Public Health England

Protecting and improving the nation's health

Maternity high impact area: Reducing the inequality of outcomes for women from Black, Asian and Minority Ethnic (BAME) communities and their babies

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-leading science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health and Social Care, and a distinct delivery organisation with operational autonomy to advise and support government, local authorities and the NHS in a professionally independent manner.

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Foreword – Professor Viv Bennett

Giving every child the best start in life is a key strategic priority for Public Health England. If we want to achieve universal health improvement for babies and children and to narrow the health gap for those who are most vulnerable, we need to work together to embed care and support for healthy conception and pregnancy through care pathways for everyone of reproductive age.

Improving prevention through individualised care pathways, with groups of women at specific or increased risk of poor outcomes, and at a population level, is key to achieving the ambitions and recommendations of Better Births and reducing inequalities in outcomes for mothers and babies.

This resource supports the drive to increase action on prevention to improve wellbeing, reduce risk and tackle inequalities from preconception through to 6 to 8 weeks postpartum and ensure every woman is fit for and during pregnancy and supported to give children the best start in life. Every woman should have access to services and support to plan a healthy intended pregnancy and advice to adopt healthy behaviours and for reducing or managing risk factors. Reducing unplanned pregnancy rates and improving heath for and during pregnancy improves individual and population outcomes and represent a significant return on investment.

These resources set out the latest evidence, guidance, resources and local practice examples for 6 key topic areas known to affect maternal and child outcomes. They aim to promote prevention across the maternity pathway by providing clear calls to action for NHS and Local Authority Commissioners, and providers and professionals including midwives, health visitors and primary care to promote a life course approach to prevention.

My thanks to the author and the team, you should be rightfully proud of your work. On behalf of PHE I am pleased to present this work to support local areas to achieve best possible outcomes

Professor Viv Bennett CBE
Chief Nurse and Director Maternity and Early Years, Public Health England

Foreword – Professor Jacqui Dunkley Bent

As England's first Chief Midwifery Officer for the NHS, I want to make sure that all women are given the right information to make safe choices that are heard and respected during a woman's life course including the preconception, pregnancy, birth and as they transition into parenthood. Consistent advice and guidance from health care professionals across the maternity pathway can make a significant contribution to the health of future generations by reducing risk before and during pregnancy. Evidence has linked the environment in the womb to the health of the baby, child and adult.

If we are to make big, long-term improvements in maternity care we need to address the inequalities that we see in society. This is as true in England as it is in the rest of the world. I want to work with groups that we inconsistently engage with such as travellers, sex workers, asylum seekers, refugees and other groups, to make sure that they receive the best maternity care possible so that their human rights are respected.

Recommendations from the National Maternity Review: Better Births are being implemented through Local Maternity Systems (LMSs) to ensure that care is personalised and therefore safer. This means that more care is provided in the community so that it is available for women that will benefit most. LMSs bring together the NHS, commissioners, local authorities and other local partners with the aim of ensuring women and their families receive seamless care, including when moving between maternity or neonatal services or to other services such as primary care, health visiting, mental health or post-natal care.

Our NHS Long Term Plan aims to support people to live longer, healthier lives by helping them to make healthier lifestyle choices and treating avoidable illness early. Our new services will help more people to stop smoking, maintain a healthy weight and make sure their alcohol intake is within a healthy limit. These behaviours are all contributing factors that can be modified before, during and after pregnancy to improve outcomes. This means working with colleagues across the health sector to ensure a person-centred life course approach for women and their families.

These documents support a system wide approach to embedding prevention across the maternity pathway. They provide the latest evidence and guidance to NHS and Local Authority commissioners and providers with the aim of promoting a comprehensive view of maternity care in England. My thanks to the team developing these documents, you should be proud of your work.

Professor Jacqueline Dunkley-Bent
Chief Midwifery Officer for the NHS

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Maternity high impact areas: overview

How the 6 maternity high impact area documents were developed and how they contribute to public health priorities

The maternity high impact area documents were developed to assist Local Maternity Systems (LMS) embed prevention approaches to better support women before, during and after pregnancy through a whole system life-course approach.

The documents provide LMSs with the latest evidence, guidance, resources and local practice examples for the high priority topic areas known to affect maternal and child outcomes in England. Implementation of the high impact areas will help support recommendations in Better Births, the Maternity Transformation Programme and the NHS Long Term Plan.

The maternity high impact areas addressed in this publication suite are:

- improving planning and preparation for pregnancy
- supporting parental mental health
- supporting healthy weight before and between pregnancy
- reducing the incidence of harms caused by alcohol in pregnancy
- supporting parents to have a smokefree pregnancy
- reducing the inequality of outcomes for women from Black, Asian and Minority Ethnic (BAME) communities and their babies

The documents were produced between 2019 and 2020 and updated prior to publication in light of the COVID-19 pandemic. Emerging evidence from the UKOSS COVID-19 study shows the disproportionate impact of COVID-19 on Black, Asian and ethnic minority pregnant women, and overweight and obese women, highlighting the importance of a continued focus in these areas. The results are also in line with earlier MBRRACE-UK findings relating to poorer outcomes for pregnant women in these groups outside of the pandemic. The HIA reports take account of new evidence and ways of working, particularly in relation to the most vulnerable mothers and babies as part of PHE's Best Start in Life strategic priority.

These resources contribute to the strategic ambitions of NHS Universal Personalised Care Model and the Modernisation of the Healthy Child Programme. Additionally, the high impact areas reflect the needed approaches to tackle health inequalities, as outlined in the Marmot Review 10 Years On.

The high impact areas are intended to be used alongside the Healthy Pregnancy Pathway and sits within the broader All Our Health framework that brings together resources and evidence that will help to support evidence based practice and service delivery; Making Every Contact Count and building on the skills healthcare professionals and others have to support women.

