Reading the Signals Oversight Group

Tue 08 August 2023, 10:00 - 12:00

Conference Room, Education Centre, Kent and Canterbury Hospital

Agenda

10:00 - 10:10
10 min

27. Welcome, Introductions and Apologies

To Note *Claudia Sykes - Chair*

10:10 - 10:15
5 min

28. Minutes from the last meeting held on the 20th June 2023

Approval *Claudia Sykes - Chair*

- 23-028 Draft Reading the Signals Oversight Group 20th June Minutes v3 (003).pdf (6 pages)

10:15 - 10:20
5 min

29. Matters Arising from the Minutes

Discussion *Claudia Sykes - Chair*

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

10:20 - 10:35
15 min

30. Updated Reports and Metrics

Discussion *Ben Stevens - Chief Strategy and Partnerships Officer*

Verbal Update

10:35 - 11:00
25 min

31. Maternity Services Update

Discussion *Michelle Cudjoe - Director of Midwifery*

- 23-031.1 Project Highlight Report - Key Action Area 1.pdf (1 pages)
- 23-031.2 Project Highlight Report - Key Action Area 2.pdf (1 pages)
- 23-031.3 Project Highlight Report - Key Action Area 3.pdf (1 pages)
- 23-031.4 Project Highlight Report - Key Action Area 4.pdf (1 pages)
- 23-031.5 MNIP Charters.pdf (15 pages)
- 23-31.6.1 - July Scorecard Front sheet.pdf (3 pages)
- 23-31.6.2 - Maternity_Dashboard_Jul23_MNAG (1).pdf (34 pages)

11:00 - 11:20
20 min

32. Your Voice is Heard - First Year Feedback

Discussion *Michelle Cudjoe - Director of Midwifery*

- 23-032 Safety Summit YVIH report July V3.pdf (14 pages)

11:20 - 11:35
15 min

33. Government Response to Reading the Signals

Discussion *Ben Stevens - Chief Strategy and Partnerships Officer and Natalie Yost - Executive Director of Communications and Engagement*

- 23-033 Government report to Reading the Signals - July 2023.pdf (5 pages)

11:35 - 11:45
10 min

34. Community Voices Update

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

Verbal Update

11:45 - 11:55
10 min

35. Terms of Reference

Information *Claudia Sykes - Chair*

23-035 Terms of Reference v5 FINAL .pdf (3 pages)

11:55 - 12:00
5 min

36. Any Other Business

Discussion *Claudia Sykes - Chair*

Date of Next Meeting - 31st October 2023

UNCONFIRMED MINUTES OF THE READING THE SIGNALS OVERSIGHT MEETING TUESDAY 20 JUNE 2023- BOARDROOM KENT AND CANTERBURY HOSPITAL AND VIA WEBEX TELECONFERENCE

PRESENT

Claudia Sykes	Non-Executive Director (Chair)	CS
Tracey Fletcher	Chief Executive Officer	TF
Rebecca Martin	Chief Medical Officer	RM
Ben Stevens	Director of Strategic Implementation and Partnerships	BS
Andrea Ashman	Chief People Officer	AA
Derek Richford	Family Representative	DR
Tania Linehan	Family Representative	TL
Phil Linehan	Family Representative	PL
Helen Gittos	Family Representative	HG
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
Sarah Hubbard	Family Representative	SH
Linda Dempster	Family representative	LD

IN ATTENDANCE

Lucy Coglan	Council of Governors Support Secretary (notes)	LC
Michelle Cudjoe	Director of Midwifery	MC
Julie Yanni	Deputy Chief Nursing Officer	JY

AGENDA ITEM NO		ACTION
23/017	**WELCOME AND INTRODUCTIONS AND APOLOGIES** CS welcomed attendees to the meeting and introductions to new members were made. Apologies were received from: Jackie Huddlestone, Locality Director Kent and Medway; Kaye Wilson, Regional Chief Midwife; Raymond Anakwe, Non-Executive Director; Jane Dickson, Interim Chief Nursing Officer Ben Stevens notified the group that Eileen Sills, Chief Nurse for the Kent and Medway ICB, had left her role.	
23/018	**MINUTES FROM THE LAST MEETING HELD ON THE 3RD APRIL 2023** Minutes from the last meeting were **APPROVED.**	
23/019	**MATTERS ARISING FROM THE MINUTES** **23/013 - Revised Draft Terms of Reference** - Update 20/06/23 - The Chair informed the ToR had been taken to Board and were AGREED. LC to circulate final version to all attendees on this group - **ACTION** 23/016 - **FW and NY to review the comms and engagement strategy and bring back to this group** - Update 7th June 2023 - Deferred to August meeting - **Update 20/06** - NY informed this action was around the family voices community sessions and the plan needed around this. The Trusts comms and engagement	

strategy had been updated following the publication of Reading the Signals, and the Pillars of Change was incorporated within this. There needed to be a more bespoke plan around this meeting. PL felt the focus on this group needed to provide oversight and what went wrong and how to put those wrongs right. PL also felt the originals pillars did not outline what the group needed to do. The ToR did not provide an outcome, and an outcome was not being sought. This group needed to see what the comments from the Board were before signing off. DR commented he felt there was not enough scrutiny being done within this group and nothing had really been achieved so far. The Chair agreed with this and commented she would push to ensure more reports were brought to these meetings for the group to look at in order to provide feedback. PL suggested the second meeting after this one should be around lessons learnt. The families had asked that this group set-up some quick solutions and see the evidence these had been implemented. NY felt that writing a comms strategy would not be beneficial and suggested a highlight report on what the Trust were doing to be brought back to this meeting instead. NY to circulate the current comms and engagement strategy to this group - **ACTION**

23/015 - Pillars of Change - Update 20/06 - This action would be addressed later on the meeting.

23/020 **EAST KENT HOSPITALS – STAFFING CHANGES UPDATE**

TF informed the group of the following staffing changes:

- Fiona Wise had stepped down from supporting the oversight group and the Trust, although she will retain oversight on the clinical review process until the end of July 2023. BS would pick up the more direct work through his role
- Michelle Cudjoe had joined as the New Director of Midwifery, and Adeline Smith as the Deputy Director of Midwifery - both had come from the Surrey and Sussex Trust
- Jane Dickson would continue in her role as Chief Nursing and Midwifery Officer (CNMO) until Sarah Hayes - the substantive CNMO, started, which was expected to be mid-September 2023

23/021 **CQC JANUARY INSPECTION**

TF informed the Trust had accepted the report by the CQC after their January visit. Following the visit, there had been a series of monitoring requirements put into place, which had been requested by the CQC and instigated by the team internally. In advance of the report being published in May, the CQC had stepped down their requirements for monitoring as the position had been reached where the improvement was demonstrated as being where it needed to be. However, the internal monitoring that had been implemented continued. The team had picked up the aspects which had caused concerns to the CQC and what needed to happen - this was positive. The focus now needed to be continuing to work on the elements/requirements that were outlined by the CQC.

PL expressed concerns around a public interview that was held by the BBC with the Trust's Chair. He highlighted that a remark had been made around hand washing which was not acceptable and had affected his faith in the Chair. TF commented she had not seen the interview, however, she felt both herself and the Chair were aligned in what needed to be done. NY confirmed the comment on handwashing had been made by the Chair but she felt it was not meant how it had come across. DR highlighted a comment he had made in the previous meeting around the Trust not using comments such as 'it happens in other trusts' as this

was not about other trusts, it was East Kent that needed to improve. AR commented that he had heard the Chair speak on many other occasions about improvements needed at the Trust, and what was being referred to did not reflect the Chair's views or attitude. CS said this would be picked up with the Chair outside of this meeting - ACTION.

LD was shocked by the CQC report as the items picked up should have been picked up by the leadership team on a daily basis. Things would not be 100% of all of the time, but how it was dealt with at the time is what was important - TF commented that this was about changing the culture at the Trust, not just in maternity services.

23/022 **MATERNITY SERVICES AND IMPROVEMENT UPDATE**

022.1 MATERNITY SERVICES UPDATE

MC provided an update and explained she had joined the Trust 30 days ago and had previously been the Director of Midwifery at Surrey and Sussex NHS Trust. Coming into the role MC's approach had been around observations of practice (this included, attending ward rounds, handovers and the observations of; clinical practice, interactions with women and families and environment, speaking with staff and speaking with families) and identifying areas of improvement. MC agreed certain things needed to be moved at pace, and there had been some things within the care group that had been implemented immediately. The team had been very welcoming with staff wanting to improve, which had made the implementation of change much easier. There had been commitment and support from executive colleagues around some issues. Prior to MC starting the role, there had been an implementation of a process for monitoring audits, which included 'stop the clock' - which was a weekly review meeting, and a result of this, monitoring compliance had been seen to improve. Quality meetings had been implemented, whereby all the midwifery team were brought together on a monthly basis, with clinical practice being reviewed and audits that were undertaken. Any immediate actions were looked at and were then being re-aligned to quality improvement. Learning lessons was also being looked at and how these messages were getting out to key staff. A safety champions forum had also been implemented with the first one due to be held on Friday 23rd June 2023 where concerns could be raised immediately. This would give the opportunity for messages to be shared amongst the team. Key issues that MC felt needed to be moved at pace had been discussed with the executive team, this included the location of the bereavement suite at WHH and the midwifery led unit (MLU). These changes would allow more space for triage, and the medication area on the Folkestone Ward at the WHH was also another area that was discussed. Full support was given by the exec team and plans were being discussed. There was also a backlog of Serious Incidents which had initially been cleared, but due to staffing challenges there were more to be actioned to avoid another backlog. This was being closely monitored. Another issue was the engagement around the maternity improvement programme. To improve the maternity service, it needed to be co-designed with women and families. A meeting was due to be held, whereby a variety of stakeholders - internal and external to the organisation and service users would be invited. A system had been implemented called 'Walking the Patch' whereby senior members of staff were present in the maternity areas and were engaging with mothers and families. There was also another 'don't take your troubles home' approach that had been implemented where a member of the senior team could be contacted at any time to listen and address any issues. MC felt it was important to continue monitoring what was happening within maternity on a daily basis and women and families were being responded to as quickly as possible.

HG commented the Maternity Transformation Plan is something that needed to involve staff and engagement with staff, as well as service users and asked what the views were to ensure this was something being generated by the hospital with staff. MC commented that the maternity transformation programme had been paused so that this engagement could be carried out, and representatives from

each band group of staff were invited to attend meetings to ensure staff voices were heard. MC agreed to present the Maternity Transformation Plan to the next oversight group – **ACTION**.

HG asked how doctors were involved in the programme, and how would it be ensured that team working was on the forefront. MC responded Dr Zoe Woodward was the Clinical Director and they were both working side by side and there would be neonatologists as well as obstetricians involved in the Quality Board meetings to ensure they were involved in decision making.

ARi asked if there was CQC-like reporting where someone reports on the behaviour being seen rather than individuals reporting on their own. MC responded that both she and her deputy had clinical time allocated every day where there was a process aligned to the CQC process and this was then discussed at the Quality Board meeting with senior leadership teams. Observations were also taking place at night.

LDP commented it was important patient-facing staff were also listening to the feedback from Your Voice is Heard and hearing where the problems lay. CS asked MC if there was a plan to put the feedback together from Your Voice is Heard and analysing themes/trends and what had changed as a result of this. MC commented that the team were working on an annual report for the Your Voice is Heard. The report was expected to be complete by the end of July 2023 and will be brought back to this meeting in August - **ACTION**
MC also commented the feedback was being shared within the care group at all forums. The team were trying to move towards obtaining consent from parents to have their stories digitalised so their stories can be shared.

HG suggested Dr Zoe Woodward to be invited to this meeting - CS agreed - **ACTION**

RM commented the Director of Midwifery or Obstetric consultant were not on the ToR for this meeting – agreed to update the ToR for this - **ACTION**. RM also advised the group that it was a requirement for all obstetricians to process and reflect in their appraisals this year on the Reading the Signals findings. This was welcomed by the group.

022.2 PILLARS OF CHANGE AND IMPROVEMENT UPDATE

BS talked through the metrics and explained the report presented was based on the first 6 months of actions. The actions were mostly green and this was because they were input actions which had been completed. The overall Pillars of Change programme was for 3 years. Some of the deep-rooted cultural changes would take approximately 3 years to embed.

Several comments were made on this update:

- Pillars were undated so was unclear when the 6 months started. BS explained that the time period was from December 2022 to May 2023.
- Some of the actions had progress stating things had been done, however, there was no evidence to support this. The group wanted to see the evidence supporting the statements of progress.
- There were actions within the pillars that did not align with the dashboard (for example; complaints highlighted green in pillars, but red in dashboard)
- Maternity FFT - metrics were based on only 5% responding with response rate at 97%. MC explained that this was because women interacted over many months with the service, but would only be captured once hence the low target for the FFT test – the group asked for the target to be checked against other Trusts - **ACTION**
- Around SIs and incidents on the dashboard it stated SIGMA and it was unclear on what this meant as there was no explanation around the narrative.

CS noted that some of these comments had also been picked up at the recent Board of Directors meeting and there was an action from this to explain the context and narrative, along with adding more metrics and evidence. The reports needed to be clear to show the progress the Trust was making, with evidence, and where improvements were still needed.

TF commented the Trust needed to find ways of presenting the progress being made and the frequency of reporting action plans and what would be the measurable metrics.

BS added that the Trust produced a lot of reports, with evidence, so it would be very helpful to clarify to what reporting needed to be brought back to this group.

HG felt there needed to be re-assurance that the data was recorded correctly. This was a simple message from Reading the Signals, that there had been false assurance in the past.

SH commented it was important for there to be openness, honesty and transparency about the wins and the challenges as this would help mothers and families to see progress was being made. Work would be required around the jargon being used in reports to make it understandable for those who were not clinicians.

LDP commented that she was concerned by the number of mothers having induced births, the figure she had seen was 33%. She felt this reflected a lack of choice and support being given to mothers in where and how they gave birth.

PL highlighted a comment by CS whereby the metrics dashboard was seen and questioned at the June Board of Directors meeting, however it was still given sign off - PL asked if the questions raised would be seen when the signed-off version was shared. CS responded the Pillars of Change update report had been reviewed at the public Board and the feedback given by Board members was around the number of greens – which could be misleading as there was still a lot of work to be done; more metrics were needed and how was evidence and progress shown around this. The overall Pillars of Change plan had been signed off by the Board previously, however, how the progress was measured against those were what was being discussed at the Board. PL had some points that he would send to CS as they may need to be looked at as one was around measurables.

TF apologised for the language not being right within the reports. The Trust needed to be clear about what was being measured and what was done. This was a journey about building confidence and trust.

CS commented a lot of feedback had been received during this meeting around the metrics, which was very helpful, however, what reporting would the group like to view for the next meeting so the same discussions were not being had. DR responded the first thing that was needed was to translate the report as all the information they need may be in there but it was not understood. BS commented he needed to distil the information into something meaningful for this group. Feedback was needed around what family representatives would want to see. RM commented there would be metrics that were ongoing, but there would also be things the Trust had already done, both needed to be shared.
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- **ACTION** and for any feedback to be sent to BS ahead of the next meeting.

HG commented that she had read all the recent Board papers, and there was a lot in there which was informative about the Trust's actions. She suggested the papers seen at Board could be seen within this group, along with a simpler version if needed. HG also commented about serious incidents (SIs) - the Trust had occasionally been the worst in the country for downgrading SIs in their seriousness and would like assurance this was now not the case. MC suggested bringing the minimum data-set metrics that were seen at Board to this meeting - ACTION

TL commented about the measurements around patients' feedback on whether they had a good or bad experience - how much was this measurement considered when the patients' do not have much choice in their care, especially when they were considered high risk. Some patients might consider they had a good outcome because they went home with a healthy baby. She asked how these views would be captured. CS commented that it could be difficult to capture the experiences of every individual with the current surveys and tools the Trust had, but this was something they could look at. BS agreed that the Trust was not ignoring the people who had not given feedback or taken part; or the people who were dissatisfied with the Trust's services – the Trust was looking at the 10% of mothers who had responded to the Your Voice is Heard survey and not had a good experience; these all needed to be followed up, and more work to ensure the Trust knew of any issues and followed these up. There was a lot to do, Your Voice is Heard was just the start, but the Trust had not even been doing this before.

23/023 **STAFF ENGAGEMENT UPDATE**

To be covered in Maternity Transformation plan at the next meeting.

23/024 **COMMUNITY FAMILY VOICES**

Deferred to next meeting.

Date of Next Meeting – Tuesday 8th August 2023 in the Conference Room, Kent & Canterbury Hospital/WebEx

SIGNED: _____

DATED: _____

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

09.05.2023	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	20.06.2023	FW	Open	Update 20.06 - The ToR have been agreed at Board, and were a work in progress. Update for August meeting - ToR approved by the Board 1st June 2023, however it is noted that this is likely to be updated at the committee review point in October, when the committee membership and reporting is more established. This also needs to consider the outcomes being monitored by the committee. Directory of Midwifery and Obs & Gynae consultant now included Updated ToR included in August meeting for information.
09.05.2023	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	20.06.2023	NY/AL	Open	Update 7th June 2023 - Deferred to August meeting Update 20/06 - NY informed this was around the family voices community sessions and a plan was needed around this and around this work. NY to circulate the comms and engagement strategy to the group - Update for August meeting - The link to this strategy would be circulated with the papers
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.
20.06.2023	23/022.1	Maternity Services Update	Dr Zoe Woodward to be invited to this meeting	08.08.2023	LC	Open	Update 17/07/2023 - Dr Woodward has been invited to the August and September meeting
20.06.2023	23/022.2	Pillars of Change Update	The 5% FFT maternity response rate compared against other trusts needed to be clarified	08.08.2023	CS	Open	
20/06/2023`	23/022.2	Pillars of Change Update	What reporting needed to be brought back to this meeting needed to be clarified	08.08.2023	BS	Open	
20/06/2023`	23/022.2	Pillars of Change Update	BS to email the group explaining the metric jargon	08.08.2023	BS	Open	
20.06.2023	23/024	Community Family Voices	Deferred - an update to be brought back to the August meeting	08.08.2023	AL	Open	On August agenda

Maternity and Neonatal Improvement Programme

Project Highlight Report

Key Action Area 1 - Monitoring safe performance – finding signals among noise

Workstream 4: Governance, Risk and Compliance

NHS East Kent Hospitals University NHS Foundation Trust Maternity Services

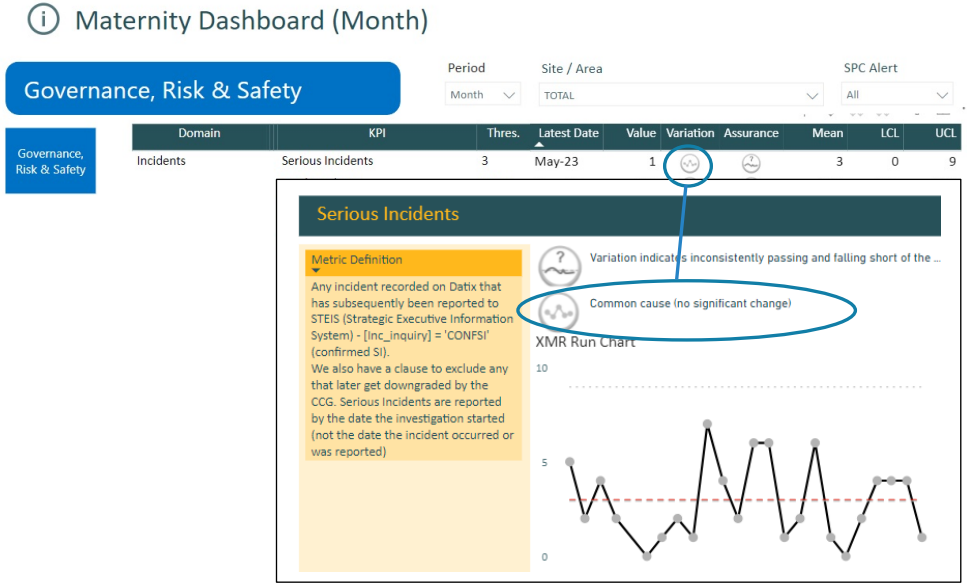
Section 1: Project Summary

Report date	30 June 2023	Report Author	Michelle Cudjoe, Director of Midwifery
Project Start date	31.10.2022	Project End date	End date detailed in detailed action plan
Current Project Status	On track	Previous Project Status	On track

