Sheffield Teaching Hospitals
NHS Foundation Trust

Executive Summary

Report to the Board of Directors

Being Held on 29 November 2022

Subject	Reading the signals: maternity and neonatal services in East Kent – the report of the independent investigation
Supporting TEG Member	Chris Morley, Chief Nurse
Author	Alison Kenny, Maternity Improvement Director Laura Rumsey, Interim Midwifery Director Andrea Galimberti, Interim Clinical Director Sue Gregory, Operations Director
Status[1]	N

PURPOSE OF THE REPORT

- This paper provides a summary of the report into maternity and neonatal services in East Kent, published in October 2022. It also identifies key actions the Trust needs to undertake in the light of this report and an outline of how this will be achieved.

KEY POINTS

- This report (Reading the signals - Maternity and neonatal services in East Kent – the Report of the Independent Investigation (publishing.service.gov.uk) examined maternity services at two hospitals, the Queen Elizabeth The Queen Mother Hospital (QEQM) at Margate and the William Harvey Hospital (WHH) in Ashford, both under East Kent Hospitals University NHS Foundation Trust (East Kent), between 2009 and 2020.
- The report highlighted serious deficiencies in care caused by failures of teamworking, professionalism, compassion and a willingness to listen to women. Failures after safety incidents, in the Trust's response and the actions of regulators were also identified.
- The report's author avoided adding to the list of regulatory requirements which usually follow such investigations, choosing instead to provide a smaller list of recommendations focussed on the cultural aspects of care.
- Many of these recommendations are for national bodies however opportunities exist for Jessop Wing to learn from this report and further improve its care.
- The Trust's maternity services has been on its own improvement journey since its two CQC inspections. As a result of this, a series of improvement actions are underway as part of the Maternity Improvement Programme.
- The Maternity Improvement Programme contains many of the cultural elements described in this report's recommendations; the maternity service is committed to ensuring it prioritises the elements described in this summary, to ensure we can learn and improve from the experiences observed in East Kent.

IMPLICATIONS[2]

Aim of the STHFT Corporate Strategy		✓ **Tick as appropriate**
1	Deliver the Best Clinical Outcomes	✓
2	Provide Patient Centred Services	✓
3	Employ Caring and Cared for Staff	✓
4	Spend Public Money Wisely	
5	Deliver Excellent Research, Education & Innovation	
6	Create a Sustainable Organisation	

RECOMMENDATIONS

- The Board of Directors is asked to note the contents of this report.

APPROVAL PROCESS

Meeting	Date	Approved Y/N
Trust Executive Group	23/11/22	Y
Board of Directors	29/11/22	

[1] Status: A = Approval
A* = Approval & Requiring Board Approval
D = Debate
N = Note

[2] Against the six aims of the STHFT Corporate Strategy 'Making a Difference – The next Chapter 2022-27'

Maternity and Neonatology response and action plan to: Reading the signals - Maternity and neonatal services in East Kent (East Kent report)– the Report of the Independent Investigation – Dr Bill Kirkup CBE October 2022

1. Introduction

This paper provides a summary of the report into maternity and neonatal services in East Kent published in October 2022. It also identifies key actions the Trust needs to undertake in the light of this report and an outline of how this will be achieved.

2. Background to the report

This report examined maternity services at two hospitals, the Queen Elizabeth The Queen Mother Hospital (QEQM) at Margate and the William Harvey Hospital (WHH) in Ashford, both under East Kent Hospitals University NHS Foundation Trust (East Kent), between 2009 and 2020. The panel found that had care been given to the nationally recognised standards, the outcome could have been different in 97, or 48%, of the 202 cases assessed, and the outcome could have been different in 45 of the 65 baby deaths, or 69% of these cases.

