Scottish Perinatal Network
MATERNITY

NHS National Services Scotland

Scottish Maternity Engagement Framework and Implementation Toolkit

September 2024

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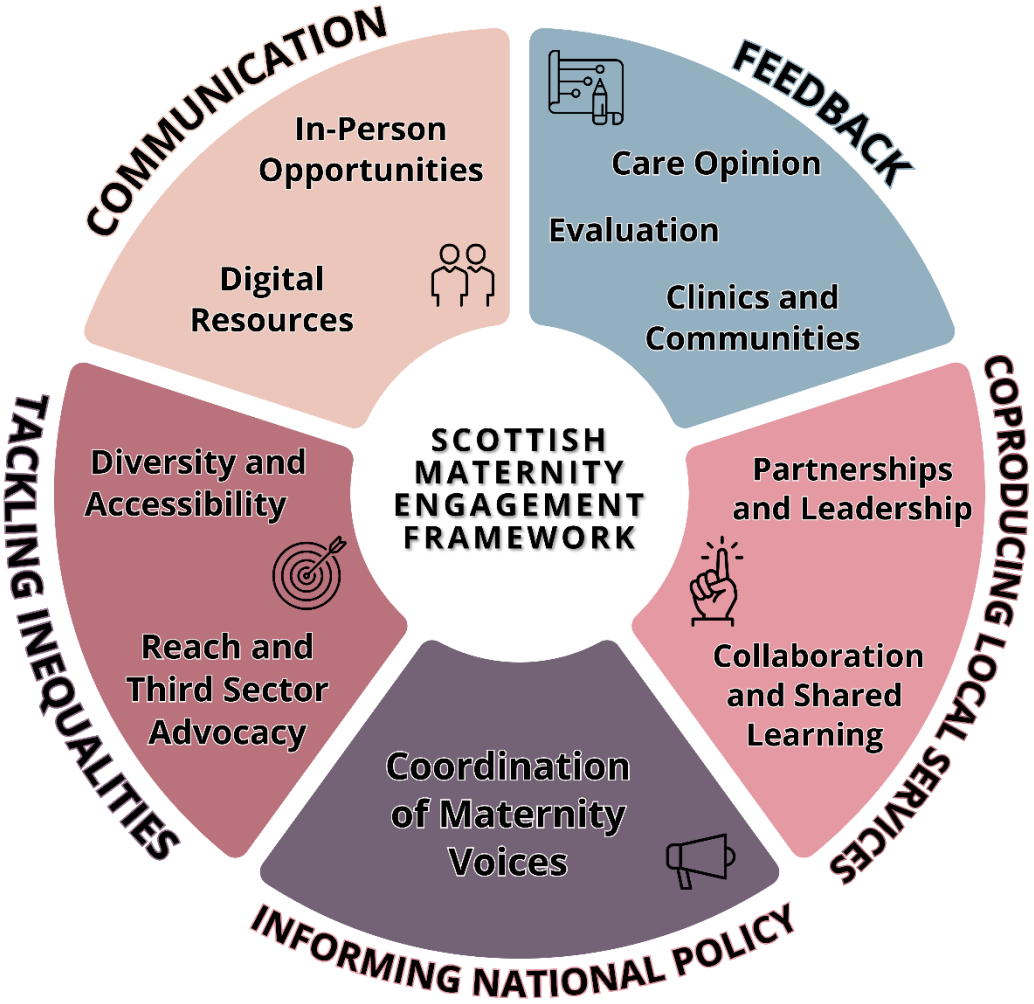
National Services Directorate

Contents

The Scottish Maternity Engagement (SME) Framework



This Framework is structured to achieve cumulative improvement where building on each principle supports delivery of the next, starting with effective communication. Implementing the principles in a cumulative way will also support consistent delivery of three minimum standard goals for maternity engagement in Scotland:

Goal 1: Gather, listen, and respond to maternity voices locally

- Principle 1: Effective **communication** is a prerequisite to maternity engagement.
- Principle 2: Reciprocal, **feedback** mechanisms can support maternity professionals to listen and respond to service users and find common themes.

Goal 2: Strategically include maternity voices in service decisions that affect them

- Principle 3: Transformation of individual maternity voices, wherever and however they are heard, into **coproduced local services** requires local leadership and coordination.
- Principle 4: Transformation of collective maternity voices into strategic representation which can **inform national policy** requires national leadership and coordination.

Goal 3: Tailor approaches to include under-represented maternity voices

- Principle 5: Consistent adoption of the Framework forms a national foundation of standards, upon which complementary approaches with **inequalities focus** can develop over time.

Scottish Maternity Engagement (SME) Framework Executive Summary

Goal 1: Gather, listen, and respond to maternity voices locally	
Principle 1: *Effective **communication** is a prerequisite to maternity engagement*.	Maternity services are encouraged to **align and optimise communication channels and activities**, including new and existing, digital and in-person, opportunities and those restricted during the COVID-19 pandemic.
Principle 2: R*eciprocal, **feedback** mechanisms can support maternity professionals to listen and respond to service users and find common themes*.	The **national adoption of Care Opinion** across maternity services is encouraged. It is available in every board, in 120 languages, and supports data capture, evaluation and presentation. 'Kiosk' enables maternity professionals to support service users to participate on any device, at home, within clinics or almost any setting.
Goal 2: Strategically include maternity voices in service decisions that affect them	
Principle 3: *Transformation of individual maternity voices, wherever and however they are heard, into **coproduced local services** requires local leadership and coordination*.	Maternity services should **identify or appoint a Maternity Engagement Lead** and administrator with dedicated remit for coproduction, to: • Coordinate and act upon maternity Care Opinion feedback (principle 2), in collaboration with community engagement teams in boards. • Develop, chair and provide secretariat to a **Maternity Voice Partnership (MVP)**, with lay or co-chairing models working well in some areas. • Lead person-centred coproduction with other health or grass-roots services for pregnant people, or people who may become pregnant. Develop effective relationships and tailor local coproduction and advocacy approaches (principle 5)
Principle 4: *Transformation of collective maternity voices into strategic representation which can **inform national policy** requires national leadership and coordination*.	Implementation of a new, sustainably funded, **national Maternity Engagement Coordinator role** could: • Establish and chair a national MVP forum to support local Maternity Engagement Leads and lay-chairs (Principle 3) and optimise national data. • Coordinate cross-board activities, responses to national requests, shared learning and best practice, and facilitate consensus views on complex topics. • Represent and advocate for the national MVP forum on strategic groups which make decisions about maternity services (visualised below). • Align MVP activities with engagement models of other services with inequalities focus (principle 5).
Goal 3: Tailor approaches to include under-represented maternity voices	
Principle 5: *Consistent adoption of the Framework forms a national foundation of standards, upon which complementary approaches with **inequalities focus** can develop over time.*	As a national foundation of maternity engagement embeds, understanding of the social complexities, needs and preferences of populations, and the grass-roots organisations supporting them, will grow. Opportunities to tailor complementary collaborative or advocacy approaches with inequalities focus will emerge and can be developed to underpin local or national activities.

