In October 2022, one year on from the publication of Reading the signals, we published a report of our progress. We have updated it to reflect information and data at October 2024, two years on from the publication of Dr Kirkup's report.

Two years on from the publication of Reading the signals

On October 19 2022, Dr Bill Kirkup published his independent investigation into maternity and neonatal care provided by our Trust from 2009 to 2020.

The report was deeply shocking, it found that women, babies and their families had suffered significant harm and the experience they endured was unacceptably and distressingly poor. This went on for more than a decade.

The report highlighted care that repeatedly lacked kindness and compassion, both while families were in our care and afterwards, when families were coping with injuries and deaths.
We did not listen to women, their families and indeed at times, our own staff.

The investigation found at least eight opportunities where the Trust Board and other senior managers could and should have acted to tackle these problems effectively. This was simply not good enough.

The consequences were devastating. Of the 202 cases that agreed to be assessed by the panel, the outcome for babies, mothers and families could have been different in 97 cases, and the outcome could have been different in 45 of the 65 baby deaths, if the right standard of care had been given.

The Trust Board has apologised unreservedly for the pain and devastating loss endured by the families and for the failures of the Board to effectively act. Losing a baby has an immeasurable impact on women and their families and whilst the Trust Board has apologised, the impact of these outcomes can never be altered and for this we are truly sorry. These families came to us expecting that we would care for them safely and compassionately, but we failed to do that. We accept all that the report says.

We also apologise to those within our communities. We are aware of the anxiety that these failings have caused among those who rely on our services. We remain determined to use the lessons in Reading the signals to put things right, to make improvements and make sure that we always listen to patients, their families and staff when they raise concerns.

At any point following the publication of Reading the signals, the importance of the report and its findings remains just as profound and significant.

We are on a journey to fundamentally transform the way we work. Changing the culture of a large and complex organisation takes time and there is much work still to do, but we are determined to succeed so that we are providing the right standard of care and compassion to everyone who touches our services, every day.

This report describes the work we are doing, the improvements we have made and where we still have work to do. We are grateful to everyone who has been involved in helping us to improve our maternity services, has given feedback and has provided both challenge and encouragement. We look forward to continuing this work with you.

The Board of East Kent Hospitals Trust.

Background

In February 2020 the government health minister, Nadine Dorries MP, announced that Dr Bill Kirkup would lead an independent investigation of maternity services in East Kent.

The *Reading the signals* report identified four key areas for action:

- Monitoring Safe Performance
- Standards of Clinical Behaviour
- Flawed Team Working
- Organisational behaviour

There was also a specific recommendation for the Trust to accept the reality of the report's findings, acknowledge in full the unnecessary harm that has been caused and embark on a restorative process addressing the problems identified, in partnership with families, publicly and with external input.

On receiving *Reading the signals* on 19 October 2022 we apologised unreservedly, publicly accepted all of the findings and gave a firm commitment to use the lessons within it to make the improvements needed to consistently deliver the safe and compassionate care local communities should expect, not just in maternity and neonatal services but across the entire Trust.

On 21 October 2022, the Trust Board held an extra-ordinary Board meeting attended both virtually and in person by families, members of the public and the media, formally accepted the report in full and committed to addressing the areas for action in the report and the recommendation for the Trust. The Trust also discussed the report and its findings in public meetings of its Council of Governors, local Health Overview and Scrutiny Committee and all subsequent public Board meetings.

In February 2023, we set out an interim response to the report which was published alongside an open letter of apology to the public and shared with every member of staff, which included immediate, short and long-term actions, include improving how we listen to and involve patients and families and specific, focused work in maternity to improve safety, as well as wider work being taken forward across the Trust.

Dr Kirkup's key areas for action are reflected in our organisational objectives, specifically:

- Patient, family and community voices
- Reducing harm and delivering safe services
- Care and compassion
- Teamwork, trust, respect and inclusion
- Reducing health inequalities

Our maternity service continues to work with families and staff to embed the changes that are needed to make continued and sustained improvement in care and outcomes for women, babies and their families and safer and more compassionate services.

Our Maternity and Neonatal Improvement Programme (MNIP) was developed throughout Spring and Summer 2023 and involved bringing together people who use the service, the maternity leadership team, all grades of midwifery, obstetric and neonatal staff, Kent & Medway Local Maternity and Neonatal System (LMNS), Maternity and Neonatal Voices Partnership (MNVP) and members of NHS England's regional maternity team to ensure it was truly co-produced. The programme was also benchmarked against, and aligned to, requirements of the Three Year Single Delivery Plan for Maternity and Neonatal Services.

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

Patient, family and community voices

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

We are working hard to change this in both our maternity and neonatal services and as a Trust.

To help us achieve this we have an embedded patient experience team specifically to work with women, birthing partners and families and staff to improve patient and staff experience. The team is led by a professional midwifery advocate, one patient experience midwife and two non-clinical patient experience administrators.

The maternity Patient Experience team has continued to respond to feedback received through 'Your Voice is Heard', a service developed in collaboration with families, our local Maternity and Neonatal Voices Partnership and a Trust governor, which is unique to East Kent.

