A better start through maternity and antenatal care

Insights from The National Lottery Community Fund's A Better Start programme

February 2024

About A Better Start

A Better Start is a ten-year (2015-2025), £215 million programme set up by The National Lottery Community Fund, the largest community funder in the UK. Five A Better Start partnerships based in Blackpool, Bradford, Lambeth, Nottingham and Southend are supporting families to give their babies and very young children the best possible start in life. Working with local parents, the A Better Start partnerships are developing and testing ways to improve their children's diet and nutrition, social and emotional development, and speech, language and communication.

The work of the programme is grounded in scientific evidence and research. A Better Start is place-based and enables systems change. It aims to improve the way that organisations work together and with families to shift attitudes and spending towards preventing problems that can start in early life. A Better Start is one of five major programmes set up by The National Lottery Community Fund to test and learn from new approaches to designing services which aim to make people's lives healthier and happier.

Learning and evidence from A Better Start enables The National Lottery Community Fund to present evidence to inform local and national policy and practice initiatives addressing early childhood development.

The National Children's Bureau (NCB) is designing and delivering an ambitious programme of shared learning and development support for A Better Start, working within, across and beyond the five partnership areas. The programme is funded by The National Lottery Community Fund.

Our aim is to amplify the impact of A Better Start:

- Embedding a culture of learning within and between the partnerships.
- Harnessing the best available evidence about what works in improving outcomes for children.
- Sharing the partnerships' experiences in creating innovative services far and wide, so that others working in early childhood development, policymaking or place-based systems change can benefit.

https://www.tnlcommunityfund.org.uk/funding/strategic-investments/a-better-start

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Introduction

A Better Start (ABS) Programme Insights aim to collate and share learning emerging from the work of ABS partnerships to inform others' work to improve babies and young children's outcomes.

This issue is number nine in the series, focusing on how ABS partnerships support families during pregnancy and the early weeks after birth.

This report includes the following:

- An overview of key evidence for the importance of pregnancy and the early weeks
- A summary of support available to families during this period – including both NHS maternity services and wider local antenatal offers
- Relevant national policy drivers
- An overview of key challenges, including inequalities in experiences
- Case studies demonstrating how ABS partnerships work within this context to support children from their very first moments.

Support during pregnancy and the early weeks after birth is key to A Better Start's work to give families the best start in life. There is now widespread recognition that experiences during pregnancy and early childhood closely inform outcomes in later life. Within this period, pre-conception, pregnancy and the early weeks after birth are the earliest opportunities for intervention, and lay the groundwork for a range of outcomes, including physical and mental health, cognitive development and academic attainment.

Supporting families during this period therefore supports all three of A Better Start's child-focused outcomes:

- Improving children's diet and nutrition
- Supporting children to develop positive social and emotional skills
- Helping children to develop their language and communication skills

A Better Start partnerships deliver a range of activities to support families during pregnancy that help achieve these goals. These activities also contribute to A Better Start's fourth key outcome – bringing about system change to better support families.

Priorities for ABS partnerships during pregnancy and the early weeks include:

Supporting families directly. Partnerships work to improve how families currently receive support during pregnancy. This includes midwifery and other relational care models, as well as wider public health support for a healthy pregnancy, such as parenting classes, activity programmes or mental health support.

Investing in the maternity and early years workforce, for example building skills around trauma-informed care.

Collaboration and co-production to ensure families' needs are built into local provision during pregnancy and the early weeks.

Integrated working, for example developing new local pathways into

and out of maternity services.

Examples of how these priorities are embedded in the work of ABS partnerships are included in the case studies later in this publication. Below, we first summarise the current research and policy background which inform partnerships' work.

Note to the reader:

This report uses the terms 'woman' and 'mother' – these should be interpreted to include all people who have given birth, even if they may not identify as women or mothers.

The report also uses both 'partner' and 'father' to refer to a woman's chosen supporter. This should be interpreted to include not only fathers, but also a woman's partner, a family member or friend, or anyone who the woman feels supported by or wishes to involve.

Evidence for the importance of pregnancy and the early weeks

There is growing international consensus that the 1001 days from pregnancy to the age of two sets the foundations for an individual's cognitive, emotional and physical development over the rest of their lifecourse.

Pregnancy is vitally important within this period. The mental and physical wellbeing of the mother, informed by the environment around her, has significant impacts on a baby's development, and positive implications for a healthy life.

There is strong evidence of the importance of a mother's **physical health** for both birth and development outcomes. Both maternal nutrition and maternal fitness are strongly related to babies' health at birth, with interventions beginning in early pregnancy most effective at preventing downstream complications for mothers and their children. Exposure to alcohol and smoking is also strongly connected to adverse outcomes for babies.

Mothers' **mental health** is a key determinant of birth and development outcomes. Guidance from the National Institute of Health and Care Excellence, for example, recognises the serious impact of undiagnosed depression and anxiety disorders on the health and wellbeing of both mother and baby during pregnancy and the postnatal period. There is a longstanding body of evidence showing that stress and poor mental health during pregnancy is associated with developmental delays in a baby's first year of life, while maternal distress is associated with increased risk of mental health problems later in life. A 2013 evidence review showed that if a mother was in the 15% of the population with the highest levels of anxiety during pregnancy, this doubled their child's chances of having a mental health difficulty at 13.

Evidence also suggests that the quality of the parent-infant relationship during pregnancy – i.e. parents' bond with and perception of their baby – is associated with the quality of their relationship after birth. This is crucial as the quality of the parent-infant relationship plays a significant role in longer-term physical and mental health, and helps babies achieve their

learning potential.

Pregnancy is a key moment to prepare families for activities that will benefit their baby after birth, including helping families to prepare for and initiate breastfeeding, understand a healthy diet, and become familiar with local services that may support their family.

There is strong evidence that intervention and support during pregnancy in these areas does make a difference. For example, a review of international evidence found a strong association between antenatal care and a wide range of short and long-term mortality and child health outcomes, while women who attend antenatal classes are more likely to have a positive birth experience.

Investing in pregnancy and the early years also makes sense from an economic perspective. Social Return on Investment studies indicate returns of between £1.37 and £9.20 for every £1 spent on the early years. Recent government policy developments have recognised these findings, prioritising investment in early intervention.

Current provision during pregnancy and the early weeks

There are currently a wide range of services available to support families during pregnancy and the early weeks after birth.

Some services – including midwifery and health visiting services - are offered to every new parent or carer. Most Local Authorities also offer a broader range of services to their families, though many of these are only offered on a 'targeted' basis in response to need.

Midwifery support

Midwives provide personalised care and support to women and their families while pregnant, throughout labour and in the first few weeks after a baby's birth. Most new mothers are offered up to ten antenatal appointments, while mothers who have had children before are offered seven. Some mothers with additional needs or complication have more than ten appointments.

Midwives provide most of the support to expectant parents in the weeks before and after birth. They work to ensure that mothers and babies remain as healthy as possible throughout pregnancy, and that the whole family – including partners - is well-prepared for labour, birth, and the early postnatal period.

This includes offering hands-on health support to mothers and babies, including conducting health checks, screening, birth planning, and supporting mothers during birth.

Midwives also support families more broadly, including advising on a healthy behaviours (e.g. around smoking, exercise and diet), providing antenatal parenting classes, supporting mental wellbeing and helping families to access any other support they may require.

A strong body of evidence shows that mothers and babies experience optimum outcomes when continuity of midwifery care is provided. Continuity of carer means a pregnant woman receives the majority of her antenatal, intrapartum and postnatal care from a

primary or named midwife, allowing them to develop a positive relationship across the maternity journey. Women who receive continuity of care during pregnancy experience a range of benefits, including being more likely to feel satisfied with their maternity care, and less likely to experience a range of negative outcomes such as foetal loss and premature birth.

The NHS Long Term Plan, published in 2019, set an ambition to make the continuity of care model the default, with targets to prioritise the model for women from Black, Asian and other ethnic minorities, and those in the most deprived areas. Targets informing this ambition were revoked in September 2022 due to concerns around safe staffing levels in the NHS, though the model is still recommended.

Health visiting and the Healthy Child Programme

Health visitors are specialist community public health nurses, registered midwives or nurses. They are commissioned by Local Authorities as part of the Healthy Child Programme.

Health visitors specialise in working with families with a child aged 0 to five to identify health needs as early as possible, and improve health and wellbeing by promoting healthy behaviours, preventing ill health and reducing inequalities. Health visitors are uniquely placed to identify where parents or their baby might require additional support and play a key role in signposting to information or targeted support.

Health visitors offer a minimum of five health and development reviews to every parent, whether or not it is their first baby. Parents should ideally first meet a health visitor for an antenatal review 28 weeks into pregnancy, then again 10-14 days after a baby's birth, at 6-8 weeks, between 9 and 12 months and between age 2-2.5.

Health visitors also lead on the delivery of the Healthy Child Programme in collaboration with other professionals, including primary care colleagues, children's centre staff, early years settings, community and safeguarding professionals.

