Reading the Signals Oversight Group meeting - Tuesday 31 October 2023

Tue 31 October 2023, 10:10 - 12:00

Conference Room, Kent and Canterbury Hospital, Ethelbert Road, CT1 3NG

Agenda

10:10 - 10:15
5 min

48. Welcome, Introductions and Apologies

To Note *Claudia Sykes - Chair/Non-Executive Director*

Verbal

10:15 - 10:17
2 min

49. Minutes from the last meeting held on the 19 September 2023

Approval *Claudia Sykes - Chair/Non-Executive Director*

23-049 - Draft Reading the Signals Minutes 19 September 2023 v4.pdf (8 pages)

10:17 - 10:20
3 min

50. Matters Arising from the Minutes

Discussion *Claudia Sykes - Chair/Non-Executive Director*

23-050 - Reading the Signals Oversight Group Action Log.pdf (1 pages)

10:20 - 10:40
20 min

51. Maternity & Neonatal Improvement Plan

Discussion *Michelle Cudjoe - Director of Midwifery*

23-051.1 - MNIP Front Sheet for Board.pdf (7 pages)
23-051.2 - Appendix 1 MNIP Charters and Workstream 1 Project Plan.pdf (13 pages)

10:40 - 11:00
20 min

52. Maternity Update

Discussion *Michelle Cudjoe - Director of Midwifery and Sarah Hayes - Chief Nursing and Midwifery Officer*

23-52 - Pack RSOG 24.10.23.pdf (14 pages)

11:00 - 11:10
10 min

53. Maternity Clinical Team Update

Discussion *Michelle Cudjoe - Director of Midwifery and Sarah Hayes - Chief Nursing and Midwifery Officer*

Verbal

11:10 - 11:30
20 min

54. Family Representative Feedback

Discussion *Claudia Sykes - Chair/Non-Executive Director*

Verbal

11:30 - 11:50
20 min

55. Next Steps

Discussion *Claudia Sykes - Chair/Non-Executive Director*

Verbal

11:50 - 11:55
5 min

56. Any Other Business

Discussion *Claudia Sykes - Chair/Non-Executive Director*

Verbal

11:55 - 12:00
5 min

57. Date of next meeting

Discussion *Claudia Sykes - Chair/Non-Executive Director*

Verbal

UNCONFIRMED MINUTES OF THE READING THE SIGNALS OVERSIGHT MEETING TUESDAY 19 SEPTEMBER 2023 - CONFERENCE ROOM, EDUCATION CENTRE KENT AND CANTERBURY HOSPITAL AND VIA WEBEX TELECONFERENCE

PRESENT

Claudia Sykes	Non-Executive Director (Chair)	CS
Tracey Fletcher	Chief Executive Officer	TF
Adaline Smith	Deputy Director of Midwifery	AS
Michelle Cudjoe	Director of Midwifery	MC
Adam Littlefield	Lead for Patient Voice and Involvement	AL
Jane Dickson	Interim Chief Operating Officer	JD
Sarah Hayes	Chief Nursing and Midwifery Officer	SHa
Andrea Ashman	Chief People Officer	AA
Bernie Mayall	Lead Governor/Elected Public Governor - Dover	BM
Alex Ricketts	Elected Public Governor - Canterbury	AR
Sarah Hubbard	MNVP Lead	SH
Carl Shorter	Deputy Lead Governor	CPl
Lucy De-Pulford	Community Representative	LDP
Abby King	Stakeholder Communications and Engagement Manager	AK
Linda Dempster	Family Representative	LD
Helen Gittos	Family Representative	HG
Becky Collins	Director of Maternity and Neonatal System Kent & Medway ICB	BC
Kaye Wilson	Regional Chief Midwife for South East Region	KW
Raymond Anakwe	Non-Executive Director and Maternity Champion	RA
Lucy De-Pulford	Doula and Community Representative	LDP
Nasmin Lappage	NHS England	NL

AGENDA ITEM NO		ACTION
23/038	**WELCOME AND INTRODUCTIONS AND APOLOGIES** Apologies were received from: Ben Stevens - Chief Strategy and Partnerships Officer, Tanya Linehan - Family Representative, Phil Linehan - Family Representative, Derek Richford - Family Representative	
23/039	**MINUTES FROM THE LAST MEETING HELD ON THE 08 AUGUST 2023** The minutes from the previous meeting were **APPROVED.**	
23/040	**MATTERS ARISING FROM THE MINUTES** **RSOG/01 - Maternity Services Update - MC to bring back to the next meeting the final Maternity Transformation Plan and the review of the Your Voice is Heard first year feedback** - Update 19.09.23 - The plan was taken to the Board of Directors in September 2023 and was **approved**. To be brought to the October 2023 meeting. To remain OPEN. **RSOG/02 - Pillars of Change Update - BS to explain jargon during the August meeting and a legend would be added into the Maternity report explaining what different symbols meant -** Update 19.09.23 - A legend had been included and was part of the meeting pack. The Chair invited feedback on this. To CLOSE **RSOG/03 - Pillars of Change Update - Produce a highlight report which is to include the governance structure and metrics and a communications and engagement update** - Update 12.09.23 - On agenda for September 2023 meeting	

RSOG/04 - Maternity Services Update - MC to add an extra column in the MNIP Charters paper to include the title/initials of the responsible person for each - Update 12.09.23 **-** This has been completed and confirmed by MC on 08/09/2023 - to be seen in October's meeting 2023.

RSOG/05 - Maternity Services Update - The audit report of IEA's that were required by the NHS England to be circulated to the group - Update 12.09.23 - Report circulated via email to group. This now fed into the Maternity Improvement Programme. To CLOSE

RSOG/06 - Maternity Services Update - Anonymised Perinatal Mortality Review Tool (PMRT) to be shared with the group - Update 12.09.23 - Report circulated via email to group. To CLOSE

RSOG/07 - Your Voice is Heard Feedback - The Trusts' target needed to be changed to reflect the national average FFT percentage - Update 19.09.23 - MC informed there had been a conversation regarding this at the Maternity & Neonatal Assurance Group (MNAG) and it was felt that the regional average would be looked at. BC was to look at other organisations within the LNMS and come to an agreement for the region. The trust was at 11% which was positive, however, the trust needed to be ambitious around this. BC commented this would be discussed at a Performance and Quality meeting during this week and it was hoped an agreement would be made across Kent and Medway by the next meeting.

RSOG/08 - AL to provide an overview report for the next meeting along with an options paper on how the community-based work may continue - Update 12.09.23 - On agenda for September 2023 meeting

RSOG/09 - Any Other Business - Get input from family representatives on communications one year on from RTS and engagement in the MNIP - Update 19.09.23 - The Chair informed this would also be a standing item on the October meeting agenda. Family representatives were invited to get involved in the trusts communications and to contact Natalie Yost - Director of Communication and Engagement if they wished to do so.

23/041 **MATERNITY PERFORMANCE UPDATE**

MC discussed the maternity data included in the pack, which related to July's performance and the following was highlighted:

- There were 2 maternity Serious Incidents (SI's), one was a baby admitted to special care and needed cooling therapy and the case met the HSIB criteria and was being reviewed. The second related to a safeguarding issue and involved a lady with severe mental health issues and this was being investigated. In terms of SI performance, the trust was in a much better position with the previous backlog and the majority of these had now been managed.
- There were 26 open complaints for the whole care group, within maternity there were 18 open complaints, 10 were in draft form and 2 had breached. The trust was managing to ensure complaints were being responded to in a timely way.
- In regards to patient involvement, the FFT response in the month of July 2023 was 11.4% - 296 women fed-back and 94.6% extremely likely or likely would recommend the trust. There were concerns around the 5-6% who would not recommend the trust and improvements were trying to be made.

- There was in increase in staff engagement in the month of July 2023, with the score increasing from 6 to 6.15 which was below target.
- There were no SI breaches in the month of July 2023 (page 6 of the pack)
- In terms of the backlog of overdue actions and incidents (page 7 of the pack). Un-reviewed incidents had been brought down from 686 to 130, which was a huge improvement in managing the backlog. There had been a reduction in open actions from 345 to 249 and there were trajectories in relation to clearing the backlog and ensuring lessons had been learnt, embedded and shared. There had been staffing challenges within the team and there was now an interim midwife who would be dedicated to dealing with those incidents.
- Some of the themes coming through complaints in the month of July were around scanning and the capacity within scanning. This had also been declared as an SI, which had been managed in the last few months and the trust were in a much better position. There had been a huge amount of work done aligning the local policies to national pathways and also looking at demand and capacity modelling around ultra-sonography.
- In relation to attitudes and behaviours, conversations were being had with individual members of the team, along with the work being done trust-wide around values and challenging inappropriate behaviours.
- The trust had taken part in the national quadrumvirate and leadership training, which was available to all maternity teams across the country. As part of this, the trust would be undertaking a score survey, which was a cultural assessment and would give a clear indication of where the trust was at in relation to some of the issues.
- The trusts rate was 2.55 per 1000 births in relation to stillbirths and 0.85 per 1000 births for neonatal deaths. Looking at the comparative group and using MBRACCE as the model, the organisation of this size, the comparative group was 5.87 per 1000 births, in East Kent the trust was currently at 3.56. It was recognised and acknowledged these were deaths, and although the numbers were low they were important, and the trust was keen to learn from them.

HG asked if an anticipated admission to neonatal intensive care was no longer being used as a reporting category for a neonatal death, as it had in the past. MC responded this was not the case, there was a separate process for reviewing un-anticipated admissions to the neonatal unit and these were reviewed independently. HG asked if it wouldn't be the case that a neonatal death was recorded as an un-expected admission. MC was clear a neonatal death would be recorded as a neonatal death and would be included in the PMRT reviews. HG also asked if this would be the case wherever a child died - if they were transferred outside of the trust, would it still be recorded as a death. MC confirmed this and commented each organisation would have this same process. JD clarified, if a baby was transferred to another organisation and passed away, that organisation was accounted for the death - MC commented what this would mean for this trusts' data, in terms of the reporting process - if a baby was transferred from this organisation and passed away at another organisation, the hospital where the baby passed away would report the death using the PMRT, however, this trust would be expected to contribute to this and the learning would be reflected in the data. BC commented under recommendation one in the Kirkup report, there would be more clarity on what was the data source, what were the thresholds and what were the regulatory of reporting so there was better oversight across all organisations and between them.

The Chair asked for comments around health and inequalities and people from ethnic minority backgrounds. MC responded from an SI perspective, it was reviewed whether there was involvement from a deprivation as well as ethnicity - MC would expand on this within the narrative. JD commented although seeing the numbers was helpful, it needed to be seen what proportion of our local population

made up that group to help compare whether those particular families were disproportionately represented and this needed to be added to the board paper.

HG commented it was disappointing to see East Kent's rates back-up into concerning territory in the MBRACCE data that was recently published. However, it was understood this was data from 2021 for stillbirths and neonatal deaths. HG asked for clarification what was being looked at within this meeting was a significant improvement, and the next set of MBRACCE data ought to look different for the trust. MC confirmed this was correct and it was confirmed that the most recent MBRACCE data was linked to 2021/2022.

