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Advancing co-production in local maternity services

Tianne Haggar and Dr Harriet Boulding
The Policy Institute, King's College London

Professor Laura Magee, Tisha Dasgupta, Dr Hiten Mistry and Professor Peter von Dadelszen
Department of Women & Children's Health, King's College London

Professor Eugene Nelson and Aricca Van Citters
The Dartmouth Institute for Health Policy & Clinical Practice

Sergio Silverio
University of Liverpool & King's College London

Ross Pow
Power of Numbers Ltd

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RESILIENT

Shaping the best future for maternity services

Contents

Throughout this document, we follow Royal College of Obstetricians and Gynaecologists' guidance, using the term 'woman' whilst acknowledging optimal maternity services are the right of all birthing people, regardless of the sex they were assigned at birth.

Policy Brief

Findings from a Policy Lab that examined how co-production can be used to improve maternity care in local health systems

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The views expressed are those of the authors and not necessarily those of the NIHR or the Department of Health and Social Care.

Summary

Maternity care is one of the most fundamental services provided by the National Health Service (NHS) in the UK. In recent years, improvements in national maternity indicators have stalled as a result of the often extreme pressures on the health and social care system. The COVID-19 pandemic led to major changes in how aspects of maternity care were delivered, there are sizeable workforce shortages, and the pressures on funding continue. On top of those factors, a culture of fear and low trust has emerged following a series of critical enquiries into safety in maternity services. This has inhibited honesty, stifled learning, and, for many, has taken much of the joy out of the profession.

Against this challenging backdrop, a learning health systems approach is an established path to improving the quality of healthcare services and the experiences of women and staff. At the heart of this is the use of co-production to bring the voices of women, families, and clinicians to the centre of maternity care – both the design and delivery of maternity services and the shared decision-making for every woman. This could help rebuild trust and improve outcomes and shared decision-making for all involved.

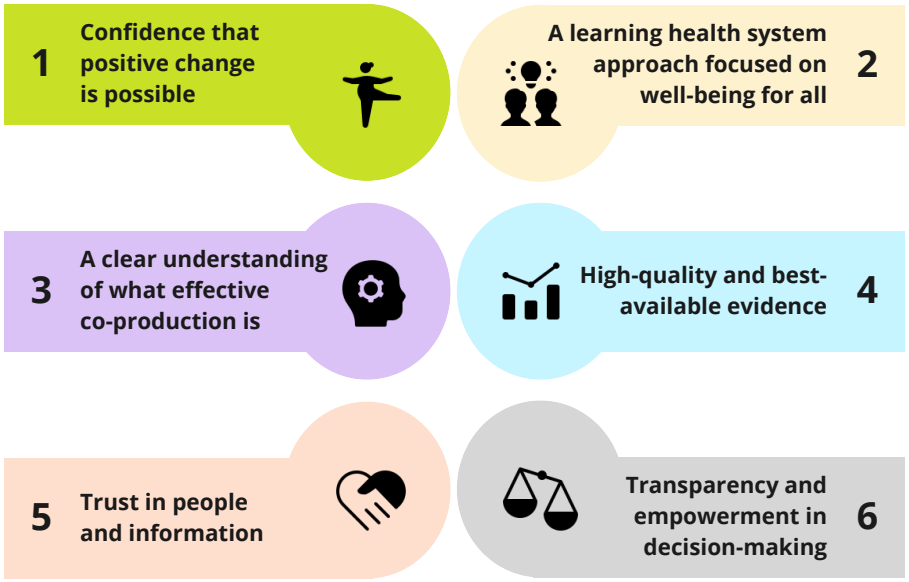
In April 2024, Professor Laura Magee collaborated with researchers at the Policy Institute at King's College London to host a 'Policy Lab' that brought together a diverse group of 30 expert stakeholders to address the question:

How can co-production be used in local health systems to substantially improve maternity care over the next two years?

Outcomes of the Policy Lab

Policy Lab participants identified six essential ingredients for co-production to flourish at the local level, and what is needed to overcome the cultural and organisational barriers to progress.

