**NOTTINGHAM AND NOTTINGHAMSHIRE**

**LOCAL MATERNITY & NEONATAL SYSTEM (LMNS)**

**MATERNITY EQUITY STRATEGY:**

**Our local high-level plan**

**April 2023 v0.3**

Forward

Across Nottingham and Nottinghamshire there are more people living longer in ill health, unprecedented levels of demand for care and support, workforce shortages and considerable funding constraints. Combined, these factors continue to place an ever-increasing strain on the local health and care system and looking to continue to do more and more of the same each year is not sustainable.

In response to this the leaders of our local health and care system have come together to develop a five-year strategic plan, underpinned by the ICS Clinical and Community Services Strategy, that sets out a shared vision to ‘both increase the duration of people’s lives and to improve those additional years, allowing people to live longer, happier, healthier and more independently into their old age’. Delivery of this vision will be characterised by moving from a health and care system that is often siloed and reactive in nature to one where all partners are focused on the entire spectrum of interventions from prevention and promotion to health protection, diagnosis, treatment and care – and integrates and balances action between them.

Addressing Health Inequalities

Health inequalities are the unjust differences in health experienced by different groups of people. In Nottingham & Nottinghamshire today, there is a significant gap in healthy life expectancy between the most and least affluent areas of the county.

Closing this gap is one of the biggest challenges we face, this about much more than access and quality of health and care services given wider determinants contribute 80% towards health outcomes. Health actions are necessary but not sufficient and this strategy covers a wide range of issues which affect our health and wellbeing including employment, education, our living situation and relationships.

“Our vision for health inequalities is that everyone has the same opportunity to lead a healthy life no matter where they live or who they are, and that our front-line professionals are valued and supported to deliver high quality care.”

*Nottingham & Nottinghamshire Integrated Care System (ICS)*

Equity in Maternity & Neonatal Services

The [MBRRACE-UK](https://www.npeu.ox.ac.uk/mbrrace-uk/reports) report about maternal and perinatal mortality shows worse outcomes for those from Black, Asian and Mixed ethnic groups and those living in the most deprived areas. Black women are 4 times more likely to die in childbirth than white women, those from mixed backgrounds are 3 times more likely and those from Asian backgrounds are twice as likely.

In addition, the NHS People Plan highlights *“…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.

Therefore, the main aims of our Local Maternity & Neonatal System (LMNS) Equity Plan 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**

Locally, we will also be looking to improve equity in maternity for other protected characteristics including (but not limited to), disability, mental health, & autism.

Good health in pregnancy significantly influences a baby’s development in the womb which, in turn, influences long-term health and educational outcomes. By giving every child the best start in life, we will help them fulfil their health, wellbeing and socioeconomic potential.

Throughout our Maternity Equity Plan, we will coproduce interventions to improve equity for all mothers & babies and improve race equality for maternity & neonatal staff.

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**Part 1 | Understanding our local picture**

1. **| Nottingham & Nottinghamshire population overview**

Nottingham and Nottinghamshire’s Integrated Care System (ICS) is made up of 4 geographical locations which vary significantly in population size, ethnicities, rurality and deprivation. Across the area there are 2 local authorities, 1 ICB and 4 place based partnerships; Bassetlaw, Mid-Nottinghamshire, South Nottinghamshire and Nottingham City. The combined estimated population is 1,170,475 as per the mid-year estimates 2020.

Nottingham City has a younger and more ethnically diverse population than the County, around 30% of the City population are aged 18-29 with a high proportion of students with two universities situated there. Around 34% of the city population is from a Black and Ethnic Minority (BAME) background, this is higher in comparison to the England average of 20.2%. Nottinghamshire is less ethnically diverse than the City with an estimated 4% of the population from a BAME background.

Across the ICS, deprivation is the highest in Nottingham City, which ranks the 11th most deprived district in England and the most deprived area across the East Midlands Region, according to the index of multiple deprivation. 57% of Nottingham neighbourhoods fall amongst the 20% most deprived in the country. Nottinghamshire County as a whole, is less deprived than the City, ranking 5th out of 9 other areas is in the region. However, the level of deprivation between the different areas of the county are vast. Nottinghamshire has 7 districts which vary in rurality, population type and deprivation. The most northern parts of the county, Mansfield, Ashfield and Bassetlaw are the more deprived areas, however Rushcliffe in the South of the county and has some of the lowest deprivation levels in the country., the Mansfield District falls within the 20% most deprived districts in the country whereas Rushcliffe is within the 3% least deprived areas within the country.

The stark disparities in deprivation levels across the ICS footprint are demonstrated in our population health outcomes. Those living in the most deprived areas have a life expectancy between 7.5 and 8 years less, however in the least deprived areas, life expectancy is better than the England average. Obesity and smoking rates are worse than the England averages in the most deprived areas and mortality rates from cancer, cardiovascular diseases are also higher in the most deprived areas. Disability and poor health are strongly associated with deprivation within Nottinghamshire, with the highest figures reported in Mid Nottinghamshire and Bassetlaw. The more deprived areas of the ICS are also more at risk of digital exclusion and over half of the Nottingham population are reported to have lower health literacy, both factors can limit access to health services and understanding of health information and management of conditions.

**1.1 | Local context for Maternity Services**

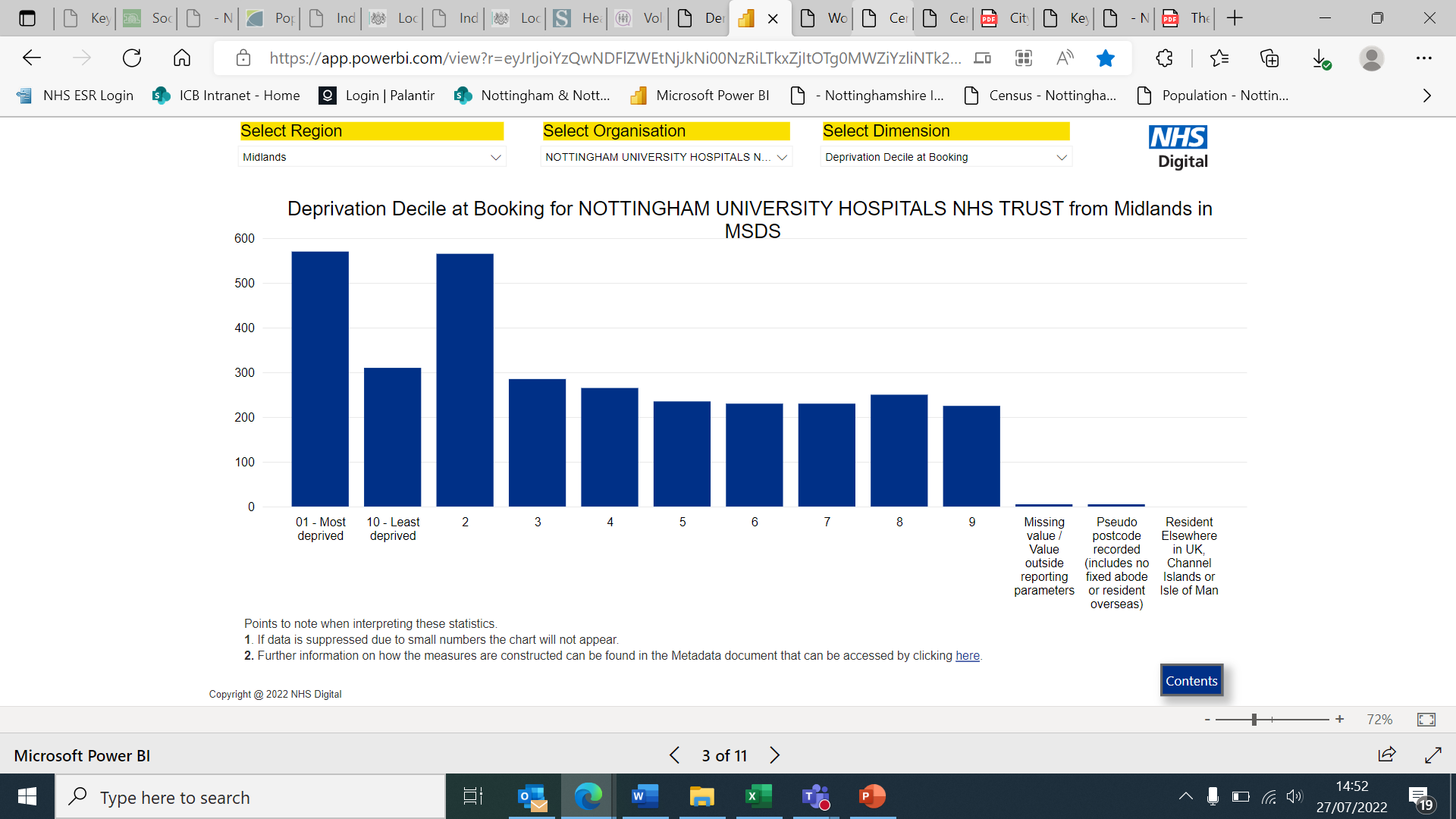
The Nottingham & Nottinghamshire Local Maternity and Neonatal System (LMNS) is made up of members from Nottingham University Hospitals (NUH), Sherwood Forest Hospital (SFH), Public Health, CityCare, Primary Care, community sector organisations and experts by experience via Maternity Voices Partnership, working together to ensure that maternity and neonatal services are safe and personalised to the needs of women and birthing people and their families.

Just over 13,000 babies are born in Nottingham and Nottinghamshire each year, having risen from an average of 11,000 in the year up to March 2020, before the pandemic.

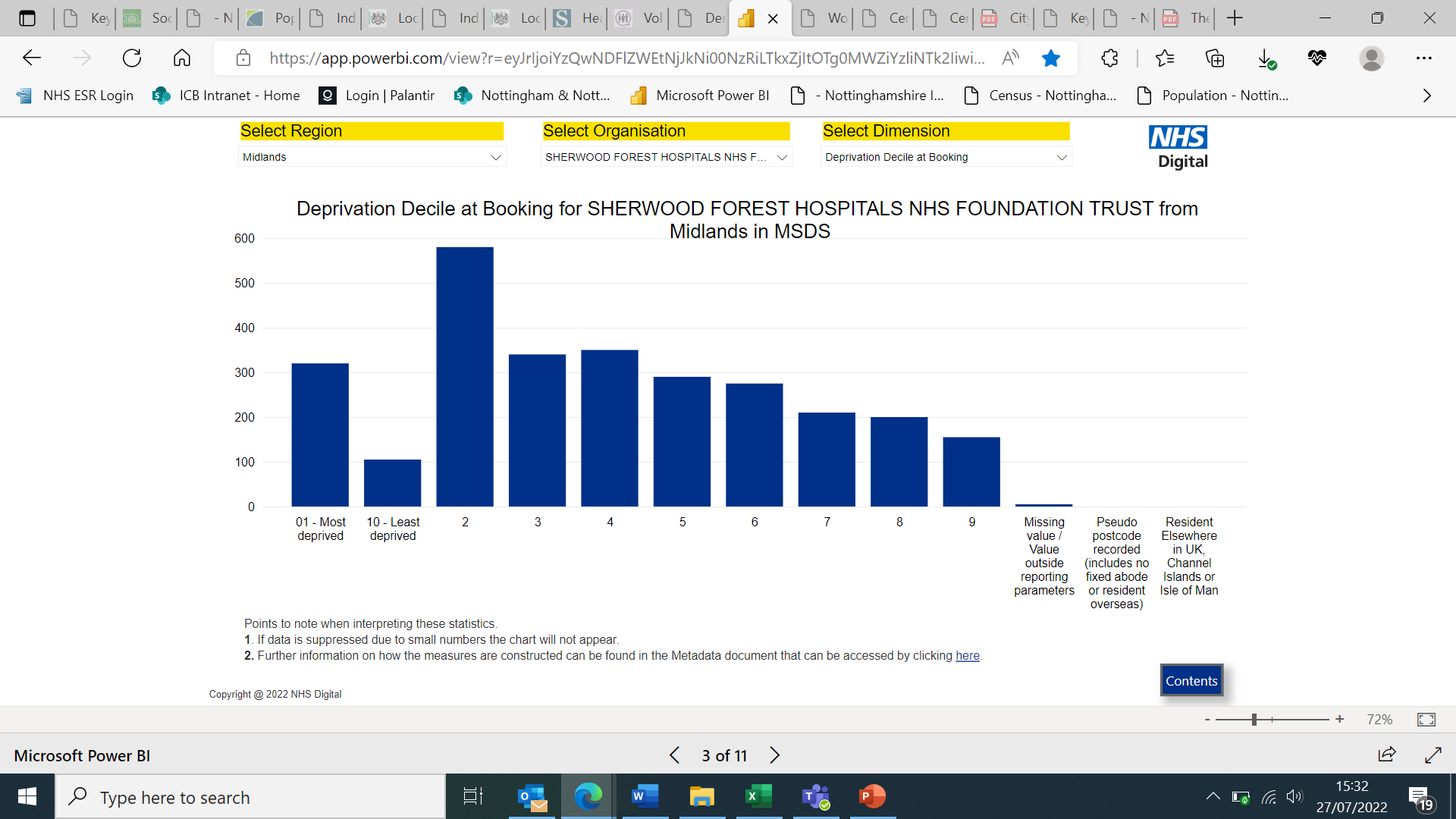
There are three hospital providers serving the ICS population, Nottingham University Hospitals (NUH), Sherwood Forest Hospital (SFH) and Doncaster and Bassetlaw Teaching Hospitals (DBTH). NUH has 2 sites for maternity services both located in Nottingham City. As well as serving city residents, the hospital sites are close to residents from Gedling, Broxtowe and Rushcliffe. SFH has sites in Ashfield and Newark, serving the two areas of Mid-Nottinghamshire, the more deprived areas of the county. DBTH also has two sites, one of which is in Bassetlaw serving North Nottinghamshire populations. The site in Doncaster is more likely to serve people living on the border of South Yorkshire.

Deprivation Decile at time of booking

According to the NHS Annual Maternity Statistics 2020-21 published by NHS Digital, 14.5% of total bookings at NUH were from the 20% most deprived areas, compared to only 7% of postcodes in the least deprived areas.



SFH has a higher proportion of bookings from those in the 20% most deprived areas, with Kings Mill Hospital serving the populations of Mansfield and Ashfield which are most deprived districts of the County. 28% of bookings at SFH are from those in the most deprived areas, compared to only 8% of bookings from the 20% least deprived areas.



Deprivation can be used as an indicator of risk for our patient populations. Those living in the most deprived deciles may be more likely to have other health conditions or lifestyle factors which can influence both the health of the baby and the mother, such as higher smoking rates and obesity.[[1]](#footnote-1) Babies born to mothers in the most deprived are more likely to be born prematurely, have a low APGAR score, require admissions to neo-natal units and are at a higher risk of being still born. The risk of maternal death is also higher in those from deprived areas.[[2]](#footnote-2) There is likely to be a higher risk of digital exclusion and lower health literacy in more deprived areas too which could make it more difficult for expectant mothers and birthing people to access services, manage health or pregnancy related conditions, and understand when and how to act if complications arise.

Ethnicity

In Dec 2021, 25% women and birthing people attending a midwifery booking appointment with NUH were from BAME communities. Data from the LMNS shows that at NUH, bookings from white mothers are lower than national average and bookings from other BAME communities are largely in line with the national averages. In comparison 4% of those booking at Sherwood Forest Hospital were from BAME backgrounds. These percentages are reflective of the local population estimations although bookings at NUH are slightly lower than the estimated 30% of the city population from BAME backgrounds.

