# GREEN MATERNITY CHALLENGE

## - The Olive Clinic -

## Reducing health inequalities for Albanian-speaking women

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In this report we will be using the word 'woman' whilst recognising that not all people who use maternity services identity or define themselves as women.

### Background:

Health and care professionals should ensure that socially excluded people can access and benefit from the services they need (PHE, 2021). Vulnerable groups, such as migrants and ethnic minorities, often face disproportionate barriers to accessing healthcare (Core20PLUS5), and experience worse clinical outcomes.

In Kingston, the Albanian community represents a particularly vulnerable population. Over the past 3 years, there has been a noticeable increase in the number of Albanian women booking to give birth at Kingston Hospital. The number of Albanians living in the UK is thought to be around 140,000 (House of Commons, 2023) - just 0.2% of the population. However, at Kingston approximately 1% of all bookings for maternity care are by Albanian women, with most having arrived in the UK within the last five years. Many experience significant social vulnerabilities, including limited English proficiency, asylum-seeking status, lack of permanent accommodation, minimal social support, financial difficulties, histories of human trafficking or sexual exploitation, and pre-existing mental health conditions. Due to these concerns, many women in this cohort are referred to our Safeguarding team, who raised concerns about the increasing number of vulnerable Albanian mothers accessing our services.

*" Some women often attended appointments accompanied by unknown men, sometimes multiple men… some would disclose their pregnancy was unplanned, others were unable to identify a specific individual as the father… some women disclosed experiences of trafficking, having fled Albania due to gang violence or exploitation."* - Safeguarding Midwife, Melissa Fox-Blach

Research highlights multiples areas of concern for vulnerable migrant women and those with limited English proficiency, including:

- Underutilisation of maternity services and contraceptive methods
- Limited access to timely, high-quality maternity care
- Communication barriers, leading to missed information and compromised informed consent
- Lack of choice in interpreter services and concerns about confidentiality
- Perception of healthcare services as a system of surveillance rather than support, particularly for women with social care involvement during pregnancy, impacting their engagement

These multiple socioeconomic, cultural and communication barriers hinder access to maternity services and lead to poorer outcomes. Twenty years ago, the *Confidential Enquiry into Maternal and Child Health (CEMACH)* report, *Why Mothers Die 2000–2002*, found that the vulnerable and socially excluded were at greater risk of dying. Late booking and poor attendance at routine maternity appointments was amongst the list of factors which may have played a part in the woman's death and it was noted that an inadequate translation service was a recurring feature for mothers with limited English proficiency who had died. These findings are still echoed today, most recently in the *MBRRACE-UK* report, *Saving Lives, Improving Mothers' Care 2024*. Almost a third of mothers who die in pregnancy, childbirth or up to one year after the birth are born outside the UK. It has been well-documented that women and babies from ethnic minority communities, particularly those who face socioeconomic inequalities, experience significant health disparities, including higher rates of stillbirth, neonatal mortality, preterm birth and foetal growth restriction. These poorer outcomes are compounded by suboptimal experiences, including discrimination and culturally insensitive care.

In the summer of 2023, our Consultant Midwife attended a local focus group of Albanian mothers with limited English proficiency. Women shared their experiences and concerns, giving us valuable insights into areas where our services could be improved. Common themes included:

- concerns about the quality and confidentiality of translations provided by telephone interpreting services
- discomfort with using male interpreters
- lack of written information in their language
- frustration over a lack of continuity and having to repeatedly explain their situation to different healthcare providers
- difficulties accessing care and navigating healthcare pathways
- fears of being charged for services
- negative experiences related to the attitudes of some healthcare professionals

Women's voices were the catalyst of this pilot project to establish a dedicated clinic for Albanian women, supported by the concerns from our safeguarding team and in alignment with national guidance on delivering action plans within Equity and Equality frameworks. By enhancing the experience of this cohort, providing improved continuity, necessary support (including interpretation), and ensuring access to information and care, we can help reduce health inequalities and promote better maternal and neonatal health outcomes.

