looked at the overall rate of neo-natal death and peri-natal loss, for the rolling 12 months that led up to that month. There had been a cluster of premature babies, who were born alive, but then died, from about mid-February 2024 through to April 2024. Knowing that each individual death was reviewed, the Trust also requested that the six deaths were reviewed together, to see if there was anything that had become apparent. The Trust were trying to get a better insight, rather than looking at the individual cases. Overall the rate was not changing much, but this would be dependent on the number of cases in the new month, compared to the month that was lost (due to the rolling 12 month review).

The Trust was following the methodology that Bill Kirkup had presented at the meeting earlier in the year. Rather than looking at the specific numbers, it was looking at the duration of when things were happening. The report was covering the full period from April 2023 to May 2024, 15 deaths in total.

Once the report had gone through the Board governance process, it would be presented to the Board and shared with the family members. It was likely to be available for the December Board meeting, but it was hoped that it could be earlier.

It was confirmed that every death was looked at individually as well.

HG had concerns over the staff engagement figures for Women's Health. SHa confirmed that, as already discussed, work was being done to address this, including the work being done within the Cultural and Leadership Programme.

TF stated that the Cultural Leadership Programme had been piloted within the maternity services and was now implemented throughout the organisation. In summary, the aim of the programme was to shift the understanding of how decisions were made, and the manner in which topics were discussed was done in a more open and collaborative way.

TF continued that the work that had been done on the transformation and improvement programme, was akin to the principals that the Trust were trying to achieve through the Cultural and Leadership Programme. She felt that there was now a difference across the Trust services of people who felt genuinely engaged.

SHa confirmed that the Obstetric, Neo-natal and Midwifery leads had just completed the National Quad Programme (which was about leadership and engagement), this was very successful. The non-executive director maternity champion (Stewart Baird), SHa and DH had been spending more time on the maternity units, listening to people.

The RCS (Restorative Clinical Supervision) as mentioned in the report, had strengthened the professional advocacy team, to spend time with staff most days. There were a lot of initiatives, but it would be "work in progress" for some time.

HG stated that for her, and the other family members, it was felt that there was yet to be any sight of "good evidence" that things were changing within the Trust. She was aware that things were happening, which were the right actions to be taken for improvement, but had not yet seen any indication of serious engagement, specifically by doctors, in the report and the aftermath. HG asked if there was a way that the families could have some assurance, which was more than a list of things that were being done?

CS confirmed that there would be some hard data from the Staff Survey, which was due to be published in February 2025. The Trust had one of the worst results in the country last year, but it was hoped that the results this year would have improved.

DH stated that on an annual basis the General Medical Council sought feedback from trainees in a formal way. They then compared the findings from all of the units with each other and also historically, within each unit. At the QEQM site, the obstetric feedback, amongst doctors, was the most improved across the Trust. This was very good evidence that there was some positive action had taken place in that environment.

DH continued that the results from WHH was less "green". Workload was an indication as being in the "red", which indicated that work needed to be done in this area to make improvements. Overall the results had improved from last year at the WHH.

TF confirmed that the GMC survey was a good indication of the improvements that had been made. The results from this survey compared the data with other organisations, which gave a better overall picture. The QEQM results showed a "stand-out" service within the Trust and also Kent and Medway.

Action: Any information relating to the GMC survey, that was in the public domain, was to be shared with the family representatives. **DH**

TF confirmed that the National Staff Survey was a good indication of improvements within the Trust. The survey results were also benchmarked against other Trusts. The collection of data was currently being undertaken, and the results were likely to be available in February 2025, or maybe March 2025. Once the results were received it would be possible to disseminate the data down to specific areas.

Action: HG stated that to mark the 2+ years since the Kirkup Report was published, by capturing some textured responses to how staff were feeling now about the report and its' recommendations. It would be good to get a sense of the improvements that had happened and what the next priorities would be. **NY**

24/022 **REVIEW OF THE TERMS OF REFERENCE**

CS stated, that as part of these discussions, she wanted to have an open conversation regarding these meetings, in more general terms. It had been almost two years since the publication of the Reading the Signals Report. Discussions needed to take place to assess if these meetings had now served their purpose.

SHa stated that there was now a very clear governance structure in place, which fed from maternity up to the Board. The restorative work had also commenced, which would drive things forward. SHa felt that an end point needed to be agreed, but that this would not stop the family members' involvement in other parts of the maternity oversight and governance processes. There were many meetings that took place, regarding maternity, all of which had a different purpose, which may be a better forum for the family members to be involved in.

PL stated that he found these meetings extremely valuable, and that he organised his year around these meetings so that he could attend the majority of them. PL stated that there was some apathy amongst the attendees. Some people did not appear to be fully engaged in the meetings, and some who did not attend at all. It was noted that TF attended all of the meetings, which was very important to the families. PL stated that he and TL got something from each of the meetings that they attended. These meetings gave them the opportunity to see the team face-to-face and to get a better feeling as to what was being done within the Trust, regarding maternity. When challenges are raised, there was the feeling that they were being listened to. What they did take from the meetings, was hearing of the things that were taking place throughout the Trust to make improvements. These meetings were a good forum for the family members to speak to the decision makers within the Trust. PL stated that if someone was proposing for these meetings to cease, he would like to see the proposals written down and have an opportunity to see what the proposals were.

CS stated that there was no formal proposal to end these meetings. She agreed that it would be useful to have a formal proposal on the continuation of these meetings for the Oversight Group to review and discuss.

TF thanked PL for his comments. TF confirmed that no one was suggesting that the work had been done. Work always need to be done to ensure that the Trust was striving to move forward.

HG stated that the first time that the group discussed how the Trust should engage with the recommendations of the Kirkup Report, was at the last Reading the Signals Meeting. HG suggested that perhaps the meetings should be held less often (ie every six months) over the next year and then to take stock of their usefulness. HG did not feel that there was enough engagement with the recommendations that were made, to feel that the work had been completed.

ACTION: A formal proposal was to be drafted, based on the feedback that had been received from the family members. Feedback was required on the aspects of the meetings that were found to be helpful, to make the meetings more manageable, without reducing the value of the discussions. This was to be circulated prior to the November meeting, to allow time for feedback to be received. **SHa**

ACTION: The family members were asked to email Jo Andrews with any feedback that would be relevant to the format of future meetings. Any thoughts as to what aspects of the meetings the group found valuable and if there were any aspects of the meetings that were felt to be no longer required. **Family Reps**

CS gave an overview of other groups which were now established which family representatives might be interested in attending, some already did. There was the East Kent Maternity Voice's Partnership Group. This was an independent group

(which JH was currently chairing) which was very active in engaging with the Trust's maternity services. CS attended their meetings as a non-executive director observer. The meetings were more informal than the Reading the Signals meetings. They were very much focused on current maternity services. A lot of people who used to attend the Reading the Signals meeting attended this meeting.

CS also attended the Patient Experience Committee meetings. This was a committee, that reported into the Quality and Safety Committee, and which was co-chaired by SHa. That group was specifically set up to hear from patients and patient voice. This committee commenced in January 2024 and was set up to listen to patients' concerns. It involved a wide range for discussions topics as to what the Trust was doing.

There were also a more formal Board Committee, the Maternity and Neonatal Assurance Group (MNAG). A lot of the papers from Reading the Signals group were discussed at MNAG. SHa confirmed that she chaired the meeting and that DH and the Chairman of the Trust (Steward Baird), were also present. Many of the maternity leaders were present, along with some of the colleagues who attended Reading the Signals. They did not yet have the number of patient representatives present at MNAG that they would like, but they were working on that. A lot of content was covered in MNAG, but they were trying to make it more strategically and assurance focussed.

The options above would be included in the proposal that was to be drafted by SHa and the team. The different styles of the meetings mentioned above, may better suit some of the family members who currently attended Reading the Signals. The content of the meetings may provide better assurance in certain areas, that Reading the Signals was not providing. There was still attendance from the Trust executives and senior managers, presenting what was happening through maternity, which still provided the possibility to scrutinise and challenge.

