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## **NCT Policy briefing: User involvement in maternity services and Maternity Services Liaison Committees**

This briefing sets out the NCT policy on user involvement in maternity services and Maternity Services Liaison Committees (MSLCs). It includes an explanation of the policy context in each of the four countries of the UK. Maternity Services Liaison Committee is the term used throughout this document for a multi-disciplinary maternity forum concerned with services provided during pregnancy, birth and the postnatal period.

### **NCT Policy**

- 1. There should be an MSLC guiding the service development and provision for every NHS trust in England, Local Health Board in Wales, NHS Board in Scotland and Health and Social Services Board in Northern Ireland.**
- 2. There should be national guidance for MSLCs for each of the countries of the UK.**
- 3. MSLCs should have members that represent all the professionals that come into contact with women and their families during the transition to parenthood. A third of members of the MSLC should be user representatives.**
- 4. Services should use a variety of means 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. MSLCs should support user representatives when engaging with other groups.**
- 5. MSLCs need to be representative of service providers and users, and should be chaired by a user representative.**
- 6. MSLCs should have an adequate budget and this should be used to pay user representatives' expenses. The system for claiming should be simple and prompt. Chair lay reps should also be entitled to administration support. The budget should also be used to pay for training for lay reps.**
- 7. MSLCs should play a central role in planning and developing maternity services. They should be able to address areas of weakness and monitor progress. Having clear terms of reference can facilitate this.**
- 8. MSLCs should meet at regular intervals and be reasonably flexible to allow as many committee members to attend as possible. The NCT recommends that MSLCs meet at least four times a year.**

## Policy background

Healthcare is managed differently in the four member countries of the United Kingdom, so the policy guiding them and the delivery structures vary in each country.

## England

MSLCs were first set up in England in 1984, with the aim of providing a forum where users of maternity services could meet the professionals providing the service to discuss how the service could be improved to meet the needs of the local population. MSLCs' roles were strengthened as part of the implementation of the recommendations in the Department of Health's 1993 *Changing Childbirth*<sup>1</sup> report. In 2006, the Department of Health published *National Guidelines for Maternity Services Liaison Committees (MSLCs)*<sup>2</sup>. These guidelines, which superseded guidelines published in 1996, set out the role of the MSLC:

"In every area there should be an effective multi-disciplinary maternity services forum, where commissioners, providers and users of maternity services bring together their different perspectives in partnership to plan, monitor and improve local maternity services. In many areas a maternity services liaison committee (MSLC) has become well established which provides this function."

The guidelines also set out the responsibilities of both the PCT and the SHA in relation to MSLCs, which, they state,

"should be established, organised and maintained by PCTs and report to them, although they may be provider or community-based depending upon local circumstances, with the MSLC then reporting to the PCT."

In those areas where PCTs work together, and only one takes responsibility for commissioning maternity services, the guidelines state that the MSLC should be run by that PCT. The responsibilities of SHAs in relation to MSLCs are clear. They are to:

- Ensure that all commissioners and providers of maternity care have representation on an MSLC in a model that best fits the local planning and provision of services.
- Ensure that within their area, appropriate arrangements are in place for MSLCs or equivalent to ensure that users play a full part in the planning, commissioning and monitoring of maternity and neonatal services.
- Facilitate PCTs to manage recruitment, training and involvement of user representatives by ensuring communications, joint training and liaison between reps locally, regionally and nationally and with PALS and PPI Forum representatives.

It is important, therefore, that the views of users are not only represented on the committee, but taken into account by the PCT, and equivalent bodies in the other countries of the UK in the provision and management of maternity services.

Section 11 of the *Health and Social Care Act 2001*<sup>3</sup> (now Section 242 of the *NHS Act 2006*<sup>4</sup>) places a duty on NHS trusts and Strategic Health Authorities (SHAs) to make arrangements to involve and consult patients and the public in service planning and operation, and in the development of proposals for changes. This is referred to as the Duty to Involve. The 2005 Department of Health document *Commissioning a Patient-led NHS*<sup>5</sup> also sets out the requirements for SHAs to work with local people and patient groups to deliver patient-led services.

