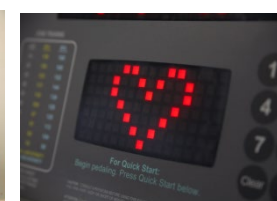


Reading the signals: Maternity and Neonatal Services in East Kent - the Report of the Independent Investigation

Maternity Leadership Team
Board of Directors (Open)
10 November 2022



Background:



Bradford Teaching Hospitals
NHS Foundation Trust

- Report examines the maternity services at The Queen Elizabeth The Queen Mother Hospital (QEQM) and the William Harvey Hospital (WHH), part of East Kent Hospitals University NHS Foundation Trust, between 2009 and 2020.
- Investigation conducted by Dr Bill Kirkup CBE.
- Published on 19 October 2022.
- Letter to Trusts from Ruth May, Stephen Powis and David Sloman sent on 20 October 2022, requesting that every Trust and ICB review the findings of the 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'.

Key Findings:



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- Failures of team working
 - Lack of respect and mutual trust between disciplines
 - Failure to recognise and escalate concerns
 - Culture of bullying, cliquey behaviour, tribalism, blame
- Failures of professionalism
 - Staff groups disrespectful and disparaging about each other in front of women and families
 - Blaming women when things go wrong
 - Deflecting responsibility when things went wrong
 - Midwives not 'in favour' allocated the highest risk women and challenged to achieve delivery with no intervention

Key Findings:



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- Failures of compassion
 - Care delivered without basic compassion and kindness
 - Multiple examples of uncompassionate care
 - Women ignored or disbelieved when in pain
- Failures to listen
 - Repeated failures to listen to women and families regarding theirs or their babies health
 - Failures to listen contributed to poor clinical outcomes and contributed to poor experience

Key Findings:



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- Failures after safety incidents
 - Lack of care and sympathy following safety incidents
 - Lack of compassion
 - Denied responsibility when things went wrong, or even that anything had gone wrong
 - Blame apportioned to the mother
 - Failure to communicate openly with families
 - Safety investigations conducted narrowly and defensively, if at all
 - False reassurance provided rather than acknowledgement and learning from errors
 - Apportioning blame to junior obstetricians and midwives

Key Findings:



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- Failure in the Trust's response, including at Trust Board level
 - Trust had a tendency to attribute cause to individual clinical error
 - Disposition towards minimising the problems
 - Failure to confront and address bullying and divisive behaviours
 - Critical weakness exercising control in relation to consultant behaviours
 - Trust was disposed to replace staff in key managerial roles who identified/challenged poor behaviour
 - Remaining staff personified the poor culture or were prepared to live with it
 - Trust Board missed several opportunities to identify the scale and nature of the problems and put them right

Key Findings:

- Failure in the Trust's response, including at Trust Board level
 - Trust Board focus on other challenges, AED, cancer targets
 - Focus on action plans masked the scale and nature of problems
 - Repeated turnover of staff including CEO- 'heroic leadership'

Recommendations



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- Kirkup has taken a different approach on the basis that the traditional approach has not worked.
- There are 4 broad areas for action rather than multiple detailed recommendations.
- Previous recommendations and policy initiatives from other maternity reports are taken as a given.

Key Action Area 1:



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- **Monitoring safe performance- finding signals among noise**
- 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 use.

- **Standards of clinical behaviour- technical care is not enough**
- Those responsible for undergraduate, postgraduate and continuing clinical education be commissioned to report on how compassionate care can best be embedded into practice 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.

Key Action Area 3:



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- **Flawed team working - pulling in different directions**
- Relevant bodies, including the Royal College of Obstetricians and Gynaecologists, 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 Colleges and employers, be commissioned to report on the employment and training of junior doctors to improve support, team working and development.

Key Action Area 4:

- **Organisational behaviour-looking good while doing badly**
- The Government reconsider bringing forward a bill placing a duty on public bodies not to deny, deflect and conceal information from families and other bodies.
- Trusts be required to review their approach to reputation management and to ensuring there is proper representation of maternity care on their boards.
- NHSE reconsider its approach to poorly performing trusts, with particular reference to leadership.

Reflections on the report



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- The description of the culture and behaviours of staff and the subsequent impact on outcomes for women and babies is a difficult read.
- Total lack of disrespect for each other, women and families stands out.
- Whilst improving culture and team working are key threads within BTHFT OMS programme, East Kent does not reflect what it feels like to work at Bradford.
- Kirkup's different approach is welcomed giving key areas for focus rather than a 'tick box' recommendation/action plan approach.

Actions for BTHFT



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- Presentation of the report to Open Board.
- No other immediate action requested at regional or national level as yet.
- Anticipated that Trust's will be asked to benchmark themselves against the report by spring time with a particular focus on culture.
- Regional offer for Trust's to take part in the perinatal culture and leadership development programme.
- BTHFT invited to join phase 1 of this programme which starts in January 2023 this will include completing the SCORE survey.

- Review existing data and information regarding culture:
 - Staff Survey results
 - National Maternity Survey results
 - GMC junior doctor survey
 - Neonatal culture survey results
 - Freedom To Speak Up data
 - Complaints, particularly around staff attitude and behaviours and not listening to women balanced with compliments received
 - Friends and Family results

Actions for BTHFT



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- Dashboard and data
 - Improving the data quality, reporting mechanisms and content of the existing maternity dashboard so that it supports recommendation 1 and the anticipated mandatory national dashboard

Actions for BTHFT



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NHS Foundation Trust

- Listening to women and families
 - Continue to foster and develop the great relationship with the local Maternity Voices Partnership
 - Co-production of services and guidelines, MVP representation on work stream working groups
 - MVP and service user representation at integral meetings such as OMS Board, Women's Core Governance, Maternity Services Forum

Actions for Trust Board



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- Recommendation 4: Trusts be required to review their approach to reputation management and to ensuring there is proper representation of maternity care on their boards.
 - Well embedded monthly reporting structure
 - DOM attendance at Board in place? Expand this to CD's for obstetrics and neonates
 - Maternity Safety Champion culture also well embedded
 - ? Increase Executive and Non-executive attendance at maternity governance meetings/PMRT/audit to increase challenge and appreciative enquiry of events
 - Continue to foster the open and honest culture with families

Recommendations for Trust Board



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Trust Board is asked:

- To note the content of the presentation, the work currently being undertaken and the new work planned
- To give continued commitment to the OMS Programme and acknowledgement that this will be one of the key drivers in delivering any future recommendations from the report
- To give continued commitment to receiving maternity services update reports to each Public Board



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Thank You

Questions?