AIMS For a better birth...

Implementing Better Births via MVPs: an interview with Ceri Durham

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AIMS Journal, 2018, Vol 30, No 2

Since 2016, Ceri Durham (an AIMS trustee) has worked for a small grass-roots health inequality and community development charity, Social Action for Health, based in the East End of London. Much of Ceri's time in this paid role is allocated to supporting her three local Maternity Voices Partnerships (MVPs), and in this interview we have asked Ceri to reflect on whether the effectiveness of MVPs might be improved with the help of such 3rd sector organisations.

Ceri, can you tell us a bit more about Social Action for Health?
Social Action for Health (SAfH) is a community development charity which recognises that manyanswers to good health are not just about medical treatment, but rather about addressing social factors which influence health. It is well known that the poorer you are, the worse your health is likely to be, for example. This is as true in maternity as in other health matters.

What is your role?
I am one of SAfH's senior managers and head up the 'community research' programme. This includes speaking to women about their maternity care, and feeding that into local MVPs and the Local Maternity System, as well as working on a range of other projects.

SAfH is responsible for supporting three Maternity Voices Partnerships. Can you tell us more about that?

We are currently commissioned by the Clinical Commissioning Groups in the London Boroughs of Tower Hamlets, Newham and Waltham Forest to administer and facilitate the MVPs in these diverse boroughs. We facilitate and support the MVPs and aim to encourage and support genuine community involvement in the leadership and membership of them.

Do you have specific targets that you must meet?
Yes, we have targets. We are responsible for delivering to each contract and there are monitoring meetings every three months where the CCG assesses whether we have done what we agreed, to the required standard. We also produce a report for each MVP every quarter, evidencing what local women are saying about maternity care in their borough.

It sounds like MVPs are taken very seriously in your area, which is not necessarily the case across the country. Do you have any reflections on this?
We are very lucky to have senior commissioners and midwives who are very supportive and genuinely want women involved in all aspects of improving local maternity services. The SAfH team definitely view the MVPs as a key vehicle for women and professionals to work together to improve maternity services. MVPs have great potential for genuine co-production, with women as partners and leaders in shaping great maternity care.

But even in our local area, there are tensions and confusion. For example, some see our role as the hosting of a patient consultation group, a complaints forum, or as a mechanism that can provide women 'on tap' whenever they need a woman's voice or to demonstrate service-user involvement. This can inevitably lead to frustration, and it is definitely work-in-progress. I think this confusion can be seen across the country, but I hope that over time, local MVPs will become more embedded in the overall decision-making process. This will represent a real shift in power and thus mean real progress.

To whom are you responsible?
SAfH is primarily responsible to the women and families whose voices we represent. They are telling us their story and trusting us to make a difference. So often we find that they deserve better from maternity services and we have a key role in making that happen. As a charity employee, I am also responsible to our board of trustees. As an organisation, SAfH is contractually responsible to the relevant Clinical Commissioning Groups.

Does having a common administrator mean that all 3 MVPs are very similar in set-up, activity and outcomes?
To some extent, the MVPs that we administer are very similar. We tend to recommend, for example, that things that work in one MVP should be considered by another. We have monthly meet-ups for the chairs, so that they can learn from and support each other. We are using a common MVP meeting format at the moment, which seems to work well.

All the current local chairs are quite new to the 'birth world'. As local service-users develop more of a sense of ownership of their MVPs, the format and operation of the meetings will start to vary more

across each one. I am very excited about this. I would also like to move to a model where the MVP itself can have more awareness and control of a budget to get things done, but as yet we are some way from having these mechanisms in place.

What is the rationale for operating an MVP in this way, and is it really affordable?
Many MVPs operate at a lower cost than ours, either relying entirely on volunteers or paying a chair or other service-users to do everything. I don't think there is a perfect model. The rationale for paying us is for consistency, quality control and sustainability, as well as volunteer support and accessing our community networks and community development expertise. This ensures we have a wide range of voices sharing experiences with the MVPs and also bringing their expertise to the meetings to help shape the development of the maternity care in the area.

As part of this, we provide training and support to our local communities, so that they are really in a position to influence change. None of our current chairs had heard of 'Better Births' or the notion of a Local Maternity System before we started working together. I do feel proud of what we've achieved.

