Pregnancy Mentor Apprentice Project

Final Evaluation Report – November 2024

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Statement on gender-inclusive language in this report
Nottingham University Hospitals NHS Trust recognise the importance of providing inclusive, respectful perinatal care to all pregnant women and people. This includes trans and non-binary people as birthing parents and co-parents. Without excluding the language of women or motherhood, this report uses language that aims to demonstrate this inclusivity.

Report summary

Nottingham University Hospitals NHS Trust (NUH) want to be regarded as an outstanding maternity service that is safe, effective, caring, responsive and well-led by the people it cares for, its staff and others.

The aim of the Pregnancy Mentor Apprentice project was to develop a new maternity workforce role that would be equipped to deliver maternity care using a different approach to supporting women, birthing people, their babies and families. Originally, the objectives were to reduce health inequalities and improve a range of public health outcomes, but as the project was implemented it was jointly agreed to focus on workforce and system change.

Background and context

The NHS Long-Term Plan (NHSE, 2019) sets out a vision for modern maternity services to deliver care which is; safer; more personalised; delivers improved outcomes; and reduces inequalities. The following year, a nationwide report was published that highlighted a constellation of biases that had led to women with multiple and complex problems experiencing difficulties in navigating the health and social care system. It found that women living in the most deprived areas are three-times more likely to die during pregnancy than those who live in the most affluent areas. Women from Black, Asian and mixed ethnicities were also shown to have a significantly higher risk of dying in pregnancy than White women (MBRRACE-UK, 2020).

In the context of a national shortage of midwives (House of Commons, 2022), NUH wanted to explore the potential contribution that Maternity Support Workers (MSWs) with additional academic and practical training could make to reducing these inequalities locally. This new workforce would be tasked to focus on the following defined populations; a) people living in areas that represent the 20% most deprived in England; b) people who smoke; c) women and birthing people from Black, Asian and minority ethnic communities; and d) population groups experiencing poorer-than-average health access, experiences and/or outcomes. NUH's ambition was to deliver enhanced support – that is, **in addition** to the routine care pathways already being provided by midwives, obstetricians and other members of existing multi-professional and multi-agency teams.

Methods

A new MSW role was devised using the national maternity support worker competency, education and career development framework originally published in 2018 and refreshed in 2024 (NHSE 2024c). Public health education priorities recommended within the NICE clinical guidelines for antenatal and postnatal care (2019a, 2019b) were then identified that could be delivered by MSWs. This was then transformed into bespoke pathways designed to offer enhanced support for families living in areas of Nottingham that were part of the National Lottery Community Fund's A Better Start Programme (2024) that was being delivered by Small Steps Big Changes (SSBC) (2024) (**appendices 5 and 6**).

The project secured financial support from the NUH apprenticeship levy account to fund up to 14 full-time equivalent MSWs to undertake the two-year, Level 5 Assistant Practitioner

(Maternity) higher apprenticeship foundation degree (FdSc) delivered by a university in the Midlands region.

SSBC's Partnership Board agreed to commission this 30-month project valued at £1.12m, using the principles of 'test and learn' to establish whether the introduction of this new MSW workforce role – Pregnancy Mentor (PM) – contributed to reducing inequalities and improving public health outcomes for the defined populations locally.

NUH evaluated the project using a mixed-methods approach. Quantitative data was collected from NUH's electronic patient record systems. Qualitative data was collected using interviews, focus groups and surveys with women, birthing people and their partners; the PM apprentices; and a range of NUH maternity staff.

Key findings

A	When compared with women and birthing people living in similar population groups, those supported by the Pregnancy Mentors were more likely to have accepted referrals to smoking cessation, weight management and other voluntary services for pregnant people.
B	Women and partners reported valuing visits from their Pregnancy Mentor in their own homes. They told us they felt more comfortable and less time-pressured and therefore felt more relaxed about talking openly and asking questions.
C	Overall women, birthing people and their partners reported feeling more prepared for parenthood and satisfied with their maternity care experiences.
D	These apprenticeships increased workforce diversity, attracting more mature individuals who were familiar or came from the local communities they served.
E	The Pregnancy Mentors valued the opportunity to gain an academic qualification alongside direct experience of the realities of work.
F	Pregnancy Mentors reported that providing continuity of care to the defined populations rewarded them with a high-degree of job satisfaction.
G	While the majority of Pregnancy Mentors were keen to secure permanent roles in community, some articulated ambitions to go further and train to become midwives or to pursue careers in public health and health visiting.

Recommendations

1	To adopt apprenticeships in maternity as it creates a valued work-based career progression pathway and opportunity for the existing MSW workforce, while providing opportunities for the local community by offering new routes into education, boosting workforce diversity, skill mix and capacity long term.
2	To unlock the contribution that community-based MSWs can make to both antenatal and postnatal care as it has the potential to be transformative, particularly for those individuals from communities that have higher exposure to health inequalities and racial disparities.
3	To diversify the workforce's skill-mix and empower highly-motivated staff with lived experience to deliver more intensive support for the public health priorities on the national maternity policy agenda as it represents an effective and cost-efficient way to get families off to a better start.

1.0 Main report

1.1 Introduction

1.1.1 National policy background and context

Governments have previously described the NHS as one of the safest places in the world to give birth. However, multiple reports and independent investigations have highlighted ongoing problems in maternity in England (UK Parliament, 2024). This has prompted the current government to commit to taking steps aimed at achieving rapid improvements.

The NHS Long-Term Plan (NHSE, 2019) has set out a vision for modern maternity services to deliver care which is; safer; more personalised; delivers improved outcomes; and reduces inequalities. However, an annual maternity survey conducted by the Care Quality Commission (CQC) of over 20,000 women and birthing people who had a live birth in England in 2022 reflected a marginal, yet significant fall in positive ratings of their maternity experiences. This included: a) perceptions that staff were not always available to help them when they needed it; b) that the level of confidence and trust in the staff delivering their care had reduced; and c) that the communication and interactions with staff giving advice and support was not always what they needed (CQC, 2022).

Ethnic inequalities in maternity care and maternal and neonatal outcomes have also been reported for several years. The MBRRACE-UK[1] annual report published in 2020 highlighted a constellation of biases that had led to women with multiple and complex problems experiencing difficulties in navigating the health and social care system. It found that women living in the most deprived areas are three-times more likely to die during pregnancy than those who live in the most affluent areas. Women from Black, Asian and mixed ethnicities were also shown to have a significantly higher risk of dying in pregnancy than White women (MBRRACE-UK, 2020). Three other key reports were published in 2022 that provided further evidence that the lived experiences of women and birthing people from marginalised groups was too often poor: a) The Black maternity experiences survey (FiveXMore, 2022); b) Invisible - the maternity experiences of Muslim women (MWNUK, 2022); and c) Racial injustice in maternity care (Birthrights, 2022).

More recently, evidence submitted to the All Party Parliamentary Group (APPG) on Birth Trauma concluded that marginalised groups have a poorer experience of maternity care. As well as ethnicity, deprivation and age, other factors that may affect an individual's experience of maternity care can include neurodiversity, sexuality and/or gender identity (APPG, 2024 p.58-64).

One of the three main objectives from the Marmot Review that looked at reducing health inequalities included ensuring high quality maternity services to meet needs across the social gradient[2] (Marmot et al., 2010). This recognised that pre and postnatal policy and

[1] MBRRACE-UK is the United Kingdom's Confidential Enquiry into Maternal Deaths and represents the gold standard around the world for rigorous investigations to drive improvements in maternity care.

[2] Health inequities are often observed along a social gradient, which is a "stepwise or linear decrease in health that comes with decreasing social position." (Marmot, 2004).

services should be integrated; that good quality services in the early years have enduring effects on health and other outcomes; that these advantages are particularly strong for those from disadvantaged backgrounds; and that a good quality workforce makes a difference to health outcomes (Marmot et al., 2010). One clear indicator of the impact of family circumstances is infant mortality; although overall rates are very low, there are inequalities linked to levels of deprivation and there have been increases in the most deprived decile since 2010 (Marmot et al, 2020 p.37).

Ethnic disparities can be clearly identified in national stillbirth rates, and there are striking disparities relating to socio-economic status too. **Table 1** below demonstrates that national stillbirth rates are lowest among those of White ethnicity, and for those who live in the least deprived neighbourhoods (MBRRACE-UK, 2023).

Table 1: Ethnic and socio-economic disparities in stillbirth rates for babies born in the UK in 2022 (MBRRACE-UK, 2023).

Stillbirth rates	Per 1,000 total births
White ethnicity	2.99
Black ethnicity	6.19
Asian ethnicity	4.27
Least deprived 20% of the population	2.61
Most deprived 20% of the population	4.60

Clearly with this background and context, there is much to do on a national scale to identify ways to improve health equity and reduce racial disparities. Improving the safety, quality and integration of maternity services requires that service providers confront these challenges in order to increase the levels of trust and confidence among the people they are here to serve.

1.1.2 Nottingham's local context

During this project, Nottingham's maternity services were subject to a government-commissioned review prompted by parents seeking answers about poor maternity care (Ockenden Maternity Review, 2024). Consequently, NUH became part of NHS England's Maternity Safety Support Programme in October 2020 (NHSEb, 2024) and NUH continues to work on delivering an extensive maternity improvement plan.

In the context of deteriorating national and local confidence in maternity services, one of NUH's responses was to explore diversification of their maternity workforce skill-mix. This was at a time when significant national shortages of midwives and obstetricians was being discussed in Parliament (House of Commons, 2022, p.13). When this project was conceived locally in 2022, NUH had a midwifery vacancy rate of around 25% - compared with the national NHS vacancy rate at that time of 9.7%.

This project was designed to explore the potential contribution that MSWs with additional academic and practical training could make to increasing the confidence of local people and reducing health inequities and racial disparities that they may be experiencing. The ambition

was to deliver enhanced support – that was **in addition** to the care already being provided by midwives, obstetricians and other members of existing multi-professional and multi-agency teams. This new workforce was tasked to focus on the following defined populations; a) people living in areas that represent the 20% most deprived in England; b) people who smoke; c) women and birthing people from Black, Asian and minority ethnic communities; and d) population groups experiencing poorer-than-average health access, experiences and/or outcomes (summarised in **Table 2** below).

Table 2: Defined populations living within the ABS programme areas in Nottingham who were positively selected for the Pregnancy Mentor project.

Defined populations			
People living in areas that represent the 20% most deprived in England according to the Index of Multiple Deprivation[3] (IMD).	**People who smoke.**	**Women and birthing people from Black, Asian and minority ethnic communities.**	**Population groups experiencing poorer-than-average health access, experiences and/or outcomes e.g. inclusion health groups[4].**

1.1.3 Workforce development

The MSW competency, education and career development framework was first launched in 2018 and has recently been refreshed by NHS England (NHSE, 2024c). This was a response to government calls to professionalise the MSW role and has provided a blueprint for the development of maternity staff employed in pay bands 2-4[5] who are not required to register with a professional body such as the NMC[6] in England. MSWs are regarded as essential members of the multi-disciplinary team in maternity and investing in their education and training is expected to improve skill mix; develop a flexible and sustainable workforce that has potential to improve recruitment, retention and workforce diversity; and contribute to the delivery of safe, high-quality maternity services.

In 2021, NUH employed around 130 MSWs and undertook a gap analysis of the skills and provision from MSWs. This was based on individual review meetings with each member of maternity staff in pay bands 2-3. The objective was to support the upskilling and upgrading of MSWs and to inform a new programme of education and training which aligned with the national framework (NHSE, 2024c). Band 4 roles had already been established in different specialties such as nursing, radiography, and theatres at NUH. It was felt therefore that if NUH maternity were going to invest in transforming its MSWs in bands 2-3, it would also be beneficial to develop roles and opportunities for staff to progress to band 4 as well.

[3] The English Index of Multiple Deprivation (IMD) is a statistical analysis of multiple factors influencing the level of deprivation in small neighbourhood areas [Lower-level Super Output Areas (LSOAs)]

[4] Inclusion Health includes any population group that is socially excluded. This can include people who experience homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery, but can also include other socially excluded groups.

[5] Agenda for Change is the NHS pay system for all staff except doctors. Roles for maternity care assistants, maternity support workers and Assistant Practitioners (Maternity) usually sit within pay bands 2-4.

[6] The Nursing and Midwifery Council (NMC) are responsible for regulating nurses, midwives and nursing associates in the United Kingdom to ensure they meet the standards to practice safely.

1.1.4 Focus on health inequalities and racial disparities

By aligning the urgency of the national context and policy direction to address health inequalities and racial disparities with local challenges in Nottingham, this pilot project was developed as an adjunct to the band 2-3 maternity workforce transformation plans at NUH. This project also sought to align with NHS England's three year delivery plan for maternity and neonatal services (NHSE, 2023) and the Core20PLUS5 (NHSE, 2024a) approach as part of NUH's actions to reduce inequalities in experience and outcomes for women, birthing people, their babies and families locally. Over the project's lifetime efforts have been prioritised with the populations defined in **Table 2** above.

