



ROYAL BERKSHIRE

Maternity & Neonatal Voices

Working in partnership to improve maternity & neonatal services

Terms of Reference

1. Royal Berkshire Maternity and Neonatal Voices Partnership (MNVP), is an independent¹ multi-disciplinary advisory and action forum with service users at the centre.
2. It uses both a formal committee structure, with written agendas and formal minutes of discussions and decisions. As well as incorporating the principles and practice of participatory co-design and co-production, using regular break-out sessions and focus group work, to ensure that the five principles of MNVPs are at the core of the commissioning, monitoring and continuous improvement of maternity services.
3. It is maintained and funded by the Local Maternity and Neonatal System (LMNS).

Five principles

4. An MNVP creates and maintains a co-production forum for maternity service users, service user advocates, commissioners, service providers and other strategic partners. Members and the collective forum operate on the following founding five principles:
 - 4.1 Work creatively, respectfully, and collaboratively to co-produce solutions together.
 - 4.2 Work together as equals, promoting and valuing participation. Listen to, and seek out, the voices of women, birthing people, families and carers using maternity services, even when that voice is a whisper. Empowering all women, birthing people, families and carers within our communities to have their voice heard.
 - 4.3 Use experience data and insight as evidence.
 - 4.4 Understand and work with the interdependency that exists between the experience of staff and positive outcomes for women, birthing people, families and carers.
 - 4.5 Forensic in the pursuit of continuous quality improvement with a particular focus on closing inequality gaps.

Aims and objectives

5. The MNVP serves the needs of local women, birthing people, families, and the Local Maternity and Neonatal System, including all acute and community services and community hubs. It links with clinical network(s), to contribute towards and follow regional strategic direction, and links with other MNVPs within the LMNS to share good practice.
6. The MNVP advises the ICB commissioning maternity care on all aspects of maternity services, including:
 - The Sustainability and Transformation Plan for maternity
 - Service specifications for maternity service contracts, performance indicators and maternity quality requirements
 - Progress on implementing the national policy and evidence-based standards and recommendations

¹ See Guidance on maintaining independence at the end of this document.

- Lessons from investigations and reviews of maternity services by the Care Quality Commission
 - Involvement of women, birthing people, and their families (patient and public involvement)
 - Configuration of services
 - Quality standards for maternity services and ways of monitoring standards
 - Clinical governance, audit, and guidelines for clinical care
 - The consistency in the delivery of maternity services and clinical practice across the district, based on reliable research evidence
7. The MNVP will listen to and act upon feedback from women, birthing people, family and carers, at all stages of the commissioning cycle – from needs assessment to contract management. The MNVP will listen to all voices, including neonatal voices and those of bereaved parents as per the MNVP Guidance. All members are committed to working in partnership and to implementing woman, and birthing person, centred care. Woman, and birthing person, centred care offers information, choice, and care based on the best available evidence, always respecting their choices and human rights.
8. Mirror clauses, acknowledging the role of the MNVP are included in the terms of reference of other groups that consult and receive advice from the MNVP including the ICB and Trust boards.

Values

9. The MNVP is committed to equity, diversity and inclusion. In all its operations it seeks to uphold equal opportunities in women's, birthing peoples, families and carers human rights in pregnancy and childbirth.
10. The MNVP is multidisciplinary, so its members will bring with them different beliefs, values, and experience. All perspectives should be valued and respected. Each member should have an equal opportunity to contribute to the MNVP discussion and decision-making process. Care will be taken to enable full participation. For example, it is important to check that the terminology MNVP members use is understood by all and clarified where necessary.
11. Members are acting in a public service capacity and are expected to be familiar with, and adhere to the Nolan principles for conduct in public life.²

Membership

12. Members will normally be appointed for no less than two years and no more than six years consecutively. The LMNS(s) will ensure that there is a balance of members from professional and user groups. Members may include:

Core MNVP Team and Service Users

Core Members

Chair
 Vice Chair
 Secretary
 Parent Community Engagement Leads (PCEL)
 Neonatal Engagement Lead

Service Users

Service Users/Parent Reps
 Service User representatives (nominated by voluntary maternity organisations and community groups)
 Fathers & Partners

² Committee on standards in public life. *Guidance: The 7 principles of public life*. (May 1995)

<https://www.gov.uk/government/publications/the-7-principles-of-public-life/the-7-principles-of-public-life--2>

