Norfolk & Norwich Maternity Services Liaison Committee

Minutes of meeting held on Tuesday 14th July 2015

Present

Lisa Brophy.....	(LB)	MSLC Chair
Rachel Graveling	(RG)	MSLC Vice-Chair
Martin Cameron.....	(MC)	Clinical Director of Obstetrics, NNUH
Elizabeth Turner	(ET)	Research Midwife NNUH
Pam Sizer	(PS)	Community Midwifery Matron
Jane Fuller.....	(JF)	Commissioning NEL CSU Representative
Rebecca Champion	(RC)	Engagement Manager North Norfolk CCG
Jackie Heffer-Cooke	(JHC)	Service User Representative
Catherine Lock.....	(CL)	Delivery Suite Co-ordinator
Dilly Turton.....	(DT)	Health Watch Norfolk
Lorna Hughes	(WS)	NCH Health Visiting Team Leader South
Tracey Andrews.....	(TA)	Improvement Officer Children's Centres Norfolk
Annabel Trick.....	(AT)	Family Nurse Partnership
Rachel Scarff	(RS)	MSLC Co-ordinator

1. Apologies for absence

Glynis Moore.....	(GM)	Head of Midwifery, NNUH
Felicity Hancock.....	(FH)	Breastfeeding Peer Supporter
Karen Dunlop.....	(KD)	MLBU Midwife / Supervisor of Midwives
Barbara Jackson.....	(BJ)	Antenatal Ward Manager
Sian Verney	(SV)	NCT Antenatal Teacher, NCT Breastfeeding Peer Supporter
Patricia Hagan	(PH)	Great Yarmouth CCG Representative
Karin Bryant.....	(KB)	Assistant Director Central Norwich CCG
Wendy Simpson.....	(WS)	NCH Health Visiting Team Leader North

2. Minutes of Last Meeting

The minutes of the last meeting held on 14th April 2015 were amended following name and title changes for CL then approved by committee.

3. Matters Arising

a) **Skin to Skin Graphic –** ET advised that Kath Evans of Public and Patient Feedback NHS UK has agreed budget for redesign and print run of 1000 of the online based infographic created. These will be distributed nationally across each trust. TA showed interest in Children's Centres purchasing some to align with the NNUH. RS/ET to investigate and provide costs etc. **Action(s) RS / ET**

b) **Birth Reflections Services –** Following the launch, members invited to join MSLC, PS advised due to staff changes no one currently available. Will review availability and update next meeting. **GM**

c) **SCN M&N setting the standards –** Following the Kirkup report, GM had advised in April that the SCN were setting the standards at their next meeting.. JF advised that NHS England is setting the standards in the Autumn. Update next meeting

d) **Face of labour working group starting up -** Following KD advice last meeting that this working group was being formed. Update carried forward to next meeting as KD not available today.

e) **Universal Antenatal Education program –** PS gave the MSLC an update on where this has come about. Advised that looking at the Healthy Child Toolkit that was relaunched, small bodies such as Bedford and Norfolk were challenged to look at how they work. Sustain, a third party company is looking at Parent Education, along with various other bodies, working on specifically getting all parties

working together, Hospital, Health Visitors and Children's centers. Using the national Birth and Beyond Toolkit a Universal Antenatal Education Program has been created. The pilots will involve two for the QEH and NNUH and one for JPUH all commencing on the 21st September. AT requested the Family Nurse Partnership be involved in the review of this also. MSLC invited to assist in the evaluation of feedback following the first cohort of sessions to assist in the design of the second cohort, due to start two weeks after the first end in November. Process confirmed as the Children's centers will collect the data and provide it to MSLC for analysis. LB also suggested that user reps attend some sessions to see what they are like first hand. RS to work with TA to coordinate. **Action(s) RS /TA**