Section 2: Project progress summary

Requirement 1: Generate measures that are meaningful, risk adjustable, available and timely / **Requirement 2:** Analyse and present these measures through statistical process charts and / or funnel plots

There is already an array of data garnered from across Maternity services and activities; this includes key patient safety, and clinical performance measures. In addition, the Service has converted its maternity data into statistical process charts, as required. The images below are snapshots of the new Maternity Dashboard:



Between September 2022 and March 2023 there were 0 Serious Incident cases meeting the threshold criteria for HSIB referral. In April and May 2023, this increased to 1 case in each month. Because these referrals broke a trend of 0 cases the SPC highlights this as an inconsistency so prompts exploration of the cause

Section 3: Key risks and issues (potential problems) for this reporting period

- Patient safety related activity backlogs have decreased over recent months; plans are in development to clear the backlogs and sustain service provision within mandated timeframes.
- Governance, Risk and Compliance is also one of the workstreams within the new Maternity and Neonatal Improvement Programme

Section 4: Work to complete for next reporting period

- Continue to reduce the patient safety related activity backlogs
- Clearly identify the link between data and areas of improvement
- Include national benchmarks to local scorecard metrics

Section 5: Change requests (time, cost, scope, risk, benefit, quality)

- The original closure date for all backlogs was May 2023; this was on target until the recent repeated increase. This has been escalated to the Strategic Improvement Committee, which has oversight of the Trust Integrated Improvement Plan (IIP)

Maternity and Neonatal Improvement Programme

Project Highlight Report

Key action area 2 – Standards of clinical behaviour – technical care is not enough

Workstream 1: People & Culture

NHS East Kent Hospitals University NHS Foundation Trust Maternity Services

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Section 2: Project progress summary

Activities completed towards the improvement of clinical behaviours, as part of the new Maternity and Neonatal Improvement Programme [formerly the Maternity Improvement Plan (MIP)], and required of the Trust's Integrated Improvement Plan, include:

2021/22

- Women's Health pilot of the NHSI Culture and Leadership Programme (CLP) - 2021/22

2022/23

- Leadership 'Connector' training – 2022/23
- Launch of 'Compassionate Customer Service' eLearning
- Publication of Trust Resolution Policy and supporting toolkit
- Staff listening forums facilitated by Interim Director of Midwifery

2023/24

- Reiteration of Trust Values
- Service user feedback: Walking the patch, 'Leave your troubles at the door' initiative, Your Voice is Heard (YVIH) 6-week feedback service, Friends and Family Test (FFT), identification of themes from complaints
- Launch of a new 'Safety Summit' to share key learning with staff
- Linking information from complaints and feedback to the Training Needs Analysis (TNA) and training plan
- Bereavement project group and redevelopment of care pathway
- Development of Principles within the new maternity improvement programme includes 'Active and responsive listening to families and staff'
- Multidisciplinary 'Civility Saves Lives' sessions
- Multidisciplinary review of maternity improvement workstreams
- MNIP Engagement (Coproduction) Away Day

Section 3: Key risks and issues (potential problems) for this reporting period

- None to report

Section 4: Work to complete for next reporting period

- Annual training programme to include a session on dignity and respect
- Recording Triage calls for training and monitoring purposes
- Women's Health senior quartet Perinatal Culture and Leadership training that will include an assessment of the current culture
- Roll-out of 'Compassionate Customer Service' eLearning
- Exploration of military-based 'Frontier Leadership' model / framework

Section 5: Change requests (time, cost, scope, risk, benefit, quality)

- None to report

Maternity and Neonatal Improvement Programme

Project Highlight Report

Key action area 3 – Flawed team working – pulling in different directions

Workstream 1: People & Culture
Workstream 2: Workforce Sustainability
Workstream 3: Clinical Pathways
Workstream 6: Engagement

NHS East Kent Hospitals University NHS Foundation Trust Maternity Services

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Section 2: Project progress summary

2022/23

- Review and reiteration of roles and responsibilities with job descriptions
- Refresh of the Maternity Escalation Policy and MOPEL levels and subsequent roles and responsibilities
- Cross-site daily safety huddles
- Site-based daily safety huddles
- Multidisciplinary training including skills drills and PROMPT

2023/24

- Multidisciplinary coproduction of the new Maternity and Neonatal Improvement Programme, with defined roles and responsibilities for areas of improvement including clinical pathways
- Recognition within the new improvement programme of the need for 'staff who work together, train together' – plans to be further developed
- NHSE-led demand and capacity review of obstetric workforce
- Clinical guidelines review and alignment to national guidance
- Midwifery representation on ward rounds
- 'Lunch and Learn' sessions
- Quad Perinatal Culture Development underway

Section 3: Key risks and issues (potential problems) for this reporting period

- Recruitment of consultant midwife to lead on care outside of clinical guidance / pathways
- Making time available for essential joint clinical simulations
- Capacity across partner services for joint training e.g. anaesthetics

Section 4: Work to complete for next reporting period

- SCORE survey planned
- Developing guidelines for women who request care outside of clinical guidance / pathways

Section 5: Change requests (time, cost, scope, risk, benefit, quality)

- None to report

Maternity and Neonatal Improvement Programme

Project Highlight Report

Key action area 4 – Organisational behaviour - looking good whilst doing badly

Workstream 1: People & Culture
Workstream 2: Workforce Sustainability
Workstream 4: Governance, Risk and Compliance
Workstream 6: Engagement

NHS East Kent Hospitals University NHS Foundation Trust Maternity Services

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Section 2: Project progress summary

2021/22

- Appointment of NHSI Maternity Improvement Advisors
- Maternity Safety Support Programme (MSSP)

2022/23

- Review of existing Maternity governance systems and processes and development of supporting plan for improved systems of control, including the application of the Duty of Candour procedure
- Review of the tone and language within complaints response letters
- Maternity and Neonatal Safety Champions roles embedded, including Board-level Champions
- Dedicated Maternity Freedom to Speak Up Guardian (FTSUG)

2023/24

- Collaboration with Trust corporate Risk department to plan for the implementation of the Patient Safety Incident Response Framework (PSIRF)
- Oversight from external stakeholders e.g. every PMRT has independent reviewer, full implementation of Perinatal Quality Surveillance Model (PQSM) using the Perinatal Quality Surveillance Tool (PQST) that enables oversight at departmental, Board and regional levels
- Process for all Duty of Candour letters reviewed - signed off by Director of Midwifery (DoM) or Deputy Director of Midwifery (DDoM)
- Openness and transparency in external messaging e.g. scanning waitlists
- Work with Trust Communications team on sharing issues (as well as progress) externally via public platforms / media
- Joint working with external partners e.g. Healthcare Safety Investigation Branch (HSIB)
- Representation of Maternity on Trust Board
- Monthly communication and assurance reviews with regulators
- Initial Safety Champions summit held 23 June 23 – ward to board reporting
- 'We Hear You' platform for staff to raise concerns
- Increased service user involvement in all key forums, policy development and improvement workstreams

Section 3: Key risks and issues (potential problems) for this reporting period

- None to report
- User's experience of the legal local legal services

Section 4: Work to complete for next reporting period

- Reach out to women and families wishing to share their views
- Detailed benchmarking by new Maternity senior leadership team against Reading the Signals as part of MNIP development; identified learning to be shared at the Maternity Safety Summit
- 'Walking the patch' and 15-Steps with service users
- Snapshot audit of MBBRACE reports

Section 5: Change requests (time, cost, scope, risk, benefit, quality)

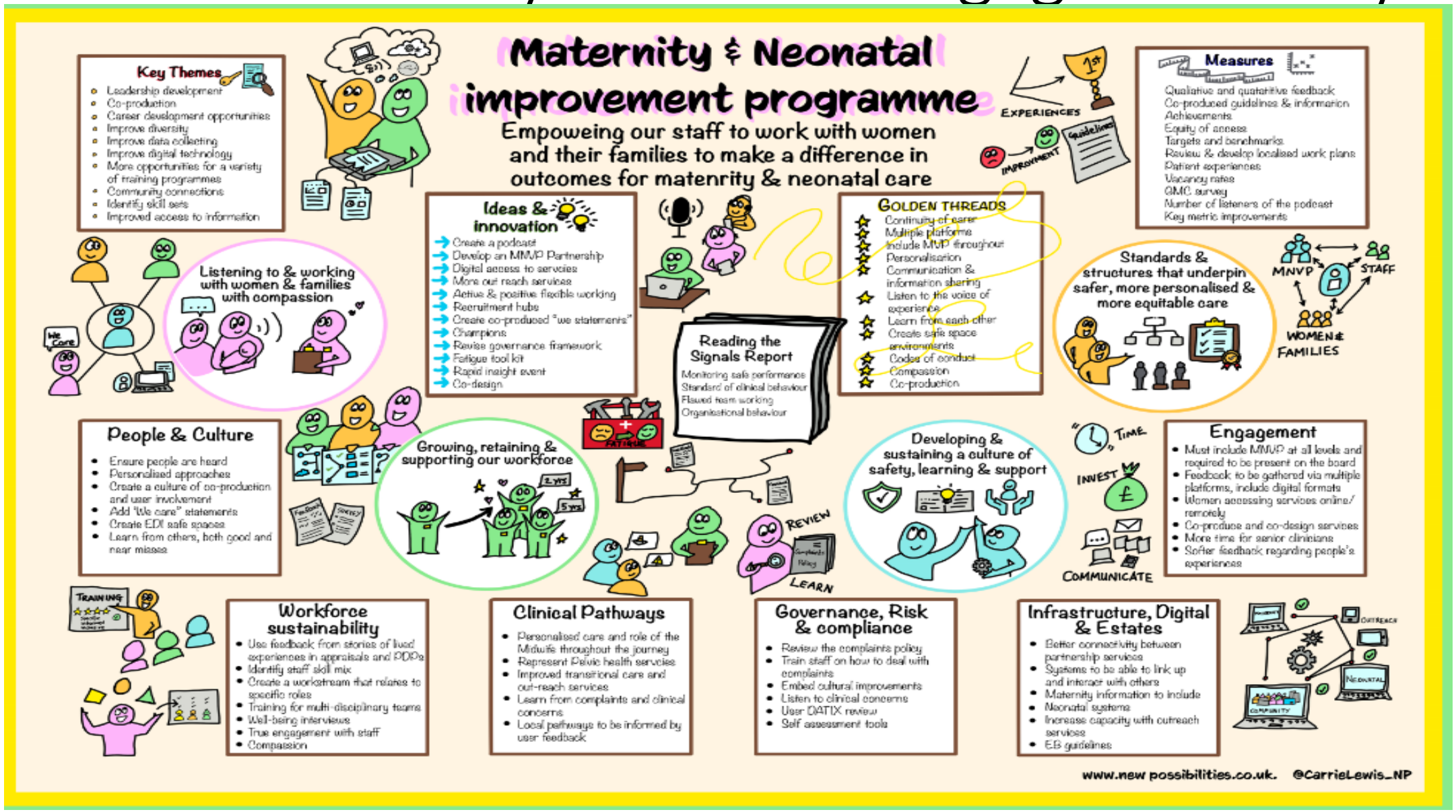
- None to report

Maternity and Neonatal Improvement Programme July 2023

Michelle Cudjoe

DOM

MNIP - Visual Synthesis of engagement day



List of improvement workstreams

6 workstreams aligned to the Single Delivery Plan for maternity services

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

Engagement Timeline

- ‘We hear you’ engagement day 28th June 2023 (internal and external stakeholders including MNVP/families)
- Workstream charters amended to include feedback – DoM, DDoM, CD and Project Lead
- Elements of workstream charters relevant to RTS recommendations shared with RTS family 26th July - feedback received
- Amended charters reviewed by MIA and shared with ICB/Regional Midwifery lead and MNVP chair for feedback on 28th July 2023
- Charters to be shared with RTS oversight group 8th August 2023
- Charters to be presented to MNAG on 8th August 2023
- Presentation to BoD September

Maternity and Neonatal Improvement Programme

Workstream 1: Developing a Positive Culture

Objective: To build an inclusive culture where staff feel safe, valued, listened to and supported to deliver kind and compassionate, person-centred care

Associated Document: Reading the Signals, October 2022 – Dr Bill Kirkup CBE

NHS East Kent Hospitals University NHS Foundation Trust Maternity Services

High-level Milestones What?	Timeframes When?	Outcomes (objectives/improvements) Why?	Outputs (deliverables) How?	Measurable Benefits (results) Our achievements will show through…
❖ Delivery of NHSI Culture and Leadership Programme (CLP) ❖ Delivery of Trust-level leadership development programme for those recruited into leadership posts	March 2025 *(Aligned to Trust Pillars of Change and timeframes)*	The workforce provides care with professionalism, kindness, compassion and respect whilst feeling listened to by an inclusive leadership team There are opportunities for routine welfare checks across the workforce to support and maintain a culture of consideration of others, and their mental wellbeing Service users feel they receive professional, kind, compassionate, inclusive, personalised care and support The workforce and managers alike are in receipt of, and provide, personalised leadership that consistently exhibits the Trust values and behaviours	A programme based on nationally recognised workforce culture assessment tools / frameworks e.g. NHSI CLP Perinatal Quality Leadership Programme for Care Group Quad Alignment to Royal College of Obstetricians & Gynaecologists (RCOG) Leadership and Management Framework Use of acquired skills and learning to demonstrate compassionate leadership and nourish a safe working environment Improved capacity of resources to deliver services due to improved workforce morale Implementation of the Trust-level Leadership Behaviours Framework once published linked to a re-launch of the Trust values Wider workforce opportunities through statutory and mandatory training programme to include values and behaviours of leaders across the service Embedded process and practice for managing behaviours that do not meet Trust values	• Register of Change Managers appointed through NHSI Culture and Leadership Programme (CLP) and outputs from their programme of work • Perinatal Quality Leadership Programme completion • Yearly upward trends in NHS Staff Survey / Quarterly Pulse Survey results • CQC Maternity Survey results for patient experience aligned to national scores • Downward trend in complaints/concerns about poor staff attitude, communication, and people not feeling listened to • 85% service users feel listened to and their questions answered • 85% completion of the B7 Connected training by the midwifery leadership/management workforce • 85% attendance of the senior medical workforce or doctors in leadership roles on the Trust Leadership Development Programme • NHS Staff survey re: Bullying and Harassment, and poor behaviours

❖ Implementation of Inclusion and Respect Charter	August 2024	There are clearly defined standards of behaviours that set out expectations for all interactions throughout the maternity journey and neonatal care	Cohesive team working and safe spaces based on common goals, and a shared understanding of the individual and unique contribution of each team member
			Alignment to Trust-level Inclusion and Respect Charter once published
			Values-based recruitment and achievement reviews inclusive of requirements for demonstrable adherence to Trust Values
				• Improved trajectory for NHS Staff Survey:
				  ▪ People Promise 1 – we are compassionate and inclusive
				  ▪ People Promise 3 – we have a voice that counts

❖ Structured escalation processes for raising concerns for the workforce and service users outside of clinical situations* *Clinical escalation in Workstream3	March 2025	There are development opportunities for the multi-professional workforce to be involved with and support a culture of safety Service users increasingly feel that their concerns will be heard and acted upon	Freedom to Speak Up (FTSU) Guardians listen to, act upon and respond openly and effectively to concerns Workforce access to FTSU training Clear, available and accessible processes of escalation for the workforce and service users Visible leadership and presence in the clinical setting	• Your Voice is Heard (YVIH): 90% women feel listened to • FTSU report routinely presented to Maternity and Neonatal Assurance Group (MNAG): case figures, themes, escalation and resolution • FTSU training completion rates • Full implementation of Maternity Safety Champions
❖ Completion of the SCORE survey	May 2024	A clear understanding of the current culture in the maternity service	Identified areas for quality improvement through gap analysis of SCORE results	• SCORE Survey Results • Identified improvements against previous survey

❖ Achievement of UNICEF Baby Friendly Initiative (BFI) accreditation for infant feeding	March 2027* (national timeframe goes beyond the duration of this programme)	A workforce supported to provide sensitive and effective care so that service users can make informed choices about feeding, and overcoming challenges to enable successful breastfeeding when this is the preferred option	Alignment to the UNICEF BFI guides and standards and implementation of tools, forms and eLearning Promotion of the infant feeding specialist teams across maternity and neonatal services, and development of a project plan to prepare the service for implementation	• Maternity and neonatal service accreditation with UNICEF BFI • Infant feeding dashboard metrics

❖ Implementation of escalation pathways for service users and members of the workforce to raise patient safety concerns	December 2023	Clear pathways for clinical escalation identify roles and responsibilities and actions to take based on the need / acuity of emerging emergency situations
		
		Service users and the workforce are empowered to, and are cared for/work within the right culture, behaviours and conditions that enable effective clinical escalation when they identify concerns, deterioration or a potential mistake
		
		Service users are witness to respectful and conducive conversations that provide reassurance and better understandings of their own situation
			Embedded use of the Maternity Escalation Policy and use of MOPEL action cards
			
			Implementation of structured escalation framework e.g. Each Baby Counts: Learn and Support Escalation Toolkit
			
			Standardise a daily cross-site multi-professional safety huddle every day to identify any concerns/issues anticipated that day
			
			Staff and service users report feeling listened to
				• Introduction of scheduled 'Escalation surveys':
				  • Do you know everyone on your shift today?
				  • Do you know who you're going to escalate concerns to during the shift?
				  • Have you said thank you to a colleague?
				  • Have you celebrated your successes together?
				  • Have you made sure your colleagues are okay at the beginning and end of each shift?
				• Reduced adverse outcomes from serious incidents
				• Alignment to NHS Staff Survey national average scores for:
				  • People Promise 3 – we have a voice that counts (5.6 v 6.6)
				• 85% YVIH metric services users 'felt listened to'
				• Compliance checks against SITREP template

❖ Implementation of NHS South East Clinical Delivery and Networks Maternity and Neonatal Co-Production Resource Pack		Embedded coproduction into the culture and practice of maternity services to ensure that pathways and patient information are robustly developed to reflect and be responsive to local need	Use of NHS South East Co-production tool(s) when mapping out clinical pathway development needs to inform the content of supporting project plans	• Use of the coproduction tool as part of clinical pathway development approach/plans within the Maternity and Neonatal Improvement Programme (MNIP)
				• Improved service user feedback re: involvement in local redesign of maternity and neonatal services e.g.
				  • Maternity and Neonatal Voices Partnership (MNVP) Feedback Log
				  • Formal compliments
				  • MNIP Feedback processes

Maternity and Neonatal Improvement Programme

Workstream 2: Developing and sustaining a culture of safety, learning and support

Objective: To embed robust governance structures that underpin continuous improvement and delivery of high quality, person-centred care

