University Hospitals of Leicester NHS
NHS Trust

Meeting title:	Public Trust Board **public Trust Board paper H**					
Date of the meeting:	3rd November 2022					
Title:	Review of the findings of Reading the Signals; Maternity and Neonatal Services in East Kent – the Report of the Independent Investigation.					
Report presented by:	Julie Hogg -Chief Nurse					
Report written by:	Julie Hogg -Chief Nurse					
Action – this paper is for:	Decision/Approval		Assurance		Update	X
Where this report has been discussed previously	N/A					

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which
This report provides assurance that the recent report into East Kent maternity services has been reviewed and that the recommendations are being actioned in line with the expectations outlined in a letter to the Chief Executive and Board Chair from NHS England dated 20th October 2022.

Impact assessment
N/A

Acronyms used:
Please see abbreviations commonly used in maternity reports

Purpose of the Report

The report provides a summary of the key issues identified within the report into the care provided within East Kent maternity services and the recommendations arising from this.

In a letter sent to the Chief Executive and Board Chair by NHS England on the 20th October 2022 (attachment 1) there was an expectation that the report and its findings would be discussed at the Trust's next public board and seek assurance that mechanisms are in place to respond where concerns have been identified or are arising. This report addresses this expectation.

Executive Summary

In February 2020, NHS England and NHS Improvement (NHSE/I) commissioned Dr Bill Kirkup to undertake an independent review into maternity and neonatal services at East Kent Hospitals University NHS Foundation Trust. This followed concerns raised about the quality and outcomes of maternity and neonatal care.

The independent review looked at 202 cases where the families had asked to be involved and where their care fell within the scope of the investigation. The results of the case reviews draw upon evidence from family listening sessions, clinical records and interviews with clinical staff and others, including external partners such as the CQC, HSIB and the CCG's aligned to East Kent. The investigation spans the period from 2009 – when foundation trust status was achieved – to the end of 2020.

The report content is reflective within its key themes of the findings from both the Morecombe Bay and Shrewsbury and Telford reports into maternity care. Whilst articulated differently within each report, themes of bullying, poor working relationships and lack of professional oversight and accountability are clearly evident. Acknowledging this the East Kent review report author has not set out detailed changes to practice and management, the focus instead is on four areas of action:

- Identifying poorly performing units.
- Giving care with compassion and kindness.
- Teamworking with a common purpose.
- Responding to challenge with honesty.

Throughout the report the following key themes were identified:

- Failures of team working.
- Failures of professionalism.
- Failures of compassion.
- Failure to listen.
- Failures after safety incidents.
- Failure in the Trust's responses including at Trust Board level.
- The actions of the regulators, the Trust was faced with an array of regulatory and supervisory bodies, but the system as a whole failed to identify the shortcomings early enough and clearly enough to ensure that real improvement followed.
- Missed opportunities - in relation to the care provided and responses to early warning signs within some of the cases reviewed, and from commissioned reviews throughout the review scoping period.

Key areas for action and aligned recommendations

The report as described provides four key areas for action and supporting recommendations – most of these are for a national response although there is an opportunity for UHL to consider utilising the themes to review the current situation within our maternity services for both assurance and where relevant development. The one recommendation for each Trust is highlighted within the recommendations to the UHL Trust Board.

The paragraphs below summarise the East Kent themes and the national recommendations supporting these.

1. **Monitoring safety performance**.

The report identifies that there is a wealth of useful information on the outcome of maternity services, a large amount of which are process measures of which the author felt to be of dubious significance, such as caesarean section rates. The minority that are related to outcomes are high level and conceal events susceptible to clinical intervention among a larger, unrelated group, such as perinatal mortality. It was identified that the Trust used high-level information inappropriately as reassurance, taking comfort from the grouping that at least there were other trusts in the same boat. At times, the Trust used this false reassurance as a bolster against the evidence from other sources that there were very significant problems in its maternity services.

Recommendation

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

2. Standards of clinical behaviour – technical care is not enough

The report identified a number of graphic examples from staff as well as families, that showed just how far the standards of behaviour had fallen within East Kent Trust. The report author was keen to point out that in his experience there is a danger in assuming that such serious lapses of such a distressing nature are restricted to one trust alone.

Unprofessional conduct is disrespectful to colleagues and endangers effective and safe working; it undermines the trust of women. Lack of compassion significantly affects the wellbeing of women, often leading to unnecessary long-term harm. When families are treated unkindly in the aftermath of a safety incident, as was often evident within the cases reviewed, it compounded and prolonged the harm caused by the event itself. Failure to listen directly affects patient safety, as was identified repeatedly within the East Kent Trust's maternity services, and therefore vital information was ignored.