HG asked for re-assurance the trust was certain that staff were recording data much more accurately. MC responded there were now spot-checks on the MBRACCE reporting, against the actual data. Maternity SI reviews were now undertaken with an independent panel member on each review to give assurance on a trust and a regional level. HG understood that SI investigations would be changing dramatically, and was concerned that trusts would be much more selective in what they would investigate. HG asked for assurance that this would not present opportunities in the future, as had been used in the past. MC commented that for maternity the existing system would continue for example, incidents would still be referred to HSIB, which was an independent body and the PMRT process would remain unchanged. This along with the oversight seen in maternity services should give the assurance needed. BC commented, the process was going through the Integrated Care Board (ICB) for 'sign-off' the plans that every provider had for the implementation of Patient Safety Incident Response Framework (PSIRF) which included maternity and neonatal services. It gave an opportunity to agree, as a system, where incidents were happening that may yield the most learning and to influence where the focus on improvement was at a provider or system level.

LDP asked for clarification around complaints around staff/doctors' attitude, and what the plan was to address it. MC clarified there was a score survey which was a culture assessment and was used nationally, most maternity services would have used this in the past. East Kent Hospitals were managing the implementation of the score survey and it was hoped this would be started in October 2023. There would be a range of questions and the process was managed externally, with the trust receiving feedback in the form of heat maps.

LDP commented she had received feedback from patients and staff around disrespectful care, which wasn't logged, midwives who were reporting things said in the staff room about other members of staff along with numerous other issues. These problems were still manifesting and LDP felt these things could become dangerous. MC acknowledged this and informed staff members had raised these issues. There were discussions being had with the HR team, who were looking at culture and awareness and inequality and cultural competency. The trust was managing this and there was a zero-tolerance approach. There were some ways of capturing this and a plan was in place. AA thanked LDP for bringing these points forward. The Culture and Leadership Programme was a nationally recognised programme the trust was undertaking. This was being used across the whole organisation and not just within maternity. The staff survey had been launched, which will run for 10 weeks and there were quarterly pulse surveys which looked at a lot of things that were manifesting around behaviours. There was also an opportunity for individual surveys with patient feedback. This work would never finish and the trust were always striving to do better. Some small movement had been seen, but more was needed.

LD commented it was important to consider all other events/near misses as the learning was so important to help prevent deaths - the whole patient journey needed to be focused on.

RA commented, if the trust just looked at incidents or just looked at culture then it would fail. The incidents, complaints and cultural work around feedback from staff and patients needed to be triangulated.

TF apologised on behalf of BS who was not present. TF informed the progress against the Pillars of Change was reported to the Board of Directors regularly. This was a trust document, and not just related to maternity. TF highlighted the following:

- The Culture and Leadership programme - It was confirmed this was underway and there had been a lot of interest. This programme would operate across the whole organisation. There was a really good foundation of a wider group of people who were committed to this work.
- Continuing to use feedback from staff was really important, in whichever ways they felt comfortable.TF stated the staff survey gave a lot of great information and it was encouraged for staff to complete this as it gave a wealth of information.
- The trust needed to ensure it was developing its approach around communications. There had been a lot of work done around the approach to the comms and comms strategy. The trust was constantly trying to build in how they engaged with staff across the organisation. The Chairman was due to start engagement sessions with colleagues.

SH asked if the staff survey was anonymised. TF confirmed it was, and any information that was received back, there had to be at least 11 people as part of the cohort to then feedback against a service area. AA added the survey was posted by an external organisation, who sent the surveys via email and all responses were returned straight back to them. There was no way the trust could ascertain any further information.

The Chair asked the attendees for feedback on whether the right level of reporting was now being seen in this meeting. HG commented she felt it was the right level of papers. LD agreed, but asked how the message was put out to the wider East Kent community and how the families could help with this.

23/042 **MATERNITY & NEONATAL IMPROVEMENT PLAN AND YOUR VOICE IS HEARD**

MC commented the Your Voice is Heard (YVIH) one year on update would come to the next meeting. There was feedback coming from many sources - the Friends and Family Test (FFT), the national CQC report, walking the patch and ‘leave your troubles at our door’. The plan was to triangulate all these data sources and themes. Once this had been done the quality improvement projects would be worked on, which was being co-produced with SH and it would then move into the MVP strategy for the year - it was hoped by the next meeting the outputs of this would be clear. There would be a really clear focus on postnatal care especially around feeding - either breast feeding or bottle feeding, so women would feel supported whatever their choices. The trust had reached out to Birth Rights (which was a charitable organisation) regarding consent training, and masterclasses had been planned. Discharges from the post-natal wards was also being prioritised. The midwifery led discharge process had just been launched which would help speed up the discharge process. Another area for priority was the experience of births and partners. In terms of next steps, it was important to bring all the data sources together to help improve care. In the CQC maternity survey, East Kent was one of the best performing in labour and birth within the whole region which was positive and there were also positives coming from YVIH - a large number of women had been in contact. It was hoped the Midwifery Led Unit would re-open around the end of September 2023.

23/043 **SERIOUS INCIDENTS**

As discussed in agenda item 23/041

23/044 **COMMUNITY FAMILY VOICES**

AL presented and the following highlights were noted:

- The Community Family Voices sessions were set-up, which ran in July 2023 with one in Thanet and one in Canterbury - these sessions were not highly attended, but the feedback received was dense. Work was being done on sharing this across the trust.
- The five key themes were around; pain assessment, training, discharge and support for birthing partners - the bigger issue was around communication and re-assuring people.

AL had put together some options for what happened next with the community family voices work. Three options had been put forward; continue as is, something radical and new - which would require a lot of resource, or triangulate everything together. AL commented the MNVP had a lot of good work happening, and a lot of good internal work within the MC and her team and the patient experience midwives. AL thanked everyone who had been involved and shared their personal experience. AL suggested a relocation of the people within these stories and their experience would be useful - if this could somehow be built into the reporting which staff would benefit from.
SH commented there was a meeting being held on the 23rd September 2023 with the MNVP, patient experience team, AL, MC and AS to start the triangulation process and gathering all the feedback. SH stated it was important to not duplicate things and triangulation was the way to do this. AL suggested it would be useful for staff to have something that explained all the pillars and how they tied together and shared information, which could also be shared with people who were not staff, which would be really valuable.

23/045 **COMMUNICATIONS UPDATE**

The Chair commented the trust needed a very sensitive approach to anything shared and needed to be mindful on how this may come across.

AK informed a report was being drafted, with the service, which summarised some of the improvement work that was underway after the publication of the Kirkup report. Feedback had been sought from some members of this meeting, and this should begin to be shared within a couple of weeks. The chair asked if this was something that could be shared with other family representative of this group. AK responded this would be possible, and the more feedback received the better. The first week of November there was a plan to pull together a community-based event, which was an opportunity to showcase the improvements, listen to the community and build on the engagement event that took place earlier this year. As soon as there was a confirmed date and more detail, it would be shared.

The Chair commented there was a need to bring in current service users. SH commented monthly listening events would take place, some online and some locally to share some recent feedback. The chair asked SH what her view was on communication from the trust and how effective she felt it was. SH responded, there was some women who would follow the Facebook page for the period of time while they were pregnant and not for much longer after. Unless there was a particular interest, those people would not be kept in the audience. SH commented the content was good, and the balance needed to be right to avoid offending or triggering people, whilst also celebrating success. There also needed to be transparency around who ran the page.
BM suggested public governors needed to be made more use of, which was agreed.
AS raised some of the language used sounded a little more corporate and work was needed to be done around this, especially when sharing statistics.

AL commented there was a lot of people who were disengaged with social media around birth and there needed to be something physical to hand out, which needed to be something communicated simply. The chair asked LDP what she felt the trust could do to help re-build trust with the people she was in communication with. LDP commented she would put some thought into this, but commented, if a family felt traumatised by a service, they would not talk openly to that service, they would talk to a community voice and this was why LDP was attending these and other meetings - to try and link together, however she did not feel she was also being heard. SH commented the MNVP was there to help bridge the gap between and the service and service user, and invited a further discussion with LDP to help with this. The chair asked SH if she felt she had support from the trust and did she feel heard. SH responded she had been in post as chair of the MNVP since the end of August 2023 and had weekly meeting with MC, AS and the patient experience team and felt anything that had been raised had been dealt with by the patient experience team. This was a new relationship with the MNVP, but it had been a positive start. BM asked if the governors could get involved with this.

LR asked the following questions:

- Were the MLU at QEQM and WHH open. MC confirmed the QEQM unit was, however, WHH was going through some building works and it was expected to open by the end of September 2023. The bio-mechanics training had been sourced, which would be in November 2023.
- When would ante-natal classes would be reinstated. MC responded there had a been a huge piece of work around antenatal classes and these would take different formats. The trust had access to classes in different languages, which had been launched at both sites, with face-to-face due to resume in the future.
- What measures or actions were in place to address the issue of consent before a crisis. MC responded training had been arranged for staff which the Birth Right charity would be facilitating by the end of the year. One of the trusts clinical directors had also facilitated a session on consent, to all clinicians. From a midwifery perspective, in terms of training and development for midwives, the brain model of the consent had been included and looking at a framework midwifes can use when having those discussions, ensuring the benefits, risks and alternatives around treatment, and how a woman feels were discussed. The model had been shared with the team. Once training had been delivered, there would be auditing practice around this.
- What percentage of mothers at the point of discharge or after 28 days, were assessed as having a form of mental health symptoms - MC would follow this up outside of this meeting - **ACTION**. The Chair commented it would be useful to have an update on how the trust were supporting mothers suffering with mental health.

LDP commented around the training as mentioned above that was aimed at midwifes - there was an issue of obstetric representation being part of this meeting. Having been on the unit LDP stated there was distinctive issue with the obstetric team. LDP asked why a representative from the obstetric team was not present at these meetings and engaging, as they led care. The chair clarified Miss Zoe Woodward had been invited to these meetings, and MC commented the training was multi-disciplinary and would be mandatory. This was additional training that would start with a masterclass in December 2023. It was recognised the issue around obstetric presence at these meetings, however, internally there was representation around rapid reviews and audit meetings. It was being looked at how there could be obstetric representation at meetings such as this and it was noted this meeting fell on a doctors' strike day and other meetings had been cancelled. SH commented there was representation at the MVP. HG agreed with LDP's comments and raised that unless there was obstetrician presence in the room, there would be no confidence change was going to happen - SHa would take this forward.

23/046 **ANY OTHER BUSINESS**

For the next meeting the Chair would like to discuss the effectiveness of this meeting as it has now reached the 6-month period. Would members like to have the meeting taken forward, with the comments around obstetric representation taken into consideration, or whether there was patient or family representation at other committees in other ways, such as the MNVP. It needed to ensure it remained topical and not duplicating the work of the MNVP.

The chair thanked all for attending.

23/047 **DATE OF NEXT MEETING -** 31st October 2023.