Associated Document: Reading the Signals, October 2022 – Dr Bill Kirkup CBE

NHS
East Kent Hospitals University NHS Foundation Trust
Maternity Services

High-level Milestones What?	**Timeframes** When?	**Outcomes (objectives/improvements)** Why?	**Outputs (deliverables)** How?	**Measurable Benefits (results)** Our achievements will show through…
❖ Clear patient-safety related backlogs	December 2023	Incidents, Serious Incidents (SIs), complaints, guidelines, and patient information leaflets reflect current regulatory requirements and best practice	There is a clear process for review of patient-safety related activity and documentation to ensure that documents and processes are updated prior to deadlines and expiry dates becoming overdue	• No. overdue 'open' incidents • No. overdue 'open' serious incidents • No. overdue 'open' complaints responses • No. expired guidelines • No. expired patient information leaflets
❖ Achievement of local safety measures to support national maternity safety ambition to halve rates of perinatal mortality from 2010, by 2025	March 2025	Improved safety for service users, the workforce, and regional / national standards of maternity and neonatal care	Implementation of Saving Babies Lives Care Bundle (SBLCB) v3 through Workstream 3 – Clinical Pathways Implementation of Maternity and Neonatal Safety Champions as a point of contact to raise concerns, with established governance processes for sharing learning/escalation of concerns	• 50% reduction in incidents of avoidable harm with adverse outcomes benchmarked against 2010 data • Compliance with the process and outcome indicators defined within Saving Babies Lives Care Bundle (SBLCB) v3 – dashboard metrics to be developed and reviewed with oversight and support of a structured governance process • Progress against areas of concern raised through Maternity and Neonatal Safety Champions
❖ Compliance with 15 x Immediate and Essential Actions (IEAs) of Ockenden (Final) – March 2022	March 2025	Meaningful and sustained changes will be made to the quality and safety of services to prevent future avoidable adverse outcomes for service users and their families	Gap analysis of 15 x IEAs with current Trust performance to identify remaining areas for improvement to be included in supporting project plan Sustained delivery of the 15 x Immediate and Essential Actions (IEAs)	• Compliance with Ockenden IEAs
❖ Compliance with 10 x Safety Actions within Clinical Negligence Scheme for Trusts (CNST) Year 5	January 2024 *Submission by 01 Feb 2024*	Supporting continuous improvement to patient safety through alignment to the NHS Maternity Safety Strategy, which sets out the Department of Health and Social Care's ambition to reward those who have acted to improve maternity safety Improved patient outcomes Improved service user and workforce experience	Gap analysis of CNST Year 5 with current Trust performance against ten safety actions to identify areas for improvement Development of local guidance and a project plan to successfully implement and achieve compliance with CNST supported by clearly defined roles and responsibilities for each of the ten safety actions Monthly local and regional CNST reporting using the Perinatal Quality Surveillance Tool (PQST) to demonstrate month-on-month progress against the ten safety actions within the CNST framework Shared knowledge and awareness of Maternity Services Data Set (MSDS) with monthly results and trends used to compliment identified areas for improvement	• Compliance with CNST Year 5 • Benchmarked results of MSDS data with EKHUFT producing comparable outcomes (within middle 50%) to national trends

❖ Implement Maternity and Neonatal Quality and Safety Framework v3 (to replace current Risk Management Strategy v2)	September 2023	Good systems of control underpin safer care through a governance model that sets out robust monitoring and reporting structures, patient safety processes and methods for identifying and sharing lessons learned to improve services, patient experience processes, clinical effectiveness, and clear roles and responsibilities	Embedded governance structure with clear reporting lines from ward to Board (includes representation of Maternity at Trust Board) with supporting terms of reference that define purpose and membership, and a suite of template documents for professional presentation, consistency and standardisation Standardised processes for managing patient safety activities (including escalation and/or referral criteria), patient experience, and clinical effectiveness activities Alignment of local guidelines to the Trust-level 'Development and Management of Trust Policies' with a clear governance process for derogation from national guidelines Implementation of agreed annual clinical audit plan Alignment to 3-Year Single Delivery Plan for Maternity and Neonatal Services Theme 3: Developing and sustaining a culture of safety, learning, and support	• 75% attendance of members at meetings within the governance reporting structure • Governance report templates for all forums • 95% Serious Incident (SI) investigations complete within 'X days (monitored via SI tracker) • 95% of families involved in a serious incident have been offered to be involved in the investigation • 75% of families involved in the investigation process felt listened to, involved, and had their needs met with the support of an ISA • 30% reduction in complaints/concerns being returned for the reason of questions not being fully answered • Ethnicity to be included in compliance monitoring • Confirmed exit from National Oversight Framework level 4 to National Oversight Framework level 3
❖ Implementation of NHS Patient Safety Incident Review Framework (PSIRF)	March 2024	Embedded and effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety	Alignment to Trust-level preparations and plans in readiness for the roll-out of PSIRF, including plans for engaging and involving patients, families and staff following a patient safety incident Refresh of Datix incident reporting system – aligned to Trust-level Datix upgrade work - to align to future case management, monitoring and reporting requirements Implementation of Independent Safety Advisor (ISA) role to support learning, and service improvements "Finding signals among noise" and taking learning from data to inform areas for improvement, that contribute to the Training Needs Analysis (TNA) Specialist training for roles involved with delivery, engagement, and oversight of PSIRF A proactive and coproduced culture of learning using recognised PSIRF Learning Tools Lessons are learned, identified and shared to inform a cycle of continuous improvement through the Trust's 'We Care' quality improvement framework; underpinned by an Appreciative Inquiry approach	• 100% compliance with PSIRF Standards, including policy, plan and oversight standards • Attendance/completion of PSIRF-specific training by role, as identified in the PSIRF training guidance • Compliance audits and trends of outcomes from changes in practice following use of PSIRF Learning Resource Tools • 'We Care' outcomes
❖ Publication of updated Maternity Dashboard with agreed performance and outcome measures	December 2023	A generation of measures that are meaningful, risk adjustable, available and timely and are analysed and presented using a statistical-based approach to identify random variation versus significant trends and outliers to improve the monitoring and identification of clinical outcomes	Collaboration with NHSE 'Making Data Count' team Alignment to the national requirement for 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	• Agreed maternity dashboard with performance and outcome measures presented in Statistical Process Chart (SPC) format that identify outliers and trends
❖ Sustained compliance with environmental daily checks	March 2024	An improved environment to support and meet health and wellbeing needs of servicer users and the workforce	Collaborative working with Infection Prevention Control (IPC), and Estates teams to complete quality checks and arrange remedial and/or repair/replacement works 'Stop the clock' assurance process of daily, weekly and monthly environmental safety checks	• 95% compliance Monthly Infection Prevention Control (IPC) Led Environmental Audits • 90% compliance Hand Hygiene (HH), Personal Protective Equipment (PPE) • 95% compliance Weekly Environmental Audit • 100% Daily Environmental Checks • 100% compliance accessible fire routes • Progress against minor works log • Downward trend of patient safety incidents relating to poor estate / infrastructure (Inc. equipment)

❖ Care Quality Commission (CQC) 'Good' rating	March 2025	Safe: People are protected from avoidable harm and abuse, and legal requirements are met Effective: People have good outcomes because they receive effective care and treatment that meets their needs Caring: People are supported, treated with dignity and respect, and are involved as partners in their care Responsive: People's needs are met through the way services are organised and delivered Well-led: The leadership, governance and culture promote the delivery of high-quality person-centred care	Programme of local quality assurance checks and ongoing monitoring based on the CQC assessment framework Joint working with corporate services to implement and escalate necessary improvements including (but not excluded to) Pharmacy, Safeguarding, Infection Prevention Control, Medical Devices, and Estates Delivery of all must and should do requirements identified through the CQC inspection of EKHUFT Maternity Services in January 2023 Routine completion and benchmarking against the Maternity Self-Assessment Tool Compliance with 'Well-led' and 'Safe' CQC domains to meet requirements of the Maternity Safety Support Programme (MSSP) Regulatory compliance reporting through governance forums including (but not excluded to) Women's Health Care Group Governance meeting, CQC Oversight and Assurance Group, Maternity and Neonatal Assurance Group (MNAG)	• 'Good' ratings for CQC self-assessment compliance against the regulatory framework • Compliance with Maternity Self-Assessment Tool • Exit from the Maternity Safety Support Programme • 'Good' rating from future CQC inspection
❖ Coproduction of Maternity and Neonatal guidelines, and patient information	March 2024	Improved involvement of development of information that recognises the workforce and service users as experts in their own right with valuable experiences and knowledge that contribute to service improvement	Establishment and use of stakeholder engagement and involvement forums to gain feedback, thoughts and ideas for guideline and patient information development	• Response rate from stakeholder consultation for guideline development • Response rate from stakeholder consultation for development of patient information

Maternity and Neonatal Improvement Programme

Workstream 3: Clinical Pathways that underpin safe care

Objective: To progress evidence-based clinical care pathways to consistently deliver equitable, high quality, safe care and treatment

Associated Document: Reading the Signals, October 2022 – Dr Bill Kirkup CBE

NHS East Kent Hospitals University NHS Foundation Trust Maternity Services

High-level Milestones What?	Timeframes When?	Outcomes (objectives/improvements) Why?	Outputs (deliverables) How?	Measurable Benefits (results) Our achievements will show through…
❖ Compliance with Saving Babies Lives Care Bundle (SBLCB) v3	March 2025	Delivery of the six elements of care within SBLCB v3 supports the national maternity safety ambition to halve rates of perinatal mortality from 2010, by 2025 Improved patient outcomes Improved service user and workforce experience	Gap analysis of SBLCBv3 with current Trust performance against defined process and outcomes measures to identify areas for improvement Development of local guidance and a project plan to successfully implement and achieve compliance with SBLCBv3 supported by clearly defined roles and responsibilities for each element of the care bundle Monthly local and regional SBLCBv3 reporting to demonstrate month-on-month progress against the six elements of the framework	• Compliance with the process and outcome indicators defined within Saving Babies Lives Care Bundle (SBLCB) v3 – dashboard metrics to be developed and reviewed with oversight and support of a structured governance process • Routine use of the Perinatal Mortality Review Tool (PMRT) with escalation reporting to local, Trust and regional governance forums
❖ Implementation of Maternal Early Warning Score (MEWS) 2 and Newborn Early Warning Track and Trigger (NEWTT) 2	March 2025	Identification of abnormal physiological parameters and early intervention may prevent further deterioration and reduce maternal and newborn morbidity and mortality	Embedded use of MEWS tool to help identify women and birthing people at risk of deterioration Alignment to, and implementation of, MEWS2 following completion of the national pilot Embedded use of NEWTT2 tool to detect subtle deterioration in clinical conditions that can lead to early medical review, which in turn reduces morbidity	• Upward trend in MEWS compliance audit results • Upward trend in NEWTT2 compliance audit results • Reduced trend in serious incidents resulting from failure to recognise and act on the deteriorating woman, birthing person, and/or baby
❖ Development of clinical care pathways: o *Sonography* o *Triage* o *Diabetes* o *Perinatal Mental Health* o *Recognition of Deteriorating Woman (HDU)* o *Antenatal Systems and Processes* o *Postnatal Care Pathway* o *Antenatal Newborn Screening* o *Multiple Pregnancy* o *Transitional Care / ATAIN* o *Fetal Medicine Unit* o *Midwifery-led Care* o *Fundamentals of Care* o *Removal of Virtual Appointments* o *Clinical Practice Standards* o *Bereavement Care* o *Discharge Processes*	July 2023 – March 2026	Consistency in the application of 'best practice' care through the adoption of Integrated Care System (ICS) shared standards and guidelines to be part of an NHS service with joint initiatives that respond to local and regional maternity and neonatal care needs Service users will have timely access to the right care, in the right place, at the right time from the right person	Benchmarking against, and alignment to, evidence-based best practice and national guidelines with a clear governance process for derogation Use of national and local clinical outcome data, incidents, compliments and complaints to inform areas for improvement and shape ways of working Implementation of the Maternity and Neonatal Improvement Programme (MNIP) for development through care pathway project plans delivered by pathway Leads and multidisciplinary teams Alignment to 3-Year Single Delivery Plan for Maternity and Neonatal Services Theme 4: Standards and structures that underpin safer, more personalised, and more equitable care	• Improved perception of service user choice for place of birth CQC Maternity Survey results • Delivery of Key Performance Indicators (KPIs) within project plans for clinical pathway development – dashboard metrics to be developed and reviewed with oversight and support of a structured governance process • MSDS Benchmarking with EKHUFT producing results within 5% of national comparator group • Compliance with Perinatal Quality Surveillance Model (PQSM) reported monthly through local and regional governance structures using the Trust Perinatal Quality Surveillance Tool (PQST) • Downward trend in complaints/concerns and incidents results from poor quality of care • Benchmarked results of national clinical audits with EKHUFT producing comparable outcomes (within middle 50%) to national trends

Maternity and Neonatal Improvement Programme

Workstream 4: Listening to and working with women and families with compassion

Objective: To listen to our birthing people and our workforce to design coproduced, personalised and equitable Maternity & Neonatal Services

Associated Document: Reading the Signals, October 2022 – Dr Bill Kirkup CBE

NHS East Kent Hospitals University NHS Foundation Trust Maternity Services

High-level Milestones What?	Timeframes When?	Outcomes (objectives/improvements) Why?	Outputs (deliverables) How?	Measurable Benefits (results) Our achievements will show through…
❖ Implementation of Personalised Care and Support Plans (PCSPs), aligned to the Core20PLUS5 Framework	December 2023	People are empowered and have choice and control over the way their care is planned and received based on 'what matters' to them and their individual needs and preferences without repetition Core20PLUS5 is an Integrated Care System (ICS) framework to target clinical areas requiring accelerated improvement based on; - 20% of the national population as identified by the Index of Multiple Deprivation (IMD) - ICS-chosen population groups experiencing poorer-than-average health access, experience and/or outcomes - Five clinical areas of focus which require accelerated improvement; one of these being **Maternity**	Sharing of PCSP Information with, and completion of Personalised Care Institute training by, the maternity workforce Implementation of the NHSE Personalised care and support planning guidance With their midwife or obstetrician, service users will consider and discuss their life, family situation, health and wellbeing, and preferences, so that their care reflects their needs and wishes Through the eLearning for healthcare (eLfH) Cultural Competence programme the workforce responds to the needs of our diverse population through an understanding of the key issues relating to culture and how this may influence the uptake of health care and treatment options 'Intentional rounding' ensures regular checks that fundamental care needs of service users are met, as recorded in their PCSP (pain, placement, personal needs, positioning) Care outside guidance pathway	• Benchmarked PCSP completion rates against registered pregnancies to identify compliance • Intentional Rounding compliance audit results • Improved CQC Maternity Survey results
❖ Improved results of indicators from the CQC Maternity Survey	March 2024	CQC Maternity Survey 2023 demonstrates improved service user experience of antenatal, intrapartum and postnatal care including support services e.g. infant feeding	Delivery of local CQC Maternity Survey action plan to address results from 2022, focused on identified areas for improvement	• Progress against local CQC Maternity Survey 2022 action plan • Improved CQC Maternity Survey 2023 Results
❖ Implementation of Maternity and Neonatal Engagement Framework	March 2024	Coproduction of services with the workforce and service users garners valuable feedback about how healthcare services work in practice, considers what works well and brings about ideas for improvement. Participation helps to improve health inequalities experienced by protected characteristic groups	Collaborative development of an Engagement Framework including, but not exclusive to: - Maternity and Neonatal Voices Partnership (MNVP) - Local Maternity and Neonatal System (LMNS) - Integrated Care System (ICS) - EKHUFT Patient Participation Group - EKHUFT Maternity service user feedback - EKHUFT Maternity workforce feedback	• Progress against Engagement Framework development plan

❖ The workforce and service users feel involved in the improvement of Maternity and Neonatal services through coproduction	March 2024		Collaborative working with local and regional stakeholder groups opens opportunities for sharing learning from service user experiences, and for involvement with service redesign
			
			Support and promotion of opportunities for engagement with service developments are provided through multiple platforms including the Professional Midwifery Advocate (PMA) team
				• Improved trajectory of NHS Staff Survey for:
				  • Staff Engagement
				  • Morale
				  • People Promise 3 – We have a voice that counts
				• Progress against the MNVP Feedback Log
				• Progress against the MNVP Work Plan

❖ Improved equity and equality in maternity and neonatal care	March 2024	All service users achieve good health outcomes by responding to each person's unique health and social situation, with increasing support as health inequalities increase, so that care is safe and personalised for all	Alignment to the NHSE Equity and Equality guidance for local maternity systems Equitable access to perinatal mental health services Equitable access to perinatal pelvic health services Alignment to NHS Accessible Information Standard (AIS) ensures information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss are met Increased diversity of the East Kent Maternity and Neonatal Voices Partnership (MNVP) to reflect the local community	• MBRRACE-UK Perinatal mortality metrics for stillbirths and neonatal mortality for Black and Asian babies divided by the rate for White babies in the UK, expressed as a ratio • Office for National Statistics (ONS) Perinatal mortality metrics for stillbirths and neonatal mortality for the most and least deprived communities in England, measured using the slope index of inequality • AIS Guideline compliance • Case numbers accessing perinatal mental health / pelvic health services by ethnicity and Index of Multiple Deprivation (IMD) • NHS Mental Health Dashboard metrics • Maternity dashboard metrics are available by ethnicity and Index of Multiple Deprivation (IMD) • MNVP demographic data
❖ Embedded communications plan and Patient Voices Model to improve service user and workforce engagement, feedback and experience	March 2024	Good experience of care, treatment and support underpins excellent maternity and neonatal services, alongside clinical effectiveness and safety, and helps to shape service improvement	Consistent, structured and timely information is shared and received between maternity and neonatal services, its workforce, service users and regional partners though an agreed communications plan, which includes multiple formats such as: - Patient stories - Newsletters - Surveys - Infographics Platforms for sharing messages include: - Workshops - Meetings / forums - Social media - Email - Videos / podcasts - Patient information screens Maternity Patient Voices Model collates feedback from all formal sources into a central point for analysis of response rates, satisfaction measures, themes and trends. Learning is shared through the communications plan and identifies areas for improvement; areas for improvement are collated into a central point for oversight and triangulation 'Little Voices are Heard' local initiative for children and young people to raise concerns in a safe space to a trusted person	• Friends and Family Test (FFT) results • Your Voice is Heard metrics • Compliance with CNST Safety Action 7 • Themes and tone of qualitative service user feedback from all sources • Feedback results from the Patient Voices Model

Maternity and Neonatal Improvement Programme

Workstream 5: Growing , retaining and supporting our workforce

Objective: To embed a process of continuous review and planning that produces and retains a competent, supported and sustainable workforce

Associated Document: Reading the Signals, October 2022 – Dr Bill Kirkup CBE

NHS
East Kent Hospitals University NHS Foundation Trust
Maternity Services

High-level Milestones What?	Timeframes When?	Outcomes (objectives/improvements) Why?	Outputs (deliverables) How?	Measurable Benefits (results) Our achievements will show through…
❖ Implementation of a structured framework for supporting the local workforce	March 2024	Improved quality and confidence across the multi-professional workforce through a structured framework of support, reflection and learning that harnesses personal and professional development	Implementation of a medical clinical supervision model aligned to Royal College of Obstetricians and Gynaecologists (RCOG), and British Association of Perinatal Medicine (BAPM) guidance A dedicated Professional Midwifery Advocate (PMA) team to support local needs and priorities through restorative clinical supervision, aligned to a formalised clinical supervision model such as A-EQUIP Thematic lessons learned from reflective practice and clinical supervision activities	• Live register of clinical supervisors with assigned supervisees across all grades/functions • Evaluation and feedback on the clinical supervision programmes and supervisor(s) • Improved trajectory for NHS Staff Survey for: • People Promise 5 – We are always learning
❖ Agreed Maternity and Neonatal Succession Plan using a recognised NHS talent management toolkit,	March 2025	Workforce planning supports current and future, local, national and international resource requirements with clearly defined career pathways to meet and adapt to service needs	Alignment to the NHS People Plan Medical job plans reflective of demand and capacity Maternity and Neonatal workforce, recruitment and retention plan(s) Clearly defined local and regional career pathways to provide guidance and options to the workforce when making career choices	• Progress against the Succession Plan • Improved trajectory for NHS Staff Survey for • People Promise 2 – We are recognised and rewarded • 85% Appraisal rate
❖ Implementation of 3-year Training Needs Analysis (TNA), and Annual Training Plan (ATP)	March 2024	Teams that work together, train together across all pre- and post-registration training for all professions, to understand and respect each other's skills and perspectives. Supported to complete local, regional and national training requirements the multi-professional workforce is knowledgeable of, and works to, current statutory and mandatory standards A highly competent workforce uses skills and knowledge gained through a dedicated learning environment with specialist resources and learning tools to provide personalised, high-quality care. These skills are aligned to a formalised competency framework, include a focus on professional behaviour and compassionate care, and provide opportunities to progress in-line with an inclusive succession plan	Training Needs Analysis (TNA) identifies annual and 3-yearly statutory and mandatory training requirements by grade and clinical / non-clinical roles, including Internationally Educated Midwives (IEMs) and preceptors/preceptees The TNA also includes thematic learning from patient-safety related activities and feedback from the workforce and service users where improvements for knowledge and skills are identified A funded programme of training and education is collated into an Annual Training Plan (ATP) with opportunities including Continued Professional Development (CPD) shared through a Maternity and Neonatal prospectus Competency frameworks that underpin each role across Maternity and Neonatal services	• 85% compliance with annual statutory and mandatory training completion rates • Benchmarked General Medical Council (GMC) National Training Survey (NTS) results with EKHUFT showing comparable outcomes to national trends (upwards trend in 'green' ratings) • Progress / compliance of delivery of the TNA/ATP • Monitoring and review of the training budget/spend • Compliance with the Competency Framework, by staff grade, benchmarked against national requirements

❖ An effective 'Safe Staffing' model to meet local and regional service needs	March 2025	Workforce (safe staffing) planning tools are used and monitored to ensure sufficient skill mix requirements are provided on each shift / clinic to enable teams to maximise the ability for high-quality patient-centred care
		
		Reduced absence and improved workplace satisfaction resulting from improved and safer working conditions enables people to have more positive experiences whilst caring for service users, and each other's wellbeing at work.
		
