Co-production good or promising practice examples template – projects & programmes

This template has been designed to help you share co-production learning and practice. It may also be used where evidence of co-production is required to be submitted e.g. Maternity Incentive Scheme safety action 7 (CNST), Ockenden immediate and essential actions from the interim report 2-Listening to women & families and 7-Informed Consent, Perinatal Equity action plans.

Title of project/programme or service area	**Co-production in setting up the Maternal Mental Health Service (MMHS) - known locally in Kent and Medway as: 'Thrive – Psychological Support for Birth Trauma and Loss'.**
Aims and objectives	The NHS Long Term Plan includes a joint PMH and maternity transformation objective: by 2023/24, 'Maternity Outreach Clinics' (now known as 'Maternal Mental Health Services') will be available across the country; combining maternity, reproductive health and psychological therapy for women experiencing mental health difficulties directly arising from, or related to, the maternity experience. During September 2020, NHS England (NHSE) invited proposals for the testing and development of a Maternal Mental Health Service during 20/21 and 21/22. The commissioner (Kent and Medway CCG) and the providers (the Kent and Medway NHS and Social Care Partnership Trust (KMPT) and the East Kent Hospitals University NHS Foundation Trust (EKHUFT) worked together to complete and submit an Expression of Interest (EoI) to be an Early Implementer to test the new service within East Kent. Following a period of consultation with healthcare staff, colleagues and those with lived experience of birth trauma and loss, this service was named 'Thrive – Psychological Support for Birth Trauma and Perinatal Loss'. Being a completely new NHS service, we needed to ensure this service was developed from the outset with those who had lived experience of birth trauma/birth loss or tokophobia (severe fear of childbirth) who could provide valuable, key information on a number of items such as where the service should be held (so not to potentially retraumatise people by asking them to revisit a building where they may have experienced trauma for example), the types of intervention / treatment they felt would be most beneficial and what the clinical working model should look like. The objective was also to co-produce service items such as information leaflets and posters, the service name and imagery and the language used in internal and external communications about this new service. Ultimately, we wanted to ensure we were building a service ***with*** people who had experienced birth trauma or perinatal loss, ***for*** people who experience birth trauma or perinatal loss, to make sure it was equitable, inclusive and fit for purpose.

Scope and target audience	Within the Perinatal Mental Health Community Service (PMHCS), KMPT, there are five employed Peer Support Workers who have lived experience of perinatal mental ill health and of receiving care from mental health services. We did not have anyone however that had specifically experienced birth trauma, perinatal loss or been in receipt of care for PTSD following these experiences. We therefore set about linking in with services that already supported those people and their families.
Date commenced	August 2020
Date completed	Ongoing
Stakeholders e.g. • Who? (include equality, diversity and inclusion (EDI) best practice) • How identified? • How involved?	Before we submitted our EoI, we linked in with five local charities across Kent and Medway that support those who have experienced birth trauma and perinatal loss: SANDS: https://www.sands.org.uk/ Abigail's Footsteps: https://www.abigailsfootsteps.co.uk/ Birth Trauma Association: https://www.birthtraumaassociation.org.uk/ Make Birth Better: https://www.makebirthbetter.org/ Making Miracles: https://makingmiracles.org.uk/ We undertook a series of online discussion forums for attendees to put forward, with their lived experience in mind, certain items for the service, including what they felt Thrive should provide, where and when it should be held, the clinical offer and the expected outcomes. We also worked with the Kent and Medway CCG Engagement Team in putting together a survey to obtain further views on the development of Thrive to ensure co-production. This survey asked questions such as where the service should be held, and at what time, the interventions it should provide, and views on the use of both face to face and virtual appointments. This survey was shared online by CCG, KMPT and EKHUFT communications teams, and promoted on social media platforms by our local Maternity Voices Partnership Chairs, who have a large readership – we received 170 responses to the survey, which was a great sample. Tonic (independent research consultants) were also asked to conduct a scoping activity, as part of the early implementer project, to inform the future roll out of the MMHS across Kent and Medway. The aim of this work was to gather the thoughts of those with lived experience of birth trauma or birth loss on how the MMHS should run and how it could be delivered to ensure women, people and their families are supported as effectively as possible. The scope of this work was also to examine inequalities within Kent and Medway and explore barriers to accessing support services, particularly for those living in areas of deprivation and minoritised groups, including obtaining a separate report from the Association of South Asian Midwives.

Description/additional information	Thrive also has an employed Peer Support Worker with lived experience of birth trauma and of receiving EMDR therapy. She is able to make contact with those referred to Thrive in a way tailored to them, which includes sharing her recovery journey and modelling recovery, providing support via phone calls, appointments or attending assessments, and also linking the person with further support groups as required.
Training or guidance provided to support the co-production process (include name and details of training provider if applicable)	• Before we held any of the online sessions with those who linked in with us via the local charities, we made sure by speaking with the charity contacts, that there was someone who attendees could debrief with if necessary after the session, for example a therapist or counsellor. Although we were very clear that we would not ask anyone on the session to disclose details of their actual experience, we were aware that just talking through certain items could potentially be retraumatising for some people. • In terms of the ongoing lived experience group that KMPT run online (details below), every person is asked to register with the KMPT Patient Engagement Team who formally register the person, provide them with access to training courses, support, and guidance, and can signpost to debrief sessions as necessary.
Evaluation, main impact and outcomes	• The information put forward in the aforementioned survey helped to inform our Thrive clinical model, with 97% of respondents putting forward that 'therapy' would be their priority intervention for what Thrive would offer. • Those with lived experience informed us that instead of a peer support network for Thrive, they would prefer a person to be able to link in with at times they felt would be useful for them. This informed our clinical model of having an employed peer support worker (as above) with lived experience of birth trauma, to support people in their recovery journey. • From the initial lived experience online sessions via the local charities, those that attended were asked to contact the project lead if they felt they would like to be involved in co-producing the service as it develops. A number came forward, which provided a pool of people who have (and continue to do so) worked incredibly hard and given up their time to ensure Thrive is continually co-produced in all areas of decision making. • Those with lived experience were also invited to be standing members of the monthly LTP communications working group, chaired by the Thrive Project Manager, which includes communications managers from the CCG, KMPT and the acute hospital trusts This group provides a forum in which to jointly agree all messages and communications on Thrive and the LTP to the public, referrers, those with lived experience and stakeholders.