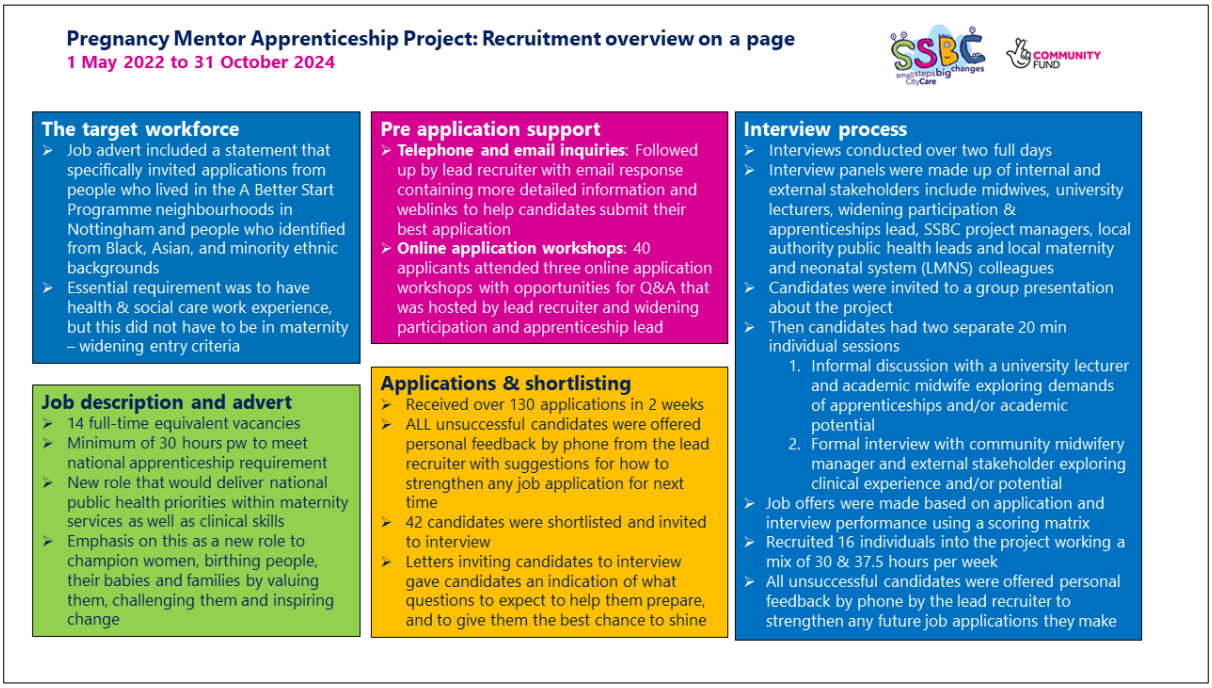
1.1.5 Outline description of the project intervention

a) Recruitment

This project was to **'test and learn'** from the introduction of a new workforce role into NUH's community maternity team. On the recommendation and wider learning of SSBC, NUH took a new approach to recruitment with the aim of attracting people who may not have considered an apprenticeship opportunity due to the academic requirements for entry. This included inviting applications from people living in the ABS programme areas in Nottingham, and people from Black, Asian and minority ethnic backgrounds to apply for this opportunity – the local communities that this project was designed to work with. Additional support and feedback was put in to every stage of the recruitment process to offer everyone who applied for the role something beneficial.

Appendix 1 of this report provides an overview of the recruitment process that was adapted with an intention to attract a more diverse and representative workforce into maternity services. A snapshot is included below in **Figure 1** for illustration only.

Figure 1: Outline of the Pregnancy Mentor recruitment process



Out of 130 applications, 42 people were shortlisted and invited for interviews. The 88 people who were not shortlisted were offered individual feedback by telephone from the lead recruiter and some coaching on how they might strengthen a future job application. 26 people who were unsuccessful at interview were also offered personal feedback by telephone.

16 PM apprentices were originally recruited into this project. However, three of these left the project before their university course started – one had secured a place on a nursing degree and two others had changes in their personal circumstances. Of the remaining 13 PM apprentices, two people were from minority ethnic backgrounds, and another five people had either grown up or lived in the ABS programmes areas.

The PM role at NUH was created to work alongside midwives at the frontline of a family's journey though pregnancy, childbirth and into parenthood. This new role presented an opportunity to become a champion for women and families – valuing them, challenging them and inspiring change. Helping women navigate across the health and social care landscape and listening to them – recognising when a woman, birthing person and/or her family is in need, or at risk. By taking a holistic and family-centred approach, the PMs would build on the values and preferences of women, birthing people and families to support shared decision-making for aspects of their maternity care journey. This would include offering both emotional and practical support to build on the family's existing strengths. By increasing their confidence during pregnancy and into parenthood, the goal was to assist families in becoming more independent and resilient.

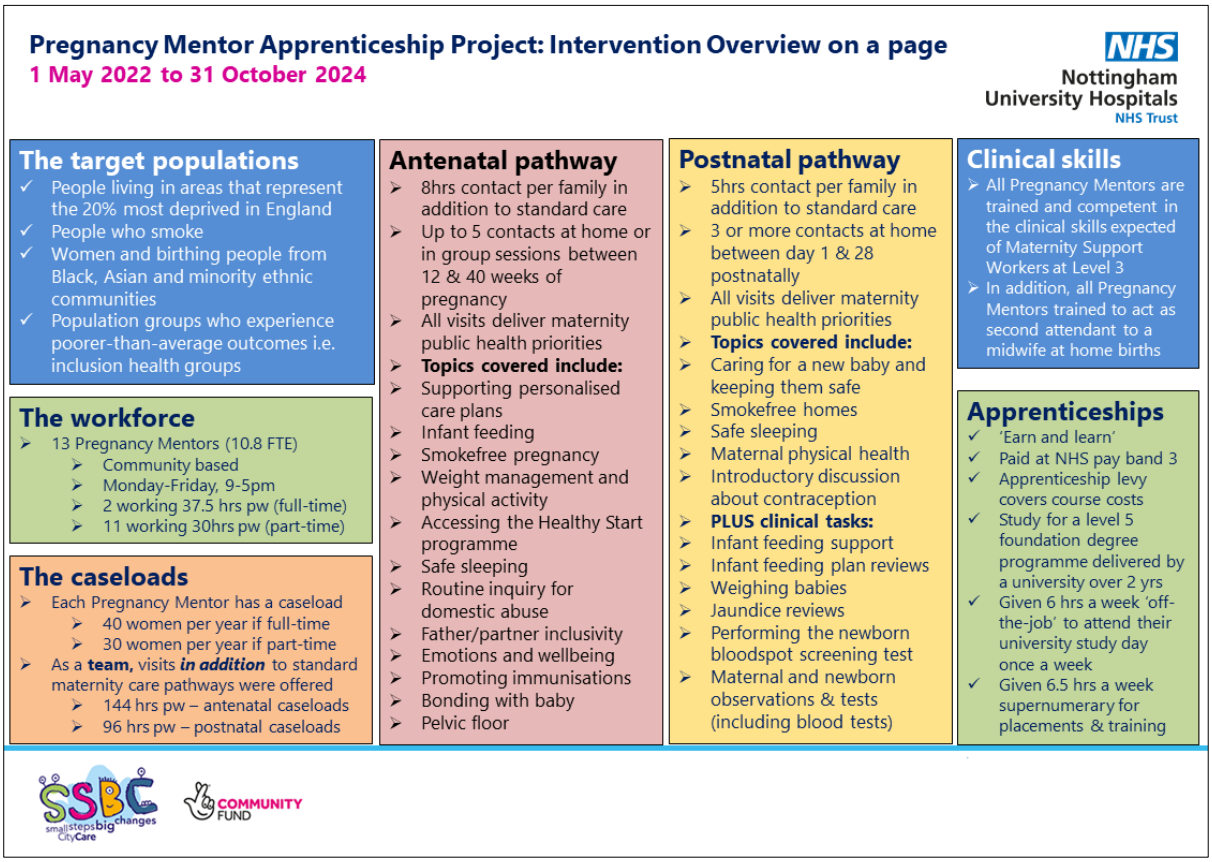
The initial job title of 'Senior MSW (Pregnancy Mentor) Apprentice' was eventually deemed too long and caused some initial confusion over role boundaries. The shorter job title of PM was adopted in June 2023. This was the term preferred by the service-users consulted by SSBC and was felt to describe the service aim for this workforce to become 'trusted advisers' for local families. The term 'mentor' also mirrored another project funded by SSBC in Nottingham as part of the ABS programme that had introduced a new workforce of Family Mentors whose focus was to provide support during the first four years of an infant's life.

b) Intervention

The PMs at NUH were tasked with piloting new antenatal and postnatal care pathways [a summary is provided in **appendices 5 and 6**] that focused on prioritising enhanced support for the defined populations described in **Table 2** above. The content of the care pathways was informed by the public health priorities detailed in the NICE antenatal and postnatal care guidelines (NICE 2021a, 2021b) as well as local ambitions for the A Better Start (ABS) Programme delivery in Nottingham. These include father inclusivity, and public health messaging that could improve the health and wellbeing of children under four years old in the most deprived neighbourhoods of Nottingham City.

The PMs would aim to provide continuity of care to a caseload of women and birthing people between 12 weeks gestation and day 28 postnatally. This would be ***in addition*** to contact that was part of the standard maternity care pathways. **Appendix 2** of this report provides an overview of the planned intervention to be delivered for this project. A snapshot is included below in **Figure 2** for illustration only.

Figure 2: Overview of the Pregnancy Mentor project intervention



c) Training – academic component

As part of the project intervention, each PM would be facilitated to complete an academic programme at Birmingham City University for their Level 5 Assistant Practitioner (Maternity) apprenticeship foundation degree (FdSc). The apprenticeship involved 20% off-the-job learning for which the PMs were allocated a protected university study day each week. The project budget hired a dedicated coach to transport the PMs between Nottingham and Birmingham for this. The PMs were required to attend and complete modules and a practice assessment document (PAD) that included:

Year 1

- Knowledge and skills to practice in maternity
- Principles of anatomy and physiology
- Principles of personal and professional development
- Supporting physiological birth

Year 2

- Supporting transition to parenting
- Advanced knowledge, skills and assessment in maternity
- Becoming a paraprofessional
- Evidence based healthcare
- Introduction to management and leadership in health and social care

d) Training – practice component
At NUH, each PM was allocated 12.5 hours per week for both their off-the-job and on-the-job learning requirements. Practice placements, insight visits and shadowing were facilitated across maternity in both the hospital and community settings. These were organised and supported by a band 6 Clinical Apprentices Practitioner (CAP) Midwife working 22.5 hours per week for the project. The CAP midwife provided an invaluable role in supporting and overseeing the progress of the PMs. As well as personally mentoring the PMs in their practice placements they would also represent NUH at the regular tripartites (progress reviews) with the PMs and university tutors. They would also provide support for line managers to navigate their responsibilities for the learners which included monitoring any individual learning plan needs, absences or breaks in learning and ensuring that if any PMs were off-track, they received appropriate support from both the university and NUH.

In line with the national apprenticeship rules, the PMs recruited to the project were required to work a minimum of 30 hours a week in order to complete the qualification requirements within 2¼ years. This included an end point assessment (EPA) which is a final, independent assessment that tests and apprentice's knowledge, skills and behaviours at the end of their apprenticeship. This involves a practice observation and professional conversation with an assessor independent from the university and NUH, and a separate 90-minute multiple choice exam.

e) Training – in-house component
In addition to attending the routine mandatory training programme provided for all MSWs at NUH, each PM was also supported to attend a new in-house training programme co-designed by the PMs, CAP midwife and project team. The aim was to equip the PMs with enhanced knowledge and skills to deliver the range of public health priorities identified in the new antenatal and postnatal pathways [a summary is provided in **appendices 5 and 6**]. **Figure 3** below presents some of the enhanced training provided in-house for the PMs. These sessions were delivered each month of the project and often involved inviting external experts to deliver content.

Figure 3: Word cloud demonstrating a selection of the enhanced training topics organised for the PMs by the Clinical Apprenticeships Practitioner Midwife between September 2022 and September 2024

1.1.6 The addition of Pregnancy Mentors – quantified

The project operated with 13 individuals (10.8 FTE). Each PM was allocated 12.5 hrs per week for their off-the-job training. This meant the project could deliver 242.5 on-the-job hours per week for the project (equivalent to 6.5 FTE).

1.1.7 Summary

The key objectives for this project were to achieve workforce and system-change that would improve a range of public health outcomes and the care of women, birthing people and babies. It set out to develop a completely new workforce role in maternity for Nottingham, supported by an approved academic programme of study using the apprenticeship framework. This project was planned to be piloted with families from defined populations living in the ABS Programme neighbourhoods in Nottingham [**Table 2**] and provide them with enhanced support through the delivery of new pathways of care [**appendices 5 and 6**]. This would be in partnership with community midwives at the frontline of a family's journey through pregnancy, childbirth and into parenthood.