How these documents were developed

The development of this document was led by Monica Davison (Public Health England) and Octavia Wiseman with support from Dr Ellinor Olander (Centre for Maternal and Child Health Research, City University of London) from October 2019 to March 2020. The document was reviewed by Catherine Swann, Tamara Bacchia and Paul Johnstone (BAME inclusion lead, Public Health England. The document was systematically developed using three strands of evidence – academic research, current UK guidance and policy, and the experiences of those working in Local Maternity Systems. Firstly, a rapid review was conducted using Scopus and PubMed to identify international reviews and UK empirical studies published since 2014 on supporting BAME women during and after pregnancy. Relevant journals not included in these databases (such as 'Journal of Health Visiting') were hand searched. Search terms included pregnancy, ethnicity, vulnerability and variations of these. Good quality evidence was ensured by only including peer-reviewed research. To be included studies had to provide information on supporting BAME women during and after pregnancy and could be randomised controlled trials, surveys, service evaluations and qualitative studies with either women or healthcare professionals. This inclusion criteria was used to ensure focus was on practical suggestions in line with current guidelines for those working within Local Maternity Systems.

Secondly, the websites of Institute of Health Visiting, NICE, NHS England, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists and Public Health England were searched to identify relevant and current reports and guidelines as well as good practice examples. The database OpenGrey was also used to identify practice examples. Examples were deemed good practice if they were in line with current guidelines and provided information on positive outcomes for women. The most recent MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) reports were also checked for relevant information.

Finally, the draft document was reviewed by topic experts, public health experts and healthcare professionals. Twenty-four representatives from Local Maternity Systems, national bodies and Public Health England also attended a review workshop in January 2020. Based on this feedback the documents were revised and further academic research was added when it had been deemed missing from the first draft. The document was subsequently reviewed by a small number of topic experts within PHE

before being finalised. As such, this document benefitted from many people providing feedback, and we thank them for their time and input.

Who these documents are for and how they should be used

These resources are for Local Maternity Systems professionals who wish to acquaint themselves with the latest evidence and good practice guidance on maternity priority topics in England.

The documents should be used a guide to support the early signposting of evidence-based actions that can be practically applied according to local population needs.

Executive summary

The importance of reducing inequalities experienced by Black, Asian and Minority Ethnic (BAME) women

"Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society" – Public Health England(1)

Maternity and early years services care for an increasingly diverse population.(2, 3) In 2018, more than 1 in 4 of all live births in England and Wales were to mothers born outside the UK(4) and 13% of all babies born in 2013 to 2017 belonged to a Black, Asian or minority ethnic (BAME) group.(5, 6) Although it is important to recognise that even in these groups, maternal and neonatal death is rare, the differences are significant, with Black women 5 times more likely to die during pregnancy and Asian or Asian British babies having a 73% increased risk of neonatal death compared to White babies.

Mortality figures are the 'tip of the iceberg', indicating higher level of morbidity. Disproportionate outcomes in terms of preterm birth, perinatal mental health and hospitalisation from COVID-19 have all been found.

The cause of poorer outcomes for women and babies from BAME communities are multi-factorial and more research is needed to better understand the contributory factors. Common issues which can exacerbate problems for this population include:

- low socio-economic status or social support(7)
- lack of proficiency in English(7)
- multiple vulnerabilities such as FGM or recent migrant status(7)
- policy of charging undocumented migrants for maternity care(8)
- a 'one size fits all' approach to maternity care which does not consider differences in women's abilities to understand or access care, or serve the most vulnerable appropriately, can result inequalities in healthcare provision, contributing to structural racism(9, 10)
- cultural barriers combined with insufficient training of healthcare professionals in cultural sensitivity and knowledge(11)

Continued awareness of these inequalities within our services and questioning whether the way we deliver care before, during and after pregnancy unconsciously disadvantages different groups of women (based on ethnicity, socioeconomic status or pre-existing social, mental or physical health problems) is an immediate first step we can all take in tackling inequality.

Following recommendations from MBRRACE-UK, several research projects are underway to explore the underlying reasons for the disparity of outcomes in maternal and infant mortality and morbidity experienced by women from Black, Asian and Minority Ethnic communities, and identify specific actions to reduce them. The research projects and this document strategically aligns with NHS Long Term Plan's ambitions to reduce health inequalities experienced BAME individuals and communities across England.

Addressing the disadvantages experienced by women from BAME communities and their babies is a public health priority, and Local Maternity Systems can play a vital role in levelling this inequality.

High impact area connections with other policy areas and interfaces

This high impact area document supports delivery of the NHS Long-Term Plan, the Healthy Child Programme, the Maternity Transformation Programme, What Good Children and Young People's Public Health Looks Like and the Social Mobility Action Plan.

Summary of key actions

This is a summary of key actions for LMSs to undertake in implementing prevention approaches in their work to address 'Maternity high impact area: Reducing the inequality of outcomes for women from BAME communities and their babies'.

See the sections Evidence-based approaches to reduce outcome inequality for BAME women and their babies and Associated tools and guidance for supporting evidence, guidance and good-practice case studies.

Note: these actions relate to supporting women before, during and after pregnancy

Frontline healthcare professionals

- deliver healthy lifestyle messages to encourage women to change their behaviour, offering them information on access and entitlement to healthcare, and signposting them to other specialist and community services that can support them(12) through 'Making Every Contact Count'
- avoid making assumptions based on a woman's culture, ethnic origin or religious beliefs(12)
- provide continuity of carer to improve outcomes for women of BAME ethnicity and other vulnerable groups
- discuss pre-conception care, including weight loss and early booking

- offer Healthy Start vouchers and vitamins to families with an annual income below £16,000
- give additional support to BAME populations regarding immunisations and antenatal and new-born screening. Sensitively address beliefs about immunisation among some BAME communities(13)
- encourage genetic screening if appropriate
- offer Bacillus Calmette-Guérin (BCG) vaccination to all babies up to 1 year old who have a parent or grandparent who was born in a country where there is a high rate of TB

