Greater Manchester and Eastern Cheshire (GMEC)
Local Maternity and Neonatal System (LMNS)

Maternity Equity and Equality

Action Plan 2022-2027

Part of Greater Manchester Integrated Care Partnership

NHS
Greater Manchester and Eastern Cheshire
Strategic Clinical Networks

LMNS
Greater Manchester and Eastern Cheshire
Local Maternity and Neonatal System

Contents

Executive Summary

It is safer than ever to have a baby in England. The stillbirth rate is at its lowest on record and the neonatal mortality rate for babies born from 24 weeks gestation onwards continues to fall, with the maternal mortality rate lower now than in 2010. However, in Greater Manchester and Eastern Cheshire (GMEC), some of our maternity outcome measures are not where we need them to be, with some measures, including stillbirth rates, increasing through the pandemic and we are yet to see them return to pre-pandemic levels or align with national averages.

In September 2021, national guidance was produced, directing all Local Maternity Systems to undertake a programme of work to improve equity and equality within maternity services and consider those wider determinants of health that impact on a pregnancy long before it begins. We started this in 2021 and have subsequently developed this Equity and Equality action plan that describes the steps we need to take over the next 5 years, from 2022-2027, to address our gaps and improve outcomes for those most in need.

The recent MBRRACE-UK reports into maternal and neonatal deaths show different outcomes for women and babies from Black, Asian and Mixed ethnic groups and those living in the most deprived areas. We are therefore compelled to focus on these groups in particular but have taken into consideration other groups that we have identified locally that might have additional needs.

We have also looked at how staff from ethnic minority backgrounds are represented within our workforce and to ensure they have the same opportunities and experience as others.

Our plan has been carefully co-designed and co-produced with the people we serve, by establishing Core and Task & Finish groups with a broad range of stakeholders across the LMNS, Integrated Care System (ICS) & other Sectors. 36 Intervention leads were identified, including many service users and representatives, along with our Maternity Voice Partnerships in GMEC and our Voluntary and Charitable organisations. They have produced this work and we offer our sincere thanks to all those who have contributed.

It is an ambitious plan that contains 36 Interventions against 6 national or local priorities and there are 363 individual actions.

Over 50 resources were used from a national, regional and local level across different sectors when developing the plan. Year 1 actions mainly reflect agreed, funded and ongoing work and there are other actions later in the plan that will require ICS agreement and funding to progress.

We have identified a number of areas that we wish to prioritise in anticipation that they will have a greater impact on improving equity and reduce inequality.

10 High Impact interventions for GMEC include:

Preconception care	(Intervention 12)
Early access to antenatal services	(Intervention 10)
Enhanced Midwifery Continuity of Carer	(Intervention 23)
Personalised Care & Support Planning	(Intervention 15)
Black & Asian Maternity Equity Standards	(Intervention 30)
Universal & Targeted vitamin D supplementation	(Intervention 2)
Embedding of Saving Babies' Lives Care Bundle, including GM Smoke free Pregnancy programme	(Intervention 9 & 24)
Addressing raised BMI	(Intervention 27)
Establishment of Family Hubs across GM	(Intervention 33)
Our staff from ethnic minority backgrounds are representative of our local populations and will have the same opportunities and experience as others	(Intervention 32)

Our next step will be to implement this plan and it is essential that we continue this work together with our families and wider partners, so that our care is effective, accessible, personalised and improves outcomes

Vision

We want Greater Manchester and Eastern Cheshire to be a place where everyone can live a good life, growing up, getting on and growing old in a greener, fairer more prosperous city region.

We want to improve maternity outcomes and experiences for those women and people using maternity and neonatal services in GMEC who face inequality on the basis of their circumstances or protected characteristics, such as ethnicity, faith, belief, sexual orientation and disability.

In collaboration with the North West Regional Chief Midwife Office, the North West Neonatal Operational Delivery Network, the Voluntary sector and Public Health colleagues, we will use this action plan over the next 5 years to reduce health inequalities and improve equity in maternity and neonatal services across GMEC.

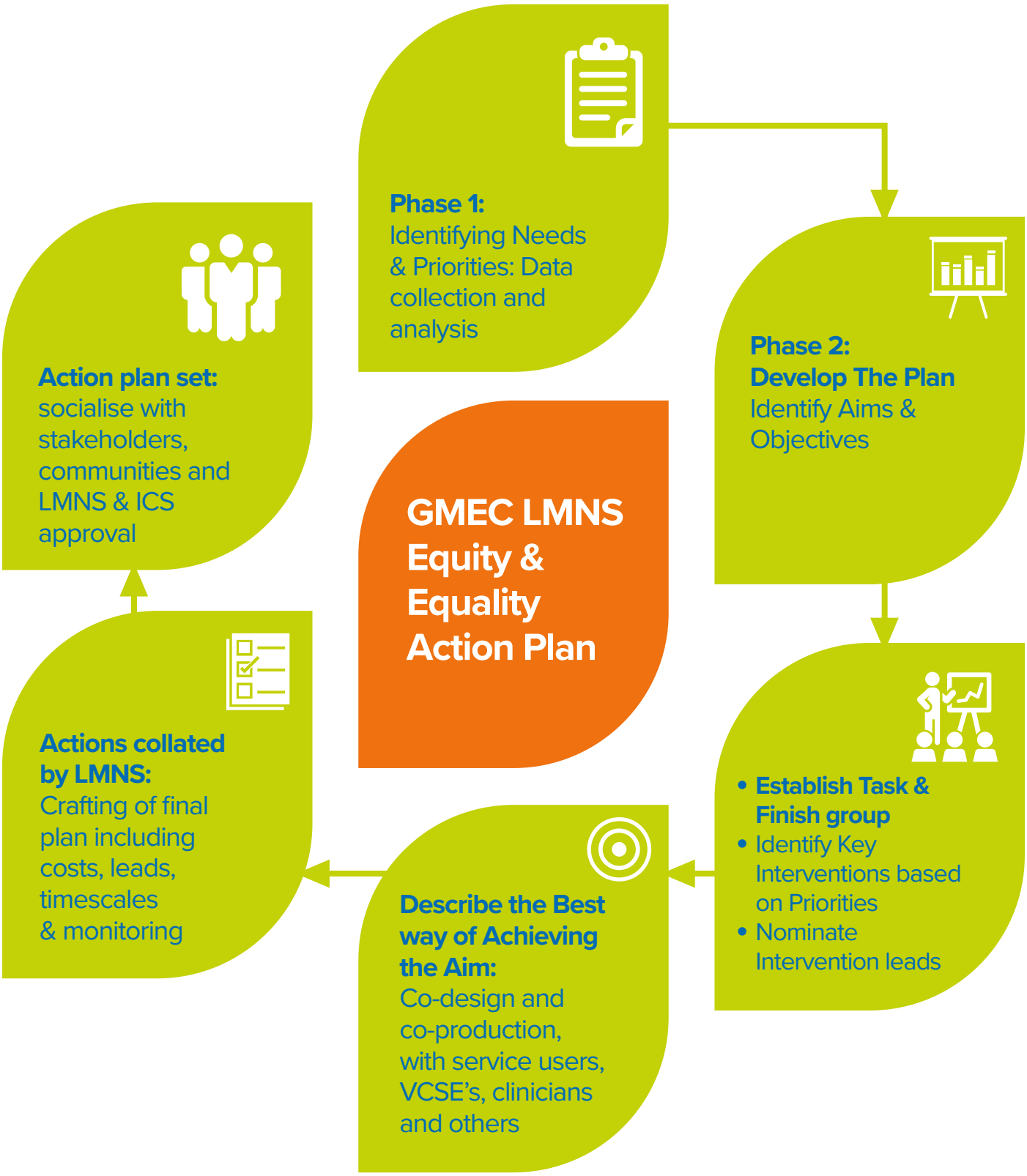
Background

In September 2021, national guidance was produced, directing all Local Maternity Systems to undertake a programme of work to improve equity and equality within maternity services and consider those wider determinants of health that impact on a pregnancy long before it begins.

We began in 2021 and although we found that some of our data was not of sufficient quality to give us a full picture of what was happening to these groups of women and babies, we were able to identify a number of local gaps and needs. Using that information, we have subsequently developed this Equity and Equality action plan that describes the steps we need to take over the next 5 years, from 2022-2027, to improve outcomes for those most in need.

The recent MBRRACE-UK reports into maternal and neonatal deaths show different outcomes for women and their babies from Black, Asian and Mixed ethnic groups and those living in the most deprived areas. We are therefore compelled to focus on these groups in particular, but have taken into consideration other groups that we have identified locally that might have additional needs.

Methodology



Priorities

1

Restore NHS services, following COVID pandemic (COVID 4 actions), inclusively

2

Mitigate against digital exclusion

3

Ensure datasets are complete and timely

4

Accelerate preventative programmes that engage those at greatest risk of poor health outcomes:

A: Understand your population and co-produce interventions

B: Action on maternal mortality, morbidity and experience & Action on neonatal mortality and morbidity

C: Action on perinatal mortality and morbidity D: Support for maternity and neonatal staff

E: Enablers

5

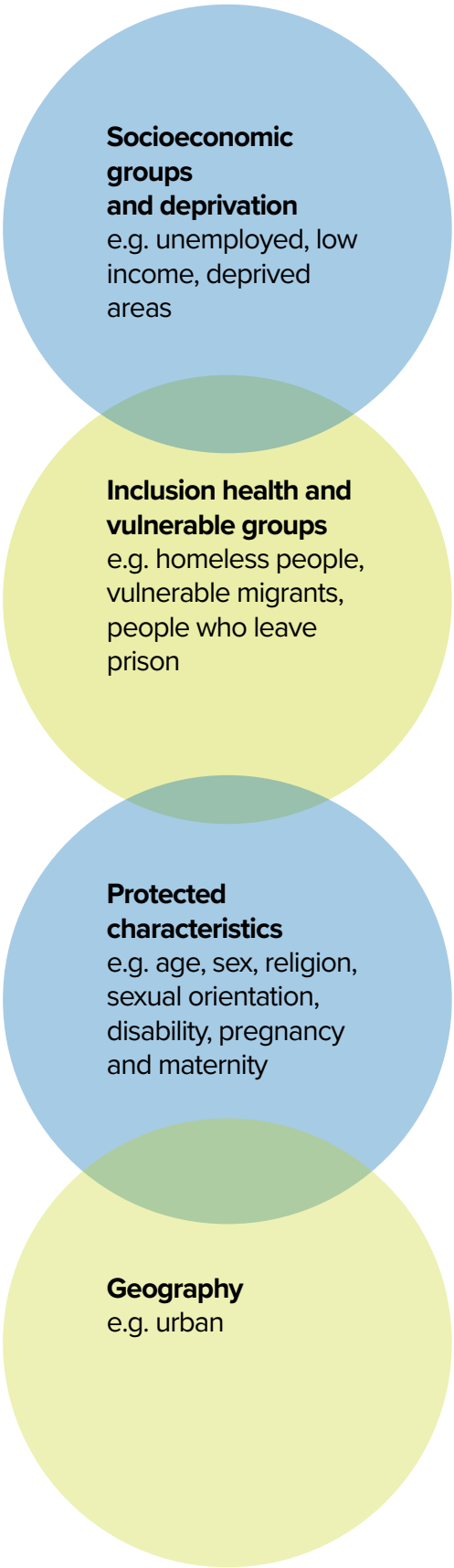
Strengthen leadership

Local Priorities

Context: High diversity; High deprivation; Poverty; Refugees; Smoking in Pregnancy; Women's Prison

Outcomes: Higher rates of Stillbirth; Late Booking; Raised BMI; Poor Perinatal Mental Health; Low rates of supplementation & low vaccination uptake

Overlapping dimensions of health inequalities



Co-production

Priority 1

Restore NHS services, following COVID pandemic inclusively

Intervention 1

To increase support for at-risk pregnant women. To tailor COVID-19 communications for specific groups

Rationale

National guidance has highlighted the decline in access to care amongst certain groups early in the COVID-19 pandemic.

Existing differences in experience and outcomes of pregnancy have widened during the pandemic and maternity services were asked to undertake 4 key actions to address this, including increased support for at risk pregnant women/people, reassurance through tailored communication, vitamin D supplementation and accurate recording of ethnicity.

Deaths from COVID-19 infection in GM was 38% higher than the national average and a significant number of pregnant women who Groups that will benefit the most were severely affected by Covid-19 infection required admission to hospital, with some needing complex medicine to treat them.

COVID-19 vaccination for pregnant women and people in GMEC will prevent severe disease and therefore vaccination for COVID-19 and needs to be promoted across all maternity providers and the wider health and social care system.

Within the ten boroughs of GM, there were large differences in COVID-19 mortality rates: Manchester was 60% higher than national average, whilst Trafford was 5% lower than the national average (reflecting differences in the levels of deprivation).

