East Kent Hospitals University NHS Foundation Trust

One year on from Reading the signals

On October 19 2022, Dr Bill Kirkup published his independent investigation into maternity and neonatal care provided from 2009 to 2020 in East Kent.

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

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

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

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

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

We also apologise to those within our communities. We are aware of the anxiety that these failings have caused among those who rely on our services.

We remain determined to use the lessons in Reading the signals to put things right, to make improvements and make sure that we always listen to patients, their families and staff when they raise concerns.

One year on from the publication of Reading the signals, the importance of the report and its findings remains just as profound and significant.

We have embarked on a journey to fundamentally transform the way we work. Changing the culture of a large and complex organisation takes time and there is much work to do, but we are determined to succeed so that we are providing the

right standard of care and compassion to everyone who touches our services, every day.

This report describes the work we are doing, the improvements we have made and where we still have work to do.

We are grateful to everyone who has been involved in this work, has given feedback and has provided both challenge and encouragement. We look forward to continuing this work with you.

The Trust Board.

Background

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

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

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

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

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

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

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

We have taken each of Dr Kirkup's key areas for action and adopted them as five of our seven organisational objectives, we call these:

- Patient, family and community voices
- Reducing harm and delivering safe services
- Care and compassion
- Engagement, listening and leadership
- Developing our organisation.

Our maternity service is working to embed the changes that are needed with families and staff to make continued and sustained improvement in care and outcomes for women, babies and their families. We recognise there is much more we need to do. This work is ongoing and we need to involve more people as we continue our work to develop safer and more compassionate services.

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

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

Patient, family and community voices

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

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

To help us achieve this we have recruited a patient experience team specifically to work with women, birthing partners and families and staff to improve patient and staff experience. The team is made up of a professional midwifery advocacy lead, one patient experience midwife and two non-clinical patient experience administrators.

This year the maternity Patient Experience team has focused on embedding 'Your Voice is Heard', which is a feedback service unique to East Kent. This service was co-produced with our local Maternity and Neonatal Voices Partnership, families and a Trust governor.

The Director and Deputy Director of Midwifery have introduced *Walk the patch*, regularly walking around the units to listen to women and birthing people and directly hear about their experiences of their maternity care. By doing this they are also assessing that the environment is safe and clean, are observing what staff are doing well and what needs improving. They bring their feedback to the heads of midwifery and the matrons so it can be acted on quickly and/or included in staff training. The Maternity and Neonatal Voices Partnership will continue to take this work forward.

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

We are increasing the ways we involve people who use our services, working with the Maternity and Neonatal Voices Partnership. We have much more work to do in this area. We are involving families in investigations from the outset; have co-produced our maternity and neonatal improvement programme and new pathways of care; and we are working with families directly involved in Dr Kirkup's investigation.

We want our service to be welcoming, safe, clean, friendly, calm and well organised. This Autumn the Maternity and Neonatal Voices Partnership will lead a '15-Steps challenge', which sees the service through the eyes of people who use it and what they see and experience within 15 steps of entering a department. We invite service users and will use the feedback to inform improvements.

The age and quality of our buildings, and a lack of funding for our maternity and neonatal estate is an ongoing challenge. We are working with the Kent and Medway Integrated Care Board, local MPs and NHS England regionally to identify sources of funding to enable us to deliver the much-needed expansion and refurbishment of both maternity units.

Your Voice is Heard

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

So far, we have heard from more than 5,000 women who have given birth in our hospitals, and from their partners, too. We want everyone to have a positive experience of all aspects of their care and to be 'happy to return', we have a lot of work to do to reach this point. We are committed to using the feedback we have from this initiative and other methods to make the necessary changes to achieve this.

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

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

We have reinstated home visits on the first day home from hospital and we are working with our system partners and the Patient Voice and Involvement team to listen to families about developing improved and accessible antenatal education. We need to do much more to improve people's experiences of postnatal care, including support for infant feeding, discharge processes and partner experiences; choice of place of birth; and consent and communication.

It is important that we also know where things are going well so we can build on them. More than 2,000 compliments from families have also been shared directly with staff. We are extending Your Voice is Heard to include the neonatal service this autumn and later this year, we will extend it further to include bereaved families, in addition to the support in place for them.

