Reading the Signals Oversight Group

Tue 19 September 2023, 14:40 - 16:30

Conference Room, Education Centre, Kent and Canterbury Hospital, Ethelbert Rd

Agenda

38. Welcome, Introductions and Apologies

To Note *Claudia Sykes - Chair*

39. Minutes from the last meeting held on the 8th August 2023

Approval *Claudia Sykes - Chair*

23-039 Draft Reading the Signals Oversight Group 8 August 2023 v5.pdf (7 pages)

40. Matters Arising from the Minutes

Discussion *Claudia Sykes - Chair*

23-040 Reading the Signals Oversight Group Action Log.pdf (1 pages)

41. Maternity Performance Update

Discussion *Ben Stevens - Chief Strategy and Abby King Partnerships Officer and Stakeholder Communications and Engagement Manager*

23-041 Maternity Performance Update.pdf (14 pages)

42. Maternity & Neonatal Improvement Plan and Your Voice is Heard

Discussion *Michelle Cudjoe - Director of Midwifery*

Verbal

43. Serious Incidents

Discussion *Michelle Cudjoe - Director of Midwifery*

Verbal

44. Community Family Voices

Discussion *Adam Littlefield - Lead for Patient Voice and Involvement*

23-044 Community Family Voices Engagement on Maternity OG Brief Sept 2023.pdf (9 pages)

45. Communications update

Discussion *Abby King - Stakeholder Communications and Engagement Manager*

Verbal

46. Any Other Business

Discussion *Claudia Sykes - Chair*

Date of next meeting - 31 October 2023

UNCONFIRMED MINUTES OF THE READING THE SIGNALS OVERSIGHT MEETING TUESDAY 08 AUGUST 2023 - CONFERENCE ROOM, EDUCATION CENTRE KENT AND CANTERBURY HOSPITAL AND VIA WEBEX TELECONFERENCE

PRESENT

Claudia Sykes	Non-Executive Director (Chair)	CS
Tracey Fletcher	Chief Executive Officer	TF
Ben Stevens	Director of Strategic Implementation and Partnerships	BS
Derek Richford	Family Representative	DR
Tania Linehan	Family Representative	TL
Phil Linehan	Family Representative	PL
Adam Littlefield	Lead for Patient Voice and Involvement	AL
Bernie Mayall	Lead Governor/Elected Public Governor - Dover	BM
Alex Ricketts	Elected Public Governor - Canterbury	AR
Jennifer Hamilton	Chair East Kent Maternity Voices Partnership/Co-production and Engagement Lead LNM	JHa
Carl Plummer	Deputy Lead Governor	CPl
Lucy De-Pulford	Community Representative	LDP
Natalie Yost	Executive Director of Communications and Engagement	NY
Lucy Coglan	Council of Governors Support Secretary (notes)	LC
Michelle Cudjoe	Director of Midwifery	MC
Raymond Anakwe	Non-Executive Director	RA
Jackie Huddlestone	NHS E Regional Team Locality Director Kent and Medway	JHu
Kaye Wilson	Regional Chief Midwife for South East Region	KW
Jennifer Hamilton	Chair East Kent Maternity Voices Partnership/Co-production and Engagement Lead LNM	JHa

AGENDA ITEM NO		ACTION
23/027	**WELCOME AND INTRODUCTIONS AND APOLOGIES** CS welcomed attendees to the meeting and introductions to new members were made. Apologies were received from: Linda Dempster - Family Representative, Sarah Hubbard - Family Representative, Helen Gittos - Family Representative, Andrea Ashman - Chief People Officer and Dr Zoe Woodward - Obs & Gynae Consultant	
23/028	**MINUTES FROM THE LAST MEETING HELD ON THE 20 JUNE 2023** There was some confusion around the following action - 23/016 - **FW and NY to review the comms and engagement strategy and bring back to this group** - DR commented he had expected the link circulated with the papers to view the Engagement and Communication Strategy to be an updated version, as per the action, however it was last updated in January 2023 and had not been reviewed. NY clarified the strategy had been refreshed after the Reading the Signals report was published and was refreshed yearly. DR commented the strategy had referenced the Reading the Signals group would be set-up, however, this had now been done. NY welcomed comments/feedback from the group on the strategy. TF commented it needed to be clear whether it was felt this group and the work associated with maternity should have a separate comms and engagement strategy. TF agreed there was something specific to maternity that was needed on how the Trust communicated around the work that had been done and the work being done to build confidence and re-assurance.	

It was agreed a highlight report would be produced which was to include the governance structure and metrics and a communications and engagement update - **ACTION**. TF asked for a mock version to be created. PL commented he was happy to share anything the Trust allowed, outside of this group.

DR commented he had not seen any action around the following sentence: **CS asked BS if he could produce an email that could be circulated to the group to explain the metrics and other feedback on reporting**. BS explained the dashboard was included within the agenda for today's meeting and more would be explained further in the meeting and felt this was better than communicating via email. DR responded he was expecting an email to help get a better understanding of the papers, and this had not been received. DR suggested a courtesy email to be sent explaining Ben's comments above so the group were aware.

23/029 **MATTERS ARISING FROM THE MINUTES**

23/013 - Revised Draft Terms of Reference - In terms of purpose and the oversight the ToR should include the wording 'and influence' and to include the Director of Midwifery and the Senior Obstetric lead as members - **Update 8th August 2023** - ToR had been updated as above and were included within this agenda for information - CLOSED

23/016 - Any Other Business - FW and NY to review the comms and engagement strategy and bring back to this group. NY to circulate the current comms and engagement strategy to the group - **Update 8th August 2023 -** Discussed in the minute agenda item - CLOSED

23/022.1 - Maternity Services Update - MC to bring back to the next meeting the final Maternity Transformation Plan and the review of the Your Voice is Heard first year feedback - **Update 8th August 2023** - First Year Feedback - On August agenda, Maternity Improvement Plan was being discussed for approval at September 2023 Board meeting and will be shared at this meeting in October 2023 - To Remain OPEN

23/022.1 - Maternity Services Update - Dr Zoe Woodward to be invited to this meeting **- Update 17/07/2023** - Dr Woodward has been invited to the August, September and Octobers' meetings - CLOSED

23/022.2 - Pillars of Change Update - The 5% Friends & Family Test (FFT) maternity response rate compared against other Trusts needed to be clarified - **Update 8th August 2023** - MC clarified the percentage for July 2023 for this organisation was 11% and the national best was 18% - To Close
The Trusts target needed to be changed to reflect this - **New Action**

23/022.2 - Pillars of Change Update - What reporting needed to be brought back to this meeting needed to be clarified - **Update 8th August 2023** - To be discussed during this meeting - TO CLOSE

23/022.2 - Pillars of Change Update - BS to email the group explaining the metric jargon - **Update 8th August** - BS to discuss during this meeting. A legend would be added into the Maternity report explaining what different symbols meant - TO REMAIN OPEN

23/024 - Community Family Voices - Deferred - an update to be brought back to the August meeting - **Update 8th August 2023** - On agenda for this meeting - CLOSED

23/030 **UPDATED REPORTS AND METRICS**

BS talked around the maternity dashboard and explained this had been created and used for the Maternity and Neonatal Assurance Group (MNAG) and it was felt it was an appropriate dashboard with the right metrics for oversight within this group. This dashboard used SPC charts which was the national recommendation in terms of monitoring progress against performance metrics. There was narrative at the start of the paper in regards to what the symbols meant. The SPC charts were a statistical application of change within metrics and analysed the previous movement and informed whether it was a normal movement or a movement that was outside of what was expected. DR asked what the 'P' stood for in the Governance, Risk and Compliance Overview paper (MBRRACE NND rate 12m and MBRRACE Ext Perinatal Rate 12m columns). BS brought to people's attention the more detailed charts for each of the components as this took the position with the graph and described what the chart was telling. DR felt there needed to be something that was more easily indexed on what the symbols' meant and needed to be appropriate for this meeting - DR highlighted this was discussed at the last meeting. DR challenged the Total Incidents figure of 255 and whether this figure was for the month July 2023 - this would be clarified further into the meeting. CS commented the documents were not easy to understand and information that could be easily picked up needed to be produced for this meeting.

TF commented it needed to be clarified whether higher level of reporting or detailed reporting was needed for this group.