Groups that will benefit the most

- Those with sight or hearing loss and/ or learning disabilities
- Those with complex medical needs
- Black, Asian and Mixed ethnic groups
- Immuno-suppressed
- Those whose first language is not English
- Those living in deprived areas

2022- 2023
Procedures for each provider which describes the threshold for required intervention for ethnic minority groups.

2022-2023
Establish GMEC COVID-19 vaccination in pregnancy working group with maternity providers and local immunisation and vaccination leads to improve staff knowledge and confidence in holding conversations skills.

2022- 2023
Pilot a nurse led vaccination tea to improve uptake of COVID-19 and other vaccinations required in pregnancy.

2022-2023
Safety messages from the North West maternity safety group and those produced locally will be made available in different languages, on the 'MyBirthMyChoice' and other provider websites:
Communication to pregnant women/birthing people will outline the importance of having COVID-19 (and flu) vaccination to reduce pre-term births and other poorer birth outcomes as a result of COVID-19.
Tailored information will be commissioned using a range of media, working with local multi-faith leaders and communities.

Intervention 2

To increase support for at-risk pregnant women. All women to be in- formed re vitamin supplements (vitamin D and Folic acid) / nutrition

Rationale

Women and babies from Black, Asian and Mixed race ethnicities are more likely to experience lower levels of vitamin D and yet have poorer access to vitamin D supplements.

The uptake of Healthy Start vitamins for babies once discharged from maternity services is currently unknown.

Across GMEC, Black or Black British women (82%) and any other ethnic groups (86%) have lower uptake of Folic acid supplements compared with White women (94%).

Women living in the most deprived areas (87%) have a lower uptake of Folic acid when compared with the least deprived at (97%).

Groups that will benefit the most

- Pregnant and breastfeeding women/breast-fed babies/ babies taking less than 500mls of formula a day
- Those at highest risk of low vitamin D, dark skin, covered skin, high BMI
- Black, Asian and Mixed ethnic groups
- Those living in deprived areas
- Refugees living in temporary accommodation

2023-2024
Review current policies to identify best practice in relation to access to Healthy Start (HS) vitamin D and (400IU) Folic acid. Liaise with Health visitor services to capture uptake of HS vitamins for babies.

2023-2025
Providers are able to report offer of vitamin D, uptake and compliance throughout pregnancy.

2023-2024
Population health team with Maternity services across GMEC to use existing workstreams to secure and commission direct provision of Healthy Start vitamins in pregnancy via a midwife and improve access for babies.

2023-2023
Scope current provision of enhanced dose of vit D to high risk pregnant women across GMEC providers to capture best practices and what's working well.

2023-2025
Explore the offer of a one-off dose of vitamin D for all women combined with daily HS supplements to improve vitamin D levels.

2023-2025
Undertake research to understand the enablers and barriers to vitamin D uptake in at risk groups.

2023-2024
Staff training to raise awareness of the guidance relating to vitamin D and the links to poorer outcomes.

2024-2025
Improve documentation relating to vitamin D advice, information and uptake in the Child Health (Red Book) Record.

Priority 2

Mitigate against digital exclusion

Intervention 3

Develop digital services that are accessible to and meet the needs of all pregnant woman and birthing people

Rationale

Not all digital maternity systems are able to capture a full ethnicity profile nor level of deprivation linked to postcode, making it difficult to get a full picture of need.

While there are several benefits to developing unified digital records, this may pose problems in terms of access for some and our initial analysis demonstrated that there is a need to explore further:

The factors which lead to digital exclusion.

The impact of offering digital access or appointments on pregnant women/people.

A standardised way of communicating relevant information electronically to maternity service users.

Groups that will benefit the most

- Those with sight or hearing loss and/or learning disabilities
- Cultural groups (e.g. Orthodox Jewish community)
- Black, Asian and Mixed ethnic groups
- Those living in deprived areas
- Refugees living in temporary accommodation

2023-2024
Understand the reasons why individuals and communities don't have digital access, such as those experiencing digital poverty due to the cost of devices and affordability/ connectivity of broadband contracts, or those with no desire to use technology, due to lack of digital literacy or cultural factors.

2022
All women/people are offered face-to-face care for key antenatal appointments. Remote monitoring apps such as BP monitoring may still be used.

2023-2024
Obtain feedback from pregnant women/people on the impact of digitalisation of maternity care, particularly where digital access is an issue.

2023-2027
Improve and enhance Digital Information Systems across antenatal, intra-partum and post-partum care, by developing electronic patient records in each provider and uploading a Maternity data set from existing Maternity Information Systems into the Greater Manchester Care Record.

2024-2025
Develop digital means of getting key safety and other messages to all groups over the perinatal period.

2023-2024
Utilise data and technology to test and target screening initiatives at local populations to improve uptake of services and address health inequalities, such as online booking.

Priority 3

Ensure datasets are complete and timely

Intervention 4

Continuously improve the data quality of the mother/ person's ethnicity and postcode (indices of deprivation) on maternity information systems

Rationale

A lot of data related to maternity outcomes isn't easily broken down by ethnicity or level of deprivation at the moment.

The ability to harness this valuable information would allow interventions to be focused on areas of greatest concern and enable us to address health inequalities.

Groups that will benefit the most

- Those living in deprived areas
- Specific ethnic groups
- Those with the poorest maternity outcomes
- All parents

2022-2023
Extract data on mortality and morbidity from the regional measures/ICS /LMNS dashboards and breakdown the data according to ethnicity, deprivation, region and provider.

2022-2024
Standardise definitions and management of data. National or regionally agreed terminology should be used where possible.

2023-2024
Enable 'external to the NHS' partners, such as academic researchers, to access the data through easier, more manageable, processes. This should be facilitated by the Integrated Care Board (ICS).

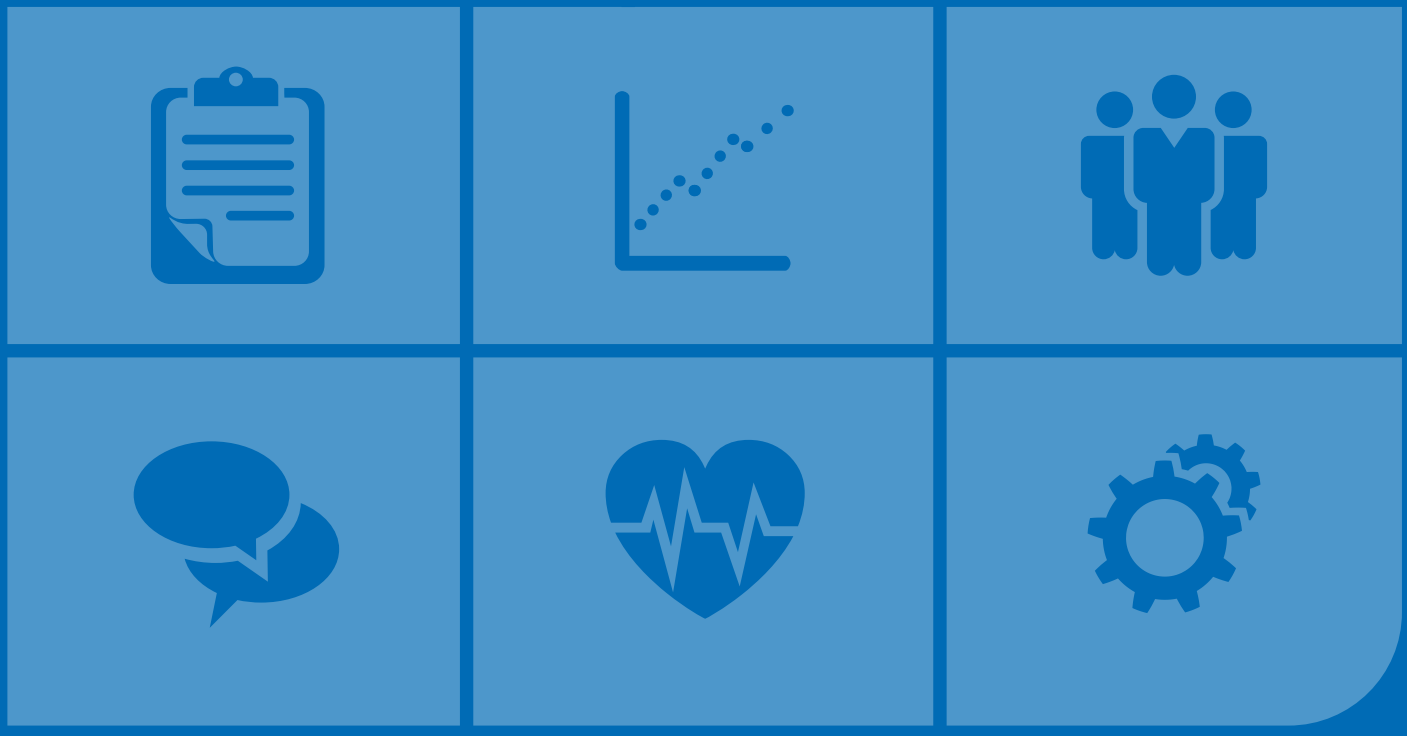
2023-2025
Work with Voluntary and Advisory groups in GMEC to strengthen co-production in relation to analysis on metrics linked to health inequalities.

2022-2024
'Join up' maternity providers representatives with ICS data leads and convene weekly meeting via Head of Business Intelligence to maximise data coverage.

2025-2027
Undertake an academic data review to produce a series of reports outlining trends in outcomes by i) ethnicity, ii) deprivation, iii) other axes of inequalities (such as language', homelessness, disability, etc.).

2022-2027
Collaborate with Population Health, Analytical, Digital and Health innovation partners, to establish a GM Population Health management model that strengthens the development and utilisation of strategic intelligence within the 'Build Back Fairer framework'.

2024-2025
Data relating to both parents/next of kin to be added to infant records.



Priority 4

Accelerate preventative programmes that engage those at greatest risk of poor health outcomes

4a: Understand your population and co-produce interventions

4b: Action on maternal mortality, morbidity and experience

4c: Action on perinatal mortality and morbidity

4d: Support for maternity and neonatal staff

4e: Enablers

Priority 4a

Accelerate preventative programmes that engage those at greatest risk of poor health outcomes: Understand your population and co-produce interventions

Intervention 5

To understand the local population's maternal and perinatal health needs, including the social determinants of health

Rationale

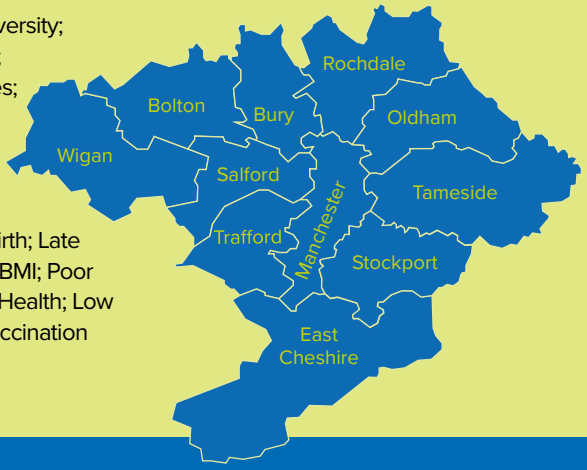
In 2021 we worked with communities to understand our local population and describe maternity outcomes. We determined the main issues relating to maternity care, recognised where gaps in service provision occur and where disparity in outcomes exist. This analysis formed the foundation and rationale of our maternity equality and equity action plan.

Groups that will benefit the most

- Those living in deprived areas
- Black, Asian and Mixed ethnic groups

Context: High diversity; High deprivation; Poverty; Refugees; Smoking in Pregnancy; Women's Prison

Outcomes: Stillbirth; Late Booking; Raised BMI; Poor Perinatal Mental Health; Low supplement & vaccination uptake



Intervention 6

To map the community assets which help to address the social determinants of health.

Rationale

Local Government Action (2021) outlines an assets approach which seeks to reduce health inequalities by building on the strengths and resources in a community. Evidence shows that:

"When practitioners begin with what communities have – their assets – as opposed to what they don't have – their needs – a community's ability to address those needs increases. So too does its capacity to lever in external assistance"

Groups that will benefit the most

- Those living in deprived areas
- Black, Asian and Mixed ethnic groups
- Those with sight or hearing loss and/or learning disabilities
- Those living with digital poverty

2023-2025
Review the asset mapping exercise to close gaps in provision across areas with the most deprivation and diverse ethnicity.

2022-2025
Work with the GM ICS & Children & Young People's (CYP) Network to identify and improve access to information and community assets for pregnant women/people, parents and staff, including a web-based platform. It will include details of statutory support services, local community groups and services that support wider social needs e.g. food banks, interpreting services, social prescribing, employment rights etc.