3. Report findings

The report categorises the main reasons for the poor clinical care and outcomes as:

1. Failures of Teamworking

- Culture of tribalism & factionalism
- Lack of mutual trust & a disregard for other points of views. This directly impacted on escalation and interventions were delayed
- Bullying

2. Failures of professionalism

- Staff disrespectful to other staff in front of women
- Blaming women and deflecting responsibility when things went wrong
- Midwives not part of the 'favoured in-group' assigned to highest risk mothers

3. Failures of compassion & failure to listen

- Women's views dismissed
- Inadequate pain relief administered due to women being ignored or not believed

4. Failures after safety incidents

- Failures to communicate openly with families – clinical and management
- Safety investigations conducted narrowly and defensively – with the aim of minimising the event and providing false reassurance
- Lack of acknowledging errors and learning from them

5. Failures in the Trust's response, including at Trust Board level

- Failure to address known problems
- Blame assigned to junior or locum staff & lack of control of consultant body
- Replacing staff who identified and challenged poor behaviour
- Repeated action plans from newly appointed staff that masked true scale and nature of problems
- A focus on reputation management rather than gaining a true understanding of the issues

6. The actions of regulators

- Trust faced with 'bewildering array of regulatory and supervisory bodies' but system as a whole failed to identify the shortcomings
- Trust deflected into managing those relationships rather than dealing with its own responsibility
- Denial of scale of issues to regulators by Trust
- Multiple missed opportunities by regulators to identify and address the problems

The report found evidence of repeated problems that were systemic, particularly reflecting problems of attitude, behaviour and teamworking, and a persistent failure to look and learn. They included poor professional behaviour among clinicians and a failure to work as a cohesive team with a common purpose.

4. Recommendations as a result of the investigation

Dr Kirkup described the usual pattern of health service investigations as producing "lengthy reports" containing "earnest and well-intentioned recommendations." However, he recognised that "experience shows that the aspirations are not matched by sustained improvement… we have become all too aware that a conventional report, with multiple recommendations, overlapping with recommendations from other inquiries, other periods and other sources, is unlikely to break free of this pattern." As a result, a more limited number of recommendations have been produced. These recommendations are described as '**Key Actions Areas'** below. The majority of these are for national bodies to implement; however, these action areas provide local opportunities to ensure we have learned from this report and are therefore followed by specific aims and focus areas that Obstetrics, Gynaecology and Neonatology (OGN) Care will prioritise within its Maternity Improvement Programme (MIP).

Key Action Area 1: Monitoring safety performance – finding signals among noise

- **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.**

Dr Kirkup described the need to ensure clinical measures are related clearly to outcomes, take into account the complexity of work in a unit and its effect on outcomes and are available & timely. He also identified that these need to be analysed and presented in a sound, statistical way that shows both common ('random noise') and special cause variation (the 'signal') in statistical process control (SPC) charts and funnel plots.

Whilst the report described the need to elevate the focus on compassionate care, our mandatory regulatory requirements remain. However, it is essential that we simplify the mandatory transactional target driven requirements as much as possible as we see from this report that complexity distracts. Good healthcare is hampered by conflicting complexity and safe exemplary healthcare facilitated by simplicity.

OGN aim: To ensure appropriate improvement outcome, balance and process metrics are used to measure the success of the MIP and the use of SPC charts becomes the norm.

To ensure that we describe and manage our regulatory requirements in a simple to understand manner, avoiding unnecessary complexity and 'distractions.'

MIP elements:

- All Maternity Leads and MIP Leads to attend Organisational Development Department (ODD) 2-day Introduction to Quality Improvement course to receive instruction on metrics that matter and SPC charts.
- Monthly Maternity Improvement Director training session to include clinical outcome measure training.
- All MIP workstreams to use appropriate outcome, process and balance metrics displayed in SPC charts to capture and monitor progress of improvements.
- To ensure our programme plan truly reflects the improvement work that is being undertaking and ensuring this is the one version of the truth rather than having multiple action plans in circulation (creating distractions or 'noise').

Key Action Area 2: Standards of clinical behaviour – technical care is not enough

- **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.**

The report emphasised that every interaction with a patient, mother and family must be based on kindness and respect. Dr Kirkup recognised that this will not be achieved merely through training, but through the attitudes and daily behaviour of clinicians themselves, at every level but most particularly those in more senior positions who are role models for less experienced staff.

Various studies show that a lack of compassion can affect the quality of treatment; patients being treated with compassion will talk more about their symptoms and concerns, yielding more accurate understanding and diagnoses (Epstein et al 2005). This is vital in maternity services where escalation and timely interventions can save lives.

OGN aim: To ensure a culture of compassion is visibly embedded in OGN.