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Family Support Workers, Peer Supporters

Associate/additional members

Trust Patient Lead

Service User, or community workers, with specific expertise and experience relating to protected characteristics as set out in the Equality Act 2010

Local Maternity and Neonatal Systems

Core members

Commissioning Manager, or other designated lead person, who acts as the link with the Chair and Vice Chair of the MNVP

Associate/additional members

GP Commissioner

Clinical Governance Manager

Other expertise as required

Local authority

Core members

Public Health Representative

Health Visitor

Associate/additional members

Community Engagement Partners

Health Inequalities Leads

Health promotion

Other expertise as required, e.g. School Nurse Representative

Service Provider/Trust

Core members

Director of Midwifery (DOM)

Head of Midwifery (HOM)

Head Matron

Neonatal Lead

Consultant Midwife

EDI Midwife

Consultant obstetrician

Consultant Paediatrician / Neonatologist

Midwife from Antenatal, Intrapartum and Postnatal

Associate/additional members

Board level Maternity Champion(s)/ Non-Executive Director

Anaesthetics

Antenatal screening

Bi-lingual Link Worker or advocate, where employed locally

Business Management

Chaplaincy

Bereavement Service

Health promotion

Infant nutrition

Medical / midwifery education

Neonatal nursing

Obstetric physiotherapy

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PND specialist
Psychiatrist
Parent education
Radiology
Sure Start / Children's Centre Coordinator
Trust Governor
Local Authority Children's Social Care
Director of Children's Services
Substance Misuse Lead

13. The core membership will vary according to the local situation. It may also be appropriate to nominate associate/additional members, who receive papers and join subcommittees as appropriate, but will only attend meetings where there are issues of special interest to them. If the MNVP covers more than one provider unit, each unit should be represented by at least one senior professional. Other professional and staff group representatives may be agreed between the Trust, so that the committee does not become too large.
14. Members of the MNVP should liaise with the groups or professions that they represent. This will include regular reporting on the activities of the MNVP to their group/colleagues and feedback to the MNVP.
15. Out-of-pocket expenses will be payable to service user members.
16. Service user members (not core team) should have accessed local maternity services in the last 6 years, or provide services or support to those who have.
17. The ICB and LMNS will pay an annual budget to the MNVP, which will be held in the MNVP community bank account. From this the MNVP will remunerate the chair, vice chair, PCELS and secretary, and also service users and parent reps who undertake project work for the MNVP, as well as out of pocket expenses for attending any meetings and or focus groups. The ICB will ensure that the Chair's remuneration reflects the skills, experience and significant time required for the role as per the MNVP Guidance.³
18. Members shall be given reasonable access to the ICB and provider unit libraries, to the internet and are encouraged to access NICE guidance and the Cochrane Library online.
19. The officer appointed to service the committee will provide information to members of the committee and identify any training needs that members may have.

Core team

20. The Chair of the committee will be elected by the membership for a fixed term of up to four years. The start and expected finish date shall be minuted. At the end of that four-year term, if the committee agrees via a private vote, the chair may continue for an additional term to be agreed by the committee, and this process may be repeated at the end of subsequent terms. The Chair should be independent of those directly responsible for commissioning or providing services and normally be a user member. If there is no user member willing to take on the role of chair, the commissioning ICB, in consultation with the committee, will consider who would have an informed, user-focused perspective and be able to take on the role. The Chair should not normally be a practising or recently practising member of a profession directly concerned with providing maternity services, or employed by a trust with whom the commissioning ICB has a contract.

³ <https://www.england.nhs.uk/long-read/maternity-and-neonatal-voices-partnership-guidance/>

2.22 ICBs will need to consider how MNVP leads are appropriately remunerated. This requires matching the level of remuneration with the demands of the role.

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21. Ideally at all times, and definitely if the Chair is not a user member, a user member should be encouraged to take the role of Vice-chair for a fixed term of up to four years. The start and expected finish date shall be minuted. At the end of that four-year term, if the committee agrees via a private vote, the vice chair may continue for an additional term to be agreed by the committee, and this process may be repeated at the end of subsequent terms. Sharing the chairing role as a job-share or 'chair team' is another way to ensure central service user involvement. The Vice-chair provides essential support to the committee Chair.
22. If there is no service user willing to be vice chair, the role may be appointed by the chair via an open and accountable recruitment process.
23. In the rare absence of both the Chair and Vice-chair, members shall elect one person to take the chair for the duration of the meeting.
24. The Secretary of the committee will be appointed by the chair (and vice chair if applicable) via an open and accountable recruitment process, for a fixed term of up to four years. The start and expected finish date shall be minuted. At the end of that four-year term, if the committee agrees via a private vote, the vice chair may continue for an additional term to be agreed by the committee, and this process may be repeated at the end of subsequent terms.

