NATIONAL MATERNITY VOICES

NATIONAL FORUM OF MSLC SERVICE USER REPRESENTATIVES

Position Statement on Maternity Voices Partnerships

National Maternity Voices (formerly MSLC Voices) the national forum for service user chairs and service user members[1] of Maternity Service Liaison Committees (MSLCs)

Introduction

National Maternity Voices, the national forum for service user chairs and members of Maternity Service Liaison Committees (MSLCs) would welcome introduction of Maternity Voices Partnerships (MVPs) funded by clinical commissioning groups to ensure a multidisciplinary maternity forum with a clear strategic role, **provided that it is sufficiently local to women and communities**. We seek to have influence while the guidance is being drafted, based on our extensive experience. At this crucial time of transformation, we are able to share our knowledge of what works well and what are some of the barriers to effective service user involvement.

At a national meeting for service user chairs and members of MSLCs in November, the draft guidance for the new MVPs was presented by Mary Newburn and Rachel White of NHS England, and those of us present were very concerned about whether this crucial forum for service user involvement and local service development would be embedded as a well-resourced, truly local, quality improvement body. The proposal outlined to us recommended that Maternity Voices Partnerships (MVPs, as MSLCs will come to be known when new guidance is issued) will exist only at maternity system level for a population of 0.5-1.5 million – in many cases for the same footprint as the Sustainability and Transformation Plan (STP) area.

We believe the MVP needs to be geographically close and to feel relevant in order to successfully involve local women, family members, communities and representatives of interest groups who can influence the future of maternity services through strategic planning and monitoring. At a time when there is a clear focus on co-production between commissioners, healthcare providers and service users, a development that we wholeheartedly endorse, we are making this strategic contribution to the new guidance for clinical commissioning groups. The main audience for this statement is maternity policy leads at NHS England, leads for 'patient and public involvement' and the health minister.

[1] Recent service users & also individuals & representatives of organisations who work with service users and are not commissioners/NHS healthcare professionals, such as antenatal teachers, doulas, breastfeeding counsellors and peer supporters, community workers etc

1. MSLC - a model that works and has potential

An MSLC is an independent NHS advisory body, made up of service users and NHS professionals working in partnership, monitoring services and advising on commissioning. This includes a formal governance role. Typically, an MSLC looks at the work of a **single maternity service** – home birth service, clinic, freestanding and alongside midwifery units and the associated obstetric unit. Women (and sometimes their partners) get involved to improve their local service, where they are having their babies. We know from our network that well-run MSLCs, of which there are dozens in England, have enabled true collaborative multidisciplinary working in which service users and healthcare professionals participate as equals. Through MSLCs, real co-design and co-production happen. The parties understand and respect each other and value the changes and improvements that are being made on the ground, in their community, their maternity service – whether they are service users or NHS people.

We believe, based on our collective experience, that the success of MSLCs is due to both:

- **their ability to engage and involve service users and**
- **formal integration into governance structures and the ability to influence networks at the level of local maternity services, in the places where women give birth.**

In addition, MSLCs/MVPs are key to implementing Better Births and the NICE guideline CG190, Intrapartum care for healthy women and babies. This implementation work will involve huge culture change in both local communities and local services. Based on our experience, regional meetings alone will not effect this. People will, locally.

> *'I urge you to play your part in creating the maternity services you want for your family and your community. Voice your opinions, just as you have during this review, and challenge those providing the services to meet your expectations'*
>
> Julia Cumberlege, 'A letter to the women of England and their families' Better Births, the report of the National Maternity Review, 2016

2. Potential threats of the NHS England proposal for regional (STP level) MVPs

If there were only one Maternity Voices Partnership (MVP) for each STP area:

- The MSLC chairs and women as service user representatives might have a less strong connection to grassroots views in the community. Maternity Systems or STP footprints are so large in some areas, it could be physically impossible for service users to access meetings without making very inconvenient and time

consuming journeys, and/or needing to make complex childcare arrangements. The voices of seldom heard groups, already difficult to capture in our experience, would be even harder to hear.