2023-2024
Canvas the local population to determine the value and need for community health/link workers/ connectors to support pregnant women/ people and new parents to provide practical information and support.

2023-2025
Where gaps in maternity assets are identified, these will be highlighted to the ICS, VCSE Panels and other community providers and further action agreed.

Intervention 7

To conduct a baseline assessment of the experiences of maternity and neonatal staff by ethnicity using WRES indicators 1 to 8

2021/22
Contact each provider to request their WRES data.

2021/22
Collate WRES data and conduct analysis.

Initial work with a focus group of staff regarding their experience has taken place. We will continue to work with providers to gain further understanding of the WRES (Workforce Race Equality Standard) indicators for Maternity and Neonatal staff groups and provide a platform for our staff from a minority ethnic background that enables them to tell us about their experiences of working in our services and how we can improve upon what we learn (please see Intervention 32 for actions).

"The reality is even when you can be a 'good one' you're constantly having to work harder for any recognition and end up training people for a role you applied for and were rejected from."

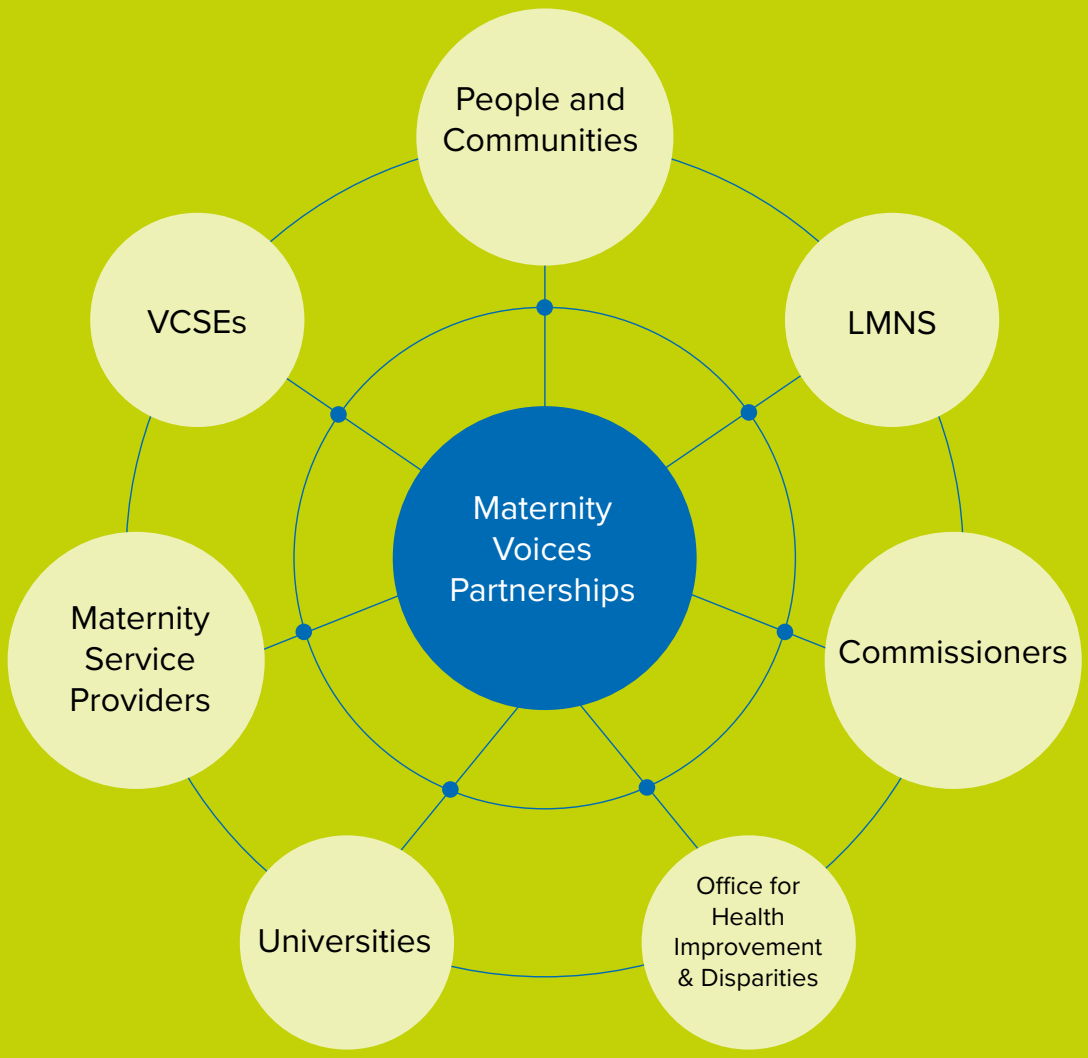
"The whole system is biased against marginalised communities and if you can't be the 'good asian or black midwife' you will be ostracised openly, more so than if you can."

"I'm tired and considering leaving the profession, it's not that I'm not resilient, I am just exhausted of fighting for the basics."

"I have witnessed/heard whilst on duty that mothers from different ethnic backgrounds felt like they had not had their wants and needs listened to and felt this was due to their race/culture/ethnicity."

Intervention 8

To set out a plan to co-produce interventions to improve equity for mothers, babies and race equality for staff



2023-2027
Training will be provided to maternity services and MVP membership on the value of co-production, using 'good practice' examples and with a focus on engagement with women and families in deprived areas and areas with high levels of ethnicity.

2023-2024
Create a practical 'how to' guide to support co-production in maternity services, that can be used in planning/training.

2022-2023
MVP LMNS Leads to scope level of knowledge of GMEC MVP chairs regarding CNST safety action 7; provide training to Chairs to support their role and report to the LMNS Group..

2022-2027
MVP LMNS Leads, MVP Chairs, and representatives from Voluntary and Charitable organisations (including cultural and religious leaders) to have an active role in the implementation of the Equity and Equality action plan, at both a provider and system level, acting as an honest broker and co-designing services accordingly.

2023-2026
The ICS/LMNS will identify a proportion of budgets for public health initiatives to cover co-production and co-design.

2024
Develop a procedure that outlines roles and responsibilities when co- producing actions and services. The SOP It will describe the process for individual maternity providers to receive, act upon and feedback to service users what has been done in response to their comments.

2023-2026
Create an annual LMNS equity and diversity celebration event, to showcase innovative projects in terms of improving equity and inclusion through co-production.

2022-2027
Regular service user feedback must be collected by Maternity providers and utilise.d when planning services.

Intervention 8

To set out a plan to co-produce interventions to improve equity for mothers, babies and race equality for staff

We involved a high number of organisations and partners to develop our plan together

Intervention 8

To set out a plan to co-produce interventions to improve equity for mothers, babies and race equality for staff

ack and Asian Maternity Advisory Focus groups

Organisation commissioned	Number of focus groups	Number of women/birthing people attending focus group and from which ethnicity
British Muslim Heritage Centre	3	10 Pakistani, 9 Bangladeshi, 10 Arab/Middle Eastern
Caribbean and African Health Network	3	10 French speaking Africans, 9 African, 9 Caribbean and African
MAMA Health and Poverty Partnership	2	20 African women - many of whom were migrants
Sangha Manchester	1	10 Indian
Maternity Voices Partnership	1	Attendance by 7 women from range of ethnicities including: Afro Caribbean x2, Pakistani x1, Bangladeshi x1, Indian x1, mixed ethnicity (Afro Caribbean and African x1, White and Afro-Caribbean x1)
Totals	10	94 Participants

What we heard: Focus group feedback about interacting with maternity services

- Inadequate Health Literacy
- Feelings of neglect and inequitable care - lack of trust resulting from racism and discriminatory practices
- Fear of clinical interventions
- Inadequate postnatal support
- Poor knowledge of maternity system & complains procedure
- Lack of ethnic representation in maternity services
- Limited involvement in decision making
- Poor interpretation services resulting in non-consented interventions or gaps in care and understanding
- Language, culture and religious insensitivities
- Need for Education, engagement and support

What we did: Production of Maternity Equity Standards

STANDARD 1: Women/people should have access to high quality interpretation services

STANDARD 2: Written information to be available in range of languages

STANDARD 3: Clear information for women/people on postnatal support

STANDARD 4a: Religious needs, to be part of assessing pregnancy care needs

STANDARD 4b: Cultural considerations in pregnancy and post-delivery for support, guidance and safety

STANDARD 5: Women/people and their families to be informed of how to raise their worries/concerns

STANDARD 6: Vitamin D supplementation information and discussion including higher dosages

STANDARD 7: All staff involved in care of women/people during pregnancy and early postnatal period to have mandatory Cultural Competency Training

STANDARD 8: Each maternity provider to have a named equality, diversity & inclusion (EDI) champion

STANDARD 9: Recording ethnicity of women/people in maternity healthcare systems

STANDARD 10:: Each maternity provider to have a named equality, diversity & inclusion (EDI) champion

STANDARD 11: All maternity and neonatal training to be inclusive of all ethnicities including consideration of training aids

STANDARD 12: All maternity providers to ensure that they are completing Equality Impact Assessments as part of the development of local policies, procedures and practises

Priority 4b

Accelerate preventative programmes that engage those at greatest risk of poor health outcomes

Action on maternal & neonatal mortality, morbidity and experience

Intervention 9

Reduce stillbirth, neonatal death and morbidity and optimise the conditions for preterm infants

Rationale

We saw a year-on-year decrease in the stillbirth rate across GMEC, which has continued up to 2019, however there has been an increase (but not statistically significant, P-value >0.05) in this metric from 2019 to 2021.

The GMEC rate is now above the national rate (England 2019). 5 of 8 provider sites in GM reported an increase in Stillbirths in 2020 in comparison with 2019, and in one provider the increase was significant within the most ethnically diverse population.

We aim to reduce Stillbirth and Neonatal death by half by 2025, in line with the National Ambition

Groups that will benefit the most

- Those living in deprived areas
- Black, Asian and Mixed ethnic groups
- Those experiencing loss/neonatal loss
- Cultural groups (e.g. Orthodox Jewish community)

2022-2027
Embed Saving Babies' Lives Care Bundle (SBLCB) in full.

2022-2023
Funding to be agreed at system level to sustain the services and leadership required to implement SBLCBv2 in full.

2023-2024
Explore data relating to SBLCBv2, with a breakdown for ethnicity and postcode in order to understand the local population needs in relation to Stillbirth, Neonatal death and preterm birth.

2023-2024
Consider targeted interventions relating to SBLCBv2 and further analysis of outcomes for those groups most at risk.

2023-2026
Support the establishment of midwife-led fetal surveillance clinics utilising Midwifery Ultrasound Practitioners.

2022-2025
Work with the NW Neonatal ODN to link data sets and monitor trends for Early Neonatal Death and Preterm birth in relation to ethnicity and deprivation.

2022-2025
Work with Maternity and Neonatal Safety Improvement programme to implement Neonatal Optimisation and the Neonatal Deterioration tool (NEWTS).

2022-2023
Consider the utilisation of guidance for the Jewish and other communities about practises at the time of the death of a baby in the bereavement pathway.

2022-2027
Use local groups such as Sands as a sounding board for any materials/ relevant training relating to stillbirth/ neonatal death/bereavement being developed for health care professionals.

2024-2025
Maternity providers to facilitate options for women/people undergoing late miscarriage that are sensitive to cultural and religious requirements, such as guidance on retention and disposal of products of conception.

Intervention 10

Improve early access to ante-natal care for women from ethnic minority backgrounds and living in deprivation

Rationale

In 2019 in Greater Manchester, 40% of women/people did not book for maternity care before 10 weeks of pregnancy. Most of those had an ethnic minority background or lived in an area of deprivation.

A recent UK study outlined a number of reasons for late booking such as poor health, caring responsibilities, previous negative healthcare experiences, travel, unaware of pregnancy, taking time off work, newly arrived in UK, changing GP/hospitals, cancellation of appointments and self-isolation. Local work in GM in recent years has identified similar reasons.

Across GM, uptake of early tests such as Sickle cell and Thalassaemia screening at 10 weeks of pregnancy is low and a more in-depth understanding of the reasons for late booking in GMEC is required.

Groups that will benefit the most

- Those living in deprived areas
- Black, Asian and Mixed ethnic groups
- Those with complex social needs

2022-2024
The GM Screening and Immunisation Team, supported by the LMNS will carry out community engagement and insight gathering, using focus groups to understand the barriers to early booking and identify the key needs of those most likely to book late for antenatal care.

2022-2024
The LMNS to conduct a local review of GMEC referral systems for booking to identify barriers that cause delay.

2023-2026
GMEC maternity providers to utilise Enhanced Midwifery Continuity of Carer models where possible and introduce other practises that target the most vulnerable groups and facilitate early booking, taking into consideration.

2024
LMNS to review provider approaches to early booking 24 months after the completion of the benchmarking exercise, to determine if changes have been made.