The Healthy Child Programme is the national public health framework setting out the support that local authorities should provide to families with young children in England, from pre-conception to 19, or 25 where there is a statutory entitlement. It outlines a wide range of evidence-based prevention and early intervention activities, including health promotion, health surveillance and screening, advice and support. It includes community and universal elements, as well as targeted and specialist support for families with higher levels of need.

The Healthy Child Programme recently underwent a process of modernisation. Priorities for this included ensuring it foregrounded place- and community-based approaches, better addressed inequalities, included new areas of focus based on new evidence, and puts a greater emphasis on preconceptual care.

In 2023 the Healthy Child Programme published an interactive schedule of

interventions setting guidance for what local authorities should implement to support a healthy start to life. This includes guidance for implementation of support from across the pregnancy journey, from pre-conception to the period from birth to 6 – 8 weeks.

Within the antenatal period, for example, the Healthy Child Programme has recommendations around over 30 different areas – including community, universal, targeted and specialist interventions. Some of these areas include:

- Supporting infant mental health
- Promoting positive adult relationships and reducing parental conflict
- Promoting physical activity within pregnancy
- Managing diabetes in pregnancy
- Child Protection and safeguarding
- Addressing female genital mutilation

Mental health support

There is a range of provision to support parents' mental health during pregnancy. This is underpinned by the NHS Long Term Plan's commitment to improve perinatal mental health, pledging increased access to specialist perinatal services for women, with care being available from preconception to 24 months after birth.

Health visitors, midwives, social workers and other practitioners have a key role in identifying mental health needs. The Improved Access to Psychological Therapies (IAPT) Manual also recommends that women in the perinatal period are prioritised for assessment by IAPT services within two weeks of referral and commence treatment within four weeks.

More recently, following the recommendation by the Best Start for Life report that perinatal mental health and parent-infant relationships are essential services to ensure that every baby gets the best start in life, the Family Hubs and Start for Life programme (2022-2025) has allocated £100 million of funding for 75 local areas to provide bespoke parent-infant relationship and perinatal mental health support.

Parenting support

A key element of the Healthy Child Programme is to help all new and expectant parents to make the transition to parenthood as smoothly as possible.

This has recently been reinforced by the Family Hubs and Start for Life programme, which places key emphasis on the importance of sensitive and attuned caregiving. The programme has allocated £50 million for the implementation of evidence-based parenting programmes, peer-to-peer support networks and community outreach activities.

Antenatal parenting classes are a common example of parenting support. They may be delivered by midwives, or through a number of other programmes, including the National Childhood Trust and Baby Steps.

Wider wraparound support

A range of wider public sector and civil society organisations provide families

with support during pregnancy and the early weeks after birth.

This includes financial assistance in the form of benefits and grants. It also includes a variety of other local support, including around disability, housing and social services, as well as more specialised areas like safeguarding and domestic abuse. Other national programmes to support families during pregnancy include programmes like the National Breastfeeding Helpline or smoking cessation programmes.

Key policy relevant to pregnancy and the early weeks

There are several key policy drivers and developments relevant to NHS maternity services and the wider local antenatal offer.

NHS England's Three-Year Delivery Plan for maternity and neonatal services

Published in 2023, the Three Year Delivery Plan sets out how the NHS will 'make maternity and neonatal care safer, more personalised, and more equitable for women, babies and families'.

The Three-Year Delivery Plan builds on 2016's Better Births, which identified key areas to improve the outcomes of maternity services, including: personalised and choice-informed care, continuity of carer, safer care, improved perinatal and postnatal mental health, safer staffing and integrated care. It also picks up on evidence of poor maternity care identified by a range of independent reports, including the Ockenden Review, as well as commitments set out in the NHS Long Term Plan around continuity of care and care integration.

The Three-Year Delivery Plan details what NHS England expects Local Maternity and Neonatal systems (LMNS) and Integrated Care Boards (ICBs) to commission, and what NHS Trusts are expected to deliver.

These expectations are organised into four key themes:

- Listening to women and families with compassion, which promotes safer care.
- Supporting the workforce to develop their skills and capacity and provide high-quality care.
- Developing a culture of safety to benefit everyone.
- Maintaining and improving standards and structures that underpin national ambition.
- Wider policy to support reduction of inequalities.

Policy to support reduction of inequalities in maternity care

There are several additional recent policies that aim to reduce inequalities in maternity care. These build on objectives set out in the NHS Long Term Plan and Better Births to reduce socioeconomic and racial inequalities in outcomes for women and babies, and are informed by findings in recent MBRRACE-UK Reports highlighting ongoing inequalities in maternal and perinatal mortality.

- Core20Plus5 is a national NHS England approach to support the reduction of health inequalities

at both national and system level across five clinical areas of focus. Maternity is one of these areas, and the approach includes specific recommendations to ensure continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups.

- Equity and Equality: Guidance for Local Maternity Systems. This guidance sets expectations around what Local Maternity Systems (LMSs) should provide to ensure that women and babies receive care that meets their needs regardless of their ethnic background or where they live. This includes reducing digital exclusion, better recording ethnicity data, accelerating preventative programmes aimed at those at greatest risk of poor health outcomes, and strengthening leadership and accountability through equity and equality action plans.
- A new Maternity Taskforce aims to explore inequalities in maternity care and identify how the government can improve outcomes for women from ethnic minority communities.
- The NHS People Plan sets out the NHS's ambitions to be an open and inclusive organisation. It states that 'where an NHS workforce is representative of the community that it serves, patient care and experience is more personalised and improves.' However, it also recognises that in some parts of the health service 'the way a patient or member of staff looks can determine how they are treated.' Action is being taken in this area through the Workforce Race Equality Standard (WRES), which supports equal access to career opportunities, fair treatment in the workplace, and action to tackle the causes of discrimination.

NHS Workforce Plan

The NHS Workforce Plan was published in June 2023 and is the first of its kind in the NHS's 75 years of existence. The plan was developed in response to increasing challenges within the NHS workforce, and aims to provide a clear approach to making improvements to the system. The plan has three key objectives:

- Increasing education and training across the workforce
- Retaining existing staff within the NHS
- Reforming productivity in the workforce by developing new approaches to training and education

The plan sets out specific ambitions for the maternity workforce, including to recruit and train enough midwives to fill the shortfall of 5000 staff by 2027/28, and double the number of qualified health visitors by 2031.

Healthy Child Programme

The Healthy Child Programme is the national public health framework setting out the support that local authorities should provide to families with young children in England, from pre-conception to 25. (Please see above for more information).

Family hubs and Start for Life Programme

The Family Hubs and Start for Life Programme provides 75 local authorities with a share of nearly £302 million for 2022-25.

The programme aims to deliver on the government's commitments as set out in The Best Start for Life: A Vision for the 1001 Critical days, and builds on the delivery of the Healthy Child Programme. This report highlighted that services offered to families in the critical period between conception and age two are often disjointed, making it hard for those who need help to navigate the support available to them. It aims to address this by transforming the way services are designed and delivered to enable more accessible and seamless support, developing 'Family Hubs' as centralised locations for families to access services and build stronger relationships with professionals.

The programme aims to improve support and early intervention for local families – offering additional funding for both universal and targeted services. This funding will be targeted specifically at parenting support, bespoke parent-infant relationships and perinatal mental health support, and infant feeding support services.

Through this funding, it also aims to build an empowered, modern and skilled Start for Life workforce that is able to meet the changing needs of families.

Key challenges around provision during pregnancy and the early weeks

There is growing evidence of the need for improvement in the support offered to women during pregnancy and the early weeks after birth. Much of this is focused on improvement in NHS maternity services, though there is also evidence that speaks to wider local antenatal services and support.

Evidence of the need for improvements in maternity safety

Since the publication of Better Births in 2016 and subsequent implementation of the Maternity Transformation Programme, some progress has been made towards the national ambition to halve the rates of stillbirths, neonatal deaths, maternal deaths and brain injuries that occur during or soon after birth by 2025.

Data from the Office for National Statistics shows that significant progress has been made towards this goal, with a 19% reduction in stillbirth rates and a 30% reduction in neonatal mortality rates between 2010 and 2021. However, these rates are slightly less positive than before the COVID-19 pandemic, and suggest that the national ambition is unlikely to be met. NHS England indicates this may have been driven by the direct effects of Covid-19, as well as the indirect impact of the pandemic on accessing maternity services.

Data on maternal mortality (deaths during pregnancy or within 42 days

after birth) is also challenging. The latest data from MBRRACE-UK shows a statistically significant increase in the overall maternal death rate in 2020-2022 compared to 2017-19, which remains significant when deaths due to Covid-19 were excluded.

There are also stark differences in maternal outcomes amongst women from different backgrounds – this is explored further in the next section.

Evidence highlights other challenges NHS maternity services for families during pregnancy and the early weeks.

The National Institute for Health and Care Research, for example, notes that recent years have seen a decline in other key indicators of safety and quality. This is substantiated by the Care Quality Commission's 2023 State of Care report, which highlights that 49% of maternity units now have an overall quality rating of either 'inadequate' or 'requires improvement' - both increases since 2022. The report highlights a range of factors underpinning this decline, including leadership challenges, staffing issues, poor communication between different teams, and inequalities in care.

