The implementation of the integrated birth care policy in the Netherlands

A PROCESS EVALUATION

MASTERTHESIS

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Preface

This is the thesis that is the result of the process evaluation of the integrated birth care policy in the Netherlands. This thesis is the final component before obtaining the title 'Master of Health Sciences' at the University of Twente. From February 2020 to November 2020, I have been conducting this research. It was a strange time to graduate due to COVID-19, which slowed down the process.

However, without the guidance throughout the process creating this master thesis would not have been possible. That is why I want to thank my supervisor Pieter-Jan Klok for his good guidance, ideas, motivation and help where necessary. In addition, I would like to thank Magda Boere-Boonekamp for last-minute indentation as a second supervisor.

I would also like to thank my supervisors at CPZ, Caroline van Weert and Jolijn Bethlem for their help. They have helped in a very comprehensive way and were always there for me, in good and desperate times. The employees of the CPZ also deserve my thanks since I could turn to them whenever I had questions. Furthermore, I would like to thank everyone who took part in the interviews for taking time and efforts to help me with this thesis.

Lastly, I would like to thank my family, friends and partner for their support, advice, and trust in me.

I wish you a lot of reading pleasure.

Judith Schenau

Enschede, December 2020

Summary

Background

The Netherlands had one of the highest perinatal mortality rates in Europe in 2004. The figures showed that the perinatal death rate in the Netherlands was above the European average. To address this, the Minister of Health, Welfare and Sport appointed the Steering Committee on Pregnancy and Birth. They created an advice report to optimize birth care, which especially emphasized that more intensive cooperation between all birth care professionals was needed and thus an integrated approach. They also advised that College Perinatale Zorg (CPZ) should be established to create and facilitate the Integrated Birth care Standard (ZIG). The ZIG was established in 2016, the policy that was described was mandatory for all care providers involved in birth care and the implementation had a timeframe of four years. Since the advice of the steering group, the figures of the perinatal death rate have fallen in the Netherlands but have flattened in recent years. This could have something to do with the fact that the integrated birth care policy has not been optimally implemented yet, therefore it was important that this was examined.

Objective

The primary aim of this study was to gain insight on whether the integrated birth care policy has been implemented as intended and to what extent in the form of a process evaluation of the policy of the ZIG. The focus was on the implementation phase.

Method

This study focused on the implementation of the integrated birth care policy. First, a content analysis was carried out in which it became clear which activities, objectives and responsible actors were described for the integrated birth care policy. It became clear that two layers of implementers were appointed. The local obstetric partnerships (VSVs) and the National umbrella organisations involved in birth care. These two layers were examined. For the VSVs existing data has been used which were telephone interviews from CPZ and indicator results. Both methods included the performance of certain activities that were to be performed by the VSVs. When an activity occurred in both datasets, the results could be compared in the activity analysis. Next to that an overall analysis, based on the telephone interviews, of the VSVs was performed which presented to what extent all activities have been carried out by all VSVs. In addition, the distribution of the VSVs was examined in the form of a group analysis. They could be divided into a low group, average group, and high group.

Semi-structured interviews were held with the National umbrella organisations about their contribution to the implementation of the ZIG. Next to that the factors influencing implementation were discussed.

Results

The telephone interviews and the indicator set were analysed when it came to the VSVs and it became clear that the activities that were best performed: Working with integral care paths and or protocols, a quality policy, multidisciplinary consultation (MDO) and client experience measurement. Activities that were carried out the least were: Working with an integral dossier, client participation, a coordinating care provider and working with an individual birth care plan. On the latter two the indicator however showed that most VSVs carried out those activities. The VSVs were also divided into three groups when it came to the implementation of the ZIG. 30% of the 57 VSVs were in the high group, 30% of the VSVs in the average group and another 30 % in the low group. The high scoring group of VSVs scored reasonably high on all activities except for working with an integral dossier. The average group was shown that working with integral care paths or and protocols, client experience measurement, MDO and a quality policy were carried out by the majority of this group. The activities that were carried out the least by this group were: Client participation, individual birth care plan and joint website. These scored all below the 50 %. For client participation it is however shown that there is a high level of not discussed as for working with an individual birth care plan. Regarding the low group the level of ''Not discussed'' stood out, since for nearly every activity this was above 60%. The activity that was carried out the most by this group was: Integral care paths or and protocols. It also became apparent that the level of ''In development'' was low for all activities.

Interviews were conducted with Bo geboortezorg, Koninklijke Nederlandse Organisatie van Verloskundigen (KNOV), Nederlandse Vereniging voor Obstetrie en Gynaecologie (NVOG), Federatie van VSV's, Patiëntenfederatie Nederland, CPZ, ZonMw and Perined. It became clear that activities that had to do with an association other than their own, were carried out the least by Bo geboortezorg, KNOV, NVOG and the Federatie van VSVs. Next to that the activity regarding risk assessment was carried out the least. An activity concerning the development of monodisciplinary guidelines into multidisciplinary guidelines was also carried out the least. For Patiëntenfederatie Nederland it became apparent that they were engaged in most activities that were described for them. The activities that were not carried were: Carry out own activities that promote the application of integrated birth care in accordance with the Integrated Birth care Standard, looking for cooperation and synergy between own activities and the activities of healthcare professionals and professional associations and communication about relevant aspects of the Integrated Birth care Standard, including trying to get pregnant women / parents involved in participation in advisory boards of VSVs. CPZ carried out nearly every activity. The only activity that was not carried out was: Supports the VSVs in their choices when working together in a shared electronic file. For Perined and ZonMw it became apparent that they both fulfil a role when it comes to integrated birth care, although no activities were described for them in the implementation plan.

When it comes to the factors of influence the policy and policy theory, the implementing organisation, the implementers, and the characteristics of the environment played an important role. When it comes to the policy and policy theory factors that were of influence are: inaccuracies in the implementation plan, time pressure in the development of the implementation plan, overambitious objectives, the

necessary resources were not in order when it comes to capacity and finance, incorrect assumptions about the degree of organization within a VSV and the digital data exchange. Regarding the implementing organisation factors that were of influence were: The existence of CPZ, Confusion about the role of CPZ, The image of CPZ, first communication outing to the field. When it comes to implementers several factors played a role such as: the differences between professionals, lack of trust between professionals, disagreements about some objectives. Concerning the environment factors that were of influence were: The implementation of the integrated birth care policy and integrated funding intertwined, distracting riot around a client experience measurement and the practical help consortia offered VSVs.

Conclusion

The conclusion of this study is that the implementation of integrated birth care is on the right track. However, the integrated birth care policy is not totally implemented as intended. There is variation between VSVs as between the different National umbrella organizations. The VSVs carried out the minority of activities. The activities that were carried out by the majority of the VSVs were: working with integral care paths or protocols, client experience measurements, MDO and a quality policy. The indicator set showed that working with an individual birth care plan and a coordinating care provider were carried out by the majority. It can therefore not be said with certainty that the VSVs carried out the minority of the activities. Furthermore, were most activities carried out in different ways. The activities that have not been performed as intended based on the overall analysis were: Working with multidisciplinary training, joint website, client participation and integral dossier, individual birth care plan and coordinating care provider.

Whether the policy was carried out as intended differed per National umbrella organization. CPZ, the KNOV and Bo geboortezorg carried out most of the activities that were described for them. For CPZ it became clear that the ‘’who’’ changed hey however did carry out the ‘’what’’. The organizations that carried out the minority of the activities they were supposed to, were the NVOG and Patiëntenfederatie Nederland. This also applies to the federatie van VSVs, but at the time when the implementation plan was drawn up, they did not yet exist, so they were not mentioned as a national umbrella organization in the implementation plan. If the policy had been implemented as intended all activities were carried out by the organizations that had to do so, this is however often not the case as for this policy.

Glossary

Directors meeting: Directeurenoverleg**.**

Midwife: Verloskundige

Workgroup Integrated Birth care Standard: Werkgroep Zorgstandaard Integrale Geboortezorg.

CPZ in general: College Perinatale Zorg (CPZ) in het algemeen, omdat er ook algemene activiteiten zijn besproken voor die activiteiten is CPZ in het algemeen benoemd.

Staff bureau: Stafbureau CPZ.

Support group VSVs: Supportgroep Verloskundig Samenwerkingsverband (VSVs), dit is een gremium dat genoemd staat in het implementatieplan.

Members: Achterban of ook wel leden van een brancheorganisatie.

Grant groups: Subsidie groepen voor onderzoek.

National umbrella organizations/stakeholders: De landelijke organisaties die zich bezighouden met de geboortezorg in Nederland.

Telephone interviews: De jaarlijkse belronde van het CPZ.

Integrated funding: Integrale bekostiging.

Multidisciplinary consultations: Multidisciplinair overleg (MDO).

Advocate: Belangenbehartiger

Client councils: Cliëntenraad

Reviews: Beoordelingen (op Zorgkaart Nederland)

Target group: Doelgroep.

Central editorial board: Centrale redactie raad.

Back channel: Ruggespraak.

The Executive committee: Dagelijks Bestuur.

The participants' council: Deelnemersraad.

ZIG/ Integrated Birth care Standard integrated birth care: Zorgstandaard integrale geboortezorg.

Perseverance: Doorzettingsmacht waar Zorginstituut Nederland over beschikt.

Table of Contents

Chapter 1. Introduction

1.1.INTRODUCTION

The organization of birth care in the Netherlands has been under discussion in the past decade. An important reason for this was that, according to the Euro-Peristat report, the Netherlands had one of the highest perinatal mortality rates in Europe in 2004 [1]. The figures showed that the perinatal death rate in the Netherlands was above the European average. The fetal death rate, the number of stillborn babies during pregnancy and delivery, was 7.0 out of 1000 births in the Netherlands in 2004. This was except for France, with a figure of 9.1 per 1000, the highest fetal death rate of the 25 European countries that were included in the report. The neonatal death rate, which is the death rate that indicates live births within 28 days of birth, was 3.5 of the 1000 births in the Netherlands in 2004. This brought the perinatal death rate, which is the sum, at 10.5 per 1000 births. The explanations [2] found for this were: The Netherlands has a relatively large number of older mothers and multiple pregnancies. Another explanation lied in the registration system. What could also play a role was the Dutch midwifery system, the midwife had a very independent role, which is unique in the world. The number of home births could also be an explanation. It also appeared that there was more smoking during pregnancy in the Netherlands. Lastly was there a problem that lies in peripheral areas, the accessibility and availability of acute care had deteriorated.

To address this, the Minister of Health, Welfare and Sport [2] appointed the Steering Committee on Pregnancy and Birth. They had the task of creating an advice report to optimize birth care. In 2009 the advice report [2] was delivered by the committee. It was called ''Een goed begin, veilige zorg rond zwangerschap en geboorte'' in English it translates to ''a good start, safe care for pregnancy and birth''. The objective of this report was that the number of maternal and perinatal mortality rates were halved in 2014. The report existed out of sixteen recommendations to improve the quality of birth care. What was especially emphasized in this report was that more intensive cooperation between all birth care professionals was needed. They also advised [2] on the establishment of the College Perinatale Zorg (CPZ), the development of a cross-professional research program and closer cooperation between healthcare professionals through compulsory participation in a local Obstetric Partnership (VSV). Following this report, the CPZ [2] was established to provide direction for improvement of birth care. According to the Steering Committee, the CPZ is responsible for common quality policy with a standard of care for all healthcare professionals regarding birth care. CPZ's [3] range of duties included drawing up the Integrated Birth care Standard (ZIG), the first version was prepared by an expert group between 2014 and 2016. The ZIG describes from the perspective of the (expectant) pregnant woman, the basic care she should receive and, in that way, offers a quality framework to which birth care should comply with. The Integrated Birth care Standard is included in the national quality register [4] of Zorginstituut Nederland (ZIN). Entry in the quality register means that the Integrated Birth care Standard is not optional, but there is an obligation [4] for all parties involved in birth care to make an effort when it comes to the implementation of the ZIG and guidelines and deliver the

indicator data to the public database of ZIN for monitoring the quality of care. The CPZ monitors, facilitates and evaluates the implementation of the Integrated Birth care Standard. They were also instructed to develop an indicator set, an implementation plan and a client version of the ZIG. They all have been added to the quality register in 2017. The implementation plan [5] provides tools or guidance for the parties that are involved in birth care to implement the Integrated Birth care Standard. The client version [6] offers information for (upcoming) pregnant women and their partners about the agreements in the Integrated Birth care Standard.

A research from Perined [7] regarding numbers of 2015 showed that the mentioned figures of perinatal death rate had fallen. Explanations [8] for this were in the fact that there were fewer teenage pregnancies and there was a small decrease in preterm births and multiple pregnancies. Next to that was indicated that more intensive cooperation between the involved care providers, the introduction of the perinatal audit, the activities of CPZ and the active approach of the government played an important role. Perinatal mortality [9] had dropped to 7.3 per 1000 births, this is a relative decrease of 30% compared to 2004 . This means that there was already a sharp decrease in the perinatal death rate in the Netherlands, but as there was a decline everywhere in Europe, the position of the Netherlands is improving limited compared to other countries. The central government indicates the position has improved, but that the Netherlands is still in the middle bracket in terms of perinatal death rates in Europe. It is clear that the perinatal death rate has fallen sharply over the years, but this has been levelling off [10] in recent years. The newest figures that Perined [10] published showed that the perinatal death rate was 7.9 per 1,000 children born in 2018 and this is comparable to that in 2017.

1.2 PRINCIPAL

CPZ is the principal for this thesis. CPZ is a network organization, founded by Bo Geboortezorg, Koninklijke Nederlandse Organisatie van Verloskundigen (KNOV), Nederlandse Vereniging voor Obstetrie en Gynaecologie (NVOG), Nederlandse Vereniging voor Kindergeneeskunde (NVK), Nederlandse Vereniging van Ziekenhuizen (NVZ), Patiëntenfederatie Nederland and Zorgverzekeraars Nederland (ZN) [11]. They are committed to integrated care and prevention regarding pregnancy and birth [3]. Their core activities are: Putting shared issues on the agenda and addressing them, initiate and facilitate policy development, connect the different parties that are involved in perinatal care and support the birth care field with knowledge and information. As a national college, the CPZ [5] also conducts the direction of national implementation of ZIG and facilitates the local introduction of Integrated Birth care Standard in collaboration with partners in the field. Their main goals [3] are reducing the mortality and morbidity of mothers and children and promoting a good start for every child in the Netherlands. They have identified several objectives that must be achieved for 2022. These are formulated in the following manner:

- *''In 2022, every pregnant woman, baby & family will receive a state-of-the-art comprehensive birth care and we offer them proven the best possible start''*
- *''In 2022, the client is an equal partner and she decides together with the healthcare professional''*
- *''In 2022, birth care is the example of one efficient, solidary and well-functioning network''*

The accountability [12] of the CPZ board is twofold. They must be accountable to the participants' council and to the Ministry of Health, Welfare and Sport. The participant council includes the participating parties: Bo Geboortezorg, KNOV, NVOG, NVK, NVZ, Patiëntenfederatie Nederland and ZN. The Ministry of Health, Welfare and Sport (VWS) provides the budget for the existence of CPZ and the activities they carry out. And so, the CPZ has to report yearly to that Ministry of VWS.

1.3 GOVERNANCE CPZ

The governance of the CPZ [12] was renewed in 2018. The governance of the CPZ [13] was adjusted since a structure was devised when the CPZ was established, which was not workable. The structure was mainly aimed at connecting all birth care parties. The governance consisted of a board who had no burden or back channel. It was manned by members nominated by the participating parties. In addition, there were various committees where all relevant birth care parties participated in which they did have burden and back channel. The work would take place in the committees. The board decided based on the interests of the pregnant woman, if necessary, with perseverance *(*doorzettingsmacht*)*. However, the committees yielded too little and were not effective enough. This was also due to their size. In addition, the perseverance came to lie with ZIN. The CPZ responded to this by adapting the governance. The committees were disbanded, thematic expert/working groups were set up and the preparatory work was mainly carried out from within the bureau. After this had been adjusted, uncertainties continued to arise. Therefore, it was decided, during an invitational conference of the board of CPZ in 2017 regarding a new strategic agenda, that there should be a board without burden, but with a back channel. Board members of the CPZ had to be practicing in their professional practice and (thus) have a good feeling with the members. The practical and administrative parts were to be separated. In the elaboration of the above, a governance note has been discussed in a meeting with the CPZ participants. After this CPZ started to consider the best governance structure with the help of different parties. Currently, the main bodies and consultation structures are: Participating parties, board CPZ, executive Committee, director CPZ, participants' council, directors meeting and expert, advice or working group.

- **The participating parties** are as mentioned before: Bo Geboortezorg, KNOV, NVOG, NVK, NVZ, Patiëntenfederatie Nederland en Zorgverzekeraars Nederland.

- **CPZ board:** The board of the CPZ consists of eight directors. The board consists of one independent chairman and seven directors appointed by the parties participating in CPZ. They are all active in the field of birth care. In the current governance, the board is responsible for the implementation, they ensure that the CPZ bureau carries out tasks with regard to the implementation of the ZIG. Their role is more in governing and supervision of the company CPZ.

- **The Executive committee** consists of the chairman and the treasurer. They act on behalf of the board.

- **The director of the CPZ:** The director is in charge when it comes to the bureau and is responsible for policy preparation and development, drawing up annual plans, multi-year plans and the budget.

- **The participants' council** is formed by board members of the participating parties. These consultations are strategic by nature and relate to the long-term agenda. The consultation is chaired by the chairman of the CPZ. This takes place at least once a year.

- **The directors meeting:** Representatives of the CPZ participants at board level participate in this. In this meeting, more tactical-operational topics are discussed and coordination is sought between the parties. The meeting is chaired by the director or board secretary of the CPZ. The Directors' meeting takes place at least 4 times a year.

- **Expert, focus, advice or working group**: It should firstly be mentioned that the governance of the CPZ is not set-in stone. Depending on the assignment or issue, a different structure of governance may be required. The CPZ determines this on the basis of a so-called governance decision tree. This decision tree is used to determine which parties should be involved, how consultation and decision-making procedures should be shaped and whether it can be tackled in a new or existing body. This is determined by CPZ. Parties outside the CPZ participants can also participate.

  Currently there is for example the working group actualization Integrated Birth care Standard, who logically deal with the actualization of the ZIG and a working group indicators.

- **Taskforce integrated funding**: The taskforce falls under the director of the CPZ but does not have to be accountable to the parties, but to the Ministry of VWS. From the Programma Transitie Geboortezorg [14], the taskforce helps regions that want to and can switch to integrated funded birth care with customized support during the transition and implementation. It is a funding system for birth care but it is still under discussion how necessary this particular method of integrated funding is in order to work as a team.

1.4 PROBLEM AND RESEARCH QUESTIONS

Birth care has taken major steps in the last years, but it is still not optimal since the perinatal death rate of 2009 was is still not halved [2]. This could have something to do with the fact that the Integrated Birth care Standard is not optimally implemented yet. The Nederlandse Tijdschrift voor Obstetrie en Gynaecologie (NTOG) [15], for example, mentioned in 2019 that many VSVs are experimenting with the provision and implementation of integrated birth care. It indicates that the implementation of the ZIG did not go the way as it was stated in the policy. Next to that, CPZ and the other involved parties have indicated that they would like to know how the implementation of the Integrated Birth care Standard is progressing. This means that a policy evaluation of the ZIG is desirable. Therefore, the central research question for this research is:

"To what extent has the integrated birth care policy been implemented as intended?"

To find the answer to this question, various sub-questions are answered. The sub-questions are formulated in the following manner:

''What does the integrated birth care policy entail and what activities and responsibilities are distinguished?"

''To what extent are the activities described in the implementation plan carried out?"

''Which factors influence the implementation of the Integrated Birth care Standard of care?"

1.5 OBJECTIVE

The aim of this study is to gain insight on whether the policy is being implemented as intended and to what extent in the form of a process evaluation of the policy of the ZIG. The focus here is on the implementation phase.

1.6 END PRODUCT

CPZ stated that a process evaluation and an impact analysis is desirable. The end product for this study will be a process evaluation, which will provide clarity about whether the policy is being implemented as intended. A subsequent intern or organisation that is involved with the CPZ can perform an impact analysis to create a complete picture. This also depends on the other evaluations that are carried out regarding birth care.

Chapter 2. Theoretical Framework

2.1. INTRODUCTION

The topics that are relevant to this research are highlighted below. First the concept policy will be described since this research involves an evaluation of a policy. After that, the focus will lie on policy evaluation, because of the latter named reason. Lastly the factors that can be of influence on the implementation of a policy will be discussed.

2.2 POLICY

According to the Cambridge Dictionary [16] policy can be defined as: *''a set of ideas or a plan of what to do in particular situations that has been agreed to officially by a group of people, a business organization, a government, or a political party".* The objectives of policy can vary, but overall, it defines certain norms and values. In that way, policy shapes plans. In policy there is a sequence of events which are often captured by a policy cycle [17]. This cycle can be viewed in figure 1.1.

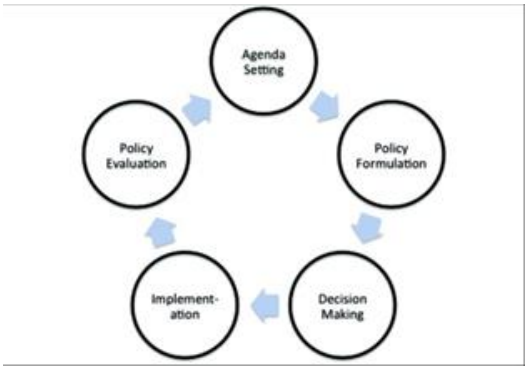

Figure 1. The policy cycle model [15]

This policy cycle consists of the following steps [18]: Agenda-setting, policymaking, decision making, policy implementation and policy evaluation. The focus of the cycle is on generic characteristics of the policy process. Before a problem [18] is put on the agenda it needs to be acknowledged. Furthermore, it needs to be determined whether the problem is urgent enough to put on the agenda. This is also part of selecting the problem that needs to be addressed. The second phase [18] which is policy formulation exists of what is to be achieved with the policy, this is translated in the definition of the objectives. The process [18] whereby the policy makers adopt a specific course of action, while considering a small number of alternative policy options which can resolve public problems is defined as the decision-making phase. During the implementation [18] phase the policy that is decided upon is executed. This phase is crucial since *''it involves putting a solution into effect''*[19]. The responsibilities need to be assigned and the resources need to be allocated in an effective manner [19], otherwise the policy will not work as was initially intended. Jan Wenrich [18] describes

in his book that ''In a lot of cases the execution of policies will be changed or distorted; delayed or even blocked all together''. In the evaluation phase [18] the attention is on the intended outcomes of the policy. Next to that it also focuses on the unintended consequences. The evaluation can be performed for every phase of the policy cycle, this is unrestricted. Evaluation will be outlined further below.

2.3 POLICY EVALUATION

Since a policy evaluation will be conducted during this research it is of importance to first understand the meaning of this concept. Policy evaluation [20] can be seen as the evaluation of the content, processes, or effects of a policy. Evaluation research is scientific research in view of a policy evaluation. Evaluations rest on three issues: Choice of subject, observation of that subject and the criteria against which this observed subject is assessed. When it comes to evaluation research, there are different types. Some of these subdivisions relate to the subject, others to the observation of the subject and others to the criteria.

For the subject of evaluation[20] a distinction can be made regarding the policy area to which the evaluation relates, the second distinction concerns the time dimension. In an ex-ante evaluation, the content, processes and/or effects of a policy are assessed in advance before the policy is actually implemented. For ex post evaluations, an assessment is made of a policy that is already in force or has been enforced. Next to that there is an ongoing evaluation [21], this determines the interim effects and results of a policy. When it comes to this type of evaluation the implementation and realization phase in the policy cycle [18] is still ongoing. Wollmann [21] has stated in the handbook of public policy analysis that *''The essential function of "ongoing" evaluation is to feed relevant information back into the implementation process at a point and stage when pertinent information can be used in order to adjust, correct or redirect the implementation process or even underlying key policy decisions*''. A third distinction according to subject matter is the focus on the content, the process, or the effects of the policy. These three can each be evaluated separately. During this study, the focus will lie on the process, with emphasis on the implementation process.

Evaluation research can also be distinguished based on the criteria used. This is especially done for evaluations that regard the effects, this does not apply to this study. In implementation evaluation, the criteria are in the policy itself. This regards the intended activities of the policy.

When it comes to observation of the subject, there are also distinctions that can be made. Namely the quantitative approach and a qualitative approach. The qualitative approach, for example, focuses more on the process and the quantitative approach more on the actual effects. Furthermore, when it comes to the qualitative approach, data collection focuses on participatory participation and interviews, while the quantitative approach focuses on data collection through statistical data and written surveys. In practise the different aspects of both approaches are used in evaluation; this can also be seen as triangulation.

Another distinction is made, when it comes to type of evaluation, between

internal and external [21]. Internal evaluation can be seen as self-evaluation since it will be performed by the operating organisation itself. External evaluation is initiated by an outside source.

Evaluation research [21] consists of 3 phases: The preparation phase, implementation phase and the finalization phase. In the preparation phase the subject and the criteria are determined. The main focus here is the implementation phase, this consists of four steps.

The first step exists out of systematically describing the policy content in relation to the policy field. The second step in this research focuses on determining the criteria, namely the intended activities described in the ZIG and Implementation plan. Determination of the criteria normally exists out of two activities: operationalisation and data collection. In this research the criteria are already operationalized into measurable criteria. After this the required data is to be collected. The third step looks into the degree of implementation of the policy. There are often many developments in the policy field that can be influenced by all sorts of factors other than policy, these are also declared.

2.4 FACTORS THAT ARE OF INFLUENCE

In the model described by Coolsma [22] four factors are of great importance for the likelihood of compliant policy performance. Those are: The characteristics of the policy and policy theory, the characteristics of the implementing organization, the characteristics of the implementers and the characteristics of the environment. In the model it is shown that interaction exists between the various factors. Characteristics can therefore influence each other.

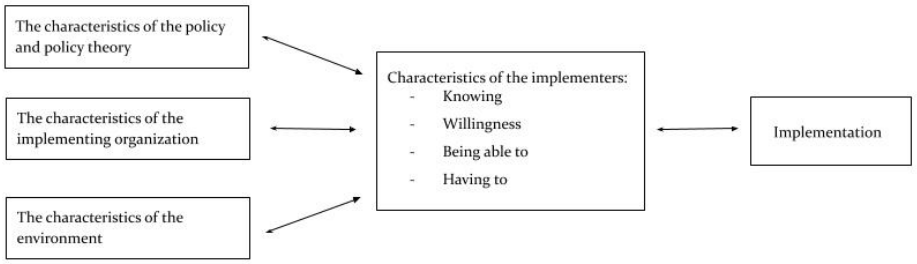

Figure 2. Factors that influence the implementation of a policy [22]

The characteristics of the policy and policy theory

The nature and the quality of the policy and the policy theory have a major influence on the process of policy implementation. Unclear and unexplained goals, just like the degree of disagreements about means and ends of the policy can affect the feasibility of the policy. What can further influence policy are overly ambitious objectives. Setting

those high-strung goals can lead to cynicism in the implementing organizations. Another policy feature that strongly influences implementation is the extent to which policymakers provide the intended implementers with the necessary resources. When these resources are insufficient, the implementation of the policy will be slower and there may be resistance. Policy theory can also influence the course of implementation. Policy theory can be seen as the set of assumptions that underlie a policy. The correctness and acceptability of these assumptions may also affect the progress of implementation. If there are incorrect assumptions underlying the policy, then this can lead to inadequate policy as well as the application of the wrong measures.

The characteristics of the implementing organisation

When it comes to the implementing organisation two types of organizations can be distinguished: horizontal policy networks and vertical hierarchies. This research concerns a horizontal policy network. The policymaker is dependent on various organizations. Control must be achieved by binding on the basis of equal communication between the organizations.

The characteristics of the environment

Environmental influences also play a role in the implementation of a policy. Four different environmental influences can be distinguished: Influence from within the task environment, the political administration, the economy, and the technological environment.

Influence from within the task environment mainly regards the fact that the target group of a policy influences the implementation process. They may be willing to implement the policy, but they may also oppose it. Implementation is therefore not a one-way street, but that there is also cooperation and negotiation with the target group.

The political administration account must be given to political governance by the implementing organization. This dependence can be supportive, but it can also be limiting. For example, a particular policy is not seen as a priority, so that the implementation is limited. When a new technology becomes available, it can make it easier to pursue a policy. In addition, it may also be the case that new solutions can be found for an existing problem.

When it comes to the economy, less or more financial resources may become available for the policy plan.

Characteristics of implementers

Implementers can, with the policy freedom they have been given, to some extent decide how they will use the resources that are available to them. Over time, standard working methods emerge. These are fixed patterns in the way things are handled and decisions are made and motivated. These standard working methods may be informal by nature, however, they can also be formalized in work instructions, protocols, and policies. The chance of a compliant policy performance depends on several characteristics of the implementers. These characteristics are: " knowing ", " the willingness ", " being able to " and " having to ". The knowing is about that the implementers must know what the policy entails. The implementers must be well instructed about the objectives and means of a policy, and they must also be aware of the assumptions underlying the policy. The willingness regards the fact that they must be willing to implement the policy. It is about the extent to which practitioners agree with the means, goals, and the imposed rules of conduct. If the goals do not match their motives, there is less likely to be compliance with the policy.

In addition, they must also be able to implement the policy. This mainly refers to the competences of the implementer. This has to do with the training of the implementer, but the person must also have access to resources. The 'having to' relates to the degree to which employees are free to implement the policy as they wish. Influence can be exerted through supervision, accountability, and performance contracts. Stricter forms of internal control do not leave much room for the operator. This can have a positive effect on policy compliance, but it can also be counterproductive.

Chapter 3. Method of Content analysis

3.1 INTRODUCTION

In this chapter a method is designed to answer the first sub-question: ‘*’What does the integrated birth care policy entail and what activities and responsibilities are distinguished?”*. First the process evaluation is described and then it is discussed how the content analysis was carried out.

3.2 PROCESS EVALUATION

This research takes the form of a process evaluation of policy implementation, which focuses on the question to what extent the implementation of the policy is carried out and whether this was in line with the expectations [23]. This involved looking at the actual implementation of the policy and which factors influenced the implementation. This provides insight into the objectives and the activities that are identified to achieve these objectives. With this information an answer can, be obtained for the first sub-question. The answer to the first sub-question is used as input for the sub-question about the actual implementation. With the use of the analysis of the objectives and the activities that belong to those objectives, it can be examined whether the implementation of the policy is as intended. After this the factors that influence the implementation of the policy are examined. The effects of the policy were not considered in this study. With the effects is meant the perinatal death rate and the satisfaction of clients.

3.3 CONTENT-ANALYSIS

With the content analysis the activities that belong to the policy are identified and described. The responsible actors who had to carry out certain activities are also appointed. There will be looked at various documents associated with the policy, to determine in which document the activities, objectives and responsibilities are described. On the basis of this analysis, it is therefore determined which activities are looked at and which implementers are the focus. Then it becomes clear which data is to be collected and the method for the other sub-questions are determined.

Chapter 4. Content Analysis

4.1 INTRODUCTION

The analysis of integrated birth care is about describing the policy content of the ZIG [3] when it comes to the objectives and the associated implementation activities. The purpose of this is to provide a basis for the following sub-questions, in which it is examined whether the policy as stated on paper is also implemented in practice. The implementation activities and the responsible implementers must be identified while studying the policy. In the analysis it is important to clearly specify who is responsible for which activity since it can differ per activity.

4.2 DESCRIPTION OF THE POLICY

Firstly, a background of the ZIG will be provided, followed by a description of what the policy consists of.

4.2.1 Background of the policy

The ZIG [24] was developed between 2014 and 2016 by an expert group of the CPZ. After this, it was supposed to be offered to ZIN before January 1, 2016. However, that period was not met since the parties involved could not agree on the interpretation of some cooperation agreements described in the Integrated Birth care Standard. In the first quarter of 2016, the content of the ZIG, as approved by all parties in the CPZ working group, was sent to the involved professional organizations for authorization. Not all National umbrella organizations wanted to authorize the ZIG at the time, because they could not reach consensus on the interpretation of some cooperation agreements that were described. The main issue was that the professional groups of gynaecologists and obstetricians were unable to agree [25] on the organization of risk assessment. They disagreed whether risk assessment was a responsibility of the midwife or the multidisciplinary birth care team. In April CPZ [24] transferred the Integrated Birth care Standard to the ZIN. In the interest of adequate birth care, ZIN subsequently asked the Quality Council to take charge of the development of the ZIG. ZIN has the legal authority to do so, they have perseverance. This was necessary because the stakeholders could not agree. The conflict was thus not put to bed by the parties themselves, but by an external party, namely the ZIN. After that, an expert committee of the Quality Council amended the ZIG and presented the new version to all parties involved. In the new version of the ZIG healthcare providers were given the freedom to organize the risk assessment [25] at their own discretion in their region. Both parties were satisfied with the adjustment. Then the administrative consultation of the ZIG [24] took place. In doing so, the Quality Council asked the boards of the parties involved about their views on the operational feasibility and regional feasibility of the Integrated Birth care Standard. After processing the responses from the consultation, the Board of Directors of the ZIN finalized the Integrated Birth care Standard on 28 June 2016, then it was also included in the quality register. ZIN

transferred control of the further development and implementation of the ZIG to CPZ in July 2016.

4.2.2 The Policy

The policy exists out of a few components. First of all, the ZIG itself, the implementation plan, the client version, and the set of indicators. As mentioned before is the ZIG [3] an ongoing document which means it has the possibility to adapt to changes for example when it comes to guidelines, this is based on version 1.1. published on 28th June in 2016.

4.2.3 Integrated Birth care Standard

The ZIG [3] describes what the integrated birth care policy entails, that includes various topics. The main objective of the ZIG is: ''Reducing perinatal mortality and comorbidity through better integrated collaboration''. Other objectives of the ZIG are described as; ''Putting the needs and wishes of the pregnant woman first'' and ''the multidisciplinary seamless collaboration''. The need for care of the pregnant woman is the main focus. With "integrated birth care" is meant the entire process of care from the preconception phase up to and including the first six weeks after birth, including cooperation with and / or transfer to the maternity care, youth health care (JGZ), general practitioner and / or transfer or referral on indication to other health care providers, such as the paediatrician.

The Integrated Birth care Standard describes the necessary care and supervision of a (prospective) pregnant or maternity woman in stages. This primarily concerns the basic care that every (expectant) pregnant or maternity woman should be offered. The care standard describes which care is provided. Where possible and relevant, it refers to the applicable guideline. The Integrated Birth care Standard also contains agreements that have not yet been included in existing guidelines. Those require further elaboration in practice, such as, for example, the support of self-management (with the individual birth care plan), the task and working method of the interprofessional birth care team and the role of the VSV. Next to that it was stated that through this document, more cooperation between the care providers should be realized. They must have a shared vision and make use of everyone's expertise and attention to each other at executive level work processes. The ZIG outlined a future perspective that was supposed to be filled in step by step after it was reimbursed in 2016. The implementation plan, quality indicators and the client version were, as mentioned before, added in 2017. Furthermore, CPZ has stated that the ZIG is a ''living'' document which means that next to the methods and description of care that are generally used in practice, there is also room for innovative developments. CPZ had to periodically and as often as the underlying (multidisciplinary) guidelines initiate, consider whether adjustments are required. Updating and completing are on the agenda since the ZIG should be in accordance with current knowledge and insights. This is guaranteed by means of a so-called maintenance plan.

Since the ZIG is included in the quality register, it means that all parties involved in birth care have to undertake an effort to implement the Integrated Birth care Standard. It is mandatory for all the healthcare professionals in birth care. It also facilitated the ability to monitor the quality of care.

4.2.4 Implementation plan

The implementation plan [5] represents the operationalisation of the ZIG and describes the activities that were supposed to be carried out. The implementation plan was drawn up on the basis of implementation group meetings and discussions that have taken place with those affiliated with CPZ industry, professional and patient associations. Due to a mix of people and backgrounds in the conversations and meetings of the implementation group, the implementation plan has been given direction and elaboration. The implementation plan indicates how VSVs can tailor this step-by-step introduction of the ZIG and how they are facilitated by CPZ and the other National umbrella organizations. The main objectives of the implementation are formulated as follows:
1. *''Healthcare professionals and VSVs provide good quality, effective and efficient birth care as described in the Integrated Birth care Standard."*
2. *''Pregnant women know what to expect from integral birth care and what efforts are expected of themselves to jointly realize good quality of care''.*
The implementation plan consists of the goals and phases, the organization, the activities, and the last point that is discussed is the monitoring and evaluation section. The activities that needed to be undertaken are divided per phase. Which means that attention has been paid to timing when it comes to achieving goals. There are four phases identified, phase 0, phase 1, phase 2 and phase 3. For each element mentioned in the ZIG a target date is set in the implementation plan. Phase 0 is until July 2017. Phase one is until January 2018. Phase two is until January 2019 and phase 3 is till January 2020.