		Clarity around expectations and acceptance of personal duties, including the authority of clinical leaders, that are provided to the highest of standards - aligned to the respective scope of practice - by each member of the multidisciplinary team
			Embedded use of an activity/acuity-based workforce assessment and planning tool to identify daily and long-term establishment needs, such as Birthrate Plus (BR+)
			
			Implementation of a process for RCOG Certificate of Eligibility for short-term locums providing middle-grade cover
			
			Alignment to 3-Year Single Delivery Plan for Maternity and Neonatal Services Theme 2: Growing, retaining and supporting our workforce
			
			Rotas that reflect and provide the appropriate skill mix required for each shift, including e.g. anaesthetics, neonatal services, sonography
				• Improved trajectory for NHS Staff Survey:
				  • People Promise 4 – We are safe and healthy
				  • People Promise 6 – We work flexibly
				  • Morale
				• Improved People & Culture (HR) related rates:
				  • 11.5% Turnover Rate
				  • 5% sickness absence
				  • 10% Vacancy
				  • 85% Appraisals
				• Rota fill rate / compliance
				• Reduction in Premium Pay (PP) costs
				• Compliance with CNST SA4 & 5

❖ Sustained levels of improved staff satisfaction	December 2024	People work effectively as a diverse team with varied but equally weighted skills and experience that drives an inclusive culture and sense of belonging that supports equal opportunities for personal and professional development	Access to a full suite of wellbeing support, which includes mental health services, and return to work meetings to support people coming back into the workplace following a period of absence
			
			'Check in / Check out' opportunities at the beginning and end of each shift support safe spaces to have conversations about any personal worries or concerns
			
			Promotion of, and equal opportunities for, flexible working
			
			Routine stay / exit interviews to understand the reasons that people remain in post / leave the EKHUFT Maternity Service to enable identification of the what could be improved or done more consistently well to retain the workforce
				• Reduced sickness absence rate due to work-related mental wellbeing
				• 11.5% Turnover rate
				• Improved Royal College of Midwifery (RCM) survey results
				• Improved trajectory of NHS Staff Survey for
				  • People Promise 6 – We work flexibly
				  • People Promise 7 – We are a team
				• Friends and Family Test results aligned to national average for Maternity and Neonatal services
				• CQC Maternity Survey results aligned to national average scores

❖ Improved provisions for student development	March 2024	Undergraduate and postgraduate medical students are trained to deliver high-quality, safe patient care with good outcomes through joint working with partner medical schools and within the requirement of regulatory and educational frameworks All trainees including apprentices, student midwives, and medical students will be supported through their programme of education by EKHUFT Maternity and Neonatal services to learn local and regional policies and procedures (based on national guidance) for the delivery of good quality maternity and neonatal care Maternity and Neonatal clinical educators work to secure the future workforce, retain existing employees through, and maximise productivity through education and training to optimise capability and confidence at every level (NHS Educator Workforce Strategy)	Reintegration of student midwives into EKHUFT A multi-professional 'student plan' will form part of the over-arching recruitment / workforce plan for Maternity and Neonatal Services, at local and regional levels Recruitment hubs will promote new opportunities across Maternity and Neonatal services, including international recruitment, and a suite of unique selling points (USPs) will set EKHUFT apart from, but remain complimentary to and considerate of, national peers, to establish the Trust as a preferred choice of employment Students will spend the necessary time for their education programme in clinical practice with direct contact with service users. This could be at home, in the community, on midwifery-led units, in specialist clinics, and in other hospital-based settings supported by a team of qualified practice placement educators Learning resources, time and spaces will ensure compliance with regulatory and educational frameworks	• Progress against Student Plan • Defined set of Unique Selling Points (USPs) • Improved trajectory of NHS Staff Survey for • People Promise 5 – We are always learning • Completion rates for student education modules • Student Qualification rates • Benchmarked General Medical Council (GMC) National Training Survey (NTS) results with EKHUFT showing comparable outcomes to national trends (upwards trend in 'green' ratings) • Compliance with requirements of Health Education England (HEE) Quality Interventions Review Report requirements – June 2023 • 'Student to employee' conversion rates • Compliance audits of job plans / rotas for members of the education faculty

❖ A workforce reflective of the service demographic	March 2025	An understanding of local and regional cultural needs from the sharing and learning of cultural experiences from maternity and neonatal involvement at local, regional and national equality and diversity networks
		
		A support network for colleagues, including internationally educated midwives, from black, Asian and minority ethnic backgrounds to have a voice that speaks clearly to leadership, about their unique experiences within the healthcare system
			Established Maternity and Neonatal Equality, Diversity and Inclusion (EDI) network
			
			Representation of Maternity and Neonatal services at the Trust's Ethnic Diversity Engagement Network (EDEN)
			
			Alignment to NHS People Plan, recruitment and retention hubs supported by targeted and accessible recruitment campaigns with diverse recruitment panels
			A workforce reflective of the service demographic
				• Membership and attendance at EKHUFT EDI network meetings
				• Membership and attendance at EKHUFT EDEN meetings
				• Benchmarked Workforce Equality Data Standards
				  • Workforce Race Equality Standards (WRES) data
				  • Workforce Disability Equality Standards (WDES) Data

Maternity and Neonatal Improvement Programme

Workstream 6: Infrastructure and Digital

Objective: To establish an environment with enhanced digital systems to ensure the workforce and service users have access to the information and facilities they need, when they need it

Associated Document: Reading the Signals, October 2022 – Dr Bill Kirkup CBE

NHS East Kent Hospitals University NHS Foundation Trust Maternity Services

High-level Milestones What?	Timeframes When?	Outcomes (objectives/improvements) Why?	Outputs (deliverables) How?	Measurable Benefits (results) Our achievements will show through…
❖ Implementation of Maternity and Neonatal Digital Strategy ❖ Implementation of regional Maternity and Neonatal Information System	March 2025	Digital ways of working and innovation through technology are used to improve access to healthcare and information, quality of services and safer service provision, and effective integration between services and the wider healthcare system Frontline electronic patient record management system(s) enable secure and timely access to relevant clinical information at the point of care by the appropriate person to support clinical decision-making and clinical management for the best clinical outcome(s)	Coproduction with internal and external stakeholders will ensure that objectives within the Digital Strategy are realistic and achievable and consider the needs of people using digital systems for accessing, recording, assessing, monitoring and managing information Engagement with the WGLL Hub and Integrated Care System (ICS) for support regarding digital health information and good practice examples of technology-enabled healthcare, standards, guides and policies, useful tools and templates and networking information The multi-professional workforce is able to access electronic patient records at the point of care throughout each stage of the maternity and neonatal journey to improve timeliness and effectiveness of clinical assessment, decision-making, and management Service users are able to access their digital records, patient information leaflets and Personalised Care and Support Plans (PCSPs) through the Patient Portal	• Periodic (six-monthly) completion and review of digital maturity assessment • Progress against the MNIP Infrastructure Project Plan and specific digital requirements (e.g. connectivity in the Community, Euroking Developments) • End-to-end electronic patient record system across maternity and neonatal services • Pending standards through WGLL page • Patient Portal registration vs pregnancy rates
❖ Compliance with Health Buildings Note (HBN) 09-02: Maternity care facilities – aligned to Trust-level Estates Plans	March 2026	Alignment to best practice guidance on the design and planning of adaptation/extension of existing facilities across all maternity settings to provide safe care of service users in a comfortable, relaxing environment that facilitates what is a normal physiological process, enabling self-management in privacy whenever possible, and enhances the family's enjoyment of an important life event	Coproduction with service users to understand preferences for room design to enable choice and control over their labour and birth Collaboration with key interfaces to ensure appropriate facilities are available for intervention when complications occur Provision of dedicated training spaces	• Compliance with 'key recommendations' within HBN 09-02 guidance • Compliance with Health Education England (HEE) Quality Framework relating to learning environment • Downgrading of Estates risk (CR144) on Corporate Risk Register • Relocation of Bereavement Suite (WHH) • 30% Reduction in the number of complaints relating to Estates and Facilities
❖ Sustained compliance with Planned Preventative Maintenance (PPM) schedule, and equipment management	December 2023	Embedded systematic approach to the acquisition, deployment, maintenance (preventive maintenance and performance assurance), repair and disposal of medical devices to ensure delivery of safe, efficient, high-quality services	Alignment to national Managing Medical Devices guidance Effective processes and collaborative working to undertake routine equipment safety checks with agreed arrangements for service, repair and replacement Escalation process for 'failed' medical devices 'Stop the clock' assurance process of daily equipment safety checks	• 90% compliance with Planned Preventative Maintenance (PPM) schedule • 100% compliance Daily Equipment Safety Checks (all settings)

East Kent Hospitals University NHS Foundation Trust

REPORT TO READING THE SIGNALS OVERSIGHT GROUP

Report title: **MATERNITY SCORECARD**

Meeting date: **8TH AUGUST 2023**

Board sponsor: **CHIEF NURSING & MIDWIFERY OFFICER**

Paper Author: **DIRECTOR OF MIDWIFERY**

Appendices: **NONE**

MAXIMUM OF TWO APPENDICES *(Scorecard)*

Executive summary:

Action required:	**Discussion**
Purpose of the Report:	The Maternity Scorecard is brought to the MNAG in compliance with the CNST and Ockenden requirement for an overview/oversight of Maternity metrics at departmental, board and regional levels. The purpose of the report is to provide assurance on the maternity dashboard and associated actions. The maternity dashboard provides oversight on the key safety and quality metrics within the maternity services in East Kent including governance, workforce, clinical pathways and engagement with service users. The Trust's maternity dashboard is presented monthly to both the MNAG group and Trust Board. This report covers the month of July 2023
Summary of key issues:	• The rolling 12 month SB rate remains at 2.55 per 1000 births compared to the national average of 3.6 per 1000 births. • The neonatal death rate remains at 0.85 per 1000 births compared to the national average of 2.39 per 1000 births. • There were no SBs, NNDs in the month of July • *2 SIs were declared in the month of July – these are reported in the PQST report* • *1:1 care and the supernumerary status of coordinators are recorded at slightly lower than the 100% threshold .However validation of the data has shown that the co-ordinator was supernumerary but this was inaccurately recorded.*

We care

East Kent Hospitals University NHS Foundation Trust

	• *Compliance with Hand Hygiene audits are recorded at 61.2% against a threshold of 85%. 2 main issues were identified as driving this non compliance: There was some confusion around the new hand hygiene audits on tendable which superseded the previous hand hygiene assessment. Secondly, due to competing demands the trainer was unable to regularly assess and complete esr. The team is now on a trajectory of being compliant by the end of September with support from ICP and PD team.* • *Appraisal rates at WHH is significantly lower than expected at 58.7% All out of date staff have been allocated to senior staff and given 8 weeks to complete. HOM and matrons holding staff to account if not completed.* • *Safeguarding training is currently 68.1% compliant against a threshold of 90%. All non compliant midwifery staff have been booked to attend. The trajectory for compliance is now November 2023*
Key recommendations:	*What is the recommendation?* *The Board to note areas of non compliance, mitigation and actions to improve compliance*

Implications:

Links to 'We Care' Strategic Objectives:	*(State which 'We care' Strategic Objective(s) this report aims to support:* • *Our patients* • *Our people* • *Our future* • *Our sustainability* • *Our quality and safety*
Link to the Board Assurance Framework (BAF):	
Link to the Corporate Risk Register (CRR):	
Resource:	Y/N *If yes, state resource impact*
Legal and regulatory:	Y/N *If yes, state legal or regulatory impact*
Subsidiary:	Y/N *If yes, please indicate the Subsidiary and how its business will be impacted.*

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Assurance route:

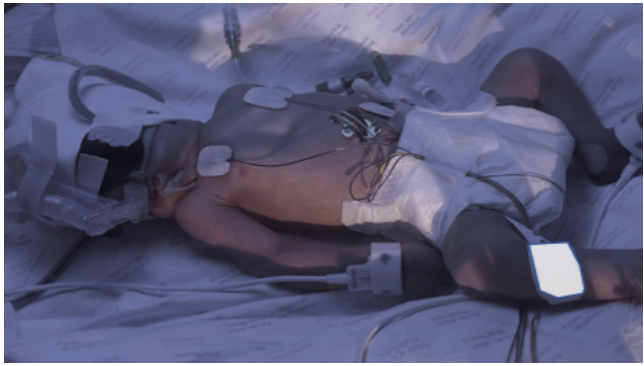
Previously considered by: *Has this paper been considered at other Committees? List the Committees and dates.*

East Kent Hospitals University NHS Foundation Trust

Maternity Dashboard Performance Report

July 2023



Maternity Dashboard - Revised

Following the March Maternity and Neonatal Assurance Group (MNAG) meeting, discussions took place NHSE regarding the use of **statistical process control (SPC)** as a more informative way for reporting performance and tracking improvement.

This month's dashboard has aligned the format to the use of SPC where appropriate. Metrics which are flagging under the SPC rules will have a separate exception report slide, outlining the metric definition, what the data is telling us, any interventions, impacts and risks/mitigations will be discussed.
The SPC rules used to indicate the need for an exception report are:

- These symbols indicate that performance is significantly worse; either above/below average over a longer period, a run of 6 or more increases or decreases, 1 or more periods outside of the upper or lower confidence limits, or 2 out of 3 points close to the confidence limits – these are **special cause variation**

- These symbols indicate that performance is significantly better (defined above). Once the metric has been discussed and performance remains good (i.e. better than average for a number of consecutive months) the graph and a brief description will be given on a combined slide, in order to keep the dashboard pack as succinct but informative as possible

- This symbol shows a metric which is consistently falling short of the target/threshold.

Governance, Risk & Compliance

To embed robust governance structures that underpin continuous improvement and delivery of high quality, person-centred care

Governance, Risk & Compliance: Overview

Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	Mean	LCL	UCL
Incidents	Serious Incidents	3	Jul-23	2			3	0	7
	Total Incidents	Sigma	Jul-23	255			247	110	384
	Moderate+ Harm (C - E)	Sigma	Jul-23	4			3	0	9
	No/Low Harm (A & B)	Sigma	Jul-23	251			244	107	381
	Unit Divert Diff Site	1	Jul-23	0			2	0	6
	Unit Closure	0	Jul-23	0			0	0	1
	Birthrate+ Red Flags	Sigma	Jul-23	11			23	0	49
Morbidity & Mortality	MBRRACE Stillbirth 12m Rate	3.92	Jul-23	2.55			3.81	2.99	4.64
	MBRRACE Stillbirths	2	Jul-23	0			2	0	5
	MBRRACE NND Rate 12m	1.96	Jul-23	0.85			1.04	0.75	1.33
	MBRRACE Neonatal Deaths	1	Jul-23	0			0	0	2
	MBRRACE Ext Perinatal Rate 12m	5.87	Jul-23	3.40			4.85	3.97	5.73
	Maternal Deaths	0	Jul-23	0			0	0	0
Regulatory Compliance	Comm MW Equipment Audit	100.0%	Jul-23	98.8%			94.4%	88.6%	100%

Governance, Risk & Compliance: Exception Report

East Kent Hospitals University NHS Foundation Trust

MBRRACE Stillbirth Rate 12m

MBRRACE methodology is used, Babies who were born stillborn at EKHUFT, and which excludes births <24+0 weeks gestation and terminations (even if over 24+0w). The rate is a rolling 12 month measure counting cases per 1000 births

Datasource: Euroking & PAS. Threshold based on the average of the Trust's comparator group (MBRRACE 2021). Average was 3.92

Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
3.64	3.63	3.96	4.30	4.00	3.69	3.88	3.46	3.63	3.48	2.86	2.55

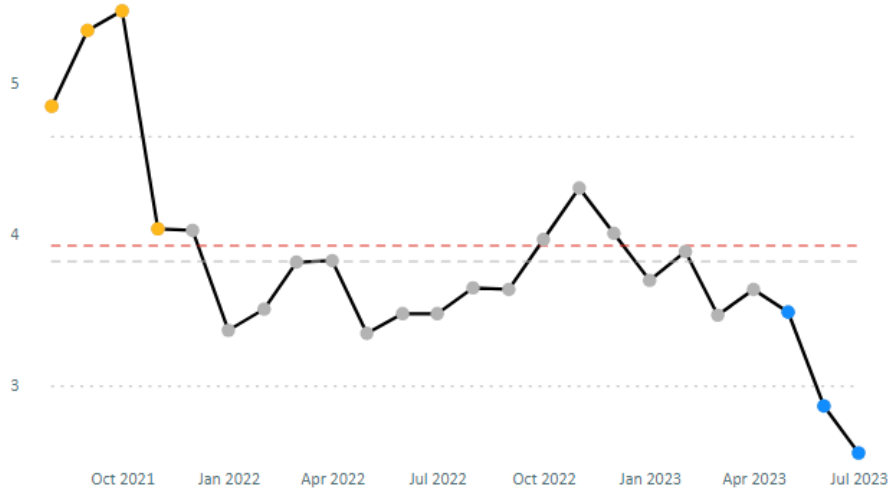
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

Astronomical Point
Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us

The rolling 12 month rate for stillbirths remains below the lower confidence limit at 2.55 stillbirths per 1,000 births

In July there were 0 stillbirths reportable to MBRRACE

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

Intervention and Planned Impact

All neonatal deaths and stillbirths are reviewed through the Perinatal Mortality Review Tool by a multidisciplinary panel and external attendees.