> As an example, the population of Bromley is 300,000 compared to the South-East London STP population of 1.7 million. A Bexley, Bromley and Greenwich MSLC was attempted in the past, under South London Healthcare Trust, and it was meaningless to everyone involved as it was too big a geographical and demographic area to achieve anything. There was only one service user present at the initial meeting and the committee was disbanded a short time after the first meeting. In the South-East London STP area, there are currently six well-established MSLCs (Bexley, Bromley, Lewisham, Greenwich, Kings, Guys and St Thomas) which are all individually successful because they are able to focus on their own local community.

- We fear that local influence would be lost. Involvement and influence often happens locally in an informal and spontaneous way, when there are systems in place for regular, respectful meetings between equals. Service users and providers share an interest in care provided for their service, and in influencing local implementation of national and regional clinical guidance and policy. This happens when a Head of Obstetrics stops an MSLC chair in a hospital corridor to sound them out about a service improvement or to seek some advice; or when a Head of Midwifery asks if she can arrange for a presentation to be made to the MSLC about a new project as a first step in embedding a service change, with the commissioner present and involved. This influence depends on close team working where people really get to know each other and develop relationships of mutual trust and respect. Connection and shared values, developed in this way, can be used to create a deep commitment to individualised, woman-centred, evidence-based maternity care.

Experienced service user advocates and people with skills and willingness to take on the role of the committee (MSLC/MVP) chair are mentored and supported as they develop. People in leadership roles are grown from among local service users who start by making a less demanding commitment. This process of continuous recruitment, engagement, involvement and succession planning is vital for:

- sustainability and growth of service user involvement
- equity of access
- developing people – mentoring women into formal public service in MSLC roles
- welcoming and developing a contribution to the community from each service user representative that will always be local, and may become

national. For example, MSLCs have a long history of supplying lay members to NICE guideline development groups.

3. Why MVPs must be local as well as regional: networks are the way forward

Keeping involvement local, in communities, matters, and is supported by the relevant NICE guidance (see recommendations 1.5.1 and 1.5.2 NICE Guideline 44 March 2016 Community engagement: improving health and wellbeing and reducing health inequalities; see recommendation 1.1.17 NICE CG190 December 2014 Intrapartum care - care of healthy women and babies). Service users also have the right to inclusive, equitable, accessible, and real local involvement under the NHS Constitution.

> *'You have the right to be involved, directly or through representatives, in the planning of healthcare services commissioned by NHS bodies, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.'*
>
> (Handbook to the NHS Constitution)

- **Women can see and experience the impact their work is having on their local maternity service when they serve as MSLC/MVP service user representatives and chairs at community level**
- **Seeing local impact is what motivates service users to stay involved**
- **At a practical level, local meetings of their MSLC/MVP make it possible and convenient for service user members to be involved**
- **Service users give the time they can around family and work commitments – follow #mslc on Twitter and you will understand the lived reality**

We value our current involvement in the Strategic Clinical Networks. We are already involved in creating a hub and spoke model in which the local MSLCs retain the key characteristics we have outlined here. MSLC networks encompassing South London and Thames Valley are established, with East of England just forming, and northern MSLCs actively discussing networking possibilities as we prepare to publish this statement.

We hope that NHS England recognises the expertise that it can draw upon in the MSLCs to advise at this point regarding not only engagement, but real involvement as contemplated by the NHS constitution. We expect our commitment and experience of service user engagement and multidisciplinary working to be recognised as a true asset, and used in collaboration with us to shape future opportunities and successes. We look forward to hearing that:

- the MSLC/MVP model will continue to be **an NHS-funded multidisciplinary MVP with governance status in each community-level maternity service** (typically a home birth service, community hubs, midwifery units and associated obstetric unit – though local circumstances vary. See illustration from Better Births below).
- We would **welcome an MVP network in every STP area,** with local MVP chairs serving on the maternity steering group (regional MVP) of every STP ensuring that a comprehensive and resilient network of local MVPs at community level feeds into and helps shape decisions at STP level.

