NIHR | Applied Research Collaboration South West Peninsula

OCTOBER 2021

CHILD HEALTH AND MATERNITY PROGRAMME NEWSLETTER

In this newsletter:

The Prioritisation Process

This three-year programme of research seeks to find effective ways to implement evidence-based interventions to improve children's and maternity services widely across England by supporting four prioritised projects.

All ARCs were asked to consult with their networks of providers, commissioners and Patient and Public Involvement (PPI) groups to suggest interventions that were likely to meet the **APEASE** criteria used by the programme. This produced 32 suggestions which were then screened based on their evidence of efficacy and effectiveness, producing a shortlist of 14 interventions.

In January four workshops, chaired by PPI members, were held to explore the feasibility, acceptability and impact on equity of these interventions. The nine partner ARCs were asked to nominate one member of the public, one provider or commissioner, and one academic to attend each workshop. After hearing from intervention representatives and having an opportunity to ask questions, workshop participants were asked to give interventions a score reflecting their global assessment against the three criteria; these were used indicatively to rank and prioritise the interventions.

Nine interventions were particularly highly rated in this process. The next step was to undertake rapid but formal reviews of the evidence of efficacy/effectiveness to produce priority briefings for the shortlisted interventions. Using these reviews, the final projects were selected and sense-checked against national priorities with our Programme Advisory Board, which includes PPI representatives and national leaders in Child Health and Maternity. **Read more about this process here.**

32 INTERVENTIONS SUBMITTED

Interventions were submitted by academics, clinicians and providers from 12 Applied Research Collaborations (ARCs) across England.

4 THEMED WORKSHOPS

14 ideas were short-listed for two Child Health and two Maternity focused workshops. Representatives presented their idea and attendees gave each a score from 1-10 based on the acceptability, practicability and equity of the idea.

WITH OVER 80 ATTENDEES

Attendees included members of the public, people with lived experience, clinicians, practitioners, providers and academics from 9 collaborating ARCs.

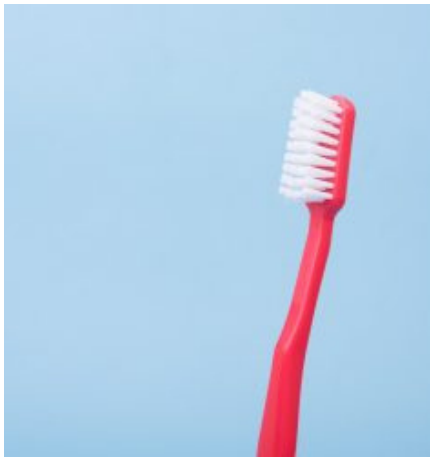
9 PRIORITY BRIEFINGS

In-depth reviews of effectiveness and cost effectiveness were conducted for the top 9 ranked interventions from the workshops.

4 INTERVENTIONS SELECTED FOR IMPLEMENTATION

4 interventions were prioritised by the Programme Management Group based on their potential for impact and alignment with national agendas.

CH&M Supported Research Projects



BRUSH (optimising toothBrushing pRogrammes in nUrseries and ScHools)

A quarter of five-year-old children in England have tooth decay. This figure can rise up to 50% in deprived areas of the country. Supervised toothbrushing programmes are effective in reducing tooth decay, especially in children at greatest risk and are cost-effective. However, uptake and maintenance of these programmes are fragmented with funding coming from a variety of sources and there is considerable variation in how they are implemented. This project will work with stakeholders, to learn how best to implement these programmes and how to increase their uptake and success in the longer term. Read more about this project here.

ESMI-III: The Effectiveness and Implementation of Maternal Mental Health Services

In recent years, significant investments have been made to improve perinatal mental health care in the UK. The most recent initiative to achieve this goal was laid out in the NHS Long-Term Plan, with the implementation of Maternal Mental Health Services (MMHS). In 2021, the MMHS will be implemented across 30 sites in all areas of England – referred to as 'Early Implementer' and 'Fast Follower' sites, before a national scale-up and sustainability phase in 2022-24. Read more about this project here.