Date of Next Meeting – 31st October 2023

SIGNED: _____

DATED: _____

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

RSOG/01	20.06.2023	23/022.1	Maternity Services Update	MC to bring back to the next meeting the final Maternity Transformation Plan and the review of the Your Voice is Heard first year feedback	08.08.2023	MC	Open	Update - First Year Feedback - On August agenda, Maternity Improvement Plan was being discussed for approval at September 2023 Board meeting and will be shared at this meeting in October 2023. **Update 19.09.23** - The plan was **APPROVED** by the Board of Directors and the paper will be shared at this meeting in October 2023.
RSOG/04	08.08.2023	23/031	Maternity Services Update	MC to add an extra column in the MNIP Charters paper to include the title/initials of the responsible person for each	19.09.2023	MC	Open	Update - This has been done completed - confirmed by MC on 08/09/2023. **Update 12.09.23** - This has been completed and confirmed by MC on 08/09/2023 - to be seen in October's meeting 2023
RSOG/07	08.08.2023	23/032	Your Voice is Heard Feedback	The Trusts' target needed to be changed to reflect the national average FFT percentage	19.09.2023	MC	Open	Update - MC to email the Regional Chief Midwife for her perspective. **Update 19.09.23** - MC informed there had been a conversation regarding this at the Maternity & Neonatal Assurance Group (MNAG) and it was felt that the regional average would be looked at. BC commented this would be discussed at a Performance and Quality meeting during this week and it was hoped an agreement would be made across Kent and Medway by this next meeting.
RSOG/09	08.08.2023		Any other business	Get input from family representatives on communications one year on from RTS and engagement in the MNIP	19.09.2023	MC/AL/NY	Closed	**Update 19.09.23** - The Chair informed this would also be a standing item on the October meeting agenda. Family representatives were invited to get involved in the trusts communications and to contact Natalie Yost - Director of Communication and Engagement if they wished to do so. **Update 10.10.23** - A draft one year on report was shared with the group, 7 sets of comments and feedback was received from members of the group and incorporated into a final draft which went to the Public Board on 5 October and uploaded to the public website. Content from the report will be used in communications.
RSOG/10	19.09.2023	23/045	Communications Update	MC to follow up LR's question in regards to the percentage of mothers who at the point of discharge, or after 28 days were assessed as having some form of mental health symptoms.	31.10.2023	MC	Open	

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: MATERNITY AND NEONATAL IMPROVEMENT PROGRAMME (MNIP)

Meeting date: 7 SEPTEMBER 2023

Board sponsor: CHIEF NURSING & MIDWIFERY OFFICER

Paper Author: DIRECTOR OF MIDWIFERY

Appendices:

APPENDIX 1: SIX WORKSTREAM CHARTERS

Executive summary:

Action required:	**Approval**
Purpose of the Report:	The paper is brought to the Board for approval of the amended Maternity and Neonatal Improvement Programme.
Summary of key issues:	• A Maternity Transformation Programme (MTP) was developed in March 2023 following the publication of the *Reading the Signals* report in October 2022 and the Care Quality Commission (CQC) inspection in January 2023. • It was aligned to the 5 pillars of change outlined by the Trust in its response to *Reading the Signals*. • Some Quality Improvement (QI) projects were non-negotiable as linked to the Integrated Improvement Plan (IIP) and Trust exit strategy. • The programme included 6 workstreams with designated Executive leads. • In May 2023 the Single Delivery Plan – a 3-year plan that sets out how the NHS will make maternity and neonatal care safer, more personalised and more equitable was published. • 'We hear you' engagement day 28 June 2023 (internal and external stakeholders including Maternity and Neonatal Voices Partnership (MNVP)/families). • The name of the programme (The Maternity and Neonatal Improvement Programme (MNIP)) and the vision was co-produced with all stakeholders. The 6 Workstream charters have been amended to include feedback received from all stakeholders. • The amended workstream charters have been reviewed by the Maternity Improvement Advisor, shared with the Integrated Care Board (ICB), Regional Midwifery lead and MNVP chair for feedback on 28 July 2023. • The workstream charters shared with the Reading the Signals Oversight Group on 8 August 2023. • The amended MNIP was presented to the Maternity and Neonatal Assurance Group (MNAG) on 8 August 2023.

We care

East Kent Hospitals University NHS Foundation Trust

Key recommendations:	The Board of Directors is asked to **APPROVE** the amended charters and programme for delivery.

Implications:

Links to 'We Care' Strategic Objectives:	• Quality and Safety • Patients • Our people • Partnerships • Sustainability
Link to the Board Assurance Framework (BAF):	N/A
Link to the Corporate Risk Register (CRR):	N/A
Resource:	N
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: MNAG – 8 August 2023, and Reading the Signals Oversight Group – 8 August 2023.

East Kent Hospitals University NHS Foundation Trust

Maternity and Neonatal Improvement Programme

1. Purpose of the report

The paper is brought to the Board for approval of the amended Maternity and Neonatal Improvement Programme (MNIP).

2. Background

Following the publication of Dr Kirkup's report into maternity and neonatal care in East Kent between 2009 and 2020, *Reading the Signals* in October 2022 and the CQC inspection in January 2023, a Maternity Transformation Programme (MTP) was developed.

The MTP was aligned to the 5 pillars of change outlined within the Trust's response to *Reading the Signals*. Some quality improvement projects were non-negotiable as linked to the IIP and Trust exit strategy.

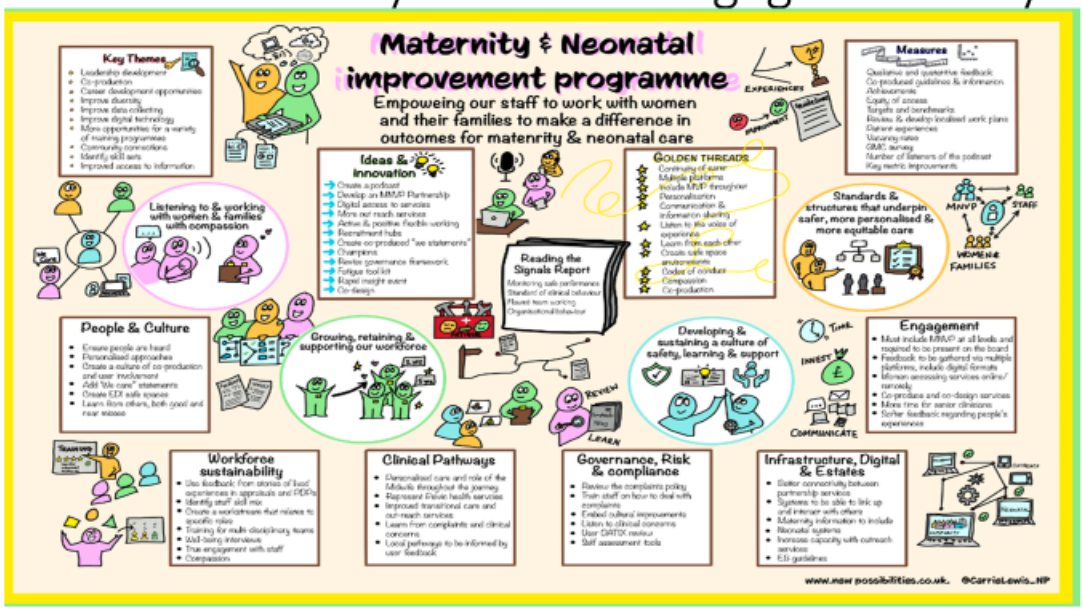
The programme included 6 workstreams with designated Executive leads as Senior Responsible Officers (SROs).

- People and Culture - Chief People Officer
- Workforce - CNMO
- Clinical Pathways – Chief Medical Officer
- Governance - CNMO
- Engagement - CNMO
- Infrastructure and digital – Chief Strategy & Partnerships Officer

In May 2023 the Single Delivery Plan – a 3-year plan that sets out how the NHS will make maternity and neonatal care safer, more personalised and more equitable was published. The incoming leadership team facilitated an engagement day for internal and external stakeholders including the MNVP/families.

East Kent Hospitals University NHS Foundation Trust

MNIP - Visual Synthesis of engagement day



The name of the local programme and the vision was co-produced with all stakeholders and is now referred to as **the Maternity and Neonatal Improvement Programme (MNIP)**.

The 6 Workstream charters have been amended to include feedback received from all stakeholders. The elements of the workstream charters relevant to the Reading the Signals (RTS) recommendations were also shared at the Reading the Signals Oversight Group.

3. Summary of Workstream Charters

The MNIP comprises of the following 6 workstreams that are aligned to the Trust's Pillars of change and the Single Delivery Plan. The project timescales have also been aligned to the Trust Integrated Improvement Plan, the Single Delivery Plan and the Maternity Safety Support Programme (MSSP) milestones. The action plans aligned to each workstream set out clear responsibilities and measures of success across the service.

1. **Developing a positive culture (leadership)**

   The need for a positive culture and leadership of services was highlighted in the *Reading the Signals* report and other high-profile failings within Maternity Services across the UK. Workstream 1 sets out actions in relation to developing and sustaining a positive culture through empowering the team to work with kindness, professionalism and compassion at both Trust and departmental levels.

2. **Developing and sustaining a culture of safety, learning and support**

   Whilst workstreams 1 & 2 are interlinked in relation to safety culture, workstream 2 focusses on actions that will be taken in relation to monitoring safety performance articulated in the *Reading the Signals* report as 'finding signals among noise'. This also includes understanding

national data in the context of the local demographics and how this impacts on local women and families using the service.

3. **Clinical Pathways that underpin safe care**

   Dr Kirkup's investigation identified that clinical care was poor, additionally, other national reports found that despite advances in clinical practice many women were not offered care in line with best clinical practice.

   This workstream sets out the Clinical pathways that are to be embedded incorporating nationally defined best practice. The ambition being to consistently implement best practice in order to reduce variation.

4. **Listening to and working with women and families with compassion**

   It is well known that listening and responding to women and families is an important element of safe care within maternity services. The *Reading the Signals* report highlighted the need to re-establish listening to patients as a vital part of clinical practice.

   This workstream sets out actions aligned to listening to families and working with service users, in order to achieve personalised care and improve equity.

5. **Growing retaining and supporting our workforce**

   There is national recognition that for maternity services to achieve the ambition of safer, more personalised and equitable care there must be a commitment to ensuring that care is provided by skilled teams with sufficient capacity and capability.

   This workstream sets out the actions required to achieve this ambition and is also aligned to recommendations within the NHS Long Term Plan and the NHS People Plan.

6. **Infrastructure and digital**

   The *Reading the Signals* report highlighted the detrimental effect that sub-optimal estates have on the provision and experience of care.

   This workstreams sets out the actions that are required to address these issues to both enable women and service users to have access to the information they need and ensure safe and personalised care.

