

In October 2023, one year on from the publication of [Reading the signals](#), we published a report of our progress. We have updated this report to reflect information and data about our maternity service, three years on from the publication of Dr Kirkup's report.

Three years on from the publication of Reading the signals

On October 19 2022, Dr Bill Kirkup published his independent investigation into maternity and neonatal care provided by our Trust from 2009 to 2020.

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.

At any point following the publication of [Reading the signals](#), the importance of the report and its findings remains just as profound and significant.

We are 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 still 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 helping us to improve our maternity services, has given feedback and has provided both challenge and encouragement. We look forward to continuing this work with you.

In September 2025 our Trust was chosen to take part in the national investigation of maternity and newborn baby care across England led by Baroness Valerie Amos.

Fourteen trusts have been chosen to take part. One of the criteria for the national review was to learn from reviews already taken place.

We are one of the three Trusts where previous investigations have taken place and learnings from these will be incorporated in this new investigation.

The investigation will deliver one clear set of national recommendations to achieve consistently high-quality, safe maternity and neonatal care.

We welcome the opportunity to take part in this important review and to share our learning from our journey to improve maternity services in east Kent and we are committed to continuing this journey to provide the highest standard of care for our communities.

The Board of East Kent Hospitals Trust

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, which included 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.

Dr Kirkup's key areas for action are reflected in our organisational objectives, specifically:

- Patient, family and community voices
- Reducing harm and delivering safe services
- Care and compassion
- Teamwork, trust, respect and inclusion
- Reducing health inequalities

Our maternity service continues to work with families and staff to embed the changes that are needed to make continued and sustained improvement in care and outcomes for women, babies and their families and 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 Three-Year Single Delivery Plan for Maternity and Neonatal Services.

We are grateful to the families and colleagues who supported us as part of the Reading the Signals Oversight Group and for their challenge and involvement; to those currently working

with us as representatives on our new Maternity and Neonatal Assurance Board and those involved in developing the independent restorative process - 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 changes needed 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 continue to work hard to change this in both our maternity and neonatal services and as a Trust.

To help us achieve this we have an embedded patient experience team specifically to work with women, birthing partners and families and staff to improve patient and staff experience. The team is led by a professional midwifery advocate, one patient experience midwife and two non-clinical patient experience administrators.

The maternity Patient Experience team has continued to respond to feedback received through 'Your Voice is Heard', a service developed in collaboration with families, our local Maternity and Neonatal Voices Partnership and a Trust governor, which is unique to East Kent.

The Director and Deputy Director of Midwifery *Walk the patch*, regularly walking around the maternity units to listen to people who use our services, and families to directly hear about their experiences of 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 upon quickly and/or included in staff training. This is also now undertaken by the Maternity and Neonatal Voices Partnership, separately and during both day and night shifts.

In order to improve quality and any required training, all calls to maternity triage are now recorded, monitored and audited. In this way, not only the quality of information and care can be monitored, but also how service users are engaged with.

Leave your troubles at our door, is as an additional patient experience service providing 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 have increasingly innovative ways of involving people who use our services, in partnership with the Maternity and Neonatal Voices Partnership, including holding Facebook "Live" sessions, a consultant midwife specifically leads work to reduce health inequalities and focus on under-served communities, for example with Lithuanian families. We are pursuing funding for a community bus to go out to our communities and recruiting two maternity support workers in Thanet to support under-served communities.

We also involve families in investigations from the outset, ensuring their voice is heard throughout the investigation process; co-produced our maternity and neonatal improvement programme and new pathways of care with them; and continue to work with families directly involved in Dr Kirkup's investigation.

We want our service to be welcoming, safe, clean, professional, friendly, calm and well organised. The Maternity and Neonatal Voices Partnership lead an annual '15-Steps challenge' with service users on both units and have seen significant improvements. This sees the service through the eyes of people who use it and what they see and experience within 15 steps of entering a department. Improvements include making the units more

welcoming, murals on walls, soft lighting in labour rooms and a co-produced post-natal booklet with information about leaving hospital.

The age and quality of our buildings, and the need for capital funding to improve our estate is an ongoing challenge. We worked with the Kent and Medway Integrated Care Board, local MPs and NHS England regionally to identify sources of funding to improve our maternity units and have been granted funding to finalise the business case for a £25m investment for the development of the maternity unit at Queen Elizabeth The Queen Mother Hospital, which will increase the size of labour rooms and provide a second obstetric theatre for caesarean sections. It will also extend the maternity triage area in the next phase of refurbishment at William Harvey Hospital.

There has also been investment in the relocation and refurbishment of the bereavement suite at William Harvey Hospital. The refurbished Twinkling Stars suite is a dedicated area for families located away from the busy Labour ward, with the work funded by donations to East Kent Hospitals Charity.

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.

By the end of August 2025, we had heard from 13,243 women who have given birth in our hospitals, and from birth partners, too, an average 71.4% response rate. We want everyone to have a positive experience of all aspects of their care and to be 'happy to return'. There remains work to do to reach this point, in August 2025 89.7% of women were 'happy to return'. Our quality improvement work is aligned to the themes from this valuable feedback in order 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, hot drinks and sleeper chairs for birthing partners, a post-natal booklet and providing a family bathroom on each site.