Health inequalities undermine the sustainability of healthcare systems across financial, social, environmental, and clinical domains. When vulnerable populations, such as Albanian women face barriers to accessing timely and appropriate care, the resulting delayed interventions and poorer health outcomes often necessitate more intensive, resource-heavy treatments. This reactive approach strains financial and operational resources, increases healthcare system inefficiencies, and exacerbates workforce pressures; all of which have a negative impact on the environment. But importantly, the poorer patient experience and outcomes can result in reduced trust and engagement in healthcare services in the future, increasing the likelihood for similar reactive, resource intensive management with poorer health outcomes again. By focusing on prevention, patient empowerment, and equitable access to services, we can foster a culture of resource stewardship, improve long-term outcomes, and create a more resilient and sustainable system for future generations. This project is particularly focused on health promotion and empowering women to take greater care of their own health and that of their baby, recognising empowerment as a core principle of sustainable healthcare.

## Specific Aims:

Reduce health inequalities for pregnant Albanian speaking women by:

- establishing a dedicated midwifery-led clinic, provided by our Safeguarding team and supported by a female face-to-face interpreter within 6 months
- improving the provision of maternity-specific written information in Albanian within 6 months
- improving antenatal education through dedicated classes in Albanian within 9 months
- improving care in labour by exploring the provision of an Albanian-speaking doula within 12 months

## Methods:

*Studying the system*

While we had a broad understanding of the challenges women were experiencing, we conducted a more in-depth review of our current practice to clearly define and understand the issues. We reviewed 108 records of Albanian women who gave birth within our services between August 2022 and October 2024.

**Lack of continuity**

Most women (57%) saw more than two midwives during their pregnancy, with some meeting a different midwife at every routine appointment.

A process mapping exercise of our existing antenatal care pathway helped identify that continuity of care would not only benefit the women's care and experience but would also:

- Optimise staff resources by reducing the time and effort required for referrals
- Avoid duplicate appointments

**Inappropriate language support**

A third of women required an interpreter, although this number is likely to have been higher, as the need for language support is not always consistently documented and midwives receive no training in assessing English language proficiency. Professional interpreting services were primarily provided via telephone, which does not allow for the choice of a female interpreter. Their use was also inconsistent throughout pregnancy: only 19% of women had an interpreter for all their routine antenatal appointments, which coincided with women receiving midwifery continuity.

Some women were occasionally supported by friends, family members, partners, and even Google Translate. Some women who were offered an interpreter declined the service (14%). Where staff had documented comments, their observations aligned with the concerns raised by women in the focus group related to the accuracy and confidentiality of interpreter services. Other barriers to using interpreting services included technical issues.

Attendance at antenatal classes was recorded inconsistently and, as a result, was not formally audited. However, observations indicated that some women declined to attend when classes were conducted in English due to limited language proficiency. Conversely, when in-person classes were offered in Albanian with the support of a female doula interpreter, attendance remained low, highlighting potential barriers that require further exploration, such as willingness or means to travel, lack of childcare and limited understanding of the potential value of such classes.

**Social and mental health complexities**

Almost a quarter of the women in this cohort were referred to our safeguarding team due to social issues or pre-existing mental health issues. In addition to the standard maternity care, the team could then offer appointments for close monitoring and to establish a bridge with support networks, such the perinatal mental health services, health visiting team, domestic violence services and support charities.

*Designing Improvement:*

**Reviewing the evidence**

The lack of continuity of care and inadequate interpreting services were two key issues in our existing service provision, which we sought to address by establishing a dedicated clinic for Albanian women, to be led by our Safeguarding team.

Continuity of care has been shown to deliver more personalised maternity care that is valued by women, with cost benefits to healthcare providers (Cochrane, 2024). Authors have also described how mothers with limited English could benefit from this model when the care is provided by a specialist midwife and supported by appropriately trained interpreters (Cull, J. et al, 2022). While developing the pilot, the Government's national healthcare strategy (Core20PLUS5) and the

national guidance *Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors* (NICE, 2010) were also considered, as these focus on reducing health inequalities.