BS explained the papers included in the meeting pack. The more detailed slides outlined were metrics that had triggered something because they were not a movement that was expected. The serious incidents were in a control level, with 255 being a number that did not trigger a more detailed discussion. Where there were movements that triggered more detail, such as the MBRRACE stillbirth rate, more detail was therefore included. The challenge was the balance between a sheet that had numbers against a description versus providing detail of what the number was informing and there was more work to do go get this right for this group.

DR asked what LCL and UCL meant. BS responded these meant 'Upper Control Limit' and 'Lower Control Limit'. There was a range in which movement would be considered normal variation, and when the movement went outside of this the lower or upper limit triggers would be looked at.

LDP felt it would be useful to have more detail on what the incidents were before they became more serious harm and begin to signpost exactly where the problems lied.

MC joined the meeting at approximately 10:40am.

CS asked MC for clarification around the Total Incident figure of 255. MC confirmed this figure was for the month of July 2023, and were the number of incidents that had been reported via Datix within maternity. Some of these incidents were near misses, a range of delays, medication errors and obstetric incidents and some would include Serious Incidents (SI's). The national statistic would expect 1 in 10 people who accessed NHS care to have an incident that should be reported and reviewed. If the birth rate was used as a denominator for example, out of 500 women who had given birth in the month of July 2023 you would expect around 50 incidents reported linked to the birth episodes - some of these would be part of maternity care. In general, this would include a wide range of incidents.

There was a trigger list in place for situations which midwives would be expected to report as an incident as active reporting is encouraged. Within these there would

be a triage of incidents and categorisation depending on outcomes and harm. The incidents were reviewed and categorised to determine what met the SI threshold and what would be considered a moderate incident.

CS asked MC how the Trust classified what was moderate harm. MC responded a moderate incident was where there had been some harm (ie a third-degree tear or baby born during a traumatic birth and sustained a laceration) but on review the management was appropriate but learning is identified. There was an external team the Trust worked with and there was constant overview of these cases. For the cases that met the threshold for either Serious Incidents (SI's) or PMRT reviews these were reviewed with a clinician, midwife or obstetrician who were independent of the Trust.

23/031 **MATERNITY SERVICES UPDATE**

MC provided and update and the following highlights were noted:

- The governments response to Reading the Signals report had been published and one of the actions that would be taken forward by NHS England nationally was to look at what data should be taken to Board and committee meetings.
- The information included in the dashboard was what would be reviewed at a divisional level and could be streamlined for this group - MC invited comments from the group on what sub-set information they would like to see.
- The 12-month stillbirth rate for the Trust was 2.55 to 1000 births which was compared to the national average of 3.6 to 1000 births.
- The neonatal death rate for the Trust was 0.85 to 1000 births with the national average being 2.39 to 100 births.
- In the month of July 2023 there were no serious neonatal deaths.
- There were 2 SI's declared in the period of July 2023 - one being an unexpected admission to the neonatal unit, which was being investigated by HSIB. The other was linked to mental health issues which were also being investigated.
- Other key safety metrics were related to super-numery status of midwives. 1 to 1 care was 100% compliant as was the super-numery status of midwives.
- Areas of non-compliance; there were workforce metrics that were challenged around achievement of appraisal rates and safeguarding training - this was being prioritised and those who were not compliant were booked to attend - MC would be monitoring this. It was important from a wellbeing perspective that appraisals needed to me meaningful - these had all been booked and there was a trajectory for those being completed within the next 8 weeks

CS invited feedback on what level of reporting the group would find helpful going forward. DR responded he was happy with the level of detail as long as questions could be raised and answered.

TF commented around the performance report and the complexity within it. It was agreed it would continue but to include a legend.

DR asked in regards to the Maternity and Neonatal Improvement Programme, who was responsible should things go wrong - a name or job title of such individual needed to be included in the 'measurable benefits' column. MC responded and explained the workstream charters (which were overall objectives) were seen at the meeting today and sitting beneath each workstream charter was a detailed project plan and within this was more detail including timescales and leads. DR commented he did not need to see that level of detail, however, suggested an extra column added with the job title or initial of the responsible person. JD

commented it would ultimately be the Executives who were responsible. **ACTION -** to bring updated version back to the next meeting.
DR also commented around the 'clear patient-safety related backlogs' high-level milestone - the timeframe for completion of this was December 2023, however it should from this date, be ongoing improvement and not able to slip again. MC responded there was a backlog in May 2023 of 868 incidents which needed to be managed. There had been a 60% reduction since then with the new figure sat at around 300 incidents. The trajectory was for these to be dealt with within the next two months. The process had also been streamlined in terms of reviews and how quickly they were being done. With the new process in place and the additional resource, the Trust would be ensuring what was monitored on a monthly basis.

DR also felt the 'Compliance with 15 x Immediate and Essential Actions (IEA's)' in compliance with the Ockenden report did not feel very 'immediate' and 'essential' with a timeframe given of March 2025. MC commented the timescale given was aligned to the Single Delivery Plan and was the national timescales within the single delivery plan. CS commented in addressing the IEA's in the Ockenden requirements - this could not be seen from the report and was there a way assurance could be given around this without creating extra reporting - MC clarified this was sat within the project plan.
DR would like to see the audit report of IEA's that was required by the HSE at this meeting - **ACTION**
BS commented a summary progress summary report could be done for this meeting from the highlight reports on current progress and the charters/each of the programmes of work that sat under the Maternity and Neonatal Improvement programme - **ACTION**
MC commented there had been an engagement day that had taken place on the 20th June 2023 which was attended by families, MVP, regional teams, ICB and internal and external stakeholders. The opportunity was used to benchmark the transformation programme as it was against the outputs of the single delivery plan. All of the suggestions and feedback from this was fed into the six workstream charters. The charters had been aligned to the single delivery plan and the Reading the Signals areas of action. The external consultants and the Midwifery Independent Advisors (MIA's) had sight and involvement in the feedback. Next steps included looking at the SRO's and presenting them to the Trusts' Board of Directors meeting in September 2023. Overall the engagement day went well and staff were engaged with the process and wanting to take forward the work that sat under the workstream charters. An artist was also in attendance to capture the day.
KW commented the day was very positive and had been set-up and led in a helpful way that gave people the opportunity to contribute and have their voices heard. KW also felt there was a will to take things forward and action now.

TL commented around the statistics - there would always be a percentage of these that were neonatal admissions and stillbirths that may have been expected, and the focus needed to be around the ones that weren't. MC commented a report around the reviews of whether deaths were avoidable and unavoidable could be brought to this meeting. The group agreed - PMRT review tool to be shared with the group - **ACTION.** TF commented the Trust had an obligation to other families to do this in a confidential and respectful way. JD commented there was a balance between looking at the numbers and SPC charts and understanding that in every individuals case where an SI was raised, what could the Trust learn. This would be something to bring back to this meeting in a confidential way.

RA felt the reporting wasn't right and asked what was it this group wanted to do. The added value of this group was the challenge and input from the patients, communities and families. RA felt the same papers shouldn't be seen at this group that were seen at other committees. Themes, learning, what the Trust had done and how the Trust can ensure it did not happen again RA felt was more in line with the purpose of the ToR.

23/032 **YOUR VOICE IS HEARD - FIRST YEAR FEEDBACK**

MC informed this report was presented to staff at a safety summit, which enabled staff to raised concerns from ward to Board. This initiative started a year ago and was co-produced with the MVP. There had been a slight reduction in the response rate, which was around 77-78%. It was not the only platform used to gather feedback and could be used in conjunction with the friends and family score, as well as the annual CQC maternity survey along with other initiatives (Walking the Patch and Don't Take Your Troubles Home). Antenatal and Intrapartum care scored above 90% in terms of satisfaction. Postnatal care was lower than expected but was consistent with some of the challenges seen across the country. The comments included in the papers were shared verbatim. 80% of women overall had a positive experience, but it was important to learn from the 20% who had not.

CS asked about the 5% FFT percentage and was this a national average score. MC informed the percentage for July 2023 for this organisation was 11% and the national best was 18%. A national percentage was no longer shared, however this was MCs personal research. CS informed the Trust's target needed to be changed to reflect this - **ACTION**

DR commented the response rate was higher compared to the number of people being listened to. MC responded everyone was contacted within the first 6 weeks of birth, however, some declined. The figure also depended on the number of births for that month. DR also commented the focus needed to be on those mothers who were not happy to return to East Kent Hospitals.