SME Framework Implementation Toolkit

Introduction

The Scottish Maternity Engagement Framework (SME) has been coproduced by the Scottish Perinatal Network (SPN) with maternity services and service users, third sector and other strategic partners. It comprises five principles to implement three key goals for effective maternity service user engagement, and a toolkit of suggestions and resources to support their adoption. It is primarily for maternity and service user engagement professionals in Scotland. It seeks to provide additional advice and guidance to build on and enhance the existing activities by Scottish maternity services to engage with their users.

The terms woman/women have been used throughout this Framework, as this is how most people who are pregnant and having a baby identify. For this document, the terms include girls and people whose gender identity does not correspond with their birth sex or who may have a non-binary identity. Healthcare professionals should be respectful and responsive to individual needs and ask people how they wish to be addressed throughout their care.

Context

This Framework exists on a busy landscape of other national guidance about engagement and volunteering, including:

- Health and social care - Planning with People: community engagement and participation guidance (SG & COSLA) (updated 2024): sets out responsibilities of NHS Boards, local authorities and Integration Joint Boards around community engagement when health and social care services are being planned or changed and supports them to involve people meaningfully. It aligns with:
  - Health and Social Care Standards: My support, my life (2017)
  - National Standards for Community Engagement: We believe communities matter and Scottish Co-production Network
  - Independent Review of Adult Social Care in Scotland (2021)

- A complementary Quality Framework for Community Engagement and Participation (HIS) and Participation Toolkit (2023) support standards and consistent practice. They include a mechanism for paying expenses of volunteers but not remuneration.

- Community Engagement and Transformational Change Directorate is part of Healthcare Improvement Scotland (HIS), the national improvement agency for Health and Social Care in Scotland, with a network of staff who support each of the 14 NHS Scotland Boards. By including people and communities they aim to drive better health and care through meaningful and quality assured engagement, innovative system redesign and sustainable improvement, including in maternity services. It is governed through the Scottish Health Council. Its focus is on the strategic direction of services rather than addressing the care of individuals or their complaints.

- NHS Healthcare Improvement Scotland (HIS) Volunteering in Scotland Programme: provides infrastructure, resources and tools to support engagement with and management of volunteers. Led by NHS Scotland Volunteering Advisory Board, it facilitates peer support and best practice through a Volunteer Managers Network.

Within this broader policy context, this Framework intends to provide complementary principles and operational suggestions about how they can be applied in maternity services.

Background

In 2004, Scottish Government (SG) mandated that all NHS Boards in Scotland should have a Maternity Services Liaison Committee (MSLC). In 2020, a review of the MSLC model (HIS) described persistent challenges with leadership, implementation and sustainability of MSLCs. In response, SG commissioned the SPN to complete an options appraisal (2021), then to develop its recommendations into a business case for improvement (2022/2023).

The business case included a Health Inequalities Impact Assessment (HIIA) (gap analysis), Equality Impact Assessment, and Maternity Service Engagement Analysis Report (2023), synthesising professional views about maternity engagement assets, challenges and opportunities, with service user views. This analysis demonstrated consistent appetite to improve maternity engagement in Scotland, constrained by shortfalls in leadership, operational guidance, and mechanisms for strategic influence. These could be addressed efficiently and effectively by targeting national support in 5 key areas: communication, feedback, coproducing local services, informing national policy and tackling inequalities.

SG accepted the recommendations of the business case and commissioned SPN in 2023 to coproduce this Framework of goals, principles and minimum standards to provide practical, operational support to maternity services seeking to improve maternity engagement in Scotland. This Framework references the findings of the Maternity Service Engagement Survey Analysis Report (linked above) rather than replicating already published information.

The framework is structured as a cumulative improvement cycle, where building on each principle supports delivery of the next, starting with effective communication. Building on the principles collectively supports delivery of three minimum standard goals for maternity engagement in Scotland, wherever people may live.

It does not seek to stop or replace any existing activities. Suggestions can be interpreted and adapted to align with local processes, preferences or governance.

The Framework was ratified by the SPN Oversight Board in March 2024.

Goal 1: Gather, listen, and respond to maternity voices locally

Principle 1: *Effective communication is a prerequisite to maternity engagement.*

Rationale

Maternity services are encouraged to be proactive in designing a blended approach that provides the benefits of both digital and in-person communication opportunities. This would be especially valued by pregnant or new parents who live in remote and rural areas or are more at risk of social isolation.

The Maternity Service Engagement Survey (analysis report linked in the background section) found that service users need opportunities to communicate with local services that fit into their lives, through a mixture of in-person and online formats - leaflets and posters, websites and social media, phone and text message, face-to-face with health professionals, and with other parents and community groups.

They overwhelmingly preferred to receive communications, including about changes to services and opportunities to get involved, directly from a midwife or other professional from the NHS, other public or third sector.

Suggestions and Resources for Implementation

Suggestion 1: Reinstating In-Person Communication Opportunities

Boards could reinstate in-person groups that were paused during the COVID-19 pandemic and develop new options to support communication with service users. This is supported by The importance of social support in pregnancy and ways to connect with others (2023) work by Tommy's and the Scottish COVID-19 Inquiry's listening project 'Let's Be Heard' (2024).

Suggestion 2: Exploring In-Person Communication Opportunities

Service users said that all groups, whether facilitated by health professionals, charities or community volunteers, present an opportunity for parents to support each other and for health professionals to communicate with them. For example:

- **In-person opportunities for expectant parents to support each other** could include facilitated groups where pregnant women and/or dads and partners meet for the purpose of supporting each other. However, it could also be an incidental benefit of groups facilitated for another purpose, such as antenatal classes or feeding workshops.

