NHS

Equity and equality
Guidance for local maternity systems

September 2021

Contents

Foreword

Equity means that all mothers and babies will achieve health outcomes that are as good as the groups with the best health outcomes. For this, maternity and neonatal services need to respond to each person's unique health and social situation – with increasing support as health inequalities increase – so that care is safe and personal for all. This will help us ensure that England is the safest place to be pregnant, give birth and start parenthood.

The MBRRACE-UK reports about maternal and perinatal mortality show worse outcomes for those from Black, Asian and Mixed ethnic groups and those living in the most deprived areas. This guidance seeks to respond to those findings. In doing so, it is important to consider the strong evidence highlighted in the NHS People Plan that "…where an NHS workforce is representative of the community that it serves, patient care and…patient experience is more personalised and improves". If equity for mothers and babies is to improve, so must race equality for staff.

Maternity and neonatal services contribute to the health, wellbeing and socioeconomic development of the nation. Good health in pregnancy significantly influences a baby's development in the womb which, in turn, influences long-term health and educational outcomes.[1] By giving every child the best start in life, we will help them fulfil their health, wellbeing and socioeconomic potential.

NHS staff, Maternity Voices Partnerships (MVPs), the voluntary community and social enterprise (VCSE) sector and others are doing incredible work to improve equity and equality, as the case studies in this guidance show. Thank you all.

Yet, if we are to achieve equity, even more needs to be done to address the social determinants of health. The NHS Long Term Plan (p33) makes clear that the public, private and third sector need a greater focus on the social determinants of health.

This guidance has been developed by examining the evidence and consulting MVPs, staff, royal colleges, arm's length bodies, government, the VCSE sector and others.

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[1] Marmot M, Goldblatt P, Allen J, et al (2010) Fair Society Healthy Lives (The Marmot Review)

Thank you to all those who have contributed; your input has made this work all the stronger.

This guidance is for Local Maternity Systems. Its structure reflects the five health inequalities priorities described in the [2021/22 priorities and operational planning guidance: Implementation guidance](#), and therefore helps Local Maternity Systems align their Equality & Equality Action Plans with the health inequalities work of Integrated Care Systems. This guidance includes an analysis of the evidence, interventions to improve equity and equality, resources, indicators and metrics.

Alongside this guidance is published [NHS pledges to improve equity for mothers and babies and race equality for staff](#). Four pledges help create a shared understanding of why work on equity and equality is needed, and the aims and outcomes of this work. The four pledges may be used in co-production work – where women and their families and NHS staff work in partnership to design, improve and evaluate services.

Everyone can help to achieve our equity and equality aims. Let's commit to work together to improve equity for mothers and babies and race equality for NHS staff.

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1. Introduction

Equity means that all groups in society can achieve health outcomes that are as good as those for the most socially advantaged group.[2] Addressing inequities requires action on the social determinants of health as well as the health determinants.[3] Therefore, the NHS cannot achieve equity in health outcomes alone – it needs support from the public, private and third sectors.

The Marmot review called for action to be universal, but with a scale and intensity proportionate to the level of disadvantage; this is known as 'proportionate universalism'. To do this maternity and neonatal services need to respond to each person's unique health and social situation – with increasing support as health inequalities increase – so that care is safe and personal for all.

The review underlines how important maternal health is to fetal development. Low birth weight is associated with poorer long-term health and educational outcomes. This guidance aims to give each child the best start in life to help them fulfil their health, wellbeing and socioeconomic potential.

The government's national maternity safety strategy sets out an ambition, by 2025, to halve rates of stillbirths, neonatal and maternal deaths and brain injuries during or soon after birth and to reduce the rate of preterm births from 8% to 6%. To achieve the 'halve it' ambition, it is important to improve outcomes for those groups most at risk.

Maternity features in NHS England and NHS Improvement's health inequalities action plan, chapter 2 of The NHS Long Term Plan and Implementing phase 3 of the NHS response to the COVID-19 pandemic. The COVID-19 pandemic had a greater impact on pregnant women from ethnic minority groups, and the NHS took four specific actions to minimise the additional risk of COVID-19 for them.

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[2] Braveman P, Gruskin S (2003) Defining equity in health. *J Epidemiol Community Health* 2003; 57: 254-8.
[3] World Health Organization (2020) Equity

What the data say

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.[4] The maternal mortality rate is lower now than in 2010, although more recently progress has stalled.[5] However, the MBRRACE-UK reports about maternal and perinatal mortality show disparities in outcomes for women from Black, Asian and Mixed ethnic groups and their babies and women living in the most deprived areas and their babies.

Maternal and perinatal mortality in the UK in 2018*

	Ethnic group				Quintiles of deprivation	
	Black	**Asian**	**Mixed**	**White**	**Most deprived**	**Least deprived**
Maternal mortality rate per 100,000 maternities[4]	34.27	14.65	25.14	7.87	15.27	5.70
Number of maternal deaths 2016–18	28	28	8	117	74	15
Relative risk of maternal death	x4	x2	x3	Reference	x3	Reference
Stillbirths per 1,000 total births[6]	7.35	5.31	4.25	3.39	4.68	2.61
Ratios of mortality rates for stillbirth	2.17	1.57	1.25	Reference	1.79	Reference
Neonatal mortality rate per 1,000 live births[6]	2.39	2.63	1.56	1.65	2.2	1.23
Ratios of mortality rates for neonatal death	1.45	1.59	0.94	Reference	1.79	Reference

* For maternal mortality, quintiles of deprivation are for England only.

[4] Office for National Statistics (2021) Child and infant mortality in England and Wales: 2019.
[5] Knight M, Bunch K, Tuffnell D, Shakespeare J, Kotnis R, Kenyon S, Kurinczuk JJ (eds) on behalf of MBRRACE-UK (2020) Saving lives, improving mothers' care – Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18. Oxford: National Perinatal Epidemiology Unit, University of Oxford.
[6] Draper ES, Gallimore ID, Smith LK, Fenton AC, Kurinczuk JJ, Smith PW, et al, on behalf of the MBRRACE-UK Collaboration (2020) MBRRACE-UK Perinatal Mortality Surveillance Report, UK Perinatal Deaths for Births from January to December 2018. Leicester: The Infant Mortality and Morbidity Studies, Department of Health Sciences, University of Leicester.

Women's experience of maternity care is improving and there are no significant differences in the experience of maternity care by ethnicity, index of multiple deprivation or a range of other factors.[7] The NHS is working to continue to improve women's experience.

The NHS People Plan notes that "there is strong evidence that where an NHS workforce is representative of the community that it serves, patient care and the overall patient experience is more personalised and improves". Workforce Race Equality Standard (WRES) data shows that people from ethnic minorities are significantly more likely to be nurses, midwives and health visitors compared to their representation in the population, yet they are under-represented in senior Agenda for Change pay bands across the NHS.

Aims and values

Our two aims relating to equity and equality for maternity and neonatal care are to improve:

- equity for **mothers and babies** from Black, Asian and Mixed ethnic groups and those living in the most deprived areas
- race equality **for staff**.

We will be guided by three values:

Value	Rationale	Source
Proportionate universalism	To 'raise and flatten' the inequalities gradient, universal action is needed with a scale and intensity that reflects need.	Marmot review 2020
Collaboration	Achieving equity will require unity and co-ordinated effort across many stakeholders, especially to tackle the social determinants of health.	NHS Constitution Health and Care White Paper
Co-production	Interventions are more likely to be culturally and socially relevant and clinically effective if parents and staff work in partnership to improve clinical quality.	Better Births NHS Constitution

[7] Care Quality Commission (2020) 2019 survey of women's experiences of maternity care.

2. Five priorities

COVID-19 has highlighted the urgency of the need to prevent and manage ill health in groups that experience health inequalities, as outlined in the NHS Long Term Plan. To help achieve this, NHS England and NHS Improvement issued guidance as part of their phase 3 response to the COVID-19 pandemic, setting out eight urgent actions for tackling health inequalities.

The 2021/22 priorities and operational planning guidance: Implementation guidance asked systems to focus on five priority areas, distilled from the eight actions.