Key benefits of continuity of care models for this cohort include:

- Flexibility and consistency: ensuring ongoing support throughout pregnancy
- Trauma-Informed care: particularly beneficial for trafficked women, as it reduces anxiety, improves disclosure of social risk factors, and enhances their ability to seek timely help
- Building trust and control: for women with past trauma or those who lack a sense of control, a trusting relationship with a healthcare professional helps rebuild confidence and engagement with maternity services.

**Our proposal**

A dedicated clinic for Albanian-speaking women, where appointments would be led by our safeguarding midwife and supported by a female interpreter who had also trained as a doula, a woman whose job is to provide emotional and physical, but not medical, care to a woman in labour and to the parents and child after birth (Chambers App, 2025).

The doula would have provided face-to-face interpreting during clinic appointments and had offered to be on call to support women in labour whom she had met during their visits. This support is particularly valuable for this cohort, as many of these women may be socially isolated and suffer mental health issues. Examples of good practice (Maher, S. 2012) show that combining language interpretation with doula care improves communication, cultural competence, and emotional support for women with limited English proficiency during the perinatal period. This approach enhances patient experience, staff satisfaction, and maternity outcomes while also being cost-effective.

Unfortunately, shortly after we launched our pilot, our doula interpreter informed us that she could no longer support the clinic, requiring us to find an alternative solution quickly. The options considered were using a phone interpreter or arranging face-to-face interpretation. The decision was guided by the feedback from the focus group and data analysis of the women who had given birth in the previous two years. They had expressed a clear preference for a female, face-to-face interpreter. Our Safeguarding Midwife contacted a local professional interpreter she had worked with before, who agreed to support us while we continue searching for a possible alternative.

***Improvement implemented***

The Olive Clinic commenced in November 2024 and has been welcoming Albanian women every Thursday. The clinic was named in recognition of the olive tree's symbolism - representing peace, wisdom, and longevity - deeply rooted in Albanian culture.

Written resources in Albanian are now accessible on our website on a range of topics, including: baby movements in pregnancy, coping with early labour, pain relief, induction of labour and contraceptive choices. These resources have been specifically selected, with more planned, including those on mental health and coping with a crying baby.

To implement this change we needed to consider the following:

1. Infrastructure/Space:

The clinic is based at Kingston Maternity Unit, where we have secured a suitable space, "The Nest," within our newly refurbished Birth Centre. It is a large, inviting and calming space, with sofas, soft lighting and minimal clinical equipment on display. This location is close to all birthing areas and provides an opportunity to offer tours of our maternity unit to women at the time of their antenatal appointments.

2. Staffing:

Midwives: The clinic was set up and run by our Safeguarding Midwife who has extensive experience supporting vulnerable women both within our Trust and through her work with another organisation. Over the years, she has developed skills in providing trauma-informed and culturally centred care.

Our aim is for women to receive continuity of care with our Safeguarding Midwife and therefore provision has been made to adjust clinic days when she is on leave. Additionally, in cases of short-notice leave, her team members have agreed to provide cover whenever their schedules allow, ensuring the ongoing support of the Safeguarding team to women accessing this service. In this report, they will subsequently be referred to as 'buddy midwives'. This will be explained to women and pictures of the Safeguarding team members will be shared to allow women to familiarise with 'buddy midwives'.

Interpreter: Interpretation is currently provided by a professional local female interpreter who is booked by our Safeguarding Midwife in advance of the clinics via Kingston Interpretation Services. This also ensures continuity in translation services.

3. Funding:

The maternity service was allocated ring-fenced funds by South West London Local Maternity and Neonatal System (LMNS) as part of their equity and equality action plan to support teams to address health inequalities through continuity, focusing on those from minority ethnic backgrounds and those living in deprived areas as well as pregnant women with complex social factors. Decisions about how to spend the funds were made by the Consultant Midwife in consultation with the Director of Midwifery. Although most of the funding for this project came from the existing budget, the extra funds allowed for spending on face-to-face interpreters and translation of written resources.

4. Referrals into service:

Our referral pathway for pregnant women to Kingston maternity services stays unchanged. When booking, women are asked to provide information about the main language they speak at home, whether they speak English and if they would like an interpreter for their appointments.
Albanian speaking women are identified through their referral and our administrative team is now aware to book them into the Olive Clinic. An email was sent to the wider team, introducing the

service and outlining referral procedures, this is particularly relevant for late bookers presenting for the first time via emergency services.