Providers

- provide training to enhance sensitive and personalised care, both general (cultural sensitivity, unconscious bias and trauma-informed care) and relevant specialist training (FGM, HIV, entitlement to care, sickle cell and thalassaemia screening and so on)(12)
- arrange appropriate translation services to improve equity of access to high-quality information; offer flexibility in the number and length of antenatal appointments when interpreting services are used, over and above the appointments outlined in national guidance(12)
- expand the number and reach of community mental health teams (increasing their period of care from 12 to 24 months)
- work across boundaries to include agencies that provide housing and other community services to enhance care for women living in complex circumstances(12)
- involve local community leaders, third sector organisations and lay groups, including the Maternity Voices Partnership, to actively co-produce the design of universal and speciality services will ensure they are accessible, acceptable, appropriate and not stigmatising
- provide information about pregnancy and antenatal services in a variety of languages and formats, such as posters, notices, leaflets, photographs, drawings or diagrams, online video and audio clips in a variety of settings, including pharmacies, community centres, faith groups and centres, GP surgeries, family planning clinics, children's centres and hostels(12)
- audit local outcomes using national indicators such as ethnicity, language status, country of birth and migrant status to drive changes to services in order address areas of greatest local need

Commissioners

- work across boundaries to address complex needs. This may include flexible commissioning and supporting the third sector
- move to outcome-focused commissioning by identifying the outcomes which require improvement and developing appropriate key performance indicators

- collect the appropriate data and apply this to improve local services(14)
- engage the local community to understand their need. This can include working closely with Maternity Voices Partnerships and supporting them to include local charities and advocacy groups (that is, HealthWatch), and service users, including those in marginalised groups. This may require covering expenses including childcare and offering training(14)
- reduce health inequalities by commissioning evidence-based services which respond to local need set against clear outcome measures, empowering providers to make service improvements and monitoring progress regularly(6)
- work closely with services to support the roll-out of continuity of carer models, in particular those aimed at BAME and other vulnerable groups
- providers must ensure Newborn Screening results reach families, health visitors and GPs in a timely fashion

Partnership approaches to improve outcomes

This is a summary of key actions to improve partnership approaches in collaborative commissioning, effective service delivery, and professional mobilisation.

Effective collaborative commissioning can lead to a reappraisal of the serious health, social and economic impacts of alcohol on the wellbeing of women, pregnant and pre-pregnant, on children, on families and on the long-term health of the population.

Service delivery can be made more effective through a review of service design at all levels using co-design to ensure equity of access, investment to enable the roll-out of continuity of carer and other specialist services which respond to the needs of local BAME communities.

Professionals can be mobilised to reducing inequalities in outcomes for BAME communities through providing training in cultural competence, unconscious bias, trauma-informed care and speciality clinical areas of relevance to local BAME communities for healthcare professionals working in Local Maternity Systems.

Collaborative commissioning

- use Public Health Outcomes Framework indicators to provide insight of how best to collaboratively commission services locally – data is collected via the Maternity Services dataset and the Children and Young People's Health Services dataset.
- Incorporate Collaborative initiatives developed by the Better Start areas which have focused on improving outcomes for people living in areas of diversity and deprivation
- ensure information-sharing agreements are in place across all agencies
- plan the design and delivery of services together through Local Maternity Systems, Transformation Partnerships and Integrated Care Systems, focusing on 1. access to

maternity care, including mental health and specialist services, for women from BAME backgrounds and 2. quality of services provided to this community
- promote public engagement through the Maternity Voices Partnerships and other BAME groups to understand the needs of the local community, ensuring that their voices feed into the design of delivery of services
- use Joint Strategic Needs Assessments, including Fingertips (Public Health Profiles) to identify and respond to agreed joint priorities
- develop systems to capture and support at risk parents/families who may face multiple vulnerabilities
- build reporting of service user satisfaction into data collection
- demonstrate value for money and return on investment

Effective service delivery

- improve accessibility to maternity care, including mental health services, for women from BAME backgrounds. This can be demonstrated by earlier booking and higher levels of attendance for antenatal care
- improve quality of care for women from BAME backgrounds, in particular the provision of midwifery-led continuity of care
- provide specialist services for women from BAME backgrounds with multiple vulnerabilities (FGM, HIV, refugee or migrant, non-English speakers). Multiple vulnerabilities may intersect and increase risk
- increase the use of community-based multi-agency programmes tailored to vulnerable communities such as those developed by the Better Start areas, including peer-support programmes
- provide consistent, culturally relevant information for parents and carers
- improve the use of interpreting services across the maternity pathway
- ensure culturally sensitive care is provided by midwives, health visitors, GPs, dental teams and other healthcare professionals
- improve data collection on attendance and outcomes analysed by ethnicity to inform areas where improvement is necessary
- identify risk or resilience factors at an individual level using validated screening and assessment tools, alongside professional judgement
- use systematic collection of user experience to inform action (for example, NHS Friends and Family Test, engagement with MVP, outreach work)

Professional or partnership mobilisation

- improve multi-agency cultural competence and trauma-informed care
- develop training support for midwives who will be providing continuity of carer which involves new ways of working
- provide support for Trusts who will need to re-organise services to enable continuity of care models to be implemented

- improve the understanding of data of local need, evidenced within the Joint Strategic Needs Assessment to inform priority setting by the local Health and Wellbeing Board and its actions via the Joint Health and Wellbeing Strategy
- engage with local voluntary and charity sector working with BAME groups and exploring opportunities to enhance this work, including peer support programmes
- identify skills and competencies to inform integrated working and skill mix, including engaging individuals from BAME backgrounds in paid and voluntary positions to feed into service design. Financial support of voluntary positions (covering travel and childcare for example) could be considered
- review the provision of local public health services that can support the wider health and wellbeing of families from BAME backgrounds, including preconception and specialist services

Measuring success

High quality data analysis tools and resources are available for all public health professionals to identify the health (and health needs) of the local population. This contributes to the decision-making process and plans to improve services and reduce inequalities. Commissioners and local services need to demonstrate the impact of their services and this can be achieved by using local measures:

Access

- evidence of the number of women who attend for booking by 10, 12 and 20 weeks (sub-analysed by ethnicity and migrant or language status)(12)
- evidence of the number of women who attend the recommended number of antenatal appointments in line with maternal guidance (sub-analysed by ethnicity and migrant or language status)(12)
- evidence of the number of women booked onto a continuity of care pathway (sub-analysed by ethnicity and migrant or language status). This will include service-level reporting of team composition and of which midwife undertakes each appointment(15)
- availability of mental health services in a variety of community settings(16), evidence of personalised needs assessment and specialist care pathways for women with multiple vulnerabilities

Case study 1: Using local audit data

Homerton University Hospital Foundation Trust audited their women's risk factors and some outcomes by ethnicity and found that they reflected national data. Women from BAME communities had disproportionately high levels of pre-term birth. As a result of the audit the Trust expedited the development of a dedicated pre-term clinic, amongst other actions arising from the work.