Several recent reports also have highlighted significant failings in the performance of specific local maternity services. The Ockenden Review of maternity services at the Shrewsbury and Telford Hospital Trust, for example, identified:

- Patterns of repeated poor care, including significant or major concerns in the maternity care provided that, if altered, might or would have resulted in a different outcome
- Failures in governance and leadership, including failures to escalate concerns, a lack of compassion and poor working relationships
- Poor investigation into serious incidents
- Poor review by external bodies

NHS England's Three Year Delivery Plan for maternity and neonatal services recognises these challenges, acknowledging that 'some families have experienced unacceptable care, trauma and loss' while engaging with support.

Evidence of the need for improvement in wider antenatal support

Beyond maternity safety, there is also evidence that points to the need for improvement in wider local antenatal services.

The Care Quality Commission's 2022 survey of experiences of maternity care (which includes support in the community during the antenatal period), for example, has highlighted that 'people's experiences of care have deteriorated in the last five years.'

Despite some improvements, for example around mental health checks and provision during the antenatal period, the survey highlighted a range of areas where experiences of care had worsened since 2017. For example:

- 69% of women reported 'definitely' having confidence and trust in the staff delivering their antenatal care, down from 82% in 2017.

- The proportion of women who reported having received the care they needed when they contacted a midwifery team during the antenatal period dropped from 74% in 2017 to 69% in 2022.
- 45% said they could 'always' get support about feeding during evenings, nights or weekends, down from 56% in 2017.

Covid-19 also had a significant impact on families during pregnancy and the early weeks. A survey of 573 pregnant women indicated that reduced face-to-face interactions with healthcare professionals, alongside limits on partner attendance at appointments, led to increases in pregnancy-specific stress.

Evidence also points to other impacts of Covid-19 on mothers during pregnancy, including feelings of isolation due to lack of access to parenting groups, feelings of disconnection from staff, and general impacts on mental health due to reduced social support.

Some parents face additional adversity during pregnancy and birth. This includes parents whose babies are removed from their care at birth due to safeguarding concerns. This is an increasing issue, with the number of newborn babies being born into care almost doubling between 2008 and 2018.

Evidence shows that mothers' experiences can be very negative across all elements of this process, from preventative work pre-birth, through to birth, hospital discharge and follow-up. This includes difficulties and delays around accessing preventative support pre-birth, discontinuity and turnover of key professionals, and shortfalls in family-inclusive practice. The Nuffield Family Justice Observatory recently published best practice guidelines to address some of these challenges.

Evidence of inequalities in maternity and antenatal care

There is strong evidence of persistent inequalities of both outcomes and experiences of maternity and wider local antenatal support.

Inequalities in birth outcomes

The latest data from MBRRACE-UK for 2020-2022 shows a continued gap in birth outcomes between women from deprived and affluent areas, women of different ages and women from different ethnic groups. This includes data on maternal mortality:

- Women living in the most deprived areas are twice as likely to die during pregnancy or within the 42 days after birth than those who live in the most affluent areas.
- Women from Black ethnic backgrounds are almost three times more likely to die during pregnancy than women from White groups.
- Women from Asian ethnic backgrounds are almost twice as likely to die compared to white women.

MMBRACE-UK data also shows inequalities in other outcomes. Rates of stillbirth and neonatal death were significantly higher for babies from

particular ethnic groups living in the most deprived areas. For example, babies from Black African or Black Caribbean backgrounds in most deprived areas had the highest rates of stillbirth (8 per 1000 births), while babies of a White ethnicity in the least deprived areas had the lowest rate (2.78 per 1000 births). Women from a Black ethnic background are 40% more likely to experience a miscarriage than white women.

Wider inequalities in maternity and antenatal care

Other recent research reiterates inequalities in experiences of maternity and antenatal care.

Research by FiveXMore reported that more than half of surveyed Black women and women from a mixed ethnic background (54%) 'faced challenges with healthcare professionals during their maternity care', including 43% feeling that they had been discriminated against. An enquiry into racial injustice by Birthrights (2022) also reported women feeling unsafe, ignored or disbelieved, with racism and racial discrimination having a direct impact on their sense of safety. The enquiry also documented a lack of choice around care and difficulties accessing interpreting services.

There is also evidence of inequalities in access to wider local support as set out in the Healthy Child Programme. Evidence underpinning National Institute of Health and Care Excellence guidance on antenatal care, for example, recognises that some groups of women are less likely to attend antenatal classes, while women with more complex social factors (recent migrants, under 20s and victims of domestic abuse) face additional barriers to engaging with antenatal support in general.

Challenges facing the maternity and antenatal workforce

Safe staffing levels are essential to the provision of safe and effective maternity care and wider antenatal support. However, recent data shows significant shortfalls in staffing for both midwives and health visitors – both key groups in supporting families during pregnancy.

Challenges in the midwifery workforce

The latest figures report there are now 22,391 full-time midwives working for the NHS in England.

Though the latest data from 2023 shows changing trends, The Royal College of Midwives reports that numbers of midwives have been falling year-on-year since 2020, with the workforce shrinking by 438 in the year to September 2022. The RCM believes this is primarily driven by poor retention of older staff as a result of burnout, rather than failures to recruit new staff. The RCM estimates that there is now a shortfall of 2500 midwives in England, with the workforce increasingly stretched to deliver the high level of support delivered to individuals.

This shortfall has consequences for the wellbeing of the workforce. A 2023 Royal College of Midwives survey of

midwives and midwife support workers in England found that:

- 88% of respondents were working additional unpaid hours
- 74% of respondents often or always faced unrealistic time pressures and workloads
- 87% of respondents did not feel their workplace had safe staffing levels

This also has consequences for the perceived quality of care midwives are able to provide. National-level results from the NHS Staff Survey 2021 showed that:

- 87% of midwives did not think there are enough staff at their organisation for them to do their job properly
- 63% of midwives said they feel burnt out because of their work either often or always

Challenges in the health visiting workforce

Data for the combined health visitor workforce (both NHS and independently employed) shows that in 2022 there were 7,030 FTE health visitors. This total is a 'record low', with the workforce having decreased by 37% since 2015.

A recent report from the Institute of Health Visiting (2023) outlined a range of implications of this shortfall, describing health visiting as a 'service struggling to meet the scale of rising need', with babies, children and families facing a 'postcode lottery' to receive adequate support. Key findings from the survey included that:

- Only 37% of health visitors felt they could provide a 'good' or 'outstanding' service, while 14% rated their service's ability to safeguard children as inadequate.
- Only 3% of health visitors in England are able to provide families with continuity of health visitor.
- Only 6% of health visitors work with the recommended ratio of 250 children per health visitor, while 28% have more than 750 children.
- 78% of health visitors stated that their stress levels had increased in the last 12 months, with 48% of health visitors in England intending to leave the profession in the next 5 years.

The report also concluded that health visitors were often unable to deliver the expected contact with families, including the antenatal and 6-8 postnatal review.

Similarly, an NSPCC report notes that from 2021-2022, 100,000 new-born babies did not receive their first health visit within 14 days as recommended by the Healthy Child Programme. It highlights the significant implications of this, given the vital importance of the Healthy Child Programme in setting the foundations for health and wellbeing in the early years.

Measures to address workforce challenges

A number of organisations, including the NSPCC, Royal College of Midwives and Institute of Health Visiting, have called for urgent investment in the maternity and health visiting workforce

to improve recruitment, retention, culture and quality of care.

The Health and Social Care Committee also stressed the urgent need for a maternity workforce plan and for the budget for maternity services to be increased. The Ockenden Review similarly recommends that all maternity services in England have an escalation policy for where staffing falls below the agreed minimum level.

The Royal College of Midwives has welcomed the NHS long-term workforce plan (noted above) as well as the introduction of midwifery apprenticeships as a new route into the profession, but has warned that, without necessary investment to accompany it, it will be rendered 'meaningless'.

Evidence to support improvement during pregnancy and the early weeks

Evidence to support improvement in NHS maternity services

The National Institute for Health and Care Research recently published a report drawing together research on NHS maternity care in response to growing evidence of inequalities and wider issues in care quality.

The report recognises the potential impact of the policies mentioned above, with further recommendations based on four themes:

- **Kind and compassionate care.** This theme includes recommendations on better enabling patient-focused care and shared decision-making, offering more culturally sensitive maternity care, and better bereavement care when a baby dies
- **Teamwork in maternity care.** This theme includes recommendations focused on understanding and valuing colleagues' skills and attributes, offering opportunities for continuous improvement at all levels, ensuring all team members have a voice in improvement, establishing common purpose, and comparison within and between teams.
- **Identifying poor performance.** This theme includes recommendations to supplement existing national measures, making better use of existing national, local and trust-level reporting mechanisms; and maximising the learning and improvement from performance data.
- **Organisational oversight and response to challenge.** This theme includes recommendations in response to a lack of effective action by health boards when presented with information suggesting quality issues.

Several bodies, including the Royal College of Midwives, continue to call for action to address staffing shortages in maternity services, encouraging delivery on NHS and government staffing commitments, sustaining the number of places for student midwives

and focusing on retaining the most experienced staff.