For women already receiving pregnancy care, our Safeguarding Midwife contacted them to offer the option of transferring their care to the Olive Clinic. Some women may already be known to the Safeguarding Midwife due to the additional support they have received from her in relation to social or mental health complexities, so this was not a large change part way through their pregnancy.

5. Appointment timing, structure and content:

The length of clinic appointments is based on each woman's individual needs, including interpretation requirements and any additional complexities, which our Safeguarding Midwife assesses during the initial meeting and re-evaluates at subsequent appointments. A "regular booking" is scheduled for 60 minutes, with "regular follow-up appointments" lasting 30 minutes. However, the Olive Clinic has the flexibility to extend appointments up to twice this duration, ensuring that women receive the comprehensive care and support they need.

The antenatal classes have been delayed (more information in next steps) but are expected to begin shortly. In the meantime, our midwife is integrating key antenatal education into routine appointments. Information provided addresses topics such as birth preparation and choices, infant feeding, care to the newborn and contraceptive choices after birth; providing essential knowledge to empower women to make informed decisions. Additionally, women are offered tours of our Maternity Unit to familiarise themselves with the environment.

Ongoing plans: Continuous improvement

1. *Recruitment of an Albanian doula:* We continue our search for a local Albanian doula and have expanded our outreach by liaising with doula charities and user groups. Additionally, we have identified an Albanian midwife who previously worked in interpreting services and lives locally. We are engaged in promising discussions regarding her potential contribution to the project, including delivering antenatal classes and providing additional support to women accessing our services.
2. *Antenatal Classes & Translation Efforts:* We are currently in the process of translating materials to set up our antenatal classes. Feedback from women attending the clinic confirms that online classes would be a suitable option, and we plan to launch these within the next month.
3. *Optimise access to the clinic:* we will assess the geographical distribution of women seen in the Olive Clinic and if a specific area emerges as a clear point of need, we will explore relocating the clinic. This has shown to mitigate inequalities in access and engagement with maternity care. (Rayment-Jones, H. et al., 2023)
4. *Expanding Health Literacy & Inclusive Care Models:* This pilot has highlighted opportunities to develop initiatives that improve health literacy and explore alternative models of care which could benefit women with limited English proficiency. We are committed to further exploring these approaches to enhance access and equity in maternity care. Other strategies to reduce the commute may also include the use of technology such as e-consultation. Implementing these changes will require consultation with our service users.

Our proposal is to conduct a follow-up review in 12 to 24 months to compare experience and outcomes with our initial cohort of women. While we require a minimum of 12 months to truly evaluate the full financial, environmental, social and clinical impacts of the clinic, due to the nature of the change and pregnancy care, we have detailed our measures and potential impacts below.

## Measurement and potential results

*Patient outcomes*:

At the time of submitting this report, a total of 16 women have attended the clinic, with 33 appointments completed. Six women joined the clinic from their initial appointment ("booking"), while the remaining women were offered and chose to transfer care to the clinic at some point in their pregnancy.

**Timely booking:**

From August 2022-October 2024, more than 40% of Albanian women booked for their pregnancy care later than nationally recommended, with more than 1 in 5 bookings made after 12 weeks gestation, thereby missing out on care and screening programmes. Of those who booked late, more than half required interpreting support at some point during their pregnancy. Increased awareness of the clinic within the local Albanian community has the potential to reduce late bookings as women may feel more comfortable to attend or refer to the service. It is not possible to measure this in the pilot timeframe, however we will continue to monitor this long term.

**Continuity of care**:

Since implementation of the Olive clinic, women have received 100% continuity of care with a named midwife, supported by a 'buddy midwife' in cases of unexpected absence. This is a significant improvement; previously, 57% of Albanian women previously saw more than two midwives, with many seeing a different midwife at each appointment.

**Interpreting services:**

All women who required interpretation services received them, with the majority provided consistently by the same, female face-to-face interpreter.

Timely bookings, continuity of care and continuity in interpreting services all improve the standard of the care that women receive. Care will be more patient-centred, timely and efficient, which is supportive for optimising outcomes.

