Lancashire and South Cumbria Integrated Care Board

Integrated Care Board

Date of meeting	7 December 2022
Title of paper	Reading the signals Maternity and neonatal services in East Kent – the Report of the Independent Investigation
Presented by	Professor Sarah O'Brien, Chief Nurse
Author	Vanessa Wilson – Director Children, Young People and Maternity
Agenda item	12 (a)
Confidential	No

Purpose of the paper

Following the recent publication of the report into maternity services in East Kent, NHSE wrote to all Trust Chief Executives, Trust Chairs, ICB Chief Executives and LMNS (Local Maternity and Neonatal System) Chairs with the following:

'We expect every Trust and ICB to review the findings of this report at its next public board meeting, and for boards to be clear about the action they will take, and how effective assurance mechanisms are at 'reading the signals'.'

The purpose of this paper is to summarise the findings of the East Kent report and outline the actions being taken across Lancashire and South Cumbria.

Executive summary

The report by Dr Bill Kirkup into maternity services at East Kent Hospitals University NHS Foundation Trust (East Kent) published on 19 October 2022 has revealed how substandard care, a dangerous culture and a failure by the Trust's management to act on warnings contributed to the deaths of at least 45 babies spanning an 11-year period.

These devastating findings underscore the fact that the necessary changes in practice and culture have not been fully incorporated across the NHS following previous NHS maternity scandals and national reports.

The East Kent report draws upon the experience of patients, key interviews with families and medical records to provide conclusions and lessons in relation to the Trust's approach to risk management and service delivery from ward to Board. In its scope, the report examines how the Trust responded to – and sought to learn lessons from – not only failings in individual cases in which there were avoidable deaths or harm, but also the wider signalling of problems within maternity services.

The report identifies four areas for action, which are described as:

The NHS could be much better:

-at identifying poorly performing units
-at giving care with compassion and kindness
-at teamworking with a common purpose
-at responding to challenge with honesty

Dr Kirkup considers that a proper standard of care could have improved the outcome in at least 97 of the 202 cases investigated, preventing the deaths of at least 45 babies.

Maternity and neonatal services nationwide must embark on a process of addressing the need for stronger, multi-disciplinary team-working, for open and honest disclosure and learning over concealment and deflection, and for compassionate care to form the bedrock of clinical practice. A suite of purposeful and timely outcome measures must be used by clinicians, regulators and the public in order to ensure that the findings of the Kirkup Report, along with the plethora of sources which in recent years have clearly evidenced significant problems in maternity services, are implemented in a meaningful way.

The vision of the Kirkup Report can be delivered through locally led and managed transformation, with support at national and regional levels, in order to ensure a higher quality of maternal and neonatal care for mothers and babies.

Recommendations

The Board is asked to note the content of the report and the actions being taken by the LSC Maternity and Newborn Alliance (as the maternity arm of the ICB) to ensure quality and safety oversight of the 4 maternity service providers, to enable early identification of problems, provide support and collaboration and ensure a culture of shared learning and understanding.

Governance and reporting (list other forums that have discussed this paper)

Meeting	**Date**	**Outcomes**
Local Maternity and Newborn Alliance Board	2nd December 2022	Discussed the content of the East Kent report rather than this specific report
Maternity and Newborn Quality Assurance Panel	15th November 2022	Discussed East Kent report and local actions

Conflicts of interest identified

'not applicable'

Implications

If yes, please provide a brief risk description and reference number	**Yes**	**No**	**N/A**	**Comments**
Quality impact assessment completed		x		
Equality impact assessment completed		x		
Data Privacy impact assessment completed		x		

Financial impact assessment completed		x		
Associated risks	x			Logged at provider Trusts and for LMNS
Are associated risks detailed on the ICB Risk Register?				

Report authorised by:	Prof Sarah O'Brien – Chief Nurse

Reading the signals
Maternity and neonatal services in East Kent – the Report of the Independent Investigation

1. Introduction

1.1 The East Kent report of the independent investigation into Maternity and Neonatal services in East Kent by Dr Bill Kirkup CBE was published on 19th October 2022.

1.2 The report follows Dr Kirkup's independent investigation commissioned by NHS England and NHS Improvement in response to the number of avoidable baby deaths and concerns raised about the quality and outcomes of maternity and neonatal care at East Kent in recent years. Dr Kirkup investigated the circumstances, management, service delivery and outcomes of care provided by the maternity and neonatal services at East Kent since 2009. Drawing upon the methodology he had followed in the Morecambe Bay investigation, he appointed independent experts, including obstetrics, midwifery, neonatology and paediatrics, and had conversations with affected families – enabling them not only to be heard, but to help inform key lines of enquiry.

1.3 The investigation involved 202 families and reviewed 11 years of maternity provision on 2 hospital sites.

1.4 Over the 11 years there were 8 missed opportunities to expose the poor practice with various inspectorates visiting and reviewing the services as well as significant service user complaints.

