DERBYSHIRE MATERNITY AND NEONATAL VOICES

Terms of reference

1. Derbyshire Maternity and Neonatal Voices (DMNV), is an independent[1] multi-disciplinary advisory and action forum with service users at the centre.

2. It uses a formal committee structure, with written agendas and formal minutes of discussions and decisions, and incorporates the principles and practice of participatory co-design and co-production through regular smaller groups and meetings in order to ensure that the five principles of Maternity Voice Partnerships (MVP) are at the core of the commissioning, monitoring and continuous improvement of maternity and neonatal services.

3. It is hosted by Derby and Derbyshire Clinical Commissioning Group

Five principles

4. An MVP 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:

- Work creatively, respectfully and collaboratively to co-produce solutions together.
- Work together as equals, promoting and valuing participation. Listen to, and seek out, the voices of women, families and carers using maternity services, even when that voice is a whisper. Enabling people from diverse communities to have a voice.
- Use experience data and insight as evidence.
- Understand and work with the interdependency that exists between the experience of staff and positive outcomes for women, families and carers.
- Forensic in the pursuit of continuous quality improvement with a particular focus on closing inequality gaps.

Aims and objectives

5. The DMNV serves the needs of local women and families and the Local Maternity System, including all acute and community services and community hubs. It links with clinical networks, to contribute towards and follow regional strategic direction, and links with other MVPs to share good practice.

6. The DMNV advises the CCG commissioning maternity care on all aspects of maternity and neonatal services, including:

- The Sustainability and Transformation Plan for maternity
- Service specifications for maternity and neonatal service contracts, performance indicators and maternity quality requirements
- Progress on implementing the national policy and evidence-based standards and recommendations
- Lessons from investigations and reviews of maternity and neonatal services by the Care Quality Commission
- Involvement of women and their families (patient and public involvement)
- Configuration of services
- Quality standards for maternity and neonatal services and ways of monitoring standards

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

- Clinical governance, audit and guidelines for clinical care
- The consistency in the delivery of maternity and neonatal services and clinical practice across the district, based on reliable research evidence.

7. DMNV will listen to and act upon women, family and carer feedback at all stages of the commissioning cycle – from needs assessment to contract management. All members are committed to working in partnership and to implementing woman-centred care. Woman-centred care offers women information, choice, and care based on best available evidence, always respecting their choices and human rights.

8. Mirror clauses, acknowledging the role of the DMNV are included in the terms of reference of other groups that consult and receive advice from the DMNV including the CCG and Trust boards.

Values

9. DMNV is committed to diversity and equal opportunities and upholds women's human rights in pregnancy and childbirth.

10. DMNV is multidisciplinary, so its members will bring with them different beliefs, values and experience. All these perspectives should be valued and respected. Each member should have an equal opportunity to contribute to the DMNV discussion and decision-making process. Care will be taken to enable full participation. For example, it is important to check that the terminology DMNV members use is understood by all and clarified if necessary.

11. Members are acting in a public service capacity and are expected to adhere to the Nolan principles for conduct in public life.[2]

Membership

12. Members will normally be appointed for a one year term and no more than four years consecutively. CCG will ensure that there is a balance of members from professional and user groups. Core membership will include some of the following:-

Service users - minimum one third of total core membership

Service users
Service user representatives (nominated by voluntary maternity organisations and community groups)
Fathers groups
Family support workers, peer supporters

Clinical commissioning groups
Commissioning manager, or other designated lead person, who acts as the link with the Chair

Local authority
Public health representative
Health visitor

Service Provider

[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

A minimum of one service provider from CRH and UHDB to be present at each sub group meeting and each quarterly meeting

Midwife in clinical practice
Bi-lingual link worker or advocate, where employed locally
Neonatal Nurse
Board level maternity champion(s)/ Non-executive director
Head of midwifery
Consultant obstetrician
Consultant paediatrician / neonatologist
General practitioner

13. The core membership will represent users from Chesterfield, Derby, Burton and Derbyshire county. 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. DMNV covers more than one provider unit, therefore 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 DMNV should liaise with the groups or professions that they represent. This will include regular attendance of trust meetings and feedback to their service users, members and provider organisations.

15. Out-of-pocket expenses will be payable to service user members.

16. The CCG will remunerate the Chair and Co-Chair dependent on work done and feedback received. The rate will be £75 per half day and £150 per day for work done as an expert advisor. (NB Payment may affect entitlement to state benefits and is subject to income tax. The CCG accept no responsibility for the declaration of additional income by the recipient)

17. Members shall be given reasonable access to the CCG and provider unit libraries, to the internet and are encouraged to access NICE guidance.