Nationally, those from ethnic minority backgrounds have a higher risk of maternal mortality than white women. Black women are 4 times more likely to die in childbirth than white women, those from mixed backgrounds are 3 times more likely and those from Asian backgrounds are twice as likely.[[3]](#footnote-3) Those from BAME backgrounds are also overrepresented in other aspects of pregnancy and childbirth such as pre-term births, perinatal mental health and are more likely to have poorer experiences of care.

Across our ICS, the number of serious incidents (SI) involving mothers and birthing people from BAME backgrounds is disproportionate to the ethnicities of the booking population at both NUH and SFH. Nearly 50% of SIs at NUH and 33% of SIs at SFH being from non-white British, despite them only representing 25% and 4% of the booked patient population, respectively.

Lifestyle Factors

In 2019, Public Health Fingertips data showed that Nottingham City and Nottinghamshire have higher rates of obesity and smoking in early pregnancy compared to the England averages and the majority of the East Midlands. These numbers are particularly high in the areas of Mansfield, Ashfield and Nottingham City. Obesity, defined as having a BMI of 30 and above during pregnancy, can increase the risk of complications such as gestational diabetes, high blood pressure and pre-eclampsia. This can lead to adverse health outcomes for both the mother and baby. It may also mean instrumental delivery is also more likely with an increased risk of emergency caesarean and it can be more difficult for some pain relief methods, such as an epidural, to be administered. This could lead to a more complicated birth for the mother. The risk of miscarriage and still birth is also higher in obese mothers.[[4]](#footnote-4) Expectant mothers with obesity may require more monitoring and attendance at antenatal appointments than those who are a healthy weight.

Smoking rates remain high, with LMNS data showing that in June 2022, a rate of 15.6% of pregnant persons smoking at the time of booking. The data also shows that the majority of these patients remain smokers throughout their pregnancy with 12% of pregnant persons smoking at the time of delivery (SATOD). The smoking rates at SFH are significantly higher, with 16.4% SATOD (May 2021 – May 2022). In comparison, the national rate of SATOD is much lower 9% whilst it is targeted numbers of smokers at time of delivery to reach 6% by the end of 2022. Smoking in pregnancy presents several health risks to the unborn baby; babies may grow at a slower rate in the womb which can result in low birth weight, they are also at more risk of infant mortality and stillbirth.3 However it is important to note that our Maternity services, often provide intrapartum (labour) care to cross-boundary service users where we have not had opportunity to provide antenatal care and smoking support to them prior to birth. This context is not reflected in our SATOD figures.

Nottingham and Nottinghamshire have the lowest rates in the East Midlands region for baby’s first feed being breastmilk and this is particularly low in the localities of Newark and Sherwood, Mansfield and Ashfield, and Nottingham City where we see the lowest breastfeeding rates. 64.5% of babies born in Nottingham and Nottinghamshire received their first feed from breast milk (from the mother or donor), at the 6-8 week check only 43.3% of babies were reported as being partially or fully breastfed. Breastfeeding provides the best possible nutritional start in life for a baby, protecting the baby from infection and offering important health benefits for the mother.3 The colostrum produced in the first few days after birth is especially important for the baby to receive antibodies and nutrition. Breastfeeding can help to reduce hospital admissions because of fewer infections and illnesses to the baby and further benefits can continue into adulthood with the prevention of obesity and cardiovascular disease. Breastfeeding can also help protect the mother against the risk of breast cancer and ovarian cancer.[[5]](#footnote-5) Skin to skin contact associated with breastfeeding can also help to establish the bond between the mother and baby.3

Timing of Booking

NICE Guidance states that a first booking appointment with a midwife should take place within the first 10 weeks of pregnancy for all women. This will enable participation in antenatal screening programmes which can detect genetic conditions and Downs Syndrome, accurately dated ultrasounds and develop a personalised plan of care which sets out the number of appointments needed with any specialist interventions or clinical oversight required[[6]](#footnote-6). Those with complex social factors such as those who misuse substances, are recent migrants, asylum seekers or refugees, are under age 20 or experience domestic abuse, are known to book later, on average than mothers without these factors. Late booking is associated with poorer obstetric and neonatal outcomes and due to some of the additional complexities which may be experienced in pregnancy in these populations, early booking is even more important for these groups. Within our ICS, current maternity booking for women and birthing people with complex social factors before 10 weeks is 56% at NUH and 57% at SFH (Dec, 2021). The number identified as having a complex social factor was greater at SFH during 2020-21.

**1.2 | Equality for Maternity & Neonatal staff**

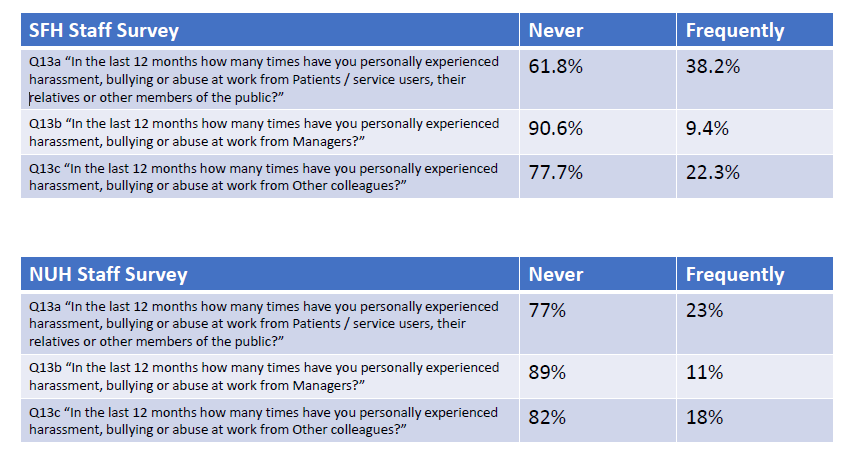
The Nursing and Midwifery Council’s standards of proficiency for midwives include that midwives “demonstrate an understanding of and the ability to challenge discriminatory behaviour to promote equity and inclusion for all” and consistently provide and promote non-discriminatory care.

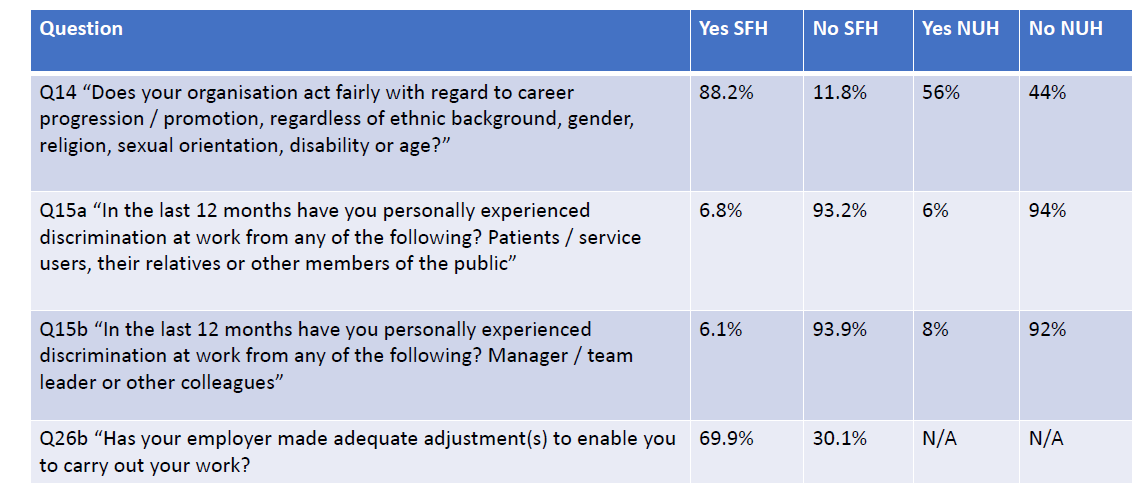
In addition, the NHS People Plan states that “there is strong evidence that where an NHS workforce is representative of the community that it serves, patient care and…patient experience is more personalised and improves”. Looking at our local 2020 Workforce Race Equality Standard (WRES) data, we can see that the number of midwives at NUH from BAME backgrounds was 6.9% and at SFH it was 2.7%. This is not representative of the maternity booking population (25% booking from BAME backgrounds at NUH and 4% at SFH).

Nurses and midwives form the largest collective professional group within the NHS. One in every five is from an ethnic minority group. 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).

Staff surveys from our local Trust Providers indicate harassment and bullying exist in the workplace for staff from BAME backgrounds – so work to address this is required. In addition, the surveys revealed that 44% of the workforce at NUH feel their organisation doesn’t act fairly regarding career progression or promotion so plans to change this are needed.

Safe environment – bullying & harassment:

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**Equality, Diversity & Inclusion 2020/21:

**Part 2 | Our Maternity Equity Plan - Approach**

“Our neighbourhoods, places and systems will seamlessly integrate to provide joined up care Every citizen will enjoy their best possible health and wellbeing.”

*Vision for Nottingham & Nottinghamshire Integrated Care System (ICS)*

**2.0 | Vision, Values & Aims**

In support of the ICS, our **LMNS vision** is for maternity services across Nottingham & Nottinghamshire to become safer, more personalised, kinder, professional and more family friendly; where every woman has access to information to enable her to make decisions about her care; and where she and her baby can access support that is centred around their individual needs and circumstances.

**Our Vision**

Our values

Our LMNS sits under the newly formed Integrated Care Board (ICB) and will follow the 4 core values below:

1. We will be **open** and **honest**

2. We will be **compassionate** and **respectful**

3. We will be **empowered** to be **innovative**

4. We will work **collaboratively**

Aligning our aims

|  |  |
| --- | --- |
| Aims of the ICS | Aims of the LMNS |
| Improving the health & wellbeing of our population | Improve equity for mothers and babiesfrom Black, Asian and Mixed ethnic groups and those living in the most deprived areas |
| Improving the overall quality of care and life our service users and carer are able to have and receive |
| Improving the effective utilisation of our resources | Improve race equality for maternity & neonatal staff |

Our approach to this plan

The Maternity Equity Plan has been underpinned by six key principles:

|  |
| --- |
| **To demonstrate how we will address the priorities and interventions laid out by NHSE/I** LMNS Teams were provided with guidelines and a specification to support with the planning and development of their maternity equity strategies. Clear priorities were laid out (see appendix 4.3) for LMNS teams to demonstrate how they will meet these requirements locally. |
| **To provide oversight of the initiatives we plan to improve equity for mothers, babies and race equality for maternity & neonatal staff**  Our equity plan will provide a clear description od the interventions which are most likely to reduce health inequalities for maternity services users and staff. |
| **To align the initiatives to other health inequality plans, including mapping against the ICS Outcomes Framework (see appendix 4.4)** **This will also include national policies and drivers such as the Women’s health Strategy.** Partners across our ICS have also developed equity plans or frameworks to deliver local strategies. We have cross referenced and incorporated these into this plan to support a cohesive system-wide approach to equity. |
| **An agreed culture of working in partnership across the whole system and a commitment to coproduction and stakeholder engagement** Collaboration withkey stakeholders on the background, content, endorsement & implementation of the plan, including a coproduction lens & close working relationship with MVP and experts by experience. |
| **A robust approach to monitoring & evaluation of the planned initiatives**  NHSE/I specified indicators and metrics to assess equity across maternity & neonatal systems. These have been incorporated into the plan. In addition, our LMNS dashboard will enable a localised route to measuring, reporting and evaluating impact of our equity initiatives. |
| **Identify clear governance and accountability for the plan**  A structured approach for reporting and monitoring progress is in place locally. Our equity plan will sit under these tried and tested arrangements to ensure continuous quality improvements are being made, or indeed to provide channels of escalation where required. |

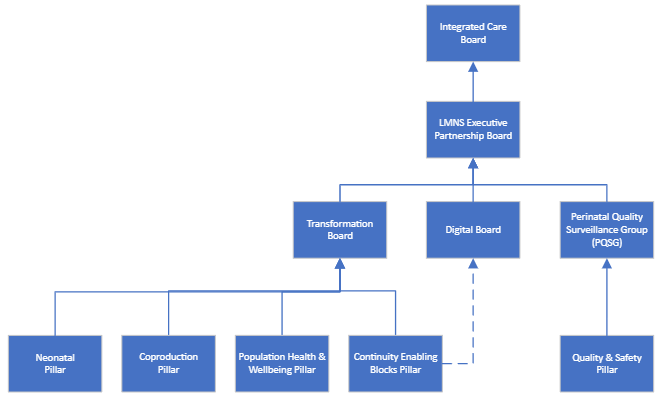
We have established a programme of LMNS pillars and workstreams to oversee delivery of action plans, drawing on skills, capacity and expertise from partners across the system. We have approached our Maternity Equity Plan by aligning the interventions to these workstreams. Too often, strategy documents are left untouched to gather dust, rather than supporting the implementation of the important aims intended. Locally we wanted a structure to our equity plan with sections that could be ‘lifted and shifted’ into different workstream delivery action plans. This way, specific teams will concurrently have accountability for driving forward equity activity within their fields of expertise. In effect, providing bite size chunks of the plan will enable our success.

Eight LMNS workstreams and/or supporting teams have been identified to deliver our Maternity Equity Plan:

1. Digital *(Continuity Enabling Blocks Pillar)*
2. Communications, Engagement & Coproduction *(Coproduction Pillar)*
3. Personalisation *(Continuity Enabling Blocks Pillar)*
4. Perinatal Mental Health *(Population Health & Wellbeing Pillar)*
5. Workforce & Training *(Continuity Enabling Blocks Pillar)*
6. Continuity of Carer *(Continuity Enabling Blocks Pillar)*
7. Maternal Health *(Population Health & Wellbeing Pillar)*
8. Quality & Safety Guidelines *(Quality & Safety Pillar)*

Our plan is therefore split into eight different tables, with the intention that each identified workstream or team will take the one aligned to them, and they will be accountable for implementing SMART action plans with a structured approach for reporting and monitoring. Each table contains an ‘aligning to partner strategies’ section. This is where we have mapped our equity initiatives against other health inequality plans in our system and to priorities and interventions laid out by NHSE/I. A summary of how our LMNS workstreams map to the latter is provided in appendix 4.3.

**2.1| Monitoring arrangements** **for ensuring continuous clinical quality improvement**



LMNS Governance Structure

Maternity Equity Plan

Our LMNS has a clear and effective governance structure in place as shown in the schematic. Sitting under the ICB, we have our LMNS Executive Partnership Board (EPB) which has a specific role in overseeing delivery of the national priorities to tackle health and care inequalities focusing on the transformation and delivery of high quality, safe and sustainable maternity and neonatal services and improved outcomes and experience for woman and their families. The Board will obtain assurance that plans are progressing at a local level ensuring that transformation remains person centred to address national priorities and trajectories.

Below the LMNS EPB, are three further boards, providing operational delivery support and expertise to our agreed system-wide pillars of work. Within each pillar, are our subgroups or workstreams as identified earlier. Our pillars are scrutinised and assured by the LMNS Transformation Board with a clear relationship into the Digital Board, which is a constant enabler for all that we do.

A final part to our governance, is the Perinatal Quality Surveillance Group (PQSG). LMNSs and providers are required to oversee perinatal services through the implementation of the NHSEI Perinatal Quality Surveillance model. The aim of the model is to improve oversight for effective perinatal clinical quality and to ensure a positive experience for women and their families, with five key principles:

Principle 1 Strengthening trust-level oversight for quality

Principle 2 Strengthening LMS and ICS role in quality oversight

Principle 3 Regional oversight for perinatal clinical quality

Principle 4 National oversight for perinatal clinical quality

Principle 5 Identifying concerns, taking proportionate action and triggering escalations

PQSG supports LMNS oversight and assurance to ensure that the quality of services commissioned, including joint commissioning, is monitored and to promote continuous improvement, learning and innovation with respect to safety of services, clinical effectiveness, and experience. Our PQSG is responsible for implementing the intelligence received from our Serious Incident (SI) Shared Governance Group and our LMNS Dashboard Subgroup.