Evidence to support improvement in local antenatal provision

There is also a wide range of evidence to support improvements in wider local antenatal provision, including that covered by the Healthy Child Programme.

Involving partners in antenatal care.

Evidence shows that well-supported partners can have a positive impact on women's perinatal experiences and outcomes. However, despite a number of recent policy developments encouraging improvements in father engagement, the Royal College of Midwives and Fatherhood Institute have highlighted that there remains a 'dad-shaped hole' in maternity services.

There is growing literature on how to better engage fathers/partners during pregnancy. The National Institute for Health and Care Excellence (NICE) considers a range of evidence for the benefits of engaging with partners during pregnancy and in the early weeks, but highlights that partners often face barriers to engaging with antenatal services. It makes recommendations to better enable access, including ensuring flexibility in the timing of sessions, providing information about pregnancy to partners as well as pregnant women and positively framing partner involvement. The Royal College of Midwives has also published an 'engaging dads' toolkit to help professionals provide a more inclusive experience for fathers and partners.

A 2018 systematic review highlighted the relative lack of programmes involving fathers in antenatal education programmes, and called for more evidence in this space.

Improving experiences for vulnerable groups. Evidence shows some groups of women – including women from low income or disadvantaged backgrounds – may be less likely to attend antenatal classes. Recommendations to address this include ensuring classes are accessible, welcoming, and adapted to meet the needs of local communities. The National Institute for Health and Care Excellence also offers tailored guidance to better support specific groups of vulnerable women during pregnancy, including women who misuse substances, recent migrants or those not fluent in English, women under 20 and women who have experienced domestic abuse. The Royal College of Midwives also suggests specific measures to meet the needs of vulnerable migrant women.

Prioritising parent-infant relationships. There is strong evidence that when caregivers are more responsive, sensitive and attuned to their baby's needs, both early development and caregiver mental health outcomes improve. However, the Parent-Infant Foundation has highlighted significant shortfalls in provision to meet the needs of families in this area, with the 45 specialised parent-infant teams currently operating estimated to offer only a tenth of the support needed across the UK. Parent-infant relationships were highlighted as an 'essential service' in the Family Hubs and Start for Life programme guide, with £100 million

earmarked to help develop bespoke parent-infant relationship teams and wider perinatal mental health support.

Peer support and other community-based approaches. There is also evidence for the benefits of peer support – including peer groups, volunteers and doulas – during pregnancy. Evidence shows peer support can help provide practical support, build confidence and reduce isolation, and may be of particular benefit to certain subpopulations, including migrant women, women of lower economic status, women with intellectual disabilities and younger women.

Trauma-informed practice. A report by Blackpool's Centre for Early Child Development offers guidance for both clinical and non-clinical staff working with perinatal women around accounting for psychological trauma in the perinatal period. It offers recommendations on recognising and understanding the impact of psychological trauma, responding in a sensitive and compassionate way, and supporting staff with the effects of vicarious trauma.

Handovers of care from midwifery to health visiting. Care continuity between midwifery and health visiting is vital for ensuring safe, high-quality and personalised care is delivered in a timely manner, however evidence shows this is not always done effectively. Public Health England published guidance on this based on a review of current research and interviews with midwives and health visitors in Local Maternity Systems. This includes recommendations to ensure that women and their partners are given consistent information throughout their journey, helping them to understand how their information will be shared, and enabling care to be tailored to each family's individual needs. This is supplemented by NICE Guidance on effective communication between healthcare professionals at transfer of care.

Summary

- Pre-conception, pregnancy and the early weeks after birth are the earliest opportunities for intervention in a baby's life. Evidence shows that this period lays the groundwork for a range of later outcomes, including physical and mental health, cognitive development and academic attainment.
- There is a wide range of support available to families during pregnancy and the early weeks, including both maternity services and wider local provision. Certain key professionals - midwives and health visitors - play a particularly central role in ensuring families access the right support to meet their needs.
- There is significant evidence of the need for improvement in NHS maternity services, including declines in key indicators of safety and quality, and evidence of inequalities in birth outcomes and experiences of maternity care. Evidence also points to the need for improvement in wider antenatal services, particularly around consistent access to support.
- The maternity and health visiting workforces are under significant pressure. Staffing shortfalls and rising levels of need mean many services are struggling to provide adequate care, with workforce wellbeing also suffering.
- Several policies have been introduced to combat challenges in maternity care, including the NHS Long-Term Workforce Plan, a Three-Year Delivery Plan for maternity and neonatal services, and a range of policies to support reduction of inequalities.
- Recent policy developments, including the Start for Life Programme and modernisation of the Healthy Child Programme, also recognise the importance of improving wider support for families during pregnancy and make accessing support easier.
- Evidence suggests a range of additional approaches to improving the quality of care during pregnancy, including improving continuity and handover of carer, partner involvement, trauma-informed practice and community-based approaches. There is also strong evidence for prioritising certain key areas during pregnancy – including parent-infant relationships.

Support during pregnancy and the early weeks within A Better Start: case studies

The following case studies highlight a range of approaches A Better Start Partnerships have been employing to support families during pregnancy and the early weeks after birth.

These case studies include examples of direct support for families, investment in the maternity workforce, collaboration and co-production of services, integrated working approaches and wider systems change activities.

It is important to note that the pandemic and the ongoing cost-of-living crisis are having a significant impact on families and the services which support them. The context within which ABS partnerships operate has therefore changed significantly since the start of funding, and many activities supporting families during pregnancy and the early weeks have had to adapt to meet changing needs.

Personalised care during pregnancy: learning from the Lambeth Early Action Partnership (LEAP)

LEAP utilises a public health approach to improve outcomes for very young children and their families by delivering services in parts of Lambeth, south London, where families and young children experience greater inequalities than the rest of the borough.

Across the UK, the risk of maternal death is 3.8 times higher for women from Black ethnic backgrounds and 1.8 times higher for women from Asian backgrounds, compared with White women; maternal mortality rates are also highest for women living in the most deprived areas. 43% of LEAP neighbourhoods are classified as 'most deprived,' and 58% of the LEAP population identify their ethnicity as Black, Asian, mixed or other. Given the markedly higher maternal mortality risk for women living in the LEAP area, we implemented a variety of services and systems change projects to improve both maternal and infant outcomes. Our collection of pregnancy-related services is well-integrated with wider local support services, with the ultimate aim of working across disciplines to holistically support the unique needs of each family we serve.

Two of LEAP's flagship pregnancy-related activities are our Midwifery Continuity of Care service and our Maternity Vulnerability Assessment Tool.

1. Midwifery Continuity of Care (MCoC)

LEAP's MCoC service began providing care for pregnant people living in the LEAP area in 2018. Within the MCoC pathway, each pregnant person receives midwifery care by a named midwife throughout pregnancy, labour, birth and the postnatal period. Care

is provided in the community and clients benefit from longer and more frequent appointments, depending on their needs. MCoC is the gold standard model of midwifery care for pregnant people most at risk of worse outcomes.

LEAP's MCoC clients also benefit from well-established referral pathways into wider LEAP and non-LEAP support (e.g. breastfeeding peer support; enhanced domestic abuse support; support with parent-infant relationships; community food support; etc.). This is a good example of integrated, community-based service delivery that holds the needs of the family at its heart.

2. Maternity Vulnerability Assessment Tool (MatVAT)

In 2017, LEAP developed an innovative 'Health Team': a small team of healthcare providers (GP, health visitor, midwives) who work with families during pregnancy and in the earliest years. The aim of the team was to explore how their disciplines could work together to improve care pathways for pregnant people and their young children.

Through shadowing each other the team discovered that midwives didn't have a tool for assessing social needs in the same way that GPs and health visitors do. To fill this gap the team's midwives developed the Maternity Vulnerability Assessment Tool (MatVAT)—a tool for use during routine midwifery appointments to enable midwives to more consistently identify social risk factors in pregnant people, and signpost or refer to local sources of support. The tool supports national ambitions for more personalised, client-centred midwifery care.

The tool, along with a care planning template and an e-training module, will be hosted by the Royal College of Midwives and will be available nationally in 2024.

What works? Lessons learned

LEAP's MCoC service has frequently been featured as an example of good practice. The team was acknowledged for their role in supporting women, babies and families in receiving equity in maternity and neonatal care and in reducing inequalities, during a Regional Ockenden Assurance visit, and was invited to present to the NHSE Maternity Stakeholder Council. By delivering gold-standard midwifery care to pregnant people most at risk of worse outcomes, with demonstrated positive clinical outcomes, the team has improved maternity equity; this work was lauded as a 'promising model for addressing inequalities in the United Kingdom' by the World Health Organization.

The Royal College of Midwives' decision to host and promote the MatVAT clearly demonstrates the tool's potential to influence more personalised maternity practice nationally. Earlier identification and support of social risk factors during pregnancy can result in fewer inequalities and greater health equity for pregnant people and their babies, and LEAP is proud to facilitate systems change in this way.

Midwife staffing shortages across the UK create significant pressures on maternity units, and LEAP's MCoC service has been impacted by these, for example by LEAP team members being asked to cover shifts for other teams. This was particularly

acute during the Covid-19 pandemic, but continued beyond that time.