PL commented the positives were talked about in this paper and the charts reflected this, however, over the last 6 months the negatives were not great. The Trust was making progress and PL appreciated the honesty.

LDP was keen to see as much data as possible. LDP also felt there was a disconnect between what the Trust were hearing versus what the community's thoughts were and people were speaking more freely outside of the Trust - AL agreed. CS acknowledged there was a lot of work the Trust still needed to do, including where staff engagement scores were low. The questions staff were asked were shared within the meeting papers. LDP commented she was trying to engage with the Trust but felt she was not being responded to. MC was keen to meet with LDP to progress her concerns and thoughts.

TL asked what questions had been included in the Your Voice is Heard form. MC stated that the YVIH form questions had been co-designed with input from the Maternity Voices Partnership last year. It was agreed that as this had been running for a year now, it was worth reviewing the questions being asked which needed to be done at MNAG.

23/033 **GOVERNMENT RESPONSE TO READING THE SIGNALS**

The report was taken as read and the group noted the report.

BS commented the Trust needed to ensure that the onus in Reading the Signals and Pillars of Change mapped across to the national report. It was unsure what the engagement through the national process would be and it would work with what the Trust already had in place - it was hoped it would be a similar a requirement to what the Trust already had.

NY informed the Trust were looking at doing more engagement coming up to one-year since Reading the Signals was published. This would include a progress report and NY was keen to have thoughts from the group on this. DR commented it was important to include the reduction in neonatal deaths and stillbirths, whilst remaining sensitive.

23/034 **COMMUNITY VOICES UPDATE**

AL updated the group and the following was noted:

- Two sessions were held in July 2023 which were relaxed and based within the community. The sessions were not very well attended, however there had been a big response to them since they had been promoted.
- Approximately 60 people had been spoken to, at length of their experiences - AL would put the summary of these into a paper to be brought back to the next meeting - **ACTION**
- How the Trust continued to share things within the community was critical - some conversations had been had with people around this and what they would like to see.
- Mental health first aiders were present and a private room was available to those who needed it.
- There had been a lot of feedback from fathers and birthing partners, which was a focus for AL and work was being done around this.

AL would provide an overview report for the next meeting and an options paper on how the community-based work may continue.

23/035 **TERMS OF REFERENCE**

Deferred to the next meeting.

23/036 **ANY OTHER BUSINESS**

BS commented around whether people were ready to answer questions within 6 weeks within Your Voice is Heard and whether this was part of the response rate. BS asked if there was an option for those that did not respond or declined to do something between 6-12 weeks. CS suggested the Your Voice is Heard questions were reviewed.

MC would like the feedback from the community voices meetings to be brought to the MNVP meeting for the information to be reviewed. Where there was feedback from a variety of difference sources, along with the annual report from the CQC everything could be pulled together so there was a clear understanding on where the gaps were.

23/037 **DATE OF NEXT MEETING - 19 SEPTEMBER 2023**

Date of Next Meeting – Tuesday 19th September 2023 in the Conference Room, Kent & Canterbury Hospital/WebEx

SIGNED: _____

DATED: _____

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

RSOG/01	20.06.2023	23/022.1	Maternity Services Update	MC to bring back to the next meeting the final Maternity Transformation Plan and the review of the Your Voice is Heard first year feedback	08.08.2023	MC	Open	Update - First Year Feedback - On August agenda, Maternity Improvement Plan was being discussed for approval at September 2023 Board meeting and will be shared at this meeting in October 2023.
RSOG/02	20/06/2023`	23/022.2	Pillars of Change Update	BS to email the group explaining the metric jargon	08.08.2023	BS	Open	Update 08/08/2023 - BS to explain jargon during the August meeting and a legend would be added into the Maternity report explaining what different symbols meant.
RSOG/03	08.08.2023	23/028	Minutes from the last Meeting held on 20/06/2023	Produce a highlight report which is to include the governance structure and metrics and a communications and engagement update	19.09.2023	BS/MC/NY	to Close	Update 12.09.23 - On agenda for September 2023 meeting
RSOG/04	08.08.2023	23/031	Maternity Services Update	MC to add an extra column in the MNIP Charters paper to include the title/initials of the responsible person for each	19.09.2023	MC	Open	Update - This has been done completed - confirmed by MC on 08/09/2023
RSOG/05	08.08.2023	23/031	Maternity Services Update	The audit report of IEA's that were required by the NHS England to be circulated to the group	19.09.2023	MC	to Close	Update - To be shared with the group on Monday 11/09/2023 **Update 12.09.23** - Report circulated via email to group
RSOG/06	08.08.2023	23/031	Maternity Services Update	Anonymised Perinatal Mortality Review Tool (PMRT) to be shared with the group	19.09.2023	MC	to Close	Update - To be circulated to the group on Monday 11/09/23 **Update 12.09.23** - Report circulated via email to group
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.
RSOG/08	08.08.2023	23/034	Community Voices Update	AL to provide an overview report for the next meeting along with an options paper on how the community based work may continue	19.09.2023	AL	to Close	**Update 12.09.23** - On agenda for September 2023 meeting
RSOG/09	08.08.2023			Get input from family representatives on communications one year on from RTS and engagement in the MNIP	19.09.2023	MC/AL/NY	Open	

East Kent Hospitals University Foundation Trust
Reading the Signals Oversight Group

19th September 2023

Contents

Reading the Signals/Pillars of Change Communications and Engagement Update: Sept 2023

Key progress during last period:

Internal

- Target to recruit <100 change team members as part of the Culture Change Programme has been met and training provided, change team members' stories/videos in internal comms and team are currently interviewing Board and senior leaders as part of diagnostic phase.
- Freedom to Speak Up training and Caring with Compassion training is now mandatory for all staff.
- Filming staff-led values video with colleagues across Trust to build engagement and pride
- To build on 'East Kent Conversation', we have added staff suggestion boxes as another way for staff to give feedback, these have been produced and being distributed across sites

External

- Calls for concern pilot at William Harvey Hospital supported with posters and leaflets
- Restructure outcome published and recruitment to most posts complete.
- Trust Communications & Engagement Strategy refreshed
- Monthly stakeholder bulletin included maternity updates and compassion video
- Crib cards for all parents on the postnatal ward: a keepsake with helpful contact information and midwife information in case of concerns or compliments
- Development of materials for Triage, e.g. pull up banners for the entrances to direct women to the correct areas/explain the service.
- Website and social media updates about community midwifery teams and how to contact
- Welcome to the World series introduces new arrivals, with social media views over 70,000.
- Social media included 'Your Baby's Movements', FAQ Friday series and 'Who can I talk to?'.
- Supporting chaplaincy with baby loss memorial event, the first since the pandemic.
- Patient Voice and Involvement supporting YVIH calls and to link to wider Trust engagement
- Outreach to patients who may not have been comfortable engaging with the RTS OG, feedback incorporated into Trust-facing Patient Voice training.
- Two Community Family Voices sessions with parents, community groups, midwives and MNVP. While the numbers attending were low, led to further engagement opportunities.

Plan for next period:

- Maternity engagement event: working with the service and MNVP on event in November.
- Production of 1 year on progress report in maternity
- Implement CLP leadership survey communications campaign and publication of assets to describe what the CLP journey will look like
- EKHUFT Improvement Journey stories wk 18 September
- 'Check in' face-to-face staff engagement initiative launches, with Chairman Niall Dickson at QEQM 20 Sept
- Campaign to launch annual NHS Staff Survey
- See ME first Equality, Diversity and Inclusion campaign to launch during National Inclusion Week w/c 25 September
- Link patient and staff stories to maternity improvement plan
- Team brief to be formalised with attendance register for new care groups
- Annual Members' Meeting 28 September.
- 'Your hospitals' magazine printed, includes patient stories and maternity update

Evidence of impact of actions undertaken:

- We have added more maternity specific social media channels, combined maternity social media following is now 6k, is monitored daily with good direct engagement (via direct messages) as well as information sharing/commenting.
- Take up of training, in maternity and Trust-wide e.g. caring with compassion video and F2SUG

Statistical process control (SPC)

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 guides us to take the most appropriate action.
- The main aim is to understand what is different and what is normal, so we know 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

