**Maternity:MK Group**

**Wednesday July 26th 2022, 11:00 – 13:00**

**Online Microsoft Teams**

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| **MINUTES** |
| **Attendance:**  Roxy Clarke (Co-Chair MK MVP), Temi Bademosi (Co-chair MK MVP), Michelle Ansell (Co-chair Luton MVP), Lila Ravel (risk and quality improvement midwife MKUH), Rachael Bickley (service user rep), Milly Morris (Independent midwife, service user rep), Katrina Caen (Ward co-ordinator MKUH), Hema Sutton (Program Manager LMNS), Francesca Teasdale (MKUH), Maxine Taffetani (Chief Exec Healthwatch), Emma Mitchener (Deputy Head of Midwifery MKUH), Sara-Beth Sutherland (Senior Research Nurse MKUH), Natalie Olivadoti (service user rep), Emma Ponsonby (co-chair Luton MVP), Michelle Hancock (infant feeding lead MKUH), Gloria Aldridge (Operational Manager for the MK Specialist Perinatal Service and the Maternity – Trauma Loss Care Service (M-TLC).), Christina Edley (MKUH)  Welcome & Introductions,  Consent for recording  Type name and role in chat box  Welcome: New co-chair Roxy and Thank you to Rachael – outgoing co-chair  **LMNS update – Hema**  Priorities and key project areas for LMNS:  Equity and Equality in maternity and neonatal services. Putting together a 5-year action plan, that will set out how we're going to address maternal and perinatal equality in our systems. This includes a lot of the national initiatives that are in place at the moment, such as continuity of carer, preterm birth clinics, maternal medicine networks.Locally specific initiatives are around how we support pregnant people, antenatally in terms of the non-medical support and looking at how we can use the social prescribing model. Pilot in Bedford.  Temi and Michelle are leading on the input into this project from the MVP and the 5 year plan will be submitted  Digital Maternity strategy work is drawing to a close next month. Service user groups have responded to surveys, there have been digital maternity strategy workshops held, feedback on kind of what should be looking at in terms of the vision and the values and our and the aims and outcomes of what we want from this strategy. So, once we've done that piece of work and got it through our governance processes we will move forward.  We're looking at how digital technology can support safer and better access to maternity services for our staff and service users. End goal where pregnant people their own notes so that they can make those informed decisions and ask the right questions when they're when they're in their appointments. As well as making things better for staff, removing the need for duplication and allowing quick access to the relevant notes on one unified system. Therefore, they have more time high quality conversations and build relationships pregnant people on their caseloads.    BLMK fast follower for Pelvic Health service – national model for single point of access, education for health professional and women around pelvic health. BLMK is early implementers for this model. Ensuring women are signposted and can access the service promptly. Over the next 9 months the focus is around building specialist workforce for pelvic health across BLMK with a view to hopefully next April will have a service that is full complement workforce and we can start to see more women.  Maternal Mental health and wellbeing. Particularly support for those who have had a traumatic experience. In the process of recruiting key clinical roles. In Milton Keynes there's a well-established service with a good level of resource. Work to be done to bring Bedford and Luton up to same level.  Supporting our MVP colleagues, meeting last week to discuss workplan and how we take that forward.  **MVP update - Temi**  Our working days remain at 6 days each per month, so a total of 12 days. Between myself (Temi) and Roxy we are available the majority of the week except Thursdays at the moment due to out other work commitments.  Discussion to change the name from Maternity MK to Maternity Voices Partnership Milton Keynes. This will bring us in line with the other MVPs nationally and across BLMK.  **EM** – in agreement, same logo design will be more uniformed and will be easily recognisable as the MVP and perhaps reduce confusion.  **RB** – to highlight there is a national request/plan to move to MNVP to include neonatal. If the MVP is to include neonatal then funding will need to be reviewed as it will be more work for the MVP to take on.  **HS**- raised at LMNS level need to understand the current parent groups for neonatal and how this feed into the services. Funding is on the list to be looked at. Need to have equity across the maternity and neonatal parent voices.  **RB-** the move to MNVP is going to happen, need to perhaps make the move and then review the funding and how to expand. We currently don’t have materials to go out for face to face MVP work which is needed. It could be a waste to produce marketing materials now and then again in 6 months.  **Action: HS to feedback from LMNS around change to MNVP and how this currently looks at regional level and to the strategic board.**  **RC –** so we are keen to increase membership to the MVP and ideally, we need materials to be able to do this to promote the MVP. We have identified some areas on a walk round of the wards where we can use notice boards. Can we agree to use cheaper marketing options for now until the feedback on MNVP has happened. For example, leaflets and posters. Banners that are more expensive will be on hold until agreement on MNVP.  **TB** – to clarify everyone is happy for the name change to MVP MK and to use cheaper marketing materials until the MNVP has been discussed.  **NO-** to consider eco-friendly marketing options- paper only for now to allow recycling when all updated.  **All agreed**.  **TB-** second funding question is around obtaining admin support. Looking at half to one day a month for admin support with tasks like meeting minutes/contact lists/meeting invites etc to allow more time for face to face work by the co-chairs.  **MM-** how are things going with social media management?  **TB-** myself and Roxy are managing at the moment but it would be great to get some support. Takes time to respond to all the messages and get up to date information promptly.  **RC-** I spoke with Melissa last week who has offered potential support from some of the staff in maternity to help manage some of the more direct service queries or anything clinical. Also aiming to link in the MKUH comms team with help from Natalie Lucas so when info is posted to MKUH site we can easily share and update MVP social media.  **Action: RC to follow up with Melissa Davis (HoM MKUH)**  **MM-** Suggestion to look at what other MVP’s do to manage social media as almost a full job role in itself. Peterborough and Hinchinbrook have a good set up.  **RB**- a lot of variation across MVP how socials are managed. Need to be careful if asking service users to manage/monitor as could be used for personal campaigns, not members of MVP so not obliged by same rules. MVP also can’t employ anyone for support in this sort of role as MVP is a working group. Consider asking a volunteer for their time a few hours a month to help with posting.  **NO**- would welcome admin support to allow co-chairs to be out more using their time for service user engagement. Also, with volunteer’s consideration of the training and if the MVP train people or ask for volunteers with particular skill set how is that maintained when they leave. Key would be being really clear on where/when/who to sign post to for particular questions and comments raised on the social media platforms.  **RC-** one of the considerations myself and Temi have thought about is digital training for the MVP co-chairs that we can then develop into an induction for anyone coming into the MVP roles which will allow for that continuity. Development of a rule set to direct what can/can’t be posted.  **MM**- also to consider the type of messages you may be getting thinking of the emotional/physical state the person may be in and how to direct for the right support in a timely manner needs to be clear. Supervision for yourselves to get support with how to respond to the feedback you are getting.  **NO -** Flow charts actually that need to be provided to the MVP admin person. This is where different enquiries go. It needs to be simple again so that it's scalable and you can share it with other volunteers. Could this work sit within the admin/staff team already in post at MKUH? Perhaps a place to start is using the social media platforms for broadcasting rather that direct responses, to raise awareness of the MVP. Perhaps aim by Christmas that people know what the MVP is, what we do and where to go for further info.  **RB –** in agreement, great point use the social media to broadcast, sign post and share information. Ensure you are linked in with all the right areas. Then look at development and training of volunteers.  Also, admin use to be provided by LMNS and then that got scaled back but funding increased for the co-chairs. Perhaps worth a conversation with LMNS as the admin support needs to come from somewhere.  **Action:** agreed - initial focus should be how we promote raise visibility and MVP and using social media.  **TB-** Workplan – we met with the BLMK co-chairs to agree the workplan for the MVP at LMNS level which includes digital maternity, equity and equality, pelvic health, mental health.  **Action:** by next meeting we will have put together a workplan so our priorities are visible to all and we can share what we are doing.    **MKUH update: Emma M**  We are making sure that we keep our women's and services that safety experience at the heart of it all. Around 16 new starters other September, so a lot of those are our newly qualified midwives. Los of training including continuation of the Birth Rights training that will run from October through into round April 2023  The Birmingham Symptom specific obstetric triage system – 24hr triage model we're looking to hopefully have that in by the end of the year. The MVP will be invited to comment on the model and its implantation.  MK is an outlier for smoking in pregnancy looking at improving that and improving our data collection around making sure that we introduce Co2 monitoring. Introduction of a smoking cessation support worker to work with the community midwives to streamline referral processes. This role will sit under the healthy lifestyle midwife which has gone out for recruitment. If proved to be successful will help keep a focus on the public health agendas such as smoking cessation, obesity, diabetes, infant feeding.  Digital midwife Abby – created an ethnicity dashboard looking at local and national trends. I will share this when we have more data as it is in the early stages.  Welcome to Roxy and Temi to be back on the ward to carry out 15 Steps.  **TB-** question around the FB post about the new women’s and children’s centre if there is any plans for MVP involvement?  **RB –** invite to meeting tomorrow morning regarding this has only just come through.  **Action:** RC to send EM copy of fb post.  **RB** – with regards to train the trainer for Birth Rights can we make sure that human rights in birth and consent training doesn’t fall off the agenda. Important about the translation of knowledge into practice.  **EM -** when the cultural competency training starts in October, we can start keeping and a record of those attending and then how the train the trainer will look after that.  **RB-** if the training's only for specific staff, then actually we know, for example, people like MCA's, often chaperones and if they identify or see something that they should be reporting as safeguarding but don't know how, where, when or don't identify it as safeguarding, then actually those behaviours will continue. And I think it's incredibly important. It's such valuable training that the people who really need that training, who perhaps don't attend it, need a way to access it.  **EM-** there is some specific training around chaperoning in healthcare generally, so it said that certainly something that's worth looking into as well.  Appointed Lucy Napthine, is our named midwife for safeguarding and Gloria is here. Elizabeth Payne, who's our perinatal and specialist mental health midwife specialist. They will support the and have oversight of those women that require safeguarding. Midwives will keep hold of those women, but Lucy and Liz will do the oversight will do the leg work to ensure that the pathways are followed and that the plans are robust as possible. Then Community midwives don't feel like they're overwhelmed, overloaded with that particular element of the work with those women, and it recognizing the vulnerability.  **AOB**  **Gloria Aldridge (**Operational Manager for the MK Specialist Perinatal Service and the Maternity – Trauma Loss Care Service (M-TLC).**) –**  since I was in the last meeting they have expanded, most recently is a part time pharmacist. We will have our own dedicated pharmacist, she's going to be term time only. We also have a new speciality doctor, it’s also a female doctor because there are some patients from particularly some of our different backgrounds who can still feel uncomfortable seeing a male doctor  Need to meet the long-term plan and see the numbers of women long term plans. Since we have to see 10% of our birth in population, which is significant because two years ago the requirement was 4.6%.  Bedford and Luton service are called Ocean. MK service is MTLC maternity trauma loss care service.  The MTLC are co-located within Stantonbury with IAPT as feedback through MVP was that it was a trigger for the trauma visiting the hospital. Parking is also easier.  we're particularly focusing on two models focusing on birth trauma, which seems to be at the moment the greatest path referrals were having and then also focusing on loss, neonatal loss, they've linked up with the neonatal team as well linking up with paeds.  the referrals are by a professional, majority of from midwives. We do have to have a referral form and that is from midwives through to the CNWL single point of access, but then it gets filtered straight over to us. We are going to have an official launch that's going to be the 29th of September.  **FT and SB-S – Research**  Starting a study on the antibody booster for RSV. It's not a trial to see the safety of the antibody booster that's already been looked into prior to this, one that we've looked at the safety and have decided that it's safe and it does protect infants from RSV lower respiratory tract infections. Studies are completely voluntary and we want everyone to have the option to hear about it, but they're still no pressure to take part at all with just want to have the opportunity. So just a little bit of background for anyone who might listen into your recording, who's not familiar with RSV. RSV is the most common viral infection, and can cause some chest infections in infants. Most infections are mild and cause runny nose, cough, cold. It can be very severe, leading to hospitalization ITU and even a few deaths in the UK and it's responsible for one in six of all hospital admissions in infants in the UK and about half of those children go on to have symptoms of asthma, including wheezing and coughing. Throughout the world, RSV is the second largest cause of death in children under one. This antibody booster created by AstraZeneca, it's main aim is to try and protect all children and prevent hospitalization for RSV. the booster provides immediate protection and and should protect for the entire RSV season. it's one injection, and there are two dose strengths dependent on child’s weight. Eligibility will be checked. They're given all the extra information that they might need to be happy to sign the consent form and after that they are randomized. So they're randomized for their baby to either receive it or not receive it. it's a passive immunization. It's not expected to interfere with Co administered childhood vaccines when it's been given alongside other vaccines. there will be a phone support line and patients are given a card to carry in case of hospitalisation they will be asked to carry out a nasal swab. There is a gift for completing the study as it requires completion of an online diary. The GPS hopefully are going to link up with us and send referrals to us of potential participants that we can contact. There'll be a social media link.  **MM-** is data being collected on whether the baby is breast/bottle fed as this is a great opportunity to collect data to see about antibodies through bf.  **SBS-** no the data is not currently collected on the way the baby is fed but this is a good point and we will raise with the team.  **EM** – what age is the booster given up until and have you linked in with the Health Visitors?  **SBS**- it can be given up to the age of one and as of yet we haven’t linked with the HV’s but this is something to consider. Most referrals will be coming through the GPs/practice nurses who give the usual immunisation vaccines.  **EM** – question about the £75 payment is quite enticing and could be an incentive for those taking part especially for those struggling with the cost of living.  **SBS** – yes I see your point. The payment is compensation for their time to complete the diary, rather than a payment to have the booster. The research has been through ethics approval. We will consider at which point patients are informed of the payment so it doesn’t entice those they may not otherwise have consented.  **RB** - around the payment, it's a recognised methodology for recruitment and to offer funding for people's time. There is that catch 22 of people may do things that they ordinarily would not have done. However, it's not unusual and it is a recognized methodology of increasing participation, particularly in groups who perhaps would not have ordinarily taken part. my initial question was really about the recruitment materials and what the study is doing to make sure that the sample is representative of our population. Do we have materials in a number of languages? Are we recording ethnicity to make sure that it's representative, because otherwise we then have the results for a particular group of people and we don't know then whether or not the results are translated across people in our communities. I'm thinking specifically of non-English speaking people and certainly in terms of their access to research, their emission from research because they're not always offered the clear consent isn't always sort as the information about the studies is only in English. Also, some people don't read as well, so having those materials in a video format would be useful. Ethically, it's appropriate to make sure that this study is available to as many people as possible. Otherwise the results are only proportionate to a particular population.  **SBS –** we will take all this back to the research team and ask the questions. This issue with the materials in language is there are cost implications to the research and any changes have to the go through approval which can take time.  **RC** – what about considering information at the walk-in centre as this is where a lot of parents are directed when they can’t get apts at the GP.  **NO-** Firstly is to absolutely endorse the if there's any way that breastfeeding question could be included that would be useful. Secondly, I think that just on the postnatal wards is overwhelming, there's too much going on and this is a bit too early. I recalled it was a few years ago that antenatal appointments at the hospital under the consultants I was invited at enrol my baby in a diabetes study that was a good time. There was plenty of time to think about it.  **SBS-** if we were approaching women's of antenatally that are coming in, would they be consultant LED women? So, would that be skewing the results of it and that these women might then be within that already have maybe some other issues going on and things  **RB –** yes that would be a sample from that are only consultant led. Publicly accessible areas, as you're saying that the children's centres postnatally early on and the health visiting the GP centres shopping, I mean, I know lots of people don't really think about shopping centres, supermarkets, they have public community boards, you know, ask your midwife about this study. I absolutely know for a fact from working with women that the majority of the postnatal leaflets and even the antenatal leaflets just don't get read, especially in post Natal leaflets, and they're continually asking, you know, questions that are definitely in the information that I'm that we know that they've been given in their sleep but. And so, having things in posters that are short, quick, not very long with that later, you know, with that information in the leaflet for them to think about later on, if they've got more questions.  If any further questions/comments to email: Action: to confirm email for comments about RSV booster research  **TB**- question on FB about partners being allowed on the wards?  **EM** – on labour ward 2 birth partners are allowed for the duration. Only one partner allowed on the ward after birth. (ward 9)  **TB-** ok great are there any comms we can share about that to let service users know as it seems to be a common question.  **Action:** EM to speak to Melissa D  **TB-** last on the agenda to confirm is the frequency of meetings – agreed full MVP meeting will be quarterly and parent rep meeting will be 2 monthly.  **Action:** TB and RC to plan meetings in advance for the next year  **GA** – do we have a service user rep from the mental health pathway as there use to be but not sure if there is now? In the past these users feedback has been really useful.  **TB** – Roxy is leading on the mental health projects and we are working on increasing MVP membership to look for specific service users.  **RC** – we are also looking at way to bring in more representation from birthing partners/dads who also need support.  **AOB**  **MM –** can we discuss the removal of the CoC teams? There must be many complex reasons behind it but it seems such a shame when MK were really foreword in this and one of the first working groups under MLC was about the continuity. Its upsetting this decision has had to be made as there is a crisis with staffing that no one higher up is listening to.  **EM-** we pulled three teams for safety due to staffing. Nationally there is a crisis and we don’t have enough students training to fill the vacancies. If safety becomes a concern then we have to prioritise provision to women. We are in a consultation with the remaining teams. It hasn’t stopped completely and we will begin consultation before re-implementing.  **TB**- thank you any other business before we close as aware we have now overrun.  Agreed and meeting ended.    Future meeting dates will be sent by the end of next week. |