	As a result of the ongoing co-production process, the following pieces of work have taken place: • A consultation process took place to decide upon a name for this new Maternal Mental Health Service – discussed with both staff and those with lived experience. Name agreed as 'Thrive'. The logo for Thrive was created and agreed following a consultation process as above. • Thrive service leaflet and poster: wording and imagery co-produced. Clinicians working in other services within the perinatal mental health pathway such as IAPT (talking therapies), counselling and Psychosexual Health services were also consulted to ensure all details within the service leaflets relating to their services were accurate. • A trauma-informed care (TIC) policy for Thrive was devised by the consultant clinical psychologist and reviewed by those with lived experience to ensure the terminology was clear and compassionate. • Venues to avoid for the services were considered, i.e. best not to have appointments in medicalised settings for those who had experienced birth trauma, and best practice to avoid a Children's Centre for those who had experienced perinatal loss. • The wording for the Thrive public facing website was co-produced. • A service user satisfaction survey was created, to obtain the views of everyone who receives care from Thrive on their personal experience of the service. This was co-created with those with lived experience who provided really important feedback such as not having 'leading' questions and having a particular section for the partners/family members of the person. In addition, as a result of the Tonic engagement scoping work, 73 people who engaged with Tonic (via online or face to face surveys) have come forward to be available to provide views on the future development of Thrive for rollout.
Learning points e.g. • What went well? • Challenges and resolutions	• Surveys: manage expectations. We asked people what time they would like Thrive to be held, and some asked for it to be at a weekend or evening. Unfortunately, this would not have been a possibility due to the funding and staffing model. A better survey question, instead of 'when would you like the service to be offered?' may have been 'within the hours of 9am to 5pm, Monday to Friday, are there better times for the service to be run, i.e. first thing, over lunchtime, early afternoon, later afternoon' etc. • Approach people very early, before writing expressions of interest for funding or writing service specifications. This way they can be an active part of all decisions, not just when we get to a certain point in a process. • Include those with lived experience in as many areas of review and decision making as possible. Although a task may appear regular or usual to a staff member, a person with lived experience could provide an

	example, view or insight that could completely positively change the way the service is developed. • Continual reflection is key – look at what is working well and what we can do together to continually improve the service we provide.
Future plans e.g. • Learning and practice presented where and to whom? e.g. Trust, LMNS website, FutureNHS platform • Review (e.g. after 12 months) • Maintaining relationships • New areas of work identified	• Continue with the monthly online lived experience group so all items are continually co-produced. • Between groups, the project manager emails the lived experience group with updates on items and feeds back on work the group have been doing. For example, if the group have devised a leaflet, the project lead will let them know when the communications team have formatted it. It's important for those giving up their time to be communicated with and to feel valued, as they absolutely are. • Continue to link in with the 73 people who have come forward via the Tonic work – actively engaging them in the Thrive rollout development. • Work/learning/reflections already shared nationally via a number of NHSE webinars. Any more future invitations will very much be taken up. • 6 month and 1 year Thrive service evaluations have been completed, which include clinical outcomes as well as qualitative feedback from patients, their families and healthcare staff across the midwifery and obstetric system.

What is Thrive?
Thrive offers assessment and treatment to those experiencing moderate/severe mental health difficulties as a result of their maternity experience, such as birth trauma and/or perinatal loss and tokophobia (severe fear of childbirth). The service is available to support those who have previously received psychological care and treatment from counselling services or talking therapies but are still experiencing trauma symptomology and require further treatment.

Presentations may include (but are not limited to):
- PTSD following birth trauma
- PTSD following perinatal loss (including early miscarriage, unsuccessful recurrent miscarriage, stillbirth, neonatal death)
- Tokophobia (severe fear of pregnancy/childbirth)
- Repeated unsuccessful IVF
- Termination of pregnancy for any reason

Clinically appropriate psychological treatment including NICE recommended Eye Movement Desensitisation and Reprocessing (EMDR) therapy and Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) is provided by a Therapist. These are forms of therapy that can be useful and effective for those who have experienced trauma.

Specialist Mental Health Midwives within the service can provide their clinical expertise and knowledge in relation to birth trauma and birth loss, and support for future pregnancies, as well as providing advice to Midwifery colleagues across the system and support referrals to be made.

Co-production good practice example – Kent & Medway
'Thrive – Psychological Support for Birth Trauma and Loss'

Additionally, a person working within the service with lived experience of birth trauma is available to make contact with each person, to offer support and advice as required. This includes supporting someone at their assessment, sharing their experience of their recovery journey, or linking in with support groups.

Based on the needs of each person, further advice, support and signposting can be offered.