- Priority 1: Restore NHS services inclusively
- Priority 2: Mitigate against digital exclusion
- Priority 3: Ensure datasets are complete and timely
- Priority 4: Accelerate preventative programmes that engage those at greatest risk of poor health outcomes
- Priority 5: Strengthen leadership and accountability.

The NHS will improve equity and equality in maternity and neonatal care, aligned to the five priorities. Each priority will be realised through a set of underlying interventions implemented by all or selected local maternity systems (LMS), for example, some NHS Long Term Plan interventions are being scaled-up over time.

Different populations have different risk and protective factors. Therefore, different approaches are needed for different populations: one size does not fit all. Each intervention specifies the populations that will most benefit from it – with a focus on mothers and babies from Black, Asian and Mixed ethnic groups and mothers living in the most deprived areas. It should be noted that ethnicity is confounded by deprivation: a higher proportion of live births within the Asian and Black ethnic groups are in the most deprived areas compared with the White ethnic group.[8]

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[8] Office for National Statistics (2021) Births and infant mortality by ethnicity in England and Wales: 2007 to 2019.

The effective use of data is central to tackling health inequalities. Priorities 1, 3 and 4 have associated process and outcome indicators, the data for most of which (30 of the 40) can be sourced from existing datasets or collections.

Summary tables describe each priority and its associated interventions, along with process and outcome indicators. These tables are followed by the rationale for each intervention and information to help LMS with implementation. Case studies highlight work underway to improve equity and equality; they appear in blue boxes throughout this guidance.

Priority 1: Restore NHS services inclusively

Description		
At national level, the decline in access among some groups during the first wave of the pandemic broadly recovered in later months. Some pre-existing disparities in access, experience and outcomes have widened during the pandemic.		
Interventions	**Implementation**	**Groups who will benefit most**
Intervention 1: continue to implement the **COVID-19 four actions.**	All LMS	Black, Asian and Mixed ethnic groups
Continuous quality improvement		
Support is available, through the MatNeoSIP, from your Patient Safety Network. To find out how to join yours, email nhsi.maternalandneonatalsafety@nhs.net		
Process indicators	**Outcome indicators**	
Implementation of the COVID-19 four actions	Women using folic acid (source: Regional Measures Report)	

Rationale and implementation

COVID-19 four actions: 56% of the pregnant women admitted to hospital with COVID-19 were from ethnic minority groups, even though they only make up a

quarter of those giving birth in England and Wales.[9] Maternity units in England were asked to take [four actions to minimise the additional risk of COVID-19 to pregnant women and their babies from ethnic minorities](#):

1. Increase support for at-risk pregnant women – for example, make sure clinicians have a lower threshold to review, admit and consider multidisciplinary escalation in women from ethnic minority groups.

2. Reach out and reassure pregnant BAME women with tailored communications.

3. Ensure hospitals discuss vitamins, supplements and nutrition in pregnancy with all women. Women low in vitamin D may be more vulnerable to coronavirus so women with darker skin or those who always cover their skin when outside may be at particular risk of vitamin D insufficiency and should consider taking a daily supplement of vitamin D all year. Folic acid can help prevent certain birth defects, including spina bifida; it's recommended that women take a 400 micrograms folic acid tablet every day before pregnancy and until 12 weeks of pregnancy[10].

4. Ensure all providers record on maternity information systems the ethnicity of every woman, as well as other risk factors, such as living in a deprived area (postcode), co-morbidities, BMI and aged 35 years or over, to identify those most at risk of poor outcomes.

Support available includes:

*   the [Help Us Help You maternity campaign](#), which promotes access to care for ethnic minority pregnant women in various languages
*   [leaflets for parents of newborn babies in 11 languages](#)
*   a [communications toolkit for local maternity teams to improve communications with women from ethnic minority groups](#).

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[9] Knight M, Bunch K, Vousden N, Morris E, Simpson N, Gale C, et al. Characteristics and outcomes of pregnant women admitted to hospital with confirmed SARS-CoV-2 infection in UK: national population based cohort study. *BMJ* 2020; 369: m2107 DOI:10.1136/bmj.m2107.
[10] nhs.uk (2021) Vitamins, supplements and nutrition in pregnancy. Available at: https://www.nhs.uk/pregnancy/keeping-well/vitamins-supplements-and-nutrition/

Resources

- Royal College of Obstetricians and Gynaecologists (RCOG) Coronavirus (COVID-19) infection and pregnancy

Priority 2: Mitigate against digital exclusion

Description
Systems are asked to ensure that: • providers offer face-to-face care to patients who cannot use remote services • more complete data collection is carried out, to identify who is accessing face-to-face, telephone or video consultations, broken down by relevant protected characteristic and health inclusion group • they take account of their assessment of the impact of digital consultation channels on patient access.

Interventions	Implementation	Groups who will benefit most
Intervention 1: ensure **personalised care and support plans (PCSPs)** are available in a range of languages and formats, including hard copy PCSPs for those experiencing digital exclusion	All LMS	Those living in deprived areas; those with sight or hearing loss and/or learning disabilities

Continuous quality improvement
Support is available, through the MatNeoSIP, from your Patient Safety Network. To find out how to join yours, email nhsi.maternalandneonatalsafety@nhs.net

Process indicators	Outcome indicators
• The number of women with a Personalised Care and Support Plan which covers: ○ antennal care by 17 weeks gestation ○ intrapartum care by 35 weeks gestation ○ postnatal care by 37 weeks gestation	None.

• The numbers of women who had all three of the above in place by the gestational dates All indicators are available with breakdowns by ethnicity and index of multiple deprivation (source: MSDS)	

Rationale and implementation

Personalised care and support plans (PCSPs): The NHS Long Term Plan asks integrated care systems (ICS) to implement PCSPs in maternity services. This tool supports and documents the conversations and decision-making process from which an agreed plan is developed that reflects an holistic assessment of the woman's health and wellbeing needs. The PCSP should set out a woman's decisions about the care and support she wants. Women need evidenced-based information in advance of decision-making so that they are well prepared.

Better Births states that digital tools should leave nobody behind. Reasons for digital exclusion include that people are unable to afford sufficient data or because of telecommunications infrastructure issues (the government's broadband plan aims to maximise coverage in the areas of greatest need by 2025). The personalised care and support planning guidance states that the PCSP, both digital and hard copy, should be available in a range of languages and formats.

Priority 3: Ensure datasets are complete and timely

Description
Systems are asked to continue to improve the collection and recording of ethnicity data. NHS England and NHS Improvement will support the improvement of data collection, including through the development of the health inequalities improvement dashboard.

Interventions	Implementation	Groups that will benefit most
Intervention 1: on maternity information systems continuously improve the **data quality** of ethnic coding and the mother's postcode.	All LMS	Ethnic minority groups; those living in deprived areas

Continuous quality improvement	
Support is available, through the MatNeoSIP, from your Patient Safety Network. To find out how to join yours, email nhsi.maternalandneonatalsafety@nhs.net	
Process indicators	**Outcome indicators**
• Safety action 2, category 9: data submitted to Maternity Services Data Set (MSDS) contains valid postcode for mother at booking in 95% of women booked in the month. • Ethnicity data quality (source: Regional Measures Report). • Safety action 2, category 10: data submitted to MSDS includes a valid ethnic category for at least 80% of the women booked in the month. Not stated, missing and not known are not valid records.	None.

Rationale and implementation

Data quality: recording ethnicity and postcode data at booking helps clinicians and LMS understand how health outcomes vary by geographical area and ethnicity. Services can then identify and prioritise those groups with poorer health outcomes for whom service improvements are needed.

NHS Resolution's Maternity Incentive Scheme supports the delivery of safer care by giving trusts a significant financial incentive to achieve 10 safety actions. Safety action 2 supports data quality improvement.

Priority 4: Accelerate preventative programmes that engage those at greatest risk of poor health outcomes

The Maternity Transformation Programme is one of the preventative programmes that are engaging those at greatest risk of poor health outcomes, as set out in the 2021/22 priorities and operational planning guidance.

This priority is divided into five sub-priorities:

- 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.