2023-2024
Create a campaign to encourage booking by 10 weeks, specifically targeting key groups and using a variety of approaches, such as public events, promotional material (including use of appropriate language) to raise awareness and utilising Maternity Voice Partnerships (MVP), the voluntary and charitable sectors (VCSE) and social and cultural groups.

2023-2024
GMEC LMNS to work with the North West Regional Chief Midwife Office to improve early access.

2025-2026
Develop and carry out training events for staff/people in the wider system to understand the importance of early booking, e.g. Early Years/Family Hub staff, MVP and VCSE groups.

In greater Manchester

40%

of women/people did not book for maternity care before

10 weeks **of pregnancy**

Intervention 11 Establish a regional Maternal Medicine Network

Rationale

Maternal complications are increased by diseases that pre-date pregnancy and by complications that arise during pregnancy. Pregnancy brings significant changes in all aspects of bodily processes and optimal outcomes are achieved where care for pregnant women is guided by consultants with specific pregnancy expertise and with input from relevant physicians.

Groups that will benefit the most

Pregnant women/people from Minority ethnic groups with complex medical needs

2022
Agree North West Maternal Medicine Network (MMN) Model Proposal with GMEC hosting one of the Maternal Medicine Centres and establish a board for oversight and decision making.

2022
The MMN to undertake a gap analysis against the national service specification.

2022-2026
NW MMN to develop a national profile to inform policy developments and share experiences, learning and progress with other maternity regions.

2022-2023
Undertake a mapping of patient activity and flows within each NW LMNS to inform care pathways and gaps in service provision and funding requirements.

2023-2024
Development and agreement of joint Development and agreement of joint clinical care pathways across the NW MMN.

2022-2024
Undertake a MMN Telemedicine pilot to support shared care arrangements between maternity providers in order to negate the need for women from vulnerable communities to travel.

2022-2024
Establish a NW MMN Co-production reference group and lead on consultation and engagement with relevant groups on service developments.

2022-2025
Develop a website that will enable sharing of information on Maternal Medicine with women and clinicians.

Intervention 12

Improve follow up support to women with a past diagnosis of gestational diabetes mellitus (GDM)

Rationale

Research conducted by The University of Manchester and others found that mothers with elevated blood glucose during pregnancy were significantly more likely to have developed Type 2 diabetes a decade after pregnancy than their counterparts without high blood glucose.

The 'Healthier You' programme rolled out across GMEC will help women to take control of their health, supporting them to make changes to their diet, weight and the amount of exercise they undertake. Improvements in referral to the programme from maternity services and primary care can be improved.

Groups that will benefit the most

- Those with a current or past diagnosis of gestational diabetes
- Those with raised BMI
- Black, Asian and Mixed ethnic groups
- Women of childbearing age

2023-2026
Preconception services are available within the community setting that optimises health prior to pregnancy and reduces the risk of GDM e.g. reducing raised BMI & culturally appropriate healthy eating advice.

2025-2026
All women of childbearing age to be provided with preconception advice utilising the GM 'Primary Care Standards for Type II diabetics' during GP/practice contact (Every Contact Counts) and coded in the GP system.

2024-2026
GP Practice clinical staff to receive training in preconception information and advice to maximise contact with women of childbearing age.

2023-2025
The GP is notified at post-natal discharge of any women/people with GDM to enable follow-up 12 months post-partum.

2023-2026
GPs/Nurse to offer a referral as appropriate (If HbA1c between 42-48) to the 'Healthier You' programme to women with a past diagnosis of Gestational Diabetes who are not currently pregnant and do not currently have diabetes.

2025-2026
The GMEC SCN to explore using different thresholds for the diagnosis of GDM dependent on pregnant women's/persons ethnicity.

Intervention 13

Implement NICE CG110 antenatal care for pregnant women with complex social factors

Rationale

Poor maternity outcomes can often be linked to other, more complex social factors rather than physical conditions alone. The MBRRACE Confidential Enquiry report published in 2021 considers the factors that lead to maternal death in the UK, reviewing statistics from 2016 – 2018, including the 566 women that died during or up to a year after their pregnancy in the UK and Ireland. It was found that 90% of the women had multiple problems relating to physical, mental health and social factors, including systemic biases.

In GMEC, a third of all women using maternity services are from minority ethnic groups: 10% of these women also live in the lowest decile for deprivation.

The same MBRRACE report found that 15% of women who died were using substances during pregnancy which had both physical and psychologically harmful effects, with a number of women dying by suicide.

Domestic Abuse (DA) is a serious population health issue that affects many families. There is clear evidence about exposure of physical assault in pregnancy on unborn child including higher risk of miscarriage and low birth weight. Between 23 March 2020 and 10 January 2021, there were 49,437 domestic violence incidents reported to Greater Manchester Police.

In 2020 in GMEC the under 18's conception count was 880 with 175 teenage mothers. In the same year, all boroughs of GMEC - except Eastern Cheshire and Trafford - had higher teenage conception rates than the national average. Whilst many young parents manage well, others face a range of challenges that contribute to poorer health outcomes for these young people.

2022-2023
Revisit NICE CG110 definition and agree at GMEC level.

2023-2024
GMEC maternity providers will have a guideline outlining the care and clinical management of pregnant women and people with complex social needs.

2023-2024
Education materials are available to inform maternity staff as to the definition and guidance for care of pregnant women/people with complex social needs.

2023-2025
Undertake research to understand the experience of services in GMEC to inform/guide service development of pregnant women and people with complex factors.

2023-2024
Relevant pathways and signposting is in place to support young parents (under 20) and are included in the Personalised Care and Support Plan e.g. access to VCSE services such as the Healthy Gems Hub in Oldham.

2022-2023
Maternity providers have clear guidance and pathways to ensure that pregnant women and people are supported by the appropriate service when substance misuse during pregnancy is identified, including liaison with the perinatal mental health team.

2024-2025
GMEC SCN to develop and agree an objective assessment for use at booking to determine the level of need for an interpreter.

2023-2025
Where interpreters are required, access to an interpreter or interpreting service (in person/ online/ phone) is made available at all key appointments and interventions.

2023-2024
Maternity providers to identify areas where Focused Care Practitioners (named practitioners who carry a caseload of vulnerable individuals who do not access mainstream care) exist and establish links to maternity care.

Groups that will benefit the most

- Those with complex social needs
- Pregnant and homeless groups
- Maternity staff
- Those affected by substance misuse in pregnancy
- Pregnant refugees, migrants and asylum seekers, including refugees living in temporary accommodation
- Those whose first language is not English
- Young parents
- Those experience domestic abuse during pregnancy and the perinatal period
- Those who require safeguarding support
- Those with complex social needs who are not engaging with traditional health services

Intervention 14

Improve access to maternal mental health services and support for women from ethnic minorities and who live in deprived areas

Rationale

The Equity and Equality analysis undertaken in November 2021 indicates the widespread need for perinatal mental health services across GM.

The GM data demonstrates that overall, our ethnic minority population is accessing the Community Mental Health Team. However, some ethnic groups are under-represented and overall access is not fully representative of our pregnant population. This is demonstrated in the finding that 33% of our pregnant population are from an ethnic minority background, whereas approximately 70% of patients seen by this service were White.

The Royal College of Midwives (RCM) suggests that women from ethnic minority backgrounds are more likely to experience poor mental health associated with a range of factors such as poverty and low social support.

Uptake of perinatal mental health services in GM varies in different areas and across different ethnic groups. For example, in 2019, less than 7.4% of those attend perinatal mental health services (PNMH) services in Bolton were from an ethnic minority community, despite a high number of people from South Asian and Black ethnic background living in Bolton.

Groups that will benefit the most

- Those with complex social needs
- Black, Asian and Mixed ethnic groups

2022-2027
To ensure that all staff working within the wider Perinatal & Parent Infant Mental Health (PPIMH) system have comprehensive training on cultural competence.

2022-2026
Understand the diversity of population access to PPIMH services, identifying access by ethnicity per Locality, using Specialist data.

2022-2025
Understand the variation in experience in the inpatient setting by ethnicity, with regards to the Perinatal Mental Health (PNMH) Mother and Baby Unit (MBU), by reviewing inpatient demographics and mapping length of stay and detention rates against ethnicity – using complete data sets for 2 consecutive years of MBU admissions.

2022-2023
Maternity providers work with PPIMH services to develop, agree and disseminate Maternity Mental Health Standards.

2022-2024
Increase VCSE offer across GM, to identify need and support inclusion; work with PNMH mental health and diversity champions, including

- Dad Matters
- Level up VCSE offers across GM supporting perinatal champions.
- NW Neonatal ODN to work with Spoons to establish trained peer supporters on every GMEC neonatal unit.

2022-2025
Co-produced trauma infographic to develop understanding of impact of trauma on maternity experience across cultures and ethnicity.

2023-2026
Additional consideration should be made for asylum seekers, refugees and recent migrants and those with complex social needs, as their environment may make them more vulnerable to mental health difficulties.

2023-2026
Produce a database of trauma-informed training packages, which can be accessed by all healthcare professionals requiring training.

33% of our pregnant population are from a minority ethnic background

whereas **70%** of patients seen by Community Mental Health Team were White

Intervention 15

Personalised Care and Support Plans for all maternity service users

Rationale

Maternity care should be personalised, safe and centred on the person. It is a tool to support and document needs based on their unique circumstances and should be used to document the conversations and decision-making processes required to develop a plan of care that means individuals will receive the best care possible for them.

In GMEC, Personalised Care and Support Plan (PCSP)s in hard copy were developed and rolled out as part of the Better Births programme, however further work is required to support equity and equality and improve shared decision making.

We aim to develop the PCSP to improve access to care and social support and to promote individualised care

Groups that will benefit the most

- Those with complex medical and social needs
- Black, Asian and Mixed ethnic groups
- Learning disabilities
- Neurodiverse
- Those who do not speak/read English as a first language
- Groups with other protected characteristics who require individualised care

2022-2024
Establish a GMEC PCSP working group. Membership to include representatives from each maternity provider, digital leads, ICS representative for personalised care and MVP/VCSE representation.

2023
Scope current position on PCSP offer across all GMEC providers.

2023-2024
Develop a GMEC wide PCSP that meets National PCSP standards. Available in a range of languages and in both hard copy and digital. The PCSP will address cultural, religious and translation needs, learning disabilities and neurodiversity along with other individual needs. It will include tailored communications, wider referral such as signposting to community assets and other means of support, such as social prescribing. To be piloted before roll-out.

2023-2025
Survey maternity providers in GMEC to determine how they will demonstrate PCSP offer via the national Maternity Dataset (including breakdown by ethnicity and deprivation) at the following gestation for all pregnant women/people:
- antenatal care by 17 weeks gestation
- intrapartum care by 35 weeks gestation
- postnatal care by 37 weeks gestation.

2023
Audit the quality of PCSPs that are currently being used by maternity providers, taking into account individual needs and wider support such as social support (e.g. social prescribing; parenting information on digital platform).

2025-2026
Roll-out of GMEC PCSP to all providers.

2026-2027
Evaluation of GMEC PCSP use, quality, implementation and impact.

Intervention 16

Ensure the MVPs in GMEC LMNS reflect the ethnic diversity of the local population, in line with NICE QS167

Rationale

NICE QS167 is a quality standard pertaining to promoting health and preventing premature mortality in Black, Asian and other minority ethnic groups; NICE NG44 calls for community engagement to improve health and wellbeing and reducing health inequalities. It is therefore vital that our Maternity Voice Partnerships (MVP) are representative of the population we serve.

Groups that will benefit the most

- Those living in deprived areas
- Black, Asian and Mixed ethnic groups
- Groups with protected characteristics
- All maternity & Neonatal service users

2023-2024
MVP leads to agree the membership and how to measure diversity.

2023-2026
MVP Chair role and membership to reflect the local population, in particular improve representation of Black, Asian and Mixed ethnic groups.

2022-202^
The LMNS to share current and future analysis of the population in GMEC with MVP groups in order to inform targeted work.

2023-2025
To scope the extent of cultural competency of current MVP members in order to inform future training programmes for the membership.

2023-2027
MVP chairs to utilise local VCSE organisations, including social, religious and cultural groups to understand the needs of the local population in relation to maternity and neonatal care.

2023-2026
The LMNS to agree to support training for MVP Chairs and members.

2023-2026
LMNS to consider expanding the current MVP model in GMEC to include funded outreach roles for MVP members, particularly in those areas with high deprivation in order to target Black, Asian and Mixed race pregnant women/ people, fathers/partners and families.

2023-2027
Individual maternity providers must include an MVP member on all working groups that aim to change or design maternity services.

2024-2026
Annual MVP Equity & Diversity led Workshop / celebration event to showcase effective partnership working/ co-production activities and good practise across GMEC.