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

We also have feedback from other national surveys although the timeline for receiving the results is much longer. The latest annual CQC Maternity Services Survey, conducted in 2022 and published in January 2023, had a response rate of 51%. It showed East Kent maternity services as having lower than average scores for antenatal care and postnatal care and higher than average scores for patient experience during labour and birth.

We also work closely with and receive feedback from the Maternity and Neonatal Voices Partnership. We look at the themes coming from all the sources of patient feedback to understand what actions we need to take to co-produce improvements with our patients and families.

Your Voice is Heard data

We speak to between 300 and 400 people each month. In May 2022, our response rate was 56%, in September 2023 it was 76.4%.

Figure 1: Your Voice is Heard response rate

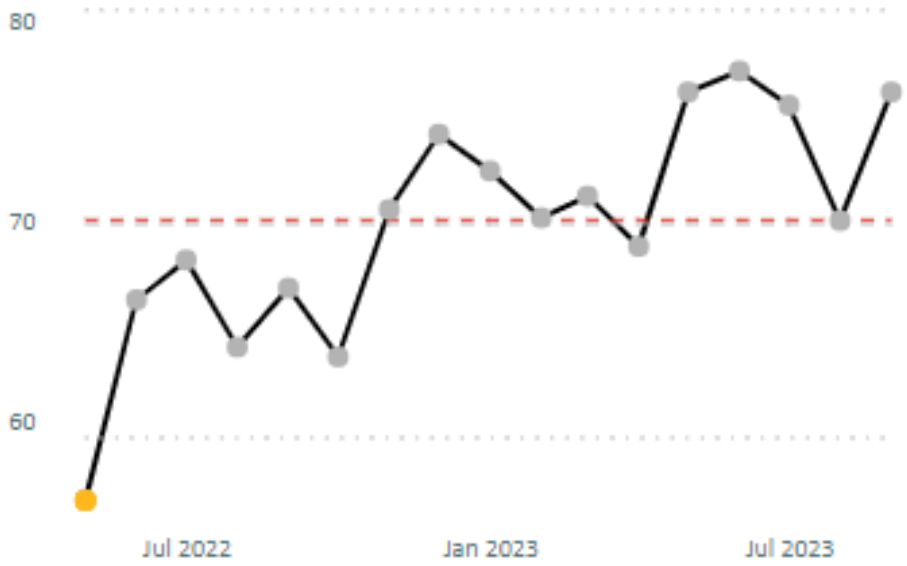
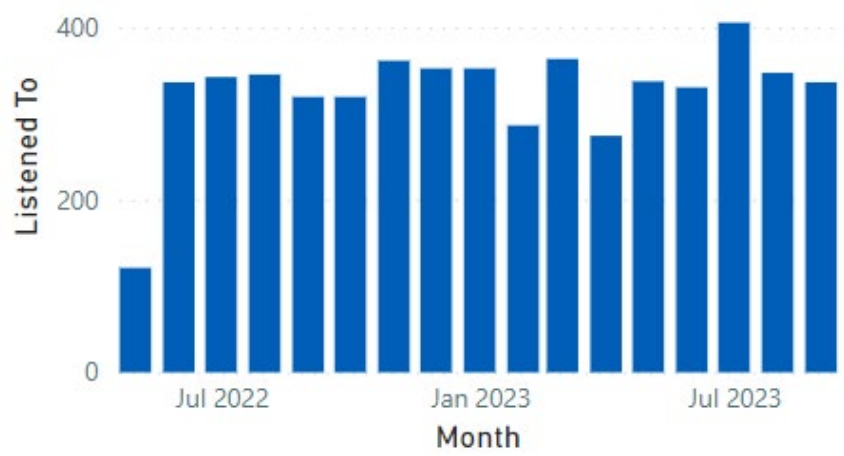
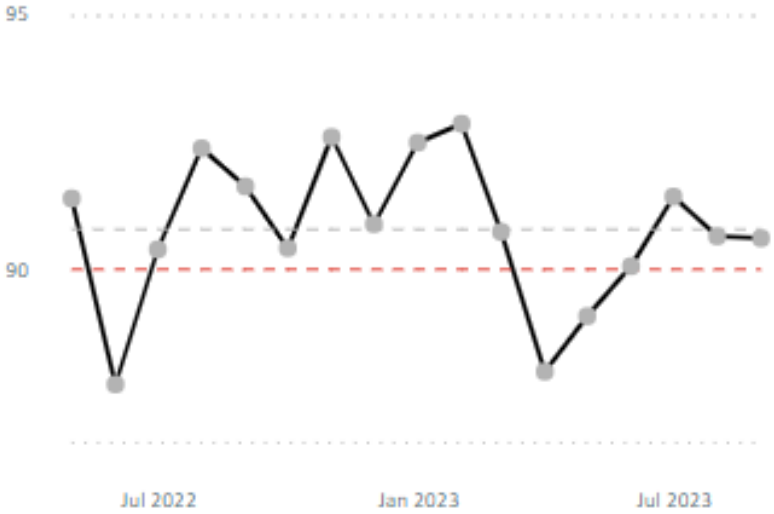