MIP elements:

- To ensure a renewed focus on STH Proud Values and Behaviours, Civility Saves Lives and What Matters to You (WMTY) as part of Leadership and Culture MIP workstream.
- Senior leaders to role model PROUD behaviours and use this framework to identify and challenge behaviours that are not compassionate.
- To ensure all line managers are aware of Unacceptable Behaviour at Work policy and its recommendations are followed.
- To review guidance for 1:1s and ensure PROUD behaviours are an integral part of these conversations.
- To ensure Clinical Directors and Clinical Leads have participated in the trust LEAD programme and have undergone a leadership training needs analysis.
- To listen to our patients by increasing our involvement with Maternity Voices Partnership (MVP) and launching the OGN website with interactive elements to ensure we encourage our patients to provide feedback.
- OGN triumvirate to visibly model and promote compassionate leadership.

Key Action Area 3: Flawed teamworking – pulling in different directions

- **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.**

The report emphasised the need to find a stronger basis for teamworking in maternity and neonatal services, based on an integrated service with common goals, and a shared understanding of the contribution of each team member in achieving them. Training together is a start but working together and solving problems together ensure that this culture is embedded as part of everyday practice.

Connor et al in 2016 found that 63.6% of serious or moderate incidents in their study were down to a poor quality of collaboration. He found that a lack of shared models of care and communication was associated with higher levels of potential risk to patients. The barriers to teamwork are well described– stress, a culture of fear and judgement, burnout, low staffing and a target driven culture. To promote a culture of effective teamworking, these elements also have to be directly addressed.

OGN aim: To ensure the environment and culture exists so that all professional groups and grades can work together as a cohesive team at OGN and articulate a common goal.

MIP elements:

- To go beyond the regulatory requirements for multi-disciplinary team (MDT) training and ensure as many sessions are MDT as possible – to conduct a review to identify further opportunities to achieve this, particularly at a care pathway level.
- MIP leads to work as an MDT triumvirate to oversee their workstream and solve problems together.
- Joint mission statement and goals to be created for Maternity & Neonatal Services
- To ensure key meetings are multi-disciplinary with protected time for those required to attend.
- To continue to address workforce shortages
- To prioritise staff well-being as part of the MIP.
- To promote compassionate leadership.

Key Action Area 4: Organisational behaviour – looking good while doing badly

- **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.**
- **Trusts be required to review their approach to reputation management and to ensuring there is proper representation of maternity care on their boards.**
- **NHSE reconsider its approach to poorly performing trusts, with particular reference to leadership.**

The report highlighted the need for openness, honesty and disclosure. It stated that learning must outweigh "any perceived benefit of denial, deflection and concealment." Healthcare organisations have a lasting duty of care to those affected and when families experience harm, the response must be based on compassion and kindness as well as openness and honesty. The identification of problems should not be seen as a sign of individual or collective failure, but as a sign of readiness to learn.

OGN aim: To ensure openness, honesty, disclosure and learning are our guiding principles

MIP elements:

- To ensure the continued development and embedding of a robust approach to understanding our issues, including accurate reporting of incidents and data through the Quality Surveillance Model and Board reports.
- To engage fully with the implementation of Patient Safety Incident Response Framework (PSIRF) to ensure compassion and learning are integral to the management of serious incidents.
- To ensure we understand our current state, both with regards to our regulatory requirements and the MIP – continually undertaking an honest assessment of where we are now.

5. Conclusion

OGN has been on its own improvement journey since its CQC inspections. As a result of this, a series of improvement actions are underway to improve our compliance with the CQC action plan (must-dos and other recommendations), Clinical Negligence Scheme for Trusts (CNST) requirements (including Saving Babies Lives Care Bundle version 2), Avoiding Term Admissions In Neonates (ATAIN) and the two Ockenden reports. These elements deal with many technical, governance, staffing and leadership requirements and the unit is showing progress in all of these. However, this report describes elements that provide a greater focus on the cultural aspects of maternity care. Research clearly states that safe care is hampered by a lack of compassion. Women will be less open and less likely to communicate what they are feeling or experiencing if we do not connect sensitively and empathically with them. It's clear the impact this could have on clinical escalations. When compassion, professionalism and a willingness to truly listen to our women and pregnant people is forgotten, when care becomes transactional and autocratic, women and babies suffer.

In July of 2022, the Maternity Improvement Programme was launched, and this contained many of the cultural elements described in this report's recommendations. OGN is committed to ensuring it prioritises the elements described in this summary, to ensure we can learn and improve from the experiences of maternity and neonatal services in East Kent.