SIX COMPONENTS TO ADVANCE CO-PRODUCTION AT A LOCAL LEVEL



Whilst recognising that women and service-users have key roles to play in service improvement, recommendations from the Policy Lab were targeted at three audiences: a) Government b) local system leaders c) individual hospitals.

IMMEDIATE ACTIONS FOR GOVERNMENT, LOCAL SYSTEM LEADERS, AND HOSPITALS

For Government	**Trust local systems with the freedom to create effective learning health systems (LHS)**	**Link the use of co-production to the maternity services dataset**
For ICBs	**Build co-production into the learning of healthcare professionals**	**Ringfence funding for Maternity Voices Partnerships (MVPs)**
For hospitals and frontline healthcare teams	**Ensure digital health transformation supports co-production**	**Embed proper shared decision-making at an individual level**

Maternity Care in the UK

Maternity is one of the most important services provided by the NHS

There were 694,685 live births in the UK in 2021[1], with childbirth being the most common reason for admission to hospital.[2] Provision of high-quality, patient-centred care has been a standing priority of the National Health Service (NHS). The importance of high-quality support and care before, during and after pregnancy was underlined in a 2016 national review which led to the 'Better Births' vision for maternity services in England.[3]

Maternity outcomes and experiences of care have stalled in recent years, whilst pressures on the workforce have grown significantly

Improvement in national maternity indicators has stalled over recent years as the health and social care system faced extreme pressures.[4] Whilst the NHS workforce is growing overall, there remains a shortage of nurses and midwives, resulting in many working overtime and in stressful working conditions. Not surprisingly, staff report high levels of exhaustion and low job satisfaction.[5] Further exacerbating the problem, various public enquiries and reports have contributed to an increasingly challenging culture within maternity services, with a breakdown of trust between staff and service-users. [6] [7] [8]

The COVID-19 pandemic led to marked changes in the delivery of maternity services

The NIHR-funded RESILIENT project examined maternity services and outcomes during the COVID-19 pandemic, gathering the views of women, partners, healthcare providers, and policy-makers across England, Wales, Scotland, and Northern Ireland. Changes to service delivery during the pandemic included increased virtual antenatal appointments (by telephone or video-conferencing) and women monitoring their own health (e.g. measuring blood pressure or blood sugar levels at home) as part of routine maternity care provision. These changes were met with mixed responses from stakeholder groups. Some preferred the flexibility offered, but most felt the loss of personal contact and had concerns about the quality of care. Additionally, there was a significant increase in poor mental health among pregnant and recently-delivered women.[9]

Reforms to maternity care are supported by a powerful economic case

The cost per pregnancy to the NHS continued rising during the pandemic (by 4% compared to pre-pandemic), with mental health-related expenditure doubling, and additional costs associated with virtual care.[10] The cost of compensating mothers for harm caused by NHS maternity services is almost 3 times that which the health service spends on delivering care. In 2022, maternity services accounted for 70% of settled and outstanding NHS litigation claims (over £40bn) with 1,243 new claims.

The Women's Health Strategy for England emphasises the voices of women, families, clinicians and healthcare workers should be at the centre of reforms

Maternal mortality, pregnancy outcomes, and access to services are worse for women from minority ethnic communities, and women living with socio-economic disadvantage, pre-existing health conditions or complex social risk factors. In 2022, the Women's Health Strategy set out to improve health outcomes and health system engagement with service-users. Central to this is hearing the voices of women and their families. Women and healthcare practitioners across all four nations of the UK want to see greater communication and more personalised approaches.

Co-production, as part of a learning health system, is effective in placing these voices at the heart of maternity care improvement

Adopting a learning health system (LHS) creates a supportive learning environment, so that maternity staff feel supported and confident to provide high-quality care. An LHS uses iterative learning based on key insights, to reshape service design and delivery, evaluate the impact of these changes, and feed the lessons learned into the next cycle of improvements.

Service-users, healthcare workers, and other key stakeholders are crucial to generating key insights and driving change. The process of 'co-production' can be used in the design of services and/or at the level of individual patient-clinician interactions. It recognises people as having assets and resources beyond their position within a system or hierarchy, and focuses on building reciprocal relationships, identifying what matters most to people who use/provide services, and addressing power sharing and decision-making.

