Maternity services liaison committees (MSLCs) have a long history but were affected by 2013 health reforms. An online survey of heads of midwifery (HoMs) and service users was conducted to assess how many NHS trusts in England had a functioning MSLC and whether they were supported by clinical commissioning groups (CCGs) and working with Healthwatch, the new statutory consumer advocate. Results showed that at least 62 per cent of trusts had an MSLC. However support from commissioners varied widely. Around two fifths of MSLCs had administrative support provided by the CCG or their local NHS trust. One in eight MSLCs had a budget including an allowance for the Chair. Some MSLCs were struggling to continue due to little or no support. Both HoMs and service users wanted commissioners to provide more consistent support for MSLCs. One in five MSLCs had a clear link with Healthwatch. This is a legacy to underpin the transition to CCG-funded Maternity Voices Partnerships in 2017.

Introduction

‘Local maternity systems need to ensure that they co-design services with service users and local communities, engaging with patient groups and Maternity Services Liaison Committees’ (NHS England 2016).

Maternity Services Liaison Committees (MSLCs) are multi-disciplinary advisory and action groups with service user involvement at the centre. From their inception, guidance suggests they should have an independent ‘lay’ or service-user chair. They are a forum in which commissioners, providers and service users work together to identify strategic priorities for maternity services.

MSLCs were first set up in 1984 following publication of Maternity Care in Action report (Maternity Services Advisory Committee (MSAC) 1984). They were strengthened during the implementation phase of Changing Childbirth (Department of Health (DH) 1993), the first British maternity service policy to establish women-centred care. In order to address the needs and concerns of women, services need to engage with women and hear their stories.

In the years since, MSLCs have consistently had a central place in maternity. Section 11 of the National Service Framework (NSF) said they ‘provide a useful vehicle for professional interdisciplinary working with informed user input and may play a useful part in monitoring implementation of this National Service Framework’ (DH 2004, p7). Maternity Matters (DH 2007, p18) said use the MSLC to agree ‘a common set of objectives for maternity services, [to] set the service specification for maternity services…’ Guidance published on the national MSLC website, included a template terms of reference document for local adaptation.
Health service reform

In 2013, primary care trusts were replaced with clinical commissioning groups (CCGs), as part of NHS reconfiguration (Her Majesty’s Government (HMG) 2012). Concern about lack of updated guidance and, as a consequence the new commissioners not prioritising support for MSLCs, prompted a consensus report from the royal colleges and NCT on their value (Fletcher 2013).

Anecdotally, the absence of guidance for CCGs has undermined the status and functioning of MSLCs. The Morecambe Bay Investigation into deaths of mothers and babies at the Furness General Hospital highlighted the value of having a well-functioning MSLC in voicing parents’ concerns (Kirkup 2015). In 2016, the National Maternity Review emphasised the importance of experience-based co-design in maternity services, and the role of MSLCs as ‘a means of ensuring that the needs of women and professionals are listened to’. The Review team ‘saw how effective they could be when properly supported and led’ (NHS England 2016, p13).

Service users’ right to involvement

The NHS Constitution speaks directly to service users and the public. It states: ‘You have the right to be involved, directly or through representatives, in the planning of health care 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’ (NHS Constitution 2015, p9).

NCT believes that MSLCs are a useful mechanism for service involvement in maternity services. In 2015, NCT designed a study to establish how many MSLCs were functioning, and the extent to which they were being supported by CCGs. We also wanted to know whether local Healthwatch, established across England in 2013, with statutory powers to ensure that service users’ voices are heard, were working with MSLCs. Funding for the survey was provided by NHS England.

Methods

An online questionnaire was designed for Heads of Midwifery (HoMs) via the Royal College of Midwives (RCM). Six weeks later a reminder was sent out. As the response rate remained relatively low, NCT-registered service users on MSLCs and NCT practitioners were involved. They were sent a link to a slightly adapted version of the questionnaire.

The data from the HoMs and the service users were downloaded and combined in Excel. Duplicate cases for the same trusts were compared. Usually HoM and service-user accounts (SUAs) were fairly consistent. Descriptive statistics are
reported. Percentages are rounded to the nearest complete number. Additions of percentages in sub-groups may be +/- 1 per cent of expected values. No statistical tests have been used. Responses to open-ended questions from both HoMs and SUAs are reported to add depth and further meaning to the closed responses.

Results

Sample characteristics

Overall, 67 HoMs responded to the survey and 77 service users. At the time of the survey, there were 136 NHS trusts providing maternity services. HoMs from 49 per cent of trusts (67/136) responded. Data were provided for an additional 36 trusts by service users. By combining information from both sources, data were available for 76 per cent (103/136) NHS trusts. In 40 trusts (29 per cent) both the HoM and a service user provided data.

Active MSLCs

Of the 103 trusts for which data were available, 86 (83 per cent) had one or more MSLC in place. This is equivalent to at least 63 per cent of all trusts in England (86/136) having an active MSLC. Many HoMs valued the role and contribution of the MSLC. In free-text comments, HoMs referred to actions and achievements initiated by the MSLC:

‘The MSLC is improving all the time with good representatives, good agendas and making changes.’

‘We have a large and well-organised MSLC. We have good working relationships.’

‘I am new to the Trust (I have attended the MSLC); it appeared to be well led, very active, focused and clear about what it wanted to achieve and its vision.’

