Kingston Hospital NHS Foundation Trust

KIRKUP REPORT

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

Meeting: Trust Board	**Item: 8**
Date: 30 November 2022	**Enclosure: E**

Executive Summary

On 13 February 2020 the Minister of State, DHSC, confirmed in Parliament that, following concerns raised about the quality and outcomes of maternity and neonatal care, NHS England and NHS Improvement (NHSEI) had commissioned Dr Bill Kirkup CBE to undertake an independent investigation into maternity and neonatal services at East Kent Hospitals University NHS Foundation Trust. The report was published on 19 October 2022

The report sets out the truth of what happened, so that maternity services in East Kent can begin to meet the standards expected nationally and identifies four areas for action. The NHS could be much better at:

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

For: Information ☐ **Assurance** ☒ **Discussion and input** ☐ **Decision/approval** ☐

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Risk Implications – Link to Assurance Framework or Corporate Risk Register:	N/A
Legal / Regulatory / Reputation Implications:	
Link to Relevant Strategic Theme:	-
Document Previously Considered By:	- SEMC

Recommendations:
The Board is asked to note the report and national actions.

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

Background

The Panel examined the maternity services in two hospitals, the Queen Elizabeth The Queen Mother Hospital (QEQM) at Margate and the William Harvey Hospital (WHH) in Ashford, between 2009 and 2020. Responsibility for these services lay with East Kent Hospitals University NHS Foundation Trust.

The review identified a clear pattern. Those responsible for the services too often provided clinical care that was suboptimal and led to significant harm, failed to listen to the families involved, and acted in ways which made the experience of families unacceptably and distressingly poor.

The individual and collective behaviours of those providing the services were visible to senior managers and the Trust Board in a series of reports right through the period from 2009 to 2020 and lay at the root of the pattern of recurring harm. At any time during this period, these problems could have been acknowledged and tackled effectively. Eight separate opportunities were identified when that could and should have happened.

Harm was not restricted to physical damage. The report identifies the disturbing effects of the repeated lack of kindness and compassion on the wider experience of families, both as care was given and later in the aftermath of injuries and deaths.

It is apparent that the Trust failed to read the signals and missed opportunities to put things right. The authors are clear that this needs to be stated and acknowledged, or there is a real danger that the Investigation will become yet another missed opportunity, not only in East Kent but elsewhere.

Key Findings and Recommendations

The panel have put forward recommendations which are different from the norm and have not sought to identify multiple detailed recommendations.

They acknowledge that NHS trusts already have many recommendations and action plans resulting from previous initiatives and investigations, and have not added further detailed recommendations that would inevitably repeat those made previously, or conflict with them, or both. Instead, they have identified four broad areas for action based firmly on the findings but with much wider applicability. None are susceptible to easy analysis or a “quick fix”, as the traditional approach has not worked:

Key Action Area 1: 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

Key Action Area 2: 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: Flawed teamworking – 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 teamworking 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, teamworking 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.

The Board is asked to:

Note the content of the Kirkup report and associated action for Trusts.