The Policy Lab

A Policy Lab was hosted in April 2024, bringing together 30 stakeholders with diverse expertise, including women, fathers, partners and non-gestational parents, researchers, academics, social scientists, clinicians (including, but not limited to, obstetricians, midwives, sonographers and mental health specialists), implementation experts, communication and co-production specialists, ethicists, and policy-makers, including NHS leadership. Plenary discussions and structured group activities were used to address the question:

How can co-production be used in local health systems to substantially improve maternity care over the next two years?

Policy Lab participants created a vision for how co-production could be used to improve maternity services, with the aim of promoting better maternity outcomes and reducing inequalities. They identified potential barriers to making progress and practical actions that could drive forward co-production at a local level.

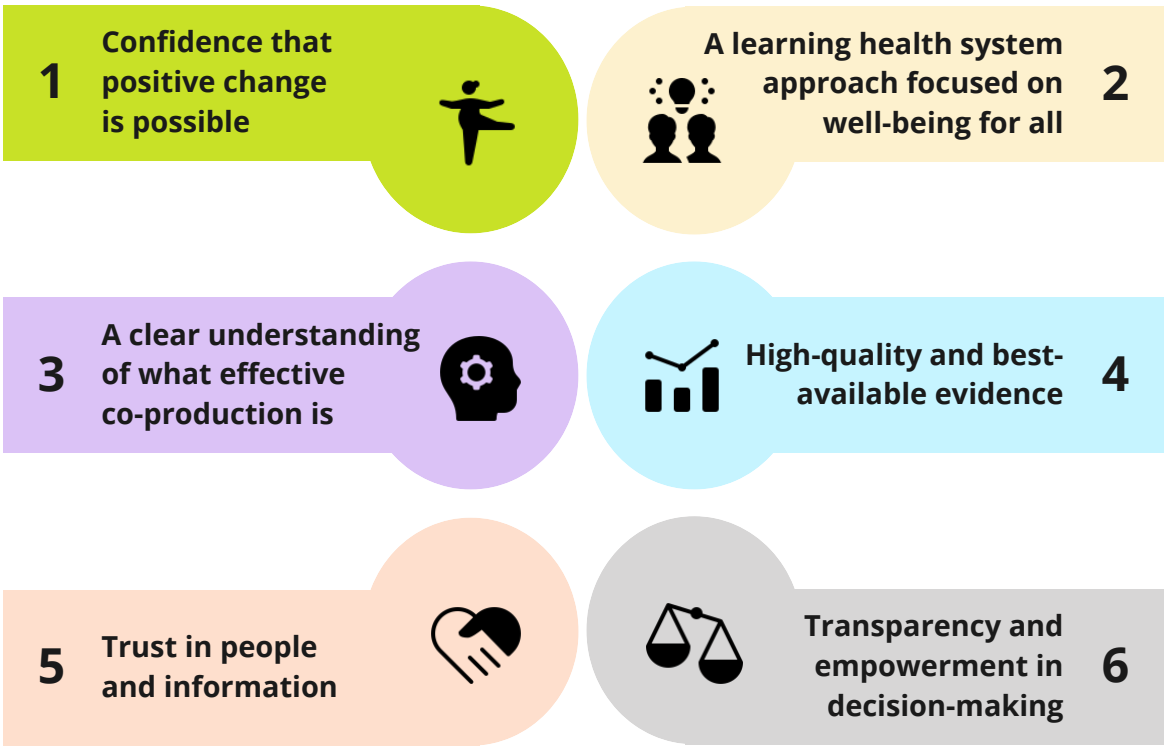
Policy Labs

The Policy Institute at King's College London delivers collaborative workshops known as Policy Labs, which convene diverse stakeholders with research, policy, practitioner and experiential expertise to assess the evidence regarding an issue, understand barriers and constraints to change, and use this understanding to inform policy options that can help improve outcomes.