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 more timely way.

We have improved access to antenatal education with online antenatal sessions and the development of face to face sessions delivered in the community by our own team of midwives.

To improve people's experiences of postnatal care we have introduced intentional care rounding which is audited and reported weekly to the Director and Deputy Director of Midwifery. To enable families to leave hospital more quickly, we have more midwives to do new born physical examinations and midwifery-led discharge where appropriate.

We have improved support for infant feeding during evenings, nights and weekends and the information available when leaving hospital. While there is still work to do in this area, our results for women being discharged without delay has increased from 60%-70%.

It is important that we also know where things are going well so we can build on them. By the end of August 2025 more than 6,000 compliments from families had been shared directly with staff. We have also extended Your Voice is Heard to include families whose babies have been in neonatal care.

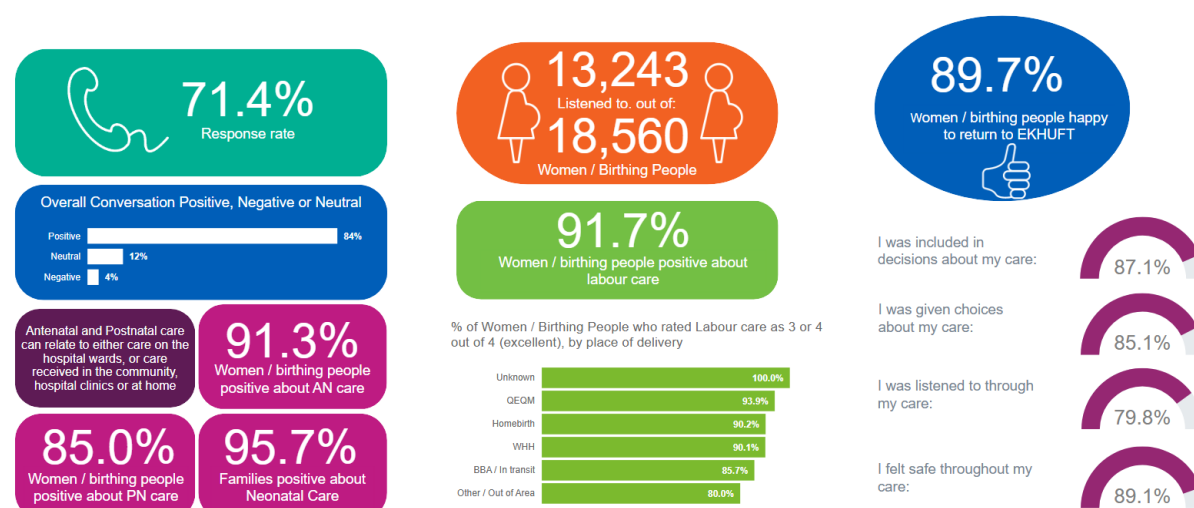
Your Voice is Heard is in addition to the [Friends and Family Test](#) surveys and is one of 12 ways we gather and use feedback in maternity. We review the feedback by ethnicity and deprivation to ensure we are hearing from people from a wide range of backgrounds. We also use a theming tool so that all feedback is brought together from all sources, including national surveys although the timeline for receiving these results is much longer.

The latest annual [CQC Maternity Services Survey](#), conducted in 2024, had a response rate of 36%. It showed the areas where improvements were needed were: delays in being able to go home on the day of leaving hospital; enough information provided about feeding; feeling that healthcare professionals did everything they could to help manage pain; feeling that concerns during antenatal care were taken seriously and midwives and/or doctors working well together.

These are areas of focus with improvements having been made, or are being made, since the survey was undertaken in 2024. The 2025 survey results are expected in November 2025.

The areas that scored highest were partners or someone else close to you being able to stay as much as you wanted; being given contact details and advice about potential changes to mental health after birth; not being sent home when you were worried about yourself or your baby and healthcare professionals doing everything they could to manage your pain in the ward after birth.

Your Voice is Heard data since we launched in May 2022



We started Your Voice is Heard in May 2022 and usually speak to between 300 and 400 people each month. In the July and August 2025 we spoke to around 200 people each month, due to temporary staffing problems within the your voice is heard team which we are addressing.

Figure 1: Your Voice is Heard response rate

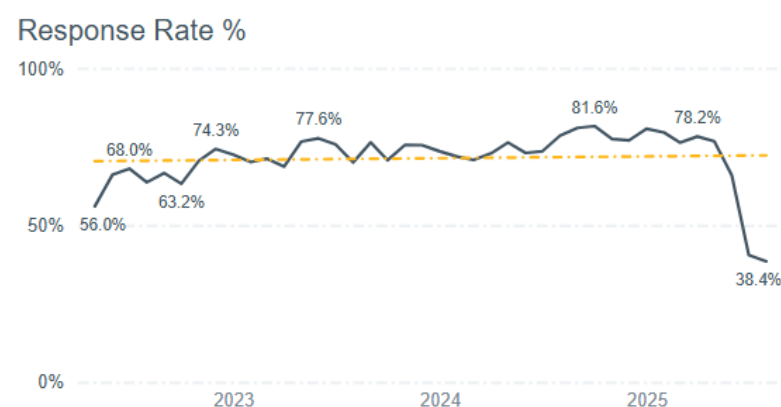
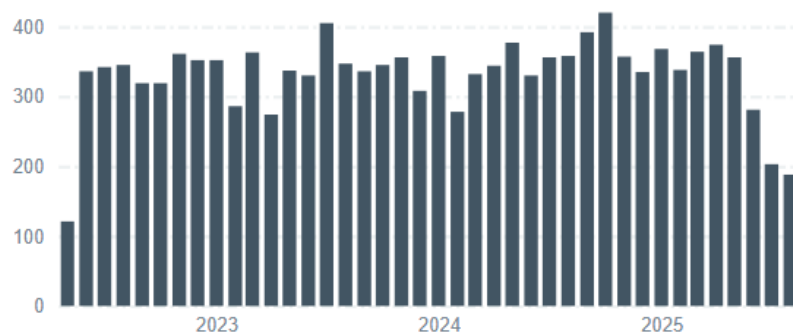