2.0 Methods

2.1 Duration

This project was designed as a 30-month pilot to be delivered between 1 May 2022 and 31 October 2024. Each apprentice had a fully-funded place on the Assistant Practitioner (Maternity) foundation degree (FdSc) higher apprenticeship programme at Birmingham City University (BCU, 2024). Their course started in September 2022 and each apprentice was expected to complete the 'end point assessment' of their qualification before December 2024.

2.2 Setting

The PM apprentices were originally based within the four local authority wards in Nottingham that were part of the ABS Programme managed by SSBC. In December 2023, this was expanded to include other areas within Nottingham where pregnant women and people lived that were also recognised as within the 20% most deprived neighbourhoods in Nottingham and Nottinghamshire (according to the IMD[7]).

2.3 Design

A mixed method design was adopted for the evaluation to obtain in-depth qualitative and quantitative data. This method recognised the 'test and learn' nature of this project, how it evolved over time, was not led by fixed ideas and processes but sought to adapt within the local context. A logic model was developed to identify the inputs, outputs, expectations and outcomes of the project which facilitated setting the key performance indicators (KPIs) for the project [**Appendix 3**].

During the lifetime of the project, three different electronic patient record systems (EPRS) were used by community staff, which has presented challenges for comparing data from different time phases. This report presents data collected for 14 months using the most recently introduced EPRS, rather than for the full 30 months of the project. Regrettably, manual data collection efforts by the PMs also returned incomplete data and has therefore not been included in this report.

The qualitative data was collected using interviews, focus groups, online surveys and individual reflective accounts from the PMs. A text survey was also employed to explore the reasons why some families declined the PM service offer. Whenever identified as appropriate, the offer of a language interpreter was made.

2.4 Recruitment

A Project Evaluation Midwife (PEM) oversaw all data collection. The 13 PMs participated in collecting data from the defined population, and as participants in staff interviews and focus groups. Managers, midwives and MSWs from across the maternity service, including hospital-based staff where the PM apprentices had undertaken placements, were also invited to participate in interviews and online surveys.

[7] The English Index of Multiple Deprivation (IMD) is a statistical analysis of multiple factors influencing the level of deprivation in small neighbourhood areas [Lower-level Super Output Areas (LSOAs)]

Women and birthing people, and their partners, who both accepted or declined the PM service were also invited to participate in this evaluation through interviews, focus groups and/or surveys that were conducted and delivered by the PEM.

Women and birthing people living in an area where a PM apprentice was based were originally offered the service following contact from a PM or a community midwife around the time of their first maternity care booking appointment. The referral process was streamlined in December 2023 following the introduction of a new patient record system with electronic referral functionality which enabled midwives to send details of women and birthing people directly to the PM team. The criteria selected for referral were:

- People who have previously experienced pregnancy loss and require a language interpreter.
- People from ethnic minorities who require a language interpreter.
- People from ethnic minorities who also have a pregnancy complexity such as diabetes or hypertension.
- People who are current or recent smokers.
- People with a Body Mass Index (BMI) above 35.
- People with current safeguarding issues.
- People with a mental health or anxiety disclosure.
- Other reasons for enhanced support (midwife discretion).

The NHS England Core20PLUS5 (2024) approach that was introduced in November 2021 to reduce healthcare inequalities, informed the defined populations detailed in **Table 2** above. This was combined with national guidance and evidence from MBRRACE-UK and others associated with potentially modifiable risk factors that relate to maternity safety and experience. This includes analysis that has demonstrated:

- Significant disparities in stillbirth rates for babies born to mothers living in the most deprived areas, and mothers from non-White ethnicities.
- That pregnant women who do not speak fluent English are at a greater risk of poor birth outcomes compared to their English speaking counterparts.
- That deaths linked to poor mental health, including suicide and substance misuse, have remained the leading cause of deaths between six weeks and one year after pregnancy.
- That maternal smoking and exposure to second-hand smoke is associated increased rates of stillbirth, miscarriage, preterm birth, low birth weights, heart defects and sudden infant deaths.
- That obesity puts women at a greater risk of pregnancy-related complications including pre-eclampsia, gestational diabetes and caesarean birth.

3.0 Findings

3.1 Evaluation approach

The evaluation of the findings aimed to establish what impact the PM apprentice project had on achieving system change by introducing a new workforce role to support people living in the ABS programme neighbourhoods in Nottingham. It explored the following topics:

- To discern whether this new workforce were able to deliver measurable outcomes for the intended beneficiaries.
- To discover how families in Nottingham who were mentored experienced the PM service.
- To explore whether the integration of this new workforce into the existing maternity services structure provided an effectual change to the service.
- To understand whether the role of the PM facilitated fulfilling personal and career progression for the individuals who undertook this apprenticeship.

3.2 Evaluation strategy

In recognition that this pilot would be undertaken in a contemporary open health system, the evaluation needed to be both exploratory and explanatory and would need to capture multiple perspectives.

3.3 Quantitative data

Most of the data in this section of the report has been derived from the current NUH EPRS. It includes women and birthing people who were booked for maternity care between 1 April 2023 and 31 May 2024 (14 months). During this time, the PM service supported 538 people through the antenatal and postnatal phases of their pregnancies. Not all the people had had their babies yet, 200 were still antenatal, and 338 were postnatal.

The data presented in this report reflects 14 rather than the full 30 months of the project as this was a period of relative stability. However, it would be appropriate to regard these as indicative findings only. A conservative estimate is that this data may represent less than half of the total people who actually received the PM service intervention. Please refer to section 5 of this report which discusses limitations associated with data reliability.

3.3.1 The reach of the Pregnancy Mentor service with the intended beneficiaries

Typically, 30% of women who book for maternity care with NUH identify from Black, Asian or minority ethnic backgrounds. Within the PM caseloads, the proportion of people seen from these ethnic backgrounds was 42%.

Typically, 19% of women who book for maternity care with NUH do not consider English as their primary language. Within the PM caseloads, this proportion was 38%. This reflects the population demographics for the ABS programme areas and indicates that midwives were identifying and referring women in line with the referral criteria detailed in section 2.4 above.

Table 3 demonstrates that majority of women and birthing people seen by the PMs (68%) were from the target demographic i.e. the 20% most deprived neighbourhoods.

Table 3: Women and birthing people seen by PMs by IMD deciles based on home postcodes[8] April 2023 to May 2024.

IMD deciles[9]	Women seen by PMs	Percentage of women seen by PMs	All NUH women**
1 & 2	365	68%	35%
3 & 4	84	16%	19%
5 & 6	52	10%	15%
7 & 8	19	3%	11%
9 & 10	17	3%	20%
Total	**537***	**100%**	**100%**

***Notes**:*
** 537 of 538 reported here. One person had no home postcode that could be used to determine their IMD decile.*
*** For comparison only, this is the typical percentage of women accessing maternity care from NUH in each decile.*

Table 4 shows that most visits made by PMs were conducted in the antenatal phase of their care. This is consistent with the objective of the project to provide up to eight-hours of additional contact time to deliver an enhanced level of support for public health and education priorities during the antenatal phase of care. The PMs would then predominantly provide practical and clinical support such as infant feeding, caring for the new baby and newborn bloodspot screening with up to five-hours of additional contact time in the postnatal phase of care.

Table 4: Number of antenatal and postnatal contact visits conducted by PM apprentices June 2023 to July 2024.

Type of visit	Number of visits
Antenatal	980 (68%)
Postnatal	465 (32%)
Total	**1445**

Father/partner inclusivity

One of the project objectives was to increase the inclusion of fathers in their own parenthood journey. Further analysis of the data presented in **Table 4** indicated that fathers and/or partners were present and included at 404 visits (28%). Results from the online survey of partners indicates that being at work was the most common reason for not being able to attend visits.

[8] Data extraction from the electronic patient record systems has been challenging due to transition between three different system providers during the lifetime of the project. Figures are therefore likely to be a conservative representation (under-estimate) of all women seen by the PMs.
[9] IMD deciles are a ranking system that divides small geographical areas into 10 groups based on the Index of Multiple Deprivation (IMD). Decile 1 represents neighbourhoods with the most deprived 10% of the population, and decile 10 represents neighbourhoods with the least deprived 10%.

3.3.2 Activity undertaken by Pregnancy Mentors with the intended beneficiaries

Awareness that there is a social gradient[10] in health has attracted varying interpretations of how to approach the delivery of health equity initiatives effectively. For some programmes it has been interpreted as delivering higher-doses of the same 'universal' initiatives for a selected demographic. While others have preferred universal provision to avoid targeting specific groups which can lead to criticisms of labelling or stigmatising (Carey et al., 2015). This project took a targeted approach based on need, to deliver a 'higher dose' of the universal public health priorities in maternity for the defined population groups [see **Table 2** above].

a) Development of a comparator cohort

As explained in section 3.3 above, the data that follows provides limited scope to arrive at conclusions about the impact of the PM service on the health outcomes of the beneficiaries. In order to explore the potential impact of delivering a 'higher dose' of public health information, an NUH Data Analyst created a separate comparator cohort of women and birthing people (a matched-pair group) who shared certain characteristics with the PM cohort. These included; IMD deciles; ethnic category; month of booking; whether they were a smoker at the time of booking; the range of their BMI[11] at booking; how many times they had been pregnant before; and whether they were antenatal or postnatal. Data for this comparator cohort has been added to tables 5-10 below.

b) Smoking prevalence

Typically, around 19% of women and birthing people who book for maternity care with NUH are smokers at booking, and 10% are still smokers when they give birth. **Table 5** below presents data from within the PM cohort demonstrating that 30% were smokers at booking, and of the women who had given birth at time of data collection, 18% were still smokers when they gave birth. This means that less than half of smokers were able to stop smoking during their pregnancy. However, data from the EPRS indicated that women in the PM cohort were more likely to have accepted a referral to a smoking cessation support service than the comparator cohort.

Table 5: Smoking data comparing Pregnancy Mentor cohort with comparator cohort April 2023 to May 2024.

Smoking	Pregnancy Mentor cohort	Comparator cohort
Women who were smokers at booking	160 of 532* (30%)	129 of 533 (24%)
Smokers who were referred to cessation services during pregnancy	117 of 160 (73%)	56 of 159 (43%)
Smoking status at time of birth**	59 of 334 (18%)	33 of 320 (10%)

** Missing data for six women*

*** Not all women in both cohorts had given birth at time of data reporting*

[10] Health inequities are often observed along a social gradient, which is a "stepwise or linear decrease in health that comes with decreasing social position." (Marmot, 2004).

[11] BMI = Body Mass Index is a medical screening tool that measures the ratio of height to weight to estimate the amount of body fat.

c) Weight management referrals

Typically, only 2% of women and birthing people who book for maternity care with NUH are recorded as agreeing to be referred to a weight management service. The number of referrals accepted for this support across the PM cohort (16%) is much higher than both the typical rate, and the rate within the comparator cohort (4%). This is presented in **Table 6** below.

Table 6: Weight management referrals for PM cohort and comparator cohort April 2023 to May 2024.

Weight Management	Pregnancy Mentor cohort	Comparator cohort
Women with BMI above 35 at booking who were referred for weight management support	27 of 167 (16%)	6 of 144 (4%)

d) Healthy Start vitamins

Typically, 45% of women and birthing people who book for maternity care with NUH are recorded as being offered Healthy Start vitamins[12]. The proportion of women and birthing people who were recorded as being offered vitamins was much higher in the PM cohort (72%), and this was also higher than in the comparator cohort (60%). This is presented in **Table 7** below.

Table 7: Healthy Start for PM cohort and comparator cohort April 2023 to May 2024.

Healthy Start	Pregnancy Mentor cohort	Comparator cohort
Women offered Healthy Start	386 (72%)	321 (60%)

e) Vaccine uptake antenatally

Typically, 20.5% of women and birthing people who book for maternity care with NUH are recorded as accepting antenatal vaccinations. **Table 8** below presents the proportion of women and birthing people who were recorded as having the influenza or COVID-19 vaccine administered during their antenatal care. This was low across both the PM and comparator cohort.

Table 8: Antenatal vaccination uptake for PM cohort and comparator cohort April 2023 to May 24.

Vaccinations antenatally	Pregnancy Mentor cohort	Comparator cohort
Influenza	86 (16%)	79 (15%)
COVID-19	1 (less than 1%)	5 (1%)

f) Breastfeeding outcomes

Typically, 78% of women and birthing people who give birth to their babies at NUH initiate breastfeeding, and 51% are recorded as continuing to breastfeed on transfer to the Health Visiting service. There was missing data for breastfeeding across both the PM and

[12] The NHS Healthy Start scheme helps young families on low incomes to buy healthy food and milk. People can be eligible for NHS Healthy Start if they are more than 10 weeks pregnant or have children under four and receive certain benefits.

comparator cohorts. The data presented in **Table 9** below shows that recorded breastfeeding initiation and continuation was significantly lower for both cohorts when compared with all births at NUH.