4a: Understand your population and co-produce interventions

Description		
• Understand the local population – its health outcomes and community assets. • Understand staff experience, using Workforce Race Equality Scheme data. • Use this understanding to plan co-production activity to design interventions to improve equity for women and babies and race equality for staff.		
Interventions	**Implementation**	**Groups that will benefit most**
Intervention 1: understand the local population's maternal and perinatal health needs (including the social determinants of health).	All LMS	Black, Asian and Mixed ethnic groups; those living in the most deprived areas; other protected characteristic and inclusion groups
Intervention 2: map the community assets which help address the social determinants of health.	All LMS	As above
Intervention 3: conduct a baseline assessment of the **experience of maternity and neonatal staff by ethnicity** using WRES indicators 1 to 8.	All LMS	Ethnic minority staff
Intervention 4: set out a plan to co-produce interventions to improve equity for mothers, babies and race equality for staff.	All LMS	Black, Asian and Mixed ethnic groups; those living in the most deprived areas; other protected characteristic and inclusion groups

There are no process or outcome indicators for this sub-priority.

Rationale and implementation

Local maternity transformation plans in 2017 included **an understanding of the local population and what it needs from maternity services**, in line with Implementing Better Births: A resource pack for local maternity systems, which stated: "…the local joint strategic needs assessment will bring together relevant information, as will the latest strategic needs assessment for maternity care and relevant other service areas…Local maternity systems will want to consider the population profile, physical factors, for example, transport, health, deprivation and disability, the needs of culturally diverse communities and areas of multiple deprivation".

It is time to review and refresh the population needs analysis for maternity services. The refresh should include an analysis by ethnic group (particularly Black, Asian and Mixed ethnic groups) and those living in the most deprived areas. LMS should consider other protected characteristics and inclusion groups where local data and/or intelligence indicates health inequalities are present.

The population needs analysis for maternity services should consider data from the:

- Regional Measures Report (include all equity measures as a minimum)
- maternity services dashboard
- Perinatal Mental Health Dataset
- Public Health England (PHE) fingertips profiles for child and maternal health and perinatal mental health
- operational delivery network implementation plans for the Neonatal Critical Care Transformation Review (background and local context section)
- National Maternity & Perinatal Audit, Sprint audits
- MBRRACE-UK Perinatal Mortality Surveillance Report. UK perinatal deaths for births from January to December 2018
- Perinatal Mortality Review Tool (PMRT)

- [Health Safety Investigation Branch](#) investigation reports
- [Serious Incident](#) two working day reports and final reports
- CQC [Maternity services survey](#)
- baseline data for the process and outcome indicators set out in priorities 1, 3 and 4b–d of this document
- local data for other protected characteristics and inclusion groups.

Support to carry out this analysis is available from ICS, [PHE's local centres](#) and local public health teams (including through the [Joint Strategic Needs Assessment](#)).

An **assets approach** seeks to reduce health inequalities by building on the strengths and resources in a community. A growing body of 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".[11]

Health assets are factors or resources that enhance health and wellbeing. They can be 'social capital' (networks, friendships, faith-based groups); public, private and third sector resources that support communities; physical and economic resources (such as buildings and employment); or the skills, knowledge and capacity of residents.

The principles of a health assets approach include:

- value what works well in an area
- identify what has the potential to improve health and wellbeing
- promote relationships which provide care, mutual help and empowerment
- make these community assets visible
- co-produce health and wellbeing with citizens and communities
- empower communities to control their futures and create resources.

Asset mapping is the process of identifying these assets and collating the links between the community and the agencies. Sub-priority 4e: intervention 2 – address the social determinants of health – suggests assets that might be included. The assets map should be readily available to and searchable by healthcare

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[11] Local Government Association (2021) [An asset approach to community wellbeing – glass half full](#)

professionals to support personalised care and planning. It does not need to be in map form.

Workforce Race Equality Standard (WRES): human resources departments can provide WRES data for maternity and neonatal services. The data can be used to identify priorities for action and inform staff engagement processes which aim to improve the experience of staff from ethnic minority groups. For more information see sub-priority 4d: intervention 3.

Co-production "is a way of working that involves people who use health and care services, carers and communities in equal partnership; and which engages groups of people at the earliest stages of service design, development and evaluation. [It] acknowledges that people with 'lived experience'…are often best placed to advise on what support and services will make a positive difference to their lives".[12]

Co-production with ethnic minority communities: NICE quality standard (QS) 167 considers how to promote health and prevent premature mortality among ethnic minority groups. It is relevant to all age groups and all settings. Quality statement 1 asks care providers to "[involve] people, community organisations and faith leaders who can represent the views of local ethnic minority groups…to ensure that…services reflect the needs and preferences of the local population".

Co-producing obstetric care for underserved communities

Noticing that some women who have experienced female genital mutilation were reluctant to access medical care, Dr Alison Wright, Consultant Obstetrician and Gynaecologist, spoke to women at a Somali community centre. Alison listened to their concerns and provided reassurance. "It was an important first step" says Alison, "but took a further visit with a colleague to build trust with the women and for them to talk freely. We had to be patient and genuinely listen to their concerns so that women felt confident to attend clinics".

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[12] NHS England and NHS Improvement (2021) Co-production resources.

Co-production with women with complex social factors: [NICE clinical guideline (CG) 110](#) states that:

- "Commissioners should ensure that women with complex social factors presenting for antenatal care are asked about their satisfaction with the services provided; and the women's responses…guide service development". (paragraph 1.1.3)
- "Commissioners should involve women and their families in determining local needs and how these might be met". (paragraph 1.1.4)

Co-producing care for women with complex social factors

To understand how well maternity services were addressing the needs of women with complex social factors, North Central London Local Maternity and Neonatal System asked for help from the charity [Birth Companions](#). It and its [Lived Experience Team](#), which includes women who are trained and supported to help services improve care, worked with:

- **Safeguarding leads and specialist midwives** to understand how each hospital trust identifies women with complex social factors and how its services respond. The information will feed into an LMS-wide strategy focused on disadvantaged groups.
- Four **MVPs**. MVP lay chairs were trained in trauma-informed co-production and helped to establish a network to share learning. Chairs were given one-to-one and group support and changes identified, such as holding some meetings in the community instead of hospital sites and involving local voluntary sector agencies to support better engagement.

The co-production plan will outline the activity to co-produce interventions to improve equity for mothers, babies and race equality for staff. It can be a simple list of dates, meetings, groups to be consulted and the time allocated for the consultation discussion. This allows flexibility in where co-production takes place: at dedicated meetings, through existing meetings and/or outreach activities. The groups consulted should reflect those experiencing the greatest health inequalities, as described in the population health needs assessment (sub-priority 4a: intervention 1).

The VCSE sector and MVPs can help identify parents and communities who can support co-production work. When working with service user voice representatives LMS should ensure that any out-of-pocket expenses such as travel and childcare are reimbursed and consider offering an involvement payment where appropriate (in accordance with local and/or national guidance).

Alongside this guidance is published [NHS pledges to improve equity for mothers and babies and race equality for staff.](#) Four pledges help create a shared understanding of why work on equity and equality is needed, the aims and outcomes of this work. The four pledges can help 'set the scene' in local co-production work.

As well as women and babies from Black, Asian and Mixed ethnic groups and those living in the most deprived areas, LMS may wish to consider those from other protected characteristic or inclusion groups where local data and/or intelligence indicates significant health inequalities are present.

Resources

- NHS England and NHS Improvement [The Equality and Health Inequalities Hub](#)
- PHE [Health Equity Assessment Tool (HEAT)](#)
- Improvement & Development Agency [A glass half-full: how an asset approach can improve community health and well-being](#)
- NHS England and NHS Improvement [NHS pledges to improve equity for mothers and babies and race equality for NHS staff](#)
- NHS England and NHS Improvement [Working with our Patient and Public Voice Partners – Reimbursing expenses and paying involvement payments](#)
- Picker and The King's Fund [Understanding integration: how to listen to and learn from people and communities](#)
- NHS England and NHS Improvement [Involving people in health and care guidance](#)
- National Maternity Voices [co-creation ideas](#)
- NHS England and NHS Improvement [Working with seldom heard groups](#)
- Department for Communities and Local Government [Ensuring a level playing field: funding faith-based organisations to provide publicly funded services](#)

4b Action on maternal mortality, morbidity and experience

Description
LMS are asked to ensure equity in access, experience and health outcomes for women from Black, Asian and Mixed ethnic groups and those women living in the most deprived areas. They may consider other protected characteristics and inclusion groups.