Evaluating models of health-based Independent Domestic Violence Advisor (IDVA) provision in maternity services

The aim of Independent Domestic Violence Advisors (IDVAs) is to secure the safety of those at risk of harm from intimate partners, ex-partners, or family members. While there is evidence for the effectiveness of IDVAs across a range of health settings, less is known about their implementation or impact within maternity services. This project aims to evaluate current implementation activities of health-based IDVA provision within maternity services and to generate practical advice on the successful implementation of IDVA models through utilising improvement science techniques. Read more about this project here.

Trauma-focused Cognitive Behavioural Therapy for children in care

Young people in care have substantially higher rates of mental health difficulties compared to their peers. Services often struggle to effectively address their mental health needs and prevent wide-ranging consequences. To begin to address this complex issue, we are undertaking a pilot implementation project, working with CAMHS, social care, and third-sector mental health services across four NIHR Applied Research Collaborations, spanning South West, West, East, and North England. The primary goal of this work is to identify the key barriers and facilitators to services providing best-evidenced cognitive-behavioural based mental health treatments to children and young people with experience of the care system. Read more about this project here.

A PPI Perspective

by Naomi Morley, Research Associate within the PenARC PPI team

In the past months I've had many conversations with public contributors and PPI leads of this programme and other projects about diversifying public involvement and the inclusion of seldom heard voices in health research. And in all good conscience, diversity and inclusion should be high on our agenda if we're truly concerned about addressing inequalities, rebalancing power structures and representation of communities that are affected by our research but often unheard.

Despite Patient and Public Involvement having become requisite to conduct health research and in some institutions is now often commonplace, it's clear from these conversations that many communities are still marginalised and unable to actively participate in research.

One of our public member's comments had particular resonance - "*it is not kindness to simply open our doors wider.*" And it cannot be an easy fix to let people enter our knowledge space without the genuine commitment to treat them as equal partners; to offer support, space and audience so that their voices have influence on the research. People told me how they have been invited to share their experiences, but the researcher didn't appear to listen or respond to what they were saying so they didn't feel understood or taken seriously. How they were unable to participate in conversation because of their complex needs or because they didn't understand the language, research and/or premise of their role. How they were discouraged because they felt they had much more to give but their skills were not valued. Lay members often have to adjust to our research culture and language, while we (researchers) don't adjust to theirs. This is not inclusion.

Instead, we should invest in people and nurture relationships to understand their needs, skills and expectations. We should match roles/tasks to these needs and define with clarity the remit of people's roles and how this sits in the research. There has to be a willingness to support a change in our research culture, in our language and to balance power structures to give people the opportunity to be heard and have influence. Otherwise, we're not inclusive and we'll fall back into box ticking with lay members merely occupying a space. This is meaningless and only perpetuates inequalities, and would be ironic if community members on a study about health inequalities feel side-lined and marginalised by the professionals.

Patient and Public involvement is a complex, dynamic construct and it demands progressive development to truly embrace diversity and inclusion. One size does not fit all, and mistakes happen. But awareness opens the opportunity to challenge ourselves, reflect and mutually learn and benefit.

Throughout the first stage of the Child Health and Maternity programme we worked with a diverse group of public contributors from across the collaboration in all levels of the prioritisation process. We were mindful of addressing power structures and tried to minimise these by changing our language and practices. Our processes remained fluid so that lay members could shape the programme and we could adjust to their needs and feedback. For the next stage of the programme, we are forming a PPI Community of Practice to create a shared space for reflection and support to the projects and the people involved; as well as collectively contributing to new learning to the community.

If you would like to explore this topic further the National Institute for Health Research (NIHR) is facilitating a webinar on the 1st December 2021 on '**How to incorporate Equality, Diversity and Inclusion (EDI) in Patient and Public Involvement (PPI)**'.
Additionally, the National Co-ordinating Centre for Public Engagement (NCCPE) is running an '**Engage Unconference Programme**' throughout October and November, including for example a workshop on 'Including children and young people in research'.