NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care Board

Date of meeting: 15 November 2022	**Paper no:**09

Title of paper: Maternity: Initial response to **Reading the signals:** Investigation into maternity and neonatal services in East Kent by Dr Bill Kirkup

Paper is for:	delete tick as appropriate	**Discussion**	√	**Decision**		**Information**	√

Purpose and executive summary:

- This paper gives a brief overview of The Local Maternity and Neonatal System (LMNS) work underway in response to the report **'Reading the Signals'**[1] (Kirkup, 2022) and the status of maternity and neonatal services in the Buckinghamshire, Oxfordshire and Berkshire West (BOB) system. The report details significant failings at Queen Elizabeth The Queen Mother Hospital (QEQM) in Margate and the William Harvey Hospital (WHH) in Ashford, Kent.
- NHS England (NHSE) have asked all Trusts and Integrated Care Boards (ICBs) to review the findings of the report and outline the actions being taken and the assurance mechanisms in place to respond to the recommendations within the report.
- The ICB have previously noted the actions underway across the Local Maternity and Neonatal System (LMNS) to implement the recommendations from the Ockenden report - Final (Ockenden, 2022[2]). The Ockenden Report details failings over a number of years, and describes a culture where women and families were not listened to, their choices not supported, of staff and hierarchical structures that prohibited escalation of concerns and promoted the egos of those in charge.
- The result of these care failings were a significant number of baby deaths and brain injuries, which were avoidable, and trauma to women and families that has far-reaching impacts.
- This Kirkup report, which comes approximately six months after the publication of The Ockenden Report – Final (Telford and Shrewsbury Foundation Trust), has once again turned the spotlights onto maternity and neonatal services and impresses on all commissioners, providers and stakeholders to closely examine their services and the care they provide. In addition, there is a recommendation for the culture and practices of staff within maternity and neonatal services to be rigorously assessed and challenged where necessary.
- The Chief Nursing Officer will present a more detailed report to the Population Health and Patient Experience Committee, outlining the assurance against the actions being taken and areas for improvement across all three providers before a further report is presented to the ICB in January 2023.

[1] Reading the signals: Maternity and neonatal services in East Kent – the Report of the Investigation Findings. Dr Bill Kirkup October 2022 http://www.gov.uk/official-documents

[2] Ockenden Report – Final. Findings, conclusions and essential actions from the independent review of maternity services at The Shrewsbury and Telford Hospital NHS Trust. Donna Ockenden. March 2022 http://www.ockendenmaternityreview.org.uk

Financial implications of paper:

Monies received from NHS England directly to the LMNS have all been allocated to various workstreams in response to the requirements from the national maternity transformation programme. These monies did not include specific funding for equity strategies. However, the LMNS have continued to pursue equity as a 'golden thread' in all the transformation work at system level, as well as supporting the trusts at place to ensure this is captured in every area of service.

Action required:
The Integrated Care Board are invited to discuss and note the information contained within this report.

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Date of paper: 4 November 2022

Conflicts of Interest
None for the purpose of this paper

No conflict identified	✓
Conflict noted: conflicted party can participate in discussion and decision	
Conflict noted, conflicted party can participate in discussion but not decision	
Conflict noted, conflicted party can remain but not participate in discussion	
Conflict noted, supported paper withheld from conflicted party e.g. pecuniary benefit	
Conflicted party is excluded from discussion	

Maternity: Initial response to **Reading the signals;** Investigation into maternity and neonatal services in East Kent by Dr Bill Kirkup

Background

1. The **Ockenden Report - Final** (Ockenden, 2022) was published following the investigation into the failings at Shrewsbury and Telford NHS Trust maternity services in March 2022, set out Immediate and Essential Actions (IEAs) that every provider of maternity and neonatal services must take.

2. In October 2022, **Reading the signals -** Investigation into maternity and neonatal services in East Kent, by Dr Bill Kirkup, was published detailing the consequences of harm and failings in relation to care of women and babies at this Trust. In response to this, NHS England have asked all NHS Boards to review the report in detail and ensure that the experience of women, babies and families who use maternity and neonatal services are listened to, understood and responded to with respect, compassion and kindness.

3. NHS England have worked alongside the Local Maternity and Neonatal System (LMNS) colleagues and members of the Maternity Voice Partnership (MVP) to undertake assurance visits in all providers of maternity and neonatal services. All three providers of maternity and neonatal services across the BOB system have had positive assurance visits. Any additional actions that the Trusts need to take following these visits will be incorporated into their existing transformation plans and monitored through the LMNS and Trust governance processes.

4. In 2023, NHS England will publish a delivery plan for maternity and neonatal care which will bring together the actions required following the publication of the Kirkup report, the report into maternity services at Shrewsbury and Telford NHS Foundation Trust and NHS Long-Term Plan and Maternity Transformation Programme deliverables. The LMNS, in collaboration with the Trusts, continue to drive forward immediate and sustainable actions that will save lives and improve the care and experience for women, babies and their families.

Reading the signals - Investigation into maternity and neonatal services in East Kent

5. From 2010 onwards a number of reviews raised concerns about maternity services in East Kent. The investigation reviewed 202 cases where the families involved felt care fell within the scope of the investigation.

6. The full report can be found through the link below. Members of the Board are invited to read and consider the details within the report.
Reading the signals - Maternity and neonatal services in East Kent – the Report of the Independent Investigation (publishing.service.gov.uk)

7. The report highlighted ***four*** key areas of action for the NHS:

    - Monitoring safe performance – finding signals among noise

There will be a prompt review of maternity and neonatal outcome measures that will allow the display of significant trends and outliers. There will be a retrospective review of the current available data to identify any key themes and trends. This work will commence across the LMNS and with the Trusts immediately pending further guidance from NHSE on national metrics.

- Standards of clinical behaviour – technical care is not enough
  There will be an immediate and thorough review of historical cultural surveys, staff surveys and clinical education surveys in every Trust in order to identify key themes and trends.
- Flawed teamworking – pulling in different directions
  In addition to the action above the LMNS will work with regulators and professional bodies to review historical feedback across all professional groups.
- Organisational behaviour – looking good while doing badly
  Support for trusts to be open, honest and transparent about their maternity and neonatal services will continue with assurance visits continuing and planned with all partners, including the MVP to ensure wide and diverse representation.

Next Steps

8. The ICB are asked to discuss and note the content of this report, including the initial actions in place to address the recommendations within the report.

9. However, recruiting staff into maternity and neonatal servicesis our biggest challenge and focus .

10. The Chief Nursing Officer will present a more detailed report to the Population Health and Patient Experience Committee, outlining the assurance against the actions being taken and areas for improvement across all three providers, before a further report is presented to the ICB in January 2023.