East Suffolk and North Essex NHS Foundation Trust

Board of Directors

3 November 2022

Report Title:	**Initial response to the East Kent Maternity Review Report**
Executive/NED Lead:	Nick Hulme, Chief Executive
Report author(s):	Steve Parsons, Interim Director of Governance
Previously considered by:	N/A

☐ **Approval** ☑ **Discussion** ☐ **Information** ☑ **Assurance**

Executive summary

Following a substantial investigation into maternity and neonatal incidents at East Kent Hospitals University FT, Dr Bill Kirkup has submitted the report *Reading the Signals; Maternity and Neonatal services in East Kent- the report of the independent investigation* which was published as a House of Commons paper on 19 October 2022. Following publication of the report, NHS England has written to all NHS organisations requiring them to hold a public Board discussion at their next available meeting.

This paper, taking up the items that NHS England has asked Boards to focus on, picks up the key lines of accountability that enable the Board to have assurance in respect of the items identified in the report; and to note that there will be a more substantial report prepared for the Board's consideration of these areas, expected to be brought forward to the public session in January 2023.

Action requested of the Board

The Board is invited to-

i. Note the key findings of the *Reading the Signals* report;
ii. Note the current systems that provide intelligence to the Board related to the key matters identified in the report;
iii. Note that a more detailed report will be made to the public Board meeting in January 2023.

Link to Strategic Objectives (SO)		**Please tick**
SO1	Keep people in control of their health	☑
SO2	Lead the integration of care	☐
SO3	Develop our centres of excellence	☑
SO4	Support and develop our staff	☑
SO5	Drive technology enabled care	☐

Risk Implications for the Trust *(including any clinical and financial consequences)*	If the concerns identified in East Kent and other maternity/ neonatal reviews are present within the Trust's maternity and neonatal services, there is a risk of avoidable harm to patients up to and including death.
Trust Risk Appetite	The Board has a cautious view of risk when it comes to patient safety, patient experience or clinical outcomes and places the principle of "no harm" at the heart of every decision it takes. It is prepared to accept some risk if, on balance, the benefits are justifiable at the heart of every decision it takes. It is prepared to accept some risk if, on balance, the benefits are justifiable and the potential for mitigation actions are strong. When taking decisions involving choices between a wide range of outcomes, it will prioritise the option resulting in the greatest benefit for the most patients.
Legal and regulatory implications *(including links to CQC outcomes, Monitor, inspections, audits, etc.)*	Having behaviours and/ or outcomes similar to those seen in the East Kent Inquiry would be likely to fail to meet the Essential Standards set out in the 2014 Regulations, and might lead to enforcement action by the Care Quality Commission.

Financial Implications	N/A
Equality and Diversity	Some recent reviews of concerns with maternity and neonatal services have identified that certain ethnic groups have worse outcomes that others.

Initial response to the East Kent maternity review report

Overview

Following a number of concerns regarding the quality of maternity and neonatal care being provided through East Kent Hospitals University FT, in March 2021 the then Minister of State at the Department of Health and Social Care (Nadine Dorris MP) commissioned Dr Bill Kirkup to conduct an investigation. Dr Kirkup had been involved in a number of similar investigations, most notably into the maternity and neonatal services provided by Morecambe Bay FT in the Barrow-in-Furness area.

Dr Kirkup has now published his report, *Reading the Signals; Maternity and Neonatal services in East Kent- the report of the independent investigation.* The report has identified a potential 45 cases from those they reviewed, where a different approach might have led to the individual surviving; and has also identified areas of concern on a wider basis, not least as the conclusions are aligned to those reached by earlier enquiries into Morecambe Bay, Shrewsbury and Telford Trust, and other providers. The report has therefore refrained from making detailed recommendations, and has rather made some recommendations for more deep-seated changes in broad areas.

Following the publication of the report, NHS England have written to all NHS provider organisations to draw the report to the clear attention of Boards. It has expressed a clear expectation that, at the next public Board that the organisation holds, the Board will-

- Review the findings of the report;
- Examine the organisation's culture, and how the Board listens and responds to staff;
- Take steps to assure itself as a Board, and the communities that the organisation serves, that leadership and culture across the organisation positively supports both care and patient experience that the Trust provides;
- Evaluate the effectiveness of the mechanisms which provide the Board with effective intelligence to act on ("reading the signals");
- Be clear about the actions that the Board will take as a result of the above.

