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Evaluation of enhanced midwifery continuity of carer

Insights report

5th September 2024

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Disclaimer

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List of abbreviations

BSiLAs	Best Start in Life Advisors
eMCoC	Enhanced midwifery continuity of carer
FTE	Full-time equivalent
LMS	Local maternity systems
MSDS	Maternity Services Dataset
MSW	Maternity support worker
VCSE	Voluntary, Community, and Social Enterprise
REVAL	Rapid Service Evaluation Team

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1. Executive Summary

The enhanced Midwifery Continuity of Carer (eMCoC) pilot programme provides additional resource (funding) to midwifery teams operating in the 10% most deprived areas in England. The enhanced funding service aims to provide additional support to those at greatest risk of poor maternal health outcomes. Target populations include women living in the most deprived areas, and may include Black, Asian, and Mixed ethnic groups. Following a pre-pilot phase, eMCoC funding was made available to fifty-eight 'enhanced' midwifery teams in twenty-three Local Maternity Systems (LMS) in 2022/23.

The NIHR funded REVAL team at the University of Manchester have conducted an independent formative evaluation of the implementation of the eMCoC programme on behalf of NHS England's Maternity and Neonatal Programme.

We identified five different eMCoC service delivery types reflecting the contextual differences in need, populations and geography across the implementing sites. The extra resource was mainly used to fund additional maternity support workers (MSWs) and the core activities undertaken by the additional roles were consistent across the services. Teams described themselves as 'enhanced teams', where activities included delivery of mental health and wellbeing support, signposting to non-clinical services as well as support for breastfeeding. It was also reported that the eMCoC resource reduced pressures on midwives' workload and enhanced their capacity to deliver care.

Largely, eMCoC services successfully targeted women living in the most deprived areas and this focus was valued by enhanced teams. Equally, enhanced teams strived to broaden the characteristics of focus to include a wider and more diverse set of social risk factors and vulnerabilities, based on local needs and priorities.

Service users have reported being well supported by the enhanced teams including receiving relational and wellbeing support and personalised one-to-one public health education, information and support. Service users have emphasised that enhanced teams went 'above and beyond in their care'.

Service users have also valued familiarity with all team members. Where they had seen more than one midwife or team member, there was often pre-existing knowledge and awareness about themselves as a patient, and that the team communicated in a beneficial way about their care and personal circumstances.

Throughout our evaluation, emphasis was placed on the 'enhanced team' with the enhanced funded support staff member(s) cited as a central feature. The additional enhanced funded role was seen as providing enhanced care in its own right, as well as facilitating greater capacity for midwives to deliver enhanced care. This demonstrates the ongoing merits of team-based care in this context, as judged by staff and service users.

There appears to be many routes (i.e. different service types) to delivering enhanced care, and the multiplicity of service types found in this evaluation suggest no tightly prescribed way of meeting eMCoC's objectives. The flexibility of the initial funding specification guidance from NHS England has been a key driver of local ownership and permitted eMCoC services to be organically built "from the ground up". Our conclusions point to the value of autonomy afforded to local areas to use enhanced funding as they deem necessary, to best suit the needs of their staff and specific service user groups.

Implementing eMCoC was not without challenges. Many of the fifty-eight teams initially funded were unable to implement eMCoC during the evaluation period because of institutional and organisational barriers. These barriers to implementation echo the wider barriers of implementing midwifery continuity of carer.

Due to the timeframes of this rapid, formative evaluation, longer-term clinical outcomes fell outside of the evaluation scope. Instead, we focused on developing a logic model for eMCoC, to identify process outcomes and potential key clinical outcomes which should be explored in a longer-term evaluation. The logic model is presented on page 13.

2. Evaluation context

The National Maternity Review *Better Births* report (NHS England 2016) outlines a vision for improved NHS maternity services, echoed in the Department of Health's *Maternity Action Plan* (2016) and follow-up report *Safer Maternity Care – Next steps towards the national maternity ambition* (Department of Health 2017). To deliver this vision, NHS England implemented a wide-ranging maternity transformation process.

Recognised in these reports are the significant inequalities in maternal and neonatal health outcomes that persist for ethnic minority women and women from deprived areas in the UK. The government's National Maternity Safety Strategy sets out ambitious targets to reduce these inequalities. Maternity features in NHS England's health inequalities action plan, and Core20PLUS5 — an NHS England approach to support the reduction of health inequalities at both national and system level.

The NHS Long Term Plan (2019) committed to rollout midwifery continuity of carer as the default model of care, available to all pregnant women in England by March 2023. Implementation was to be targeted towards ethnic minority women and those living in the most deprived areas to improve outcomes and reduce inequalities. In March 2022, however, the Ockenden Review (2022) called for NHS Trusts to review and suspend, if necessary, the continuity of carer model due to safety concerns around minimum staffing requirements. NHS England (2022) issued a letter to all maternity services in September 2022 advising that Trusts were no longer expected to deliver against a target level of midwifery continuity of carer. The letter also reiterated guidance to Trusts that midwifery continuity of carer should only continue in maternity services that had safe staffing levels.

The NHS Long Term Plan (2019) also committed to rollout eMCoC. The eMCoC pilot programme provides additional funding to midwifery teams operating in the 10% most deprived areas in England. The eMCoC service echoes priorities identified in the Equity and Equality Guidance (2021) for Local Maternity Systems (LMS), which included a focus on accelerating preventative programmes that engage those at greatest risk of poor health outcomes. Within the guidance, eMCoC is identified as a key intervention to address disparities in maternal and neonatal mortality and morbidity outcomes for groups including Black, Asian, and Mixed ethnic groups and women living in the most deprived areas. Smoking-cessation, increased rates of breastfeeding and culturally sensitive support are also identified as ways of addressing perinatal mortality and morbidity for babies from these groups.

Following a pre-pilot in nine LMS in 2021/22, eMCoC funding was made available to fifty-eight midwifery teams in twenty-three LMS in 2022/23. Funding was given of up to £46,102 per team, the equivalent of one full-time equivalent (FTE) band 4 MSW. In their funding specification, NHS England specified the funding was to provide "holistic support" to "reduce midwives' workload and release additional time for midwives to care for women". There was flexibility in the guidance for enhanced teams to decide on the additional staff

they funded. This could include “creative approaches” such as working with voluntary, community and social enterprise (VCSE) organisations sector to provide joined-up care, or the provision of extra staff including:

- MSWs, e.g. those who speak languages of local communities, or to provide breastfeeding support;
- link workers (i.e. who connect people to community-based support);
- administrative workers.

Eligibility for eMCoC funding was stipulated as neighbourhoods that contain one or more of the 10% most deprived neighbourhoods in England (based on the Index of Multiple Deprivation). Selection panel criteria to receive eMCoC funding included the following domains:

- Suitability of area
    - Are the proposed postcodes included in the plan?
- Suitability of team model
    - Is the proposed caseload and whole-time equivalent of midwives credible and does it meet criteria of midwifery continuity of carer?
- Suitability of enhanced staffing
    - Is the proposed additional staffing credible and meets the ambitions of the eMCoC pilot?
- Suitability of cost
    - Are costs provided? Are costs realistic? Does spending make appropriate use of the full funding for this LMS?
- Readiness to implement
    - confidence that the enhanced team will be rolled out to timeframes as described

As the rollout of eMCoC is in its pilot phase, the NHS England Maternity and Neonatal Programme requested an evaluation to gain insights into the implementation of the service and understand early impacts. This rapid formative evaluation aims to inform on-going learning and decision-making for NHS England, serving as a basis for future longitudinal evaluation.

