Maternity services liaison committees (MSLCs): a consensus statement from NCT, RCM and RCOG

Our shared views on the importance of engaging with women and their partners in the planning and monitoring of maternity services and the role played by MSLCs
Key recommendations

We recommend that MSLCs:

• Continue to exist, under the auspices of an appropriate body in the local health structure.
• Continue to be the main means of giving service users an influence over maternity strategy and delivery of the service.
• Are provided with a ring-fenced budget to make sure they can meet regularly in suitable settings, and that chairs and members have the appropriate training and support.
• Continue to act as strategic advisory groups that help create and maintain high quality maternity services, defined as those where women and their partners have a safe transition to parenthood and an experience that is positive and life-enhancing.
• Are constituted as at present and chaired or co-chaired by a lay user.
• Continue to have responsibility for creating mechanisms to elicit and collate both qualitative and quantitative input from users.

Introduction

“No decision about me, without me”

“Women and their partners want a safe transition to parenthood and they want the experience to be positive and life enhancing. Quality maternity services should be defined by the ability to do both.”

As users of the service, women and their partners can make valuable contributions to the design and provision of maternity care. For nearly 30 years, Maternity Services Liaison Committees (MSLCs) have been the means by which service users have been able to make those contributions. They have an excellent track record: maternity services have changed to meet the expressed needs of women, and their partners and babies, more than any other service. This is due, at least in part, to the unique approach of MSLCs, and their consensual, multidisciplinary ethos.

The structure governing healthcare commissioning in England has recently changed, casting into question the continuing role of MSLCs, which were set up under a different commissioning structure. This consensus statement sets out the reasons why we believe MSLCs should continue to exist under the new structure, and why we regard them as the best means of fulfilling the obligations of the new commissioning bodies to listen to the views of service users. We believe that the new structure, with its emphasis on user involvement, provides a good opportunity to strengthen the role of MSLCs.

Although the statement has a particular focus on England, we have taken into account user involvement policies and guidance about MSLCs from all four countries of the UK in making our recommendations. Scotland, Wales and Northern Ireland all have slightly different commissioning structures, but MSLCs play an important role in each of those structures, and we believe that they should continue to do so.
The role of MSLCs — and why we need them

MSLCs were introduced in 1984, as a way of providing an effective channel for users of maternity services to influence the local provision of maternity services. Each MSLC, which meets at least four times a year, is currently made up of representatives from the following groups:

- Users (local people who have had a baby recently or who are expecting a baby)
- The local primary care trust (PCT)
- Maternity healthcare professionals, such as obstetricians, midwives, neonatologists, health visitors and GPs
- Voluntary groups representing pregnant women and new parents, such as NCT

The role of the MSLC is to make sure that the body that commissions maternity services listens to, and takes account of, the views and experiences of both the users and providers of those services. As a result, MSLCs, since their inception, have played an important part in shaping the delivery of maternity services to meet the needs of users.

Because MSLCs have been so successful, there are good reasons to keep them in their existing form:

- MSLCs play a unique role in the health service. While maternity services share many of the challenges faced by other NHS services, the sector is unique for three reasons: a maternity episode starts with one woman and her partner; and ends with a family of three people or more; the majority of women and babies receiving care are not ill, but fit and healthy; and timing of activity is unpredictable — it cannot be demand-managed or controlled through referrals. Therefore the design and provision of this type of care cannot be supported by generic patient/user representation or feedback.¹
- Effective engagement with users of services can help to deliver inclusive and successful commissioning. A service supported by well-functioning MSLC will be accessible and attractive to women, trusted and valued by expectant and new parents. Meaningful engagement is about establishing robust, user friendly and sustainable mechanisms, not about one-off activities.²

The MSLC remit is to be a multidisciplinary independent advisory group to the commissioners.³ It is not a user group — the success of MSLCs derives from their role as a discussion forum for a variety of parties involved in maternity services. They enable different views to be debated and for the resulting consensus to be fully integrated into decision-making in an effective, timely and appropriate way.

MSLCs have broad support from all parties involved in maternity services: midwives, obstetricians and users (see ‘In their own words’ on page 11). A history of policies affecting MSLCs is given in the appendix.

MSLCs and the new commissioning structure in England

Under the changes and new arrangements for commissioning of maternity services set out in the Health and Social Care Act England 2012 Primary Care Trusts (PCTs) have been fully disbanded and Clinical Commissioning Groups (CCGs).formed principally of groups of GPs, will take over much of the commissioning of health care in England. Whilst responsibility will sit with CCGs, the NHS Commissioning Board will set a national framework for quality and choice, and will require CCGs to work collaboratively to ensure this is delivered.