The Director and Deputy Director of Midwifery *Walk the patch*, regularly walking around the maternity units to listen to people who use our services, and families to directly hear about their experiences of maternity care. By doing this they are also assessing that the environment is safe and clean, are observing what staff are doing well and what needs improving. They bring their feedback to the heads of midwifery and the matrons so it can be acted upon quickly and/or included in staff training. This is being undertaken in future by the Maternity and Neonatal Voices Partnership.

In order to improve quality and any required training, all calls to maternity triage are now recorded and monitored. In this way, not only the quality of information and care can be monitored, but also how service users are engaged with.

Leave your troubles at our door, is as an additional patient experience service providing women and birthing people in hospital with direct access to a senior member of the midwifery team, as someone to speak to if they wish to talk about their care. This is promoted through posters displayed on the wards.

We have increasingly innovative ways of involving people who use our services, in partnership with the Maternity and Neonatal Voices Partnership, including holding Facebook "Live" sessions, appointing a midwife specifically to lead work on reducing health inequalities and focussing on under-served communities, for example we held an event with Lithuanian families and are seeking funding for a community bus to go out to our communities.

We also involve families in investigations from the outset; have co-produced our maternity and neonatal improvement programme and new pathways of care; and we are working with families directly involved in Dr Kirkup's investigation.

We want our service to be welcoming, safe, clean, professional, friendly, calm and well organised. The Maternity and Neonatal Voices Partnership led a '15-Steps challenge' with service users on both units. This sees the service through the eyes of people who use it and what they see and experience within 15 steps of entering a department. Improvements include making the units more welcoming, murals on walls, soft lighting in labour rooms and improved information about leaving hospital.

The age and quality of our buildings, and a lack of capital funding to improve our estate is an ongoing challenge. We are working with the Kent and Medway Integrated Care Board, local MPs and NHS England regionally to identify sources of funding to improve our maternity units and have been granted an initial £1.6m to progress the initial work up of plans.

Your Voice is Heard

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

By the end of September 2024, we had heard from 9,659 women who have given birth in our hospitals, and from birth partners, too, an average 71.9% response rate. We want everyone to have a positive experience of all aspects of their care and to be 'happy to return', there remains a lot of work to do to reach this point. Our quality improvement work is aligned to the themes from this valuable feedback in order to achieve this.

Some of the changes we have made are small but practical and important to people using our services, such as introducing soft-close bins to reduce noise on the postnatal wards, offering snack boxes and hot drinks for birthing partners and are trialling new sleeper chairs for birthing partners. We need to make sure these are consistently available.

Feedback has also been used to create a pain management working group, to understand and consider how we respond to the pain relief needs and options of our women and birthing people, including providing these in a timelier way, this is an area where we still need to improve.

We have reinstated home visits on the first day home from hospital and are working with a user group to provide improved and accessible antenatal education, this has included providing access to online antenatal sessions.

To improve people's experiences of postnatal care we have introduced intentional care rounding, provided a family bathroom, and to enable families to leave hospital more quickly, have more midwives to do new born physical examinations and midwifery-led discharge where appropriate.

There is still more work to do in this area, including support for infant feeding during evenings, nights and weekends, being provided with information and being discharged without delay.

It is important that we also know where things are going well so we can build on them. By the end of September 2024 almost 4,000 compliments from families had been shared directly with staff. We have extending Your Voice is Heard to include families whose babies have been in neonatal care and we are exploring how best to extend this service to include bereaved families, in addition to other support in place for them.

Your Voice is Heard is in addition to the Friends and Family Test surveys and is one of 12 ways we gather and use feedback in maternity. We review the feedback by ethnicity and deprivation to ensure we are hearing from people from a wide range of backgrounds.

We also use a theming tool so that all feedback is brought together from all sources, including national surveys although the timeline for receiving these results is much longer.

The latest annual CQC Maternity Services Survey, conducted in early 2023, had a response rate of 41%. It showed East Kent maternity services as having lower than average scores for antenatal care and postnatal care, but improvements in people feeling they received help and advice about feeding their baby in the first six weeks after birth, in partners being able to stay as long they wanted, support for mental health in pregnancy and a choice of where to have their baby.

Your Voice is Heard data since we launched in May 2022

We started Your Voice is Heard in May 2022. We speak to between 300 and 400 people each month. In May 2022, our response rate was 56%, in September 2024 it was 81%.