4. Updates on ongoing items

a) Maternity Guidelines Committee – Action carried forward next meeting as GM advised waiting on Alastair McKelvey (Chair of MGC) as GM to find out program of reviews for the next year for MSLC to add to work plan which will allow for a wide array of user feedback. **Action(s) GM / RS**

b) Birthing partners staying overnight – Awaiting feedback from Trust Feedback Group on final version. Revised launch date of Monday 3rd August is planned. PS to send copy of approved leaflet to RS for MSLC distribution. Confirmed once again this can now be public information and it is for both Cley and Blakeney. **Action(s) PS**

c) Website update – No update on revised Delivery Suite pictures, GM to update next meeting. ET advised soft launch now taken place. TA asked if CC links can be added to NNUH site. TA to discuss with ET. Input from Luisa Lyons Infant Feeding, Alison Evans for Antenatal and Carolyn Bramble, the site is set to be a huge asset to Maternity Services. **Action(s) GM/TA/ET**

d) CCG input into Home Birth Service – Discussion on how providers can better link in with the commissioning of Maternity Services, MSLC invited into CH&M network monthly meetings, PS requested that they (NNUH) also attend. With commissioning intentions deadline of 30th September, MSLC to comment on this before this date. JF confirmed that CCG do not set the tariff, this is a national guide. MC commented on financial restraints of the Tariff and a lot of work is going into where savings and efficiencies can be made. RC confirmed she will feedback on the quality issues raised. RC advised there are small pots of money for investment, and asked whether the Birmingham home birth pilot would be something to be adopted by the NNUH, as it was discussed Home Birth is the cheapest delivery option in some cases. PS agreed to provide RS with the model to pass on to RC, possibly at CH&MN. RS and PS also to meet to discuss how MSLC can help with Home Birth Birmingham model plans. **Action(s) RC/PS/RS**

e) Guidelines following Microbirth press – GM confirmed that the NNUH will not act on any maternal request for newborn seeding following a C section. This policy will be reviewed if / when NICE guidelines are produced.

5. Work plan 2015/2016

a) All members agree current format of the 2015 / 2016 work plan, it being a positive move to productive working for the MLSC.

b) Item 2, relating to Antenatal Clinic accessibility, has been tuned to reflect that MSLC will help towards the NNUH taking these actions.

i) Following said item discussion RS to consult with Fiona Divine to see if the MSLC website pages can help with the multilingual online resources. **Action(s) RS**

c) RS to contact GM and KB to obtain specification to fall in line with the CCG deadline of September 30th to allow for the MSLC to provide the woman's voice to the specification. **Action(s) RS/KB/GM**

d) MSLC to support the NNUH in planning, process and application of a proposed Obstetric Day Assessment Unit. This was added to work plan. Also added was MSLC to support NNUH in plans for piloting a scheme relating to homebirth. RS to contact relevant parties to arrange a meeting for both items in due course. **Action(s) RS/PS/MC**

e) A copy of the draft work plan has been submitted to the CH&MN Report – RS to provide the new revised version to JF to replace these ASAP to the CH&MN as key items have changed. **Action(s) JF/RS**

6. User Rep Experiences

a) Anecdotal Feedback – LB advised group that recently the rate of women having inductions feels to have increased locally. PS confirmed the results from the 2011 – 2014 data analysis which identified

only very small increases in these rates, which is reflected nationally, although the most recent last six months data was not available. PS will follow this up. **Action(s) PS**

I. MC further clarified that the new toolkit for identifying small at risk babies, GROW, will be a likely contributor to induction rate going up, but this has increased the identification rate of these at risk babies from approx 12% to 45%. RG has asked whether there is analysis to show the success rate post birth of the identification method, MC confirmed he would provide MSLC with that data. **Action(s) MC**

II. Technical Use of language session June 12th – Following the sessions, feedback was overall very positive and the session was well attended. Hopefully more to be run in the future with fine tuning to the administration of said sessions to be made. Write up of the session provided by RG attached in appendix 1. Review in January Meeting.

b) Online survey – JF confirmed that along with a copy of work plan a copy of the quarterly survey report will also be presented to the CH&MN. RS to provide copies to JF and RC.