Implementation of MCoC on a larger scale is challenging for a variety of reasons. These operational difficulties reflect a tension between national aims and priorities, which call for increased provision of MCoC for pregnant people living in deprived areas and/or with Black or another minority ethnicity, and the real-world challenges of delivering MCoC at scale.

How have families and community supported the work?

LEAP has always prioritised hearing from our service users. Feedback about the MCoC service is consistently positive and indicates that clients feel safe, cared for, listened to and respected. One person said: "I have been nurtured all the way through my pregnancy and the LEAP midwives have stepped up at every stage. Any concerns were handled and answered with care, consideration and knowledge. The closer to birth, the more reassurance I required, the care came to meet my needs."

What difference is this making for children and families?

LEAP's targeted approach in allocating pregnant people to a MCoC pathway appears to be reaching those who need enhanced care: 90% of LEAP women on the pathway live in areas of greatest deprivation, with 40% reporting their ethnicity as Black, Asian, mixed or another minority ethnicity. The most common social risk factors in MCoC clients include mild to moderate mental health problems, social care involvement, domestic violence, refugee status, survivors of childhood sexual abuse or teen pregnancy. Feedback is overwhelmingly positive; clients report feeling cared for, listened to and respected.

LEAP's MCoC service has demonstrated improved clinical outcomes for its clients. We have evidenced a significant reduction in preterm birth rates in women/birthing people allocated to MCoC care, when compared with women who received traditional midwifery care (5.1% vs 11.2%). Caesarean births were also significantly reduced in women/birthing people allocated to MCoC, when compared with traditional midwifery care (24.3% vs 38.0%), including emergency caesarean deliveries (15.2% vs 22.5%). The service has also evidenced improved breastfeeding initiation rates and skin to skin contact, and reductions in low-birth weight babies and neonatal unit admissions, all of which have important longer-term public health benefits.

A video which captures the experiences of four service users is available here.

A small feasibility pilot of the MatVAT was conducted in 2021, and findings indicate that it has value as an internal threshold document for enabling referrals to multidisciplinary teams and specialist pathways. Further work could be undertaken to understand the impact of the tool on outcomes in patients with social risk factors.

How is ABS adding value to the wider system?

With these two pieces of work, LEAP strives to improve maternity equity: not only at the individual level, by supporting improved clinical outcomes for MCoC clients at

risk of worse outcomes, but also at the population level by introducing a tool that has the potential to strengthen midwifery practice nationally.

LEAP is working closely with an academic partner to better understand the longer-term impacts for and experiences of MCoC clients. These findings will complement the published clinical findings and will be an invaluable contribution to the wider midwifery evidence base.

Future priorities across the partnership

Establishing a smooth pathway between maternity care and parent-infant relationship work has been an important way of providing more upstream support for improved infant mental health. LEAP's Parent and Infant Relationship service (PAIRS) has embraced opportunities to support pregnant people, and we think it would be valuable to explore opportunities for making this kind of support available on a wider scale.

LEAP will support the development of Guy's and St Thomas' NHS Foundation Trust's 5-year maternity strategy by sharing examples of good practice, especially in relation to addressing inequalities, from across our suite of pregnancy-related services.

For further information, please contact Carla Stanke, LEAP Public Health Specialist: cstanke@ncb.org.uk

Better Start Bradford: Midwife-led 'Continuity of Carer' (MCC), Better Start Bradford's Personalised Midwifery Project (PMP)

Women living in social disadvantage (including some ethnic minorities, and low socioeconomic status) are at greater risk of poor birth outcomes. There is also evidence of substantial inequality in the disclosure and identification of perinatal mental health problems in parents living in socially disadvantaged circumstances (Prady *et al.*, 2021). Common mental health problems (such as depression and anxiety and a poor mother-child relationship) are also more likely to be experienced by those who are socially and financially disadvantaged because they are likely to be experiencing more stress and discrimination (ibid.). In 2017, the UK National Health Service (NHS) produced the 'Better Births' plan (NHS, 2017) to improve midwifery led care in England. Within this plan, the Maternity Transformation Programme aimed to implement the midwife-led 'continuity of carer' (MCC) model to support safer, more streamlined maternity care, while fostering positive relationships between women and their midwives, to ensure better outcomes for women and their babies (NHS, 2022). Continuity of Carer is based around continuous, relationship-based care, that has been demonstrated to improve outcomes for mothers and babies in the UK. The improved outcomes include the reduction in preterm births and stillbirths, further reduction in the likelihood of maternal mental ill health, and increased breastfeeding rates.

How has the model been implemented in Bradford?

In 2017, Better Start Bradford commissioned Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) to pilot a midwife-led continuity of carer model, delivered alongside traditional maternity care. Bradford has an infant mortality rate of almost double the rate of England (6.6 per 1,000 children versus 3.9 per 1,000, respectively), with rates particularly high in Bradford City at 24 per 1,000 children (BIRU, 2020) Therefore, it is key to look at ways in which improved maternity care could reduce health inequalities and reduce infant mortality.

The continuity team were known locally as the Opal Team, to become the Clover Team, and are part of the community midwifery services at BTHFT. The team was staffed at a level which allowed them to deliver the model of smaller caseloads and greater ongoing support to pregnant women living in a defined area, within the three Better Start Bradford wards of Bowling and Barkerend, Bradford Moor and Little Horton.

Initially, the pilot aimed to identify how well the model could be implemented, and its acceptability for both the midwives delivering care, and the patients receiving care. Phase two focused on ensuring at least 70% of care was delivered by the patients' dedicated or buddy midwife, and included giving women longer appointments, labour assessments at home and improved continuity during the postnatal stage (up to six weeks post birth).

Phase three is still ongoing and commenced in 2021. This phase uses a tripartite funding model between Better Start Bradford, Reducing Inequalities in Communities (RIC) and BTHFT. It aims to further improve the level of continuity provided across the intrapartum and postnatal periods, while also improving the level to which women receive a personalised care plan, including a choice in the number of appointments they have, the duration of appointments and the location of their birth.

What works? Lessons learned

Evaluation completed by the Better Start Bradford Innovation Hub has shown that the key components of the midwife-led continuity of carer model valued by midwives and women were smaller caseloads, longer appointment times and flexible working. Midwives reported high levels of job satisfaction, with reduced stress and increased role fulfilment compared to midwives working within traditional models of midwifery care. Women receiving this model of care reported that the trusting relationships that evolved allowed them to disclose mental health issues. Continuity in the postnatal period promoted disclosure, identification and monitoring of women's mental health needs, with women feeling well supported and able to talk about their mental health with their midwife (Dharni et al., 2021).

In phase two, with the implementation of continuity at birth, the team of midwives reported that supporting women during the intrapartum period was the most difficult part of the model but did not feel this was detrimental to women. Challenges between the continuity team and labour ward were evident as it was felt that the continuity team put extra strain on existing resources, and midwives at the birth centre did not always call on the continuity team midwives, especially when women said they were happy with the core team.

More recently, maintaining continuity became challenging for the team, especially in the months the team size reduced to three midwives due to staffing issues. There were also rare occasions when a midwife from another team performed antenatal appointments. Despite the different challenges the team faced, they remained successful in providing continuity of antenatal care; the range of achievement of scheduled care by the named midwife or buddy was 76-100%.

Continuity in the antenatal period of a women’s journey through pregnancy remains important to both the midwives and the women receiving the care. Staff continue to reflect these views, with evidence found in the women’s feedback of their views on continuity of care in pregnancy. The ability to be flexible in the continuity team has also helped provide continuity for antenatal appointments. The flexibility of allowing the midwives to manage their own time and diaries appears to have been beneficial in supporting continuity for the women.

The above evidence has helped us to learn that:

- Continuity teams provide significant levels of continuity of carer throughout the antenatal period for women.
- Staff absences and staff turnover can have an impact on the workload of the midwives and has the potential to impact levels of continuity due to a lack of a buddy system.
- Antenatal continuity matters equally to mothers and midwives.

How have families and communities supported the work?

Evaluation has been embedded within each phase and has provided a unique opportunity to examine the impact on the experiences of both midwives and women. Many women supported in phases one and two suggested this model was crucial for helping them build trust with their midwives. The longer appointment times gave expectant parents space to share concerns about their mental health and discuss birth plans.

How is Better Start Bradford adding value and improving the wider system, and what difference is it making for children and families?

Better Start Bradford works in collaboration with our evaluation partners at the Better Start Bradford Innovation Hub (based within Born in Bradford) who have undertaken the evaluation. We are also working with the local maternity provider (Bradford Teaching Hospitals Foundation NHS Trust) and other programmes (Reducing Inequalities in Communities) to tackle health inequalities.

Better Start Bradford has been pivotal in 'testing and learning' what works for our local population to address inequalities in health, specifically the provision and access to high quality, effective personalised maternity care. This project has enabled the local maternity provider to understand that additional support from administrative staff and a maternity support worker within the team has hugely contributed to improved key performance indicators, including levels of continuity provided, both antenatally and postnatally, and supported the delivery of public health messages and signposting to appropriate services, to support families' wellbeing at the earliest opportunity. Further in-depth analysis and learning from this project has been shared in blogs, journals and other publications to influence the wider maternity system.