In light of the timescales available to support the Board in undertaking this discussion, this paper supports the Board in having initial discussions on these areas, with a particular focus on the assurance routes available to "read the signals". It is intended that a more substantial paper will be provided to the Board, in the public session in January 2023, to enable a full report on these matters based on a detailed review of all relevant items.

The key findings of the *Reading the signals* report

Chapter 6 of the report sets out the key findings and recommendations arising out of the Inquiry. There are four areas that are identified-

i. Being able to identify signals that are of concern, amongst the 'noise' of data; noting the specific need for effective and timely outcome measures to be introduced in the provision of maternity and neonatal services, which would be mandatory across England and Wales.

ii. Having compassionate, caring and professional behaviours across all areas of care not just maternity and neonatal. Particular reference is made to the need to have proportionate employment/regulatory responses available for senior staff such as consultants who fail to display appropriate behaviours; clinical leadership roles being identified as important in their own right, and not rotating sinecures; and to drive best behaviours through continuing professional development and ensuring leaders display them to more junior staff, in order to break the cycle of negative role modelling.

iii. The need to have effective teamwork in providing services; noting that maternity services can show particular dysfunction between medical and nursing colleagues, but the wider point is that objectives should be shared and aligned for different groups working together. The report notes that, in the particular context, that there was generally a reaction of looking to blame a junior individual, rather than learning, when a safety incident occurred.

iv. The need to drive all organisations, and areas within organisations, to default to openness, honesty, disclosure and learning; rather than defensiveness and concern about organisational reputation. The Inquiry recommends passage of a Public Authority (Accountability) Act to make this a legal obligation. The Inquiry also recommends that NHS England reconsider how it approaches leadership changes for poorly-performing Trusts, and that individual organisations ensure that they have appropriate representation of maternity care at Board level.

As the Board will appreciate- and as the Report makes clear- these are areas where change would not be expected to be achieved quickly or without continuing focus and effort. A number of areas will require action at a national level, either from NHS England, professional regulators or professional associations; and in one case will require legislation.

Key lines/ systems that provide intelligence to the Board

There are a range of lines and systems that provide intelligence to the Board, both in maternity and neonatal, and more widely. Without attempting at this stage to provide a comprehensive review of all the systems, these include-

- Feedback from the Every Birth, Every Day (EBED) programme and work streams;
- Detailed Maternity data is included in the Integrated Patient Safety and Experience Report which is presented to the Quality and Patient Safety Committee and Trust Board;
- A range of survey information, including the national patient and staff surveys, the 'Family and Friends Test' information, and the General Medical Council surveys of doctors in training;
- The feedback provided by Governors in their representative capacities, together with intelligence provided by other elected representatives such as MPs;
- The direct experience of patients and staff provided to the Board through the patient and staff experience items regularly agendered;
- Feedback on the performance of services and groups of staff from both statutory regulators (such as the General Medical Council and the Nursing and Midwifery Council), the Royal Medical Colleges, and other professional bodies within healthcare;
- Findings and observations from HM Coroner;
- Intelligence fed back from the Integrated Care System on patient experience and satisfaction;
- The discussions and feedback from the local Maternity Voices Partnership;
- Feedback from the various patient support groups supporting specialities across the Trust;
- Direct feedback and triangulation from Director and Governor visits to services.

These sources of intelligence can be fed into the discussions of Board Committees and the Board, to inform debate and triangulate the information provided in papers against the other evidence and intelligence available to the Board.

Next steps

As noted above, this paper has been prepared to support an initial discussion of the matters identified as key by the Inquiry Report, and the matters identified by NHS England for discussion in that context, given the expectation from NHS England of a report at the next public Board meeting following publication of the Inquiry Report.

Following and informed by that discussion, it is intended that there will be a more detailed and in-depth review of the various matters identified for concern in the Inquiry Report, and by NHS England, in the context of this Trust. The intention is to provide a further paper for review and decision by the Board at its public session in January 2023, based on that further review.