- **In-person opportunities for health professionals to communicate with expectant parents** could include groups for pregnant women, or groups for people with other shared interests, backgrounds or characteristics. For example, by reaching out to local groups for people with shared faith, culture, ethnicity, first language, health conditions or anything else, and talking to members who are pregnant or have used maternity services. Interviews or focus groups could be useful.

To the extent possible, service users thought in-person groups should share characteristics:

Characteristics of Successful Groups	
Monitored and Managed	Well Chaired and Facilitated
Attendees and Hosts are Supported	Buddy System
Networking with Parents and Professionals	Locally Available
Provides opportunities for service users to speak directly to professionals	Avoids Scaremongering and Negativity
Informed by service user (rather than professional) availability	Have hybrid and 'drop-in' options

Suggestion 3: Mapping Local Groups

Mapping the groups in local areas for, or which may be accessed by, pregnant women and/or dads and partners could be a good way to understand service users and their communication needs. Building relationships with group chairs or leaders could help facilitate direct communication with people accessing existing services, or development of advocacy approaches. It could also help identify gaps and opportunities to collaborate and coproduce solutions to reach under-represented groups and people not reached by existing provision.

Inspiring Scotland have created an interactive directory for local groups related to perinatal and infant mental health.

Suggestion 4: Antenatal In-person opportunities

Service users made the suggestions for antenatal groups which could be hosted at local maternity units, coinciding with clinics and for parents at similar stages of pregnancy.

Topic/Theme Suggestions for Antenatal Groups	
Infant First Aid	Preparing for Parenthood
Early Pregnancy	Birth Choices (including Home Birth)
Fathers and Partners	Surrogate Parents
Family and Friends	Community or Hospital Walking Groups
Working Parents	Pregnancy Yoga
Perinatal Mental Health	Pregnancy After Loss
Sleeping Support	LGBTQ+ Parents
Remote and Rural Community	Maternity Voices Partnerships

They thought 'Early Pregnancy' (first trimester) group options could help newly pregnant women to support each other while preparing to disclose pregnancies to friends and family.

'Preparing for Parenthood' classes could be professional-led and offered from around 36 weeks' gestation, covering topics like breastfeeding, making formula, collecting colostrum, changing nappies, bathing, making cot bed, safe sleep, lack of sleep, and mental health.

Suggestion 5: Postnatal In-person opportunities

Service users suggested that, unlike antenatal groups, postnatal groups should not be hosted at local maternity units. They thought returning to them after the birth may be difficult for some, especially those with difficult birth experiences.

They suggested some topics:

Topic/Theme Suggestions for Postnatal Groups	
Breast Feeding	Baby Yoga/Baby Massage/Baby Gym
Parents of Children with Health Issues	Becoming a Parent
Postnatal Mental Health	Infant First Aid
Baby Walks and Pram Meetings	Bottle Feeding
Parent and Baby Exercise	Birth Trauma
Age and Stage sessions	Baby Sensory
Physical Recovery after birth	Parents of Multiples
Community Cafes / coffee mornings	Families with Shared Culture/ Beliefs
Drop-in Play Events	Weigh in clinics

Suggestion 6: Antenatal and Postnatal Digital Opportunities

While valuing in-person opportunities, service users sometimes found scheduling and travelling while pregnant or with babies challenging, so needed digital options as well. Although neither digital literacy nor internet access can be assumed of all service users, digital and online platforms have clear potential as communication tools.

For example, phone or NHS Near Me calls, email and text messaging are still useful channels. Maternity services should consider having a dedicated shared mailbox for receiving and responding to feedback. Text messages can be generated in the preferred language of the service user. Group sessions can be facilitated on Microsoft Teams, Zoom or WhatsApp. Drop-in sessions can be more practical and accessible online, for those with access to the internet or a smart phone.

Most service users who responded to the Maternity Engagement Survey felt there should be an interactive NHS Maternity Engagement social media presence, and two-thirds thought it should be on Facebook. They thought it should be part of a suite of approaches, though, acknowledging some may not be comfortable with or have access to communications there.

More detail on professional and service user views on communication is in the analysis report. Whatever the channel, communications should be person centred and flexible.

Suggestion 7: Social Medial and Maternity Services

Boards could utilise social media pages and online communication platforms where they already exist or establish an online presence that antenatal and postnatal service users can follow to hear about what support is available in their local area. This could be through development and review of service and Board level websites, Facebook pages, Instagram and Twitter accounts, and/or other local platforms.

Health professionals reported varied experiences of using social media. They advocated for robust moderation of accounts and governance structure around posting and responses, while recognising capacity challenges of this. Most Boards have a local social media Policy, and maternity services should align themselves with these and access support from their communication teams. For example, this is the NHS Tayside policy.

Boards with existing Facebook pages suggested developing a strong profile which manages expectations about what the channel should and should not be used for. For example, stating clearly that clinical responses are not available, encouraging a supportive peer community and signposting other channels for clinical questions or feedback as appropriate.

Here are some examples of maternity Facebook pages in Scotland:

Examples of NHS Board Maternity Facebook Pages	
NHS Fife	facebook/healthypregnancyfife
NHS Grampian	facebook/DrGraysWomenandChildren
NHS Highland	facebook/birthab/ and facebook/highlandmaternityvoice
NHS Lanarkshire	facebook/NHS-Lanarkshire-Mums-Babies
NHS Lothian	facebook.com/HavingABabyInLothian
NHS Orkney	facebook/orkneybalfourmaternity
NHS Shetland	facebook/Shetland-Maternity-Unit

Suggestion 8: Evaluation and Planning

Boards should evaluate their current engagement activities and use existing resources and guidance to initiate new activities and groups, as per their local population needs.

Evaluating engagement activities is key to reflecting on what is working well, where improvements can be made, assessing the impact and value and deciding the best ways to target resources in future. Here are some resources to help with evaluation and planning.

Evaluation Resources	
Healthcare Improvement Scotland and Scottish Health Council	Evaluating Participation; A Guide and toolkit for health and social care practitioners
Health and Social Care Alliance Scotland: People at the Centre	Lived experience Knowledge Hub Guidance
Scottish Recovery Network*	Let's Do Peer Support Bump, Birth & Beyond
Inspiring Scotland*	Perinatal Peer Support Evaluation Toolkit
-From further afield-	
University of Bristol (England)	How to evaluate public engagement projects and programmes
Centre of Excellence on Partnership with Patients and the Public (Canada)	Patient and Public Engagement Evaluation Toolkit

*****Developed initially to support recovery following perinatal mental illness but are considered to promote wellbeing and preventative benefits in any pregnancy context.