Future priorities across the partnership

Expansion of the model to a larger number of women in the third phase means that our evaluation plans are now more ambitious. A randomised controlled trial is now underway with random allocation of women to either the enhanced continuity of carer model or traditional maternity care embedded within maternity service processes (Willan et al., 2023). Women who participate in the Born in Bradford Better Start birth cohort (Dickerson *et al.*, 2016) will be used to evaluate differences in key outcomes including rates of spontaneous vaginal delivery, breastfeeding rates

(often linked to a secure personal relationship with a midwife) and levels of postnatal mental depression.

A complementary qualitative evaluation will include interviews with midwives and team leaders, to explore experiences of maintaining and delivering the model, and the impact the model has on their work. The team will examine the experiences of women who received the enhanced model of care to understand the impact on their pregnancy journey and if this differed depending on the level of continuity they received at different stages.

For further information on a) the learning from this model of care, contact Rachel Middleton – rachel.middletone@betterstartbradford.org.uk and b) the evaluation, contact Dr Rachael Moss Rachael.moss@bthft.nhs.uk

This Case Study has been written using the Better Start Bradford Innovation Hub Midwife-led Continuity of Carer Phase 3 End of Contract Report November 2023 which was produced for Better Start Bradford. The report was provided by the Better Start Bradford Innovation Hub (BSBIH) for Better Start Bradford and the Continuity of Carer / Personalised Maternity Project and can be viewed here: BSB Innovation Hub - Born In Bradford

A Better Start Southend's Perinatal Mental Health Service: The Think Family approach, father-inclusive mental health and wellbeing support in the perinatal period

The A Better Start Southend Perinatal Mental Health (henceforth ABSS PMH) service, started in 2018, works alongside the Essex Wide Health Visiting Service to promote the health and wellbeing of families with children under the age of five both in the antenatal and postnatal period. The ABSS PMH service is delivered by trained health visitors with specialist training in child development and family health. It differs from the Essex-wide service in that it helps those with mild symptoms of perinatal associated depression/anxiety, while the former treats those with severe cases. Together they help the entire spectrum of sufferers, with the ABSS PMH aiming to be proactive and curb mild symptoms from developing into more severe cases (which would then be serviced by the Essex wide team). The ABSS PMH offer itself is composed of one-to-one support, health visits, attendance at Mindful Mum's Groups, Wellbeing Walks, and workforce development training. It is also entwined with Parent-infant, mental health, children's and maternity services.

The ABSS PMH service has instituted a 'Think Family' approach, which aims to move away from purely maternal thinking seen in traditional PMH services, which are often treated simply as an extension of maternity services. With this new approach, we aim to see fathers/men not simply as an add-on-to the vital work we do with mothers (seeing fathers only as a conduit for further supporting maternal/child wellbeing) but as a separate entity, equally in need of help, while still recognising the important secondary effects paternal wellbeing can have on co-parenting, the paternal/maternal dyad, and on the child both in the short and long term.

What works? Lessons learned

One of the main challenges, and one we have sought to redress, is the lack of paternal participation in our delivery (albeit relative to maternal participation). This was highlighted by RSM[1] evaluation reports contending that fathers are underrepresented in our service delivery in comparison to women/mothers, and increasing evidence that men can suffer from mental health issues pertaining to parenthood almost as frequently as women. As such, we need to conceptualise how we can best cater services towards those who are underrepresented, and recognise that traditional practice directed towards mothers does not adequately meet the demands of partners. It is not a one size fits all problem.

[1] Early Years Alliance (EYA) asked RSM UK Consulting LLP (RSM) and University of Essex (UoE) to measure the impact of the A Better Start Southend (ABSS) programme. The purpose of the Summative Evaluation is to measure the impact of the ABSS programme to date.

Therefore, we have aimed, and are still aiming, to transform services in line with emerging father's research. After the PMH service delivery was redirected to also include fathers, we have seen steep growth in the numbers of fathers accessing services. The quarterly caseload of fathers from 2020-21 to 2022-23 has tripled in almost every quarter, which indicates that fathers feel the service is giving them what they need.

We also have taken considerable steps to upskill our workforce by training them in emerging practices and approaches. For example, our health visitors attended courses delivered by the Institute of Health Visiting, allowing them to become Perinatal Mental Health Champions. Additional Solihull training also ensures that each member of our PMH team can deal with the multiplicities of need for different demographic groups. We are always seeking to source further training to ensure care is the best it can be.

How have families and communities supported the work?

Families and communities supported this work in line with our inclusive, community-oriented ethos. In the infancy of the PMH programme (when it was targeted towards women) during COVID and furlough, many fathers were naturally at home and as a result began to share their own thoughts, feelings and concerns during routine check-ups with mothers. Taking this into account – and noticing a dearth of services for such fathers to engage in – we began to make appropriate adjustments to our service delivery to better meet the needs of an emerging, but distinct, group of individuals with different needs and struggles. The PMH offer really captured our desire here at ABSS to be robust in our service delivery and to not only adapt to the changing needs of those we serve but allowing them to take the reins in shaping practice.

Alongside the PMH remit being extended to include emerging demand from fathers, other projects have been started to further engage them in services such as Families Growing Together (which also invests in a biweekly 'Saturday Dad's Club').

What difference is it making for children and families?

ABSS PMH quarterly caseload volume shows the number of mothers accessing the service has grown from 117 in Q1 2020-21 to 250 in Q1 2022-2023. In the same time period, the number of fathers accessing the service has increased from 16 to 46 and the trend is similar for all other quarters in the same time frame. As such, the offer is seemingly capturing a burgeoning desire for wellbeing services, and we hope numbers will continue to grow into 2024.

In the long term, research has shown that when fathers participate in services, they are more likely to be a constant in the family dynamic. The 'Think Family' approach aims to mediate between the great benefit that PMH services can bring for fathers themselves (who often feel they are targeted for the secondary effect on mothers)

yet still be aware of the cascading benefits to the whole family structure. Evidence shows that targeting fathers' wellbeing leads to a range of benefits for the whole family, including improved breastfeeding outcomes (both in initiation and duration), curtailing instances of smoking (in both parents), acting as a buttress against maternal postnatal depression, and reducing instances of emotional and behavioural problems in children, all the while having a positive impact on a child's educational attainment and social competence (Bateson et al, 2017). The benefits of the kind of intervention, therefore, are far greater than the immediate effect we see on the direct service user. What remains to be further discussed is how best we can convey to fathers how central they can be in improving family outcomes, without them feeling as if we merely treat them as a tool for those ends.

How is ABS adding value to the wider system?

ABSS is adding value to, and improving, the wider system by leading the way in service delivery. We have already adopted the model proposed by the London School of Economics (LSE), in which health visitors, midwives and mental health practitioners are integrated alongside preexisting structures of care like GPs and local services to ensure a more holistic approach is delivered. Some preliminary research into the LSE model of integrated care illustrates how it could save the NHS £50m a year, through addressing mild PMH symptoms before they develop into more serious forms requiring specialist intervention. We believe that any parent experiencing symptoms of perinatal depression or anxiety, regardless of how mild they may be, deserves attention and care.

The ABSS PMH service's remit has also been extended to cover all of Southend until March 2025 and ensure that everyone inside Southend can benefit from the crucial work we undertake. In addition, we have also funded the PMH team to deliver training sessions to Southend professionals, in the hope that best practice (including our ethos of early intervention, targeting of mild symptoms, and wider recognition of paternal struggles) becomes integrated across wider care and clinical community.

Future priorities across the partnership

With the A Better Start programme ending on the 31st of March 2025, one of our priorities is to ensure continuity of care. This means we are already working out how best to ensure referrals are managed. So that those experiencing low/mild PMH symptoms are not left by the wayside in the long term, we are funding additional training and composing a workforce development strategy aligned to legacy plans to enhance local offers for prospective low/mild sufferers in the future. Our primary aim is to ensure that the vital care we provide is not discontinued once the programme ends.

For further information, please contact Julie Lannon, ABSS Programme Manager, at julie.lannon@eyalliance.org.uk

Small Steps Big Changes (SSBC) Nottingham: Father-Inclusive Practice

NICE guidance advises that fathers/birth partners should be involved in their partner's postnatal care (up to 8 weeks after birth) and the care of their baby. Despite this, evidence shows that fathers can feel excluded from their partner's maternity care.

In Nottingham, since the beginning of the Small Steps Big Changes (SSBC) programme, we have had a commitment to promoting Father Inclusive Practice across services that support families with 0–4-year-olds, including during pregnancy and postnatally. It sits as one of the programme's "systems change" objectives. Effectively creating and embedding systems change requires deliberate activity to influence policies, practices and procedures; actions to influence relationships and connections; alongside activity aimed at changing power dynamics and mental models. Various projects have been developed and implemented within maternity services to support changing the system and shifting mindsets, alongside practical tools to implement changes at a strategic and operational level to ensure both fathers and the workforce see and value the importance of the father's role.