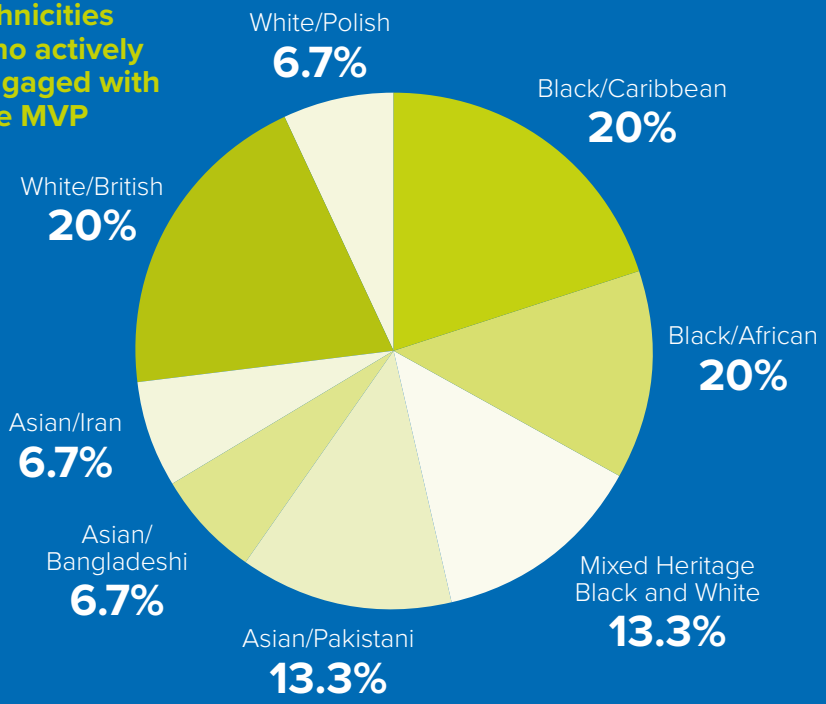
2025-2027
MVP LMNS Leads to facilitate a training and mentoring programme for service users from diverse communities who want to become involved with MVPs to support MVP Chair and membership succession planning.

Work already carried out by one of our MVP Chairs for their locality

Ethnicities Engaged with MVP 2021

Diversity within out MVP allows us to hear from service users from different ethnicities who wouldn't usually get involved through outreach work and focus groups.

Ratio of Ethnicities who actively engaged with the MVP



Intervention 17

Address the contributors of poverty and associated deprivation: Food poverty, Fuel poverty; Digital poverty; Benefit deficit

Rationale

GMEC has high levels of social deprivation with more than third of pregnant women/people living in the 10% most deprived Council Ward areas. 26% of children (0-15 years) live in poverty as compared to the England average of 15.6%.
Anecdotal evidence tells us that some pregnant women have their benefits reduced at a critical time when physical and mental wellbeing and access to good nutrition is essential.

There is an increase in cost to families whose baby have an admission to a neonatal unit.

Groups that will benefit the most

- Those living in deprived areas
- Those experiencing digital poverty
- Those experiencing digital exclusion
- Black, Asian and Mixed ethnicity groups
- Those in receipt of the Healthy Start card
- Those with poor access to transport
- Pregnant refugees, asylum seekers and migrants

2022-2024
Liaise with Department of Work and Pensions to define a standardised process so that pregnant women/people continue to receive their benefits during pregnancy and in the perinatal period to maximise health.

Work with GMEC ICS Population Health team,
to implement the Population Health plan relating to poverty and maternity services.

2022-2023
GMEC LMNS to initiate liaison between Healthy Start and Digital Inclusion Action Network (DIAN) in Greater Manchester to share learning and address digital exclusion.

2022-2026
Maternity providers must ensure that information on good nutrition is available, accessible and culturally relevant, taking into account level of income.
VCSE organisations offer /signpost to culturally appropriate food and advice during religious periods.

2022-2026
GMEC maternity providers work with communities and councils to ensure sufficient access to food by referral and signposting to relevant providers
(Food Banks/Food Pantries/Food clubs).
Relevant food providers to support diverse foodstuffs within Foodbanks.

2022-2024
Consider roll out of GM Poverty Action Money Advice Referral Tool (MART).

2023-2025
Maternity services to consider transport when planning care. Fuel poverty and poor access to public transport may prevent women from attending appointments.
Recording when transport has been a factor in non-attendance.

Intervention 18

Consider maternal need for pregnant asylum seekers/refugees given the high proportion within GMEC

Rationale

Our GMEC asylum seekers population is growing and larger than the NW/National average of asylum seeker population with 5,309 people claiming asylum in GM in the year up to March 2021.

The needs and barriers in this group are significant and considerable midwifery resources and understanding are required to manage their needs.

Groups that will benefit the most

- Those living in deprived areas
- Those with complex social needs
- Refugees, asylum seekers and migrant groups, including refugees living in temporary accommodation

2023-2025
Ensure a trauma-informed approach for pregnant women/people who have experienced trauma i.e. FGM and Domestic Abuse (DA) / sexual exploitation.

2022-2027
Implement a translation tool in required areas to aid communication and enable pregnant refugee women/people to articulate their needs. Implementation should take an incremental approach, with an evaluation undertaken prior to further rollout.

2022-2027
Consideration should be made to social as well as obstetric medical needs when caring for women with a background of refugee, new migrant or asylum seeker e.g. transportation difficulties, interpreter needs.

2022-2023
Direct provision of vaccination and immunisation as per pregnancy programme (including COVID-19 vaccination) to pregnant women/people in temporary accommodation.

2022-2027
To offer information/support services in relation to social need to pregnant asylum seekers, refugees and migrants utilising VCSE, Maternity Action and other organisations. Maternity service to refer into local enhanced support models where present.

2023-2027
Link into existing action plans and strategies addressing DA in GMEC. A link Independent Domestic Violence Advisor is identified for each unit, with consideration for outreach to pregnant refugees living.

Intervention 19

Ensure that Maternity and Neonatal services are equitable across all individuals and have the necessary provisions to include and offer the same outcomes for the wider population of individuals with protected factors, such as LGBTQ+ and disabilities

Rationale

In 2017 there was an estimated population of 215,000 LGBT people in GM according to the LGBT Foundation. Trans people are at risk of health inequalities and in England, a higher percentage of trans and non-binary birthing parents of colour reported that they did not access maternity support during pregnancy compared to the general maternity population.

There are 521,314 disabled people in Greater Manchester (GM); that is 19% of the GM population. Of those, there are an estimated 65,000 people with learning disabilities. People with disabilities face inequality in all areas of their lives, including health, housing, employment, education, support, justice and relationships. There is limited data regarding pregnant disabled and LGBTQ+ women/ people using maternity services, as there is no current digital capture within maternity information systems.

Groups that will benefit the most

- LGBTQ+ groups
- Disability groups

2023-2025
Data workstream priorities to include developing the capacity to capture data regarding maternity service users with other characteristics, such as LGBTQ+ and those with disabilities.

2022-2026
GMEC LMNS to scope maternity providers on what provision/support is made for LGBT+ community and people with disabilities throughout their maternity journeys.

2022-2026
Ensure inclusive, respectful and appropriate terminology in all GMEC's maternity verbal and written communication (including information leaflets/ handouts and speech).

2022-2023
Encourage maternity providers in GMEC to review the learning and recommendations from the LGBT Foundation ITEMS report and work with providers to implement changes, such as visible markers of inclusion, social media, creating channels for feedback and coproduction of service offer to these groups.

2022-2026
Explore how to improve access to maternity, neonatal and perinatal services for people with physical and learning disabilities. Examples may include use of visual information, pared back language, sign language and use of 'Deaf Awareness' information, advocacy, facilitating easier access to services and buildings, along with the development of a co-produced service offer to these groups.

2022-2025
Personalised care training include trauma-informed and personalised care, specifically for LBGTQ+ groups and people with disabilities. Personalised care training should be co-produced with MVP's and VCSE's.

There are over

215,000

LGBT people in Greater Manchester

There are also

521,314

disabled people in GM, that is 19% of the GM population

Intervention 20

Ensure seamless care between midwifery and Health visiting services

Rationale

Historically, communication between maternity, neonatal and Health visiting services is fragmented and sporadic. Reliance on paper systems impacts on the ability to communicate effectively in a way that supports the family.

Groups that will benefit the most

- Maternity & Neonatal service users
- Those with complex needs

2023-2027
Improve digital communication and handover/transfer of care during the perinatal period between midwifery and Health vsiting.

2023-2027
Establish a working group to review the content and timing of communication between maternity and Health visiting. Content of communication should include significant health information e.g. genetic diseases, current medical and obstetric history and be issued at a time to optimise care e.g. at 28 weeks gestation, following antenatal screening results.

2023-2027
Maternity services to develop a process to notify Health visitors if a mum and baby remain on the ward after 24 hours post-delivery. Admission to neonatal unit/services should be part of the communication pathway.

Intervention 21

Fully implement and embed the Maternity and Neonatal Safety Improvement Programme

Rationale

The Maternity and Neonatal Safety Improvement Programme (MatNeo SiP) aims to improve the safety outcomes of maternity and neonatal care by reducing unwarranted variation and provide a high quality healthcare experience for all women/people, babies and families across maternity and neonatal settings in England.

Groups that will benefit the most

- Maternity & Neonata service users
- Black Asian and Mixed race groups

2022-2025
The LMNS to work closely with Health Innovation Manchester (HInM) to implement the Neonatal Optimisation care bundle in all maternity providers in GMEC, focussing on the temperature of baby at birth and best practise for cord clamping.

2022-2023
LMNS to work closely with HInM in the adoption and spread of the national Maternity Early Warning Score tool within an effective Prevention, Identification, Escalation and Response (PIER) pathway for managing deterioration and support.

2022-2023
The LMNS to pilot (in 4 maternity sites within GMEC) the feasibility and acceptability of Omega 3 supplementation to support prevention of preterm birth across GMEC.

2022-2023
The LMNS to work closely with HInM to roll out the national culture work programme including culture surveys as appropriate.

2022-2023
HinM to support GMEC SCN/LMNS to implement the 'Each Baby Counts' toolkit to improve escalation, communication and culture across the maternity system.

Priority 4c

Accelerate preventative programmes that engage those at greatest risk of poor health outcomes

Action on perinatal mortality and morbidity

Intervention 22

The LMNS will address the leading causes of perinatal mortality and morbidity , including systemic bias and institutional racism, for pregnant women/people and babies from Black, Asian and Mixed ethnic groups and those living in the most deprived areas

Rationale

Maternal mortality in GM is collated, but due to small numbers has not been published by ethnicity in order to maintain confidentiality.

In the UK, Neonatal mortality rates in babies whose mother are of White ethnicity decreased between 2015-2017, whereas Neonatal mortality in babies born to women/people of Asian, Asian British, Black and Black British ethnicity in the same period increased (Bliss).

Babies born to Black or Black British parents in the UK had a 67 per cent increased risk of neonatal death, while babies born to Asian or Asian British parents had a 72 per cent increased risk of neonatal death, compared to babies of White ethnicity.

Infant deaths are also linked to deprivation - in 2017 more babies born to mothers living in the most deprived areas died in the neonatal period when compared to mothers who lived in less deprived areas.

Our latest data show that over three quarters of infant deaths in Manchester occurred when the residence was in the most deprived quintile.

Groups that will benefit the most

- Black, Asian and Mixed ethnic groups
- Those with complex social needs
- South Asian groups
- Those living in deprived areas

2023-2026
Establish preconception services in the community throughout GM in a variety of settings, utilising VCSE groups to improve information and access to preconception care and advice to targeted groups.

2022-2025
Make information about congenital anomalies a part of all routine pre-conception care for women/people who may be at risk of this outcome (e.g. due to genomics/ consanguinity) when they become pregnant through the use of community midwives/health or lay workers.

2023-2026
Pregnant women/people with existing morbidity such as Epilepsy, Diabetes and serious mental health difficulties must have ease of access to specialised preconception services, including folate supplementation for diabetics of childbearing age.

2022-2024
Create targeted campaigns with key messages regarding early booking and access to maternity care.

2022-2025
All pregnant women/people booking for maternity services (particularly targeting refugees, recent migrants and those whose first language is not English) should be given clear information in the appropriate format and language regarding Antenatal and Newborn screening, including screening for Severe combined immunodeficiency (SCID), as part of the Newborn screening in pilot areas.

2022-2027
Pregnant women/people of Black, Asian and Mixed ethnic groups with complex needs should be offered Enhanced Midwifery Continuity of Care when available and allocated to the appropriate obstetric pathways following early assessment.

2022-2026
Consideration of a pregnant woman/person's social circumstance must be considered alongside the clinical picture and referral made to local services to support good health e.g. nutritional support, Healthy Start vitamins, Family hubs and VCSE food banks.