4. Support, oversight and measuring success

Each of the six workstreams will have a supporting project plan and identify:

- Responsible project/workstream leads at Executive, care group, management and action level
- Milestones taken from the Charters
- Supporting tasks required to achieve each milestone
- Associated costs
- Evidence log

- Progress against completion vs assurance
- Key Performance Indicators (KPIs)

A dashboard containing all metrics from each of the workstreams will be developed to support monitoring and oversight of the programme's implementation. Each MNIP Workstream will have a nominated Executive Senior Responsible Officer and there will be a robust quality assurance process to review and approve evidence in support of achievement of each milestone within each plan.

The table below is a draft of the proposed Women's Health Governance Reporting Structure to oversee delivery of improvement alongside business as usual activity; this is being progressed as part of the development of the revised Women's Health Quality and Safety Framework (QSF):

<table>
<tr><td colspan="8">Trust Board</td></tr>
<tr><td colspan="2">Quality + Safety Committee
Performance Management Board</td><td colspan="6">Maternity + Neonatal Assurance Group</td></tr>
<tr><td colspan="8">Women's Health Care Group Integrated Assurance Meeting
Chairs: DOM/CD/ADOP/DDoM</td></tr>
<tr><td>Operational Performance Group
Chairs: Ops Site Leads</td><td>Transformation and Improvement Group
Chair: Transformation Lead/HoMs</td><td colspan="3">Patient Safety Group
Chair: DDOM/Obs Governance Leads</td><td colspan="2">Experience and Engagement Group
Chair: TBC</td></tr>
<tr><td colspan="8">Reporting Groups</td></tr>
<tr><td>Workforce meeting Inc. professional standards</td><td>MNIP Programme Management</td><td>Clinical Groups*</td><td colspan="2">Governance Groups</td><td>Women/Birthing People</td><td>Workforce</td></tr>
<tr><td rowspan="2">Efficiency</td><td rowspan="6">MNIP Operational Workstream Meetings
1. Positive Culture
2. Safety Culture
3. Clinical Pathways
4. Listening
5. Workforce
6. Infrastructure (Inc. Digital)</td><td rowspan="2">Antenatal Pathway Forum (future)</td><td>Monthly</td><td>Weekly</td><td>MVP (PPAG)</td><td>Staff Side meeting</td></tr>
<tr><td>Risk Meeting</td><td>Local incident meetings</td><td rowspan="2">Partners Group</td><td rowspan="2">PMA Meetings</td></tr>
<tr><td>Estates, Equipment and Procurement</td><td>Antenatal Screening Forum</td><td>PMRT Group</td><td>SI tracker</td></tr>
<tr><td rowspan="4"></td><td>Integrated Improvement Plan (IIP)</td><td>Intrapartum (labour ward) group</td><td>M+M Group</td><td>Rapid Review</td><td>YVH (PPAG)</td><td>Women's Group</td></tr>
<tr><td>Reading the Signals</td><td>Postnatal pathway/ATAIN forum (future)</td><td>Guideline & PILs Group</td><td rowspan="3"></td><td>Pt. Info Group</td><td>Consultant Meeting</td></tr>
<tr><td>We Care Metrics</td><td>CQC</td><td>Audit Group</td><td>FFT (PPAG)</td><td>Band 7 meetings</td></tr>
<tr><td></td><td></td><td>Education and Learning Faculty</td><td colspan="2">Patient Voices Model will report into a local PPAG forum, that reports through this structure into Trust-level PPAG</td></tr>
</table>

*Business as usual forums; improvement elements have oversight via MNIP under 'Transformation and Improvement Group'

The 'Transformation and Improvement Group' within the above draft structure is supported by this proposed MNIP Governance Reporting schedule that sets out review dates at operational, care group, and Trust level:

East Kent Hospitals University NHS Foundation Trust

Maternity and Neonatal Improvement Programme (MNIP) Planner 2023/24

Overview

	MNIP Project Groups							Care Group Reporting				Trust-level Reporting			
	Culture	Workforce	Clinical Pathways	Safety Culture (Governance)	Infrastructure	Listening	No. Meetings	WH Improvement & Transformation Group	WH Integrated Assurance Group	MTP Board (Project Board) MNAG?	No. Meetings	MNAG	Strategic Improvement Committee (SIC)	Trust Board	No. Meetings
Chair	Clinical Director	Director of Midwifery	Director of Operations	Dep. Director of Midwifery	Director of Operations	Director of Midwifery		Service Development Programme Lead	Head of Governance	Chief Nursing & Midwifery Officer (CNMO)		Chief Nursing & Midwifery Officer (CNMO)	Chief Executive Officer (CEO)	Trust Chairman	
Frequency & Forum	Monthly Snr MW Mtg 3rd Thursday of each month	Monthly Snr MW Mtg 3rd Thursday of each month	Monthly Cross-Site Mgmt Mtg 3rd Friday of each month	Monthly WH Governance Mtg 2nd Thursday of each month	Monthly Cross-Site Mgmt Mtg 2nd Friday of each month	Monthly Snr MW Mtg 2nd Friday of each month		Monthly - TBA	Monthly - TBA	Monthly - TBA		Monthly - 2nd Tuesday of each month	Monthly - 	Monthly Trust Board 1st Thursday of each month	
Oct 2023	07-Sep-23	07-Sep-23	15-Sep-23	07-Sep-23	08-Sep-23	08-Sep-23	6	22-Sep-23	29-Sep-23	03-Oct-23	3	10-Oct-23	TBA	02-Nov-23	3
Nov 2023	05-Oct-23	05-Oct-23	20-Oct-23	12-Oct-23	13-Oct-23	13-Oct-23	6	27-Oct-23	03-Nov-23	07-Nov-23	3	14-Nov-23	TBA	07-Dec-23	3
Dec 2023	02-Nov-23	02-Nov-23	17-Nov-23	09-Nov-23	10-Nov-23	10-Nov-23	6	24-Nov-23	01-Dec-23	05-Dec-23	3	12-Dec-23	TBA	TBC	3
Jan 2024	28-Dec-23	28-Dec-23	15-Dec-23	07-Dec-23	08-Dec-23	08-Dec-23	6	22-Dec-23	29-Dec-23	02-Jan-24	3	09-Jan-24	TBA	TBC	3
Feb 2024	25-Jan-24	25-Jan-24	19-Jan-24	11-Jan-24	12-Jan-24	12-Jan-24	6	26-Jan-24	02-Feb-24	06-Feb-24	3	13-Feb-24	TBA	TBC	3
Mar 2024	22-Feb-24	22-Feb-24	16-Feb-24	08-Feb-24	09-Feb-24	09-Feb-24	6	23-Feb-24	01-Mar-24	05-Mar-24	3	12-Mar-24	TBA	TBC	3

5. Conclusion

The paper provides an overview of the six workstreams within the Maternity and Neonatal Improvement plan which will be implemented in response to Dr Kirkup's investigation, other high-profile maternity reports, the local CQC review and recommendations contained within the Single Delivery Plan.

The workstreams have been developed with internal and external stakeholders including women and families.

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

Executive Senior Responsible Officer (SRO): Chief People Officer

Maternity and Neonatal Improvement Programme

NHS East Kent Hospitals University NHS Foundation Trust Maternity Services

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

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 Listening to and acting upon issues raised by staff or service users through complaints, MNVP or FTSU	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 Evidence of 'you said, we did' in relation to staff concerns and patient concerns	• 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

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

Maternity and Neonatal Improvement Programme

NHS East Kent Hospitals University NHS Foundation Trust Maternity Services

Executive Senior Responsible Officer (SRO): Chief People Officer

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

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

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

Maternity and Neonatal Improvement Programme

NHS East Kent Hospitals University NHS Foundation Trust Maternity Services

Executive Senior Responsible Owner (SRO): Chief Medical Officer

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

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, including: • Sonography • Triage • Diabetes • Perinatal Mental Health • Recognition of Deteriorating Woman (HDU) • Antenatal Systems and Processes • Postnatal Care Pathway • Antenatal Newborn Screening • Multiple Pregnancy • Transitional Care / ATAIN • Fetal Medicine Unit • Midwifery-led Care • Fundamentals of Care • Removal of Virtual Appointments • Clinical Practice Standards • Bereavement Care • 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

❖ 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

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

Maternity and Neonatal Improvement Programme

NHS East Kent Hospitals University NHS Foundation Trust Maternity Services

Executive Senior Responsible Owner (SRO): Chief Nursing and Midwifery Officer

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

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
❖ Ensuring the availability of bereavement services 7 days a week for families who sadly experience loss	March 2024	Bereaved families receive compassionate high-quality care including appropriate accommodation	Implementation of a 7-day bereavement service	• Evidence of required workforce, dedicated bereavement accommodation and facilities across sites • Rotas demonstrate availability of a 7-day service
❖ 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 and Action Group (PPAG) - 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 • Evidence of AIS needs recorded in patient record systems e.g. Euroking, PAS, Sunrise • 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

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

Executive Senior Responsible Officer (SRO): Chief Nursing and Midwifery Officer

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

Maternity and Neonatal Improvement Programme

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 Staff feel valued when they are supported to develop	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, in line with clinical competency framework, 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
		
		Staff feel valued at al stages of their career
			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 education facilitators 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
				• 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

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

Executive Senior Responsible Officer (SRO): Director of Strategic Development and Partnerships

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

Maternity and Neonatal Improvement Programme

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)

MNIP Workstream 1 - Developing a positive culture

Today's Date: 16/08/2023

Highlights (work completed this reporting period)

- ✓ Development of draft project plan to reflect requirements of Workstream 1 Charter
- ✓ Commencement of Perinatal Culture Leadership Programme for Care Group Quad (Leaders)
- ✓ Initial discussions with NHSI to plan for launch of SCORE survey in October 2023
- ✓ Launch of 'We Hear You' escalation process for the workforce
- ✓ Leave your troubles at the door' and Maternity & Neonatal Safety Champion posters shared with Maternity ward

Project SRO	Chief People Officer	**Project Care Group Senior Lead**	Director of Midwifery
Project Lead	Care Group Head of People and Culture	**Project Start Date**	01/04/2023
Project Support	MNIP Project Manager	**Project End Date**	31/03/2025

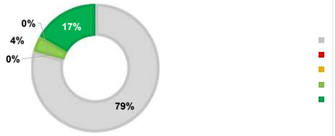
Maternity and Neonatal Improvement Programme

PROJECT Progress Bar

17%

No. Actions	24	Status (%)
Not scheduled to start	19	79%
Off track	0	0%
At risk	0	0%
On track	1	4%
Complete	4	17%
	24	**100%**

ACTION COMPLETION STATUS (%)



PROJECT Cost

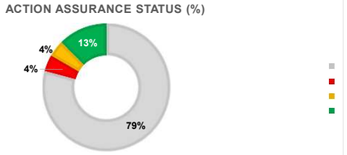
£0.00

PROJECT Delivery Status

15%

Level of Assurance	24	Status (%)
Not scheduled to start	19	79%
Not yet delivered	1	4%
Delivered, not evidenced	1	4%
Evidenced and assured	3	13%
	24	**100%**