Published in 2004, the *National Service Framework for children, young people and maternity services (NSF)*<sup>6</sup> calls for public and patient involvement in the NHS, and MSLCs have a valuable role in involving users in service design. Standard 11 of the *NSF*<sup>7</sup>, under section 13 on Planning and Commissioning Maternity Services, says:

“Strategic Health Authorities, Primary Care Trusts and NHS Trusts [should] implement a service user involvement programme for maternity services and ensure that the local population has representation on a Maternity Services Liaison Committee (MSLC), within a clinical network.”

A 2007 review by the Healthcare Commission of maternity services<sup>8</sup> said 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:

- Engage with stakeholders, including women, so that 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 to share recommendations with trust board or appropriate subcommittee at least once a year.

In 2008 the principle of public consultation was further strengthened by the publication of *Real Involvement*<sup>9</sup> by the Department of Health, which strengthened ‘Duty to Involve’ by providing statutory guidance for it. This follows on from Lord Darzi’s review of the NHS<sup>10,11</sup> earlier in 2008 in which he recommended that any changes to NHS services should be transparent, locally-led and for the benefit of patients. The *NHS Constitution*, published in January 2009,<sup>12</sup> has also made it clear to patients that they have a right to be involved in decisions about NHS services.

Despite the abundance of policy driving health services to involve users, the 2008 Healthcare Commission report *Towards Better Births*<sup>13</sup> found a mixed picture when it came to the functioning of MSLCs. The majority of trusts (72%) had committees that had met at least four times in the past year, but only 41 per cent of trusts reported sharing recommendations from their committee with the trust board. While most MSLCs have about four user representatives, seven trusts reported having no user representatives on the MSLC.

## Scotland

In Scotland, healthcare has been organised independently of the rest of the UK even before devolution in 1999. Healthcare is provided by 14 regional boards, and these also run the MSLCs, although they are sometimes known by different names. Structurally, they are meant to operate in the same way as in England, with multi-disciplinary representation from the medical profession and from users, and with quarterly meetings.

User involvement has been a guiding principle of NHSScotland since devolution. *Designed to Involve*,<sup>14</sup> was published in 1999 by the Scottish Association of Health Councils, the Scottish Consumer Council and the Scottish Executive. The Designed to Involve Initiative was funded by the Executive (as it was then referred) from October 1999 – October 2001. The project aimed to develop the level of public involvement in the planning, delivery and monitoring of Primary Care.

One of the core values of NHS Scotland is involvement and participation. In December 2000, *Our National Health: A plan for action, a plan for change*<sup>15</sup> was launched. To achieve the aims of delivering high quality services, improve health and wellbeing and reducing inequalities the

Scottish Government felt that health was something services should do with rather than to people. In December 2001 *Patient focus and public involvement*<sup>16</sup> was published, which stated the government is trying to achieve a service where individuals, groups and communities are involved in improving the quality of care, in influencing priorities and in planning services, that is designed for and involves users. The framework states that NHSScotland must make public involvement a day to day reality that is fully integrated across the different levels and different organisations of the NHS. The National Health Service Reform (Scotland) Act 2004<sup>18</sup> put the duty on Health Boards to consult users on service design. It became a statutory requirement to gather service users' views.

User involvement has also been a key principle with regard to maternity services for a number of years. *A Framework for maternity services*<sup>19</sup> published in 2001 states that public consultation should be fundamental to the planning, development and provision of local maternity services and should be the forum to do this MSLCs. The documents also states that NHS Boards should provide education and training for lay representatives on MSLCs.