2023-2026
GMEC LMNS to agree what triggers for a lower threshold for admission/interventions should be considered in pregnant women/people from Black, Asian and Mixed ethnic groups.

2023-2024
Intrahepatic cholestasis of pregnancy (ICP) is more common in South Asian pregnant women and therefore information should be provided to those.

2022-2026
Allocation to appropriate expertise when significant fibroids or previous complex abdominal surgeries are found in pregnant Black, Asian and Mixed ethnic women.

2022-2026
Maternity providers to ensure that pregnant women/people have their concerns listened to, questions answered and concerns addressed whilst maintaining dignified and respectful care in which the pregnant woman/person is able to make informed choices.

2024-2027
Research to examine the poor outcomes of ethnic minority pregnant women/people who are induced.

2022-2026
Ensure examination of the placenta is carried out by a specialist pathologist for every baby who has a poor outcome following birth and provide information to families as to why this is important.

2023-2025
Information in a language accessible to pregnant women/people should be available in the postnatal period regarding wound care, wound scarring and perineal care/wound breakdown.

2023-2026
Provide preconception information and advice aimed at next pregnancy at postnatal transfer home or discharge from community midwife. Including reducing BMI, smoking cessation, early booking and management required for existing.

2024-2026
All pregnant women/people should be provided with information during the antenatal period so that they are aware of potential complications that could occur, including signs and symptoms of pre-term birth, complications occurring immediately after birth, and information about the first weeks following the birth. This information should include bonding and the first 1001 critical days, safe sleeping, emotional wellbeing, physical health, baby care and wellbeing, and include contact details for maternity services in the immediate postnatal period.

2022-2025
Units should establish dedicated perineal care follow up clinic and wound care clinic where referrals from community settings can be expedited.

Intervention 23

All providers implement targeted Midwifery Continuity of Carer models focused on Black, Asian and Mixed ethnic groups and those living in deprived areas

Rationale

Pregnant women/people from Black, Asian and Mixed ethnicity and those living in the lowest decile for deprivation have poorer outcomes and face additional risks. GMEC focus groups have highlighted that women in these groups have poorer experiences of maternity care.

GMEC is diverse with higher rates of women and people from ethnicity background using maternity services. Poverty and deprivation prevalence in Greater Manchester is high.

As part of the Northwest Core20Plus5 programme, GM ICS is looking to Midwifery Continuity of Carer (MCoC) as a vehicle to reduce health inequalities for the family as a whole.

We aim to make the provision of care more individualised and tailored for those most at risk.

Groups that will benefit the most

- Black, Asian and Mixed ethnic groups
- Those living in deprived areas

2022-2023
Sustain safe models of staffing to ensure a safe and effective maternity service.

2023
Action plan to align with NW CORE20Plus5 workstream, and VCSE groups such as Caribbean and African Health Network and BME Network to continue to developing relationships and collaboration with locality leaders to co-design pathways across the 5 areas of CORE20PLUS5, including maternity.

2022-2023
LMNS to work with providers and HEIs to address workforce: Consideration of student number expansion; improved resilience through preceptorship utilising the A-EQUIP model; improved access to return to practice; consider retention/pastoral care; improved career progression; leadership development, including equity and equality for staff from ethnic backgrounds.

2023-2026
Providers will utilise the Enhanced Midwifery Continuity of Carer model where possible to focus on those most at risk of poorer perinatal outcomes.

2023-2026
Each maternity provider in GMEC will implement their MCoC plan having ensured the required Building Blocks are in place first.

2023-2027
Outcomes from established MCoC models of care will be shared on an annual basis with the LMNS to measure impact on outcomes.

Intervention 24

Continue to implement and embed a smoke-free pregnancy programme for mothers and their partners across GM

Rationale

Smoking during pregnancy is the single, largest, modifiable factor related to adverse pregnancy and birth outcomes. Pregnant women/people from lower socioeconomic groups are more likely to smoke during pregnancy, reinforcing health inequalities.

Recent data (Fingertips) show Smoking at time of delivery is 10.8% nationally and 12.6% in GM. 7 of 10 local authorities have SATOD rates above the national average, with those same authorities scoring above average in the Index of Multiple Deprivation ranking.

Over half of the Child deaths in GM in 2019/2020 where smoking was deemed likely to have contributed to the death of a child were also in the lowest decile for deprivation. 15% of the Child deaths in 2019/2020 involved maternal smoking. This is an increase from the 11% if cases in 2018/2019.

The ethnicity of pregnant women/people who smoke in GM has been explored – 85% are White women/people. The majority of smokers in ethnic minority groups were more likely to be from Eastern European and Traveller communities.

Groups that will benefit the most

- White British, White other and traveller groups
- Those living in deprived areas
- Pregnant women/ people and families who smoke or are exposed to smoke
- All GM NHS staff
- Mothers identified with serious mental health difficulties and their families
- Mental health providers
- PCNs

2022-2024
Embed and scale up the GM Smokefree Pregnancy programme.

2022-2026
Identification and referral of all those at risk from smoking or raised carbon monoxide levels during pregnancy by a locally agreed pathway.

2022-2024
Identify all those at risk and offer pathways specific interventions.

2022-2024
All relevant maternity staff to be trained on the use of CO monitors and having a brief and meaningful conversation that leads to an immediate opt out referral for those that are at risk of smoking.

2022-2024
Embed Risk Perception Interview (a means of providing motivational interviewing and offer of additional support) to those who continue to smoke post-booking.

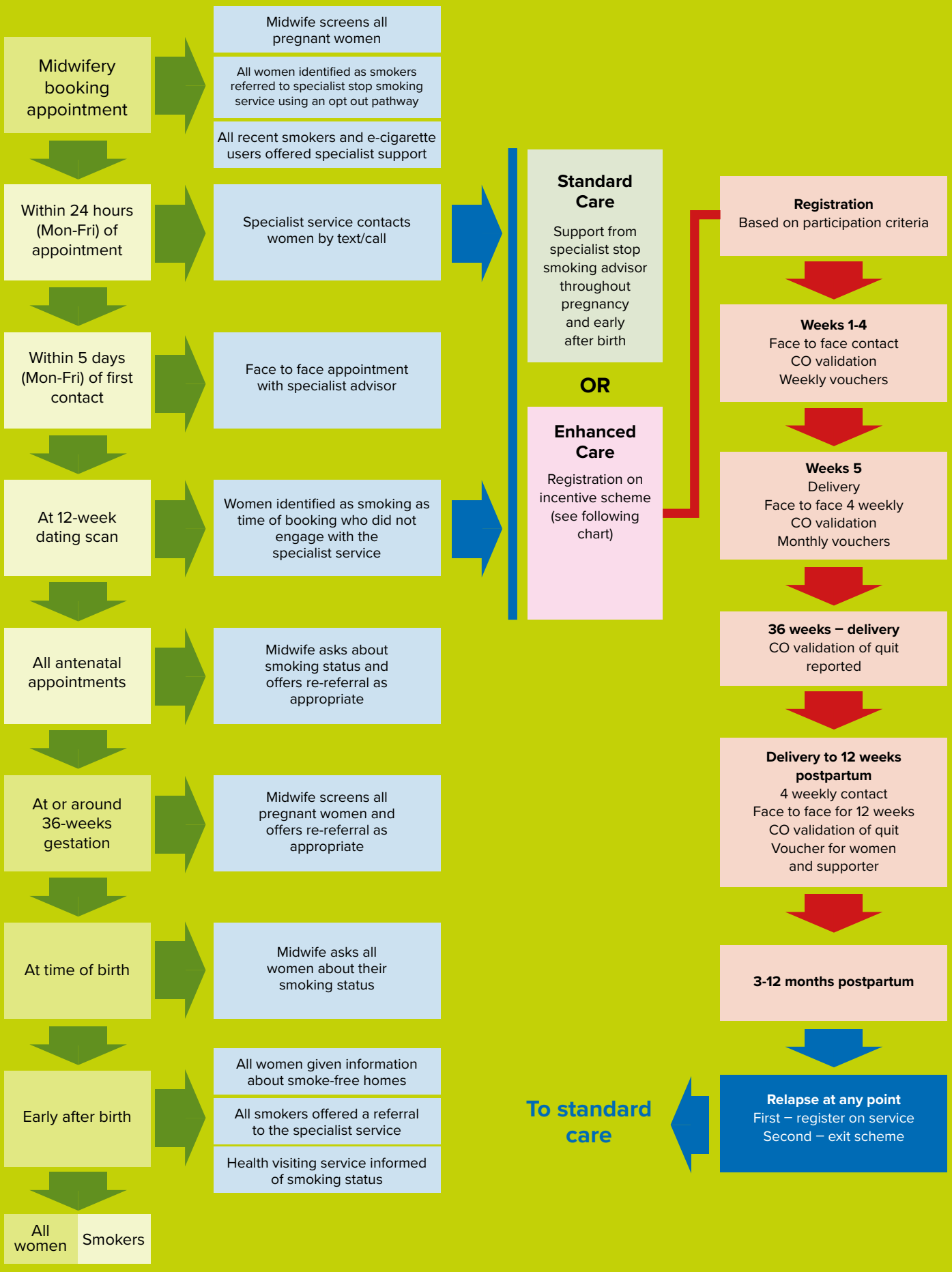
2022-2024
Maternity Providers to conduct an audit and insights review for those who are not engaging in smoke free pregnancy services, exploring the links to postcode and levels of deprivation and engage with VCSE to co- produce a solution.

2022-2024
Offer training to wider stakeholders including neonatal and HV services, on the benefits of stopping smoking during pregnancy and how to support women/birthing people to stop smoking which would double up as an opportunity to 'hear' what is needed.

2022-2024
Implementation of a new NHS England Stop Smoking staff offer. Introduction of a digital App including fulfilment offer for behavioural support and treatment (NRT and vaping products).

2022-2025
Targeted work with perinatal mental health to offer interventions that align with the wider CURE (treating tobacco dependency in the acute setting) programme supporting in-patient and out-patient settings.

The Journey


Midwifery booking appointment
Midwife screens all pregnant women
All women identified as smokers referred to specialist stop smoking service using an opt out pathway
All recent smokers and e-cigarette users offered specialist support
Within 24 hours (Mon-Fri) of appointment
Specialist service contacts women by text/call
Within 5 days (Mon-Fri) of first contact
Face to face appointment with specialist advisor
At 12-week dating scan
Women identified as smoking as time of booking who did not engage with the specialist service
All antenatal appointments
Midwife asks about smoking status and offers re-referral as appropriate
At or around 36-weeks gestation
Midwife screens all pregnant women and offers re-referral as appropriate
At time of birth
Midwife asks all women about their smoking status
Early after birth
All women given information about smoke-free homes
All smokers offered a referral to the specialist service
Health visiting service informed of smoking status
All women
Smokers
Standard Care
Support from specialist stop smoking advisor throughout pregnancy and early after birth
OR
Enhanced Care
Registration on incentive scheme (see following chart)
Registration
Based on participation criteria
Weeks 1-4
Face to face contact
CO validation
Weekly vouchers
Weeks 5
Delivery
Face to face 4 weekly
CO validation
Monthly vouchers
36 weeks – delivery
CO validation of quit reported
Delivery to 12 weeks postpartum
4 weekly contact
Face to face for 12 weeks
CO validation of quit
Voucher for women and supporter
3-12 months postpartum
Relapse at any point
First – register on service
Second – exit scheme
To standard care

Intervention 25

All providers implement an accredited, evidence-based infant feeding programme, such as the UNICEF Baby Friendly Initiative

Rationale

There has been a statistically significant increase (P value <0.05) in the rate of Initiation of Breastfeeding in GMEC from 2019 to 2020, approaching the national rate. There are however significant differences between boroughs in GMEC in initiation and 6-8 week rates, with lowest rates being in Wigan and highest being in Manchester and Trafford.

Some of the deprived areas in Oldham have a population that is 63.4% White and 22.8% Pakistani, with breastfeeding rates between 35-38%. This reflects other areas of deprivation within GMEC that have lower rates of breastfeeding. Areas of Oldham with the highest percentage of ethnic minorities are more likely to breastfeed.

Whilst ethnicity appears to be a protective factor for breastfeeding, it must be noted that feedback from Black, Asian and Mixed ethnicity women/birthing people across GMEC state how important it is to have sufficient infant feeding support antenatally and postnatally and has been identified as an area requiring improvement.

Groups that will benefit the most

- White British communities
- Those living in deprived areas
- Those women/people who struggle to maintain breastfeeding

2023-2024
Each provider unit to employ a Band 7 Lead Infant Feeding Co-ordinator (supported by a team in larger units) with clear roles and responsibilities and time allocated to undertake the role.