**Other outcomes:**

Based on existing literature, we anticipate that this project could also improve various outcomes for women and babies which we are not able to measure in this pilot due to low numbers. They include:

**Birth outcomes**: a recent Cochrane review (2024) concluded women benefiting from continuity of care versus other models of care for childbearing women were less likely to experience a caesarean

section or an instrumental birth, and were more likely to experience spontaneous vaginal birth. They were also more likely to report a positive experience.

Our data showed us that birth outcomes for Albanian women in our previous cohort were similar to the national average (see table below). In order to detect a significant difference we would need a much larger sample.

| | Our cohort | National Average, HES, NHS England data |
|---|---|---|
| Spontaneous vaginal birth | 51 % | 49 % |
| Instrumental birth | 14 % | 12 % |
| Caesarean | 35 % | 39 % |

**Initiation and duration of breastfeeding** (Jack, A. 2024):
Our data indicates that women in our previous cohort had a higher breastfeeding initiation rate than the national average (see table below). Additionally, we have collected data on feeding methods at discharge from our maternity services (10 to 28 days postnatal). However, this data cannot be directly compared with national figures, which focus on breastfeeding rates at six to eight weeks postnatal.

| | Our cohort | PHE 2023 -2024 |
|---|---|---|
| Breastfeeding at birth | 83% | 71.9% |

**Access to contraception options** - contraception is not a topic that we cover in our regular antenatal classes. However, given the challenges identified within this cohort, as well as findings from the literature and guidance from the Women's Health Strategy for England (DHSC, 2022), we have decided to incorporate contraception information into our antenatal education. To improve accessibility, we also had our contraception leaflet translated to ensure that women receive clear and relevant information. All women seen in the Olive Clinic will have the opportunity to discuss contraceptive options as part of the birth preferences discussion and for those who wish to initiate contraception postpartum, arrangements will be made to ensure it is dispensed before discharge. This proactive approach could help reduce the likelihood of unexpected or unwanted pregnancies, preventing potential distress for women and contributing to a reduction in future demand for maternity and reproductive health services.

**Improving engagement with the healthcare system**: continuity of care with the support of our Safeguarding midwife can increase trust of a vulnerable cohort in healthcare and social services. This may encourage women coming forward and seeking help if experiencing social issues such as history of abuse.

**Reduce the need to access healthcare services for women and their families in the long term**. Our midwife, supported by an interpreter, will be delivering messages of prevention and empowering women to take on a greater role in the management of their own health and healthcare. Topics

may include dental care, healthy eating, smoking cessation services, screening programs (such as smear testing), mental health services as well as sexual and reproductive health.

*Environmental sustainability*:

The carbon footprint (expressed in Carbon Dioxide Equivalents, or CO2e) is a common measurement used to show environmental impact. Most of the environmental impacts of this project can only be assessed once the service has been running for some time (at least 1 year). However, we have looked at the impact on interpreter travel, formula feeding and estimated the annual carbon footprint baseline of visits to the maternity assessment unit and birth outcomes.

**Interpreting services:**

*Previous*

From August 2022 - October 2024 there were 62 episodes (74.3 hours) of face-to-face interpreting services, 28.8 episodes per year. As data of the number of interpreter journeys is not available, we have assumed each episode equates with 1 interpreter journey. Due to the unavailability of data on the types of transport and distance travelled by the interpreters, the carbon footprint calculations of interpreter travel was based on the information of the average distance staff commute at Kingston Hospital as provided by the Health Outcomes Travel Tool (HOTT) which is 17.2 miles return. It was assumed that all interpreters travelled by the transport mix as provided by HOTT. This results in an emissions factor of 0.068 kgCO2e/ mile.

The carbon footprint of interpretation services provided via phone was based on the record of 46.1 hours / year and the carbon footprint of a phone consultation of 0.1 kgCO2e as provided by the Greener NHS's Digital Tool. The carbon footprint of the previous interpreting service has been estimated as 42.62 kgCO2e per year: 33.68 kgCO2e interpreter travel and 8.93 kgCO2e interpretation service via phone.