CS did not review the Terms of Reference in full, considering the discussions that had already taken place. The only other point that CS wanted to highlight was that originally the plan was to engage with other voices in the community, who may not have felt comfortable coming to a more formal meeting, like Reading the Signals. Adam Littlefield, from the Patient Voice and Experience Team, had been doing a lot of work going out to a lot of different community groups. It was noted that, that work had continued and the outcomes were reported through the Board packs. Adam was working closely with the MNVP as well, and the Patient Voice team attended those meetings as well.

HG requested if it would be possible to have a summary of the feedback of Adam Littlefield's meetings at the next Reading the Signals meeting?

ACTION: CS was to request an update from Adam Littlefield, on the work that he had been doing in the community, for the next Reading the Signals meeting. **CS**

24/023 **MEDICAL EDUCATION AND MEDICAL TRAINEE PERCEPTION IN LINE WITH BILL KIRKUP'S RECOMMENDATIONS**

DH reported that the junior doctors, who were with the Trust for training purposes, rotated in and rotated out of the Trust. Trainee doctors were generally within the Trust for six months or a year. Some were the more junior, that were more recently qualified, and others were the foundation doctors. There were also the core specialists and higher trainees. Therefore, their responses from the GMC Survey came through separately.

There was quite a lot of good responses back from QEQM experiences, but less good news (although improved from 12 months ago) from WHH. From DH's interpretation of the responses, they showed that the WHH was perceived to be a more high-pressured environment. Some of this was supported by the free text

and narrative comments that were included in the feedback. The GMC Survey included some standard questions, which the response was graded as to where the person felt that they were on a spectrum, which also included the ability to add free text and narrative into some of the sections.

What came back from the comments from the WHH, was that there was a feeling of a lack of respect and lack of inclusion, in some of the work within the unit. It was particularly noted in between the relationship of doctors and midwives. DH felt that the relationship between doctors, nurses, midwives and other health professionals, was not were it needed to be.

DH and SHa had held a number of listening events with a number of teams (at the teams' requests). One of the feelings that came through, was that often people felt that their contribution was not recognised, or people's voices were not heard. It was known that this was happening in a number of areas throughout the Trust, not just maternity and neonatal unit. DH confirmed that worked needed to be done to address this.

DH confirmed that he had spoken to the Director of Midwifery, the Chairman and the consultant in Obstetrics and Gynaecology, specifically regarding these issues within maternity at WHH. They had decided to see if they could have a compact, on the WHH labour ward, regarding the relationships of those staff groups on the ward.

Another piece of feedback that DH reviewed, related to the undergraduates' experience (medical students on the labour wards). The outcomes appeared to be fairly similar.

DH had asked the Director of Midwifery for an update on any themes, in the complaints that had been received, on the culture that had been observed by women using our services. The Director of Midwifery had reported back, that this had been tracked month on month, and that overall there had been a steady decrease in the number of complaints, that related to the observed culture, within the maternity department.

DH confirmed that further work was to take place regarding the relationship of the different professional groups within the organisation. Following a question from PL, DH confirmed that the foundation doctors all changed rotation at the same time, and everyone else changed, mostly at the same time. There were some that were a bit out of sequence, but they did not change at the same time as the foundation doctors.

PL raised that fact that his family's experience had included a problem, which had related to the fact that all of the junior doctors had changed over at the same time. One of the requests that PL and his family had requested, during the time of the Kirkup investigation, was that the change over of the junior doctors was phased. This was shown to be one of key failures in the care that TL had received during her stay in hospital.

DH confirmed that the rotation dates, were national dates. All of the doctors that exit medical school, begin with their first job at the beginning of August. Once in a post for 12 months, they would then rotate to new positions at the same time. There was a stagger that the higher specialist trainees, didn't start and finish on the same 1st August deadline. Different people would had different rotations.

ACTION: DH was to feedback regarding the rotation, and how this process was managed to mitigate risks within the NHS **DH**

HG added that there were three parts of the Kirkup recommendations that related to education and training. HG added that these were completely fundamental and that the EKHUFT Trust had some leeway and that this would be something that it would be good to discuss further at a later date. HG felt that this was important and that things could be changed locally.

ACTION: CS asked for HG to email her directly with the aspects that she specifically would like to be addressed, regarding the education and training aspects of the Kirkup recommendations. These could then be addressed at the next meeting. **HG**

24/024 **UPDATE ON THE FINDING FROM MSSP INSPECTION**

SH confirmed that the Maternity Support Programme (MSSP) had been running in East Kent for a number of years. It ran separately, but alongside, the Maternity and Neonatal Improvement Programme (MNIP). The MSSP was how the national maternity team provided oversight and support to the EKHUFT team, regarding the quality of provision and improvements that needed to be made.

A review was held a few weeks ago, which related to the next stage in terms of decision making, whether EKHUFT was to remain on the maternity support programme. It was also a review of the progress that had been made, against the objectives that had been set. The leadership Quad presented on the day and the attendees to the review visited the maternity units and spent time talking to women and their families, but also to the staff.

The team were pleased with what they found, although there were still actions to be completed. There was still the need for a second theatre at QEQM, succession planning for the leadership team, amongst other actions.

The team asked the Trust to present to the Chief Nurse, Director of Midwifery and other colleagues across London and the South East, which took place last week. A second review was to take place on Monday 7 October at Kent and Canterbury Hospital, at which a decision was to be made as to whether EKHUFT remained on the programme, or not. The governance programme and improvement programme would still continue, even if the Trust were removed from the maternity support programme.

The national, regional and local LMNS team were keen to spend some time with family representatives here, to talk about what they had found and seeking their views. They were to be included in the meeting on Monday 7 October.

To be included in the meeting were, Kaye Wilson, Mai Buckley and also Alison Talbot, the Deputy Chief Midwife for England. Alison had been in discussion with Kate Brintworth and Duncan Burton. Duncan Burton was Ruth May's replacement.

Everyone was to be contacted separately, regarding the details of the meeting.

24/025 **FAMILY REPRESENTATIVE FEEDBACK**

HG confirmed that it would be helpful to have time at the next meeting in November, to have some more discussion about how one might locally implement the recommendation of the Kirkup Report.

CS confirmed that at the last meeting SH had given a presentation about the themes and the actions that had been put against them.

SH suggested a further catch up with HG, as this topic had been raised at most meetings.

ACTION: SHa was to contact HG outside of the meeting for a further catch up regarding the actions that had been taken regarding the Kirkup Recommendations. **SHa**

ACTION: SHa to give an update on the previous presentation that she had given, regarding the themes and actions from the Kirkup Report. **SHa**

TL raised the question, as to how much these experiences, that the families had had, had resulted in a change. TL had previously had conversation with the Director of Midwifery, discussing the possibility of some family members being filmed to discuss their experiences, for other families to then watch and learn from it. Initially,

TL had agreed to take part, but subsequently decided not to. It would be a very distressing for her to have to relive the experience again. There was also the concern that people might not even learn from it, if they could not be bothered to read the Kirkup Report.

DH confirmed that staff members were encouraged to read the report, but there were no figures as to how many had, and how many had not. There had been a variety of material that had been generated as a result of the report. This material was used during the induction of new staff and also during teaching sessions. DH stated that people consumed information in a variety of ways, and some people who may never read the report, but would consume information from a video that had key messages or personal stories. This did not mean that TL needed to be involved in the making of the video, but that the Trust needed to think of ways to get the information across by the use of videos and other ways.

PL suggested that when staff (who worked in maternity) attended their induction, they should be handed a copy of the Kirkup Report. These staff should then have a follow-up and be asked if they had read the report. If “no”, why not and if “yes”, what are your key take-aways? PL had concerns that people were not reading the report.

PL also stated, regarding the discussions about videos of TL’s experience as a training tool. PL suggested that an actress could be used for the videos, so that TL would now have to go through the process herself. Some of the reviews in the Kirkup Report were quite small, but that did not make them any less powerful. The videos could be utilised at the start of team meetings, to ensure that anyone joining the Trust was fully aware of the problems that had occurred previously.