Through exploring a range of perspectives and co-producing practical ideas, Policy Labs also create a highly-invested group who can become powerful advocates for the subsequent application of a Lab's conclusions.

Six components for using co-production to drive improvement

The Policy Lab identified six components needed for co-production to flourish. These apply to the process of designing and planning the delivery of maternity care at service and individual levels, to ensure effective, personal, shared decision-making.



1 Confidence that positive change is possible

What is the vision?	**Co-production is "a *practical mechanism for turning the rhetoric around the need for better maternity services into reality, and doing this in a way that women want*".** **Rapid improvements are possible at a local level if**: - leaders focus on learning - the 'enthusiasts' and 'opinion leaders' in local systems are empowered to shape change - the right evidence is available to support co-production.
What is stopping this?	**Maternity services have operated in challenging circumstances for over 20 years.** Despite several enquiries and the Better Births strategy, positive change has been difficult to achieve and improvement has stalled since the COVID-19 pandemic.[3] **The NHS financial environment and a lack of ring-fenced funding means the drive to invest further in co-production is not there.** This is the case even though rates of mental ill-health and other factors related to poor maternity outcomes are increasing. Staff, women and other stakeholders are left feeling that there is *"a lot to do"* and holding doubts about the ability of local systems to achieve change. ***"If we have not succeeded before, what will be different now?"***
What can be done?	**1. <u>Create space and resources to invest more in co-production</u>** by streamlining how local systems approach service improvement. 'De-implementation' can reduce the number of initiatives and ensure that those that remain (whether around technology, tests, processes or other changes) are properly fit-for-purpose. **2. <u>Identify, recognise and expand the existing work on co-production/shared decision-making</u>**, so that resources are shared, and can easily be drawn on by any unit, hospital, or local system. **3. <u>Focus on supporting 'innovators and early adopters' at a local level</u>**. By driving change where it is most possible, the learning from and example of change leaders can then accelerate improvement across all maternity services.

2 A learning health system approach focused on well-being for all

What is the vision?	**A Learning Health System approach is the most effective way of improving local maternity services.** Co-production is at the heart of this, with women, families, staff, and other stakeholders originating and implementing change as 'experts' with their own insights, experiences, and skills. **The focus must be on what works well, spreading learning *within* and *between* local systems.** Leaders should act as facilitators of co-production, creating safe cultures where curiosity, openness and listening can thrive to support learning. **The well-being of women and staff should be an important barometer for quality and safety** and a critical enabler in getting staff involved in effective co-production.
What is stopping this?	**High-profile inquiries following serious safety lapses have led to a *culture of fear*** and the compassion, joy, and celebration in maternity services has been lost for many staff. **Improvement plans tend to be driven by what has gone wrong with services** rather than by what women and staff actively want for maternity services. **An environment which prioritises regulation and assurance over openness and learning is not conducive to innovative and resilient services founded on co-production.**
What can be done?	**1. Develop an evidence base** for how an LHS approach offers the best mechanism for improving the performance of local maternity services. **2. Support the implementation of no-fault clinical negligence** to enable more rapid and complete learning from problem issues while appropriately protecting justice for clinicians and families. **3. Assess women and staff well-being** in ways which capture how they experience and feel about maternity services, and use this to guide tests to improve care delivery.

3 A clear understanding of what effective co-production is

What is the vision?	The **truest form of co-production positions a woman as the expert of her own maternity care** (shared decision-making and evidence-based care) and involves women, staff and other stakeholders in the process of service design and delivery. **Effective co-production relies on having diverse groups contribute the required insights and take ownership of the resulting changes.** It extends well beyond the current understanding of patient and public involvement and engagement (PPIE) to share power in the decision-making process with women, clinicians and other stakeholders, at different levels, in different roles, and with diverse characteristics and backgrounds.
What is stopping this?	**Too many people do not understand what effective co-production is.** Some clinicians equate it with relatively narrow ways of soliciting the views of patients and the public on how services are experienced. Others see it as being primarily about their role in determining how provision of services should be changed. **Shared decision-making at a personal level can also be misconceived** as clinicians providing the information (even when this is incomplete) and framing the choices with the role for women limited to expressing their values and experience.
What can be done?	**1. <u>Better define, utilise, and operationalise the NIHR definition of co-production</u>** in research, to educate women, clinicians and other stakeholders at local levels about the principles for running projects to generate improvement changes. **2. <u>Create simple media/materials to explain co-production</u>** with easy-to-understand definitions at different levels (service co-design, service co-delivery, individual shared decision-making) and the principles and values needed to support implementation (e.g., involve and respect all voices, inform with balanced evidence).