Principle 2: *Reciprocal feedback mechanisms can support maternity professionals to listen and respond to service users and find common themes.*

Rationale

Service users said that reciprocity is important to them. If they gave feedback, they would expect a response, especially if it suggests improvement is needed.

They preferred to give positive feedback online, face to face, or writing a letter or email. Writing a letter or email became the top preference if feedback was negative. They wanted to know how to give feedback to their maternity services and for this to be easy to do.

Engagement professionals said collation of feedback and responses often follows the 'You Said, We Did' model to acknowledge and thank service users for their feedback and inform them how it has contributed to improvement, but mechanisms could be inconsistent. Opportunities for service users to give and receive feedback depended on where they lived and accessed services, which contributed to inequalities within and between boards.

All Boards had started to address this through implementation of Care Opinion, a social enterprise which takes a value-led approach to online feedback. Care Opinion enables people to share the story of their care and can help services to respond to individuals and collate qualitative and quantitative data to inform changes to services.

Professionals using the platform had identified benefits, no notable drawbacks and were achieving an average 95% feedback response rate, but there was significant variation in whether and how it had been implemented in maternity services.

Suggestions and Resources for Implementation

Suggestion 1: Care Opinion in Maternity Services

The Care Opinion platform is suitable for rapid roll-out across maternity services in Scotland with immediate effect to improve board level and national consistency and reduce inequalities. It is suggested a Maternity Engagement Lead is recruited or appointed with remit to coordinate Care Opinion activities. There is more about this at **Principle 3**.

Care Opinion is a subscription based service, endorsed and licenced for all NHS Boards nationally by Scottish Government until 2026. Therefore, it is free to maternity services.

Each Board already has supporting infrastructure. Care Opinion Operational and Executive Leads, usually based within local Patient Experience Teams, can support implementation aligned with local processes and needs. Maternity services should identify and liaise with these colleagues. To find out who they are in your board, contact: info@careopinion.org.uk.

Care Opinion offers free bespoke training to NHS Boards on request. There are limited free resources available, such as leaflets and flyers, and additional resources can be purchased from Care Opinion as required from sales@careopinion.org.uk.

Full detail about functionality is on the Care Opinion website. Here are some of the ways it might be useful in maternity services:

➢ Inclusion and Reach

Care Opinion could support maternity services working towards **Principle 5**. For example:

- inclusion of maternity voices of service users with digital literacy or accessibility challenges. It has online and offline functionality, including a **Freepost form** and a **Freephone number** where Care Opinion colleagues can help maternity service users to complete their feedback for upload onto the website.
- enabling maternity service users to provide feedback in their preferred language or format, and service providers to receive it in their own preferred language or format. Care Opinion has functionality and Grammar checker in **120 languages**, including ISL and British Sign Language, and Voice Reader and Picture Story options. Website contrast features and font sizes can be changed.
- Care Opinion **Kiosk** options can be installed in static or mobile devices, so maternity professionals could encourage and support service users to feedback at clinics or in their homes or communities (see **Clinics and Communities**).

➢ Anonymising, Moderating and Responding to Feedback

Participants choose an anonymous username when submitting a story or comment to Care Opinion, and they can remain **anonymous** throughout if they choose. Each submission is **monitored** and **moderated** by Care Opinion staff, who allocate a score (1 – 5) to show how 'critical' they think it is, for consideration by maternity staff. Maternity services can choose to respond **privately** to service users and/or **publish** stories or responses on Care Opinion. No story about maternity services would be published without **consent** from the service.

➢ Sharing and Using Materials

Service users choosing to participate want their stories to get to those who can use them to make a difference, so Care Opinion enables stories to be shared subject to a Creative Commons licence and Crown Copyright. This means maternity services could **share**, **distribute** and **display** postings, and use them in their work, if they credit the source.

➢ Data and Reporting

Care Opinion has a self-service function, where feedback tagged to Maternity (or any) service can be extracted and downloaded by staff as, for example, word clouds and tables showing trends over time. Services receiving large amounts of feedback through Care Opinion can contact the Healthcare Improvement Scotland Data Measurement & Business Intelligence team for help with analysis or to create a feedback dashboard to meet their needs by emailing his.dmbiteam@nhs.scot. Qualitative and quantitative feedback data from Care Opinion can be analysed to inform coproduced local services (**Principle 3**) and national policy (**principle 4**).

➢ Raising Awareness

Services implementing Care Opinion should consider how to raise awareness amongst staff and service users and encourage and support its use. For example, including a QR code or link to Care Opinion in email signatures, 'You Said, We Did' communications and on posters and leaflets at clinics, can enable service users with a digital device of their own to feedback. Tablets in clinics or units could enable feedback at appointments, inpatient, or at discharge.

Suggestion 2: Care Opinion in Clinics and Communities: Kiosk Option

Boards could offer opportunities for service users to feedback at clinics and at home or community visits and support them to do this.

The Care Opinion 'Kiosk Option' can be downloaded onto any digital device. Upon request, Care Opinion staff can install the Care Opinion platform onto devices and provide technical support specific to use of the platform.

Maternity services can support financial inclusion by providing and maintaining digital devices (such as tablets) with Care Opinion Kiosk Option installed, within clinical areas. This enables service users to feedback anonymously on Care Opinion even if they do not have an internet enabled device or data.

Participation can be encouraged and facilitated by unit staff. This support may enable service users with complex social circumstances or other barriers to have their say. Once feedback is submitted, devices reset for the next user.

Care Opinion is available in 120 languages, and using Kiosk Option on mobile devices to take the platform to service users wherever they are could further increasing accessibility and reach. For example, community midwives could offer and support feedback opportunities at home visits or other locations.

While enabling feedback through Care Opinion, maternity professionals can also raise awareness of local peer support and volunteer opportunities, such as Maternity Voice Partnership (MVP) activities (see **Principle 3**) and support them to get involved.

Suggestion 3: Complaints Processes, Rights and External Feedback Channels

Boards have complaint management processes, which have a related but distinct function to feedback processes and are not considered in this Framework and toolkit. Service users can also choose to access support from the independent, third sector Patient Advice and Support Service (PASS) at Citizens Advice Scotland. PASS supports anyone who uses the NHS to understand their rights and responsibilities as a patient in Scotland, and to advise those who wish to raise concerns, give feedback or comments, or make a complaint about NHS treatment (including maternity care) in Scotland. While PASS has a role as an escalation pathway for individual service users, it is not recommended as the primary channel for maternity service feedback and engagement.