ACTION: SHa was to take away PL’s concerns regarding new members of staff not reading the Kirkup Report when working on the maternity wards, and would have a discussion with the Director or Midwifery to see how these concerns should be addressed. **SHa**

24/026 **ANY OTHER BUSINESS**

There was no other business.

DATE OF NEXT MEETING – Tuesday 19 November 2024

SIGNED: _____

DATED: _____

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

	Date of Meeting	Min No.	Item	Action	Target date	Action owner	Status	Progress Note (to include the date of the meeting the action was closed)
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 **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. **Update 16.07.24** - To remain OPEN. **Update 17.09.24** - This was to be addressed during the discussion of the Terms of Reference, as to how useful these meetings were. Were items still being covered that people wanted to be addressed? Discussions had taken place at previous meetings as to how long The Reading of the Signals Oversight Group was to continue, as these meetings had been in place for the past two years.
RSOG/15	14/05/2024	24/006	Update on Trust Response to Kirkup	Review of topics for future meetings	Jul-24	All	Open	A review needed to take place to decide on what topics should be brought to future meetings. **Update 16.07.24** - To remain OPEN. **Update 17/09/2024** – This action would be addressed when the Terms of Reference were discussed later in the meeting.
RSOG/22	16/07/2024	24/013	Specific Response to the Issues in the RtS Report "You said, we did"	It was agreed that SHa would produce a slide for the next meeting regarding the "Common Purpose". SHa was happy to send this to HG prior to the meeting to ensure that it met her requirements.	Sep-24	SHa	Open	**Update 17.09.24** SHa was to produce a slide regarding "Common Purpose". This was then to be circulated to the group. Action to remain open.
RSOG/24	17/09/2024	24//021	Maternity IPR	If a target, on the IPR Dashboard, had been changed on any of the IPR data sets, then this should be clearly noted on the reports.	Nov-24	BS	to Close	BS has noted as an action for the IPR. TO CLOSE
RSOG/25	17/09/2024	24/021	Maternity IPR	Any information relating to the GMC survey, that was in the public domain, was to be shared with the family representatives.	Nov-24	DH	Open	
RSOG/26	17/09/2024	24/021	Maternity IPR	HG stated that to mark the 2+ years since the Kirkup Report was published, by capturing some textured responses to how staff were feeling now about the report and its' recommendations. It would be good to get a sense of the improvements that had happened and what the next priorities would be.	Nov-24	NY	Open	**12 Nov 2024** NY undertaking interviews with maternity colleagues to capture textured responses. These will be included in Reading the Signals progress report which has been refreshed to reflect 2 year on data and performance, working with DoM and DDoM. Home page of website has been updated to reflect How we are Improving maternity care in east Kent at 2 year anniversary.
RSOG/27	17/09/2024	24/022	Review of the Terms of Reference	A formal proposal was to be drafted, based on the feedback that had been received from the family members. Feedback was required on the aspects of the meetings that were found to be helpful, to make the meetings more manageable, without reducing the value of the discussions. This was to be circulated prior to the November meeting, to allow time for feedback to be received.	Nov-24	SHa	Open	
RSOG/28	17/09/2024	24/022	Review of the Terms of Reference	The family members were asked to email Jo Andrews with any feedback that would be relevant to the format of future meetings. Any thoughts as to what aspects of the meetings the group found valuable and if there were any aspects of the meetings that were felt to be no longer required.	Nov-24	Family Reps	Open	
RSOG/29	17/09/2024	24/022	Review of the Terms of Reference	CS was to request an update from Adam Littlefield, on the work that he had been doing in the community, for the next Reading the Signals meeting.	Nov-24	CS	Open	
RSOF/30	17/09/2024	24/023	Medical Education & Medical Trainee Perception	DH was to feedback regarding the doctor rotation and how risks were mitigated	Nov-24	DH	Open	
RSOF/31	17/09/2024	24/023	Medical Education & Medical Trainee Perception	CS asked for HG to email her directly with the aspects that she specifically would like to be addressed, regarding the education and training aspects of the Kirkup recommendations. These could then be addressed at the next meeting.	Nov-24	HG	Open	
RSOF/32	17/09/20244	24/025	Family Representative Feedback	SHa was to contact HG outside of the meeting for a further catch up regarding the actions that had been taken regarding the Kirkup Recommendations.	Nov-24	SHa	Open	
RSOF/33	17/09/2024	24/025	Family Representative Feedback	SHa to give an update on the previous presentation that she had given, regarding the themes and actions from the Kirkup Report.	Nov-24	SHa	Open	
RSOF/34	17/09/2024	24/025	Family Representative Feedback	SHa was to take away PL's concerns regarding new members of staff not reading the Kirkup Report when working on the maternity wards, and would have a discussion with the Director or Midwifery to see how these concerns should be addressed.	Nov-24	SHa	Open	

East Kent Hospitals University NHS Foundation Trust

REPORT TO READING THE SIGNALS OVERSIGHT GROUP

Report title: **Maternity Integrated Performance Report**

Meeting date: **19 November 2024**

Board sponsor: **Chief Nursing & Midwifery Officer**

Paper Author: **Deputy Director of Midwifery**

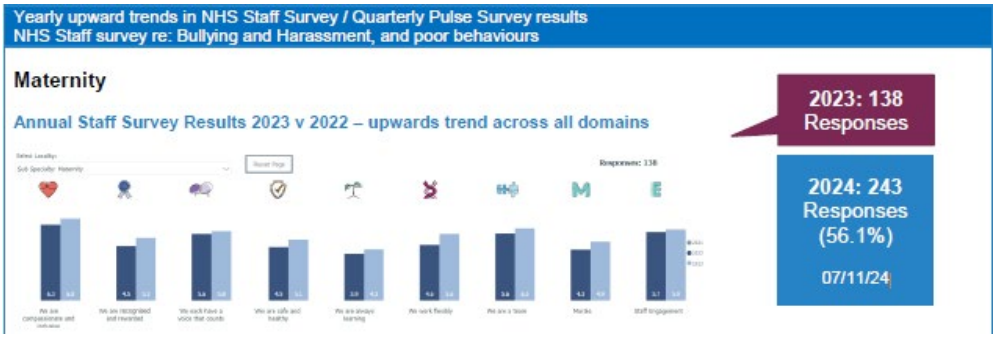
Appendices:

MAXIMUM OF TWO APPENDICES
Maternity Integrated Performance Slide Deck

Executive summary:

Action required:	Information, Assurance
Purpose of the Report:	The Trust's IPR forms the summary view of Performance against the organisations five strategic themes; Patients, Quality & Safety, People, Partnerships and Sustainability. It also collocates the metrics which are intrinsic to our Integrated Improvement Plan and monitors progress against the quarterly milestones which will enable the organisations exit from National Oversight Framework 4 and Tier 1 monitoring.
Summary of key issues:	The extended perinatal rate remains consistently below the threshold of 5.42 per 1,000 births, with the September 12 month rolling rate at 3.94 per 1,000 births. This rate includes stillbirths and neonatal deaths, and whilst the stillbirth rate remains significantly low (1.37 per 1,000 against a threshold of 3.61 per 1,000), the neonatal death rate has recently risen to 2.57 per 1,000 against a threshold of 1.82 per 1,000. An external review is currently in progress which consists of a Senior midwife, Consultant Neonatologist and Senior Neonatal Nurse who have monthly engagement with the DDOM and the aim to have a final report in December The Friends and Family Test (FFT) maternity response rate, calculated using the national methodology based on delivery episodes, has remained below average for consecutive months. Local and LMNS initiatives continue to be explored to improve the uptake in addition to exploring the timeliness of the text systems. A task and finish group has been set up to explore methodologies to improve response rates. At month end (September 2024) the service has 5 open cases referred to and accepted by MNSI for external Patient Safety Incident Investigation (PSII) and 2 internal PSII's in progress. One draft report has been received from MNSI for factual accuracy checking with no safety recommendations at this stage. 1 moderate / severe patient safety incident reported in September referred to MNSI