18. The officer appointed to service the committee will provide information to members of the committee and identify any training needs that members may have.

Chair

19. The Chair and Co-Chair of the committee will be elected by the membership for a fixed term of one year, up to a maximum of four years, subject to review. The start and expected finish date shall be minuted. The Chair and Co-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 CCG, 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 and Co-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 CCG has a contract. The Chair and Co-Chair will each lead the sub groups for either the area served by UHDB or CRH.

20. In the rare absence of the Chair and Co-Chair, members shall elect one person to take the chair for the duration of the meeting.

Committee proceedings

21. DMNV Meetings will be held quarterly with representatives from each sub group present. Sub group meetings will be held four to six times per year. All core members have voting rights. Associate members do not have voting rights.

22. A quorum shall be one third of the full core DMNV committee membership.

23. The Chair and Co-Chair may invite individuals on an ad hoc basis to a meeting for particular items on the agenda.

24. The DMNV will set up multi-disciplinary sub-groups that include user members to meet in between quarterly meetings to work on specific topics relevant to the local community around CRH and UHDB. These sub groups may co-opt members as appropriate who are local to the area and have recently been involved with local maternity services provided by CRH or UHDB.

25. Proposed amendments to the terms of reference shall be circulated to all members in writing at least two weeks before the meeting at which such amendments are to be considered.

26. The CCG commissioning maternity and neonatal care will appoint an officer to service the committee and ensure that a CCG lead person acts as the link with the Chair and Co-Chair of the DMNV. A current list of named core members, and the person servicing the committee, will be maintained, with changes agreed and minuted.

27. Agenda and papers will normally be circulated two weeks before each meeting. Any members may ask for items to be included on the agenda.

28. The minutes of the quarterly meetings will be produced, for approval by the Chair or Co-Chair prior to circulation, and circulated within three weeks of the meeting to DMNV core and associate members, the chief executives of all relevant CCGs and trusts and be made available to others on request. Support from the CCG for minute taking may be available on request.

29. Attendance at the Maternity Transformation Board Meetings is required. Where the Chair or Co-Chair is unable to attend a meeting he/she will inform the committee secretary of this before the meeting and advise whether a designated deputy will be attending the meeting. The deputy will then have full voting rights.

30. Where a member fails to attend three meetings within a one-year period their membership should be reviewed and, if necessary, a replacement sought.

Annual Programme

31. The DMNV will be consulted by the CCG commissioning maternity and neonatal care on:

- proposals for developing or changing services, including the Sustainability and Transformation Plan
- service specifications for maternity and neonatal 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 and neonatal services.

32. The DMNV will receive reports from, and advise local provider units on:

- the development of their business plans relevant to maternity and neonatal services
- any proposals for changing or developing service
- clinical governance, including clinical audit
- 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.

33. The DMNV 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 and neonatal service user groups.

Annual Report

34. DMNV will produce an annual report that includes:

- the work of the MNVP over the past year
- progress on local strategies and targets
- work-plan for the coming year
- links and connections to Community Hubs and community organisations
- recommendations to maternity care commissioners

35. It may also include a synopsis of local statistics and services and act as an overview prospectus for local unit(s) and services.

36. The annual report will be circulated by the CCG commissioning maternity care to the trust and CCG boards, and other relevant statutory and non-statutory groups with an interest in maternity and neonatal services. It will be discussed by the Chair at the Maternity Transformation Board Meeting.

Date Terms of Reference last reviewed 12/01/2021

Guidance on maintaining independence

The MVP will be independent and accessible to all sections of the community.[3] It must be seen by women 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 MVP to listen to the voices in their communities carefully and impartially.

Independence of purpose, of voice and of action

The MVP 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 MVP 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 MVP must make sure that local people and stakeholders on the MVP 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 MVP 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 MVP will lack credibility.

If the MVP chair, or a subgroup of the MVP decides to take on extra commissioned work it must be clear, within the contract, how the MVP's independence will be preserved. For example, that the MVP owns the information collected, has the right to publish any information collected and publish a final report in full.

In order to maintain independence and respect, MVPs:

- 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 MVP 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 contractual requirements, however, any control over daily activities shall not have undue influence on freedom to set priorities.
- in undertaking contracted work (such as ongoing services or time-limited projects), may be at risk of commissioners becoming confused about the MVP's independence. It is important always to make this independence explicit so as to manage expectations.
- 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 MVP's independence and credibility.
- must protect the reputation of MVPs 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 MVPs, Healthwatch England,

[3] This has been adapted from Healthwatch England guidance.

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. MVPs 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.[4]

[4] https://www.gov.uk/guidance/manage-a-conflict-of-interest-in-your-charity