Interventions	Implementation	Groups that will benefit most
Intervention 1: implement **maternal medicine networks** to help achieve equity.	All LMS	Black, Asian and Mixed ethnic groups; those living in the most deprived areas
Intervention 2: offer referral to the **NHS Diabetes Prevention Programme** to women with a past diagnosis of gestational diabetes mellitus (GDM) who are not currently pregnant and do not currently have diabetes.	All LMS	Black African, Black Caribbean and South Asian ethnic groups
Intervention 3: implement **NICE CG110** antenatal care for pregnant women with complex social factors.	All LMS	Pregnant women with complex social factors
Intervention 4: implement **maternal mental health services** with a focus on access by ethnicity and deprivation.	Selected LMS until March 2022 All LMS from April 2022	Black African, Asian and White other ethnic groups; those living in the most deprived areas
Intervention 5: ensure **personalised care and support plans** are available to everyone.	All LMS	Black, Asian and Mixed ethnic groups; those living in the most deprived areas
Intervention 6: ensure the **MVPs** in your LMS reflect the ethnic diversity of the local population, in line with NICE QS167.	All LMS	Black, Asian and Mixed ethnic groups

Continuous quality improvement	
Support is available, through the MatNeoSIP, from your Patient Safety Network. To find out how to join yours, email nhsi.maternalandneonatalsafety@nhs.net	
Process indicators	**Outcome indicators**
• The Maternal Medicine Network is implementing the KPIs in the non-mandatory national service specification. They are broken down by level of deprivation of the mother's postcode and ethnicity • Booking at <70 days gestation (source: Regional Measures Report) • Proportion of women with complex social factors who attend booking by 10 weeks, 12+6 weeks and 20 weeks (source: Regional Measures Report) • For each complex social factor grouping, the number of women who: attend for booking by 10, 12+6 and 20 weeks; and attend the recommended number of antenatal appointments • % of parent members of the MVP who are from ethnic minority groups • % of women attending the booking appointment who are from ethnic minority groups (source: Regional Measures Report) • Ethnicity data quality (source: Regional Measures Report)	None

Rationale and implementation

Maternal mortality data by ethnicity is an unadjusted comparison – other characteristics will not have been accounted for. Having adjusted for nine factors – medical co-morbidities, maternal age, inadequate use of antenatal care, previous pregnancy problems, substance misuse, anaemia, diabetes, multiple pregnancy and unemployment – there is no significant difference in the risk of death from direct and

indirect causes between women from different ethnic groups.[13] Therefore, these factors should be considered when seeking to reduce health inequalities in maternal mortality rates between different ethnic groups.

Factors amenable to healthcare interventions and their contribution to maternal mortality (population attributable fractions, %)[13]

All seven risk factors combined	Pre-existing medical co-morbidities	Maternal age (30 years+)	Inadequate antenatal care	Previous pregnancy problems	Substance misuse	Anaemia	Unemployment
87	66	29	24	19	7	2	1

Pre-existing medical co-morbidities contribute to most maternal deaths. Interventions 1 and 2 seek to address this factor.

Under the NHS Long Term Plan, **maternal medicine networks** will be established so that by March 2024 every woman in England with medical problems has access to specialist advice and care. The model service specification includes key performance indicators (KPIs) relating to outcomes and equalities and requires that information and guidance is co-produced, culturally competent and delivered through accessible channels. The service should use the Health Inequalities Programme matrix to assess how well it is addressing health inequalities.

Gestational diabetes mellitus (GDM) occurs in about 5% of pregnancies. Women at high risk of developing GDM include those living with excess weight or obesity; those from Black African, Black Caribbean and South Asian ethnic groups;[14] and those living in areas with greater socioeconomic deprivation.[15] Women with a history of GDM are at high risk of developing GDM in subsequent pregnancies and Type 2 diabetes in future.

Where a woman is diagnosed with GDM, maternity services should inform her GP practice. Women with a history of GDM should be reviewed and offered testing for diabetes postnatally and subsequent annual checks (with a glycaemic test) by their

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[13] Nair M, Knight M, Kurinczuk JJ (2016) Risk factors and newborn outcomes associated with maternal deaths in the UK from 2009 to 2013: a national case–control study. _BJOG_ 123(10): 1654-62.
[14] Editorial (2019) Gestational diabetes in England: cause for concern. _Lancet_ 393(10178): 1262.
[15] NHS Digital (2019) National Pregnancy in Diabetes (NPID) Audit report 2018, p23.

GP practice as described in the NICE guideline [NG3] diabetes in pregnancy. Women with a past diagnosis of GDM who are not currently pregnant should be offered a referral to the NHS Diabetes Prevention Programme once a blood test has excluded Type 2 diabetes. These steps will help improve prevention and early detection of Type 2 diabetes.

Continuous glucose monitoring is available to pregnant women with Type 1 diabetes who meet certain criteria. The NHS Diabetes Programme will monitor the uptake of continuous glucose monitoring in pregnant women with Type 1 diabetes, with a particular focus on driving equality in uptake among people from ethnic minority groups and those living in the most deprived areas.

The next of the seven factors which is most amenable to healthcare intervention is **use of antenatal care**. NICE CG110 recommends that commissioners ensure that, for each complex social factor grouping, the numbers of women who attend for booking by 10, 12+6 and 20 weeks and attend for the recommended number of antenatal appointments are recorded. The guideline states: "Commissioners should ensure that women with complex social factors presenting for antenatal care are asked about their satisfaction with the services provided; and the women's responses are recorded…and used to guide service development".

MBRRACE-UK identified a group of women at **severe and multiple disadvantage**.[13] The main elements of multiple disadvantage are a mental health diagnosis (women with serious mental illness have a higher risk of obstetric near misses at the time of birth, emphasising the importance of integrated physical and mental healthcare before and during pregnancy for this group[16]), substance misuse and domestic abuse.

Maternal mental health services (referred to as maternity outreach clinics in the NHS Long Term Plan) bring together maternity, psychology and reproductive health services for women who develop moderate–severe mental ill health from loss or trauma due to their maternity experience. These services provide care and support to women whose needs would not be met by other services. When implementing maternal mental health services, LMS should consider the access to them by ethnicity and the level of deprivation of the mother's postcode, in partnership with the

[16] Easter A, Sandall J, Howard L (2021). Obstetric near misses among women with serious mental illness: Data linkage cohort study. *Br J Psychiatry* 1-7.

local perinatal mental health (PMH) team. The PMH dashboard provides access data by ethnicity and deprivation.

Personalised care and support plans (PCSPs): Better Births describes the principle of personalised care as centred on the woman, her baby and her family, based around her needs and decisions, where there has been genuine choice, informed by unbiased information. The NHS Long Term Plan asks ICS to implement PCSPs in maternity services. Personalised care and support planning guidance: Guidance for local maternity systems describes how to implement PCSPs, including the need for a risk assessment at every contact.

Maternity Voices Partnerships (MVPs): NICE QS167 asks that those from ethnic minority groups "…are represented in peer and lay roles within local health and wellbeing programmes ….[to] encourage uptake of services among groups that may otherwise be reluctant to get involved" and help design interventions that are relevant to the local population. MVP chairs and co-chairs already reflect the ethnic make-up of the wider population.[17] This webinar shows how MVPs can be safe spaces for all ethnic groups. NHS Resolution's maternity incentive scheme supports the delivery of safer maternity care; safety action 7 requires evidence that the MVP hears the voices of women from ethnic minority groups and those living in areas with high levels of deprivation.

Diverse Maternity Voices Partnerships

Find out what an MVP is and the importance of having a diverse membership to ensure high quality maternity care for every woman in this short film featuring Temi Bademosi and Rachael Bickley who co-chair Milton Keynes MVP.

Resources

- Royal College of Midwives Position statement: supporting midwives to address the needs of women experiencing severe and multiple disadvantage
- Birth Companions Making Better Births a reality for women with multiple disadvantages

[17] National Maternity Voices (2020) Diversity survey of MVP chairs Sept 2020

- NHS England and NHS Improvement [A good practice guide to support implementation of trauma-informed care in the perinatal period](#)
- PHE [Perinatal mental health](#)

4c Action on perinatal mortality and morbidity

Description
LMS are asked to address the leading causes of perinatal mortality and morbidity for babies from Black, Asian and Mixed ethnic groups and born to women living in the most deprived areas. LMS may consider other protected characteristics and inclusion groups.