East Kent Hospitals University NHS Foundation Trust

	Immediate learning has been shared with the wider maternity service team. Women's Health Engagement Score for September is 6.12. • Upward trend NHS Annual Staff Survey / Quarterly Pulse Survey results • 85% completion of the B7 Leadership Development training ('Connected') • 85% attendance of all managers on the Trust Leadership Development Programme  Successful recruitment to Complaints co-ordinator role. Weekly meeting in place with Governance, complaints manager and Deputy Director of Midwifery to maintain oversight, quality and timeliness of responses.
Key recommendations:	The Group is asked to note the content of this report relating to the metrics which are intrinsic to our Integrated Improvement Plan

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People
Link to the Trust Risk Register:	
Resource:	N

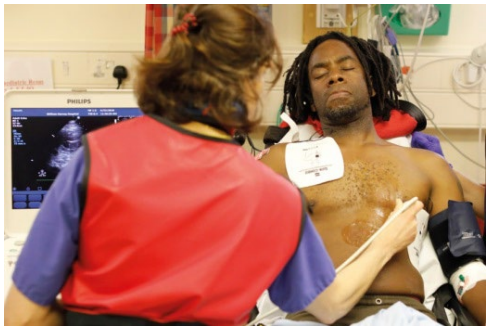
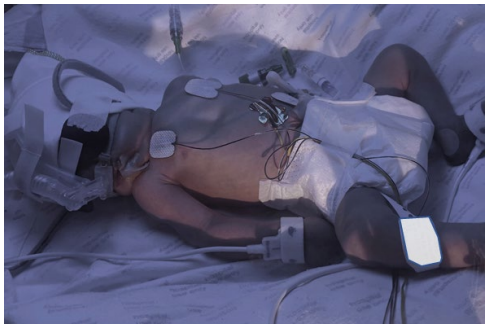
Maternity Integrated Performance Report

SEPTEMBER 2024







Integrated Performance Report

Statistical Process Control

The Trust's IPR forms the summary view of Performance against the organisations five strategic themes; Patients, Quality & Safety, People, Partnerships and Sustainability. It also collocates the metrics which are intrinsic to our Integrated Improvement Plan and monitors progress against the quarterly milestones which will enable the organisations exit from National Oversight Framework 4 and Tier 1 monitoring. To do this is uses Statistical Process Control to assess performance.

What is statistical process control (SPC)?

Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation and in doing so, guides us to take the most appropriate action.

Our Trust Integrated Performance Report incorporates the use of SPC Charts to identify common cause and special cause variations and uses NHS Improvement SPC icons to provide an aggregated view of how each KPI is performing with statistical rigor.

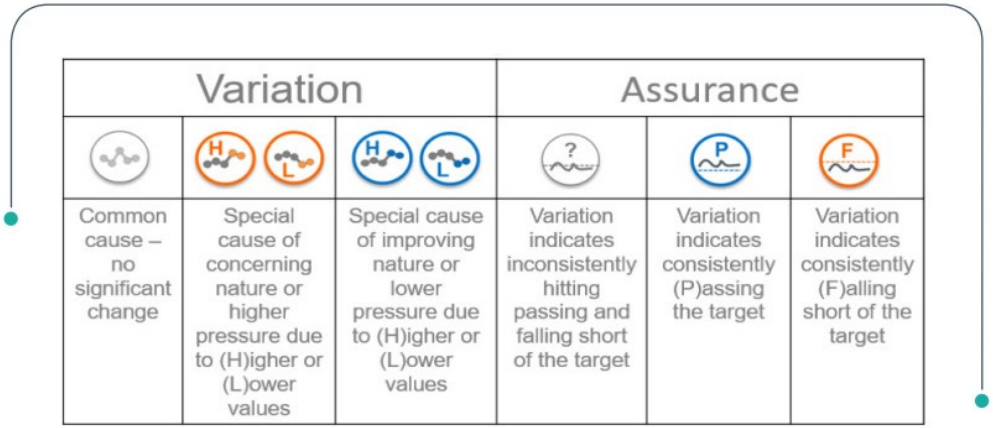
The main aims of using statistical process control charts is to understand what is different and what is normal, to be able to determine where work needs to be concentrated to make a change. The charts also allow us to monitor whether metrics are improving.

Key Facts about an SPC Chart

A minimum of 15-20 data points are needed for a statistical process control chart to have meaningful insight. 99% of all data will fall between the lower and upper confidence levels.

If data point falls outside these levels, an investigation would be triggered.

It contains two types of trend variation: Special Cause (**Concerns** or **Improvement**) and Common Cause (i.e. no significant change.



Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Variation icons: **orange** indicates concerning **special cause variation** requiring action; **blue** indicates where improvement appears to lie, and **grey** indicates no significant change (**common cause variation**).

Assurance icons: **Blue** indicates that you would consistently expect to achieve a target. **Orange** indicates that you would consistently expect to miss the target. A **grey** icon tells you that sometimes the target will be met and sometimes missed due to random variation – in a RAG report this indicator would flip between red and green.

The colours used for data points in the dashboard (tabular view) represent the position of each KPI from an SPC (Variation) perspective. The colours are based on statistically significant movement. The key is as follows:

Statistically significant improving variation	Statistically significant variation of concern	No significant change

Maternity

Variation	Assurance: P — Will consistently pass the target if nothing changes	Assurance: ? — Will not consistently pass or fail the target if nothing changes	Assurance: F — Will consistently fail the target if nothing changes
Improving Variation (High or Low)		Serious Incidents Maternity	
No Significant Change	Extended Perinatal Mortality	FFT Maternity (IP) Recommended FFT Maternity Recommended Maternity Complaint Response Maternity Complaints Maternity Incidents Moderate / Severe Maternity Patient Incidents Moderate / Severe	
Concerning Variation (High or Low)		FFT Maternity Response Rate	WH Engagement Score

Maternity

September Highlights:

The extended perinatal rate remains consistently below the threshold of 5.42 per 1,000 births, with the September 12 month rolling rate at 3.94 per 1,000 births.
This rate includes stillbirths and neonatal deaths, and whilst the stillbirth rate remains significantly low (1.37 per 1,000 against a threshold of 3.61 per 1,000), the neonatal death rate has recently risen to 2.57 per 1,000 against a threshold of 1.82 per 1,000. An external review is currently in progress which consists of a Senior midwife, Consultant Neonatologist and Senior Neonatal Nurse who have monthly engagement with the DDOM and the aim to have a final report in December.

The Friends and Family Test (FFT) maternity response rate, calculated using the national methodology based on delivery episodes, has remained below average for consecutive months. Local and LMNS initiatives continue to be explored to improve the uptake in addition to exploring the timeliness of the text systems

At month end (September 2024) the service has 5 open cases referred to and accepted by MNSI for external Patient Safety Incident Investigation (PSII) and 2 internal PSII's in progress. One draft report has been received from MNSI for factual accuracy checking with no safety recommendations at this stage.
1 moderate / severe patient safety incident reported in September referred to MNSI
Immediate learning has been shared with the wider maternity service team.