## **Wales**

The organisation of MSLCs in Wales is different from England because healthcare is a devolved issue and is managed by the Department for Health and Social Care. The *Welsh National Service Framework*,<sup>20</sup> launched in September 2005, states that maternity services should be delivered in partnership with women and their families. In Wales, MSLCs are organised into three regions; South East Wales, Mid and West Wales and North Wales. Each unit has a local MSLC group that feeds into their region. There is an all Wales MSLC meeting once a year.

## **Northern Ireland**

Healthcare in Northern Ireland is managed by the Department of Health, Social Services and Public Safety (DHSSPS). Four Health and Social Services Councils are responsible for the planning, commissioning and monitoring of services for the residents in their areas. Below them sit six health and social care (HSC) trusts that manage staff and services and control their own budgets.

The DHSSPS has published its own draft guidelines for MSLCs,<sup>21</sup> based on the 2006 Department of Health guidelines. These guidelines state that each health and social care trust should have "an effective Multi-disciplinary MSLC where commissioners, providers and users of maternity services bring together their different perspectives, to plan, monitor and improve local maternity services."

## **NCT policy**

- 1. There should be an MSLC guiding the service development and provision for every NHS trust in England, Local Health Board in Wales, NHS Board in Scotland and Health and Social Services Board in Northern Ireland**

Every maternity unit in the UK should have its development guided and performance monitored by a multi-disciplinary forum involving a range of local service users and experienced parent representatives. This forum is usually called a maternity services liaison committee (MSLC) though a range of other terms are also in use. It should be the body that commissions and plans health services that is responsible for the MSLC rather than the provider. In other words, hospitals should not have their own MSLC, but the PCT in England, Local Health Boards in Wales, NHS board in Scotland and Health and Social Services Board in Northern Ireland should host an MSLC, which may cover one or more maternity service provider unit. This structure ensures that MSLCs are

acting at the appropriate high level; making strategic decisions about the planning of maternity care, rather than dealing with day-to-day issues of the labour ward.

## **2. There should be national guidance for MSLCs for each of the countries of the UK**

To entrench the importance of MSLCs, they should follow nationally agreed guidance, relevant and tailored to each of the four countries of the UK. Currently there is guidance for England<sup>2</sup> and Northern Ireland conducted a consultation in 2008 on guidance for MSLCs,<sup>21</sup> but is yet to publish the final document. The NCT believes there should be nationally agreed guidance on MSLCs for each of the countries of the UK. This will ensure that MSLCs are consistently committed to principles that ensure a high standard of performance. We would urge the Welsh and Scottish governments to conduct consultations so that the public, users and members of MSLCs can influence the content of the guidelines.

The NCT supports the nationally agreed guidance in England and the draft guidance for Northern Ireland. They contain the following principles, which we believe should be reflected across all national guidance for MSLCs:

- multi-disciplinary working
- consultation with local people and user involvement
- addressing diversity and promoting public health
- integrating health and social care services and
- the planning and monitoring of maternity services.

## **3. MSLCs should have members that represent all the professionals that come into contact with women and their families during the transition to parenthood. A third of members of the MSLC should be user representatives.**

To be able to plan maternity services effectively, an MSLC should have a representative of all the professionals that provide services to women and their families present at meetings. This can include midwives, health visitors, obstetricians, anaesthetists, commissioners, GPs, teen pregnancy outreach workers etc.

English national guidelines for MSLCs state that one third of MSLC members should be lay representatives, which the NCT supports. This ensures that the views of users are instrumental in shaping maternity services for their local community.

## **4. Services should use a variety of means 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. MSLCs should support user representatives when engaging with other groups.**

To be successful, an MSLC needs to represent the broad range of users within the local community. Diversity needs to be reflected as much as possible on the committee itself, or by consulting regularly with users. However, user members may not be representative of the wider community. Not all users can sit on MSLCs and some diverse communities may not be represented or feel comfortable sitting on formal committees. Yet it is essential that the views of these communities are heard on MSLCs so that maternity services can meet their needs. User representatives on MSLCs can do outreach work to gather the views of under represented groups. Consultation can be carried out by going to groups where users gather, such as mother-and-baby groups, faith groups or Sure Start Children's Centres and talking to them informally.