Single commissioning groups of 250,000 populations generating only 3000 pregnancies per year will probably be too small to commission the full range of maternal-fetal medicine and high-risk services effectively. The most efficient model to adopt is a federated one, in which a lead commissioner takes responsibility for local negotiations with the main providers. Commissioning groups within a federation will need to jointly agree, at the outset, the principles underpinning local arrangements, which should include (among others):

- Outreach to vulnerable women encouraging them to engage with the services
- Contributing to the Joint Health and Wellbeing Strategy⁴

The NHS Commissioning Board’s requirements for a maternity service that:

- Is flexible, appropriate and accessible to all women
- Is provided in accordance with evidence and best practice
- Reflects local needs and priorities
- Seeks and acts on feedback from women and their families⁵

Strategic clinical networks

The new commissioning structure also sees the creation of strategic clinical networks. These are organisations that enable groups of health professionals, hospitals and other providers and commissioners to work together to make improvements in their local area, either in a particular pathway or for a particular group of patients.

The strategic clinical networks are designed to improve local accountability. They will be expected to involve patients and the public by supporting robust engagement processes that will inform the strategic development of services.

Four strategic clinical networks will be established immediately, one of which will cover maternity & children. Others may follow at a later date.

The strategic clinical networks have already begun clarifying their work plan and should be setting up a series of meetings to agree the detailed mechanisms by which they will engage with patients and the public. The existing MSLCs in each area team should be involved in this process.

Healthwatch

The new commissioning structure will see the creation of Healthwatch, a local independent consumer champion for health and social care that gives citizens and communities a stronger voice.

Healthwatch will have a seat on the new statutory Health and Wellbeing Boards. Its role will be to make sure that the views and experiences of service users are taken into consideration when the joint Strategic Needs Assessment (JSNA) is being undertaken and the Health and Wellbeing Strategy (HWS) is being developed. Clinical Commissioning Groups will need to take the JSNA and HWS into consideration when deciding on commissioning priorities.

Healthwatch will carry forward the functions of Local Involvement Networks (LINks) with some additional functions and powers.⁶ Because MSLCs have historically helped inform decision-making in commissioning maternity services, the role of LINks has been to focus on the needs of the elderly and patients with long-term medical conditions. Our view is that, because Healthwatch takes forward the historic functions of LINks, it is not currently in a good position to represent the needs of people who use maternity services.

Specialised services

Previously specialised services, which treat patients with rare conditions, were commissioned by PCTs. Under the new commissioning structure, they will be directly commissioned at a national level by the NHS Commissioning Board.

The specification for each relevant specialist service includes a paragraph setting out the requirements in relation to specialist maternal care. When they plan the commissioning for maternal care, CCGs will need to make sure that the commissioning includes specialist care from providers delivered within a dedicated, multi-disciplinary service staffed by a maternal medicine specialist, a physician and supporting multi-disciplinary team.

Friends and family test

The changes to the commissioning structure are informed by a commitment to making services more patient-centred. The mandate to the NHS Commissioning Board requires patients to have a positive experience of care. Every patient will be able to give feedback on their care in the form of a Friends and Family test — this will be a simple question such as, ‘How likely are you to recommend this service to friends and family if they needed similar care of treatment?’ The test will be introduced for users of maternity services from October 2013. The data derived from this test can be used to inform MSLC discussions and decision-making.
How MSLCs fit into the new structure in England

We believe that MSLCs represent the best medium for providing a voice for users of maternity services, and we recommend that CCGs, Healthwatch and Health and Wellbeing Boards explore the role MSLCs can play within their locality. The diagram opposite shows how we think the four organisational roles would fit together.

To make sure that MSLCs are effective, they should include representatives from the key commissioner and provider bodies relevant to maternity. These bodies should acknowledge the pivotal role of the MSLC and demonstrate clear lines of communication and accountability in relation to the MSLC within their own terms of reference. Maternity experience evolves all the time, and is dependent on both the shape of services and on the situations of women and their families. For that reason, constant feedback is needed from a diverse range of current service users.