Maternity: Metric Dashboard

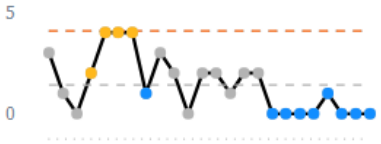
Domain	Nat	Flag	KPI	SPC	Ass...	Target	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Maternity	NAT		Serious Incidents Maternity			4	2	1	2	2	0	0	0	0	1	0	0	0
	KEY		Maternity Incidents Moderate / Sev...			7	4	0	2	1	1							
	KEY		Maternity Patient Incidents Moderat...			7					0	5	1	1	3	2	2	1
	KEY		Maternity Complaints			20	5	9	6	12	7	1	8	8	6	8	10	14
	KEY		Maternity Complaint Response			90.0%	0.0%		33.3%	50.0%	21.1%	72.7%	0.0%	20.0%	0.0%	44.4%	75.0%	40.0%
	KEY		Extended Perinatal Mortality			5.87	2.62	2.29	2.81	2.99	2.45	2.61	2.77	3.46	3.65	3.81	3.98	3.94
	NAT		FFT Maternity Response Rate			15.0%	13.6%	16.0%	15.0%	14.1%	12.8%	11.5%	9.2%	9.1%	12.1%	11.1%	10.7%	9.7%
	NAT		FFT Maternity Recommended			90.0%	96.3%	93.0%	88.9%	93.5%	93.2%	88.1%	88.5%	94.7%	96.3%	91.8%	90.2%	95.9%
	NAT		FFT Maternity (IP) Recommended			90.0%	96.8%	93.8%	90.4%	94.1%	92.9%	90.9%	92.7%	94.8%	95.3%	93.0%	89.3%	96.5%
	KEY		WH Engagement Score			6.90	6.38	6.38	6.38	6.35	6.35	6.35	6.07	6.07	6.07	6.12	6.12	6.12

Maternity: Actions

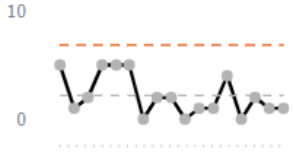
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
FFT scores	• Review existing process in relation to the promotion of the FFT	• Patient Experience Team		• QR codes being introduced on Congratulations on your Birth Cot Cards • Promotion of the FFT as well as the YVIH initiative • Exploration of text reminders • Work with the LMNS to promote engagement • Publication of a single thematic tool for all sources of patient feedback
Overdue Incidents	• Email and communication with individual action owners with ongoing monitoring and expected completion date • Agreed with corporate team an understanding that some maternity incidents will remain open for longer than 6 weeks, given the complex nature of some investigations.	• Denise Newman • Head of Governance		• Downward trajectory • Agreed number of incidents to be closed by teams on a daily basis • All overdue incident handlers for Women's Health emailed weekly • Number of maternity overdue incidents in September is **47.** • Continued monitoring of incident management has identified an increase in maternity overdue incidents to **64** (as of 21st Oct) initiating increased surveillance and support.
External Review Neonatal Deaths	• Aggregate review of all NNDs from 1st April 2023 to 31st March 2024 by an external Neonatologist, senior midwife and Neonatal Nurse	• Adaline Smith Dep Director of Midwifery		• Honorary contracts now in place . • All families will be contacted by the PMRT midwife to inform them followed by a letter • Plan for report to be available to the Trust by early December • Education on signs of life in the extremely premature baby to be shared
Engagement Score 6.07	• Board Level meetings with staff and actions taken to close the loop on feedback • Several platforms for escalating concerns • Focus on RCS facilitated by PMA team • Explore promotion of the national staff survey	• Care Group Quadrumvirate		• Survey Monkey undertaken shared in various forums • Pulse Survey results now available • Senior team all trained on the use of TED to be able to obtain real time information from teams • The WCYP score remains the highest in the Trust
Complaints	• Temporary depleted staffing resource within Governance Team	• Denise Newman, Head of Governance		• Complaints manager appointed with commencement date of 11th November • Compliance / Quality / Assurance Midwife successfully recruited to commences November • Interim local action plan developed with DDOM for maintenance of service provision within governance team. • **46** current open complaints at various stages of completion. **6** currently breaching care group deadlines.

Maternity: Metric Run Charts

Serious Incidents Maternity

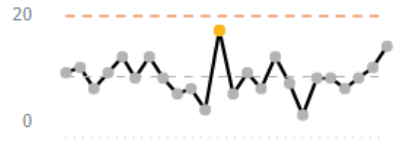


Maternity Incidents Moderate / Severe

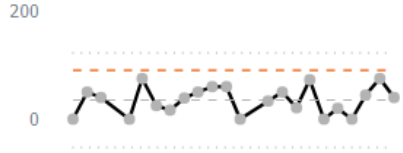


Maternity Patient Incidents Moderate ...

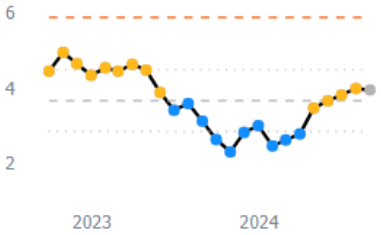
Maternity Complaints



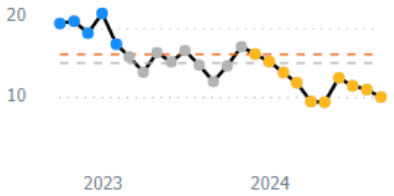
Maternity Complaint Response



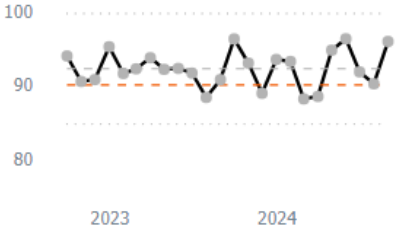
Extended Perinatal Mortality



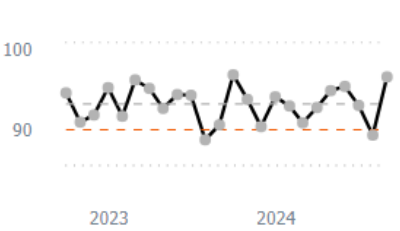
FFT Maternity Response Rate



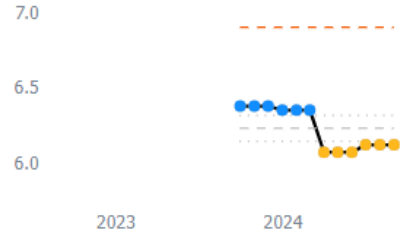
FFT Maternity Recommended



FFT Maternity (IP) Recommended



WH Engagement Score



East Kent Hospitals University NHS Foundation Trust

REPORT TO READING THE SIGNALS OVERSIGHT GROUP

Report title: **Reading the Signals Update 2024**

Meeting date: **19 November 2024**

Board sponsor: **Chief Nursing and Midwifery Officer**

Paper Author: **Lead for Patient Voice and Involvement**

Appendices:

1. **PowerPoint presentation**

Executive summary:

Action required:	Discussion
Purpose of the Report:	The report gives a summary of the work completed by the Patient Voice and Involvement Team at EKHUFT which identifies: • key themes arising in public engagement of Maternity and Neonatal Services in 23/24
Summary of key issues:	The Patient Voice and Involvement Team has completed face to face engagement in communities, gathered feedback from stakeholder groups, produced locally focussed surveys and analysed Friends and Family Test (FFT) data to identify trends in patient experience: • The majority of feedback across all stakeholders has been positive and focussed on staff attitude and compassionate, quality care. • Quality of Treatment, Communication/Information and Wait Times to be Seen are all areas to focus on as they have a lower FFT rating than the Trust's average. • The assertive outreach undertaken with birth partners, deprived wards and people who do not speak English as a first language did not have any clear themes arising other than trust-wide considerations around system-wide preventative measures like smoking cessation and effective use of interpreters.
Key recommendations:	To discuss and note the report.