4.2.5 Client version

The client version [6] is the ZIG but without the medical jargon, in that manner it is also understandable for clients. In this version, the client reads how birth care is arranged in the Netherlands and what role the client and her partner have in this. An overview of the choices she has in each phase of the pregnancy is given. Tips have also been described, so the client can organize the care according to her wishes and needs. The aim is that the client can be more involved and participate in the care she receives.

4.2.6 Indicator set

Zorginstituut Nederland has drawn up the indicators [26] that correspond to the ZIG. With the indicators, the quality of the birth care provided can be measured. The indicators belonging to the Integrated Birth care Standard are divided into three categories:

o Care-related indicators: what are the outcomes of birth care?
o Client experience indicators: how did pregnant women experience birth care?
o Customer preference indicators: What services do the VSVs , hospitals, midwifes and the maternity care offer to clients?

This annual set of indicators has several targets namely: Healthcare providers can learn from the results and improve their work where possible. It makes it easier for pregnant women to make choices for a healthcare provider. Insurers can use the information when contracting healthcare providers.

4.3 ANALYSIS

This research will mainly consider the objectives and activities of the partnerships (VSVs) and the National umbrella organisations: BO geboortezorg, KNOV, NVK, NVZ, NVOG, PFN, ZN, Federatie van VSV's, ZONMW, Perined and CPZ to support this policy. Thus, this analysis is about identifying the activities, which according to the policy, must be carried out by the implementers but also the policymakers. The integrated birth policy distinguishes between the tasks and responsibilities of the healthcare providers and policymakers and other organizations involved, which is why this distinction will be followed in the analysis. Furthermore, the emphasis is on the ZIG [3] and implementation plan [5] as these documents describe the objectives and the intended implementation practice. The rest of the documents are mainly supporting information without additional relevant responsibilities or activities.

The description of the main activities and activities have been taken over from the implementation plan [5]. The phases of implementation are also described if they were mentioned in the implementation plan. The objectives that match the activities are obtained from the ZIG. First there will be looked at the activities that were to be carried out by the VSVs which means the health care providers that are working according to the ZIG and the mentioned guidelines. Next to that an inventory is made of the activities that the CPZ and the other National umbrella organisations had to carry out.

4.3.1 VSV activities

Organizational VSV Activities

The first activity is that each VSV has to come up with a plan of implementation regarding the ZIG. In this plan they are free to make their own choices in terms of content, order, and pace when it comes to implementing the different elements of the ZIG. The VSVs had to start with drawing up a vision for their VSV. According to this vision, they first had to implement those parts that underlined the unity of demand-oriented care. This should also include a quality cycle. This was planned for phase 0. In the ZIG [3] several objectives were described of which twelve objectives match the organizational activities of the VSVs. The objectives, main activities and activities are shown in Table 1.

Table 1. VSV activities and objectives organizational activities

Objective [3]	Activities [5]	phase
1: There should be shared decision making, treatment and informed consent.	• Method of exchange of information between woman and care provider that leads to a shared decision about the care to be provided. • The care provider listens actively and pays attention to questions and wishes of the woman. • The coordinating care provider and the pregnant woman draw up a birth care plan together.	0
2: Work cyclically on improving the quality of care. The main activity [5] is: realization of quality policy including quality cycle and indicators.	• A quality system has been set up, which also takes into account aspects such as effectiveness and efficiency. • Quality promotion and monitoring has been approached methodically, in a cyclical process and is structurally embedded within the care organization. • Joint continuous monitoring of quality in their own region and drawing up improvement plans. Analysing and improving performance from the	1

	perspective of both the health care provider and pregnant. Recommendations for improving cooperation, guideline development / care paths, inventory training need. • Participation of health care providers in perinatal audits and perinatal registration of Perined. • The measured results are discussed, analysed and lead to improvement and assurance plans.	
3: Putting the pregnant woman and her (unborn) child first, this requires a care system (integrated care), whereby professionals are jointly responsible for coordination and policy (in the region) and provide transparent explanations about the quality of care throughout the care process. The main activity [5] is: There is multidisciplinary and crossline collaboration between all healthcare providers	• There is an integrated care system where professionals are jointly responsible for mutual coordination and regional policy. • Providing a transparent explanation of the quality of care throughout the care process. • Multidisciplinary and crossline collaboration between relevant professional groups, care institutions and social organizations and expectant parents on the basis of equality. • Special attention to communication and transfer.	1
4: Promote multidisciplinary and crossline collaboration.	• A care related MDO takes place at least once a month. • Organizing permission from pregnant women for discussion in MDO. • Policy composition, task and working method interprofessional birth care team	1

The main activity [5] is: Set up an interprofessional birth care team.	incl. agreements on quality, registration, deviation from policy, accountability, and transparency. • Establish a birth care team with representation of all care providers involved in birth care in the region.	
5: The pregnant woman and child are the main point of focus.	• Every pregnant woman has the choice to give birth at home, in a birth centre or in an outpatient hospital. • Preventing over- and under-treatment. • Supporting women with respect and safety and creating availability and quality, regardless of the chosen place of delivery. • Demand-oriented care offer. • Create a policy on how to deal with questions from women outside the guidelines. • Every woman is told at the beginning of her pregnancy that she has the right of an informed choice and about the importance of all check-ups. • Every woman has the option at all times to waive or deviate from the care offer described in for coordinating the ZIG. • Care providers support each woman to make their own choices when it comes to care, the time and the place. • Inform the woman on registration of data in her electronic file, in the National Perinatal Registration and population surveys, for the parts where her permission is needed. • Capturing the consent of the pregnant woman about discussing her in MDO, the birth care team, and conducting investigations in her electronic file.	1

6: Support the pregnant woman in her directing role. The main activity [5] is: A coordinating care provider is appointed.	• Every pregnant woman has an appointed caretaker who is responsible for coordinating the care and functions as a confidential advisor during pregnancy, which is: the coordinating care provider. • Coordinating care provider monitors pregnant interests, supports self-management, and supervises on integrated birth care according to individual birth care plan. • Establishing permission of the pregnant woman on a decision on who is the contact point. • Supporting and advising women in choosing the location of the delivery of the child.	1
7: Improving care through an integrated, multidisciplinary approach The main activity is: The care is organized in an obstetric partnership (VSV).	• Develop regional networks, VSVs (professional groups: obstetric care providers, maternity care organizations and other regional birth care professionals). • Drafting Regional policy VSV. • Risk assessment (medical, psychosocial, care and lifestyle-related risks), with primary input from The Birth care Indication List (VIL). • Describe how complaints are handled mutually. • Client information on pain relief. • Work according to the protocol: Division of responsibilities, tasks and working method for the interprofessional birth care team including agreements on quality, registration, accountability, transparency, guarantee freedom of choice pregnant	1

	woman incl. protocol “parallel action” about debriefing. • Annual discussion of annual figures regarding quality, benchmark, analysis, and adjustment of regional agreements. • Participation in Perinatal audit. • Annually delivering a jointly quality annual report incl. benchmark, analysis, policy adjustments. • Develop regional care paths. • Implementation of regional care paths. • Setting a policy regarding Client Council / Regional Advisory Council for pregnant women / (young) parents. • Arrange for registering to which VSV the pregnant woman belongs. • Use the information standard for recording data. • Ensuring the privacy of women with regard to patient records. • Provide a complete and up-to-date file and ensure clear transfer between involved care providers.	
8: Put the wishes and the needs of the pregnant woman and the child first/central. Main activity [5]: There is a sense of adequate information and counselling.	• There is a policy and all health care providers within the VSV use uniform information material for properly informing the pregnant woman about her pregnancy, childbirth, maternity period and guidance and care options (incl. pre- and neonatal screening). • Every pregnant receives support for self-management.	2

9: Operationalize the wishes and needs of a pregnant woman. The main activity [5] is: Work with an individual birth care plan.	• All needs and wishes of the pregnant woman are captured in an individual birth care plan. • All agreements with care providers / The regional care path of the pregnant woman is included in her individual birth care plan.	2
10: Improving care through an integrated, multidisciplinary approach. The main activity [5] is: Continued development of an obstetric partnership.	• Expanding regional networks (new professional groups in line with the then updated Integrated Birth care Standard). • Adjusting MDO (which frequency, which professional groups in line with the then updated Integrated Birth care Standard). • Implementation of the Client Council. • Annually offer and discuss the results of the annual report and policy plans with the Client Council. • Discuss with the Client Council about the quality standard of pregnant / perceived quality. • Involving the Client Council in the elaboration of the VSV responsibilities regarding preconception, pregnancy, birth, and postnatal period (incl. interconception care). • Arranging access to multidisciplinary patient records for all healthcare providers and the patients. • Preparing Perinatal Web-based Dossier: A fully and up-to-date multidisciplinary consultable file for all pregnant women.	2
11: Improve information provision, communication, and collaboration in perinatal care.	• Provide a complete, up-to-date, and reliable multidisciplinary electronic file that can be safely consulted at any time by all healthcare providers and patients.	3

The main subject [5] is: A perinatal Web Based Dossier.	• Transfer implementation to Perinatal Web-based Dossier.	
12: Improve access to care for women with low health skills and strengthen their intrinsic capacity (empowerment) to improve their own situation and care regarding pregnancy. The main activity [5] is: There is attention for women with low health skills.	• Seek coordination with municipalities, general practitioners and others about structured offering information and education for women with low health skills • All healthcare providers can provide women with low health skills with information. • Provide all healthcare providers with insight into regional channels / capacity for referral of women with low health skills.	3

Types of care related activities for the VSVs

There is also the aim [3] that everyone in the Netherlands receives the best care regarding pregnancy and birth. This applies to the different types of care described in the ZIG and how it should be delivered. Per phase of care the activities [5] (phase 1) are shown in Table 2.

Table 2. VSV care related subjects and activities

Subject	Activities	Phase
Prenatal care:	• Basic care as described in ZIG is provided. With a complicated care path additional care is provided. • First consultation takes place after19 weeks of amenorrhoea. • Intake of pregnant and partner is carried out this includes: risk assessment, general information, discussion of prenatal screening.	1

Care during childbirth and birth	• Basic care as described in ZIG is provided. With a complicated course of action, additional care is provided.	1
Care after childbirth and birth	• Basic care as described in ZIG is provided. With a complicated course of action additional care is provided.	1
Acute care	• Drawing up a policy for dealing with calamities and incidents. • Implementation policy dealing with calamities and incidents.	1
Preconception care	• Structured (or arranged) provision of information and education about preconception consultations. • Preconception consultation is offered. • Specialist preconception consultation that leads to preconception advice and a plan of action is offered. There is coordination with municipalities and GPs about recruiting and informing women with low health skills.	3

4.3.2 CPZ activities

CPZ [5] has the task of identifying, placing on the agenda, coordinating, and stimulating the national implementation of the Integrated Birth care Standard. The objective [5] is facilitating the local implementation of the Integrated Birth care Standard in collaboration with partners in the field. The activities are:
o National implementation activities.
o Directs on further development of the Integrated Birth care Standard and maintenance of the Integrated Birth care Standard.
o CPZ will work together with those affiliated with the birth care industry, professional and patient associations to promote good implementation.
o They need to support the VSV with the transition and put bottlenecks on the agenda and keep addressing them until resolved by parties including informing supervisory

authorities as ZIN, IGZ and NZa about the bottlenecks and progress.
o The CPZ is also responsible for communication and knowledge management.

CPZ in general activities

o CPZ has made an inventory of the bottlenecks and needs regarding the implementation of the Integrated Birth care Standard.
o Taking charge of providing information about the Integrated Birth care Standard.
o CPZ stimulates and supports the sector of professional and patient associations to take responsibility in creating support among their own members and to stimulate involvement in the actual implementation of the Integrated Birth care Standard.
o Stimulating the development of multidisciplinary guidelines.

CPZ staff office

o The CPZ staff office supports the implementation group.
o CPZ staff bureau stimulates unambiguous client information by the national birth care parties, professionals, industry, and patient associations when it came to introducing the Integrated Birth care Standard and the client version.
o Communicate with the field.
o Facilitate Kennisbank

Support organization VSVs

There is also a support organization VSVs [5] within the CPZ. It offers general, specific, and generic support to VSVs when it comes to implementation of the ZIG. The following activities were identified:
o Facilitating learning networks.
o Organizing meetings for exchange of information for and by VSVs.
o Retrieving and distributing best practices for inspiration.
o Increase awareness and implications of the Integrated Birth care Standard among caregivers and pregnant women through availability providing information and training materials.
o Provide a toolbox (based on best practices) with support offer, incl. references to scientific research, to be able to apply the Integrated Birth care Standard in practice, including sample documents of plan of actions of VSVs, Step-by-step vision formulation, tick-off list for the implementation of the Integrated Birth care Standard.
o Drawing up a clear healthcare provider version (summary) of the Integrated Birth care Standard or digitally disclose the care standard.
o Supporting VSVs in the choices when working together in a shared electronic file.
o Identifying any bottlenecks in the (financial) preconditions that are necessary for a good implementation and escalation of this towards the implementation group.
o Signalling the lack of underlying guidelines that do not fit the scope of the Integrated Birth care Standard and escalation towards the implementation group.

Implementation Group

CPZ has also designated an implementation group [5]. Their goal is facilitating the implementation of the ZIG. The following activities belong to that:
o Drawing up the implementation plan.
o Monitoring and if possible, providing support for implementation activities such as drafting of a client version of the Integrated Birth care Standard and the (further) development of quality and process indicators.
o Identifying any bottlenecks in the (financial) preconditions that are necessary for a good implementation and escalation of this towards the CPZ board.
o Give priority to a thorough inventory of all bottlenecks that hinder implementation and come up with proposals for possible solutions.
o Identifying the absence of underlying guidelines that do not fit the scope of Integrated Birth care Standard and escalation towards the CPZ board.
o Taking care of drawing up a maintenance plan incl. staffing of the Maintenance Committee
o Evaluation of the implementation.
o She ensures maximum use of knowledge, expertise and strengths of the members of the industry consultation, by a representation with mandate (with space for coordination regarding authorization with the board), so that there is effective collaboration on implementation and further development of the integrated birth care.

Quality indicator working group

Next to that there is also a quality indicator working group [5]. There were several activities they had to carry out:
o Drawing up quality indicators.
o Further development of quality indicators and process indicators, and with the coordination and fine-tuning of the standard with already developed products and / or methods.
o They can enlarge the enforceability of the ZIG by providing suggestions to the implementation group for the addenda.

Client version working group

There is also a client version working group [5]. This exists out of the patient federation. The activities they have to carry out are:
o Drawing up the client version of the ZIG
o Offering the client version to the ZIN

Support to VSVs per communication

o CPZ has taken the initiative to start up the collaboration in a Communication Consultation.
o CPZ takes the lead together with the support group VSVs to convert the joint wishes

and objectives in the Communication Consultation into a framework communication plan and a joint action plan that supports and brings together the partial communications of the organizations.
o CPZ is taking the lead in terms of communication activities related to the ZIG.
o CPZ maps the current communication of the affiliated organizations and the CPZ and their coherence.

4.3.3 The National umbrella organizations

The National umbrella organisations [5] also play a major part in the implementation of the ZIG. The aim is to promote the application of integrated care in accordance with the ZIG. In the implementation plan was referred to an appendix with ''Possible activities'' for branch and professional associations. Those activities are divided into one-off activities and ongoing activities.

The one-off activities for branch and professional associations include:
o Give information / purchase information / organize training
o Communication to own employees or members about relevant aspects of the Integrated Birth care Standard in newsletters, magazines, via own website, information packages.
o Carrying out own activities that promote the application of integrated birth care in accordance with the ZIG, such as conferences, mini-symposiums, courses, presentations in work meetings, employee meetings and study days.
o Informing own employees or members and the CPZ about its own activities and possibilities for training both its own training offer and external offer.
o Looking for cooperation and synergy between own activities and the activities of (other) healthcare professionals and (other) professional associations.
o The professional associations appoint representatives to CPZ to contribute to the realization of the client version of the Integrated Birth care Standard.

The ongoing activities are:
o The further development of mono-disciplinary guidelines to multidisciplinary guidelines, standards and agreements.
o Communication to own employees or members about updates of the Integrated Birth care Standard in newsletters, magazines, via their own website, folders.
o Identifying bottlenecks around the introduction of integrated birth care at the CPZ (whereby the support group acts as the point of contact for CPZ).
o Actively share proprietary solutions with other regions and share solutions, models and documents through CPZ.
o Ensuring or encouraging employees or members to participate in multidisciplinary consultations for joint risk assessment.

Patient associations
Possible activities for patient associations [5] are also divided into one-off activities and

ongoing activities the one-off activities are:
o Carry out own activities that promote the application of integrated birth care in accordance with the standard.
o Informing the members and the CPZ about their own activities.
o Delegate a representative to CPZ to contribute to the realization of a client version of the Integrated Birth care Standard.
o Looking for cooperation and synergy between own activities and the activities of healthcare professionals and professional associations.
o Actively share own solutions with others by sharing solutions, models and documents via the CPZ.
o Further development of the indicators of customer preferences.

The ongoing activities are described as:
o Communication about relevant aspects of the Integrated Birth care Standard, including trying to get pregnant women / parents involved in participation in advisory boards of VSVs.
o Stimulating self-management for pregnant women by providing information.
o Identifying bottlenecks that occurred during the implementation of integrated birth care at the CPZ (whereby the support group acts as the point of contact for CPZ).
o Facilitating valuations: making valuations for precautionary organizations available and comparable for other patients / clients via ZorgkaartNederland.

4.3.4 Supporting activities

The branch organisations and CPZ also had supporting activities [5], The text of the implementation plan explained the activities associated with the various topics in more detail. The explanation about the activities will be added to the topics below.

Objective: Inform. Activities are: increase awareness, knowledge in the field about the standard of care and what that means for daily practice. Activities explained in more detail:
o Creating support among their own members for the implementation of the ZIG.
o Encourage involvement in the actual implementation of the Integrated Birth care Standard among their members.
o The associations have the channels to inform their members about the new insights from the Integrated Birth care Standard.

Objective: Motivate (create a positive attitude and motivation to make them implement the ZIG). Activities are: underline added value applies of standard of care for themselves but also for quality of care. Activities explained in more detail:
o Members must become convinced that the new working method is valuable and is efficient and saves time and costs
o The professional groups conclude on the basis of application that the new method satisfies and confirms its usefulness.

Objective: Facilitate. Activities are: removing bottlenecks, educating, and training (Branch organizations), knowledge exchange, implementation guidance. Financial support or incentives. Activities explained in more detail:
o Offering training to the members.
o Identify which training courses are offered by other parties.

Objective: Guarantee (the ZIG is structurally integrated into the existing routines):
o legal requirements, purchasing criteria, checking.

Objective: Monitoring and evaluation (adjust policy if necessary)

4.3.5 Communication activities

It is mentioned in the implementation plan [5] that informing and motivating will largely take place via communication. The branch, professional and patient organizations play an active role in motivating their members by communicating, organizing, mapping of training opportunities and giving targeted advice. The aim is creating a good balance between partial communication via the organizations and joint communication with CPZ. Communication objectives and activities [5] are:

The objective [5] is: Inform (increase awareness, knowledge in the field about the standard of care and what that means for daily practice). Activities are:
o Create awareness.
o Sharing best practices & knowledge sharing.
o Digital disclosure of Integrated Birth care Standard / client version.

The objective[5] is: Motivate (underline the added value of applying the Integrated Birth care Standard for themselves but also for quality of care, exchange of good practices and promoting mutual discussions). Activities are:
o Examples of working in an integrated manner.
o Highlight where things are going well and mention the tricky issues.
o Establish a connection between national and local.

Another objective [5] is: Facilitation (removing bottlenecks, training and training, knowledge exchange, developing joint communication tools). Activities are:
o Directing communication in the entire field by supplying building blocks so that healthcare institutions, professional and patient associations communicate one and the same message.

For communication [5] there was also presented a list with *possible resources and activities.*
o Organization of learning and inspiration meetings in close cooperation with the

support organization VSVs.
o Supply building blocks of communication: message, visual translation.
o Establishment of an inspiration group for assessment against practice.
o Digital version ZIG & Client version ZIG.
o Tool for insight into the progress of implementation for VSVs.
o Online collaboration for VSVs in workgroups on Kennisnet Geboortezorg.nl.
o Community on knowledge network birth care of more than 1800 professionals.
o Knowledge base at www.kennisnetgeboortezorg.nl with examples, manuals, tools, step-by-step plans, models, Q & As etc.
o Website www.kennisnet geboortezorg.nl.
o Newsletter.
o Development CRM / social card berth care included overview VSVs.

4.3.6 Evaluation and monitor activities

Another objective [5] is: evaluating and monitoring (identify when and on which points changes the Integrated Birth care Standard of care is needed). Activities are:
o Implementation group and the CPZ board meet every six months and look at the results at the end of the implementation period, to see whether the implementation plan needs to be adjusted.
o Coordination about both the design and the results of the research with the IGZ and the ZIN regularly takes place.
o An impact analysis must be performed.
o A process evaluation must be performed.
o CPZ takes the initiative in (phase 0) to discuss this with parties such as Ministry of VWS, Zorginstituut, ZONmw, RIVM, NZa and IGZ to discuss the options for this and to ensure proper monitoring.

4.4 INTERPRETATION

It became clear that a specific list of goals and activities has been drawn up for the implementers of the policy namely the care professionals within the VSVs. It even included target dates in the form of phases. However, they have also been given the freedom to make their own choices in terms of content, order, and pace in implementing the different elements of the ZIG [5]. This could be confusing since on the one hand they are left free when it comes to implementation, but on the other hand it is expected of them that certain results will be achieved.

For CPZ and the National umbrella organisations activities, few target dates have been set which may be difficult when it comes to prioritization of activities. For the branch and patient organizations, many activities have also been designated as: " possible ", which could also lead to the fact that those activities are not carried out. This should be kept in mind when considering whether all activities have been executed in practise.

4.5 CONCLUSION

The policy has been described and analysed. This shows that the most important documents are the ZIG and the implementation plan, the rest of the documents are intended more as support. In the ZIG the whole policy is outlined, and the objectives are described. This mainly addresses the different stages of care. The implementation plan serves as the operationalization of the ZIG and is of great importance for the evaluation since it describes the activities when it comes to implementation. The implementation plan mainly focussed on the care providers within the VSVs, they are seen as the implementers of the policy. But the CPZ and the other National umbrella organisations also had some implementation activities. Activities have therefore been selected for both layers that will eventually be used to examine the extent to which the activities are carried out. During this evaluation, the goal is to evaluate all the activities that were supposed to be carried out by the VSVs, except for the ''types of care related activities''. For the National umbrella organisations, other than CPZ, the choice has been made to look at the support activities and the possible one-off activities and ongoing activities. For CPZ the choice has been made to look at the activities that were supposed to be carried out by the CPZ staff office, support organization VSVs and the implementation group. Furthermore, there were some general activities and the activities that fell under support to VSVs per communication, when it comes to CPZ, which will also be investigated. In some cases, the possible activities overlap with the supporting activities, this will be examined.

Chapter 5. Methodology

5.1 INTRODUCTION

In this chapter the study design will be described first, then the study sample and selection will be described. After that the data collection and analysis will be discussed. The distinction is made between the VSVs and National umbrella organisations since both layers are examined and this provides more clarity.

5.2 STUDY DESIGN

This research is a process evaluation, and the chosen research design is qualitative and exploratory since it looks at the extent to which the integrated birth care policy has been implemented and which factors influenced this.

The first sub question *''What does the integrated birth care policy entail and what activities and responsibilities are distinguished?''* is answered trough desk research, this was carried out to create a good impression of what the policy of the ZIG with the associated implementation plan entailed. After this the content analysis was performed whereby the focus lied on the described activities of the policy and which task should be performed by each stakeholder. During the content analysis it appeared that several implementers emerged, namely the VSVs, but also the National umbrella organizations and in addition, a number of activities were also assigned to CPZ.

The second sub question: *''To what extent are the activities described in the implementation plan carried out?''* is separated into two layers: The VSVs and the National umbrella organizations. To collect information on whether the activities of the policy are carried out by the VSVs the database of the CPZ is used. This exists out of 1) telephone interviews [27] with VSVs and 2) monitoring indicators out of the public database of the ZIN [28]. The telephone interviews keep track of the progress of VSVs when it comes to implementing the Integrated Birth care Standard and were conducted by employees of the CPZ, in particular by the forum taskforce integrated funding. The telephone interviews that are used in this research are from 2019. All the involved parties together, under chairmanship of the CPZ, have drawn up a set of indicators for ZIN with which the implementation of the ZIG can be monitored, this will also be used to gain insight into the progress of policy implementation in this study. However, this does not include all activities described for the VSVs, this will be explained in more detail later.

For the National umbrella organizations was also investigated whether the described activities have been carried out. The activities were first identified by means of the content analysis. The aim was to question each organization involved about what they have contributed to the implementation of the ZIG. Next to that, certain documents on what they offer on, for example, the knowledge network was looked at. The two layers of VSVs and National umbrella organizations will be discussed separately in this thesis.

The third question '' *''Which factors influence the implementation of the*

Integrated Birth care Standard of care?" only applies to the National umbrella organizations. This has also been investigated by means of interviews.

5.3 THE VSVS

5.3.1. Study sample & Selection

The respondents to this survey are representatives of the VSVs. That could be one of the eight disciplines listed below:

- Midwives
- General practitioners
- Maternity care providers
- Paediatricians
- General hospitals
- The gynaecologists
- Clients
- The health insurers

The aforementioned disciplines are all organized in partnerships (VSVs), those partnerships are regional networks [3] and can be seen as the research population. All 75 VSVs were included in this study, (N=75) when it comes to the indicator set. Eight of these are integrale geboortezorg organisaties (IGOs), those are partnerships that work with integrated funding.

Fifteen VSVs were excluded when it came to the telephone interviews, 57 VSVs remained (N=57). Of the 57 VSVs three of them are IGO's. Reasons for exclusion of the eighteen VSVs were: The answers for a telephone interview were only described from 2017/2018 instead of 2018/2019, it was indicated that no contact had yet been made with the VSV in 2018/2019 or all subjects regarding the implementation of the ZIG were not discussed.

5.3.2 Data Collection

To provide an answer to the sub question *''To what extent are the activities described in the implementation plan carried out?*" Existing data has been used when it comes to the VSVs: the telephone interviews and the indicator set, both from 2019. The telephone interviews are held annually by the CPZ, in this way they keep track of the status of implementation of the Integrated Birth care Standard. No new data has been collected by the researcher when it comes to the VSVs. The first step was mapping which objectives and activities, described in the integrated birth care policy, are reflected in the telephone interviews and/or indicators by crossing off which activities occur in

both datasets. This was of importance since it is possible to see whether each activity is covered by this. It then became clear which activities recur in both instruments, which led to the possibility of checking whether there are any discrepancies.

The telephone interviews

The telephone interviews are tracked in an Excel file by the CPZ. This file contains data from 72 VSVs. This are 72 VSVs instead of 75 since there have been mergers among hospitals and therefore also in VSVs. The telephone interview can be with one representative of the VSV or with more. The telephone interviews are not recorded, therefore it should be noted that the answers listed in the interview report are summaries of what has been said. The following main topics are discussed during the telephone interviews: The ZIG, integrated organization, and integrated funding. The list with questions can be found in Appendix A. Integrated funding will not be discussed further because it is not listed in the ZIG and falls outside the scope of this study. The questions about the ZIG cover the following topics:

o Individual Birth Care Plan

o Care paths / joint protocols

o Client experiences

o Coordinating care provider

o MDO / crossline collaboration / interprofessional health care team

o Multidisciplinary training

o Quality policy (PDCA, indicators)

o Mother council/Client participation

o Joint website

o Integrated dossier

o Examples available for other VSVs.

o Support

The questions regarding integrated organization cover topics like: legal entity, the status of the legal entity, development plan, implementation of the plan. The choice was made to disregard the subjects: sharing examples with other VSVS and support since those are not linked to any activities that were supposed to be carried out by the VSVs. In appendix B is shown which activity is measured with which question.

Indicator set

Each year, the indicators must be submitted to Zorginstituut Nederland no later than May first following the relevant reporting year by an organization set up for this purpose that meets ZIN delivery specifications. These indicators are filled in by all the VSVs. Some indicators are specifically aimed at organizations within a VSV. From this indicator set, indicator 6 was used for the analysis. Indicator 6 focuses on the VSV in total and looks into the cooperation and care offer provided by the VSV. The indicator can be found in Appendix C.

5.3.3 Data analysis

The answers to the questions during the telephone interviews are coded. The deductive coding [29] method is used. Using this approach, a pre-set coding scheme was formulated. This was chosen since the subjects that are analysed are known. Codes are developed based on the question list that is made by CPZ. Five general subcategories have emerged from the telephone interviews: Yes, No, In development, Unclear and Not discussed. The categories yes and no do not need to be explained because they speak for themselves. In development applies if VSVs have indicated that they are engaged in a certain activity but it is not up and running yet. ''Unclear'' was assigned when the interviewer asked whether an activity had been carried out, but it was not possible for the researcher to determine from the described answer whether this activity had been carried out or not. The ''Not discussed'' category was assigned if a question regarding an activity was not asked during the telephone interview. Another possibility could be that the question was asked but the answer was not written down. The category unclear and not discussed do not need to be elaborated since this does not address whether or not activities are performed. On the basis of those subcategories three types of analyses have been performed: Per activity, per group and an overall analysis.

The indicator set results are only included in the activity analysis and not in the group and overall analysis since the indicator set does not cover every activity that the telephone interview covers. The answers to the questions in the indicator set are shown in bar charts. This was then juxtaposed to reinforce conclusions when it comes to the fact whether activities are carried out or not, and it could also reveal discrepancies. This is done in an anonymous way, it will therefore not be possible to trace which information comes from which VSV.

Activity analysis

Per activity a score was assigned to each VSV. As mentioned before there are five score categories: Yes, No, In development, Unclear or Not discussed. Each score was counted per activity and divided by the total number of VSVs which led to a percentage which described how many VSVs had a certain score. It can therefore be deduced from this to what extent the total group of VSVs carries out a certain activity. This is shown in Bar charts.

For the indicator set applies that the analysis was provided by CPZ in the form of bar charts. The values in the bar charts were converted to percentages so the results of the telephone interviews could be compared with the results of the indicator set if possible. This was done by the researcher.

Group analysis

Each VSV received a score for every activity, then the total score of the VSVs are summarized leading to an overall score of implementing the activities. Next the VSVs are ranked into three groups based on the overall score: High, average, or low. That ranking regards the degree of implementation. The decision was made to look at ''Yes'' and ''In development'' because it reflects the potential of the development of a VSV when it comes to the implementation of the ZIG. When the % yes + % in development is above 0.7, a VSV falls under the high group. For the medium group applies that a VSV is between 0,4 and 0,7. For the low group the VSVs have to have a score below 0,4. These values have been chosen in terms of groups in relation to the group sizes. Some groups would be too small if different values were used. For each group, the score per activity is viewed by counting the score options per activity. The percentage of this was then calculated.

5.4 NATIONAL UMBRELLA ORGANISATIONS

5.4.1 Study Sample & Selection

The National umbrella organisations that are involved in integrated birth care and that are used for the evaluation of the ZIG are: BO geboortezorg, KNOV, NVK, NVZ, NVOG, patiëntenfederatie Nederland, ZN, Perined, Federatie van VSV's, ZonMw and CPZ. The aim was to interview one representative from each National umbrella organization. An exception was CPZ, where three interviews with employees from different departments were conducted since they all have their own area of expertise. For the National umbrella organizations, the research population was established through consultation with various CPZ employees, since not every person who works at an organization knows which activities have been carried out with regard to the ZIG, and certain interests may also play a role. Inclusion criteria for the interviewees were that the participants worked for the organization when the Integrated Birth care Standard was implemented in 2016 or that they had a lot of knowledge about the implementation of the ZIG.

5.4.2 Data collection

To answer the sub question *''To what extent are the activities described in the implementation plan carried out?''* regarding the branche organizations, interviews were used as a method. Interviews were held with the following parties: BO geboortezorg, KNOV, NVOG, PFN, ZONMW and Perined and CPZ. It was not possible

to conduct an interview with: NVK, NVZ and ZN. This was partly due to the holiday period from July till August. Another reason was the fact that there was no one working there anymore who had the necessary knowledge about the implementation of the ZIG. Nevertheless, they were included through desk research.

The interviews are semi structured since a set list with questions was asked, with the option to deviate from this or to ask further questions. The Patiëntenfederatie Nederland, ZonMw, Perined and CPZ received a different list of questions considering the list of activities they had to perform is different from the other organizations mentioned. These interviews were also semi-structured. Next to that the organizations were asked for documents about the activities they have carried out to support or refute the statements that are made during the interviews. This desk research is not exhaustive and concerns examples.

The interviews

The interviews discussed the activities described in the implementation plan [5] that had to be carried out by the National umbrella organizations. For BO geboortezorg, KNOV, NVOG and Federatie van VSV's the questions focused on the supporting activities and the possible one off and ongoing activities. In Appendix D can be viewed which activity applies to which question. In the implementation plan [5] there was some overlap when it comes to the activities, effort was made to remove this when it comes to the interview schedule. The interview schedule first consists of a few introduction questions that discuss the role of the organization in integrated birth care, but also whether they think they have a responsibility. After the introduction questions the schedule is structured in the following topics: motivation, information, facilitation, assurance, and factors that influenced the implementation. The schedule is structured in this way because if there was no motivation among the branch organizations, this could influence the way they informed their members. A question that falls under the subject of information is, for example: *What channels does the organization have, to inform its members about the insights from the Integrated Birth care Standard?* The complete set of questions can be found in Appendix E.

A different list of questions has been made for Patiëntenfederatie Nederland as different activities applied to them. The operationalisation scheme can be found in Appendix F and the list of questions in Appendix G.

For CPZ the questions regard the activities that were supposed to be carried out by the CPZ staff bureau, support organization Support VSVs and the implementation group. Furthermore, there were some general activities and support to VSVs per communication. The operationalisation scheme can be found in Appendix H and the list of questions in Appendix I .

Perined and ZonmW have not been described as implementers of the policy in the implementation plan. However, CPZ found it important to include them in the evaluation because they do play a role when it comes to implementation of the ZIG. The questions they are asked therefore mainly focussed on the role of the organization

in integrated birth care and what they have contributed to the implementation of the ZIG. The set of questions can be found in Appendix J.

5.4.3 Data analysis

When performing a qualitative analysis, the collected data was fully transcribed. The program Amber script was used and the missing parts were completed manually. A code book with codes was drawn up in advance, based on the activities described in the implementation plan. The Atlas.ti program was used for coding. During coding, a search was started for the codes drawn up from the codebook. However, there was scope to add other codes during this process, on topics that were not thought up beforehand but are still discussed. There is no axial and selective coding because the questions are fairly straightforward. The results from the interviews were linked to the activities that have been requested. The conclusions were then supported or refuted by the submitted documents, if there were submitted documents otherwise the conclusions were drawn based solely on the interview.

Factors that were of influence

The factors that were of influence are mapped per organization in a ''factors that are of influence'' paragraph. Then it was examined how often certain factors that are of influence are mentioned, also trough coding but without a code book with codes that were made in advance. In the conclusion section regarding the National umbrella organisations the various factors were subdivided according to the factors described by Coolsma [22]: The characteristics of the policy and policy theory, the characteristics of the implementing organization, the characteristics of the implementers and the characteristics of the environment.

Chapter 6. Results VSVs

6.1 INTRODUCTION

In this chapter the sub question *''To what extent are the activities described in the implementation plan carried out?''* is answered. This answer is provided on the basis of the results of telephone interviews in combination with the results of the indicator set. The results show to what extent the activities were carried out. The chapter starts off with findings regarding the telephone interviews itself since this is of importance when interpreting the results. Then it is discussed how many VSVs have or have not carried out a certain activity. Bar charts are used to represent the results to create clarity. They are interpreted and where necessary explanations are given. The activities that are analysed are derived from the topics that were asked during the telephone interviews and the indicator set, that are relevant when looking at the implementation of the policy. Those topics are: Individual birth care plan, integral care paths, client experience measurements, coordinating care provider, MDO, multidisciplinary training, quality policy, joint website, client participation and integral dossier and uniform delivery of information. In addition, an overall analysis of the activities is shown in a bar chart. There is also looked at how the VSVs are distributed when it comes to implementing the policy in the group analysis of the telephone interviews. After that, the additional results are discussed, this has not been investigated but emerged during the data analysis and is of importance to include since it it relates to the implementation of the ZIG.