The NIHR funded Rapid Service Evaluation Team (REVAL) at the University of Manchester was commissioned by NIHR to design and conduct the evaluation.

3. Gathering insights

This was an iterative, multi-site formative evaluation focused on generating rapid insights detailing the practical implications of the implementation of and access to eMCoC from a range of staff and service user perspectives. The evaluation focused on the pilot eMCoC cohort (2022/23) **only**. An additional twenty-one teams were funded in 2023/24 but this cohort was not considered in this evaluation.

Evaluation development and mapping

We started developing the evaluation in November 2022, undertaking scoping of the literature on midwifery continuity of carer approaches in high-income countries delivered to disadvantaged groups. To inform our evaluation design further, we met with stakeholders including the NHS England Maternity and Neonatal Programme team, the National Maternity Voices Partnership and other VCSE organisations including the Parent-Infant Foundation. Other stakeholder-related activities we undertook included:

- Meeting with other researchers including the team undertaking an NHIR-funded longitudinal evaluation of the implementation of midwifery continuity of carer (Award ID NIHR151802) to maximise awareness and synergies between the concomitant projects.
- Meeting regional midwifery leads to explore wider contextual factors surrounding implementation of the eMCoC service nationally and regionally. These discussions provided insights into how support is organised and functions in each region, as well generating 'soft intelligence' relating to teams who are delivering the enhanced service.
- Collating available eMCoC funding documents, which had been completed by LMS leads for submission to NHS England, and meeting with LMS leads (or equivalent) covering forty-four midwifery teams, to get a clearer overview of how services have been developed, designed, implemented and targeted to specific population groups.
- Collation and review of available LMS equity and equality plans to explore local maternity inequalities strategies and objectives and their fidelity to the plans surrounding eMCoC.
- Setting up a patient, public and VSCE study Advisory Panel to inform the evaluation activities and provide feedback and insights on preliminary findings.

This scoping work shaped the evaluation design, and generated an initial logic model, outlining the steps through which eMCoC could, potentially, achieve impact on clinical outcomes. The logic model was used to shape the scope of this evaluation; we could not meaningfully assess impact on clinical outcomes within the timeframe due to:

- the limited duration of pilot eMCoC service implementation (initially a year but extended part way through our evaluation period to two years);

- the length and timeframe of this evaluation meaning there was not sufficient time for significant data to accrue on key clinical outcomes, especially rare events (such as still birth or neonatal mortality);
- and, relatedly, the relatively small number of women receiving the service.

Assessment of process outcomes captured in the logic model however, could provide important insights, further guide the development of theories of change and support longer-term evaluation. The logic model has been iteratively shaped throughout to reflect developing insights and findings from the evaluation, with the iterated version presented in Figure 1 and reference made to this iteration throughout the "Insights" section.

Case sites selection and data collection

With the NHS England Maternity and Neonatal Programme team and our study's Advisory Panel, we then discussed and agreed ten case sites (with seventeen teams) to explore eMCoC implementation. Our intention was to employ a maximum variation sample to ensure variation in eMCoC service type, area-level characteristics, implementation status and service delivery history. However, as of October 2023 when we were recruiting case sites (of the initial fifty-eight teams offered funding) only twenty-three teams were active or planning to be active. This reduced our sample pool size for case site selection.

We included five sites who had no previous experience with the specific service type, three sites who implemented the service later than other sites, and one site who had previously received pre-pilot funding but were not successful in the 22/23 funding round. Table 1 presents details of the included case sites:

Table 1: Overview of case study sites (eMCoC= enhanced midwifery continuity of carer; MSW = maternity support worker)

Region	LMS	No. of sites	No. of teams	eMCoC role
Midlands	Northamptonshire	1	2	MSW
Greater London	North Central London	1	1	Administration support
North West	Cheshire & Merseyside	2	7	Care Coordinators; MSWs
North East & Yorkshire	North East & North Cumbria	1	1	Best Start in Life Advisors
	Humber & North Yorkshire	1	1	MSW
	Mid & West Yorkshire	2	2	MSW and administration support; MSW
South East	Southampton, Isle of Wight, Portsmouth and Hampshire	2	3	MSWs; Administration support & midwifery time

From July 2023 – May 2024, we conducted seventy-two qualitative interviews with staff in the eMCoC teams and service users (Table 2). We were only able to recruit service users from six of our planned eight sites[1]. This was due to a) an inability to receive Trust-level approvals in one site due to a lack of capacity in the midwifery team and b) the nature of recruiting from under-served, marginalised groups and known barriers to participating in research for these groups. We obtained informed consent from participants and interviews were recorded. Further details of the interviews are provided below (Table 2).

Table 2: Qualitative interviews conducted in case sites (eMCoC = enhanced midwifery continuity of carer; MSW = maternity support worker)

Timeframe	Interviewees	Scope of interviews	No of sites	No. of interviews
July 2023 – April 2024	• Team midwives, team leads and continuity of care lead midwives • MSWs, • Matrons, • Heads and Deputy Heads of Midwifery, • other eMCoC funded staff e.g., administrators and care coordinators etc	• Staff views towards and acceptability of eMCoC, • Barriers and facilitators to implementing the service, • Impact on staff • Anticipated service users, outcomes and benefits, • Unintended consequences.	10	38
January – May 2024	• Antenatal women • Postnatal women	• Service user experience of eMCoC, including positive and negative experiences.	6	34

We rapidly analysed data from the staff and service user interviews, and a set of themes and sub-themes were coded. An initial set of themes from the staff interviews were discussed with the study's Advisory Panel, the NHS England Maternity and Neonatal Programme team, and the NHS England convened monthly Evaluation Sub-group meeting which includes stakeholders such as regional and LMS continuity of carer lead midwives, patient/public representatives and academic midwives. In these sessions, we focused on identifying potential gaps in the data and interpretation of the themes and sub-themes. A final set of themes from the staff and service user interviews were discussed with study's Advisory Panel, with feedback provided around the interpretation of these and reflections enabling greater context of the analysis.

As well as exploring implementation we wanted to assess the characteristics of service users who were accessing eMCoC services. We worked closely with NHS England data analysts who conducted descriptive analyses using the Maternity Services Dataset (MSDS) on six case sites[2] to help describe who were accessing eMCoC services. The decision was made to

[1] Two sites in our cohort did not have an active eMCoC service during the data collection period and as such were excluded from our data collection activities.
[2] Data was only available in six case study sites

prioritise these sites as they had implemented the eMCoC service within the evaluation timeframe. The analysis provided aggregated descriptive statistics on eMCoC service users, non-eMCoC service users, and remaining available data on service users that did not fall under either of these two categories. For each of these categories total numbers and percentages were provided for: Age at booking; ethnicity, deprivation decile; mental health indicator; support status indicator; complex social factors and pregnancy losses prior to 24 weeks.

The following section summarises insights from those delivering and receiving eMCoC. A formal academic output will be produced thereafter and will be aimed to be published by the end of the year.