Figure 2: Number of people listened to

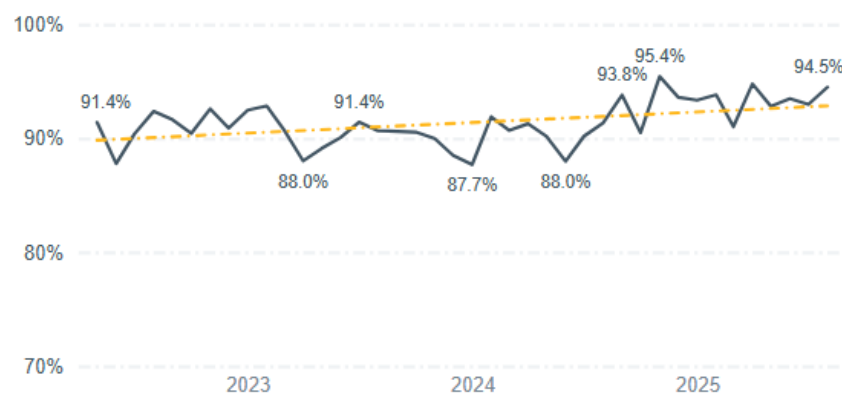
Number Listened To



The score for antenatal care has shown a consistent upward trend, reaching a positive response score of 94.5% in August 2025.

Figure 3: Respondents positive about antenatal care

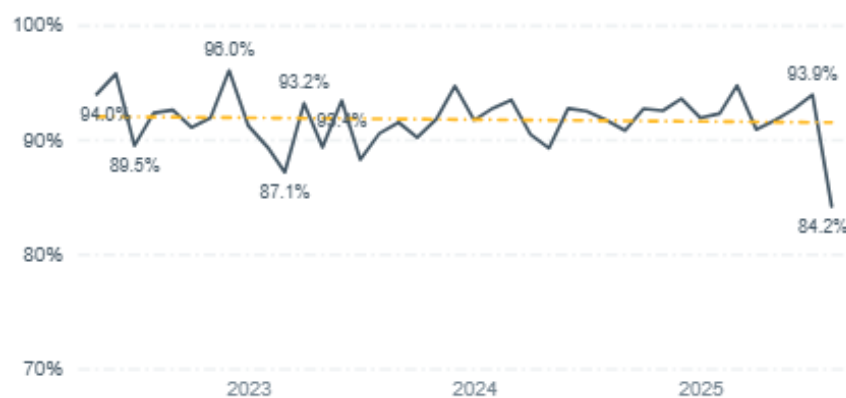
AN Care Positive %



Care on our labour wards has remained steady at around 92%, although there was a decline to 84.2% in August 2025, which we are reviewing to understand the factors that caused this drop.

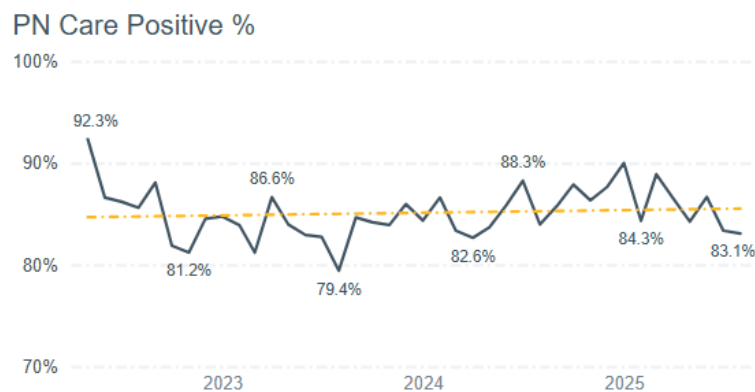
Figure 4: Respondents positive about care on our labour wards

IP Care Positive %



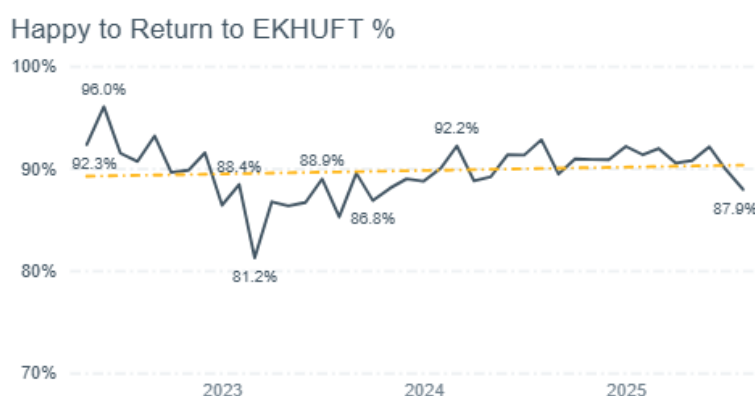
Positive responses for postnatal care have remained around 85%, with some variation.