Implications:

Links to Strategic Theme:	Strategic Theme this report aims to support: • Quality and Safety

East Kent Hospitals University NHS Foundation Trust

	• Patients • People
Link to the Trust Risk Register:	**Corporate 118**: There is a risk that the underlying organisational culture impacts on improvements that are necessary to patient and staff experience which will prevent the Trust moving forward at the required pace. Specifically, there is a requirement for urgent and significant improvement in relation to staff attitudes and behaviours. **Maternity: 2702**: Failure to provide up to date patient information to enable women to make informed choices.
Resource:	N
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: *N/A*

NHS
East Kent
Hospitals University
NHS Foundation Trust

Patient Voice

We care

Reading the Signals
Update October 2024

Adam Littlefield
Lead for Patient Voice and Involvement

We care

How the Team Works

Healthwatch and Community Sector Stakeholder feedback

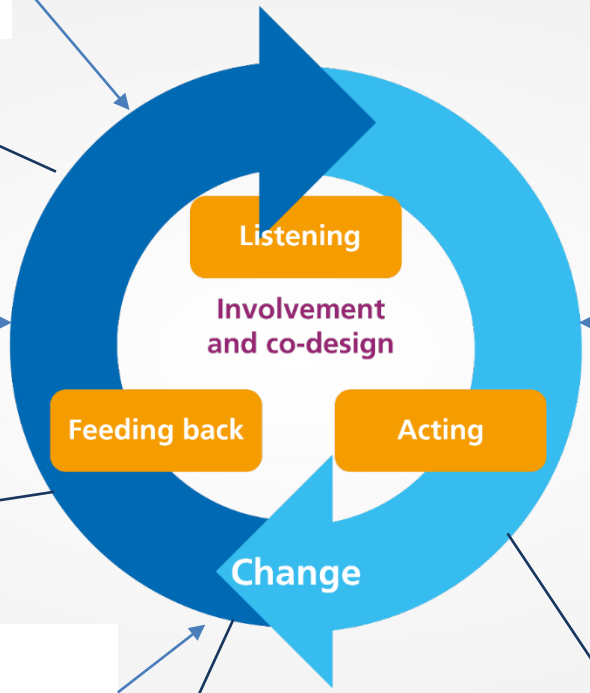
Emmaus co-produced Unhoused Patient Training

Locally Focussed Surveys and engagement in our hospitals

AAA Accessibility and visibility in communities

Friends and Family Test, Care Opinion data

Reports to the Patient Experience Committee, Fundamentals of Care and Board



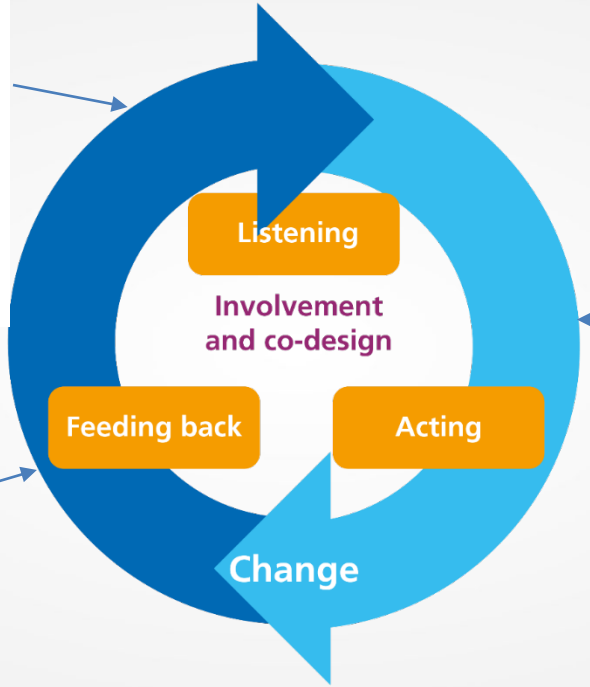
Assertive Outreach to underserved communities, responses to patient contact and prompts from our Participation Partners, NHSE and EKHUFT leaders

Stroke Discharge and Peer Support, Patient Transport, Cancer and CYP Focus

Maternity Engagement 23/24

- Healthwatch and Community Sector Stakeholder feedback shared with Maternity colleagues/Patient Experience Midwives (PEMs)/Board-level reports

- Locally Focussed Surveys completed by patients and shared with Maternity colleagues
- Internal support for Maternity workstreams: Interview panel, PEM collaboration, Equity & Equality Task and Finish Group



Assertive Outreach with parents from underserved communities, focussing on:

- birth partners
- deprived wards
- people who don't speak English as a first language

Key Findings from Maternity Engagement 23/24

The vast majority of feedback we have heard across all of our engagement has been positive and focussed on staff attitude and compassionate, quality care.

Healthwatch and Community Sector Stakeholder feedback

- We heard from migrant mothers that sometimes when we say, “do you have any questions for me?” we aren’t clear enough that the patient is in a safe space to share concerns. This was presented by service users as a patient story at Board.
- **The majority of feedback in this area was positive and focussed on quality of care and empathy and compassion from staff involved in all stages of a patient’s maternity pathway**

Locally Focussed Surveys

- Newborn hearing – all patients surveyed would recommend the service and focussed on communication and the staff being gentle and calm
- Smoke-free Maternity – low response rate but universally positive feedback
- General maternity experience at QEQM – low response, universally positive
- Pre-term babies SCBU/NICU/birth surveillance clinic launched in Oct, awaiting data

Key Findings from Maternity Engagement 23/24

Friends and Family Test, Care Opinion data

There were 951 positive and 138 negative FFT responses between July and September 2024. Of the 13% negative comments:

- **Quality of Treatment, Communication and Information and Wait Times to be Seen was slightly below the Trust averages**
- **Care Opinion feedback has been very low, we assume this is due to the assertive work being done by the PEMs**

Assertive Outreach

- Birth partners felt that their needs were met and commented on the support available to them and a noticeable focus on wellbeing/mental health in some situations
- People living in deprived wards faced universal barriers to accessing care (travel costs and time pressures): there was no maternity-specific trend in their feedback. There is an opportunity to do more assertive work on preventative measures (smoking cessation)
- People who don't speak English as a first language provided generally positive feedback although there were some comments about the availability of interpreters

Key Findings from Maternity Engagement 23/24: Patient quotes

East Kent Hospitals University NHS Foundation Trust

"I had a c section. The operation and care were professional and personable. The anaesthetic team in particular were in control and very caring."

"The midwife and all the staff were very helpful and friendly. I didn't have to wait a long time to be seen. Everything was done in less than 30 minutes. Thank you so much everyone, you are always amazing and do a great job!"

"This is not to do with the sonography appointment. It is to do with the plotting of my scan after in maternity triage. Twice now I have had to wait an hour just to get my scan plotted to then be told to go home and call triage as they are too busy. It is really anxiety inducing"

"I didn't really know what was going on but the team were so kind to (my partner) and she felt really supported. They looked after me too, (even though) I wasn't the priority and getting a cup of tea and a shower was a nice touch"

We care

How to contact us

- **Adam Littlefield** (Lead for Patient Voice and Involvement): a.littlefield@nhs.net

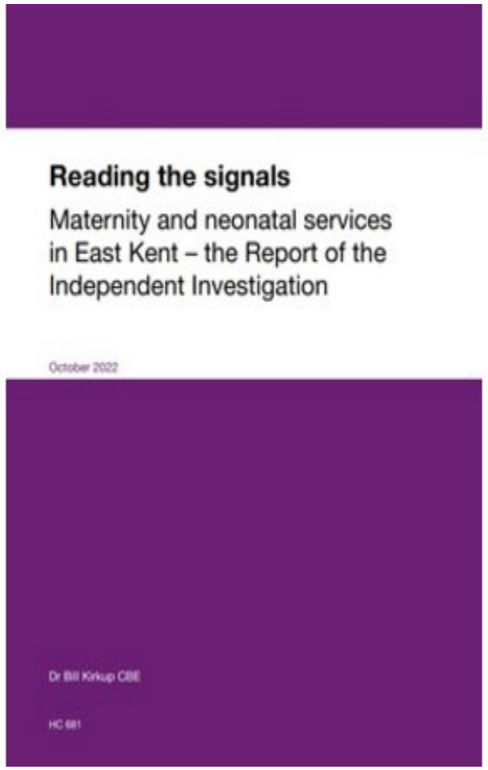
- Team email: ekhuft.patientvoice@nhs.net
- Team phone number: **01227 868605 (722 8605)**

EKUFT Maternity & Neonatal

Neonatal Death Review, 2023/24

NHS
East Kent
Hospitals University
NHS Foundation Trust

Key Action Area 1: Monitoring safe performance – finding signals



Recommendation 1

The prompt establishment of a Task Force with appropriate membership to drive the introduction of valid maternity and neonatal outcome measures capable of differentiating signals among noise to display significant trends and outliers, for mandatory national use.