4. Insights

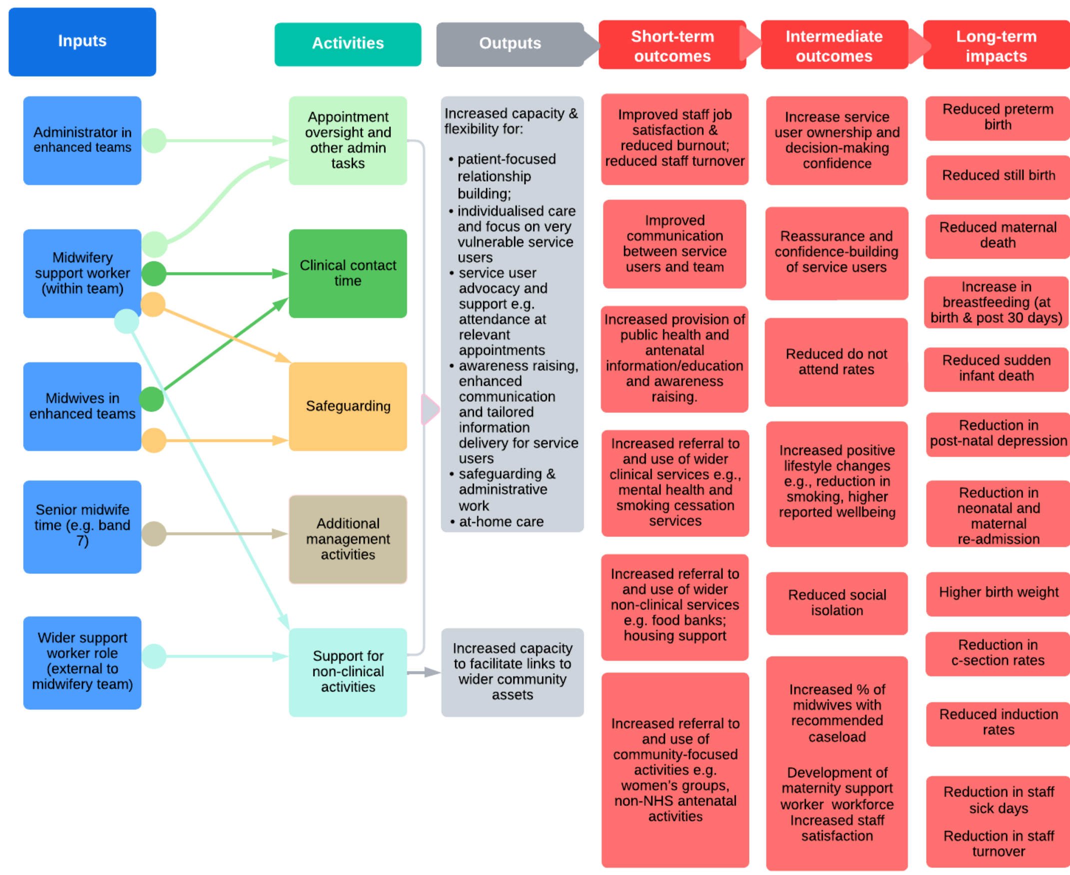
Logic model

The logic model details the inputs, associated activities, and expected outputs of eMCoC activities, derived from the mapping work, the primary qualitative research, existing theory and discussion with wider stakeholders. Insights from the staff and service user interviews confirms anticipated short-term outcomes. The model also incorporates key medium and longer-term outcomes as identified by staff as perceived to potentially link to eMCoC services and activities.

The aim is that this logic model can inform an underlying theory of change model to support future, longer-term evaluation.

A copy of the logic model is provided below.

Figure 1: Logic model of the enhanced midwifery continuity of carer service



4.1 Selection of 2022/23 funded enhanced teams

In August 2023, NHS England confirmed eMCoC funding for fifty-eight midwifery teams across twenty-three LMSs.

Insights from our 'mapping' phase suggest that, largely, the midwifery teams themselves were not directly involved in the application for enhanced funding, and that this was done at a Trust and LMS level. Several factors played a part in which teams were put forward for funding. These included:

- whether there was institutional buy-in from management and staff on the ground,
- whether or not they were already doing midwifery continuity of carer or had the capacity to initiate it,
- whether the teams were likely to be continued or if there was a risk of discontinuation (because of staffing etc.).

At the funding allocation stage, the criteria to receive enhanced funding was based on domains which included perceptions around the local teams' ability to implement eMCoC. Such factors included the ability of teams to deliver midwifery continuity of carer, sustaining staffing levels as per midwifery continuity of care, and their overall readiness to implement eMCoC (see list on page 7).

In addition, as indicated in the previous section, when we were recruiting case sites, there were twenty-three (from the original fifty-eight funded) teams who were active or planning to be active. As such, there is a potential positive bias in terms of assessing the implementation of the service in teams who were most well placed to implement eMCoC services.

This context instigates a specific cohort of teams who were:

- perceived to be able to implement and sustain their enhanced teams at the pre-bidding stage,
- were successful in receiving the funding, based on the funding selection criteria,
- were successful in implementing the eMCoC service within the timescale of the evaluation, limiting the number of teams that could be evaluated.

This serves as an important finding of the evaluation, as well as an important contextual backdrop to the ensuing insights reported in the following sections.

4.2 'Mapping' eMCoC services in the funded teams

Our 'mapping' work of the fifty-eight teams revealed that most teams planned to use the eMCoC funding to pay for a band 3/4 MSW role and/or a band 2/3 administrator. Some teams planned to fund some additional senior midwifery time (i.e. Team Leader) alongside

one or more, other supporting role (i.e. an MSW or admin role). Some teams planned to use the funds for other types of roles i.e. Family Health/Care Coordinator roles, “Best Start in Life Advisors” (BSiLAs), although broadly these roles undertake similar activities to those described for MSWs across the full cohort.

Across the funded sites, the rationale behind and implementation of eMCoC aligns closely to the specification guidance, with teams privileging capacity for midwives accommodated via the implementation of the eMCoC service.

4.3 Types of eMCoC services implemented in case sites

Focusing on our sample of case sites, Table 3 presents the different eMCoC service types and associated activities across the seventeen teams in our ten sites. Each service type describes how the additional eMCoC funding has been used; we refer to the specific additional resource funded by the NHS England pilot as the **‘enhanced role’**. Activities undertaken by these roles are what delineate these eMCoC services from midwifery continuity of carer per se. We describe each service type’s characteristics to illustrate the contextual and nuanced variation in between the services. The history column details how the funded eMCoC roles relate to teams’ previous activities and thus provides important contextual information.