Figure 1: Your Voice is Heard response rate

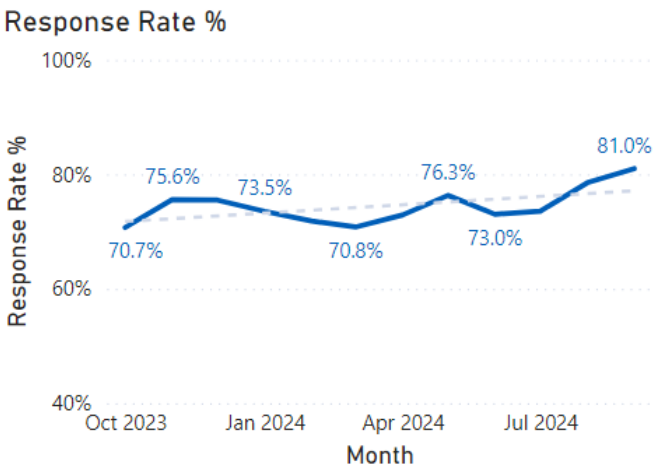
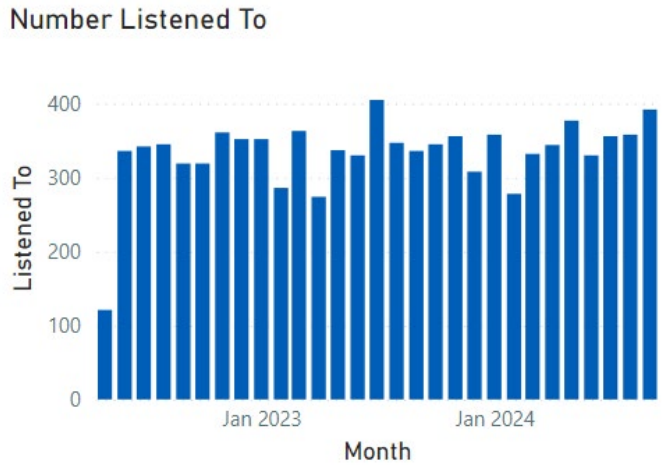
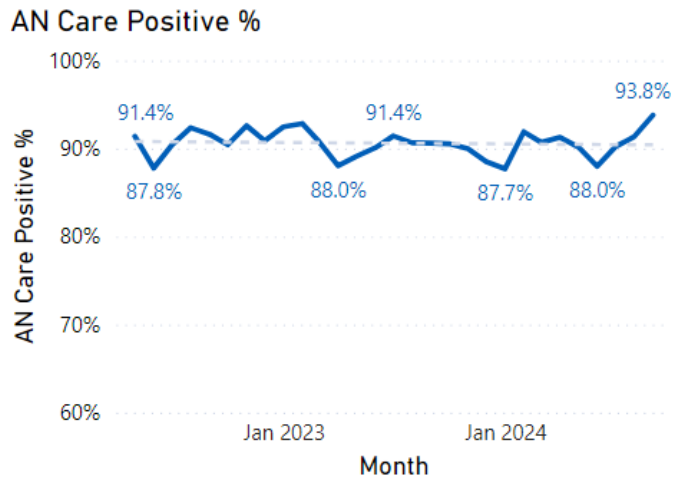


Figure 2: Number of people listened to



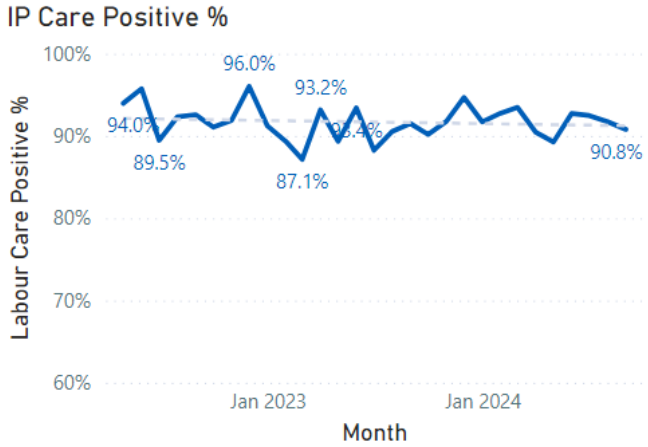
The score for antenatal care was at its lowest at 87.7% in Jan 2024, it was 93.8% in September 2024.

Figure 3: Respondents positive about antenatal care



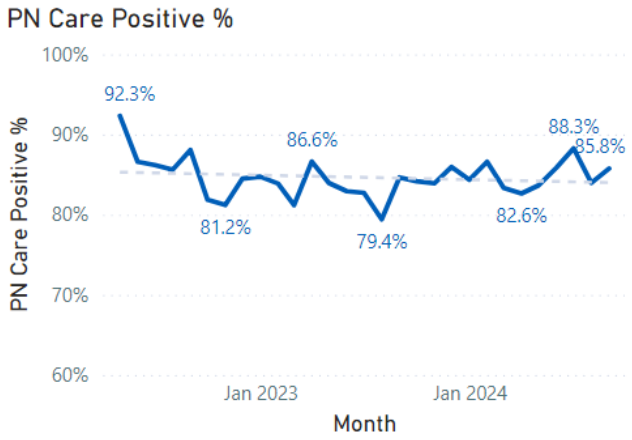
Care on our labour wards was at its lowest at 87.1% in March 2023 and was 90.8% in September 2024.

Figure 4: Respondents positive about care on our labour wards



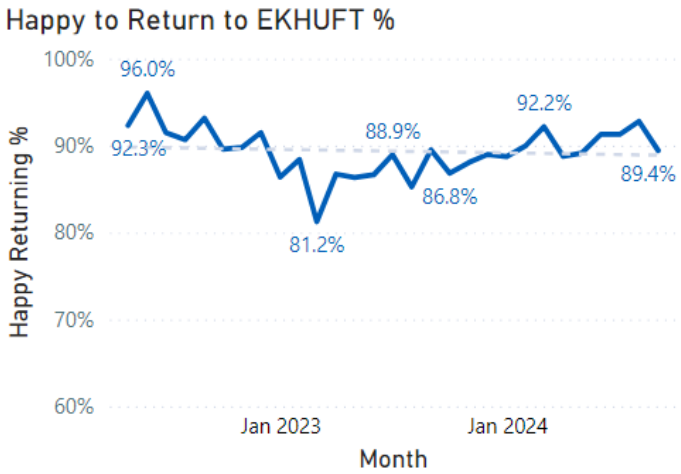
Postnatal care has declined from 92.3% in May 2022 and was at 85.8% in September 2024.