6.2 FINDINGS CONCERNING THE TELEPHONE INTERVIEWS

When looking at the telephone interview round in itself, a number of things stood out. The first thing that stood out, about the way the data was collected, was that during most of the telephone interviews the focus seemed to lie on integrated funding. This is based on the fact that every question related to this topic is almost always asked or noted during every interview, while not every question related to ZIG is asked or noted. Next to that the questions regarding the Integrated Birth care Standard are no longer asked or noted, when it is known that a VSV is a pioneer, because it is assumed that they are already far along when it comes to implementing the ZIG. The description ''pioneer'' is in most cases appointed to an IGO. Even when the IGO is not described as a pioneer, fewer questions are asked or noted about Integrated Birth care Standard because it has that particular form.

There can be several explanations for this. It could be due to the fact that when a VSV answers that it is not going for integrated funding, there is a why question, where in most cases a lot is written or told. When it comes to questions about the ZIG, explanations are not always asked for or if they are, it is not always written down.

Another reason could be that the focus of the task force integrated funding [30] is simply on integrated funding because that is their discipline.

It could also be the case the VSVs focus more on integrated funding and

therefore elaborate more on it than on topics of the Integrated Birth care Standard.

There is quite a lot of resistance when it comes to integrated funding, so it may also be the case that the structure [31] of the questions asked during the telephone interviews are the reason the focus lies on that subject. The questions regarding integrated funding were asked before the questions about the ZIG. It might be that the interviewee may have been immediately frustrated [31] by the questions about integrated funding, therefore there may also be less explanation about the topics related to the ZIG. These findings should be considered when reading the results when it comes to the telephone interviews.

6.3 ACTIVITY ANALYSIS

The results of the activities from the telephone interviews will be shown consecutively, in which, if possible, the comparison with the indicator outcome is made.

6.3.1 Individual birth care plan

The first activity that will be looked at is working with an individual birth care plan. In figure 3 is shown that 40% of the 57 VSVs have indicated that they work with an individual birth care plan. The way in which the individual care plan is shaped can differ per VSV. In some cases, it was indicated that this was drawn up from primary care and in other cases it was done integrally by the midwife and gynaecologist together. One of the representatives of the VSVs stated that *''The individual birth care plan is drawn up at the first integrated consultation by the midwife with the gynaecologist at the hospital*". Furthermore, it was also indicated by 5% of the 57 VSVs that they have an individual birth care plan but that it is not actually being used.

12% of the 57 VSVs were assigned the category ''In development". 5% out of 57 of the VSVs described as an answer that a working group within the VSV was working on the individual birth care plan. Another VSV stated that they would like to have a national format as an example regarding this.

9% of the 57 VSVs have been assigned the category no. In three out of five, nothing was written next to no. For the two VSVs it was stated that *''It is not uniform, however there is a joint care path consultation".*

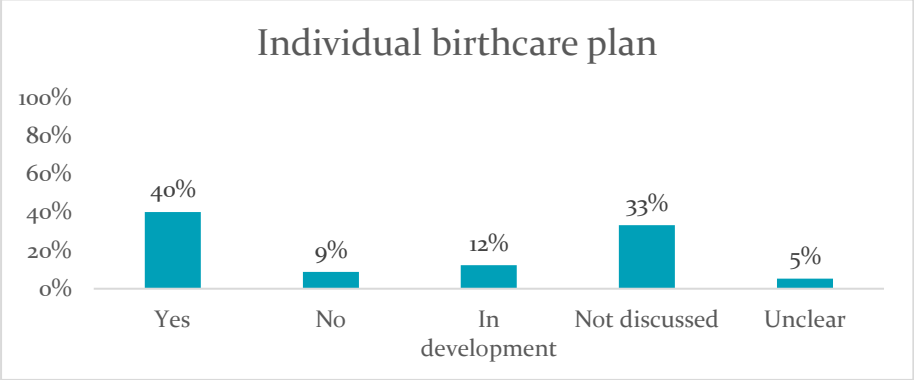

Figure 3. Individual birth care plan results from telephone interviews

Looking at the indicator set, figure 4 shows that 95% of the 75 VSVs work with an individual birth care plan. 27% of them indicate that clients can view the plan digitally. 47% of the 75 VSVs provide the clients with a paper version. 21% of the 75 VSVs indicate that they do not create an individual birth care plan, for every pregnant woman, that is accessible for them. For 5% of the 75 VSVs is indicated that they do not work with an individual birth care plan.

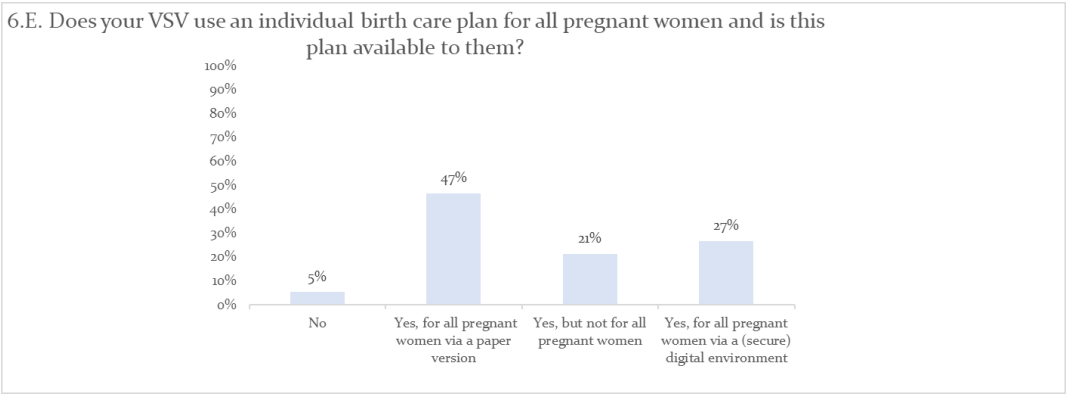

Figure 4. Individual birth care plan results from the Indicator set

Partial conclusion

It is shown that the results of the telephone interviews and the results of the indicator set diverge. From the telephone interviews it becomes clear that the minority of the VSVs have worked with an individual birth plan in 2019 versus almost all of them in an indicator set. The percentage of the category ''No" does not differ tremendously which could mean that the difference is more due to the not discussed percentage and the in-development percentage in the telephone interviews. The indicator set results should be leading since this includes all VSVs.

6.3.2 Integral care paths or and protocols

The second activity regards working with integral care paths within a VSV. In figure 5 is shown that there is a large majority namely 81% of the 57 VSVs have indicated that they work with integral care paths. How this is shaped can, again, differ per VSV. For 30% only ''yes" is written without further elaborating. 5% of the VSVs stated that they work with a basic care path. From the responses of 39% of the VSVs it could be deduced that they work with multiple care paths. Furthermore, 5% of VSVs indicated that the care paths are being rolled out and shared via LOQS. This stands for Limburg Obstetric Quality System [32], whereby the content of obstetric care in Limburg is uniformized by making care paths (work agreements and protocols) about all aspects of obstetric care. These were the most relevant findings in this regard.

4% of the 57 VSVs were assigned the category in development. The reason given for one of those VSVs was that " *It is difficult to reach agreement between primary care providers and second line care providers ".* The other VSV stated that they wanted to set up a certain care path, which means the intention of working with a care path is existent.

Only 2% of 57 VSVs has been assigned the category no. This is not elaborated further in the answer.

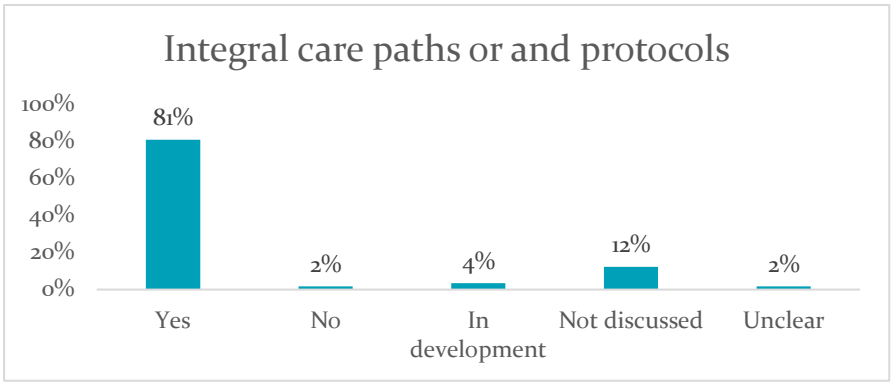

Figure 5. Integral care paths or protocols results from telephone interviews.

6.3.3 Client experience measurement

The third activity is about measuring client experience within a VSV. In figure 6 is shown that 60% of the 57 VSVs have indicated that they measure client experiences. In 2016, the VSVs were allowed to choose which instrument they would like to use to measure client experience but from 2018 [33] they are required to use the Net Promoter Score (NPS). There will therefore also be looked at how many VSVs have used the NPS. 39% of VSVs have stated that they use NPS to measure client experience. 5% of the VSVs expressed their dissatisfaction regarding the NPS, one statement that was made was *'' They had indicated that they wanted to use the maternity list because it is considered useful and NPS is not".* Other questionnaires were also mentioned by the VSVs. The responses of 7% of the VSVs indicated that the ReproQ was used, in some cases in addition to the NPS. 5% of the VSVs used the Pregnancy and Childbirth Questionnaire (PCQ) [34]. 4% of the VSVs mentioned that they work with the

Bespreken Uitkomsten Zwangerschap met de Zwangere (BUZZ) to measure client experiences. 7% of VSVs mentioned the International Consortium for Health Outcome Measures (ICHOM), which is also a client experience measurement instrument.

Answers provided by 7% of the 57 VSVs fell under the category ''In development''. The NPS was unknown to 4% of them, but they did indicate that they were going to set it in motion. In another VSV, measurements were only taken from maternity care and no joint measurements. The other VSV indicated that they would like to get involved with the BUZZ project and another reason that was described was "*Measuring satisfaction is still an issue.*"

The category ''No'' was assigned to 2% of the 57 VSVs without explanation.

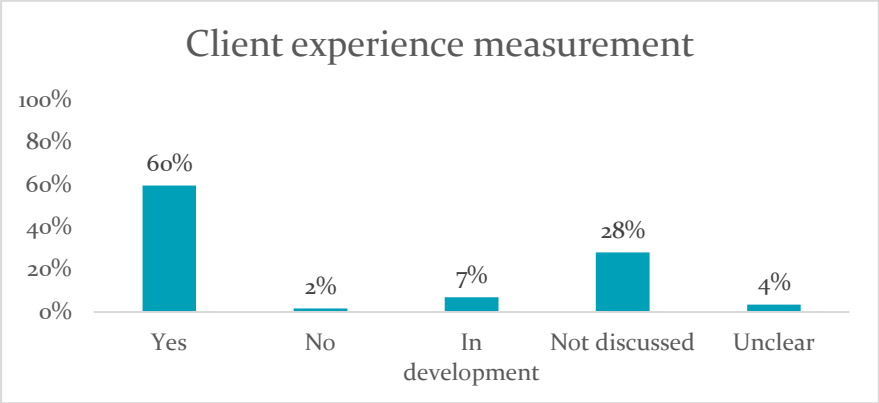

Figure 6. Client experience measurement results from Telephone interviews.

6.3.4 Coordinating care provider

The fourth activity regards working with a coordinating care provider within a VSV. In figure 7 is shown that 39% of the 57 VSVs have indicated that they work with a coordinating care provider. For 25% of the VSVs, only yes is written without further elaborating. 5% of the VSVs have indicated that they have agreed that every pregnant woman has a coordinating care provider that delivers primary care. Others indicated that the coordinating care provider could be from within primary and secondary care. For one VSV it was stated that *''they do work with a coordinating care provider, but it is not clear how this is arranged''*.

18% of the 57 VSVs were assigned the category ''In development''. The often-stated reasons were: working on it, a working group is working on it and busy with implementation. For one VSV the following answer was written down: *''left with questions about how that role unfolds when someone moves between primary care and third line care''*. It is therefore unclear to them how working with a coordinating care provider exactly works.

The category ''No'' was assigned to 4% of the 57 VSVs. For one VSV it was stated that they find it a hassle and wondered if this it is really necessary to work with a coordinating care provider. For the other VSV it was stated that primary care

midwifes are against working with the coordinating care provider because it does not suit them.

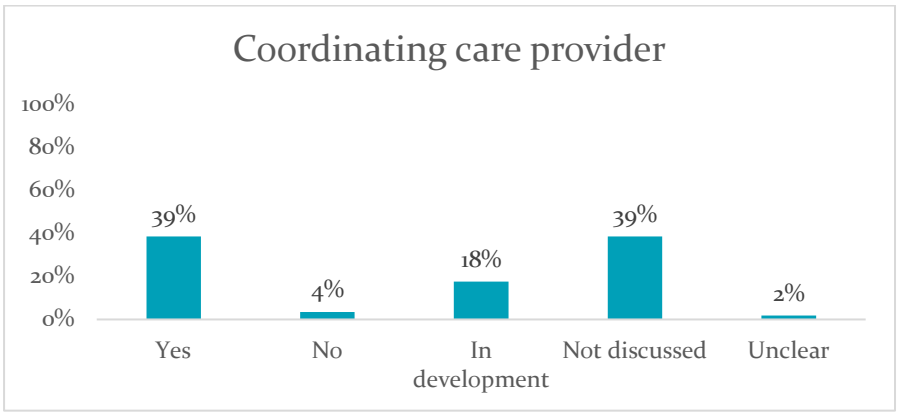

Figure 7. Coordinating care provider results from telephone interviews.

Looking at the indicators outcome figure 8 shows that 63% of the 75 VSVs answered yes when it comes to the question if they are working with a coordinating care provider. 37% of the 75 VSVs indicated that they were currently not working with a coordinating care provider but that they were striving for it.

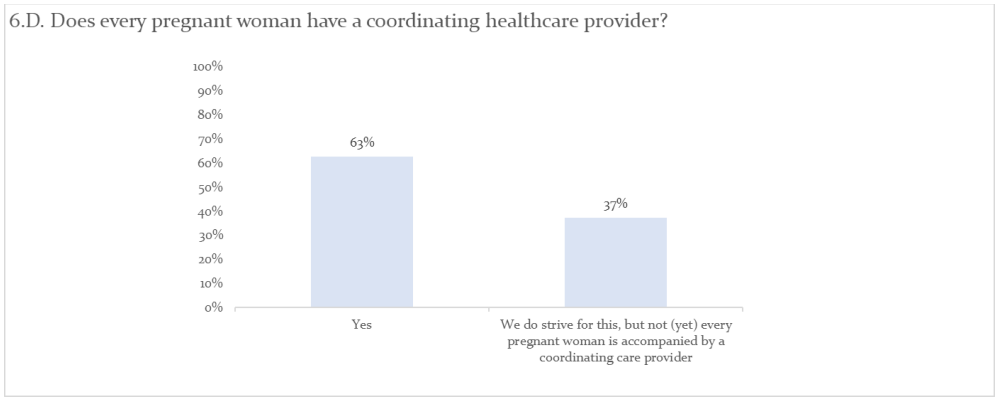

Figure 8. Coordinating healthcare provider results from Indicator set.

Partial conclusion

It is again shown that there is a discrepancy between the results from both datasets. Looking at the indicator set it becomes clear that the majority of the VSVs is working with a coordinating care provider, in figure 7 is shown that the minority of the VSVs works with a coordinating healthcare provider. However, there is a large number of not discussed and a smaller number of ''in development''. In the indicator set the VSVs only got two answer options that are shown in the bar chart, however in the telephone interviews it becomes clear that some of the VSVs that do not work with a coordinating care provider also do not strive for it, therefore the indicator outcome does not provide the overall picture. In addition, the telephone interviews show that

VSVs have different manners of working with the coordinating care provider, the indicator set does not show this and therefore provides a limited answer.

6.3.5 Multidisciplinair Overleg (MDO)

The fifth activity regards working with a MDO within a VSV. In Figure 9 is shown that 60% of the 57 VSVs have indicated that they work with an MDO. For 39% of the VSVs, only ''yes'' is written without further elaborating. 7% of them have stated that they discuss every pregnant woman during the MDO. Another 7% of VSVs work with an MDO on indication, which means that not all pregnant women are discussed. 5% of the VSVs indicated that they work with an MDO and it is arranged in such a way that the gynaecologist does his consultation hour at the location of the midwife. These were the most relevant findings in this regard.

Answers provided by 7% of the 57 VSVs fell under the category ''In development''. 5% of the VSVs described as an answer that a working group within the VSV was working on the implementation of an MDO. The following reason applied for one VSV: *''It is a working document that continues to change''.* It can be deduced from this that they are working on implementing this.

7% of the 57 VSVs have been assigned the category ''No''. For 4% of the VSVs it was stated that the gynaecologist does his consultation hour at the location of the midwife, but it has not been stated that an MDO is taking place. For one VSV it was stated that *'' Did a successful pilot but the funding is missing therefore stopped''.* They do work with an integrated consultation. For one VSV it was stated that they do not carry out an MDO, but they do a joint multidisciplinary intake discussion.

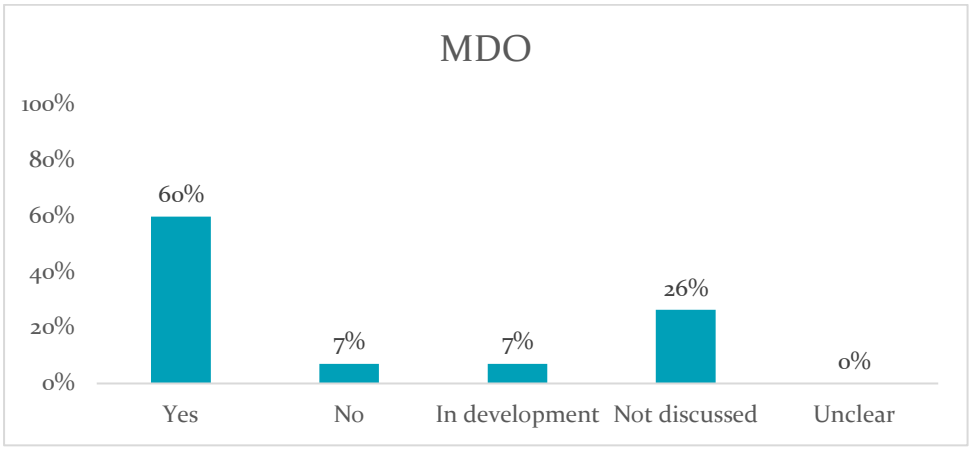

Figure 9. MDO results from the telephone interviews.

When it comes to the indicator set it is shown that 36% of the 75 VSVs indicate that every pregnant woman is discussed during an MDO. 64% of the 75 VSVs state that a pregnant woman only is discussed when found necessary. These results show that all of the VSVs work with an MDO in some way.

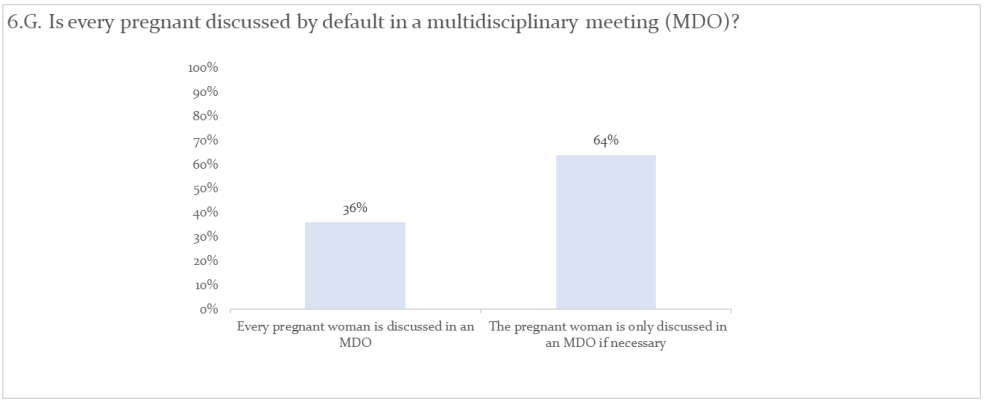

Figure 10. MDO results from the indicator set.

Partial conclusion

The results of the telephone interviews and indicators again differ considerably. In the indicator set the answer option ''no'' is not present. Which indicates that it is assumed that all VSVs work with an MDO. In the telephone interviews however, it is shown that this is not the case. 7% indicate that they do not work with an MDO and for another 7% it is stated that the MDO is in development. This is 14% of the VSVs in total who were not working with a MDO in 2019. The results of the indicator set should not be used indiscriminately.

6.3.6 Multidisciplinary training

The sixth activity regards working with multidisciplinary training. In figure 11 is shown that 47% of the 57 VSVs have indicated that they work with multidisciplinary training. For 32% of the VSVs only ''yes'' or ''they do'' is written without further elaborating. One has stated *'' yes, it has been there for years and has also resulted in better cooperation ''.* There are several training courses that are used, the following have been mentioned: Medsim training, baby reanimation, cave training, communication training, FIT training, management heidagen, joint CRM training, skills, and drills trainingen and quality policy training.

Answers provided by 5% of the 57 VSVs fell under the category ''In development''. The statements were that a working group is working on it and it is also indicated that they are themselves working on it.

5% of the 57 VSVs have been assigned the category ''No''. For all of them only ''No'' was written without further elaborating.

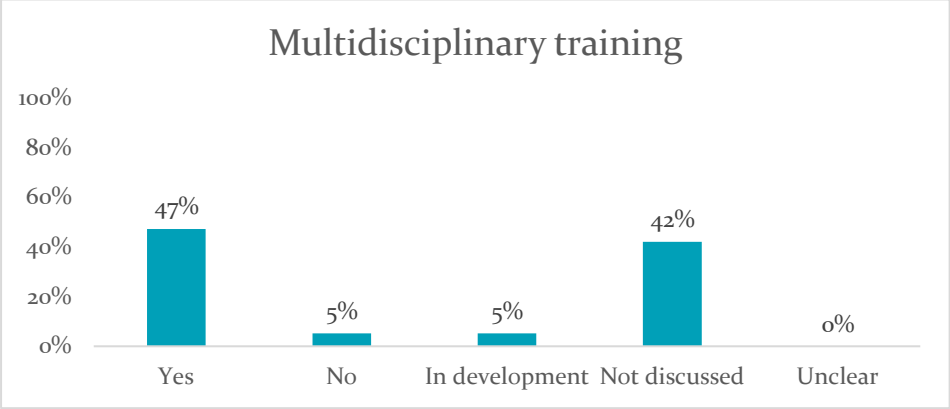

Figure 11. Multidisciplinary training results from the telephone interviews.

6.3.7 Quality Policy

The seventh activity regards having a quality policy within a VSV. In figure 12 is shown that 58% of the 57 VSVs have indicated that they have a quality policy. For 21% of the VSVs only ''yes'' or ''they have'' is written without further elaborating. Forms of a quality policy that have been mentioned by the other VSVs are: annual quality report, use of indicators, evaluation of protocols, PCQ, BUZZ, quality policy only from primary care, quality policy from second line care, joint complaints procedure. The PDCA cycle was mentioned by 9% of the VSVs, 7% of them indicated that they use the PDCA cycle for their quality policy.

12% of the 57 VSVs were assigned to the category ''In development''. The reasons for this are mainly that a working group is working on the quality policy or that it is in development. There was also a quote with *"This is still difficult. Are working on this, but missing support"*. Another VSV stated that the quality policy is set and will start soon.

2% of the 57 VSVs fell under the category ''No''. This is not elaborated further in the answer.

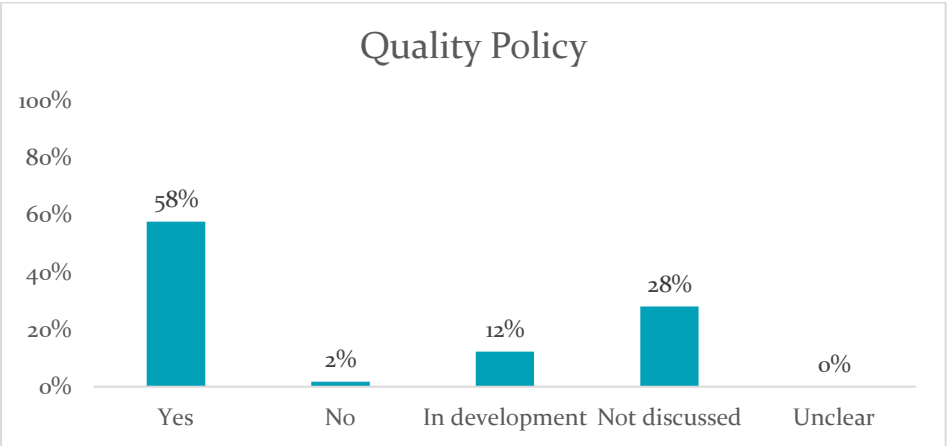

Figure 12. Quality Policy results from the telephone interviews.

6.3.8 Joint website

The eighth activity regards having a joint website within a VSV. In figure 13 is shown that 44% of the 57 VSVs have indicated that they have a joint website. It emerged that some VSVs only have a website that is accessible for care providers and other VSVs also have a website with a section that is accessible for the client.

Answers provided by 7% of the 57 VSVs fell under the category ''In development''. For one VSV it was described that "*they do not have a joint website yet and it is also difficult to realize because there are no financial resources*". For the other VSVs no further explanation was described.

19% of the 57 VSVs have been assigned the category ''No''. For 16% nothing was written next to ''No''. A VSV said that they work with workgroups through Kennisnet. Which implies that they may not find it necessary to create a joint website. Furthermore, no relevant explanation was described.

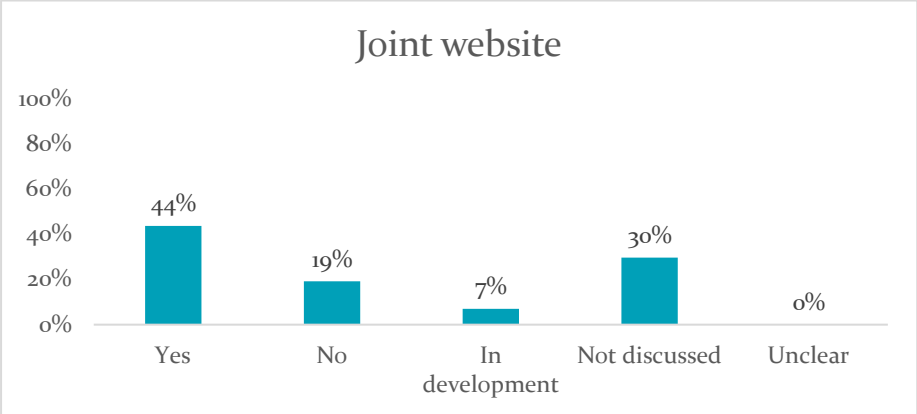

Figure 13. Joint website results from the telephone interviews.

6.3.9 Client participation

The ninth activity regards working client participation within a VSV. 35% of the 57 VSVs are working with client participation as is shown in figure 14. For 11% of VSVs only ''yes'' or''they have'' is written without further elaborating. It is also indicated by 14% of the VSVs that they work with a mother council. Other VSVs have chosen another form. One VSV stated *''Chosen to set up a parent-child panel, so a bit more versatile than just a pregnancy council''*. Four VSVs work with mirror meetings, in which questions are asked about different subjects about the care that is provided. Another VSV works with a client council based on a hospital formula.

For 18% of the 57 VSVs client participation is still in development. Some VSVs indicated that they were still looking at examples from others. Some VSVs were looking into a mother council and how to shape it. It was also indicated often that VSVs are orientating when it comes to client participation.

5% of the 57 VSVs have been assigned the category ''no''. This is not elaborated further in the answer.

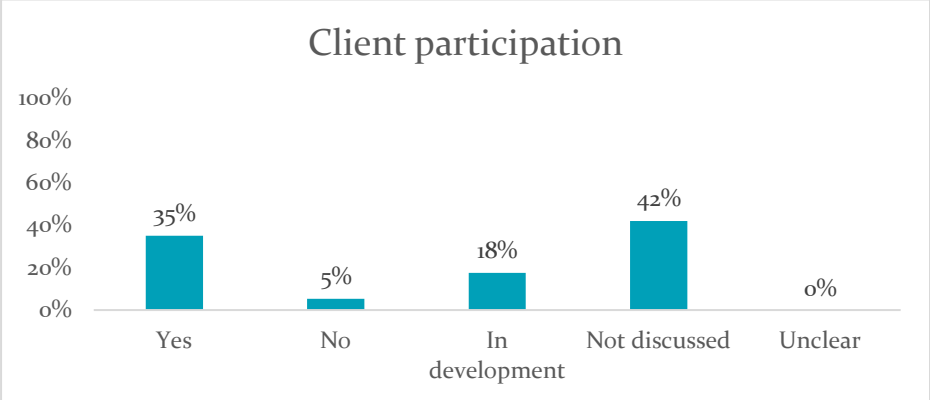

Figure 14. Client participation results from telephone interviews.

When it comes to the indicator set, figure 15 shows that 27% of the 75 VSVs are working with client participation in the form of an advisory council of pregnant women or young parents. 32% of the 75 VSVs answered yes but they are still working on the shape of the council. 41% of 75 VSVs have indicated that they do not work with an advisory council.

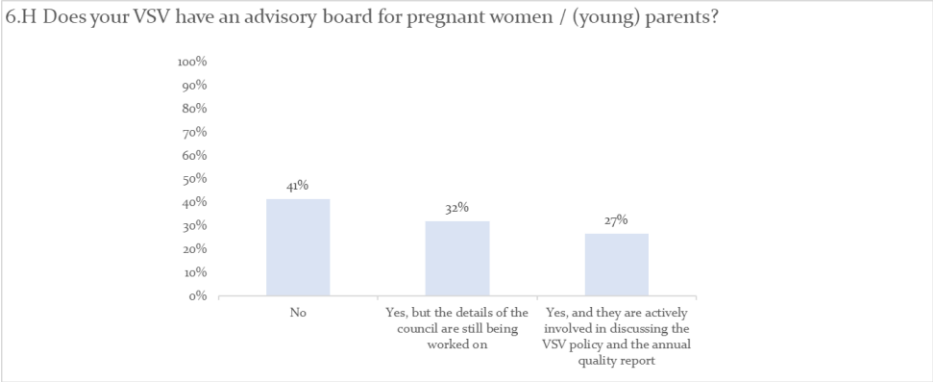

Figure 15. Client participation results from the indicator set.

Partial conclusion

It can be seen that the results of the telephone interviews and the results of the indicator set, again, differ quite a bit. When it comes to the telephone interviews only 5% of the 57 VSVs indicated that they do not work with client participation and in the indicator set that is 41% of the 75 VSVs. This difference may also be due to the fact that they talk about client participation in the telephone interviews and about an advisory board for pregnant women/parents in the indicator set. The telephone interviews have already shown that some VSVs also make use of other forms of client participation. It could also be due to the ''not discussed' percentage, since this is relatively high. Furthermore, can be concluded that the indicator set is shown that 59% of the 75 VSVs has the intention to carry out this activity. The indicator set again ensures that a limited answer can be given since not all answer options are included.

6.3.10 Integral dossier

The tenth activity regards working with an integral dossier within a VSV. There should however be mentioned that due to new insights CPZ and the National umbrella organisations have let go of that idea, they now believe that every healthcare professional should keep his own file but make data exchange possible in a standardized way. In figure 16 is shown that 9% of the 57 VSVs have indicated that they work with an integral dossier. For 5% of the VSVs only ''yes'' is written without further elaborating. For the other 4%, the reason cannot be described because it can be traced back to the VSVs involved.

42% of the 57 VSVs were assigned to the category ''In development''. Some VSVs indicate that they are developing the integral dossier, others have a working group working on it and another reason is that they are still orientating. A few VSVs also indicate that they are looking into baby connect.

16% of the 57 VSVs have been assigned the category ''No''. For 14% of them, this is not elaborated further in the answer. One VSV asked what tools are available, which indicates that they do not know how they should approach the integral dossier.

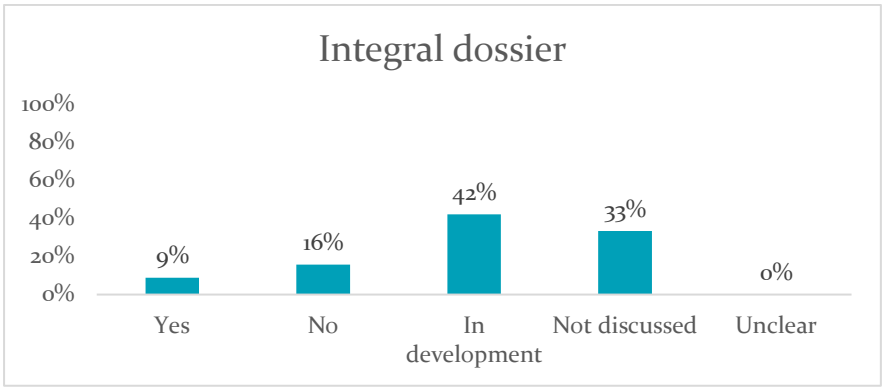

Figure 16. Integral dossier results from the telephone interviews.

As for the indicator set the figure shows that 15% of the 75 VSVs indicate that they are working with an integral dossier, where they have access to all the information. 7% of the 75 VSVs indicate that they are working with an integral dossier and that all healthcare providers can also work in this. 13% of the 75 VSVs answered with: No, only some of the care providers have access to all information. The majority, namely 65% of the 75 VSVs, indicate that every organization has their own client dossier.

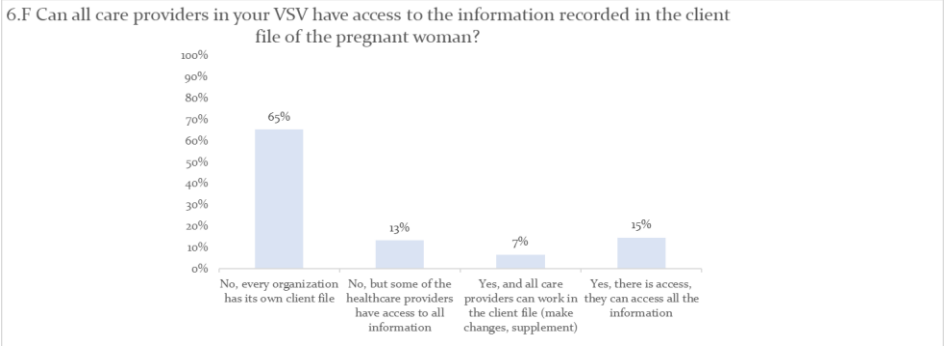

Figure 17. Integral dossier results from the indicator set.

Partial conclusion

The results from both datasets differ again, but both show that the minority of the VSVs is currently carrying out this activity. Again, due to progressive insight and changes regarding this activity, it is easy to explain why this activity is not performed by most VSVs.

6.3.11 Uniform delivery of information

The indicator set looks at various aspects when it comes to providing uniform information. Those aspects are: Which care providers and organizations are part of the VSV, accessibility of the care providers in the VSV, jointly formulated vision on integrated birth care, responsibilities of the caregivers in the VSV, working arrangements such as referral and transfer between health care providers, to whom the pregnant woman can go with which questions, when the pregnant woman can go to the office for check-ups and consultation forms and consultation times between the care providers.

In figure 18 is shown that 87% of the 75 VSVs provide uniform information about which care providers and organizations are part of the VSV. 13% of the 75 does not provide uniform information about this.

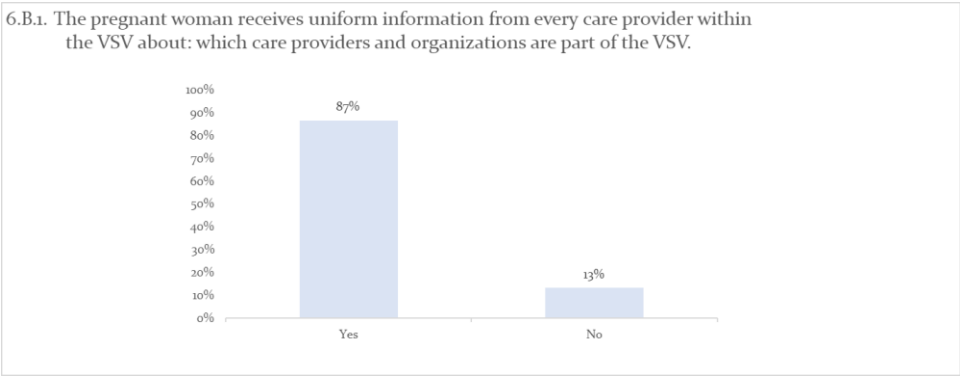

Figure 18. Uniform information about the care providers.