By listening to service users, and linking these views with well-informed, evidence-based input from more experienced user representatives, health professionals and commissioners, MSLCs have an important role to play in the commissioning and provision of women-centred, high-quality maternity care. All commissioners in England should be making arrangements to implement a philosophy of ‘No decision about me without me’, using the MSLC as a model.

By providing a focus for users’ views, MSLCs are essential to the commissioning process. They can provide feedback which will help commissioners to ensure that they deliver women-centred care, meeting the needs and aspirations of women and their families.

MSLC

NHS Commissioning Board
- Local Area Team
- Allocates resources, oversees CCGs, develops commissioning guidelines. Supports clinical networks. Is responsible for neonatal care commissioning.

Clinical Commissioning Groups (CCGs)
- Hold budgets and commission services from various providers.

Local Authorities
- Host directors of Public Health. Fund and hold local Healthwatch (formerly LINks) to account.

Health and Wellbeing Boards
- Co-terminous with local authorities, they will scrutinise local health provision. Will lead on public health initiatives such as teenage pregnancy, smoking cessation. They have a duty to ensure commissioning of health and social care join up at local level, based on proper assessment of needs and joint strategies.

User/parent/community groups

Providers
- Hospital obstetric units, midwifery led units, home birth services.

GP Practices
- All GP practices must be members of CCGs.

Commissioning Support Service (CSS)
- Supports CCGs in delivering commissioning.

Note: The structures in Wales, Scotland, Northern Ireland and the Channel Islands have not changed.
How MSLCs work: some examples of good practice

Below are some case studies demonstrating how MSLCs are able to respond effectively to the needs of service users.

Tower Hamlets MSLC Project

In 2008, Tower Hamlets PCT commissioned Social Action for Health, a charity based in East London, to engage local mothers, especially from the Somali and Bengali communities, to involve them in their MSLC and consult them about their experiences of using local maternity services. Women were engaged through an existing consultation process with local people, known as health guides. These health guide sessions were one hour long, with up to 20 people, and facilitated by workers trained to run sessions in Bengali, Somali, Turkish, Gujarati, Urdu and Congolese.

The sessions recruited more than 30 interested women from a number of different communities including Chinese, Nigerian and Indians. Nine women were selected to represent these communities at MSLC meetings. An IAPT Voices training workshop, designed to prepare people to work effectively as part of a committee, was held for commissioners, health professionals and the new user representatives before the first MSLC meeting. (This workshop is shown in the photograph below)

The MSLC was launched at a public event attended by 91 local people. A DVD has been produced with user representatives informing local women, in their own languages, about the MSLC and how they can get their views heard.

Between 2009 and 2011, a collaboration between the MSLC and a mothers’ network called the Mothers Support Group (MSG) resulted in 10 community engagement sessions carried out in several different languages including Bengali, Chinese, Somali, Lithuanian and Urdu.

The MSLC now made up of 53 women drawn from these sessions, aims to create a supportive network, develop an opportunity for local people to attend and speak up at MSLC meetings as well as increasing awareness of how the services operate.

Women’s stories, user group reflections and local surveys were used to bring about change to an aspect of the services that had concerned many women from ethnic minority groups – that of staff attitude. Their views were followed up by a consultant midwife who worked on influencing midwives through supervision, encouraging them to reflect on their behaviour and its impact on women’s experiences. This work resulted in a reduction in the numbers of complaints and increased satisfaction with the maternity services.

Talkback: A Strategic Approach To Working With Maternity Service Users

Following a review of user involvement within the local maternity service in Stockport, the MSLC developed a strategic approach to building the capacity of service users to work with commissioners and providers. Talkback sessions, funded by the PCT, were arranged, aimed at giving maternity service users an opportunity to feed back their experiences. These included specific sessions targeting seldom-heard groups such as teenagers, fathers and Muslims. Over 100 parents shared their experiences with local midwives who solicited answers to the following questions:

• What went well?
• What could have been better?
• Do you have any suggestions for improving our services?

This was then shared with staff and local service users who had indicated they would like to be further involved. As a result, the Talkback group was formed, with approximately 12 members at each meeting from a making list of 40. The MSLC was then reinstated, with service users forming 75% of the membership. The MSLC’s lay chair attends MSLC meetings.

In an article in Practising Midwife, consultant midwife Debbie Garrod wrote, ‘The composition of service users in moving our service forward is invaluable. They make decisions that matter.’

In Your Shoes

A PCT commissioning manager in Newham recruited a facilitator to run an event at an inner London Children’s Centre, to provide an opportunity for local women to share their stories with midwives. It was also a chance for local women to find out what an MSLC is and how user involvement could improve local maternity services.