Table 9: Breastfeeding outcomes for PM cohort and comparator cohort April 2023 to May 2024.

Breastfeeding	Pregnancy Mentor cohort	Comparator cohort
Initiation at birth	248 (46%)	267 (50%)
Maintenance on transfer to health visiting service	26 (5%)	40 (7%)

g) Other referrals – local charity for financial advice

Typically, less than 1% of women and birthing people who book for maternity care with NUH are referred for support from a financial advice charity. **Table 10** below demonstrates that the number of referrals made for support with financial worries to Hope4U was much higher in the PM cohort (8%). This rate was also considerably higher than the comparator cohort (1%) which was similar to the NUH average.

Table 10: Financial advice referrals for PM cohort and comparator cohort April 2023 to May 2024.

Financial support charity referrals	Pregnancy Mentor cohort	Comparator cohort
Hope4U	42 (8%)	5 (1%)

3.3.3 Survey data from intended beneficiaries evaluating the Pregnancy Mentor service

a) Online survey results – women and birthing people

Online surveys of women and birthing people accessing the PM service were launched in March 2024 via the EPRS, and in July 2024 via SSBC social media channels. Indicative demographics for the 26 respondents were as follows:

- 77% (n=20) were aged between 18-34 years old
- 85% (n=22) identified from minority ethnic backgrounds, with 11 people in this group identifying from the Urdu speaking Pakistani community
- 58% (n=15) were receiving care for a first pregnancy.

The key findings from these surveys are as follows:

- 92% (n=24) said they received care from a PM.
- 84% (n=21) rated their overall experience highly.
- 58% (n=15) of respondents mentioned they found the interpreting service working with the PMs as particularly beneficial.
- 92% (n=24) said they trusted, felt at ease and had a good relationship with the PM.
- 84% (n=21) said they were happy with the number of visits they received.
- 77% (n=20) felt the PMs focused on what was important to them.
- 88% (n=23) could identify knowledge, skills and support they had gained including improving their confidence and ability to parent, help with making healthier choices, and help with making appointments.
- 84% (n=21) felt supported in their chosen method for feeding their baby.

3.4 Qualitative data

The section builds on the quantitative data presented above. It presents a range of perspectives and opinions from those involved directly and indirectly in the PM project that were collected by the PEM. It has also utilised explanatory narrative to tell the story of the project.

3.4.1 System change: Perspectives on whether effectual change was achieved

3.4.1a Background and context

The nature of introducing the project into a contemporary open system meant that at times it conflicted with operational priorities to deliver a safe service. In the NHS, mobilising all available workforce resources to maintain patient safety is standard operational practice.

For NUH, the local objective of prioritising improvements to the safety and quality of maternity services for ALL women, birthing people and babies was the primary focus. This meant that during a national shortage of midwives, introducing a new service that was tailored to the needs of specific population groups by employing a proportionate universalism[13] approach, was not always fully understood by all the maternity workforce. While many staff appreciated the need to provide more support to the defined populations, convincing them that piloting a new workforce to help them deliver this was often challenged. Many midwives indicated that they would prefer more midwives to be recruited instead, while at the same time acknowledging that there was a national shortage of midwives available to recruit (House of Commons, 2022, p13).

Similarly, introducing learners undertaking apprenticeships was also new for the maternity service. This involved releasing the PMs to attend university one day a week and supporting them to undertake supernumerary placements within different clinical areas across hospital and community settings to meet the academic requirements of their programme.

It should also be noted that the community service was still in a recovery phase following the COVID pandemic; that there were ongoing maternity workforce deficits; and that significant digital service improvements to the EPRS that involved switching from one system, to another, and then another in the space of 12 months may have resulted in a degree of change fatigue among some of the workforce.

> *'An eroding of respect… Midwives are getting a raw deal across the board. No breaks, working late, doing admin. work and also our own. Nothing is out of our remit.' [**Community Midwife, 2023**].*

This manifested into a lower-level of effort than expected and ongoing tensions around supporting the overall objectives for this project at the operational level. This inevitably impacted on the scale and intensity at which the project's outcomes could be realised.

[7]Proportionate universalism recognises and tackles the social gradient, aiming to improve the health of everyone but with a greater focus on those facing the greatest need and worst health outcomes. Where proportionate universalism has been effective, health services have allocated greater resource the greater the need, and have avoided simply supporting those who are easiest to support.

3.4.1b The project leads

The PEM undertook three individual interviews with the project leads in June/July 2023 to gain their perspective of setting up the project and what could be learnt from this process.

a) Aspirations for the project

The project leads all recognised they had a responsibility to ensure external funding was put to effective use and that this meant delivering real change for both service-users and staff. They had anticipated that introducing a new skill-mix into the workforce would be challenging but ultimately valued and welcomed, even though it would provide only a partial solution to the workforce pressures at that time. They were also ambitious for the future of maternity services at NUH and were keen for the project to be a trailblazer.

> '*I'm hoping it will help us build for the future of our maternity service.' [**Interview 2 – Project Team, 2023**]*

The project leads were also able to make links with the national policy framework and were enthusiastic about improving career pathways for MSWs locally.

> *'I would really like to see that we have a career pathway for our MSW workforce to go from [pay] band two to three to four and then if we can get a midwifery degree apprenticeship up and running, that we are growing our own [midwives]…' [**Interview 2 – Project Team, 2023**]*

Introducing this project in a dynamic health system using 'test and learn' principles required a creative and hands-on approach from the project team to try and adapt the project to changing service demands. The project had been launched at pace to ensure it could be delivered within the SSBC ABS programme window (2015-2025). All the project leads reflected that if they were starting the project again they would budget for more planning and preparation time.

> *'It's a bit of a roller coaster in a pilot project, but also you, you know, you see tenacity with people, like pushing things through and you can't prepare for all eventualities.' [**Interview 1 – Project Team, 2023**]*

> '*I think the planning stage should take a long time. So yeah, planning, communicating, preparing. I think you need six months probably. It's like managing change, isn't it? So you need everybody on board to manage this in order to get the change.' [**Interview 3 – Project Team, 2023**]*

The project leads also felt that having more administrative project support would have been beneficial. One of the leads completed training as a PRINCE2[14] Practitioner in their own time to develop their skills to deliver this project. This experience had helped them to appreciate that more structure would have created more clarity around the project's trajectory for all stakeholders.

> *'More [pre]-planning [was] needed… I think if we'd have had more time to plan… we could have put in [more] structure.' [**Interview 2 – Project Team, 2023**]*

[14] PRINCE2 is a process-based methodology for effective project management.

All three project leads felt they had underestimated how much invention, problem-solving and re-engineering of the project would be required at the outset, but found this a positive experience.

> *'I am hoping it works but it is a new [workforce] role so [we have] nothing to base it on… [there] doesn't seem to be this model anywhere else, you know, that you can use for what we're doing. So yeah, so that's been difficult.' [**Interview 2 – Project Team, 2023**]*

> *'Yeah, it's been very reactive rather than proactive. I probably underestimated how much I'd have to invent.' [**Interview 2 – Project Team, 2023]***

> '*It's been very reactionary, if you know what I mean, which I say is not a bad thing, when you have never done it before, when we're learning as we go along. I think it shows that we have responded well.' [**Interview 1 – Project Team, 2023**]*

3.4.1c The wider maternity workforce

Six individual interviews with maternity staff were conducted by the PEM in July and August 2023 with four midwives and two MSWs. A subsequent online survey in 2024 received 83 responses from maternity staff.

i) Communication

Communication about the project with NUH staff was approached through a variety of channels including emails, online and face to face meetings, posters and letters. It was recognised that knowledge of the project was generally considered as good among staff and there was a fair understanding why the project was taking place.

As the project progressed, information about it was communicated from the PMs themselves with several staff mentioning they relied on this as their main source of information about the project, a factor that ties in with the PMs feeling more confident and self-assured about their role as the project evolved.

> *'… most of the information [about the PM role] I do get from the PMs themselves telling me what's happening…. but then we do get emails occasionally.' **[Interview 3 – Community Midwife, 2023]***

The online survey showed that staff preferred to access information about the project through online or face to face meetings, rather than via emails. Posters were also favoured but needed to be updated regularly.

ii) Team Integration

It was felt that having good communication at the launch of the project was important to help the community teams prepare for the project and help to integrate the PMs into the community team bases.

In practical terms, there was some initial challenges associated with the choice of the original job title for the PMs – Senior MSW (Pregnancy Mentor) Apprentice. This reflected the desire for consistency from the operational managers and suggestions based on consultation with service-users. This was addressed by truncating the job title to 'Pregnancy

Mentor' in June 2023, which had been the preference of service-users and both suited and defined the role more closely.

Another practical challenge was the PM uniform colour (which was the same as other MSWs). The PMs felt that a different coloured uniform would establish them as distinctly different from general MSWs and help to prevent midwives allocating MSW tasks to the PMs. A number of options to resolve this concern were explored with the PMs, however no consensus could be reached between them. It was eventually noted over time that the PMs felt less concerned about their uniforms as the project progressed in response to the midwives and MSWs establishing a better understanding of the PM role.

> *'I think there was a lot of pressure put on [the PMs] that was unnecessary… that perhaps led to… confusion as to what they [were] doing [initially]'* ***[Interview 3 – Community Midwife, 2023]***

PMs would be asked to assist MSWs during workload surges in the general community teams. This became more routine as the PM team completed their clinical skills training and is discussed further in section 3.4.1d (i) below. However, there was evidence that team integration was facilitated by PMs providing support to MSWs and that this led to better understanding and reciprocity from both staff groups. There was also evidence that as the PM role evolved over time, it became more accepted and integrated into the teams where PMs were based.

> *'The only way it's affected me for my work load is that if the [PMs] have got their pathway [women] and they've got their postnatal [visits] l, maybe there's not as much for me to do in the [neighbourhood] as I'd like. So I do get shipped out to do visits in other areas, but it's not always a bad thing, and I don't mind it… You know, if I was swimming in referrals and things like that and they did have a spare 5 minutes they would help me out if I needed it'.* ***[Interview 1 – MSW, 2023]***

> *'Having worked with [PMs] in community [since] launch, it feels like the role has now adapted into what it could be.'* ***[Staff Survey – Community Midwife, 2024]***

iii) Impact on midwifery care

43% of community midwives who responded to the survey said they had referred a woman to the PMs and described how the PM service had positively impacted their workload.

Community midwives reported feeling that PMs had helped them meet the needs of their caseload and provided an enhanced service to women and their families to a standard they felt proud of. Community midwives in the ABS programme areas were more likely to recognise the benefit of the PM role.

> *'Because we're so rushed off our feet in clinic, it's nice to know the PMs are going out to women's homes to see their home environment, to talk to them about those really important health promotion topics that we can only really skim over in clinic.'* ***[Focus Group 1 – Community Midwife, 2023]***

> *'They've taken a weight off my shoulders really – the PMs are invaluable.'* ***[Interview 2 – Community Midwife, 2023]***

'So the PMs are absolutely like my eyes and ears at the moment in so many ways.' ***[Interview 3 – Community Midwife, 2023]***

'It is obviously like a very different role to my role. Mine is so… medically focused, whereas that's not so much the focus of what [the PMs are] doing. But I think it supports our role really and it's good to have people you can refer families to and I can say, "oh can you focus on this when you speak to this family" so that's nice, it's positive.' ***[Focus Group 1 – Community Midwife, 2023]***

The staff who responded to the online survey recognised and agreed that PMs had increased service capacity and time to focus on important public health priorities.

'[PMs] are particularly valuable for their contribution to public health messaging and extra support for families with additional needs.' ***[Staff Survey – Hospital Midwife, 2024]***

This role is essential to support women and midwifery staff at NUH as they have the time to concentrate on health promotion as well as identifying difficulties so they can signpost and refer on to other health professionals thus providing a seamless package of holistic care.' ***[Staff Survey – Hospital Midwife, 2024]***

Most hospital midwives and MSWs who responded to the online survey acknowledged the benefits of the PM role in the intrapartum care setting and most agreed that with appropriate additional training, they would welcome PMs as permanent members of the labour ward teams.

60% of respondents to the online survey agreed that the PM role had increased their job satisfaction or reduced their levels of workplace stress. Midwives were keen to maintain the midwifery scope of practice, but were open to utilising the PMs for the additional clinical tasks they did not always have time for. Practical and in-depth support for the midwife and the women/birthing people and families was seen as being the biggest advantage from a midwifery perspective.

'… our [PM] is offering the support that we didn't give previously. I think it's a fabulous service, and we need more of them, [the PM] who works with us is fabulous!' ***[Staff Survey – Community Midwife, 2024]***

'It's been really nice saying "ohh I've got these colleagues that will do this and they'll be around to give you more in depth support".' ***[Interview 3 – Community Midwife, 2023]***

The majority of MSWs working in maternity who responded to the survey felt positive about career progression to band 4 roles and were generally interested in becoming an Assistant Practitioner (Maternity) or a registered midwife through an apprenticeship route. This route into midwifery was endorsed by both midwives and MSWs in the staff interviews. Having people with experience of the demands and realities of the job was seen to be beneficial to the service.