“This was our local data. These were our women, and this was an issue for us - even though we were a very diverse group of professionals our unit was not immune. This data was an opportunity to open up the conversation around this issue and has been very helpful.”

Effective delivery

- evidence of work carried out to gather intelligence about ethnic diversity of the local population, mapping this against existing services (Data source: electronic patient records: joint strategic needs assessment)(16, 17)
- evidence of actions taken to gather the views of local people from BAME groups to identify the needs and barriers to service access; health and wellbeing programmes; the views of vulnerable women who may be unable or unwilling to access services (that is, migrants and refugees) with a focus on building trust and co-design.
- evidence of how this information is used to inform commissioning so that care is tailored particularly to these populations, addressing their needs in an integrated way. (Data source: focus groups, records from meetings, local health equality assessments)(16, 17)
- women from BAME backgrounds are represented in professional, peer and lay roles within local health and wellbeing programmes(16)

Outcomes

- measure the uptake of key local health and wellbeing services among people from BAME groups (that is, perinatal mental health services, parent education)(16)
- measure the proportion of women and babies from BAME backgrounds who experience mortality and serious morbidity(12)

User experience

- proportion of women from BAME groups who felt the local maternity and early years services met their needs (Data source: Friends and Family questionnaire; CQC Maternity survey)(16)

- a woman-reported measure of whether women feel they have had continuity (Data source: CQC Maternity survey)(15)
- evidence that this feedback is recorded and monitored and used to guide service development(12)

Other measures can be developed locally and could include measures such as initiatives within healthcare professionals' building community capacity, exploring opportunities for peer support and multi-disciplinary working.

Supporting evidence and good practice guidance

Context

“Local Maternity Systems may want to pay attention to sectors of the population who are more likely to experience poor outcomes to ensure that local transformation has an impact on reducing health inequalities.” Implementing Better Births(14)

Maternity and early years services care for an increasingly diverse population.(2, 3) In 2018, more than 1 in 4 of all live births in England and Wales were to mothers born outside the UK(4) and 13% of all babies born in 2013 to 2017 belonged to a Black, Asian or minority ethnic (BAME) group.(5, 6) Although it is important to recognise that even in these groups, maternal and neonatal death is rare, the differences are significant.

Maternal mortality

Recent MBRRACE report data show that compared to White women, Black women are 5 times more likely to die during pregnancy, mixed-race women are 3 times more likely to die and Asian women are 2 times more likely to die (see Figure 1).(6) Gypsy, Roma and Traveller (GRT) communities also have higher levels of maternal mortality.(18)

Neonatal mortality

Asian or Asian British babies are at the highest risk for neonatal death (73% increased risk compared to White babies). However, between 2015 and 2017 Black or Black British babies had the sharpest rise in neonatal deaths (from 43% to 67% increased risk compared to White babies; see Figure 2).(19) In Ireland GRT communities had 4 times higher infant mortality than the general population.(18) In real terms this equates to 1,911 white neonatal deaths versus 911 BAME neonatal deaths in 2017.

Figure 1: Maternal mortality by ethnicity(6)

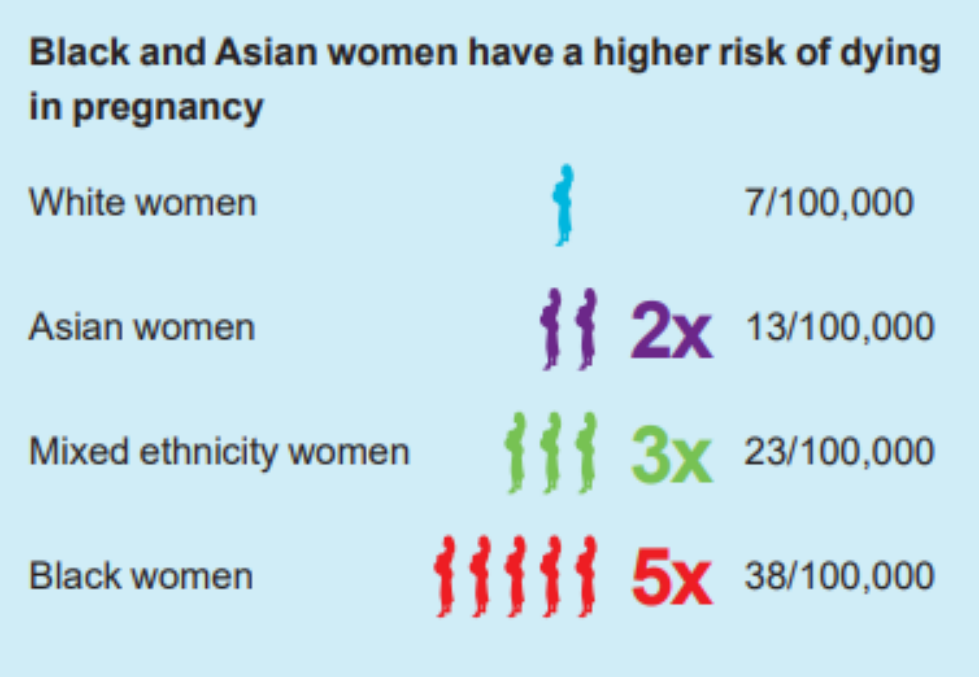
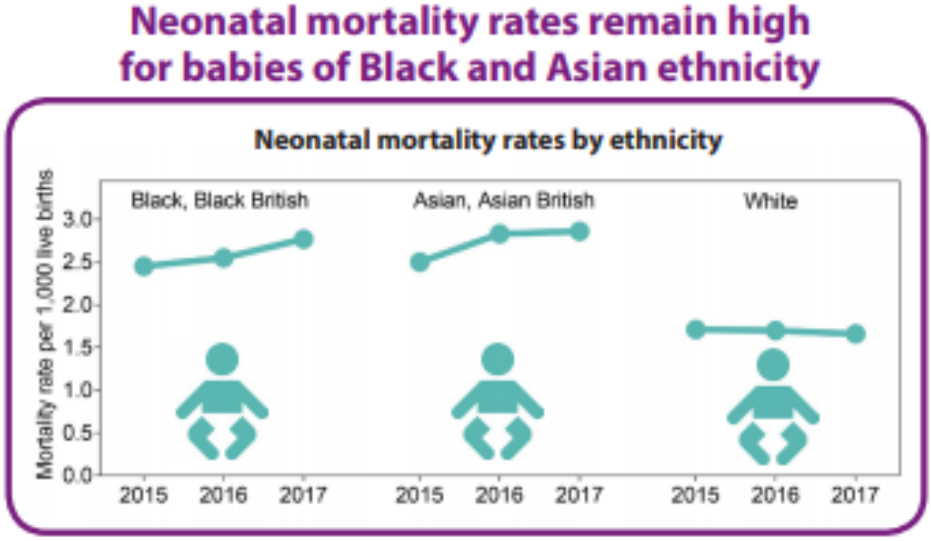


