ESSENTIALLY
MIDIRS

This article was originally published in Essentially MIDIRS, a professional magazine aimed at midwives, students, maternity support workers, and all who work within maternal and infant health.

The journal is published eleven times a year, with a combined December/January edition.

You can find out more and subscribe at

www.midirs.org

How maternity services liaison committees (MSLCs) work in the UK

There are many active 'MSLCs'— maternity services liaison committees — in England. Their remit is to be independent, multidisciplinary advisory groups that aid in the planning of maternity services. They usually include commissioners, service users, midwives, doctors and representatives from voluntary groups representing pregnant women and new parents (NCT 2013, Public Health England 2014). An MSLC is not a service user group. All members are equal, and should seek to achieve consensus through discussion and debate. Commissioning arrangements are slightly different in Scotland, Wales and Northern Ireland, but MSLCs have a similar role in those structures (NCT 2013).

> “It is usually these informed advocates who raise questions in MSLC meetings about whether current care reflects the best available research evidence, and cite examples of good practice from elsewhere”

The history of MSLCs

MSLCs were first introduced in 1984, to involve women, alongside health care professionals, in the design of local maternity services (NCT 2013) and their value has continued to be recognised in successive policy and guidance documents (NCT 2013) to the present day. They are typically led by a lay chair and meet at least quarterly. The chair's annual report includes recommendations to the commissioners about services, which should be used to inform the annual round of maternity commissioning (Department of Health 2007). I have had personal experience of this system in my role as an MSLC chair, when, informed by both best available research evidence and women's views in feedback on the local maternity service reviewed by the MSLC, I recently commented on the draft maternity services specification for 2015-16 in my area.

Women's voices

Maternity has a rich combination of service user voices. MSLCs include both women who have recently used services, and women who have become experienced and informed lay advocates. The lay advocates include representatives from voluntary groups such as Lamaze, Doula UK, the Breastfeeding Network, NCT and homebirth groups. Fathers are also welcome to participate, as partners of maternity service users (some MSLCs also consider neonatal care and include parents in that context). The voices of recent service users, in all their diversity, are important because their stories are powerful in explaining what it is that women need from their maternity care providers, and the effects of the current system of care. MSLCs are careful to explore the range of local views. They usually seek feedback directly from women (asking what was good about care and experiences, what was not good, and any suggestions for improvement. An example of this can be found at: https://www.surveymonkey.com/r/Reading_Maternity_Forum_Survey) as well as reviewing the results of the Friends and Family test and other NHS surveys.

Many informed lay advocates are knowledgeable about research evidence relating to maternity care, health care practice and service organisation. It is usually these informed advocates who raise questions in MSLC meetings about whether current care reflects the best available research evidence, and cite examples of good practice from elsewhere. Proposals to develop services may also come from health professional MSLC members. Locally, all of our service user representatives value hearing formally about service improvement projects as they are developed, and the opportunity to comment and contribute.

During the most recent NHS reforms, a small number of MSLCs have been disbanded. There has been some discussion in the national network of MSLC service user members suggesting that this is due to a few commissioners and providers not understanding the function of MSLCs and the value of multidisciplinary working that includes lay people as equals; it is also possible that that they may also find questions from informed lay advocates uncomfortable. There may be an assumption, too, that lay advocates cannot act as representatives, as Mander & Murphy-Lawless (2013) note. Yet where hospital Trusts support midwives in collecting feedback, the approach used is often similar to that used by MSLCs. For example, Maternity Voices @Frimley, a midwife-led group of midwives and service users meet with women in children's centres, as do Cambridge MSLC. Excellent as such NHS-led work often is, a key benefit of an MSLC is that it is chaired by a lay person, and review of feedback on services is service user led. MSLCs are not captive — they don't 'belong' to NHS Trusts.