'I'm sure as long as you're getting the same training and you know they've got the same qualification and [professional registration] at the end of the day, it doesn't really matter what route they go down.' ***[Interview 1 – MSW, 2023]***

3.4.1d The Pregnancy Mentors

The PEM held focus groups with all 13 PMs at two time-points, May 2023 and May-June 2024 and these were analysed thematically. The PMs also wrote reflections on their roles in July 2024.

i) Supporting the general service

NUH had 19 community midwifery teams working in different neighbourhoods across Nottingham and Nottinghamshire. The PMs were assigned to work in four of these teams that covered the ABS programme neighbourhoods. This was a requirement from the project funders in order to support the pilot to 'test and learn' from the agreed intervention. In practical terms, this meant these four teams were assigned 3 or 4 PMs each, while staffing in the other 15 teams remained unchanged.

This created a perception among the general community service that the ABS neighbourhood teams were overstaffed. This initially led to managers calling on the established MSWs already based in the same teams as PMs to cover work in the other 15 teams. This generated some resistance from these MSWs, who had concerns that the PM role was beginning to supplant their role. To minimise this tension, during service escalation[15] the community managers began to allocate MSW clinical work required across the other 15 teams to the PMs as well. This was impacting on the time available to the PMs to undertake their caseload activity. It also meant the PMs were increasingly being asked to curtail attendance at scheduled 'off-the-job' training and placements organised by the Clinical Apprenticeships Practitioner (CAP) Midwife.

As this started to become a routine practice by the community managers, the PMs escalated this to the project leads who in turn, escalated to the project board. Regular meetings with the community matron and managers were held to explore ways to prevent the PMs being included in service escalations. The matron and managers acknowledged that it was impacting on the capacity of the PMs to build their caseloads, and consequently on the delivery of the project outcomes. In turn, the project team and project board were sympathetic to service pressures. Therefore, the project leads and community managers worked together to develop an adaptation that set agreed limits on when PMs would be called upon to cover during escalation. This took the form of an algorithm [**Appendix 4**] to be used by the community 'manager of the day'. Regrettably from a project delivery perspective, these limits continued to be breached on a weekly basis throughout the project in response to service escalation.

PMs felt there was a tension between having the skills to support the community teams with routine MSW workload pressures, and trying to give priority to establishing their distinct new role of PM.

[15] Escalation can be described as temporary measures applied to maintain patient safety. This could be in response to a lack of capacity, acute staff shortages, infection control measures, major operational failures e.g. power failure, and major incidents.

> *'We've been employed on this apprenticeship to do a certain role. We've all been employed thinking we're doing health promotion, Pregnancy Mentor, etc. But actually, up until this point, we're still working as a regular MSW in the community.'* ***[Focus Group 1 – Pregnancy Mentor, 2023]***

From the 2024 focus groups, some PMs reflected on the amount of time they had spent contributing to routine MSWs visits. They were aware that this had impacted on their ability to deliver continuity in the way the project had been designed for the families on their caseloads. Similarly, the PM working pattern of Monday to Friday meant this also impacted on their availability to provide continuity of care for their caseloads and this too was diminishing their job satisfaction.

> *'… and then even managers are ringing up (saying) you've got to cancel pathway visits and do essential visits… to help the service. So for me, it's still difficult.'* [***Focus Group 3 – Pregnancy Mentor, 2024]***

> *'I've still got the frustration where I'll have a busy day, half the women are [my caseload] women, half the women aren't. And I am ending up [cancelling] my [caseload] women to get the other visits done, when really I should be visiting [my caseload women] and offering them day 10 breastfeeding support.'* [***Focus Group 3 – Pregnancy Mentor, 2024]***

> *'I've really struggled with that. You go off a week and you, you come back and you see that [a person on your caseload is] seven days postnatal or more and you… feel a little bit like you've let them down…'* [***Focus Group 1 – Pregnancy Mentor, 2024]***

What was evident from PM accounts was that they often had to invest some emotional labour to gain the trust of their colleagues to be afforded time and space to deliver the care pathways to their caseloads as intended at the scale and intensity required to make a difference.

> *'It has been important to promote the role of the PM with midwives and maternity support workers both in the community and during my hospital practice placements. Taking time to explain how the PM role can be utilised can help to maximise how we can help and support other team members.'* [***Reflection – Pregnancy Mentor, 2024****)*

For some PMs, their relationships with midwives and MSWs in their teams felt transactional, where their contribution only appeared to be appreciated if they took on tasks to help the general community service.

> *'…[if] we're not seen to be doing anything [to help] them… we're not taking any of the workload off of them… I think that's probably the [problem].'* [***Focus Group 2 – Pregnancy Mentor, 2024****]*

There was a sense from some of the PMs that some colleagues remained unsure of where the boundary of the PM role met or overlapped with those of the midwife and MSW. Some PMs had experienced difficult interactions with midwives who felt the PM role was encroaching on the role of the midwife such as offering antenatal appointments, having more time to spend discussing issues such as infant feeding choices or being trained to act as a second attendant to a midwife at a home birth. One PM put it like this:

*'[Midwives] think we are taking all the nice parts of [their] job.' [**Focus Group 2 – Pregnancy Mentor, 2023**]*

This was reflected in a comment made by a community midwife who participated in the 2024 staff survey.

*'Sadly the PM role has arisen due to workloads and lack of community midwives. It complements the care that community midwives can offer women, but sadly takes away some of the role I used to enjoy.' [**Staff Survey – Midwife, 2024**]*

ii) The training environment

Each PM was assigned a named midwife mentor when they started working in their community teams. The intention was for the PM to work in a supernumerary capacity with the midwife for one day a month, alongside them in a clinic or accompanying them on visits. However, it became apparent that there were not enough midwives in most teams to provide this support for individual PMs.

To ameliorate this, the CAP Midwife attached to this project took on a more substantial role in training and supervising the PMs in the clinical setting. They also organised placements and insight visits within the hospital setting. By 2024, most PMs reported that they found hospital midwives were accepting and had a greater understanding of their role and that their learning needs were being met by NUH.

While the PMs were reporting that they had found it challenging to integrate into the community teams overall, they had drawn on support and encouragement from their PM peers and felt bonded as a cohort. This was something that was encouraged through the project providing free weekly coach travel that enabled them to commute to the university in Birmingham together. Similarly, a monthly PM training day was facilitated by the CAP Midwife. This gave the PMs a dedicated monthly study-day together to encourage cohort cohesion and expose them to additional enhanced training from subject-experts, both internal and external to NUH.

*'I think we're quite strong as a team… I don't think it was until we started uni. and we had that two hours that was back on the coach where we actually got to know each other… until we went to Birmingham and had that true opportunity to chat.' **[Focus group 1 – Pregnancy Mentor, 2023]***

PMs reflected that the content of the training days with the CAP Midwife were beneficial, but they were not always able to put their learning into practice with their caseloads if the general community service had workload surges that led to requests for support from the PM team. However, the PMs demonstrated increased confidence as they progressed through their apprenticeship course and became more settled over time.

3.4.1e The intended beneficiaries of the project

The PEM conducted 13 in-depth interviews between December 2023 and February 2024 with service users. The women (and sometimes partners) seen spoke either English, Urdu or Romanian. An interpreter was present for all interviews with Urdu and Romanian speakers. In addition, two online surveys for women and partners were launched in March 2024.

i) The value of home visits

The women interviewed reported feeling more comfortable, at ease and less anxious because their PM visits had taken place in their own homes. Women appreciated the PMs flexibility around the timing offered for appointments and opportunities for their partner to feel more involved if they were also at home. Women described attending hospital and midwife clinic appointments as important for their pregnancy, but the home visits were something they looked forward to as they found them more personalised.

> *'We were alone in the UK and needed this support. The best thing was the visits were at home where we felt comfortable, everything was explained fully with plenty of time.'* ***[Interviews – Postnatal Mum, 1st baby]***

> *'The fact that we saw [the PM] in our own home was so good, it helped with my anxiety, the PM regularly coming to see me and I knew I could ask her anything… I didn't have that relationship with the midwife.' [**Interviews – postnatal Mum, 1st baby]***

ii) Being given more time

Women felt that the PMs had more time to listen and respond to their questions than the midwives in the clinic or hospital settings. Women said they felt more comfortable asking PMs for practical support such as help with registering their baby with their GP that meant they could access benefits, signing up to the Healthy Start programme and accessing other services.

> *'The midwife had 15 minutes, it was good care but just not enough. The PM [does] home visits, so she was accessible and I could contact her whenever I needed her and we had a good relationship, she was like family.' [**Interviews – Postnatal Mum, 1st baby**].*

> *'I gave up breastfeeding with my first baby because of a lack of support. But this time, especially with the interpreter, the PM and time, I could understand the advice and have continued.' [**Interviews – Postnatal Mum, 2nd baby**].*

> *'My financial situation is not great, I couldn't buy bottles but my PM sourced some for me and showed me how to make up a feed, otherwise I wouldn't have known.' [**Interviews – Postnatal mum, 1st baby**].*

> *'Just knowing I had someone on hand and knowing I could contact them. My PM said, if you need me – I will be there. No-one else said that.' [**Interviews – Postnatal Mum, 1st baby**].*

iii) Valuing continuity and professionalism

The women found having multiple appointments with the same PM helped them to establish a professional relationship. Women who had no family in the UK spoke of the service as being a lifeline for them, as they felt they had no-one else to ask for help and advice. Some women shared how they regarded visits from the PM and an interpreter together as invaluable.

> *'The PM explained everything…she was very gentle with the baby. Even though I have a few children, she still took time to explain everything. She was always smiling, and approachable, not straight faced, I really loved her.' [**Interviews – Postnatal Mum, 4th baby**].*

*I was not ready to have my 2nd child, and the PM helped me. It was important that she was female and the interpreter too. Because of my culture, the way they approached me was important.' [**Interviews – Postnatal Mum, 2nd baby**]*

*'My [PM] was really amazing. I had a good relationship with her and she was so supportive. Helped me through every step… from how to feed my baby to caring for her and even myself. She was so supportive'. **[Online survey – Postnatal Mum, first baby]***

*'I wouldn't be able to mother my first-born the way I am doing now. I had no other person to teach me….' **[Online survey – Postnatal Mum, first baby]***

iv) Experiences of fathers/partners

Fathers and partners were also approached share their experience of the PM service. In total, 9 people responded, either via an online survey launched in March 2024 and via social media channels in July 2024; or accompanying their partners to face-to-face interviews.

The online survey indicated that on average, fathers/partners attended 5-6 appointments with PMs (range = between 3 and 10 visits). When asked to rate on a scale of 1-5, all seven respondents gave the highest rating when asked if they felt fully involved in the care. Free-text comments were invited from participants and two quotes are shared below, along with two quotes from fathers who accompanied their partners to face-to-face interviews.

*'We didn't know what to do and [the PM] was crucial helping us with that. We were 100% prepared, we wouldn't have been otherwise without this service'. [**Interviews - postnatal father, 1st baby**].*

*'The continuity was essential, we wouldn't have engaged if it had been different people.' [**Interviews - postnatal father, 1st baby**].*

*'Without this service I believe my partner would have seriously struggled throughout her antenatal care. The pregnancy mentor was an absolute highlight and joy to have. Consistently going out of her way to make us feel at ease and to calm any worries we may have had.' [**Online survey - partner 3**]*

*'The pregnancy mentor was completely available and understanding throughout any situation we had. Constantly asking for us, and about us, and making sure that not only were we well, but so was the baby.' [**Online survey - partner 4**]*

v) Online survey results – Women who declined the Pregnancy Mentor service

Nine women responded to a text survey in July 2024 designed to explore the reasons why pregnant people declined the offer of a PM. They stated that they either could not fit the visits in due to work commitments or other children, or that they felt they had plenty of support already. This aligns with the experience of the PMs who were contacting women to offer them their services.

3.4.2 The impact of the project on the Pregnancy Mentor apprentices

Focus groups with all 13 PMs were conducted by the PEM in May 2023 and May-June 2024. In addition, the PMs each wrote a reflection on their experiences of being part of the project in July 2024.

3.4.2a Was the Pregnancy Mentor role interesting and fulfilling?

A selection of quotes from reflections shared by the PMs in July 2024 are presented below.

	*'I have enjoyed being a voice for women and standing up for what is right for them. This has been especially rewarding when the outcome for them is positive.' (Lucinda)*
	*'By getting to know the people we care for, I have been able to help them navigate their maternity journey and I feel sure the Pregnancy Mentor role has contributed to them having a healthier and safer pregnancy.' (Vicky)*
	*'It has been rewarding to build relationships and trust with families empowering them to make positive changes for their pregnancy and themselves.' (Aimee)*
	*'I am proud to be part of changing the way maternity care is delivered to local women and helping them to have safe pregnancies and healthy relationships with their babies.' (Amber)*

From the 2023 focus groups, the PMs demonstrated a strong desire to make a difference to the lives and life chances of women, birthing people, their babies and families living in the ABS neighbourhoods in Nottingham. This went along with furthering their education.