Figure 5: Respondents positive about postnatal care



The number of women 'happy to return' from May 2022 to August 2025.

Figure 6: Respondents happy to return



Changes across our Trust: Patient Voice and Involvement

The Reading the Signals report has not only affected how we work in maternity, but also within the wider Trust. We established our patient voice and involvement team in August 2022, to help us involve patients, their families and our communities in improving patient and family experience of our services.

The team work across all the Trust's sites with operational and clinical staff to make improvements based on patient feedback from a wide range of sources. This includes using feedback from the Friends and Family Test (FFT) survey, Care Opinion, the NHS website reviews, the national Care Quality Commission (CQC) Patient Surveys and engagement with local communities, including people who are underserved.

Friends and Family Test feedback is themed and reported to services and the Trust's Patient Experience Committee every two months. The quarterly report on Complaints and PALS also goes to the Patient Experience Committee. The themes from FFT, other surveys and Complaints and PALS are generally related to communication, care given by staff, staff attitude, quality of treatment and waiting times on site. Whilst feedback is overwhelmingly positive, there are areas for improvement such as discharge processes, involving carers and families of patients and information for the patient on what will happen after discharge.

The most recent CQC Maternity survey, based on people receiving maternity care in February 2025 shows much improved scores in many areas, and our improved scores puts the Trust in the top three of maternity services who used the same survey provider (3rd

place out of 50 trusts). Maternity Services received a 'Good' overall rating from the CQC earlier in 2025.

Community engagement work has focused on underserved communities, and this has included people with hearing and sight loss and people with learning disabilities. We have co-designed a communication passport for people with sensory loss, and we work with people with learning disabilities to co-design easy read clinical patient leaflets. The Trust's work on the Accessible Information Standard (AIS) has resulted in several awards and recognition by colleagues at NHS England.

As the result of feedback from Trust staff and community groups we've improved our interpreting and translation provision. Our main provider has improved fulfilment of bookings, we can now access video relay interpreting on demand for spoken languages using dedicated tablet devices, and in August 2025 we contracted with an additional provider who is supporting the demand for face to face interpreting in Nepali, Dari, Slovak and Kurdish Sorani.

People can get involved with the team 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, to co-designing patient surveys to being involved in Ward Accreditation audits or supporting staff training. We now have Participation Partners on the Fundamentals of Care Committee, End of Life Care Committee, the Ethics Committee and Patient Experience Committee. We also have VCSE sector partners on several working groups and committees.

The Patient Participation and Action Group (PPAG) holds us to account for implementing the Patient Voice and Involvement Strategy. Membership of the group is 50% Participation Partners, 30% voluntary community and social enterprise sector (VCSE) representatives and 20% EKHUFT staff.

The team has worked with our services to get them involved in theming the comments from the FFT survey for their service. This has a positive impact on staff morale as most comments are positive but also means they read the comments first hand to help understand what needs to improve.

We send out a 'Five for Friday' each week to three services / care groups. This highlights five positive comments, the themes of patient comments, and their theming compliance. This has encouraged services to look at their FFT feedback more carefully and find areas for improvement.

Where patient comments have highlighted the need for additional training for staff, this has been passed on to the appropriate team to work with the ward or department.

In July 2024 the Trust received our Veteran Aware accreditation. The Patient Voice and Involvement team led this work, including setting up the working group to deliver the changes needed to gain accreditation. There will be on-going work needed to retain accreditation and meet our obligations under the Armed Forces Covenant. The team will continue to support this work.

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 all of 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 providing the standards of maternity care women and families should expect and the service was rated inadequate.

The service was re-inspected in December 2024 and the maternity services at William Harvey Hospital, Ashford and Queen Elizabeth The Queen Mother Hospital, Margate were upgraded to 'good'. The CQC found that the Trust had made 'significant improvements' since its last inspection in 2023. It rated both units as 'good' for being caring, effective, responsive and well-led.

The inspection team found that the women and babies were protected and kept safe; that the units were clean and well-maintained; that there were enough staff who were well-trained; and that the units had a good learning culture, where people could raise concerns.

It also found that the outdated hospital buildings meant some clinical areas and labour rooms in both units are too small and lack ensuite facilities, compromising the care staff are able to give, and that there is currently only one obstetric theatre at Queen Elizabeth The Queen Mother Hospital. It therefore rated the units as 'requires improvement' for 'safe'.

This is being addressed through a £25m development to increase the size of labour rooms and provide a second obstetric theatre at the Queen Elizabeth The Queen Mother Hospital. There will also be an extension of the maternity triage area in the next phase of refurbishment at William Harvey Hospital.