An article by Jacqueline Dunkley-Bent and Hazel Jones for the Royal College of Midwives magazine *Midwives*<sup>22</sup> describes how a London MSLC had tackled the problem of how to represent the views of a wider group of users on the committee. Having found traditional methods such as surveys to be ineffective, it introduced a technique called “Walking the patch”. According to the report,

*“It was agreed that the committee would focus on an activity that provided one-to one, face-to-face contact with women and their partners from all backgrounds, at which time their views of maternity services would be sought and recruitment to the committee encouraged. This activity was called ‘walking the patch’, which means visiting clinical areas and speaking to women and their families when appropriate about the services they received.”*

MSLC should support and encourage user representatives to engage in this outreach work. Expenses should be paid that are incurred, for example, which should include loss earnings if time away from paid employment is required. There should also be space on the agenda at each meeting to discuss strategies to engage with diverse communities.

**5. All members of MSLCs should have equal weight in decision making and the committee should be chaired by a user representative.**

MSLCs should represent all health professionals that come into contact with women and their families during the transition to parenthood and all those who make decisions about maternity services. This includes midwives, obstetricians, managers, health visitors, GPs and in England, commissioners.

To operate successfully, there should be no hierarchy between professionals and user representatives. It can be challenging to find meeting times that suit the schedules of midwives, hospital doctors and parents of young children. Users’ experiences of, and approach to, the maternity services are inevitably different from those of a consultant obstetrician or a GP. Some users may feel intimidated by the expertise of the professionals, particularly if they use unfamiliar jargon. Research by Nadine Edwards of the Women’s Informed Childbearing and Health Research Group, University of Sheffield, found that some user representatives felt silenced and bullied on their MSLC.<sup>23</sup>

This is why English national guidance and the NCT recommend that the chair on a MSLC is a user representative. This position of authority can give the user representatives on the MSLC a sense of power and control which can be empowering and address the power imbalance between health professionals and users. It also puts the needs of users at the heart of maternity service design and implementation.

**6. MSLCs should have an adequate budget and this should be used to pay user representatives’ expenses. The system for claiming should be simple and prompt. Chair lay reps should also be entitled to administration support. The budget should also be used to pay for training for lay reps.**

It is not possible to attract all representatives of the local community to sit on MSLCs without offering them adequate expenses and remuneration for their time. The MSLC budget should include allocations for:

- expenses, including travel and childcare
- evaluation of users’ views and experiences

- outreach work to involve different community group and
- training.

All host MSLC organisations, such as PCTs in England, should have a clear and transparent policy on user representatives' expenses. This policy, and details on how to claim should be given to all new user reps, and easily downloadable from the MSLC host organisation's website. The system for claiming expenses should be simple and easy to understand. Minimal effort should be required from the claimant. The payment of expenses should be prompt, the NCT recommends within 10 working days.

User representatives often incur travel expenses when attending meetings and all of these should be reimbursed. All forms of travel should be reimbursed, which includes petrol, parking, bus, train and tube fares. If a friend gives the user representative a lift to meetings their fuel should also be covered.

Ideally a crèche should be provided during MSLC meetings and should be in a room close to where the meeting is being held, or at least in the same building. If user representatives are not comfortable with leaving their children with a stranger or if it not possible to provide crèche facilities, all childcare expenses should be provided. Expenses for childcare should be paid even if the childminder is a friend or relative of the user representative. Childminders should not have to be registered with OFSTED for expenses to be paid.

All MSLCs should have a budget that expenses should be paid out of. This should be provided by the host organisation, not the hospital. The budget should adequately cover all expenses incurred by all user representatives.

Lay chairs and vice chairs should receive payment for their services to the MSLC. The NCT would recommend £2000 per annum for a vice chair and £3000 per annum for a chair. This would cover loss of earnings as well as additional time and responsibility spent on MSLC business. Lay chairs should also be entitled to administration support from the host body to facilitate the smooth running of the MSLC. This may include typing up and distribution of the minutes, for example.