Figure 2: Number of people listened to



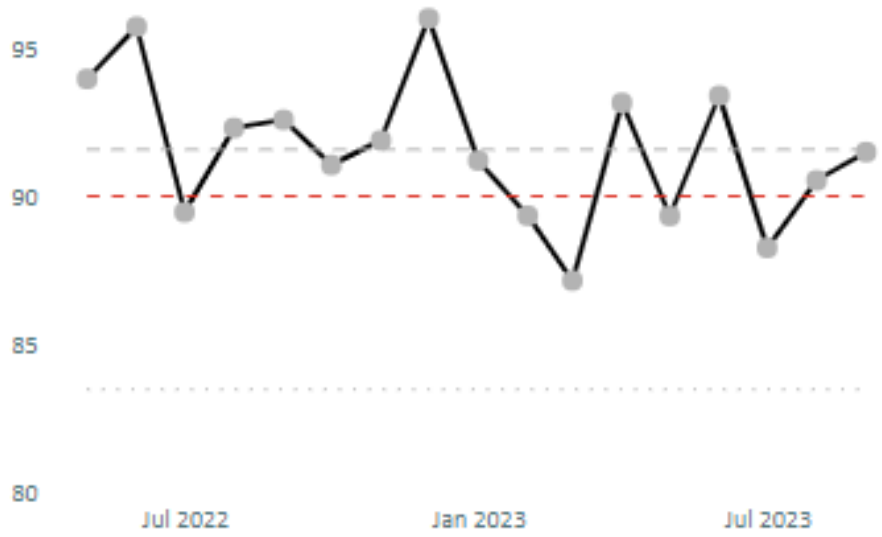
We started Your Voice is Heard in May 2022. The score for antenatal care was at its lowest at 87.8% in June 2022, it was 90.6% in September 2023.

Figure 3: Respondents positive about antenatal care



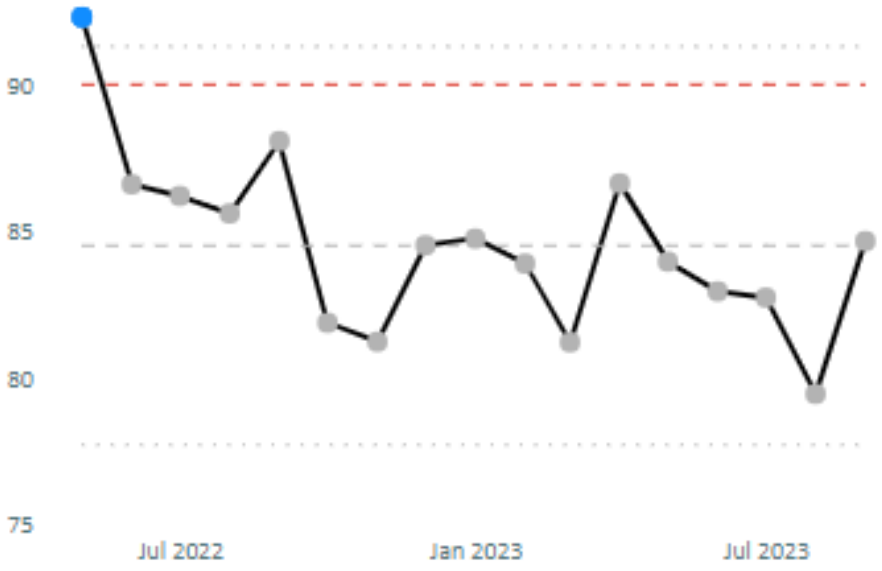
Care on our labour wards was at its lowest at 87.1% in March 2023 and was 91.5% in September 2023.