Figure 5: Respondents positive about postnatal care



The number of women 'happy to return' has declined from 92.3% to 89.4%. We are working hard to understand the reasons for this and to make changes.

Figure 6: Respondents happy to return



Changes across our Trust: Patient Voice and Involvement

The Reading the Signals report has not only affected how we work in maternity, within the wider Trust, we established our patient voice and involvement team in August 2022, to help us involve patients, their families and our communities in improving patient and family experience of our services.

The team work across all the Trust's sites with operational and clinical staff to make improvements based on patient feedback from a wide range of sources including the Friends and family Test (FFT) survey, Care Opinion, the NHS website reviews, the national Care Quality Commission Patient Surveys and engagement with local communities, including from people who are underserved. Feedback is themed and reported to services and the Trust's Patient Experience Committee every two months. This includes the themes from PALS contacts and Complaints.

Community engagement work has focused on underserved communities, and this has included migrant women in Thanet and homeless men in Dover. The community group working with the migrant women has presented to the Trust Board, and the work with the group that supports homeless men – Emmaus – has resulted in co-designed awareness training for our staff that will be launched soon.

The team and our Participation Partners have worked closely with the Trust's IT department to develop the Trust's Patient Portal, so that it includes not only communication preferences, but enables people to record their communication needs related to a disability. We believe we are one of the few NHS Trusts in England that offers this.

People can get involved with the team on a voluntary basis by becoming a Participation Partner. Participation Partners get involved in a range of activities – everything from being a member on a Trust group or committee, to being on an interview panel, to co-designing patient surveys, to being involved in a project or supporting staff training.

The Patient Participation and Action Group (PPAG) holds us to account for implementing the Patient Voice and Involvement Strategy. The group is co-chaired by a Participation Partner and the Lead for Patient Voice and Involvement. Membership of the group is 50% Participation Partners, 30% voluntary community and social enterprise sector (VCSE) representatives and 20% EKHUFT staff. There are six places for Participation Partners on the Patient Experience Committee.

The team has worked with a wide range of our services both to get more patient feedback, but also to make improvements based on this feedback. For example, improved information for patients, better identification of patient's communication needs and practical measures such as more water stations.

Reducing harm and delivering safe services

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

Despite the commitment and hard work of our staff, when the Care Quality Commission (CQC) inspected our maternity service in January 2023, they very disappointingly found that the Trust was not consistently providing the standards of maternity care women and families should expect.

We acted at once to respond to the CQC's concerns. For example, by increasing doctor cover in the triage service at William Harvey Hospital and introducing additional training and electronic alerts for staff when a fetal monitoring check is due.

Out of the 40 actions recommended by the CQC, 38 had been fully completed by summer 2024. The remaining two: a second obstetric theatre at QEQM, is subject to a bid for national capital funding (funding has been provided to do the initial work), and moving the Twinkling Stars bereavement suite which will be completed in 2025.

Other immediate changes included improving access to and regular checking of emergency equipment and increased cleaning of the environment and the equipment. We continue to monitor these standards daily, alongside hand hygiene and PPE compliance. Data is collected weekly, monitored by the Director and Deputy Director of Midwifery and shared with the CQC on a monthly basis, with the results consistently showing high compliance.

To improve the safety of our triage service, we implemented the Birmingham Symptom Specific Obstetric Triage System. The service was shortlisted for a Royal College of Midwifery Award for Outstanding Contribution to Midwifery Services: Digital, for this work.

The system is designed to ensure women and birthing people are assessed promptly on arrival at either of our maternity units and triaged appropriately according to their clinical need. The aim is for everyone to be assessed within 15 minutes and given a clinical priority using a recognised colour coding system so that people with the most urgent need(s) are treated first. The timeliness and assessment of the triage service is monitored, to ensure patients are being cared for appropriately. Any breaches of this target are reported and harm reviews completed, the physical capacity of the department being the main reason for breaches.

To improve the quality and safety of care we have increased the numbers of midwives and doctors, including specialist roles. Filling vacancies had remained challenging, particularly in midwifery at William Harvey Hospital. To support our recruitment drive last year, we appointed 18 internationally educated midwives who have since completed their UK registration and have increased our midwifery capacity, and all of our student midwives have been offered permanent positions with us.

We are also developing our existing workforce, for example by using the NHS Health Education England Maternity Support Worker Competency Framework to upskill the maternity support workforce and provide a clear pathway for career progression.

Medical staff have developed and trained 200 midwives in enhanced maternity care, allowing patients who need enhanced care to remain on the labour ward with their babies in dedicated enhanced maternity care rooms at both William Harvey Hospital and Queen Elizabeth the Queen Mother Hospital.

Doctors have also reviewed and updated all clinical guidelines to improve safety.

In December 2023 we reopened the Singleton Midwife-led Unit at William Harvey Hospital as a place of birth, offering more choice to women in relation to their preferred place of birth. By September 2024, 183 babies have been born in the unit.

To ensure we have the right staff in the right places, we use a workforce acuity tool supported by a live tracker to make sure staff are where they are most needed. In September 2022, staffing met acuity needs 55.7% of the time. This figure was 67.6% in September 2024.