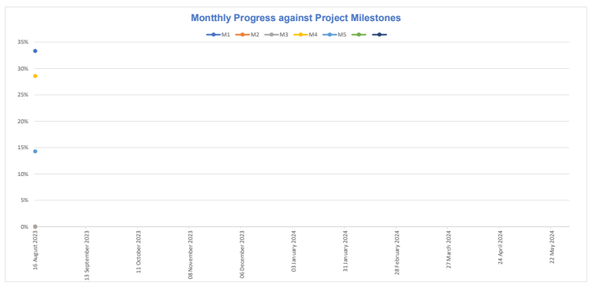
ACTION ASSURANCE STATUS (%)



No DAYS left

593

Montthly Progress against Project Milestones



Monthly Progress against Project Milestones

Milestone Ref	16 August 2023	13 September 2023	11 October 2023	08 November 2023	06 December 2023	03 January 2024	31 January 2024	28 February 2024	27 March 2024	24 April 2024	22 May 2024
M1	33%										
M2	0%										
M3	0%										
M4	29%										
M5	14%										

Status	Summary of At Risk / Overdue Actions	Action Ref.	No. Days Overdue
OT	None	N/a	N/a
AR	None	N/a	N/a

< 30 Days of completion date

> 30 Days of completion date

	Key Risks to Delivery	Mitigations
1	Misalignment with Trust-level programmes of work and timelines	All MNIP workstreams have been coproduced and triangulated with known Trust-level programmes of work for example, with the Executive Integrated Improvement Plan (IIP) in response to 'Reading the Signals' (Oct 2022)
2	Missed deadlines resulting from lack of clarity regarding roles and responsibilities	There are clearly defined owners at Executive, Care Group, Management and Project levels. Work has been ongoing to develop relationships with key interfaces / teams required for successful delivery of the full programme of work. All tasks will be shared with task owners, and each owner will be a member of the project group to attend monthly progress review meetings and attendance will be monitored and shared through the MNIP governance reporting structure
3	Implementation of initiatives and improvements are not sustained	Some initiatives and improvements may be superseded by further enhanced ways of working either organically, through a cycle of PDSA (Plan, Do, See, Act) or because outcomes have proved them to be ineffective. However, effective changes will be underpinned by the the NHSI Sustainability framework and championed by service leaders / ambassadors; they will also be monitored by project leads for a six-month period following completion of the project plan before being reviewed for approval to become 'business as usual' ways of working

Maternity and Neonatal Improvement Programme - Project Plan		Project Title	Workstream 1 - Developing a positive culture	Executive Sponsor	Chief People Officer
Care Group Senior Lead	Director of Midwifery	Project Lead	Care Group Head of People and Culture	Project Manager	MNIP Project Manager
MNIP Vision	**Empowering our staff to work with women and their families to make a difference in outcomes for maternity and neonatal care**				

Maternity and Neonatal Improvement Programme

	Project Milestones	Project Outputs	Project Qualitative and Quantitative Measures	Cost
1	Delivery of NHSI Culture and Leadership Programme (CLP) – 31/03/2025	• 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 • Downward trends in NHS Staff survey re: Bullying, harassment, and poor behaviours	1 £0.00
2	Delivery of Trust-level leadership development programme for those recruited into leadership posts – 31/03/2025			2 £0.00
3	Implementation of Inclusion and Respect Charter – 31/08/2024	• 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	3 £0.00
4	Structured escalation processes for raising concerns for the workforce and service users outside of clinical situations* (*Clinical escalation in Workstream 3) – 31/03/2025	• 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 • Evidence of 'you said, we did' in relation to staff concerns and patient concerns	• 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	4 £0.00
5	Completion of the SCORE survey – 31/05/2024	Identified areas for quality improvement through gap analysis of SCORE results	• SCORE Survey Results • Identified improvements against previous survey	5 £0.00

Project Start Date	01/04/2023
Project End Date	31/03/2025
Total No. Days	730
Days Left	593

Objective (Milestone) 1 — Delivery of NHSI Culture and Leadership Programme (CLP)

Milestone Completion Date: 31/03/2025 | Milestone Status (RAG): Not scheduled to start | Milestone Progress: 33% | Milestone Delivery: 33% | Milestone Costs: £0.00

Action Ref.	Action	Owner (Role)	Start Date	Due Date	No. days	Action Status (RAG)	Progress Bar	Completion Date	No. Days Overdue	Cost (£)	Progress notes	Level of Assurance	Delivery Progress	Evidence Log (to demonstrate output)
1.1	As part of Phase 1 of the Perinatal Culture and Leadership Programme (PCLP) share care group Quad delegate details with NHSI for registration and enrolment	*To be agreed*	01/04/2023	31/08/2023	152	Complete	100%		0	£0.00	16.08.23 - Care group Quad for this programme are: DoM (MC) / Ass. Medical Director (ZW) / Head of Ops (CK) / Neonatal Clinical Lead (SM)	Evidenced and assured	100%	1.1 01 PCLP Welcome Document 1.1 02 PCLP Programe Timeline
1.2	Care Group Quad to complete 8 x development days over a six-month period (mix of virtual, and face-to-face) that will be hosted by an external provider ('Safe and Reliable')	Women, Children and Young People Care Group (WCYP CG) Quad	01/04/2023	30/09/2023	182	Not scheduled to start	0%		-45	£0.00	16.08.23 - Pending copy of Phase 1 dates for evidence folder	Not scheduled to start	0%	
1.3	Following completion of Phase 2 (milestone 5 - SCORE Survey), Care Group Quad to engage with, and deliver, Phase 3 of the PCLP	Women, Children and Young People Care Group (WCYP CG) Quad	01/03/2024	31/05/2024	91	Not scheduled to start	0%		-289	£0.00	16.08.23 - Dependent on successful delivery of Phases 1 and 2	Not scheduled to start	0%	

Objective (Milestone) 2 — Delivery of Trust-level leadership development programme for those recruited into leadership posts

Milestone Completion Date: 31/03/2025 | Milestone Status (RAG): Not scheduled to start | Milestone Progress: 0% | Milestone Delivery: 0% | Milestone Costs: £0.00

Action Ref.	Action	Owner (Role)	Start Date	Due Date	No. Days	Action Status (BRAG)	Completion Date	No. Days Overdue	Cost (£)	Progress notes	Level of Assurance		Evidence Log (to demonstrate output)
2.1	Identify medical leadership requirements aligned to Royal College of Obstetricians & Gynaecologists (RCOG) Leadership and Management Framework and work with Medical Education to produce a plan for implementation across the medical workforce	Zoe Woodward, Associate Medical Director for Women's Health	01/09/2023	31/03/2025	577	Not scheduled to start	0%		-593	£0.00		Not scheduled to start	0%	
2.2	Embed the B7 Connected (Leadership) training for all new appointments to midwifery leadership/management roles	Jess O'Reilly, Quality and Education Matron	01/09/2023	31/03/2025	577	Not scheduled to start	0%		-593	£0.00		Not scheduled to start	0%	
2.3	Implement the Trust-level Leadership Behaviours Framework once published (linked to a re-launch of the Trust values)	Claire Everley, Organisation Development Business Manager	01/09/2023	31/03/2025	577	Not scheduled to start	0%		-593	£0.00		Not scheduled to start	0%	
2.4	Embed Trust processes and practice for managing behaviours that do not meet Trust values	To be agreed	01/09/2023	31/03/2025	577	Not scheduled to start	0%		-593	£0.00		Not scheduled to start	0%	

Objective (Milestone) 3 — Implementation of Inclusion and Respect Charter

Milestone Completion Date: 31/08/2024 | Milestone Status (RAG): Not scheduled to start | Milestone Progress: 0% | Milestone Delivery: 0% | Milestone Costs: £0.00

Action Ref.	Action	Owner (Role)	Start Date	Due Date	No. Days	Action Status (BRAG)	Completion Date	No. Days Overdue	Cost (£)	Progress notes	Level of Assurance		Evidence Log (to demonstrate output)
3.1	Share the Trust's current version of the Inclusion and Respect Charter across the Women, Children and Young People Care Group (WCYP CG) with an introductory biography to the role of Head of Equality, Diversity and Inclusion	Parveen Kumi, Head of Equality, Diversity & Inclusion (EDI)	01/09/2023	30/09/2023	29	Not scheduled to start	0%		-45	£0.00		Not scheduled to start	0%	
3.2	Implement values-based recruitment and achievement reviews (appraisals) inclusive of requirements for demonstrable adherence to Trust Values	Karl Woods, Head of People and Culture for Women, Children and Young People Care Group (WCYP)	01/09/2023	31/08/2024	365	Not scheduled to start	0%		-381	£0.00		Not scheduled to start	0%	
3.3	*Work to be agreed*	*To be agreed*	01/09/2023	31/08/2024	365	Not scheduled to start	0%		-381	£0.00		Not scheduled to start	0%	

Objective (Milestone) 4 — Structured escalation processes for raising concerns for the workforce and service users outside of clinical situations* (*Clinical escalation in Workstream 3)

Milestone Completion Date: 31/03/2025 | Milestone Status (RAG): Not scheduled to start | Milestone Progress: 39% | Milestone Delivery: 29% | Milestone Costs: £0.00

Action Ref.	Action	Owner (Role)	Start Date	Due Date	No. Days	Action Status (BRAG)	Completion Date	No. Days Overdue	Cost (£)	Progress notes	Level of Assurance		Evidence Log (to demonstrate output)
4.1	Embed 'We Hear You' service and promote across the care group, including email contact address and posters for display around the units / in community	George Bennett, Patient Safety Midwife	01/05/2023	30/06/2023	60	Complete	100%		0	£0.00	31.05.23 - We Hear You poster templates shared by Patient Safety Midwife for comment	Evidenced and assured	100%	
4.2	Launch 'Leave your troubles at the door' support for the workforce as well as families	Adaline Smith, Deputy Director of Midwifery	01/07/2023	31/08/2023	61	Complete	100%		0	£0.00	08.08.23 - Posters produced and shared with local midwifery management teams for displaying on the wards at WHH and QEQM 16.08.23 - Further work potentially needed to share the purpose and intention of this service, and to increase awareness amongst the workforce	Delivered, not evidenced	67%	4.2 01 Maternity Posters - 08 Aug 2023
4.3	Freedom to Speak Up Guardian (FTSUG) to routinely report into MNAG with anonymised caseload figures and high-level themes for shared awareness, learning and triangulating with other workstreams e.g. Patient Safety / People and Culture themes, MNIP workstreams	Katie Clark, Maternity Freedom to Speak Up Guardian	01/08/2023	31/03/2024	243	On track	75%		-228	£0.00	16.08.23 - Agreed at MNAG in August for FTSU report to be a standing agenda item and scheduling to be arranged between MNAG administrator and Maternity FTSUG	Not yet delivered	33%	
4.4	FTSU training to be made available across the care group with monitoring of completion rates	Katie Clark, Maternity Freedom to Speak Up Guardian	01/09/2023	31/03/2025	577	Not scheduled to start	0%		-593	£0.00	16.08.23 - Training opportunities to be scoped out, discussed and agreed with FTSUG and Education team for events to be planned and shared	Not scheduled to start	0%	
4.4	Embed 'You said, We did' in response to themes of escalated concerns from the workforce	Adaline Smith, Deputy Director of Midwifery	01/09/2023	31/03/2024	212	Not scheduled to start	0%		-228	£0.00		Not scheduled to start	0%	
4.5	Promote and embed awareness of Maternity and Neonatal Safety Champions across the service; themes of concerns shared with Safety Champions to continue to be reported to MNAG and Trust Board	Michelle Cudjoe. Director of Midwifery	01/09/2023	31/03/2024	212	Not scheduled to start	0%		-228	£0.00		Not scheduled to start	0%	
4.6	*Work to be agreed*	*To be agreed*	01/09/2023	31/03/2025	577	Not scheduled to start	0%		-593	£0.00		Not scheduled to start	0%	