Table 3: Description of eMCoC services (eMCoC = enhanced midwifery continuity of carer service; MSW = maternity support worker; FTE = full time equivalent; VCSE = voluntary, community and social enterprise)

eMCoC service	Enhanced roles	Summary characteristics of service	Description of activities delivered as part of enhanced role	History	No of teams
Service Type 1 MSW (role already existed in team)	MSWs only Directly service-user facing	Service funded extra time of MSWs (increased their FTE or added another MSW)	Supporting antenatal and postnatal care (including postnatal visits). Support includes mental health and wellbeing support, breastfeeding support, signposting to non-clinical VCSE services, baby weights and checks, repeating bloods, chasing up referrals etc.	Teams have previously had MSW support prior to enhanced funding, undertaking similar activities.	8
Service Type 2 (MSW role – new to team)	MSWs only Directly service-user facing	Service funded extra time of MSWs (increased their FTE or an additional MSW)	Supporting antenatal and postnatal care (including postnatal visits). Support includes mental health and wellbeing support, breastfeeding support, signposting to non-clinical (VCSE) services, baby weights and checks, repeating bloods, chasing up referrals etc.	Teams had **not** previously had MSW support in this way in these teams. The service is 'new'.	2
Service Type 3 (additional administrat ion support)	Administrat ion support only Indirectly service-user facing	Service funds a separate administrator role	Booking women, re-arranged missed appointments, chasing up non-attenders, chasing up referrals etc.	Teams have **not** had a specific administrator role assigned/ supporting their team previously. The service is 'new'.	1
Service Type 4 (additional administrat ion support combined	Administrat ion support plus other role Both directly &	Service funds a separate administrator role and another staff member (senior	Booking women, re-arranged missed appointments, chasing up non-attenders, chasing up referrals etc.	Teams have **not** previously had an assigned administrator role.	1

with other service-user facing role)	indirectly service-user facing	midwife (team lead) or MSW)	Administrator provides additional support for team leader or wider team through task-shifting.	The service is 'new'.	
Service Type 5 (other role)	Other support role (e.g. non MSW or administrator roles Directly service-user facing	Service funds 'new' roles, non MSW, midwives or admin: Care Coordinator or "Best Start in Life Advisors" and these roles are separate to the specific team.	Supporting antenatal and postnatal care (including postnatal visits). Support includes mental health and wellbeing support, breastfeeding support, signposting to non-clinical (VCSE) services. Women are referred into enhanced support (automatically based on criteria or by midwives)	Some of these roles are new. These services were later to implement the service.	5

We identified five different eMCoC service delivery types across ten sites, driven by contextual difference and nuances in implementing sites. Despite this variation, it is striking that the different enhanced roles and services undertake similar activities consistent across the various service types including: signposting to additional services, public health education and support and supporting midwives with clinical and non-clinical duties. This can be viewed as a direct, and positive, implication from the flexibility of NHS England's specification and implementing guidance. By not being overly prescriptive on the format of eMCoC service delivery, NHS England's specification guidance has provided the flexibility local sites require to ensure delivery of the essential functions of eMCoC.

eMCoC funding was most often being used to fund multiple, band 3 posts. For instance, all the MSWs in our cohort were band 3, and within sites enhanced funding was used to boost the hours for multiple band 3 MSW posts or to consolidate one band 3 MSW post and another separate role (i.e. an administrator or equivalent). The exception were the BSiLAs and Care Coordinator roles, which are band 4.

It should be noted that no teams within our case sites demonstrated that they were using enhanced funds to fund colleagues in the VCSE sector or explicitly fund link-workers. Although, many of the tasks and activities undertaken by MSWs, BSiLAs and Care Coordinators (described in more detail below) may be comparable to aspects of a link worker role.

Several sites described themselves as working as an 'enhanced team' prior to the pilot. Five teams across three of our case study sites, emphasised working in this way previously – by focusing on high-needs groups, and most teams in our case sites previously had a support

role. In addition, it is worth noting that many teams had access to Trust-funded additional resources, e.g. specialist midwives and nurses, health visitors, breastfeeding support teams, mental health support teams, safeguarding support.

4.4 Service users targeted by funded enhanced teams

NHS England's eMCoC guidance stipulated that enhanced funding should be used to develop services that target women in the most deprived 10% of postcodes, with a proxy focus on women from ethic minority backgrounds who are prioritised as part of the targeted rollout of midwifery continuity of carer.

Teams across all case sites in our cohort described focusing on women from deprived backgrounds and from ethnic minority backgrounds. However, some of the sites noted that the geography in which some of their teams were based included mixed demographics that included large, predominantly White populations or some more affluent areas. This was especially the case for those that served large geographical areas with a mix of highly urban, smaller towns and more rural populations.

The MSDS analysis confirms that largely, eMCoC service users in six of our cohort of case[3] study sites live in the most deprived postcodes, with 54% living in the 20% most deprived postcodes (and 39% living in the 10% most deprived postcodes). In comparison, 24% of service users receiving care under midwifery continuity of carer (no enhanced role) (as recorded in MSDS) were living in the 20% most deprived postcodes (11% in the 10% most deprived). In terms of ethnicity, 62% of eMCoC service users in our cohort are White (52% White British), 15% of the cohort are Asian/Asian British, and 11% are Black/Black British. It is unclear whether this is driven by geography (i.e. targeted on deprivation) or by an explicit focus on targeted ethnic minority groups. In comparison, the service users recorded as receiving midwifery continuity of carer (no enhanced role) were recorded as 66% White, 17% Asian/Asian British and 7% Black/Black British.

Alongside deprivation and ethnicity, staff in most sites also emphasised targeting service users with other types of social risk factors and additional vulnerabilities. For instance, these included: people facing insecure housing and financial issues, asylum seekers and refugees, non-English language speakers, traveller communities, people with mental health conditions, non-attenders, and people with complex social issues (including high rates of smoking, drug and alcohol dependency issues, and homelessness). Some sites emphasised the high rates of safeguarding and social service involvement of their caseload: three teams in three different sites reported up to 70–85% of the service users on their caseload had some degree of safeguarding concerns or responsibilities. Younger parents were also raised as a specific vulnerability, with one site (one team) targeting young parents only (under 21), within a large geographical area. The MSDS analysis confirms that sites placed this additional focus on these factors compared to midwifery continuity of carer teams. Indicators for mental health and complex social issues demonstrate that of eMCoC service

[3] Data in MSDS was only available on 14 teams across six of our case study sites.

users living in six case study sites, 16% had complex social issues, compared to 15% receiving care under midwifery continuity of carer (no enhanced role). In terms of mental health, 78% of eMCoC service users were flagged as having a mental health indicator, compared to 51% of service users receiving care under midwifery continuity of carer (no enhanced role). A full table of the descriptive statistics is provided in Appendix A.

The wider focus of sites on social risk factors and additional vulnerabilities aligns with key equity frameworks such as the Health Disparities Framework (2006) and the Equity and Equality Guidance for LMS (2021).

Overall, most sites strived to adapt the guidance to better meet the needs of local service user groups with an emphasis on additional social risk factors, based on local knowledge and understanding of vulnerable groups. There was some pushback from sites on the eMCoC funding criterion stipulating that teams solely targeted care to service users based on their post codes. There was a sense that targeting care by post codes meant that other social risk factors and vulnerabilities were de-prioritised as a result, and vulnerable communities and other at-risk groups may miss out on enhanced support. For instance, some sites indicated that targeting care on low-income postcodes did not necessarily reach the most vulnerable groups in highly urban areas like London, nor enabled them to reach ethnic minority women in other areas. Within sites, some teams served a range of mixed affluence postcodes that meant the enhanced team's resource was at risk of being spread across a range of service users from these mixed affluent areas.