Risks/Mitigations

.

Governance, Risk & Compliance: Exception Report

MBRRACE NND Rate 12m

MBRRACE methodology is used, Babies who were born at EKHUFT and died within 28 days, and which excludes births <24+0 weeks gestation and terminations (even if over 24+0w). The rate is a rolling 12 month measure counting cases per 1000 live births
Datasource: Euroking & PAS. Threshold based on the average of the Trust's comparator group (MBRRACE 2021). Average was 1.96

Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
0.48	0.63	0.48	0.64	0.64	0.64	0.65	0.99	0.99	1.00	1.01	0.85

P

Variation indicates consistently passing the target

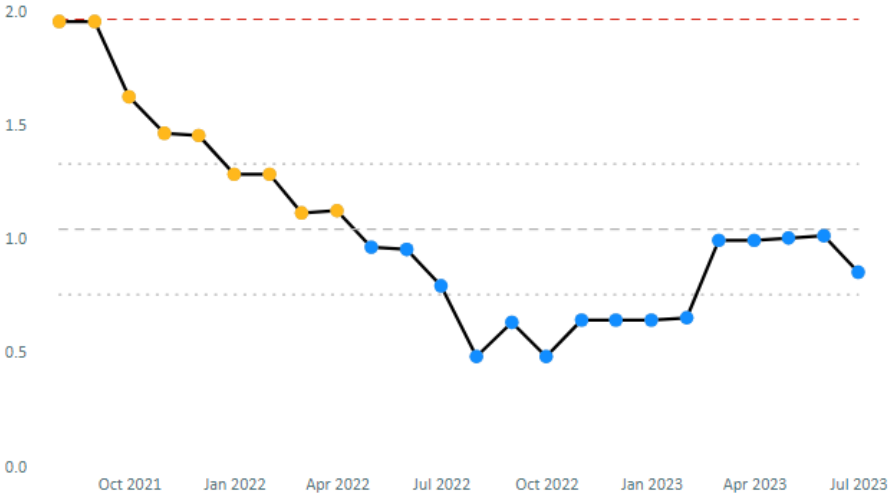
L

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

Flag Description

Below Mean Run Group

XMR Run Chart



What the chart tells us

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 Julu 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)

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

Intervention and Planned Impact

All neonatal deaths and stillbirths are reviewed through the Perinatal Mortality Review Tool by a multidisciplinary panel and external attendees.

Risks/Mitigations

.

Governance, Risk & Compliance: Exception Report

Community Equipment

Weekly audits of the community teams day, on-call and homebirth bags are carried out to assess equipment compliance

Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
91.2%	91.9%	94.7%	97.2%	96.4%	96.4%	97.5%	98.3%	98.4%	98.4%	96.5%	98.8%

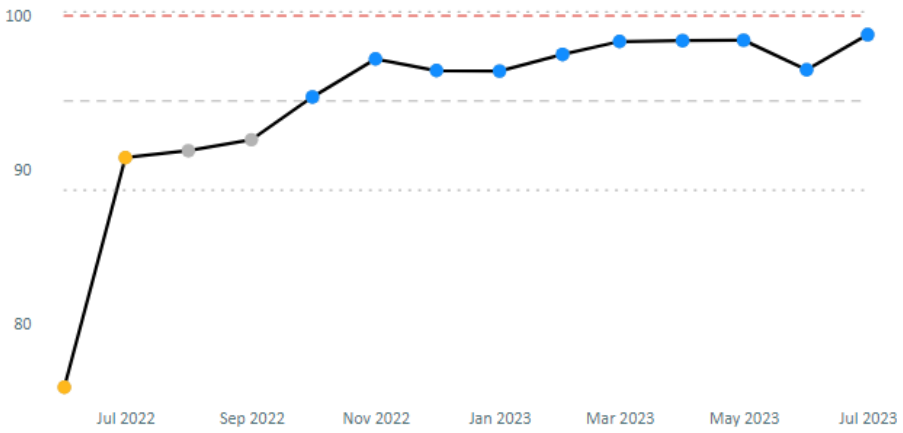
Variation indicates inconsistently passing and falling short of the target

Special cause of improving nature or lower pressure due to higher values

Flag Description

Above Mean Run Group Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us

Compliance remains short of the 100% target level.

All teams and bags were 100% compliant, except:

- Ashford (98%)
- Coastal (99%)
- Folkestone (98%)
- Thanet (99%)

Note - data may be incomplete this early in the month

Intervention and Planned Impact

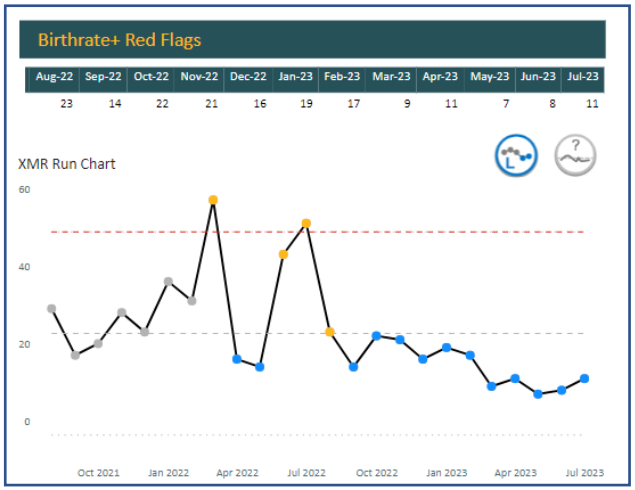
Community matrons undertaking weekly spot audits and developing action plans to address shortfalls

- 1:1 with individual midwives
- Reviewing data collection methodology
- Results and performance shared with the community teams to highlight gaps

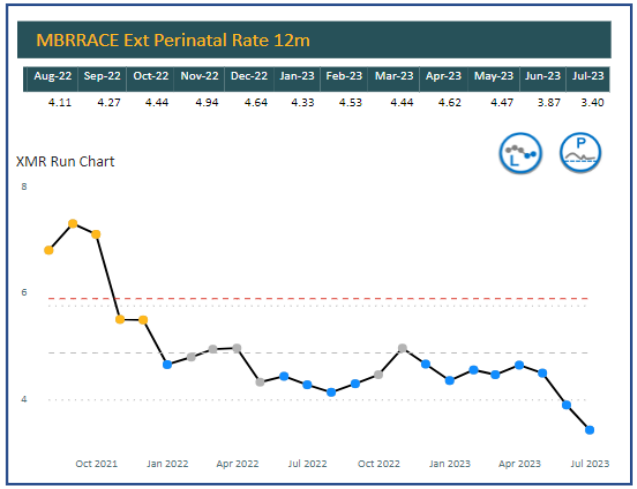
Risks/Mitigations

Data capture concerns and community matrons working with digital midwife to address. When staff are on leave or sick this is included in miss check denominator which impacts the overall compliance.

Governance, Risk & Compliance : KPIs consistently achieving threshold or sustained improvement (exception reported in previous months)



Red Flags continue to be recorded at levels lower than average



Stillbirths and Neonatal deaths discussed in previous slides.

This metric is a combination of both and demonstrates a continued number lower than average, with July below the lower confidence limit

13 consecutive months with 0 maternal deaths

Maternal deaths include women who died either during pregnancy , or within 6 weeks of delivery. May include deaths unrelated to obstetric health or care

Governance, Risk & Compliance : Other notable

Serious Incidents

Domain	Incidents
Datapoint	01 July 2023
Num	2
Denom	
Threshold	3
Value	2
Value Type	Number
Direction	Lower is Better
Previous Val	3
Change (%)	-33%
Hyperlink	

Metric Definition

Any incident recorded on Datix that has subsequently been reported to STEIS (Strategic Executive Information System) - [Inc_inquiry] = 'CONFSI' (confirmed SI). We also have a clause to exclude any that later get downgraded by the CCG. Serious Incidents are reported by the date the investigation started (not the date the incident occurred or was reported)

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

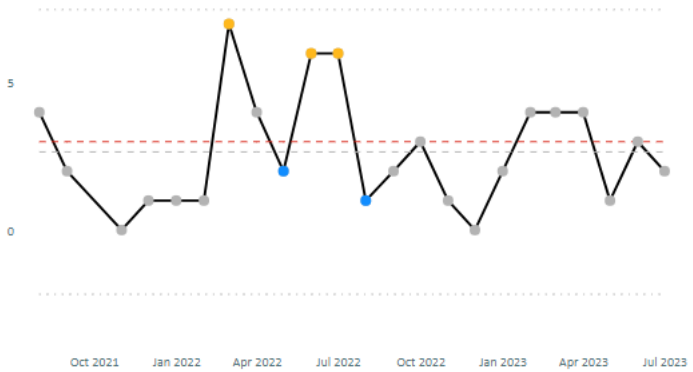
Variation indicates inconsistently passing and falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



Serious Incidents remain within confidence limits

In July, the serious incidents reported were:

- Adult protection (other issue)
- Unanticipated admission to SCBU

People & Culture, Workforce Sustainability

To build an inclusive culture where staff feel safe, valued, listened to and supported to deliver kind and compassionate, person-centred care

To embed a process of continuous review and planning that produces and retains a competent, supported and sustainable workforce

NHS
East Kent
Hospitals University
NHS Foundation Trust

People & Culture, Workforce Sustainability: Overview

Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	Mean	LCL	UCL
Staff Survey	Staff Involvement Score	6.90	Jun-23	5.60					
Workforce	1 to 1 in Labour	100.0%	Jul-23	99.2%			99.6%	98.6%	100%
	Worked WTE: Birth Ratio	24.00	Jun-23	19.46			21.19	17.10	25.29
	Midwifery/MSW Turnover Rate	11.5%	Jun-23	10.6%			6.52%	4.97%	8.07%
	Midwifery/MSW Vacancy Rate	10.0%	Jun-23	8.1%			11.2%	0%	13.3%
	Midwifery/MSW Appraisal Rate	85.0%	Jun-23	58.7%			68.5%	62.1%	74.8%
	Sickness Rate	5.0%	Jun-23	7.1%			7.86%	5.12%	10.6%
	Total On-Call Hours	Sigma	Jul-23	257.4			388.8	37.6	708.9
	Occurance On-Call In	Sigma	Jul-23	78			84	30	114
	Birthrate+ Meets Acuity	Sigma	Jul-23	73.5%			55.0%	35.0%	75.1%
	Supernumerary Status	100.0%	Jul-23	99.7%			96.0%	90.0%	100%
Maternity Training	Fetal Monitoring Training	90.0%	Jul-23	93.8%			88.4%	83.3%	93.6%
	PROMPT Excl ML & LTS	90.0%	Jul-23	95.8%			90.5%	83.6%	97.3%
	Fetal M. Excl ML & LTS	90.0%	Jul-23	98.1%			91.9%	87.4%	96.5%
	PROMPT	90.0%	Jul-23	91.3%			86.9%	79.5%	94.3%
	NLS Training	90.0%	Jul-23	89.7%			83.7%	77.6%	89.7%
	NLS Excl ML & LTS	90.0%	Jul-23	94.7%			85.8%	79.8%	91.8%

People & Culture, Workforce Sustainability: Overview

Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	Mean	LCL	UCL
Mandatory Training	Safeguarding Adult Lvl 1	90.0%	Jun-23	100%			100%	100%	100%
	Safeguarding Adult Lvl 2	90.0%	Jun-23	69.3%			84.0%	77.3%	90.8%
	Safeguarding Adult Lvl 3	90.0%	Jun-23	68.1%			22.4%	0%	45.0%
	Prevent Lvl 1	85.0%	Jun-23	100%			100%	100%	100%
	Prevent Lvl 2	85.0%	Jun-23	81.8%			82.8%	65.5%	100%
	Hand Hygiene	85.0%	Jun-23	61.2%			50.0%	43.5%	56.6%
	Dementia	85.0%	Jun-23	85.7%			35.1%	4.12%	66.1%
	Resus Adult	85.0%	Jun-23	93.7%			70.9%	57.1%	84.6%
Statutory Training	Equality & Diversity	85.0%	Jun-23	94.5%			92.9%	91.0%	94.8%
	Child Protection Level 1	90.0%	Jun-23	100%			100%	100%	100%
	Child Protection Level 2	90.0%	Jun-23	71.4%			87.5%	81.5%	93.6%
	Child Protection Level 3	90.0%	Jun-23	77.2%			88.0%	84.9%	91.1%
	Manual Handling	85.0%	Jun-23	91.7%			88.6%	86.5%	90.6%
	Fire	85.0%	Jun-23	86.2%			87.8%	85.1%	90.4%
	Health & Safety	85.0%	Jun-23	94.2%			92.2%	90.6%	93.7%
	Infection Control	85.0%	Jun-23	95.7%			93.0%	85.6%	100%
	Information Governance	85.0%	Jun-23	81.7%			86.5%	82.9%	90.2%

People & Culture, Workforce Sustainability: Exception Report

Midwifery / MSW Turnover Rate
WTE (whole time equivalent) leavers in month, divided by the total WTE. This is a rolling 12 month rate, 1 month in arrears.

This metric includes all nursing and midwifery registered staff under 560 midwifery, and all 'additional clinical services' – all MSW/MCAs apart from those recorded under the budget code of 3208 Midwifery Management.

Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
5.4%	5.4%	5.9%	6.9%	7.0%	7.5%	8.9%	9.5%	10.2%	10.2%	9.9%	10.6%

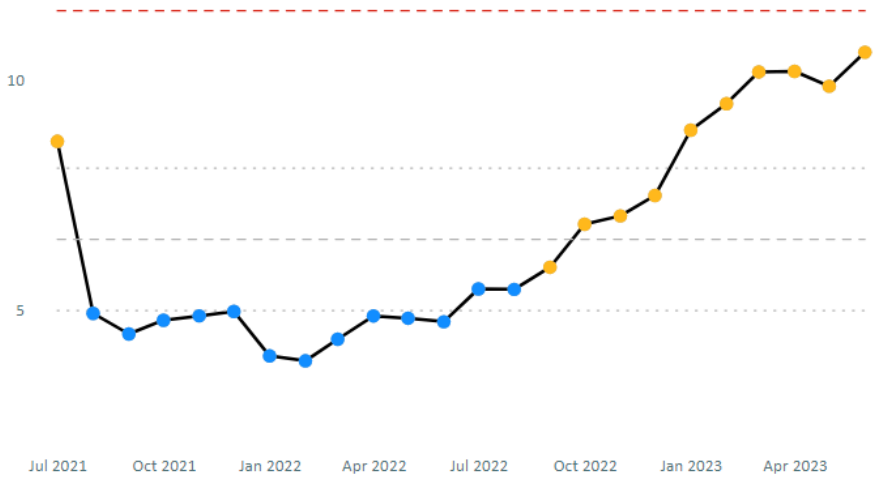
P — Variation indicates consistently passing the target

H — Special cause of concerning nature or higher pressure due to higher values

Flag Description

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

XMR Run Chart



What the chart tells us
There has been a significant rise in turnover up to June, at 10.6% for maternity (midwives and support staff)
Within this figure, the turnover rate at WHH is the driving factor – with a significantly high rate of 21.7%, compared to the QEQM rate of 3.1%, and Community at 5.4%.

Intervention and Planned Impact

- There have been a total of 13 Internationally educated midwives with 5 passing their OSCE and commencing their bridging programme. They should commence there preceptorship programme in September 2023, with the other 8 completing their OSCE and commence their bridging programme in early September. This will be a total of 13 additional midwives. There has also been the recruitment of 3 band 5 midwives due to commence in September 2023.
- We continue to advertise for band 5,6 and 7 midwives and have interviews for the band 7 vacancy in August 2023 where we hope to successfully recruit
- We are in the process of advertising for a dedicated elective caesarean section team which it is hoped this will encourage interest from external applications.
- We are hopeful that year 2 and 3 students will return in October 2023 and we are honouring their offers of employment.

Risks/Mitigations

- Data cleansing of the esr data and it has been noted in June that 5 midwives were still allocated the hospital at WHH, however, they have been in the community setting for some months and this hadn't been changed so has impacted the data
- Use of NHSP and agency midwives, request for incentive for WHH staff
- Lower threshold for divert between units to equalise activity
- Ongoing recruitment

People & Culture, Workforce Sustainability: Exception Report

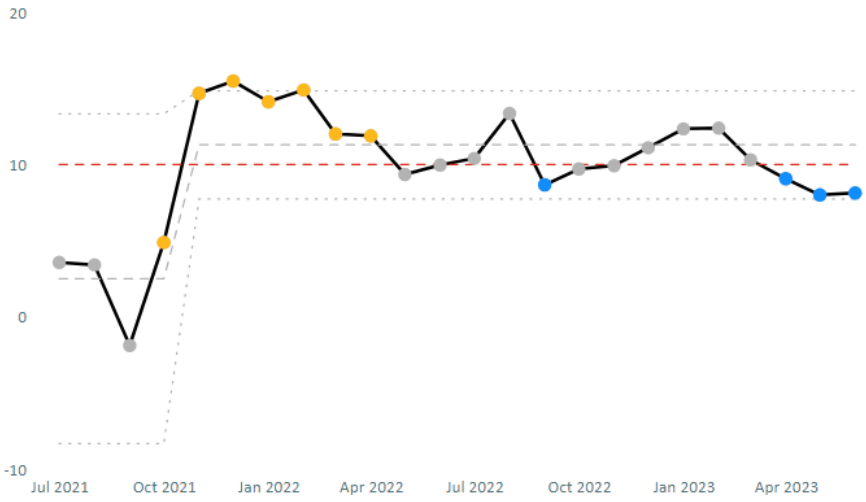
Midwifery / MSW Vacancy Rate
The proportion of vacant positions against the number of Whole Time Equivalent (WTE) funded establishment.
Nursing and Midwifery and Additional Clinical Services (MSW/MCA) staffing group under specialty of 560 - Midwifery (includes management)

Threshold locally agreed

Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
10.4%	13.3%	8.7%	9.7%	9.9%	11.1%	12.3%	12.4%	10.3%	9.1%	8.0%	8.1%

Variation indicates inconsistently passing and falling short of the target	Special cause of improving nature or lower pressure due to lower values	Flag Description Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us
There has been a significant decrease with 2 out of 3 of the last months close to the lower confidence limit.
There are specific shifts in each area:

- WHH vacancy rate is reducing, from a high of 22% in Feb, to 8.6% in June
- QEQM vacancy remains static – and low – at 2.4%
- Community has been increasing – nothing significantly flagging yet, but it may do so next month (currently 12.3%)

Intervention and Planned Impact

Need to discuss – Does not feel correct data

Risks/Mitigations

People & Culture, Workforce Sustainability: Exception Report

Midwifery / MSW Appraisal Rate
Appraisal rate for all staff under 560 maternity, excluding admin and clerical staff

Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
74.2%	71.7%	74.2%	73.4%	74.2%	71.2%	68.0%	65.2%	63.2%	61.7%	60.0%	58.7%

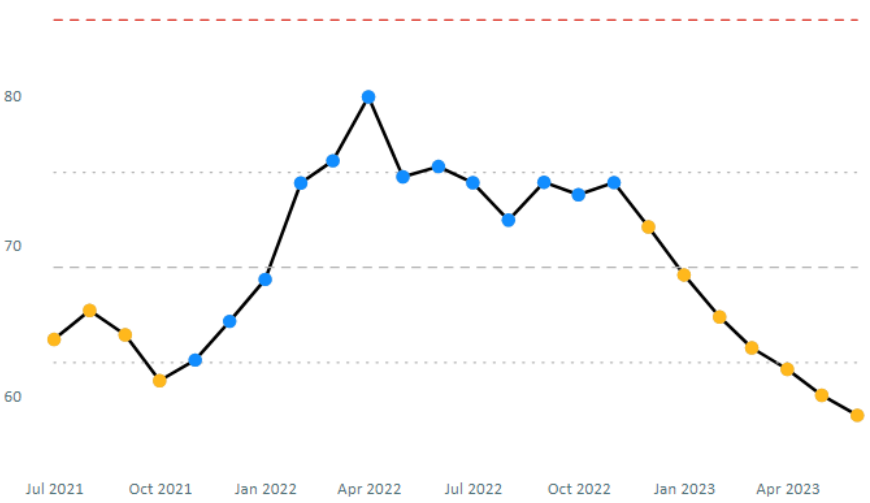
F — Variation indicates consistently falling short of the target

L — Special cause of concerning nature or higher pressure due to lower values

Flag Description

Astronomical Point
Descending Run Group
Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us
Appraisal rates continue to fall, with 3 months beyond the 2 sigma group. There is significant disparity between the sites:

- WHH compliance is 29.5% - 48 midwives and 19 support staff non-compliant
- QEQM compliance is 74% - 26 midwives and 4 support staff non-compliant
- Community compliance is 73% - 22 midwives and 2 support staff non-compliant
- Management (including governance/specialised MW) compliance is 53%

Intervention and Planned Impact

- Matrons have allocated the appraisals to all staff to complete within 8 weeks**, this is 5 weeks in to this process**
- Additional training given to staff in relation to uploading to ESR
- HOM's are holding staff to account and asking for weekly updates on completion and compliance.

