Extra-Ordinary Board of Directors Meeting - Open (Friday 21 October 2022)

Fri 21 October 2022, 10:00 - 11:00

Kent Suite, Ashford International Hotel, Simone Weil Avenue, TN24 8UX / WebEx

East Kent Hospitals University NHS Foundation Trust

Agenda

10:00 - 10:00
0 min

22/126
Welcome and Apologies for Absence (10:00)

To Note *Chairman*

Verbal

10:00 - 10:00
0 min

22/127
Confirmation of Quoracy

To Note *Chairman*

Verbal

10:00 - 10:00
0 min

22/128
Declaration of Interests

To Note *Chairman*

22-128 - REGISTER 2022-23 V54 - from October 2022.pdf (5 pages)

10:00 - 10:10
10 min

22/129
Chairman's Opening Statement on the Independent Investigation into East Kent Maternity Services (10:00)

Discussion *Chairman*

Verbal

10:10 - 10:20
10 min

22/130
Chief Executive's Opening Statement on the Independent Investigation into East Kent Maternity Services (10:10)

Assurance *Chief Executive*

22-130 - IIEKMS report Board of Directors 21 October 2022.pdf (6 pages)

10:20 - 10:35
15 min

22/131

Council of Governors Statement on the Independent Investigation into East Kent Maternity Services (10:20)

Discussion *Lead Govenor*

Verbal

10:35 - 10:35
0 min

22/132

Questions from Council of Governor members on the Independent Investigation into East Kent Maternity Services

Discussion *Governors*

Verbal

10:35 - 11:00
25 min

22/133

Questions from the public

Discussion *Public*

Verbal

Date of Next Meeting: Thursday 3 November 2022

REGISTER OF DIRECTOR INTERESTS – 2022/23 FROM OCTOBER 2022

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
ANAKWE, RAYMOND	Non-Executive Director	Medical Director and Consultant Trauma and Orthopaedic Surgeon at Imperial College Healthcare NHS Trust **(1)**	1 June 2021 (First term)
ASHMAN, ANDREA	Chief People Officer	None **Closed interest** MY Trust (started 11 November 2014/finished 20 July 2020) **(4)**	Appointed 1 September 2019
BAIRD, STEWART	Non-Executive Director	Stone Venture Partners Ltd (started 23 September 2010) **(1)** Stone VP (No 1) Ltd (started 15 August 2017) **(1)** Stone VP (No 2) Ltd (started 1 December 2015) **(1)** Hidden Travel Holdings Ltd (started 16 May 2014) **(1)** Hidden Travel Group Ltd (started 15 October 2015) **(1)** Trustee of Kent Search and Rescue (Lowland) (started 2013) **(4)** Non-Executive Director of Spencer Private Hospitals (started 1 November 2021) **(1)** **Closed interests** Stone VP (No 3) Ltd (started 20 November 2017/finished 21 March 2022) **(1)** Qunifi Holdings Ltd (started 30 November 2017/ finished 21 March 2022) **(1)** Qunifi Ltd (started 13 February 2015/ finished 21 March 2022) **(1)** Unicus Travel Ventures Ltd **(1)** **Companies Non-Trading interests** Tempco 0819 Ltd **(1)** Solution Telecom Holdings Ltd **(1)** Qdos Communications Ltd **(1)** Solution Builders Ltd **(1)** Hidden Travel (Flights) Ltd **(1)** Pebble Holidays Holdings Ltd **(1)**	1 June 2021 (First term)