Recommendations

- Those responsible for undergraduate, postgraduate and continuing clinical education be commissioned to report on how compassionate care can best be embedded into practice and sustained through lifelong learning.
- Relevant bodies, including Royal Colleges, professional regulators and employers, be commissioned to report on how the oversight and direction of clinicians can be improved, with nationally agreed standards of professional behaviour and appropriate sanctions for non-compliance.

3. Flawed teamworking – pulling in different directions

Dysfunctional teamworking was identified both within and across professional groups within East Kent maternity units. The lack of trust and respect between midwives and obstetric staff, and between paediatric and obstetric staff, posed a significant threat to the safety of mothers and their babies, many examples were identified within the review of how this caused conflict, made staff feel vulnerable, prevented information from being shared, and encouraged complacency and a lack of accountability.

After a safety incident, the most common response was to find somebody to blame for it – often the most junior midwife or doctor involved – preventing important lessons from being learned. The consequences for mothers and their babies were stark. The one feature of flawed teamworking that is particularly striking in maternity care within the East Kent units was the divergence of objectives of different groups for example between midwives and obstetricians, obstetricians and paediatrics and more.

Recommendations

- Relevant bodies, including the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives and the Royal College of Paediatrics and Child Health, be charged with reporting on how teamworking in maternity and neonatal care can be improved, with particular reference to establishing common purpose, objectives and training from the outset.
- Relevant bodies, including Health Education England, Royal Colleges and employers, be commissioned to report on the employment and training of junior doctors to improve support, teamworking and development.

4. Organisational behaviour – looking good while doing badly

Denial, deflection, concealment and aggressive responses to challenge, within the Trust was evident throughout the review this was felt to have prevented learning and improvement, and impacted upon the way in which families were treated and denied them access to the truth about what has happened when something had obviously gone wrong, compounding the harm that had already been suffered.

Recommendations:

- The Government reconsider bringing forward a bill placing a duty on public bodies not to deny, deflect and conceal information from families and other bodies.
- NHSE reconsider its approach to poorly performing trusts, with particular reference to leadership
- Trusts be required to review their approach to reputation management and to ensuring there is proper representation of maternity care on their boards.

Recommendation for the Board of Directors

- The board of directors are asked to consider the content of the report, acknowledge this addresses the requirements outlined by NHS England letter previously highlighted.
- To accept a further report detailing our local response to the report.

Attachment 1

Classification: Official

Publication reference: PR2099

To:
- Trust Chief Executives
- Trust Chairs
- ICB Chief Executives
- LMNS Chairs

cc.
- Regional Directors
- Regional Chief Nurses
- Regional Medical Directors
- Regional Chief Midwives
- Regional Obstetricians

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

20 October 2022

Dear colleagues

Report following the Independent Investigation into East Kent Maternity and Neonatal Services

Yesterday saw the publication Reading the Signals; Maternity and Neonatal Services in East Kent – the Report of the Independent Investigation.

The report sets out the devastating consequences of failings and the unimaginable loss and harm suffered by families for which we are deeply sorry.

This report reconfirms the requirement for your board to remain focused on delivering personalised and safe maternity and neonatal care. You must ensure that the experience of women, babies and families who use your services are listened to, understood and responded to with respect, compassion and kindness.

The experiences bravely shared by families with the investigation team must be a catalyst for change. Every board member must examine the culture within their organisation and how they listen and respond to staff. You must take steps to assure yourselves, and the communities you serve, that the leadership and culture across your organisation(s) positively supports the care and experience you provide.

We expect every Trust and ICB to review the findings of this report at its next public board meeting, and for boards to be clear about the action they will take, and how effective assurance mechanisms are at 'reading the signals'.

The report outlines four areas for action:

- To get better at identifying poorly performing units

- Giving care with compassion and kindness
- Teamworking with a common purpose
- Responding to challenge with honesty.

NHS England will be working with the Department of Health and Social Care and partner organisations to review the recommendations and implications for maternity and neonatal services and the wider NHS.

In 2023 we will publish a single delivery plan for maternity and neonatal care which will bring together action required following this report, the report into maternity services at Shrewsbury and Telford NHS Foundation Trust, and NHS Long-Term Plan and Maternity Transformation Programme deliverables.

The publication of the delivery plan should not delay your acting in response to this report and the actions you are taking in response to the report of the independent investigation at Shrewsbury and Telford NHS Foundation Trust. Immediate and sustainable action will save lives and improve the care and experience for women, babies and their families.

Yours sincerely,

Sir David Sloman
Chief Operating Officer
NHS England

Dame Ruth May
Chief Nursing Officer
NHS England

Professor Stephen Powis
National Medical Director
NHS England