- An SPC chart has three reference lines that help you appreciate variation in the data, they are:
- centre reference line: the average line (often represented by the mean, sometimes the median)
- upper and lower reference lines: the process limits, also known as control limits.
- A minimum of 15-20 data points is needed to have meaningful insight, the process limits are defined by the how the data varies. You can expect approximately 99% of data points to fall within the process limits. If a 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).
- Special cause variation occurs when one (or more) of these things are happening;
- A single data point falls outside the process limits
- A run of consecutive data points is above or below the mean
- Six consecutive data points follow an increasing or decreasing trend
- Two out of three data points are close to the process limits

NHSE Improvement Icons and where to find them

As an organisation we use the NHSE Improvement Icons to signify the variation demonstrated in all of our scorecard reporting. These icons are outlined in the table below;

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

You will routinely see these icons displayed against our data packs, an example of which is shown below;

Maternity

Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	LCL	Mean	UCL	Understanding the Latest Position
Maternity	Serious Incidents Maternity	Sigma	Jul-23	5			-3	3	9	Common cause (no significant change)
	Maternity Incidents Moderate / Sev...	Sigma	Jul-23	1			-3	3	9	Common cause (no significant change)
	Maternity Complaints	Sigma	Jul-23	6			-3	6	15	Common cause (no significant change)
	Maternity Complaint Response	90.0%	Jul-23	45.5%			-36	33	101	Common cause (no significant change)
	Extended Perinatal Mortality	5.87	Jul-23	3.40			4	5	6	Special cause of improving nature or lower pressure due to lower values
	FFT Maternity Response Rate	5.0%	Jul-23	11.4%			6	11	15	Common cause (no significant change)
	FFT Maternity Recommended	90.0%	Jul-23	95.3%			84	91	98	Common cause (no significant change)
	FFT Maternity (IP) Recommended	90.0%	Jul-23	97.5%			84	93	102	Common cause (no significant change)
	Maternity Engagement Score	6.90	Jul-23	6.15			6	6	6	Special cause of improving nature or lower pressure due to higher values

July Performance Summary

Incidents: There were 5 serious incidents reported in July for Women's Health; 2 for Maternity and 3 for Gynaecology.
The 2 maternity incidents involve:

1. Unanticipated admission to SCBU – term baby received therapeutic cooling. This meets HSIB and ENS criteria and is an automatic SI.
2. Adult protection / safeguarding of adults – failure to follow mental health pathway.

At month end there are no SI breaches.

Complaints: 6 Stage 1 complaints received in July 2023 for Maternity. At month end there were 26 open complaints of which 7 had breached.

Patient Involvement: FFT Response rate 11.4% - 296 comments made in total. 94.6% extremely likely or likely to recommend

Staff Engagement: Score 6.15 – increase in month

Serious Incidents

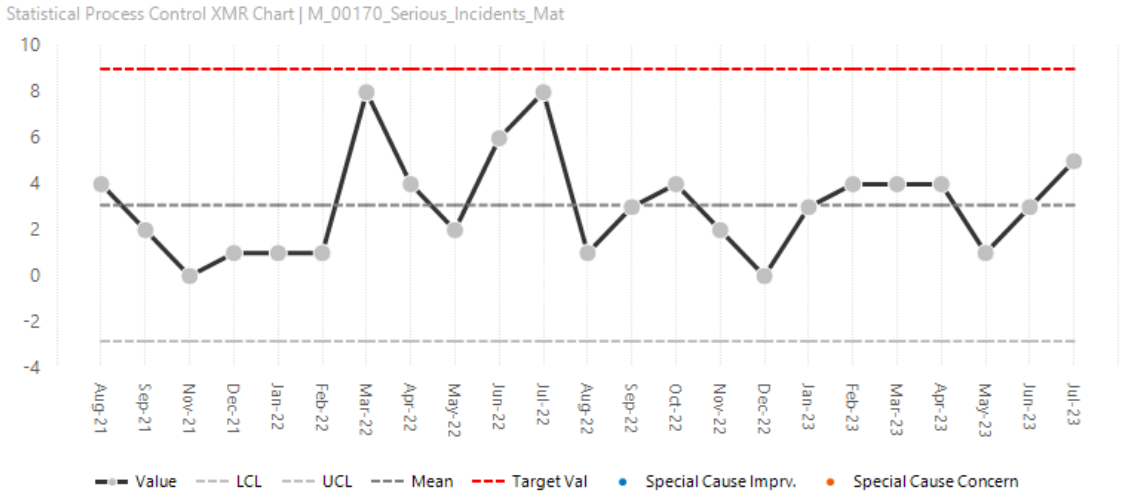
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This metric measures any maternity incident recorded on Datix that has subsequently been reported to STEIS (Strategic Executive Information System). Any maternity incidents that are subsequently downgraded are removed retrospectively therefore this number is subject to change. Serious Incidents are reported by the date the investigation started and not the date the incident occurred or was reported.

Serious Incidents Maternity

Month	Value
Aug-22	1
Sep-22	3
Oct-22	4
Nov-22	2
Dec-22	0
Jan-23	3
Feb-23	4
Mar-23	4
Apr-23	4
May-23	1
Jun-23	3
Jul-23	5



Understand the most recent data point

Variation Type

Common cause (no significant change)(No Special Cause Flags)

Variation indicates inconsistently passing and falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
There were 5 serious incidents reported in July for Women's Health – 2 for Maternity and 3 for Gynaecology.	The Maternity SI's refer to: 1. Unanticipated admission to SCBU – term baby received therapeutic cooling. 2. Adult protection / safeguarding of adults – failure to follow mental health pathway.			1. This meets HSIB and ENS criteria and is an automatic SI. HSIB investigation in progress – automatic extension 2. RCA in progress
At month end there are 18 open SI's in women's Health – 13 for maternity and 5 for gynaecology.	For all SI investigations to be completed within agreed timeframes.	• Interim Head of Governance	• Monthly - ongoing	• At month end there are no SI breaches within Women's Health or Maternity. All open SI's under investigation are within agreed timeframes.
Closure of actions from SI's on the datix actions module.	• Focussed work to close open actions on datix module with action owners • Weekly progress reporting of backlog and current position	• Interim Head of Governance	• 31/08/2023	• The number of overdue actions from the backlog has reduced from 345 to 249 at 14/08. However, the overall current overdue actions has increased due to action plans being added to the module. Progress on closing these actions have been impacted in July and August with the high annual leave period, vacancies and the Patient Safety Team supporting clinical staffing.

Incidents Causing Harm

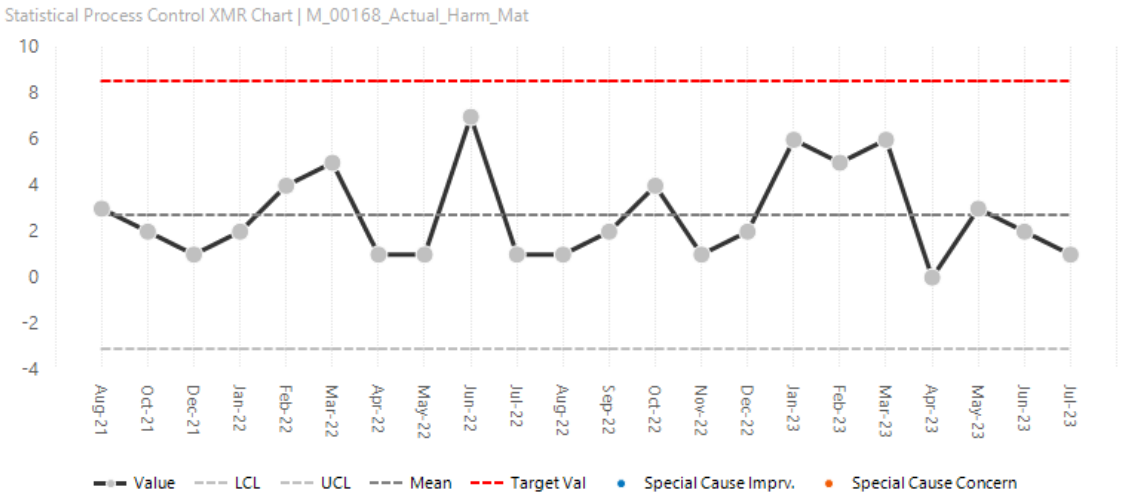
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This metric measures the number of maternity incidents where the harm status was moderate or above.