‘(We have a) very active MSLC and well-supported and structured work programme aligned to maternity network priorities. (We are) always seeking to engage more diverse user representation by using different consultation formats.’

But frustrations were also expressed about lack of structured support: ‘[Name] Hospital has agreed to provide admin support and a meeting room, but … we had six different administrators over eight meetings in the transition from the PCT (having responsibility) to trust (taking over the lead) … with no provision for handover.’ (Service user)
Support from trusts and CCGs

Responses suggested that the level of support from CCGs varied, with around one third of the MSLCs (36 per cent, n=31) being ‘fully supported’ and a further quarter (23 per cent, n=20) receiving ‘some support’.

Questions were asked about administrative support, a ring-fenced budget, provision of an honorarium for the Chair, and whether the CCG had signed off the MSLC terms of reference, a question intended to gauge the degree of their engagement and support (see Table 1).

- **Administrative support** was provided in two fifths of trusts (42 per cent, n=36) either by the trust or the CCG. In a further fifth (21 per cent, n=18) neither body provided administration support.
- **A ring-fenced budget** for running costs, such as the cost of ‘meetings, travel expenses, training, user involvement’ was provided to around a quarter of MSLCs (27 per cent, n=23). A similar proportion said there was no provision (26 per cent, n=22).
- **An honorarium for the Chair** was paid in 10 MSLCs (12 per cent); In another some vouchers were provided.
- **CCG review and approval of the terms of reference** had been done in around a third of cases (38 per cent, n=33).

Table 1 Support from CCGs and NHS trusts for MSLCs (n=86) (percentage in brackets)

<table>
<thead>
<tr>
<th>Administration support</th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
<th>Missing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ring-fenced budget</td>
<td>36 (42)</td>
<td>18 (21)</td>
<td>2 (2)</td>
<td>30 (35)</td>
</tr>
<tr>
<td>Honorarium for MSLC Chair</td>
<td>23 (27)</td>
<td>22 (26)</td>
<td>12 (14)</td>
<td>29 (34)</td>
</tr>
<tr>
<td>CCG-agreed terms of reference</td>
<td>10 (12)</td>
<td>33 (38)</td>
<td>14 (16)</td>
<td>29 (34)</td>
</tr>
</tbody>
</table>

i) This includes one Chair given some vouchers and one who was a salaried staff member.

ii) A HoM where the MSLC was well resourced said that funding the MSLC ‘enables hospitals to effectively engage with women and their families’ and the service user chair said: ‘The MSLC is funded three ways – the Trust pays one third of my remuneration of £10K plus expenses and the two CCGs pay a third each. As a remunerated rep I do all the admin.’
**Gaps in provision**

Data were reported for 17 trusts (17 per cent) on reasons why there was no active MSLC, from a provided list of options (12 HoMs and six service users). Across these trusts, the contributing factors given most frequently were lack of funding (n=7) and lack of CCG support (n=7). Five had another forum; five gave no explanation; four HoMs indicated that there was a problem with the committee not being representative enough; one reported using Healthwatch as an alternative; seven HoMs indicated that they would like to create or re-establish an MSLC, including one HoM with a valued patient and public involvement (PPI) forum, but which lacked strategic influence.

‘This forum enabled me to put a change in place to allow partners to stay overnight. However an MSLC would add drive to this as it will be multidisciplinary rather than midwife-led, which has different advantages.’

A service user from another trust echoed that sentiment:

‘The CCG isn't interested; we have no funding. We use another forum, Maternity Partnership, which involves (service) user reps, HoM, a health visitor, children’s centres (staff) and Healthwatch. It was set up when the CCG wouldn't support the MSLC – it is keeping dialogue going and working on projects like user info and refurbishment of unit. [However, it] has no strategic remit.’

**Links with Healthwatch**

Respondents were asked whether there were links between their MSLC and Healthwatch. Around one fifth of trusts with an MSLC had links in place (19 per cent, n=16). In a further fifth there was ‘some contact’ (22 per cent, n=19). The remainder either had no links (34 per cent, n=30) or left the question unanswered. Comments demonstrated ways that Healthwatch was working with MSLCs.

A HoM: ‘Someone from Healthwatch co-chairs our MSLC along with a user (NCT member).’

Service user: ‘We have no formal links with Healthwatch, but they are very, very supportive and we are in the process of formalising (links) following a report about us.’

**Conclusion**

The transition of commissioning from primary care trusts to CCGs in 2013 and failure to update national guidance for MSLCs seems to have disrupted arrangements for sustaining MSLCs, previously a commissioner responsibility. Despite patchy CCG
support, in 2015 at least 62 per cent of trusts had an active MSLC. Some areas had introduced another forum for service user involvement. While valued, these have had less impact than multi-disciplinary MSLCs with strong public involvement, (usually) a service user chair, and a remit to influence strategy. In some areas, financial support for the MSLC has included an allowance for service users to lead on community engagement. This has proved a successful strategy (Newburn and Fletcher 2015). NHS England (2015) recommends that its own staff reward PPI ‘expert advisors’ for their contribution, recognising their expertise. Where MSLCs are not in place and supported by CCGs, and there are no acceptable alternative methods to involve the community in planning and developing maternity services, there is a strong argument that CCGs are failing in their duties under The NHS Constitution. In recognition of need, guidance – for rebranded ‘Maternity Voices Partnerships’ (Newburn 2016) – will be published alongside other maternity commissioning guidance for the NHS in 2017.

References


http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted


