AIMS For a better birth...

Implementing Better Births: why Maternity Voices Partnerships (MVPs) are key

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Since 1984, Maternity Services Liaison Committees (MSLCs) have been working away in the background of maternity care. These forums are made up of health care professionals, commissioners and the women who use the service, together with their families and other service-user representatives. They were created as a way of enabling women to be involved in shaping the maternity care provided for them, and strengthened during the implementation phase of Changing Childbirth.

Since MSLCs were established, there have been many examples of extremely effective, well-supported, committees making a real improvement to maternity care in their local area, from reaching out to seldom heard groups, designing information posters on how to personalise the birth space, to setting up online birth information hubs and supporting the development of a local perinatal mental health pathway. Confusion over which body was responsible for resourcing the MSLCs following the Health and Social Care Act (2012)[1], however, meant that some floundered due to lack of financial support or a lack of engagement, either from health care providers, commissioners, or service users.

With Better Births, there is a new focus on how to make such structures work more effectively, so that more service users can get involved in helping to shape local maternity services, through a co-production model. The "ladder of engagement and participation" model[2] based on the work of Sherry Arnstein,

shows different forms and degrees of service user involvement. True co-production means the collaboration and involvement of service users in the design of services (rather than service-user involvement being limited, for example, to reviewing services once they've been developed).

The idea of co-production with patients and their families is a common thread throughout the NHS. For maternity in particular, commissioners have received guidance on how they can meet their objectives of co-production most easily by setting up and maintaining an effective Maternity Voices Partnership. NHS Trusts are being offered incentives too to support the MVP initiative, for example through discounts in the cost of their contributions to the NHS 'insurance fund' (via the NHS Resolution Maternity Incentive Scheme). So with commissioners and providers everywhere (almost!) at the ready, now is the time for birth activists and service users to step forward and get involved, to ensure that the Better Births' call to put local Maternity Voices Partnerships at the centre of all planning for maternity services in England becomes a reality.

The NHS England resource pack for commissioners[3] – produced as a key part of the Maternity Transformation Programme – calls for:

- the 'establishment of independent formal multidisciplinary committees, [or] 'Maternity Voices Partnerships' to influence and share in local decision-making. (Department of Health 2017, p4)
- all women in the local area being able to participate in an MVP by giving feedback or becoming service-user members of an MVP (ibid, p16)
- existing MSLCs to change to become known as Maternity Voices Partnerships. (ibid, p17) (NB: MSLCs will continue in Wales, Scotland and Northern Ireland)

The resource pack also makes recommendations for the leadership, membership and funding of these Maternity Voices Partnerships. As with MSLCs, an MVP should be service-user-led, which should usually involve a service-user representative taking the role of chair, and at least one third of its members should be service-users or service-user representatives. It states that the maternity commissioner is responsible for facilitating and organising the funding of the MVP, usefully giving a breakdown of what that funding may be needed for (including providing administrative support, remunerating the chair and providing childcare provision and travel expenses for service--user volunteers) (ibid, p18), in line with the Patient Public Voice partner reimbursement policy in use throughout the NHS. For some local areas, this transition to an MVP will require very little other than a simple name change for their existing MSLC. For other areas with a less effective or a non-existent MSLC the transition will require some careful planning, as well as a renewed commitment to partnership working.

Following Better Births, there is also one particular new role for MVPs: as well as continuing to work closely with their own local maternity commissioners and current providers, MVPs should be represented by their service-user chair at the new Local Maternity System level, ensuring that service users are also at the centre of the regional decision-making process. Better Births also expects that MVPs will henceforth 'play a lead role in capturing and interpreting local data' (ibid, p20-21). Whilst this has always been a key role for MSLCs, for most MVPs, this will require developing improved processes to

gather service user feedback from a 'full range' of service users, including from those whose feedback has sometimes been more challenging to obtain, such as women and families who have experienced loss. All voices will be needed to inform local transformation activity, and the principles of diversity and inclusion should be core values of every MVP.

What makes for an effective MVP?