Figure 4: Respondents positive about care on our labour wards



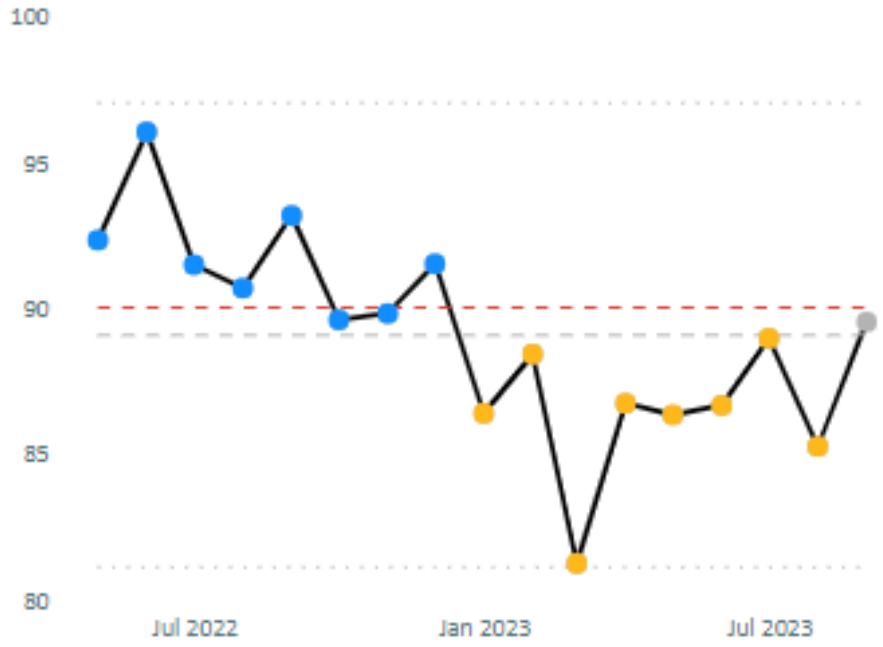
Postnatal care has declined from 92.3% in May 2022 and was at 84.6% in September 2023.

Figure 5: Respondents positive about postnatal care



The number of women ‘happy to return’ has declined from 92.3% to 89.5%.

Figure 6: Respondents happy to return



Changes across our Trust: Patient Voice and Involvement

The lessons within *Reading the signals* apply as much to the rest of our Trust and all our services, as they do in maternity. Within the wider Trust, we have recruited a new patient voice and involvement team to help us involve patients and our communities in our services. The team has been in place for 12 months and we are at an early stage of this work.

There are patient involvement officers, based at our three acute hospitals in Ashford, Canterbury and Margate, who's role is to reach out to local communities and voluntary, community and social enterprise organisations to reach people who may not often get a chance to have their voice heard For example, the feedback from this team and their engagement activities is being used to improve equity and access to care, by addressing people's accessibility needs for example, translation and interpretation services, adapted reading levels for all published documents and alignment to the Accessible Information Standard.

People can get involved on a voluntary basis by becoming a Participation Partner. Participation Partners get involved in a range of activities – everything from being a member on a Trust group or committee, to being on an interview panel or supporting staff training.

The Patient Participation and Action Group (PPAG) holds us to account for implementing the Patient Voice and Involvement Strategy. The group is co-chaired by a Participation Partner and the Head of Patient Voice and Involvement, and a Non-Executive Director attends as the Board Champion for Patient Voice. Membership of the group is 50% people who use our services or are carers or family members, 30% voluntary community and social enterprise sector representatives and 20% EKHUFT staff.

Reducing harm and delivering safe services

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

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

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

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

To improve the safety of our triage service, we have implemented the Birmingham Symptom Specific Obstetric Triage System. The system is designed to ensure women and birthing people are assessed promptly on arrival at either of our maternity units and triaged appropriately according to their clinical need. The aim is for everyone to be assessed within 15 minutes and given a clinical priority using a recognised colour coding system so that people with the most urgent need(s) are treated first.

The timeliness and assessment of the triage service is monitored, to ensure patients are being cared for appropriately. The number of women and birthing people being seen on time by a midwife has increased from 97.3% in October 2022 when the system was implemented to 99.1% in August 2023.

