Sharing maternity journeys in Maternity Voices Partnership (MVP) meetings

Guidelines followed by lay chairs in HCV Maternity Voices group

One important aspect of MVP meetings is to hear from recent maternity service users about their experiences. To keep the content appropriate for the multidisciplinary meetings we follow these guidelines:

Prior to someone joining the meeting to share their experiences we would:

- Listen to the person coming to speak prior to the meeting to hear their full story
- Explain that an MVP is not part of the complaints process in a Trust but an opportunity to share their feedback in a meeting with other parents, healthcare professionals and members of the MVP to help us improve maternity care for everyone
- Discuss how they would like to share their story, requesting that the information they share does not name specific members of staff, but is about the care they received and their views on this
- Contact the relevant lead professional (for example Head/Deputy Head of Midwifery) to let them know who wants to attend, the key points they wish to raise and confirm there are no issues with this.

We work to keep all feedback constructive so we can learn from peoples' experiences and encourage people to share their feedback as examples of themes and trends we have picked up during engagement events and surveys. Sometimes an individual's story is about an issue we haven't picked up from our wider engagement but their experience clearly highlights a need for development in the service and it is important their voice is heard.

We ask someone who has an active complaint* to wait to share their story at an MVP meeting until the complaint has been closed, but if they contact us and ask to speak at the meeting, we would liaise with professional colleagues to agree the best course of action.

Ruth Prentice

Lay Chair, Humber Coast and Vale Maternity Voices group

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*complaint includes formal complaints; complaints /concerns through Patient Advice and Liaison Service (PALS); Healthcare Safety Investigation Branch (HSIB) investigations; organisational Serious Incident (SI) investigations; Perinatal Mortality Review (PMR); litigation claims; coroners cases.