Interpreters were on hand for four different ethnic groups (Bengali, Somali, Chinese and Polish), and lunch was provided. The event was attended by 39 people, including the head of midwifery and numerous midwives from the local hospital. Each woman was given an opportunity to tell her birth story without interruption for 10 minutes while others in the small group listened to each story. The group was then asked to highlight three things that they liked about the maternity services and three things that needed some improvement, and together come up with some suggestions for those improvements. Discussion between the women and the midwives was very lively.

After lunch, a user representative from the local Tower Hamlets MSLC came to talk about why she became a user representative, how the MSLC works, and how the user group in Tower Hamlets had influenced changes in maternity care through the MSLC. People interested in joining the proposed new local MSLC were then invited to give feedback to the PCT commissioning manager and to suggest different ways in which they felt they could be involved. Giving people a range of options, or even asking them to suggest how they might want to be involved, offers a greater opportunity to engage a wide range of women than asking them to fill in a questionnaire or attend a meeting.

Walking the Patch

Walking the Patch was an idea originally developed by professor of midwifery Jacqueline Dunkley-Bent, head of midwifery education at London South Bank University, and Hazel Jones, former joint chair of the MSLC at Guy’s and St Thomas’ NHS Foundation Trust. ‘Walkers’ are user representatives who, one hour before an MSLC meeting, visit women and their partners on the postnatal wards and sometimes in antenatal clinics and bring their views directly back to the committee.

They have a guidance sheet to help them tell their story and make a difference.

Use the way forward

Under the new commissioning structure, the role played by MSLCs will be more important than ever. Below are our recommendations for how MSLCs can be strengthened and maintained at both local and national level.

The way forward

Local recommendations

To get the best out of your local MSLC

• Review the role of your local MSLC and explore new mechanisms for effectively working together within the commissioning structures.
• Celebrate and build on past MSLC successes.
• Highlight their role and status and establish sound communication links within current and newly developing structures for commissioning maternity services.
• Review their membership to take account of the local population in line with Healthcare Commission indicators for success (see appendix).

National recommendations

• Attention should be paid to the way in which MSLCs can be integrated into any future maternity networks or other potential new structures developed for commissioning services.
• Guidelines regarding payment of expenses for service users should be strengthened. The ability to make prompt payment of expenses is likely to improve the involvement of service users from disadvantaged backgrounds.
The Department of Health Guidelines for MSLCs, produced for England and largely adopted for MSLCs in Northern Ireland, Scotland and Wales, clearly identify MSLCs as an important role in advising on and monitoring all aspects of maternity care. Despite changes of government, policies and systems since they were first introduced in 1984, there is no reason to suppose that MSLCs are needed any less now. A 2007 review of maternity services in England by the Healthcare Commission stated that PCTs have a duty to ensure that MSLCs are in place and functioning properly if they are to meet their obligation of engaging stakeholders to improve services. The review put in place four indicators to measure the success of the MSLCs:

- At least 40% of committee members are user representatives.
- At least two minority groups are represented on each MSLC.
- At least four MSLC meetings are held a year.
- MSLCs are to share recommendations with the trust board or appropriate subcommittee at least once a year.10

Despite the abundance of policy driving health services to involve users, the 2008 report Towards Better Births found a mixed picture when it came to the functioning of MSLCs.11 The majority of trusts (72%) had committees that had met at least four times in the past year, but only 43% of trusts reported sharing recommendations from their committee with the trust board. While most MSLCs have four user representatives, seven trusts reported having no user representatives on the MSLC.

Where they are acknowledged as valuable and supported by commissioners, they operate effectively and can have a key role in the planning, monitoring, and improvement of high quality, user-centred maternity services into the future. In other localities they need reviewing and strengthening. Currently we have a unique opportunity to renew maternity user engagement and the role and remit of MSLCs for the future.

In the 2010 consultation document, Liberating the NHS, Commissioning for patients, the coalition government fully supports the principles of user engagement, and states the need to:

- Put patients at the heart of everything the NHS does.
- Focus on continuously improving those things that really matter to patients - the outcome of their healthcare.
- Empower and liberate clinicians to innovate, with the freedom to focus on improving healthcare services.12

Northern Ireland

Northern Ireland guidelines, issued in May 2009, state that maternity services need to be appropriate, acceptable and accessible to the local population.12 For this reason, users need to be involved in the service improvement, planning and monitoring of services.