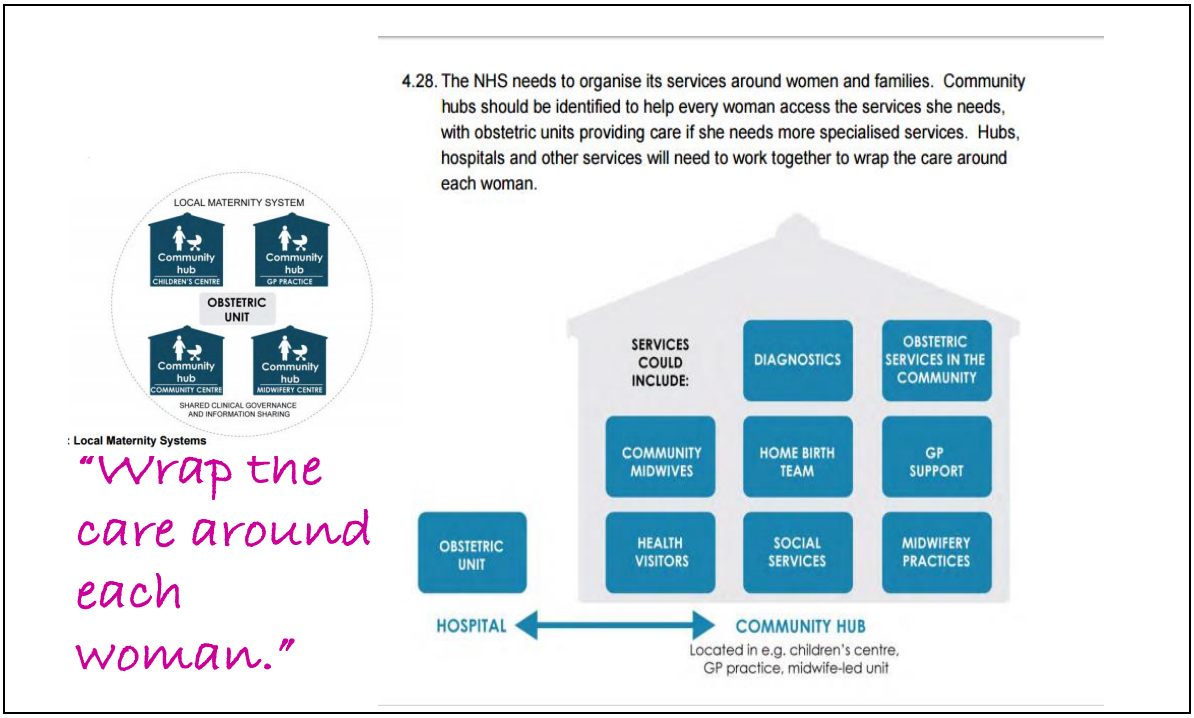

Illustration: Individualised, women-centred care – focused on community hubs – local care. Text/images from Better Births, 2016

4. Additional information and resources

To assist NHS England, we have set out in the Additional Information supporting this statement:

Section 1: The technical detail – the governance role of MSLCs and why it matters

Section 2: How MSLCs work in practice – a model to learn from for the future

Section 3: Further information - MSLCs past & present - link to the NHS Constitution

(The Additional Information is contained in a separate file accompanying this statement.)

There is also a case study from Rachel Gardner, chair of Sheffield MSLC, included at the end of this document.

If further information is required, our representative on the NHS England Stakeholder Council for the Maternity Transformation Programme, Lisa Ramsey, chair of Reading MSLC, will be able to provide it or seek the further views of the network.

5. Conclusion

This document sets out why the most effective implementation of MVPs is at local, community level and why the cultivation, funding and development of MVPs should remain at community level.

- MSLCs are already thriving in many areas of the country, and this guidance is needed to encourage the take-up of the new MVPs everywhere.
- We welcome the opportunity of the focus by NHS England on funding and co-production, which will create the impetus for community engagement and renewal where committees have lacked support and/or direction.
- We urge NHS England not to forget that local MVPs/MSLCs have a crucial local governance role, as recognised by the Morecambe Bay Enquiry Report.

In our experience as MSLC members, women want to be involved in making their local maternity service better, for their friends, their family, their next baby. Very few new parents are willing to volunteer to sit on a regional body, with a remit removed from their own experience.