**7. MSLCs should play a central role in planning and developing maternity services. They should be able to address areas of weakness and monitor progress. Having clear terms of reference can facilitate this.**

A key principle of the English guidance for MSLCs<sup>2</sup> is that MSLCs should be the body that makes strategic decisions about maternity services for the local community. The integral role of MSLCs in planning services should be clear to all providers, particularly those at board level. To be effective, MSLCs need to have clear channels for reporting findings and recommendations to the trust board, which should be recognised in their terms of reference. Reporting to the board will ensure that the MSLC operates at the appropriate level

Quite simple changes can make a difference to the effectiveness of MSLCs. In her interviews with MSLC user representatives, Nadine Edwards,<sup>23</sup> found frequent mention of the need for travel expenses, childcare expenses and, most importantly, training. NCT Voices training can be very valuable in helping people understand how to improve their committee skills and how to read and understand policy documents. Edwards writes:

*“Many identified the need for information and training before and after joining the committee, a named person to refer to while on the committee, clear information about the role of MSLCs and how the NHS works, good administrative support, clear and concise background information to*

*agenda issues, access to research and computers, access to relevant conferences and workshops, contact with other women on MSLCs, accessible language to be used during discussions, and adequate refreshments during meetings.”*

**8. MSLCs should meet at regular intervals and be reasonably flexible to allow as many committee members to attend as possible. The NCT recommends that MSLCs meet at least four times a year.**

The NCT is aware that various members of MSLCs may have different commitments and schedules outside their MSLC work. The Committee should take the needs of its members into account when scheduling meetings. Meetings should be scheduled well in advance, to give members ample time to make any necessary arrangements. The committee may wish to vary meeting times, so as to enable as many committee members as possible to attend meetings.

MSLCs may also want to consider the location of their meetings. Meetings should be held in a location that is readily accessible to all members. When deciding where meetings are to be held, the committee should take into account things like the availability of car parking, the availability of public transport, and accessibility to wheelchair users.

### **Summary**

Although user involvement and maternity policy differs in each of the countries of the UK, they are all in agreement that MSLCs are the forum for planning the provision and delivery of maternity services. Therefore there should be an MSLC guiding the service development and provision for every NHS trust in England, Local Health Board in Wales, NHS Board in Scotland and Health and Social Services Board in Northern Ireland, and it should be these bodies, and not the provider unit, that host the committee.

To operate effectively, MSLCs should have representatives of all professions that come into contact with pregnant, labouring and postnatal women and their families. And to ensure that the needs of users are at the heart of planning maternity services, a third of committee members should be lay representatives. It should be recognised that not all communities that use maternity services will be represented on the MSLC, and members should actively try to engage with diverse communities to seek their views on how maternity services should be delivered to meet their needs.

MSLCs should be chaired by a user representative, this will put their needs at the heart of the MSLC's work, and help to alleviate any hierarchies between professionals and users on the committee. To further support lay representatives, the MSLC should have an adequate budget that can pay for all expenses incurred by users, training needs and remuneration for the lay chair and vice chairs. Meeting times and locations should also be flexible to meet the needs of user representatives.

Crucially, MSLCs should play a central role in planning and developing maternity services. They should be able to address areas of weakness and monitor progress. Their recommendations should go to the board of the PCT, or equivalent organisation, and should be addressed at the highest level of governance.

### **Other sources of information**

[www.nct.org.uk](http://www.nct.org.uk) – the NCT website

[www.csip.org.uk/~mslc/about-us.html](http://www.csip.org.uk/~mslc/about-us.html) - MSLC website

[www.aims.org.uk](http://www.aims.org.uk) – the Association for Improvements in the Maternity Services

To find out more about the structure of the NHS please refer to the NCT Document Summary on the NHS Handbook

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