Committee proceedings

25. MNVP meetings will be held every other month, the primary focus of which will alternate between reporting and coproduction. Every meeting will have agenda points requiring updates from the MNVP, the Trust and Professional Partners. All core members have voting rights. Associate members do not have voting rights.
26. To be quorate the following must be in attendance from the Trust and LMNS or deputised: Director or Head of Midwifery, Consultant Midwife, Lead Matron or Midwife representative from antenatal, intrapartum and postnatal, Birth Reflections, Infant Feeding Team, Clinical Representative, Neonatal Representative, LMNS Representative. Where apologies are given, there is a commitment from the member to read and digest the minutes (or view the meeting recording) and cascade relevant information to their teams. The meeting will not go ahead without a minimum of Director or Head of Midwifery, Lead Matron and Midwife representatives from antenatal, intrapartum, and postnatal. Additional requirements to ensure quoracy include Service User representation.
27. The Chair may invite individuals, who have specific experience and expertise relating to agenda items, to the meeting on an ad hoc basis.
28. The MNVP may set up multi-disciplinary sub-groups that include user members to meet in between MNVP meetings either on a regular or an ad hoc basis, to work on specific topics and report back to the MNVP. These sub -groups may co-opt members as appropriate.
29. Proposed amendments to the Terms of Reference shall be circulated to all members in writing at least one week before the meeting at which such amendments are to be considered.
30. The ICB commissioning maternity care will ensure that a ICB lead person acts as the link with the Chair/ Vice-chair of the MNVP. A current list of named core members, and the person servicing the committee, will be maintained, with changes agreed and minuted.
31. Agenda and papers will normally be circulated at least one week before each meeting. Any members may ask for items to be included on the agenda.
32. The minutes of meetings will be produced, for approval by the Chair prior to circulation, and circulated within three weeks of the meeting to all MNVP core and associate members, the Chief Executives of all relevant ICBs and Trusts and be made available to others on request.

33. Where a member is unable to attend a meeting, they will inform the committee Secretary prior to the meeting and advise whether, in their absence, a designated deputy will be attending. The deputy will then have full voting rights.
34. Where a member fails to attend three meetings within a one-year period. their membership should be reviewed and, if necessary, an alternative member identified.

Annual Programme

35. The MNVP will be consulted by the ICB commissioning maternity care on:
 - proposals for developing or changing services, including the Sustainability and Transformation Plan
 - service specifications for maternity services, quality standards and performance indicators
 - the Joint Strategic Needs Assessment
 - implementing standards and targets
 - priorities for clinical audit
 - specific user involvement, personalisation and choice, and women's experience initiatives relating to the planning and monitoring of maternity services
36. The MNVP will receive reports from, and advise local provider units on:
 - the development of their business plans relevant to maternity services
 - any proposals for changing or developing service
 - clinical governance, including clinical audit
 - work of the labour ward forum where applicable
 - the number and nature of maternity services complaints, and actions arising
 - user surveys, complaints, and local maternity statistics
 - user involvement in the planning and monitoring of their maternity services
37. The MNVP will review services with information from sources including:
 - community groups, consumer research and quality assurance
 - Care Quality Commission findings, statistics and recommendations
 - clinical audit reports from provider units, regular summaries of comments
 - subjects/themes of complaints from service users
 - feedback from maternity services user groups

Annual Report

38. The MNVP will produce an annual report that includes:
 - the work of the MNVP over the past year
 - progress on local strategies and targets
 - work priorities for the coming year
 - links and connections to Community Hubs and community organisations
 - it may also include recommendations to maternity care commissioners if appropriate
39. It may also include a synopsis of local statistics and services and act as an overview prospectus for local unit(s) and services.
40. The annual report will be circulated by the ICB commissioning maternity care to the Trust and ICB boards, and other relevant statutory and non-statutory groups with an interest in maternity services. It may be discussed by the Chair and Vice-chair at a meeting with the Chief Executive or Lead Director of the ICB, and

with the Trust Chief Executive and/or the board level Maternity Champion, usually with a senior provider manager present.