REGISTER OF DIRECTOR INTERESTS – 2022/23 FROM OCTOBER 2022

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
CARLTON, REBECCA	Chief Operating Officer	None	Appointed 16 July 2021
CAVE, PHILIP	Chief Finance Officer	Wife works as Head of Contracts for NHS Kent and Medway Integrated Care Board (ICB) (started 1 April 2021) **(5)** **Closed interests** Wife worked as a Senior Manager for Optum, who run the Commissioning Support Unit (CSU) in Kent, which supports the Clinical Commissioning Groups (CCGs) (started 9 October 2017/finished 31 March 2021) Interim Managing Director for 2gether Support Solutions **(1)** (started 21 December 2021/finished 28 February 2022)	Appointed 9 October 2017
CORBEN, SIMON	Non-Executive Director	Director and Head of Profession, NHS Estates and Facilities, NHS England **(1)**	1 October 2022 (First term)
DICKSON, NIALL	Chair	Director, Leeds Castle Enterprises (started 31 May 2012) **(1)** Senior Counsel, Ovid Consulting Ltd (trading as OVID Health Company) (started November 2020) **(1)**	5 April 2021
FLETCHER, TRACEY	Chief Executive	None	Appointed 4 April 2022
FOX, ALISON	Group Company Secretary	Company Secretary, Grabba Enterprises Limited (started 1 December 2020) **(1)** Director, MinervaPro Limited (started 28 November 2021) **(1)**	Appointed 11 November 2013

REGISTER OF DIRECTOR INTERESTS – 2022/23 FROM OCTOBER 2022

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
FULCI, LUISA	Non-Executive Director	Director of Digital, Customer and Commercial Services, Dudley Council (started 6 April 2021) **(1)** Director of Dudley & Kent Commercial Services Ltd. (started 11 May 2022) **(1)**	1 April 2021 (First term)
HOLLAND, CHRISTOPHER	Associate Non-Executive Director	Director of South London Critical Care Ltd **(1)** Shareholder in South London Critical Care Ltd **(2)** Dean of Kent and Medway Medical School, a collaboration between Canterbury Christ Church University and the University of Kent **(4)** South London Critical Care solely contracts with BMI The Blackheath Hospital for Critical Care services **(5)**	Appointed 13 December 2019
IVANOV, TINA	Executive Director of Quality Governance	None	10 May 2021
MANSLEY, NIGEL	Non-Executive Director	None **Closed interests** Jeris Associates Ltd (started 1 July 2017/finished 26 January 2021) **(1) (2) (3)** Chair, Diocesan Board of Finance (Diocese of Canterbury) (started 22 January 2018/finished 14 July 2021) **(1)**	1 July 2017 (Second term)
MARTIN, REBECCA	Chief Medical Officer	None	Appointed 18 February 2020

REGISTER OF DIRECTOR INTERESTS – 2022/23 FROM OCTOBER 2022

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
OLASODE, OLU	Non-Executive Director	Chief Executive Officer, TL First Consulting Group (started 9 May 2000) **(1)** Chairman, ICE Innovation Hub UK (started 11 September 2018) **(1)** Independent Chair, General Purposes and Audit Committee, London Borough of Croydon (started 1 October 2021) **(1)** Independent Non-Executive Director, Priory Group (Adult Social Care and Mental Health Division) (started 1 June 2022) **(1)**	1 April 2021 (First term)
OLLIS, JANE	Non-Executive Director	The Heating Hub (started 8 May 2017) **(1)** Non-Executive Director of the Kent Surrey Sussex Academic Health Science Network (AHSN) (started 1 July 2018) **(1)** Founder of MindSpire (started 30 October 2018) **(1)** Non-Executive Director of Community Energy South (started 30 October 2018) **(1)** Vice President of the British Red Cross in Kent (started November 2018) **(4)** Non-Executive Director of 2gether Support Solutions (started 22 May 2019) **(1)** Non-Executive Director of Riding Sunbeams (started February 2020) **(1)**	8 May 2017 (Second term)
SHINGLER, SARAH	Chief Nursing and Midwifery Officer	None	Appointed 7 June 2021
SHUTLER, LIZ	Deputy Chief Executive/Chief Strategy Officer	None	Appointed January 2004

REGISTER OF DIRECTOR INTERESTS – 2022/23 FROM OCTOBER 2022

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
WIGGLESWORTH, NEIL	Executive Director of Infection Prevention and Control	Chair and Director of the International Federation of Infection Control (started 1 January 2018) **(1)** Trustee of the International Federation of Infection Control (started 1 January 2018) **(4)**	15 March 2021
YOST, NATALIE	Executive Director of Communications and Engagement	None	31 May 2016