*New*

With the new service, the interpreter will travel once per week to the clinic by car (2.6 miles return journey). The emissions factor is 0.33939 kgCO2e/ mile driven in an average sized car. The carbon footprint of the new service is predicted to be 45.89 kgCO2e due to the travel of the interpreter travelling to the clinic once a week by car, leading to a small increase in greenhouse gas emissions of 3.27 kgCO2e per year. The travel carbon footprint is not significantly higher than that of the previous service whilst providing better quality interpreting services. The overall carbon footprint of the new interpreting service remains low.

**Infant feeding methods:**

*Previous*

Between August 2022 and October 2024, out of the 108 women, 90 (83%) breastfed at birth and 65 (60%) still breastfed at discharge (day 10-28 post birth). This means that on average 41.4 women breastfed at birth per year and 29.9 at discharge. The calculation of the carbon footprint of formula feeding was based on the difference between the carbon footprint of formula feeding and breastfeeding as reported in Andresen et al's study (2022). Over the first 8 weeks it is estimated that the carbon footprint of formula feeding is 27.5 kgCO2e higher than breastfeeding.

The carbon footprint of formula feeding per year before the start of the project was 440.4 kgCO2e.

*New*
There is no data available yet to show the impact of breastfeeding rates at birth and at discharge. However if the rates in both cases increase by 5%, the carbon footprint of formula feeding would be 418.4 kgCO2e. A carbon saving of 22 kgCO2e per year.

**Unexpected attendance to maternity triage / A&E:**
*Previous*
The carbon footprint of visits to the maternity assessment unit was estimated by applying the carbon footprint per unit of healthcare activity of an A&E visit developed by the Sustainable Healthcare Coalition, 13.8 kgO2e, to the number of visits recorded. In the 26 months there were 79 visits, which equates to 36.46 a year.

The total yearly carbon footprint of these visits to the maternity assessment unit is 503.17 kgCO2e.

*New*
There is no data yet, to explore if the project has increased or decreased the number of unexpected visits to the maternity assessment unit. It is possible that the number of visits might increase due to better antenatal education. In the long run, it is hoped that the number of visits will reduce due to better continuation of care.

**Modes of birth:**
The carbon footprint of spontaneous, instrumental and caesarean births was estimated applying the carbon footprint estimation for each mode of birth from the maternity carbon footprinting report to the number of births. The emissions factors used are:

- Spontaneous vaginal birth: 259.5 kgCO2e
- Assisted vaginal births: 293.6 kgCO2e
- Planned and emergency caesarean: 142.4 kgCO2e

*Previous*
During the 26 months before the start of the project, 21 emergency caesarean, 17 planned caesarean, 15 assisted vaginal and 55 spontaneous vaginal births were recorded. This translated to a yearly average of 9.7 emergency caesarean, 7.9 planned caesarean, 6.9 assisted vaginal and 25.4 spontaneous vaginal births.

The baseline average annual carbon footprint of all births in the birth centre and delivery suite is 11,117.4 kgCO2e.

*New*
The project has the potential to improve birth outcomes for Albanian women. However, spontaneous and assisted vaginal births are associated with a higher carbon footprint than planned and emergency caesareans, as women are more likely to use Entonox, a gas with a high global

warming effect. With no specific data available on Entonox use within our cohort, we have based the carbon footprint of spontaneous and assisted vaginal births on an estimated 76% Entonox use rate (Spill et al., 2024).

Our team has schemes progressing to mitigate our emissions from Entonox use. These include the introduction of 'cracking' technology to minimise the release of Entonox into the atmosphere. If this technology had been in place over the past 26 months, the annual carbon footprint would have been reduced to 7,609.6 $kgCO_2e$.

Additionally, to prevent wastage, we plan to replace the current system of piping Entonox from larger cylinders across the hospital site with smaller cylinders placed directly in labour rooms. This has been shown to reduce leakage and waste without compromising the availability of Entonox during birth.

If the new service leads to an increase in vaginal births among our cohort, we aim to significantly reduce the carbon impact of these births through sustainable Entonox use.

