East Kent Hospitals University NHS Foundation Trust

FREEDOM OF INFORMATION REQUEST

RF24-026

Request:

For the calendar years 2019, 2020, 2021, 2022, and 2023, please provide:

1. The number of midwifery "red flag" incidents (examples provided here: https://www.nice.org.uk/guidance/ng4/chapter/recommendations#box-3-midwifery-red-flag-events) identified in your maternity departments, broken down by year
   - If your organisation has other "red flag" incidents agreed locally, please specify what they are and how many occurred per year
   - Of these, please specify how many of these incidents (as a proportion - i.e. 65%, and the raw number) related to staffing levels. NHSE guidelines state that the midwife in charge should document whether midwifery staffing is the cause: https://www.england.nhs.uk/wp-content/uploads/2021/05/safe-staffing-maternity-apendices.pdf
2. Please also specify the number of times patients needed to be diverted to other trusts to deliver their baby, broken down by year
   - Of those, please break down (again as a proportion and raw number) how many diverts were
     - a) due to a lack of staff
     - b) for other reasons, please provide details

Response:

We can confirm East Kent Hospitals University NHS Foundation Trust (EKHUFT) holds the information you have requested.

1. Please note we only hold Birthrate+ red flag data from June 2021.

   Please note that we are unable to determine how many red flags were specifically down to staffing levels. We have therefore provided the number and percentage of red flags.

	2021		2022		2023	
Red Flag	**Number**	**%**	**Number**	**%**	**Number**	**%**
Delayed or cancelled time critical activity	7	4.4%	27	7.8%	8	6.9%
Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	9	5.6%	23	6.7%	3	2.6%
Coordinator not able to maintain supernumerary/supervisory status	46	28.8%	94	27.3%	10	8.6%
Delay between admission for induction and beginning of process - Delay of 2 hours or more	77	48.1%	149	43.3%	81	69.8%
Delay between presentation and triage - Delay of 30 minutes or more	5	3.1%	5	1.5%	0	0.0%
Delay in providing pain relief - Delay of more than 30 minutes	9	5.6%	25	7.3%	9	7.8%
Delayed recognition of and action on abnormal vital signs (for example sepsis or urine output)	0	0.0%	2	0.6%	0	0.0%

Full clinical examination not carried out when presenting in labour	0	0.0%	1	0.3%	0	0.0%
Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	1	0.6%	1	0.3%	0	0.0%
Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	6	3.8%	17	4.9%	5	4.3%
Total	**160**	**100.0%**	**344**	**100.0%**	**116**	**100.0%**

2. The majority of our diverts are between our own hospitals - the Queen Elizabeth the Queen Mother Hospital (QEQM) and the William Harvey Hospital (WHH). Please see the below for the incidents on the diverts/closures to other Trusts:

   - Diversion to Darenth Valley on 11th Feb 2023. There is no record of how many women may have been diverted. Reason given is both units were full to capacity.
   - Diversion to Medway on 1st May 2022. Documented as one woman transferred. Reason given was Neonatal Unit was 'Black'.
   - Diversion from WHH to QEQM and Medway on 7th March 2020. Documented as two women affected (but not recorded if they went to QEQM or Medway). Reason given is 'Acuity 5'.

(DATE OF RESPONSE: 30 JANUAY 2024)