2023-2024
Implement a standardised Infant feeding strategy across GMEC, focusing on areas where improvements are most required:
- White British deprived communities
- Culturally appropriate support
- Support of breastfeeding when mother readmitted for medical/obstetric reasons.

2023-2027
Implement Baby Friendly Accreditation in all maternity units across GMEC, with associated training for maternity staff.

2022-2027
All neonatal units to work towards Baby Friendly Accreditation.

2022-2025
All HEIs midwifery programmes within GMEC to attain Baby Friendly Accreditation.

2022-2025
All neonatal units within GMEC to optimise early maternal breastmilk for pre-term infants (e.g. support to harvest colostrum).

2022-2026
Infant feeding to be part of the core offer within Family hubs.

20223-2027
All maternity providers must facilitate, or have easy access to tongue-tie services, with rapid referral.

2022-2027
Maternity and health visiting services to work together to improve continuation of breastfeeding as measured at 6-8 weeks.

2023-2025
Clear support and information (in different languages) must be available for those mothers/parents who choose to formula feed, in line with Baby Friendly Accreditation. Services must be sensitive and non-judgemental.

2023-2027
Businesses in GMEC to be encouraged to sign up to Breastfeeding Friendly Schemes.

Intervention 26

Establish culturally-sensitive genetic services across GMEC

Rationale

There is correlation between consanguinity where parents are married to a close relative and increased risk of child mortality, disability and other conditions linked to autosomal recessive inheritance.

Parents who are both unaffected healthy carriers of a genetic disorder present a 1 in 4 (25%) chance that the child could be affected and a 50% chance that the child could be a healthy carrier with no sign of the disorder but could pass the unusual gene on to the next generation. Unrelated parents have a 2% risk of having a child with a severe abnormality, whilst parents who are first cousins have a 5% risk and second cousins have a 3% risk. However, couples that are more closely related, such as a family with a history of cousin marriages going back generations, will have a higher risk of having a child with autosomal recessive disorders.

In GM we have a number of different areas of with a high population of families who more commonly enter into consanguineous marriages; for example, Manchester City area is one of the 8 areas nationally with highest incidence of consanguinity.

Groups that will benefit the most

- Those in close relative relationships

2022-2025
Implementation of national genetic literacy programme. Primarily focusing on Central Manchester (as one of the 8 areas of high incidence identified nationally), with the intention to widen to other areas of need once evaluated.

2023-2025
Booking questionnaire to include questions regarding consanguinity.

2023-2025
Develop pathways to improve referral for women and couples who are in a consanguineous relationship to genetic counselling.

2023-2027
Training in Genomics is required and embedded in undergraduate curricula.

2024-2025
Work with community leaders, faith leaders and VCSE groups to learn the views of the community to improve referral to genetic services.

Intervention 27

BMI: Address high body mass index in pregnant population

Rationale

Obesity is becoming increasingly prevalent in the UK population

and has become one of the most commonly occurring risk factors in obstetric practice, with 21.3% of the antenatal population being obese. In GM, the rates of obesity are higher than the national average.

In GMEC, the rates of overweight/obese at the time of booking for maternity care are approaching 50%.

MBRRACE reports highlight that young women with high BMI but no other risk factors have poorer outcomes linked to pulmonary embolism and deep vein thrombosis.

Groups that will benefit the most

- Those living in deprived areas
- Black, Asian and Mixed ethnic groups
- Those with raised BMI
- Those with a current or previous diagnosis of GDM

2022-2026
Understand the demographics in relation to raised BMI including ethnicity and deprivation post code data.

2023-2025
Improve midwives knowledge of local community assets that support healthy weight and lifestyle.

2023-2025
Work with pregnant women/people to understand what they want/need, to improve engagement and access to healthy weight and lifestyle community assets.

2025-2026
Raised BMI pathways to be linked into wider provision postnatally, e.g. local weight management programmes.

2024-2026
All pregnant women/people should be offered healthy weight support after pregnancy in a seamless way and in preparation for subsequent pregnancies, focusing on healthy eating and physical activity.

2025-2027
Understand how the GP 6-8 week postnatal check continues healthy weight and lifestyle to help pregnant women/people to return to a healthy weight.

2026-2027
Develop Routine Preconception Care programme for those of childbearing age with a raised BMI.

2024-2027
Work with VCSE groups to provide local cook and eat groups and Family hubs to support cooking skills, ideas for cooking healthy meals on a budget and wider social support.

2023-2027
Offer messages to recommend physical activity in the perinatal period and beyond for pregnant women/people and young families across GMEC and identify Physical Activity Champions.

2023-2025
All leisure facilities, public and private employers should display the Chief Medical Officer infographics.

2024-2025
Maternity staff trained to be skilled, knowledgeable and confident and able to undertake effective behaviour change conversations in relation to maternal nutrition, healthy weight and physical activity in pregnancy.

2023-2025
Ensure health professionals are aware of 5mg Folic acid requirement for pregnant women/people with BMI over 30 along with 20 mcg of vitamin D daily.

Intervention 28

Embed proportionate interventions to prevent the incidence and associated harms of alcohol use in pregnancy

Rationale

and neurodevelopmental birth defects, yet 41% of unborn babies in the UK are exposed to alcohol, the 4th highest rate in the world.

The harm caused by pre-natal alcohol exposure is diagnosed by the term Fetal Alcohol Spectrum Disorder (FASD). FASD is a neurodevelopmental condition with lifelong cognitive, emotional and behavioural challenges. It is estimated that in Greater Manchester during 2016, 1,195 babies were born with FASD. Our data regarding the use of alcohol in pregnancy is not yet captured in a standardised way across GMEC, so we do not fully understand the scale of alcohol exposed pregnancies.

Our aim is to prevent alcohol harm in pregnancy by providing consistent and accurate advice on the risks of alcohol use in pregnancy, embed routine alcohol screening and recording throughout pregnancy and offer support to those who require it.

Groups that will benefit the most

Pregnant women/people who use alcohol

Children affected by exposure to alcohol in pregnancy

2022-2023
Co-produce a GMEC Alcohol Exposed Pregnancy (AEP) Perinatal Procedure to prevent alcohol harm in pregnancy.

2022-2023
GMEC maternity providers to identify AEP maternity leads within their trusts to provide leadership.

2022-2026
All GMEC maternity units to implement routine AEP screening throughout pregnancy.

2022-2027
Maternity Providers to consider embedding AEP training once every 3 years for all GMEC maternity staff and at induction for new maternity staff.

2022-2026
GMEC maternity staff deliver alcohol brief intervention.

2022-2027
Update maternity information systems to capture AEP data as per procedure in order to gather reliable data to focus where required.

Intervention 29

Pregnant people in custody: Improve access to healthcare services for pregnant people in custody of His Majesty's Prison Styal

Rationale

Greater Manchester has a women's prison, HMP Styal, within its footprint and has a small cohort of women each year who are pregnant or have recently given birth on arrival.

A recent incident highlighted gaps in the provision of early and accessible maternity care, and the support of women with complex needs. As a result, a Specialist Midwife has been appointed to HMP Styal who will be linked with the local Wythenshawe maternity unit.

Key interventions and actions will facilitate timely and accessible maternity care for those women in custody.

Groups that will benefit the most

- Pregnant women in custody
- Those with complex social needs

2022-2024
Collect data on the number of pregnant women in HMP Styal within GM and their outcomes.

2022-2023
All women to be offered a pregnancy test when they arrive in custody at HMP Styal prison and once thereafter at a suitable interval.

2022-2025
Women in custody to be supported to breastfeed their baby.

2022-2025
Women in custody to be involved in individualised care planning, making decisions about their maternity care, including preference for place of birth and mode of birth.

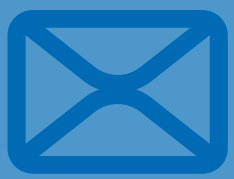
2022-2024
All pregnant women in custody to have equal access to maternity care at all times. This will include rapid access to triage (if specialist midwife not on site): explore whether the triage number can be identified as a pre-approved number on the personal mobile phones of pregnant inmates.

2022-2023
Promotion of mental health well-being using the Whooley questions (at booking, 28 weeks and 36 weeks gestation) and prompt referrals made to the Perinatal Mental Health services where required.

2022-2023
All pregnant women in custody to be informed of external appointments by letter the day prior to the appointment.

2022-2025
HMP Styal must make every effort to facilitate attendance at antenatal, scan and triage appointments in the time indicated by the maternity service.

2022-2025
Maternity providers to ensure that women in custody have easy access to information regarding women's health, sexual health and contraception services.



Priority 4d

Accelerate preventative programmes that engage those at greatest risk of poor health outcomes

Provide support for maternity and neonatal staff

Intervention 30

Achieve culturally competent perinatal workforce and services, including governance processes to address systemic bias and institutional racism

Rationale

The NHS system was built for a demographic that has vastly changed over the years, which is especially true in Greater Manchester. In 2017, the Office of National Statistics (ONS) estimated that the ethnic population in Greater Manchester had increased to 21%; a mean population growth of approximately 6.7% was noted in the 2021 census.

The MBRRACE 2021 report highlights that of 566 maternal deaths, 510 (90%) women had multiple problems relating to physical, mental health and social factors, including systemic biases. 119 deaths were from women with a minority ethnic background. The constellation of biases highlighted in the report show how multiple intersections of factors increase the likelihood of poor perinatal outcomes and the more categories the women falls into (such as ethnicity AND deprivation), the higher risk of a poor outcome.

Processes and models of maternity care need to be transformed in order to address the impact of ethnicity, culture and deprivation on outcomes in a positive way.

Groups that will benefit the most

Black, Asian and Mixed ethnic groups

2022-2023
GMEC LMNS to implement the co- produced Maternity Equity Standards developed by the Black and Asian Maternity Advisory Group. The standards will improve maternity and neonatal care for pregnant women/people from Black,
Asian and Mixed race ethnic groups. The essence of each of the 12 standards are contained within this Equity and Equality action plan.

2022-2025
Women/people from Black, Asian and Mixed ethnic groups should have access to high quality interpretation services during antenatal, intrapartum, postnatal and neonatal care (interpretation should not be used just to deliver information, it should be a two-way process, enabling the person to articulate their concerns or needs).

2022-2023
Providers to offer clear information for women/people from Black, Asian and Mixed race ethnic groups on postnatal support.

2022-2025
Religious and cultural needs to be part of assessing pregnancy care needs, to offer support, guidance and underpin safety.

2022-2023
Women/people from Black, Asian and Mixed race ethnic groups, fathers/partners and their families to have easier access to local complaints/ PALS procedures and provide information in different languages on how to raise their worries or concerns.

2022-2026
All maternity providers to ensure that they are completing Equality Impact Assessments as part of development of local policies, procedures and practices.

2023-2024
Maternity and neonatal providers to carry out a survey of existing Black, Asian and Mixed race ethnic staff to understand the additional skills, competencies and knowledge they bring to the service, such as language, cultural knowledge, and other expertise to aid individual provision of care for women/people from different ethnic cultures.

2022-2027
Serious incident investigation processes must align with national incident management and take into account the impact of ethnicity, deprivation and cultural factors as potential contributors to the incident and outcome. Involvement of service users with a related ethnicity should be considered where ethnicity is a factor.

2022-2024
When summarising incidents for Maternity Programme Group reports, a breakdown of ethnicity and any related themes should be included and discussed as required.

2023-2027
Child Death Overview Panel reports should determine the action or inaction that was a factor in the outcome for the child, such as poor access to genetic services, rather than recording 'ethnicity or consanguinity' as a factor in itself.

2023-2026
LMNS to work with Black, Asian and other minority ethnic representatives to review LMNS Safety SIG and other governance processes by maternity providers and advise.

2023-2026
Consideration of religious values: how cultural and religious beliefs can affect maternity experiences, e.g. wearing a hijab, care by women doctors, ability to pray, dietary requirements on labour ward, birth plan considerations including rituals/customs, breastfeeding values, concerns about fetal screening to check for genetic or chromosomal conditions, preference of support for post-natal depression.




Intervention 31

Roll out multidisciplinary training in cultural competency across maternity, neonatal and health visiting services

Rationale

The recent publication of a number of reports such as '5XMORE', or 'Invisible' tell us how lack of consideration for cultural and religious values can affect maternity experiences and this is reflected in the feedback from our own focus groups within GMEC.

Unconscious bias, systemic bias and racism all contribute to poorer outcomes, therefore the development of cultural competency training will help us to understand, to actively listen, to empathise and communicate effectively with people across all cultures. In doing so, we will promote equity and equality and resolving some of the increased risks to pregnant women/people from minority ethnic groups and their babies.

Groups that will benefit the most

- Black, Asian and Mixed ethnic groups
- Other minority ethnic groups

2023-2027
All maternity and neonatal staff in GMEC to undertake the e-Learning for Health 'Cultural Competence' training package on at least 2 yearly basis.