Risks/Mitigations

- The appraisal data will remain poor until these have been uploaded so would expect significant improvement with the June data.
- Staffing levels and sickness remain a challenge and impact on the completion of planned appraisals due to staff being pulled to work clinically

People & Culture, Workforce Sustainability: Exception Report

Supernumerary Status
Supernumerary status achieved. Based off documentation from Birthrate+.
Of all the time periods captured, how many of those did not record 'Coordinator not able to maintain supernumerary/ supervisory status'

Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
98.2%	97.8%	98.6%	98.9%	98.9%	99.0%	98.5%	99.0%	99.3%	99.7%	99.7%	99.7%

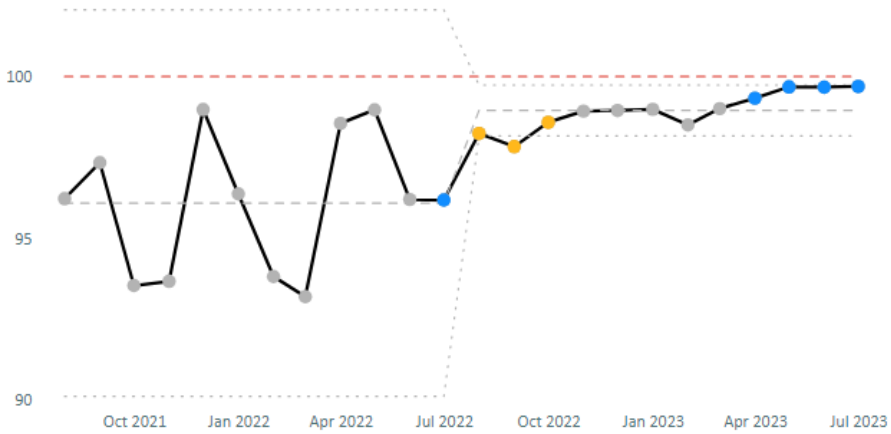
F — Variation indicates consistently falling short of the target

H — Special cause of improving nature or lower pressure due to higher values

Flag Description

Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us
The % compliance remains below the 100% target, but has been higher than average for 4 consecutive months, and 2 of the last 3 points were close to the upper limit
There was 1 breach on WHH labour ward in July. When reviewing this data was during high activity when the Co-Ordinator covered inductions whilst awaiting the arrival of an on call midwife. Which is in accurate recording

Intervention and Planned Impact
- Training of Band 7 of what supernumerary means and how to learning how to avoid a breach.

Risks/Mitigations
- **Staffing levels at WHH are challenged**
- **Band 7 interviews in August to increase to full complement of band 7 staff to ensure 2 x band 7 per shift**

People & Culture, Workforce Sustainability: Exception Report

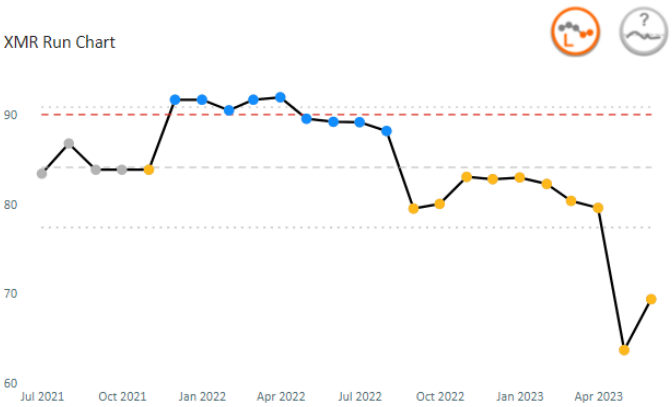
Safeguarding Adults Training

Safeguarding Adults Level 2 training compliance for staff on ward/department 344 3210 Maternity WHH, 344 3211 Maternity QEQM and 344 3212 Maternity K&C and Canterbury Coastal Community. This training is required for the majority of the staff

Safeguarding Adults Level 3 training compliance for staff on ward/department 344 3210 Maternity WHH, 344 3211 Maternity QEQM and 344 3212 Maternity K&C and Canterbury Coastal Community. Note – this level of training relates to a small number of staff

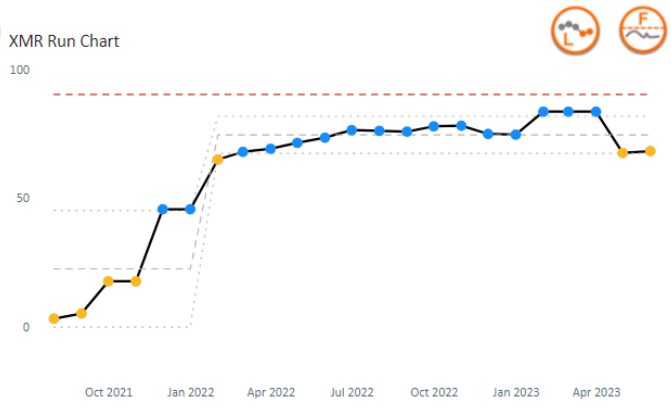
Safeguarding Adult Lvl 2

Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
89.1%	88.2%	79.5%	80.0%	83.0%	82.8%	83.0%	82.2%	80.3%	79.6%	63.6%	69.3%



Safeguarding Adult Lvl 3

Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
76.2%	75.9%	75.6%	77.6%	77.9%	74.7%	74.4%	83.3%	83.3%	83.3%	67.4%	68.1%



What the chart tells us

Level 2

Compliance has not been achieved for 13 consecutive months, and the June remains below the lower confidence limit

- WHH compliance : 57% (reduction)
- QEQM compliance : 83% (improvement)
- KCH/Community compliance : 70% (improvement)

Level 3

Compliance has dropped for the last 2 months to the lower confidence limit

Intervention and Planned Impact

All staff out of date have been booked on to training and the trajectory if that all staff will be training by the end of November. Matrons will be reviewing the data to ensure the trajectory is being reached.

Risks/Mitigations

- Staffing levels remain an issue and though there is recognition of the importance of this training direct care at times takes priority.

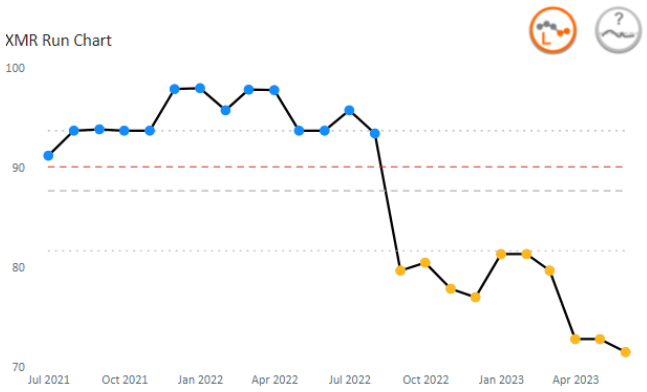
People & Culture, Workforce Sustainability: Exception Report

Child Protection Training

Child Protection Level 2 training compliance for staff under 344 3212 Maternity K&C and Canterbury Coastal Community, 344 3211 Maternity QEQM and 344 3210 Maternity WHH.
Note – this level of training relates to a small number of staff
Child Protection Level 3 training compliance for staff under 344 3212 Maternity K&C and Canterbury Coastal Community, 344 3211 Maternity QEQM and 344 3210 Maternity WHH.
This training is required for the majority of the staff

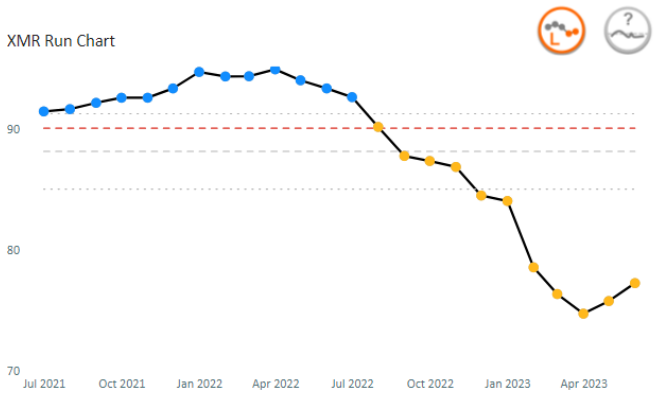
Child Protection Level 2

Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
95.7%	93.3%	79.6%	80.4%	77.8%	76.9%	81.3%	81.3%	79.6%	72.7%	72.7%	71.4%



Child Protection Level 3

Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
92.6%	90.1%	87.7%	87.3%	86.8%	84.4%	84.0%	78.5%	76.3%	74.7%	75.7%	77.2%



What the chart tells us

Level 2

Compliance has not been achieved for 10 consecutive months, with all months below the lower confidence limit and a big drop in May

- WHH compliance : 55% (reduction)
- QEQM compliance : 95% (improvement)
- KCH/Community compliance : 75% (static)

Level 3

There has been an improvement in May/June, but performance is significantly below the target in Level 3.

- WHH compliance : 67% (reduction)
- QEQM compliance : 84% (increase)
- KCH/Community compliance : 80% (static)

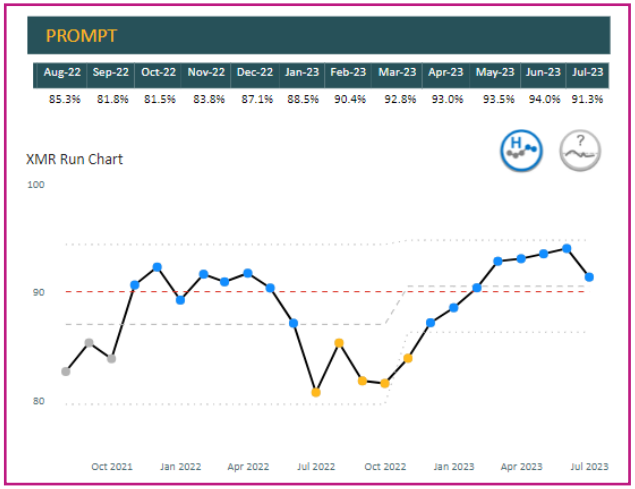
Intervention and Planned Impact

All staff out of date have been booked on to training and the trajectory if that all staff will be training by the end of November. Matrons will be reviewing the data to ensure the trajectory is being reached

Risks/Mitigations

- Staffing levels remain an issue and though there is recognition of the importance of this training direct care at times takes priority.

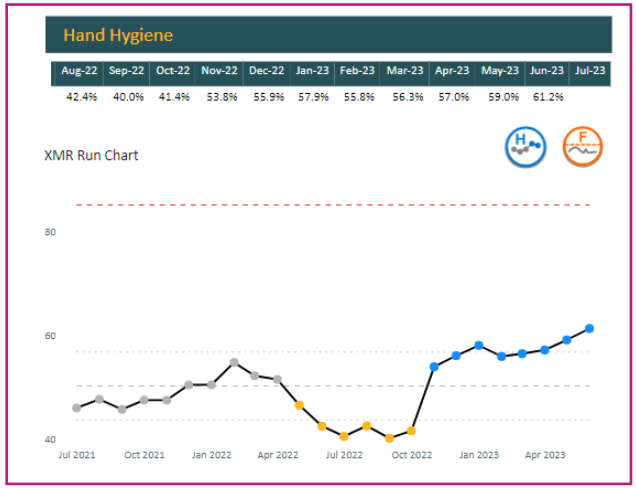
People & Culture, Workforce Sustainability: KPIs consistently achieving threshold or sustained improvement (exception reported in previous months)



PROMPT training
All staff (includes staff on maternity and long term sick)

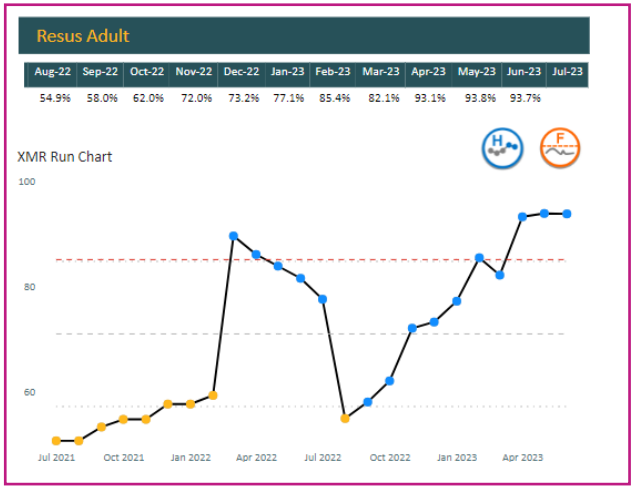
Compliance achieved for 6 consecutive months, with an upwards trend near the upper confidence limit.

Percentage of compliance for staff exc LTS and maternity leave is 96%



Hand Hygeine
Remains below target, but improving performance

Targeted hand hygiene training is being carried out and should be achieved by end of September.



Resus (adult)
Remains above target for 3 consecutive months

This is continued hard work of the PD team to ensure all staff attend their resus training

Clinical Pathways

To progress evidence-based clinical care pathways to consistently deliver equitable, high quality, safe care and treatment

Clinical Pathways: Overview

Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	Mean	LCL	UCL
Antenatal	Number of Bookings	Sigma	Jul-23	544			570	406	735
	Bookings <13w Exceptions Excl	Sigma	Jul-23	94.0%			92.9%	89.5%	96.3%
	Bookings <13w	Sigma	Jul-23	88.1%			86.8%	83.3%	90.3%
	Bookings <10w	Sigma	Jul-23	45.4%			47.3%	36.2%	58.4%
	Total AN Appointments	Sigma	Jul-23	3,970			4,476	3,454	5,498
	Total AN Appts Virtual	Sigma	Jul-23	5.5%			15.3%	12.1%	18.5%
	Revised Birth Place at AN Appt	95.0%	Jul-23	98.0%			97.5%	97.1%	98.0%
	Revised Care Plan at AN Appt	95.0%	Jul-23	99.5%			99.5%	99.2%	99.9%
Triage	Telephone Triage by MW	95.0%	Jul-23	99.5%			87.6%	70.5%	100%
	BSOTS Total Seen	Sigma	Jul-23	2,196			2,268	1,775	2,761
	BSOTS Midwife Assessment	Sigma	Jul-23	97.1%			98.0%	94.7%	100%
	BSOTS Dr Assessment	Sigma	Jul-23	90.1%			92.0%	85.7%	98.2%
	BSOTS Datix Completed	Sigma	Jul-23	28.6%			54.4%	1.07%	100%
	BSOTS Red Rating	Sigma	Jul-23	6			25	0	55
	BSOTS Orange Rating	Sigma	Jul-23	224			305	203	406
	BSOTS Yellow Rating	Sigma	Jul-23	526			437	288	586
	BSOTS Green Rating	Sigma	Jul-23	633			506	375	636
	BSOTS Non Triage Activity	Sigma	Jul-23	775			786	555	1,018
	BSOTS Rating Undocumented	Sigma	Jul-23	31			211	36	386

Clinical Pathways: Overview

Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	Mean	LCL	UCL
Scanning	Attended Scans	Sigma	Jul-23	3,272			3,480	2,855	4,105
	Cancelled by Hospital	Sigma	Jul-23	1,204			1,071	854	1,288
	Cancelled by Patient	Sigma	Jul-23	257			315	172	459
	DNA Scans	Sigma	Jul-23	265			338	213	463
	DNA Rate	Sigma	Jul-23	8.9%			10.6%	7.31%	13.9%

Clinical Pathways: Overview

Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	Mean	LCL	UCL
Delivery	Total Babies Born	Sigma	Jul-23	493			511	426	595
	Term Livebirth Delivery Rate	Sigma	Jul-23	92.3%			91.5%	88.0%	95.0%
	Induction Rate	Sigma	Jul-23	34.8%			33.7%	27.3%	40.2%
	Spon Vaginal Delivery Rate	Sigma	Jul-23	51.8%			48.8%	43.0%	54.7%
	Instrumental Delivery Rate	Sigma	Jul-23	8.8%			10.5%	6.75%	14.3%
	Forcep Delivery Rate	Sigma	Jul-23	6.6%			6.96%	3.31%	10.6%
	Vacuum Delivery Rate	Sigma	Jul-23	2.3%			3.60%	1.18%	6.02%
	Total Section Rate	Sigma	Jul-23	39.3%			37.5%	30.7%	44.2%
	Elective Section Rate	Sigma	Jul-23	17.6%			16.4%	11.0%	21.9%
	Emergency Section Rate	Sigma	Jul-23	21.7%			21.0%	17.2%	24.8%
	Cat 1 Section <30m	Sigma	Jul-23	70.0%			78.6%	59.8%	97.4%
	Cat 2 Section <75m	Sigma	Jul-23	72.9%			67.8%	48.2%	87.3%
	Robson Group 1 C/S Rate	Sigma	Jul-23	16.3%			15.7%	11.5%	27.8%
	Robson Group 2 C/S Rate	Sigma	Jul-23	51.6%			51.9%	31.0%	66.0%
	Robson Group 5 C/S Rate	Sigma	Jul-23	89.1%			79.6%	72.8%	86.3%
	VBAC	Sigma	Jul-23	12.5%			14.6%	13.1%	19.9%
	Homebirth Rate	Sigma	Jul-23	2.0%			1.85%	0.24%	3.46%
	Planned Homebirth Rate	Sigma	Jul-23	1.0%			0.97%	0%	2.12%