Our Maternity Equity Plan will sit under this robust governance structure.

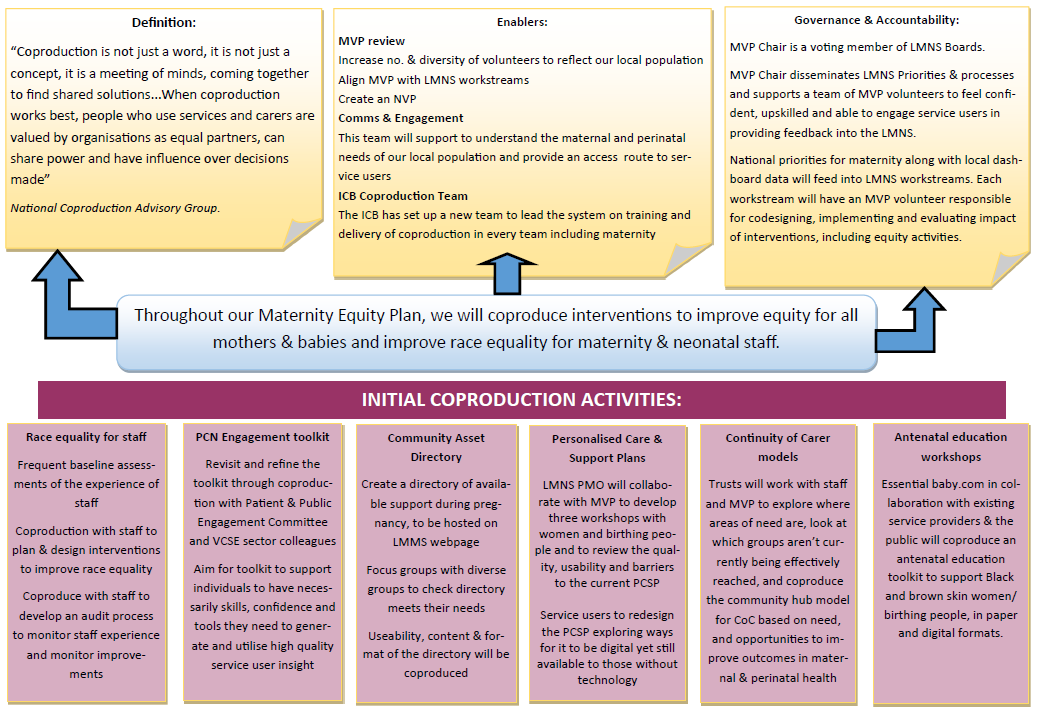
**2.2 | Coproduction**

The Nottingham and Nottinghamshire ICB’s ambition is to make a real difference to citizens’ health and wellbeing, quality of service delivery and use of resources. One way of achieving this is through a commitment to a coproduction approach to service improvement and redesign. The ICB recognises that working in partnership with people who live their lives with a health condition, whether themselves, as a carer, or who access health and care services, provides valuable insight and information so that the ICB and the System can ensure that health and care services meet the needs of our population.

All Maternity Service Improvement, Transformation and Service Re-design will take place in a coproduced way, working to the coproduced ICB Coproduction Strategy and in doing so ensure that the lived experience voices of those using maternity services are embedded within our work approaches, improvement and key decision making.

**ICB Coproduction Principles and Values**

1. We will put people with lived experience, including carers, at the heart of all we do by valuing their skills, knowledge and interests and giving them an equal voice alongside those of paid employees to improve services.
2. To work as equal partners, we need to be honest and open with each other to promote mutual trust.
3. We will ensure a co-production plan is developed at the start of any new project or service and will be co-produced to its end.
4. We will plan for and work to realistic timeframes for coproduction- recognising that coproduction will take time to do well.
5. We will actively recruit or involve diverse voices in a meaningful way, to ensure everyone has a chance to shape our system and the services within it and ensure that anyone who wants to be involved is able to do so.
6. We will use language, written information and other kinds of communication that works for all.
7. To show that we value people’s voices, we will pay out of pocket expenses and offer involvement payments and reimbursement options for the time they give.
8. We will support everyone to access training and support to enable them to develop their skills and knowledge.
9. We will always tell people what has been achieved because of their contribution.
10. We will work across the system, sharing knowledge and insight from different coproduction projects, to prevent duplication of work, and to show that co-production works.

  
**2.3 | Stakeholder & Communication plan**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Phases** | **Activity** | **Key stakeholders** | **Timescales** | **Outputs** |
| Phase 1  Background & Context | Who are the stakeholders for equity?  What do we already know about the local maternity population?  What maternity data is held in the system?  What do the latest JSNAs tell us?  What does the WRES data & staff survey say? | ICB Population Health Management  Nottingham City Council Public Health Team  ICS Health Inequalities Team  Trust Board Level Safety Champions  Nottingham CityCare Partnership  Small Steps Big Changes  Lincolnshire LMNS – Buddy  Nottinghamshire County Council Public Health  Nottingham University Hospitals NHS Trust  Sherwood Forest Hospitals NHS Foundation Trust | Aug 21-Nov 21 | Maternity Equity Analysis  Part 1 of strategy: Understanding our local picture |
| Phase 2  What is already happening across the ICS footprint? | Understanding of NHSE/I Maternity Equity Guidance  Alignment to ICS HI strategy  Alignment to LMNS workstream delivery plans  EDI Policies  Community Asset Mapping  Assimilate National Drivers & Policies  Current activities and further plans in the system to support equity | NHSE/I Midlands Perinatal Team  NHSE/I Midlands Equality & Inclusion  ICS Outcomes Frameworks  Digital Notts  Associate Director of System Assurance - ICB  Maternity Commissioner  ICS Health Inequalities Team  Nottinghamshire Best Start  Place Based Partnerships  Primary Care Networks  CVS Organisations  MVP/Experts by experience  LMNS PMO Team  ICB Communications & Engagement Team  Nottinghamshire Healthcare NHS Foundation Trust | Feb 22- May 22 | System-wide mapping of partner strategies  Map current and planned activities to NHSE/I requirements  Draft community asset directory to go on website |
| Phase 3  Working collaboratively to develop the plan | Subgroup to develop a plan  What should be included?  Themes from Equity Analysis  Vision, Values & Aims  Processes to monitor progress  Coproduction  Resources & Interdependencies  How to structure the plan? | MVP/Experts by experience  LMNS Serious Incident Shared Governance Group  LMNS Dashboard Subgroup  ICS Health Inequalities Team  Nottingham University Hospitals NHS Trust  Sherwood Forest Hospitals NHS Foundation Trust  Nottinghamshire County Council Public Health  Specialist Midwives  LMNS PMO Team  LMNS Personalisation Workstream  LMNS Continuity of Carer Workstream  Consultant Midwives  LMNS Perinatal Quality Surveillance Group  LMNS Transformation Board  ICB People & Culture Group | May 22-June 22 | Form a Maternity Equity Subgroup  Applied  coproduction lens  First draft plan |
| Phase 4  Plan endorsement & sign off | Identify appropriate forums to showcase the draft plan  Book time on meeting agendas/forums to gain comments on draft plan  Understand timescales & sign off governance  Implement comments/feedback  Publication  Feedback from NHSE/I Regional Team | NHSE/I Midlands Perinatal Team  MVP Board  LMNS Senior Responsible Officer  PCN Forum  LMNS Transformation Board  LMNS Perinatal Quality Surveillance Group  LMNS Executive Partnership Board  ICB Board  LMNS Senior Responsible Officer | June 22 -Dec 22 | PowerPoint presentations to showcase the plan & approach  Governance plan  Final strategy |
| Phase 5  Implementation plans | Commitment from workstreams to implement assigned equity actions  Workstreams to prioritise, design, implement and monitor assigned equity actions  Workstreams to report into agreed governance routes to ensure continuous quality improvement | LMNS Transformation Board  Nottingham University Hospitals NHS Trust  Sherwood Forest Hospitals NHS Foundation Trust  LMNS Quality & Safety Guidelines Workstream  Trust Board Executive Leads for health inequalities  ICB Communications & Engagement Team  LMNS Workforce Working Group  MVP/Experts by experience  LMNS Continuity of Carer Workstream  LMNS Personalisation Workstream  Consultant Midwives  Trust Board Level Safety Champions  ICB Personalisation Team  GPs  MIS-R Programme Board  LMNS Senior Responsible Officer  ICB Coproduction Team  Commissioned services  LMNS Perinatal Mental Health Workstream  LMNS Maternal Health Workstream | Jan 23 onwards | SMART & coproduced equity implementation plans |

**Part 3 | Our Maternity Equity Plan –** Planning through Workstreams & Enablers

|  |  |  |  |  |  |  |  |  |
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| **3.0| Digital**  The Nottingham City JSNA (2019) identified that information technology systems required improvement across the maternity pathway. The maternity systems used in hospitals and in the community are different, which prevents maternity records being accessed and updated by midwives based in the community whilst ensuring safe and effective data-sharing with other services including GPs, Health Visiting and IAPT services. In addition, digital mechanisms to enable women and birthing partners to have access to their own digital maternity records should be prioritised.  There will be an ICS wide approach to enable a system level shared understanding of Nottingham and Nottinghamshire health inequalities including prevalence, risk factors, access, experience, and outcomes.  The digital activity to support equity in maternity services will include activity to restore NHS services inclusively, ensuring datasets are complete, timely and support an understanding of the population and their health needs. In addition, the LMNS Digital workstream will ensure they mitigate against digital exclusion.  While staff routinely ask for demographic information at maternity booking appointments, which will support personalised care, antenatal screening, and appropriate referral pathways, locally we need to improve our digital information systems to enable us to pull through these data sets and report accurately, in particular on ethnicity. Locally we have procured a new Maternity Information Replacement System (MIS-R) and activity around the implementation and function of this will support equity. | | | | | | | | |
| NB: This is a high-level plan as approaved by our ICS/LMNS Board. Following this, our next steps will be to coproduce separate and detailed action plans for the agreed milestones & deliverables, with *named* responsible owners, all overseen by the accountable LMNS Pillar & Workstream Leads. | | | | | | | | |
| Aligning to partner strategies | | | | | | | | |
| *Maternity Equity Guidance Priorities*  *1.4, 2, 3.1* | | | *ICS Outcomes Framework*  SLO-25 | *ICS Health Inequalities Plan*  √ | | *Place Based Partnerships*  √ | | |
| Short term – for implementation in 2022/23 | | | | | | | | |
| Initiatives | Cohort | Description | | | Impact | | Metrics | Responsibility |
| Funding, procurement, training & implementation of one unified maternity information replacement system (for the 2 local trust providers of maternity services)  Implement Covid-19 four actions*: Ensure all providers record on maternity information systems the ethnicity of every woman and birthing person, as well as other risk factors, such as living in a deprived area (postcode), co-morbidities, BMI and aged 35 years or over* | Maternity staff, pregnant women and birthing people across the ICS footprint | Secure and meet funding requirements of £1,768,500 from the NHSX Unified Tech Fund.  Procure a Maternity Information replacement system – Badgernet  The Digital team to create the governance framework for the implementation phase ensuring that both local delivery, system oversight and accountability is in place, including clear links to the wider ICS digital programme and standards.  Ensure Badgernet meets local needs and captures the data and reporting mechanisms to support clinical effectiveness, safety and maternity improvements. This will include pulling through patient identifiable data from child health records including ethnicity, postcode, DoB, BMI and comorbidities and other potential risks to the mother or baby. Additional data fields will be built into the new Badgernet system to capture the number & proportion of women with complex social factors who attend booking by 10 weeks, 12+6 weeks and 20 weeks and then for each complex social factor grouping, the number of women who attend the recommended number of antenatal appointments.  Maternity staff to undergo training on the new system, its functionality and their own responsibilities. This will include training on recording accurate postcode and ethnicity coding at midwifery booking appointments.  Enable self-referral by women and birthing people and families into maternity services via Badgernet Maternity Notes – an online portal and app that allows access to their maternity records in a read and write format. Longer term, Badgernet Maternity Notes App will have interoperability to the NHS App/login.  The MIS-R programme team will be developing a digital PCSP by the end of the 2023. Reviewing the needs and access requirements of a digital PCSP so women and birthing people can effectively use their plans and pregnancy care records digitally are underway.  The new system will enable women and birthing people to own their care records and add into them during pregnancy care and postnatal pathways.  In addition, plans to explore incorporating neonatal pathways into the digital system are being scoped.  Longer term, the reporting functionality of Badgernet will be explored, including how to replicate locally some of the work done by the *Black Country* on their data reporting and impact on Equality & Diversity. | | | One programme team to support interoperability, sharing best practice and benefit realisation. A single digital system will improve quality of care for women and birthing persons and support midwives and other clinical users.  Greater integration and interoperability will reduce the risk of harm to women and birthing people, and enable digital leadership and maturity into both Trust providers.  Greater patient ownership of their own care records will improve patient experience as details are not missed or repeated to different healthcare professionals.  To enable maternity staff to identify those most at risk of poorer outcomes. | | Increased valid postcodes for mothers and birthing persons at maternity booking in 95% of cases.  Increased valid ethnic categories for at least 80% of the women and birthing persons booked in the month.  Improved ethnicity data quality.  Compliance to COVID-19 four actions. | MIS-R Programme Board  NUH Digital Team |
| Data integrity through the Systems analytics intelligence unit (SAIU) | Ethnic minority groups | All organisations across the ICS have processes in place to improve the completion rate and accuracy of capturing ethnicity in their patient records –focus will continue during 22/23  ICS will be using local technology that will allow systems to communicate with each other in order to safely share ethnicity information. This will allow individual organisations to use this shared access to improve completion rates and processes can be put in place to improve accuracy if there are any conflicting records.  Local databases of GP records have been used to identify Primary Care Networks with a high proportion of ‘Not Stated’ or ‘Unknown’ ethnicity codes (ranges from 3%-18%). Practices within these PCNs have been targeted for a pilot programme using direct messaging to patients with ‘Not Stated’ or ‘Unknown’ ethnicity code, patients are asked to complete a short survey to update their ethnicity.  Project in place to substitute ethnicity codes from secondary care settings where they are available but missing from the primary care record.  SAIU is integrating workforce data and analysis into its functions so will be able to provide the ethnic breakdown of midwifery staff.  The governance structures of the ICS include a Strategic Analytical Unit with representation from analysts across all partners. The SAIU is supported by an operational group and strategic oversight board. The ICS also has a Data and Information Board with a focus on data sharing and data integrity. | | | Ensure Datasets are Complete and Timely | | Decrease the proportion of GP records with ethnicity codes of Not Stated or Unknown  Increased valid ethnic categories for at least 80% of the women and birthing persons booked in the month. | SAIU  ICS Data & Information Board |
| ICS Public facing Digital Service Strategy | All persons living in Nottingham & Nottinghamshire, including maternity service users | A Public Facing Digital Strategy that is supported by a Digital Patient Advisory Group and underpinned by local research and a digital inclusion map. This information is utilised by the PHM analytics team to inform reviews. | | |  | | No. of patients across the ICS footprint who have registered, logged in and/or accessed the NHS App and patient knows best functionality. | PHM analytics Team  Digital Notts |
| Digital Inclusion Plans | Those living in deprived areas; those with sight or hearing loss and/or learning disabilities  For those where English is not their first language | Improve digital and social inclusion and health literacy across the ICS area by reducing health inequalities and ensuring that socio-economic factors do not disadvantage access to digital services. Through the introduction of a number of innovative schemes, the project helps people to get the most out of technology and supports them in gaining the essential skills and confidence they need to start using it for their health, care and wellbeing needs. We will support people to get online and become more confident and capable of using digital tools that support their health, care and wellbeing.  Initiatives to include:   * A Digital Support Line * Virtual training sessions * Community and Voluntary Service (CVS) Grant Scheme to embed digital inclusion support to local communities * Digital support pop-up hub roadshows supporting individuals to access digital services (the NHS App) in GP Practices.   Devices will be provided to service users to support them to access & engage with services, including through pregnancy.  Evaluation to give a strong evidence base for different types of intervention and show the impact of schemes and how they are changing health and care for the better. | | | To mitigate against digital exclusion  Supporting those digitally excluded to access primary care services to maintain their wellness / ongoing medical needs without the need to access secondary care services.  Improved patient access & experience  Ensure people are not left out of digital services because of socioeconomic factors. | | Positive evaluation /impact on digital inclusoin | Digital Champions Network  Digital Patient Advisory Group  Local CVS  Digital Inclusion Co-ordinators  MIS-R Programme Board |
| PCN digital inclusion officer(s) | Those living in deprived areas; those with sight or hearing loss and/or learning disabilities  For those where English is not their first language  Those that are digitally excluded e.g. refugees. | Digital inclusion officers will support those who are currently digitally excluded to access primary care services. This will involve building relationships with organisations locally who already support refugee populations and those identified as being digitally excluded across the ICS footprint. PCN inclusion officers will support those seeking refuge in our neighbourhoods to access health care systems and also wider societal networks to give these families the best start to their resettlement within Notts. This will include navigating access to:  •Register with a GP  •Repeat prescriptions  •Care for long term conditions  •Health Checks  •Women and birthing people and children’s health needs including maternity  •Mental health support | | | Improved experience of resettlement and community integration within Nottinghamshire.  Will provide access to the Single Point of Access (SPA), prebooking assessment.  To mitigate against digital exclusion | | Increased access to primary care services from cohorts previously excluded | Digital Inclusion Officers |
| Medium term - for implementation in 2024/25 | | | | | | | | |
| LMNS Maternity Dashboard & Dashboard Subgroup | Black, Asian and Mixed ethnic groups | Development of a monthly LMNS dashboard which is fed by national and locally available datasets, as well as data from trust and partner specific activity e.g. smoking in pregnancy or mental health.  Established Dashboard Subgroup comprising of local data, quality and clinical experts to assess the data and to pull out trends, themes, gaps and areas of concern.  Develop a robust process for using the dashboard to support maternity outcomes. This will include a feedback loop into and out of the Dashboard Subgroup to share the data and trends pertinent to different maternity workstreams and to support staff and patients to access and use the data themselves.  Targeted interventions required support vulnerable, deprived, BAME and other at-risk groups will be easily identified.  Adding in and monitoring new data collection requirements locally as required. | | | This data will enable the LMNS to have understanding of the local population’s maternal and perinatal health needs.  Maternity workstream delivery plans will be driven by and evaluated current and wide data sets within the dashboard.  The dashboard subgroup will support workstream delivery managers and service users to prioritise maternity interventions. | | Increased range of data metrics will be collected locally.  Booking at <70 days gestation, Low birth weight  Deliveries under 27 & 37 weeks  % of women attending the booking appointment who are from ethnic minority groups  % of EM parent members of the MVP | LMNS Dashboard Subgroup  LMNS PQSG  LMNS Workstreams |
| Long Term - for implementation in 2025/26 | | | | | | | | |
| Recording ethnicity of all patients registered within the PCN | Ethnic minority groups | Improve ethnicity coding in Primary Care using direct text messaging to patients. This work is targeted in areas that have a high percentage of patients with “Unknown” or “Not stated” ethnicity codes.  Data mapping exercises are being carried out to use secondary care data to fill in the gaps in primary care data for population health management and health inequalities analysis. | | | Improved data quality of ethnic coding. | | Increased valid ethnic categories for at least 80% of the women and birthing persons booked in the month.  Decrease in the no coded as ‘Not stated, missing and not known’ | PCNs |