Footnote: All members of the Board of Directors are Trustees of East Kent Hospitals Charity

The Trust has a number of subsidiaries and has nominated individuals as their 'Directors' in line with the subsidiary and associated companies articles of association and shareholder agreements

2gether Support Solutions Limited:
Simon Corben – Non-Executive Director in common
Jane Ollis – Non-Executive Director in common
Alison Fox – Nominated Company Secretary

Spencer Private Hospitals:
Stewart Baird – Non-Executive Director in common
Nic Goodger – Nominated Director
Alison Fox – Nominated Company Secretary

Categories:

1 Directorships
2 Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS
3 Majority or controlling shareholding
4 Position(s) of authority in a charity or voluntary body
5 Any connection with a voluntary or other body contracting for NHS services
6 Membership of a political party

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
REPORT TITLE:	**INDEPENDENT INVESTIGATION INTO EAST KENT MATERNITY SERVICES (IIEKMS) REPORT – READING THE SIGNALS**
MEETING DATE:	**21 OCTOBER 2022**
BOARD SPONSOR:	**CHIEF EXECUTIVE OFFICER (CEO)**
PAPER AUTHOR:	**MATERNITY SERVICES STRATEGIC PROGRAMME DIRECTOR**
APPENDICES:	N/A

Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	**Assurance**	Discussion
Purpose of the Report:	This report presents the report of the Independent Investigation into Maternity and Neonatal Services in East Kent to the Board of Directors, provides detail of the report including the four key areas the report identifies for action and the associated recommendations. There is also a specific recommendation for the Trust. There can be no substitute for the reading of this report and considering it in full. This paper should be read in conjunction with the full report which can be accessed by the following link: https://www.gov.uk/government/publications/maternity-and-neonatal-services-in-east-kent-reading-the-signals-report				
Summary of Key Issues:	The Report is very difficult to read as it sets out details of systemic failures in care, a failure to listen to families and a failure of governance processes over a large period of time, both for the Trust and the wider NHS: The Panel has examined the maternity services at the Queen Elizabeth The Queen Mother Hospital (QEQM) at Margate and the William Harvey Hospital (WHH) in Ashford, between 2009 and 2020. It found that too often clinical care was suboptimal and led to significant harm, we failed to listen to the families involved, and acted in ways which made the experience of families unacceptably and distressingly poor. Individual and collective behaviours were visible to senior managers and the Trust Board in a series of reports right through the period from 2009 to 2020, and lay at the root of the pattern of recurring harm. At any time during this period, these problems should have been acknowledged and tackled effectively. There were eight clear separate opportunities when that could and should have happened. Had care been given to the nationally recognised standards, the outcome could have been different in 97, or 48%, of the 202 cases assessed by the Panel, and the outcome could have been different in 45 of the 65 baby deaths, or 69% of these cases. The Panel had				

	not been able to detect any discernible improvement in outcomes or suboptimal care, as evidenced by the cases assessed over the period from 2009 to 2020. Nor was the harm restricted to physical damage. Chapter 3 of the report sets out the equally disturbing effects of the repeated lack of kindness and compassion on the wider experience of families, both as care was given and later in the aftermath of injuries and deaths. The Trust has apologised to those women and families affected by these failures and has given its commitment to learn, to improve and to deliver the best possible services for the communities it serves. The Trust would like to thank Dr Kirkup and his team for the review, the report and associated actions arising from it.
Key Recommendation(s):	The Board of Directors is asked to **DISCUSS** and **RECEIVE** the IIEKMS report. The Board is asked to **ACCEPT** the recommendations in the report and accept the reality of these findings; acknowledge in full the unnecessary harm that has been caused; and embark on a restorative process addressing the problems identified, in partnership with families, publicly and with external input.