Objective (Milestone) 5 — Completion of the SCORE survey

Milestone Completion Date: 31/05/2024 | Milestone Status (RAG): Not scheduled to start | Milestone Progress: 14% | Milestone Delivery: 14% | Milestone Costs: £0.00

Action Ref.	Action	Owner (Role)	Start Date	Due Date	No. Days	Action Status (BRAG)	Completion Date	No. Days Overdue	Cost (£)	Progress notes	Level of Assurance		Evidence Log (to demonstrate output)
5.1	Meet with NHSI Perinatal Culture and Leadership (CLP) team to understand local arrangements needed for the publication of the staff SCORE survey	Leane Jeffrey, Service Development Programme Lead	01/08/2023	31/08/2023	30	Complete	100%		0	£0.00	16.08.23 - Discussed with NHSI Lead and timeline received for all three phases of the perinatal CLP, including requirements for the planning and delivery of Phase 2 - SCORE survey. Pending receipt of SCORE mapping template from NHSI to complete and return by 15/09/2023	Evidenced and assured	100%	5.1 01 Email re NHSI SCORE Meeting - 16 Aug 2023 5.1 02 PCLP Welcome Document - 16 Aug 2023 5.1 03 PCLP Timeline - 16 Aug 2023
5.2	Facilitate completions of the SCORE mapping document with MDT senior management team and return to NHSI to support the structural requirements of the survey based on service specific information e.g. locations, headcount by location	Leane Jeffrey, Service Development Programme Lead	21/08/2023	15/09/2023	25	Not scheduled to start	0%		-30	£0.00	16.08.23 - Pending receipt of the mapping template from NHSI	Not scheduled to start	0%	
5.3	Work with local and corporate Communications teams / channels to share resources to promote the SCORE survey to maximise completion rates (min. required response rate is 40%, ideal rate is <60%)	Leane Jeffrey, Service Development Programme Lead	01/09/2023	10/12/2023	100	Not scheduled to start	0%		-116	£0.00	16.08.23 - Survey will lauch 17 Oct 2023 and available for 7 weeks	Not scheduled to start	0%	
5.4	Launch and share the link for completion of the staff SCORE survey	Leane Jeffrey, Service Development Programme Lead	17/10/2023	10/12/2023	54	Not scheduled to start	0%		-116	£0.00	16.08.23 - Pending receipt of the link / QR code from NHSI once the survey has been built and is ready to publish	Not scheduled to start	0%	
5.5	Once results received, the care group Quad to work with Culture Coach from 'Safe and Reliable' to understand survey results, understand benchmarking against national themes, identify what's working well to replicate wider across the service and identify areas for improvement	Michelle Cudjoe. Director of Midwifery	01/01/2024	28/02/2024	58	Not scheduled to start	0%		-196	£0.00	16.08.23 - Schedule of Culture Coach sessions to be confirmed	Not scheduled to start	0%	
5.6	Care group Quad to present outcomes and plans for sustainable change to Trust Board	Michelle Cudjoe. Director of Midwifery	01/03/2024	30/04/2024	60	Not scheduled to start	0%		-258	£0.00	16.08.23 - Pending results of SCORE Survey by 28/02/2023	Not scheduled to start	0%	
5.7	Change agents to be trained by NHSI to support ongoing culture conversations for continous improvement, and shadow Culture Coach from 'Safe and Reliable' provider	Karl Woods, Head of People and Culture for Women, Children and Young People Care Group (WCYP)	01/03/2024	30/04/2024	60	Not scheduled to start	0%		-258	£0.00	16.08.23 - Dependent on completion of previous actions within this milestone, then register of Change Agents / Managers to be developed and shared across the service	Not scheduled to start	0%	

East Kent Hospitals University NHS Foundation Trust
Reading the Signals Oversight Group

31 October 2023

Contents

Reading the signals Communications and Engagement Update: October 2023

Key progress during last period:

- This month's communications theme was focused on reinforcing the messages in Dr Kirkup's report *Reading the signals,* acknowledging the continued impact for families and more work to do and sharing progress and outcomes in maternity.
- Discussion at Clinical Executive Management Group, staff forum and Team Brief on changes made, work still to do, importance of listening/acting on staff and patient feedback, followed up with written briefing for cascade.
- Internal communications also included message from the CEO and focus in Team Brief and Staff Zone.
- Stakeholder visits to maternity service and opportunities for scrutiny and questions from East Kent MPs and KCC Health Overview and Scrutiny Committee.
- External communications included publishing one year in report on RTS pages on website, working with broadcast media and ongoing use of maternity focussed social media platforms.
- Other internal comms included Freedom to Speak UP sessions and NHS Staff Survey
- See 'ME First' Equality, Diversity and Inclusion communications begun, with a dedicated Staff Zone page and promotion through the desktop wallpaper and Trust News
- Patient Information leaflets and map to support patients using emergency pathway
- Accessible information standard campaign launched, including a dedicated area on Staff Zone, resources for managers and promotion through desktop wallpaper, Trust News, posters and a 'pop up' quiz on Staff Zone.

Plan for next month:

- Continue the NHS Staff Survey completion campaign
- Working with Medical Education department to recruit lay representatives to become involved in the education and training of doctors in training in East Kent
- Reading the signals oversight group on 31st October
- Development of visitors charter and new extended visiting times starting from Monday 30th October.
- Your Stay in Hospital booklet being rolled out Trust wide.
- Focus on winter communications including sharing winter plans with staff and stakeholders and promoting alternatives to A&E with the public
- Attendance at Joint Health Overview and Scrutiny Committee to discuss the future of transformation of hospital services
- Briefings stakeholders to build support for capital investment
- Continue to link patient and staff stories to improvement plan and use campaign approach to engage all staff in individual projects

Limitations to delivery of Comms & Engagement plan:

- Number and pace of initiatives for staff to be aware of/engaged in.
- Mitigation for this; 'joining the dots' in the narrative to describe how each supports our improvement journey; a monthly focus on one key theme.

Evidence of impact of actions undertaken:

- Staff survey response rate at 30.49% (as of 19 Oct), above average acute trust rate of 24.13%
- Assessment of impact or RTS one year on to be produced including use of team brief/attendance at events/web stats

Statistical process control (SPC)

What is statistical process control (SPC)?

- Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation and guides us to take the most appropriate action.
- The main aim is to understand what is different and what is normal, so we know where work needs to be concentrated to make a change. The charts also allow us to monitor whether metrics are improving.

Key Facts about an SPC Chart

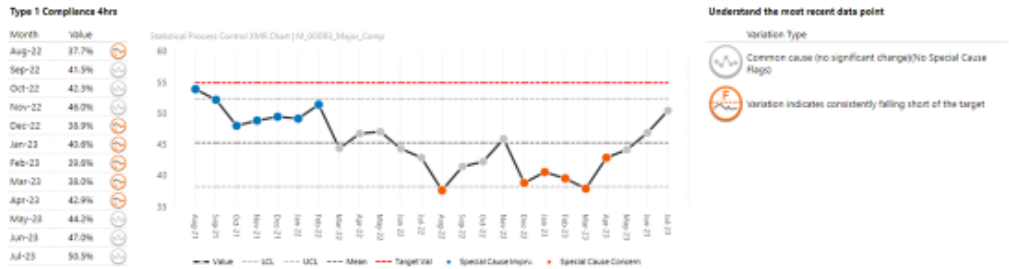
- An SPC chart has three reference lines that help you appreciate variation in the data, they are:
- centre reference line: the average line (often represented by the mean, sometimes the median)
- upper and lower reference lines: the process limits, also known as control limits.
- A minimum of 15-20 data points is needed to have meaningful insight, the process limits are defined by the how the data varies. You can expect approximately 99% of data points to fall within the process limits. If a data point falls outside these levels, an investigation would be triggered.
- It contains two types of trend variation: Special Cause (Concerns or Improvement) and Common Cause (i.e. no significant change).
- Special cause variation occurs when one (or more) of these things are happening;
- A single data point falls outside the process limits
- A run of consecutive data points is above or below the mean
- Six consecutive data points follow an increasing or decreasing trend
- Two out of three data points are close to the process limits

NHSE Improvement Icons and where to find them

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

Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

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



Maternity

Integrated Improvement Plan

NHS
East Kent
Hospitals University
NHS Foundation Trust

Domain	Nat	Flag	KPI	SPC	Thres.	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Maternity	IIP		Serious Incidents Maternity		Sigma	3	1		2	4	4	4	1	3	2		2
	IIP		Maternity Incidents Moderate / Severe		Sigma	4	1	2	6	5	6		3	2		2	2
	IIP		Maternity Complaints		Sigma	9	10	6	9	12	8	9	8	3	6	1	16
	IIP		Maternity Complaint Response		90.0%	0.0%	50.0%	40.0%		0.0%	75.0%	25.0%	16.7%	35.3%	45.5%	66.7%	60.0%
	IIP		Extended Perinatal Mortality		5.87	4.44	4.94	4.64	4.33	4.53	4.44	4.62	4.47	3.87	3.40	3.58	3.11
	IIP		FFT Maternity Response Rate		15.0%	16.6%	17.0%	14.9%	16.2%	14.0%	12.2%	11.6%	11.7%	12.8%	13.0%	11.1%	9.3%
	IIP		FFT Maternity Recommended		90.0%	93.9%	90.5%	90.7%	95.2%	91.6%	92.2%	93.7%	92.1%	92.3%	91.6%	88.8%	90.8%
	IIP		FFT Maternity (IP) Recommended		90.0%	94.5%	90.9%	91.8%	95.2%	91.7%	96.2%	95.1%	92.6%	94.3%	94.3%	89.3%	90.7%
	IIP		WH Engagement Score		6.90	5.89	5.89	5.89	5.45	5.45	5.45	5.87	5.87	5.87	6.15	6.15	6.15

September Performance Summary

Incidents: There were 2 serious incidents reported in September in Women's Health for Maternity, and 2 moderate harm incidents.