Figure 2: Neonatal mortality rates by ethnicity(19)



Mortality figures are the tip of the iceberg, indicating higher levels of morbidity. For example:

Pre-term birth

Prematurity is a major cause of long-term morbidity in infants, and Black mothers (especially those from a Black Caribbean background) are twice as likely as White British women to give birth before 37 weeks of pregnancy.(20)

Perinatal Mental Health

Suicide is the leading direct cause of maternal death within a year of pregnancy.(6) UK studies show that women from a BAME background are significantly more likely than White British women to be suffering from common mental health disorders, yet were less likely to access treatment, with Pakistani and Indian women at greatest risk.(21, 22) Ethnicity was found to be a stronger predictor than migrant status.(7, 22)

COVID-19

The UKOSS study has shown that more than half of pregnant women admitted to hospital with SARS-CoV-2 infection in pregnancy were from black or other ethnic minority groups. Over-representation of ethnic minority and other groups among the cohort of pregnant women admitted with SARS-CoV-2 infection may reflect a higher risk of infection, a higher risk of severe disease given infection among vulnerable subgroups, or both. Most pregnant women admitted to hospital with SARS-CoV-2 infection were in the late second or third trimester, supporting guidance for continued social distancing measures in later pregnancy. Most had good outcomes, and transmission of SARS-CoV-2 to infants was uncommon.

Potential causes

The causes of poorer outcomes for women and babies from BAME communities are multi-factorial.(6) Self-reported ethnicity is the main measure used to report outcomes by the Office of National Statistics and the NHS. Other important factors to consider are country of birth, facility with language, biological status, migration and socio-economic status. Nevertheless, research suggests that ethnicity remains a significant independent risk factor.(3)

Migrant status: Recently arrived migrants, women with limited English proficiency (LEP), asylum-seekers or refugees, undocumented migrants and trafficked women are known to be at high risk of adverse outcomes, and multiple vulnerabilities can intersect and increase risk. However, migrant status on its own does not always confer higher risk: When comparisons are made within a single ethnicity, outcomes for infants of foreign-born mothers are sometimes better than those of UK-born mothers of the same ethnicity.(3)

Biological factors: 67% of Black women are overweight or obese (BMI >25) at booking compared to 49% of White women.(23) Black women are also more likely to suffer from hypertension and diabetes as well as sickle cell and thalassaemia, female genital mutilation (FGM), Hepatitis B and Tuberculosis. The impact of biological factors is restricted to certain conditions, for example congenital anomalies.(3) Congenital abnormalities cause 9.2% of stillbirths and 36.1% of neonatal deaths.(6) They are the

leading cause of infant deaths for Pakistani babies where the mortality rate from congenital abnormalities is 3.4 deaths per 1,000 live births and for Bangladeshi babies, with 2.1 deaths per 1,000 live births whereas the rate for White babies is 0.74 deaths per 1,000 live births.(24)

Social determinants of health: There is a clear relationship between migration and disadvantage.(7, 25) This relationship is especially strong for recent migrants who may have little English, be single parents or have lower educational levels.(2, 7) Social disadvantage alone cannot explain ethnic disparities in birth outcomes: when comparisons are made within single ethnic groups, living in disadvantaged or affluent socio-economic circumstances does not always correspond with improved outcomes.(3)

Access to and utilisation of care: Pregnancy is a unique opportunity to identify health needs with a potential long-term impact. Women from minority ethnic groups are more likely to book late, with 62% of Black women booking after 10 weeks of pregnancy compared to 46% of the overall population.(23) Women of BAME ethnicity are less likely to access high-quality perinatal education(26) and less likely to take up childhood immunisations, independent of deprivation.(13) Reasons include difficulty navigating services; lack of understanding of the purpose of care; cultural differences (such as not disclosing a pregnancy to protect the child from ill-wishers)(27); perceptions of poor cultural sensitivity and stereotyping by healthcare providers; concerns about confidentiality and being charged for maternity care.(8, 28)

Systemic issues: Confidential enquiries have shown that transitions between services and across systems are risk points in women's care, and where vulnerable women fall through the cracks.(6) A lack of joined-up services affect women living in complex circumstances more(20) and 'one size fits all' services may exclude certain groups.(29) Uneven provision of interpreting services and insufficient training in cultural sensitivity impacts on communication and informed consent.(28, 30)

Service user view

All women, especially those who face the greatest challenges, have the right to receive maternity care which is dignified, safe, trauma-informed and respects their fundamental human rights.(11) Women from minority ethnic groups report feeling less likely to feel spoken to so they can understand, to be treated with kindness, to be sufficiently involved in decisions or to have confidence and trust in the staff.(31)

For women with FGM, care is reported to be haphazard and suboptimal due to variable levels of staff expertise and inconsistent and unclear referral pathways.(32) For refugee women, the potentially damaging effect of disparities in care can result in re-traumatisation.(33)

Positive experiences are described as healthcare professionals meeting women's medical, emotional and social needs by being caring, confidential and communicative.