> *'I was already an MSW and wanted to develop my skills, and I thought it'd be a really good opportunity to do that. I wanted to try and make a difference with the women living in deprived areas.'* ***[Focus Group 2 – Pregnancy Mentor 2023]***
>
> *'I applied because I was working in a similar field and wanted to expand that knowledge and support families.'* ***[Focus Group 2 – Pregnancy Mentor 2023]***

This commitment to the people they were caring for was carried forward into the 2024 focus groups where most PMs reported feeling fulfilled and content in their role with a sense of responsibility for the families they were seeing. The PMs regarded their roles as a valuable addition to the skill-mix of the maternity teams and could feel that it was appreciated by the women, birthing people and families they were caring for.

> *'…I absolutely love it. I think it really makes a difference. I really do. I am really glad I got to do this'. [**Focus Group 3 – Pregnancy Mentor, 2024**]*
>
> *'I feel like I've been lucky enough to… support quite a few women in labour and it's made me think about what I want to do (in the future).' [**Focus Group 3 – Pregnancy Mentor, 2024**]*

Some of the challenges of working with families with complex needs had also impacted on job satisfaction for some apprentices. In particular, the limited difference maternity professionals can make to the housing issues of pregnant people was a recurrent theme.

> *'… when you're getting referrals about housing and mental health and you can't do anything about it, you just feel like a fraud.' [**Focus Group 2 – Pregnancy Mentor, 2024**]*

> *'… I don't think the issues stop at health. Housing issues and stuff like that. Sofa surfing. There's only so much I can do. I can signpost, but my main job is not to [deal with housing issues]... I'm not a social worker. My job is to talk… about being as healthy as you can during your pregnancy.' [**Focus Group 2 – Pregnancy Mentor, 2024**]*

> *'the [woman] that I went to see, she was going to be evicted. They needed a roof over their head. So… you can't talk to them about the benefits of breastfeeding and, you know, what to expect in labour and how to manage in labour and stuff. Like, you can't. You can't talk about those things as they're thinking about where they're going to live.' [**Focus Group 3 – Pregnancy Mentor, 2024**]*

3.4.2b Has the apprenticeship facilitated personal and career progression?

A selection of quotes from reflections shared by the Pregnancy Mentors in July 2024 are presented below.

	*'This apprenticeship has given me the opportunity to develop my clinical practice through training to deliver a range of extended skills.' (Candice)*
	*'I have gone through a great deal of personal discovery over the course of this apprenticeship. I [now] have a greater insight into my own strengths and areas for improvement.' (Elvi)*
	*'The role has not only assisted me to become a more competent and confident healthcare professional by deepening my understanding and knowledge through the completion of a foundation degree, it has also helped me to develop personally too.' (Amyjo)*
	*'I have enjoyed learning about the different cultures we have in Nottingham and how they differ with their different traditions during pregnancy and the postnatal period.' (Michaela)*
	*'[The course] has allowed me to...enrich my personal development and understanding of working among a diverse population and with families who have a multitude of needs.' (Nicole)*

During the 2023 focus groups, the PMs viewed their apprenticeships as a rare opportunity for paid learning. Those with family commitments felt they could not justify the expense of going to university full-time, but the apprenticeship offered them the opportunity to 'earn and learn' and get back into education. Career progression after qualifying with a Level 5 foundation degree was also a strong incentive to join this project. Most of the apprentices had previous jobs in health or social care where they felt opportunities to progress had been limited.

> *'I had been working in hospitals for 10 years, and I was already at the top end of a band three, and I knew I needed to progress further. So I'd been looking for jobs that will put me into band four or an education type role. I've got two kids so can't just go out and quit my job and go to uni. So I had to find other ways around that…. And then I stumbled across this [apprenticeship]… something that I… could get my teeth into.' [**Focus Group 1 – Pregnancy Mentor, 2023**].*

> *'I was already a band three health care assistant in the NHS and I wanted to take the next step… I did want to go to university… [with] our priorities and our personal life, I knew I couldn't do it full time financially. I did have an interest in midwifery at college and I saw this [apprenticeship] as an opportunity.' [**Focus Group 1 – Pregnancy Mentor, 2023**].*

> *'I wanted to get a better education [but I] couldn't afford it because I'm a single parent, so I didn't think I'd be able to do that… I worked in general medicine… and I'd kind of gone as far as I could go without having a degree. So when this [apprenticeship] came, I thought, it'd be nice.' [**Focus Group 2 – Pregnancy Mentor, 2023**].*

Again, from the 2023 focus groups, it was evident that some of the apprentices were finding the course content challenging. In response, they felt that they should be allocated more 'off-the-job' time for personal study. However, in the 2024 focus groups this anxiety had diminished with PMs reporting that they were finding the university course stimulating, enjoyable and that it had boosted their confidence in their academic abilities and potential for career progression.

For some PMs, their apprenticeship had led to them developing an ambition to pursue a career as a midwife, or to go into roles in public health or health visiting. The lack of paid midwifery degree apprenticeship courses was an issue for those who had families but those without felt they would consider applying for traditional midwifery degrees taking on the associated financial loans. However for others, seeing related careers in close proximity had helped them to decide not to pursue those paths.

> *'It shows that we've had a Level 5 education and it shows that we can work at a higher level. We have our leadership and management courses, we've learned [about] evidence based practice and stuff like that. So it shows we can work at a high level. Yes, definitely.' [**Focus Group 2 – Pregnancy Mentor, 2024**]*

*'…I've always thought I couldn't do university. I didn't think I was intellectually like, clever enough, academically clever enough…. I know, I want to progress, so I'm looking to see what my family can deal with in the sense of if I become a full time student. So I like the thought of getting an apprenticeship. I like the thought of my bills still being paid and not having to get student loans. But I'm not letting that be my only factor to not continue my education.' [**Focus Group 2 – Pregnancy Mentor, 2024**]*

*'I would still potentially want to be a midwife so if that apprenticeship was… available to everyone I would very much think about it. Yeah, and even though you'd have to start from, you know, do a whole three years. I hope that there will be change.' [**Focus Group 2 – Pregnancy Mentor, 2023**].*

All the PMs were offered permanent contracts with NUH maternity before the end of the project. **Table 11** below details how many are expecting to stay with NUH. The six PMs who have been promoted to Band 4 roles will be called Assistant Practitioners (APs) rather than PMs. This is to align with nationally recommended job titles and descriptors which identify the scope of the roles for support workers at levels 2, 3 and 4 (NHSE, 2024c).

Table 11: Destination for all 13 Pregnancy Mentors at the end of the project (as at November 2024)

Next career step	
Successfully applied for permanent band 4 Assistant Practitioner position with NUH in community team	**6**
Accepted permanent band 3 MSW position with NUH in community team	**4**
Accepted permanent band 3/4 roles with other NHS providers	**3**

Moving forwards, the focus for the band 4 AP roles will be to deliver enhanced support for the populations defined in the NHS England CORE20PLUS5 approach (NHSE, 2024a). Although just 6.0 FTE band 4 AP roles have been advertised so far for the community team, a business case has been approved to recruit a total of 15.2 FTE APs over the next three years.

The current referral criteria [**Table 2** on p.8] and process [2.4 on p.15] will remain in place and the team will have capacity to support 250 women/people per year. The antenatal care pathway will be revised from five to three visits, and the postnatal care pathway will be revised from three to two visits. This reduces the enhanced input from an additional 13 to 10 hours per pregnancy. In addition to their caseloads, APs will provide support in the community maternity setting for smoking cessation, antenatal clinics with midwives and interpreters, leading antenatal/postnatal education groups, as well as other specialist clinics. At the appropriate time, NUH anticipate that APs will also be supported to attend low-risk home births, alongside qualified community midwives.

In addition to support for two further MSW cohorts to undertake Level 5 apprenticeships in 2023 and 2024, NUH will also be part of a three-year pilot in 2025 to introduce new social prescribing link worker roles in partnership with the LMNS and NHS Integrated Care Board.

4.0 Analysis and discussion of results

4.1 The Reach of the Pregnancy Mentors

National data demonstrates that communities with the greatest need are often under-served. This is why the PM service was designed to focus on ensuring those living in the most deprived neighbourhoods and/or were proportionately more likely to identify from minority ethnic backgrounds, were the beneficiaries. The importance of having a straightforward process with a defined referral criteria for key staff to use cannot be overstated. The referral criteria for this project was based on population categories where worse outcomes at the national population level had been demonstrated. Moving forwards, tailoring the PM service to reflect local outcome data has the potential to ensure this intervention is targeted to reach the groups and communities most in need locally.

Learning point 1: It may be beneficial for more work to be undertaken with local outcome data that could help to refine referral categories based on local population needs.

4.2 Reaching populations where the need is greatest

In terms of health outcomes, the data provides only limited interpretive value for assessing the effectiveness of the PM role. However, it does raise questions about the additional challenges faced by people living in the ABS programme areas that may impact on their ability to access and/or engage with services (King's Fund, 2024). While it can be determined that women and birthing people in the PM cohort were more likely to have agreed to referrals to adjacent services than the comparator cohort, it is evident from the PM accounts in section 3.4.2.a above that when people have complex lives, their priorities shift to focusing on dealing other pressures such as housing, financial or mental health concerns.

Further work is needed to understand what adaptations and modifications can be made to reach populations with the poorest health outcomes and how to engage them with screening and other early detection and preventive public health initiatives. For example, in response to the Khan report (2022), the government have announced that all pregnant women who smoke will be offered financial incentives in the form of vouchers worth up to £400 alongside behavioural support by the end of 2024. Similarly, the Family Nurse Partnership in Nottingham offered a voucher scheme to mothers who were providing breastmilk to their baby at six stages after birth: 2 days, 10 days, 6-8 weeks, 3 months, 6 months and 1 year (SSBC, 2024b). There is also evidence that providing transparent and culturally appropriate information on immunisations and ensuring equitable access to vaccinations may help build trust and reduce hesitancy.

Home visiting created opportunities for PMs to recognise when a woman, her baby, and/or her family was in need, or at risk. With sensitive and non-judgemental support, appropriate referrals could then be facilitated to adjacent services and partner agencies. Measuring what impact community-based continuity of carer contributes to increasing safety and reducing risk in pregnancy and beyond could provide valuable system-wide learning.

Learning point 2: This project set out to test and learn whether delivering initiatives at a higher dose would lead to better engagement and uptake of public health priorities for maternity with the intended beneficiaries. To understand the effectiveness of adaptations and modifications to standard delivery models, it is recommended that there is clarity about what the mechanism of any new way to deliver initiatives will be. This will then enable the effect to be measured and evaluated in terms of outcomes, any increase in service-user satisfaction and contributions to service and cost-efficiencies.

4.3 The benefits of continuity of carer

There is evidence from both service-users and the PMs in this report that having the opportunity to establish a professional working relationship was both valued and rewarding for both parties. This was achieved through a caseloading model that aimed to provide continuity of care from the same PM throughout the antenatal and postnatal phases of care.

While English speakers were complimentary of the PM service and found it helpful, those who needed an interpreter were far more likely to regard the PM service as essential. Those who received visits from a PM and an interpreter at the same time, were more likely to report that this enabled them to have meaningful interactions with the service and gain a better understanding of how to stay healthy during pregnancy and feel more prepared for the arrival of their new baby. While this is based on a small data sample, it is a significant finding. Recommendations from NICE and MBRRACE-UK are that anyone who has difficulty understanding or speaking English should be offered an interpreter, and that this should not be a member of their family. They also recommend that these women are given longer appointments (or more appointments) so that there is enough time for everything to be translated. A study by Rayment-Jones et al (2021) also found that high-quality interpretation can have a significant impact on pregnant women living socially complex lives as this enables them to communicate their concerns and access support. This not only impacts on their safety and pregnancy outcomes, but also their wider holistic needs.

Literature around interpreter services in the wider healthcare arena has highlighted concerns around the lack of regulation and access to high-quality interpretation. While new digital and AI[16] technologies are evolving to take on translation tasks, there should be careful consideration of how effectively they can replace appropriate in-person translation services for particular practitioner-parent interactions, before any whole-service changes are adopted.

Learning point 3: There is evidence that demonstrates the beneficial impact of midwifery continuity of carer models (e.g. Sandall et al, 2024). Further work could be undertaken to understand whether non-midwifery continuity of carer models – like this project has attempted – could deliver improved outcomes for women and birthing people as well.

Learning point 4: How language translation services are delivered impact on the quality and effectiveness of communication.

[16] Artificial Intelligence.

Learning point 5: Introducing new workforce roles such as maternity link-workers and/or social prescribers who perhaps have additional language skills may contribute a cost-efficient way to improve safety, effectiveness and service-user satisfaction within maternity services over the longer term.