Implications:				
Links to 'We Care' Strategic Objectives:				
Our patients	**Our people**	**Our future**	**Our sustainability**	**Our quality and safety**

Link to the Board Assurance Framework (BAF):	**BAF 32:** There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care.	
Link to the Corporate Risk Register (CRR):	**CRR 77:** Women and babies may receive sub-optimal quality of care and poor patient experience in our maternity services. **CRR 122:** There is a risk that midwifery staffing levels are inadequate.	
Resource:	N	
Legal and regulatory:	N	
Subsidiary:	N	
Assurance Route:		
Previously Considered by:	N/A	

Independent Investigation into East Kent Maternity Services (IIEKMS)

1. Publication of the Report

1.1 The report of the Independent Investigation into Maternity and Neonatal Services in East Kent was shared with families on the morning of 19 October 2022, in line with the Families First Principles.

The Report was published in Parliament on the same day and a statement given the following day.

On the day of publication, on behalf of the Trust, the Chief Executive gave the following statement:

"I want to say sorry and apologise unreservedly for the harm and suffering that has been experienced by the women and babies who were within our care, together with their families, as described in today's report.

These families came to us expecting that we would care for them safely, and we failed them.

We must now learn from and act on this report; for those who have taken part in the investigation, for those who we will care for in the future, and for our local communities. I know that everyone at the Trust is committed to doing that.

In the last few years we have worked hard to improve our services and have invested to increase the numbers of midwives and doctors, in staff training, and in listening to and acting on feedback from the people who receive our care.

While we have made progress, we know there is more for us to do and we absolutely accept that. Now that we have received the report, we will read it in full and the Board will use its recommendations to continue to make improvements so that we are providing the safe, high-quality care our patients expect and deserve.

I want every family – whether they contributed to the investigation or not – to know I am here to listen to them, to learn and to lead our Trust in acting on this report.

I would like to thank Dr Bill Kirkup and the investigation team for their work. Today, our thoughts remain with those who have shared their experiences. We are grateful to them."

1.2 This statement has been published on the Trust's website and shared widely, along with details of support available to current, past and future users of the service.

1.3 The report covers the review of the maternity care provided by the Trust to 202 families between 2009 and 2020. The report identifies four areas for action for this Trust and the NHS more widely:

1. identifying poorly performing maternity units
2. giving care with compassion and kindness
3. teamworking with a common purpose, and
4. responding to challenge with honesty

As well as a key recommendation specifically for the Trust, to accept the reality of these findings; acknowledge in full the unnecessary harm that has been caused;

and embark on a restorative process addressing the problems identified, in partnership with families, publicly and with external input.

1.4 Dr Kirkup states that these areas for action require a broader-based approach by a wide range of experienced experts.

1.5 The report also identifies that the NHS must become serious about measuring outcomes in maternity services. It recognises that there are obvious difficulties, given that pregnancy and childbirth are physiological in most cases and poor outcomes less common, but this must not become an excuse. The report says meaningful, risk-sensitive outcome measures can be found, as they have been in other specialties.

1.6 They can be used, not to generate meaningless league tables, but to identify results that are genuine outliers. The report says: “Only in this way can we hope to detect the next unit that begins to veer off the rails before widespread harm has been caused, and before it has had to be identified by families who have suffered unnecessarily. There is work under way in the NHS but it needs further support and direction and the approach must be mandatory, not optional.”

2. Findings of the investigation

2.1 The panel found that too often clinical care was suboptimal and led to significant harm, we failed to listen to the families involved, and acted in ways which made the experience of families unacceptably and distressingly poor.

2.2 Individual and collective behaviours were visible to senior managers and the Trust Board in a series of reports right through the period from 2009 to 2020, and lay at the root of the pattern of recurring harm. At any time during this period, these problems should have been acknowledged and tackled effectively. There were eight clear separate opportunities when that could and should have happened.

2.3 Had care been given to the nationally recognised standards, the outcome could have been different in 97, or 48%, of the 202 cases assessed by the Panel, and the outcome could have been different in 45 of the 65 baby deaths, or 69% of these cases. The Panel had not been able to detect any discernible improvement in outcomes or suboptimal care, as evidenced by the cases assessed over the period from 2009 to 2020.