2023-2024
GMEC LMNS to agree and commission a cultural competency training package, delivered face-to-face in all maternity providers to complement e-learning.

2022-2027
Deaneries, Midwifery and Nursing undergraduate course leads to consider the curriculum in relation to decolonisation, equity, diversity and equality. This should Incorporate focused lectures and problem-based learning activities on unconscious bias, allostatic load, systemic racism; inclusive terminology, obstetric, medical and surgical complications relating to ethnicity (Sickle cell, Thalassemia, Fibroids etc) and learning around cultural safety and what it means to be a culturally safe practitioner.

2022-2024
Deaneries, Midwifery and Nursing undergraduate course leads should gain an understanding of the experience of students from minority ethnic groups, in particularly those from Black, Asian and Mixed race ethnicity, in relation to clinical practice and feed this back through to the clinical learning environment.

2022-2026
Internal provider training should take the opportunity to increase awareness of the evidence relating to poor maternal and neonatal health outcomes, including obstetric, medical and surgical complications that can affect women/people and babies from ethnic backgrounds (e.g. Sickle cell, Thalassemia, Fibroids etc), either by embedding the information within existing training packages or held as a separate information sharing event. Feedback from these groups should be used to support the content of the training.

2022-2024
GMEC maternity services to produce a maternity-specific handbook to raise awareness of how common conditions of pregnancy can present differently on darker skin tones in order to improve assessment, diagnosis and treatment of Black, Brown and Mixed Ethnicity maternity service users and create a manual of images of commonly presenting medical conditions on darker skin tones ('Mind the Gap').

2022-2025
HEIs to collate and use imagery of pregnancy and birth within specific ethnic groups to improve diversity, avoid the pathologizing of Black and Brown bodies and that White bodies are not solely used as the norm in midwifery education and use appropriate teaching aids.

Intervention 32

Address concerns raised by the findings of the Workforce Race Equality Standards (WRES) in maternity and neonatal services

Rationale

It is evident that GMEC maternity providers have significant gaps in data when it comes to data and experiences relating to the maternity workforce with an ethnic minority background.

The ethnic population in Greater Manchester has increased to 21% and HEI student intakes need to reflect these changes in future yearly estimated trajectories.

A Local GMEC survey has given some insight into WRES indicators 2-4, highlighting that recruitment bias is a concern for ethnic minority midwives & neonatal nurses within our LMNS.

Staff experience highlights that this group of staff are more likely to face formal disciplinary procedures across both midwifery and neonatal nursing fields. The most significant and consistent finding was the lack of support in non-mandatory CPD. Further monitoring and exploration of staff experience is required, along with measures to help improve the diversity of our workforce, support them to remain in our workforce and to progress.

Groups that will benefit the most

Black, Asian and Mixed ethnic groups, including staff

We aim to support our staff from a minority ethnic background to join our services, to remain with us and to flourish.

Getting in

2022-2023
To identify maternity and neonatal workforce data in relation to the WORKFORCE RACE EQUALITY STANDARDS (WRES) indicators 1-4 for staff from an ethnic background compared to White staff from all maternity and neonatal providers which will form an accurate baseline of the workforce from an ethnic background within GMEC.

2023-2024
To analyse the annual data from the WRES indicators 1 – 4. Outputs from the analysis to be discussed at Maternity Programme Group/HoM's meetings.

2022-2024
Develop an infographic for all Trusts within the GMEC to enable them to annually capture and share the WRES indicators 1-4 for the maternity and neonatal workforce (including clinical, support staff, non-clinical and medical staffing).

2023-2027
Encourage volunteers from existing staff and retired workforce to attend career workshops, open days etc, to role model and encourage young people with a minority ethnic background to consider a career in midwifery/children's nursing/health visiting. Utilise images that represent a diverse workforce during these sessions.

2023-2025
Work with HEIs to address recruitment bias/ examine factors that can act as a barrier for applicants from Black, Asian or other ethnic minorities. Ensure midwives are included on University recruitment panels.

2023-2026
HEI student intake and lecturing staff should, where possible, reflect the local population.

Staying in

2023-2024
GMEC LMNS to work with HEIs, VCSE organisations and maternity providers to develop and commission a local mentoring scheme that will support midwifery undergraduate students and lecturers from minority ethnic groups in the academic and clinical/placement environment and on initial recruitment within GMEC.

2023
Establish a GMEC LMNS quarterly forum for maternity and neonatal staff from a minority ethnic background (with provider support to attend).

2023-2024
Commission an annual survey of maternity and neonatal staff from a minority ethnic background. Survey to include feedback on obstacles to career progression.

2022-2025
Representation of staff from a minority ethnic background, supported by appropriate training, on disciplinary panels.

2024-2025
HEI's to inform the GMEC LMNS on a bi-annual basis of the attrition rates and reasons that midwifery/children nursing/health visiting students from a minority ethnic background are leaving undergraduate education.

2023-2027
Providers to access organisational, regional and national programmes that support staff wellbeing, taking into account different cultural and religious values.

Getting on

2022-2024
Representation of staff from Black, Asian and Mixed ethnic background, supported by appropriate training on recruitment panels for senior posts and trusts signed up to the GM Positive Action Programme to consider holding a percentage of positions in order to increase diversity.

2022-2027
LMNS and provider comms to consider a balanced representation of the workforce in publications (staff newsletters etc).

2022-2027
LMNS to support the development of the Greater Manchester Health and Care Workforce Collaborative People and Culture Strategy.

Priority 4e

Enablers

Accelerate preventative programmes that engage those at greatest risk of poor health outcomes

Work with System partners and the VCSE sector to address the social determinants of health

Include actions from GM Build Back Fairer; GM Population Health Plan; GM Poverty Strategy

Intervention 33

Establish community hubs in the areas with the greatest maternal and perinatal health needs

Rationale

The GMEC analysis of our population demonstrated that a third of children in GM are living in poverty; and babies and young children in Black, Asian and Mixed race families and those living in deprivation experience disproportionately poor health and educational outcomes. Care and support is often fragmented and difficult to navigate for the most disadvantaged and vulnerable families and a whole-system approach is required for families to access the help they need.

Groups that will benefit the most

- Families affected by income deprivation
- Groups living in lowest deprivation decile
- Diverse communities

2022-2024
Create Family hubs in those localities in GM that are eligible according to Deprivation Indices.

2022-2027
Establish a multiagency working group (with multi-sectoral representation) to the delivery of Family hubs and the Start for Life programme. Across Greater Manchester.

2022-2027
To ensure the service offer in those areas not eligible for Family hub funding is aligned with national standards and guidance, sharing learning from other hub areas and wider partners.

2022-2025
Agree a minimum service offer regarding maternity in each of the Family hubs.

2022-2025
Each Family hub to develop services to meet the needs of the local population, for example, offering culturally sensitive services within the hub in areas with high levels of diversity.

Intervention 34

Promote multi-agency working to support Early Years child development, including access to information platforms for women/people, dads/partners families and available to maternity services when planning personalised care

Rationale

A critical aspect of the Early Years programme in Greater Manchester will be the development of a multi-agency workforce, with standardised skills and knowledge, using a common language and philosophy that supports families and child development in a seamless way.

Groups that will benefit the most

- Those living in deprived areas
- Black, Asian and Mixed ethnic groups
- Those with sight or hearing loss and/or learning disabilities

2022-2025
Explore digital solutions to harness information that will support pregnant women/people, fathers, partners and families across the Perinatal and Early Years period.

2022-2027
Rollout of Essential Parent platform to relevant localities, to provide parents with information that supports the perinatal journey and Early Years development.

2022-2025
An Early Years Workforce Competency Framework to be shared with maternity staff (such as community midwives) to encourage self-assessment and knowledge relating to Early Years support and relational multi-agency practise. The competencies should include the development needs of children who have had an admission to a neonatal unit.

2023-2026
The results from maternity self-assessments against the Early Years Competency framework are fed into the LMNS in order to influence workforce development.

2022-2025
Review the enhanced support model for Early Years/Maternity services in Stockport. Findings will support a rollout to other areas, improving outcomes for children growing up in deprived areas.

2022-2026
Commissioners and antenatal education providers will deliver an integrated and standardised antenatal education offer across GMEC, utilizing the whole system and engages hard to reach communities with targeted and universal offers.

2023-2024
Implement the Family Integrated Care Model and philosophy in all GMEC neonatal units.

2023-2027
Maternity services need to align with the GM 'Thrive' model to underpin early years development and the potential for children in GM to flourish.

Intervention 35

Continue to co-produce maternity with system partners and the VCSE sector to address the social determinants of health

Rationale

NICE guidance for community engagement (NG44) stipulates that services should ensure local communities, community and voluntary sector organisations and statutory services work together to plan, design, develop, deliver and evaluate health and wellbeing initiatives.

The success of the GMEC Equity and Equality Action Plan is dependent on a sustainable and long-term whole system investment in Population Health as a whole in GMEC.

Improved collaborative working between maternity services and other sectors is equally important, particularly in utilising the third sector to achieve a holistic, individualised approach to maternity care that will have a positive impact on health.

Groups that will benefit the most

- Families affected by income deprivation
- Groups living in lowest deprivation decile
- Diverse communities

2022-2027
Share GM Population Analysis with relevant partners, MVPs and VCSE organisations, with a view to co-producing actions to address inequality and provide additional support to the implementation of the E&E action plan.

2022-2027
GMEC LMNS to work with GM ICS Population Health/ VCSE panel to support the maternity offer.

2024-2027
GMEC LMNS will work with the GM ICS Population Health Team, localities and the ICS to coordinate preconception care, utilising VCSE organisations to target specific groups, for example, using faith and social groups to communicate key messages and raise awareness of measures that improve maternity outcomes.

2023-2027
GMEC LMNS to work with GM ICS Population Health team to identify and agree funding for VCSE organisations to target those most in need in order to tackle health inequalities. For example, providing information and raising awareness about early access to maternity services, screening, infant feeding and vaccination.

2023-2027
GMEC LMNS to work with GM ICS Population Health team to work alongside Social Prescribing providers to enhance the maternity offer, for example utilising link workers based in the locality to provide social support to those with perinatal mental ill health.

Priority 5

Strengthen leadership and accountability

Intervention 36

Strengthen leadership and accountability

Rationale

The development and implementation of the GMEC Equity and Equality Plan is dependent on the support and approval of the LMNS and ICS. A key aspect of success for the GMEC LMNS is to secure strong leadership. A number of new and emerging leaders have joined our maternity services over the last year and we aim to support and develop that leadership, whilst looking to the future and nurturing aspiring leaders.

We aim to area of the plan is to improve equality for staff from an ethnic background. In the initial analysis (priority 4a: Understanding your population), WRES data found little representation of Black and Asian staff from Band 7 onwards in GMEC and positive action is required to address this imbalance.

Staff from minority ethnic background told us they had experienced discrimination at work from managers and other colleagues, more so than their White counterparts.

We aim to create an environment for staff to have a clear voice and advocacy.

Groups that will benefit the most

- Quadrumvirate, Clinical Leads, Director and Heads of Midwifery
- Aspiring leaders
- Staff from an ethnic background
- Perinatal service users
- Midwifery Higher Education workforce

2022-2023
GMEC maternity services to nominate the perinatal quadrumvirate to attend the national leadership programme.

2022-2023
Deliver a GMEC programme for the development of, Directors and Heads of Midwifery.

2022-2027
Identify leadership opportunities for aspiring leaders within GMEC, focussing on encouraging staff from an ethnic background within the maternity and neonatal workforce.

2023-2025
Labour ward co-ordinators will attend a fully funded and nationally recognised education programme.

2023-2027
Facilitate opportunities for midwifery staff to move into education roles, including mixed clinical/ academic roles.

2022-2023
Ensure robust governance within the LMNS and into the ICB, delivering the GM programme. Provide assurance to the system regarding implementation of national recommendations, investment into maternity services and the safety of maternity services offered to the GMEC population.

2023-2024
LMNS and ICS to explore opportunities to strengthen workforce capability, culture and system leadership, as part of the development programme in the Build Back Fairer strategy and the GM Population Health Characteristics Framework.

2023-2027
Develop a GMEC framework for a mentoring programme for midwives from Black, Asian and Mixed ethnicities to encourage continuation of studies and employment in midwifery, and increased promotion into leadership roles.

2023-2025
Ensure executive and Trust Board awareness of service user survey findings by ethnicity to inform future planning and any recommended actions to be taken.

Next steps

1

We plan to establish an Equity and Equality working group for the implementation phase.

2

We will invite key partners to work with us, including strong representation from our service users, voluntary organisations and community and faith groups to support the work over the next 5 years.

3

We will provide regularly updates to the LMNS, ICB and regionally to demonstrate our progress.

Acknowledgements

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