There are many MVPs which seem to operate brilliantly, facilitated by a team led by a service-user chair. But I have seen many occasions when a chair steps down and the MVP folds because there is no one to sustain it. As every service-user chair and representative knows, there is often a great deal of emotional energy involved in MVP meetings. Often, hospital staff are defensive where feedback is concerned, and women can get annoyed that providers do not seem to do anything in response to their feedback. Working with a third party, in a more structured way, can help take the 'personal' out of the equation.

What do you think are the main downsides to having a 3rd sector organisation working alongside an MVP in this way?
There is an inherent conflict of interest. If the women say they want to prioritise one issue, but the commissioners want to prioritise another, we could be stuck between pleasing the person who pays us (the commissioner) and the women. This can also be a problem for other MVP models; our model might just make such tensions explicit, which is perhaps no bad thing! Another issue is that our involvement can translate as SAfH being seen as *the* service-user representative, which is not how we see ourselves.

Locally, we have tried to head-off both of these potential problem by having the MVPs focus on the outreach feedback we collect from local women. MVPs each collectively agree their priorities and use these to define the questions we ask in our outreach work and other improvement priorities. This is effective if you believe that the role of the MVP is co-production and that everyone has an equal voice at the table. For some people, however, this way of working is seen as pointless, because the perception is that women don't really know what the key issues are in birth, or in the provision of maternity care. I am sure you can guess where my personal view is on this spectrum!

In Better Births, service-user involvement via MVPs is imagined as a key part of the Local Maternity System framework. Did the MVPs you administer play any meaningful part in developing your local Better Births implementation plan, for example?

We are generally quite lucky in our area. MVPs are increasingly seen as a key part of the Local Maternity System. So, for example, we had some input on the Better Births implementation plan, and some of the chairs provided comments. We also conducted a surface level engagement exercise designed to help the Local Maternity System get user input. The problem is that the NHS often wants service-user involvement at very short notice, without any thought as to how this might be resourced in practice. We aim to help as much as we can – and we would rather provide basic input than there be no service-user input at all – but it can be very frustrating. Not all our chairs have the interest or expertise (yet!) to comment on strategy documents like this, nor the time in between family and other commitments.

To try and improve the input of the MVPs to the Local Maternity System, a women's experience sub-group has been set up. These meetings take place on a weekday morning during school hours – not at school pick-up time, when many of the Local Maternity Systems meetings had originally been scheduled – and in a central and accessible venue. A key part of our strategy is to support the MVP chairs to get involved at this less intimidating and slightly more user-friendly level, and for decisions made here to be passed to the main Local Maternity System for sign-off and implementation. The meetings are still relatively formal and full of 'policy-speak', but it is definitely a step in the right direction.

Many MVPs are trying to ensure a wider voice from a more diverse range of service-users. What advice can you offer to chairs and other MVPs trying to do this.
My first question is to always ask *why* you are wanting a more diverse voice. Not that you should not – far from it – but this will often tell you what you need to do. Very often, service-users find themselves stuck in an impossible predicament … the Head of Maternity (or whoever) wants input from people who are 'not the usual suspects'. At the same time, s/he wants input from people who are able to provide expertise on the subject and who actually understand the maternity system. These are, of course, the usual suspects!

I think sometimes it is also expected that people from different educational, social or cultural backgrounds will have totally different views. However, in my experience, all women want the same thing from their maternity services: compassion, dignity, and respect, underpinned by safe medical practice and midwifery care.

My top tip would be to think about your community and who you are not speaking to and just get out there. Get out there into your communities – and write down what you find. Very often, as far as the NHS is concerned, if it is not in a report, it is not happening. This way, even if a more diverse group of women are not attending the meetings, you know that their voice is still being captured. It can be very hard in practice to do this though, so use existing community groups and ask them to ask their attendees. Ask the leaders of the groups to come along to the MVP meetings to contribute and to represent their communities. If you are on social media, use that too. Capturing the voices – and showing what you do with them – is the first step. Slowly, you will build your wonderfully diverse and inclusive MVP.

If a fairy godmother was going to grant you one Better Births wish, what would it be?
Continuity of carer through pregnancy, birth and beyond! I honestly think this will make the biggest

difference to making maternity services safer and kinder. At last, providers seem to have stopped moaning about continuity, and are trying to make some effort towards implementing the national March 2019 20% coverage target. Viva la revolution!

And finally, what has been your worst moment in this role?!
Being accused of making up the feedback we obtained from the outreach, because it did not reflect the local friends and family test feedback. Grrr...