NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet template and Guidance for all governance meetings

All reports MUST have a cover sheet

Subject:	East Kent Report-Sherwood Forest Hospital Response	**Date**: 1st December 2022
Prepared By:	Paula Shore, Director of Midwifery/ Head of Nursing	
Approved By:	Phil Bolton, Chief Nurse	
Presented By:	Paula Shore, Director of Midwifery/ Head of Nursing, Phil Bolton, Chief Nurse	

Purpose

To update the board in regards to the findings and our actions

Approval	
Assurance	X
Update	X
Consider	

Strategic Objectives

To provide outstanding care	To promote and support health and wellbeing	To maximise the potential of our workforce	To continuously learn and improve	To achieve better value
X	X		X	

Identify which principal risk this report relates to:

PR1	Significant deterioration in standards of safety and care	X
PR2	Demand that overwhelms capacity	
PR3	Critical shortage of workforce capacity and capability	
PR4	Failure to achieve the Trust's financial strategy	
PR5	Inability to initiate and implement evidence-based Improvement and innovation	
PR6	Working more closely with local health and care partners does not fully deliver the required benefits	
PR7	Major disruptive incident	
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change	

Committees/groups where this item has been presented before

Maternity and Neonatal Safety Champions Meeting

Executive Summary

Following concerns raised about the quality and outcomes of maternity and neonatal care, Dr Bill Kirkup undertook an independent investigation into maternity and neonatal services at East Kent Hospitals University NHS Foundation Trust. The report wanted to find the truth of what happened, so that maternity services in East Kent can begin to meet the standards expected nationally.

Through the review the report identified 4 areas for action:

- Monitoring safety performance – finding signals among noise
- Standards of clinical behaviour – technical care is not enough
- Flawed teamworking – pulling in different directions
- Organisational behaviour – looking good while doing badly

The below paper outlines the SFHT updates and actions following this report.

Background

Since the report of the Morecambe Bay Investigation in 2015, Dr Bill Kirkup summarised that maternity services have been the subject of more significant policy initiatives than any other service, yet, since then, there have been major service failures in Shrewsbury and Telford, in East Kent, and (it seems) in Nottingham.

The report into the care at East Kent concluded that had care been given to nationally recognised standards, the outcome could have been different in 97 of the 202 cases (48%), and it could have been different in 45 of the 65 cases of baby deaths (69.2%). Dr Bill Kirkup noted that if we do not begin to tackle this differently, there will be more.
For that reason, this Report is somewhat different to the usual when it comes to recommendations

This is also supported by the themes which are identifiable between the Ockenden and East Kent Report, these being;

Lack of good governance and data analysis
Culture
Multi-disciplinary Team Working
Conflict
Women's feedback on experience and involvement in investigations
Organisational behaviours
Leadership appointments
Open and honest ethos

For these reasons, the East Kent Report's recommendation are different to the usual when it comes to recommendations. Unlike the Ockenden Report, it has not provided any NHSE/LMNS lead actions. Dr Bill Kirkup notes the actions below are not likely to be easily addressed or necessarily straightforward, because longstanding issues become deeply embedded and difficult to change, which they require a broader-based approach by a wide range of experienced experts.

1.Monitoring safety performance – finding signals among noise
2.Standards of clinical behaviour – technical care is not enough
3.Flawed teamworking – pulling in different directions
4.Organisational behaviour – looking good while doing badly

SFHT Response and Actions

Currently NHS England are out for consultation nationally around a revised maternity and neonatal services refreshed single delivery plan. The expectation is that this will include a single reporting framework maternity service. Whilst awaiting the response to this the teams have.

Noted through the governance forums within the Division
Benchmark practice at SFHT against the four identified key action areas
Update the Board through the Maternity and Neonatal Safety Champion Paper

The Board are asked to note the contents of this paper.