4.5 Implementation of eMCoC services: activities, perceptions and experiences

4.5.1 Increasing midwives' capacity via the use of additional roles

Across our case study sites, staff positively reported that capacity increased for midwives (as anticipated in the logic model, see 'outputs', column 3, Figure 1) because of the funded enhanced roles. This largely because the enhanced roles were usefully undertaking tasks for the midwives. For example, we heard that MSWs assisted with antenatal clinics (blood pressure, urine tests, taking blood, glucose tests) and pre-booking clinics, as well as doing postnatal visits (day 3 and day 5 visits, weighing and re-weigh visits, breastfeeding support, jaundice checks, blood spot tests etc.). MSWs also supported midwives with administrative tasks such as following up with patient notes, chasing referrals, organising *Meet the Midwives* sessions (i.e. team-service users meet and greets) etc. (see 'activities' in the logic model, column 2 Figure 1). In eMCoC service delivery types 1, 2 and 5, enhanced roles (i.e. MSWs and BSiLAs) also took on some of the antenatal public health support and education (see Section 4.5.3. below). In two sites, it was identified that without the MSW in post to provide these antenatal breastfeeding classes and 'baby clubs', they were unlikely to happen.

Similarly, it was noted that eMCoC funded administrator roles increased midwives' capacity by re-booking women's appointments, helping to manage the midwives' diaries and

following-up with non-attenders and referrals. It was emphasised that onerous amounts of administrative work eroded midwives' time to offer clinical support, and there was a sense that this administrative workload led to overworked hours. Additional administrative support was viewed as giving midwives valuable time to meet the additional timely requirements of high-risk groups e.g., attending safeguarding meetings and administration related to safeguarding referrals and involvement with children's services. It was highlighted that greater capacity for these tasks was especially needed due to the increased needs and support demands of target groups. For instance, using an interpreter in midwifery appointments took additional time, and high rates of non-attenders created additional administrative burdens and inefficiencies for midwives. Vulnerable groups also required greater one-to-one and relational support. Indeed, capacity was also reported to enable midwives to have more time to better support vulnerable service users, e.g. to facilitate following-up on sensitive issues and concerns such as mental health or domestic abuse, undertake additional home visits and offer extra appointments.

4.5.2. Increased flexibility and targeting care to service user needs

Staff highlighted that the eMCoC service allowed both midwives and enhanced roles (i.e. MSWs, Care Coordinators, BSiLAs) to provide flexible, tailored care and individualised support. This included enhanced team members (i.e. both midwives and enhanced roles) being flexible with their time to provide holistic support responsive to women's needs: doing at-home appointments, providing one-to-one breastfeeding support, doing numerous and repeat postnatal visits for breastfeeding support, doing extra antenatal appointments, providing tailored information, keeping postnatal women on longer. These are detailed in the anticipated outputs in the logic model (See 'outputs' in logical model, column 3, Figure 1). It was highlighted that the MSW role was especially flexible, and this enabled the MSWs to provide tailored support including more time with women with specific needs.

4.5.3. Enhanced activities

In two sites, MSWs ran antenatal breastfeeding support groups or organised frequent antenatal sessions in local community spaces. In these groups and sessions, they provided public health information around safe sleeping, bathing and breastfeeding, where mothers and partners or other family members were invited to attend. Other types of parent education support provided by the enhanced role included other practical skills, such as how to sterilise equipment, infant feeding etc., (see 'outputs' in the logic model Figure 1). Service users and staff in sites also reported numerous examples of MSWs providing one-to-one breastfeeding support (on some occasions alongside groups classes) and doing specific at-home repeat visits to provide breastfeeding support.

Staff described how service-user facing enhanced roles provided signposting to other non-clinical services. In Service Types 1, 2, 4 and 5, those in the funded enhanced roles directly utilised links to other services (including the VCSE sector) to source baby equipment through baby basics charities and specialist charities (e.g. support for asylum seekers). They also signposted to other support services including breastfeeding networks, mother and baby

groups, foodbanks, maternity grants and financial support charities, mental health and wellbeing support, domestic violence support, housing support services, bereavement support and charities, and linked up with children's centre, housing support services etc. This is described in the outputs and short-term outcomes in our logic model (Figure 1, columns 4-6).

Broadly, eMCoC activities undertaken in the case study sites align to their respective LMS maternity equity and equality plans. There is consistent messaging and aims relating to target groups (i.e. deprived groups and ethnic minority women) in most of the LMS plans in our case study cohort. Similarly, some activities and target priorities outlined in the LMS plans link to eMCoC activities, such as relational support and individualised care, drawing on community assets, accessible information, public health support and education.

4.6 Staff views towards eMCoC services

4.6.1 The value of 'more time' via increased capacity

For staff, the importance of increasing capacity for midwives was paramount. As judged by staff, enhanced teams (i.e. the enhanced roles and midwives) are perceived to deliver better team-based care by doing more because of the additional capacity provided by the enhanced role. There was a sense that this team-based 'enhanced' care, provided by both midwives and the enhanced role, went above and beyond what was being delivered before, where elements related to public health and parent education were able to be more thoroughly addressed (see 'inputs' and 'activities' in the logic model Figure 1, columns 1, 2).

The enhanced roles funded by the eMCoC pilot were described as "part of the team", leading to a heightened sense of team functionality and better working arrangements. Service Types 1-4 enhanced roles (i.e. MSWs and administrators) were described as "invaluable" and "essential"; "a lifesaver" to the team. It was noted in Service Type 1, where MSWs had been in the teams prior to eMCoC pilot, that this close integration between the MSWs and midwives and the usefulness of their roles was underpinned by the fact that the MSW role had developed organically to become part of the team delivering support where it was needed most.

There was a sense that additional support provided by eMCoC reassured midwives that important non-clinical aspects were covered more completely than they would have otherwise been, leading to better care, less pressure and reduced workload on the midwives (especially in terms of unpaid overtime), which may lead to reduced burnout (as depicted in 'outcomes' in the logic model Figure 1, column 4). A key element as emphasised by staff was that extra capacity within the team via the enhanced role created "an extra pair of hands", ensuring that the "'I's were dotted and 'T's were crossed". There was a sense that this meant there was a "fresh set of eyes", an "extra safety net" which meant that aspects of patient care were less likely to get missed.

This dovetailed with some staff describing close communication between team members, where the enhanced role was in regular and close contact with the midwives, and this enhanced communication enabled increased knowledge and oversight. This was emphasised more in Service Types 1-4 (i.e. roles with MSWs and administrators embedded within the teams), although it was noted by some in Service Type 5. Some staff (midwives and MSWs) also reported that the MSW enhanced roles would liaise directly with other staff: e.g. obstetricians or paediatricians, although it was also emphasised by a couple of midwives that this tended to be done by midwives.

4.6.2 Potential unintended consequences of eMCoC

Initial conversations with LMS leads revealed that there was some confusion and misunderstanding towards the eMCoC specification guidance regarding the aims of eMCoC. In particular, some voiced confusion that by including a MSW or other additional support role in a midwifery continuity of care team, midwifery-led continuity could be disrupted if MSWs undertook service user-facing activities usually undertaken by midwives (i.e. home visits). There was a perceived risk that eMCoC could result in the provision of two different forms of continuity: one from MSWs providing holistic/relational support, and from midwives doing clinical continuity. Insights from the staff interviews however, did not support these concerns. Frontline staff revealed using eMCoC funding to increase capacity with additional resources within the teams had a positive impact on staff, with no evidence that staff perceived eMCoC to disrupt the principles of midwifery continuity of care.