Action(s) RS

7. NNUH Maternity Services

a) Friends and Family Test – Results to be provided to RS for user rep review **GM**

b) Maternity Services Statistics – To be provided to user reps after IT systems go live

c) PALS Report - RS advised confidentiality agreement added to ToR and asked all members present if they were happy with content. Online version of revised ToR to be provided and all members advised they are automatically in agreement to the revision unless they state otherwise. RS to confirm to legal department that we can now be in agreement of said confidentiality. **Action RS**

d) Staffing Standards in Midwifery Service – PS advised that following launch of NICE guidance, NICE and Birth Rate Plus are looking at developing a new toolkit which will be more effective in Maternity staffing. PS also confirmed the unit had been on divert the last weekend, and a few times this quarter. Birth Rate has increased during these months.

8. A.O.B.

Trust CQC visit – PS advised CQC visit for the whole trust on the week beginning the 9th November, this will involve around 40-50 staff from CQC visiting for around 3-4 days.

Obstetric Day Assessment Unit – As mentioned in Work plan, MC has advised the MSLC that as the hospital is developing the Emergency department of NNUH, there is a knock on effect with the hope to incorporate an ODAU into freed up space. MC asks if MSLC can be involved in this. RS to set up separate meeting to discuss further. **Action(s) RS**

Next MSLC Meeting:

Tuesday 13th October 2015 at 10:00-12:00 Room 23 off Coltishall Ward

Attached is Appendix 1

Action Log

ITEM	NOTE	ASSIGNED TO	BY WHEN
3. a)	Skin to Skin Infographic print run and pricing	ET / RS	Next meeting
3. e)	Universal Antenatal Education Program review	RS / TA	Next meeting
4. a)	Maternity Guidelines Committee Program of review	GM	Next meeting
4. b)	Partners overnight approved leaflet to MSLC	PS	Before launch
4. c)	Website del suite tour & children's centre links	GM / ET	Next meeting / Ongoing
4. d)	CCG supporting new home birth strategy plans	RC / PS / RS	ASAP before Sept
5. b)	Further investigate option of multilingual links on site	RS	Next Meeting
5. c)	Maternity Specification for MSLC input	RS / KB / GM	ASAP before Aug
5. d)	Investigate further MSLC input into NNUH plans	RS / MC / PS	Next Meeting
5. e)	Provide revised copies of work plan to CH&MN	JF / RS	Before 6th August
6. a) i	MSLC to gain back data MSLC data as well as new	PS	Next meeting
6. a) ii	MSLC to view analysis into GROW identification	MC	Next meeting
6. b)	Quarterly Survey Report to be provided to CH&MN	RS / JF	Before 6th August
7. c)	Revised ToR to be distributed to all members	RS	ASAP

Appendix 1

Rachel Graveling write up of language use sessions run on the 12th June 2015.

Meeting between recent maternity service users and obstetric staff plus Sue Holland (risk management) on June 12th 2015. Facilitated by Rachel Graveling.

The NNUH MSLC organised and provided a feedback session for recent service users to describe to clinicians how their experience of the maternity services had impacted them. The purpose was for the service user voice to be heard. It was NOT about reviewing or questioning clinical decisions. The intention was to seek solutions and practical ways forward to improve future service user`s experience.
The issues which are repeatedly highlighted by service users in their responses to the MSLC survey and which were the focus of the meeting were:

- The way risk is presented.
- The way care options are presented; particularly the impression often given that certain care is mandatory.
- The way women`s knowledge of their own bodies/family history is treated particularly the tendency to ignore/disregard it.
- Communication skills in general and sensitivity and compassion in particular.

What follows are thoughts and ideas which came up in the meeting.
Fear is not a good basis for decision making or policy. Service providers and service users would benefit from a culture of listening, sensitivity, clear factual information provision and the absence of the use of emotive/coercive language. Continuity of carer, where ever possible, would aid this process.
Recognition that clinicians are responsible for providing accurate research based information where it is available and honestly admitting its absence where that is the case. Support for women`s decisions should be the norm.