Maternity Incidents Moderate / Severe

Month	Value
Aug-22	1
Sep-22	2
Oct-22	4
Nov-22	1
Dec-22	2
Jan-23	6
Feb-23	5
Mar-23	6
Apr-23	0
May-23	3
Jun-23	2
Jul-23	1



Understand the most recent data point

Variation Type

Common cause (no significant change)(No Special Cause Flags)

Variation indicates inconsistently passing and falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
		• Interim Head of Governance	• Monthly - ongoing	• MDT attendance affected by strikes/annual leave/vacancy on some days in July but cases reviewed in a timely manner. Themes and learning identified from rapid reviews disseminated via Message of the Week, Safety Threads, Lunch and Learn.
Closure of datix open more than 6 weeks	• Focussed work to close open actions on datix module with action owners • Weekly progress reporting of backlog and current position	• Interim Head of Governance	• 31/08/2023	• The number of open datix from the backlog for Women's Health has reduced from 762 to 217 at 14.08.2023. For maternity, the backlog has reduced from 686 to 187. However, the overall current overdue datix has plateaued. Progress on closing these incidents has been impacted in July and August with the high annual leave period, vacancies and the Patient Safety Team supporting clinical staffing.

Maternity Complaints

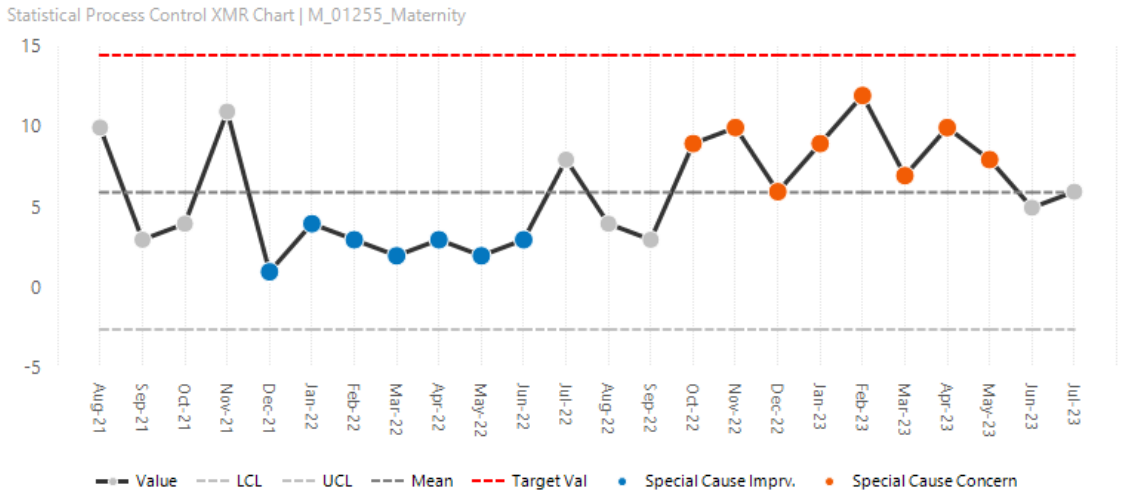
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This metric measures the number of complaints made to Obstetrics, Midwifery or New-born Hearing Screening Services.

Maternity Complaints

Month	Value
Aug-22	4
Sep-22	3
Oct-22	9
Nov-22	10
Dec-22	6
Jan-23	9
Feb-23	12
Mar-23	7
Apr-23	10
May-23	8
Jun-23	5
Jul-23	6



Understand the most recent data point

Variation Type
Common cause (no significant change)(No Special Cause Flags)
Variation indicates inconsistently passing and falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
6 Stage 1 complaints received in July 2023 for Maternity	Themes : • Delay in receiving diagnosis • Delays in receiving treatment • Doctor communication issues • Problems with department appointment • Problems with doctor's attitude • Unexpected outcome / post op complications	• Patient Experience and Complaints Coordinator	• Monthly reporting	• Sent to HOMs and Clinical Lead, as well as other Care Groups for comments – some awaiting leads to be assigned.

Maternity Complaints Response Rate

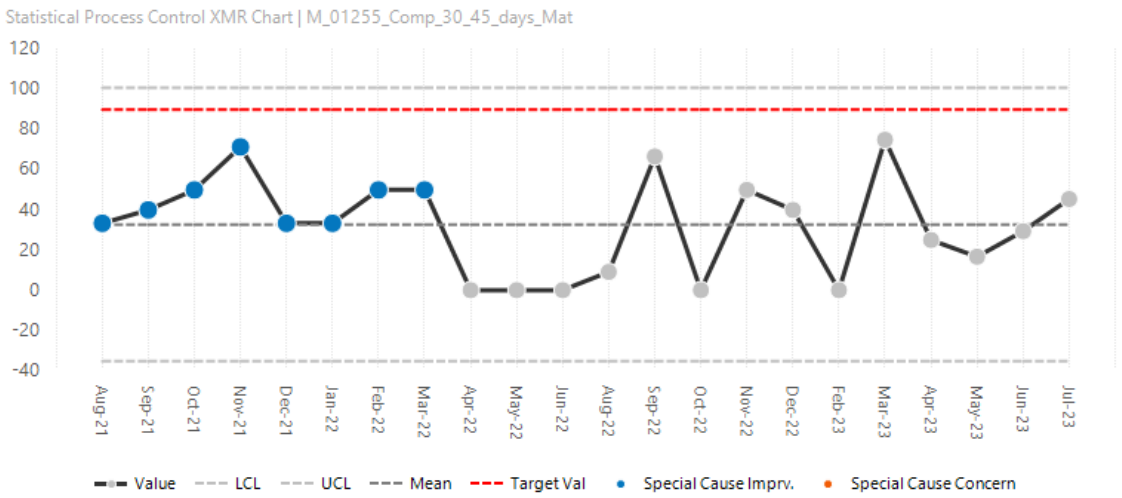
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This metric measures the proportion of complaints which were responded to within the agreed timescale of the complaint being received. This includes both 30 and 45 working day timescale targets.
Complaint Types included are Formal, External and MP Formal that have not been rejected.
Complaint Stages included are extensions 1,2,3 and extensions agreed by Chief Nurse, Local Resolution, On Hold and Withdrawn.

Maternity Complaint Response

Month	Value
Jun-22	0.0%
Aug-22	9.1%
Sep-22	66.7%
Oct-22	0.0%
Nov-22	50.0%
Dec-22	40.0%
Feb-23	0.0%
Mar-23	75.0%
Apr-23	25.0%
May-23	16.7%
Jun-23	29.4%
Jul-23	45.5%



Understand the most recent data point

Variation Type

Common cause (no significant change)(No Special Cause Flags)

Variation indicates inconsistently passing and falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Competing priorities of clinical staff cause delays in case reviews and providing the Complaint Coordinator with comments for content	• Complaint Coordinator has set up weekly 'huddle' meetings with HOMs and newly appointed Clinical Lead to try and spotlight urgent cases .			• At month end there were 26 open complaints of which 7 had breached.
Maternity complaints can span a 10+ month period of care in Maternity & comments needed from lots of teams (EPU, Infant feeding, Community, Maternity Triage, USS, Neonates, Midwifery, Consultant etc.) Paper notes cannot be in more than one place at a time.	• Complaint Coordinator has sought approval for a process to have notes collected and scanned at 'triage' stage to make electronic shared simultaneous access to patient notes. This is to help suit the different availabilities of staff and reduce time waiting for notes to be taken between sites.	• Patient Experience and Complaints Coordinator	• Ongoing	• Process in place

Extended Perinatal Mortality

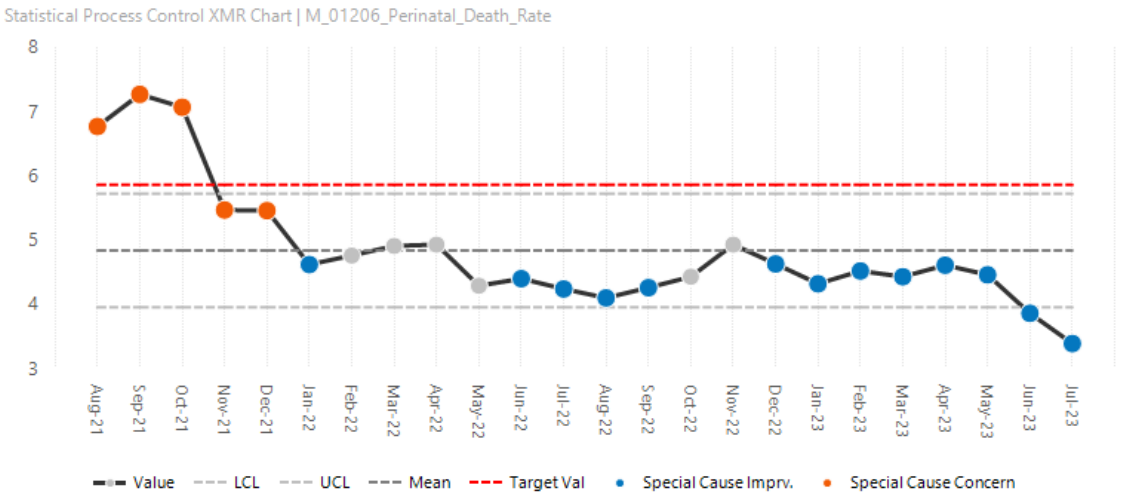
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

Extended perinatal mortality refers to all stillbirths and neonatal deaths, MBRRACE methodology is used, which excludes births <24+0 weeks gestation and terminations (even if over 24+0w). The rate is per 1000 total births.
Datasource: Euroking & PAS
Threshold based on the average of the Trust's comparator group (Trust with level 3 NICU) from the 2021 MBRRACE report.