**Translation of information leaflets produced online**
Providing translated information leaflets online reduces the potential waste associated with printing while ensuring greater accessibility for diverse language groups. Digital distribution minimises paper consumption, printing costs, and environmental impact, aligning with sustainable healthcare practices.

**Raising the profile of sustainability**
Our Safeguarding Midwife has used the Olive Clinic to share about the Green Maternity Challenge, providing more information about the new service but also raising awareness on the climate crisis amongst staff and women.

*Economic sustainability*:
Most of the funding for this project came from the existing budget. The LMNS funds allowed for spending on face-to-face interpreters and translation of written resources. Expenses have been carefully considered, and the clinic has been strategically designed to maximise cost efficiency.

**Interpreting services:**
Our services rely on a combination of face-to-face and phone interpreting services, provided by Kingston Interpreting Services for in-person interpretation and The Big Word for telephone-based language support.

*Previous*: The data presented below was shared by our providers and is based on the period August 2022 - October 2024.

*New:* To minimise unnecessary costs, the clinic operates two sessions per day:

- A morning session dedicated to women requiring interpretation services.

- An afternoon session for women who do not require an interpreter.

Additionally, face-to-face interpreters are booked according to clinic needs. If only one appointment requires an interpreter, they may be scheduled for just 60 minutes, rather than for an entire session, further optimising costs.

Projections for the new service are based on the Olive Clinic operating at full capacity: one session of four hours per week, 52 weeks per year. Although the new service will primarily rely on face-to-face interpreters, we have allocated 5% of the total hours to phone interpreting services to account for instances of interpreter unavailability, ensuring a realistic estimation.

Additionally, we have included a cost comparison between our initial proposal, which involved working with a doula interpreter paid at band 5 (NHS Employers, 2024), and the pilot service now in place.

| Use of interpreting services (hours per year) | | | |
|---|---|---|---|
| | Phone | Face to face | Total |
| Previous service | 46 | 34 | 80 |
| New service | 10 | 198 | 208 |

The new service is expected to significantly increase the use of interpretation services during the antenatal period, from 80 hours to 208 hours - an almost threefold increase.

| Interpreting services cost (GBP per year, rounded) | | | | |
|---|---|---|---|---|
| | Phone £45.60 p/h | Face to face £45.00 p/h | Doula £17.65 p/h | Total |
| Previous service : 80 hrs | 2,098 | 1,684 * | - | 3,782 |
| New service - proposal: 208 hrs | 547 | - | 3,495 | 4,042 |
| New service - pilot: 208 hrs | 547 | 9,284 ** | - | 9,831 |

* Includes £154 for travel expenses – based on data provided by Kingston Interpreting Services for the period August 2022 – October 2024.

** Includes £464 for travel expenses – based on the cost of £9.46 per session for 49 weeks.

Our initial proposal was to work with a doula interpreter, which remains the most cost-effective option. Under this model, the doula interpreter would have provided 208 hours of support per year, with only a small additional cost of £260 compared to the previous service, which covered 80 hours of interpretation.

Following the loss of our doula interpreter, the pilot for this new service now relies on face-to-face interpreters contracted through Kingston Interpreting Services and phone interpreters hired via The Big Word. When comparing the hourly cost of face-to-face interpreting (£45.00 p/h) with phone-based interpreting (£45.60 p/h), the overall costs remain almost identical. However, by prioritising face-to-face interpretation, which is the preferred option among women, the new service will generate a small additional cost of £346 per year compared to relying solely on phone interpreting services (£9,485 per year). This increase is attributed to travel expenses.

Whilst continuing the search for a doula interpreter, the new service, operating at full capacity (one session of four hours per week, 52 weeks per year), with a face-to-face interpreter covering 95% of clinic sessions, will result in an additional cost of £6,049 per year compared to the previous service.

**Continuity of care:**
Continuity of care enhances the information available to women, which, according to existing literature, can improve coordination between clinical teams while reducing misunderstandings and duplication (Mortimer, F. 2010). This, in turn, contributes to the cost-effectiveness of this model.

**Translation of key documents into Albanian:** £1,326.3 + VAT
Translating documents into Albanian and making them available online enhances the economic value of the pilot by increasing accessibility, engagement, and reach.