The CQC report was an important milestone in our continuing work to improve our services, embed the lessons in *Reading the Signals* and work to provide the highest standard of care for our communities.

Changes that contributed to this improvement included increased doctor cover in the triage service at William Harvey Hospital, additional training and electronic alerts for staff when a fetal monitoring check is due, regular checking and auditing of emergency equipment, cleaning, hand hygiene and PPE compliance.

Out of the 40 actions recommended by the CQC in 2023, 39 had been fully completed by summer 2025, the remaining action being a second obstetric theatre at QEQM. The CQC lifted its section 31 order and the Trust was removed from NHS England's Maternity Safety Support Programme.

Work to improve the safety of our triage service, following implementation of the Birmingham Symptom Specific Obstetric Triage System, was recognised in a Royal College of Midwifery Award for Outstanding Contribution to Midwifery Services: Digital.

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. Any breaches of this target are reported and harm reviews completed.

To improve the quality and safety of care we have increased the numbers of midwives and doctors, including specialist roles. We appointed 18 internationally educated midwives and all 56 of our student midwives who qualified in January 2025 have now joined us in permanent positions. We have 7 midwives joining us through the south east coast graduate guarantee scheme

We are also developing our existing workforce, for example by using the NHS Health Education England Maternity Support Worker Competency Framework to upskill the maternity support workforce and provide a clear pathway for career progression.

Medical staff have developed and trained 200 midwives in enhanced maternity care, allowing patients who need enhanced care to remain on the labour ward with their babies in dedicated enhanced maternity care rooms at both William Harvey Hospital and Queen Elizabeth the Queen Mother Hospital.

Well attended multi-disciplinary rapid review meetings are held three times a week to review any incidents reported through datix or other routes of escalation to identify any actions needed.

Doctors have also reviewed and updated all clinical guidelines to improve safety.

In December 2023 we reopened the Singleton Midwife-led Unit at William Harvey Hospital as a place of birth, offering more choice to women in relation to their preferred place of birth. By August 2025, 438 babies have been born in the unit.

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 was 67.6% in September 2024 and 72.7% in August 2025.

In August 2025 the student midwife course was reinstated at Canterbury Christ Church University. It has been suspended in February 2023 when the Nursing and Midwifery Council (NMC) withdrew its approval for the midwifery programme and students were removed from all Kent and Medway placements. We worked closely with the university on the development of a training needs analysis and training programme.

To improve training for midwives, we increased the practice development team, systems for student support and supervision, and ways students can raise concerns. 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. We have also trained four of our qualified nurses in a shorter midwifery programme.

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

We also have a number of 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 consultant forums, which give staff direct access to the senior leadership team.
- A teams group to share education and governance news.

In June and July 2025 the service held a reset week where all senior managers worked in clinical areas to observe clinical practices to reduce the gap between work imagined and work done. This is a widely recognised part of human factors training to improve safety.

We have changed the way we monitor patient safety and our clinical performance, articulated in the *Reading the Signals* report as 'finding signals among noise'. We now 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. Using this system led us to ask for an external review into a rise in neonatal deaths to identify any learning. The review found that the care provided was good and the charts now show this trajectory going back down but it is an important example of how statistical process charts help identify variance.

We are one of the first Trusts to adopt [Martha's rule in our acute hospitals](#) in Ashford and Margate, which gives patients, families, carers and staff round-the-clock access to a rapid

review from a separate care team if they are worried about a person's condition. We now also have Martha's rule at Kent and Canterbury Hospital.

We relaunched our ward and clinical accreditation scheme, which assesses wards on 13 patient care standards. These include patient experience, recognition and escalation of deteriorating patients, medication safety and the culture and progressiveness of the wards. The scheme increases staff engagement, pride in their wards and a culture of patient safety as they work through the levels of accreditation to reach bronze, silver and finally gold accreditation.

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.

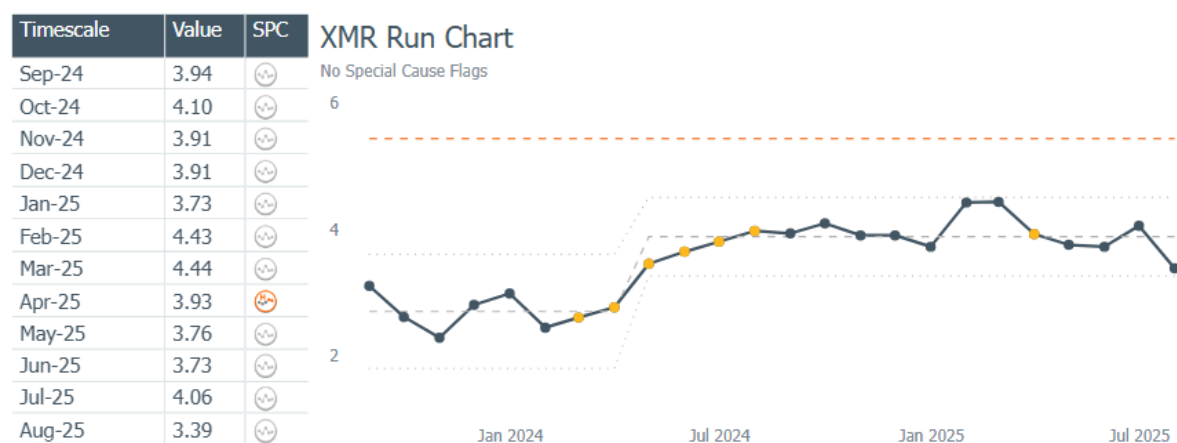
Stillbirths and neonatal deaths are measured by MBRRACE-UK. Every year MBRRACE-UK produces a "Perinatal Mortality Surveillance" report which provides rates for all stillbirths over 24 weeks and all neonatal deaths, when the baby was born alive after 24 weeks gestation, but died before 28 days of age.

