Trust Board of Directors

12 January 2023

Report Title:	'Reading the Signs' – ESNEFT response to the investigation into Maternity and Neonatal Services at East Kent Hospitals NHS Trust (October 2022)
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Previously considered by:	Women's and Children's Divisional Management Team

Executive summary

The report of the investigation into Maternity and Neonatal services at East Kent Hospitals NHS Trust entitled "Reading the signals" was published on 19th October 2022. A full action plan with recommendations is pending from the investigation and will be provided to all Trusts for implementation in due course by NHS England/Improvement (NHSEI). It is a requirement for all provider organisations to consider the report in detail, its recommendations and provide an initial overview of the actions being taken in response.

At present four main areas for action have been identified based on the report findings.

These are set out below with actions taken within the Division and across ESNEFT to provide assurance to the Board that the concerns are being mitigated despite further guidance awaited.

Action 1: Monitoring safe performance- finding signals amongst noise

Recommendation: The prompt establishment of a task force with appropriate membership to drive the introduction of valid maternity and neonatal outcome measures capable of differentiating signals among noise to display significant trends and outliers, for mandatory national reporting.

ESNEFT Actions

- Safety Champion meetings occur monthly, chaired by the Chief Nurse (maternity board safety champion), supported by the Chief Medical Officer (neonatal board safety champion), which include a robust review of key outcome measures which are identified as areas of focus for the Trust, based upon trend and outlying data points.
- Maternity Incidents Meeting. A cross divisional meeting occurs weekly designed to be open and transparent regarding incidents and sharing learning across professions.
- Avoiding Term Admissions Into Neonatal units (ATAIN) meetings which occur bi-weekly, reviewing all cases to identify any areas for improvement.
- Transitional care (TC) project: this project is designed to implement and develop physical transitional care units on both sites. Business planning has been undertaken at Colchester, whilst a TC unit based on the neonatal unit is already in place at Ipswich.
- Governance structure review supported by Maternity Improvement Advisors to ensure robust system is in place to ensure early warning signs are identified and to escalate to the clinical and leadership teams accordingly.
- Maternity Investigation process now includes wider MDT for a "Fresh eyes" approach and to ensure all learning is shared from incidents, with associated actions undertaken.

- Shared Incident learning across the LMNS and wider regional learning is in place through cross-organisation sharing. Best practise adopted from regional areas of excellent practise.
- Daily MDT safety huddle to review acuity in the unit and incidents that have occurred in the preceding twenty four hours.

Action 2. Standards of clinical behaviour -technical care is not enough

Recommendation: Those responsible for undergraduate, postgraduate and continuing clinical education be commissioned to report on how compassionate care can best be embedded into practise and sustained through lifelong learning. Relevant bodies including Royal Colleges, professional regulators and employers, be commissioned to report on how the oversight and direction of clinicians can be improved, with nationally agreed standards of professional behaviour and appropriate sanctions for non- compliance.

ESNEFT Actions:

- MDT training takes place to ensure all members of staff work together with established roles in an emergency
- "A day in the life of" communications planned following different staff for a day and sending to all staff to gain insight into each professional's day. This will be sent out as communication to all staff.
- Emotional resilience training has been undertaken by all staff
- Students are supported by specific practice education facilitators and development midwives to ensure soft skills training is in place to support compassionate care delivery
- Leadership training is in place across the division and Trust (emerging/engaging/visible leader programmes) to offer lifelong learning in leadership, which incorporates compassionate leadership skills, understanding of psychological safety for patients and staff, in addition to work on equality, diversity and inclusion.

Action 3: Flawed team working-pulling in different directions

Recommendations: Relevant bodies including the Royal College of Obstetricians and Gynaecology , the Royal College of Midwives and the Royal College of Paediatrics and Child Health be charged with reporting on how team working in Maternity and neonatal care can be improved, with particular reference to establishing common purpose, objectives and training from the outset. Relevant bodies including Health Education England, Royal College and employers, be commissioned to report on the training of junior doctors to improve support, team working and development.