To improve the quality and safety of care we have invested to increase the numbers of midwives and doctors, including specialist roles. However, filling vacancies has remained challenging this year, particularly in midwifery at William Harvey Hospital. To support our recruitment drive, we have recently appointed ten internationally educated midwives. Once their training is completed they will be added to our rosters to increase our midwifery establishment and capacity.

We are also working on development opportunities to upskill our existing workforce, including the NHS Health Education England Maternity Support Worker Competency Framework to upskill the maternity support workforce and provide a clear pathway for career progression.

Midwifery staffing challenges have meant we have been unable to offer women and birthing people the Singleton Midwife-led Unit at William Harvey Hospital as a place of birth. This unit is due to re-open later in the Autumn 2023, offering more choice to women in relation to their preferred place of birth.

To ensure we have the right staff in the right places, we use a workforce acuity tool supported by a live tracker to make sure staff are where they are most needed. In September 2022, staffing met acuity needs 55.7% of the time. This figure fluctuated through to February 2023, after which we saw a steady increase up to 76.1% in September 2023.

When insufficient workforce numbers and skill mix cannot meet safe staffing requirements, there are escalation processes available, such as the divert of services to alternative unit(s) to safeguard women and their babies. Over December 2022 and January 2023 there were nine incidents of unit diverts and by August 2023 this had reduced to 0 for the second consecutive month.

In February 2023, student midwives were removed from their placements at William Harvey Hospital due to mounting concerns about how the safety issues identified by CQC and others, including concerns with fetal monitoring, escalation of concerns and checking of equipment, were impacting on the effectiveness of the learning environment. In May, the Nursing and Midwifery Council (NMC) withdrew its approval for the midwifery programme at Canterbury Christ Church University due to broader concerns and students were removed from all Kent and Medway placements.

We have been working closely with the University of Surrey to enable student midwives to return and we are delighted to be welcoming back midwifery students to the Trust in the autumn. We have increased the practice development team and systems for student support and supervision. We are increasing the ways students can raise concerns about their clinical placement.

We will continue to work with the NMC and the University of Surrey to ensure the standards students require in order to became safe and effective registered midwives are being met. Students on clinical placement with us are not counted in our staffing numbers, but they are an important part of our team and for our future workforce.

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

We have also introduced five key ways to regularly share learning across maternity:

- ‘Hot Topics’ that require immediate dissemination
- ‘Safety Threads’ used in safety huddles and handovers

- ‘Lunch and Learn’ sessions to share learning in a relaxed space
- Monthly ‘Safety Summit’ with Board maternity safety champions, Chief Nursing and Midwifery Officer and Non-Executive Director
- ‘We Hear You’ and twice-monthly consultant forums, which give staff direct access to the senior leadership team.

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

Changes across our Trust: Call 4 concern

The national initiative ‘Call 4 concern’ is being piloted at William Harvey Hospital by our Critical Care Outreach Team (CCOT) who manage this service. It is a scheme where patients and relatives can call the team directly if they are concerned about a patient's condition.

Posters and leaflets are provided in and outside ward areas across the hospital giving information and the contact number for the service. Patients and/or carers and relatives can contact the team directly or ask a member of staff for the information. Since the pilot was introduced in July 2023 the service has received nine calls.

If a patient/relative has unresolved concerns, CCOT staff liaise between the patient and or carer/relative and the team/ward staff. The pilot will be evaluated before rolling out more widely.

Saving babies' lives

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

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

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

The chart below shows the 12-month rolling rate of MBRRACE reportable stillbirths and neonatal deaths per 1,000 births in East Kent, including births and deaths from September 2020 to September 2023.