Clinical Pathways: Overview

Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	Mean	LCL	UCL
Delivery Outcomes	3rd & 4th Degree Tears	Sigma	Jul-23	2.0%			2.92%	0.26%	5.57%
	MOH >1500ml	Sigma	Jul-23	2.7%			2.83%	0.70%	4.97%
	Shoulder Dystocia	Sigma	Jul-23	0.6%			1.52%	0%	3.75%
	Apgar <7 @ 5mins	Sigma	Jul-23	1.8%			0.90%	0%	2.53%
	Premature birth <37w	Sigma	Jul-23	7.7%			8.40%	4.95%	11.8%
Postnatal	Total PN Appointments	Sigma	Jul-23	39			384	20	124
	First PN Visit at Home	Sigma	Jul-23	20.6%			14.0%	0%	33.0%
	Total PN Appts Virtual	Sigma	Jul-23	23.1%			51.7%	23.5%	79.8%
	Maternal Readmissions	Sigma	Jul-23	5.6%			3.95%	1.78%	6.12%
	Neonatal Readmissions	Sigma	Jul-23	7.1%			8.53%	6.10%	10.9%
Anaesthetics	Anaesthetic within 30mins	80.0%	Jul-23	96.9%			92.7%	83.4%	100%
	Anaesthetic within 60mins	100.0%	Jul-23	99.0%			96.8%	91.6%	100%
	Anaesthetic Timeliness DQ	Sigma	Jul-23	6			5	0	14
Public Health	Skin to Skin Contact	Sigma	Jul-23	82.5%			77.9%	71.5%	84.3%
	Breastfeeding First Feed	Sigma	Jul-23	67.6%			68.1%	60.4%	75.9%
Other	ITU Admissions	Sigma	Jul-23	1			2	0	5

Clinical Pathways: Overview

Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	Mean	LCL	UCL
SBLCB	E1 - Co Taken at Booking	80.0%	Jul-23	97.4%			94.8%	91.6%	98.0%
	E1 - Co >=4ppm at Booking	Sigma	Jul-23	12.6%			15.9%	10.9%	20.8%
	E1 - Co Reading taken at 36w	80.0%	Jul-23	92.3%			80.9%	72.1%	89.7%
	E1 - Co >=4ppm at 36w	Sigma	Jul-23	10.0%			9.90%	4.29%	15.5%
	E1 - Quit by 36w	Sigma	Jul-23	46.8%			51.6%	12.1%	91.0%
	E2 - SGA Detected Antenatally	Sigma	Jul-23	2.9%			3.74%	0.55%	6.93%
	E2 - Babies <3rd Centile 38w+	Sigma	Jul-23	40.0%			50.0%	19.0%	80.9%
	E2 - Babies <10th Centile 39w+	Sigma	Jul-23	37.7%			45.6%	23.8%	67.5%
	E2 - FGR Risks recorded	80.0%	Jul-23	99.1%			99.3%	98.4%	100%
	E3 - RFM Computerised CTG	80.0%	Jul-23	87.5%			88.1%	78.0%	98.2%
	E3 - RFM Leaflet Given by 28w	80.0%	Jul-23	83.6%			90.0%	86.0%	94.0%
	E4 - Fetal Monitoring Training	90.0%	Jul-23	93.8%			88.4%	83.3%	93.6%
	E5 - AN Steroids within 7 days	80.0%	Jul-23	33.3%			51.0%	11.5%	90.5%
	E5 - AN Steroids > 7 days	Sigma	Jul-23	33.3%			14.0%	0%	50.1%
	E5 - Mag Sulph within 24hrs	80.0%	Jul-23	100%			78.7%	0%	100%
	E5 - Appropriate Birth Setting	80.0%	Jul-23	100%			99.7%	99.0%	100%
	E5 - Singleton Born 16+0-23+6w	Sigma	Jul-23	0.0%			0.12%	0%	0.45%
	E5 - Singleton Born 24+0-36+6w	Sigma	Jul-23	5.7%			7.02%	3.87%	10.1%

Clinical Pathways: Exception Report

Scanning – Cancellations by Hospital

Number of scanning patients cancelled by hospital

Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
1,023	957	984	1,092	1,044	1,074	1,034	1,342	1,242	1,277	1,271	1,204

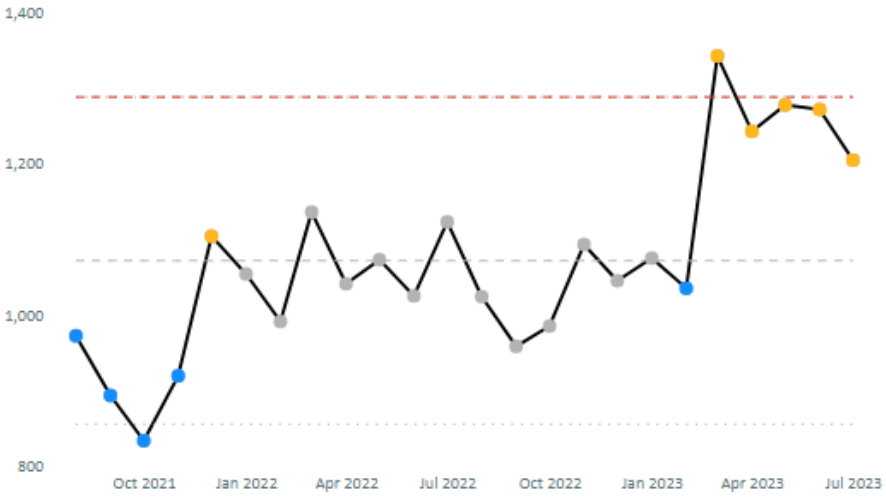
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us

The number of patients who had a scan appointment cancelled by Hospital has increased above average for 5 months however, this has started to reduce in July

The number remains high as validation continues on the scanning caseload, and multiple requests are cleared from the system

Interventions and Planned Impact

A full report will be provided on actions in relation to this issue

Risks/Mitigations

Clinical Pathways: Exception Report

East Kent Hospitals University NHS Foundation Trust

Maternal Readmissions

Percentage of mothers who are readmitted non-electively within 28 days of selivery

Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
3.3%	3.5%	3.2%	2.9%	3.4%	3.2%	4.1%	5.3%	4.1%	6.4%	6.6%	5.6%

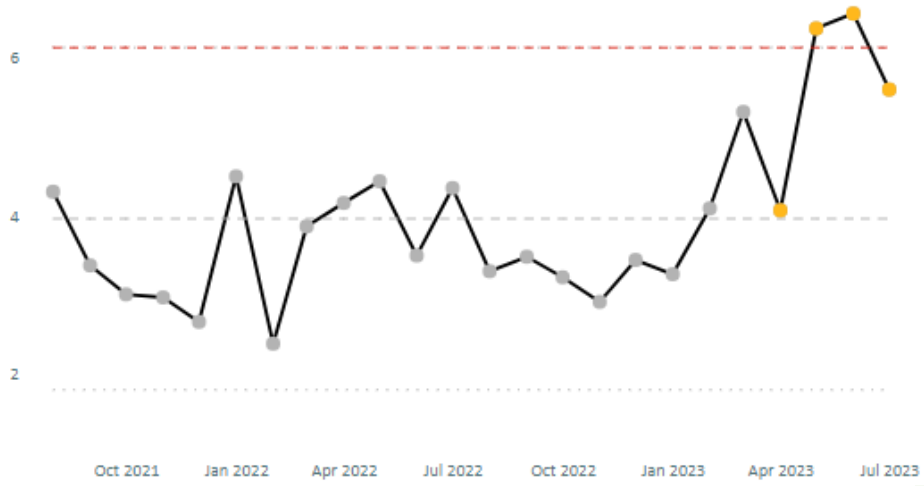
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us

Readmissions remain higher than average, with 27 maternal readmissions in June – double the usual amount

Reasons for readmission included:

- Delayed PPH x 4
- Severe Pre Eclampsia x 2
- Infection/disruption of wound x 2

Interventions and Planned Impact

Risk team have been asked to explore/review re-admissions and share learning

Risks/Mitigations

Clinical Pathways: KPIs consistently achieving threshold or sustained improvement (exception reported in previous months)

Engagement

To listen to our birthing people and our workforce to design coproduced, personalised and equitable Maternity & Neonatal Services

Engagement: Overview

Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	Mean	LCL	UCL
Patient Experience	Complaints	Sigma	Jul-23	6			6	0	15
	FFT Maternity Response Rate	5.0%	Jul-23	11.4%			12.7%	3.24%	17.1%
	FFT Maternity (All)	90.0%	Jul-23	95.3%			91.1%	83.9%	98.3%
YVIH	Response Rate	70.0%	Jul-23	75.7%			69.3%	59.5%	79.1%
	AN Care Positive	90.0%	Jul-23	91.4%			90.7%	86.2%	95.3%
	Intrpartum Care Positive	90.0%	Jul-23	88.3%			91.6%	82.9%	100%
	PN Care Positive	90.0%	Jul-23	82.7%			84.8%	78.6%	90.9%
	Happy Returning	90.0%	Jul-23	88.9%			89.3%	81.7%	96.9%
	Involved in Decisions	90.0%	Jul-23	87.8%			87.6%	81.8%	93.5%
	Choices About Care	90.0%	Jul-23	84.1%			84.6%	78.2%	91.0%
	Felt Listened To	90.0%	Jul-23	78.8%			81.2%	74.0%	88.3%

Engagement: Exception Report

YVIH Happy Returning

% of women who answered that they'd be happy returning to EKHUFT for future pregnancy care

Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
90.7%	93.2%	89.6%	89.8%	91.5%	86.4%	88.4%	81.2%	86.7%	86.3%	87.5%	88.9%

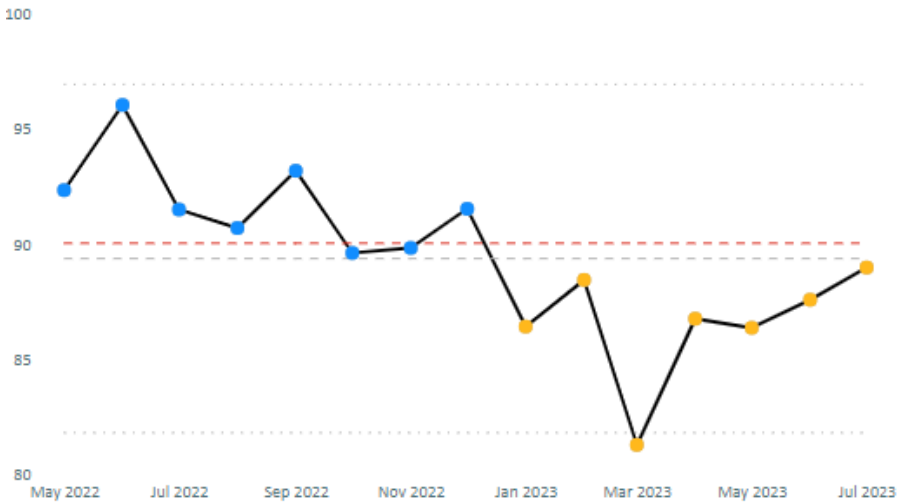
Variation indicates inconsistently passing and falling short of the target

Special cause of concerning nature or higher pressure due to lower values

Flag Description

Below Mean Run Group

XMR Run Chart



What the chart tells us

Performance remains below the target of 90%

Ashford area has the highest level of women who say they wouldn't be happy to return (19) and a rate of 74%

Interventions and Planned Impact

Risk / Mitigations

Other / Appendix

Your Voice Is Heard July 2023

NHS East Kent Hospitals University NHS Foundation Trust

75.7%
Response rate

405
Listened to, out of:
535
Women / Birthing People

88.9%
People happy to return to EKHUFT

Antenatal and Postnatal care can relate to either care on the hospital wards, or care received in the community, hospital clinics or at home

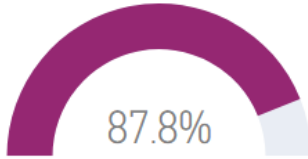
88.3%
People positive about labour care

91.4%
People positive about AN care

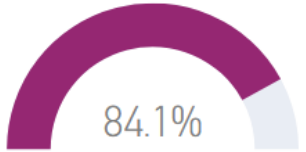
82.7%
People positive about PN care

% of Women / Birthing People who rated Labour care as 3 or 4 out of 4 (excellent), by place of delivery

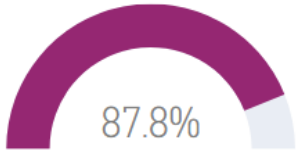
I was included in decisions about my care



I was given choices about my care



I was listened to through my care



Maternity Infographic - July 2023

NHS
East Kent Hospitals University NHS Foundation Trust

493 Babies born

251 Boys (51%)

242 Girls (49%)

301 Babies breastfed at first feed

68%

Busiest day

23 babies born

Spontaneous vaginal delivery

Vaginal deliveries which needed no assistance from forceps, ventouse or caesarean section

253 Percent of spontaneous vaginal deliveries which were induced: 52%

41%

Bookings for pregnancy care

543

Twin / multiples

5

Women / birthing people induced

170 35%

Delivery outcome for inductions:

61%	Spontaneous Vaginal
28%	Emergency Caesarean Section
11%	Assisted Vaginal

Top Reasons for Induction:

Reduced fetal movements	
Other maternal reason	12%
Suspected SGA	12%
Pre labour rupture of membranes at t...	11%
Gestational diabetes	9%

Caesarean section delivery

192 39%

Cat 1. Immediate/Life Threat	14%
Cat 2. Emergency No Life Threat	42%
Cat 3. Emergency No Immediate Risk	22%
Cat 4. Elective/Planned	22%

488 Women / birthing people delivered

William Harvey	56%
QEQM	39%
QEQM MLU	2%
Homebirth	2%
BBA/Transit	1%

Assisted vaginal delivery

Vaginal deliveries which required the assistance of forceps or ventouse

43 9%

74% 26%

Forcep Deliveries Ventouse Deliveries

Your voice is heard

NHS
East Kent Hospitals University
NHS Foundation Trust

Your Voice is Heard – Feedback from local families

Safety Summit - July 2023

EAST KENT Maternity Voices
Working in partnership to improve maternity services

Jill Roffey, Lead PMA
Ashley Lamb and Cassie Crayford, Patient Experience Midwives

We care

Your voice is heard

Your Voice is Heard (YVIH) was coproduced to ensure families' voices are heard and their feedback used to inform and shape future maternity care. Initially a 6-week pilot, this is now a successful substantive service at EKHUFT.

There are 12 questions are asked during the phone call/conversation:

These are the questions we will ask you at your telephone appointment:

How would you describe your care?

What do you feel went well?

Is there anything you feel we could have done better?

Do you feel you were given choices about your care?

Do you feel you were included with making decisions about your care?

Did you feel listened to throughout your care?

Does your support partner have any comments?

How would you score your pregnancy (antenatal) / birth / after care (postnatal care) on a scale of one to four, with one being poor and four being excellent?

If you were to have another baby, would you choose to return to us for your maternity care, or would you choose go to a different NHS Trust, if it was just as close to you?

Do you have any other comments you would like to share?