The importance of Local Maternity Systems

Better Births, the Maternity Transformation Programme and NHS Long Term Plan set out a clear vision and principles for how maternity services can be brought together through Local Maternity Systems with strong links to services to provide personalised, kinder and safer care to women and their families.

The purpose of a Local Maternity System is to provide system leadership for transformation, putting in place the infrastructure that is needed to support services to work together effectively, including interfacing with other services that have a role to play in supporting women and families before, during and after birth.(13)

Women from BAME communities come from diverse national, socio-economic, educational and linguistic backgrounds and assumptions cannot be made about individual women and their families based on ethnicity or cultural norms.(30) Services which do not consider differences in women's abilities to understand/access care can result in inequality of healthcare provision. A place-based approach to reducing health inequalities would help ensure that accessibility favours the most disadvantaged.(1)

Local Maternity System's strategic role

The Local Maternity System could explore local needs and collaborate with local communities using a 'whole family approach' in order to co-design maternity systems which can provide flexible, personalised care which is equitable, accessible and meaningful.(27, 34) In approaching this challenge Local Maternity Systems can be guided by the Healthy Child Programme(35) which is based on the principle of proportionate universalism, a mix of universal and targeted provision. A multi-agency strength-based approach can build social support and resilience which are important protective factors.(2, 36)

Enablers which will support the delivery of Local Maternity System' vision include:(14)

- effective service user co-production, in particular working with Maternity Voices Partnerships
- collecting the right data using nationally developed data collection tools and applying this to improve services
- designing and delivering maternity services across boundaries

Case study 2: co-design of services

As part of Better Births, Surrey Heartlands Health and Care Partnership funded a specialist 2-year outreach project for Gypsy, Roma and Traveller groups (GRT) due to their poor maternal and infant outcomes. The project is led by nurses and health visitors and has been co-designed with the communities at every stage.

The team use a multi-agency approach which involves informal discussions and debriefs, linking the community to a range of services and inviting community representatives to feed into service design. They have arranged for the Surrey Community Gypsy Forum to deliver multi-disciplinary cultural awareness training. They have developed enhanced communication pathways for vulnerable GRT clients including prompts with texts and calls, addressing digital exclusion by printing out notes, having literacy issues sensitively highlighted so can women get extra support with information and health advice. As a result of the GRT team's success, a separate inclusion team has now also been funded.

"This approach requires true multi-agency working and building trust with the communities. It is an ongoing project requiring creativity to address the complex challenges of multiply excluded groups."

Local Maternity System membership

Potential membership of a Local Maternity System is presented in Figure 3 below, and includes service users, commissioners, providers and community groups and organisations. By bringing these stakeholders together, the Local Maternity Systems can create shared protocols, information sharing and coherent plans to implement and apply the Better Births vision and principles to meet their population's needs.

Figure 3: Potential membership of a Local Maternity System

Potential membership of a Local Maternity System	
Service user voice	• Maternity Voices Partnerships, Healthwatch and representative parent groups where appropriate • Local stakeholders and charities representing service users
Commissioners	• Clinical Commissioning Groups • NHS England • Local Authority directors of public health • Other Local Authority as appropriate • Providers
Providers	• Providers of NHS antenatal, intrapartum and postnatal care including independent midwifery practices and voluntary and community sector providers involved in providing the local NHS funded maternity offer • Local Neonatal Operational Delivery Network • Primary care • Mental health teams, including mother and baby units, IAPT, AMHS, CAMHS • Community child health and tertiary centres • Local authority providers of health visitor services, children and adult social care teams and public health programmes
Others	• Representatives of other clinical networks, higher education establishments and teaching hospitals involved in workforce training and research • Local workforce advisory boards • Representatives of the staff voice, such as professional organisations and trade unions • Community organisations

Using evidence to embed prevention through a community-centred approach

The place-based approach offers new opportunities to help meet the challenges public health and the health and social care system face. This impacts on the whole community and aims to address issues that exist at the community level, such as the local social/ethnic/linguistic mix, poor housing, social isolation, poor or fragmented services, or duplication and gaps in service provision.

A place-based, or community-centred, approach aims to develop local solutions that draw on all the assets and resources of an area, integrating services and building resilience in communities so that people can take control of their health and wellbeing, and have more influence on the factors that underpin good health.

Healthy Pregnancy Pathway

The maternity high impact area documents can be used alongside the Healthy Pregnancy Pathway.

The Healthy Pregnancy Pathway is an online interactive tool that provides Local Maternity Systems easy access to the latest maternity life-course guidance using a stepped-up service level approach, from universal to targeted and specialist care systems grounded in the community setting.

The Healthy Pregnancy Pathway uses a place-based approach through the integration with the All Our Health Townscapes. The All Our Health townscape demonstrates how improving outcomes is everyone's business, working across both traditional and non-traditional settings such as the workplace, green spaces and community centres.

The Healthy Pregnancy Pathway uses the following service-level descriptors across the maternity pathway (preconception, antenatal and birth 6 to 8 weeks):

Universal - universal service is offered to all people, ensuring they receive immunisations, screenings, contraception, maternity advice, support and referral to specialist services according to need.

Targeted - targeted service provides people with timely, personalised expert advice and support when they need it for specific issues, such perinatal mental health, diabetes management and breastfeeding.

Specialist - specialist service provides people specialist practitioner treatment, where providers will often work with other agencies to coordinate holistic wrap around support for people with acute or ongoing needs, including complex needs management.

Evidence-based approaches to reduce outcome inequality for BAME women and their babies

This section outlines the supporting guidance and good-practice case studies for 'Maternity high impact area: Reducing the inequality of outcomes for women from BAME communities and their babies'.

See above for a summary of this section under the heading Summary of key actions.