Neonatal Deaths

A neonatal death is a baby born at any time during the pregnancy who lives, even briefly, but dies within four weeks of being born

Evident signs of life after birth would include one or more of the following:

- easily visible heartbeat seen through the chest wall.
- visible pulsation of the cord after it has been clamped
- breathing, crying or sustained gasps.
- definite movement of the arms and legs.

EKHUFT Data and Analysis

Analysis of the Trust's mortality data using ONS definitions provides a comprehensive overview of all deaths within the service, in contrast to the MBRRACE definition, which focuses on babies born at 24 weeks or later to allow for comparable unit analysis and is primarily used for reporting in the Trust's maternity dashboard.

All NNDs are discussed in our Rapid Review process and are also reviewed using the Perinatal Mortality Review Tool with external MDT panel members
Babies at born after 37 weeks who die within 6 days a referred to the Maternity and Newborn Safety Investigation team (MNSI)

Stillbirth Data | ONS

- The Trust's stillbirth rate, based on ONS methodology, has significantly declined since 2022.
- The rate for 2023/24 was 2.6 stillbirths per 1,000 births, compared to the national average of 4.1 (2021 data)
- ONS methodology includes all stillbirths and terminations 24+0 weeks and over. MBRRACE only includes stillbirths 24+0 and over. The MBRRACE 23/24 rate was 1.39 (8 stillbirths)

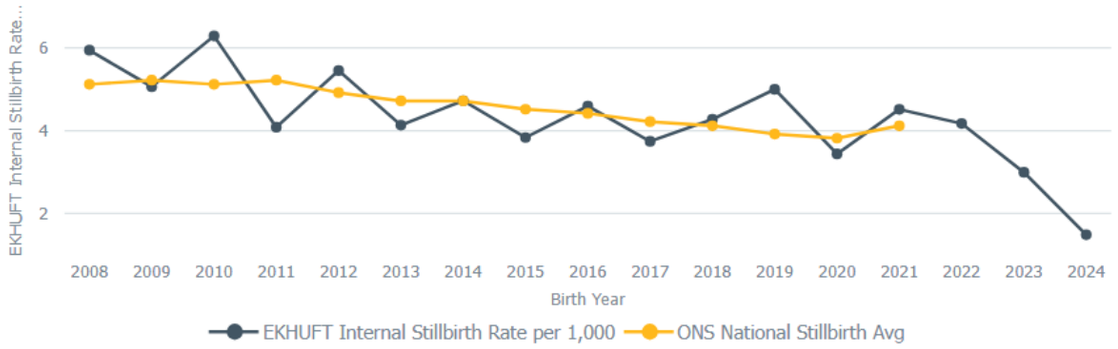
ONS Stillbirth Data

ONS

Birth Year	Stillbirths	Births	Rate per 1,000	ONS National Average
2008	44	7,427	5.92	5.10
2009	37	7,336	5.04	5.20
2010	47	7,497	6.27	5.10
2011	30	7,382	4.06	5.20
2012	41	7,546	5.43	4.90
2013	29	7,048	4.11	4.70
2014	33	7,011	4.71	4.70
2015	27	7,076	3.82	4.50
2016	32	6,995	4.57	4.40
2017	26	6,985	3.72	4.20
2018	28	6,579	4.26	4.10
2019	32	6,425	4.98	3.90
2020	21	6,140	3.42	3.80
2021	28	6,228	4.50	4.10
2022	26	6,258	4.15	
2023	17	5,715	2.97	
2024	4	2,723	1.47	

ONS Stillbirth Rate (internal real-time monitoring)

ONS / Euroking / PAS / Badgernet



Neonatal Death Data | ONS

- The Trust's NND rate, based on ONS methodology, has increased this year (2024 YTD)
- The 2023/24 rate was 2.6 NNDs per 1,000 livebirths, compared to the national average of 2.7 (2021 data).
- In 2023/24, there were **15** neonatal deaths using the ONS methodology.
- ONS methodology includes all deaths occurring at the Trust, regardless of gestation or place of birth
- MBRRACE methodology includes babies born at/past the age of viability (24 weeks) and born at the Trust

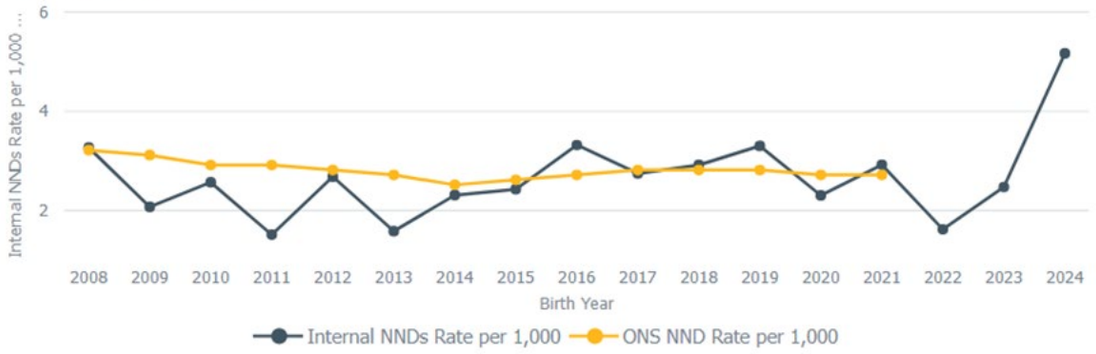
ONS Neonatal Death <28d Data

ONS

Birth Year	ONS Neonatal Deaths <28d	Livebirths	Rate per 1,000	ONS National Average
2008	24	7,383	3.25	3.20
2009	15	7,299	2.06	3.10
2010	19	7,450	2.55	2.90
2011	11	7,352	1.50	2.90
2012	20	7,505	2.66	2.80
2013	11	7,019	1.57	2.70
2014	16	6,978	2.29	2.50
2015	17	7,049	2.41	2.60
2016	23	6,963	3.30	2.70
2017	19	6,959	2.73	2.80
2018	19	6,551	2.90	2.80
2019	21	6,393	3.28	2.80
2020	14	6,119	2.29	2.70
2021	18	6,200	2.90	2.70
2022	10	6,232	1.60	
2023	14	5,698	2.46	
2024	14	2,719	5.15	

ONS Neonatal <28d Death Rate (internal real-time monitoring)

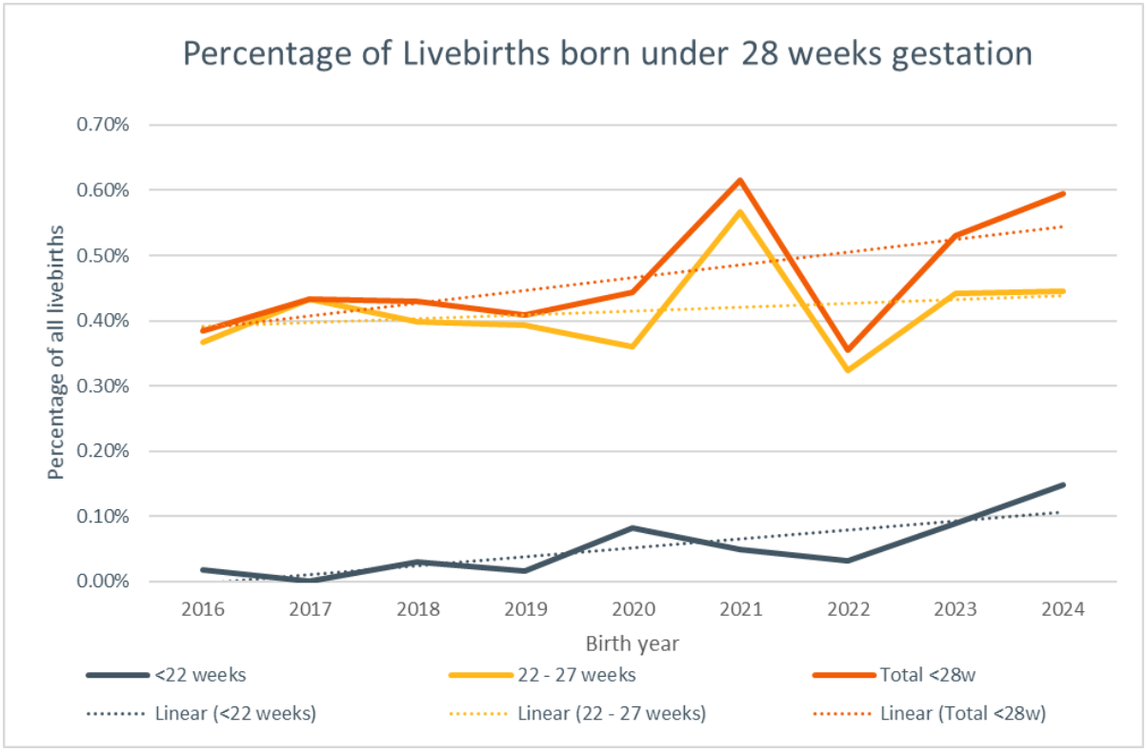
ONS / Euroking / PAS / Badgernet



Pre-term Livebirths

EKHUFT data indicates an increasing trend in extremely premature babies (<28 weeks) being born, who then have a 30-80% chance of survival according to BAPM stats