Goal 2: Strategically including maternity voices in service planning that affects them

Principle 3: *Transformation of individual maternity voices, wherever and however they are heard, into coproduced local services requires local leadership and coordination.*

Rationale

While important, embedding Goal 1 alone (effective communication and feedback mechanisms) cannot by itself deliver service level change. A complementary mechanism is needed to transform knowledge into action. The resilient embedding of coproduction approaches which can deliver change needs intentional coordination and leadership.

As described in the **context** section, there is fast-moving broad national guidance about engagement, volunteering and coproduction, to be adapted for local needs.

In the maternity context, there is also need for multi-professional, person-centred alignment between maternity engagement activities and those of other perinatal services or partners (such as neonatal or perinatal mental health engagement), and non-perinatal services or partners which pregnant women may also access (such as diabetes or cardiology services, and grass-roots community or faith groups).

Suggestions and Resources for Implementation

Suggestion 1: Maternity Voice Partnerships

Each Board in Scotland should establish a Maternity Voices Partnership (MVP), where there is not one currently in place.

An MVP is a volunteer working group of women and their families and community representatives working together with NHS staff to support the development and co-production of maternity services with service users.

➢ MVPs in Scotland

Three of the 14 Scottish boards have fully implemented the MVP lay-chair model:

- NHS Lothian had sustained the MSLC model since the 1980s, largely through the exceptional input of its long-serving lay-chair. It rebranded to Lothian MVP in 2019, maintaining and building on the strengths of its MSLC remit, leadership and membership. Lothian MVP, in partnership with University of Edinburgh, has secured grant funding for important research about attracting MVP membership which is representative of the maternity service user population. Lothian MVP uses a website to raise awareness and invite service users to Get Involved.

- NHS Grampian had sustained the MSLC model for around 5 years, when it rebranded to Grampian MVP in 2019. It operates a 'satellite' approach, with one network lay-chair providing oversight and support for two satellite groups integrated in local communities (often covering remote and rural areas), each group with two or more lay co-chairs. This model is evolving in Grampian and learning will be useful in other areas with geographical challenges. Groups meet in-person or online depending on the geography covered. In 2024, Grampian MVP are implementing local feedback forums in a bid to provide a balance of service-user friendly sessions alongside more formal, action-focused meetings and other feedback platforms like Care Opinion.

- NHS Highland had initiated an MVP approach around 2020, led by a lay-chair. Highland MVP is currently a single service, but similar to Grampian is exploring the challenges of reaching remote and rural populations.

NHS Forth Valley and NHS Tayside have emerging staff-led MVPs, with NHS Greater Glasgow and Clyde working towards adopting the model in 2024.

➢ Learning from MVPs in England

Implementation of MVPs in England was a recommendation of the 2016 'Better Births' report. Movement towards perinatal approaches through Maternity *and Neonatal* Voices Partnerships (MNVPs) is reflected in NHS England three-year Delivery Plan for Maternity and Neonatal Services and Maternity and Neonatal Voices Partnership Guidance (2023). NHS England published its report on Maternity and neonatal services – Listening to women and families and MNVP resource allocations in May 2024. There is lots of useful learning for Scottish MVPs from the experiences of implementing them in England, and progress towards MNVPs, although commissioning and funding models are very different.

➢ National Maternity Voices (NMV) Resources for MVPs

National Maternity Voices (NMV) is an association of Maternity Voices Partnership Chairs. It is a Community Interest Company, established in 2019 (and originally commissioned by NHS England) to support the work of MVPs. NMV is no longer commissioned by NHS England, but continues to support MVPs by:

- Sharing ideas and resources to support NHS staff and service users working together in MVPs to improve local maternity and neonatal services and their influence.
- Providing a free-to-use MVP Toolkit to support MVP initiation, development and maintenance in England, which may be adaptable for Scottish context.
- Adding MVPs to an interactive UK map, to support visibility for service users and other MVPs seeking to collaborate or share learning.
- Producing a newsletter MVP members can sign up to.
- Providing purchased services, such as chair training, mentoring and consultation.

NMV does not:

- Direct or supervise MVP chairs.
- Adopt a policy position, to protect local MVPs as open spaces where all views, including minority perspectives, can be freely shared and discussed
- Act as a "national MVP." All MVPs in England are local.

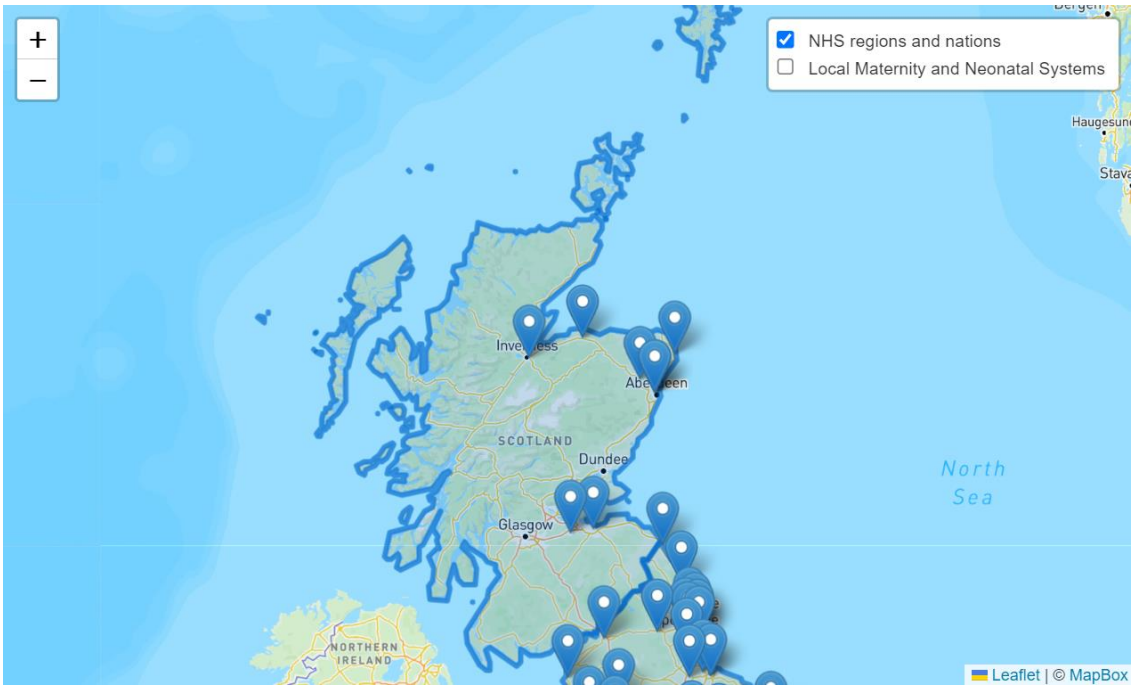


Figure 2. MVP UK wide interactive map

Suggestion 2: Maternity Engagement Leadership

Boards should identify or appoint a Maternity Engagement Lead and administrator with remit to, for example:

- Chair and provide secretariat to new or emerging local MVPs, working in parallel with or progressing to a lay or co-chairing model
- Act as Board-level point of contact for maternity-related engagement activities
- Liaise with relevant local maternity, perinatal and community engagement colleagues to align activities and share learning
- Provide dedicated maternity engagement leadership capacity within the Board
- Represent the Board in national discussions, advocating for maternity service providers and service users in their area
- Lead development of online and in-person engagement channels suggested at **Principle 1**
- Develop understanding of the local landscape of third sector partners and build relationships to enable engagement with under-represented populations
- Gather, analyse, and coordinate responses to maternity-related feedback, including moderation of Care Opinion responses
- Manage a shared mailbox for receiving and responding to feedback

Maternity Engagement Lead and Administrator remits could be standalone posts or integrated within existing roles, in whichever way works best locally. These roles will most likely be based within maternity services but depending on local circumstances, could also sit with community engagement colleagues with dedicated maternity remits.

The individuals who take on these roles must be clearly identified, as they would become internal and external points of contact for maternity engagement activities in the Board, lead local developments and represent the Board in national discussions, advocating for their maternity service providers and service users.

The Maternity Engagement Lead role should support and complement MVP lay-chairing models already in place, with NHS and voluntary colleagues working together to optimise the strengths of both sectors. For example, enabling the MVP to benefit from NHS IT and governance infrastructures where useful and lay-chairs to have a clear pathway to robust senior support within the board, while safeguarding the MVP chair's independence to freely advocate for and represent the experiences and interests of service users.

The Maternity Engagement Lead should be able to interface and align maternity engagement activities proactively with those of other services or networks accessed by the same service users, such as for Neonatal or Perinatal Mental Health care.

Building on the in-person and digital, antenatal and postnatal, communication examples at **Principle 1**, they should build relationships and develop direct, and advocacy approaches with wider third sector or other local organisations supporting people with protected or under-represented characteristics, including while they are also maternity service users. For example, Shelter Scotland, which supports people affected by homelessness, Stonewall Scotland, which supports people who identify as LGBTQ+, Circle, which supports families facing complex social circumstances. There more about this at **Principle 5**.

Maternity Engagement Leadership Examples

Four Boards have current or previous examples of leadership structures, which could help Boards decide a Maternity Engagement Leadership approach that is right for them:

- NHS Grampian has dedicated resource within the maternity team for service-user engagement. The post (two-year fixed term, Band 7, Maternity Community Engagement Manager) was developed to enable service user engagement with high-profile service redesign activities but demonstrated multiple additional benefits over time. The post has since been extended and is jointly funded to support collaborative engagement activities which span perinatal and perinatal mental health policy and healthcare teams.

- NHS Greater Glasgow and Clyde has established, integrated, dedicated maternity engagement resource within the Patient Experience Team. Remit includes responding to maternity feedback, complaints, data gathering and analysis and activities following an adverse event. The current postholder presented at the Maternity & Midwifery Festival in Edinburgh in 2023 about optimising BadgerNet functionality to tackle language barriers in engagement opportunities and is working towards launch an MVP approach in 2024.

- NHS Highland (Argyll & Bute) piloted a dedicated resource within the maternity team with remit for service-user engagement (fixed term, 0.2 WTE), but could not be sustained due to task exceeding capacity and non-recurrent funding.

- NHS Tayside has no staff with dedicated maternity-specific service user engagement remit but routinely identified appropriate resource tailored to the feedback received. They initiated an MVP approach from existing capacity which stalled for capacity reasons but is currently being reinvigorated.

Please reach out to these boards directly to learn from strengths and challenges of the approaches and develop an approach to meet local needs, or email nss.perinatalnetwork@nhs.scot for help to contact them.

MVP Chairing Considerations

It is suggested that the Maternity Engagement Lead should chair new or emerging MVPs in the first instance, with a view to transitioning to an independent or third sector lay-chair once established. Some Boards already have a lay-chair or may prefer a co-chairing approach.

All current MVP staff and lay-chairs reported difficulty sustaining their resource-intensive chairing roles and concern that existing MVPs are person-dependent and would fail if individuals stepped down. This echoed the systemic weaknesses identified by HIS in their (2021) review of the MSLC model linked in the background section. Clear and dedicated Maternity Engagement Leadership capacity anchored within each Board could address these factors. More about this under **Principles 4 and 5.**

In moving to a lay-chairing or co-chairing model, Boards should be thoughtful that while NHS England has a national Patient Public Voice (PPV) Payment Policy (2021) – which recommends "involvement payments" for volunteers in "roles that demonstrate strategic and accountable leadership and decision making activity" (such as MVP chairs) – NHS Scotland does not currently have an equivalent mechanism. Adoption of a similar approach will be a consideration for NHS Scotland more broadly and having a strong collective voice from the maternity community representing the needs of MVPs will be important in those wider national policy conversations.

The SG 'Out of Pocket' expenses guidance was updated in collaboration with HIS in November 2023, alongside other guidance described in the **Context** section above. It focuses on volunteering to support operational delivery of NHS services more than stakeholder engagement and does not fully account for complexities of regular remuneration of volunteers or employment law (such as entitlement to benefits, pensions and protection).

MVP Administrator Considerations

Basic administrative support is routinely provided by NHS Boards to their local MVP(s), such as managing stakeholder contact lists, arranging and facilitating meetings and events. Most MVPs in Scotland meet six times per year.

Secretariat is currently a resource intensive element of the lay-chair role. Opportunities to enhance how administrative support is provided to MVPs should be considered alongside local decisions about identifying or recruiting a Maternity Engagement Lead.

Most MVPs adopted a digital first approach to meetings during the COVID-19 pandemic and are still considering how to move to hybrid options, including travel and accommodation costs and complexities of in-person events.