Date Terms of Reference last reviewed [July 2024]

Guidance on Maintaining Independence

The MNVP will be independent and accessible to all sections of the community.⁴ It must be seen by women, birthing people, and their partners and families as relevant and reflecting the experiences they have when using maternity services and related community support services. To maintain this independence requires the MNVP to listen to the voices in their communities compassionately and impartially.

Independence of purpose, of voice and of action

The MNVP must be able to speak up independently, without fear or favour. The chair, other elected officers, and all members of the committee have a responsibility to maintain this independence. Sometimes this may feel difficult. The MNVP must work on both popular and minority causes, with mainstream groups and with marginalised and vulnerable groups in order to serve the whole community. Adequate resources must be provided through arrangements with commissioners, service providers, voluntary organisations, Healthwatch, researchers, and/or consultants to make realistic work plans.

To maintain independence, the MNVP must make sure that local people and stakeholders on the MNVP are clear about the committee's independent position, which must not be compromised for any reason. Independence can be undermined by external pressures and conflicting expectations, or if the MNVP becomes out of touch with the real concerns of local women and families or fails to take account of high-quality evidence.

The principle of presenting lived experiences in an evidence-based way is vital. If proposals and presentations are not grounded in local service users' experiences and formal evidence, the MNVP will lack credibility.

If the MNVP chair, or a subgroup of the MNVP, decides to take on extra commissioned work for the ICB/commissioners or Trust(s), additional to the main workplan for the MNVP (the usually annual workplan, which all members have agreed by consensus or by voting, under these terms of reference), it must be clear, within the project plan agreed with the ICB/commissioners or Trust, how the MNVP's independence will be preserved. For example, that the MNVP owns the information collected, has the right to publish any information collected and publish a final report in full. It is important to be clear that an MNVP is not a body that can enter into legal contracts – it is an NHS working group/partnership with members from relevant stakeholder groups, including NHS Trust staff, service users, NHS ICB/commissioner, and others (see Terms of Reference). While an MNVP will settle its annual workplan (collectively, at an MNVP meeting) following discussion with the ICB and local Trust(s) as organisations (these bodies have members on the MNVP who should facilitate these discussions, supporting the MNVP chair), this must not compromise the independence of the group and its freedom to work on topics that the MNVP has collectively decided are important in the local context.

In order to maintain independence and respect, MNVPs:

- shall work to the highest levels of transparency and accountability in all activities. Good governance is fundamental.
- must declare and manage conflicts of interest – it can be the public's perception of a conflict that undermines trust and independence. The MNVP must be careful about any political affiliations and seek to maintain political impartiality.
- must be seen as independent and accessible to all, representing all parts of the community.
- are subject to oversight by clinical commissioning groups and may need to meet requirements in creating and delivering on its workplan in relation to co-design and co-production, however, any control over budget and activities shall not have undue influence on freedom to set priorities.
- in undertaking additional work (such as agreed time-limited projects), may be at risk of commissioners becoming confused about the MNVP's independence. It is important always to make this independence explicit so as to manage expectations.

⁴ This has been adapted from Healthwatch England guidance.

- must not compromise their independence through commercial or provider interests. This does not mean avoiding involvement of independent practitioners or NHS providers. Strong and trusted relationships with a range of stakeholders is vital to having local insight and influence. But any conflicts of interests must be stated and managed to maintain the MNVP's independence and credibility.
- must protect the reputation of MNVPs and be respectful of local partners and stakeholders, avoiding inappropriate statements, language or associations which cannot be justified or may be damaging.
- should attempt to resolve any disputes or misunderstandings locally, minuting all formal meetings. They should seek advice from independent trusted sources such as: peers in other MNVPs, Healthwatch England, NCT, Royal Colleges, NHS England, Birthrights, known independent service user advocates or lawyers if any tensions or conflicts cannot be resolved locally.

Managing conflicts of interest

A conflict of interest involves a conflict between a public duty and a private interest, in which the person's personal interest, e.g. a commercial interest or opportunity for self-promotion, could improperly influence the performance of their public duties and responsibilities. MNVPs should manage any conflicts of interest and seek guidance if necessary. Healthwatch England has produced guidance on *Conflicts of Interest* and there is guidance available for charities.⁵

⁵ <https://www.gov.uk/guidance/manage-a-conflict-of-interest-in-your-charity>