1.5 Following the report publication, a letter was sent to all Trust and ICB Chief Executives from Sir David Sloman (NHSE), Dame Ruth May (Chief Nursing Office) and Professor Stephen Powis (National Medical Director) requesting that the report should be presented at the next ICB public board meeting and for boards to be clear about the action they will take, and how effective assurance mechanisms are at 'reading the signals'.

1.6 NHSE will publish a single delivery plan in 2023 for maternity and neonatal care which will combine actions required following this report, the report into maternity services at Shrewsbury and Telford NHS Foundation Trust, the NHS Long-Term Plan and the Maternity Transformation Programme deliverables. However, the expectation is that this should not delay systems acting on the recommendations from this and the Shrewsbury and Telford report.

2. Summary findings:

2.1 The report outlined several failures.

- Failures of teamworking
- Failures of professionalism
- Failures of compassion
- Failures to listen
- Failure to change dysfunctional behaviours after incidents
- Failure in Trust's response, including at Trust board level

2.2 In the open letter to the Secretary of State for Health and Social care and Deputy Prime Minister and the Chief Executive of the NHS, Dr Kirkup states:

'This Report identifies four areas for action. The NHS could be much better at identifying poorly performing units, at giving care with compassion and kindness, at teamworking with a common purpose, and at responding to challenge with honesty. None of these are easy or necessarily straightforward because longstanding issues become deeply embedded and difficult to change. Nor do I pretend to have the answers to how best they should be tackled: they require a broader-based approach by a wide range of experienced experts. But unless these difficult areas are tackled, we will surely see the same failures arise somewhere else, sooner rather than later. This Report must be a catalyst for tackling these embedded, deep-rooted problems'.

In addition, Dr Kirkup states - *'Above all, we must become serious about measuring outcomes in maternity services. The approach must be mandatory, not optional. I am ready to discuss and explain further how this can best be done'.*

2.3 The poor outcomes cannot be explained or justified by geography, distance, demographics, estates, single shortcomings or individual error.

2.4 Had care been given to nationally recognised standards, the outcomes could have been different in 97 of the 202 cases the Panel assessed (48%), and it could have been different in 45 of the 65 cases of baby deaths (69.2%).

2.5 In the 25 cases involving injury to babies, 17 involved brain damage. This included hypoxic ischaemic encephalopathy (HIE, and/or cerebral palsy attributable to perinatal hypoxia. Had care been given to nationally recognised standards, the outcome could have been different in 12 of these 17 cases (70.6%).

2.6 In the 32 cases involving maternal injuries or deaths, the Panel's findings are that in 23 (71.9%), had care been given to nationally recognised standards, the outcome could have been different.

3. Areas for Action

3.1 The report highlights:

- An unacceptable lack of compassion and kindness
- A grossly flawed teamworking
- Internal and external denial

3.2 The report has not sought to identify multiple detailed recommendations as NHS trusts already have many recommendations and action plans resulting from previous initiatives and investigations (of which this report supports). Instead, four broad areas for action have been identified and none are susceptible to easy analysis or a "quick fix".

- Key Action Area 1: Monitoring safety performance – finding signals among noise

  Recommendation: establishment of a task force with appropriate membership to drive the introduction of valid maternity and neonatal outcome measures capable of differentiating signals amongst noise to display significant trends and outliers.

- Key Action Area 2: Standards of clinical behaviour – technical care is not enough

  Recommendation: for action by those who train undergraduates, postgraduates and continuous clinical learning and Royal Colleges/Regulators

- Key Action Area 3: Flawed teamworking – pulling in different directions

  Recommendation: for action by those who train undergraduates, postgraduates and continuous clinical learning and Royal Colleges/Regulators

- Key Action Area 4: Organisational behaviour – looking good while doing badly

  Recommendations: Trusts be required to review their approach to reputation management and to ensuring there is proper representation of maternity care on their boards.
  NHSE consider its approach to poorly performing trusts with reference to leadership.
  A Bill to be passed placing a duty on public bodies not to deny, and defect and conceal information from families and other bodies

4. Actions to be taken by LSC LMNS/ICB to ensure assurance mechanisms are effective at reading the signals?

4.1 A senior midwife has been appointed as the Associate Director for the LSC LMNS who has experience as a Regional Chief Midwife and currently holds the position of Senior Clinical Quality Lead for maternity within the Regional Nursing Directorate. With her extensive experience and connections, she will be perfectly placed to lead on LSC Maternity Quality along with a Safety lead midwife and the Maternity Safety and Quality Manager.

4.2 In advance of the 2023 NHSE single delivery plan, the LMNS will continue to have oversight over provider deliverables as per the Perinatal Quality and Safety Framework via the Quality Assurance Panel and escalation to ICB Quality Committee and Regional Quality surveillance and Concerns Group.

4.3 The LMNS will work with the ICB Quality Assurance team, the regional maternity team and the CQC to develop and act on early warnings of problems before they cause significant harm. This will include reporting concerns to the NW Regional Perinatal Safety, Surveillance and Concerns group in addition to oversight and monitoring via the Regional Heatmap.