What works? Lessons learned

'Think Dads' conference October 2023: This was an opportunity to bring family-facing services across Nottingham and Nottinghamshire together to raise awareness of the role of the father, how this has changed in society, and the impact of the father figure on both a child and the whole family. The conference provided an opportunity to think about Father Inclusive Practice and how practitioners could provide a service that is father-friendly - where fathers in Nottingham City feel supported in their parenting role. The conference was attended by colleagues covering a wide spectrum of babies, children and family services, including midwifery colleagues. Further information is available here.

'Think Dads' Training: SSBC provides "Think Dads" training – a training programme designed and developed by SSBC in partnership with fathers and partners. The training aims to improve the knowledge and confidence of practitioners, including maternity staff, in engaging with and working with dads. In 2023, 11 of the 13 (85%) Pregnancy Mentors (an SSBC commissioned maternity support worker role with a public health focus) were early adopters across the maternity workforce and were amongst 219 early years staff to access training. Evaluation of the training overall showed that attendees' knowledge about a father's role in child development and the importance of fathers increased after attending.

Recliner Chairs: To support creating a welcoming environment for fathers on the postnatal wards, SSBC funded recliner chairs to be included in all postnatal spaces. These chairs allowed fathers to stay over and support their partners. On paper, it seems an easy solution, but required significant work, strong leadership and persistence to accept and embed this initiative across the workforce.

The recliner chairs project has been particularly successful in changing staff attitudes to the importance of partners on wards, with most surveyed staff saying they improved the postnatal environment. Following the introduction of recliner chairs in one local hospital, the initiative has also been implemented in another trust across the region, suggesting the importance of fathers is starting to be considered more widely.

SSBC Information Pack for New Fathers: Alongside projects designed around workforce needs, SSBC has also focused on work that makes fathers themselves feel included. The SSBC Information Pack for New Fathers was developed in response to a local consultation with fathers, who said that they wanted a one-stop shop to evidence-informed advice on supporting fathers.

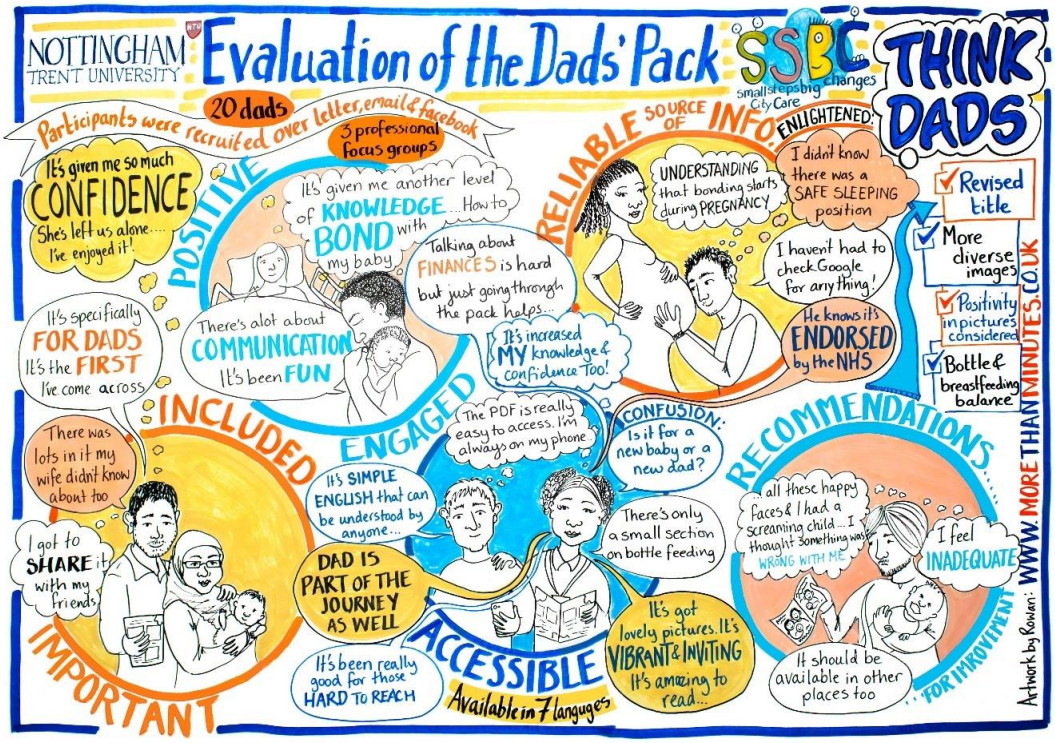
The pack was developed in conjunction with partners and parents. Over 13,000 printed copies of the pack have been distributed. In recognition of the diversity of languages spoken in Nottingham the pack has been translated into six different languages, with 1500 printed copies distributed and translated resources available online to download.

'Feed Your Way' Public Health Breastfeeding Campaign: SSBC commissioned a behaviour change specialist to produce a local breastfeeding public health campaign targeted at the breastfeeding dyad and those that influence and support infant feeding decisions, including fathers. Fathers' voices were included amongst over 1800 responses to a survey, which helped inform the campaign messaging and design. Fathers told us they wanted to be involved in breastfeeding and understand how they could support breastfeeding. The campaign's collection of case studies includes a story from local family Iain and Eleanor, explaining how Iain supports his partner's breastfeeding journey.

Fathers were proactively recruited to focus groups as part of the mid-point evaluation of the campaign. In response to feedback further work is planned to co-produce an additional father-focused case study that champions the male role, whilst also including information about challenges without fear-based messaging.

How have families and communities supported the work?

Work with parents is one of SSBC's guiding principles, with parental knowledge interpreted as expertise. Fathers' voices were actively sought throughout project development, implementation, and evaluation. The Father Inclusive work of the programme is overseen by the Father Inclusive Practice group, which includes fathers. See above for specific examples.



What difference is it making for children and families?

In the longer-term, evidence tells us that positive father involvement improves outcomes for children in many areas including education, behaviour, health and social and emotional development. (Sarkadi, et al. 2008; Opondo, Redshaw and Quigley 2017).

An independent evaluation of the Information Pack for New Fathers in 2023 was undertaken by Nottingham Trent University (NTU). The pack was viewed as having the potential to speak to 'seldom heard' fathers. Fathers considered the pack a valuable source of information and a useful reference tool which they felt comfortable and confident in sharing with others. They recommended it should be shared nationally. The full evaluation report can be accessed here.

How is ABS adding value to the wider system?

The SSBC Partnership recognises the importance of pregnancy and the early postnatal period in laying the foundations for positive health and development outcomes for our babies and children. Our approach has been to understand the local context, challenges and opportunities and consider additions to the existing offer to create long-lasting impact. The impact of this approach has been seen across the partnership – in developments such as updated recording systems which recognise fathers, the adoption of 'father friendly' groups and the attendance of the less obvious workforce at the "Think Dads" training. SSBC has continued to maintain good relationships with local stakeholders throughout this period which has resulted in key projects and approaches being commissioned. Implementation of innovative ways of working into a system that has capacity issues has been enhanced by SSBC ring-fenced funding.

Future priorities across the partnership

A priority for the work with maternity and other services in the postnatal period is on the further embedding and sustainability of Father Inclusive Practice after the SSBC programme ends.

Father Friendly Service standards have been developed alongside tools to implement these changes across services. These are being piloted during the spring term 2024 and will be available for wider roll-out in the summer term. A strategic workshop is being planned for senior leaders locally and regionally to identify a lead organisation to sustain the fathers' inclusion work beyond the SSBC programme end.

Additionally, work is currently taking place to translate the “Think Dads” training into an accessible e-learning format for maternity colleagues to access at their convenience. This work is part of wider work to ensure the legacy of local developments.

Finally, a national version of the ‘SSBC Information pack for New Fathers’ is being developed with a host being sought.

For further information, please contact Amy McDonald, SSBC Evaluation Manager
amy.mcdonald1@nhs.net

Blackpool Better Start: Working with partners to improve support during and after pregnancy for families whose baby is at risk of being born into care.

The number of newborn babies subject to care proceedings has more than doubled in the last decade (Broadhurst *et al.*, 2018). Blackpool has one of the highest rates in the country of babies being separated from their parents' care at birth, owing to safeguarding concerns. Mothers who experience this often face multiple adversities, have histories of trauma and many are care experienced themselves. Systemic practices surrounding safeguarding during pregnancy and separation at birth, which often include late decision making, poor communication between agencies and with families, and shortcomings in the specialist support shown to mothers, often leave mothers feeling overwhelmed (Mason *et al* 2022). Even small changes that promote sensitive interactions and improve their sense of control and choice, may help to mitigate the impact of trauma. Building on research from the national Born into Care: Developing best practice guidelines for when the state intervenes at birth project, Blackpool Better Start partnership committed to co-producing a local action plan to develop more sensitive and humane practice in Blackpool.

Born into Care is a collaborative national research project led by Lancaster University, The Rees Centre at Oxford University and the Nuffield Family Justice Observatory. Blackpool is one of the partner sites which contributed to the research and plays a leading role, through an innovative co-production approach, in responding to the guidance. The Blackpool Better Start partnership recognised the opportunity to bring together parents and carers with lived experience of child protection and care proceedings, alongside key stakeholders, including midwives, social workers, and specialist services, to collaborate in bringing tangible change to local service and systems.