**Potential financial savings:**
We have collected data on missed appointments, recording a total of 50 across midwifery checks, obstetric assessments, ultrasounds, and postnatal visits for our cohort. By improving communication, we expect to reduce this number. Although the clinic has only recently started, we are pleased to report that no appointments have been missed so far.

*Social sustainability*:
As part of our data collection, we distributed questionnaires to all women who had attended the clinic more than twice (9/16) to gather feedback on:

- Their experience of receiving continuity of care
- The use of face-to-face interpretation services
- Their overall experience of the clinic

At the time of writing this report five women had responded. Women were asked to rank their responses using the following scale: *Very Positively / Positively / Neither Positively nor Negatively / Negatively / Very Negatively.*

- All respondents stated that having the same midwife at each appointment had a *very positive* impact on their experience.
- Four made use of the face-to-face interpreting service. Three reported that having the same female interpreter had a *very positive* impact, one reported a *positive* impact.
- Overall, the service was rated as having a *very positive* impact by four respondents and a *positive* impact by one.

- All participants stated they would recommend this service to a pregnant Albanian-speaking friend who does not speak or understand English.

Although the sample size is small, this initial feedback was encouraging. The provision of continuity of care and face-to-face interpreting services had a positive impact on women's experiences.

*"Is my second time here and I feel very confortable",* Anonymous response to our survey

**Staff:**

We asked midwives working in the community and in our antenatal clinic their feedback about the pilot project and how it may impact their work. The comments below provide a summary of the findings;

*" Finally they [Albanian women with limited English proficiency] will be able to access antenatal classes"*

*"I find it difficult to do an antenatal check and provide all the information [related to pregnancy and birth] to women who need an interpreter when we have the same slot [30 min] than for other women."*

*"Women can be very confused about the care pathway and as a result miss appointments. This clinic should help improve their understanding."*

*"It can be very frustrating and time consuming to find an interpreter. The clinic will solve this problem."*

*" Referrals take time, and we may be going home late to finish our paperwork on time. It can be very stressful to have multiple referrals to make at the end of your day"*

The data collected is limited, however the project was well accepted by our staff and had a positive impact on the overall workload and time management on the people interviewed.

## Discussion:

In response to women's concerns and within a very limited timeframe, our team successfully launched a pilot service dedicated to Albanian-speaking women booked with our maternity services. The review process of our initial data and relevant literature was extensive but invaluable, allowing us to gain a deeper understanding of the complexities faced by this cohort and optimise the pilot accordingly.

Although we had anticipated some delays, the departure of our doula interpreter at the start of the project was unexpected, requiring us to quickly adapt and find a suitable alternative. This change in care provision impacted both the vision and cost of the clinic, and we continue our efforts to recruit an Albanian doula interpreter to enhance the service.

We are pleased that this pilot and the data collected have sparked productive discussions about potential improvements. The feedback received from women attending the clinic has been very positive; however it remains limited in scope, and we will continue to gather insights over the next year to further refine the service.

This pilot has demonstrated the potential impact of a tailored maternity care model. With further evaluation, it could be expanded to support other local vulnerable groups or adapted for different maternity services to meet the specific needs of their populations.

**Conclusions:**

The Green Maternity Challenge has provided an opportunity to pilot a low-carbon service aimed at reducing health inequalities within maternity care. The new service, The Olive Clinic, offers continuity of care with a specialist midwife and face-to-face female interpreter for Albanian-speaking women. Optimum cost-effectiveness would be achieved if interpretation were provided by a doula interpreter.

Beyond improving women's experiences, the Olive Clinic plays a crucial role in promoting choices, empowering vulnerable women to take greater care of themselves and their children; and building trust in the local health and social care system. These factors are essential in improving long-term health outcomes for both mothers and their families, while also potentially reducing their long-term reliance on healthcare services.

At the time of writing, we are continuing the search for a doula interpreter while awaiting confirmation on provisions for the next financial year. We remain committed to working collaboratively with women and staff to explore options for further refining and adapting the clinic to better meet the needs of Albanian-speaking women and deliver sustainable, high-quality maternity care.