4.4 System change in a context that is open and dynamic

This project was designed as a pilot for people living in the most deprived areas of the city to 'test and learn' whether the project could make an impact on their maternity outcomes. Convincing a pressured service that; a) a project applying the principles of proportionate universalism[17]; to b) introduce a new workforce role; that c) would selectively focus on a defined population and geography; presented a significant paradigm shift[18].

It is clear from the data presented in this evaluation that there were a number of contextual factors in play that influenced the outcomes for this project. On one level there was the timing of the project's introduction to a service with an extensive improvement programme to deliver already in progress. At another level it was introducing a new workforce role where the risk of being perceived as encroaching on the professional territory of midwives and MSWs was real. At a further level, the intervention risked being perceived as a departure from the concept of a universal model of care which opens up debates about what is just and fair for all.

'Context' is a slippery topic. Should efforts be focused on changing the context, or to fitting the intervention into the prevailing context? (Riddell-Bamber, 2014). Change fatigue, professional fears of usurpation and debates about the merits of equality vs equity. This project attempted to both 'change' and 'adapt to' the prevailing context which achieved limited success. By aiming to win hearts and minds through regular engagement and communication with stakeholders, while at the same time re-profiling and re-launching the project on at least three occasions to try and fit it into the prevailing context, the project leads found themselves actively engaged in an iterative process to deliver an effectual change.

The project team actively listened to the PMs and the wider maternity team to try and address conflicts associated with introducing a more public health focused role into maternity. In doing so, they have demonstrated that adopting a more fluid approach achieved more than if they had adopted an overly structured approach. Given the contextual challenges and despite delivering some significant successes, the project leads still felt this project had potential to achieve more.

[17] Proportionate universalism recognises and tackles the social gradient, aiming to improve the health of everyone but with a greater focus on those facing the greatest need and worst health outcomes. Where proportionate universalism has been effective, health services have allocated greater resource the greater the need, and have avoided simply supporting those who are easiest to support.

[18] Paradigm shift has been defined as a fundamental change in approach or underlying assumptions.

Learning point 6: Context is everything. Alongside the importance of what you do (intervention), and how you do it (implementation), the environment or context that you do it in also matters. It is the interaction between these three elements that makes for success (Riddell Bamber, 2014).

4.5 The future of apprenticeships for maternity

Apprenticeships have the power to transform lives. They aim to improve social mobility and ensure more people gain the skills and training they need to build successful careers. Apprenticeships can also bring tangible benefits to NHS organisations as they can create skilled, motivated and qualified colleagues, that if used properly, can help to address skills shortages across the workforce.

It is clear from the testimonies of the PMs that they regarded their apprenticeship as a meaningful development opportunity, both personally and professionally. Not only did they share that it had enhanced their personal confidence and skills, but many of the PMs had developed an appetite to continue their education further and advance their careers.

This pilot project has demonstrated that these apprenticeships have raised the aspirations of the staff who were afforded these opportunities. Service providers should not regard the completion of these qualifications as an end-point, but as an opportunity to 'grow their own' talent. To harness the investment made in these PMs, NUH have committed to creating a number of specific permanent band 4 vacancies for the PM apprentices to apply for.

Learning point 7: Apprenticeships represent an indisputable tool for social mobility that confers benefits for workplace learners – such as enhanced career earnings, continued education and richer, more fulfilled lives. This can only provide benefits for the local population.

Learning point 8: Check that your organisation's recruitment and interview processes are designed in a way that ensures inclusivity. Think creatively about how to support and encourage non-traditional applicants to apply to your organisation [see **Appendix 1**].

Learning point 9: To sustain a legacy following this pilot project, future workforce planning could include embracing apprenticeships that creates realistic career pathways that enable individuals to move up and through the organisation.

Learning point 10: For maternity, it would also be advantageous to commit to working with local education providers to commission places on a registered midwifery degree apprenticeship[19] (RMDA) programme.

[19] Find out more about Registered Midwifery Degree Apprenticeship (RMDA) programmes in the report authored by Professor Richard Griffin (2023) in the references section.

4.6 Key learning – SOAR analysis

Finally, a SOAR[20] analysis has been undertaken to summarise key learning from the current project and any future potential:

S **Strengths**	• The intended recipients consistently reported valuing the PM service. • The PMs gained a high degree of job satisfaction by working with women and birthing people from the defined populations in the ABS programme neighbourhoods of Nottingham. • The PMs valued the opportunity to gain an academic qualification alongside direct experience of the realities of work.
O **Opportunities**	• There is value in investing in the contribution that community-based MSWs can make to early intervention and prevention for those individuals from communities that have higher exposure to health inequities and racial disparities, to improve their health outcomes. • Adoption of apprenticeships in maternity has the potential to create a valued work-based career development progression pathway.
A **Aspirations**	• The national policy ambitions for maternity to deliver contributions to the development of healthy parent-infant relationships could be delivered effectively by MSWs with enhanced training. • There is huge scope to explore adaptations and modifications that can be made to improve the reach and efficacy of public health interventions for deprived and vulnerable populations groups. • Diversifying the workforce skill-mix could represent an efficient cost-effective way to get more families off to the best start.

R
Results
	• A legacy of 'system change' for:
	  ○ **Service-users**:
	  ▪ The value of continuity of carer from non-midwives.
	  ▪ Improving health equity and addressing racial disparities for service-users.
	  ▪ The value of home visits.
	  ▪ Effective use of interpreters.
	  ▪ Increasing meaningful father/partner inclusivity.
	  ○ **The Workforce**:
	  ▪ Business case for permanent band 4 Assistant Practitioner (Maternity) roles agreed by NUH.
	  ▪ More Level 5 apprenticeship places funded for MSWs at NUH.
	  ▪ More support for home birth created by enabling all apprentices to complete Level 4 training with skills to become a second birth attendant to a midwife.
	  ▪ Developing a proposal to introduce a Registered Midwifery Degree Apprenticeships (RMDA) programme in the region.

[20] SOAR is an acronym for **Strengths**: what is doing well; **Opportunities**: What could be leverage to improve successes; **Aspirations**: What could be achieved in the future; and **Results**: What tangible outcomes demonstrate success.

5.0 Challenges and limitations

a) Missing data

As described throughout the report, there were considerable challenges associated with extracting accurate and comparable data from the EPRS. This was largely due to narrative fields, rather than specific data fields being used by staff to document activity associated with many of the key performance indicators (KPI) for this project. The time available for the PEM to manually search for KPI data was limited and it was decided this would be unfeasible. Therefore, only data captured from the current EPRS has been included in this report. The issue of missing data remains however, as data extraction from the new EPRS was also technically challenging. It is anticipated that this will improve over time, but not within the timeframe to report on this project.

b) Intervention data

We estimate that we have been unable to present outcome data for at least half of all women, birthing people and babies who benefited from the PM service. In the absence of reliable quantitative measures, we have relied on qualitative data to reflect the impact of the service on both the intended beneficiaries of the PM service, and on the PMs themselves.

6.0 Acknowledgements

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Appendix 1: Pregnancy Mentor Apprenticeship Project: Recruitment overview

Pregnancy Mentor Apprenticeship Project: Recruitment overview on a page

1 May 2022 to 31 October 2024

The target workforce

- Job advert included a statement that specifically invited applications from people who lived in the A Better Start Programme neighbourhoods in Nottingham and people who identified from Black, Asian, and minority ethnic backgrounds
- Essential requirement was to have health & social care work experience, but this did not have to be in maternity – widening entry criteria

Job description and advert

- 14 full-time equivalent vacancies
- Minimum of 30 hours pw to meet national apprenticeship requirement
- New role that would deliver national public health priorities within maternity services as well as clinical skills
- Emphasis on this as a new role to champion women, birthing people, their babies and families by valuing them, challenging them and inspiring change

Pre application support

- **Telephone and email inquiries**: Followed up by lead recruiter with email response containing more detailed information and weblinks to help candidates submit their best application
- **Online application workshops**: 40 applicants attended three online application workshops with opportunities for Q&A that was hosted by lead recruiter and widening participation and apprenticeship lead

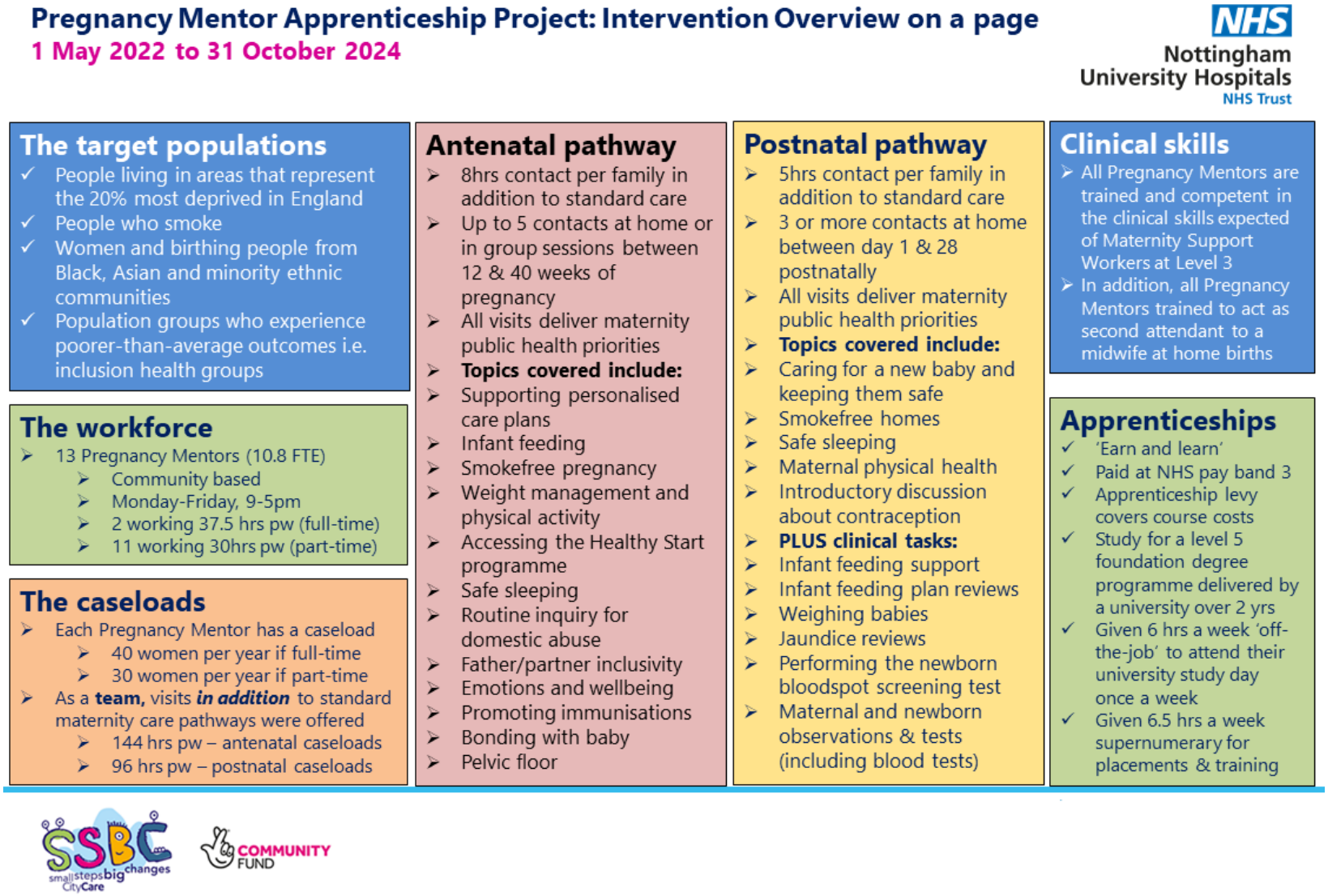
Applications & shortlisting

- Received over 130 applications in 2 weeks
- ALL unsuccessful candidates were offered personal feedback by phone from the lead recruiter with suggestions for how to strengthen any job application for next time
- 42 candidates were shortlisted and invited to interview
- Letters inviting candidates to interview gave candidates an indication of what questions to expect to help them prepare, and to give them the best chance to shine

Interview process

- Interviews conducted over two full days
- Interview panels were made up of internal and external stakeholders include midwives, university lecturers, widening participation & apprenticeships lead, SSBC project managers, local authority public health leads and local maternity and neonatal system (LMNS) colleagues
- Candidates were invited to a group presentation about the project
- Then candidates had two separate 20 min individual sessions
    1. Informal discussion with a university lecturer and academic midwife exploring demands of apprenticeships and/or academic potential
    2. Formal interview with community midwifery manager and external stakeholder exploring clinical experience and/or potential
- Job offers were made based on application and interview performance using a scoring matrix
- Recruited 16 individuals into the project working a mix of 30 & 37.5 hours per week
- All unsuccessful candidates were offered personal feedback by phone by the lead recruiter to strengthen any future job applications they make