In February 2023, student midwives were removed from their placements at William Harvey Hospital, and in May 2023 the Nursing and Midwifery Council (NMC) withdrew its approval for the midwifery programme at Canterbury Christ Church University and students were removed from all Kent and Medway placements.

We worked closely with the University of Surrey to enable student midwives to return to their placements with us in September 2023. They will qualify in January 2025 and have all been offered and accepted placements with us. We increased the practice development team, systems for student support and supervision, and ways students can raise concerns. Their feedback about the support and pastoral care they receive has been very positive. Students on clinical placement with us are not counted in our staffing numbers, but they are an important part of our team and for our future workforce.

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

We also have a number of ways to regularly share learning across maternity:

- 'Hot Topics' that require immediate dissemination
- 'Safety Threads' used in safety huddles and handovers
- 'Lunch and Learn' sessions to share learning in a relaxed space
- Monthly 'Safety Summit' with Board maternity safety champions, Chief Nursing and Midwifery Officer and Non-Executive Director
- 'We Hear You' and consultant forums, which give staff direct access to the senior leadership team.

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

We are one of the first Trusts to adopt Martha's rule in our acute hospitals in Ashford and Margate, which gives patients, families, carers and staff round-the-clock access to a rapid review from a separate care team if they are worried about a person's condition. This follows the national initiative 'Call 4 concern' which is run by our Critical Care Outreach Team (CCOT), and continues at Kent and Canterbury Hospital.

Saving babies' lives

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

Stillbirths and neonatal deaths are measured by MBRRACE-UK. Every year MBRRACE-UK produces a "Perinatal Mortality Surveillance" report which provides rates for all stillbirths over 24 weeks and all neonatal deaths, when the baby was born alive after 24 weeks gestation, but died before 28 days of age.

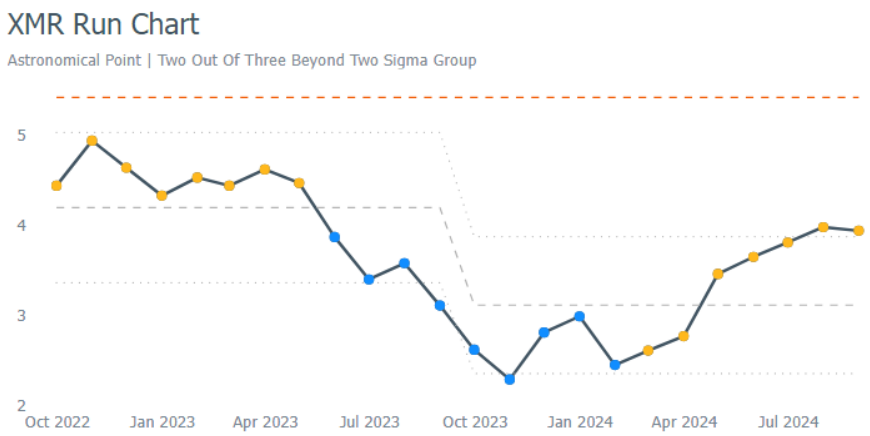
Rates vary between hospitals, particularly if those hospitals care for larger numbers of babies or very sick babies. MBRRACE-UK uses the number of babies born in an organisation, as well as whether they have a neonatal intensive care unit or facilities for surgery for new born babies, in order to group together similar Trusts.

The chart below shows the 12-month rolling rate of MBRRACE reportable stillbirths and neonatal deaths per 1,000 births in East Kent, including births and deaths from September 2020 to September 2024.

Figure 7: Extended perinatal mortality

MBRRACE Ext Perinatal Rate 12m

Timescale	Value	SPC
Oct-23	2.62	
Nov-23	2.29	
Dec-23	2.81	
Jan-24	2.99	
Feb-24	2.45	
Mar-24	2.61	
Apr-24	2.77	
May-24	3.46	
Jun-24	3.65	
Jul-24	3.81	
Aug-24	3.98	
Sep-24	3.94	



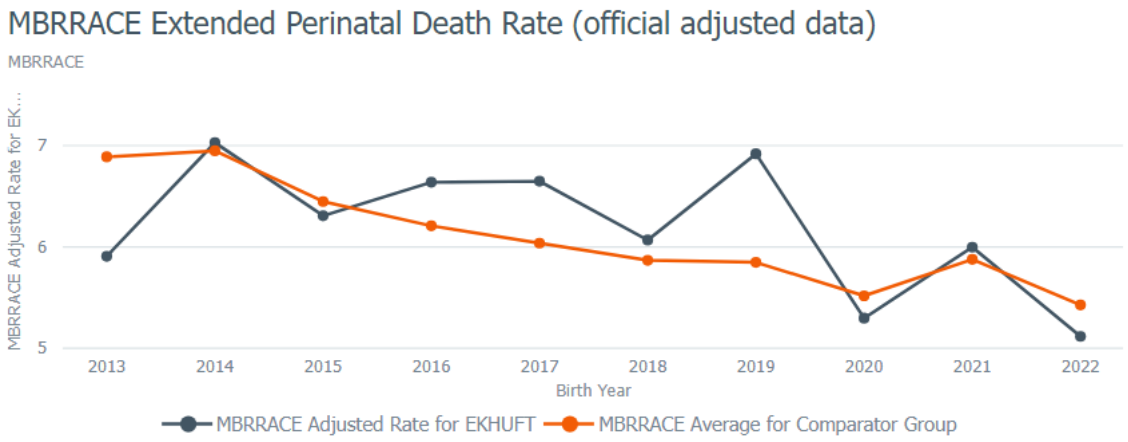
In September 2024, East Kent had 1.37 stillbirths per 1,000 and 2.57 neonatal deaths per 1,000.