Extended Perinatal Mortality

Month	Value
Aug-22	4.11
Sep-22	4.27
Oct-22	4.44
Nov-22	4.94
Dec-22	4.64
Jan-23	4.33
Feb-23	4.53
Mar-23	4.44
Apr-23	4.62
May-23	4.47
Jun-23	3.87
Jul-23	3.40



Understand the most recent data point

Variation Type

Special cause of improving nature or lower pressure due to lower values(| Below Mean Run Group | | Astronomical Point | | | Two Out Of Three Beyond Two Sigma Group)

Variation indicates consistently passing the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
In July there were 0 stillbirths reportable to MBRRACE	• The rolling 12 month rate for stillbirths remains below the lower confidence limit at 2.55 stillbirths per 1,000 births. In the 12 month rolling period, there have been 15 stillbirths reportable to MBRRACE. The expected number of deaths based on the group average and our current birthrate would be 23.			
In July there were 0 neonatal deaths reportable to MBRRACE, and 1 neonatal death which is not included under the MBRRACE methodology (baby born at 20+2 weeks)	• The rolling 12 month rate for neonatal deaths remains lower than both the threshold and average at 0.85 neonatal deaths per 1,000 livebirths, and has been so for 15 consecutive periods. In the 12 month rolling period, there have been 5 neonatal deaths reportable to MBRRACE. The expected number of deaths based on the group average and our current birthrate would be 12			
Perinatal Mortality Review Tool	• All neonatal deaths and stillbirths are reviewed through the Perinatal Mortality Review Tool by a multidisciplinary panel and external attendees.	• Emma Parkin	• Monthly	• PMRT Lead Midwife in post from mid June. 100% of perinatal mortality reviews include an external reviewer

Friends & Family Test: Response Rate

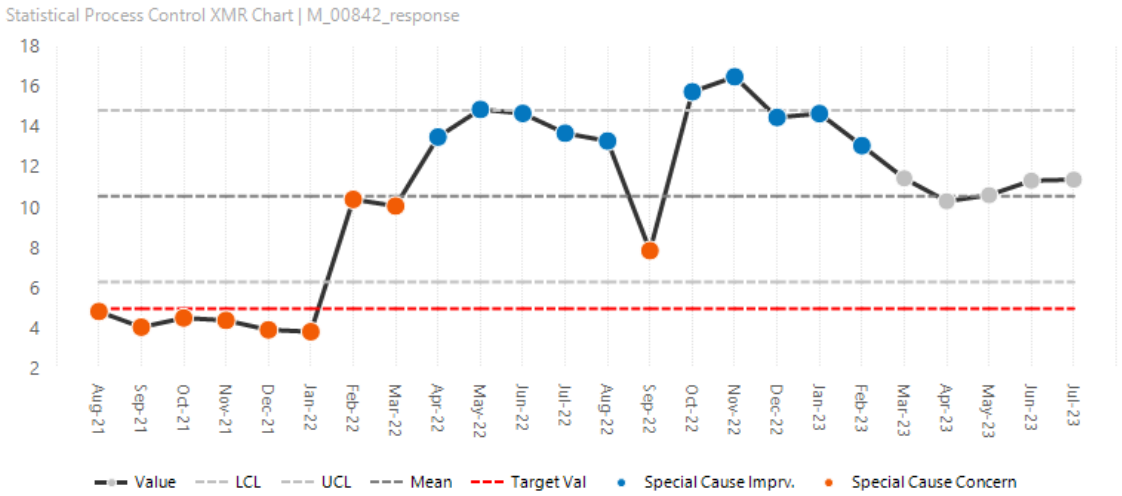
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This metric measures the number of responses to the maternity friends and family questionnaires and displays as a % of the total questionnaires sent.

FFT Maternity Response Rate

Month	Value
Aug-22	13.3%
Sep-22	7.9%
Oct-22	15.8%
Nov-22	16.5%
Dec-22	14.5%
Jan-23	14.7%
Feb-23	13.1%
Mar-23	11.5%
Apr-23	10.3%
May-23	10.6%
Jun-23	11.4%
Jul-23	11.4%



Understand the most recent data point

Variation Type

Common cause (no significant change)(No Special Cause Flags)

Variation indicates consistently passing the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
				• There is a new PTL for FFT- the aim that FFT feedback is themed in a standardised way and is comparable.
Response rates are typically low for FFT therefore only reflect a minority of women, birthing people and their families, and their experiences	• Embedded communications plan and Patient Voices Model to improve service user and workforce engagement, feedback and experience	• Patient Experience Midwives	• March 2024	• This is a milestone within the Maternity and Neonatal Improvement Plan due to be presented to Trust Board for approval in September 2023

Friends & Family Test: Recommended

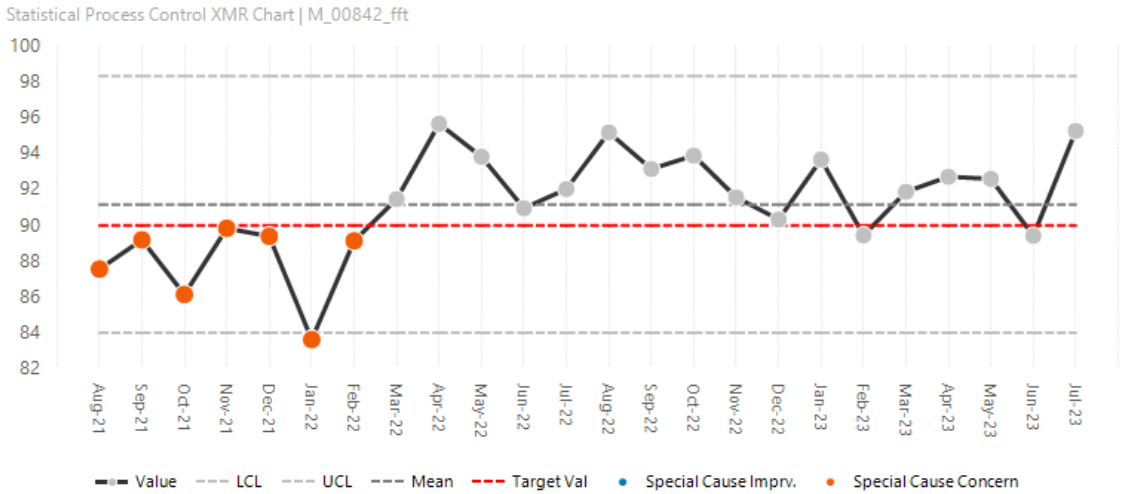
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This metric is a summary of all Maternity Friends & Family responses which indicated that the woman would recommend the Trust's Maternity Services.

FFT Maternity Recommended

Month	Value
Aug-22	95.2%
Sep-22	93.2%
Oct-22	93.9%
Nov-22	91.6%
Dec-22	90.3%
Jan-23	93.7%
Feb-23	89.4%
Mar-23	91.9%
Apr-23	92.7%
May-23	92.6%
Jun-23	89.4%
Jul-23	95.3%



Understand the most recent data point

Variation Type

Common cause (no significant change)(No Special Cause Flags)

Variation indicates inconsistently passing and falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Negative comments include: • Staff attitude - rude/not confident • Communication and information • Delayed analgesia • Building and facilities • Delayed discharge • Long wait to be seen	• Escalate concerns at monthly meeting with Matrons/HOMS/Ward Leads- Next meeting 28/8/23 • Pain Assessment and Management in Maternity Bi-Monthly meetings ongoing • Limitations due to estates. PEM have put forward some suggestions from feedback received about the estates and awaiting estate plans to be agreed and actioned. • Discharge Group set up to look at the processes and identify potential Quality Improvements. Also, discussions around managing expectations and information around discharge.			