In figure 19 is shown that uniform information about accessibility of the care providers in the VSV is provided by 97% of the 75 VSVS. 3% indicates that they do not.

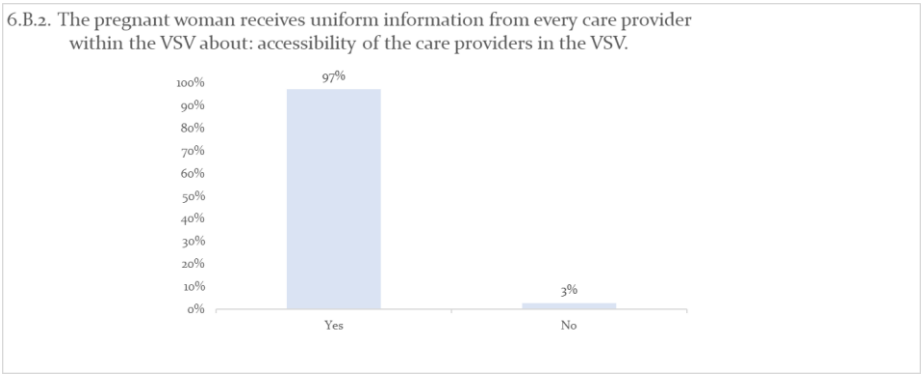

Figure 19. Uniform information about accessibility result from indicator set.

In figure 20 is shown that 69% of the 75 VSVs provide uniform information about their jointly formulated vision on integrated birth care. 31% of the 75 VSVs indicated that they did not.

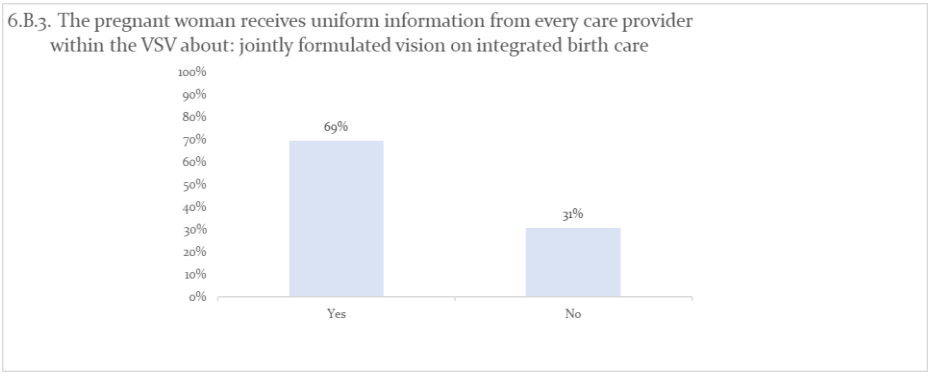

Figure 20. Uniform information about jointly formulated vision result from indicator set.

For information on responsibilities of the caregivers in the VSV, 85% of the 75 VSVs indicated that they do this in a uniform manner. 15% of the 75 expressed that they do not provide uniform information about the responsibilities of the care providers within the VSV. This is shown in figure 21.

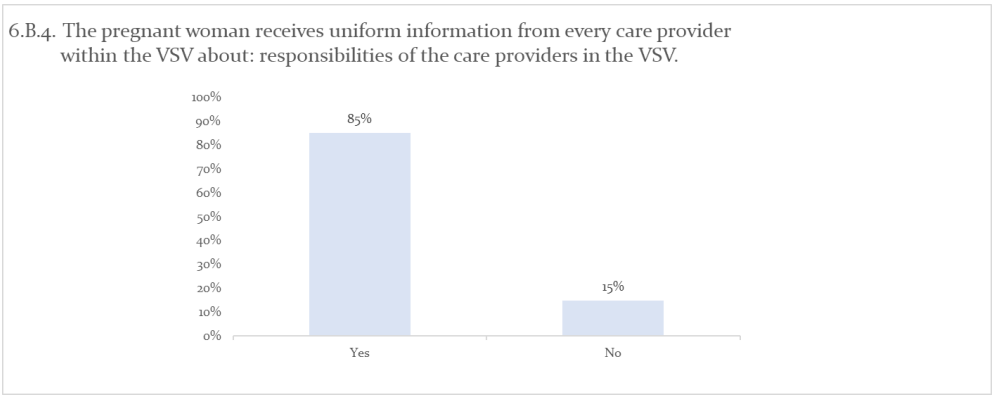

Figure 21. Uniform information about responsibilities result from indicator set.

Figure 22 shows that 95% of the 75 VSVs provide uniform information on the working agreements such as referral and transfer between different health care providers. Only 5% of the 75 VSVs answered with no.

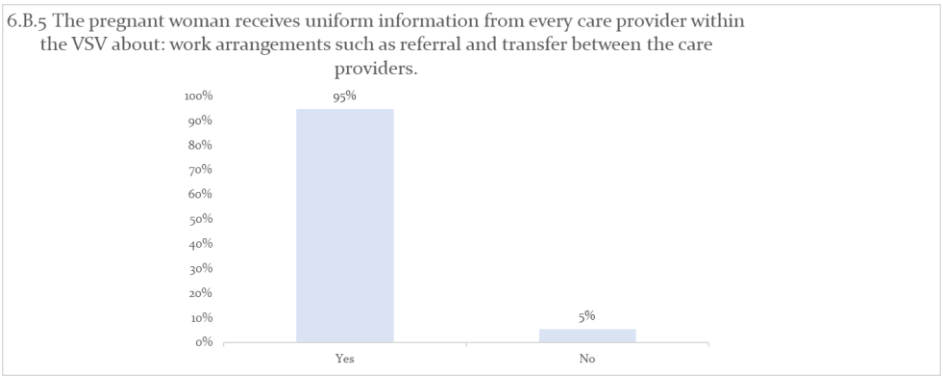

Figure 22. Uniform information about work arrangements result from indicator set.

In figure 23 is shown that uniform information about to whom the pregnant woman can go with which questions is provided by 97% of the 75 VSVs. Only 3% said they did not.

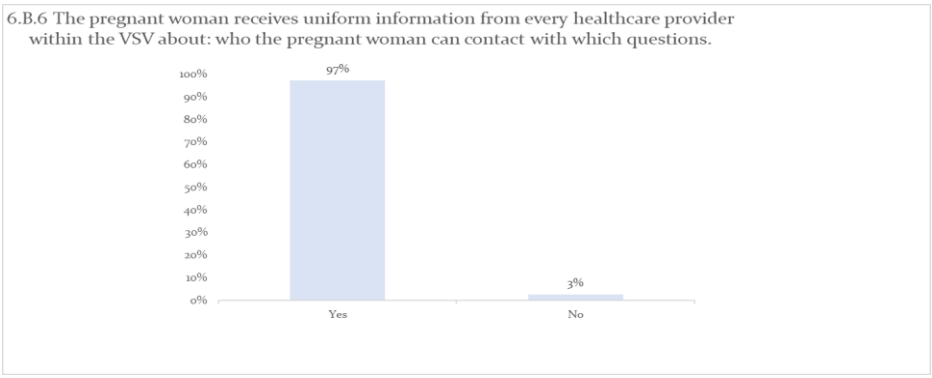

Figure 23. Uniform information about point of contact result from indicator set.

Figure 24 shows that all 75 VSVs provide uniform information about when the pregnant woman can go to the office during the consultation hours for check-ups.

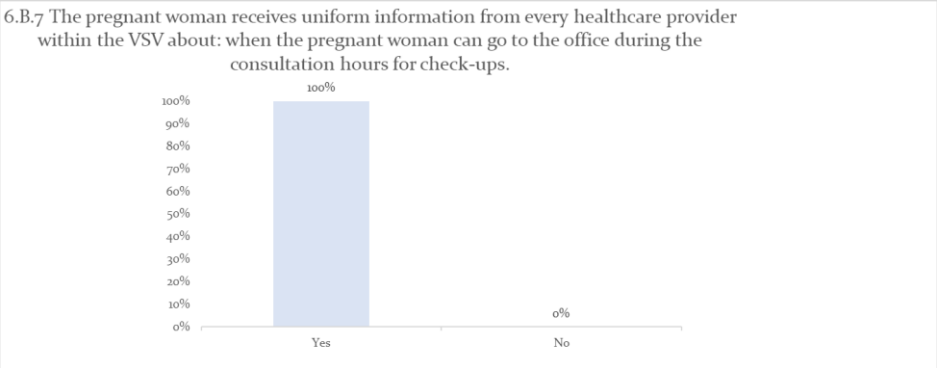

Figure 24. Uniform information about check-ups result from indicator set.

In the last figure is shown that 92% of the 75 VSVs provide uniform information about forms of consultation and consultation moments between the care providers. 8% of the 75 VSVs indicated that they do not.

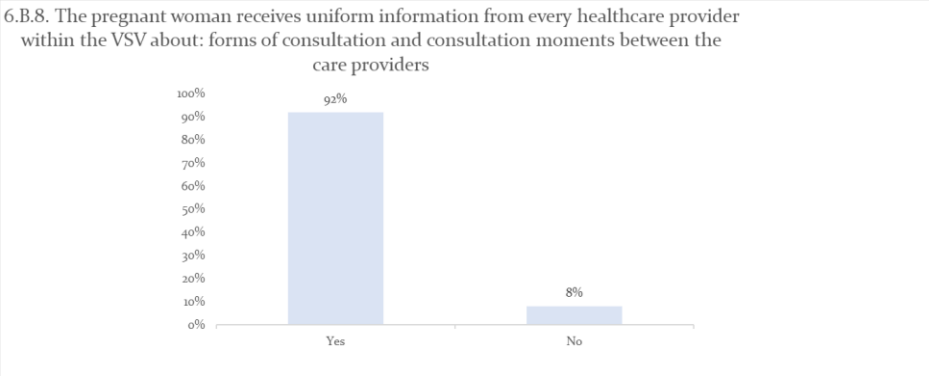

Figure 25. Uniform information about forms of consultation result from indicator set.

Partial conclusion about providing uniform information

About all the subjects that uniform information needs to be provided the majority of the VSVs indicate that they do so. For a number of subjects this was even above 90% namely: accessibility of the care providers in the VSV, working agreements such as referral and transfer between health care providers, whom the pregnant woman can go with which questions, when the pregnant woman can go to the office during the consultation hours for check-ups and about forms of consultation and consultation moments between the care providers. What stood out was that when it came to providing uniform information about the VSVs jointly formulated vision on integrated birth care the percentage of VSV was significantly lower than when it came to the other subjects. However still the majority of VSVs does provide uniform information concerning this.

6.4 OVERALL ACTIVITY ANALYSIS

For all VSVs it is shown in figure 26 that the activity that is carried out the most is working with integral care paths and or protocols. Working with a quality policy, MDO and client experience measurement is carried out by more than 50% of the 57 VSVs. Working with an integral dossier is the activity that is carried out the least with 42 % ''No'', which could be due to the fact that VSVs are not expected to carry out this activity in that particular manner anymore. Other activities that are carried out to a small extent are working with client participation, only 35 % scored ''Yes'', working with a coordinating care provider and working with an individual birth care plan, who scored 39% and 40% ''Yes''. Those activities, however, also have a high level of not discussed. This differs from the indicator set results. '

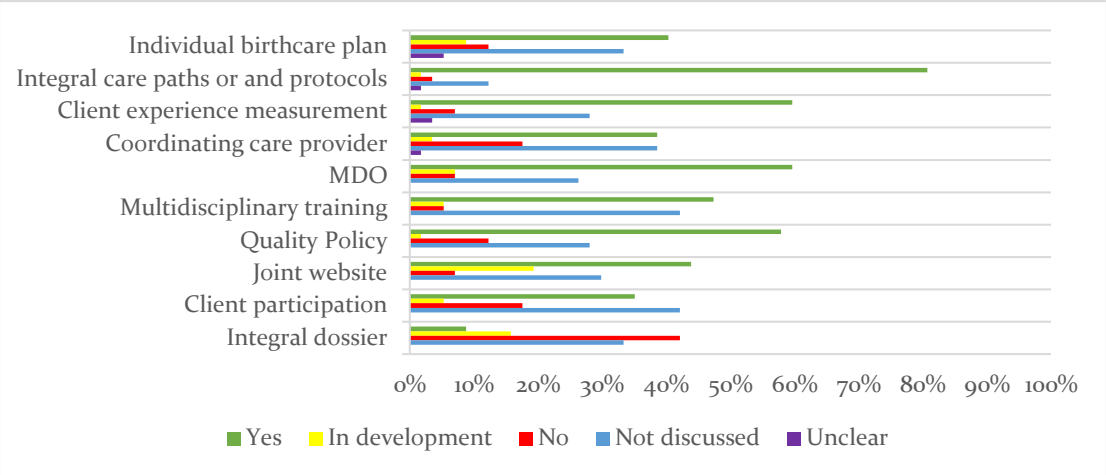

Figure 26. Overall activity Analysis VSVs.

6.5 GROUP ANALYSIS

In addition to looking at how many VSVs have carried out a certain activity, it is also important to see how the distribution is when it comes to VSVs regarding the implementation of the policy. In table 3 the distribution of the VSVs can be seen. It is shown that 40% of the VSVs are assigned to the high group, 30% of the VSVs to the average group and another 30 % to the low group.

Table 3. VSV group distribution according to the telephone interviews regarding the implementation of the ZIG.

	Score	Percentage of VSV's
High	>= 0,7	40%
Low	<= 0.4	30%
Average	0.4 <=> 0.7	30%
Total		100 %

6.5.1 High group of VSVs

For the high scoring group of VSVs is shown in figure 27 that they score reasonably high on all activities, especially when it comes to working with integral care paths, working with a quality policy, and working with a client experience measurement. Only the activity integral dossier is carried out by the minority of this group, there is however a quite high percentage of VSVs that is looking into this. As mentioned earlier, that activity has got a new interpretation. Activities that are also performed by fewer VSVs than the rest of the activities are: Coordinating care provider and client participation. For working with a coordinating care provider and working with client participation it is shown that 65% and 57% of the VSVs in the high group are carrying out these activities.

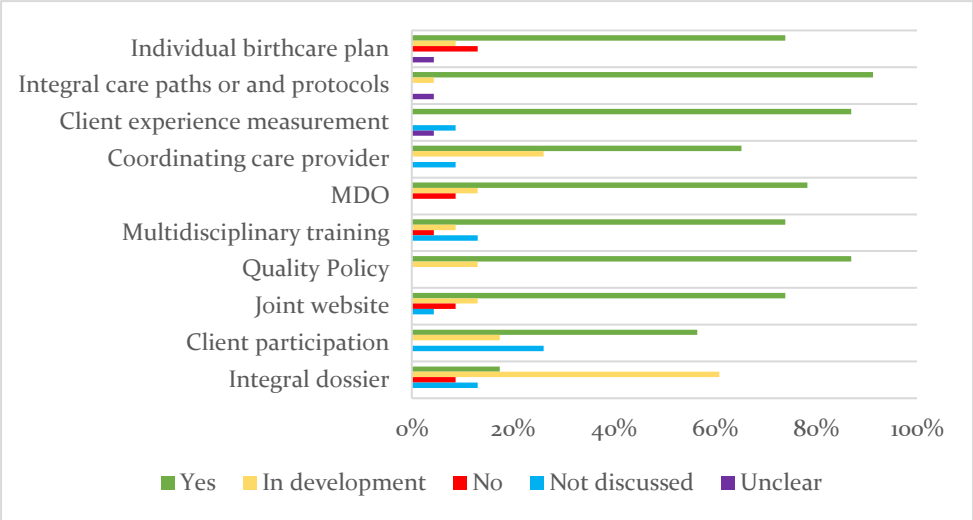

Figure 27. High group of VSVs.

6.5.2 Average group of VSVs

When it comes to the average group it is shown that working with integral care paths or and protocols is carried out by almost all VSVs within this group. Furthermore, it is shown that working with client experience measurement, MDO and a quality policy are carried out by the majority of this group. What also stands out is that not one VSV in this group works with an integral care dossier, although almost 50% is looking into it. The activities that are carried out the least by this group are: Client participation, individual birth care plan and joint website. These scored all below the 50 %. For client participation it is however shown that there is a high level of not discussed as for working with an individual birth care plan.

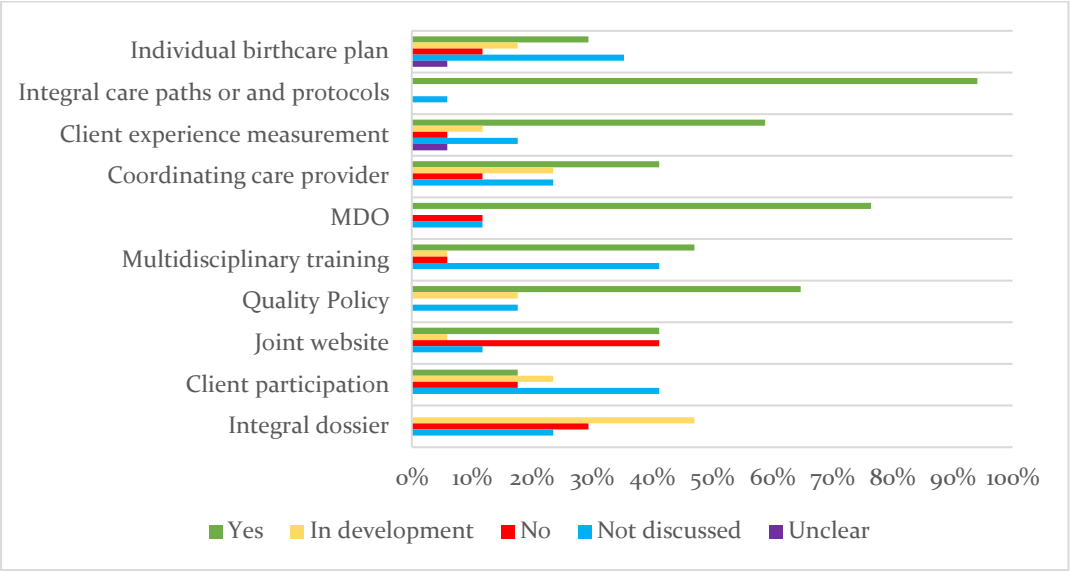

Figure 28. Average group of VSVs.

6.5.3 Low group of VSVs

For the low group, the level of ''Not discussed'' stands out, since for nearly every activity this is above 60%. This does not apply to the activity: Integral care paths or and protocols, the most carried out activity for this group. Working with a client experience measurement, MDO and client participation also scored higher than the rest of the activities, but still below 25 %. With regards to working with a coordinating care provider, it can be seen that these results do not provide insight into whether or not the activity was performed in this group because it only consists of not discussed and unclear. What also stands out is the level of ''In development'' is low for all activities, all below 12%.

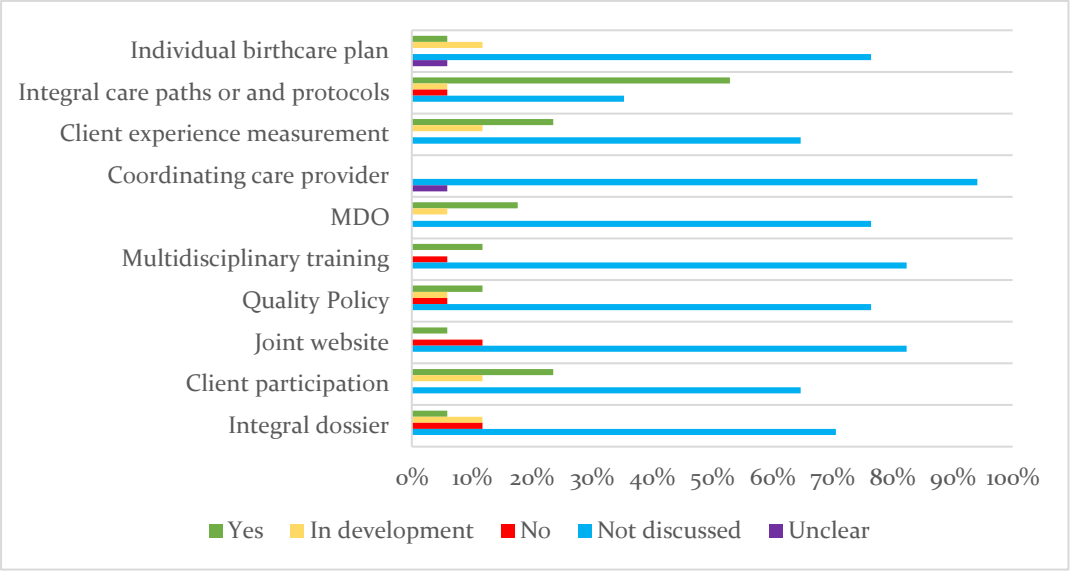

Figure 29. Low group of VSVs.

6.6 ADDITIONAL RESULTS

Additional results resulting from the coding of the telephone interviews are mentioned here, because they also provide insight into the implementation of the policy. These results were therefore not aimed for but were often reflected in the interview reports.

6.6.1 Use of Kennisnet

Kennisnet [35] is a website where information about integrated birth care can be found for care providers and the clients. Kennisnet was mentioned by 30% of the 57 VSVs in its entirety. 21% of the VSVs said that they make use of Kennisnet. 5% VSVs make use of Kennisnet but are unsatisfied with the application. For 3,5% of the VSVs it was only described that they are familiar with Kennisnet.

6.6.2 Use of the implementation tool

The implementation tool has been appointed by 47% of the 57 VSVs. For 18% of them it was reported that they use the implementation tool. Noted answers from 9% of the VSVs indicated that they are familiar with the implementation tool and in some cases use the tool to gain insights and look at examples from other VSVs.

6.6.3 Vulnerable pregnant women

Vulnerable pregnant women have been appointed by 14% of the 57 VSVs. It is stated in the ZIG [3], there must be a regional policy for the care of vulnerable pregnant women, which is why these results are mentioned. Although no explicit question was devoted to it when it comes to the telephone interviews. Three general comments were described: *'We are working on: vulnerable pregnant women"*, *'"They do a lot when it comes to vulnerable pregnant women"* and *''Are concerned about vulnerable pregnant women and ICT policy"*. The first two simply indicate that there is attention for this subject. The last quote indicates that the VSV does not know how to organize this.

Two quotes related to the MDO: *'' There is a polyclinic vulnerable pregnant woman"* and *''proud of their approach to vulnerable pregnant MDO"*.

Two quotes related to joint protocols: *''a lot of attention is paid to vulnerable pregnant women"* and *''Want to set up care paths for vulnerable pregnant women"*. The last quote indicates that they would like to pay more attention to it and make the care paths concrete.

6.6.4 Factors that were of influence

A number of bottlenecks were also identified during the telephone interviews, especially when it came to financing and capacity.

Finance

The financial bottleneck is mentioned by 14% of the 57 VSVs, this does not include the answers to the questions regarding integrated funding. Some general quotes on financing from the telephone interviews were:*''Current rates get in the way when it comes to implementing the ZIG."* , *''There is a need for financial safety nets in general*'', *''Would like more attention to be given to the work and costs associated with the implementation of this type of large organizational transition."* and *''The contribution is not sufficient to perform organizational tasks".* These quotes all indicate that the current budgets are not sufficient when it comes to implementing the ZIG.

One quote related to the MDO: *''MDO is well organized but finances are not arranged''* . This indicates that it is not clear how the MDO should be paid for.

One quote related to the quality policy: *''Quality system is in good order. Is organized within maternity care. But the other disciplines are not joining. Financing is a bottleneck in this. The will is there but cannot all be done during spare time".*

Capacity

The capacity bottleneck is mentioned by 12% of the 57 VSVs in the described answers. Some statements are: *''Everyone was active in the first year, now they suffer from too few hands during implementation*'', *''Indicated that she does endorse matters from ZIG but runs into manpower VSV".*

The following quotes apply not only to capacity but also to costs, although this is often related. *''The time that needs to be invested is particularly difficult. they have insufficient number of people and also consider the compensation to be small", ''Would like more attention to be given to the work and costs associated with the implementation of this type of large organizational transition.", ''It takes too much time that is not paid".*

According to a small VSV *''working with the same people has advantages, but it also quickly becomes too much when it comes to tasks*''. This can mean that when it comes to carrying out activities related to the implementation of the ZIG, there is too little manpower.

One quote regarding Client participation: *''Integrated Birth care Standard approach plan is ready. The problem is implementation: simple things like client participation: they know what they want, costs 1500 euros, who will pay for it and who will do it. Too little time and money."*

Support for the implementation

The third bottleneck, regarding the support for implementation, is mentioned by 12% of the 57 VSVs. Some general quotes on support for the implementation from the implementers were: *''All parts of the implementation plan are ready on paper. The members remain difficult to affiliate", ''Sometimes a feeling that members are difficult to move"* and *''They are working on joint protocols but that takes a long time and the workgroup does not get members to affiliate well, so implementation depends on that."*

The following quote regards the implementation plan and the ZIG not landing well with the members: *''Almost all points of the implementation plan have been achieved on paper. But not everything has landed with the members''.* This statement was made twice during the telephone interviews.

Another statement discussed the pace of implementation of the members: *''Bottleneck is in speed, management wants to progress very quickly, but members are not so fast''.*

Relationship primary care providers and second line care providers

The telephone interviews revealed that 12% of the 57 VSVs experienced friction between the first- and second-line care providers. Some general statements on the friction were: *''Cooperation between the first and second line is still difficult'' and ''It is difficult to get agreement between 1st and 2nd line''.* When it comes to joint protocols, it was stated that: *''Sometimes run into the fact that the first line does not want to participate, for example the joint diabetes protocol is now stagnating''.*

One quote regarding finances*: ''There are sometimes uneven playing fields: hospital and primary midwives''.* One statement regarding mild medical indication*: ''They prefer not to have to deal with the hospital at all, they prefer to hand it over.''* There was also a statement that regarded the mother council: *''The primary care wanted to set up a mother council but the hospital is working against it because they already have their own client council''.*

On the other hand were also VSVs who experienced good cooperation between the different lines of care. 23% of the 57 VSVs have indicated that this is the case. Some general statements on good cooperation were: *''Atmosphere and cooperation with the first and second line is going very well'', ''Integrated cooperation is going well'', ''VSV has short lines, work well together'', ''Mutual good cooperation with the first line'', ''Implementation is progressing well. Cooperation between the lines too'', ''Positive about mutual cooperation'', ''Cooperation between the lines with a lot of trust and substitution of care''* and *''VSV has a long history of cooperation. It goes very well''.* 4% of the 57 VSVs indicate that the first and second line of care are cooperating better, presumably since they have been implementing the ZIG*: Previously it felt as if the second line was pushing things through, now everyone feels heard and more equal in decisions* and *'It is going well now. it is more coherent, no more loose entity''.*

Chapter 7. Results National umbrella organizations

7.1 INTRODUCTION

In this chapter the sub question *''To what extent are the activities described in the implementation plan carried out?''* is answered when it comes to the National umbrella organizations. First, it is discussed what role the organizations see for themselves when it comes to integrated birth care, the responsibility will also be discussed. Then the carrying out of the activities will be shown in a table. The detailed interviews can be found in the appendices. The branch and professional associations will be discussed first and these include interviews with: BO geboortezorg, KNOV, NVOG and Federatie van VSVs. Then Patiëntenfederatie Nederland are discussed. The activities of the CPZ are discussed as well. Then the contribution of the organizations that were involved in the ZIG but not seen as implementers are discussed. Lastly the organizations with whom no interviews could take place are discussed.

7.2 BO GEBOORTEZORG

On their website [36] their role is described as: Bo geboortezorg core task is to represent and support national interests and support for care organizations active in birth care. They are initially aimed at maternity care organizations. It is also important to note that Bo geboortezorg is an employers' organization and not an employee organization which the other branch organizations are. She is therefore mainly committed to entrepreneurs [36] in maternity care. The role of BO geboortezorg is described by them as *''We have really focused on ensuring that maternity care is included as a fully-fledged link in the chain and we are also a representative of interests for employers and for joint organizations, in terms of role, we have also represented interests to the various parties to ensure that maternity care got a good place in the chain and was also a real part of integrated birth care''*.

They immediately addressed the implementation of the ZIG when was asked about responsibility: *'I hope that is the same for all parties involved in the way that everyone feels responsible to ensure that their members are hooked on well so that the right information is spread and that you actually provide them with what is stated in the implementation plan to motivate them to participate''*. Furthermore, was mentioned that problems are identified and that those problems can be tackled together with the other branch organisations.

Bo geboortezorg thinks the ZIG is useful; they also indicated that they think that the ZIG has yielded a lot already namely that: The different parties are better able to find each other and for maternity care it has in any case yielded that they are seen more as part of the birth care chain. It was furthermore stated that *'' It also has brought up where some pain points lie and a kind of domain struggle has become visible that may have been there before, but which has become clearer when you have to work together like this''*.

Their organization is furthermore aware of the implementation plan and also has informed their members through the newsletter.

7.2.1 Activities

The further explanation and substantiation of the activities that were carried out by Bo Geboortezorg can be found in Appendix K.

Table 4. Activity table Bo Geboortezorg

Activity	Yes	No	Partly	Unknown/ unclear
Members must become convinced that the new working method is valuable and is efficient and saves time and costs			X	
The professional groups conclude on the basis of application that the new method satisfies and confirms its usefulness.	X [37][38] [39][40]			
Encourage involvement in the actual implementation of the Integrated Birth care Standard among their members.	X			
The associations have the channels to inform their members about the new insights from the Integrated Birth care Standard.	X			
Offering training to the members.	X			
Identify which training courses are offered by other parties.		X		
They inform the support organization of the CPZ and the other industry and professional and patient associations about their own activities regarding the implementation of the Integrated Birth care Standard and look for cooperation and synergy between their own activities and the activities of others.		X		
The professional associations appoint representatives to CPZ to contribute to the realization of the client version of the Integrated Birth care Standard.	X [6]			
Communication to own employees or members about updates of the Integrated Birth care Standard	X			

in newsletters, magazines, via their own website, folders.				
Identifying bottlenecks around the introduction of integrated birth care at the CPZ (whereby the support group acts as the point of contact for CPZ).	X			
Actively share proprietary solutions with other regions and share solutions, models, and documents through CPZ.			X	
Ensuring or encouraging employees or members to participate in multidisciplinary consultations for joint risk assessment.			X	
The organization contributed to the further development of monodisciplinary guidelines to multidisciplinary guidelines, standards, and agreements.		X		

7.2.2 Factors that were of influence

Promoting factors were according to Bo geboortezorg the fact that as a national party they have tackled a lot through the CPZ when it comes to the implementation. Furthermore, they indicate that the level of communication, with their members, was helpful. The checklist is also seen as promoting: *''I think the checklist was also very useful, that really provided a clear picture on all that still needs to be done when it comes to the implementation of the ZIG".*

Hindering factors were time and finance. About finance was stated that *"The funding itself because I think that has sometimes gone through the collaboration, so instead of just focusing on okay, how are we going to work well together, you must first arrange that properly before we start talking about funding, that the funding still has to pass somewhere in between so the conversation is more about how are we going to do this financially than about what do we think is the best in terms of care?".*

Furthermore, it was mentioned that their organisation only started in 2016 as the ZIG, that could be seen as hindering since they were more focussed on their own establishment as an organization. They mentioned that *''I don't think that we have neglected the implementation but I do think if the ZIG needed to be implemented now it would get a little more attention".*

7.3 KNOV

Prior to the interview with the KNOV, it was indicated that some questions might be outside of the scope of this study. It also remains difficult to speak for the entire professional group. Those questions relate to how the KNOV perceived the ZIG and whether they supported it and confirmed its usefulness. When it came to the role of the KNOV they mentioned that, as an organisation, they are part of CPZ and, as such, play a significant role in integrated birth care. It was explained that the KNOV views itself as an organisation which stands for the best birth care for women and their babies. Furthermore, the KNOV also has a role in representing her members, midwives in the Netherlands .

It was indicated that each of the parties involved in childbirth care has a responsibility. Working in accordance with the ZIG enshrined in law: *"I think that everyone has a responsibility with regard to integrated childbirth care. After all, the Integrated Birth care Standard is included in Zorginstituut Nederland. The KNOV is one of the signatories, not only the Integrated Birth care Standard but also the implementation plan"*

As signatories, the KNOV are aware of the role they have in communicating with their members. As such, they shared the details of the implementation plan with their members through a newsletter and the website.

7.3.1 Activities

The further explanation and substantiation of the activities that were carried out by the KNOV can be found in Appendix L.

Table 5. Activity table KNOV.

Activity	Yes	No	Partly	Unknown/ unclear
Members must become convinced that the new working method is valuable and is efficient and saves time and costs			X	
The professional groups conclude on the basis of application that the new method satisfies and confirms its usefulness.				X
Encourage involvement in the actual implementation of the Integrated Birth care Standard among their members.	X			
The associations have the channels to inform their members about the new insights from the Integrated Birth care Standard.	X [41]			
Offering training to the members.	X			

Identify which training courses are offered by other parties.	X [42]			
They inform the support organization of the CPZ and the other industry and professional and patient associations about their own activities regarding the implementation of the Integrated Birth care Standard and look for cooperation and synergy between their own activities and the activities of others.			X	
The professional associations appoint representatives to CPZ to contribute to the realization of the client version of the Integrated Birth care Standard.	X [6]			
Communication to own employees or members about updates of the Integrated Birth care Standard in newsletters, magazines, via their own website, folders.	X			
Identifying bottlenecks around the introduction of integrated birth care at the CPZ (whereby the support group acts as the point of contact for CPZ).	X			
Actively share proprietary solutions with other regions and share solutions, models, and documents through CPZ.		X		
Ensuring or encouraging employees or members to participate in multidisciplinary consultations for joint risk assessment.				X
The organization contributed to the further development of monodisciplinary guidelines to multidisciplinary guidelines, standards, and agreements.	X			

7.3.2 Factors that were of influence

There are factors that can enhance or hinder progress. Hindering factors include both money and time. It was stated that: *'The low-hanging fruit has already been picked up when it comes to the implementation of the ZIG and it simply takes time which does not always fit within the current budgets".* While this may be accurate, it presents a challenge to all professions to continue striving for the best possible birth care.

7.4 NVOG

On the website of the NVOG [43] is stated that they are the scientific professional association for gynaecologists. Their mission is to provide the best quality of care for women during all stages of life. In this capacity NVOG wants to monitor the quality of women's health care in general and the gynaecological, obstetric, oncological, and reproductive medicine (sub) specialties in particular. They also represent the interests of the specialisms and their professionals, whereby the social position is stimulated and supported. NVOG mentioned that they think they have an important role when it comes to birth care since their members are part of the transfer between the first to the second line of care, which can be difficult at times. Next to that they have shaped the ZIG [11] with the other National umbrella organizations involved. It is further mentioned that *" We are also one of the national organizations that are members of the CPZ"*.

NVOG addressed responsibility in two areas *"We have an important role in integrated birth care and have a responsibility to ensure that everything runs smoothly, in various aspects. In the medical aspect we have a responsibility on the work floor but also on the organizational level and I think that the NVOG has the responsibility to communicate to the members how important the implementation of the Integrated Birth care Standard is and that the policy should be carried out"*.

It is mentioned that the NVOG as an organization fully supports the working method described in the ZIG, since they were included when the ZIG was developed. However, they do say that the implementation is sometimes a bit more unruly since it is arranged locally per VSV and that this can be difficult at times.

NVOG thinks that the method described in the ZIG certainly yields something because there is already much better cooperation between the various care providers, which will be reflected in the gains in the quality of care, in particular prenatal mortality and atonal problems.

Furthermore it was indicated that they are aware of the implementation plan and that their members have also been made aware of it.

7.4.1 Activities

The further explanation and substantiation of the activities that were carried out by the NVOG can be found in Appendix M.

Table 6. Activity table NVOG.

Activity	Yes	No	Partly	Un-known/Un-clear
Members must become convinced that the new working method is valuable and is efficient and saves time and costs			X	

The professional groups conclude on the basis of application that the new method satisfies and confirms its usefulness.	X [44] [45]			
Encourage involvement in the actual implementation of the Integrated Birth care Standard among their members.	X			
The associations have the channels to inform their members about the new insights from the Integrated Birth care Standard.	X [44] [45][46]			
Offering training to the members.		X		
Identify which training courses are offered by other parties.			X	
They inform the support organization of the CPZ and the other industry and professional and patient associations about their own activities regarding the implementation of the Integrated Birth care Standard and look for cooperation and synergy between their own activities and the activities of others.		X		
The professional associations appoint representatives to CPZ to contribute to the realization of the client version of the Integrated Birth care Standard.	X [6]			
Communication to own employees or members about updates of the Integrated Birth care Standard in newsletters, magazines, via their own website, folders.				X
Identifying bottlenecks around the introduction of integrated birth care at the CPZ (whereby the support group acts as the point of contact for CPZ).	X			
Actively share proprietary solutions with other regions and share solutions, models, and documents through CPZ.		X		
Ensuring or encouraging employees or members to participate in multidisciplinary consultations for joint risk assessment.		X		

The organization contributed to the further development of monodisciplinary guidelines to multidisciplinary guidelines, standards, and agreements.				X

7.4.2 Factors that were of influence

As a promoting factor was mentioned that it was necessary to change the working method given the high rate of the perinatal deaths, the NVOG felt that this was stimulating to improve birth care.