Our perinatal mortality cases are reviewed by expert panels, with independent expert review, using the national Perinatal Mortality Review Tool.

While the neonatal death rate in East Kent had been going down, we have seen an increase in neonatal deaths, including among very premature babies, during 2023/24. This is being externally reviewed to ensure that we are providing the best care possible.

The latest nationally-published MBRRACE data (for the year 2022) shows that the rate of stillbirths and neonatal deaths in East Kent in 2022 was 5.11 per 1,000 births. The average for similar trusts was 5.42.

Figure 8: MBRRACE adjusted rate for East Kent and MBRRACE average for comparator group by birth year



The neonatal death rate in East Kent for 2022 was 1.43 per 1,000 births, compared with an average for similar trusts of 1.82.

The stillbirth rate for 2022 was 3.65 per births, compared with an average for similar trusts of 3.61.

The tables below show the number of stillbirths and neonatal deaths at our Trust since 2013, alongside the MBRRACE-UK rates.

Stillbirths

Birth year	Stillbirths	Births	EKHUFT Crude Stillbirth Rate	MBRRACE Crude Rate for EKHUFT	MBRRACE Adjusted Rate for EKHUFT	MBRRACE Average for Comparator Group
2013	24	7,039	3.41	3.58	4.28	4.75
2014	31	7,000	4.43	4.85	5.01	4.98
2015	22	7,062	3.12	3.66	4.31	4.41
2016	27	6,953	3.88	3.70	4.12	4.11
2017	21	6,973	3.01	2.72	3.82	3.95
2018	27	6,571	4.11	3.80	4.00	3.95
2019	27	6,413	4.21	4.20	4.07	4.01
2020	20	6,127	3.26	3.60	3.84	3.81
2021	25	6,213	4.02	4.18	4.11	3.92
2022	25	6,246	4.00	3.84	3.65	3.61

Neonatal deaths

Birth year	Neonatal deaths <28 days	Livebirths	EKHUFT Crude Neonatal Death Rate	MBRRACE Crude Rate for EKHUFT	MBRRACE Adjusted Rate for EKHUFT	MBRRACE Average for Comparator Group
2013	10	7,015	1.43	1.29	1.95	2.09
2014	14	6,969	2.01	1.86	1.93	1.97
2015	14	7,040	1.99	1.62	2.01	2.04
2016	20	6,926	2.89	2.57	2.53	2.10
2017	21	6,952	3.02	3.01	2.84	2.09
2018	11	6,544	1.68	1.68	2.08	1.92
2019	19	6,386	2.98	2.97	2.99	1.84
2020	7	6,107	1.15	0.99	1.56	1.71
2021	9	6,188	1.45	1.45	1.88	1.96
2022	4	6,221	0.64	0.64	1.43	1.82

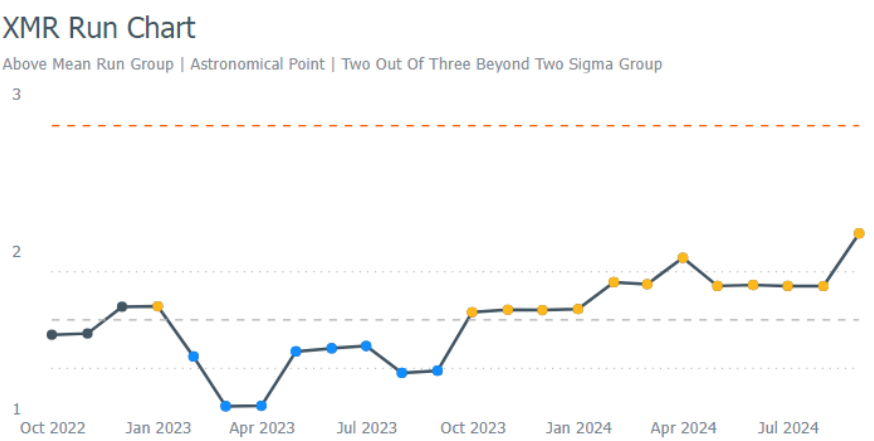
Hypoxic Ischemic Encephalopathy (HIE)

Hypoxic Ischemic Encephalopathy (HIE) - moderate or severe brain damage. The expected range is 2.4- 2.8 per 1,000 live births. The last 12 months rate for East Kent has been 2.1 cases per 1,000 live births.

Figure 9: Hypoxic Ischemic Encephalopathy

HIE Rate Rolling 12m

Timescale	Value	SPC
Oct-23	1.6	
Nov-23	1.6	
Dec-23	1.6	
Jan-24	1.6	
Feb-24	1.8	
Mar-24	1.8	
Apr-24	2.0	
May-24	1.8	
Jun-24	1.8	
Jul-24	1.8	
Aug-24	1.8	
Sep-24	2.1	



Care and compassion

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

We co-produced a new bereavement care model in our maternity and neonatal service with families who wanted to ensure other families did not experience a lack of care and compassion. Specialist bereavement midwives worked with families and the Saving Babies Lives charity (SANDS) to improve and expand the emotional and practical support available to families who have tragically experienced baby death or severe injury or illness.