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| **3.1| Communications, Engagement & Coproduction:**  As stated in the City JSNA (2019), recent migrants, asylum seekers and refugees are far less likely to seek antenatal care early in pregnancy or to stay in contact with maternity services. Delays in accessing maternity care often results in worse outcomes for both mother and baby; this is a key concern given Nottingham’s diverse population. In addition, Pregnant women and birthing people who have difficulty reading or speaking English are the least likely to access maternity services within recommended timescales. Challenges in gaining timely access to translation services is a key barrier to accessing maternity services. This can sometimes result in the use of an inadequately trained (or no) interpreter (family member or friends) which poses risks for both the mother and healthcare provider. When this occurs, neither the healthcare provider nor patient can be assured that accurate and effective communication is taking place. Challenges around language barriers are a particular issue in Nottingham as over one-third of births (37%) are to mothers born outside the UK.  Comms and Engagement will act as an enabler for the maternity equity plan, by bringing together information and knowledge about system partners including those CVS organisations and how we can all link and support women and birthing people in their pregnancy journey. In addition, active coproduction, comms and engagement will put the voice of the people with lived experience at the heart of our work and enable the wider system to understand our population needs. | | | | | | | | | |
| NB: This is a high-level plan as approaved by our ICS/LMNS Board. Following this, our next steps will be to coproduce separate and detailed action plans for the agreed milestones & deliverables, with named responsible owners, all overseen by the accountable LMNS Pillar & Workstream Leads. | | | | | | | | | |
| Aligning to partner strategies ambitions | | | | | | | | | |
| *Maternity Equity Guidance Priorities*  1.2, 4a, 4a.1, 4a.2, 4e.2 | | | *ICS Outcomes Framework*  *SLO-09, SLO-14, SLO-16, SLO-26* | *ICS Health Inequalities Plan*  √ | | *Place Based Partnerships*  √ | | | |
| Short term – for implementation in 2022/23 | | | | | | | | | |
| Initiatives | Cohort | Description | | | Impact | | Metrics | Responsibility | |
| Development of coproduction approaches | Pregnant women and birthing people, their families | MVP Review - following a review of our MVP, the LMNS Executive Partnership Board agreed to spend a year of time and funding within the ICB to shape the future need, functions & delivery model of MVP to make it fit for purpose, including how MVP can/will support equity across the maternity & neonatal footprint.  Redesigning our MVP model will ensure we have a core mechanism through which we will undertake coproduction work to embed the voice of women in all key quality improvement, transformation and decision making.  Increasing diverse voices and representation of the MVP members will be crucial to ensuring all experiences are captured and learnt from and coproduction will form the bedrock of all the LMNS work.  ICB Coproduction - A new coproduction team has been set up to ensure all service improvement and redesign has a coproduction lens. The new team will support those delivering the equity plan with guidance and expertise to be fully coproductive. | | | Learning from direct voices of people with lived experience and shaping improvements together | | No. of coproduced activities undertaken  No. of people with lived experience involved in LMNS Pillars | LMNS PMO team  Provider Trusts  Commissioned Services  ICB Coproduction Team |
| Community asset directory | Statutory & VCS workforce across the ICS footprint.  Pregnant women and birthing people and families with vulnerable, complex or diverse needs. | A community directory which will list available services and support across  Nottingham and Nottinghamshire pertinent to pregnant women and birthing people and families will be developed.  Plans to host the community directory on a LMMS webpage, aligned with Best Start initiatives, are being explored.  Focus groups to engage women and birthing people and families from vulnerable, complex and diverse groups of our population will be undertaken to ensure the directory will meet the needs of the local population.  The useability, content and format of the community directory will be coproduced with service users via the MVP.  Training will be provided to workforce and CVS organisations in how to signpost the directory to members of the public as required. This will include PCN Social Prescribing Link Workers. In addition, this may include push notification via the BadgerNotes App. In addition QR codes on poster is being explored.  Need to ensure the directory signposts to the cross-border provision from other counties for women and birthing people who may go outside of our ICS for care.  Plans to audit downloads/usage of the directory to demonstrate effectiveness will be developed | | | Mapping the community assets into a one stop shop directory will help to address the social determinants of health | | Patient satisfaction scores.  Scores of the Workforce’s experience of the directory  No. of downloads | LMNS PMO Team  LMNS Digital Workstream  ICB Comms & Engagement Team |
| Citizens’ Panel | Pregnant women and birthing people and families within our localities | Our Citizens’ Panel is aimed at engaging members of the public in the future of local health and care services, and is an important opportunity for people to have their say on a wide range of health and care topics. Initially recruiting from the Nottingham City area, but if this pilot initiative is successful, we ntend to broaden membership out to other parts of the area we are responsible for.  The Panel will primarily be online, and will consist of a number of surveys, polls and questionnaires throughout the year. | | | Maternity staff and service users will have increased signposting and access to wider support from across the partnership.  Allow engagement to be conducted at relatively short notice. | | Increased engagement rates/survey responses | ICB Comms & Engagement Team |
| Engagement training & toolkit | Maternity staff and volunteers | In 2020 a PCN Engagement toolkit was coproduced with our Patient and Public Engagement Committee and VCSE sector colleagues. In 2022 we conducted a survey and piece of engagement work to revisit and refine the toolkit to ensure that this was fit for purpose and provided the right materials to help and assist with engagement guidance at neighbourhood and place levels.  A training package for individuals working with people and communities to ensure the necessarily skills, confidence and tools they need to generate and utilise high quality citizen intelligence and insight. | | | Increased confidence and skills to conduct engagement activity. | | Increased teams across the LMNS footprint engaging with maternity service users | ICB Comms & Engagement Team |
| Implementation of COVID-19 four actions - tailored maternity communications | BAME communities; those living in deprived areas | *Reach out and reassure pregnant BAME women and birthing people with tailored communication:*  ICB Comms & Engagement team coproduced infographics, communications and information leaflets to support maternity service users doing the COVID-19 pandemic and these messages are updated as required.  Trusts also developed BAME maternity information leaflets which highlight the increase risks during pregnancy to this cohort, including information and signposting about increased complications from COVID-19.  LMNS to collaborate with the communications team to improve informationsharing around accessing maternity services earlier – will prioritise how to target communities that experience poorer outcomes first, tailor communications for these communities and groups, map this against responses from survey (access, support, smoking, breastfeeding etc.) | | | These comms will help to restore NHS services inclusively | | Compliance to implementation of COVID-19 four actions | ICB Comms & Engagement Team  LMNS PMO Team |
| On-boarding Videos | Local populations including BAME, non-English speaking, asylum seekers & refugees | LMNS workforce will focus on building relationships with the local community and CVS organisations such as the refugee forum and Women’s Centre.  Project entails educating patients by creating video-based information in their own languages to increase understanding of the role of Primary Care and how to access services. | | | Enabling patients to receive the right care, from the right professional including access from and to other PC and GP services and reduce inappropriate use of primary care and A&E. | | Increased BAME accessing primary care services | Population Health Management |
| Comms & engagement for targeted antenatal courses/ workshops | Ethnic minority groups; those living in deprived areas | The Essential Baby Company in collaboration with existing service providers & the public will coproduce an antenatal education toolkit to support Black and brown skin women/ birthing people, in paper and digital formats.  Antenatal education embedded within workshops, aims to prevent risk escalation, and promote early intervention to address issues such pre-term labour. This approach provides support throughout the perinatal period minimising over-medicalisation and increases knowledge of existing medical conditions to manage risk factors effectively and safely. The toolkit will be achieved by creating a clinical and community antenatal care support toolkit with content, tools and videos, for those able to access digital material and those who are digitally excluded; delivered through workshops. The toolkit is an education tool and communication solution. Culturally appropriate evidence-based information for women and healthcare professionals to identify risks and manage them in one straightforward document that is simple to understand and able to translate into different languages. The toolkit enables health professionals and women to work collaboratively to overcome barriers to health and social needs, enabling management of self-care and continually identifying ongoing risks  The embedding of social prescribing to support patients through the workshops and beyond, to ensure that staff are actively involved in sourcing and collating community and health asset information to support social prescribing directory, providing early support and tools to prevent risk escalation.  Develop the first health inequality risk assessment via pre-written scripts using screening questions and incorporating common clinical conversations to determine early identification and intervention needs at booking stage, 2nd/ 3rd trimester to formulate a personalised health, social and maternity care plan. | | | By pooling resources and upskilling workforces to overcome determinants of co-morbidity factors and deliver consistent, trustworthy and efficient maternity services to marginalised communities.  The workshops will bring health, social and community services together in one place to help lower health inequalities in maternity services. The workshops will help women gain new skills and make choices about their care.  This targeted provision will enable us to reach out and reassure pregnant BAME women and birthing people with tailored communications. | | Improved partnership working across the maternity pathway.  Increased personalisation and experience reported in BAME cohorts. | The Essential Baby Company  NUH |
| Medium Term - for implementation in 2024/25 | | | | | | | | | |
| Improved translation & interpreting services | Pregnant women and birthing people who are recent migrants, refugees, asylum seekers and/or those who have difficulty speaking or reading English. | Face-to-face interpreting services is the standard practise where possible and has restarted across maternity services as the COVID pandemic has less impact on this way of working. BIG WORD and/or telephone interpreting is used as a minimum at each appointment when required.  Given Nottingham’s diverse population, multilingual leaflets and materials will be available as standard practice and developed or sourced by midwifery services. | | |  | |  | ICB Comms & Engagement Team? | |
| Equality Impact Assessment | Families for whom English is not their first language | The 0-19yrs Public Health Nursing Team are undertaking a mapping exercise to ensure they have the knowledge and understanding of who their communities are and how to target appropriate communications and group support, with the use of an interpreter or translated literature as needed.  In addition, seamless communication across the partnership to share any risk factors and /or safeguarding needs of women and birthing persons will be explored. Having an understanding of the backgrounds and risk factors for pregnant women and birthing parents, will enable bespoke & personalised one: one appointments to be planned. | | | Personalised provision will enable us to reach out and reassure pregnant women and birthing people through tailored communications and appointments. | | Increased literature available in common languages.  Patient satisfaction ratings. | Nottingham CityCare Partnership | |
| Community Insights Hub | Ethnic minority groups; those living in deprived areas | The community insights hub will be a repository of information on our local communities and will help to inform programmes on community needs and characteristics.  The Hubwill be a key resource for capturing and reporting community intelligence that includes findings drawn from all system partners including statutory sector, VCSE, Healthwatch, citizens’ panel and networks at place and neighbourhood level.  It is the intention that the hub will also draw in data and insights created and published from outside our system, e.g., census data, ONS reports and wider public sector focussed reports and research. All of this will be captured and recorded in a database (to be developed over time) enabling a systematic record of what we know about certain communities or geographies. | | | Collaborative working will help to address the social determinants of health. | | Work with system partners and the VCSE sector will help to address the social determinants of health. | Placed Based Partnerships | |
| Long Term - for implementation in 2025/26 | | | | | | | | | |
| Health Champions Programme | Black, Asian and Mixed ethnic groups | Develop a Community Health Champions Programme specifically aimed at engaging BAME communities in areas of health inequalities (vaccinations, maternity, IAPT services etc).  Newly recruited Health Champions via the Majority Black Led Churches (MBLC) will support us to develop even closer partnerships with people living and working in our communities to understand barriers to access | | | Empowering communities to access primary care services | |  | Place based partnerships | |