Individual

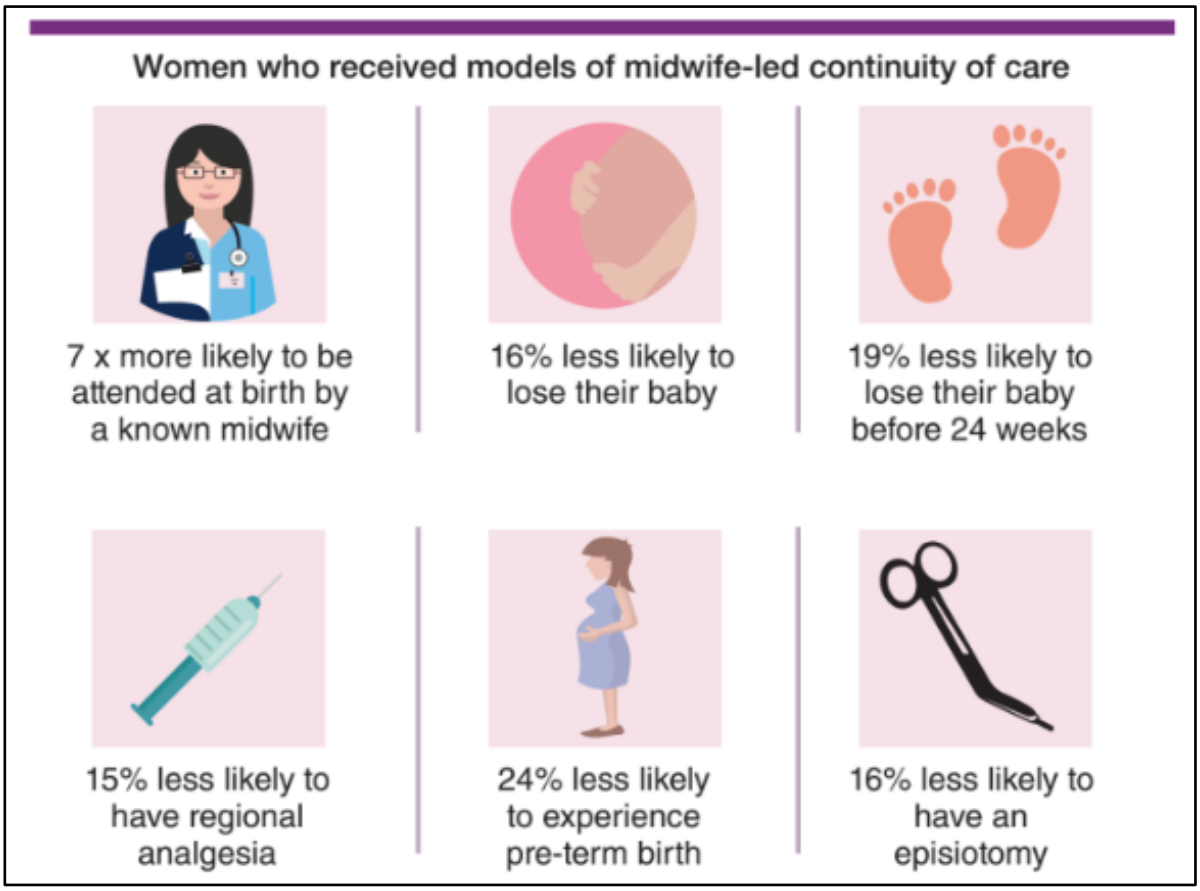
Personalised care is the key to safe care. There is high-level evidence that midwifery-led continuity of carer (see Figure 4) across the antenatal, intrapartum and postnatal period improves care and health outcomes.

Definition of midwifery-led continuity of carer

'Implementing Better Births' defines this as each woman having a named midwife who is responsible for coordinating her care and who will provide continuity throughout her journey, including at her birth. Midwives will work in a small team of 4 to 8 midwives, and may have a 'buddy' who can provide care when the named midwife is not available.

Continuity of carer focuses on relational, woman-centred care and can build trust and significantly improve outcomes for mothers and babies (see Box 2 below).(37) Socio-economically disadvantaged women benefit disproportionally from continuity of carer models.(38, 39) In response to this, the government has prioritised rolling out this model for women from BAME communities. 75% of women from BAME communities will receive midwifery-led continuity of care by 2024.

Box 2: Key outcomes for women from the Cochrane systematic review on midwifery-led continuity of care.(39)



There is clear evidence that the use of high-quality language resources (interpreting services, translated materials, infographics) is essential to ensure informed choice when caring for women with limited English proficiency.(12)

Several targeted, culturally sensitive interventions have been developed and piloted to improve the access to and quality of maternity care for women from BAME backgrounds to address the increased risks they face when giving birth in the UK. While these may have beneficial outcomes, most are local, short-term, or small-scale pilots which lack rigorous evaluation.(28, 40) What all these interventions have in common is that they are embedded in the communities they serve rather than being hospital-based, and many are delivered by multi-disciplinary teams. Overall such interventions are based around 3 main approaches:

Enhanced care: As well as continuity of care, examples of enhanced care which may benefit women from BAME backgrounds include group antenatal care (that is, Centring Pregnancy or Pregnancy Circles) or women receiving additional social support from health visitors.(41, 42) There is a need for Trusts to develop specialist services and referral pathways which are shaped by local need and protected as a core function, that is, to address female genital mutilation (FGM), refugees and asylum seekers and Sickle/Thalassaemia screening.(11, 41, 43)

Peer support: a variety of peer-support based interventions (including volunteer doulas, peer befriending and peer breastfeeding support) have been found to improve emotional wellbeing and self-esteem in BAME women while also enabling volunteers who come from an ethnically diverse background to gain skills and qualifications.(23, 41) Successful peer support may break down perceived barriers between service users from BAME backgrounds and statutory services, enabling the trained peer supporters to act as a cultural and sometimes linguistic 'bridge', enhancing access to quality services as well as providing social support.(40, 44)

Tailored parent education: Tailored parent education designed to meet the needs of disadvantaged parents can improve knowledge, confidence and relationships, in particular strength-based approaches which can build resilience in vulnerable populations.(33) The best known of these programmes is Baby Steps which was developed by the National Society for the Prevention of Cruelty to Children (see case study below).(45) Positive outcomes have also been reported for a variety of specialist education services in areas of ethnic diversity focused on teenage pregnancy, weight management, and school-based interventions for pregnant women with older children.(41, 46)

Case Study 3: Bespoke parent education for BAME parents

Baby Steps aims to help vulnerable parents manage the transition to parenthood. The programme is jointly delivered by a health practitioner (midwife or health visitor) and a children's services practitioner. The programme consists of 9 group-based sessions spanning the antenatal and postnatal period and is designed to be flexible and responsive, using a range of engaging approaches. Interpreter are provided as needed, and sessions can address issues of concern to migrant parents. As well as covering traditional antenatal education, the sessions also aim to address parent-infant and couples' relationships, building support networks and improving self-confidence.