As noted in earlier sections, many sites struggled to implement within the evaluation timeframe, and some sites implemented later than others due to delays (see Section 4.8). In later-implementing sites, where enhanced roles had only been operational for a few months and service users are referred into the enhanced role support provision (i.e. BSiLAs and Care Coordinators) (Service Type 5), some midwives working in these teams were unfamiliar with the role and were not able to articulate to a full degree the purpose of the BSiLAs or Care Coordinators.

Overall, the activities undertaken in eMCoC services are largely similar across the multiplicity of service types, with emphasis placed on the extra capacity and flexibility that the enhanced roles provides to teams, enabling the team (including the enhanced role) to provide team-based enhanced care. For staff, the importance of relieving capacity for midwives was paramount. This may be especially important as this task-shifting suggests such activities would not be thoroughly addressed or undertaken otherwise, in large part due to the extra pressures on midwives' time in these teams with high-needs service user populations. Contrary to initial concerns, the enhanced service, and the enhanced roles itself was seen to deliver better team-based care, in virtue of having greater capacity at the team level to provide more tailored, one-to-one care, from both midwives and the enhanced roles.

4.7 Service user perspectives and staff-reported service-user experiences

Service users reported feeling well supported by enhanced teams. In terms of the eMCoC roles themselves, the BSiLAs were met positively, where wellbeing and relational support were especially highlighted. The MSWs in Service Type 1 who provided one-to-one, at-home and group breastfeeding and education classes were also highlighted as particularly valued by service users in terms of being supportive and informative.

Service users (and staff) reported that the enhanced service provided relational and wellbeing support. Staff perceived that the enhanced service, and the enhanced role specifically, served to build relationships with service users, because of their flexibility to provide additional support. MSWs and BSiLAs were also perceived as having a positively distinct relationship with service users to that of midwives. Some service users emphasised they had received a relational form of care from the enhanced team; they were made to feel comfortable, the team invested in their care and they felt cared for, were able to build rapport and had built a good relationship with the team. This dovetailed with staff and some service users describing wellbeing support provided by the enhanced team (including the enhanced role) as well as being signposted to additional wellbeing services (see 'outputs' in the logic model, Figure 1, column 3). There was a sense that enhanced teams regularly checked about women and their partner's mental wellbeing throughout the pregnancy, which was seen by service users as a pleasantly unexpected element to their care.

A small minority of service users reported some negative experiences from the care provided by enhanced teams, around a lack of clear communication e.g. issues with specific electronic records or linked digital resources, a lack of follow up and issues with contacting midwives.

4.7.1 Service users' familiarity with the team

Service users reported a sense of familiarity with team members (including the enhanced role) and that where they had seen more than one midwife and an enhanced role, there was often pre-existing knowledge and awareness of themselves amongst the team. It was deduced that this was driven by team communication about their care and personal circumstances. Activities like the *Meet the Midwives* session held by two of the sites were praised as useful ways to build familiarity with the members of the team, especially when they may have had intrapartum care by a midwife other than their named midwife. Some women acknowledged familiarity with the MSWs from having attended *Meet the Midwives* or the antenatal classes or clinics.

4.7.2 Process outcomes and potential mechanisms towards change

Interviewees perceived the enhanced role of eMCoC to impact on several service user-specific outcomes. For example, the enhanced roles across all service types (both directly and in-directly patient-facing) were reported by staff as providing an advocacy role for

women, through following up specific appointments or referrals in hospital, sourcing specific support (e.g. foodbanks, reading and writing classes) and supporting women to access that support, attending appointments and support groups with vulnerable groups (see 'outputs' in the logic model, Figure 1 column 3).

Both staff and service users reported holistic patient outcomes (see 'outcomes' in the logic model, Figure 1 columns 4–6) because of the enhanced service. Staff emphasised that the enhanced service provides empowerment and confidence building to women, in virtue of the provision of extra support, parent education and awareness of additional support and services, enhanced communication with the team, and personalised care. In turn, service users reported feeling reassured by the care they had received from enhanced teams. This was partly related to a sense of enhanced communication with the team, having questions answered and feeling informed to make choices.

4.8 Barriers and enablers to the implementation of eMCoC

4.8.1. Barriers to implementation: the wider institutional and policy context

Many of the sites were slow to implement the eMCoC service, with three starting up to nine months later than anticipated. Key barriers identified in the mapping and staff interviews included delays in receiving the enhanced funding at Trust level, which delayed implementation of eMCoC (specifically, the ability to advertise roles and hire new staff). It was noted that this delay was due to a slow release of funding from the Integrated Care Boards to provider level.

Broader challenges also played a significant role in the implementation of eMCoC. Early conversations with regional and LMS leads illustrated that the Ockenden review had placed Trusts into disarray over the rollout of midwifery continuity of carer. Notably, when asked about barriers to implementation of the enhanced service, staff respondents tended to discuss wider and more general barriers that were more closely related or aligned to the barriers of implementing midwifery continuity of carer, e.g. around staffing levels, sickness and midwives being called for escalation support. Many of these issues reflect themes identified in the recent evaluation of the implementation of midwifery continuity of carer by City University.

4.8.2 Barriers to implementation: sustainability

Broader institutional challenges around implementing midwifery continuity of carer and the ongoing workforce challenges meant that several eMCoC teams were paused or discontinued over the course of the evaluation. The sites that did manage to implement in the evaluation period also faced implementation issues and risks in terms of the sustainability of the eMCoC service. As delivering midwifery continuity of carer was the prescribed precursor to eMCoC, several sites struggled to maintain midwifery staffing levels. For example, one site did not implement the eMCoC service until Q3 of 2023 because of the

ongoing risk of teams being paused in that area. One site's eMCoC service was halted as the enhanced staff member left and they were unable to hire a replacement because of hiring challenges and the short-term nature of the contract. Some staff in other sites also raised issues around MSWs being 'borrowed' by other community teams when they were short of midwives or MSW support.

Several factors impacting implementation of the service was found to be key, including:

- whether there was institutional buy-in from management and staff on the ground,
- whether or not teams were already doing midwifery continuity of care or had the capacity to initiate midwifery continuity of care,
- delays in funding received to Trusts, leading to delays in implementing eMCoC
- initial and ongoing risks to sustainability of eMCoC teams related to the sustainability of continuity of care, staffing levels etc.

4.8.3 Enablers to implementation of the enhanced service

The evaluation team explicitly asked sites about facilitators to implementing the enhanced service, however respondents largely did not respond to this, focusing instead on the barriers to implementation. Two respondents from different sites, however, highlighted the supportive nature of management at the operational and team level in facilitating the implementation of eMCoC (and more widely in the context of continuity of carer).

In eMCoC Service Types 1 and 5, some teams described they had been using MSWs or other supporting roles in a similar capacity previously and it was deemed successful, in so far that the MSW role had expanded and developed to increase the support to the team and support to the women. This was also the case in Service Type 2, where the eMCoC resource was new, in which the rationale for these new resources (i.e. MSWs) stemmed from successful examples elsewhere in the Trust.