Intervention	Implementation	Groups that will benefit most
Intervention 1: implement **targeted and enhanced continuity of carer**, as set out in the NHS Long Term Plan. This means that, as continuity of carer is rolled out to most women, women from Black, Asian and Mixed ethnic groups and women living in deprived areas are prioritised, with 75% of women in these groups receiving continuity of carer by 2024. It also means ensuring that additional midwifery time is available to support women from the most deprived areas.	All LMS	Babies from Black, Asian and Mixed ethnic groups; babies of women living in the most deprived areas
Intervention 2: implement a **smoke-free pregnancy pathway** for mothers and their partners.	All LMS	Women living in the most deprived areas
Intervention 3: implement an LMS breastfeeding strategy and continuously improve **breastfeeding** rates for women living in the most deprived areas.	All LMS	As above

Intervention 4: culturally-sensitive **genetics services for consanguineous couples.**	Selected LMS	Pakistani and Bangladeshi babies

Continuous quality improvement		

Support is available, through the MatNeoSIP, from your Patient Safety Network. To find out how to join yours, email nhsi.maternalandneonatalsafety@nhs.net

Process indicators	**Outcome indicators**
• Placement on a continuity of carer pathway – Black/Asian women • Placement on a continuity of carer pathway – women living in the most deprived areas • Baby Friendly accreditation	• Breast milk at first feed • Low birth weight (<2,500g for term births) • Deliveries under 27 weeks • Deliveries under 37 weeks
Source: all indicators are available from the Regional Measures Report	

Rationale and implementation

Continuity of carer is care from the same midwife or small team of midwives throughout pregnancy, labour and the postnatal period. Each continuity of carer team should have a linked named obstetrician to ensure swift access to medical care. Women who receive continuity of carer are 16% less likely to lose their baby and 24% less likely to experience preterm birth; and their experience of care during pregnancy and birth is also improved.[18] When continuity of carer is implemented well, staff satisfaction improves.[19]

Immaturity-related conditions are the leading cause of death in Black Caribbean and Black African infants and perinatal mortality is higher for Asian babies and those born to mothers living in the most deprived areas. These groups are a priority for continuity of carer given its impact on preterm birth rates and perinatal loss.

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[18] Sandall J, Soltani H, Gates S, Shennan A, Devane D (2016) Midwife-led continuity models versus other models of care for childbearing women. Cochrane Database of Systematic Reviews. (4).
[19] NHS England (2019) unpublished survey of 432 maternity services staff.

Infant mortality rate from immaturity-related conditions per 1,000 live births[20]

Black Caribbean infants	Black African infants	White infants
3.0	2.4	1.0

Under the NHS Long Term Plan, continuity of carer is being rolled out to most women. In accordance with the principle of proportionate universalism, by 2024 75% of women from Black, Asian and Mixed ethnic groups and a similar percentage of women from the most deprived areas will receive continuity of carer. Funding is being targeted at those LMS covering the most deprived areas to help them address health inequalities (see page 40).

Saving babies' lives and improving mothers' experience

In Leicester, 53% of births are to women from ethnic minority groups and 23% of children live in poverty. Culturally-sensitive maternity care is a priority for University Hospitals of Leicester. The hospital worked with its MVP and the Shama Women's Centre (which helps women from diverse communities overcome cultural, economic and language barriers) to co-produce continuity of carer midwifery services for an area in Leicester city with high levels of ethnic diversity and deprivation.

The Lotus team offer services which reflect population health needs, including those around gestational diabetes, healthy relationships and mental health. The team have a named consultant for support and to liaise with other specialists as needed to formulate safe plans of care. Basing the continuity of carer team in the community reduces stigma as women see this as their local team, rather than a team focusing on health and/or social issues. Mothers and families love continuity of carer, as these testimonials show:

"Thank you…for the several home visits you did. You made me feel at ease…from the beginning…I felt more confident that I would have a positive

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[20] Kurinczuk, J (2018) Inequalities in maternal and perinatal mortality, unpublished analysis of cause of death by ethnic group (source: Office for National Statistics data for singleton livebirths in England and Wales from 2006-2012).

> birth experience this time!...you delivered my baby girl!! I couldn't have done it without you – you kept me involved and informed all the way..."
>
> "You are amazing. It was unbelievable that you work so hard and selfless... There is no word we can express our gratitude"

Stopping smoking in pregnancy reduces the risk of stillbirth, preterm birth and infant death; however, rates of smoking in pregnancy in the most deprived areas of England are nearly six times those in the least deprived areas.[21] Smoking also varies by ethnicity (and sex), religion (and sex), sexual orientation and country of birth.[22] The NHS Patient Safety Strategy sets a national ambition to increase the proportion of smoke-free pregnancies to 94% or more by Q1 2023/24. The NHS Long Term Plan is introducing a smoke-free pregnancy pathway for expectant mums and their partners that includes focused sessions and treatments. Saving Babies' Lives version two: a care bundle for reducing perinatal mortality brings together five, evidence-based elements of care to reduce perinatal mortality; element 1 provides a practical approach to reducing smoking in pregnancy by following NICE guidance.

Breastfeeding: *Better Births* recognised that the benefits of breastfeeding are clear and mothers need practical support to help them breastfeed, rather than pressure. Evidence shows that the longer a baby receives breastmilk, the greater the benefits. Breastfeeding reduces a baby's risk of infections, diarrhoea and vomiting, sudden infant death syndrome; and obesity and cardiovascular disease in adulthood. For mothers, breastfeeding lowers the risk of breast and ovarian cancer, osteoporosis, cardiovascular disease and obesity.[23] The World Health Organisation recommends exclusive breastfeeding for the first 6 months of life[24]. It is important to recognise that some women have chosen not to breastfeed and others can't breastfeed due to health conditions.

Breastfeeding initiation is high for Asian and Black mothers at 95–96% and lower for White mothers at 79%. In the most deprived areas, 76% of mothers initiate

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[21] Public Health England (2019) Health of women before and during pregnancy: health behaviours, risk factors and inequalities.
[22] Office for National Statistics (2020) Adult smoking habits in the UK: 2019.
[23] NHS (2021) Benefits of breastfeeding
[24] WHO (2021) Breastfeeding

breastfeeding compared with 89% in the least deprived areas.[25] In the first weeks following birth, 46% of mothers in the most deprived areas breastfeed compared to 65% in the least deprived areas.[26]

Every LMS should agree and implement a breastfeeding strategy to ensure that women have the information and support they need, when they need it in maternity services and in the community. The strategy should include an analysis of feeding trends across the LMS, identifying variation and inequalities between communities, along with actions to address them with a focus on the most deprived areas.

Achieving Unicef's UK Baby Friendly Initiative accreditation in all maternity services will help ensure women receive consistent information on feeding options and get breastfeeding off to a good start. NHS England and NHS Improvement and Unicef have agreed a support offer for the 38 maternity services that have not yet achieved full Baby Friendly accreditation.

Culturally-sensitive genetics services. Among unrelated couples, 2–3% of all births have a congenital abnormality, for first cousin couples this is around 6%.[27] In some populations the higher risk of recessive genetic disorders accounts for some of the increased rate of congenital abnormality, infant and child mortality and serious illness.

Infant mortality rate from congenital abnormalities per 1,000 live births[28]

Pakistani infants	Bangladeshi infants	White infants
3.4	2.1	0.74

Improving understanding about genetic inheritance among families and healthcare professionals and improving access to culturally-sensitive genetics counselling can empower affected families and reduce unexpected affected births. During 2021/22, online training and health promotion materials will be made available to all LMS and

[25] NHS Digital (2012) Infant Feeding Survey – UK, 2010
[26] RCPCH (2021) Breastfeeding in the UK - position statement
[27] Sheridan E, Wright J, Small N, Corry PC, Oddie S, Whibley C, et al (2013) Risk factors for congenital anomaly in a multi-ethnic birth cohort: an analysis of the Born in Bradford study. *Lancet* 382 (9901): 1350–9
[28] Li Y, Quigley MA, Dattani N, Gray R, Jayaweera H, Kurinczuk JJ, et al (2018) The contribution of gestational age, area deprivation and mother's country of birth to ethnic variations in infant mortality in England and Wales: A national cohort study using routinely collected data. PlosOne

areas whose populations can benefit most will be invited to bid for funding and support to implement or develop an evidence-based approach.