The Born into Care Blackpool project includes several work strands:

Co-production

Each work strand is built on co-production. Through a process of building relationships, mothers and fathers with lived experience of pre-birth assessment and/or separation were recruited as paid sessional workers and supported to become part of the co-production group. Along with senior leaders in children's services and health, four mothers and three fathers became part of the two initial co-production groups, recognising the impact the system has on mothers, fathers, babies, wider family and the workforce.

These first groups aimed to develop a set of eight principles for change within systems and practice.

1. An offer underpinned by a consistent, respectful relationship built on trust and transparency.

2. An offer that respects and values the experience and expertise of those with lived experience in the system.
3. An offer that understands the impacts of trauma.
4. Assessment and support offered from the earliest point in pregnancy and with a specialist focus.
5. An offer that recognises and builds on families' assets and strengths and matches support to specific need.
6. Parents must be helped to understand the process and kept informed of plans at every step of the way.
7. A specialist offer that works with both mothers and fathers.
8. An offer that continues after the baby is born and offers support to parents after the separation.

A film was developed to explain the co-production process, the journey that professionals and those with lived experience have been on, and the eight key principles, covering the pre-birth/pre-proceedings process through to the importance of providing support to mothers and fathers who are separated from their babies by court decisions.

A Steering Group was also established to identify priority areas of work and ensure that the work continues to move at pace. The six co-production workstreams below have a mix of parents with lived experience of child protection and care proceedings, senior leaders or decision makers, practitioners, specialist midwives, public health representatives, third sector organisations and representatives across the better start partnership.

- **Practice models:** This aimed to collate available evidence and data to help guide what the practice model and approach may look like in Blackpool.
- **Recurrent care:** This focused specifically on families who had previously experienced legal proceedings resulting in separation from their child.
- **Relationships and transitions:** This considered how the system can better understand families' histories and respond appropriately.
- **Mapping:** This aimed to help parents and practitioners understand the care process during each step, through the co-creation and co-design of a physical resource. This included mapping the current process locally, identifying available information nationally and locally, and explaining each area of the process in plain language.
- **Legal**: This task and finish group includes judiciary, Cafcass, private practice solicitors, midwifery and senior leaders from Blackpool Council. After discussions a timeline of system changes has been developed, focussing on four separate areas: pre-proceedings, proceedings, the time spent on the ward and the first hearing.
- **Lived experience:** This workstream considered models of lived experience involvement on peer support, advocacy and co-production. A recommendation

for a specific role was developed, including job description and business case.

What works? Lessons learned

Critical to the success of the Born into Care Blackpool work is senior level buy-in, co-production and the breadth of organisations and practitioners working to reduce the number of babies born into the care system. Co-production is a huge strength of the Blackpool Better Start partnership and has been further evidenced through this project. A key difference is that parents are equal partners in all aspects of the work. Co-production brings together people from different parts of the system to collectively problem solve, gaining a deeper understanding of the system itself.

Building relationships has also been critical, taking time and trust. Initial meetings were in neutral spaces such as local parks or walking on Blackpool promenade and focused on getting to know one another. Agreements were developed about how best to work together, acknowledging conversations may be highly emotional and challenging. Safe spaces were created where all could be comfortable.

Practicalities of mothers and fathers attending co-production groups were also considered, with links made with a local nursery so parents could access childcare whilst attending groups.

One challenge has been to better understand what the data tells us about Blackpool families. Whilst there is a wealth of data collected across services, it was agreed that a file audit would help better understand community needs and avoid assumptions. This was initially challenging due to practitioner capacity, however, over several months, 93 files of families and babies born into care in Blackpool have been audited. Data ranging from presenting issues of referrals to the final court order, have been collated.

How have families and communities supported the work?

Blackpool families have more than supported this work; they have led and are shaping it. No decision is made without them. This work is driving meaningful change locally and nationally because of the involvement of parents who have faced separation from their babies. The work has strength and credibility because of their bravery and commitment to sharing their experiences to help others.

This work has given local dads a voice, with good representation within the working groups. Being part of this work gave one dad the opportunity to influence future workforce by sharing his experiences with student social workers as part of a teaching session at a local University.

What difference is it making for children and families?

A parents group has been developed so mothers and fathers can come together in an informal space. Parents have told us that knowing they are not alone and that others have had similar experiences has helped. The group can be used as part of a consultation process and is a great way for new parents to have their voices heard without attending a weekly workstream.

The Giving HOPE boxes project, aligned with the Born into Care national project, demonstrates real change in the system. Blackpool is an implementation site for the Giving HOPE (Hold On Pain Eases) boxes, which were designed by researchers at Lancaster University, Birth Companions and in partnership with women with lived experience, and are a therapeutic intervention to help mothers who are separated from their babies at birth. The HOPE boxes aim to:

- offer some comfort to lessen the pain and trauma that having your baby removed from your care can bring
- help other women feel they are not alone
- support maintaining a bond and connection
- help both mother and baby build memories.

You can find out more about the contents and purpose of the boxes here.

There are 60 pairs of HOPE boxes now available for families in Blackpool who may experience their baby being removed from their care at birth over the coming year. This project runs across Lancashire and South Cumbria with Specialist Midwives from each locality leading the initiative. There is a commitment to this project regionally longer term through the local Maternity and Newborn Alliance.

How is ABS adding value to the wider system?

Born into Care Blackpool is making a difference and impacting systems change. Along with the above, system changes include:

- Support at the earliest point due to a reduction from 16 to 12 weeks of the gestation age at which a referral can be made to Children's Social Care;
- Family assessments being completed by a specified team (Strengthening and Supporting Families Team),
- Birth arrangements forms are now co-produced with parents, children's services, midwifery, and specialist teams,
- Midwifery continuity of carer to ensure parents are represented in meetings by the midwife they have the relationship with.

Future priorities across the partnership

A future priority for Blackpool Better Start partnership is to support the reduction of tobacco and e-cigarettes (smoking and vaping) in Blackpool during pregnancy, as Blackpool has some of the highest rates of Smoking at Time of Delivery (SATOD) in England. Whilst rates across the country have declined, Blackpool's rate of 21% is over twice the national rate of 9.1%, and the North-West rate of 10.6%. Local maternity data suggests that the issue is much worse than the nationally reported data, with SATOD in A Better Start wards reported at 30.5% while exposure to second-hand smoke in pregnancy for the same wards was 40.6% (all 21/22 data). Nationally, smoking cessation is a core priority area with campaigns such as the 'Smoke Free Generation'.

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Lessons from A Better Start

The case studies above provide evidence for how A Better Start partnerships are not only supporting local families to bring about improved outcomes for infants and their families but are looking to the future in terms of driving wider system change. ABS lessons already extend beyond the funded wards, with implications for much wider change. While the examples provided showcase the wide range of areas in which ABS is leading the way, there are several common areas of learning to reflect on.

- Each strong example shows how a **holistic approach to family support** drives improved outcomes. In some cases, this is considering the wide range of family needs, and identifying ways in which the services addressing those needs can work closely together in an integrated, multidisciplinary way. In other cases, this is thinking about how the wider family is supported, e.g. in developing services for fathers and partners. Each views the baby in context, considering the full spectrum of needs as well as the key people around them.

- As is central to all A Better Start work, services which have been **codesigned with service users** are better placed to address needs. The examples above all demonstrate the variety of ways in which A Better Start services have been driven by lived experience and tailored to service user needs. Ongoing local evaluations also provide useful evidence to feed back into service design, continuing to make services stronger and more effective and efficient. In many cases, service-user engagement has resulted in the development of new services, such as the father-inclusive practice examples or support for care-experienced families highlighted above, or new ways of working within existing services, such as the Continuity of Care models shared.

- **Building strong relationships** between service users and those who support them are key, no matter what the service. This is clearly seen in the Continuity of Care models summarised above, where pregnant women, and their partners, can get to know their supporting midwife and team, meaning a more personalised service can be delivered which takes account of individual circumstances and needs. The work with care-experienced parents also demonstrates the importance of relationship building, before and after birth, to understand individual needs. However, this personalised approach is challenging amid workforce shortages and competing pressures.

Overall, ABS learning shows that supporting families at the earliest point reduces the need for later intervention and supports the building of strong physical, social, and emotional development. Intervening early, with a variety of services and initiatives to meet individual and changing needs, will help to address inequalities later in life. As always, this requires investment in workforce skills and capacity; engagement of families to consider what will work best to address current, individual needs; and evaluation and impact measurement approaches that continue to demonstrate what works, for whom, and how services can continue to be improved.

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A Better Start

A Better Start is a programme set up by The National Lottery Community Fund, the largest community funder in the UK. A Better Start works with families so they play an active part in deciding on and designing the services and support they get so they can give their babies and very young children the best possible start in life. It is one of five major programmes set up by The National Lottery Community Fund to test and learn from new approaches to designing services which aim to make people's lives healthier and happier. Learning and evidence from A Better Start enables The National Lottery Community Fund to present evidence to inform local and national policy and practice initiatives addressing early childhood development.

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