

Quality and Patient Safety Committee

| Report Title: | Compliance with CNST Maternity Safety Standard 7 |
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| Executive/NED Lead: | Darren Darby, Chief Nurse |
| | Hussein Khatib, NED |
| Report author(s): | James Borthwick – Assistant General Manager W&C |
| | Amanda Price-Davey – Director of Midwifery |
| Previously considered by: | Women's and Children's Divisional Management Team |

Approval Discussion Information Assurance

Executive summary

NHS Resolution is operating year five of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care.

This paper sets out the Trust's current position on Safety Action 7:

"Listen to women, parents and families using maternity and neonatal services and coproduce services with users

Reporting period 30th May 2023 to 7th December 2023

Required Standard 1

Ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (due for publication in 2023).Parents with neonatal experience may give feedback via the MNVP and Parent Advisory Group.

Required Standard 2

Ensuring an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board.

Required Standard 3

Ensuring neonatal and maternity service user feedback is collated and acted upon within the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions.

Action Required of the Performance Committee

To consider and approve the contents of the report.

| Link to Strategic Objectives (SO) | | Please tick |
|-----------------------------------|--|----------------|
| SO1 | Keep people in control of their health | • |

| SO2 | Lead the integration of care | | V |
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| SO3 | Develop our centres of excellence | | |
| SO4 | Support and develop our staff | | |
| SO4 | Drive technology enabled care | | |
| | mplications for the Trust (including any I and financial consequences) | If the Trust is unable to meet the expectations of the CNST SA7 the ris non-compliance against the standard Services won't be designed collabora with service users and could potentia meet the requirements of the popular There is also a reputational and finar risk to not meeting the 10 Safety Actions | ls. atively ally not tion. ncial |
| Trust | Risk Appetite | Quality: The board will take minimal when it comes to patient safety, patie experience or clinical outcomes. Its tolerance for risk taking will be limited decisions where the impact is low an potential mitigations are strong | ent d to |
| Legal and regulatory implications (including links to CQC outcomes, Monitor, inspections, audits, etc) | | MIS applies to all trusts that deliver maternity services and are members of CNST. If ESNEFT is unable to meet the requirements of the MIS then there is an increased risk of breaches to the Fundamental Standards and associated Regulations as outlined in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2015. | |
| Finan | cial Implications | Risk to reputation and subsequent fir loss by not meeting the incentive sch standards | |
| Equality and Diversity | | MNVPs listens to the experiences of women, birthing people, and families brings together service users, staff a other stakeholders to plan, review an improve maternity and neonatal care are pivotal in ensuring the voices of from all communities, backgrounds, religions and ethnicities are heard an an integral role in designing services meet their needs. | , and nd nd . They women nd play |

1. Narrative summary

Work with our MNVPs has been challenging this year, due to having no Chairs or more recently referred to, Leads, in place at the beginning of the financial year. This was due to the previous chairs stepping down and meant that some works and meetings had to be paused. We have also been awaiting the nation guidance around MNVPs that is referred to in the CNST documentation that was not published until late November this year. However, service user collaboration has been continued with other partner organisations led by the LMNS programme team and utilising national transformation funds devolved to the LMNS. This work has been discussed and articulated well in the slides presented to the World Patient Safety Day celebration, Improving Patient Safety through Co-Production (Evidence 0.4).

The submitted evidence demonstrates compliance:

- Evidence submission 0.1 demonstrates compliance with standard 1
- Evidence submission 0.2 demonstrates that an MNVP work plan has been co-produced with service users, LMNS and Trust teams. There was a delay in developing this as new chairs were only recently appointed in September 2023 and developing into these roles. This is evidenced by email from LMNS 0.3
- Minutes of meetings demonstrating how feedback is obtained and evidence of service developments resulting from coproduction between service users and staff is evidenced in files 0.5 – 0.9
- Evidence that the MNVP is prioritising hearing the voices of neonatal and bereaved families as well as women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, given the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality is evidenced in files 1.0-1.3
- Evidence of LMNS oversight in demonstrated in LMNS Choice and personalisation tracker evidence file 1.0 and minutes of LMNS meeting evidence file 0.5
- Safety champion oversight can be demonstrated in minutes of Mat Neo meetings and safety intelligence sharing template which started in November 2023. Evidence file 1.4-1.6

2. Conclusions

Following discussions and support from the LMNS, we believe the Trust is compliant with safety action 7 within CNST Year 5.

| 3. Evidence | |
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| 0.1 | July 2023 LMNS Programme Report |
| 0.2 | MNVP work plan 23-24 ESNEFT FINAL |
| 0.3 | Email confirming new chairs in post (Sept 2023) |
| 0.4 | World Patient safety day slides – Improving Safety through Co-Production |
| 0.5 | LMNS Meeting minutes |
| 0.6 | MNVP meeting minutes 12 th Sept 2023 |
| 0.7 | MNVP meeting agenda 28 th Sept 2023 |

| 0.8 | MNVP meeting minutes 28 th Sept 2023 |
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| 0.9 | MNVP meeting agenda 11 th Dec 2023 |
| 1.0 | Maternity Choice and Personalisation work stream tracker |
| 1.1 | Maternity Equity form tracker |
| 1.2 | LMNS SG 061223 Agenda |
| 1.3 | NHS Race and Health Observatory benchmarking LMNS agenda item 7e from December meeting |
| 1.4 | Mat Neo Meeting Minutes 20 July |
| 1.5 | Mat Neo meeting Minutes 24 August |
| 1.6 | Mat Neo sharing safety intelligence- Nov 23 v2 |