Appendix 2: Pregnancy Mentor Apprenticeship Project: Intervention Overview



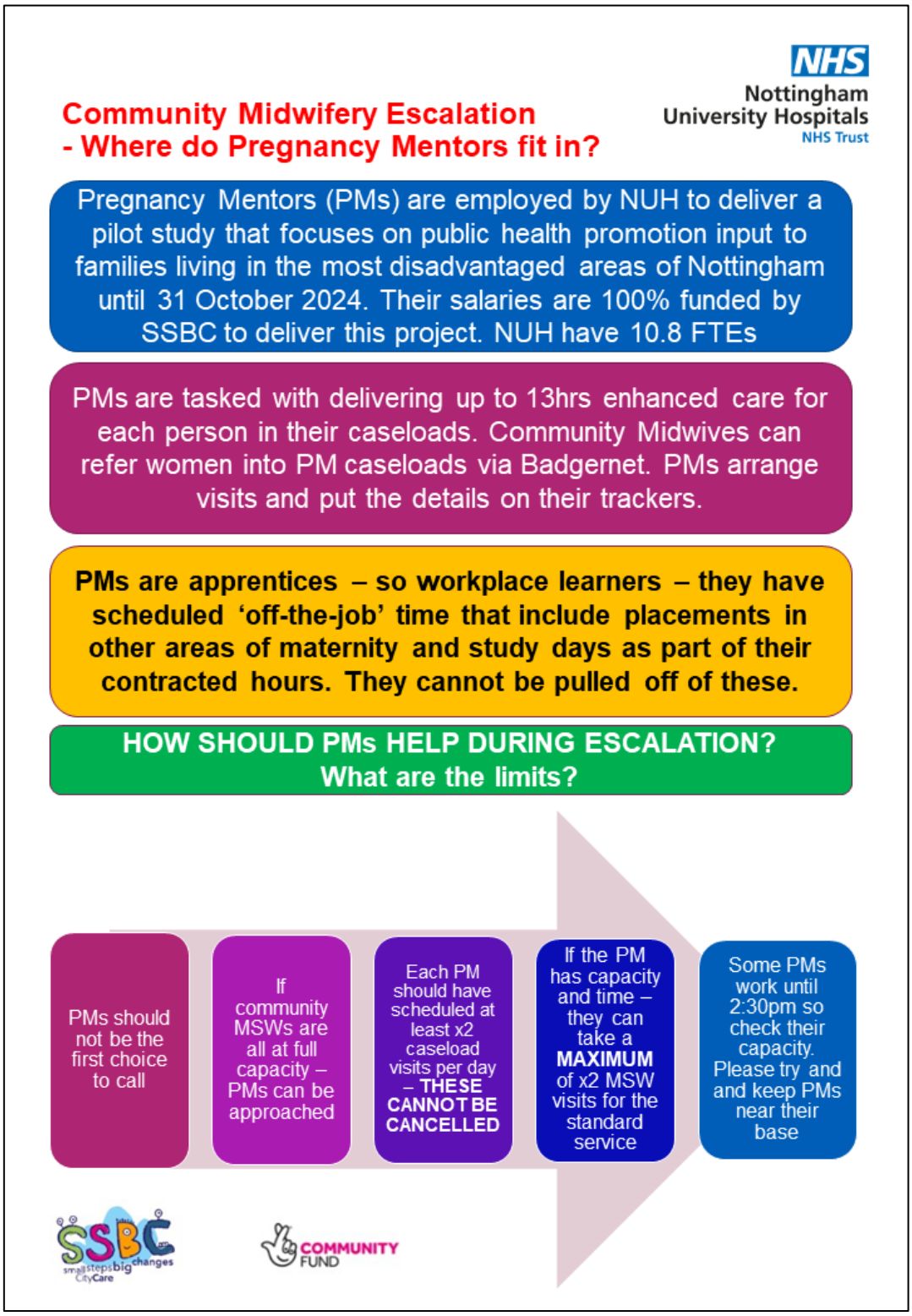
Appendix 3: Key Performance Indicators (KPI) considered for this project

The following list demonstrates the range of KPIs considered for measurement as part of this project.

1	Families have a positive experience including a trusted and supported relationship from their maternity care with the SMSW service
2	Families develop knowledge, skills and increased confidence and self- esteem around preparation for parenthood
3	At least 50% of fathers report feeling included in their own parenthood journey
4	Numbers of 'hardly reached' communities trust and engage with the service
5	Families feel supported with their infant feeding decision
6	Women report feeling supported with their maternal mental health
7	PMs are integrated into the service and there is understanding and acceptance of the role within the wider service
8	NUH Maternity Service continues to employ and retain PMs which improves the skill mix and productivity within maternity services locally
9	New ways of working are developed based on what works for the families involved
10	Community Midwifery Service report benefits from the project as a service change
11	PMs commitment to the role and progression to a band 4 role within NUH maternity service
12	Increased attendance for vaccinations of whooping cough, influenza and covid in pregnancy
13	Uptake of smoking cessation support and engagement with smoking cessation services
14	Decrease in carbon monoxide (CO) levels at 36 weeks gestation
15	Decrease in CO levels at 28 days postnatal
16	Increased breastfeeding rates at birth
17	Increased breastfeeding rates at transfer to Health Visitor
18	Increased referrals to the infant feeding team for support with breastfeeding
19	Reduction in neonatal admissions relating to weight loss at 28 days
20	Earlier attendance at triage for reduced fetal movements
21	Decreased % of babies born between the 4th and 10th centile
22	Reduced pre-term birth

Appendix 4: Agreed limits on how Pregnancy Mentors would be used during escalation (February 2023)

This was the algorithm developed by the project team and community matron/managers for the 'Manager of the Day' in community who was responsible for allocating clinical workloads during escalation.



Appendix 5: Summary overview of antenatal care pathway content delivered by Pregnancy Mentors

Content	Details	12-14 weeks	18-20 weeks	24-26 weeks	29-30 weeks	34 weeks
Location	H = Home visit C = Clinic appointment G = Group session	H or C	H	H or G	H or G	✓
Duration	H or C = Up to 1hr G = up to 2 hrs	1hr	1hr	1-2hr	1-2hr	1hr
Interpreter	Before appointment check language requirements arrange interpreter Prepare and print any resources in different languages	✓	✓	✓	✓	✓
Electronic Patient Record System (EPRS)	Assist with downloading app and pre-populating fields	✓				
Maternal observations	Weight, blood pressure, urinalysis	✓ if C				
PCSP	Discuss document, assist with completion, Birthrights factsheet	✓	✓	✓	✓	✓
Dad's pack	Share with non-birthing parent (discuss specific pages based on gestation)	✓	✓	✓	✓	✓
Preparation for birth (packing a bag)	What to pack/prepare, birth companion facilities, no-smoking on-site etc.					✓
Emotions and wellbeing	Discuss and share resources		✓	✓	✓	✓
Bonding with baby	Discuss and share resources			✓	✓	
Safe Sleeping	Discuss and share resources, Lullaby Trust			✓	✓	✓
Infant Feeding	Discuss and share resources		✓	✓	✓	✓
Baby Buddy App and/or Baby Check App	BB = Baby Buddy BC = Baby Check Show how to download	BB				BC
Smoke Free Pregnancy	Discuss, share resources, offer referral	✓	✓	✓	✓	✓
Carbon Monoxide (CO) reading	Conduct and discuss result	✓	✓	✓	✓	✓
Alcohol in pregnancy	Discuss resources	✓		✓		
Healthy weight and exercise in pregnancy	Discuss and share resources, offer referral	✓				
Pelvic floor exercises and perineal care	Discuss and share resources PF = Pelvic Floor PC = Perineal Care			PF	PF	PF & PC
Contraception information	Discuss and share resources					✓
Routine inquiry for domestic abuse	ONLY IF WOMAN ALONE – discuss	✓	✓	✓	✓	✓
Healthy Start	Discuss vitamins, registered for programme if eligible and/or assist	✓	✓	✓	✓	
Influenza/COVID vaccination offer	Discuss and share resources	✓	✓	✓	✓	
Offer and schedule next visit	Agree date and time AN = Antenatal PN = Postnatal	AN	AN	AN	AN	PN
Confirm contact numbers for maternity	Share Maternity Advice Line 0115 970 9777 and check understanding that they can call it 24/7/365 with any concerns about themselves or the baby	✓	✓	✓	✓	✓
Health Visiting	Advise HV will be in touch 28-32 weeks & Nutrition Peer Support Worker			✓	✓	
Document appointment on EPRS	Complete documentation on BadgerNet	✓	✓	✓	✓	✓
Arrange any agreed referrals	Smoking cessation, weight management, physiotherapy etc.	✓	✓	✓	✓	✓
Named midwife	Discuss if any additional support, needs or concerns identified during visit	✓	✓	✓	✓	✓

Appendix 6: Summary overview of postnatal care pathway content delivered by Pregnancy Mentors

Content	Details	PN Day 1	PN Day 1	PN Day 1	PN Day 2/3	PN Day 5	Discretionary visits beyond Day 5*	PN Transfer
Location	PW = Postnatal Ward NN = Neonatal Unit H = Home	PW	NN	H	H	H	H	H
Contact method	TC = Telephone Call F2F = Face to Face	TC	TC	F2F	TC	F2F	TC/F2F	TC/F2F
Interpreter	Before appointment check language requirements arrange interpreter. Prepare and print any resources in different languages	✓	✓	✓	✓	✓	✓	✓
How are things	Check in with how woman and partner are feeling and if any concerns		✓		✓	✓	✓	✓
Check NIPE completed	To be completed within 72hrs of birth – escalate to midwife and arrange			✓		✓		✓
Exclusively formula feeding support	Ask how is feeding going and advise you will visit them when home	✓	✓	✓				
Formula feeding assessment	Offer advice on making up and storing bottles safely			✓	✓	✓		
Breastfeeding or mixed feeding visit	Offer to visit ward or NN unit to support and/or teach expressing breast milk	✓	✓					
Breastfeeding assessment	Observe positioning and attachment, responsive feeding, 8-12 good feeds in 24hrs, 3+ wet nappies and 2+ dirty nappies a day etc.,	✓		✓	✓	✓	✓	
Assess for signs of well baby/ jaundice	Any concerns, arrange for TCB test and escalate to midwife			✓	✓	✓	✓	✓
Newborn Bloodspot Test	Check understanding of test, give leaflet, gain consent to perform					✓		
Weighing baby	Check for any marks while baby undressed and compare with Red Book. Note weight and calculate percentage change from birthweight if weight loss greater than 7% implement management plan and escalate to midwife and undertake breastfeeding assement					✓	✓	
Introduce yourself to ward team	Explain purpose of your visit to midwife/NN Nurse caring for client	✓	✓					
Other in-hospital checks	Check baby ID labels, security tag, baby obs done, assess for well-baby signs	✓	✓					
Safe sleeping	Revisit advice for safe sleeping, coping with a crying baby	✓		✓		✓		✓
Dad's pack	Share with non-birthing parent (discuss specific pages based on baby's age)	✓	✓	✓		✓		✓

Emotions and wellbeing	Discuss and share resources			✓		✓	✓	✓
Advice for mum – physical health	Discuss and share resources			✓		✓		
Pelvic floor & perineal care	Discuss and share resources	✓	✓	✓		✓		✓
Caring for a new baby	Discuss and share resources, advice on skin care, bathing, care of umbilical cord			✓		✓	✓	✓
Bonding with baby	Discuss and share resources			✓		✓	✓	✓
Baby Check App	Show how to download			✓		✓		✓
Smoke Free Homes	Discuss, share resources, offer referral			✓		✓	✓	✓
Carbon Monoxide (CO) reading	Conduct and discuss result			✓		✓	✓	✓
Contraception information	Discuss and share resources			✓		✓		✓
Routine inquiry for domestic abuse	ONLY IF WOMAN ALONE – discuss	✓	✓	✓		✓	✓	✓
Healthy Start	Check registered for programme if eligible and/or assist			✓		✓		✓
How to register baby's birth	Discuss and provide details			✓		✓		
Feedback on experience of care	Share information on how to feedback on experiences of care via PALS					✓		✓
Offer and schedule next visit	Agree date and time	✓	✓	✓	✓	✓	✓	
Health visiting	Advise HV will be in touch day 10-14 postnatally and facilitate effective handover to health visiting team							✓
Confirm contact numbers for maternity	Share Maternity Advice Line 0115 970 9777 and check understanding that they can call it 24/7/365 with any concerns about themselves or the baby				✓	✓		✓
Document appointment	Complete documentation on BadgerNet	✓	✓	✓	✓	✓	✓	✓
Arrange any agreed referrals	Smoking cessation, hearing screening, BCG, NIPE, TCB, nutrition peer support, GP etc.			✓	✓	✓	✓	✓
Named midwife	Discuss if any additional support, needs or concerns identified during visit	✓	✓	✓	✓	✓	✓	✓

** Discretionary visits beyond day 5 were suitable for 1) babies on weight management plans; 2) babies discharged from the neonatal unit; 3) vulnerable babies; and 4) at the request or with agreement from community and/or community team.*