4 High-quality and best available evidence

What is the vision?	**Every local co-production project should be clear on the evidence needed to support its work and have examples of how to go about finding resources and using them.** The digital transformation at the local level should assist with this. **The evidence should be of high-quality, present a holistic view and be balanced in how it is assessed and presented.** This means placing proper value on the insights and preferences of women, looking at the pregnancy experience as a whole and not in parts, and addressing the gaps and biases in the available information.
What is stopping this?	**There are different views on what constitutes the 'legitimate evidence' needed to support co-production.** Some insights are not given sufficient weight (e.g., how cared for women feel) or some groups are not being well-represented (e.g., fathers). **Too often information-sharing is not balanced or sufficiently nuanced** (e.g., emphasising risks in generalised terms that lead to unnecessary fears or poor clinical decisions). Viewing pregnancy as separate stages (pre-conception, antenatal, intrapartum and postnatal) also prevents a holistic understanding of how the system is performing. **An inability to access or analyse data (e.g. on ethnicity or deprivation) limits the use of co-production in driving quality improvement and reducing inequalities.** This includes not being able to link co-production to potential impacts (e.g., how service improvements reduce medico-legal costs).
What can be done?	**1. Provide practical guidance on the evidence that should be sought** to inform design thinking and personal shared decision-making. This should include good examples of co-production that have successfully used data to reach their conclusions. **2. 'Fit-for-purpose' digital investments should support shared decision-making by providing information for women in meaningful ways** and help them store and retrieve their decisions/preferences throughout their pregnancy. **3. Create a financial template** for local systems to model how the results of improvement from co-production are likely to translate into greater financial sustainability and reduced medico-legal costs.

5 Trust in people and information

What is the vision?	**Maternity services should be designed and run to build trust and confidence amongst and between women and staff**. Clinicians should be sensitive to how an individual receives and processes information. **Information in clinical practice should reflect differences in language and culture that can affect a shared decision-making conversation.** This is especially important given the continued change in population demographics.
What is stopping this?	**Experiences during the COVID-19 pandemic have led to reduced trust in health professionals and maternity-related information**, such as in relation to vaccination or the risks and choices around childbirth. **Population-level information often insufficiently caters to the needs of diverse groups or communities** and then is not effective in countering misinformation. **Miscommunication and/or a lack of communication at an individual patient level** includes clinicians lacking the skills to approach conversations with women when they lack data or have honest uncertainties about the options to present.
What can be done?	1. Create and disseminate examples of providing **better information without judgement.** **2. Develop a 'Welcome to NHS Maternity Services' resource** that is accessible through multiple communication channels and tailored to local audiences by charities and other stakeholders. **3. Offer personalised birth planning resources** such as a 'My Birth plan' app drawing on evolving knowledge from women, doctors, doulas, and organisations outside the NHS. **4. Regain trust by publicising both positive and negative** reviews of maternity services.