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 2023 to August 2025.

Figure 7: Extended perinatal mortality

MBRRACE Ext Perinatal Rate 12m

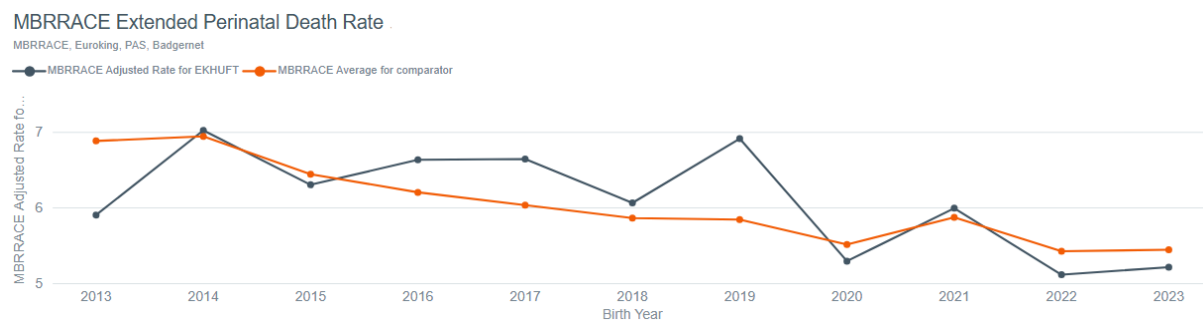


In August 2025, East Kent had 2.71 stillbirths per 1,000 and 0.68 neonatal deaths per 1,000.

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

The latest nationally-published MBRRACE data (for the year 2023) shows that the rate of stillbirths and neonatal deaths in East Kent in 2023 was 3.39 per 1,000 births. The average for similar trusts was 5.44.

Figure 8: MBRRACE adjusted rate for East Kent and MBRRACE average for comparator group by birth year



The neonatal death rate in East Kent for 2023 was 1.80 per 1,000 births, compared with an average for similar trusts of 1.84.

The stillbirth rate for 2023 was 3.42 per 1,000 births, compared with an average for similar trusts of 3.60.

The tables below show the number of stillbirths and neonatal deaths at our Trust since 2013, alongside the MBRRACE-UK latest available 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	3.84	3.65	3.61
2023	8	5,691	1.41	1.41	3.42	3.60

Neonatal deaths

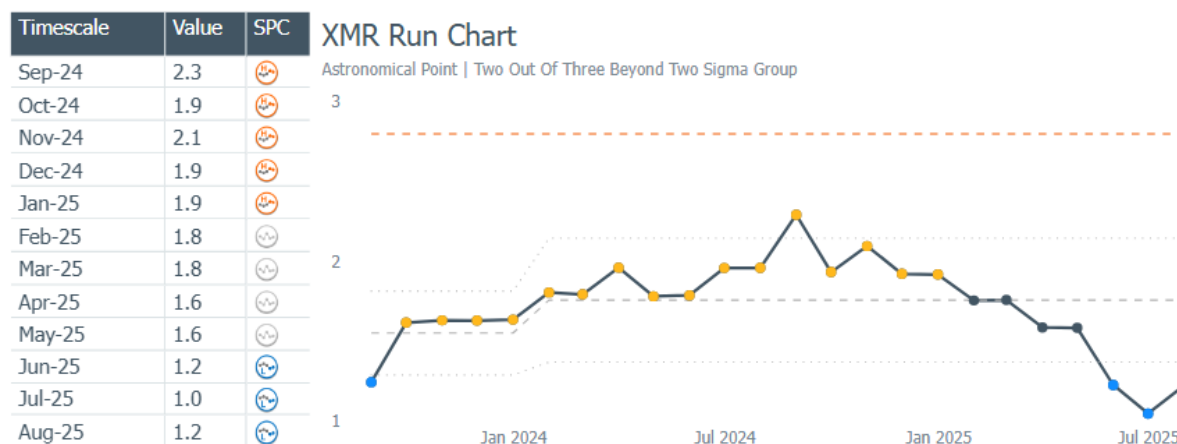
Birth year	Neonatal deaths <28 days	Livebirths	EKHUFT Crude Neonatal Death Rate	MBRRACE Crude Rate for EKHUFT	MBRRACE Adjusted Rate for EKHUFT	MBRRACE Average for Comparator Group
2013	10	7,015	1.43	1.29	1.95	2.09
2014	14	6,969	2.01	1.86	1.93	1.97
2015	14	7,040	1.99	1.62	2.01	2.04
2016	20	6,926	2.89	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	0.64	1.43	1.82
2023	8	5,683	1.41	1.23	1.80	1.84

Hypoxic Ischemic Encephalopathy (HIE)

Hypoxic Ischemic Encephalopathy (HIE) - moderate or severe brain damage. The expected range is 2.4- 2.8 per 1,000 live births. The last 12 months rate for East Kent has been 1.2 cases per 1,000 live births.

Figure 9: Hypoxic Ischemic Encephalopathy

HIE Rate Rolling 12m



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 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 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. This work has been recognised in the National Mariposa Bereavement Awards with a number of colleagues receiving awards.

The remodelling of our bereavement service included the relocation and refurbishment of the Twinkling Stars bereavement suite (a dedicated area for families) at William Harvey Hospital to a location outside of the Labour ward so that women, babies and their families can be cared for in a more considerate and suitable setting, funded by donations to East Kent Hospitals Charity.

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 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 completed the NHS Perinatal Culture and Leadership Programme and Band 7 managers completed a "connected" course designed to improve culture and leadership. Band 7 colleagues and above took part in cultural allyship training to promote diversity and inclusion and there is a greater focus on staff health and wellbeing and clinical supervision with the relaunch of the Professional Midwifery Advocates model.

The Royal College of Obstetrics and Gynaecology's Team of the Shift initiative has been introduced at all handovers on the labour and post-natal wards so that everyone on the shift knows each other, their roles and who to escalate to.

The staff survey results for our maternity and neonatal services have been a long way from where we want them to be and demonstrated the amount of work needed for staff to feel involved, engaged and positive about recommending their service and the Trust as a place to work.

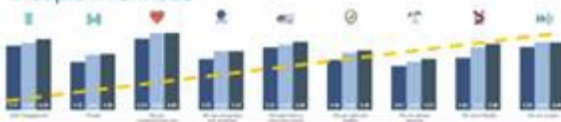
While there is still a lot of work to do to in comparison with national averages, the latest staff survey results in maternity have shown sustained improvements across all of the “people promise” areas, as well as much higher uptake of the survey among all staff. We are continuing to work hard to improve the experience of all staff across all areas.

Maternity and Neonatal Improvement Programme



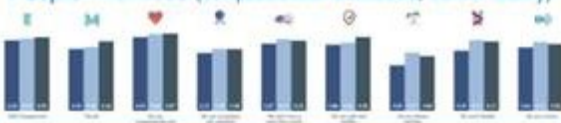
Outcomes and Impact: NHS Staff Survey Results

Maternity: continuous improvement across all People Promises



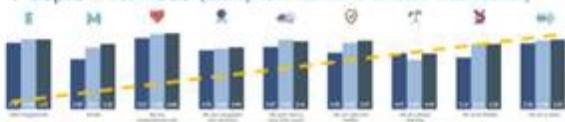
Response rates:
2022 – 144 / 2023 – 138 (32.4%) / 2024 – 251 (58.0%)

SCBU: continuous improvement across 2 of 7 People Promises (compassionate & inclusive, safe & healthy)



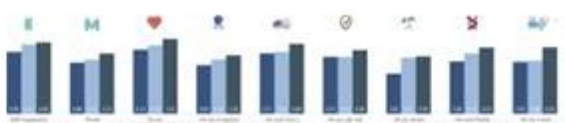
Response rates:
2022 – 17 / 2023 – 18 (64.3%) / 2024 – 25 (89.3%)

Obs & Gynae: continuous improvement across all People Promises (Exception: we have a voice that counts)



Response rates:
2022 – 20 / 2023 – 45 (35.2%) / 2024 – 81 (57.0%)

NICU: continuous improvement across all People Promises



Response rates:
2022 – ? / 2023 – 21 (27.3%) / 2024 – 48 (57.1%)