2.4 Nor was the harm restricted to physical damage. Chapter 3 of the report sets out the equally disturbing effects of the repeated lack of kindness and compassion on the wider experience of families, both as care was given and later in the aftermath of injuries and deaths.

3. Response to the publication of the Report

3.1 The Trust apologises unreservedly for the harm and suffering experienced by women, babies and their families and is grateful to those families who have shared their experiences as part of the Investigation.

3.2 For any families whether they contributed to the investigation or not, there is an open invitation for them to contact the Trust. At the meeting with families who participated in the investigation held by Dr Bill Kirkup on the morning of 19 October 2022, details of how to do this were made available.

3.3 A letter was sent on Thursday 13 October 2022 to all families who are currently registered with the Trust for maternity care, notifying them of the intended publication of the Report, providing contact details in the event of any immediate concerns or questions. The advice included details of the Maternity Enquiries line both telephone number and email address.

3.4 The publication of the Report has been widely reported on local, regional and national media.

3.5 The families' enquiry line had by 10am on 20 October 2022 received 15 enquiries.

3.6 We recognise that there has also been an impact on staff in Maternity and Neonatal services and across the organisation and support has been put in place as well as a number of staff briefings. We have also shared how staff can raise concerns.

3.7 The Trust accepts the findings of the Independent Investigation in full.

4. Areas for action

The four areas for action each have supporting recommendations and there is an additional specific recommendation for the Trust. The recommendations are as follows:

1) Monitoring safe performance – finding signals among noise:

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

2) Standards of clinical behaviour – technical care is not enough:

   - Those responsible for undergraduate, postgraduate and continuing clinical education be commissioned to report on how compassionate care can best be embedded into practice and sustained through lifelong learning.

   - Relevant bodies, including Royal Colleges, professional regulators and employers, be commissioned to report on how the oversight and direction of clinicians can be improved, with nationally agreed standards of professional behaviour and appropriate sanctions for non-compliance.

3) Flawed teamworking – pulling in different directions:

   - Relevant bodies, including the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives and the Royal College of Paediatrics and Child Health, be charged with reporting on how teamworking in maternity and neonatal care can be improved, with particular reference to establishing common purpose, objectives and training from the outset.

- Relevant bodies, including Health Education England, Royal Colleges and employers, be commissioned to report on the employment and training of junior doctors to improve support, teamworking and development.

4) Organisational behaviour – looking good while doing badly:

- The Government reconsider bringing forward a bill placing a duty on public bodies not to deny, deflect and conceal information from families and other bodies.

- Trusts be required to review their approach to reputation management and to ensuring there is proper representation of maternity care on their boards.

- NHSE reconsider its approach to poorly performing trusts, with particular reference to leadership.

5) The key recommendation specifically for the Trust, and which the Trust accepts, is to:

- accept the reality of these findings; acknowledge in full the unnecessary harm that has been caused; and embark on a restorative process addressing the problems identified, in partnership with families, publicly and with external input.

5. Implementing the recommendations

5.1 Recommendations 1 - 4 are for the Trust to consider and for the NHS as a whole, its partners and regulators.

5.2 The Trust Board must also own and take forward recommendation 5 and embark on a restorative pathway. As a first step the Board will seek the input of the Clinical Executive Management Group (CEMG) and in particular will reflect on a fresh bottom up, top down approach to build a culture of listening, kindness, excellence, openness and team working. This will require a Trust-wide approach and action across the organisation and not just in maternity.

5.3 The view of CEMG and next steps will be shared and reported to the Board at its next meeting on 3 November 2022.

5.4 The Board will support the restorative process and improvement programme and seek ongoing assurance that the right steps are being taken to identify ‘what had gone wrong and what needs to be put right’.

6. Next Steps

6.1 The Board is asked to discuss this paper and to take account of the views of the Council of Governors in deciding the next steps, including working in partnership with families.

6.2 This discussion to be taken back to Clinical Executive Management Group (CEMG).