This seven-day service model includes continuity of carer for women and their families during a bereavement but also through any subsequent pregnancies, labour and delivery. This work was recognised in the National Mariposa Bereavement Awards in March 2024 when three colleagues received awards.

The remodelling of our bereavement service includes the relocation and refurbishment of the Twinkling Stars bereavement suite (a dedicated area for families) at William Harvey Hospital to a location outside of the Labour ward so that women, babies and their families can be cared for in a more considerate and suitable setting. This is being funded by East Kent Hospitals Charity and will be completed in 2025.

There is evidence that a positive working culture improves the safety and quality of care for service users. We have included caring with compassion and respect in routine staff training for maternity and neonatal staff. For example, we have adopted 'Civility Saves Lives', a national project aimed at promoting kindness and respect within teams, based on evidence about the impact this has on patient safety. Colleagues in different roles and from different departments come together to learn about how the way we behave impacts one another, and the way we make decisions.

As part of the work to improve the culture in maternity services, service leaders completed the NHS Perinatal Culture and Leadership Programme and Band 7 managers completed a "connected" course designed to improve culture and leadership. The results of a culture survey carried out across maternity and neonatal services in 2023 has been shared through eight debrief sessions, with

support of an external culture coach for each acute hospital, and is being used to make improvements in culture.

Band 7 colleagues and above took part in cultural allyship training to promote diversity and inclusion and there is a greater focus on staff health and wellbeing and clinical supervision with the relaunch of the Professional Midwifery Advocates model.

We recognise that the staff survey results for our maternity service in 2023 were a long way from where we want them to be and demonstrated the amount of work needed for staff to feel involved, engaged and positive about recommending their service and the Trust as a place to work. The quarterly pulse surveys have shown improvement across all of the key themes although the response rate for the quarterly surveys is much lower across the NHS. The 2024 annual NHS staff survey will be published in Spring 2025.

Changes across our Trust: caring with compassion training

We recognise that the lessons within *Reading the signals* apply as much to the rest of our Trust and all our services as they do in maternity and we need to provide care that is more compassionate.

Examples of how we are doing this include launching a caring with compassion video in May 2023, which is now part of mandatory training for all Trust staff. The video was developed by the Supportive and Palliative Care Team and was funded by the East Kent Hospitals charity. The film follows the experiences of 'Peter' and his family in the last days of his life, and is a powerful reminder of the importance of recognising and responding to the holistic needs of the people using our services.

We introduced a monthly session for Health Care Support Workers focused on 'Seeing the Person' and how they can understand the vital role they play in every patient's experience.