ENSEFT Actions

- Perinatal culture and leadership development programme is underway at ESNEFT. HOM, Head of Operations and Clinical Lead to undertake and complete this course together as a Clinical Leadership Team in January 2023 and runs for six months.
- Cross site collaboration for jobs, job roles, secondments.
- Cross site policies implemented.
- On call cross site roster in place for senior leadership team, ensures senior leadership team have good oversight of pressure on both departments so collaborative plans can be made for provision of care
- National Maternity Support worker framework commenced in September 2022 to ensure all support workers have the same opportunities and feel valued within the workplace.
- Freedom to speak up guardians are available to all staff and meetings take place between HOMS's, RCM representatives and Freedom to speak up Guardians to address concerns raised

Action 4: Organisational behaviour - looking good while doing badly

Recommendations: The Government to reconsider bringing forward a bill placing a duty on public bodies not to deny, deflect and conceal information from families and other bodies. Trusts to be required to review their approach to reputation management and to ensure there is proper representation of maternity care on their boards. NHSE reconsider its approach to poorly performing trusts, with particular reference to leadership.

ESNEFT Actions

- Kings Fund Leadership course (Visible Leader) has been undertaken by several senior leaders and there is plan for all staff to complete in cohorts.
- There are two executive safety champions for maternity and neonatal services on the Board, in additiona to a Non-Executive Director champion.
- Legacy and retention midwives have been recruited to and are working collaboratively to develop a cross-site open culture underpinned by psychological safety frameworks
- Retention midwives meet with new starters and preceptors regularly. Any poor behaviour or issues with not working to Trust values are discussed and fed back to staff identified for ongoing learning and clarity of responsibility, thereby ensuring new starters and junior staff are empowered to raise concerns.
- Band 7 and above staff have attended SDI training to gain insight into team strengths and areas of potential conflict, to better understand each other.
- Delivery Unit Co-ordinators have attended an away day focusing on team work
- Further away days are in place for leaders and co-ordinators focussing on operational escalation are being drawn up.

Several elements that have been put into the action plans cross over and are multifactorial. Such actions will be monitored, with outcomes scrutinised as part of the Every Birth Every Day Programme Board, chaired by the Trust's Chief Executive, to ensure that the recommendations from 'Reading the signs' are embedded within the culture and safety of ESNEFT more widely, and beyond maternity and neonatal services.

Action Required of the Board/Committee
The Board is requested to seek assurance of the response taken by the Trust following the investigation report into maternity and neonatal services East Kent Hospitals NHS Trust in October 2022.

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)*	There is a risk that patients may come to harm should the learning from 'Reading the Signs' not be acted upon by the Trust. Such harms may

	occur within and outside neonatal and maternity services.
Trust Risk Appetite	Workforce: the board is prepared to take decisions that would have an effect on staff morale if there are compelling arguments supporting change, including some decisions with a high inherent risk if there is a potential higher reward.
Legal and regulatory implications *(including links to CQC outcomes, NHSEI, inspections, audits, etc)*	Implications relate to CQC Regulation 12: Safe care and treatment (prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm). Furthermore, there is a clear expectation from NHSEI that the Trust responds appropriately to the findings of the report irrespective of a clear action plan being developed, as evidence of a pro-active safety culture.
Financial Implications	There is a potential for financial implication as a result of the failure to deliver safe services as a result of harm occurring which is similar to that identified in the 'Reading the Signs' report. The Trust sets the ambition to enhance consistent high quality care delivery, thereby minimising the risk of this occurring.
Equality and Diversity	In accordance with the Equality Act 2010 and the Francis Report (2013), and as outlined in the Trust's Quality Strategy the Trust to will ensure that patient safety and patient experience is consistently managed with fairness and transparency ensuring that all staff regardless of their protected characteristics are supported and listened to when raising a concern relating to the quality of care and patient safety and that all staff are included in the development of Patient Safety programmes of improvement.