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| **3.2 | Personalisation:**  Personalised Care & Support Plans (PCSP) should set out a woman and birthing person’s decisions about the care and support she wants and support and document conversations and decisions about agreed care plans that reflect a holistic assessment of the woman and birthing person’s health and wellbeing needs. Women and birthing people need evidenced-based information in advance of decision-making so that they are well prepared. We do know that since the Better Births report (2016), our midwives routinely provide individual care plans which support personalised care with tailored pathways, recommended number of appointments, referrals to specialist support and so on. However, being able to lift this detail off our current information systems to enabling birthing persons to ‘own’ this approach to their care is problematic. Therefore, we are unable to understand how personalisation is benefiting our local women and birthing people or if they are contributing to improved equity outcomes.  A paper PCSP is given out to every woman and birthing person at their midwifery booking appointments, but in most cases, it is not being used. We need better understanding from staff and birthing people about how PCSPs can be used to capture the personalised care already experienced and how they can support a cultural shift enabling greater decision making for women and birthing people in their maternity journey.  Proactive care, self-management and personalisation is a key enabler to progress the ICS health inequalities strategy and there has been an increased awareness of the importance in addressing inequities in health across access, experience and outcomes. This programme of work is reviewed through a Personalisation Board and supports maternity services to mitigate against digital exclusion and to make improvements in maternal morbidity, mortality and experience. | | | | | | | | |
| NB: This is a high-level plan as approaved by our ICS/LMNS Board. Following this, our next steps will be to coproduce separate and detailed action plans for the agreed milestones & deliverables, with named responsible owners, all overseen by the accountable LMNS Pillar & Workstream Leads. | | | | | | | | |
| Aligning to partner strategies | | | | | | | | |
| Maternity Equity Guidance  *2.1, 4b.5* | | | ICS Outcomes Framework  *SLO-09, SLO-16, SLO-18, SLO-27* | ICS Health Inequalities Plan | | Place Based Partnerships | | |
| Initiatives | Cohort | Description | | | Impact | | Metrics | Responsibility |
| Short term – for implementation in 2022/23 | | | | | | | | |
| Understanding barriers to PCSP | Pregnant women and birthing people across the ICS footprint. | To better understand why the current PCSP isn’t being used effectively, LMNS will work in collaboration with our local Maternity Voices Partnership, to develop three workshops with women and birthing people and to review the quality, usability and barriers to PCSP. | | | Improve the number of women and birthing people and staff realising the benefits of PCSP. | | Attendance at workshops | Maternity Voices Partnership  Personalisation Workstream |
| Personalisation training | Maternity staff | 700+ maternity staff trained in personalised care and support planning and shared decision making. This will involve online training of the workforce in shared decision making and the principles of choice and personalisation, supported by the ICS Personalisation Team.  All maternity professionals will use PCSP with women and birthing people so that it is reviewed and recorded at all stages of their maternity journey - antenatally, during intrapartum care and postnatally. | | | The training will support the culture change needed to embed personalisation & informed decision making into practise, ultimately improving service-user experience and outcomes. | | The No. of women and birthing people with a PCSP at:  17, 35 & 37 weeks gestation.  The numbers of women and birthing people who had all three of the above in place by the gestational dates with breakdowns by ethnicity & multiple deprivation | LMNS Personalisation Workstream  LMNS PMO Team |
| Digital PCSP / Patient Knows Best |  | Work with the NHS app and Patient Knows Best to increase the digital use of peoples care and support plan, and a one page profile –All about me -so it can be shared and used as a starting point to understand what matters to people, and what they want to achieve in relation to their health and wellbeing and how they can achieve it.  The MIS-R programme team will be developing a digital PCSP by the end of the 2023. Reviewing the needs and access requirements of a digital PCSP so women and birthing people can effectively use their plans and pregnancy care records digitally are underway. | | | Support improvements in maternity care systems including responding to the recommendations of the Ockendon review. | | No of PCSP being used | Digital Notts  LMNS Digital Workstream |
| Coproduce PCSP | Black, Asian and Mixed ethnic groups; those living in the most deprived areas | The current PSCP had been developed with the support of the MVP. After a period of use in practice, the need for further co-production has been evidenced by the incorrect application of the document and is now underway. Consultation will include service-users and workforce.  Adaptation of the Personalised Care and Support Plan is required to support accessibility and an equitable service offer. The aim is for the maternity PCSP to be available in a range of languages and formats, including hard copy PCSPs for those experiencing digital exclusion.  Explore ways to audit use and benefit of PCSP, including capturing & recording ethnicity and postcode of women and birthing people on the Badgernet information system. | | | Improvement of the PCSP document will enhance:  Inclusivity  Patient-experience  Practitioner application  Efficiency  Care outcomes  Appropriate use  This will benefit those living in deprived areas, BAME, those with sight or hearing loss and/or learning disabilities.  Ensuring the audit processes and resultant data is reflective of current service delivery will support future improvements and transformation work. | | The No. of women and birthing people with a PCSP at:  17, 35 & 37 weeks gestation.  The numbers of women and birthing people who had all three of the above in place by the gestational dates with breakdowns by ethnicity & multiple deprivation | LMNS Personalisation Workstream  MIS-R Programme Board |
| Medium Term - for implementation in 2024/25 | | | | | | | | |
| Data capture for PCSP |  | Badgernet will enable data collection on the number of women who have a PCSP and if they are used/review at different stages of gestation. In addition, the PCSP can be mapped to the personal record to capture ethnicity and multiple deprivation breakdowns. | | | A robust recording process to capture who and when  PCSP are in use will support risk and impact analysis of those lining in deprived or BAME communities. | |  | LMNS Digital Workstream |
| Home Birth Service development | Pregnant women and birthing people across the ICS footprint | Project support is being offered by the LMNS PMO to provider organisations for initiatives which improve choice and personalisation. An example of this is supporting NUH in piloting a renewed home birth service, a service which was impacted by the COVID-19 pandemic. | | | Increasing choice within care delivery improves service user experience and ultimate care outcomes, including mental health outcomes postnatally. | |  | LMNS PMO Team  NUH/SFH |
| Long Term - for implementation in 2025/26 | | | | | | | | |
| Green Social Prescribing | Those women and birthing people with low income, high long-term unemployment  Pregnant women and birthing people who are Inactive, overweight and/or experiencing mental health problems | Promoting exercise, heathy lifestyles, wellbeing and nature based activities including local community based activities such as:  Community Garden Project  Community chair based exercise &social wellbeing groups  Implementing social prescribing teams to support referrals and engagement, encouragement, support and guidance to patients who are reluctant to attend social activities from the social prescribing team to ensure that all patients are able to access local community services. | | | The reduction in factors associated with poor health outcomes such as:  Loneliness  Substance use  Inactivity  Isolation  Generational tendencies towards inactivity  Aversion to activities for financial reasons  Improved mental health and wellbeing through community networking, physical exercise, and shared experiences.  Activities are frequently associated with financial implications. Providing the community with free activities supports those who are eager to engage with the community but are financially unable in accessing worthwhile experiences. | | Referral and engagement rates to social prescribing offers in the community | Personalisation Team |

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| **3.3| Perinatal Mental Health:**  Increasing access to perinatal mental health services is an ongoing requirement. Nottinghamshire County Council’s JSNA recommends a need to better identify and support women and birthing people with mild to moderate mental health needs, not just those with severe mental health concerns. The Maternity Specification (2021) wants to ensure the mental health needs of all women and birthing people are assessed at booking, after 28 weeks and postnatally (as a minimum) with appropriate referrals to specialist perinatal psychiatry or psychological therapy services, along with information sharing with the woman and birthing person’s GP and health visitor.  This programme of work will support maternity services make improvements in maternal morbidity, mortality and experience by focusing access by ethnicity & deprivation. | | | | | | | | |
| NB: This is a high-level plan as approaved by our ICS/LMNS Board. Following this, our next steps will be to coproduce separate and detailed action plans for the agreed milestones & deliverables, with named responsible owners, all overseen by the accountable LMNS Pillar & Workstream Leads. | | | | | | | | |
| Aligning to partner strategies ambitions | | | | | | | | |
| Maternity Equity Guidance  *4b, 4b.4* | | | ICS Outcomes Framework  *SLO-07, SLOO-09, SLO-14* | ICS Health Inequalities Plan | | Place Based Partnerships | | |
| Initiatives | Cohort | Description | | | Impact | | Metrics | Responsibility |
| Short term – for implementation in 2022/23 | | | | | | | | |
| Mental Health assessment Tool for maternity services | Women and birthing people experiencing mental health issues including those form ethnic minority groups; those living in deprived areas. | In a joint venture from the specialist midwives at NUH and SFH, a new assessment tool to support and improve pathways from maternity services in  to psychological therapy services. This tool comprises an assessment algorithm and a guideline to improve understanding of the different referral pathways available.  The tool will be accompanied by a rolling training programme with a video/power point to clarify referral pathways to particularly support the community midwifery teams.  A SOP with further guidance about mental health pathways has been written and the plan is to get this published so it can be shared widely. | | | Increased confidence in staff to assess and refer  Early and appropriate support for those women and birthing people most at risk from mental health concerns. | | Increased referrals to IAPT and psychiatric services from maternity | Specialist Midwifery for Mental Health |
| Trauma & Bereavement Service | Women and birthing people and families who have experience birth trauma or baby loss | The Specialist Perinatal Mental Health team launched their Maternal Mental Health pilot in Jan 2022. The pilot has been named The Perinatal Trauma and Bereavement service, and It sits alongside the perinatal mental health team.  It is is now accepting referrals from all Health Professionals. The team is made up for clinical psychologists, trauma informed specialist midwife and peer support worker. They offer Assessment, signposting , advice and guidance.  They also offer the following psychological intervention:  • Compassion focused therapy  • Cognitive behavioural therapy  • Art psychotherapy  • Emotional stabilisation  • Acceptance commitment therapy  • Birth trauma stay and play  • Birth reflection  • Eye Movement Desensitisation Reprocessing (EMDR) therapy is a means by which you can accelerate your natural emotional healing. Processing the trauma and helping to relieve PTSD symptoms  • partner assessment and sign posting  Upcoming projects: tokophobia pathway, implementing a screening tool for fear of childbirth and tokophobia antenatal group. | | | Tailored support for families who have experienced baby loss.  Psychological and specialist midwife support to prepare for birth.  Improving communication between mental health and obstetric teams.  Psychological intervention for women and birthing people experiencing PTSD following birth trauma.  Identifying tokophobia early so appropriate support can be given. | | Increased and appropriate referrals to trauma and bereavement team.  Psychological Outcome measures. | Perinatal Mental Health Team |
| Medium Term - for implementation in 2024/25 | | | | | | | | |
| Mental Health training for Neonatology | Staff working on neonatal units  Women and birthing people and families using neonatal services | At SFH, we will scope a collaboration between PMH Midwifery and practice development matrons in neonates to work together to increase mental health training for the neonatology unit.  This is likely to include the tailoring and or creation of the current online training package, with particular focus on recognising perinatal MH red flags and where to go for help. | | | Support clinicians working in neo-natal units to identify and signpost families with maternal mental health needs. | | Increased confidence in staff to assess and refer appropriately.  Increased referrals recommended MH support for women and birthing people. | Perinatal Mental Health Midwifery Team |
| Long Term - for implementation in 2025/26 | | | | | | | | |
| Identify and reduce health inequalities | Women and birthing people experiencing MH problems, to include those from Black, Asian and Mixed ethnic groups | To reduce inequalities in perinatal mental health, SFH will develop a peer support model and undertake community engagement with under-represented groups. This will include the following:  A survey to be developed by a parent with lived experience, easily accessible via a QR code, to capture the experiences of women and birthing persons at hospital when they have substance misuse and/or mental health issues.  The Perinatal Community Mental Health Team will employ & train peer support workers to provide for women struggling with MH needs from BAME backgrounds.  SFH MH Midwife will liaise with the vulnerable women’s midwife at NUH re. local resources/support groups for BAME women and birthing persons and to replicate similar resources for the midwifes at SFH.  Processes for accessing talking therapies for women and birthing people for whom English is not their first language will be researches and disseminated across the maternity team.  Implementation of a social prescribing plan for pregnant women and birthing people who are inactive/overweight and experiencing MH problems - starting a walking group for our MH women. | | | Peer support workers will provide additional capacity to support the most vulnerable women and birthing persons  Staff will have more resources to support them to deliver high quality personalised care  Inactive women and birthing persons with MH will benefit from connecting to other local women and birthing persons, and being in nature and undertaking exercise | | Increased engagement and positive feedback about maternity experiences  Frequency of additional resources being utilised to support vulnerable women and birthing persons with MH. | LMNS Perinatal Mental Health Workstream  Perinatal Community Mental Health Team  Specialist Midwifes for PMH |