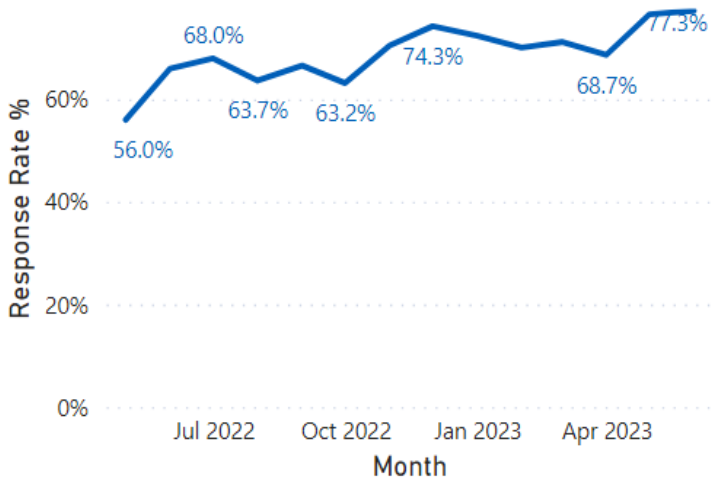
Your Voice is Heard

Place of delivery: All

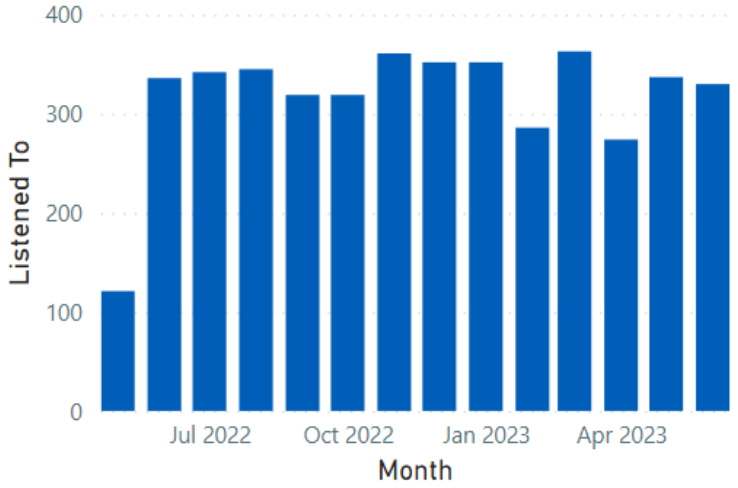
Community team: All

NHS East Kent Hospitals University NHS Foundation Trust

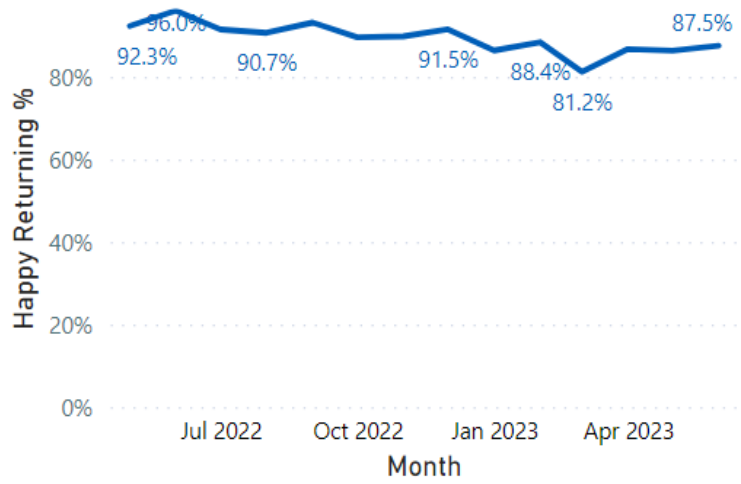
Response Rate %



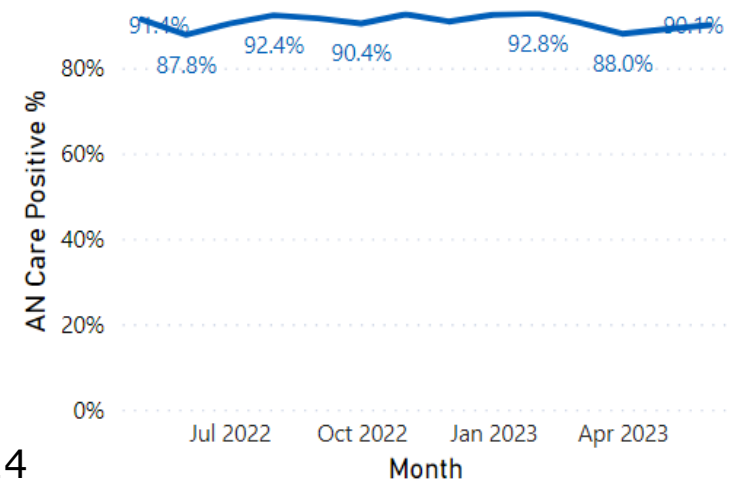
Number Listened To



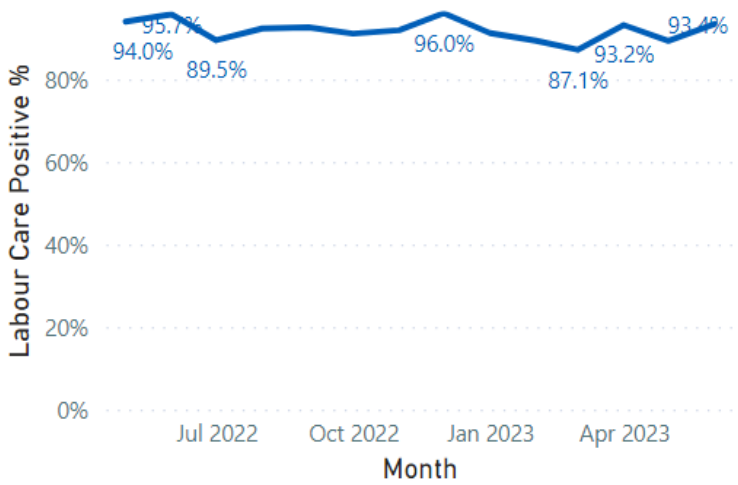
Happy to Return to EKHUFT %



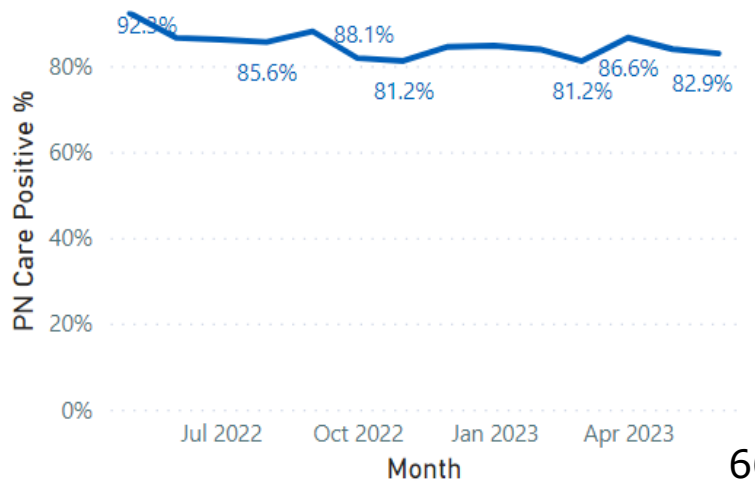
AN Care Positive %



IP Care Positive %



PN Care Positive %



Your voice is heard

NHS
East Kent Hospitals University
NHS Foundation Trust

Many staff are sent emails when they are mentioned positively in YVIH, but what about negative feedback? Here are the words of some of our families….

EAST KENT Maternity Voices
Working in partnership to improve maternity services

We care

Your voice is heard

NHS
East Kent Hospitals University
NHS Foundation Trust

Negative comments

my only issue was on the ward, lights on all through the night, staff talking at a normal level at night, not quieter, partner there every night, also talking at a normal level, there was no resting

just the ward again, they are so understaffed, I got mixed advice about feeding, one midwife said leave her, then another midwife said no feed her, my catheter was full so my husband went to the desk to tell someone, he was given a pot to empty it himself, so my husband was supposed to do it but then someone else said no you shouldn't be doing that,

there was a midwife I didn't like, that didn't listen, I wanted to push but she wouldn't let me, so when I did push he came out straight away, she should have listened to the mum more, everyone else did.

Once I had had the baby I felt forgotten about, they tried to give me extra Clexane, I had already had it but no one had written down, they left me in dirty blood soaked pads for 15 hours, when I had the catheter out after the c-section, I was told to ask for some help to get up for the toilet and a shower, but when I did, the lady said, no you are not ready, then left me for 3 hours, I had to take myself for a shower, as no one would help, I asked for some help but it was the same person, it upset me as I have had 3 other children naturally but I felt as it was a section I was forgotten about.

Continuity of carer in the antenatal period. Shorten the discharge process. I was told I could go at midday but they waited till 5pm as they needed the doctor to sign off the medication

Your voice is heard

NHS
East Kent Hospitals University
NHS Foundation Trust

What could we have done better?

consultant could have seen more didn't feel had continuity, the way the staff treat each other is disgusting, not friendly to each other, simple things like treat me no gloves on, not compassionate, was inpatient for 5/52 one doctor came and said ignorance is bliss and you are better, doctors seemed unprofessional, felt like I was arguing to get things done,
a couple of things, when I came in in labour, I was due to have a section, the doctors were so rude and brash as I still wanted a section, the doctors need to be more like the midwives, patient, also my son was given the wrong medication, he had a similar name to another baby on the ward, they need to find a system that works so this doesn't happen again
at 32 weeks I realised no bloods had been done at 28 weeks and I had to check this I was not seen for 12 weeks. Discharge was abysmal- I had done all the wees and then there was a hold up due to staff having a break and then with the medications- got to 6pm and I left without the medications and went to local pharmacy and got them there- it was so much easier- my experience is that I could have got home at midday and I didn't leave until 7- I went to local pharmacy and then got my meds on the way home. Other than that, everything was perfect. It would have been good to have seen a latch specialist team to check feeding. Staff short on the PN ward. I found that some midwives were really attentive but no one really came to me but maybe due to issues. It would have been nice to know that there was someone there to help me. staff shortages. At least tell us how long we shall be waiting for medications and if a while we should be offered the prescription for the medications if needed. Should be offered. I said I didn't want food as thought I was going home

Your voice is heard

NHS
East Kent Hospitals University
NHS Foundation Trust

But there is so much more positivity than negativity- latest data shows that 79% of our families experience were overall positive (14% neutral and 7% negative)… so what do these families say…. This is a small sample:

All the staff were really lovely well informed listened to everything that I wanted, always explained alternative route, and at ease with my pregnancy and giving birth.
I would be more then happy to return, the care i received was just outstanding. The team, that looked after me during my section I am truly grateful and thankful for the care I received, i would like to say a thank you I feel truly blessed to have been cared for by each and everyone of you, thank you from the bottom of my heart god bless you.
It is obvious that the midwives are obviously trying to provide the best care within there needs.
Everything was fine, I really appreciate the maternity team they were very good and they made my experience very good
I would give my labour score more if I could, the midwife was really friendly, she even came to see us on the ward after, she was really approachable and friendly
keep up the good work
I was really happy, we came away really positive
yeah it was really good, everyone was really attentive, my cmw was fantastic she always adressed any concerns and questions were adressed or awnsered really quickly. In labour my midwive was amzing, and post nataly I had a heamorragh they were amazing and really looked after me. i felt really safe within there care, and really well cared for.

Your voice is heard

NHS
East Kent Hospitals University
NHS Foundation Trust

I really enjoyed the AN care, The nurse in the delivery room was good too, Maybe I came across as grumpy and angry but the still took good care of me and the baby, I was impressed by that

no I just want to say thank you to everyone there and going above and beyond didn't go unnoticed and it did make everything easier. Bending the rules slightly for visiting hours in the Folkestone ward and SCBU meant a lo, it showed they are human and not robots and it was very personal and meant a lot to me. In the community though the PN care was a 4, my community midwife was brilliant though. Next time I'm having a homebirth though .The midwives have always been fantastic, I'm sorry to hear the news at the moment

there was a MCA their that was amazing, I saw her through my pregnancy, she was grate and really amazing, and there was a midwife there that was amazing during my after care and really looked after me. There was another one as well. They constantly checked in on us, and were just amazing.

I come out of my area to come to you already. I am really happy- I know on the news East kent have had it issues but I cannot fault you at all. I tell everyone!

The midwives have always been fantastic, I'm sorry to hear the news at the moment

I don't understand all the messages on the news- I feel like what they are putting up is utter bullshit. After you have a baby you are in blood- they do as much as you can and you have to help yourself. They cant do everything. There is no way they would leave the baby un-fed. People panic when pregnant as is it safe you have a baby but I couldn't fault them .

i was worried due to the report but the midwives i had was really good and gave me really good care.

Your voice is heard

NHS
East Kent
Hospitals University
NHS Foundation Trust

Some of the Actions from feedback

EAST KENT
Maternity
Voices
working in partnership to improve maternity services

We care

Your voice is heard

NHS East Kent Hospitals University NHS Foundation Trust

Basic Postnatal care -Essential rounding

"I felt like I was just left as we needed no intervention and I was at the bottom of the list"

Patient label

NHS East Kent Hospitals University NHS Foundation Trust

Please answer Y or N for each entry and clearly initial	Date:						Date:						Date:					
	02.00	06.00	10.00	14.00	18.00	22.00	02.00	06.00	10.00	14.00	18.00	22.00	02.00	06.00	10.00	14.00	18.00	22.00
Sample question	Y-yes	Y yes	Y yes	N yes	Y no	Y no												
Has the women had adequate pain relief?																		
Has the women been offered food and drink?																		
Does the women have water available?																		
Has baby fed in the last 3 hours?																		
Has bedding been changed in today if not being discharged?																		
Are the sheets clean?																		
Is the bed area de-cluttered																		
Is urinary care appropriate? (catheter emptied, supported to PU)																		
Date and time of action if answered no?																		

We care

Noise on Folkestone Ward-Bins

"The ward was so noisy -bins are so loud- bins slams shut- woke up with a heart pounding"

"Bins are so loud- baby startled"

We care

Your voice is heard

NHS East Kent Hospitals University NHS Foundation Trust

Postnatal visits- 1st day home

"Since coming home we have had a phone call instead of coming to our house, we expected more home visits"

"PN was only seen in a clinic- would have liked to be seen at home. With a new born easier to be at home"

Analgesia in Labour- Series on social media

Do you feel you were given choices about your care?

"no, not with pain relief. They offered me some but didn't discuss what was offered".

Your voice is heard

NHS East Kent Hospitals University NHS Foundation Trust

Antenatal Education- Co Production Events

"I got most of my education about PN care from a friend who had a baby recently- I had no education for postnatal part of how to care for myself and baby- that was disappointing"

No food/drink provision for birthing partners

"It would have been good to have tea for partners- he was staying with me and he had to go out to get food- I needed his help with me the whole time"

" this is an incredible improvement and I am so glad our voices have been listened to".

Your voice is heard

NHS
East Kent
Hospitals University
NHS Foundation Trust

What do our families think of the YVIH service?

EAST KENT
Maternity
Voices
working in partnership to improve maternity services

We care

I think this feedback service is really good to have the opportunity to be able to feedback.

Thank you for calling me its been lovely

Its nice to be able to say this and give the good feedback back.

I wish you had done this last time with my others- as I nearly died with the first as left afterbirth in me - so wish this service was around then.

Praise yourself as well nice to have someone who supported what I did and welcoming and listens.

Nice opportunity to feedback thank you, its such positive service you're running, I was really happy to give feedback.

Thank you for this opportunity to chat- it's a good amount of time after birth as well.

I am grateful for this

Thank you for your call - you are so far from the system and so caring.

East Kent Hospitals University NHS Foundation Trust

REPORT TO READING THE SIGNALS OVERSIGHT GROUP

Report title: **Reading the signals update**

Meeting date: **1 August 2023**

Board sponsor: **Chief Strategy and Partnership Officer**

Paper Author: **Executive Director, Communications and Engagement**

Appendices:

NONE

Executive summary:

Action required:	**Discussion**
Purpose of the Report:	To update the Board on key developments relating to *Reading the signals.*
Summary of key issues:	This report provides an update on the government's response to Reading the signals and the national recommendations within it.
Key recommendations:	The Board of Directors is requested to **DISCUSS** and **NOTE** the report.

Implications:

Links to Strategic Themes:	• Quality and safety • Patients • People • Partnerships • Sustainability
Link to the Board Assurance Framework (BAF):	**BAF 39:** There is a risk that women and their families will not have confidence in East Kent maternity services if sufficient improvements cannot be evidenced following the outcome of the Independent Investigation into East Kent Maternity Services (IIEKMS). **BAF 32:** There is a risk of harm to patients if high standards of care and improvement workstreams are not delivered.
Link to the Corporate Risk Register (CRR):	**CRR 118:** There is a risk of failure to address poor organisational culture.
Resource:	N
Legal and regulatory:	N
Subsidiary:	N

East Kent Hospitals University NHS Foundation Trust

Assurance route:

Previously considered by: N/A

East Kent Hospitals University NHS Foundation Trust

READING THE SIGNALS UPDATE

1. Purpose of the Report

This report provides an update on the government's response to Reading the signals and the national recommendations within it and an update on the *Reading the Signals* Oversight Group.

2. Background

In February 2020, NHS England commissioned Dr Bill Kirkup to undertake an independent review into maternity and neonatal services at East Kent Hospitals University NHS Foundation Trust.

On 19 October 2022, the Independent Investigation published its report into our maternity and new-born services, *Reading the signals*. The Trust Board accepted the report in full and apologised unreservedly for the Trust's unacceptable failings which led to the harm and suffering experienced by women, babies and their families, in our care. This report provides an update on the key elements of the Trust's response.

In his report *Reading the signals*, Dr Bill Kirkup made 5 recommendations for the healthcare system. In March 2023, the government provided an interim response to the report via a written ministerial statement.

On Thursday, 20 July, the DHSC published its full response which details how it is implementing Dr Kirkup's recommendations.

3. Maternity and Neonatal Care National Oversight Group

The minister for Women's Health, Maria Caulfield, will chair a new group overseeing maternity services nationwide. The maternity and neonatal care national oversight group will bring together people from the NHS and other organisations. It will look across work being carried out by a range of programmes set up to improve maternity and neonatal care, including the implementation of Dr Kirkup's and other recommendations, to ensure they are joined up and effective.

4. East Kent local forum

In East Kent, the minister will chair a local forum bringing together local NHS representatives, the Care Quality Commission and local MPs to share information and updates on the improvements being made to maternity services.

5. Reading the Signals Data Co-ordination Group

To identify early when a maternity service is vulnerable and at risk of providing unsafe care to patients, so that action can be taken, NHSE has established a Reading the Signals Data Co-ordination Group, which will bring together a series of data projects which aim to make sure the right data will be used in the right way to identify and support trusts who may be vulnerable to bad outcomes.

This will employ multiple approaches to make sure that all information that may signal concern is captured. This data will provide more timely and sensitive information to inform the data and intelligence to be shared through the perinatal quality surveillance model.

6. Work with healthcare partners

The Minister for Women's Health has appointed Dr Kirkup to lead work with healthcare partners in response to these recommendations, helping to ensure teams in maternity and neonatal care across England can work together more collaboratively so the best quality, compassionate care is provided.

Organisations from across the health and care system, including the Royal College of Obstetricians and Gynaecologists (RCOG) and the Royal College of Midwives (RCM), have been asked by the government to support its efforts to promote and improve team-working in healthcare settings.

Royal colleges, professional regulators and employers have also been asked to investigate how they can improve workplace culture so standards of professional behaviour in maternity and neonatal settings are high. They'll consider what appropriate action can be taken if high standards fail to be met.

7. Honesty and transparency

The government report sets out how healthcare professionals and organisations must be honest and transparent with patients, their families and with other bodies. Trust boards are expected to support a focused plan to improve and sustain culture, including alignment with their Freedom to Speak Up (FTSU) strategy and ensuing all staff have access to FTSU training and a guardian who can support them.

The new Patient Safety Incident Response Framework (PSIRF) makes it mandatory for providers to work compassionately with those affected by an incident and the legal expectations of duty of candour and meaningful engagement and involvement of service users and staff.

When considering the broader recommendation made by Dr Kirkup for a bill to place a "duty on public bodies not to deny, deflect and conceal information from families and other bodies", the government is to set out its position in response to Bishop James Jones' 2017 report on the experiences of the families bereaved by the Hillsborough disaster in due course. The government believes that this transparency should extend to clear understanding of the processes for families to have their voices heard, access redress and independent support.

8. Further actions

The report also included the below actions, which are being or have been taken:

- trusts will have to ensure there is proper representation of maternity care on their boards
- the government will continue to work with NHS England on its approach to poorly performing trusts and their leadership
- East Kent Hospitals NHS Trust will continue working to address the problems identified and improve standards

9. Action the Trust has taken in response to Recommendation 5

The government report sets out how the Trust has accepted the reality of the findings, acknowledged in full the unnecessary harm that has been caused and is embarking on a restorative process addressing the problems identified, in partnership with families, publicly and with external input.

This includes the Trust's initial response, the holding of an extraordinary board meeting, publishing an open letter and sets out how the Trust is overseeing the work to transform its services, with examples including:

- Establishing a Reading The signals Oversight Group
- Independent Case Review Process
- Your Voice is Heard
- Co-production of pathways e.g. bereavement pathway.
- Adopting NHS England's Culture and Leadership Programme.
- Expanded Freedom to Speak Up guardians
- Implemented a rapid incident review process
- recruited a new experienced, substantive director and deputy director of midwifery
- Introduced care with compassion mandatory training.

10. Previous reports and programmes

NHS England's Maternity Transformation Programme was established in 2016 to implement a vision for safer and more personalised care across England. The programme was initially guided by Better births, published in 2016, which set out a 5 year forward view for improving outcomes of maternity services.

The NHS Long Term Plan, published in 2019, set out to make the NHS one of the best places in the world to give birth by offering mothers and babies better support and safer care. In March 2023, NHS England published its 3 year delivery plan for maternity and neonatal services, aimed at guiding the service towards being safer, more personalised, and more equitable for women, babies and families.

11. *Reading the Signals* Oversight Group

The *Reading the signals* Oversight Group meets in public and is responsible and directly accountable to the Board of Directors. It provides oversight of the programme, making sure there is engagement with those who use our services and that steps are taken to address the issues identified in the Reading the Signals report.

Following a discussion at the last meeting we are currently reviewing the information the group views and discusses with plans to include maternity dashboard information in future.

12. Next steps

The Maternity and Neonatal Assurance Group will review the government response and any arising actions which will be reported up to the Board through the governance structure.

13. Conclusion

The Board of Directors is requested to **DISCUSS** and **NOTE** this update report.

East Kent Hospitals University NHS Foundation Trust

TERMS OF REFERENCE

READING THE SIGNALS OVERSIGHT GROUP

1. CONSTITUTION

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

2. PURPOSE

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

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

3. OBJECTIVES

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

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

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

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

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

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

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

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

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

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

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

4 MEMBERSHIP AND ATTENDANCE

4.1 Members

EKHUFT NED (Chair)

EKHUFT NED (Vice Chair)

Chief Executive Officer

Chief Nurse and Midwifery Officer

Chief Medical Officer

Chief People Officer

Executive Director Strategic Development and Partnerships

Public Governors x 3

Maternity Voices Partnership

Community Representation (1)

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

Director of Midwifery

Obstetric and Gynaecology Consultant

4.2 Attendees

Executive Director of Communications and Engagement

Kent and Medway Integrated Care Board (ICB)

Quorum

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

Attendance by Members

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

Attendance by Officers

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

5. FREQUENCY

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

6. AUTHORITY

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

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

7. SERVICING ARRANGEMENTS

7.1. The Group will be serviced by [INSERT]

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

8. ACCOUNTABILITY AND REPORTING

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

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

9. MONITORING EFFECTIVENESS AND REVIEW

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