Friends & Family Test: Inpatient Recommended

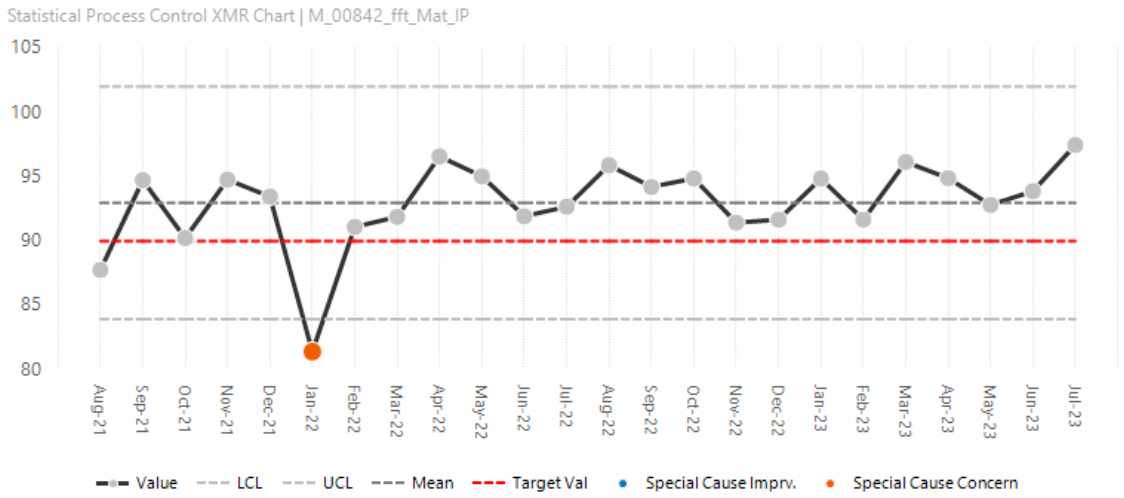
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This metric is a summary of Inpatient Maternity Friends & Family responses which indicated that the woman would recommend the Trust's Maternity Services.

FFT Maternity (IP) Recommended

Month	Value
Aug-22	95.9%
Sep-22	94.2%
Oct-22	94.9%
Nov-22	91.4%
Dec-22	91.7%
Jan-23	94.9%
Feb-23	91.7%
Mar-23	96.2%
Apr-23	94.9%
May-23	92.8%
Jun-23	93.9%
Jul-23	97.5%



Understand the most recent data point

Variation Type

Common cause (no significant change)(No Special Cause Flags)

Variation indicates inconsistently passing and falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Response rates are typically low for FFT therefore only reflect a minority of women, birthing people and their families, and their experiences	• Embedding in discharge process with the introduction of the new post natal discharge process . • Increase awareness via Maternity Voice Partnership • Include in Walking the Patch and standard work for the Discharge coordinators • Explore use of link to QR code	• Liane Ashley	• December 23	• This is a milestone within the Maternity and Neonatal Improvement Plan due to be presented to Trust Board for approval in September 2023

Staff Engagement Score

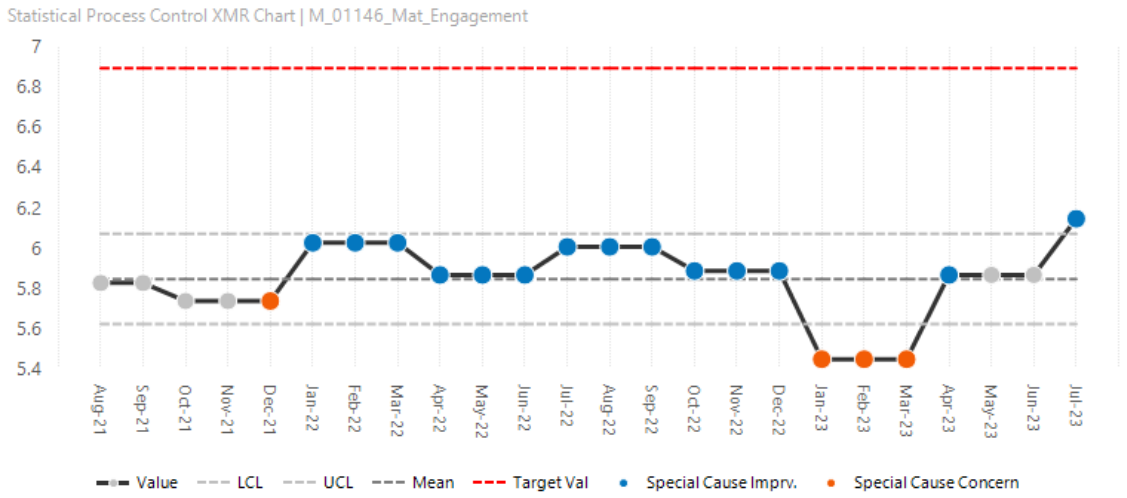
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

National annual staff survey results provided by Picker March each year.
Staff engagement questions added to Staff Friends and Family quarterly surveys commencing March 2021.
9 questions in staff survey and replicated in quarterly staff FFT (3 x motivation, 3 x involvement and 3 x advocacy) which provide the overall engagement score.

Maternity Engagement Score

Month	Value
Aug-22	6.01
Sep-22	6.01
Oct-22	5.89
Nov-22	5.89
Dec-22	5.89
Jan-23	5.45
Feb-23	5.45
Mar-23	5.45
Apr-23	5.87
May-23	5.87
Jun-23	5.87
Jul-23	6.15



Understand the most recent data point

Variation Type
Special cause of improving nature or lower pressure due to higher values(| | Outside Moving Range Limit | Astronomical Point | | |)
Variation indicates consistently falling short of the target

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Opportunities for Staff Engagement	• Introduction of " We Hear You " providing platform for feedback • Embedding Safety Champions Forum • Band specific Meetings /away days • Increase Appraisal rates and SMART objectives • Promoting Freedom to Speak Up Guardians and arrange dedicated walkarounds • Embedding retention conversations • Compassionate attendance at work conversations following absences	• Adaline Smith DDOM	• December 23	

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NHS Foundation Trust

Sept 2023

Reading the Signals Oversight Group Briefing:

A Patient Voice and Involvement Team Overview of Community-Based Engagement on Maternity Services

Contents:

Please contact Adam Littlefield, Lead for Patient Voice and Involvement, with any comments or questions about the contents of this briefing.

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1. Executive Summary

1.1 The Reading the Signals Oversight Group was set up to oversee the Trust's response to the Reading the Signals report (published in October 2022). The Oversight Group includes representatives from patients and families. This Oversight Group supported the establishment of two Community Family Voices meetings in July 2023 to:

- Develop the focus of the Trust's responses, reflecting the issues of importance to families as the organisation transforms its services
- Receive feedback from the Community Families Voices meetings on issues of importance to families

The Oversight Group is responsible for acting on feedback from the Community Family Voices meetings and is accountable to the Trust's Board of Directors.

1.2 Feedback from the Community Family Voices meetings was gathered by the Patient Voice and Involvement Team and Patient Experience Midwives. Assertive outreach was also completed to make sure people from underserved communities had an opportunity to share their experiences. A significant number of separate conversations with families were conducted both before and after the sessions in July with an awareness that many people could not attend the meetings or preferred to share their experiences individually.

- Common themes and areas for improvement within the feedback are:

Pain assessment
Training (for all staff) – specifically on standardised support/advocacy approaches and consent
Discharge
Support for birthing partners
How the Trust shares its actions and improvement plans with the wider community

2. Activity in the Community

2.1 Between March and August 2023, the Patient Voice and Involvement Team (PV&I) has spoken with more than 60 parents, families, carers and stakeholder organisations. This equates to more than one fifth of the Team's resources focussing specifically on maternity feedback. The work is in addition to the hundreds of Your Voice Is Heard calls completed each month by Patient Experience Midwives and the ongoing feedback provided to the Trust by the Maternity and Neonatal Voices Partnership.