My experience of becoming a lay advocate

When I first joined an MSLC, about eleven years ago, and attended my first meeting I was 'just a mum' (as mothers usually say). I think I probably said some heartfelt things

"It can be difficult sometimes for health professional members to recognise that women and lay advocates are acting as representatives, and have valuable things to say, and as a service user representative it can be difficult to feel equal without a health care qualification"

in that meeting, about how it is that women end up giving birth on their backs unnecessarily, as I had in my previous birth. In fact, I still have the '*I would like to join this group, please*' message that I wrote to the Chair — a determined woman, well-respected in the NHS locally for a robust, yet non-confrontational, approach to raising questions about local maternity care. I have a clear memory of speaking at the second meeting, while kneeling on the floor, changing a nappy — and that being just fine. I felt welcomed, valued and involved.

I also remember the first time I called a Sure Start centre, to arrange a visit to a mother and baby group to listen to women's stories and views. I was very nervous, but I was made to feel welcome and encouraged by the community workers. Once I sat on the floor with women and their babies, making notes of the women's words as accurately as I could manage, I was captivated by what they were saying and wanted to keep listening so that I could represent their views. Then as now, I would invite people to come along to the MSLC meetings. Many women were glad simply to 'talk to someone' and know that another parent would share their words with the MSLC — both praise for services and details of unsatisfactory experiences. I was, and remain, enthusiastic and optimistic about MLSCs. I am always keen to explain that they are not just a 'service user forum' set up to 'tick boxes' for the NHS. It is about working together with health professionals as equals, both to improve the quality of clinical care and to assert the importance of caring and a healthy birth culture (NHS England 2013a, NHS England 2013b, NICE 2014).

Not long after I joined the MSLC, the local perinatal psychology post was to be cut to save money. The service users looked up the best available research evidence and national maternity policy. We asked our local parent contacts for their views, including women who had experienced anxiety and depression before and after birth. We attended meetings along with our NHS MSLC members to explain the case that we felt should be made for keeping the service, the Trust Board was persuaded and the psychology post was saved. Our views were presented in the context of our experience of multidisciplinary working on the MSLC. We asserted our role in the process of reviewing local needs, working to our terms of reference and were valued within that process.

The regular work of the MSLC was monitoring the maternity service and looking at possible improvements. This included:

- review of feedback from service users
- work on service improvement projects with midwife MSLC members (eg helping with aspects of redesign of antenatal classes)
- raise concerns from the community (eg about hospital cleaning)
- monitor key figures (normal birth rate, caesarean rate, etc)
- look for themes in complaints.

We all helped to mentor new members (mainly mothers and midwives) as they joined the group. In our formal meetings, and in smaller project groups, we respected each other's different perspectives and learned from working together.

It is this regular, 'walking with' the maternity service and commissioning team that characterises the MSLC that I currently chair: service user representatives collect feedback mainly in children's centres; lay advocates in the group have various roles working with parents across our patch — as antenatal teachers, breastfeeding peer supporters, doulas and support group facilitators — and bring knowledge from that work and their local networks. We also 'walk the patch' in the maternity unit before each quarterly meeting, listening to women. We engage with a variety of local and regional 'stakeholders' and we have a short 'research evidence topic' discussion in each meeting, facilitated by a service user representative. When we have workshop items ('Revisiting the Birthplace evidence'; 'Caesarean birth — parents' experiences') the group's shared value 'being evidence-based' matters as much as 'being woman-centred' and 'listening with an open mind.'

Of course, the '*being equal*' that MSLC Terms of Reference (Department of Health 2006:24) specify is not always quite the reality in all MSLCs all of the time. It can be difficult sometimes for health professional members to recognise that women and lay advocates are acting as representatives, and have valuable things to say, and as a service user representative it can be difficult to feel equal without a health care qualification. It is possible for any member to see only reasons to dismiss the views of others and sometimes, reasonable, committed people of all backgrounds on an MSLC are unable to persuade anyone beyond the group to listen to the group's views and recommendations. All of these things will happen, somewhere, some of the time. Luckily, the MSLC network is active on Facebook and Twitter (#mslc), as well as in the online forum for service user representatives — sharing news, good ideas, and many positive stories of MSLCs working well (see, for example, https://www.facebook.com/NorthHampshireMSLC and @hantsmaternity)