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| **3.4| Workforce & Training:**  As a system, we are more likely to achieve equity for our maternity & neonatal staff and service users if we provide high quality clinical care. This relies on establishing adequate staffing and a high quality and maintained training programme. Workforce and training will act as a key enabler for the Maternity Equity plan, by working in collaboration across the partnership to establish robust recruitment and retention and support mechanisms for maternity staff. This will include a focus on equality and diversity for staff, alongside coherent and well-planned staffing levels.  A Nottingham & Nottinghamshire LMNS Workforce Group has been established to include HR representatives and maternity & neonatal providers. This group will oversee and be accountable for a series of task and finish groups will be set up to share best practice, find opportunities to collaborate and to overcome workforce challenges as a system. | | | | | | | | |
| NB: This is a high-level plan as approaved by our ICS/LMNS Board. Following this, our next steps will be to coproduce separate and detailed action plans for the agreed milestones & deliverables, with named responsible owners, all overseen by the accountable LMNS Pillar & Workstream Leads. | | | | | | | | |
| Aligning to partner strategies ambitions | | | | | | | | |
| Maternity Equity Guidance  *1.1, 4a.3, 4d, 4d.1, 4d.3* | | | ICS Outcomes Framework  *ICS People Plan, SLO-26, SLO27, SLO-28* | ICS Health Inequalities Plan | | Place based Partnerships | | |
| Initiatives | Cohort | Description | | | Impact | | Metrics | Responsibility |
| Short term – for implementation in 2022/23 | | | | | | | | |
| Hospital EDI Policies | Maternity staff from BAME groups | The Trusts will utilise ‘Positive Action’ in recruitment processes in direct response to staff survey feedback and Workforce Race Equality Standard Metrics. [Positive action is taking steps to help or encourage certain groups of people with different needs, or who are disadvantaged in some way, access work or training].  The trusts will regularly collect data from staff to examine how the EDI policies and practices are affecting jobseekers and employees.  Monitoring will include gathering individual personal information on the diversity of potential recruits or existing staff and comparing and analysing this against:   * Other groups of staff in the organization. * Jobseekers in the local community * The broader national labour market.   LMNS will work in partnership with the ICB EDI Partnership Advisory Partnership and through their special interest staff network groups to access all available resources, data and expertise to support implementation of this equity plan. | | | To achieve greater diversity and improve workforce equality at all levels of the organisation  Increased opportunities for career progression within BAME staff.  Eliminate disadvantage in disciplinary procedures for BAME staff. | | WRES indicators 1 to 8 for midwives and nurses in maternity and neonatal services | Trust providers  LMNS PMO Team |
| Cultural Competency Training | MDT staff at both provider trusts  Black, Asian and Mixed ethnic groups | Sherwood Forest Hospitals secured funding for 22 MDT staff from maternity to attend a 1.5day cultural competency training workshop.  Localised action plans will be written and developed by the staff attending training to take responsibility for making changes in their and colleagues’ practise.  12 staff members including PMH Specialist Midwife will then facilitate a train the trainer model to embed the learning gained from the cultural competency training into practice. The plan is for SFH to be able to deliver their own bespoke cultural competency training to staff and include it with existing mandatory training and teaching.  Staff attending training will undertake a baseline assessment of what is working well what could be improved before the training and then a reassessment following the training of how culture and conditions have changed.  A similar bespoke, train the trainer model has been agreed to be rolled out to all maternity & neonatal staff. It has been agreed for two LMNS PMO staff members to become the cultural competency trainers for the system.  Meanwhile options for all maternity staff to take brief training modules via the HEE e-learning platform are being explored as a temporary measure. | | | Increase the number of staff who have been training in cultural competency  Embed cultural competency training into mandatory training for maternity & neonatal staff  Maternity & neonatal staff due to increased cultural awareness | | % of maternity and neonatal staff who attended training about cultural competence in the last two years  Increased positive experience in BAME staff and service users | Consultant Midwife  LMNS Workforce Workstream  LMNS PMO Team |
| BAME Staff networks | Maternity staff from BAME groups | Black and Minority Ethnic (BAME) Staff Network groups have been set up at both trusts to promote equality and inclusion and provide support for staff from minority groups who may be experiencing problems in the workplace.  There is also a system-wide race equality group to support consistency of approach across all ICB partners and effective use of resources to support delivery. | | | This support will have a positive experience in BAME staff and service users | | No. of people joining the BAME staff networks | Trust providers |
| Medium Term - for implementation in 2024/25 | | | | | | | | |
| Expand and develop local maternity support workers workforce | Ethnic minority groups; those living in deprived areas | NUH have secured external funding to pilot a cohort of Band 3 AfC apprentice community Maternity Support Workers (MSW) who, upon successful completion of a L4 university-hosted programme will be eligible to apply for B4 AfC Senior MSW roles. These MSWs will be based within areas with increased levels of deprivation and high-density populations of individuals who are Black, Asian and/or within an Ethnic Minority; it is expected that the initial ‘enhanced’ MCoC Teams will be launched in these areas. We will utilise the positive action approaches to recruit MSWs from diverse backgrounds to reflect the local population. | | | Maternity Support Worker teams within targeted areas will provide additional support to BAME and economically disadvantaged communities | | Increased positive experience for vulnerable service users | LMNS Workforce Workstream  Trust Providers |
| ICS workforce, race, equality & inclusion strategy | Maternity & neonatal staff from BAME groups | This strategy has been devised in response to the People Plan and influenced by wider engagement across the 11 STPSs/ICS in the Midlands and the local People & Culture Group.  The plan aims to have the right and diverse leadership at all levels within our health care system with senior managers leading by example (see full plan in appendices). This will be achieved by:  Developing mechanisms for compassionate and inclusive leadership  Removing barriers to help staff speak up  Processes to actively tackle racism and other type of discrimination  Processes to eliminate racism/bias in recruitment and staff progression  Processes to eliminate racism/bias in staff disciplinaries | | | Addressing race inequalities has a positive impact on staff groups and also on patient outcome. | | Increase BAME trust board members  Reduction in BAME staff experiencing harassment and bullying from colleagues/staff | Nottingham & Nottinghamshire ICS |
| Long Term - for implementation in 2025/26 | | | | | | | | |

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| WRES Indicators | With BAME staff | Continued implementation and monitoring of the Workforce Race Equality Standard (WRES) in maternity and neonatal services. This will include:  Conducting frequent baseline assessments of the experience of maternity and neonatal staff by ethnicity using WRES indicators 1 to 8.  Using the knowledge from staff to plan & design interventions to improve race equality for staff – coproduction  Develop an audit process to monitor staff experience and monitor improvements. | Decreased reports of bullying & harassment to BAME staff from colleagues.  Increased opportunity for promotion and career progression | WRES indicators 1 to 8 for midwives and nurses in maternity and neonatal services | Trust Providers |
| Additional specialist midwifery roles | Support for pregnant women and birthing people who are homeless or experiencing domestic abuse | Increased capacity for specialist midwifery support for women and birthing people with complex social needs (e.g. homeless/domestic abuse/looked after/teens) and ensure a more equitable service is provided. | Peer support workers will provide additional capacity to support the most vulnerable women and birthing persons | FFT/Satisfaction scores | Trust Providers |

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| **3.5| Continuity of Carer:**  ***Historical Narrative:*** In 2019, the Nottingham & Nottinghamshire LMNS identified pilot sites by recognising geographical areas wherein health inequalities were more prevalent using local insight data. NUH launched two Midwifery Continuity of Carer Teams (MCoC Teams) in 2019 based in the geographical areas of Strelley and Bulwell, named Vale Team and River Team respectively. Both teams had an establishment of 8WTE (whole-time equivalent) Registered Midwives. Nottinghamshire Lower Super Output Area (LSOA) IMD 2019 results indicated that Bulwell ranked 130th nationally out of 32,844 therefore within 0.4% most deprived areas of England and Wales.  SFHT established two MCoC Teams in 2020, the first entitled Oak Team in January 2020 followed by Maple Team in June 2020. Both teams were GP (General Practitioner) based in the geographical area of central Mansfield. Each team was staffed with 6WTE Registered Midwives and a caseload ratio of 1:36. According to the Nottinghamshire Lower Super Output Area IMD 2019 results, Mansfield contained the 16th most deprived LSOA in England. SFHT made plans to launch a third MCoC Team in March 2021 to support its Trust in meeting the national target of 35% of women and birthing people booked onto a MCoC pathway by March 2021. However, recruitment was troublesome, and the venture was discontinued.  The COVID-19 pandemic significantly impacted both our provider organisation’s ability to meet demand for all women and birthing people booked onto the MCoC pathway.  Whilst NUH did not immediately suspend MCoC provision in response to COVID-19, the successful delivery was impaired by the need for MCOC team members who were on-call out of hours for their caseloads to be utilised as part of the escalation policy to maintain patient safety within the acute setting for women who were not part of their caseloads. A decision was made in January 2022 to disband MCoC Teams effective from 25th February 2022 to support the provision of safe staffing. A Quality Impact Assessment (QIA) was produced and agreed through the Divisional Governance Committee with subsequent executive level sign-off achieved. Whilst NUH recognised the impact upon service-user choice of suspending the local MCoC offer, the immediate need to optimise staffing alignment to improve safety and choice at a population level was of greater importance. NUH reported within the QIA that MCoC suspension would allow for increased choice in service-users who request access to a homebirth through promoting staff cover within the homebirth team which would otherwise have been utilised delivering MCoC.  SFHT disbanded the Mansfield-based MCoC Teams Oak and Maple in June 2021. Whilst the issues associated with delivering the MCoC model during the COVID-19 pandemic were also felt by SFHT, namely staff absence/isolation, SFHT also completed a thorough evaluation with the workforce on their experiences of working with MCoC Teams which further rationalised the need to pause delivery. Focus at SFHT was placed on antenatal and postnatal continuity with team members attending homebirths and elective lower segment caesarean sections (LSCS) as well as completing up to 2 shifts a month on the local birthing unit (Sherwood Birthing Unit).  In adherence to numerous communications from NHS England regarding COVID-19 priorities and shifting focus away from transformational work to support safe service delivery and the vaccination programme, Nottingham & Nottinghamshire LMNS supported provider organisations in their individual decisions to suspend MCoC.  ***Current position:*** The Nottingham & Nottinghamshire LMNS is now offering support to provider organisations in implementing the NHSE/I building blocks alongside these local initiatives to strengthen our system approach to MCoC. The development of an enhanced model of MCoC, which provides for extra midwifery time for women and birthing people and birthing people from the most disadvantaged areas will be informed by authentic workforce engagement and co-creation. This will ensure it is aligned to the needs of service users and staff, in compliance with national principles and standards, and phased alongside the fulfilment of required staffing levels. Trusts will work with staff and with the local restructured MVP to explore where areas of need are, look at which groups aren’t currently being effectively reached, and coproduce the model based on need, maximising value, and opportunities to improve outcomes in perinatal mortality, morbidity and experience. | | | | | | | | |
| NB: This is a high-level plan as approaved by our ICS/LMNS Board. Following this, our next steps will be to coproduce separate and detailed action plans for the agreed milestones & deliverables, with named responsible owners, all overseen by the accountable LMNS Pillar & Workstream Leads. | | | | | | | | |
| Aligning to partner strategies ambitions | | | | | | | | |
| Maternity Equity Guidance  *4c.1, 4e.1* | | | ICS Outcomes Framework  *SLO-08, SLO-12, SLO-16, SLO-17, SLO-26* | ICS Health Inequalities Plan | | Place based Partnerships | | |
| Initiatives | Cohort | Description | | | Impact | | Metrics | Responsibility |
| Short term – for implementation in 2022/23 | | | | | | | | |
| Refresh Birthrate Plus and establish safe staffing | All maternity service users | NUH and SFHT are presently undergoing revised BirthRate Plus assessments to ensure that staffing and skill mix requirements for each Trust are reflective of service demand.  Rolling Midwifery job advertisements will be live for both Trusts on NHS Jobs.  NHS attraction and retention experts instructed by NUH will work on marketing, branding and communications solutions to address workforce challenges.  NUH will offer financial incentives to Midwives joining the Trust.  International recruitment will be undertaken for both Trusts.  The LMNS Workforce Working Group is identifying opportunities for collaborative approaches across the two providers including the potential for joint recruitment and retention initiatives. This will inform the wider system strategic workforce development plans overseen by the ICB People & Culture Group. | | | Staffing requirements will be based on current local need, including the rates of those women and birthing people requiring additional input.  Workforce staffing and skill-mix will enhance equitable service-provision.  Improvements in midwifery staffing numbers will better enable the Trusts to deliver a consistent and dynamic service offer, acknowledging the individual needs and preferences of women and birthing people.  Decreased burnout and/or absence rates as staff pressures /resource/reduced continue to improve. | | No. placed on a continuity of carer pathway – Black/Asian women (source: Regional Measures Report)  No. placed on a continuity of carer pathway – Black/Asian women (source: Regional Measures Report) | Trust Providers  LMNS Workforce Working Group |
| Expand and develop local maternity support workers workforce | Ethnic minority groups; those living in deprived areas | NUH have secured external funding to pilot a cohort of Band 3 AfC apprentice community Maternity Support Workers (MSW). These MSWs will be based within areas with increased levels of deprivation and high-density populations of individuals who are Black, Asian and/or within an Ethnic Minority. (See workforce section of the maternity equity plan)  SFH will map their workforce to the HEE MSW framework.  A quality improvement project to pilot MSWs in the community setting is underway.  A Nottingham & Nottinghamshire LMNS Workforce Group will be established, including HR representatives and maternity providers, along with a series of task and finish groups will be set up to share best practice, find opportunities to collaborate and to overcome challenges as a system. The first task and finish will explore aspects of midwifery recruitment. Looking ahead, the group aims to develop a longer-term work plan to ensure strategic direction to recruit, train, develop and retain a safe workforce | | | Enhanced support offer for women and birthing people and families.  Increased capacity within teams to offer targeted support.  Improved evidence-based practice.  Increased capacity of registered practitioners.  More clearly defined MSW role supports team dynamic, caseload planning, guideline development and escalation policies.  Added consistency across the workforce promotes overall care provision. | | Increased positive experience for vulnerable service users | Trust Providers  LMNS Workforce Workstream |
| Developing mechanisms to support and enhance continuity in the antenatal/ postnatal periods (learning from SIs) | All maternity service-users | There is a system-wide commitment to direct caseload management towards continuity of practitioner through the maternity journey. | | | Continuity of practitioner reduces duplication within care and the risks associated with inadequate information sharing/ documentation processes. Where a service-user is consulting with familiar individual, they are more likely to share information leading to improved targeted care planning and subsequent positive care outcomes. | | No. of service-users receiving continuity from MCoC team across an agreed (TBC) percentage of antenatal and postnatal contacts.  Percentage rates of women eligible to receive MCoC that are in receipt of MCoC during the antenatal and postnatal periods | Trust Providers  LMNS Workforce Workstream |
| Establish community hubs | Areas with the greatest maternal and perinatal health needs. | SFH will move to hub working in 4 planned waves prioritising areas of greatest deprivation first. The number teams needed in each area will be mapped to the Number of WTE midwives required against the number of pregnant women and birthing people currently under the maternity service. | | | Hub-based teams allows caseload numbers to be more reflective of local need, supporting the workforce in balanced and more manageable workloads.  Moving towards hub-style working will allow ease the application of the MCoC model within Nottinghamshire. | | Successful reconfiguration project time scales.  Workforce feedback and attainment against KPIs | Trust Providers  LMNS PMO Team |
| Digitalisation and associated staff training | All maternity service-users | Nottingham & Nottinghamshire LMNS plans to use a new maternity information system replacement – Badgernet - to support and align maternity services across NUH and SFT.  Workforce training will be facilitated for all staff using the new digital system.  (See digital section of the maternity equity plan) | | | Improved clinical information sharing between NUH and SFT will improve care outcomes.  Improved safeguarding information sharing between trust providers  Appropriate training & application of the system within the multi-disciplinary teams will reduce repetition, improving service-user experience  Ease and improvement of data reporting into Maternity Dashboard. | | No. of service-users receiving continuity from MCoC team across an agreed (TBC) percentage of antenatal and postnatal contacts.  Percentage rates of women eligible to receive MCoC that are in receipt of MCoC during the antenatal and postnatal periods | MIS-R Digital team |
| Medium Term - for implementation in 2024/25 | | | | | | | | |
| Rotation models | All maternity service-users | Explore and develop effective models for staff to rotate between community and hospital teams across the system | | | Internal rotation of staff increases workforce exposure to alternate practice areas, improving care provision, referral/ escalation processes.  External rotation (NUH ⇄ SFHT) increased workforce exposure to differing demographics  Workforce rotation promotes shared learning across the system, championing best practice | | Workforce competency attainment.  Compliance against competency framework (to be explored and developed) | Trust Providers  LMNS Workforce Workstream |