The success of the enhanced role (e.g. MSWs, administrators) was often put down to the personal characteristics of the staff members themselves. These characteristics included a passion for the role, being willing to 'go the extra mile', take initiative to develop the role, and being independent. Sometimes staff cited previous examples of working with other MSWs or administrators to support these views. As highlighted in previous sections, a key factor in the success of eMCoC services was that the enhanced roles underpinning the services had been allowed to develop organically over time to, with a necessary flexibility to suit the needs of the team and service users.

Overall, many of the fifty-eight funded teams were unable to implement eMCoC during the evaluation period because of institutional and organisational barriers. These barriers to implementation echo the wider barriers of implementing midwifery continuity of carer, however, some barriers were distinct to eMCoC (around barriers to receiving funding). Delays receiving the enhanced funding at Trust level delayed implementation of eMCoC

(specifically the ability to advertise a role and hire new staff). The sites that did manage to implement in the evaluation period also faced implementation issues and risks to the sustainability of the eMCoC service. Broader institutional challenges around implementing midwifery continuity of carer and the continuing workforce challenges meant that individual teams were consistently at risk of being paused or discontinued. In terms of enablers, the characteristics of the enhanced role was seen as central to the success of the eMCoC service.

5. Implications for ongoing and future service delivery

- Overall, the additional eMCoC funding has been well received by both staff and service users. The implementation of the enhanced roles is perceived to have supported delivery of team-based care, facilitating successful release of midwifery capacity and the delivery of additional public health activities. Supporting a team-focused ethos seems an important feature of the service. This is consistent across sites and from both staff and service user perspectives.
- Service users have reported being well supported by the enhanced teams including relational and wellbeing support and personalised one-to-one public health education, information and support. Service users have emphasised that enhanced teams went 'above and beyond' in their care.
- Flexibility in the eMCoC specification guidance which permitted use of funds for a range of staff roles facilitated multiple eMCoC service delivery types. This was a positive result with each service seeming to meet the essential functions and objectives of eMCoC as well as perceived local needs. The services were thus widely acceptable to staff and service users. This flexibility should be maintained and prioritised.
- The flexible approach taken by enhanced teams to target service user groups should be supported. Sites clearly valued the focus on deprived populations but have equally strived to broaden the characteristics of focus to include a wider and more diverse set of social risk factors and vulnerabilities. In line with existing equity frameworks, a more inclusive and intersectional approach to targeting high-needs populations could be championed in the way funding is allocated.
- Attention should be placed on the barriers to implementation and sustainability issues which can be addressed, namely: delays in releasing funding from LMS/ICB to providers and protecting MSW and midwifery time to their own teams.
- The eMCoC services have been built organically from 'the ground up'. This should be learnt from, considering what has worked well previously at a local level with attention paid to enablers of eMCoC services (i.e. characteristics of the enhanced role, skills-set etc). This should be considered in line with the above recommendation around flexibility.
- Relatedly, our conclusions point to the value of autonomy afforded to local areas to use enhanced funding to best suit the needs of their staff and specific service user groups, based on local needs. This trust and autonomy should be maintained going forward.
- Due to the timeframes of this rapid, formative evaluation, longer term clinical outcomes fell outside of the evaluation scope. Instead, we focused on developing a logic model for eMCoC, to identify process outcomes and potential key clinical outcomes which should be explored in a longer-term evaluation. Exploration of the evolution of local delivery as well as longer-term sustainability should also be considered.

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Appendix A: Descriptive statistics of eMCoC service users

Table 1A: Woman who reached 29 weeks gestation during March 2023-February 2024 and were placed on either an Enhanced Midwifery Continuity of Carer (EMCoC) pathway, a MCoC pathway, or not placed on any eMCoC or MCoC pathway. With accompanying demographic and other breakdowns. Numbers are Counts of unique pregnancies (so a woman with two pregnancies in the year would be counted twice, once per pregnancy). (IMD = Indices of multiple deprivation; IQR = interquartile range;

	Teams delivering EMCoC*	**Teams delivering MCoC***	**All other (non-MCoC and non-EMCoC)***
Total	2815	99590	500250
AGE			
Mean age (std. dev)	29.1 (6.1)	30.5 (5.7)	30.3 (5.6)
Median age (IQR)	29 (25-33)	31 (27-34)	30 (27-34)
Missing	0 (0.0%)	5 (0.0%)	5 (0.0%)
ETHNICITY			
White	1750 (62.2%)	65320 (65.6%)	342295 (68.4%)
British	1465 (52%)	50695 (50.9%)	285860 (57.1%)
Irish	20 (0.7%)	695 (0.7%)	2790 (0.6%)
Any other White background	260 (9.2%)	13935 (14%)	53645 (10.7%)
Mixed	125 (4.4%)	2915 (2.9%)	13750 (2.7%)
White and Black Caribbean	30 (1.1%)	735 (0.7%)	4090 (0.8%)
White and Black African	25 (0.9%)	485 (0.5%)	1930 (0.4%)
White and Asian	25 (0.9%)	585 (0.6%)	2815 (0.6%)
Any other mixed background	45 (1.6%)	1110 (1.1%)	4915 (1%)
Asian or Asian British	430 (15.3%)	17120 (17.2%)	79030 (15.8%)
Indian	160 (5.7%)	5840 (5.9%)	27300 (5.5%)
Pakistani	55 (2%)	4165 (4.2%)	26905 (5.4%)
Bangladeshi	70 (2.5%)	2950 (3%)	9030 (1.8%)
Any other Asian background	140 (5%)	4165 (4.2%)	15795 (3.2%)
Black or Black British	310 (11%)	7245 (7.3%)	32870 (6.6%)
Caribbean	15 (0.5%)	1310 (1.3%)	4440 (0.9%)
African	240 (8.5%)	4545 (4.6%)	24620 (4.9%)
Any other Black background	60 (2.1%)	1395 (1.4%)	3810 (0.8%)
Other Ethnic Groups	150 (5.3%)	5085 (5.1%)	21025 (4.2%)
Chinese	15 (0.5%)	720 (0.7%)	3010 (0.6%)
Any other ethnic group	135 (4.8%)	4365 (4.4%)	18015 (3.6%)