We have seen how the work of community-level MSLCs, led by and truly involving service users, can make a positive difference to service quality and service design, promoting co-design work and developing outreach to vulnerable and seldom-heard communities. With proper funding of both community-level and regional-level MVPs, clear supporting guidance from NHS England, and the support that our network offers, sustainable service user presence and commitment can be achieved.

We welcome the opportunity to continue developing regional networking and involvement of local MVP/MSLC chairs at Local Maternity System/STP level. As well as facilitating implementation of evidence-based practice and quality improvements, we believe the benefits include sharing ideas and good practice between services; a key part of what our national and regional (SCN-linked) networks are about.

We hope the forthcoming NHS England guidance will mark a new era of flourishing, MVPs (whether rebranded MSLCs or newly founded) - where every maternity service has users at its heart. MVPs need to be local – nothing else will do.

National Maternity Voices (formerly MSLC Voices)

December 2016

Sheffield MSLC – a case study

By Rachel Ellie Gardner, Lead of Sheffield MSLC.

MSLCs across the county are making fundamental changes to their Maternity services. MSLCs allow a voice to families engaging with Maternity Services but much more than this they allow the makers of policies to witness effects of their policies, including the emotional impact on women and potentially on their mental health. MSLCs allow the whole picture of a woman's maternity journey to be seen, often giving great insight into what works well, what changes are needed and what gaps there are in current policies.

An hour in the work of Rachel Ellie Gardner, Lead of Sheffield MSLC.

Monday 5th December 7pm – 8pm (whilst on holiday)

- Rachel responds to an email from Head of Commissioning – Children, Young People & Maternity Portfolio to discuss a service user and service provider video offering support and guidance to parents suffering from parental perinatal mental health.
- Rachel discusses with a service user her feelings of the need for consistent 6-8 weeks checks in all GP surgeries across Sheffield. RG starts a thread about this on the Sheffield MSLC Facebook closed group and quickly it becomes obvious that this is a concern of many women.
- Rachel reads an email from the Head of Midwifery regarding RG's report from 247 women on their experiences of 'Bounty Ladies' in the wards.
- Rachel works with a sub-committee of service users to create a 'Week of treats to take to the staff on Labour Ward over the Christmas period'.
- Rachel emails Sheffield MP Gill Furniss to ask for a meeting to discuss the excellent work of Sheffield MSLC.
- Rachel plans new ways to reach harder to hear groups of families in Sheffield and more vulnerable women. She works with a small sub-group of women on Facebook to do this.

This is usual daily work for Sheffield MSLC. At varying points of the year Sheffield MSLC do large service user consultations/surveys. An average response to each bi-annual survey/consultation is about 1800, although our last survey regarding Dads staying overnight with their partners had a phenomenal response of nearly 3000 parents in Sheffield giving their very heartfelt views. This takes approximately two months to work through and feedback to the MSLC.

December 2016

SIGNATORIES: MSLC service user chairs and service user members. **85 signatures** below.

The signatories – via:

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Ruth Adekoya
Whipps Cross Hospital MSLC service user member.

Hannah Appelgren
chair Maidstone and Tunbridge Wells MSLC 'Birth Voices'.
NCT antenatal practitioner and doula

Karen Atkinson
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Sallyann Beresford
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Antenatal Teacher, Doula, Postnatal Teacher

Sarah Birch
Service user member Sheffield MSLC
Trustee of charity Forging Families

Maria Booker
Chair of Epsom and St Helier MSLC and service user rep,
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Sarah Boyd
Oxfordshire MVP User Rep
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Cathy Brewster
Stockport MSLC Service User Rep
Greater Manchester Homebirth Support Group Chair

Joanna Brien
Chair, Kings College MSLC

Sophie Brigstocke
Service User - St George's Maternity Forum
Doula, Doula Course Provider - Nurturing Birth, Breastfeeding Peer Supporter, Baby Massage Instructor

Rebecca Brione.
User Rep, Epsom and St. Helier MSLC.
Medical ethicist with interest in pregnancy and birth; volunteer for Birthrights.

Lisa Brophy
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daisy antenatal teacher

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Doula. NCT BF Peer Supporter. Prison Visitor with Birth Companions. Peterborough positive birth movement.

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(signature blocks last added & checked: **15.01.17**)