Resources

- NHS England Implementing Better Births: Continuity of carer
- The Royal College of Midwives Measuring continuity of carer: A monitoring and evaluation framework
- Health Education England (HEE) e-Learning for Health Care Midwifery Continuity of Carer programme
- NHS England and NHS Improvement Smokefree pregnancy referral pathway
- NHS Improvement – MatNeoSIP Driver diagram and change package – Improve the detection and management of diabetes in pregnancy

4d Support for maternity and neonatal staff

Description

LMS are asked to: - equip maternity and neonatal staff to provide culturally competent care - ensure maternity and neonatal staff experience race equality in the workplace.

Interventions	Implementation	Groups that will benefit most
Intervention 1: roll out multidisciplinary training about **cultural competence** in maternity and neonatal services.	All LMS	Black, Asian and Mixed ethnic groups
Intervention 2: when investigating serious incidents, **consider the impact of culture, ethnicity and language**.	All LMS	As above
Intervention 3: implement the **Workforce Race Equality Standard (WRES)** in maternity and neonatal services.	All LMS	Staff from ethnic minority groups
Continuous quality improvement		

Support is available, through the MatNeoSIP, from your Patient Safety Network. To find out how to join yours, email nhsi.maternalandneonatalsafety@nhs.net

Process indicators	Outcome indicators
• % of maternity and neonatal staff who attended training about cultural competence in the last two years • % of maternity and neonatal Serious Incidents relating to patient care with a valid ethnic code • % of Perinatal Mortality Review Tool cases with a valid ethnic code	• WRES indicators 1 to 8 for midwives and nurses in maternity and neonatal services

Rationale and implementation

Across England, hard-working clinical and non-clinical staff in maternity services take women and their families through the journey of pregnancy, birth and the first weeks of life. Their skill and compassion support families at a time of great joy and, for some, at their darkest times. This sub-priority sets out how the NHS will support staff to give culturally competent care and ensure that their skill and dedication is recognised, irrespective of their ethnic group.

Cultural competency – professional standards: The Nursing and Midwifery Council's standards of proficiency for midwives include that midwives "demonstrate an understanding of and the ability to challenge discriminatory behaviour to promote equity and inclusion for all" and consistently provide and promote non-discriminatory care. The RCOG core curriculum requires that "the doctor is able to champion the healthcare needs of people from all groups within society"; this includes that doctors promote non-discriminatory practice and are aware of broader social and cultural determinants of health as well as an individual's social wellbeing.

Multidisciplinary cultural competence training: the Cultural Competence e-learning tool, developed by Health Education England with the Royal College of Midwives (RCM) and others, supports NHS clinicians to gain knowledge and understanding of the issues around culture and health and how these might influence healthcare outcomes. The tool can support continued professional development and be included in revalidation portfolios. It comprises three 20–30 minute learning

sessions; the first two are aimed at all professional groups and the last at midwives. Some trusts have developed bespoke training packages; an example is given overleaf.

Multidisciplinary cultural understanding and engagement workshops

Multidisciplinary workshops have changed how maternity staff feel about discussing race and culture as well as their understanding of culturally competent care. The workshops, run by midwives Benash Nazmeen and Hannah Thompson, give participants the tools to self-reflect and understand their own values and attitudes towards race, migration and diversity. The 48 participants from eight professional groups in six workshops changed their attitudes in several areas:

Statement	Delegates agreeing/strongly agreeing	
	Before workshop	After workshop
"I feel at ease discussing racism at work and at home."	63%	86%
"I feel comfortable having culturally sensitive discussions with women."	60%	93%
"I am adequately trained to give culturally competent care to ethnic minority communities."	35%	70%
"I am in favour of the continuity of carer model and happy to work this way."	63%	88%

The RCM has offered the workshop to members: check here for availability.

Cultural competency and clinical care: the Summary of themes arising from the Healthcare Safety Investigation Branch Maternity Programme found misunderstandings and miscommunications between staff and parents from ethnic minority communities. Maternity services should ensure that:

- the impact of parents' culture, ethnicity and language is discussed and considered during the antenatal risk assessment process, initial assessment and follow-up

- ethnicity is recorded for all serious incidents and PMRT cases

- investigations consider whether the impact of culture, ethnicity and language on the woman's needs was discussed and considered during the antenatal risk assessment process, initial assessment and follow-up.

Workforce race equality: The NHS People Plan states that "there is strong evidence that where an NHS workforce is representative of the community that it serves, patient care and…patient experience is more personalised and improves".

Nurses and midwives form the largest collective professional group within the NHS. One in every five is from an ethnic minority group.[29] The experience of midwives from ethnic minority groups around the themes of equality, diversity and inclusion is worsening over time and is worse than that for White midwives according to the NHS staff survey (the satisfaction score was 6.97 out of 10 for midwives from ethnic minority groups and 9.24 for White midwives in 2020).

The WRES supports continuous improvement through robust action to tackle the root causes of discrimination. Implementing the WRES is a requirement for NHS commissioners and providers through the NHS standard contract. WRES: An overview of workforce data for nurses, midwives and health visitors in the NHS makes recommendations (page 15) that NHS trusts:

- "[Use] WRES data to identify areas where there is a failure to recruit staff from ethnic minority groups…spotlight directorates and divisions grades / bands where blockages, 'glass ceilings' or 'sticky floors' are most prevalent."
- "[Set] 'aspirational targets' for BME representation at leadership levels and across the workforce pipeline"
- "… [analyse] data by directorate, service, and occupation."

Of the nine WRES indicators, 1 to 8 are relevant to maternity and neonatal services. Human resources departments can support services to access data for midwives and nurses working in maternity and neonatal services; it is more difficult to ascertain

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[29] NHS England and NHS Improvement (2021) Ethnic minority nurses and midwives

WRES data for other staff groups at service level. NHS WRES experts support the implementation of the WRES; they can help LMS improve their understanding of race inequalities, embed best practice, contribute to all areas of the wider health economy and drive system change.

Resources

- NHS Shared Business Services Interpretation and translation services framework
- NHS England and NHS Improvement WRES indicators
- NHS England and NHS Improvement WRES: An overview of workforce data for nurses, midwives and health visitors in the NHS
- NHS England and NHS Improvement WRES indicators for the medical workforce 2020
- NHS England and NHS Improvement A model employer: Increasing black and minority ethnic representation at senior levels across the NHS

4e Enablers

Description
LMS are asked to create the conditions to help achieve equity by: • considering the factors that will support high quality clinical care   • working with system partners and the VCSE sector to address the social determinants of health.

Interventions	Implementation	Groups that will benefit most
Intervention 1: establish **community hubs** in the areas with the greatest maternal and perinatal health needs.	All LMS	Ethnic minority groups; those living in deprived areas
Intervention 2: work with system partners and the VCSE sector to **address the social determinants of health**.	All LMS	As above
Continuous quality improvement		

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There are no process or outcome indicators for this sub-priority.

Rationale and implementation

Community hubs help centre care around the woman and her family. Better Births recommended that community hubs "should be established, where maternity services…are provided alongside other family-orientated health and social services provided by statutory and voluntary agencies...[and] work closely with their obstetric and neonatal unit(s)". Community hubs have two key purposes:

- act as 'one stop shops' for many services – this means different teams operating out of the same facility
- provide a fast and effective referral service to the right expert if a woman and her baby need more specialised services.

Community hubs can support effective continuity of carer teams and, in turn, place-based continuity of carer can create safe spaces for women and identify their specific needs.[30] Maternity care based in the community is associated with a significant decrease in preterm birth (especially for women with the highest level of social complexity) and low birth weight, and an increase in induction of labour. Women also feel able to disclose difficult circumstances to a known and trusted midwife.[31] Unlike women accessing community-based continuity of carer, those receiving hospital-based continuity of carer described a lack of local community support and difficulty integrating into unfamiliar support services.