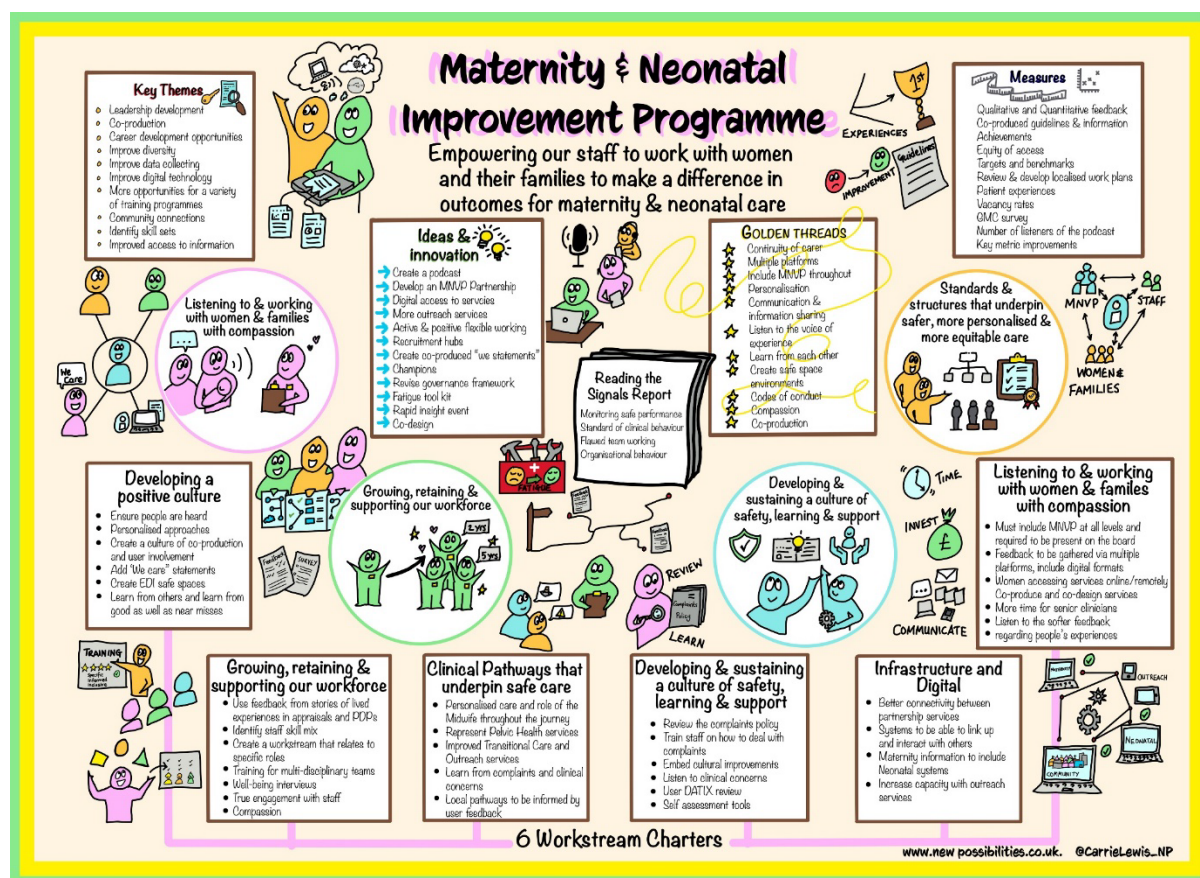
Engagement, listening and leadership

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

The service has been led by an experienced substantive Director, a Deputy Director and a Medical Director since 2023 and this has strengthened maternity leadership and supported improvements to the service across the Trust.

The maternity and neonatal leadership team worked with families, staff and partners to co-produce a Maternity and Neonatal Improvement Programme for East Kent, bringing 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.

Figure 9: A visual synthesis of outputs from the co-design 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 following the publication of the *Reading the Signals* report 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.

Progress against these priorities is reported through the Maternity and Neonatal Assurance Board and each of the Trust Board's meetings held in public. In the first 2 years 74% of the actions in the programme were delivered with emerging issues and outstanding actions prioritised based on feedback from families and staff, and learning from incidents. The remaining 26% of actions will be delivered in the third year.

Examples of improvements made through the Maternity and Neonatal Improvement Programme include an antenatal one stop shop where bloods, tests and scans are carried out as part of the same appointment; improved access to perinatal mental health services and developing a scorecard to identify and address health inequalities in global majority women and those from deprived communities through personalised care plans.

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 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, listening events and safety champion walkabouts involving the Chief Nursing and Midwifery Officer and Non-Executive Director lead for maternity.

Improving culture across our Trust

As part of the commitment to nurture compassionate leaders and effective teams that work well together, the Trust has adopted 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 more than 100 change ambassadors were recruited across the Trust to support this work.

We are acting on the results of a diagnostic carried out by change ambassadors which identified the need to ensure colleagues had a voice, are valued, have a shared vision and we have compassionate, inclusive and collective leadership.

Changes include ensuring staff have a greater voice through the introduction of a new staff congress, relaunching our staff wide recognition scheme, developing our organisational strategy, training all staff in essential leadership skills and making sure that compassionate leadership is at the front and centre of all our leadership training programmes.

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.

We reviewed how we deliver Freedom to Speak Up (FTSU) to ensure that it is sustainable and meeting the needs of our staff and as a result introduced an independent, externally provided Guardian service in 2025.

We have also introduced a sexual safety campaign making clear what is not acceptable and encouraging all staff to support tackling and reporting incidents.

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.

The Maternity and Neonatal Assurance Board, chaired by the Chief Nursing and Midwifery Officer and attended by the non-executive director maternity champion (a senior clinician), 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 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 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.

A governance framework used at all levels of the organisation 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.

Overall, we have taken the first significant steps on our journey and we are continuing to review these and make improvements. This is a continual process but we give our commitment, that we will not stop until we are offering the safe and compassionate care that all of our service users deserve.

Introducing a restorative process

We are being supported to deliver recommendation 5 in Dr Kirkup's report, that "the trust 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".

The process has been developed by the independent restorative practice team, in consultation with families, staff and current Trust leaders and is offered to anyone who participated in the East Kent investigation. This restorative opportunity offers forums for families to communicate their needs now and options they have for how those needs could be met.

For the Trust this means responding in a way that will improve wellbeing and repair trust, a sincere process of responsibility taking for harms caused and an obligation to now try to put things right to the extent possible in the circumstances.

Examples might include meetings with the right people in the room, to help address unanswered questions you have about your experiences, or make sure people have heard

what you want them to know and understand; forums for collectively agreeing solutions to problems; or a review with a psychologist to understand their emotional and psychological support needs now.