One hindering factor was finance, it was mentioned that the finance was not arranged properly. The following was mentioned: *'' Integrated funding is so half-heartedly recommended and that hinders".*

In addition, it was mentioned that a hindering factor was the relationship between two parties. This was on VSV level between the gynaecologists and the midwifes but also, on the organizational level, between the NVOG and KNOV. It was stated that: *''Within most VSVs the cooperation went simply fine and for some VSVs this was more challenging. At the organizational level, the relationship between the KNOV and the NVOG was changing from time to time and that gave some tension. That evidently does not promote the implementation of the ZIG, that hinders. And the funny thing was that sometimes it was more challenging at an organizational level than on VSV level".*

7.5 FEDERATIE VAN VSVS

The federatie van VSVs was founded in December 2017. They indicated that they were founded because the monodisciplinary professional groups: maternity carers, gynaecologists, hospitals, midwifes and paediatricians, were not able to represent the interests of the VSV as a whole. In addition, at that time the CPZ was instructed to have all VSVs work with an integrated tariff as quickly as possible, something that many VSVs had great resistance to. The most important reason for setting up the Federatie van VSVs, however, was that there are eighteen parties in the Netherlands that deal with birth care, and all those parties were and are being financed, while the VSV in itself does not receive any funding. In addition, the boards of the VSVs are not represented in any national body. This while more and more tasks were assigned to the VSVs. The implementation of the Integrated Birth care Standard only became an item, later.

Concerning their role, the Federatie van VSVs stated: *''Well the role of the federation is actually quite simple, it comes down to standing up for our members and our members are the VSVs"*. On their website [46] is also stated:*'' It represents your interests and creates a strong position for the VSVs"*. They mainly see themselves as advocates. The Federatie van VSVs however indicated that they would like to fulfil a greater role since they recently requested to join the board of CPZ for the second time,

partly to ensure that CPZ can efficiently support the VSVs with the implementation of the Integrated Birth care Standard.

Regarding responsibility the Federatie van VSVs stated:*" We have the responsibility to support the VSVs where we can and try to maintain interaction with the players in the field and by that, I mean CPZ, VWS ,NZA and all the higher regions where a local VSV cannot reach at all".*

The question related to how they view the working method described in the ZIG is a difficult one since their members consist of different professional groups. They indicate that the way people view the ZIG varies per profession. However, speaking from the federatie van VSVs it was indicated that they think the working method of the ZIG does lead to better cooperation between care providers.

It was also indicated that the organization is aware of the implementation plan and has also sent the document to their members.

7.5.1 Activities

Since the Federatie of VSV's is mostly an advocacy group some of the activities were not carried out by them since they did not see that as their task. Another reason was because they were founded in a later stage than 2016. The last reason was they would like to carry out this activity but do not have the financial resources to do so. The further explanation and substantiation of the activities that were and were not carried out by the Federatie van de VSV's can be found in Appendix N.

Table 7. Activity table Federatie van VSV's

Activity	Yes	No	Partly	Unknown/ unclear
Members must become convinced that the new working method is valuable and is efficient and saves time and costs			X	
The professional groups conclude on the basis of application that the new method satisfies and confirms its usefulness.			X	
Encourage involvement in the actual implementation of the Integrated Birth care Standard among their members.		X		
The associations have the channels to inform their members about the new insights from the Integrated Birth care Standard.	X [35][47]			
Offering training to the members.		X		

Identify which training courses are offered by other parties.		X		
They inform the support organization of the CPZ and the other industry and professional and patient associations about their own activities regarding the implementation of the Integrated Birth care Standard and look for cooperation and synergy between their own activities and the activities of others.	X			
The professional associations appoint representatives to CPZ to contribute to the realization of the client version of the Integrated Birth care Standard.		X		
Communication to own employees or members about updates of the Integrated Birth care Standard in newsletters, magazines, via their own website, folders.	X			
Identifying bottlenecks around the introduction of integrated birth care at the CPZ (whereby the support group acts as the point of contact for CPZ).	X			
Actively share proprietary solutions with other regions and share solutions, models, and documents through CPZ.	X			
Ensuring or encouraging employees or members to participate in multidisciplinary consultations for joint risk assessment.		X		
The organization contributed to the further development of monodisciplinary guidelines to multidisciplinary guidelines, standards, and agreements.				X

7.5.2 Factors that were of influence

They think a promoting factor is the fact that the federatie van VSVs helps VSVS, this will also aid with the further implementation of the ZIG.

A hindering factor was that the Federatie van VSVs did not receive any support from other branch organizations or CPZ, especially in the beginning. It was stated that *''Very slowly they start to see that they cannot ignore us, but in the beginning, they thought it was not necessary that we were founded at the time, because we had CPZ".* Concerning the communication with the CPZ was said that they have a good relationship with the staff office, but that the relationship is less good at an administrative level.

They also do not receive any financial support which they also see as hindering since they depend on membership fees.

What could also be seen as hindering according to the federatie van VSVs is the reputation of CPZ. They did not start off right, the chairman stepped down. Concerning this factor, they have stated: *"That is what we constantly notice and feel as a federation, our colleagues run into it every time".*

Another hindering factor in their opinion is the fact that the VSVs are besieged with surveys, telephone interviews and emails. All that information leads to resistance from the field since they are already so occupied with their daily tasks and besides that they do not see the point of providing all that information or how they can benefit from it.

Furthermore, it is briefly mentioned that there is a problem in finances and time: *''That cannot be delivered, so the VSVs have to come up with those resources themselves".*

7.6 PARTIAL OVERALL ACTIVITY CONCLUSION BO GEBOORTEZORG, KNOV, NVOG AND FEDERATIE VAN VSV'S

A total overview of the activities can be found in Appendix O. It is shown that the KNOV and Bo geboortezorg carried out most activities. The KNOV carried out eight out of thirteen activities and Bo geboortezorg seven. The NVOG and the Federatie van VSVs both carried out five activities. Two activities were carried out by all four organisations: *the associations have the channels to inform their members about the new insight from the Integrated Birth care Standard* and *identifying bottlenecks around the introduction of the integrated birth care at CPZ.* The activity that is carried out by least of the parties is: *Ensuring or encouraging members to participate in multidisciplinary consultations for joint risk assessment.* Although this is unknown for the KNOV and Bo geboortezorg partly does this.

7.7 PATIËNTENFEDERATIE NEDERLAND

The Patiëntenfederatie Nederland is an umbrella organization of patient associations, in which they represent [48] over 200 patient organizations. They stated *''As a patient federation, we are involved in various things, including supporting all of our members, but also more about rising themes or subjects that some of our members have to deal*

with, but not everyone specifically such as birth care". There are several patient organizations that are involved in birth care, but they all focus on specific components such as hereditary disorders, the patiëntenfederatie Nederland itself has a broader approach when it comes to birth care. When it comes to their role regarding birth care the following was stated: *'' I think when you look at, say our role within CPZ. We actually have quite a significant role since we are one of the participants".*

The Patiëntenfederatie Nederland thinks they have a responsibility on the policy side by really stimulating integrated birth care and good mutual cooperation, since that is of great importance for the client.

They implied that they did support the working method described in the Integrated Birth care Standard. *''We were ultimately able to agree with the ZIG, since a lot of our points, that we had consulted from our support base, were simply included. We think that with the ZIG, birth care can as a matter of fact, really improve".* With their points is meant: The individual birth care plan, client experience measurements and uniform delivery of information to the client.

When was asked if their members were aware of the implementation plan, they implied that they do not think that is the case. Only stichting kind en ziekenhuis [49] because they were part of the workgroup. It is also unknown whether their members have been informed of the plan, she says the following about it: *''From within CPZ, there is quite a push for broad communication and dissemination among your members and I think that is very good. However, clients cannot do anything with an implementation plan as for our client organizations because there is simply little role for them in the implementation of the ZIG. I have probably sent it to our relevant members".*

7.7.1 Activities

The further explanation and substantiation of the activities that were carried out by the Patiëntenfederatie Nederland can be found in Appendix P.

Table 8. activity table Patiëntenfederatie Nederland.

Activity	Yes	No	Partly	Unknown/ unclear
The associations have the channels to inform their members about the new insights from the Integrated Birth care Standard.	X [48][50] [51]			
Carry out own activities that promote the application of integrated birth care in accordance with the standard.		X		
Delegate a representative to CPZ to contribute to the realization of a client version of the Integrated Birth care Standard	X [6]			

Looking for cooperation and synergy between own activities and the activities of healthcare professionals and professional associations.		X		
Further development of the indicators of customer preferences	X			
Communication about relevant aspects of the Integrated Birth care Standard, including trying to get pregnant women / parents involved in participation in advisory boards of VSVs.		X		
Stimulating self-management for pregnant women by providing information.			X	
Identifying bottlenecks that occurred during the implementation of integrated birth care at the CPZ (whereby the support group acts as the point of contact for CPZ)			X	
Actively share own solutions with others by sharing solutions, models, and documents via the CPZ.			X [52]	
Facilitating valuations: making valuations for precautionary organizations available and comparable for other patients / clients via ZorgkaartNederland.	X [51]			

7.7.2 Factors that are of influence

Firstly, was mentioned all that Patiëntenfederatie Nederland did not really contribute to the implementation of the Integrated Birth care Standard. The representative thinks that what has been beneficial was making the Integrated Birth care Standard concrete in the client version. The following was stated: *''We have tried to just make things more concrete. When you communicate things to clients, it has to be concrete, because you cannot come up with vague texts about vague things, and that translation itself is often actually very good for all involved parties, since it shows what we actually mean, as has been done in that implementation plan".*

A hindering factor was the fact that the elements described in the ZIG that concern client participation have hardly been taken up, this regards: Including the voice of the pregnant woman, shared decision making and the individual birth care

plan. It was stated that the reasons for this are on one hand: *''that all costs money and effort and time".* On the other hand, it could have something to do with the fact that care providers find it easier to focus on the topics that are not directly related to the client. The following was stated: *''They may not know exactly what to do. It is quite new, how do you ensure that when you run a project that you reach your target group? Then you have to put that end target group at the table. And somehow that is more challenging than asking a colleague or something".* The Patiëntenfederatie Nederland thinks that it is difficult for professional groups to change the old way of thinking when it comes to client participation, that is why they focused more on for example adapting guidelines.

Furthermore, it was mentioned that it could be the culture especially among gynaecologists, that makes it hard to focus on the client since they think it more appealing to focus on new literature for guidelines. They mentioned that the midwives are more client orientated, but that they are less up to date when it comes to shared decision making for example.

Another limiting factor that was mentioned was the fact that they cannot monitor the client perspective on a large scale, and that actually no one performs that task.

Another limiting factor regards the client experience measurement, it was stated that *''By the way, that is also a real loss, that has also been a struggle for a long time, what is a good client experience list and what do all those parties conform to?''* The NPS is not comprehensive enough because it only has one direct question related to the client experience, nor is it used by everyone.

Lastly it was mentioned that *''Unfortunately, what you still see very often is that the midwives have their own information material. The gynaecologists do their own thing and meanwhile everyone tells something else to the pregnant woman, which is quite confusing and sometimes even contradictory on a number of points"* This is hindering when it comes to putting the client first.

7.7.3 Partial activity conclusion Patiëntenfederatie Nederland

In Table 8 is shown that the Patiëntenfederatie Nederland carries out four out of ten activities. Next to that are three activities partly carried out. Three activities were not carried out. The activities that were not carried out were: *Carry out own activities that promote the application of integrated birth care in accordance with the standard, Looking for cooperation and synergy between own activities* and *the activities of healthcare professionals and professional associations* and *Communication about relevant aspects of the care standard, including trying to get pregnant women / parents involved in participation in advisory boards of VSVs.*

7.8 CPZ

7.8.1 Introduction

During the data collection regarding CPZ it was proven challenging to make an inventory of whether an activity has been carried out and how as the implementation

process of the integrated birth care policy turned out differently in practise, then the implementation plan describes. The way in which CPZ is organized, has changed in many respects including their working method and governance. Therefore, a distinction is made between the ''what'' and the ''who''. To further clarify, the focus of the reader has to lie on the activity in itself and less on which body of the CPZ has undertaken it. In addition, the reader should keep the following in mind:

- CPZ has seen many changes over the years, CPZ-1.0 [53] hardly had a bureau in place contrary to after 2017 where for CPZ-2.0 a new chairman of the board was recruited and the CPZ was reorganized (*'herijkt'*). In the perspective of change management, it is important to note this difference because of the possible impact on the implementation process.
- CPZ does not work according to all of the bodies, as described in the implementation plan, and also did not do so at the time. Those bodies were: CPZ in general, CPZ staff bureau, Support organization VSVs, the implementation group and the communication activities. Per body will be indicated whether or not CPZ has worked with it.
- CPZ has always adjusted their working method based on the demands and needs of the field.
- The implementation plan had to be developed and published in an expeditious manner due to the pressure of Zorginstituut Nederland.

7.8.2 Activities CPZ in general

The further explanation and substantiation of the activities that were carried out by the CPZ can be found in Appendix Q.

Table 9. Activity table CPZ in general

Activity	Yes	Yes, but not by this body	No	Unknown/ Unclear
CPZ in general				
CPZ has made an inventory of the bottlenecks and needs when it comes to the implementation of the care standard.	X [27][54][55] [56][57]			
Taking charge of providing information about the integrated standard of care.	X[58][59][60]			
CPZ stimulatesthe sector of professional and patient associations, so that they saw it as their task to create support among their	X			

own members and to stimulate involvement in the actual implementation of the care standard.				
Stimulating the development of multidisciplinary guidelines.	X			

7.8.3 Activities Staff bureau

For the staff bureau of CPZ other activities were described, which will be discussed here. It was indicated that it was called ''staff bureau'' in the implementation plan, but that there was hardly a bureau at the time the implementation started. About the current bureau of CPZ was stated: ''*We support the Integrated Birth care Standard working group, with regard to the Integrated Birth care Standard, we have a specific policy advisor who is mainly responsible for supporting the further development of the ZIG".*

Table 10. Activity table Staff office CPZ

Activity	Yes	Yes, but not by this body	No	Unknown/Unclear
Staff office				
CPZ staff bureau coordinates and supports the implementation group.	X			
CPZ staff bureau ensures that one message was propagated by healthcare institutions, professionals, industry, and patient associations when it came to introducing the healthcare standard and the client version of it.	X[58]			
Communicates with the field.	X [61][62] [63]			
Manages and facilitates Kennisbank.	X			

7.8.4 Implementation Group

For the implementation group their primary task was to develop the ZIG, the implementation plan, and the client version of the ZIG. The implementation group was cancelled in 2018 because it had fulfilled its tasks, as stated in a proposition [64] of the CPZ board. The follow-up [65] were the maintenance and management of the ZIG,

the central direction in the development of multidisciplinary guidelines and a model related to the individual birth plan. These tasks were addressed by the bureau of CPZ itself to further develop this together with the National umbrella organizations.

Table 11. Activity analysis implementation group

Activity	Yes	Yes, but not by this body	No	Unknown/Unclear
Implementation Group				
Creates the client version of the ZIG	X			
Identifies bottlenecks in preconditions that are necessary for or were required for the implementation of the ZIG	X [5]			
Identifies solutions for bottlenecks and passes them onto the board.		X		
Identifies the lack of underlying guidelines that do not match the scope of the care standard		X[66] [67]		

7.8.5 Support group VSVs

The implementation plan also described activities for the so-called support group VSVs. It should be noted that this, again, turned out differently in practice. The support group was initially responsible for two components: Integrated funding and the implementation of the ZIG. During the interview it was mentioned the VSVs support group became the task force integrated funding. Naturally, the focus of the taskforce was on integrated funding. It was however mentioned that the taskforce noticed that a certain degree of organization was required in a VSV to be able to switch to integrated funding. Therefore, the task force did carry out a number of activities regarding supporting the implementation later on. But the CPZ bureau had mainly taken on the tasks of facilitating the field during the implementation from 2017. In addition, it was stated that the Federatie van VSVs also jumped in to support the VSVs when it comes to the implementation of the ZIG.

Table 12. Activity analysis support group VSVs

Activity	Yes	Yes, but not by this body	No	Unknown/Unclear
Support group VSVs				

Facilitates learning networks.		X		
Organizes meetings for the exchange of information for and by VSVs.		X		
Retrieves and shares best practices.		X		
Increases the awareness and implications of the standard of care among healthcare providers and pregnant women by making information and training materials available.		X [68]		
Makes a toolbox available (based on best practices) with a support offer.		X		
Provides a clear health care provider version (summary) of the care standard or a digital care standard.		X		
Supports the VSVs in their choices when working together in a shared electronic file.			X	
Identifying any bottlenecks in the (financial) preconditions that are necessary for a good implementation		X		
Identifying the lack of underlying guidelines that do not match the scope of the Integrated Birth care standard.		X		

7.8.6 Support to VSVs per communication

The implementation plan [5] mentioned that Support needed to be offered to the field in the form of communication, it did not specify who should perform the activities other than CPZ itself. It was indicated that a lot has changed over the years in terms of communication. In the pioneer phase, communication was used reactively instead of proactively. From 2017, CPZ has started to systematically plan the communication.

Table 13. Activity analysis Support per communication

Activity	Yes	Yes, but not by this body	No	Unknown/Unclear
Support per communication				
CPZ has taken the initiative to start the collaboration in a communication consultation	X [61]			

CPZ is taking the lead in terms of communication activities related to the ZIG.	X			
CPZ, takes the lead to convert the joint wishes and objectives in the communication consultation into a framework communication plan and a joint action plan of the organisations supports and unites.				X [69]
CPZ draws up an inventory of the current communication of the affiliated organizations and the CPZ and their coherence.	X [62][70]			

7.8.7 Factors that were of influence

All three interviewees mentioned the not exactly favourable CPZ reputation at the start of the implementation of the ZIG, this can be seen as a hindering factor. It was cautiously mentioned that at the start the communication concerning CPZ by other external parties may also have played a negative role. The following was stated: *''VSV members did not subscribe to our newsletter or watch what we did on social media because they had already determined that we were incompetent. So, they did not want to have anything to do with us".* They also indicate that the field thought the Integrated Birth care Standard was imposed by CPZ while it is in fact imposed by the ZIN [4]. Even today this line of thinking still needs to be addressed. In fact, it is a professional standard of the organisations of birth care professionals, the Patiëntenfederatie and health assurance companies agreed upon.

As mentioned before, the taskforce integrated funding was established to support the implementation of integrated funding. The taskforce made the first attempt from CPZ to support the field. They however did this in a very activistic manner since there was real emphasis by the government then to switch to integrated funding. This gave rise to the idea that integrated funding was initiated from within CPZ. They mentioned that a lot of VSVs were against integrated funding and linked that to integrated birth care which could mean that they were in no rush to start the implementation. Next to that the belief was integrated funding would become mandatory and it was a project that was already started long before the introduction of the ZIG which could also be of influence.

Next to that it was indicated that it was an extremely chaotic time especially in 2016, which could also have an influence on supporting the implementation. A lot had to be done at the same time: The implementation plan, the matching indicators, and the client version of the ZIG. In addition, those documents had to be completed in a short period of time. The following was indicated about the development of the

implementation plan: *''I think some inaccuracies slipped through".*

A lot also changed in the organization of the CPZ itself [53] during that same time. A new chairman of the board was recruited and the CPZ bureau was *built up.* The implementation plan was developed by the implementation group led by a freelancer. The working group paid too little attention to and had too little knowledge about the best way to organize the regional networks. The following was stated: *''Everything was conceived along the lines of the content. That motivates caretakers but there is a limitation how far one can go without proper regional coordination. What is needed to function well as a network organization and which conditions must be realized and how was not clearly understood by the developers of the implementation plan".*

What also influenced supporting the implementation was that the preconditions for implementation were not in place. Before the Integrated Birth care Standard was introduced, it was not considered whether this could also be achieved with the existing means. The ZIG had to be implemented budget neutral. Which implicitly indicates: *''We can do it with the same amount of money and we also provide the preconditions ourselves".* The starting point for the ZIG was also that finances should not be discussed. Therefore, one did not think of a cost-feasibility test and ZIN also has never indicated that a feasibility test should be done. One of the other conditions is trust between the different care providers within the VSVs, this needs to be in order when carrying out the integrated birth care policy. Professionals must have confidence in each other's competencies and the ability to take on responsibilities when working in an integrated manner.

Another precondition was the degree of organization within a VSV. When the ZIG was drawn up, a high degree of organization within the VSVs was assumed. While the reality was that many VSVs were barely organized. It was stated that *''If the members of the VSV came together, it was only once or twice a year, there was not much organized for drawing up a car pathway, measuring client experiences coordinating the regional multidisciplinary consultations, taking part in the audits and other quality management".*

Furthermore, the digital data exchange between the electronic patient dossiers of the hospitals and the midwifery-practices is seen as a precondition for implementation the ZIG as to exchanging information about the client, exporting information to quality dashboards and so on. This is was not yet accomplished time. Perined and the software companies for electronic patient dossiers play a major role in this, however Perined's database was not prepared for this type of new quality management and integrated collaboration. Secondly, it was assumed that a VSV was one organization that would switch to integrated funding with a shared electronic file. Later on, that idea of a shared electronic file has been abandoned, since every professional keeps their own file, now the aim is that they communicate quickly with each other and quickly pass on the essential information. Baby connect is the action program that supports the VSVs with the latter. This is financed by the Ministry of VWS.

In addition, it was mentioned that the appropriate funding was not available. This concerns the fact that the ZIG has been drawn up from a care content perspective,

but appropriate funding for all the coordination and consultation had not been considered. This regards the fact that a feasibility test was not performed before the ZIG was established.

Another limiting factor was the focus during the time ZIG was presented, was on ReproQ, since there was a riot about this. At the end of 2014, the CPZ [71] asked research agency Mediquest which client experience questionnaire is most suitable for national implementation. To this end, three most used lists have been intensively compared: the ReproQ, the PCQ and the LadyX. June 2015, the board of the CPZ adopted the advice issued by Mediquest that the ReproQ is the most suitable questionnaire to visualize differences in perceived perinatal care between the *'' lijn-en aanbiederoverstijgende"* birth care organisations. It was indicated in a memo [72] after various meetings in mid-2016 it still appeared no agreement had been reached between the aforementioned parties, due to major conflicting interests and views. This was said to dominate many meetings. In CPZ's sharepoint there were indeed found many documents/meetings concerning the ReproQ. It could therefore certainly be this case that this was a limiting factor when it comes to supporting the implementation of the client perspective into the organization of birth care.
ZIN [73] has forced to make the NPS score mandatory instead. This score only provides a minimum of information about the client's perspective on birth care. A lot of VSVs did not agree and this could therefore also be of influence on the implementation of the ZIG.

7.8.8 Partial activity conclusion CPZ

CPZ carried out most activities and still does. They have carried out 23 from the 25 exanimated activities, this is shown in Table 9, 10, 11, 12 and 13. The only activity that was not carried out was: *Supports the VSVs in their choices when working together in a shared electronic file.* For one activity no ambiguous answer could be obtained**:** *CPZ, takes the lead to convert the joint wishes and objectives in the communication consultation into a framework communication plan and a joint action plan of the organisations supports and unites.*

7.9 PERINED

On the website of Perined [74] it is stated that *''Perined's aim is to improve the quality of perinatal care in the Netherlands by looking together to see how things can be improved. Perined coordinates and facilitates the perinatal audit and the perinatal registration".* It was stated that they see their role as: *''We are the data broker in birth care".* Their tasks are in data collection, monitoring, evaluation and feeding back information. For birth care this means that they monitor on different levels. It was stated that *''On a woman-child level we record the interventions and the outcomes and things like that. But we are also the database manager of the CPZ. About the monitoring, wherever data needs to be recorded we are responsible for the database underneath it and we also give feedback on the data".* Next to that they also supply or calculate [75] the indicators. In addition, Perined organizes the process of Perinatal Audit.

When it comes to responsibility it was mentioned that Perined does not feel that they have a responsibility regarding achievement of the objectives described in the ZIG. However, it was stated that *'' We are in favour of improving care and integrated birth care is an improvement of care and we provide information for this. So, we are not concerned with the fact that care must be integrated. No, we just provide that information about how the care is going and how it can be approved according to the benchmark information that Perined also supplies".*

They contributed to the implementation of the Integrated Birth care Standard by carrying out the monitoring activities that were mentioned before.

When it comes to participation in perinatal audit and perinatal registration by healthcare providers, Perined mentioned that this is simply mandatory. In birth care, the provision of data is automatic since the data comes directly from the medical file, but then it is of great importance that the medical file is accurate. It takes a lot of time for the health care providers to verify if this is done accurately. Concerning handing over the data it was stated that *''That is a process that we are working extremely hard on together with the professional associations and CPZ. So, we do our best to get them to participate in the registration and the audit, by improving the delivery of information".* In addition, it was mentioned that Perined tries to encourage participation by feeding back information and outcomes. They find it especially important to provide information that is useful for the care providers and think that it will keep them motivated to participate, they should benefit from it themselves.

Regarding the Perinatal Web Based Dossier Perined mentioned that the idea used to be that there should be one dossier that every care provider will work in but that they have let go of that idea for a long time now. Furthermore, it was stated that *'' You just have to work in the same way, because there is always a different file, because you always have to communicate with another healthcare provider or in another part of the country, or with your fellow internist in the hospital or that sort of thing. There must therefore always be exchange, so the aim is not so much to create one file in the region, but to make data exchange possible in a standardized way"* According to Perined, this can mainly be achieved through unity of language.

7.9.1 Factors that were of influence

One of the promoting factors Perined mentioned is the extra investments in ICT.

Next to that it is beneficial that there is more attention for client-generated information in addition to information generated by care providers.

Another promoting factor is the formation of VSVs. The fact that all care providers involved in birth care are bundled is an advantage for Perined because it is a discussion partner, so that the ICT and the feedback can be tackled better.

Furthermore, it was mentioned that ''For decades, birth care has been chain care and care providers have worked very well together. That is also a great advantage and you see that this care is also a particularly good standard, that you are simply building on something that has always been there".

One of the hindering factors is according to Perined the financial resources when it comes to ICT they said: *"Money is important to be able to monitor and evaluate properly"*. It was indicated that data exchange costs more and more money and increasingly higher requirements are imposed on it. They think a new rate should be set by the NZa as it is not sufficient at the moment. Besides that, too little money is available, the distribution of money is also distracting. It was stated that: *'' The discussion about integrated birth care and integrated funding are also intertwined. But they are separate from each other, but integrated care is often contaminated by those integrated funding ideas. And that is difficult. Because care providers are often entrepreneurs, and integrated funding is quite a difficult one, because who gets what money?"*.

What also can be seen as a hindering factor is the fact that the scale increases, which means that the individual caregiver's grip on the whole is diminished.

One of the most important bottlenecks according to Perined is that maternity care often does not have a registry system in place, which means that data cannot be collected from those practices. They furthermore indicate that maternity care is an important part of birth care since a third of the budget goes to them.

7.10 ZONMW

ZonMw is an organisation [76] which stimulates health research and healthcare innovation. They focus on health and prevention, particularly vulnerable groups are important. ZonMw indicated that they indeed stimulate scientific research and sometimes also projects to implement improvements and, in any case, develop knowledge and also help stimulate that what is being developed is also applied in practice. Furthermore, it was stated that *'' We work in programs, and these are actually subjects and assignments that we usually receive from the Ministry of Health, Welfare and Sport"*. The program [77] that concerns birth care is ''Zwangerschap en geboorte". The first program mainly focused on knowledge that contributes to reducing the baby mortality rates and the cooperation between professionals that are involved in birth care.

The second version of the program [78] focuses on stimulating the development and implementation of knowledge in order to contribute to perinatal and maternal health in general, optimizing pre- and neonatal health screening and reducing differences in perinatal and maternal health. The content of the program focuses on four main subjects: Prevention in the form of health promotion, prevention in the form of pre- and neonatal screening and diagnostics, care interventions in the integrated birth care chain and organization of integrated birth care. The program therefore stimulates research within four pillars: the development of interventions, the evaluation of (cost) effectiveness of interventions, the implementation of interventions and the long-term effects of interventions. Furthermore is mentioned in the program text, that the following criteria apply to the research that is to be funded within these pillars: The research must link up with the regional and national knowledge infrastructure so that infrastructure is further strengthened, the research should pay

attention to vulnerable (prospective) pregnant women in the context of reducing health inequalities, the research must be multidisciplinary and cross-lined in order to contribute to the reinforcement of integrated birth care and the research should contribute to the participation and reinforcement of clients' own direction and their loved ones (Mother and child in the lead). It became increasingly clear that especially for vulnerable groups, the figures are less favourable, as a result, attention had to be drawn not only to cooperation between care providers themselves, but also to cooperation with youth care and municipalities.

ZonMw has grant groups like ''improve quality integrated birth care"[79] and ''perpetuation and securing multidisciplinary knowledge infrastructure birth care" [80] and many others. In all these grant groups it is stated that it is in line with the ZIG or that the results of that research are relevant to the ZIG. In addition, they also play a role in stimulating networks. A national knowledge network for birth care has been formed with the ZonMw Pregnancy and Birth program. Various regional consortia [81] exist within this. The consortia are seen as the knowledge networks.

ZonMw describes their responsibility, when it comes to integrated birth care, as *'' In particular developing knowledge in integrated birth care, with the same goal as CPZ, to promote the health of mother and child"*. They think it will help to improve the cooperation when it comes to accomplishing that goal. They furthermore state *'' The responsibility lies in that we really try to find new knowledge and innovations for this. ZonMw does not develop this knowledge themselves, but encourages the field to take this up, but of course we do check whether the applications that come in meet the Integrated Birth care Standard and which do not"*.

ZonMw indicated that they do not have a direct role when it comes to implementation of the ZIG but they did state: *''Some consortia did support the implementation of the ZIG. Next to that we take part in a coordinating meeting whereby we coordinate with representatives of those consortia and have them coordinated, especially with CPZ"* . Furthermore, they state that they try to set the conditions that they finance, that that fits the integrated standard of care and always coordinate with all stakeholders. The consortia also participate in a coordination meeting with the CPZ. Sometimes support activities were carried out by the consortium that would benefit all VSVs so that it did not always apply only to individual VSVs. They listen to the needs of the field and see that as their strength. It is therefore a very bottom-up approach. In addition to conducting research, the consortia also offer more practical support like aligning protocols. It is however indicated that it is not a formal task of the consortia to implement the ZIG. Which means it is not really their responsibility, but a few of the consortia take it up themselves. This is a bottom-up approach since they respond to the demand from within the region. The representative indicated that together with CPZ the consortiums could agree even more together which subjects are still underexposed and where research is needed.

7.10.1 Factors that were of influence

One promoting factor could be that it is mainly the coordination that takes place between the field and the CPZ. Furthermore, it was stated that'' *The experiences are exchanged, products that have been developed, those consortia map that and that they all know from each other about oh yes you created this and you have made that. So that can help. Sharing more knowledge makes it easier.".* What is very important is that there is in any case coordination with all those parties involved in birth care, what knowledge there is, and how others can use it.

No hindering factors were mentioned, but it could be seen as hindering that there is no clear way on how to support VSVs when it comes to implementation of ZIG for the consortia. It was indicated that the consortia and CPZ could explore whether they could give more substance to this together.

7.11 NVK

NVK was one of the parties where no interview could be conducted. They were seen as one of the most important parties in the development of the ZIG, together with the KNOV and NVOG. This can be inferred from a letter [82] from the CPZ to the board of NVOG, KNOV and NVK.

The role of the NVK is described on their website as *''The Dutch Paediatric Association (NVK) stands up for the health of children and the interests of paediatricians. On behalf of all paediatricians, the NVK is one voice towards the many players in the field, such as healthcare providers, health insurers, politicians, and the media".* What that means for integrated birth care could not be determined, except that they are part of the CPZ and should therefore be invested in their role in integrated birth care. Next to that does NVK [12] takes part in the directors' consultation and the Integrated Birth care Standard working group. They have also participated in the comment round of the ZIG, they have published a message on their website [83] where members were given the opportunity to comment.
When it comes to the ZIG, it was found that it was not published on their website, although other care standards[84], for example for diabetes are available.

However, they do publish news items on their website regarding the integrated birth care. Sometimes reference is also made here to the CPZ or their newsletter [85] and Kennisnet Geboortezorg. It can also be seen that updates are communicated since, for example, they posted a message about the birth care landscape [86], which was only developed recently.

There was no possibility to ask what activities were carried out, but the 2020-2022 agenda [87] mentions a number of ongoing activities of the NVK including: *" Participating in the implementation of integrated birth care. "*. This has been formulated quite generally. Another subject in the ZIG that is of great importance is client participation, in the agenda the following ongoing activity is mentioned: *''Supporting initiatives in the field of patient participation, such as shared decision making and the establishment of children's advisory councils in all hospitals"*. This means that they do include some topics from the Integrated birth care standard in their activities.

7.12 NVZ

On the website of NVZ [88] their general role is described as: ''*The Dutch Association of Hospitals (NVZ) is the branch association for general hospitals and specialist institutions in the Netherlands. We represent the interests of our members in terms of healthcare, economic and social matters. In addition, we support our members with their knowledge development, for example through training and digitally through various tools and NVZ Kennisnet*". Birth care is a specific theme for the NVZ. Their role in integrated birth care is expressed in the fact that they participate in the directors' consultation [11] and the Integrated Birth care Standard working group of CPZ. Themes they are specifically involved in are integrated funding and outcome indicators. Other themes such as labour market problems and the right care in the right place are not specifically approached separately from NVZ for birth care but are worked on in a broader context.

On their website [89] it is found that they are engaged in shared decision making. They have created a program called ''Beslist samen'' in 2018. Although this was not explicitly focused on birth care, it is a subject that is highlighted in the ZIG. Next to that they also have a working group [90] for birth care. This consists of employees from the hospitals who work in or otherwise professionally deal with the organization of birth care. When it comes to the channels, they use to inform members they work with their own Kennisnet [91]. This has several functions including: News, documents, examples, and the possibility to ask questions. News Items are not public when it comes to birth care, this is only available if you are a member on Kennisnet. It can be assumed that news items are used.

7.13 ZN

The general role of ZN is described on their website [92] as: ''Health insurers Netherlan*ds represents the interests of all health insurers. The association's goal is to support health insurers in their mission: to achieve good, affordable, and accessible care for all policyholders, aimed at promoting health and quality of life*". For birth care it is not stated what their role is but just as the other mentioned organizations they are part of the CPZ. They [12] also take part in the directors' consultation and the Integrated Birth care Standard working group of CPZ. When the ZIG implementation plan had to be developed, they were also in the implementation group.

The channels they use to inform their members about integrated birth care are their website and news items [93] published on their website.

Chapter 8. Conclusions

8.1 INTRODUCTION

In this chapter the answers to the sub-questions of this study will be described after which the main question of this inquiry will be answered.

8.2 CONCLUSION VSVS

In chapter 6, the results on the sub-question *"To what extent are the activities described in the implementation plan carried out?"* regarding the VSVs are presented. It can be concluded that not all activities are performed equally well by all VSVs. According to the telephone interviews only four activities were carried out by the majority of the VSVs which means that the other six activities were carried out by the minority. The telephone interviews showed that working with client participation, a coordinating care provider and an individual birth care plan were carried out the least. The indicator set analysis, however, showed the majority of the VSVs were working with an individual birth care plan and a coordinating care provider. If it was possible to use the latter named results of the indicator set in the overall analysis, it appears that the total of VSVs carries out the majority of the activities. It can therefore not be said with certainty that most of the activities were carried out by the minority of the VSVs.

The VSVs could be divided into three groups to see if there were differences in the performance of activities. On the basis of the group analysis of the telephone interviews can be concluded there is a high percentage of VSVs carrying out most activities, with 40%. The majority of the VSVs received an average or a low score. When it came to the high group it appeared that all activities are carried out by the majority of VSVs and if they were not carried out yet, they were ' 'In development''. The only thing that stood out was that working with an integral dossier deviated from the other activities.