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[30] Rayment-Jones H, Silverio SA, Harris J, Harden A, Sandall J (2020) Project 20: Midwives' insight into continuity of care models for women with social risk factors: what works, for whom, in what circumstances, and how. *Midwifery* 84:102654.

[31] Rayment-Jones H, Dalrymple K, Harris J, Harden A, Parslow E, Georgi T, et al (2021) Project 20: What aspects of maternity care improve maternal and neonatal birth outcomes for women with social risk factors? A prospective, observational study. *PloS one* 16(5): e0250947

Community hubs in Lincolnshire address social determinants of health

The coast of Lincolnshire experiences significant deprivation and an underdeveloped transport infrastructure makes access to services difficult. A group of young mothers in Skegness got in touch with the LMS to say that travel was difficult and that they wanted maternity services closer to home.

Lincolnshire LMS responded – engaging with staff and parents and mapping demand to select the community hub sites. Two of the six community hubs are in isolated coastal towns – Skegness and Mablethorpe – previously underserved by NHS maternity services. The use of existing NHS or local authority sites meant that community hubs were more likely to be sustainable. Working parties were set up to develop each site and ensure community hubs reflected what local communities wanted.

As well as providing maternity and health visiting services the hubs address the social determinants of health, providing training and employment advice, childcare and early education. Recognising their importance in addressing health inequalities, community hubs remained open throughout the COVID-19 pandemic; 1,170 families accessed midwifery care from the hubs between January and March 2020, with 40% of these families also accessing community hub services after birth.

Social determinants of health: the Marmot review states: "The health of the population is not just a matter of how well the health service is funded and functions…Health is closely linked to the conditions in which people are born, grow, live, work and age and inequities in power, money and resources – the social determinants of health…ethnicity intersects with socioeconomic position to produce particularly poor outcomes for some ethnic minority groups".

Midwives understand the need to "work with other professionals, agencies, and communities to share knowledge of the needs of women, newborn infants, partners and families when considering the impact of the social determinants of health on public health and well-being".[32] To do this, midwives need the skills to "identify,

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[32] Nursing and Midwifery Council (2019) Standards of proficiency for midwives

contact, and communicate effectively with colleagues from their own and other health and social care settings, and voluntary and third sector agencies".

Obstetricians understand "the impact of a patient's social, economic and environmental context on their health" and, through being aware of an individual's social wellbeing, take "an appropriate social history to identify any pertinent social issues and can signpost patients to appropriate services".[33]

A range of organisations and groups can work with maternity and neonatal services to address the social determinants of health. For example:

- **Preconception care** sets the foundation for a successful pregnancy and the subsequent lifelong health of the baby. Healthcare professionals, including GPs, school nurses, health visitors and support staff can deliver messages and support people to adopt healthy behaviours. LMS are well positioned to co-ordinate preconception care. Making the case for preconception care states that: "…local authorities have a wider role in improving preconception health through action on the wider determinants; a 'preconception health in all policies' approach could support this".

- **Local authorities'** role can include support through public health teams (including health visiting, smoking cessation and the Healthy Start scheme) and social care teams (for example, through family support workers who help and advise families facing long or short-term difficulties).

- **Social prescribing** will widen, diversify and become accessible under measures set out in the NHS Long Term Plan which states: "Link workers within primary care networks will work with people to develop tailored plans and connect them to local groups and support services". Social prescribing works for many people, including those with one or more long-term conditions, who need support with their mental health, who are lonely or isolated and/or who have complex social needs which affect their wellbeing.

- **The Health and Wellbeing Fund** 'Starting Well' is investing £7.65 million in the VCSE sector over three years from 2020/21 to reduce health inequalities among new parents and babies. The fund is part of the Health and Wellbeing Programme, a joint initiative from the Department of Health and Social Care

[33] Royal College of Obstetricians and Gynaecologists (2019) Core curriculum

(DHSC), PHE and NHS England and NHS Improvement. The 19 projects span the country from Cornwall to Lancashire and aim to improve health outcomes for children from preconception to two-and-a-half years in areas of high deprivation (rural, coastal and urban) and from ethnic minority groups.

Resources

- NHS England and NHS Improvement Social prescribing
- Health Anchors Learning Network

Priority 5: Strengthen leadership and accountability

LMS set out their shared vision in a Local Maternity Transformation Plan in 2017 and should now supplement this with a co-produced equity and equality action plan. The 2021/22 priorities and operational planning guidance: Implementation guidance sets out a two-step process for this:

- by 30 November 2021, LMS are asked to submit an equity and equality analysis (covering health outcomes, community assets and staff experience) and a co-production plan as set out in sub-priority 4a, interventions 1 to 4
- by 28 February 2022, LMS are asked to co-produce equity and equality action plans.

LMS equity and equality action plans will set out how the NHS will work in partnership to improve equity for women and babies and race equality for staff. The plan should be agreed by the LMS board and the ICS partnership board and published. Its format can be locally determined.

A good equity and equality action plan will include:

- vision, values and aims that align to ICS plans to tackle health inequalities
- a clear description of the LMS population and health outcomes, with a focus on those from Black, Asian and Mixed ethnic groups and those living in the most deprived areas. LMS may use local data to identify health inequalities experienced by those with other protected characteristics and for inclusion groups

- strong evidence of co-production from the outset and how parents and staff will be involved in implementation
- all relevant interventions in priorities 1 to 4
- interventions which are most likely to reduce health inequalities (considering both the size of the population affected and extent of the health inequalities). The plan will include core interventions and, where relevant, those that apply to selected LMS. LMS may wish to include additional interventions given the characteristics of their population and their operating context
- actions, milestones and metrics (reflecting the indicators in priorities 1, 3 and 4), with responsible owners, timescales and monitoring arrangements
- a clear mechanism for ensuring continuous clinical quality improvement
- roles and responsibilities: including of the ICS and provider executive board-level leads for health inequalities, LMS senior responsible owner, board-level safety champions, MVP(s), etc
- interdependencies with other ICS workstreams, for example, estates, workforce
- resourcing, including how the funding for this purpose will be applied
- a high-level stakeholder communication plan.

4. Support available to LMS

LMS will receive support – at national, regional and local level – to co-produce and implement their equity and equality action plans.

National support and leadership

LMS will receive £6.8 million of funding from NHS England and NHS Improvement to co-produce and implement their equity and equality action plans, including the implementation of continuity of carer for Black, Asian and Mixed ethnic groups and those living in the most deprived areas.

Multidisciplinary clinical leadership with policy support: the Chief Midwifery Officer leads on work to help achieve equity and equality, supported by the National Maternity Lead for Equality. Medical leadership is provided by the National Specialty Advisor, obstetrics – public health. Policy support is provided by the Maternity Transformation Programme.

The Chief Nursing Officer's and Chief Midwifery Officer's Ethnic Minorities Strategic Advisory Group advises about equity and equality policy and practice relating to service users and staff. The group will develop a visible and expert senior team from ethnic minority groups that will influence health and social policy development for the benefit of all service users.

The Maternity and Neonatal Safety Improvement Programme ([MatNeoSIP](#)) uses quality improvement methodologies to support local identification of safety issues (based on data and co-production) and tests interventions with segmented population groups through the Patient Safety Collaboratives. MatNeoSIP is led by the National Patient Safety team at NHS England and NHS Improvement.

The NHS Health and Race Observatory, supported by NHS England and NHS Improvement and hosted by the NHS Confederation, has been established to identify and tackle the specific health challenges facing people from ethnic minority groups. Chaired by the Chief Midwifery Officer, the maternity working group supports and helps drive the observatory's work on reducing ethnic inequalities in maternal care.

The group will focus on research and innovations in key areas from which strategic policy recommendations for sustainable change will be proposed.

Cross-government working: recognising that social determinants of health have a significant influence on health outcomes, DHSC facilitates cross-government working. For example, the Health and Wellbeing Fund is a joint initiative between DHSC, PHE and NHS England and NHS Improvement and is investing £7.65 million in the VCSE sector over three years from 2020/21 to reduce health inequalities among new parents and babies.