Figure 7: Extended perinatal mortality

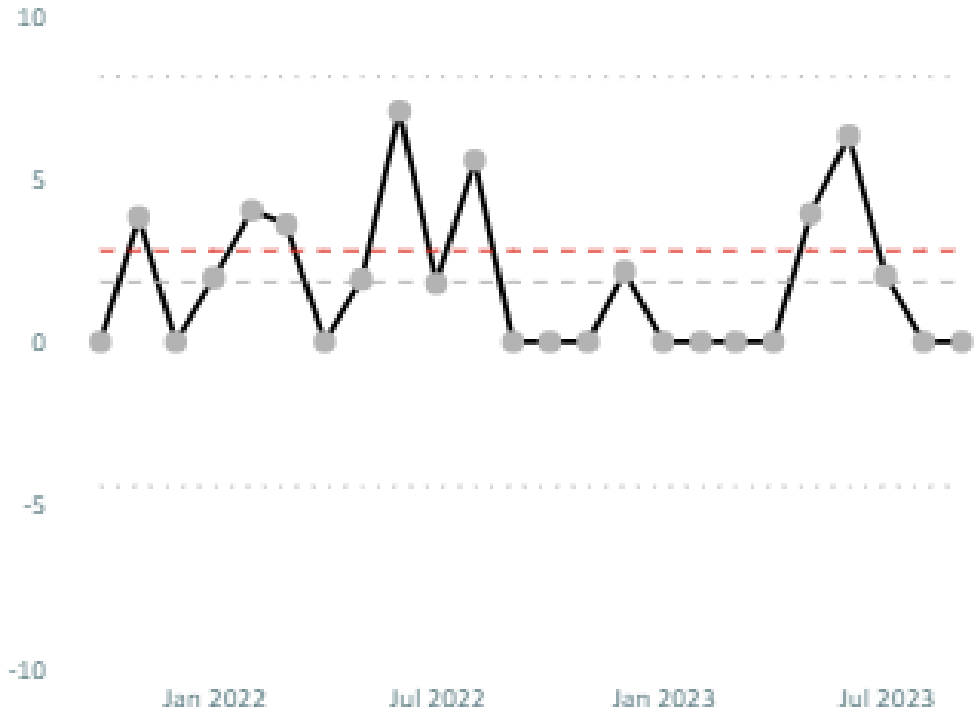
In September 2023, East Kent had 2.25 stillbirths per 1,000 and 0.87 neonatal deaths per 1,000.

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

Hypoxic Ischemic Encephalopathy (HIE)

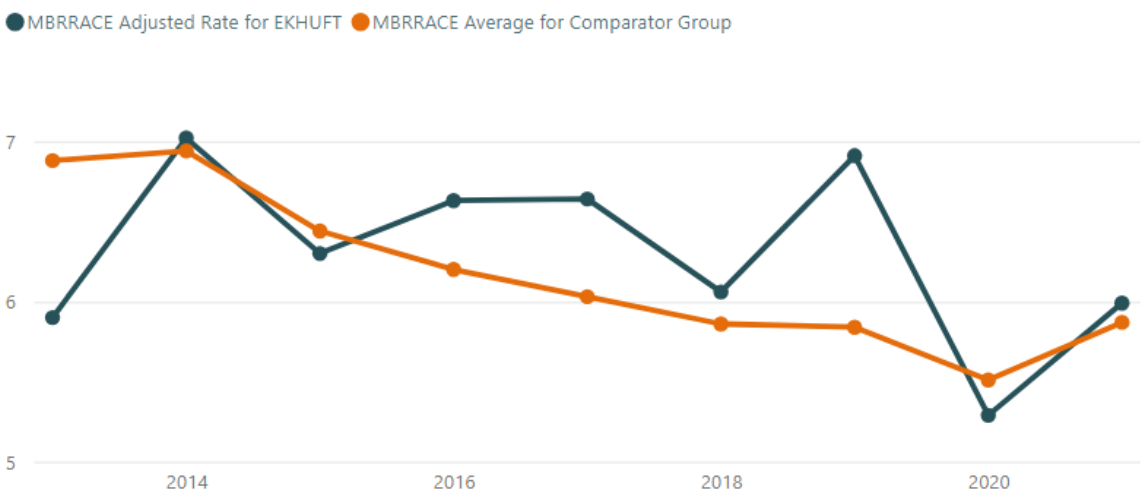
Hypoxic Ischemic Encephalopathy (HIE) - moderate or severe brain damage. The target range is 2.4- 2.8 per 1,000 live births. Between September 2022 and August 2023, the overall average for East Kent has been 2 cases per 1,000 live births. There were no cases in September 2023.

Figure 8: Hypoxic Ischemic Encephalopathy



The latest nationally-published MBRRACE data (for the year 2021) shows that in 2021, the rate of stillbirths and neonatal deaths in East Kent in 2021 was 5.99 per 1,000 births. The average for similar trusts was 5.87.

Figure 9: MBRRACE adjusted rate for East Kent and MBRRACE average for comparator group by birth year



The neonatal death rate in East Kent for 2021 was 1.88 per 1,000 births, compared with an average for similar trusts of 1.96.

The stillbirth rate for 2021 was 4.11 per births, compared with an average for similar trusts of 3.92.