Not stated	55 (2%)	1760 (1.8%)	7745 (1.5%)
Missing	5 (0.2%)	145 (0.1%)	3530 (0.7%)
DEPRIVATION			
IMD decile 1	1085 (38.5%)	10960 (11%)	68310 (13.7%)
IMD decile 2	435 (15.5%)	12420 (12.5%)	60075 (12%)
IMD decile 3	285 (10.1%)	13625 (13.7%)	55570 (11.1%)
IMD decile 4	295 (10.5%)	11640 (11.7%)	52450 (10.5%)
IMD decile 5	230 (8.2%)	9795 (9.8%)	49425 (9.9%)
IMD decile 6	140 (5%)	9170 (9.2%)	48185 (9.6%)
IMD decile 7	145 (5.2%)	8345 (8.4%)	44080 (8.8%)
IMD decile 8	95 (3.4%)	8090 (8.1%)	43075 (8.6%)
IMD decile 9	70 (2.5%)	8065 (8.1%)	40070 (8%)
IMD decile 10	30 (1.1%)	7305 (7.3%)	35835 (7.2%)
Missing	10 (0.4%)	175 (0.2%)	3175 (0.6%)
ETHNICITY AND DEPRIVATION (not including Not Stated or Missing Ethnicity data)			
White	1750 (62.2%)	65320 (65.6%)	342295 (68.4%)
IMD decile 1	610 (21.7%)	7060 (7.1%)	38350 (7.7%)
IMD decile 2	310 (11%)	6715 (6.7%)	34590 (6.9%)
IMD decile 3	170 (6%)	7315 (7.3%)	33500 (6.7%)
IMD decile 4	200 (7.1%)	7010 (7%)	33715 (6.7%)
IMD decile 5	155 (5.5%)	6400 (6.4%)	34505 (6.9%)
IMD decile 6	95 (3.4%)	6365 (6.4%)	35655 (7.1%)
IMD decile 7	95 (3.4%)	5990 (6%)	34180 (6.8%)
IMD decile 8	50 (1.8%)	6165 (6.2%)	34395 (6.9%)
IMD decile 9	35 (1.2%)	6295 (6.3%)	32430 (6.5%)
IMD decile 10	20 (0.7%)	5880 (5.9%)	29490 (5.9%)
IMD_Missing	10 (0.4%)	120 (0.1%)	1490 (0.3%)
Mixed	125 (4.4%)	2915 (2.9%)	13750 (2.7%)
IMD decile 1	45 (1.6%)	325 (0.3%)	2190 (0.4%)
IMD decile 2	20 (0.7%)	460 (0.5%)	1920 (0.4%)
IMD decile 3	10 (0.4%)	430 (0.4%)	1715 (0.3%)
IMD decile 4	10 (0.4%)	380 (0.4%)	1455 (0.3%)
IMD decile 5	15 (0.5%)	280 (0.3%)	1345 (0.3%)
IMD decile 6	5 (0.2%)	260 (0.3%)	1205 (0.2%)
IMD decile 7	5 (0.2%)	225 (0.2%)	1100 (0.2%)

IMD decile 8	5 (0.2%)	180 (0.2%)	1015 (0.2%)
IMD decile 9	5 (0.2%)	190 (0.2%)	930 (0.2%)
IMD decile 10	5 (0.2%)	175 (0.2%)	805 (0.2%)
IMD_Missing	0 (0%)	5 (0%)	75 (0%)
Asian or Asian British	430 (15.3%)	17120 (17.2%)	79030 (15.8%)
IMD decile 1	170 (6%)	1915 (1.9%)	15255 (3%)
IMD decile 2	55 (2%)	2575 (2.6%)	13090 (2.6%)
IMD decile 3	45 (1.6%)	3355 (3.4%)	11245 (2.2%)
IMD decile 4	40 (1.4%)	2405 (2.4%)	9805 (2%)
IMD decile 5	30 (1.1%)	1760 (1.8%)	7530 (1.5%)
IMD decile 6	20 (0.7%)	1445 (1.5%)	6155 (1.2%)
IMD decile 7	20 (0.7%)	1185 (1.2%)	4745 (0.9%)
IMD decile 8	20 (0.7%)	985 (1%)	3985 (0.8%)
IMD decile 9	20 (0.7%)	810 (0.8%)	3385 (0.7%)
IMD decile 10	10 (0.4%)	660 (0.7%)	2885 (0.6%)
IMD_Missing	5 (0.2%)	20 (0%)	945 (0.2%)
Black or Black British	310 (11%)	7245 (7.3%)	32870 (6.6%)
IMD decile 1	140 (5%)	960 (1%)	7565 (1.5%)
IMD decile 2	30 (1.1%)	1665 (1.7%)	6255 (1.3%)
IMD decile 3	45 (1.6%)	1475 (1.5%)	5060 (1%)
IMD decile 4	30 (1.1%)	995 (1%)	3700 (0.7%)
IMD decile 5	15 (0.5%)	640 (0.6%)	2915 (0.6%)
IMD decile 6	15 (0.5%)	460 (0.5%)	2255 (0.5%)
IMD decile 7	20 (0.7%)	375 (0.4%)	1580 (0.3%)
IMD decile 8	10 (0.4%)	265 (0.3%)	1375 (0.3%)
IMD decile 9	10 (0.4%)	245 (0.2%)	1085 (0.2%)
IMD decile 10	5 (0.2%)	150 (0.2%)	790 (0.2%)
IMD_Missing	5 (0.2%)	15 (0%)	290 (0.1%)
Other Ethnic Groups	150 (5.3%)	5085 (5.1%)	21025 (4.2%)
IMD decile 1	90 (3.2%)	505 (0.5%)	3320 (0.7%)
IMD decile 2	10 (0.4%)	805 (0.8%)	2795 (0.6%)
IMD decile 3	5 (0.2%)	810 (0.8%)	2800 (0.6%)
IMD decile 4	10 (0.4%)	660 (0.7%)	2530 (0.5%)
IMD decile 5	10 (0.4%)	545 (0.5%)	2080 (0.4%)
IMD decile 6	5 (0.2%)	450 (0.5%)	1895 (0.4%)
IMD decile 7	5 (0.2%)	375 (0.4%)	1570 (0.3%)
IMD decile 8	5 (0.2%)	330 (0.3%)	1465 (0.3%)
IMD decile 9	5 (0.2%)	330 (0.3%)	1335 (0.3%)
IMD decile 10	0 (0%)	260 (0.3%)	1065 (0.2%)
IMD_Missing	0 (0%)	15 (0%)	165 (0%)

MENTAL HEALTH PREDICTION & DETECTION INDICATOR			
Yes	2190 (77.8%)	50645 (50.9%)	241335 (48.2%)
No	625 (22.2%)	38520 (38.7%)	207380 (41.5%)
Missing	0 (0%)	10425 (10.5%)	51540 (10.3%)
COMPLEX SOCIAL FACTORS INDICATOR			
Yes	455 (16.2%)	14735 (14.8%)	61320 (12.3%)
No	2365 (84%)	84800 (85.1%)	420860 (84.1%)
Missing	0 (0%)	55 (0.1%)	18065 (3.6%)
SUPPORT STATUS INDICATOR			
Yes	2710 (96.3%)	86045 (86.4%)	379675 (75.9%)
No	55 (2%)	1215 (1.2%)	10750 (2.1%)
Missing	55 (2%)	12330 (12.4%)	109825 (22%)
PREGNANCY TOTAL PREVIOUS LOSSES LESS THAN 24 WEEKS			
Mean (std. dev)	0.3 (0.7)	0.5 (1)	0.4 (0.9)
Median (IQR)	0 (0-0)	0 (0-1)	0 (0-1)
Missing	5 (0.2%)	11280 (11.3%)	19205 (3.8%)

***Definitions:**

Teams delivering eMCoC	A pregnancy is recorded in MSDS as placed on a MCoC pathway (full MSDS data field criteria) by 29 weeks gestation, and the given Team Name matches an eMCoC Team Name provided by the research team, recorded at the relevant Trust.
Teams delivering MCoC	A pregnancy is recorded in MSDS as placed on a MCoC pathway (full MSDS data field criteria) by 29 weeks gestation, without a Team Name match to the Enhanced Team Names list provided by the research team.
All other (non-MCoC and non-eMCoC)	A pregnancy is not recorded in MSDS as placed on a MCoC pathway (full MSDS data field criteria) - either through definitively declaring they were not placed on a MCoC pathway or due to incomplete data.

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Produced by the NHIR Rapid Service Evaluation Team – REVAL

The information in this report is correct at the time of publication.