Collaboration with national bodies: through the Maternity Transformation Programme board and the Stakeholder Council, a range of national bodies, including those representing parents, have informed this guidance and are supporting its implementation.

For example, the Care Quality Commission (CQC) considers equity as part of its Transitional Monitoring Approach under the following key lines of enquiry (additional prompts, maternity): S1 and S2 – questions relating to the implementation of the Chief Midwifery Officer's four actions to minimise the risk of COVID-19 for minority ethnic women, minimising risks from quarantine/lockdown which affect women with complex social factors and their babies and the data quality of ethnic coding; and R1 – questions about the provision of continuity of carer including for ethnic minority groups and those living in the most deprived areas. These areas have also been inspected as part of the CQC's focused maternity inspections programme.

Regional maternity teams

The roles and responsibilities of the regional teams for maternity services are to:

- assure LMS equity and equality action plans, involving the Regional Service User Voice representative in this process
- provide support at regional level where appropriate (noting that the support offer is led by the clinical networks).

How the South East regional team supports LMS equity work

The COVID-19 pandemic highlighted existing health inequalities and England's Chief Midwifery Officer called on all maternity units to take four actions to minimise the additional risk of COVID-19 for mothers from ethnic minority groups and their babies.

In the South East, the regional maternity team supported LMS to implement the four actions. The team set up monthly webinars to share good practice from LMS across England and hear from senior leaders. The regional programme manager, Gulnar Irani, shared this approach with other regions and advised on the design of a national assurance process to assess implementation of the four actions. Every maternity unit in the South East had implemented all four actions by March 2021.

Maternity clinical networks

The role and responsibilities of the maternity clinical networks are to:

- offer support to LMS in developing, implementing and monitoring the health outcomes of their equity and equality action plans
- use data and insight to address health inequalities.

How the East of England clinical network supports LMS equity work

Tendai Nzirawa is passionate about making a difference to the quality of care in maternity services: "As a quality improvement manager in the East of England Maternity Clinical Network I bring together healthcare professionals, the third sector and MVPs to contribute and collaborate in system change across the East of England. The change cannot be done by one person, but a committed group that will go back into their systems and influence change locally."

A registered nurse, Tendai was redeployed to neonatal critical care during the pandemic. Asked what she looked forward to in returning to her job, Tendai said: "The passionate midwives that drive change in their local areas to address health inequalities." And what about the challenges? "Making sure that care is truly

personalised – different groups and individuals have different health needs; one size does not fit all. To do this we need to use the skills of healthcare professionals, MVPs and the third sector and be clear who is the right person to lead on each aspect of work."

Local support and leadership

Integrated care systems (ICS) are expected to collaborate locally to plan and deliver urgent action to address inequalities in NHS service provision and outcomes, as set out in action 8 of Implementing phase 3 of the NHS response to the COVID-19 pandemic and reiterated in the 2021/22 priorities and operational planning guidance: Implementation guidance. The Maternity Transformation Programme is one of four priority preventative programmes which are proactively engaging those at greatest risk of poor health outcomes. The ambition is that all ICS are successful in integrating care to deliver the NHS Long Term Plan and to:

- improve population health and healthcare
- tackle unequal access, experience and outcomes
- enhance productivity and value for money
- ensure the NHS supports broader social and economic development.

5. Metrics

The NHS will measure progress towards improving equity for mothers and babies through the metrics set out below.

Perinatal mortality metrics

Indicator: The stillbirth and neonatal mortality rate per 1,000 births for Black and Asian babies divided by the rate for White babies in the UK, expressed as a ratio. Source: MBRRACE-UK

Where reported	Baseline (2017)
NHS Long Term Plan headline metric	1.7

Indicator: The modelled difference in the stillbirth and neonatal mortality rate per 1,000 births between the most and least deprived communities in England, measured using the slope index of inequality. Source: ONS

Where reported	Baseline (2017)
NHS Long Term Plan headline metric	4.39

The English maternal morbidity outcome indicator (EMMOI)

While even among women from Black ethnic groups maternal deaths are rare, for every woman who dies, 100 women have a severe pregnancy complication or 'near miss' – when she survives but often with long-term health problems. Disparities in the numbers of women experiencing a near miss exist between different ethnic groups. Near misses are more common than maternal deaths, so we can investigate disparities at LMS or regional level to assess local variation and identify areas with

best practice. DHSC has asked the Policy Research Unit in Maternal and Neonatal Health and Care to investigate disparities in 'near misses', through the use of the English Maternal Morbidity Outcome Indicator (EMMOI),[34] which assesses the rates of various pregnancy complications and can, in contrast to investigation of maternal deaths, be compared across regions or LMS.

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[34] Nair M, Kurinczuk JJ, Knight M (2016) Establishing a National Maternal Morbidity Outcome Indicator in England: A population-based study using routine hospital data. PLoS ONE 11(4): e0153370.

6. Keeping healthy

Information to help families keep well in pregnancy and beyond.

Use trusted sources of advice

- NHS-approved pregnancy and baby apps meet a rigorous set of standards
- the nhs.uk pregnancy pages provide advice about trying for a baby, pregnancy, labour and birth
- Information about coronavirus (COVID-19) and pregnancy
- Safer sleeping advice for infants from the Lullaby Trust

Lead a healthy lifestyle

The NHS healthy weight site helps you work out what a healthy weight is for you and how to get to it. Take vitamin D and folic acid as recommended. Check if you have iron deficiency anaemia, which is common in pregnancy.

Healthy Start vouchers help you give your children a great start in life – they are for vitamins and basic foods. Ask your midwife if you qualify.

Keep fit and active during pregnancy: find out why and get exercise tips here.

Know when to call your midwife or maternity services

Maternity services are open 24 hours a day, 7 days a week. If you do not have a midwife or maternity team call a GP or use the NHS 111 online service (if you cannot get help online, call 111).

Call your midwife or maternity team immediately if:

- your baby is moving less than usual
- you cannot feel your baby moving
- there is a change to your baby's usual pattern of movements
- you have any bleeding from your vagina
- you're feeling very anxious or worried
- you have a headache that does not go away
- you get shortness of breath when resting or lying down

Do not wait until the next day – call immediately, even if it's the middle of the night.

Call 999 if:

- you feel very unwell or think there's something seriously wrong
- you have severe chest pain

Source: nhs.uk

If things don't go as you hoped they would

Many maternity services operate a Birth Reflections Service, to help you explore your birth experience and ask questions, often without a time limit on how long you can access them after giving birth. Contact the maternity unit where you gave birth to find out if this service is available.

7. Glossary

Term/acronym	Definition
Equality	To ensure that every individual has an equal opportunity to make the most of their lives and talents.[35]
Equity	The absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically.[36]
Inclusion health groups	Groups of people who have not usually been well provided for by healthcare services, and have poorer access, experiences and health outcomes. The definition covers people who are homeless and rough sleepers, vulnerable migrants (refugees and asylum seekers), sex workers, and those from Gypsy, Roma and Traveller communities.[37]
Perinatal mental health	Perinatal mental health problems are those which occur during pregnancy or in the first year following the birth of a child.
Perinatal mortality	Stillbirths and early neonatal deaths.
Population attributable fraction (PAF)	The contribution of a risk factor to a disease or a death. The PAF is the proportional reduction in population disease or mortality that would occur if exposure to a risk factor were reduced to an alternative ideal exposure scenario.[38]
Protected characteristics	As set out in the Equality Act 2010, these are age, disability, gender reassignment, marriage and civil partnership, race, religion or belief, sex, sexual orientation and pregnancy and maternity.
Slope index of inequality	A measure of the social gradient in an indicator which shows how much the indicator varies with deprivation (by deprivation decile).[39]
Senior responsible owner (SRO)	The person "accountable for ensuring a programme or project meets its objectives, delivers the projected outcomes and realises the required benefits".[40]

[35] Equality and Human Rights Commission (2021) Understanding equality
[36] World Health Organization (2021) Health systems. Equity
[37] NHS England and NHS Improvement (2021) Definitions for health inequalities
[38] World Health Organization (2021) Metrics: Population Attributable Fraction (PAF)
[39] Public Health England (2018) Slope index of inequality (SII)
[40] Infrastructure and Projects Authority (2019) The role of the senior responsible owner

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