For the average group it can be seen that four of the activities are carried out by the majority of the group and 6 activities by the minority. Those activities that were carried out by the minority were: Individual birth care plan, coordinating care provider, multidisciplinary training, joint website, client participation and integral dossier. In this group, few activities have been assigned " in development " and there is also a high level of not discussed.

When it comes to the low group what stood out was the high level of not discussed. This means that the actual situation could be better in reality, the VSVs that are in the low group could therefore be actually in the average or high group. The level of not discussed for nearly every activity is above 60%. In addition, it can be concluded that the level of ''in development'' is also low in this group just as for the average group. The only activity that was carried out by the majority of the low group was working with integral care paths or protocols.

When it comes to the additional results, there were a number of subjects that

were mentioned by a few VSVs, namely: Kennisnet, the implementation tool and vulnerable pregnant women. It can be concluded that many VSVs are therefore aware of Kennisnet and the implementation tool. When it comes to ''vulnerable pregnant women'' it turns out that this is a subject that gets attention from the VSVs.

Factors influencing the implementation of the policy have also been identified. Those factors were: Finance, capacity, support for the implementation and relationship primary care providers and second line care providers. When it comes to finance, it was mostly mentioned that the budget is insufficient for implementing the ZIG. What it comes down to, concerning capacity is, that the VSVs feel like they have insufficient time and people for all the work they need to put in. With support for implementation the main point is that the members do not stay tuned in or that some activities do not land well. When it comes to the relationship between primary care providers and second line care providers, good or bad it could be of influence when carrying out the policy. It became clear that there were more VSVs who thought that the cooperation between the different care providers was going well than those who thought that it was going badly.

8.3 CONCLUSION NATIONAL UMBRELLA ORGANIZATIONS

In chapter 7, the results on the sub-question "*To what extent are the activities described in the implementation plan carried out?*" regarding the National umbrella organizations were presented. It became clear that none of the National umbrella organizations carried out all of the described activities. For NZA, ZN, NVK this could not be determined. The KNOV, Bo geboortezorg and CPZ carried out the majority of the activities. The NVOG, Federatie van VSVs and the Patiëntenfederatie Nederland carried out the minority of the activities. From the activities that were carried out the least by the KNOV, Bo geboortezorg, the NVOG and federatie van VSVs three had to do with an association other than their own: 1) *Identify which training courses are offered by other parties*, 2) *Inform the support organization of the CPZ and the other industry and professional and patient associations about their own activities regarding the implementation of the Integrated Birth care Standard and look for cooperation and synergy between their own activities and the activities of others* and 3) *Actively share proprietary solutions with other regions and share solutions, models, and documents through CPZ.*

Another activity that was carried out the least was: *Ensuring or encouraging employees or members to participate in multidisciplinary consultations for joint risk assessment.* This was also the issue where the different parties could not agree on during the development of the ZIG.

The organization contributed to the further development of monodisciplinary guidelines to multidisciplinary guidelines, standards, and agreements is another activity that was carried out the least.

The best carried out activities by the NVOG, KNOV, Patiëntenfederatie Nederland and Bo geboortezorg were: 1)*The associations have the channels to inform*

their members about the new insight from the Integrated Birth care Standard and 2) *Identifying bottlenecks around the introduction of the integrated birth care at CPZ.*

For Patiëntenfederatie Nederland it became apparent that they carried out the minority of activities namely four out of ten, however they are engaged in most activities. Since three activities were carried out partially. The activities that were not carried out were: 1) *Carry out own activities that promote the application of integrated birth care in accordance with the Integrated Birth care Standard,* 2) *Looking for cooperation and synergy between own activities and the activities of healthcare professionals and professional association* and 3) *Communication about relevant aspects of the Integrated Birth care Standard, including trying to get pregnant women / parents involved in participation in advisory boards of VSVs.*

For CPZ it became clear that nearly every activity was carried out and thus performed well. The only activity that was not carried out was: *Supports the VSVs in their choices when working together in a shared electronic file***.** The explanation for this was that another organisation got assigned this task therefore there was no role for CPZ anymore, concerning this**.** It furthermore became apparent that many activities that CPZ had to carry out were not carried out by the bodies described, due to the changed governance. For one activity no conclusion could be drawn because no unequivocal answer was given during the interviews. This concerned the following activity: *CPZ, together with the support group VSVs, takes the lead to convert the joint wishes and objectives in the communication consultation into a framework communication plan and a joint action plan of the organisations supports and unites.* However, it can be concluded that a lot has been done regarding communication by the CPZ.

For Perined and ZonMw it became apparent that they both fulfil a role when it comes to integrated birth care, although no activities were described for them in the implementation plan. ZonMw encourages the field to develop knowledge when it comes to integrated birth care. In addition, some consortia have taken up this role and supported VSVs with the implementation of the ZIG. Perined is mainly concerned with the data collection, monitoring, evaluation and feeding back information when it comes to integrated birth care.

8.4 FACTORS THAT WERE OF INFLUENCE

To answer the sub question:*" Which factors influence the implementation of the Integrated Birth care Standard?"* interviews were conducted with the National umbrella organisations. Most organizations identified several factors influencing the implementation of the policy. Coolsma described that there are several factors that could be of influence concerning the implementation of a policy. Those factors are: The characteristics of the policy and policy theory, the characteristics of the implementing organization, the characteristics of the implementers and the characteristics of the environment. The factors that implementers have appointed will be subdivided into these four factors where possible.

8.4.1 The policy and policy theory

When it comes to the characteristics of the policy and policy theory, it was mentioned unclear and unexplained goals and the degree of disagreements about means and ends of the policy affect the feasibility of the policy. CPZ indicated that there are things included in the implementation plan that should not have been there, like some of the bodies mentioned within CPZ or certain activities under a certain body. It has been developed with too little knowledge, although the creators did the best they could. In addition, due to enormous time pressure from Zorginstituut, the plan was created in a quick manner. Later on, in 2018 a new plan of action was developed by CPZ and shared with the National umbrella organizations. This is the strategic agenda 2018-2022. In this agenda objectives and activities have also been identified.

Furthermore, some objectives and or activities of the implementation plan were overambitious, concerning the VSVs which is also of great influence according to Coolsma this could have led to cynicism, this therefore influenced the implementers. Another policy feature that was mentioned was the extent to which policymakers provide the intended implementers with the necessary resources. It was indicated by most of the National umbrella organizations that the necessary resources like appropriate funding and capacity were not in order for the VSVs. This also explains why not all activities of the policy have been carried out, it was often indicated that it was not clear who should pay or should be responsible for a certain activity.

Policy theory is the set of assumptions that underlie a policy. The implementation of the ZIG was based on a certain level of organization within a VSV, this was an assumption that was incorrect in many cases which was also of influence for the implementation of the ZIG. The VSVs first had to work on getting everyone together before they could start with the implementation and actually provide integrated care. Although one organisation indicated that the fact that chain care already existed in birth care is promoting, since the working method described in ZIG builded on something that already existed. Another incorrect assumption was that the digital data exchange already was on a certain level. This consisted of two components: The mutual data exchange between the care providers and the client versus the secondary data use for research and quality purposes to Perined. The first level has to do with the fact that maternity care often does not have a registry system in place, which means that no data can be collected from them or be exchanged. The secondary data use problem is in the discipline of filling in the data of the care providers, correct export software and the way in which the Perined registration is built up. This needs to be modernized.

8.4.2 The implementing organization

This research concerned a horizontal policy network, when discussing the implementing organization. The policymaker is dependent on various organizations, namely the National umbrella organizations, and especially CPZ since they are the network organization of integrated birth care. The existence of CPZ is seen as a promoting factor and was mentioned by two organizations since they facilitate and

connect when it comes to the parties in the birth care field and the implementation of the ZIG. There does seem to be confusion about the role of the CPZ. Many National umbrella organizations place a great deal of responsibility with the CPZ, while CPZ indicates that these National umbrella organizations themselves must also play a role in supporting the implementation of the ZIG. In addition, many VSVs assume that the implementation of the ZIG must be done in the name of CPZ, while this is the responsibility of the Zorginstituut. The image of CPZ that a lot of VSVs had was also an obstacle when it comes to the implementation. They were the party that had to facilitate the implementation of the ZIG, and the first impression of them was because of the commotion around the then chairman not positive. In addition, CPZ's first statement to the field came from within the task force, which at the time was totally focused on integrated funding instead of the implementation of the ZIG. This also did not contribute to a positive image, because many VSVs were not in favour of integrated funding. They indicated that their image seems to be improving currently.

8.4.3 The implementers

Looking at the two layers of implementers, there are several factors that play a role. The care providers who are gathered in a VSV, were before the implementation of the ZIG working in a certain way, this naturally differed per profession. During the implementation of the ZIG, these parties had to cooperate even more intensively than they already did while in many cases there was a lack of trust and the relationship between the gynaecologists and the midwives. This was seen as hindering. The ZIG and the implementation plan deal with the VSV as a whole and not per profession. The characteristics implementers have are: " knowing ", " the willingness ", " being able to " and " having to ". The VSVs were aware of the integrated birth care policy and the related documents but it was indicated in some cases that the policy had not landed well when it comes to the VSVs. This could have something to do with the fact that the ZIG and the policy were not communicated properly in 2016. Since a lot was going on with the then chairman. When it comes to ''the willingness'' of the VSVs, it can be assumed that they supported the goals of providing better birth care and reducing perinatal mortality. They however did not agree on all aspects, such as the joint risk assessment of a client and the use of NPS was also debated often. On those parts they may have been less willing to implement the policy. In addition, the first statement of the CPZ in terms of implementation of the ZIG regarding integrated funding probably played a role, the VSVs got the impression CPZ mainly focused on integrated funding, this resulted in resistance and may therefore may have delayed the implementation of the ZIG. The VSVs also had to be able to implement the policy, this brings us back to the appropriate funding and capacity, the access to those resources were not in order. Assumably, the implementation tool did help the VSVs to achieve better implementation. Regarding the ''having to'' characteristic can be said that working with the ZIG was an obligation of the VSVs and the field, they however got room to shape certain activities, as they did. The telephone interviews and the indicator set

measure the progress of the implementation in that way influence is exerted. It can be assumed that this made the VSVs feel more compelled to implement the policy.

Looking at the second layer, the National umbrella organizations. The knowing characteristic was quite high since they were all part of CPZ during the creation of the ZIG except for federatie van VSV's. Which means they knew what the policy entailed. Regarding the ''willingness'' can be concluded that most National umbrella organizations were willing to implement the policy. It was indicated that the motivation to change and implement the ZIG is high since child mortality was too high in the Netherlands. The KNOV was hesitant at first, since certain objectives did not match with their motives, however they have carried out many activities to support the implementation of the ZIG. For the federatie van VSV's can be assumed that they were not fond of CPZ at first, which could also have an influence on their members. This could have made the implementation more complicated since the VSVs were under the impression that CPZ wanted that they carried out the integrated birth care policy. For the Patiëntenfederatie Nederland the client's perspective is the main focus and they think this has not been sufficiently included in the ZIG, which could have made it harder for them to support the implementation. The ''being able to'' characteristic was not an issue for the National umbrella organizations when it comes to having enough resources to support their members with the implementation of the ZIG. Only the federatie van VSV's indicated that they do not have the financial resources to carry out the total policy. In addition, several things were at play at the start of the ZIG for some organisations, which resulted in the fact that the focus was not entirely on the implementation of the Integrated Birth care Standard. Bo geboortezorg was establishing their organization during the same time. CPZ indicated that it was a chaotic time where a lot of things needed to be arranged and determined. The ''having to'' characteristic might not have been present enough for the National umbrella organisations since, as mentioned earlier, most of the activities they had to carry out were described as ''possible''.

8.4.4 The environment

The last factor that can be of influence are the characteristics of the environment. From within the Ministry of VWS, the taskforce integrated funding within CPZ got the assignment to switch from monodisciplinary funding to integrated funding within two years, it was assumed that this would become mandatory for the VSVs. This can be seen as a disturbance factor for the implementation of the ZIG since this was intertwined and the focus seemed to lie on implementing integrated funding. Later on, the idea was abandoned that it would become mandatory, which also caused a lack of clarity.

In addition, the riot concerning the ReproQ also drew attention away from supporting the actual implementation of the ZIG, since it had to be decided which was the best client experience measurement instrument and there was a lot of discussion about this too.

Another factor that was of influence when it comes to the environment is the help that some consortia offered to the VSVs for the implementation of the ZIG, it can on the other hand be seen as hindering that it was not established as a formal task for each consortia, therefore you also get differences in the levels of implementation within a VSV.

8.4.5 Factors that could not be subdivided

A number of factors that were mentioned could not be subdivided based on the Coolsma model. One of those factors was: An adequate existing communication level from an organization to their members was already existing.

When it comes to data exchange, it was promoting that there came more attention for client generated information. Next to that, additional investments were made regarding the ICT for birth care. Another promoting factor regarding data exchange is the formation of VSVs.

The federatie van VSVs mentioned they see their own existence as a promoting factor since they are the advocates of the VSVs.

It was also seen as promoting that the content of the ZIG was made more concrete in the client version. This was mentioned by the Patiëntenfederatie Nederland who created the client version.

CPZ developed tools or products which were referred to as promoting, since this can make the implementation more practical.

8.5 ANSWER CENTRAL RESEARCH QUESTION

Based on answering all sub-questions, it is possible to answer the main question of this study:

"To what extent has the integrated birth care policy been implemented as intended?"

Integrated birth care must be provided by all kinds of care providers in the Netherlands. This study looked at the implementers at the bottom of the organization who implement the integrated birth policy in practice. Those are the VSVs. In addition, the National umbrella organizations that also play a major role in integrated birth care policy were examined. For these two layers different objectives and activities are described in the implementation plan. In general, it can be said that the implementation of integrated birth care of the performers is on the right track. However, the policy is not fully implemented yet and there is variation between VSVs as between the different National umbrella organizations.

Concerning the implementation of the policy, it can be concluded on the basis of the overall analysis that the minority of the investigated activities were carried out by the VSVs. However, this cannot be said with certainty since the indicator set

outcomes differ from the telephone interview outcomes on certain activities. The activities that were carried out by the majority of the VSVs according to the telephone interviews were: Working with integral care paths or protocols, client experience measurements, MDO and a quality policy. It also emerged that the activities are completed in different ways, for example, is each pregnant woman discussed during an MDO or on indication. The activities that have not been performed as intended were: Working with multidisciplinary training, joint website, client participation and integral dossier. According to the telephone interviews: Working with an individual birth care plan and a coordinating care provider were also not carried out as intended.

Whether the policy was carried out as intended differed per National umbrella organization. CPZ, the KNOV and Bo geboortezorg carried out most of the activities that were described for them and therefore the implementation was as intended. Although the ''who'' changed within CPZ they did carry out the ''what''. As the facilitator of birth care, they were expected to take the lead when it comes to National umbrella organizations and the implementation of the ZIG and it can be concluded that they did. The organizations that carried out the minority of the activities they were supposed to, were the NVOG and Patiëntenfederatie Nederland. This also applies to the federatie van VSVs, but at the time when the implementation plan was drawn up, they did not yet exist, so they were not mentioned as a National umbrella organization in the implementation plan. If the policy had been implemented as intended, of course, all activities were carried out by the organizations that had to do so, this is however not the case and may not be entirely realistic either, because in most cases policies are distorted or changed.

Chapter 9. Discussion

9.1 INTRODUCTION

In this chapter the results will be interpreted, after that the strengths and limitations of this study will be discussed. Lastly recommendations will be mentioned.

9.2 INTERPRETATION OF RESULTS

The aim of this study was to perform a process evaluation of the policy of the ZIG, where the implementation phase was the focus. This was to provide insight on whether the policy is being implemented as intended and to what extent. To that end, two groups of implementers were examined: the VSVs and the National umbrella organizations. For both layers became apparent that the integrated birth care policy was not totally carried out as intended. The VSVs could be divided into three groups, high average and low. This shows that there is a substantial difference between the level of implementation when it comes to the various VSVs. For the National umbrella organizations also became clear that there were differences between the degree of implementation of the policy. There were some organizations that carried out the most activities and others the minority. It is not a surprising result that the policy has not been fully implemented since policy implementation often turns out differently than was intended. Earlier the influencing factors have been ranked on the basis of Coolsma model[22]. Here it is examined which explanations are mentioned in the implementation literature and in some cases whether this corresponds with the factors mentioned by the implementers.

Boise [94] describes in his book on ''Making Health Policy'' that the implementation phase is often the most neglected phase in the process of policy making as the most important one. He furthermore describes that policy implementation is often separated from the problem identification phase and the policy formulation phase. To elaborate more on the latter Wright [95] mentioned in a technical report on the importance of health policy implementation that planning for policy implementation is done in the best manner when the policy is formulated. If this is translated into the integrated birth care policy it can be said that when the ZIG was developed and eventually became mandatory in 2016 by ZIN, it seemed to be a relief that the policy was finally in place without really thinking about the implementation. The implementation plan was not part of the development of the ZIG, this plan was developed later and became available one year later in 2017. Furthermore, it was mentioned earlier that the implementation plan was developed with too little knowledge and with time pressure. The fact that no attention was given to how the policy should be implemented during the development of the policy may have been of great importance when looking at the fact that the policy is not yet implemented as intended.

Coolsma [20] described that a factor that is of influence could be in the policy features. One of the policy features was the extent to which policymakers provide the intended implementers with the necessary resources. According to Hogwood and

Gunn [96] in a list of ten preconditions for what they termed ''perfect implementation'' was also stated one of these preconditions is: *''Adequate time and sufficient resources are available''*. One of the things that was at play during the implementation of the ZIG, was the fact that the necessary resources when it came to appropriate funding and capacity were not in order; this has played a major role in the implementation of the ZIG. This is especially the case when it comes to appropriate funding. According to Wright [95] and many others it is evident that when there is a lack of financial resources there is a great chance that policy implementation will be unsuccessful. It was also stated [95] that a lack of adequate training and staff capacity building is a barrier to policy implementation. Capacity was also an often-mentioned problem when it came to implementing the integrated birth care policy. It was unknown to the VSVs how they should start with implementing the integrated birth care policy, especially at the beginning of the implementation. They did not have any training regarding the implementation of the policy. Later on, there was more guidance from the CPZ and the other parties. The implementation tool assumably played a major role in offering guidance and therefore better implementation of the ZIG.

Another factor that is of influence on the implementation of the integrated birth care policy when it came to policy theory [22] was the incorrect assumption regarding the digital data exchange. It was assumed that this was already on a certain level, which would make it possible to work with a quality policy and an integrated digital dossier which were objectives described in the ZIG. Wright [95] indicates that *''In terms of the role of IT infrastructure, the ability to collect and share data is an important facilitator to policy implementation and ongoing learning. Vice versa, a lack of fit-for purpose IT systems can hamper implementation efforts''*. This indicates that incorrect assumption could have indeed played a huge role when it comes to the implementation of the ZIG.

When it comes to the implementing organization [22] a very important factor was the first communicating outing from CPZ to the field. The first statement to the field came from within the task force integrated funding, which at the time was totally focused on integrated funding instead of the implementation of the ZIG. In most cases the VSVs were not in favour of integrated funding. The first impression of the CPZ was therefore probably not positive for most VSVs. As a result, they may have thought that integrated birth care should go hand in hand with integrated funding, which was also the line of thought at the time since the Ministry of VWS indicated that this would be mandatory. As mentioned before, this idea was later on abandoned. This is in line with what Buse [97] states in his book. It was stated that the spread of communication technologies have a great effect on how ideas, values, beliefs, identities and even interests are produced and reproduced.

Coolsma[22] described that the implementers can also influence the implementation of a policy. Buse mentioned that an explanation for the way the policy is carried out is in the range of actors [98] that played a role. In the case of the ZIG, this was a large number of actors. The National umbrella organizations which were in total eleven. Each National umbrella organisation had its own importance and focus. Next to that there were the 75 VSVs who differed locally.

The difference between the care providers within a VSV was also mentioned as a barrier since there was a lack of trust and cultural difference. Wright [95] also mentioned that is part of organizational culture, he states *''Organisations are increasingly expected to work effectively in partnerships with other organisations that may have different values, priorities, and perspectives from their own''.* This has an influence on how organisations will interpret and undertake policy implementation. This can manifest itself in *''Organisational resistance to change, lengthy decision-making processes, risk avoidance, and lack of coordination among service providers can be barriers to implementation''[95].* When it comes to the ZIG there was a sense of organisational resistance to change since the care providers did not agree on all aspects. It appeared that this was especially the case for the midwives, this could have to do with the fear of losing their autonomy in their work. Organizational culture is also apparent when it comes to the National umbrella organisations, as mentioned before, they all have they all have a self-serving interest, next to the main interest in lowering perinatal mortality. Next to that their perspectives differed in some areas of the ZIG especially when it comes to risk assessment. This could explain why the activities that were focused on working together with other National umbrella organisations were carried out the least.

For the VSVs it turned out there are a lot of differences in the degree of implementation. An explanation could lie in the diffusion of innovation theory [99]. This theory indicates that innovations are not adopted at the same time by all individuals in a social system. The adopter distribution exists out of five categories: innovators, early adopters, early majority, late majority, and laggards. The average and low group of the VSVs presumably fall under the late majority and laggards. The late majority is sceptical when it comes to a new innovation, the fact that they have partly implemented the policy is probably because they feel pressure from systematic norms. For the laggards thus the low group, is stated they are the last group to adopt an innovation. Their focus is on the past and previous generations. For the ZIG this could also mean that the low group likes to stick to their old way of working because they have always done it that way.

In a research [100] regarding *''successful implementation of interventions in youth care''* it appeared that safeguarding (borging) played a key role. With safeguarding is meant that the method becomes a permanent part of the daily routine. This is according to that research, the last phase of the implementation process. It turned out that when it comes to the implementation of the investigated interventions mainly focused on the first stages of its implementation process: dissemination and introduction of the intervention. Less attention has been paid to sustainable safeguarding of the intervention by deploying activities that promote the embedding of the intervention in the daily working methods of professionals. What is striking about this finding is that they argue that the lack of attention to safeguarding could be the cause of the great variation in implementation between care providers. The study of the integrated birth care policy also showed that there was variation in implementation among the different VSVs, looking at the result section it became clear that some VSV for example developed an integral birth care plan but mentioned they do not actually work with it. This indicates that this activity is not embedded in their daily routine. It could therefore be that this could be part of the reason that the

implementation is not yet optimal. Safeguarding [100] also zooms in on the evaluation and adaptiveness of a policy. In the ZIG is described that it is a living document while for example the activity regarding working with an integral dossier is not altered in the document. This indicates that the ZIG and the implementation plan are outdated in that respect.

Furthermore is mentioned in the research of Kals [100] that when the implementers are offered support it stimulates them to work with the intervention/policy. Looking at the integrated birth care policy with regards to the VSVs the implementation tool and webinars are assumably stimulating. This could be part of the reason why the implementation of the ZIG is on the right track.

Stakeholder engagement was mentioned as an important factor by Wright [95], CPZ tried to enforce that by doing the telephone interviews and webinars. They also wanted to give the VSVs the feeling that they were being heard during the telephone interviews since that was the moment when they could get their say about the problems they ran into. This factor could therefore also have a positive influence on the implementation.

9.3 STRENGTHS & LIMITATIONS

A number of points will be discussed that may have been a strength or a limitation to this research. A distinction is, again, made between the VSVs and the National umbrella organizations when it comes to the limitations.

9.3.1 Strengths

A strength of this research is that the two layers of implementers to which the policy relates were investigated; The National umbrella organisations and the VSVs. This provides a total picture of the implementation of the integrated birth care policy.

Looking at the results of the research, it is assumed that it has added value for everyday administrative practice. It has become clear what value the integrated birth care policy has, which problems arise and what ways there are to improve the implementation of the policy.

9.3.2 Limitations methods VSVs

It is not certain that the results of the VSVs can be assumed to be representative. This has several reasons. The first reason is that the level of not discussed was quite high for the total group this can affect the reliability of the results. It could be the case that the results are in reality much more favourable than what this study indicates. Another reason is the fact that the IGO's are hardly included since the questions were not asked during the telephone interviews or the answers were not noted. It was indicated one reason for this may be that it was assumed that the IGOs have come a long way with the implementation of the ZIG. This may result in the total group implementing the

policy less well in the presented results than in reality, since they are not included.

The questionnaire of the telephone interviews does not include all activities that a VSV is required to perform. It only concerns ten activities, while many more activities are described in the implementation plan. It could be the case that CPZ finds these ten activities the most important ones however this leads to a conclusion about implementing a policy based on only ten activities instead of all the activities that are described. This could have an effect on the validity of this research.

The analysis of the telephone interviews was done by one researcher, whereby the answers recorded by employees of the CPZ had to be interpreted. It could be the case that answers have been misinterpreted which can give a distorted picture of the results. An attempt has been made to counter this by contacting staff about what is meant by some of the answers, for example when it only said: '' workgroup".

A limitation that regards the indicator set is that this also concerned an existing dataset, the answer options were therefore already determined. This was difficult since in some cases it made it harder to compare answers from the indicator set with the answers from the telephone interviews.

Another limitation regarding the indicator set was, just as for the telephone interviews, that the representatives of the VSVs had to fill in the questionnaire themselves, where there is again the chance that socially desirable answers were given. This can give a distorted picture of reality. This could not be limited because it concerned an existing dataset.

9.3.3 Methods regarding National umbrella organizations

The implementation by the national organizations was measured in this study by asking the respondents whether or not they carried out a certain activity. This means that they judge this according to themselves, there is a chance that they have provided socially desirable answers. With this is meant that there is a chance that the respondents judged their performance better than it is in reality. This could lead to a lower validity. Unfortunately, it was not possible to check for every activity to what extent they are actually carried out. This was also due to the fact that there was no access to the database of the organizations and it was therefore less possible to check whether they have carried out an activity or not. In some cases, their newsletters were not even public. An attempt has been made to find substantiation or a refutation based on online sources.

An interview was conducted with one representative per organization, this can give a distorted picture because the person may not have all the knowledge about the implementation of the ZIG. An attempt was made to improve this by ensuring that the interviewee has been employed by the organization since the policy took effect in 2016. However, this was not the case for every organization.

Another limitation could be that the implementation plan has been assumed as the main policy document for this research while it seems that this is no longer the guiding principle, especially when looking at the CPZ as an implementer. Their whole governance structure is changed, which made it difficult for the CPZ to discuss the structure described in the implementation plan.

It was not possible to hold an interview with a number of organizations namely: NVK, NVZ and ZN. This means that no total picture can be formed of the implementation of the policy because not all implementing organizations have been questioned. This influences the representativeness of this research. An attempt has been made to improve this by getting these organizations to give feedback on the piece about their organization but this is not nearly as detailed as the organizations that were questioned.

Some organizations were questioned more than once or made great adjustments to their piece, this includes CPZ and the KNOV. This could lead to a lower reliability since the results have been altered. However, an attempt has been made to retain the essence of the first results in the modified versions.

9.4 RECOMMENDATIONS FOR PRACTISE

9.4.1 ZIG related

The first recommendation regards the Integrated Birth care Standard. After the evaluations, the current version of the ZIG will be adapted. It is recommended when there are progressive insights, that this is actually adjusted in the document. The current ZIG is called ''a living document''. However, it contains activities or objectives that have already been abandoned, which can cause confusion when implementing the policy. The consequence of this is that there must be a form of the ZIG in which quick adjustments can be made.

When the adapted version of the ZIG is presented, this must be done in an unambiguous way without any interference. As the first time the wrong message was sent, the focus lied on implementing integrated funding. The focus should therefore be on the content of the integrated birth care and integrated funding should be seen as a precondition. The CPZ has a very professional communication function, which can certainly achieve this.

Concerning the National umbrella organizations, it should be considered to describe the activities in a stricter manner, and do not call it "possible" activities. It should however be considered, this can also be counterproductive [22] when it comes to policy compliance.

9.4.2 VSV related

The results regarding the VSVs showed that there were differences between groups. The focus should be on the average and the low groups, there is still much to be achieved here. For the average group, the focus should lie on: Client participation, individual birth care plan and joint website. For the low group, the only activity that was carried out by the majority was working with integral care paths and or protocols, therefore they could improve a lot on the rest of the activities. This should be stimulated by the National umbrella organizations and particularly CPZ. There might also be a role here for the Consortia.

Another recommendation regarding the VSVs is that there should be more

attention for safeguarding. This could be achieved by focusing even more attention on training and guiding the professionals who have to work with the integrated birth care policy in practice. It has been shown in the literature that this leads to better implementation.

9.4.3 Recommendations for further research

With regard to VSVs, this study did not look at the implementation of the entire policy, but only at the activities that were included in the telephone interviews and indicator set. There were also a lot of discrepancies between the results of the indicator set and telephone interviews. An analysis could be performed again based on the implementation tool, which does include all activities. However, it would then have to be mandatory that all VSVs complete it in order to obtain a complete picture of to what extent the policy is carried out. When it comes to the National umbrella organisations it could be useful to still conduct interviews with the organizations with which this was not successful, because they are also implementers of the policy. In this way a better picture can be formed of the total implementation of the ZIG.

RIVM and the NZA also carried out studies that contributed to the evaluation of the ZIG. The report of RIVM [101] provides insight into the experiences of healthcare professionals, administrators, and health insurers after three years of working with integrated funding. NZA [102] has investigated the method of funding. They have provided advice on which funding structures best suit integrated birth care. These studies, including this one, could be taken together to reach an overall conclusion when it comes to the implementation and the actualisation of the ZIG, if possible.

When it comes to the role of the Consortia it should be investigated whether the VSVs that were offered practical support by the Consortia also performed better when it comes to the implementation of the ZIG. At the moment this an assumption it would be of importance that this is substantiated information. Then it can also be examined whether they should play a more formal role in supporting the implementation of the ZIG.

Since costs for the implementation are mentioned as an issue by almost all parties involved, there must be a financial impact analysis when revising the ZIG. This was often indicated by CPZ, however ZIN, Ministry of VWS and the NZA indicate that this does not fit within a review process.

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Appendix A. Questions Telephone interviews VSVs

1. **Algemeen**

Klopt de VSV naam/fusies? / Contactpersoon? / bijbehorend ziekenhuis? / verzekeraar / website VSV ?

Aantal kraamzorg organisaties? Aantal verloskundige praktijken ? Aantal ziekenhuizen en welke?

Ontvangt u de CPZ nieuwsbrief?

Heeft VSV modulegelden aan gevraagd?

Wie is evt. projectleider/adviseur? NAW gegevens

2. **Zorgstandaard**

Stavaza implementatie zorgstandaard:

- Individueel Geboortezorgplan
- Zorgpaden/ gezamenlijke protocollen
- Cliëntervaringen (NPS, welke andere lijst)
- Coördinerend zorgverlener
- MDO/ lijn overstijgende samenwerking/ interprofessioneel geb.zorgteam
- Multidisciplinaire scholing
- Kwaliteitsbeleid (PDCA, indicatoren)Welke worden uitgevraagd en wat wordt er gedaan met de beschikbare kwaliteitsinformatie? Kwaliteitsjaarplan VSV?
- Moederraad?
- Gezamenlijke website
- Integraal dossier

Voorbeelden beschikbaar voor andere VSVs?

Behoefte aan voorbeelden op bepaalde thema's? (wijzen op VSV Toolkit, VSV Spiegel en Implementatietool.)

3. **Integrale organisatie**

Gaat VSV voor formaliseren van het VSV in juridische entiteit?

- Zo ja wat is de status:

Fase 1 Planning: Is er een gezamenlijke visie/missie, projectplan, project structuur, project planning,

Fase 2: uitwerken plan: randvoorwaarden stellen, documenten maken over: bestuur, toetreding etc.

Fase 3: uitvoering plan: juridische organisatie

- Zo nee, wat is de reden: intern verschillen binnen VSV, modulegelden, zorgverzekeraar, overheidsbeleid, KNOV/Novez, anders?

Wat moet er concreet gebeuren om wel stappen te zetten tot fase 1?

Behoefte aan ondersteuning van CPZ?

4. Integrale bekostiging

Gaat het VSV voor IB?

Zo ja, wat is de status:

Fase 1: planning Is er een gezamelijke visie/missie, projectplan, projectleiding.

Fase 2: uitwerken plan: simulatie, berekenen hoogte tarieven, berekenen,

Fase 3: uitvoering plan; contractering en inregelen administratie

Zo nee, wat is de reden: intern verschillen binnen VSV, modulegelden, zorgverzekeraar, overheidsbeleid, KNOV/Novez, anders?

Wat moet er concreet gebeuren om wel over te gaan tot integrale bekostiging per 1 jan 2020?

Behoefte aan ondersteuning van CPZ bij IB en welke zijn dat?

Appendix B. Operationalisation scheme VSVs

Activity	Variable
Objective: Operationalize the wishes and needs of a pregnant woman. The main activity is: **Work with an individual birth care plan.**	Individual Birth Care Plan
Another main activity is that: The care is organized in an obstetric partnership (VSV). This assumedly falls under the objective: Improving care through an integrated, multidisciplinary approach. The sub-activities to which it relates to are: o **Develop regional care paths.** **o Implementation of regional care paths.**	Integral care paths or and protocols
Another objective is: Support the pregnant woman in her directing role. The main activity that belongs to that is: **That a coordinating care provider is appointed.** The sub-activity to which it relates to is: o **Every pregnant woman has one fixed point of contact during pregnancy, which is: the coordinating care provider.**	Coordinating care provider
-	Client experiences
Another objective is: Promote multidisciplinary and crossline collaboration. The main activity is: Set up an interprofessional birth care team. The sub-activity to which it relates to is: o **An MDO takes place at least once a month.**	MDO / crossline collaboration / interprofessional health care team
Another objective is: Work cyclically on improving the quality of care. The main	Multidisciplinary training

activity that belonged to that is realization of quality policy including quality cycle and indicators. The sub-activity to which it relates to is: o Joint continuous monitoring of quality in their own region and drawing up improvement plans. Analysing and improving performance from the perspective of both the health care provider and pregnant. Recommendations for improving cooperation, guideline development / care paths, **inventory training need.**	
Another objective is: Work cyclically on improving the quality of care. The main activity that belonged to that is **realization of quality policy** including quality cycle and indicators. The sub-activity to which it relates to is: o **A quality system has been set up,** which also considers aspects such as effectiveness and efficiency.	Quality policy (PDCA, indicators)
Another main activity is that: The care is organized in an obstetric partnership (VSV). This assumedly falls under the objective: Improving care through an integrated, multidisciplinary approach. The sub-activity to which it relates to is: o **Setting a policy regarding Client Council / Regional Advisory Council for pregnant women / (young) parents.**	Client participation/Mother council

-	Joint website
Another objective is: Improve information provision, communication, and collaboration in perinatal care. The main activity is: A perinatal Web Based Dossier. The sub-activity to which it relates to is: o **Provide a complete, up-to-date, and reliable multidisciplinary electronic file that can be safely consulted at any time by all healthcare providers and patients.**	Integral dossier
Another objective is: Put the wishes and the needs of the pregnant woman and the child first/central. Main activity is: There is a sense of adequate information and counselling. The sub-activity to which it relates to is: o **There is a policy and all health care providers within the VSV use uniform information material for properly informing the pregnant woman about her pregnancy, childbirth, maternity period and guidance and care options (incl. pre- and neonatal screening).**	Delivering uniform information about: o which care providers and organizations are part of the VSV. o accessibility of the care providers in the VSV o jointly formulated vision on integrated birth care, responsibilities of the caregivers in the VSV o working arrangements such as referral and transfer between health care providers, o to whom the pregnant woman can go with which questions, o when the pregnant woman can go to the office for check-ups o consultation forms and consultation times between the care providers.