Complaints: 16 Stage 1 complaints were received in September for Maternity. This is a significant increase. There are currently 25 open first complaints of which 1 has breached

Patient Involvement: FFT Response rate decreased to 9.3% - 90.8% extremely likely or likely to recommend

Staff Engagement: Score 6.15

Maternity Serious Incidents

Integrated Improvement Plan

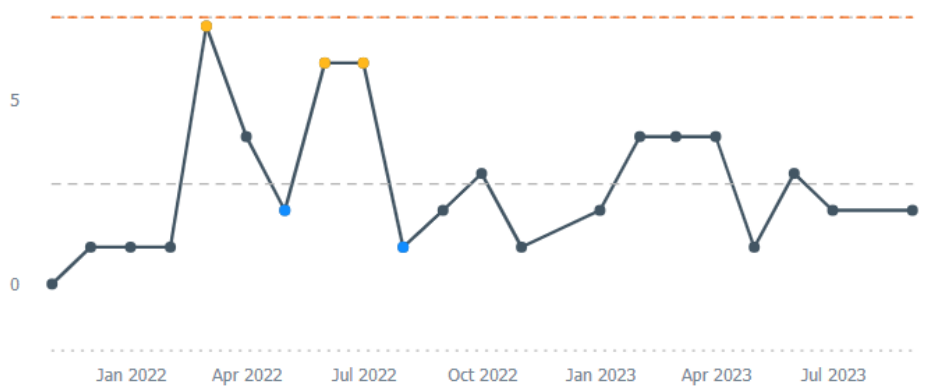
East Kent Hospitals University NHS Foundation Trust

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

Serious Incidents Mater...

Timescale	Value	SPC
Aug-22	1	
Sep-22	2	
Oct-22	3	
Nov-22	1	
Jan-23	2	
Feb-23	4	
Mar-23	4	
Apr-23	4	
May-23	1	
Jun-23	3	
Jul-23	2	
Sep-23	2	

XMR Run Chart



Understanding the most recent data point

Performance

2 — Variation indicates inconsistently passing and falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
There were 2 serious incidents reported in September for Maternity.	1. Mis-identification (mortuary) 2. Incorrect expressed breast milk	• Interim Head of Governance	• 14/12/23	RCA's commenced. Immediate actions implemented: • Support for patients and staff involved • Annual Midwifery training lesson plans updated • Updating of competencies • Hot-topic /Message of the week circulated • Update of SOP/guidance
At month end there are 11 open SI's in Maternity.	For all SI investigations to be completed within agreed timeframes.	• Interim Head of Governance	• Monthly - ongoing	• All open SI's under investigation are within agreed timeframes. • There are 2 NCR breaches that are anticipated to be submitted within the month.
Closure of actions from SI's on the datix actions module.	• Focussed work to close open actions on datix module with action owners • Weekly progress reporting of original June backlog and current position	• Interim Head of Governance	• 30/11/23	• The number of overdue actions from the original backlog (June) has reduced from 345 to 208 at 16/10/23. However, the overall current overdue actions has increased to 308 due to action plans being added to the module and further actions breaching. The Patient Safety Team continue to supporting clinical staffing at 40% until half-term and then reduce to 20%. There is additional agency resource focussing on open actions from October. Patient Safety Matron vacancy will go backout to advert following a recently recruited successful candidate withdrew

Maternity Incidents Causing Harm

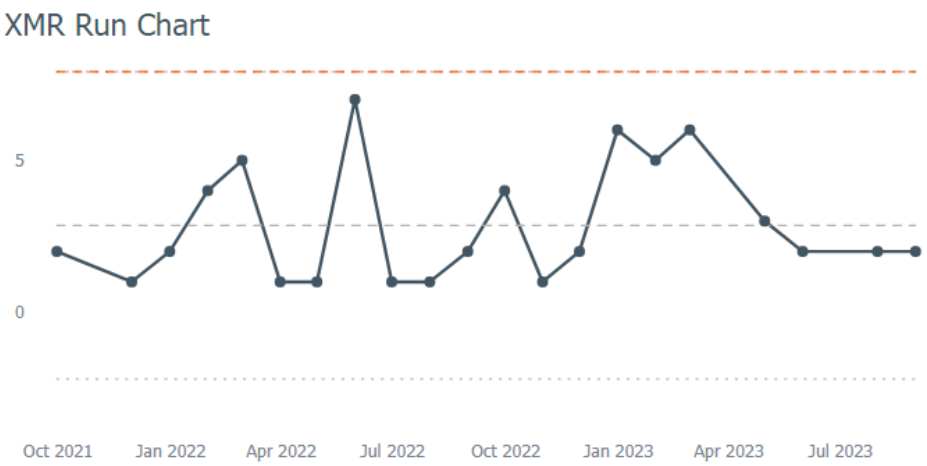
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

Maternity Incidents Mo...

Timescale	Value	SPC
Aug-22	1	
Sep-22	2	
Oct-22	4	
Nov-22	1	
Dec-22	2	
Jan-23	6	
Feb-23	5	
Mar-23	6	
May-23	3	
Jun-23	2	
Aug-23	2	
Sep-23	2	



Understanding the most recent data point

Performance

2

Variation indicates inconsistently passing and falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Rapid review of moderate incidents and other incidents on maternity trigger list.	• Rapid review process reviewed • MDT attendance • Learning identified	• Interim Head of Governance	• Monthly - ongoing	• Themes and learning identified from rapid reviews disseminated via Message of the Week and Safety Threads.
Closure of datix open more than 6 weeks	• Focussed work to close open actions on datix module with action owners • Weekly progress reporting of backlog and current position	• Interim Head of Governance	• 30/11/2023	• The number of open datix from the original June backlog for Maternity has reduced from 686 to 93 at 16.10.2023. However, the overall current overdue datix is 500. Incident handlers have been contacted to review their open incidences. This is a priority for the Patient Safety Team to close these open datix, all of which have had an initial review at the time of reporting.

Maternity Complaints

Integrated Improvement Plan

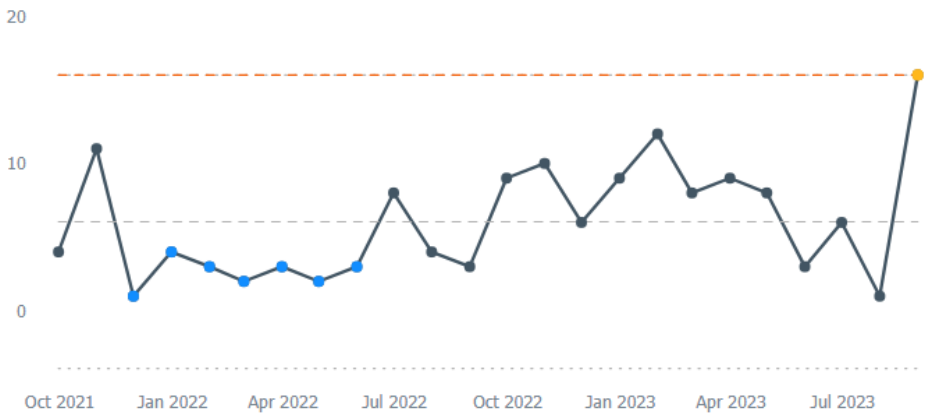
East Kent Hospitals University NHS Foundation Trust

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

Maternity Complaints

Timescale	Value	SPC
Oct-22	9	
Nov-22	10	
Dec-22	6	
Jan-23	9	
Feb-23	12	
Mar-23	8	
Apr-23	9	
May-23	8	
Jun-23	3	
Jul-23	6	
Aug-23	1	
Sep-23	16	

XMR Run Chart



Understanding the most recent data point

Performance

16

Variation indicates inconsistently passing and falling short of the target

Variation

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

Flags: Outside Moving Range Limit; Astronomical Point

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
16 Stage 1 complaints received in September 2023 for Maternity	Significant increase in the number of complaints received in September	Patient Experience and Complaints Coordinator	Monthly reporting	Complaint "sprint day" scheduled for 26/10/2023 to respond to increased complaint workload received in month in a timely manner.
Recurrent themes	The 4 main themes are • Post natal communication in relation to 'complicated' births (lack of informal debriefs/conversations to listen to their concerns) • Sonography input not matching realities at birth (placenta info, baby weights) • Busy post-natal wards causing people to feel uncared for in a timely way • Infant wellbeing checks delayed/phototherapy issues.	Adaline Smith DDOM	Monthly	We have commenced leave your troubles at the door initiative and posters can be seen at every entry point to support immediate response and action of any concerns.

Maternity Complaints Response Rate

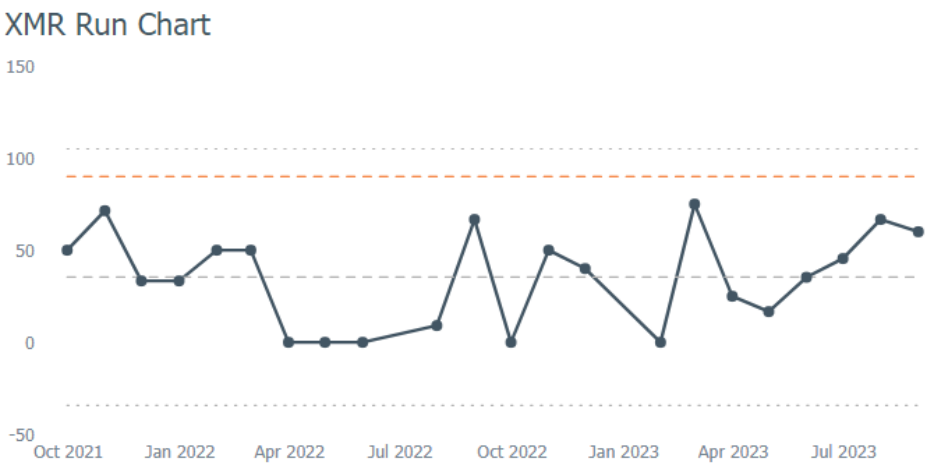
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

Maternity Complaint Re...

Timescale	Value	SPC
Sep-22	66.7%	
Oct-22	0.0%	
Nov-22	50.0%	
Dec-22	40.0%	
Feb-23	0.0%	
Mar-23	75.0%	
Apr-23	25.0%	
May-23	16.7%	
Jun-23	35.3%	
Jul-23	45.5%	
Aug-23	66.7%	
Sep-23	60.0%	



Understanding the most recent data point

Performance

60.0% — Variation indicates inconsistently passing and falling short of the target

Variation

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

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Competing priorities of clinical staff cause delays in case reviews and providing the Complaint Coordinator with comments for content	• Complaint Coordinator has set up weekly 'huddle' meetings with HOMs and newly appointed Clinical Lead to try and spotlight urgent cases .	• Patient Experience and Complaints Coordinator	• Weekly and • Bi-Weekly meetings	• There has been a significant improvement in the number of open/breached complaints in recent months. Positive feedback has been received on the quality of the complaint responses. • Sprint day 26/10/2023.