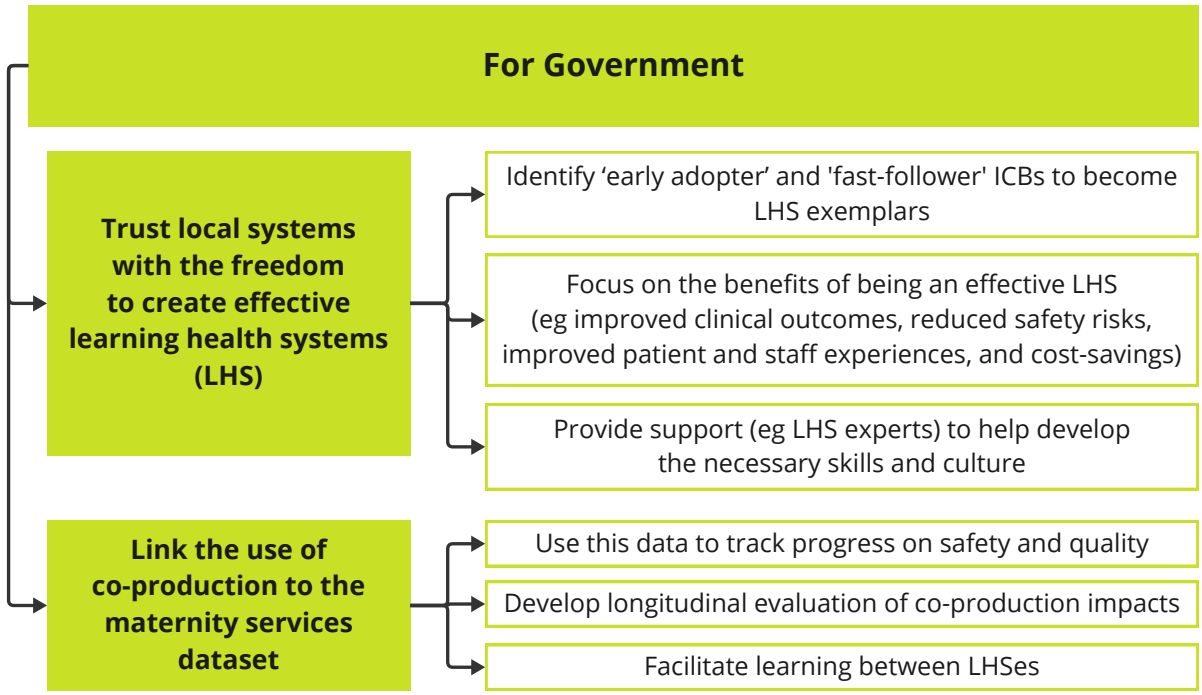
6 Transparency and empowerment in decision-making

What is the vision?	**All staff should be equipped to understand the principles of co-production** and have a positive view of women as experts on their own bodies. **Hospital and local system leaders should open up their discussions on financial and resource allocations to more diverse groups of women and staff**, to bring in what is important to them in determining the trade-offs between different service improvement priorities.
What is stopping this?	**Many staff are not exposed to ideas of co-production in their education or training.** Consequently, implementing co-production has been slower than desirable even though the evidence and resources to promote and support its use has existed for some time. **Most women are not empowered to see themselves as the expert on their own body** and they are generally not viewed as such by healthcare professionals. **Co-production is also held back by a lack of transparency in decision-making processes,** such as stakeholders not being provided with all of the necessary information or having an equal voice in the process.
What can be done?	**Build co-production into the teaching of all healthcare professionals**, along with the questioning and listening skills needed to facilitate this (e.g., with the help of digital tools). **Involve service-users in multidisciplinary (MDT) meetings**, both for individual care decisions and for investigations and quality improvement (ensuring funding is available to pay for these roles). **Involve diverse sets of women and staff in decisions** on the allocation of resources and budgets.