Appendix C. Indicator 6

Indicator 6 Samenwerking en Zorgaanbod Verloskundig SamenwerkingsVerband (VSV). (Indien van toepassing lees IGO i.p.v. VSV)	
	A. Welke zorgaanbieders maken deel uit van uw VSV? **Ziekenhuis:** **1)** ..... **2)** ..... **Verloskundigenpraktijk** **1)** ..... **2)** ..... **3)** ..... **4)** ..... **Kraamzorgorganisatie:** **1)** ..... **2)** ..... **3)** ..... **4)** ..... **B. Ontvangt de zwangere van elke zorgaanbieder binnen het VSV uniforme informatie over:** **(aanvinken, meerdere antwoorden mogelijk)** ☐ Welke zorgverleners en organisaties deel uit maken van het VSV ☐ Bereikbaarheid van de zorgverleners in het VSV ☐ Gezamenlijk geformuleerde visie op integrale geboortezorg ☐ Verantwoordelijkheden van de zorgverleners in het VSV ☐ Werkafspraken zoals doorverwijzing en overdracht tussen de zorgverleners ☐ Bij wie de zwangere terecht kan met welke vragen ☐ Wanneer de zwangere voor controles terecht kan op het spreekuur ☐ Overlegvormen en overlegmomenten tussen de zorgverleners C **D. Heeft iedere zwangere een coördinerend zorgverlener[5]?** *(aanvinken, één antwoord mogelijk)* ☐ Ja ☐ We streven hier wel naar, maar (nog) niet iedere zwangere wordt begeleid door een coördinerend zorgverlener. ☐ Nee **E. Maakt uw verloskundig samenwerkingsverband gebruik van een individueel geboortezorg plan[6] voor alle zwangeren en is dit plan voor hen beschikbaar?** *(aanvinken, één antwoord mogelijk)* ☐ Ja, voor alle zwangeren via een (beveiligde) digitale omgeving ☐ Ja, voor alle zwangeren via een papieren versie ☐ Ja, maar niet voor alle zwangeren ☐ Nee **F. Kunnen alle zorgverleners in uw VSV beschikken over de informatie die is vastgelegd in het cliëntdossier[7] van de zwangere?** *(aanvinken, één antwoord mogelijk)* ☐ Ja, en alle zorgverleners kunnen in het cliëntdossier werken (wijzigingen doorvoeren, aanvullen) ☐ Ja, er is inzage, ze kunnen over alle informatie beschikken. ☐ Nee, maar een deel van de zorgverleners heeft inzage in alle informatie

19

	☐ Nee, iedere organisatie heeft haar eigen cliëntendossier. **G.** Wordt iedere zwangere standaard besproken in een multidisciplinair overleg (MDO)[8]? *(aanvinken, één antwoord mogelijk)* ☐ Alleen als dat nodig is, wordt de zwangere besproken in een MDO[9] ☐ Iedere zwangere wordt besproken in een MDO ☐ Wij hebben geen MDO **H.** Heeft uw VSV een adviesraad van zwangeren/(jonge) ouders[10]? *(één antwoord mogelijk)* ☐ Ja, en deze wordt actief betrokken bij het bespreken van het VSV beleid en het kwaliteitsjaarverslag ☐ Ja, maar aan de invulling van de raad wordt nog gewerkt ☐ Nee I
Definities	[1] Zwangeren kunnen in een beveiligde omgeving vragen stellen aan de zorgverlener en hebben binnen 1 werkdag antwoord op de gestelde vragen. [2] Online een consult op een gezette tijd via een videoverbinding. Dit betreft een 'synchroon contact'. [3] Bijvoorbeeld via een cliëntenportaal, website of met een app. Cliënten hebben hierdoor altijd toegang tot hun belangrijke (medische) gegevens. [4] Een patiëntenportaal biedt de zwangere (en de zorgverlener) een betrouwbare en beveiligde toegang tot het krijgen (en voor de zorgverlener het leveren) van digitale zorgdiensten. De diensten kunnen bestaan uit een combinatie van de volgende toepassingen: toegang voor de zwangere tot haar medische informatie en uitslagen, e-consult of digitaal spreekuur, het maken van een afspraak, verkrijgen van informatie, toegang tot (online)cursussen of training, informatie over de zorgverleners etc. [5] Deze professional heeft primair de taak om ten behoeve van de zwangere de professionele zorgverlening te coördineren en zorg te dragen voor continuïteit in de zorg tijdens zwangerschap, bevalling en kraamperiode tot maximaal zes weken na de bevalling voor de moeder en tot en met de tiende dag na de bevalling voor de pasgeborene. En is aanspreekpunt voor de zwangere. [6] In dit plan, dat uiterlijk de 16e week van de zwangerschap beschikbaar moet zijn, worden alle aspecten vastgelegd die in de begeleiding en zorg voor een aanstaande moeder van belang zijn vanaf eerste consult aan een verloskundig zorgverlener tot en met de eerste zes weken na de geboorte. Het plan sluit aan op de eventueel geconstateerde risico's en beschrijft, toegespitst op de lokale situatie, alle belangrijke momenten en afspraken tijdens de zwangerschap (voorlichting, laboratorium- en ander benodigd onderzoek, uitvoerende zorgverleners, verdeling verantwoordelijkheden, etc.). Daarbij wordt expliciet rekening gehouden met de persoonlijke situatie doordat wensen, behoeften en afspraken voor de zorg worden besproken en vastgelegd in het plan. Het plan is eigendom van de zwangere. [7] Hiermee wordt het (medisch) dossier bedoeld dat wordt bijgehouden voor/over de zwangere. [8] Multidisciplinair overleg (MDO) is een bespreking waarbij relevante betrokken disciplines zoveel mogelijk vertegenwoordigd zijn. [9] Binnen het VSV is voor alle partijen duidelijk in welke gevallen een zwangere wordt besproken in het MDO. Daartoe zijn binnen het VSV schriftelijke afspraken / is een protocol opgesteld. [10] De adviesraad bestaat uit zwangeren, partners of (jonge) ouders. Zij ontvangen en bespreken met het VSV de uitkomsten van het gezamenlijk kwaliteit jaarverslag en de beleidsplannen. [11] Een geboortecentrum is een 'midwifery-managed' bevallocatie anders dan thuis, waar laagrisico zwangeren kunnen bevallen onder verantwoordelijkheid van een

	eerstelijns verloskundig professional. Het geboortecentrum heeft een huiselijke sfeer en inrichting, met daarbij faciliteiten die het fysiologisch verloop van de baring kunnen ondersteunen. Wanneer er reden is voor overdracht neemt de tweede lijn (gynaecoloog of kinderarts) de verantwoordelijkheid van de zorg over van de eerste lijn (verloskundige of huisarts). [12] Een geboorte/kraamhotel is een 'midwifery-managed' bevallocatie anders dan thuis, waar laagrisico zwangeren kunnen bevallen onder verantwoordelijkheid van een eerstelijns verloskundig professional. Het geboorte of kraamhotel heeft een huiselijke sfeer en inrichting, met daarbij faciliteiten die het fysiologisch verloop van de baring kunnen ondersteunen. Wanneer er reden is voor overdracht neemt de tweede lijn (gynaecoloog of kinderarts) de verantwoordelijkheid van de zorg over van de eerste lijn (verloskundige of huisarts). De zwangere kan hier ook haar kraamtijd doorbrengen. [13] Dit is prenatale groepszorg waarbij in plaats van de huidige één op één controles tijdens de zwangerschap, de prenatale zorg in circa tien sessies wordt aangeboden aan een groep van 10 tot 12 zwangere vouwen met eenzelfde zwangerschapsduur. Tijdens een sessie worden de zwangerschapscontroles (zoals de bloeddruk, groei van de foetus, etc.) gecombineerd met voorlichting, interactieve leermethoden en gesprekken over wat vrouwen bezig houdt tijdens hun zwangerschap.
Toelichting	Deze vragen hebben betrekking op het VSV. Aanlevering van gegevens is de verantwoordelijkheid van het VSV (i.c. ziekenhuis).
Technische haalbaarheid	Peildatum: 1 maart 2020

Appendix D. Operationalisation scheme Birth care organizations

Activity	Question
o Encourage involvement in the actual implementation of the Integrated Birth care Standard among their members o Carrying out own activities that promote the application of integrated birth care in accordance with the standard, such as conferences, mini-symposiums, courses, presentations in work meetings, employee meetings and study days.	Op welke manier is de betrokkenheid van de achterban bij de daadwerkelijke implementatie van de zorgstandaard gestimuleerd?
o The associations have the channels to inform their members about the new insights from the Integrated Birth care Standard. o Communication to own employees or members about relevant aspects of the Integrated Birth care Standard in newsletters, magazines, via own website, information packages.	Over welke kanalen beschikt de organisatie om de achterban te informeren over de nieuwe inzichten uit de zorgstandaard?
o Offering training to the members.	Heeft de organisatie scholingen aangeboden aan de zorgverleners/achterban?
o Identify which training courses are offered by other parties	Heeft (de organisatie) de scholingen die door andere partijen werd aangeboden in kaart gebracht? zo ja, op welke manier?

o They inform the support organization of the CPZ and the other industry and professional and patient associations about their own activities regarding the implementation of the Integrated Birth care Standard and look for cooperation and synergy between their own activities and the activities of others. o Looking for cooperation and synergy between own activities and the activities of (other) healthcare professionals and (other) professional associations.	Was er sprake van afstemming tussen eigen activiteiten en de activiteiten van (andere)zorgprofessionals en (andere) beroepsverenigingen met betrekking op de zorgstandaard? Zo, ja op welke manier?
o The professional associations appoint representatives to CPZ to contribute to the realization of the client version of the Integrated Birth care Standard.	In het implementatieplan staat dat elke (organisatie) een vertegenwoordiger moest aandragen bij CPZ om bij te dragen aan totstandkoming van cliëntversie van de zorgstandaard, wat is hier in de praktijk van terecht gekomen?
o Communication to own employees or members about updates of the Integrated Birth care Standard in newsletters, magazines, via their own website, folders.	Zijn updates wat betreft de zorgstandaard naar de eigen werknemers/leden gecommuniceerd? Zo ja, op welke wijze?
o Identifying bottlenecks around the introduction of integrated birth care at the CPZ (whereby the support group acts as the point of contact for CPZ).	Zijn knelpunten rondom de invoering van integrale geboortezorg bij het CPZ gemeld?
o Actively share proprietary solutions with other regions and share solutions, models, and documents through CPZ. o They use the knowledge, expertise, and strengths of the organization to solve	Zijn eigen oplossingen actief gedeeld met andere regio's door oplossingen, modellen en documenten te delen via het CPZ?

bottlenecks within their own target group and with other target groups.	
o Ensuring or encouraging employees or members to participate in multidisciplinary consultations for joint risk assessment.	Op welke manier heeft de KNOV gestimuleerd dat werknemers of leden deelnemen aan Multidisciplinaire overleggen voor gezamenlijke risico-inschatting?
o The further development of mono-disciplinary guidelines to multidisciplinary guidelines, standards, and agreements.	Op welke manier heeft de organisatie bijgedragen aan het doorontwikkelen van monodisciplinaire Richtlijnen tot multidisciplinaire richtlijnen,standaarden en afspraken?

Appendix E. List of questions KNOV, NVOG, BO geboortezorg and Federatie van VSVs

Intro

In het implementatieplan van de zorgstandaard en het integrale geboortezorg beleid staan de activiteiten beschreven die door de VSVs diende uitgevoerd te worden maar tevens activiteiten die de brancheorganisaties uit konden voeren om de implementatie van de Zorgstandaard te bevorderen. Dit interview heeft betrekking op het laatste. Er zullen open en gesloten vragen gesteld worden om zo inzicht te krijgen in welke activiteiten zijn uitgevoerd.

- Wat is de rol van de/het (organisatie)?
- Wat betekent dat voor de integrale geboortezorg?
- Vindt u dat uw organisatie een verantwoordelijkheid heeft wat betreft de integrale geboortezorg? Zo ja, welke verantwoordelijkheid is dat?

Motiveren:

- Op wat voor manier kijkt u beroepsgroep aan tegen de werkwijze die in de zorgstandaard beschreven staat?
- Wat denkt u dat de werkwijze opbrengt?
- In het implementatieplan staat dit *''De achterban moet overtuigd raken dat de nieuwe werkwijze waardevol en efficiënt is en besparingen in tijd of kosten met zich meebrengt ''* Wat vindt u hiervan?

- Op welke manier is er geprobeerd de beroepsgroep te overtuigen dat de nieuwe werkwijze nuttig was ?

Informeren:

- Is de (organisatie) op de hoogte van het implementatieplan van de zorgstandaard?
- Zijn de leden/achterban ook op de hoogte gebracht van het implementatieplan?

- Op welke manieren zijn ze op de hoogte gebracht?

- Over welke kanalen beschikt (de organisatie) om de achterban te informeren over de nieuwe inzichten uit de zorgstandaard?
- Op welke manier heeft (de organisatie) draagvlak gecreëerd onder de achterban wat betreft de implementatie van de zorgstandaard?
- Heeft u zicht op in hoeverre de achterban ook daadwerkelijk met de implementatie bezig is/was?
- Op welke manier is de betrokkenheid van de achterban bij de daadwerkelijke implementatie van de zorgstandaard gestimuleerd?

- Waar baseert u dat precies op?

Faciliteren:

- Heeft (de organisatie) scholingen aangeboden aan de zorgverleners/achterban?
  - Zo ja, welke verantwoordelijkheid is dat?
- Komt bij elke scholing het onderwerp integrale samenwerking voor? Is dat een onderwerp dat systematisch terug komt?
- Heeft (de organisatie) de scholingen die door andere partijen werd aangeboden in kaart gebracht? zo ja, op welke manier?

Borgen:

In het implementatie plan staat *''De Zorgstandaard Integrale Geboortezorg wordt structureel geïntegreerd in de bestaande routines. Deze nieuwe werkwijze moet zodanig verankerd en ondersteund worden binnen de zorg dat blijvende toepassing mogelijk is. Organisatorische, financiële en structurele voorwaarden moeten vervuld worden. ''*

- Wat is uw reactie hierop ?
- Op welke manier moet dat in de toekomst geborgd worden? Want het CPZ houdt in 2022 op te bestaan.

Technische aspecten communicatie

- Was er sprake van afstemming tussen eigen activiteiten en de activiteiten van (andere)zorgprofessionals en (andere) beroepsverenigingen met betrekking op de zorgstandaard? Zo, ja op welke manier?
- In het implementatieplan staat *dat elke (organisatie) een vertegenwoordiger moest aandragen bij CPZ om bij te dragen aan totstandkoming van cliëntversie van de zorgstandaard*, wat is hier in de praktijk van terecht gekomen?
- Zijn updates wat betreft de zorgstandaard naar de eigen werknemers/leden gecommuniceerd? Zo ja, op welke wijze?
- Zijn knelpunten rondom de invoering van integrale geboortezorg bij het CPZ gemeld?
- Zijn eigen oplossingen actief gedeeld met andere regio's door oplossingen, modellen en documenten te delen via het CPZ?
- Op welke manier heeft (de organisatie) gestimuleerd dat werknemers of leden deelnemen aan Multidisciplinaire overleggen voor gezamenlijke risico-inschatting?

Factoren die van invloed waren

- Welke bevorderende factoren heeft (organisatie) ondervonden bij het ondersteunen van de implementatie van de ZIG?
- Welke bevorderende factoren heeft (organisatie) ondervonden bij het ondersteunen van de implementatie van de ZIG?

Appendix F. Operationalisation scheme Patiëntenfederatie Nederland

Activity	Question
o The associations have the channels to inform their members about the new insights from the Integrated Birth care Standard. o Informing the members and the CPZ about their own activities.	Over welke kanalen beschikt de organisatie om de achterban te informeren over de nieuwe inzichten uit de zorgstandaard?
o Carry out own activities that promote the application of integrated birth care in accordance with the standard.	Welke eigen activiteiten die de toepassing van de integrale geboortezorg conform de standaard bevorderen zijn uitgevoerd?
o Delegate a representative to CPZ to contribute to the realization of a client version of the Integrated Birth care Standard.	In het implementatieplan staat *dat elke (organisatie) een vertegenwoordiger moest aandragen bij CPZ om bij te dragen aan totstandkoming van cliëntversie van de zorgstandaard*, wat is hier in de praktijk van terecht gekomen?
o Looking for cooperation and synergy between own activities and the activities of healthcare professionals and professional associations.	Op welke manier was er sprake van afstemming tussen eigen activiteiten en de activiteiten van (andere)zorgprofessionals en (andere) beroepsverenigingen met betrekking op de zorgstandaard?
o Actively share own solutions with others by sharing solutions, models, and documents via the CPZ.	Zijn eigen oplossingen actief gedeeld met andere regio's door oplossingen, modellen en documenten te delen via het CPZ?

o Further development of the indicators of customer preferences.	Op welke wijze zijn indicatoren van klantpreferenties doorontwikkeld?
o Communication about relevant aspects of the Integrated Birth care Standard, including trying to get pregnant women / parents involved in participation in advisory boards of VSVs.	Op welke manier is er gecommuniceerd over relevante aspecten van de zorgstandaard ? Ook als het aankomt op oproepen van zwangeren/ouders tot deelname aan adviesraden van VSVs.
o Stimulating self-management for pregnant women by providing information.	Op welke manier is zelfmanagement door zwangeren gestimuleerd?
o Identifying bottlenecks that occurred during the implementation of integrated birth care at the CPZ (whereby the support group acts as the point of contact for CPZ).	Zijn knelpunten rondom de invoering van integrale geboortezorg bij het CPZ gemeld?
o Facilitating valuations: making valuations for precautionary organizations available and comparable for other patients / clients via ZorgkaartNederland.	Heeft (organisatie) waarderingen gefaciliteerd en beschikbaar gemaakt voor andere cliënten via ZorgkaartNederland?

Appendix G. List of questions Patiëntenfederatie Nederland

Intro

In het implementatieplan van de zorgstandaard en het integrale geboortezorg beleid staan de activiteiten beschreven die door de VSVs diende uitgevoerd te worden maar tevens activiteiten die de brancheorganisaties uit konden voeren om de implementatie van de zorgstandaard te bevorderen. Dit interview heeft betrekking op het laatste. Er zullen open en gesloten vragen gesteld worden om zo inzicht te krijgen in welke activiteiten zijn uitgevoerd.

- Wat is de rol van de/het (organisatie)?
- Wat betekent dit voor de integrale geboortezorg?
- Vindt u dat uw organisatie een verantwoordelijkheid heeft wat betreft de integrale geboortezorg? En welke verantwoordelijkheid is dat?

Motiveren:

- Op wat voor manier kijkt u organisatie aan tegen de werkwijze die in de zorgstandaard beschreven staat?
- Wat denkt u dat de werkwijze opbrengt?

Informeren:

- Is de (organisatie) op de hoogte van het implementatieplan van de zorgstandaard?
- Zijn de leden/achterban ook op de hoogte gebracht van het implementatieplan?

  - Op welke manieren zijn ze op de hoogte gebracht?

- Over welke kanalen beschikt (de organisatie) om de achterban te informeren over de nieuwe inzichten uit de zorgstandaard?

- Welke eigen activiteiten die de toepassing van de integrale geboortezorg conform de standaard bevorderen zijn uitgevoerd?

- In het implementatieplan staat *dat elke (organisatie) een vertegenwoordiger moest aandragen bij CPZ om bij te dragen aan totstandkoming van cliëntversie van de zorgstandaard*, wat is hier in de praktijk van terecht gekomen?
- Op welke manier was er sprake van afstemming tussen eigen activiteiten en de activiteiten van (andere)zorgprofessionals en (andere) beroepsverenigingen met betrekking op de zorgstandaard?
- Zijn eigen oplossingen actief gedeeld met andere regio's door oplossingen, modellen en documenten te delen via het CPZ?
- Op welke wijze zijn indicatoren van klantpreferenties doorontwikkeld?
- Op welke manier is er gecommuniceerd over relevante aspecten van de zorgstandaard ? Ook als het aankomt op oproepen van zwangeren/ouders tot deelname aan adviesraden van VSVs.
- Op welke manier is zelfmanagement door zwangeren gestimuleerd?
- Zijn knelpunten rondom de invoering van integrale geboortezorg bij het CPZ gemeld?
- Heeft (organisatie) waarderingen gefaciliteerd en beschikbaar gemaakt voor andere cliënten via ZorgkaartNederland?

Factoren die van invloed waren

- Welke bevorderende factoren heeft (organisatie) ondervonden bij het ondersteunen van de implementatie van de ZIG?
- Welke bevorderende factoren heeft (organisatie) ondervonden bij het ondersteunen van de implementatie van de ZIG?

Appendix H. Operationalisation scheme CPZ

Activity	Question
CPZ in general	
o CPZ has made an inventory of the bottlenecks and needs when it comes to the implementation of the Integrated Birth care Standard	Op welke wijze heeft het CPZ de knelpunten en behoeften geïnventariseerd?
o Taking charge of providing information about the integrated standard of care.	Op welke wijze heeft het CPZ de regie genomen in het informeren?
o CPZ stimulates the sector of professional and patient associations, so that they saw it as their task to create support among their own members and to stimulate involvement in the actual implementation of the Integrated Birth care Standard.	Op welke manier heeft het CPZ de branche-, beroeps- en patiëntenverenigingen gevoed zodat, zij het als hun taak gingen zien om draagvlak te creëren onder hun eigen achterban en betrokkenheid te stimuleren bij de daadwerkelijke implementatie van de zorgstandaard?
o Stimulating the development of multidisciplinary guidelines.	Op welke manier is de totstandkoming van multidisciplinaire richtlijnen gestimuleerd?
CPZ staff bureau	
o CPZ staff bureau supports the implementation group.	Op welke manier is de implementatiegroep ondersteund door het stafbureau van CPZ? (denkkracht, daadkracht, organisatiekracht en handen bij de ondersteuning)
o CPZ staff bureau ensures that one message was propagated by healthcare institutions, professionals, industry, and patient associations when it came to introducing the Integrated Birth care Standard and the client version of it.	Op welke wijze is er door het CPZ gerealiseerd dat er één boodschap werd uitgedragen door de zorginstellingen, beroeps- branche- en patiëntenverenigingen als het aankwam op het ontsluiten van de zorgstandaard en/of de cliëntversie?

o Communicate with the field.	Op welke manieren is er met het veld gecommuniceerd?
o Manages and facilitates Kennisbank.	Heeft het stafbureau kennisbank gefaciliteerd? Zo ja op welke manier?
Implementation group	
o Creates the client version of the ZIG	Heeft de Implementatiegroep de cliëntversie van de zorgstandaard en de (door)ontwikkeling va kwaliteits- en procesindicatoren opgesteld?
o Identifies bottlenecks in preconditions that are necessary for or were required for the implementation of the ZIG	Heeft de implementatiegroep eventuele knelpunten in de (financiële) randvoorwaarden die nodig zijn voor een goede implementatie gesignaleerd?
o Identifies solutions for bottlenecks and passes them onto the board.	Heeft de implementatiegroep eventuele oplossingsrichtingen voor de knelpunten gesignaleerd? • Zo ja, is dit doorgespeeld naar het CPZ-bestuur?
o Identifies the lack of underlying guidelines that do not match the scope of the Integrated Birth care Standard	Heeft de implementatiegroep het ontbreken van onderliggende richtlijnen die niet passen bij de strekking van de Zorgstandaard Integrale Geboortezorg gesignaleerd? Zo ja, is dit doorgespeeld naar het CPZ-bestuur?
Support group VSVs	
o Facilitates learning networks	Op welke manier heeft de support organisatie lerende netwerken gefaciliteerd?
o Organizes meetings for the exchange of information for and by VSVs	Heeft de support organisatie bijeenkomsten georganiseerd

	voor uitwisselen van informatie voor en door VSVs?
o Retrieves and shares best practices	Op welke manier heeft de support organisatie best practices ter inspiratie opgehaald en verspreid?
o Increases the awareness and implications of the standard of care among healthcare providers and pregnant women by making information and training materials available.	Heeft de support organisatie bekendheid en implicaties van zorgstandaard bij zorgverleners en zwangeren vergroot door voorlichtings- en trainingsmaterialen beschikbaar te stellen? • Zo ja, op welke manier?
o Makes a toolbox available (based on best practices) with a support offer.	Heeft de support organisatie een toolbox (aan de hand van best practices) met ondersteuningsaanbod ter beschikking gesteld?
o Provides a clear health care provider version (summary) of the Integrated Birth care Standard or a digital Integrated Birth care Standard.	Heeft de support organisatie een heldere zorgverleners versie (samenvatting) van de zorgstandaard of digitaal ontsluiten zorgstandaard opgesteld?
o Supports the VSVs in their choices when working together in a shared electronic file.	Op welke manier heeft de support organisatie de VSVs ondersteund bij de keuzes bij het gezamenlijk werken in een gedeeld elektronisch dossier?
o Identifying any bottlenecks in the (financial) preconditions that are necessary for a good implementation.	Op welke manier heeft de support organisatie eventuele knelpunten in de (financiële) randvoorwaarden die nodig zijn voor een goede implementatie gesignaleerd?
o Identifying the lack of underlying guidelines that do not match the scope of the Integrated Birth care Standard	Heeft de support organisatie het ontbreken van onderliggende richtlijnen die niet passen bij de strekking van de

	Zorgstandaard Integrale Geboortezorg gesignaleerd?
Support to VSVs per communication	
o CPZ has taken the initiative to start the collaboration in a communication consultation	Heeft het CPZ het initiatief genomen voor het opstarten van de samenwerking in een communicatieoverleg?
o CPZ is taking the lead in terms of communication activities related to the ZIG.	Op welke manier heeft het CPZ het voortouw genomen qua communicatie activiteiten met betrekking tot de ZIG?
o CPZ, takes the lead to convert the joint wishes and objectives in the communication consultation into a framework communication plan and a joint action plan of the organisations supports and unites.	Heeft het CPZ de lead genomen om de gezamenlijke wensen en doelstellingen in het Communicatieoverleg om te zetten in een raam communicatieplan en een gezamenlijk plan van aanpak dat de deel communicatie van de organisaties ondersteunt en samenbrengt?
o CPZ draws up an inventory of the current communication of the affiliated organizations and the CPZ and their coherence.	Op welke manier heeft het CPZ de huidige communicatie van de aangesloten organisaties en het CPZ en hun samenhang in kaart gebracht?

Appendix I. List of questions CPZ

Intro

In het implementatieplan van de zorgstandaard en het integrale geboortezorg beleid staan de activiteiten beschreven die door de VSVs en brancheorganisaties diende uitgevoerd te worden maar tevens activiteiten die het CPZ uit kon voeren. Dit interview heeft betrekking op het laatste.

Algemene vragen CPZ

o Op welke wijze heeft het CPZ de knelpunten en behoeften geïnventariseerd?

o Op welke wijze heeft het CPZ de regie genomen in het informeren?

o Op welke manier heeft het CPZ de branche-, beroeps- en patiëntenverenigingen gevoed zodat, zij het als hun taak gingen zien om draagvlak te creëren onder hun eigen achterban en betrokkenheid te stimuleren bij de daadwerkelijke implementatie van de zorgstandaard?

o Op welke manier is de totstandkoming van multidisciplinaire richtlijnen gestimuleerd?

Stafbureau CPZ

o Op welke manier is de implementatiegroep ondersteund door het stafbureau van CPZ? (denkkracht, daadkracht, organisatiekracht en handen bij de ondersteuning)

o Op welke manieren is er met het veld gecommuniceerd?

o Heeft het stafbureau kennisbank gefaciliteerd? Zo ja op welke manier?

o Op welke wijze is er door het CPZ gerealiseerd dat er één boodschap werd uitgedragen door de zorginstellingen, beroeps- branche- en patiëntenverenigingen als het aankwam op het ontsluiten van de zorgstandaard en/of de cliëntversie?

Implementatie Groep

o Heeft de Implementatiegroep de cliëntversie van de zorgstandaard en de (door)ontwikkeling va kwaliteits- en procesindicatoren opgesteld?

o Heeft de implementatiegroep eventuele knelpunten in de (financiële) randvoorwaarden die nodig zijn voor een goede implementatie gesignaleerd?

- Zo ja, is dit doorgespeeld naar het CPZ-bestuur?

o Heeft de implementatiegroep eventuele oplossingsrichtingen voor de knelpunten gesignaleerd?

- Zo ja, is dit doorgespeeld naar het CPZ-bestuur?

o Heeft de implementatiegroep het ontbreken van onderliggende richtlijnen die niet passen bij de strekking van de Zorgstandaard Integrale Geboortezorg gesignaleerd? Zo ja, is dit doorgespeeld naar het CPZ-bestuur?

o Heeft de implementatiegroep zorggedragen voor het opstellen van een onderhoudsplan incl. bemensing Commissie Onderhoud ? zo ja, op welke wijze?

o Hoe vaak is de implementatiegroep bij elkaar gekomen?

Support Organisatie Ondersteuning VSVs

De support organisatie biedt aan VSVs algemene, specifieke en generieke ondersteuning bij de implementatie van de zorgstandaard.

o Op welke manier heeft de support organisatie lerende netwerken gefaciliteerd?

o Heeft de support organisatie bijeenkomsten georganiseerd voor uitwisselen van informatie voor en door VSVs?
o Op welke manier heeft de support organisatie best practices ter inspiratie opgehaald en verspreid?
o Heeft de support organisatie bekendheid en implicaties van zorgstandaard bij zorgverleners en zwangeren vergroot door voorlichtings- en trainingsmaterialen beschikbaar te stellen?

- Zo ja, op welke manier?

o Heeft de support organisatie een toolbox (aan de hand van best practices) met ondersteuningsaanbod ter beschikking gesteld? (, incl. verwijzingen naar wetenschappelijk onderzoek, om de zorgstandaard in de praktijk te kunnen toepassen, waaronder voorbeelddocumenten Plan van Aanpak VSVs, Stappenplan visievorming, afvinklijst implementatie Zorgstandaard)

o Heeft de support organisatie een heldere zorgverleners versie (samenvatting) van de zorgstandaard of digitaal ontsluiten zorgstandaard opgesteld?
o Op welke manier heeft de support organisatie de VSVs ondersteund bij de keuzes bij het gezamenlijk werken in een gedeeld elektronisch dossier?

o Op welke manier heeft de support organisatie eventuele knelpunten in de (financiële) randvoorwaarden die nodig zijn voor een goede implementatie gesignaleerd?

- Zo ja, is dit doorgespeeld naar de implementatiegroep?

o Heeft de support organisatie het ontbreken van onderliggende richtlijnen die niet passen bij de strekking van de Zorgstandaard Integrale Geboortezorg gesignaleerd?

- Zo ja, is dit doorgespeeld naar de implementatiegroep?

Support door middel van communicatie

o Heeft het CPZ het initiatief genomen voor het opstarten van de samenwerking in een communicatieoverleg?

o Heeft het CPZ samen met de supportgroep VSVs de lead genomen om de gezamenlijke wensen en doelstellingen in het Communicatieoverleg om te zetten in een raam communicatieplan en een gezamenlijk plan van aanpak dat de deel communicatie van de organisaties ondersteunt en samenbrengt?

- Zo ja, waar bestond dat plan uit?

o Op welke manier heeft het CPZ het voortouw genomen qua communicatie activiteiten met betrekking tot de ZIG?

o Op welke manier heeft het CPZ de huidige communicatie van de aangesloten organisaties en het CPZ en hun samenhang in kaart gebracht?

Appendix J. List of questions Perined & ZonMw

ZonMw

Intro

In het implementatieplan van de zorgstandaard en het integrale geboortezorg beleid staan de activiteiten beschreven die door de VSVs diende uitgevoerd te worden maar tevens activiteiten die de brancheorganisaties uit konden voeren om de implementatie van de zorgstandaard te bevorderen. Dit interview heeft betrekking op het laatste. Deze activiteiten golden niet voor ZonMw maar het is toch van belang om de rol van de organisatie duidelijk te krijgen wat betreft de implementatie van de zorgstandaard.

- Wat is de rol van ZonMW?
- Wat betekent dit voor de integrale geboortezorg?
- Vindt u dat uw organisatie een verantwoordelijkheid heeft wat betreft de integrale geboortezorg? En welke verantwoordelijkheid is dat dan?
- Op welke manier heeft ZOnMW bijgedragen aan de implementatie van de zorgstandaard?
- Lag de focus op een goed begin van stuurgroep zwangerschap en geboorte of op de zorgstandaard?
- Was er sprake van een randvoorwaarde dat onderzoeken moesten bijdragen aan de zorgstandaard?

Factoren die van invloed waren

- Welke bevorderende factoren heeft (organisatie) ondervonden bij het ondersteunen van de implementatie van de ZIG?
- Welke bevorderende factoren heeft (organisatie) ondervonden bij het ondersteunen van de implementatie van de ZIG?
-

Perined

In het implementatieplan van de zorgstandaard en het integrale geboortezorg beleid staan de activiteiten beschreven die door de VSVs diende uitgevoerd te worden maar tevens activiteiten die de brancheorganisaties uit konden voeren om de implementatie

van de zorgstandaard te bevorderen. Dit interview heeft betrekking op het laatste. Deze activiteiten golden niet voor Perined maar het is toch van belang om de rol van de organisatie duidelijk te krijgen wat betreft de implementatie van de zorgstandaard.

- Wat is de rol van Perined?
- Wat betekent dit voor de integrale geboortezorg?
- Vindt u dat uw organisatie een verantwoordelijkheid heeft wat betreft de integrale geboortezorg? En welke verantwoordelijkheid is dat dan?
- Op wat voor manier heeft Perined bijgedragen aan de implementatie van de zorgstandaard?
- Op welke manier heeft Perined ervoor gezorgd dat zorgverleners deelnemen aan perinatale audits en perinatale registratie?
- Perinataal Webbased dossier

Factoren die van invloed waren

- Welke bevorderende factoren heeft (organisatie) ondervonden bij het ondersteunen van de implementatie van de ZIG?
- Welke belemmerende factoren heeft (organisatie) ondervonden bij het ondersteunen van de implementatie van de ZIG?

Appendix K. Detailed interview regarding activities Bo Geboortezorg

Members must become convinced that the new working method is valuable and is efficient and saves time and costs. Bo geboortezorg mentioned that they agree with this quote when it comes to how the method is useful and valuable. When it came to the savings in time and costs, it was mentioned that:*'' The savings in time and costs do not seem to be very strong at the moment, because so far most organizations feel that they should mainly invest in setting up the VSV and in making those agreements but it does not mean that other tasks do not have to be carried out anymore so it is not more efficient".*

The associations have the channels to inform their members about the new insights from the Integrated Birth care Standard. Bo geboortezorg mentioned that they have several channels to inform namely: A website, news items that they publish on the website [36], newsletters [37], a survey to see what their members needed in terms of support, in the end a checklist [38] was also created for their members about the Integrated Birth care Standard which could help them with implementing the ZIG, they have had meetings where CPZ talked about the standard of care. Next to that Bo geboortezorg organises the day of maternity care [39], which is a day for maternity care workers. Workshops or held and there is a knowledge street. It was stated: *"It is a fun day combined with learning and there were also workshops on the Integrated Birth care Standard".*

The professional groups conclude on the basis of application that the new method satisfies and confirms its usefulness. It was indicated that they have tried to convince their members by: *''Especially by informing them about the ZIG as much as possible and the reason why we did this and what it means for them and what should you do exactly so I think that was mainly done*".

Encourage involvement in the actual implementation of the Integrated Birth care Standard among their members. Encouraging involvement is mostly done through informing through newsletters and news items. Furthermore, they stated that *'' We mainly try to realize that maternity care is an important link and that they must therefore take part, we certainly focused on that in the beginning and provided a lot of information, also in that checklist so that the maternity care workers really knew how to get started"* .

Offering training to the members. They mentioned that they have provided a training once:*'' We have had what we call a lecture and that is not a training in the sense of as to the professional group, but more informative and in in which we have also told them about the Integrated Birth care Standard and given them concrete support, but there were no separate training courses that can be followed when it comes to the standard of care, except for the workshops on that day of the maternity care"*. In the future Bo geboortezorg would like to offer training at the birth care academy which will focus more on the organization itself, in which management, planning and HR emerge.

Identify which training courses are offered by other parties. The training courses offered by other parties were not identified by Bo geboortezorg. However, if

they saw training courses coming by that seemed important for maternity care, such as in the corona crisis, they would include this in the newsletter or share it on their website.

They inform the support organization of the CPZ and the other industry and professional and patient associations about their own activities regarding the implementation of the Integrated Birth care Standard and look for cooperation and synergy between their own activities and the activities of others. Concerning this it was mentioned that *''I think that in general almost everything goes through the CPZ, regarding activities that are taken up jointly".* This answer indicated that they do not consider this as their task.

The professional associations appoint representatives to CPZ to contribute to the realization of the client version of the Integrated Birth care Standard. Bo geboortezorg was not entirely sure if they had appointed a representative to contribute to the realization of the client version because the interviewee was not there at that point. However, in the client version [6] is stated that Bo geboortezorg was involved.