National experience, local possibilities

For me, being an MSLC member in two different areas — active in collecting feedback from parents, and experienced in MSLC multidisciplinary working — proved to be a useful preparation for serving on the NICE Guideline Development Group (GDG) that updated the guideline for intrapartum care for healthy woman and their babies (NICE 2014). Despite knowing that NICE guidelines are written using the best available research evidence, and even after my initial training with other prospective lay members, I didn't really expect to be treated as an equal in the MSLC way. I suspected that I would find myself observing, while an all-too-familiar pattern of politics and power played out. I could not have been more wrong. We could and did challenge each other; testing each other over interpretation of the evidence, and exploring the range of women's views on every topic. We discussed care in practice, keeping a very practical focus in the process of moving from evidence to recommendations. We reflected on the values NICE adheres to (NICE 2008) in the maternity context, and wrote the recommendations accordingly. Each person brought their own particular knowledge and expertise to serve the group's work — equality means acknowledging, respecting and using that individual expertise appropriately. Sometimes our consensus view was easily achieved; at other times we acknowledged and resolved conflict together, through discussion and debate (Cooper 2014). The values that united us included commitment to woman-centred care, real informed choice, and care based on the best available research evidence.

For me, the parallel between the Intrapartum Care GDG and local MSLCs is powerful — the shared values that underpinned the making of the guideline at national level are to be found at local level too. An MSLC meeting is a safe, neutral space in which to discuss the best available research evidence, hear and reflect on women's views, and find ways to move beyond the familiar pattern of politics and power in maternity. I think that multidisciplinary working involving women as service users and lay advocates, as recommended in the recent consensus document on MSLCs from the RCM, NCT and RCOG (NCT 2013), and in current commissioning guidance (NHS Commissioning Board 2012), is one of the keys to both good governance (NICE 2014) and implementation of the guideline, and MSLCs have a part to play.

Catherine Williams

Catherine Williams

Catherine has served on two MSLCs for more than seven years and also acts as a lay member for NICE. She has worked in a consumer complaint-handling organisation at a national level, qualified as an NCT antenatal teacher two years ago, and currently works for a local Healthwatch, focusing on primary care issues. She read the *Roar behind the silence*, edited by Sheena Byrom and Soo Downe, when it was first published and notes that the call for change comes from midwives, women, doulas, and doctors, together.

References

Cooper T (2014). Promoting normal birth: courage through compassion. In: Byrom S, Downe S eds. *The Roar Behind the Silence: why kindness and compassion matter in maternity care.*[Online] London: Pinter and Martin.

Department of Health (2006) *National guidelines for maternity services liaison committees (MSLCs).* http://tinyurl.com/pmwoe2v [Accessed 23 February 2015].

Department of Health (2007). *Maternity matters: choice, access and continuity of care in a safe service.* London: Department of Health. http://tinyurl.com/k6a3vqm [Accessed 23 February 2015].

Mander R, Murphy-Lawless J (2013). *The politics of maternity*. London: Routledge.

NICE (2008) *Social value judgements: principles for the development of NICE guidance.* London: NICE. http://tinyurl.com/owlcv4q [Accessed 23 February 2015].

NICE (2014). *Intrapartum care: care of healthy woman and their babies during childbirth*. http://tinyurl.com/mercxsv [Accessed 23 February 2015].

NCT (2013). *Maternity services liaison committees (MSLCs): a consensus statement from NCT, RCM, and RCOG.* London: NCT. http://tinyurl.com/nbv9rsl [Accessed 23 February 2015].

NHS Commissioning Board (2012). *Commissioning maternity services. a resource pack to support clinical commissioning groups*. http://tinyurl.com/kehdw2q [Accessed 23 February 2015].

NHS England (2013a). *The NHS consitution*. London: Department of Health. http://tinyurl.com/d2zubyk [Accessed 23 February 2015].

NHS England (2013b). *Transforming participation in health and care*. London: Patients and Information Directorate, NHS England. http://tinyurl.com/nhs739t [Accessed 23 February 2015].

Public Health England (2014). *About MSLCs*. MSLC website of the Maternity Service Liaison Committees. http://tinyurl.com/pzrgabb [Accessed 23 February 2015].