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

Stillbirths

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

Neonatal deaths

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

Care and compassion

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

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

This seven-day service model includes continuity of carer for women and their families during a bereavement but also through any subsequent pregnancies, labour and delivery.

The next step in the remodelling of our bereavement service is the relocation of the Twinkling Stars bereavement suite (a dedicated area for families) at William Harvey Hospital to a location which provides improved privacy with its own access so that women, babies and their families can be cared for in a more considerate and suitable setting.

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

about how the way we behave impacts one another, and the way we make decisions.

As part of the work to improve the culture in maternity services, service leaders are enrolled onto the NHS Perinatal Culture and Leadership Programme. The next step for the programme will be a culture survey, which is to be issued across maternity and neonatal services in October 2023. Results of the survey will be shared back with care group senior leaders and, with support of an external culture coach for each acute hospital, an internal change team will be formed to identify and implement solutions for a culture that harnesses better outcomes and experience for service users and our workforce. This is independently facilitated and will involve service users in any areas for improvement, including working with the Maternity and Neonatal Voices Partnership.

Changes across our Trust: caring with compassion training

We recognise that the lessons within *Reading the signals* apply as much to the rest of our Trust and all our services as they do in maternity and we need to provide care that is more compassionate. We launched a caring with compassion video in May 2023, which is now part of mandatory training for all Trust staff. The video was developed by the Supportive and Palliative Care Team and was funded by the East Kent Hospitals charity. The film follows the experiences of 'Peter' and his family in the last days of his life, and is a powerful reminder of the importance of recognising and responding to the holistic needs of the people using our services.

From March, we have provided a monthly session for Health Care Support Workers focused on 'Seeing the Person'. Eighty Health Care Support Workers have participated to date, with feedback being very positive about how they can understand the vital role they play in every patient's experience.