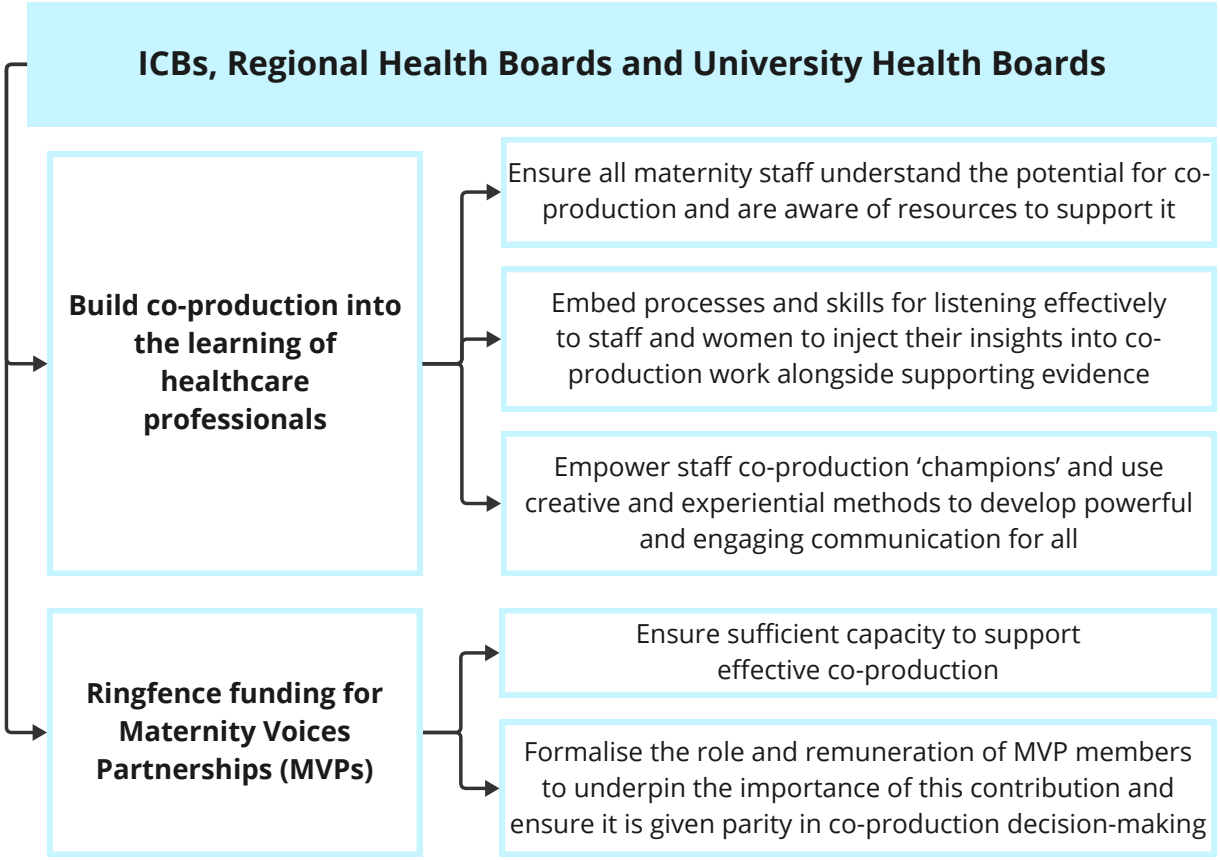
Immediate Actions

A number of the proposals from the Policy Lab provide immediate actions for Government, local system leaders (Integrated Care Boards, Regional Health Boards and University Health Boards), and individual hospitals.