4.4 The LMNS will continue to:

- Build robust relationships with provider maternity leadership teams to allow for transparent reporting and open conversations
- develop and support an open culture of sharing information and learning in a structured and systematic way, working with partners to turn learning into service improvement
- monitor and review the reporting by providers against the metrics defined in the Quality Assurance Matrix (Appendix A)
- monitor trends and themes from PMRT reviews and HSIB investigations,
- monitor trends from Serious incidents and share learning across the ICB,
- Interrogate the maternity dashboard for outliers and work with the Clinical Network Safety Special Interest Group to identify quality improvement programmes
- Review and support delivery of Ockenden action plans and workforce development.

5. Conclusion

5.1 The Report of the Independent Investigation into maternity services in East Kent was published on 19th October 2022. The report sets out the devastating consequences of failings and the unimaginable loss and harm suffered by families.

5.2 This report reconfirms the requirement for all boards to remain focused on delivering personalised and safe maternity and neonatal care. Boards must ensure that the experience of women, babies and families who use maternity services in LSC are listened to, understood and responded to with respect, compassion and kindness.

5.3 The experiences bravely shared by families with the investigation team must be a catalyst for change. Every board member must examine the culture within the ICS itself and within the constituent provider organisations and ensure staff are listened and responded to. Steps must be taken to assure board members, and the communities they serve, that the leadership and culture across organisation(s) positively supports the care and experience provided.

6. Recommendation

6.1 The Board is requested to note the contents of the report and the measures that are in place to quality assure the maternity services delivered across LSC.

Vanessa Wilson

Director Childrens, Young People and Maternity

11.11.22

For reference purposes the following documents can be found here:

- Reading the signals: maternity and neonatal services in East Kent, the report of the independent investigation (print ready) (healthierlsc.co.uk)
- PowerPoint summary of the East Kent report
- Letter to all Trust and ICB Chief Executives from Sir David Sloman (NHSE) Dame Ruth May (Chief Nursing Officer) and Professor Stephen Powis (National Medical Director)

Appendix A

LMNS Quality Assurance Process

The following information will be collated and analysed:

Provider assurances needed	ICB	LMNS
CQC assessment of maternity services	To engage in action plans resulting from CQC inspections and provide assurances to LMNS re progress / challenges	To escalate any challenges to Regional team as required To understand CQC position re the whole system
Ockenden essential actions	Assurances against implementation with action plan if needed	Gap analysis identifying improvements required across the system
CNST requirements	Assurances and action plan against requirements	System position to be identified with any themes against non – achievement
Saving Babies Lives bundle 2	Updates against provider progress for implementation	Report any challenges and barriers to implementation
StEIS reportable incidents **Regulation 28 incidents**	Share 72hr reviews / reports / invite to SI panel **MLCSU team will provide an update of all reported incidents at each LMNS Assurance Panel, along with a 6mthly thematic review Share with LMNS and NHSE/I	Theme by provider and as a system – escalation if required as a system to ensure early improvement / actions Ensure learning is shared with the system and evidence of implementation obtained
HSIB trust and national reports	Share HSIB reports	Identify any safety requirements that may need to be implemented following publication of national HSIB reports e.g. HSIB intrapartum stillbirth report
MBRRACE & PMRT reports	Trusts to share themes – nb there is sometimes an overlap here with StEIS	Identify early system themes and escalate as necessary
FFT test **MVP feedback**	Trends to be monitored and any causes for concern identified Understand local challenges and pass on issues as necessary	Collate as a system Collate as a system, acting upon concerns as required
Staff FFT **Learner Feedback**	Any causes for concern to be identified Feedback from trainees (obstetric and midwifery to be collated)	Collate as a system, understand the challenges and pressures, ensuring action places are in place when required Escalate any issues regionally Share good practice
National CQC maternity survey	Any concerns to be shared along with corresponding action plan	Collate as a system and follow up progress against action plans
Complaints	To report any trends and themes or serious complaints affecting the quality of maternity services	Collate as a system and escalate as required
Horizon scanning for maternity related issues (nationally)	Ensure national issues and reports are reviewed I.e. recent reports include: the-solution-series-4-making-maternity-services-safer-nurturing-a-positive-culture-v3.pdf (rcm.org.uk)	Raise awareness and plan next steps if issues identified

	Safety, equity and engagement in maternity services | Care Quality Commission (cqc.org.uk) These should be reviewed in line with knowledge of local providers with gaps and concerns escalated	
Soft intelligence	Collate and monitor soft intelligence, escalating as appropriate	

Safety Improvement Group outputs	**NW Strategic Coast**	**LMNS**
Outlier reports	Monthly returns to be shared with LMNS as per process	Ensure appropriate actions and follow up is in place
National guidance	Any known gaps in service compliance to be shared by collating from maternity safety champions	Ensure the governance process is followed to obtain provider assurances re compliance and implementation
Maternity dashboard (system wide)	Dashboard to be analysed and shared with LMNS via the outlier report process (appendix c)	System wide concerns to be acted upon