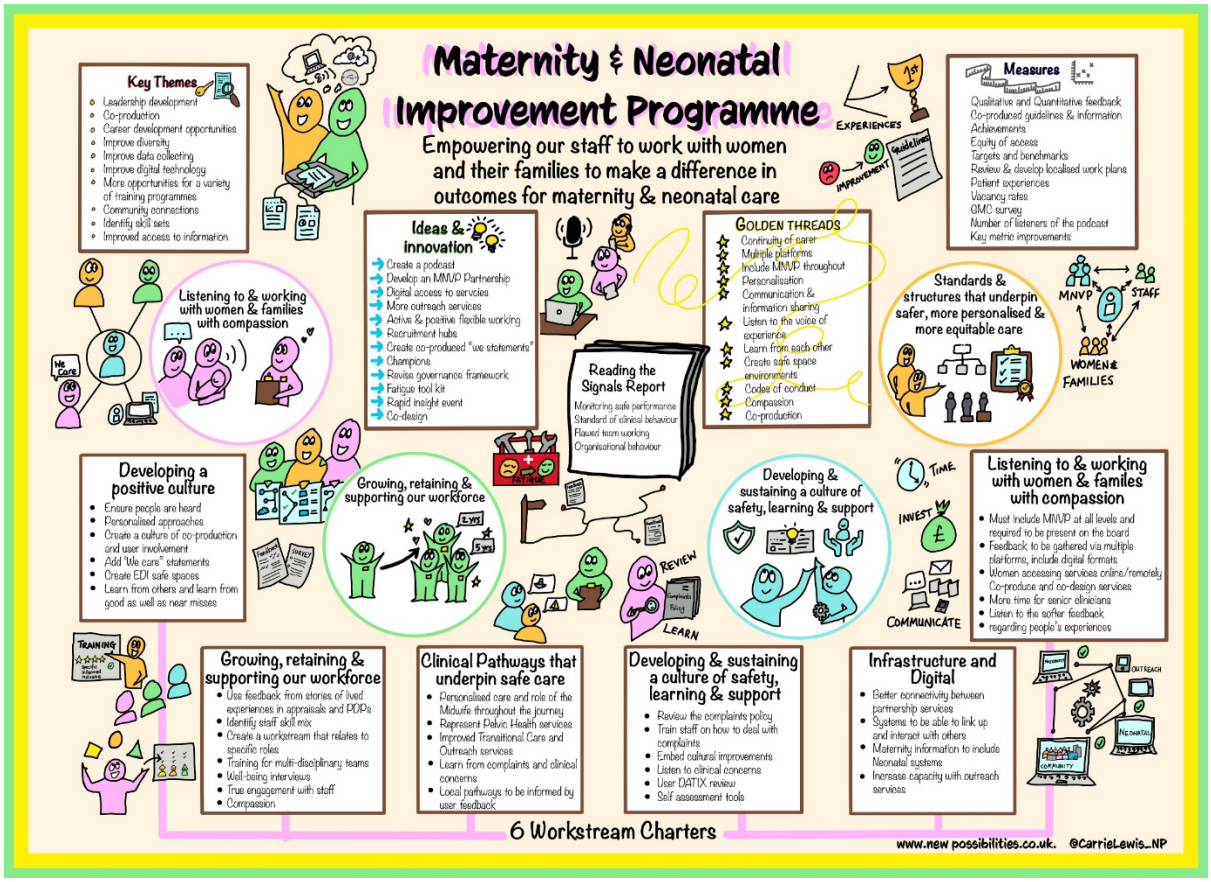
Engagement, listening and leadership

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

We recruited a new experienced, substantive Director, and Deputy Director of Midwifery, who started in post in mid May 2023 to strengthen maternity leadership and support further improvements to the service across the Trust.

The new maternity and neonatal leadership team has worked with families, staff and partners to co-produce a Maternity and Neonatal Improvement Programme for East Kent. This included a 'We hear you' engagement day, held in June, which brought together people who use the service, the maternity leadership team, obstetrics, maternity and neonatal staff, the Kent and Medway Local Maternity and Neonatal Service, Maternity and Neonatal Voices Partnership and members of NHS England's regional maternity team to co-produce the vision for the programme. The next engagement day will take place later this year.

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



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

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

This programme incorporates work developed in March following the publication of the *Reading the Signals* report in October and the Care Quality Commission (CQC) inspection in January 2023. It also reflects the national Three-Year Single Delivery Plan for Maternity and Neonatal Services published in May 2023 – a plan that sets

out how the NHS will make maternity and neonatal care safer, more personalised and more equitable.

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

Across our Trust:

Strengthening our Freedom to Speak Up support

We want to create an organisational culture which feels psychologically safe enough to speak up, learn and improve in, to do this we have expanded our Freedom to Speak Up (FTSU) team by appointing four dedicated FTSU guardians across the Trust, one specifically for maternity.

It is important that where staff have concerns they are reporting it, so we can learn and take action. We have actively promoted access to this team and we have seen a threefold increase in people across the Trust contacting the FTSU guardians in 2022/23 compared with 2021/22. As well as resolving individual issues, feedback is being used in mandatory training and with other information to identify and support areas of risk. Freedom to Speak Up activity is confidentially reported into the Maternity and Neonatal Assurance Group, and directly into the Trust Board.

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

Implementing the culture and leadership programme

As part of the commitment to nurture compassionate leaders and effective teams that work well together, the Trust is adopting NHS England’s Culture and Leadership Programme developed by the Kings Fund. This programme has been introduced elsewhere in the NHS and there are proven links between compassion in healthcare and outcomes for patients. It is aimed at all levels in the Trust and recruited more than 100 change champions across the Trust in Summer 2023 who are supporting this work.

This national programme is currently in its diagnostic phase, with change team members organising staff forums and interviewing Board members as part of gathering feedback on culture and behaviours from staff across the organisation.

Developing our organisation

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

We established the Maternity and Neonatal Assurance group, chaired by the Chief Nursing and Midwifery Officer and attended by the non-executive director maternity champion (a senior clinician). The group reports monthly to the Quality and Safety Committee and directly to the Trust Board quarterly and is attended by multiple stakeholders, including the Maternity and Neonatal Voices Partnership. It provides specific oversight of maternity and neonatal services, including training compliance, the monthly maternity dashboard, maternity and neonatal improvement programme, progress against Clinical Negligence Scheme for Trusts (CNST), Ockenden and CQC actions.

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

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

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

Across our Trust: organisation restructure to enable delivery of safe, high quality and timely services

We have reviewed how our care groups (each responsible for the management of a number of clinical services) are structured and have implemented the first phase of a restructure to enable the delivery of safe, high quality and timely services. The new structure is organised around patient ‘pathways’ to improve our ability to provide seamless care across the Trust and improve governance across the Trust.

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