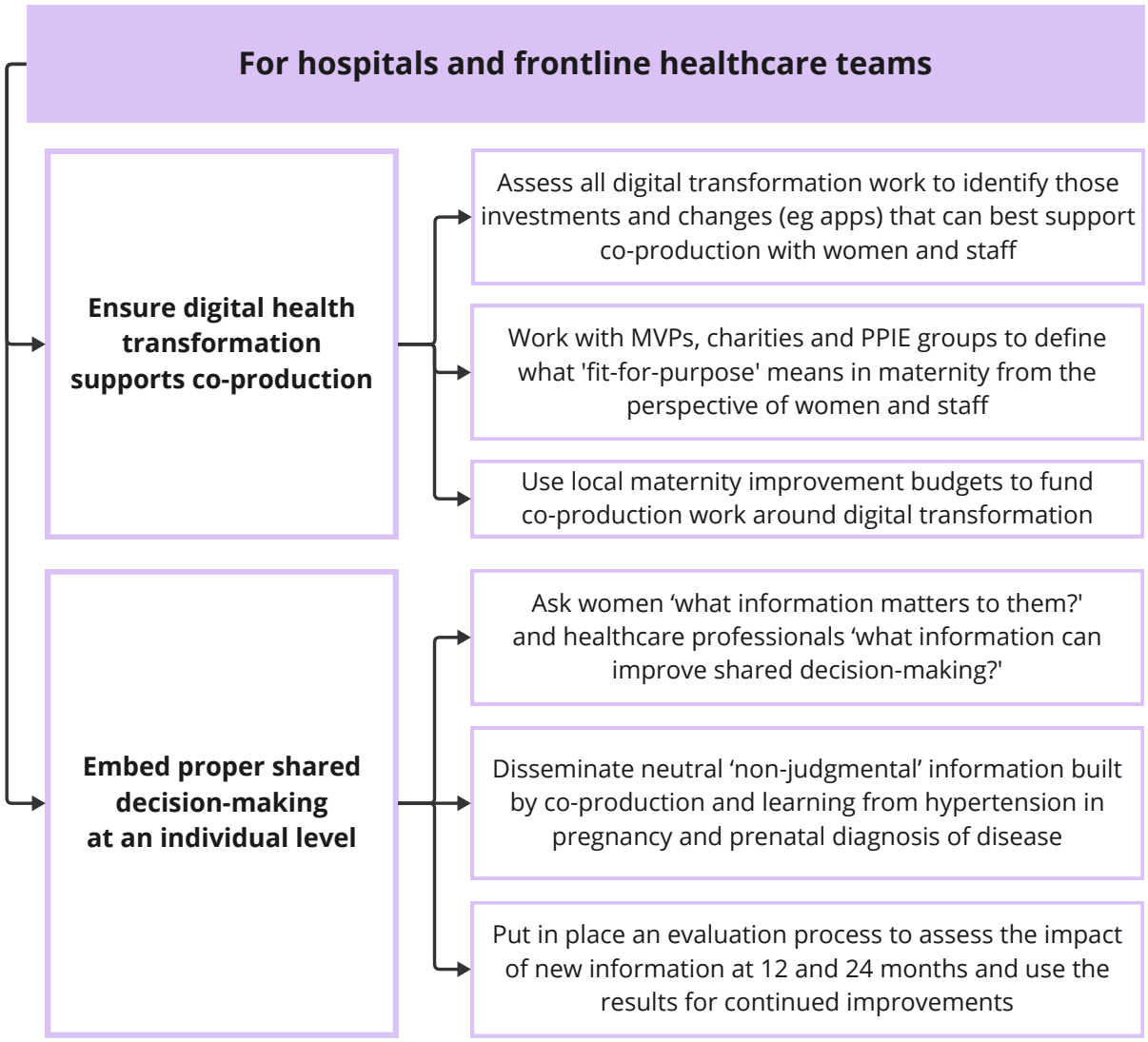
IMMEDIATE ACTIONS FOR GOVERNMENT



IMMEDIATE ACTIONS FOR LOCAL SYSTEM LEADERS



IMMEDIATE ACTIONS FOR INDIVIDUAL HOSPITALS



Next Steps

1. Start a co-production LHS Collaboratory with a 'coalition of the willing and capable'.

2. In approximately 8-12 diverse local systems (e.g. ICBs), identify a respected clinical champion and 'lead team' of healthcare professionals & women, to start a 'growable' co-production LHS (cLHS).

3. LHS Collaboratory establishes brief statements to summarise the cLHS' aim, vision, guiding principles, and measures of success ('Thinking Big'), as well as a specific 'problem area' that needs improvement (e.g., gestational diabetes, GDM), as a 'fertile ground-breaking opportunity'.

4. Each fledgling cLHS works with some of their most interested, capable front-line clinical settings (microsystems) to begin Plan-Do-Study-Act (PDSA) cycles, to test improvements and innovations aimed at improving key outcomes related to GDM.

5. Each cLHS reports monthly measures of condition-specific success (linked to GDM) and overall measures of success (i.e., outcomes, experiences, value for money), to share transparently whether the cLHS work is leading to improvements.

6. As experience is gained and progress is made, expand engagement to more local systems, hospitals, and front-line healthcare teams, to build a national, voluntary cLHS for maternity care.

All of this regional and front-line work should be supported by national programmes, policies, and support (financial and other), such as access to routinely-collected data.

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