The rate of livebirths born under 28 weeks is 5.9 per 1,000 births so far in 2024, compared to an average of 4.2 per 1,000 births during 2016-2020.
Whilst the number of babies born this early is small, this equates to a 34% increase



Extended Perinatal Death Rate

Extended perinatal death rate includes both stillbirths and NNDs (ONS methodology)

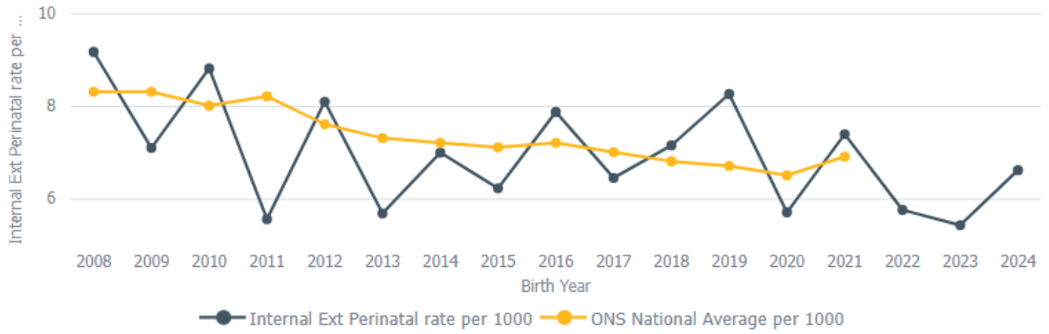
- The 2023/24 rate was 5.2 per 1,000 births, compared to the national average of 6.9 (2021 data).
- The Trust's rate has increased this year to 6.6 per 1,000, the national average of 6.9 (2021 data)

ONS Extended Perinatal Death Rate Data

ONS

Birth_Year	ONS Extended Perinatal Deaths	Births	Rate per 1,000	ONS National Average
2008	68	7,427	9.16	8.30
2009	52	7,336	7.09	8.30
2010	66	7,497	8.80	8.00
2011	41	7,382	5.55	8.20
2012	61	7,546	8.08	7.60
2013	40	7,048	5.68	7.30
2014	49	7,011	6.99	7.20
2015	44	7,076	6.22	7.10
2016	55	6,995	7.86	7.20
2017	45	6,985	6.44	7.00
2018	47	6,579	7.14	6.80
2019	53	6,425	8.25	6.70
2020	35	6,140	5.70	6.50
2021	46	6,228	7.39	6.90
2022	36	6,258	5.75	
2023	31	5,715	5.42	
2024	18	2,723	6.61	

ONS Extended Perinatal Death Rate (internal real-time monitoring)



Listening /Review / Terms of Reference

Objectives

- To conduct a comprehensive review of all neonatal deaths (deaths within the first 28 days of life) that occurred within the defined review period.
- To identify any common factors, themes or care that contributed to the neonatal deaths.
- To make recommendations to improve neonatal care and reduce preventable neonatal mortality.

Scope

- The review will cover all neonatal deaths 22+0 weeks and over that occurred at EKHUFT, and were admitted to NICU/SCBU, born between **1 April 2023 to 31 May 2024**

Equity & Equality Scorecard

The Trust has developed an Equity and Equality scorecard to monitor metrics according to ethnicity and deprivation

Domain	KPI	SPC	Thres.	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
Antenatal	Number of Bookings		Sigma	229	253	232	260	244	251	215	258	229	220	236	242
	% of Bookings		Sigma	42.3%	46.2%	39.1%	43.0%	41.4%	43.3%	43.0%	40.8%	42.0%	40.6%	42.0%	42.1%
	Bookings by 10w		60.0%	45.2%	48.8%	45.7%	46.1%	47.3%	50.6%	49.8%	42.4%	42.4%	45.2%	41.8%	44.5%
	Vitamin D Recommended		80.0%					52.5%	65.3%	67.9%	76.4%	99.6%	99.1%	100%	99.2%
	Smoking at Booking		9.0%	18.5%	12.8%	17.3%	16.5%	14.8%	14.7%	21.7%	11.0%	12.6%	11.6%	11.2%	9.3%
Delivery	Number of Deliveries		Sigma	167	199	208	194	185	170	206	202	180	205	199	208
	% of Deliveries		Sigma	35.8%	40.8%	40.4%	43.2%	39.0%	39.8%	44.3%	42.9%	38.3%	42.2%	40.0%	41.7%
	Preterm 22 to <37w per 1000		81	77	92	66	78	71	71	99	98	74	82	90	114
	Low Birth Weight		2.5%	0.6%	3.2%	3.8%	2.1%	2.2%	4.7%	3.0%	4.2%	3.7%	6.1%	4.2%	2.6%
	Apgar <7 @ 5mins		Sigma	1.8%	1.1%	1.5%	1.1%	1.2%	1.2%	0.5%	1.1%	2.2%	1.0%	0.6%	1.1%
	Smoking at Delivery		7.6%	12.6%	17.6%	16.2%	14.0%	10.6%	10.7%	9.1%	9.9%	12.5%	16.5%	10.6%	12.7%
	Total Section Rate		42.0%	46.1%	43.2%	44.7%	47.4%	37.8%	42.9%	44.2%	43.1%	47.8%	41.0%	41.7%	46.6%
Postnatal	Breastfeeding First Feed		68.0%	68.4%	62.6%	67.1%	70.9%	70.1%	69.0%	77.3%	64.9%	66.1%	63.7%	64.0%	70.8%
Morbidity & Mortality	MBRRACE Stillbirth Rate 12m		3.92	2.98	2.50	2.50	1.50	1.00	1.02	0.99	1.47	0.98	0.96	0.95	0.94
	MBRRACE NND Rate 12m		1.96	1.39	0.93	0.94	0.94	1.43	0.96	1.42	1.40	1.40	1.37	1.35	2.69
Patient Experience	YVIH Contacted		Sigma	141	170	175	164	176	174	130	189	147	165	173	175
	YVIH Response Rate		70.0%	75.9%	77.6%	74.3%	76.8%	72.2%	78.2%	75.4%	77.2%	70.7%	71.5%	71.1%	76.0%

In addition to the aggregate review

- The Trust has reviewed the rosters and shift patterns of all staff caring for the babies in the NNU in the last 24 hours prior to birth.

- Infection control measures including cot spacing will form part of the review.

- Review of the PREM 7 pathway

- The Chief Nursing and Midwifery Officer has informed the LMNS and ICB CNO and CMO as well as the CQC ensuring full transparency.

- The CNMO, DOM and DDOM have also met with Becky Collins, LNMS Director of Midwifery, Kaye Wilson, Regional Chief Midwife and Andrea Lewis, Regional Chief Nurse to inform them.

- The CMO and the CNMO are holding listening events for staff within the neonatal unit

- There is access to the FTSUGs and system wide process for making anonymous referrals which has been re-circulated to the neonatal team