Extended Perinatal Mortality

Integrated Improvement Plan

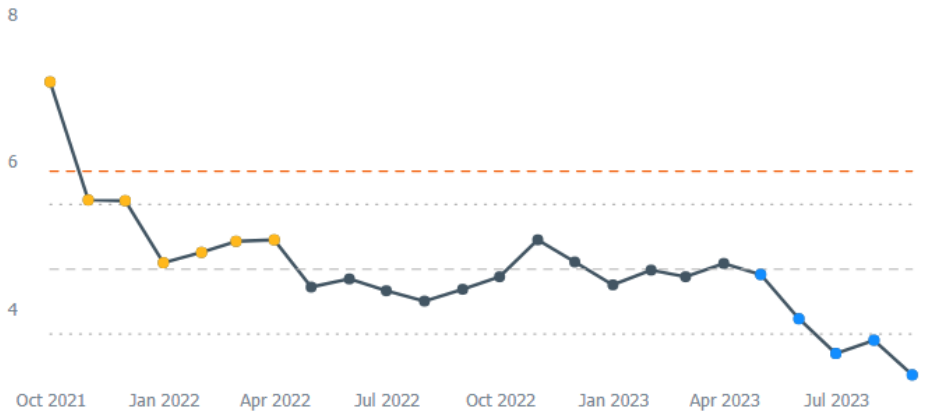
East Kent Hospitals University NHS Foundation Trust

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

Extended Perinatal Mort...

Timescale	Value	SPC
Oct-22	4.44	
Nov-22	4.94	
Dec-22	4.64	
Jan-23	4.33	
Feb-23	4.53	
Mar-23	4.44	
Apr-23	4.62	
May-23	4.47	
Jun-23	3.87	
Jul-23	3.40	
Aug-23	3.58	
Sep-23	3.11	

XMR Run Chart



Understanding the most recent data point

Performance

3.11 — Variation indicates consistently passing the target

Variation

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

Flags: Astronomical Point; Two Out Of Three Beyond Two Sigma Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
In September there was 1 stillbirth (IUD) reportable to MBRRACE – born at 36+1 weeks gestation.	The rolling 12 month rate for stillbirths remains below the lower confidence limit at 2.25 stillbirths per 1,000 births.	PMRT Lead Midwife	Monthly	• Presented at Rapid Review 13/09/2023. • Presentation prepared for PMRT review in November
In September there were 0 neonatal deaths reportable to MBRRACE	The rolling 12 month rate for neonatal deaths remains lower than both the threshold and average at 0.87 neonatal deaths per 1,000 livebirths, and has been so for 17 consecutive periods.	PMRT Lead Midwife	Monthly	
Perinatal Mortality Review Tool	All neonatal deaths and stillbirths are reviewed through the Perinatal Mortality Review Tool by a multidisciplinary panel and external attendees.	PMRT Lead Midwife	Monthly	• 100% of perinatal mortality reviews include an external reviewer

Maternity Friends & Family Test: Response Rate

Integrated Improvement Plan

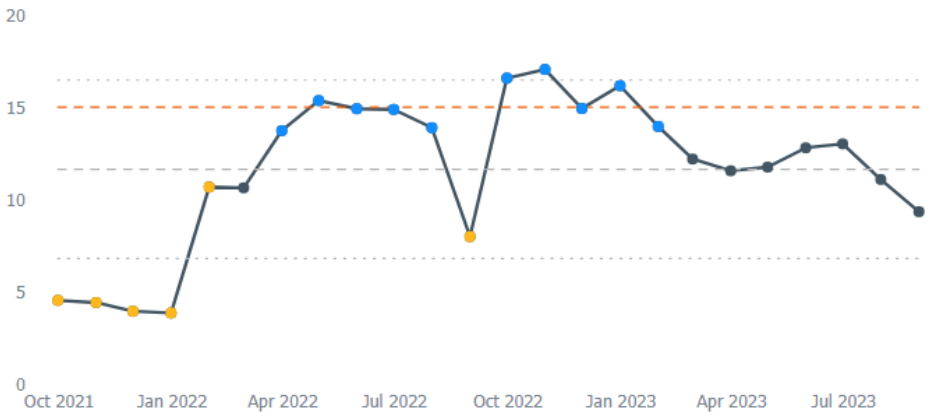
East Kent Hospitals University NHS Foundation Trust

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

FFT Maternity Response...

Timescale	Value	SPC
Oct-22	16.6%	
Nov-22	17.0%	
Dec-22	14.9%	
Jan-23	16.2%	
Feb-23	14.0%	
Mar-23	12.2%	
Apr-23	11.6%	
May-23	11.7%	
Jun-23	12.8%	
Jul-23	13.0%	
Aug-23	11.1%	
Sep-23	9.3%	

XMR Run Chart



Understanding the most recent data point

Performance

9.3%

Variation indicates inconsistently passing and falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Response rate decrease to 9.3%	Issues with coding in September. Data may not account for service users who were sent FFT at the end of the month of September- not all families respond straight away. FFT responses continue to come in throughout the following weeks/months after they have used the service and these are reported on a rolling basis.	• Patient Experience Midwives	• Monthly	• There is a new PTL for FFT- the aim that FFT feedback is themed in a standardised way and is comparable. There appears to be a discrepancy in the new theming and data. Meeting in October to discuss this and the reporting going forward. • The team shall continue to look at ways to increase the response rate.
Response rates are typically low for FFT therefore only reflect a minority of women, birthing people and their families, and their experiences	Embedded communications plan and Patient Voices Model to improve service user and workforce engagement, feedback and experience	• Patient Experience Midwives	• March 2024	• This is a milestone within the Maternity and Neonatal Improvement Plan presented to Trust Board for approval in September 2023 • The care group welcomed the new MNVP chair for EKHUFT who we will continue to work collaboratively with. The 2023/2024 work plan has now been finalised with next steps including walking the patch and 15 steps. • Feedback is being continually gathered through YVIH and FFT.

Maternity Friends & Family Test: Recommended

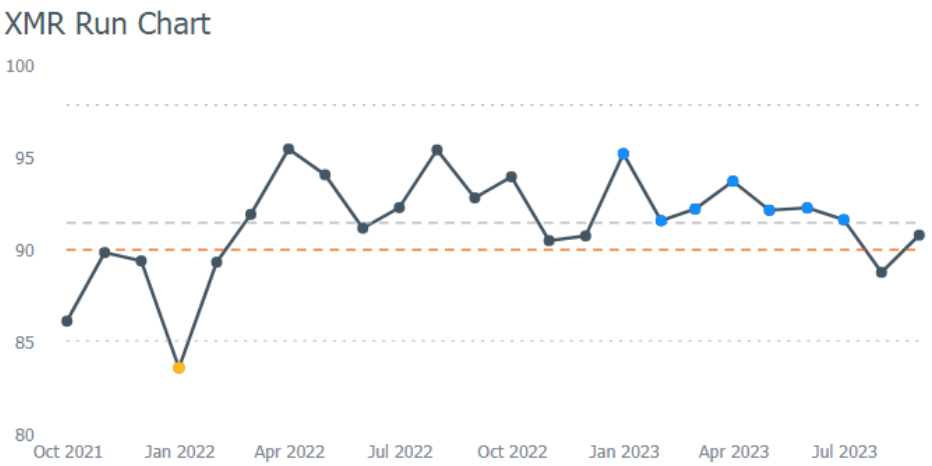
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

FFT Maternity Recomme...

Timescale	Value	SPC
Oct-22	93.9%	
Nov-22	90.5%	
Dec-22	90.7%	
Jan-23	95.2%	
Feb-23	91.6%	
Mar-23	92.2%	
Apr-23	93.7%	
May-23	92.1%	
Jun-23	92.3%	
Jul-23	91.6%	
Aug-23	88.8%	
Sep-23	90.8%	



Understanding the most recent data point

Performance

90.8%

Variation indicates inconsistently passing and falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
The responses show 90.8% extremely likely or likely to recommend which is an increase in month.	PEM feedback to staff on a regular basis via personalised email and update posters on the units/community offices and in the monthly newsletter.	• PEM	• Monthly	

Maternity Friends & Family Test: Inpatient Recommended

Integrated Improvement Plan

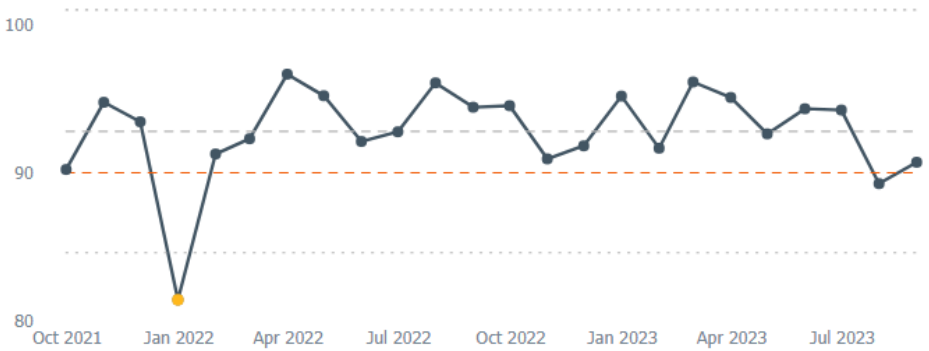
East Kent Hospitals University NHS Foundation Trust

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

FFT Maternity (IP) Reco...

Timescale	Value	SPC
Oct-22	94.5%	
Nov-22	90.9%	
Dec-22	91.8%	
Jan-23	95.2%	
Feb-23	91.7%	
Mar-23	96.2%	
Apr-23	95.1%	
May-23	92.6%	
Jun-23	94.3%	
Jul-23	94.3%	
Aug-23	89.3%	
Sep-23	90.7%	

XMR Run Chart



Understanding the most recent data point

Performance

90.7%

Variation indicates inconsistently passing and falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

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

Women's Health Staff Engagement Score

Integrated Improvement Plan

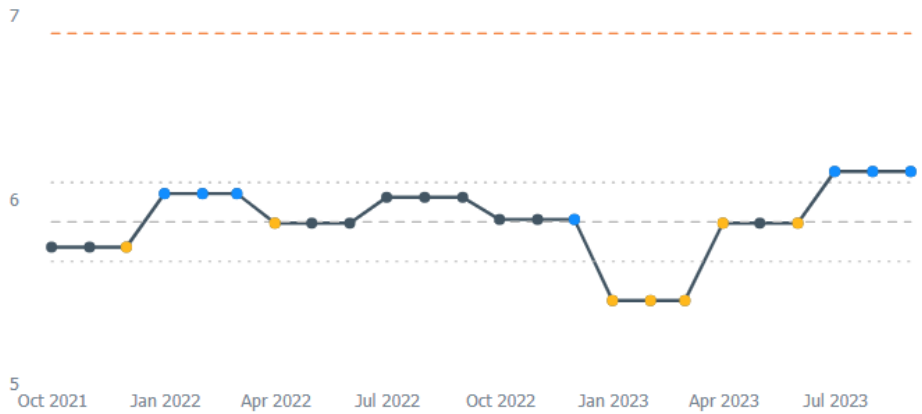
East Kent Hospitals University NHS Foundation Trust

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

WH Engagement Score

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

XMR Run Chart



Understanding the most recent data point

Performance

6.15

Variation indicates consistently falling short of the target

Variation

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

Flags: Astronomical Point
Two Out Of Three Beyond Two Sigma Group

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