In Scotland, lay-chairs highlighted the need for IT and communications support. Where possible and helpful, MVPs should optimise the strengths of NHS IT and GDPR compliant infrastructures, such as secure generic email addresses and mailboxes. The strength of the NHS brand may also be reassuring for some service users, while others may prefer independent platforms such as Gmail or WhatsApp.

The Maternity Engagement Coordinator and Administrator should liaise with local Communication, Marketing, Engagement or other relevant teams to develop approaches to meet service provider and service user needs in their Board area.

Principle 4: *Transformation of collective local maternity voices into strategic representation which can inform national policy requires national leadership and coordination.*

Rationale

Learning from challenges with MSLCs in Scotland, as well as learning from success with MVPs across the UK, suggests that national coordination and support is needed to facilitate national consistency in maternity service user engagement. This national coordination should enhance and build on strengths, and support the national flow of learning, best practice and peer support.

Suggestions and Resources for Implementation

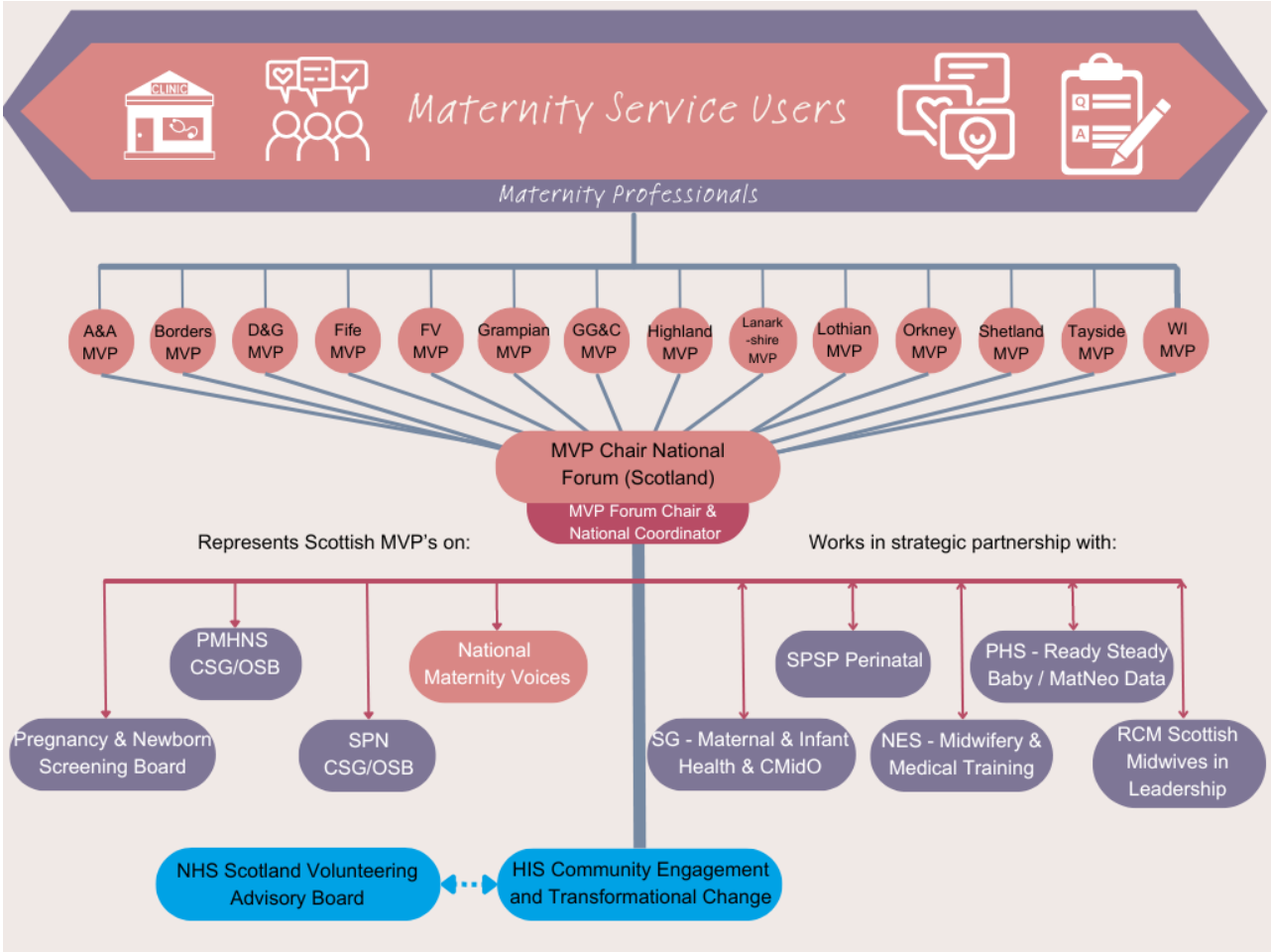
National support for maternity service user engagement would best be provided through a sustainably funded national Maternity Engagement Coordinator role.

Suggested Remit for National Maternity Engagement Coordinator	
Maintain a 'Once for Scotland' overview and national standards for maternity engagement.	Provide a central point of contact for local and national partners seeking service user input to projects or workstreams and coordinate appropriate representation.
Support local and national coproduction activities in Scotland.	Coproduce an MVP NHS staff and lay-chair training programme for Scottish needs and context, with NHS Education for Scotland, local MVPs and other partners. Support ongoing delivery of the programme.
Establish, chair and provide secretariat to a national MVP Chairs Forum to facilitate a mechanism for peer support, shared learning and consistent adoption of best practice.	Manage national communication channels for maternity service user engagement, e.g. social media. Facilitate communication flow, consistency and reach between local and national platforms.
Manage national maternity Care Opinion and other engagement data to inform national policy, with analyst support from HIS. Support local Maternity Engagement Leads to harness and interpret local data to inform local and national coproduction approaches.	Support Maternity Engagement Leads and lay-chairs to map third sector and other organisations and manage relationships.
Facilitate coproduction and advocacy approaches to include people with protected and underrepresented characteristics.	Strategically represent and advocate for MVPs in key governance structures.

The role is likely to be best developed within the HIS Community Engagement and Transformational Change structure and should consider the most appropriate level[1] to enable effective national coordination and strategic influence.

In NHS Grampian a dedicated engagement role which spans perinatal and perinatal mental health engagement activities has been successful. This model could be explored for national context as an integrated and jointly funded approach.

Wraparound support, management and administrative support for the role could be accessed through the wider Community Engagement team. The visual below suggests how, collectively, this approach could facilitate strategic influence.



[1] NHS England's Three-year Delivery Plan for Maternity and Neonatal Services suggests MVPs expand to be Maternity and Neonatal Voices Partnerships (MNVPs), with support from a coordinator role at Band 8A.

Goal 3: Tailor approaches to include seldom heard maternity voices and inequalities focus

Principle 5: *Consistent adoption of the Framework forms a national foundation of standards, upon which complementary approaches with inequalities focus can develop over time.*

Rationale

This Framework was developed to address the maternity engagement needs of most service providers and service users, most of the time.

Whilst there are limitations to what can be achieved through a broad national framework and toolkit, it forms an essential foundation to improve national consistency and promote minimum standards for maternity engagement activities.

As explored through the SPN Health Inequalities Impact Assessment (2022), some women are unlikely to be reached through a broad national framework and need different support or advocacy to be able to engage with maternity (and other) services.

Suggestions and Resources for Implementation

As maternity services in Scotland embed **principles 1 – 4**, engagement approaches will evolve and opportunities to develop mechanisms for reaching more people will emerge.

Suggestion 1: Diversity and Accessibility

Complementary work will be needed to understand and respond to diverse requirements of local populations across Scotland, including those with protected or underrepresented characteristics or complex social needs. Approaches will need to be iterative and tailored to these, and other factors such as service design and geography.

Maternity services should take a life-course approach to designing engagement mechanisms, and seek to take engagement opportunities to women, dads and partners, and the people who support them, where they are - not just where maternity services are.

Building on **principle 3**, you could contact chair.grampianmvp@gmail.com to find out more about using MVP 'satellite' approaches to reach women in remote and rural communities who may be most vulnerable to social isolation.

Suggestion 2: Collecting and Understanding Inequalities Data

Public Health Scotland (PHS) published a suite of resources to help improve collection and understanding of equalities data on the PHS website. Resources include training on how to collect patient equality and needs data and leaflets for patients and professionals. Data tailored to perinatal context is available through the Mat Neo Data Hub.

Suggestion 3: Education about Inequalities

The Cultural Humility digital resource was created by NHS Education for Scotland and NHS Scotland Academy to develop understanding of diverse cultures and backgrounds to enable use of appropriate, respectful and meaningful language and engagement approaches.

NES has adapted its introductory anti-racism training for line managers into a digital resource available for all health and social care staff in Scotland. Short films cover definitions, discrimination and harassment, power and privilege and actions that can be taken.

Leading to Change is a Scottish Government programme of work commissioned to NES as the main delivery partner. Leading to Change complements leadership development and support at local levels for the health, social work and social care workforces in the public, independent and third sectors.

The Leading to Change Allyship Hub has been developed to support leaders at all levels across social work, social care and health to become active allies against inequalities. It includes a downloadable toolkit for individual or team support and development.

Useful insights can be drawn from the Listen to Mums: Ending the Postcode Lottery on Perinatal Care (2024) report by The All-Party U.K. Parliamentary Group on Birth Trauma.

Suggestion 4: Interpreting and Translating

In 2020, NHS Scotland published the Interpreting, Communication Support and Translation National Policy as 'a clear, consistent, transparent and fair approach to the provision of information and communication support for all'. Local NHS Equality and Diversity Leads should be contacted for further guidance in providing interpretation and translation support services. NHS England guidance on Guidance on interpreting and Supporting Effective Interpretation within Maternity Digital Toolkit (2023) may also be useful. A parallel resource pack for Scotland is being developed by the Scottish Government.

Public Health Scotland (PHS) hosts a list of NHS Scotland Equality and Diversity contacts for each area. They publish patient resources in many languages, including easy-read and British Sign Language. PHS can be contacted for support translating documents at phs.otherformats@phs.scot.

Building on **principles 1-3**, preferred language of maternity service users is gathered at midwifery booking appointment and recorded on BadgerNet. Where possible, preferred language should be used in all communications. Find out more about NHS Greater Glasgow & Clyde's approach to using preferred language in maternity surveys using text messaging.

Suggestion 5: Third Sector Reach and Collaboration

Third sector and grass-roots staff and volunteers' often work directly with people who are disadvantaged by systemic barriers or racialised inequalities, and who are likely to be underrepresented or missed by broad national approaches.

They may have developed trusted and therapeutic relationships with individuals or families over time which span many life events, including pregnancy, and be able to support them to participate if they are made aware of engagement opportunities.

Building on **principles 2 and 3**, Maternity Engagement Leads should reach out to these colleagues to develop shared understandings of how they each support local populations, where there might be overlap or people accessing both.

Two-way communication channels should be established, so maternity professionals know who to contact for feedback from specific population groups, and third sector professionals know who to contact with any maternity service specific feedback that they receive.

Third sector colleagues could help identify service users who would like to engage with maternity services about topics important to them, or important to maternity services. They could support facilitation in places and ways which are sensitive and considerate of the circumstances or needs of their service users.

Relationships between a third sector and maternity colleagues could also have benefits beyond engagement context. For example, a woman with complex barriers to accessing services, such as homelessness or substance misuse, may be more likely to disclose pregnancy to a trusted third sector colleague or a maternity colleague they meet in a space where they feel safe. This could help enable sensitively facilitated earlier antenatal care.

Suggestion 6: Third Sector Advocacy

Trusted and therapeutic relationships between third sector colleagues and individuals or families can also enable them to collate, safeguard and advocate for individual or collective needs of their service users in local and national public sector forums.

This may be helpful where service users are likely to be experiencing multiple complex social factors and inequalities, and direct approaches might be inconsiderate, unfair or ineffective.

For example, Amma Birth Companions support refugee and asylum-seeking pregnant women who might otherwise give birth alone. They advised it could be inconsiderate to ask their service users to participate in the survey which informed development of this framework about ways to engage with maternity services, when the women may have significant language barriers and limited knowledge of Scottish healthcare systems, recourse to public funds or housing. Inclusion of their experiences may be better achieved through advocacy. Amma colleagues offered valuable insights on their behalf for this framework and through their Birth Outcomes & Experiences report (2024).

Third sector advocacy in maternity engagement activities is unquestionably valuable. However, it is important to consider requests for third sector involvement in context, as they could compete for limited staff capacity and inadvertently impact a frontline service. Relationships and communication with third sector partners are key in managing this well.