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| **3.6| Maternal Health:**  Addressing prevention and promoting maternal health. The City JSNA highlights that white British women and birthing people aged 21-25 living in areas of high deprivation, are least likely to access smoking cessation services and/or successfully quit. This is consistent with the trend of greater smoking prevalence in areas of greater deprivation. A new approach is needed that involves all partners across the local maternity system to support women and birthing people to stop smoking during pregnancy and prevent high levels of postnatal relapse.  The public health subgroup of the LMS should lead work with partners to develop specific interventions to reduce smoking in pregnancy and support women and birthing people who want to quit smoking, including the utilisation of the NHSE grant. In addition the system should explore the potential for nominated midwives, maternity support workers and sonographers to be trained to the same level as specialist NHS Stop Smoking advisers to enable them to offer more intensive support.  The County JSNA states local Maternity Systems, public health leads, Healthy Family teams, children’s centres services should work in close partnership to support health and wellbeing in pregnancy, with a specific focus to reduce the proportion of women and birthing people smoking in pregnancy in line with locally agreed trajectories.  This area of work will align closely with the Best Start strategies and approach at County and City to ensure work commitments are aligned to have maximum impact for women and families. Existing alignment is in place for perinatal mental health and maternal health (with workstreams supporting both LMNS and Best Start priorities) and this will develop further as Ockenden recommendations inform LMNS deliverables set by NHSE. This will include pre-conception care.  Activities detailed below will support maternity services to restore NHS services inclusively following Covid-19, support improvements in maternal & perinatal mortality, morbidity and experience. | | | | | | | | |
| NB: This is a high-level plan as approaved by our ICS/LMNS Board. Following this, our next steps will be to coproduce separate and detailed action plans for the agreed milestones & deliverables, with named responsible owners, all overseen by the accountable LMNS Pillar & Workstream Leads. | | | | | | | | |
| Aligning to partner strategies ambitions | | | | | | | | |
| Maternity Equity Guidance  *1.3, 4b, 4b.2, 4c, 4c.2, 4c.3* | | | ICS Outcomes Framework  *SLO-06, SLO-07, SLO-08, SLO-09* | ICS Health Inequalities Plan | | Place Based Partnerships  *√* | | |
| Initiatives | Cohort | Description | | | Impact | | Metrics | Responsibility |
| Short Term - for implementation in 2022/23 | | | | | | | | |
| COmonitoring | Pregnant women and birthing people who are identified as smokers | Trust providers updated their CO processes in line with the NHS guideline brought out in Oct 2021. This has meant testing pregnant persons identified as non-smokers at booking and 36 weeks. Identified smokers were tested at every contact. All women and birthing people with a reading of > 4ppm to be referred to smoking cessation support / tobacco dependence treatment via an opt out method within 1 working day.  New NICE guidance has been published and trusts are implementing new processes to align with this. This will include testing every pregnant woman or birthing person at every contact regardless of smoking status and also once postnatally. Also, COreadings at >3ppm will be referred for smoking cessation support.  In addition, maternity staff will receive some brief advice training on how to use the COdevices via a video uploaded on staff networks and Facebook groups. | | | Links to the NHS Long Term Plan to reduce smoking in pregnancy | | COrecordings  No. of referrals to smoking cessation services  No. of staff trained  Compliance to COmonitoring processes | Midwifery Teams |
| Tobacco Early Implementer Site | Pregnant women and birthing people who are identified as smokers | SFH will implement an in-house team who will provide a tobacco dependency treatment service (TDTS) during pregnancy following the NHSE/I Long Term Plan Maternity Delivery Model.  An additional element will include a pilot incentive scheme for pregnant women and birthing people. The rewards are Love2Shop vouchers issued along the pregnancy course for CO verified 100% abstinence of smoking tobacco and for one other person in household who achieves CO verified personal quit throughout the course of the pregnancy.  Carry out a local evaluation of the pathway. | | | Women and birthing people and their partners will cease smoking prior to conception / between pregnancies / postnatally.  As this is in house this model also enables the team to track smokers across their pregnancy journey and really target efforts to engage women in tobacco treatment in a more personalised way helping to reduce inequity. | | No. of patients on the TDTS scheme  Abstinence rates | SFH |
| Implement Covid-19 four actions:  Healthy Start scheme | All women and birthing people | *Ensure hospitals discuss vitamins, supplements and nutrition in pregnancy with all women and birthing people:*  Community Midwives discuss vitamins, supplements and nutrition, including folic acid, at booking and follow up appt, and is recorded on the current maternity information system.  In addition, to support women and birthing people getting their recommended pregnancy vitamins, a system wide approach to promoting the *Healthy Start Scheme* to increase access is being developed. The LMNS Maternal Health delivery plan includes the following stepped actions:  Free starter packs of vitamins at SFHFT and NUH. The starter pack contains a bottle of vitamins and a leaflet about the Healthy Start scheme. It also includes information about the importance of vitamins in pregnancy and beyond and where to collect Healthy Start vitamins locally.  Actions to promote and signpost eligible families to the scheme e.g. survey circulated widely to the workforce to raise awareness of the Healthy Start scheme and link to further information and resources.  Nottinghamshire County Council (Public Health) has identified funding to provide vitamin starter packs until March 2026. Nottingham City Council (Public Health) is currently funding vitamin starter packs until March 2023.  Some localised communications in a 2-pronged approach have been planned. One is aimed at service users to signpost them to the scheme with ideas of things to ask their midwife about. The second will be aimed at health professionals as an education tool to support with advice on healthy eating, advice and info around vitamins and conversations around future pregnancies.  An evaluation plan is in place to gain feedback on the starter packs from pregnant women and birthing people, new parents and maternity services. This will be completed by January 2023. | | | Increased numbers of pregnant women and birthing people taking vitamins, supplements & nutrition in pregnancy | | No of women and birthing people using folic acid  No. of women and birthing people signing up for healthy start scheme | Community Midwifery Teams |
| Listening clinics for women accessing the PANDA clinic | Women and birthing people and families accessing the Pregnancy, Alcohol & Drug Antenatal clinic (PANDA) | Family Voices Champions running listening clinics and creating QR code for women and birthing people accessing PANDA clinic to share their feedback of maternity services.  FVC to feedback to senior midwifery leadership team and Maternity Safety Champions to ensure any learning is shared and integrated into service improvements if needed | | |  | |  | Consultant Midwife  MVP Volunteer |
| Medium Term - for implementation in 2024/2025 | | | | | | | | |
| Weight management | Patients at risk of pre-diabetes and Type 2 diabetes | Current signposting to weight management services delivered in the community for women with a BMI of over 30, including to organisations like Slimming World.  For clients with a BMI over 35, they are supported through consultant led care.  Next steps activity will include:  Understanding and addressing barriers to engagement to support this activity further.  Scoping the potential for this referral to be ‘opt out’ as standard for both maternity provider trusts.  Review uptake of the weight management pathway by ethnicity and deprivation. | | | Weight Management & Gestational Diabetes | | No. of referrals & uptake to weight management services for pregnant women and birthing people | ICB HI Project Managers |
| UNICEF Baby Friendly Initiative | Pregnant women and birthing people in areas of deprivation | *Promote the benefits of breastfeeding through the implementation of an externally evaluated, structured programme that encourages breastfeeding, using the UNICEF Baby Friendly Initiative as a minimum standard:*  NUH made the informed decision not to maintain their BFI accreditation due to staffing and other challenges. They have continued infant feeding support and have 3 WTE maternity support workers as part of the infant feeding team. However NUH they have recently taken up the offer to have a planning meeting with NHSE/I. This will include an interim audit of BFI standards to understand their baseline, current evidence, and then future plans. The audit is within the portfolio of a consultant midwife and support by the DOM.  Nottingham City Public Health teams are developing a breastfeeding charter in partnership with SSBC, while this is not the UK Baby Friendly Initiative, it as a step in the right direction and will help support NUH’s plans to achieve Unicef accreditation  In the county, work continues o develop and promote the Breastfeeding Friendly Scheme to encourage businesses and venues within Nottinghamshire to sign up to being ‘Breastfeeding Friendly’ as part of action to provide a more welcoming and positive environment for breastfeeding mothers.  SFH Maternity department is working towards Gold Award status for UNICEF Baby Friendly Accreditation. The Neonatal Team at SFH is also working toward obtaining level 1 and level 2 accreditation. | | | Increased proportion of women and birthing people breastfeeding at 6 to 8 weeks | | Baby Friendly accreditation | Public Health Teams  Trust Providers |
| Smoke free pregnancy pathways | Pregnant women and birthing people who are identified as smokers | Currently there are 3 stop smoking community based offers (ABL Health, CityCare & Stub It). We also have a pilot community pharmacy scheme for pregnant woman and birthing people to access smoking cessation treatments from their local pharmacies. This pilot is being delivered throughout 2022-23 and will then be evaluated to determine impact and next steps.  To enhance the exiting offer and to work in line with NHS LTP, a multi-agency plan to identify & establish a tobacco reduction pathway is in place with trust and community providers that includes additional, targeted support to parts of Nottingham City with highest smoking rates and a tailored programme of care to women in Nottinghamshire County. Different options will be considered which will include patient experience feedback to be included in the chosen pathway.  SFH are doing the EIS work (see above) and NUH are planning their own in-house model using expertise from the smokefree lead in the trust. | | | Women and birthing people and their partners will cease smoking prior to conception / between pregnancies / postnatally. | | Quit & Abstinence rates (although smoking cessation is often delivered antenatally by other trust providers, due to cross boundary working) | Community Stop Smoking Providers  Public Health  Nottingham & Nottinghamshire ICB |
| Diabetes and Pre-Diabetes  awareness | Patients as risk of diabetes with an emphasis on the BAME community | Women with a BMI over 35 are on consultant-led care and receive additional support via the maternity services in dedicated clinics. Postnatally, patients with a past diagnosis of gestational diabetes are given a letter and information leaflet with their diagnosis, care plan and postnatal advice which includes referral/ invitation to the National DPP. GPs also have processes to make referrals to the programme.  Additional activity will include:  Increasing opportunities to engage women in achieving healthy weight prior to conception and postnatally.  Engaging with patients who do not currently access services  Offer patient education and opportunity to upskill staffing –increasing knowledge  Undertake a review of potential barriers in the BAME population around risk of diabetes and co-design of the existing pathway to ensure it meets the needs of BAME population. | | | Reduction in the risk of pre-diabetes to improve quality of life outcomes and the debilitating impact and risk factors associated  Reduce the burden on the NHS | | No. of BAME women and birthing people who are referred to National DPP | Community Midwifery Teams  GPs |
| Breastfeeding Strategy | Pregnant women and birthing people across the ICS footprint | Develop a breastfeeding pathway, to map the offer across the LMNS system to support women and birthing people in understanding what is available to help them to breastfeed  The mapping activity will enable opportunities to strengthen / streamline the offer across the system.  A breastfeeding data dashboard will be developed to monitor performance in initiation and maintenance rates.  The pathway and dashboard development jointly led by a City and County Best Start on Breastfeeding Partnership group.  In addition, A Joint City and County Breastfeeding Strategy will be developed to help give direction to the breastfeeding offer.  Nottingham CityCare partnership are involved with breastfeeding pathways and have employed nutrition peer support workers to work alongside Health Visiting teams. Seamless joined pathways with the community midwifery teams offering infant feeding advice are required. | | | Increased proportion of women and birthing people breastfeeding at 6 to 8 weeks | | Breastfeeding initiation rates  Breastfeeding maintenance rates | LMNS Maternal Health Workstream  Small Steps Big Changes  Nottinghamshire Best Start  Nottingham CityCare Partnership |
| Interventions for Alcohol & Substance Use | Pregnant women and birthing people identified as users of alcohol &/or substances | The Alcohol Care Team at NUH continue to ascertain alcohol usage in pregnancy through the Audit C tool to support women and birthing people to stop drinking, where appropriate, with support from alcohol services.  Additional plans to strengthen early identification and support for women and birthing people using drugs or drinking alcohol during pregnancy and postnatally. Specifically, this will include:  Improving information and raising awareness of the danger/harm of drinking during pregnancy (to include information around opiates and oxycodene.  Ensuring screening are embedded and midwives are confident in using them. This will be achieved by exploring opportunities for midwifery training / protected time and also the implementation of the single question ‘Are you drinking at the moment?’  Exploring the role of primary care in the early identification of women and birthing people with substance use needs.  Strengthening the role of multi-agency services (including 0-19yrs teams) in supporting the holistic needs of women and birthing people who have substance misuse needs (alcohol and / or drugs) in pregnancy and after they leave the maternity service. Joint training and multidisciplinary staff updates will be explored.  Ensuring women and birthing people on caseload of the specialist midwife for drugs and alcohol also receive mental health screening and onward referral for potential mental health needs. | | | Will support early identification and support to women and birthing people with alcohol and substance use concerns | | Alcohol and substance abuse rates during pregnancy and postnatally  No. of referrals made to drug & alcohol services | Trust Providers  LMNS Maternal Health Workstream  Nottingham CityCare Partnership |
| Here, there and everywhere |  | A campaign/project as part of the Nottinghamshire Best Start Strategy working in partnership with Maternity and Health Visiting, Public Health and Education will:  Recruit and pay local an ethnic and socio-economically diverse group of women, birthing parents and families to take part in a media campaign to promote & normalise breastfeeding/ chestfeeding. This campaign would feature a wide range of parental age groups, racial and ethnic backgrounds, family types, and local well-  known locations as well as settings parents will access and may feed their baby (supermarket, park, café, breastfeeding group, playgroup etc). Participants to take part in a photographic campaign of them feeding their babies/children/posing with their baby/child , and would agree for their images to be used in posters and via social media to promote benefits and positives associated with a responsive breastfeeding relationship - no images of bottles or formula as per the WHO Code and BFI Standards.  Start an Instagram account for this project which would be overseen by the Infant Feeding Midwife at SFH – with posts and videos of local people’s voices and stories to share positive stories and realistic experiences and how women and birthing people have been able to breastfeed their children – through their own determination and outside support from NHS and peer support services.  Link with NCC youth service and Schools Health Hub to influence the Relationship and Sex Health Education (RSHE), agenda that is being delivered in schools to have a long-lasting impact about feeding decisions and creation of a culture where breastfeeding is the norm.  Link the project with local and national breastfeeding charities/organisations to champion our cause and promote via their social media channels. | | | Increased partnership working across the ICS footprint.  This work will break down cultural barriers & norms to breastfeeding in public | | Breastfeeding initiation rates  Breast milk at first feed  Babies receiving breastmilk at 6-8 weeks.  Social media hits/downloads | Public Health Teams  Nottinghamshire Best Start |