2.2 At every intervention PV&I have asked the person if they would prefer to speak with a man or a woman and the time of day and method of communication they would prefer. A minority shared feedback by email, more spoke to us on the telephone or via Teams calls but the majority of interactions were completed face to face and in non-clinical settings like Children's Centres, community events and coffee shops. All engagement was open-ended so the person felt they had time to share their story at a comfortable pace. Feedback from patients and their families on this flexible approach has been unanimously positive.

2.3 The PV&I Team spoke with mothers who had been involved in the Reading the Signals report as well as many who had chosen not to engage at that stage. We also spoke with carers, birthing partners, family members and stakeholder organisations. While we are satisfied that the demographic we engaged with matches that accessing our services in East Kent, it should be noted that underserved communities (including people experiencing deprivation, disability and language and accessibility barriers) often bring the most complex feedback and are the least likely to engage and there is undoubtedly more work to do to hear their voices.

2.4 The Community Family Voices sessions were co-produced with the Maternity and Neonatal Voices Partnership, patients and their families. We agreed to hold an afternoon session in Thanet and an evening session in Canterbury, in community settings. Both sessions had a Mental Health First Aider in attendance and had provision of refreshments and a private room for people who needed to speak in confidence. The sessions were promoted online using a simple visual on social media and through mother and toddler groups and the wider stakeholder network. Attendance at both sessions was low and reasons given by stakeholders for this included:

- A lack of clarity into what the sessions would involve – What is the purpose of the sessions?
- Historic mistrust of NHS engagement events – I have given feedback before and felt disappointed by the process
- Personal priorities and availability of people who were interested – I would have come along but I had to look after my children

As previously mentioned, many parents got in touch as a result of the sessions being promoted and were spoken to individually.

3. Feedback Themes and Actions

Pain assessment **"Instead of being told, you're not in enough pain' I should have been asked if I needed pain relief. Why ask people about their pain and then dismiss it?"** • The Trust already has a working group, led by the Head of Maternity at the William Harvey, to review this area.
Training (for all staff) – specifically on standardised support/advocacy approaches and consent **"My experience could influence staff to think, 'I've done it for 20 years and I've never thought about it like that'"** **"I didn't want to be examined. Care needs to be individualised"** **"They knew more than me during my labour and I only found out afterwards…feedback wasn't clear."** • Patient Experience Midwives are developing training alongside Trust colleagues and the aspiration is to co-produce this and deliver it with people who have lived experience of maternity services to make it impactful and relevant. There has already been work in this area including the Maya's Legacy workbook that was rolled out to staff and patients earlier this year.
Discharge **"If my mum wasn't there pushing (for me to stay on the ward), a lot of things would have been different"** • Improvement work on discharge is underway, led by the Service Development Programme Lead for Women's Health.
Support for birthing partners **"My husband didn't breathe fresh air for 4 days…He wasn't offered any food or drink or shown where to go for it"** **"(As the father) I push (our experience) to the back of my head…Partners are out of the loop at the time. We are in a vulnerable situation – the person we love is in distress. Being offered a cup of tea isn't enough"** • Improvements for birthing partners are being rolled out from drinks and snack boxes to new estate plans for toilets and showers.

Appendix 1 – Detailed Feedback

Pseudo-anonymised transcripts of the feedback we heard will be shared with the Director of Midwifery, Patient Experience Midwives and Maternity Freedom to Speak Up Guardian at EKHUFT and the Maternity and Neonatal Voices Partnership. Some direct quotes are included below for context.

Staff Culture

(NB the majority of respondents were clear that while staff culture was a key area of their feedback, it was not just our maternity staff that they were talking about.)

“I found the other staff more supportive (like the snack lady) – the human came across when she gave me a satsuma. The cleaners were lovely to me too.”

“I felt like they weren’t happy with me….I was told 'you wouldn't want to do anything to upset the drs would you?'”

“When I was made to get up – both staff went ‘ugh’ while my sheets were being changed”

“We expect compassion as well as love – The NHS wasn’t built to provide individual care – it’s different now though – So how can we start to work differently?”

“The Dr said 'we've got bad news', then he laughed about that… The doctors are all like little robots. Nobody should say ‘these things happen’ to someone experiencing loss”…”Starting a sentence with 'I'm really sorry’ doesn't help me at all”.

“The way we are spoken to and the words that are used have a lasting effect - it's a memory that will stay with you forever.”

Positive Feedback

“With our last birth (2020) we had really good support from (Head of midwifery) – they said, ‘tell us what you need and we can make it happen’”

“Everyone was friendly and introduced themselves. I had a wobble during epidural but they stopped everything, the team chatted to me and my partner”

“The permanent staff were lovely – there was a clear difference between permanent and agency”

Suggestions

“Maternity services in Brighton have got a template/preferences card that they ask birthing parents and partners to fill in”

“It would be great to develop something at QEQM for new parents that the community could support like a rail of clothes/boxes of nappies and formula”

“A non-urgent email contact for enquiries would be reassuring”

Patient Experience and Care Plans

“What happened to me was 100% avoidable and 100% irreversible”

“I had to hold equipment for clinical staff”

“I would like to see more done for people who have recurrent miscarriages – it was only because I knew the consultant that I got listened to and I was treated as an individual and given the right support”

“I had a care plan due to a previous vulnerable experience - the care plan made things worse. So now I have I have a phobia of any kind of medical treatment”

Health Inequalities

“(Jehovah’s witnesses) often have a lack of understanding about the treatment options for endometriosis”

“Drug treatment (rehab) for a pregnant mother I was supporting did not support her holistically – people don’t understand the bigger picture”

“I supported a Ukrainian who spoke zero English – she ended up having a Russian translator and she had only just left her home *because of* the war with Russia which was upsetting”

Postnatal

“We need to talk more about loneliness – There is a period of recuperation after birth, it's 40 days in other countries - we could build this in to our thinking…isolation is key here”

“I feel like my trauma counsellor is really keen to avoid blame”

Community

“The community have fatigue from having to constantly repeat the problems…maternity-wise, we need to stay specific. Maternity is an area where most people are well, midwives are the experts but it often seems that they are not able to practice in the way they want”

“Getting contacted by lots of people within the trust is developing a kind of vicarious trauma around my experiences”

Appendix 2 – Building on the Community Family Voices sessions

“I want to feel healed and let the anger out.”

“People need to feel heard and there is nowhere else to go. There are survivors who continue to suffer”

“We need to be able to give responses anonymously. Not everyone wants to hear what’s happened but those that do want to find this information out easily. If no one comes to something we should keep meeting until they trust us”

“I wanted to point out after the report that there is an enormity of things that needed a lot of time to properly understand”

“We need to get everyone on the same page – all the plans in the world won’t happen without the whole system joining up”

- The work being carried out by the Patient Experience Midwives already engages with a significant percentage of parents after they have accessed maternity services. The Maternity and Neonatal Voices Partnership is an established national model for coproduction. Through recent assertive outreach we feel that the Patient Voice and Involvement Team have been able to work with many patients, families and stakeholder organisations who did not engage with either of those workstreams. The below options lay out the perceived positives and negatives about what we do next in this area, based on feedback gathered during our engagement work.

Options to consider for further community engagement around Maternity in East Kent		
No Change	New specific workstream	Combine existing workstreams
• No impact on Trust resources	• A perceived 'fresh start' for improvement work with the potential to state the independence of the workstream • Opportunity to develop a closer relationship with existing community organisations, coproduce and share outcomes • A new platform for communication around improvement work • Option to review current 'reach' of engagement work across the system and co-produce solutions	• The relationships and work already exists and by defining how it links together we would enhance outcomes and visibility of improvement work • Opportunity to develop a closer relationship with existing community organisations, coproduce and share outcomes • Pre-existing communication platforms • Option to review current 'reach' of engagement work across the system and co-produce solutions
• Community perception of a lack of improvements in maternity services and increased mistrust of wider NHS services • No platform for communication around improvement work other than pre-existing channels • No option to assertively engage with underserved communities	• Impact on Trust resources • The system is already complex and has numerous strands (MNVP, Patient Experience Midwives etc.) which this would be added to, potentially complicating things for all stakeholders	• People who mistrust existing systems would still need an opportunity to collaborate and be heard and we would need to clearly illustrate the way this could feel independent for people with lived experience