Communication to own employees or members about updates of the Integrated Birth care Standard in newsletters, magazines, via their own website, folders. It was indicated that they do communicate about updates when it comes to the ZIG. *''In principle yes, we follow the news coverage of the CPZ also on the addendum that was recently concluded. We make a management report every quarter, which goes to all members and that includes all the activities that we have done and it also states that the addendum is coming".*

Identifying bottlenecks around the introduction of integrated birth care at the CPZ (whereby the support group acts as the point of contact for CPZ). They indicated that bottlenecks are introduced at the CPZ, the following was stated: *" Yes, we have also been in that implementation group, so what was retrieved there from the survey was communicated correctly and if we encounter something that really relates to the Integrated Birth care Standard and not so much that the maternity care organization, we always sort it out with the CPZ because it is usually something that applies to several parties and we cannot solve that alone, so the CPZ is a logical point of contact".*

Actively share proprietary solutions with other regions and share solutions, models and documents through CPZ. Bo geboortezorg indicated that sharing of solutions is done more by the VSVs themselves. They stated: *''We mainly let the VSVs do that themselves, if they had documents or good examples that we can share with the CPZ, of course that also applies to the task force, they have that knowledge base and I think that is mainly via the VSVs because these are not just maternity care documents, they are usually valid for the entire birth care".*

Ensuring or encouraging employees or members to participate in multidisciplinary consultations for joint risk assessment. It was indicated that multidisciplinary consultations are just a part of the ZIG. Assumably it is meant that this is already anchored in their routine. Furthermore, it is stated that *'' The importance of maternity care being an equal partner is especially emphasized, in the beginning the focus really was on the fact that they also had to sit at the table as an equal professional and we mainly do that by pointing out the organizations so not so*

much the maternity care itself. The emphasis was therefore more on ensuring that the other parties see maternity care as an equal partner and also involve them in the multidisciplinary consultations".

The organization contributed to the further development of monodisciplinary guidelines to multidisciplinary guidelines, standards and agreements. Within maternity care, guideline development is mainly a task of the Kenniscentrum Kraamzorg (KCKZ). They took part in, for example, the development of the multidisciplinary guideline on postnatal care. This indicates that this is not the task of Bo Geboortezorg.

Appendix L. Detailed interview regarding activities KNOV

Members must become convinced that the new working method is valuable and is efficient and saves time and costs. The KNOV subscribes to the view that professional collaboration between the various professionals involved in childbirth care is essential to achieving high quality birth care but at the same time, it can be complex. One such complexity relates to the introduction of new ways of working. The KNOV highlighted that any new work method is costly, both financially and in terms of time. Gaining insights into time and costs is important. It was stated: *"That is also why the KNOV really pressed for a cost-benefit analysis, so to speak "*

The professional associations have the channels to inform their members about the new insights from the Integrated Birth care Standard. The KNOV communicates through a newsletter and via the KNOV website. However, in order to reach as many of their members as possible, the KNOV also make use of social media and have a Facebook group [40] for members of the KNOV. This platform has multiple uses: as a discussion forum for its users but also as a place to *"share the knowledge and developments in childbirth care with and between KNOV members in an accessible way, so that midwives do not have to figure that out themselves".*

Encourage involvement in the actual implementation of the Integrated Birth care Standard among their members. The KNOV encourages and facilitates midwives to become active participants in the implementation of the Integrated Birth care Standard. In order to do this, the KNOV has developed various tools which can be used to support midwives during the implementation process. The following was stated: *"Various implementation products have been devised and developed. Examples of these are, guidelines, a toolkit, factsheets, folders, e-learnings, workshops, and trainings".*

Creating support among their own members for the implementation of the ZIG. Creating support and ownership is an important aspect of successfully implementing a new approach to work or care practices. The KNOV indicates that they took a proactive stance by actively encouraging their members to read and offer feedback on the Integrated Birth care Standard during the consultation period. In its role in striving for the best possible childbirth care for women, the KNOV played a role in sharing the client version of the Integrated Birth care Standard. *"we put a call out about this to our members, about who wanted to participate"*. This was also published on the KNOV website [41].

Offering training to members. The KNOV recognised that preparing midwives for the implementation of the ZIG was an important task. To this end, the KNOV offered a lot of workshops and training. It was stated*: "Workshops, training courses and e-learnings have been offered on the implementation of the ZIG".*

Identify which training courses are offered by other parties. Additionally, the KNOV also took note of implementation activities or products offered by other professions. Concerning this, it was indicated that: *''The KNOV has made a whole list of all of the implementation products that are available: Toolkits, fact sheets, folders, training, E-learning, etc. We noted the topics, among other things, kept track of what the*

subject was, what the type of implementation product was, what the target group is for that training and the parties that are involved. I also think that it was once shared by CPZ" . The list with implementation products [42] was indeed published on their website as a "living document".

Inform the support organization (the CPZ), the other professional and patient associations about the activities of each organization regarding the implementation of the Integrated Birth care Standard and look for cooperation and synergy between their own activities and the activities of others. Collaborating with other professions in developing multidisciplinary guidelines was one example of ways in which the KNOV participated in implementation activities. Another is the various activities that support implementation although it was acknowledged that it can be challenging to synchronise these with each of the professions. The following was stated: *''I think it is just not possible for parties to say okay, you have a course A. You do not necessarily have to be attuned to course A at the KNOV. It may not be that every course really applies to all professions.... I do not know if this is the case and how far things are aligned".*

The professional associations appoint representatives to the CPZ to contribute to the realization of the client version of the Integrated Birth care Standard. In working towards the best possible birth care, the KNOV received a request to contribute to the client version. The KNOV appointed a representative to work on this version [6].

Communication to KNOV employees and members about updates of the Integrated Birth care Standard in newsletters, magazines, via their own website or folders. The KNOV took an active role in informing its employees and members about the Integrated Birth care Standard. This was done via the website, and through the weekly newsletter that is emailed to each employee and member. Any addendums to the Integrated Birth care Standard would also be communicated in this way.

Identifying/observing bottlenecks around the introduction of integrated birth care at the CPZ (whereby the support group acts as the point of contact for CPZ).). Where bottlenecks are observed or identified, the KNOV had highlighted some early identified bottlenecks: *''Yes, I think we responded during consultation rounds. I think the CPZ has also received this from us". It is unclear which if any bottlenecks had been identified or reported following the consultation round.*

Actively share proprietary solutions with other regions and share solutions, models, and documents through CPZ. It was indicated by the KNOV that CPZ is a central place for collecting 'Best Practices' and various solutions shared from the different regions. As such, the CPZ is ideally placed to share solutions with the KNOV and other involved parties. The KNOV therefore did not carry out this activity.

Ensuring or encouraging employees or members to participate in multidisciplinary consultations for joint risk assessment. The KNOV noted that this is a complex aspect of collaboration, given some of the historical differences between midwives and gynaecologists. It is unclear whether they carried out this activity.

The organization contributed to the further development of

monodisciplinary guidelines to multidisciplinary guidelines, standards, and agreements. The KNOV mentioned that they cooperate with all relevant multidisciplinary guidelines of other professional groups such as the NVOG and NHG. The KNOV itself develops guidelines in a multidisciplinary setting (this will restart in autumn and was delayed due to the impact of Covid-19). Before COVID-19, the KNOV was involved in consultations from the CPZ regarding multidisciplinary guideline development in the future. During Corona there was consultation and collaboration with all relevant professional groups about the application and possible temporary adjustment of the guidelines.

Appendix M. Detailed interview regarding activities NVOG

Members must become convinced that the new working method is valuable and is efficient and saves time and costs. The NVOG mentioned that they agree with this quote when it comes to the phrase that the method is valuable. The following was stated about saving costs and time: *''I am not sure about the time savings yet, it is more efficient in the sense of if you want to collect data etc. If you do not deliver care doubly, it is more efficient. Whether it really entails savings in costs, I cannot judge that very well because a lot has been added which makes it difficult to compare the current situation and 10 years ago".*

The professional groups conclude on the basis of application that the new method satisfies and confirms its usefulness. NVOG notes that every member has been able to read the Integrated Birth care Standard and knew what was expected from them in terms of the implementation plan, since the NVOG certainly brought this to the attention of the members. *''It is actively propagated in all kinds of ways, with newsletters, evenings have been organized for our professional group to discuss the ZIG and once a survey [44] was issued from within the NVOG".* Those newsletters could not be found since the newsletters [45] have only been on the website from the year 2018.

Encourage involvement in the actual implementation of the Integrated Birth care Standard among their members. Encouraging the involvement in the implementation was mostly done through informing through newsletters and news items and theme nights. The NVOG furthermore indicated: *''That implementation has been a while ago so we are not actively working on that right now, but an update is given at every members meeting on how working according to the ZIG is progressing".*

The associations have the channels to inform their members about the new insights from the Integrated Birth care Standard. NVOG has different channels to inform their members namely: *Newsletters [45], surveys [44], theme nights, attention was also paid to it during conferences and we have a scientific journal the NTOG[46] in which integrated birth care is a theme that is often discussed.*

Offering training to the members. It was indicated that they have not offered schooling to their members *''We do not have specific training courses for the implementation of the ZIG, I think that all went through CPZ".*

Identify which training courses are offered by other parties. The NVOG indicated that if courses were offered that they found important this was noted, however they mainly looked at CPZ when it comes to this. Furthermore, it was stated: *''If a training was offered by the CPZ, we in some cases informed our members through email".*

They inform the support organization of the CPZ and the other industry and professional and patient associations about their own activities regarding the implementation of the Integrated Birth care Standard and look for cooperation and synergy between their own activities and the activities of others. The NVOG considers that to be the task of the CPZ. They mentioned *''As the NVOG, we have often indicated that CPZ must arrange this because that's where all parties come together so in that sense you can assume that there was coordination*

within the CPZ".

The professional associations appoint representatives to CPZ to contribute to the realization of the client version of the Integrated Birth care Standard. A representative was appointed from within the NVOG. It was stated that: *''A gynaecologist was involved in this, who has been on the board here and who has also been involved in the initial phase of the Integrated Birth care Standard".* It is also mentioned in the client version [6] that they were involved.

Communication to own employees or members about updates of the Integrated Birth care Standard in newsletters, magazines, via their own website, folders. It was indicated that the interviewee did not know whether the updates have been communicated to members. When it came to the addendum, it was stated that: *''I might not have recognized it as an update, missed it probably, but whether it has been communicated to our own members, I do not really know".*

Identifying bottlenecks around the introduction of integrated birth care at the CPZ (whereby the support group acts as the point of contact for CPZ). The NVOG indicated that they provided feedback to CPZ whenever bottlenecks were introduced by their members, it is seen as a task of CPZ that they arrange this. Next to that it was indicated that they participate in various forms of consultations of the CPZ, including the directors' consultation, where bottlenecks are discussed as well.

Actively share proprietary solutions with other regions and share solutions, models, and documents through CPZ. The representative of the NVOG stated *''No, I have no idea about that".*

Ensuring or encouraging employees or members to participate in multidisciplinary consultations for joint risk assessment. It was mentioned that the NVOG did not really stimulate this, they do however think multidisciplinary consultations should take place. Furthermore, was stated that: *''What has always been exceedingly difficult is which patients are discussed. When it comes to joint risk assessment, we believe that the caregivers should jointly agree which patients are or are not discussed, but there are certainly regions where the midwifes themselves decide what they want to discuss and what they do not want to discuss. Whether that leads to problems I do not know. At the moment that midwifes do the consultation it will probably all be okay, but I think there are still midwifes who do not discuss anything, although they officially have to".*

The organization contributed to the further development of monodisciplinary guidelines to multidisciplinary guidelines, standards, and agreements. The NVOG has focused their answer on CPZ and not on how they themselves contributed to the development; It was stated that: *"As far as I am concerned, CPZ has hardly contributed to this until now. That remains difficult. However, a start is now made on renewing the cooperation agreements (the old VIL); maybe that will work and help".*

Appendix N. Federatie van VSVs

Since the Federatie of VSVs is mostly an advocacy group some of the activities were not carried out by them since they did not see that as their task. That concerns the following activities:

• ***Encourage involvement in the actual implementation of the Integrated Birth care Standard among their members.***

• ***Ensuring or encouraging employees or members to participate in multidisciplinary consultations for joint risk assessment.***

For some activities it was mentioned that they the Federatie van VSVs not carry them out because they as an organization were founded in a later stage, those activities were:

• ***Identify which training courses are offered by other parties.***

• ***The professional associations appoint representatives to CPZ to contribute to the realization of the client version of the Integrated Birth care Standard.***

For the activity: ***Offering training to the members***, it was indicated that the Federatie van VSVs would like to carry out this activity but do not have the financial resources to do so.

The following activities did relate to the Federatie van VSVs:
Members must become convinced that the new working method is valuable and is efficient and saves time and costs. The federatie van VSVs indicated that they think the working method described in the ZIG is useful. Next to that, they indicated: ‘*”The new working method in which the quality of care improves and more attention goes to setting up a quality policy, it is not expected that this will yield financial savings in the short term. It does in the area of morbidity of mother and child”.*

The associations have the channels to inform their members about the new insights from the Integrated Birth care Standard. It was indicated that a lot goes through Kennisnet [34], but that they also actively communicate through newsletters that are published on their website [47]. It was also mentioned that information can be found on their website. However, on the website there is not a lot of information available, for the public at least. They have also stated they receive questions through email, which is another channel the Federatie van VSVs works with.

The professional groups conclude on the basis of application that the new method satisfies and confirms its usefulness. For this activity it was indicated that the Federatie van VSVs has a very explicit vision that the Integrated Birth care Standard must be implemented and that they also propagate this. However, they believe that a number of items within the Integrated Birth care Standard are either outdated or not feasible for VSVs in the current circumstances.

They inform the support organization of the CPZ and the other industry and professional and patient associations about their own activities regarding the implementation of the Integrated Birth care Standard and look for cooperation and synergy between their own activities and the activities of others. The federatie van de VSVs stated: *'' It is actually the goal of the federatie to map this and to coordinate it, we hear a lot and we get a lot of information"*. They also mentioned that they have good contact with the involved parties, only less with the NVOG.

Communication to own employees or members about updates of the Integrated Birth care Standard in newsletters, magazines, via their own website, folders. The federatie van VSVs indicated that they communicate all developments regarding birth care that are relevant for VSVs, including updates both at their six-monthly conference and in their newsletters. Furthermore, it was mentioned that this went through the professional organizations per profession.

Identifying bottlenecks around the introduction of integrated birth care at the CPZ (whereby the support group acts as the point of contact for CPZ). They have indicated that that is their main task. Furthermore, they stated that they report these bottlenecks not only to CPZ but also to other major players such as NZA and RIVM.

Actively share proprietary solutions with other regions and share solutions, models, and documents through CPZ. The Federatie van VSVs indicated that they have shared a lot of solutions with CPZ, especially in the beginning. They furthermore stated that *'' We had the feeling that we had to provide a lot of information to CPZ, but that they have used that information very nicely to set up a document and we actually expected it to be the other way around, we expected more help on their part"*. They also indicate that they actively work on providing a dashboard that is accessible for every VSV, which makes it possible for them to provide indicators and to set up a PDCA cycle.

The organization contributed to the further development of monodisciplinary guidelines to multidisciplinary guidelines, standards, and agreements. For this activity, the interviewee could only speak from within her own VSV:*" From our own VSV, we started implementing the ZIG together with two other VSVs. In addition, we immediately addressed various guidelines. We therefore designed the multidisciplinary guideline together with two other VSVs and this course of action indeed arose from the fact that we had to implement the ZIG".*

Appendix O. Activity matrix Bo geboortezorg, KNOV, NVOG and Federatie van VSVs

Activity	Yes	No	Partly	unknown
Members must become convinced that the new working method is valuable and is efficient and saves time and costs			NVOG KNOV Bo geboortezorg, Federatie van VSVs	
The professional groups conclude on the basis of application that the new method satisfies and confirms its usefulness.	NVOG, Bo geboortezorg		Federatie van VSVs	KNOV
Encourage involvement in the actual implementation of the Integrated Birth care Standard among their members.	NVOG, KNOV, Bo geboortezorg	Federatie van VSVs		
The associations have the channels to inform their members about the new insights from the Integrated Birth care Standard.	NVOG, KNOV, Bo Geboortezorg, Federatie van VSVs			
Offering training to the members.	KNOV, Bo geboortezorg	NVOG, Federatie van VSVs		
Identify which training courses are offered by other parties.	KNOV	Bo geboortezorg, Federatie van VSVs	NVOG	
They inform the support organization of the CPZ and the other industry and professional and patient associations about their own activities regarding the implementation of the Integrated Birth care Standard and look for cooperation and synergy between their own activities and the activities of others.	Federatie van VSVs	NVOG, Bo geboortezorg	KNOV	
The professional associations appoint representatives to CPZ to contribute to the realization of the client version of the Integrated Birth care Standard.	NVOG, KNOV, Bo geboortezorg	Federatie van VSVs		

Communication to own employees or members about updates of the Integrated Birth care Standard in newsletters, magazines, via their own website, folders.	KNOV, Bo geboortezorg, Federatie van VSVs			NVOG
Identifying bottlenecks around the introduction of integrated birth care at the CPZ (whereby the support group acts as the point of contact for CPZ).	NVOG, KNOV, Bo geboortezorg, Federatie van VSVs			
Actively share proprietary solutions with other regions and share solutions, models, and documents through CPZ.	Federatie van VSVs	NVOG, KNOV	Bo geboortezorg	
Ensuring or encouraging employees or members to participate in multidisciplinary consultations for joint risk assessment.		NVOG, Federatie van VSVs	Bo geboortezorg	KNOV
The organization contributed to the further development of monodisciplinary guidelines to multidisciplinary guidelines, standards, and agreements.	KNOV	Bo geboortezorg		NVOG, Federatie van VSVs

Appendix P. Detailed interview regarding the activities Patiëntenfederatie Nederland

The associations have the channels to inform their members about the new insights from the Integrated Birth care Standard. When it comes to their direct members which are the member organizations, Patiëntenfederatie Nederland informs in different ways. They have a newsletter [50], AOV's and other directors' meetings. Next to that they also have commissions, when it comes to birth care, where they put their members at the table, who all do something with birth care, and non-members can also be present. They also use public websites such as, for example, ZorgkaartNederland [51]. They furthermore state: *''Our own website [48] is now much more aimed at the general public, including via social media. In this way, we really focus on reaching the public".*

Carry out own activities that promote the application of integrated birth care in accordance with the Integrated Birth care Standard. They indicated that they did not really see this as their role and therefore did not immediately start with a lot of activities when it comes to implementing the ZIG. What they did do is make sure that all the relevant care providers were involved when setting up a new guideline. This is mainly because Patiëntenfederatie Nederland noticed that in a lot of cases maternity care was not involved.

Delegate a representative to CPZ to contribute to the realization of a client version of the Integrated Birth care Standard. They did delegate a representative. Next to that, it was indicated that the representative of the Patiëntenfederatie Nederland got the assignment to create the client version in a quick manner. She mentioned that *'' Well I did not agree at first, but in the end, I got some help with creating the client version and eventually the budget was also made available by the CPZ".* It was also mentioned that eventually all parties were involved. This was also mentioned in the client version [6].

Looking for cooperation and synergy between own activities and the activities of healthcare professionals and professional associations. The following was stated: *''Not so much, but that also has to do with the fact that for the Patiëntenfederatie Nederland birth care is only a small part, while the midwife is only busy with birth care and gynaecologists also should coordinate with each other. Also, with maternity care ".* Furthermore, it was indicated that they do not really start projects when it comes to birth care but it is more the case that they are requested by other parties if the client perspective has to be represented.

Further development of the indicators of customer preferences. It was indicated that they did further develop the indicators. Next to that it was mentioned, that at first, customer preferences were only measured within the indicator set of the hospital, but that they later ensured that there were customer preference questions for the entire VSV, also to create decision aids.

Communication about relevant aspects of the Integrated Birth care Standard, including trying to get pregnant women / parents involved in

participation in advisory boards of VSVs. Regarding this activity Patiëntenfederatie Nederland also indicated that it is not necessarily their role. The following was stated: *''From the Patiëntenfederatie Nederland, the focus was very much on the national policy and thus indeed guidelines and standards, because that is for the entire country. This activity actually regards how you really shape it in the region".* They also mentioned that there are branch organisations of client councils who focus more on client councils, so it is not entirely their field. They therefore felt that they did not have to be highly active in this.

Stimulating self-management for pregnant women by providing information. About stimulating self-management was stated that: *''That is again such an overly broad term. I think mainly by translating the ZIG, into the client version ".* Furthermore, was not mentioned how self-management was stimulated.

Identifying bottlenecks that occurred during the implementation of integrated birth care at the CPZ (whereby the support group acts as the point of contact for CPZ). They work with consultations among clients, and where relevant, it ends up at the CPZ. There is no structural monitoring among clients. Often their bottlenecks concern specific topics that are not directly included in the standard, the Patiëntenfederatie Nederland thinks that CPZ will not see that as their role to tackle those bottlenecks.

Actively share own solutions with others by sharing solutions, models, and documents via the CPZ. For this question was also indicated that it is difficult to answer, but later on it was stated that *''One of the employees who no longer works here, had also done a round with parties about bottlenecks and she concluded that there was actually very little happening in the field of client participation for example, those mother councils. This was then reported to the CPZ".* It was mentioned that CPZ has put that on the agenda [52].

Facilitating valuations: making valuations for precautionary organizations available and comparable for other patients / clients via ZorgkaartNederland. It was unknown to the Patiëntenfederatie Nederland that this is also described as an activity in the implementation plan. They furthermore stated:'' *That is our website ZorgkaartNederland [51], but we have not really carried out specific action when it comes to pregnant women, I believe in recent years".* Later on, it was mentioned that there are valuations published on ZorgkaartNederland regarding midwifery practices, maternity care practices and hospitals. On the website of ZorgkaartNederland [51] it can also be seen that this activity is carried out.

Appendix Q. Detailed interview regarding the activities CPZ

Introduction
During the data collection regarding CPZ it was proven challenging to make an inventory of whether an activity has been carried out and how as the implementation process of the integrated birth care policy turned out differently in practise, then the implementation plan describes. The way in which CPZ is organized, has changed in many respects including their working method and governance. Therefore, a distinction is made between the ''what'' and the ''who''. To further clarify, the focus of the reader has to lie on the activity in itself and less on which body of the CPZ has undertaken it. In addition, the reader should keep the following in mind:

- CPZ has seen many changes over the years, CPZ-1.0 [53] hardly had a bureau in place contrary to after 2017 where for CPZ-2.0 a new chairman of the board was recruited and the CPZ was reorganized (*'herijkt'*). In the perspective of change management, it is important to note this difference because of the possible impact on the implementation process.
- CPZ does not work according to all of the bodies, as described in the implementation plan, and also did not do so at the time. Those bodies were: CPZ in general, CPZ staff bureau, Support organization VSVs, the implementation group and the communication activities. Per body will be indicated whether or not CPZ has worked with it.
- CPZ has always adjusted their working method based on the demands and needs of the field.
- The implementation plan had to be developed and published in an expeditious manner due to the pressure of Zorginstituut Nederland.

CPZ in general
CPZ has made an inventory of the bottlenecks and needs regarding the implementation of the Integrated Birth care Standard. Bottlenecks have been collected in various ways by CPZ. Firstly, all stakeholders have been invited to a consultation round of the ZIG [54], in which bottlenecks have been collected. In addition, CPZ has asked the National umbrella organisations, to get input regarding bottlenecks at the general assembly of members, repeatedly. Soon after the start of the implementation of the ZIG, in January 2017, CPZ also consulted all VSVs to collect regional bottlenecks and need for information, instruments and other support in telephone interviews. The telephone interviews [26] were initiated from within the Task force which aim it was initially to pick up bottlenecks for integrated funding and later on subjects regarding the implementation of the ZIG were added. Because of the

necessary alignment between integrated funding and a certain degree of organization. It was stated that *''From 2017 we asked all VSVs in direct terms what kind of support you need for the implementation of integrated birth care?".* It was indicated that they also have asked what the bottlenecks are, in the official question list created for the telephone interviews [26], this question is not included, however the VSVs are asked if they need support. The results of all telephone interviews were described and it was examined which bottlenecks arose. Lastly an online meeting with all the VSVs was also held in which information about bottlenecks was retrieved.

During the desk research more bottleneck inventories done by CPZ have been found, this may not be exhaustive. An inventory about the bottlenecks regarding the implementation of the ZIG was carried out and in February 2017, a bottleneck analysis[55] was carried out with possible solutions. This was initiated from within the taskforce and was focused on integrated funding. There is also an inventory on capacity problems and possible solutions in 2019 [56]. Lastly, there have also been round table meetings [57] with individual VSVs where bottlenecks were discussed. Overall, it was indicated that CPZ has a good insight about the bottlenecks in the short and long term when it comes to every aspect such as: organization, cooperation, and finance.

The 2020 work plan [56] mentioned CPZ should identify bottlenecks and put them on the agenda. This is seen as the core of their umbrella function. It also says that CPZ discusses bottlenecks in group meetings. In addition, it was mentioned that: *''We do this through intensive contacts with our network at national, regional, and personal level, also through group meetings, but also through working visits, bilaterals and other meetings, and the telephone interviews. And do not forget our own knowledge and skills network".* CPZ is certainly carrying out this activity and has been doing so for years.

Taking charge of providing information about the Integrated Birth care Standard. It was mentioned that CPZ carried out this activity from 2017, right after the publication of the ZIG. This also becomes clear when looking at the annual report of 2017 [58], it is stated that the information and professional communication function, including a set of standard communication tools were put in place in 2017. The following was stated by CPZ [58] about providing information: *''The CPZ plays a huge role in this as we are the joint organisation of which the parties in the field want to shape the joint ambitions and from which they want to communicate joint messages together as much as possible to benefit integrated birth care".* Next to that a professional communication department had been put in place. During the interview it was mentioned that they communicated with the field by using the following media: a new newsletter, webinars, improving CPZ's website and increasing their reach through social media [59] [60]. These are all channels through which CPZ informs birth care professionals, board members of VSVs and policy makers.

Regarding taking the lead in informing when it comes to the National umbrella organisations it was stated that *''Being national stakeholders, the CPZ participants themselves have all been fully involved in both the realization of the ZIG and the realization of the implementation plan. There was a working group " Integrated Birth care Standard" in place in which all parties were represented, and furthermore progress was reported to the participants 'councils, Ministry of VWS and directors' meetings".*

The National umbrella organizations were therefore fully informed.

CPZ stimulates and supports the sector of professional and patient associations to take responsibility in creating support among their own members and to stimulate involvement in the actual implementation of the Integrated Birth care Standard. Information is shared in a systematic manner by CPZ, for which there are administrative agreements. Coordination of policy and communication with regard to the ZIG is a core of the CPZ's work plans. This started in 2017, when an entire conference was devoted to different aspects of the implementation of the ZIG. Next to that, the implementation of the ZIG is regularly on the agenda of the directors' meeting, which has a formal status. The national parties are also part of the working groups, including the working group "Integrated Birth care Standard" and the working group ''Indicators". The working group "Indicators" first was part of the Perined organization and later on in 2018 CPZ took over managing this working group. This has given a boost in the improvement of the indicator set and the support of the quality management (PCDA-Cycle). Since the start of the set, the indicator set contains a number of indicators that measure the degree of implementation of the ZIG.

CPZ supports the implementation of the ZIG trough the umbrella function and the taskforce integrated funding. Creating support among their own members and stimulating involvement in the actual implementation of the Integrated Birth care Standard is therefore stimulated by CPZ by the fact that the ZIG is structurally addressed in the working groups, in which the National umbrella organisations are all represented. The following was stated: *''CPZ considers it their duty to encourage CPZ members to facilitate and support their members as much as possible. We do this through: providing information, bringing support tools to their attention, webinars and so on*".

CPZ did emphasize that the ZIG is a field norm and is not imposed by CPZ. It is a guideline owned by the National umbrella organisations since it was presented to the ZIN with all the national birth care parties, the patient organization, and the financers. It was CPZ facilitating this process. Which means that in addition to CPZ's resources, the National umbrella organisations also have a responsibility when it comes to stimulating their members implementing the ZIG.

Stimulating the development of multidisciplinary guidelines. CPZ puts it on the agenda that guidelines are being developed multidisciplinary by the National umbrella organisations involved and address it whenever they are aware of the fact that a guideline is developed. The following was stated by CPZ: *''When we know that an organization is developing a guideline, we always inquire whether it is multidisciplinary".* Furthermore, was indicated that the funding system is still aimed at monodisciplinary guidelines which complicates the process of making actual multidisciplinary guidelines.

Staff bureau

For the staff bureau of CPZ other activities were described, which will be discussed here. It was indicated that it was called ''staff bureau" in the implementation plan, but that there was hardly a bureau at the time the implementation started. About the

current bureau of CPZ was stated: *''We support the Integrated Birth care Standard working group, with regard to the Integrated Birth care Standard, we have a specific policy advisor who is mainly responsible for supporting the further development of the ZIG".*

Regarding the activity: The CPZ staff office supports the implementation group. It was indicated that at the time, CPZ immediately started with setting up a toolbox to support the implementation of the ZIG in 2017, for example a digital consultation hour was put in place. CPZ focussed on identifying the field's needs. This only required a different body than the implementation group. The following was stated about the implementation group: *''That implementation group was mainly concerned, with the entire process of the development of the Integrated Birth care Standard and also with the process for the development of the implementation plan. Once the implementation plan was in place, that implementation group actually had no role anymore and was cancelled".* After the ZIG and the implementation plan were drawn up, there was no longer an implementation group as such. There is however a working group Integrated Birth care Standard, who is supported by the CPZ staff office.

CPZ staff bureau stimulates unambiguous client information by the national birth care parties, professionals, industry, and patient associations when it came to introducing the Integrated Birth care Standard and the client version. The following was mentioned by CPZ: *"The ZIG is a shared document by the National umbrella organizations, but for the clients we have the client version which is supported by all parties and ''Alles over zwanger" which is based on the leaflet '' Zwanger!"and on the client version of the ZIG. So that is all unambiguous information".* The interviewees both mention that the fact that the client version and the Integrated Birth care Standard was supported information which all the National umbrella organisations agreed to, is the total message. It was stated that: *"In total that is the one message, with the friendly request to all those parties, to convey as much as they can".* It was also mentioned that the National umbrella organizations did propagate that message to their members. Furthermore, it was indicated that the ZIG reflected in all their documents and agendas, in that way CPZ propagates the message. In the annual plan of 2017 [58] also became clear that a convention has been organized to mark the start of the implementation of the Integrated Birth care Standard.

Communicate with the field. It was indicated that *''CPZ provides messages that the national stakeholders can share through their own means".* This was and is done in many ways. A communication meeting [61] was organized which one communication employee per involved party could attend. In this meeting a few subjects were discussed, it mainly concerned an identification of what was already existing in terms of communication, what they could learn from each other and it was emphasized that when CPZ shared messages, the National umbrella organizations should share them with their members. This has remained at one meeting, but the communication employees got to know each other which created a network between the National umbrella organizations. In addition, various webinars were given

regarding various aspects of the ZIG, they used a newsletter [62], Kennisbank and they gave an annual conference with workshops [63]. The latter is still being done.

Facilitate Kennisbank. *Kennisbank* was developed by the CPZ to support the field with the implementation of the ZIG. It has undergone changes over the years. At first it was an online information database organized by topic, containing all kinds of documents by topic. VSVs could consult the database to find examples for implementation, including best practises among other things. At one-point *Kennisbank* was revised since more and more information was added to the knowledge base, which put pressure on the user-friendliness and findability of information. This has been done in a diligent manner, with focus groups. To support the field even better, the "Implementation tool" was developed which is linked to subjects in the information database. It is safe to say that this activity has been carried out.

Implementation Group

For the implementation group their primary task was to develop the ZIG, the implementation plan, and the client version of the ZIG. The implementation group was cancelled in 2018 because it had fulfilled its tasks, as stated in a proposition [64] of the CPZ board. The follow-up [65] were the maintenance and management of the ZIG, the central direction in the development of multidisciplinary guidelines and a model related to the individual birth plan. These tasks were addressed by the bureau of CPZ itself to further develop this together with the National umbrella organizations.

The implementation group creates the client version of the ZIG. CPZ mentions that the client version of the ZIG was developed by all the national birth care parties coordinated by the Patienten Federatie Nederland. The Patienten Federatie took the lead. It was the implementation group that with the director mandate, established the client version.

Identify bottlenecks in conditions that are necessary for or were required for the implementation of the ZIG. It was indicated that the implementation group identified a number of bottlenecks when it came to the preconditions. These are included in the implementation plan [5] itself.

Identify solutions for bottlenecks and pass them onto the board. CPZ has addressed this and not specifically the implementation group since this activity was not on their agenda. This does not need to be elaborated further, because of the fact that the governance is very contrasting from what is described in the implementation plan and this has already been discussed.

Identifying the lack of underlying guidelines that do not match the scope of the Integrated Birth care Standard. The following was stated regarding this activity: *'The implementation group was about developing the Integrated Birth care Standard and was thereafter cancelled., so it was not up to the implementation group to assess which guidelines do or do not relate to the ZIG".* Furthermore, was stated when it comes to the Integrated Birth care Standard, the Verloskundige Indicatielijst [66] and the Preconceptie Indicatielijst [67] CPZ does evaluate, but the substantive guidelines

are for the birth care parties themselves.

Support group VSVs
The implementation plan also described activities for the so-called support group VSVs. It should be noted that this, again, turned out differently in practice. The support group was initially responsible for two components: Integrated funding and the implementation of the ZIG. During the interview it was mentioned the VSVs support group became the task force integrated funding. Naturally, the focus of the taskforce was on integrated funding. It was however mentioned that the taskforce noticed that a certain degree of organization was required in a VSV to be able to switch to integrated funding. Therefore, the task force did carry out a number of activities regarding supporting the implementation later on. But the CPZ bureau had mainly taken on the tasks of facilitating the field during the implementation from 2017. In addition, it was stated that the Federatie van VSVs also jumped in to support the VSVs when it comes to the implementation of the ZIG.

Making a toolbox available (based on best practices) with support offer. It was mentioned that the taskforce integrated funding has tackled this activity and that the so-called toolbox is the implementation tool.

When it comes to ***sharing and retrieving best practices,*** CPZ shared and retrieved best practices through their knowledge base, webinars, website, newsletter, helpdesk, telephone interviews, working visits and conferences.

The following activities were carried out by CPZ itself when they were not carried out by the Support organisation VSVs or the task force integrated funding:

- ***Facilitating learning networks.***
- ***Organizing meetings for the exchange of information for and by VSVs.***
- ***Increasing the awareness and implications of the ZIG among healthcare providers and pregnant women by making information and training materials available***. It was indicated that CPZ does this trough their webinars and the project 3 goede vragen [68].
- ***Drawing up a clear health care provider version (summary) of the Integrated Birth care Standard or a digital care standard.***
- ***Identifying any bottlenecks in the (financial) preconditions that are necessary for a good implementation.***
- ***Identifying the lack of underlying guidelines that do not match the scope of the Integrated Birth care Standard.***

The activity: ***Supporting the VSVs in their choices when working together in a shared electronic file*** was no longer intended for the CPZ. Baby connect has been engaged for this trough the so called ''VIP program'' by the government. This a national initiative that was introduced and therefore there was no longer a role for the CPZ here.

Support to VSVs per communication

The implementation plan [5] mentioned that Support needed to be offered to the field in the form of communication, it did not specify who should perform the activities other than CPZ itself. It was indicated that a lot has changed over the years in terms of communication. In the pioneer phase, communication was used reactively instead of proactively. From 2017, CPZ has started to systematically plan the communication.

The activity: ***CPZ has taken the initiative to start the collaboration in a communication meeting***, no longer needs to be discussed in detail since it already became clear that they did take the initiative in the one-time communication meeting[61], in the staff bureau section. It yielded that the communication employees of the National umbrella organisations knew where to find one another if necessary. The following activity was also discussed previously: ***CPZ is taking the lead in terms of communication activities related to the ZIG.***

CPZ, together with the support group VSVs, takes the lead to convert the joint wishes and objectives in the communication consultation into a framework communication plan and a joint action plan of the organisations supports and unites. One of the interviewees indicated that CPZ was more concerned with getting the means of communication up and running in 2017. Another interviewee mentioned that there was strategic advice [69] regarding communication by the board and an implementation plan which is broader than a communication plan. Another interviewee said there was indeed some sort of communication plan. Therefore, it is not completely clear at what time a "framework for communication "was launched. However, all of them agreed that a lot has been done since, in terms of communication by the CPZ and in the last years in a structural way. It was again indicated: *''What is stated in such an implementation plan often works out differently in practice ".*

Regarding the activity: ***CPZ maps the current communication of the affiliated organizations and the CPZ and their coherence when it comes the implementation of the ZIG.*** The following was indicated by CPZ: *"We tried this indirectly with a communication plan* [70]'. Another example is that is that CPZ shares news items by means of the newsletter[62], which the National umbrella organisations then take over.

Agreements for uniform information have been put in place in the last years, this keeps on evolving. There is coordination on subjects, it is examined what can be communicated jointly and what is to be done separately. For example, the involved parties have sat down together in a crisis team to discuss the communication around the Corona crisis, this had to be standardized and coherent. Furthermore, it was mentioned that the coherence of the communication will become even better in future since the national birth care parties have agreed to develop a central editorial board.