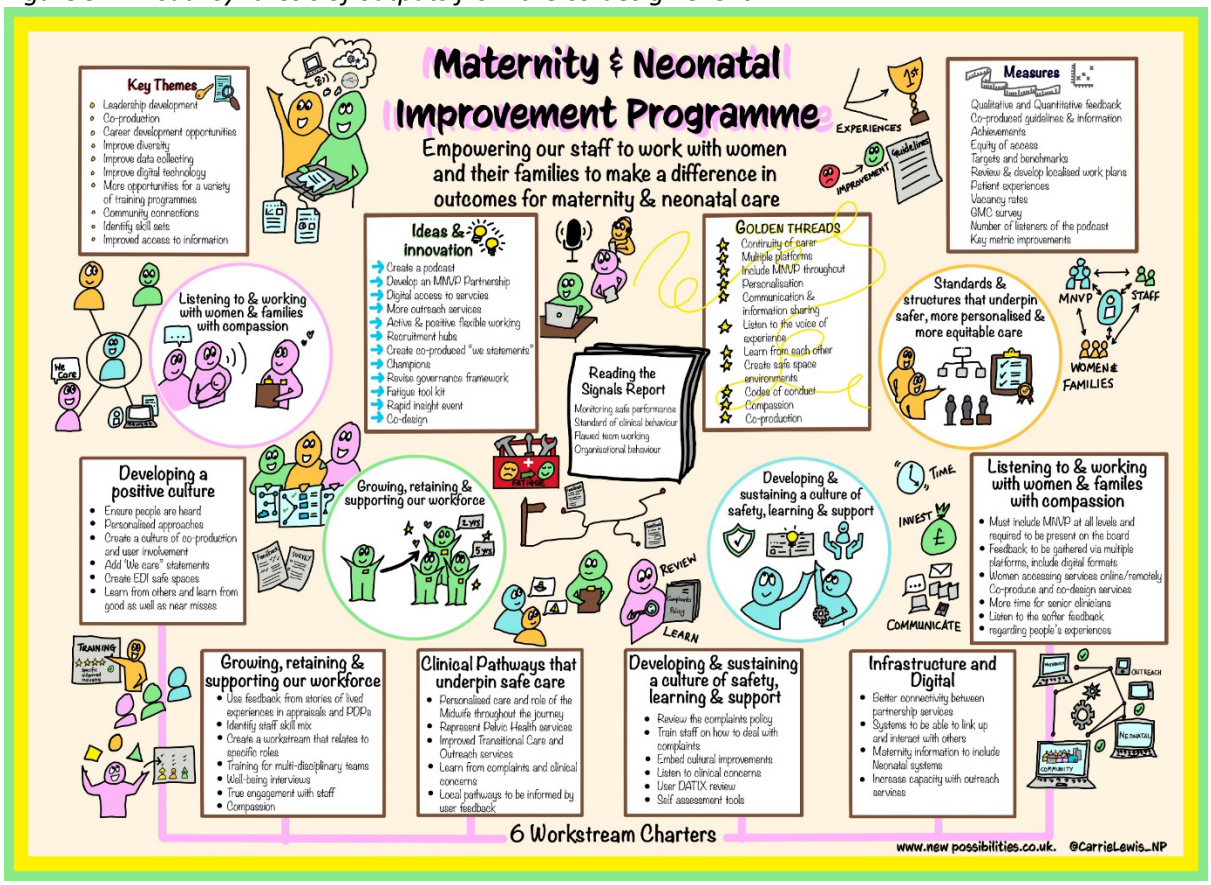
Engagement, listening and leadership

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

We appointed an experienced, substantive Director, and Deputy Director of Midwifery, in mid May 2023 to strengthen maternity leadership and support improvements to the service across the Trust.

The new maternity and neonatal leadership team has worked with families, staff and partners to co-produce a Maternity and Neonatal Improvement Programme for East Kent, bringing together people who use the service, the maternity leadership team, obstetrics, maternity and neonatal staff, the Kent and Medway Local Maternity and Neonatal Service, Maternity and Neonatal Voices Partnership and members of NHS England's regional maternity team to co-produce the vision for the programme.

Figure 9: A visual synthesis of outputs from the co-design event.



The programme has six priority areas, each with executive oversight, approved by Trust Board in September 2023:

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

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

Progress against these priorities is reported through the Maternity and Neonatal Assurance Group and each of the Trust Board's public meetings.

We recognise the importance of staff feeling listened to, and having easy access to a senior leader if they have any concerns. The leadership team introduced *We Hear You* which gives staff direct access to the Director and Deputy Director of Midwifery, and twice-monthly consultant meetings for colleagues to meet and discuss any concerns they have with the associate medical director for women's health as well as the clinical leads from each hospital site.

These forums are in addition to regular multi-disciplinary patient safety meetings. Listening events have also been held with the CEO, Chief Nursing and Midwifery Officer and Non-Executive Director lead for maternity.

Across our Trust:

Improving culture

As part of the commitment to nurture compassionate leaders and effective teams that work well together, the Trust has adopted NHS England's Culture and Leadership Programme developed by the Kings Fund. This programme has been introduced elsewhere in the NHS and there are proven links between compassion in healthcare and outcomes for patients. It is aimed at all levels in the Trust and more than 100 change ambassadors across the Trust are supporting this work.

This national programme is now in the design phase, acting on the results of a diagnostic carried out by change ambassadors which identified the need to ensure colleagues had a voice, are valued, have a shared vision and we have compassionate, inclusive and collective leadership.

Changes include introducing a staff council, relaunching our staff wide recognition scheme, developing our organisational strategy and training all staff in essential leadership skills.

At the end of 2022, we launched 'Connectors' across the Trust – a growing network of staff who are trained on a voluntary basis to support their peers and colleagues with any concerns they have at work. Connectors are trained to listen and help staff identify their next steps, which can include raising concerns.

We are currently reviewing how we deliver our Freedom to Speak Up (FTSU) service to ensure that it is sustainable and meeting the needs of our staff.

Developing our organisation

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

The Maternity and Neonatal Assurance group, chaired by the Chief Nursing and Midwifery Officer and attended by the non-executive director maternity champion (a senior clinician), reports monthly to the Quality and Safety Committee and directly to the Trust Board quarterly and is attended by multiple stakeholders, including the Maternity and Neonatal Voices Partnership. It provides specific oversight of maternity and neonatal services, including training compliance, the monthly maternity

dashboard, maternity and neonatal improvement programme, progress against Clinical Negligence Scheme for Trusts (CNST), Ockenden and CQC actions.

We have implemented the nationally-required role of the Maternity and Neonatal Safety Champion. Our multi-disciplinary Maternity and Neonatal Safety Champions are promoted across the units, as a point of reference and contact for the workforce, our families and stakeholders.

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

We are working with our partners across the health and social care system in Kent and Medway, to share our learning across the region and to learn from others.

Across our Trust we reviewed and restructured our care groups (each responsible for the management of a number of clinical services and sites) to support the delivery of safe, high quality and timely services. The structure is organised around patient 'pathways' to improve our ability to provide seamless care across the Trust and improve governance across the Trust.

A new governance framework used at all levels of the organisation sets out the Trust's approach to ensuring that roles, responsibilities, reporting and escalation lines are clear and that there are robust systems of governance and accountability in place at all levels to safeguard patients and carers from harm, ensure the care provided by the Trust is in line with regulatory and statutory requirements and provide an effective line of sight from place of care to Board.

Overall, we have taken the first significant steps on our journey and we are continuing to review these and make improvements. This is a continual process and will take time to embed, but we give our commitment, that we will not stop until we are offering the safe and compassionate care that all of our service users deserve.