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| **3.7| Quality & Safety Guidelines:**  Improved Partnership working across the system was recommended by Nottinghamshire County JSNA (2019) to provide opportunity to review and develop a consistent offer that supports pregnant women and birthing people and birthing people, especially those with complex social factors.  The governance process and structures implemented across the LMNS partnership will be the enablers to improving the equity and equality & experience in maternity services.  Any plans, policies, pathways or guidelines that focus on quality or safety should and will impact on maternity equity. Under our local Perinatal Surveillance Quality Group, we have set up a new Guidelines Workstream. The remit of this subgroup will be to look at policies and processes across the patch and to consider if and how they could become system-wide guidance. Whilst in some circumstances, it is necessary to have variance, we want to reduce complexity in the system patients and healthcare professionals who may transfer to different maternity providers. Where separate policies are held and managed by individual trust providers and/or partner organisations, there is a risk that maternity service users do not get equitable access or experience. The group will also be responsible for overseeing the development of new guidance where needed to meet national standards, CNST and Ockenden recommendations and to reduce unwarranted variation in practise.  Some specific and focused actions under this umbrella are detailed below and it is intended that they will support maternity improvements in restoring NHS services inclusively following Covid-19, and in maternal & perinatal mortality, morbidity and experience. | | | | | | | | |
| NB: This is a high-level plan as approaved by our ICS/LMNS Board. Following this, our next steps will be to coproduce separate and detailed action plans for the agreed milestones & deliverables, with named responsible owners, all overseen by the accountable LMNS Pillar & Workstream Leads. | | | | | | | | |
| Aligning to partner strategies ambitions | | | | | | | | |
| Maternity Equity Guidance  *4b.1, 4b.3, 4c.4, 4d.2,* | | | ICS Outcomes Framework  *AMB-05, AMB-06, AMB-10* | ICS Health Inequalities Plan | | Place based partnerships | | |
| Initiatives | Cohort | Description | | | Impact | | Metrics | Responsibility |
| Learning from Serious Incidents | When investigating serious incidents, consider the impact of culture, ethnicity and language. | The LMNS has an SI subgroup under the Perinatal Surveillance Quality Group. Here SI Investigations are discussed on a fortnightly basis. The terms of reference for the SI subgroup will ensure impact of ethnicity, language & culture are recognised as Key Lines of Enquiry for the group.  In addition, the group will continue to consider whether culture, ethnicity and language on the woman and birthing person’s needs was discussed and considered during the antenatal risk assessment process, initial assessment and follow-up.  Recording of ethnicity will be tracked as part of the SI indicator on the dashboard and will include this in the quarterly reports for oversight and trends.  In addition, the SI subgroup supports provider trusts to embed process to learn from our SIs. The subgroup reviews all Sis, which provides key insights and learning opportunities. Findings are translated into provider and/or the LMNS improvement and transformation work programmes. | | | Learning from previous incidents will lead to improved procedures and understanding to reduce the negative impact of ethnicity, language or culture in future woman and birthing people | | % of maternity and neonatal Serious Incidents relating to patient care with a valid ethnic code | LMNS PQSG  LMNS Serious Incident Shared Governance Group |
| NICE CG110 antenatal care guidelines | Pregnant women and birthing people with complex social factors | *This guideline covers antenatal care for all* *pregnant women with complex social factors (particularly alcohol or drug misuse, recent migrant or asylum seeker status, difficulty reading or speaking English, aged under 20, domestic abuse)*  We have a team of specialist Midwives that provide individualised care and support to service users with complex social factors, including teenage pregnancies and those in looked after care – which locally are concerns for us. This team are support by our safeguarding midwives.  We are adhering to the requirements in the NHS Long Term Plan to support pregnant women and birthing people who are at risk due to their complex social factors.  The 0-19 Public Health Nursing Service are developing a *transient families team* – a specialist team who will undertake a holistic assessment for women and birthing persons in temporary accommodation. Opportunities to deliver sessions such as first foods through the use of translators will be provided by this team. | | |  | | Proportion & No. of women with complex social factors who attend booking by 10, 12+6 & 20 weeks and attend the recommended no. of antenatal appointments. | Safeguarding Midwives  Specialist Midwives  Nottingham CityCare Partnership |
| Implementation of the Covid-19 four actions: | Women and birthing people from BAME cohorts  MDT staff at both provider trusts | *Increase support for at-risk pregnant women and birthing people for example, make sure clinicians have a lower threshold to review, admit and consider multidisciplinary escalation in women and birthing people from ethnic minority groups:*  An operational policy and virtual ward SOP for COVID was written and implemented at the start of the COVID-19 pandemic. MVP were asked to comment before it was rolled out.  Efforts to support at-risk women and birthing people continues. Workforce training (cultural competency) to support maternity staff and other healthcare professionals to listen to women, give personalised care and to be professionally curious around family’s cultural beliefs will be rolled out. | | | The SOP provides tailored care for at risk pregnant women and birthing people. | | Compliance to the COVID-19 four actions | Trust Providers |
| Culturally sensitive genetics services | Possible consanguineous couples from Bangladeshi/ Pakistani families | NUH see consanguineous couples who are concerned and request a referral to genetics. There, family history is discussed, and a risk assessment is undertaken. Where a known genetic condition in the family with known genetic mutation exists, they are offered testing.  NUH genetics services also offer cystic fibrosis common mutation testing depending on ethnicity.  Data shows that many consanguineous families in our area have Pakistani heritage and have not always taken up the offer for genetic testing or pre-natal diagnosis. Understanding the barriers to screening is needed and then improving access to culturally-sensitive genetics counselling. This would take the form of:  Guidance and support for healthcare professionals to understand genetic inheritance concerns among families with same family/relatives’ marriages and subsequent births and advise them accordingly. All staff to be trained on the pathway.  An information leaflet specific to consanguineous couples to be developed to provide the facts and benefits of genetic testing.  *Nb: SFH have low numbers so processes are in place to refer to the genetic services at NUH.* | | | Empowering affected families to reduce risks of genetic mutation in births | | No. referrals to genetics services  No. risk assessments undertaken. | NUH |
| Maternal medicine networks | Women and Birthing people with medical conditions putting them at higher risk during pregnancy | Following feedback of service user voice about accessibility of a maternal medicines hub, we are having local conversations with the NHSE/I regional team about divergence from the national spec to consider an alternative pathway that sees each hospital (Nottm, Derby, Leics) leading on different specialities - mindful that the midlands is a large geographical area and a single specialist centre for the region disadvantages the most vulnerable families who could not access this support. | | | To support equality of access, ensuring vulnerable and disadvantaged women have access to the best care the Network has to offer. | | KPIs in the non-mandatory national service specification, broken down by postcode and ethnicity | Maternity Commissioning |

**Part 4 | Appendices**

**4.0 | Resources**

To support delivery of our Maternity Equity Plan, we have committed staffing and funding resources as shown in the table below:

|  |  |  |
| --- | --- | --- |
| **Resource allocated** | **Amount** | **Approx. Costs (salary + on costs)** |
| Staffing | | |
| LMNS PMO Team – accountable for Equity, personalisation and Programme of Pillars/Workstreams | 1/3 Band 7 Project Manager  2/5 Band 7 Project Manager  ¼ Band 8a Senior Project Manager | £16,710  £20,052  £14,797 |
| ICB Coproduction Team- accountable for MVP development and coproduction activity | 1/3 Band 5 MVP Development Officer | £10,557 |
| LMNS Pillars/Workstream Leads – Partners from across the partnership actively involved in the 8 identified workstreams to deliver our equity plan | Monthly operational meetings for each of our 8 Workstreams  Pay scales unknown |  |
| System developments | | |
| ICB Coproduction - A new coproduction team has been set up to ensure all service improvement and redesign has a coproduction lens. The new team will support those delivering the equity plan with guidance and expertise to be fully coproductive. | | |
| MVP Review - Following a review of our MVP, the LMNS Executive Partnership Board agreed to spend a year of time and funding within the ICB to shape the future need, functions & delivery model of MVP to make it fit for purpose, including how MVP can/will support equity across the maternity & neonatal footprint. | | |
| Funding allocations | | |
| The LMNS has finance to support our programme of work for Digitalisation, Continuity of Carer, Maternity Transformation and Personalisation. Our financial planning ensures that a proportion of this funding will be ringfenced to support the implementation, delivery and monitoring of our maternity equity plan. | | |

**4.1| Interdependencies**

The activity detailed within the Maternity Equity Plan has several interdependencies with work taking place across the ICS. These include:

* Tomorrow’s NUH
* Neonatal Critical Care Review
* ICS Personalisation Programme
* ICB Health Inequalities Strategy & CORE 20+ work
* ICB Coproduction Strategy
* ICB Working with People and Communities Strategy
* Public Health Initiatives
* ICS Digital Services Strategy
* ICS Estates Strategy
* NUH Maternity Improvement Programme
* ICS Workforce Programme & People and Culture Board

Interdependencies will be managed throughout the programme to ensure alignment of deliverables that complement, rather than duplicate, work.

**4.2| Useful reports supporting our Maternity Equity Plan**

|  |  |
| --- | --- |
| Maternity Specification 2021 |  |
| Nottingham City JSNA |  |
| Nottinghamshire County JSNA | [Joint Strategic Needs Assessment - Nottinghamshire Insight](https://www.nottinghamshireinsight.org.uk/research-areas/jsna/) |
| CoC system wide plan |  |
| NHS Long Term Plan | <https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf> |
| ICS Health Inequalities Strategy |  |
| Core20+5 | <https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/> |
| Women’s Health Strategy | [Women's Health Strategy for England - GOV.UK (www.gov.uk)](https://www.gov.uk/government/publications/womens-health-strategy-for-england/womens-health-strategy-for-england) |
| Equity and Equality: guidance for local maternity systems |  |

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| **4.3 |** **NHSE/I Priorities & Interventions for inclusion in Maternity Equity Plan** | Mapped to LMNS Workstreams |
| **Priority 1 Restore NHS services inclusively** | |
| 1.1 Increase support for at-risk pregnant women and birthing people – for example, make sure clinicians have a lower threshold to review, admit and consider multidisciplinary escalation in women and birthing people from ethnic minority groups. | Quality & Safety Guidelines |
| 1.2 Reach out and reassure pregnant BAME women and birthing people with tailored communications. | Communications & Engagement |
| 1.3 Ensure hospitals discuss vitamins, supplements and nutrition in pregnancy with all women and birthing people. | Maternal Health |
| 1.4 Ensure all providers record on maternity information systems the ethnicity of every woman and birthing person, 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. | Digital |
| **Priority 2 Mitigate against digital exclusion** | |
| 2.1 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. | Personalisation |
| **Priority 3 Ensure datasets are complete and timely** | |
| 3.1 Maternity information systems continuously improve the data quality of ethnic coding and the mother’s postcode. | Digital |
| **Priority 4a Understand your population and coproduce interventions** | |
| 4a.1 Understand the local population’s maternal and perinatal health needs (including the social determinants of health) its health outcomes and community assets. | Communications & Engagement |
| 4a.2 Map the community assets which help address the social determinants of health. | Communications & Engagement |
| 4a.3 Conduct a baseline assessment of the experience of maternity and neonatal staff by ethnicity using WRES indicators 1 to 8. | Workforce & Training |
| 4a.4 Set out a plan to coproduce interventions to improve equity for mothers, babies and race equality for staff. | Coproduction |
| **Priority 4b Action on maternal mortality, morbidity and experience** | |
| 4b.1 Implement maternal medicine networks to help achieve equity | Quality & Safety Guidelines |
| 4b.2 Offer referral to the NHS Diabetes Prevention Programme to women and birthing people with a past diagnosis of gestational diabetes mellitus (GDM) who are not currently pregnant and do not currently have diabetes | Maternal Health |
| 4b.3 Implement NICE CG110 antenatal care for pregnant women and birthing people with complex social factors | Quality & Safety Guidelines |
| 4b.4 Implement maternal mental health services with a focus on access by ethnicity and deprivation | Perinatal Mental Health |
| 4b.5 Ensure personalised care and support plans are available to everyone | Personalisation |
| 4b.6 Ensure the MVPs in your LMS reflect the ethnic diversity of the local population, in line with NICE QS167 | Coproduction |
| **Priority 4c Action on perinatal mortality, morbidity and experience** | |
| 4c.1 Implement targeted and enhanced continuity of carer, as set out in the NHS Long Term Plan | Continuity of Carer |
| 4c.2 Implement a smoke-free pregnancy pathway for mothers and their partners. | Maternal Health |
| 4c.3 Implement an LMS breastfeeding strategy and continuously improve breastfeeding rates for women and birthing people living in the most deprived areas. | Maternal Health |
| 4c.4 Culturally-sensitive genetics services for consanguineous couples. | Quality & Safety Guidelines |
| **Priority 4d Support for maternity and neonatal staff** | |
| 4d.1 Roll out multidisciplinary training about cultural competence in maternity and neonatal services. | Workforce & Training |
| 4d.2 When investigating serious incidents, consider the impact of culture, ethnicity and language. | Quality & Safety Guidelines |
| 4d.3 Implement the Workforce Race Equality Standard (WRES) in maternity and neonatal services. | Workforce & Training |
| Priority 4e Enablers | |
| 4e.1 Establish community hubs in the areas with the greatest maternal and perinatal health needs. | Communications & Engagement |
| 4e.2 Work with system partners and the VCSE sector to address the social determinants of health. | Communications & Engagement |
| **Priority 5 Strengthen leadership and accountability** | *Governance & Monitoring sections* |

**4.4| ICS Outcomes framework**

**Aim**

**Ambitions**

**System Level Outcomes**

SLO-01

Increase in life expectancy

SLO-02

Increase in healthy life expectancy

SLO-03

Increase in life expectancy at birth in lower deprivation quintiles

SLO-04

Reduction in infant mortality

SLO-05

Increase in school readiness

SLO-06

Reduction in smoking prevalence at time of delivery

SLO-07

Reduction in illness and disease prevalence

SLO-08

Narrow the gap in the onset of multiple morbidities between the poorest and wealthiest sections

of the population

SLO-09

Increase the number of people who have the support to self-care and self-manage and improve

their health and wellbeing

SLO-10

Reduction in premature mortality

SLO-11

Reduction in potential years of life lost

SLO-12

Increase in early identification and early diagnosis

SLO-13

Reduction in avoidable and unplanned admissions to hospital and care homes

SLO-14

Increase in appropriate access to primary and community based health and care services

SLO-15

Increase in the number of people being cared for in an appropriate care settings

SLO-16

Increase in the proportion of people reporting high satisfaction with the services they receive

SLO-17

Increase in the proportion of people reporting their needs are met

SLO-18

Increase in the number of people that report having choice, control and dignity over their care and

support

SLO-19

Increase in quality of life for people with care needs

SLO-20

Increase in appropriate and effective care for people who coming to an end of their lives

SLO-21

Financial control total achieved

SLO-22

Transformation target delivered

SLO-23

Increase in the total use and appropriate utilisation of our estate

SLO-24

Alignment of capital spending for new and pre-existing estate proposal with clinical and service

improvement objectives

SLO-25

Increase in collaborative data and information systems

SLO-26

Sustainable teams with skill mix designed around our population and mechanisms to deploy them

flexibly to respond to care & support needs

SLO-27

Increase in skills, knowledge and confidence to take every opportunity to support people to self-

care and take a flexible, holistic approach to people’s needs with a strong focus on prevention and

personalised care

SLO-28

Increase in the number of people reporting a positive and rewarding experience working and

training in the Nottinghamshire health and care system

Our system is in financial balance and achieves

maximum benefit against investment

AMB-08

Improving the effective

utilisation of our resources

AIM-03

Our system has a sustainable infrastructure

Our teams work in a positive, supportive

environment and have the skills, confidence and

resources to deliver high quality care and support

to our population

AMB-10

AMB-09

Improving the overall quality of

care and life our service users

and carers are able to have and

receive

AIM-02

Our people will have equitable access to the right

care at the right time in the right place

AMB-05

Our services meet the needs of our people in a

positive way

AMB-06

Our people with care and support needs and their

carers have good quality of life

AMB-07

Improving the health and

wellbeing of our population

AIM-01

Our people live longer, healthier lives

AMB-01

Our children have a good start in life

AMB-02

Our people and families are resilient and have

good health and wellbeing

AMB-03

Our people will enjoy healthy and independent

ageing at home or in their communities for longer

AMB-04

1. National Maternity and Perinatal Audit (2022), Ethnic and Socio-economic Inequalities in NHS Maternity and Perinatal Care for Women and their Babies: [Ref 308 Inequalities Sprint Audit Report 2021\_FINAL.pdf (maternityaudit.org.uk)](https://maternityaudit.org.uk/FilesUploaded/Ref%20308%20Inequalities%20Sprint%20Audit%20Report%202021_FINAL.pdf) [↑](#footnote-ref-1)
2. NHSE/I (2021), Equity and equality Guidance for local maternity systems [↑](#footnote-ref-2)
3. NHSE/I (2021) Equity and equality, Guidance for local maternity systems: [Equity and equality: Guidance for local maternity systems (england.nhs.uk)](https://www.england.nhs.uk/wp-content/uploads/2021/09/C0734-equity-and-equality-guidance-for-local-maternity-systems.pdf) [↑](#footnote-ref-3)
4. NHS (2020) Obesity and pregnancy: [Overweight and pregnant - NHS (www.nhs.uk)](https://www.nhs.uk/pregnancy/related-conditions/existing-health-conditions/overweight/) [↑](#footnote-ref-4)
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6. NICE (2010) Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors: [Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors (nice.org.uk)](https://www.nice.org.uk/guidance/cg110/resources/pregnancy-and-complex-social-factors-a-model-for-service-provision-for-pregnant-women-with-complex-social-factors-pdf-35109382718149) [↑](#footnote-ref-6)