Use of infographics such as those in the Birth Place Decisions document 2014 King's College London, funded by a national Institute for Health Research, Knowledge Mobilisation Fellowship, could be displayed in antenatal clinic and used in discussions about care. Professor of Midwifery Denis Walsh's work on risk presentation was also recommended.

'Worst case scenario' presentation as the only information given is not helpful or balanced.
Acknowledgement that there are no 100% guarantees and that no one can promise that a care pathway will always lead to a particular outcome.

Women with high risk pregnancies (in the examples explored twins and birth after caesarean), who opt to birth in hospital, may wish to decline the routine use of obstetric procedures. Guidelines should show a clear pathway for those service users who decide to decline routine interventions.
Twins and BAC appointments should include relevant discussions as per guideline and include discussion of the option of vaginal birth as opposed to managed vaginal delivery.
Recognition that some service user choices and decisions may cause anxiety in clinicians and that structures, training and support are necessary to manage clinician`s anxiety.
Acknowledgement of the issue of who carries the "burden of risk".
Things which seem routine/insignificant to clinicians may be of great significance to service users.
Spontaneous vaginal birth is different from managed vaginal birth.
Debrief after obstetric procedures should ideally be done by the doctor who performed them and time taken to enable the woman to ask questions and say how she feels about what happened. Ideally this would happen when the service user was ready for such a discussion.
The idea was suggested of a postnatal worker to follow up with women and help them to understand what happened to them and why it happened.

Consideration needs to be given to the needs of mothers who have postnatal complications when their baby or babies are in NICU. It should be possible to receive care while also caring for/feeding a NICU based baby.
Practice can be improved and much is to be learnt from discovering the outcome of care provided and how it was experienced by the service user.

Continuity of carer, while being understood to be impractical at times, was acknowledged to be a possible solution to many communication difficulties.

Women considered as having high risk pregnancies find the stress of having to explain their individual situation over and over again to different members of staff stressful.

Midwife involvement for twin pregnancies in the antenatal clinic, especially with continuity of carer, would be welcomed.

It is never acceptable for use of language to be designed or intended to gain compliance/coerce.
The gap between women`s knowledge of due date as opposed to dating scan date is a regular problem for service users negotiating care. In one of the examples explored an 8 day discrepancy, with the scan date earlier then woman`s own date, meant induction was “offered” earlier than required. In the other example the woman`s knowledge of her own family history and that of her partner regarding birth weights was disregarded and pressure exerted to induce. Baby was 6lbs 9oz, a normal weight for this couples families.

Here are some examples of language used by obstetric staff which the service users found unhelpful.

“We can`t allow this”
“We wouldn`t allow you to do that”
“You can`t expect me to ask permission for everything I do to you”
“The placenta could have stopped working you could be starving your baby”
“I wouldn`t let you leave this hospital `til you have this baby”

Here are some things the service users said about their experiences

“I had no idea why the Drs had come into the room, I was really frightened. They didn`t introduce themselves or explain why they were there. They did an episiotomy and ventouse. Then two of them left and one of them sewed me up. I wasn`t spoken to at all. I still don`t know why they did what they did.”
“The use of language seemed to be about gaining my compliance”
“It felt like I had no options”
“I didn`t have any information given to me I was just told what would happen to me”
“I felt I had to fight for what I wanted”
“The birth was good but getting to have it was really hard”

The MSLC user reps hope this session will lead to further collaboration. We would wish to acknowledge that, using the data collected from our online survey most service users are happy with all aspects of their care(80%) but a significant number have elements of less favourable feedback from their experience (60%) and some are very unhappy. This is unsurprising in a large organisation providing a huge range of care around the unique and highly personal life events of pregnancy, birth and parenting. Service providers are under great strain at a time of acute financial pressure. The fact that maternity and obstetric care are currently organised in a way which does not utilise the considerable benefits of continuity of carer is noted.

The MSLC wishes to thank all those who were willing to come, listen and consider ways forward.