MVPs that are effective seem to have similar traits. They are adequately funded, have an engaged maternity commissioner who sees the value of these multi-disciplinary, collaborative forums, have clear terms of reference and have established effective ways in which the MVP can operate, with committee members having clear, well-defined roles. Often they have started out by identifying issues which are easily resolved, which make a difference to parents and staff alike, to build some early enthusiasm and to encourage others to join their successful team. Development days can also help MVPs develop as an effective team, and offer a dedicated space for the team to identify priorities, barriers and successes, and help with team-building and communication skills (Newburn & Fletcher, 2015[4]).

The MVP 'Unique Selling Point': three examples of where MVPs can contribute well to the maternity service improvement agenda

a) Walk the Patch

With feedback from service users as key to driving improvement, one approach used by many MVPs and MSLCs, is to "Walk the Patch". This has been proven to be a hugely important feedback-gathering exercise, and one that MVPs are uniquely able to undertake, given their privileged access to birth centres and obstetric units. It involves a (DBS checked and trained) service user visiting the maternity wards of their local unit (either midwife- or obstetric-led) and asking women and their families about their experiences. Traditionally, the questions are generic, "what did you like about the care you received/what would have made it even better?", although if there is a particular issue about which the MVP, Commissioner or Trust wants feedback, that can be incorporated. The responses are fed back to the MVP for discussion and action-planning as necessary. In some areas, women are encouraged to give the names of the staff that made a difference to their care, and this positive feedback is very much appreciated amongst the health care professionals.

There are many other ways of gathering service-user feedback that are productively used by MVPs, including holding informal coffee mornings and, increasingly, using social media to ask for feedback (which also publicises the work of the MVP). These are all really important sources of experience data for the MVP to review, alongside the Friends and Family Test data gathered by providers, complaints data and the annual service user experience survey data gathered by the Care Quality Commission.

b) Listening to seldom heard voices

MVPs can be the platform for innovative ways of engaging with local service users, especially those voices that have traditionally been 'seldom heard'. In the model terms of reference for MVPs (http://nationalmaternityvoices.org.uk/toolkit-for-mvps/setting-up-an-mvp/mvp-resources/) there is a section that really captures this idea well:

"Listen to, and seek out, the voices of women, families and carers using maternity services, even when that voice is a whisper. [Enable] people from diverse communities to have a voice."

A great example of such engagement work is happening in Tower Hamlets, where a Mothers Support Group (MSG) is supported by a 3rd-sector community development organisation, Social Action for Health. This allows the feedback of local women from many different ethnic backgrounds to be heard effectively, including Bangladeshi, Indian Caribbean, African, Chinese, Eastern European and White British women. 923 local women's voices were heard in this way in Tower Hamlets between April 2014 and March 2015. As a group, the MSG identified key issues to take to the main MSLC meeting, as well as coming up with some suggested solutions. This 3rd-sector supported approach empowers local women from the most disadvantaged communities to share their maternity experiences and builds local women's capacity to influence and shape maternity services. With the support of the user chair and the committee's administrator, we have seen how individual women gradually develop confidence to feed back directly to the health professionals and commissioner at multidisciplinary meetings.

c) Driving positive changes on specific issues

Close working relationships between commissioners, providers and service users can lead to an MVP becoming a really productive forum to discuss improvement initiatives. In Reading, for example, women

Further examples of how MVPs have used feedback to shape services can be found on the National Maternity Voices website

Further resources

It has never been more important, more relevant, or easier for health care professionals and service users to get involved in co-production. The National Maternity Voices website for the national network of MVP chairs in England has a number of resources about how to set up an MVP from scratch or to revive a flagging MSLC, including further London Clinical Network guidance for commissioners[5]. There is also a very well-established Facebook group for MSLC/MVP chairs and service user reps to share best practices, highlight common issues and challenges and celebrate successes.

Get involved!

MSLCs have been working to improve maternity care in their local areas since 1984. The 'next generation' of MSLCs, known as Maternity Voice Partnerships (MVPs) in England, are a key part of the NHS-England Maternity Transformation Programme, and should help us deliver and sustain the transformed maternity service as envisaged in Better Births. Never before has there been such an opportune time for everyone, health care professionals and service users alike, to be involved in helping shape maternity services for the future. Why not come and join us? You can find your local MVP in England here, contact your local Clinical Commissioning Group or Head of Midwifery to see what's going on in your local area, or National Maternity Voices or the MSLC and MVP leaders and members Facebook groups to find out more about us.

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