All MSLC members should recognise the positive contribution that service user members can make. They should strive to ensure broad representation and improve their effectiveness through the provision of support and training. This may include representation from the Patient and Client Council but should not be restricted solely to their input and should, where possible, reflect the nature and demography of the childbearing community.

In each Health and Social Care Trust (HSCT) offering maternity services, there must be an effective multidisciplinary Maternity Services Liaison Committee (MSLC), where commissioners, providers and users of maternity services bring together their different perspectives, to plan, monitor and improve local maternity services. Where there is more than one Maternity Unit within the Trusts, the Trust with the Commissioner will need to decide the number of MSLCs.

Scotland

The Scottish Health Council published a good practice document in 2011 highlighting the results of various reviews of User Involvement in Maternity Services, good practice and making a series of recommendations for involving women more effectively in improving their care.13

Whilst acknowledging the role of the MSLCs in the past, the report also highlighted some of the constraints of this way of working, in particular the issue of not always engaging with the ‘silent/home’ groups. It suggests a variety of different mechanisms of engagement that NHS Boards could also utilize while emphasizing key messages of accessibility, meaningful and sustained engagement:

- Boards should encourage the use of tools which encourage women to provide feedback during hospital visits or treatment making use of what the women called ‘static time’.
- Boards should encourage use of new technologies such as social networking sites and virtual meeting rooms while recognising that not everyone has access to web-based resources.
- Boards should consider working more closely with third party agencies such as existing parent and community, employment or education groups.
- Boards should consider how existing NHS contacts with maternity service users could be used to widen participation, such as through handheld records and appointment or referral letters.

They conclude that the introduction of a Participation Standard, covering patient focus, public involvement and related governance issues, should support the necessary culture change within NHS Scotland to support sustainable involvement.

Wales

The Strategic Vision for Maternity Services in Wales states that maternity services should be delivered in partnership with women and their families, playing a central role in planning and developing maternity services, including addressing areas of weakness and monitoring progress.12 MSLCs should have members that represent all the professionals who come into contact with women and their families during the transition to parenthood and one third of members of the MSLC should be user representatives. A variety of means may be used to involve people and find out about their experiences and concerns, including engagement with different communities and voluntary sector groups, using formal and informal methods to gather evidence and feedback. In Wales, heads of midwifery are currently exploring ways to effectively strengthen user involvement in maternity service monitoring and planning through development of MSLCs across Wales.

In their own words

Service users and health professionals

- “I wouldn’t want to lose the MSLC. It is part of the way we work. It is a more efficient way of working in developing services and changing practice. To lose it would be a retrograde step.”
  - Head of Midwifery and former LSA Midwifery Officer

- “As a commissioner of maternity services I have found the MSLC to be an invaluable resource in terms of driving forward change and service improvement, and it forms a key element of the PCT’s governance framework in relation to maternity services. The MSLC offers commissioners of maternity services a vital link to the people accessing and using the services for which they are responsible. Real and effective user-led engagement, through the multidisciplinary team that forms the MSLC, provides both commissioners and providers with a forum for debating local maternity services.”
  - Maternity Services Commissioner

- “I joined the committee as a way of trying to give back something to the community and helping to improve the care for users of maternity services at...[Hospital].”
  - User representative

- “Involving patients/service users allows access to expertise that clinicians and managers do not have, as not only do service users bring to the table their unique, individual experiences of having used a specific health service but also a wide range of other experiences and expertise from their own world of work. Service users tend to have an overall view of how a whole pathway of care works rather than just seeing, the sometimes, isolated aspects of care that individual health professionals are aware of. They are able to highlight the impact of care on family life.”
  - Healthcare Commission

- “My role on the MSLC is to represent the Black & Minority Ethnic Community by highlighting issues which are of concern to the community which would be relevant to the Maternity Services.”
  - User representative

Appendix: Legislation and guidance on MSLCs from the UK health administrations and other health bodies

- “As a commissioner of maternity services I have found the MSLC to be an invaluable resource in terms of driving forward change and service improvement, and it forms a key element of the PCT’s governance framework in relation to maternity services. The MSLC offers commissioners of maternity services a vital link to the people accessing and using the services for which they are responsible. Real and effective user-led engagement, through the multidisciplinary team that forms the MSLC, provides both commissioners and providers with a forum for debating local maternity services.”
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