Parents from BAME backgrounds identified a range of positive outcomes from attending the Baby Steps programme and for parents who were socially isolated these were especially important.

Case study 4: Auntie Pam's Support Service

In the Kirklees areas outside Manchester, 12% of the population is South Asian with increasing numbers of Eastern European and African migrants. Concerns about high infant mortality rates attracted public health funding to address the issue.

Co-design: Women across Kirklees were asked what they needed, revealing that it was important for them not to feel judged and they preferred to be supported by "someone like them". Local mums were trained as peer volunteers to offer confidential one-to-one chats, a cuppa and a non-judgemental listening ear. Clients and volunteers are supported with "whole-life" approaches to social, economic and financial challenges. Local volunteers receive training in motivational skills, behaviour change, bereavement, housing and benefits and so on and can achieve NVQ qualifications.

Auntie Pam's has supported 2,000 clients over 8 years and the service continues to expand. Qualitative feedback is positive, and the service has been awarded a national Local Government Chronicle community involvement award in 2016 and awarded the Duke of York Community Initiative Award in 2017.

Community

"Consider cultural sensitivities to better understand and respond to people's personal and health needs" – Nursing and Midwifery Council Code(47)

A 'one-size-fits-all' service will not fit all.(35) The ethnic profile of healthcare providers may not reflect the communities they serve which may make providing culturally sensitive care difficult.(38) Active community engagement is needed to encourage early access to services and service design.

The 3 main approaches to tailoring services to fit the local population are as follows:

Outreach: Targeted outreach and co-design, engagement with local Maternity Voices Partnerships and the use of peer support services may facilitate a more culturally sensitive service provision rooted in the community.(11, 48)

Training in cultural sensitivity, unconscious bias and trauma-informed care, tailored to the local community, can improve quality of care and stop vulnerable women from being re-traumatised by services.(1, 43)

Cross-boundary working: Given the multiple vulnerabilities experienced by some women from BAME backgrounds, providing access to a wide range of practical, emotional and legal support, including housing, may help address the complex interaction between social factors and health inequalities.(48) Multi-agency working has been shown to work well in targeted services, and in the Lottery-funded Better Start

areas which have partnership boards and parent champions (see Resources for setting up a local parent champion network).(36) Referral processes that enable easy access to early years, social care and voluntary services improves access to preventative services. Handover of care between professionals, for example between midwives and health visitors, is key to safe care. (19)

Population

Race is a protected characteristic under human rights legislation. The Public-Sector Equality Duty states that all public bodies must take steps to meet the needs of people from protected groups where these are different from the needs of other people. Resources are available to guide equalities and human rights impact assessments.

Access to healthcare depends on financial, organisational, social and cultural barriers. Equity of access can be measured through the availability, utilisation or outcomes of services. Healthcare services designed to enable equality of access, community support and tailored specialist care are a priority for leadership at a strategic level.(40, 49)

Addressing socio-economic inequality directly is beyond the remit of health providers, but an 'equigenic' approach to service design can weaken the link between socio-economic inequality and health inequality. NHS England and NHS Improvement action on this issue is led by the Chief Midwifery Officer with support from the Maternity Transformation Programme policy team and is outlined in the box below.

Eight actions to achieve equity

1. Long-Term Plan: targeted and enhanced continuity of carer and smoking cessation.
2. NHS Planning Guidance 2019/20: local systems start to implement continuity of carer models for Black and Asian women and those in the most deprived areas.
3. Health inequality measures are being developed for the Long-Term Plan.
4. DHSC Policy Research Programme is funding research to investigate:
    - the factors associated with the excess perinatal mortality experienced by BAME babies
    - excess risk of maternal death for Black and South Asian women
5. HSIB: analysis of their investigations – which include interviews with parents in 91% of cases - by ethnicity and social complexity factors.
6. Four recommended actions to reduce the risk of perinatal mortality associated with consanguinity:
    - family-centred approach to provision of genetic services
    - educate and equip professionals at the interface with the community
    - raise genetic literacy at community level
    - strengthen specialist genomic diagnostic services

7. The Maternity Incentive Scheme specifies that trusts need to achieve at least 80% completeness of ethnicity coding in their booking data in order to achieve safety action 2 for 2019 to 2020. Setting the threshold at 80% is effective because it encourages the few organisations with close to 100% missing data to improve, which has a disproportionately beneficial impact when data is aggregated at a national level. Currently 15% unknown or missing.
8. HEE have an eLfH module about Cultural Competence for health professionals.

Funding to support population-level change

Funding to support population-level change could be targeted in the following areas:

- **Targeted services** to fund voluntary, community and Social Enterprise organisations working with low-income BAME women to build capacity and expertise and to link them to statutory services through bridging, signposting and advocacy.(48)

- **Organisational change** will support the roll-out of midwifery-led continuity models, especially in areas with a high proportion of women from BAME backgrounds and stimulate the development of locally tailored specialist services. The Health and Social Care Committee has recommended that funds are made available to incentivise the transformation of local commissioning and provision covering the first 1,000 days, drawing on the successes of the Better Start areas.(36, 50)

Case study 5: Improving health visiting

Better Start Bradford and Public Health Blackpool undertook a review of health visiting in partnership with local parents in an area of diversity and deprivation. In 2018 they launched an enhanced health visiting offer with 8 mandatory visits starting from 28 weeks gestation, including a universal offer of Baby Steps education, additional targeted services such as the Family Nurse Partnership and additional visits as needed to proactively support families who may not have previously engaged with services. Although Better Start paid for materials, the offer was provided within the existing financial envelope.

In the first year the service reached 8,367 children under 4 and 181 health professionals have been trained in trauma-informed care, motivational interviewing and peer to peer supervision. Early evaluation from parents and staff is positive and it is expected that in the long term this service will reduce the need for families to access services later in the child's life. The model changed the way local health data is recorded and used, and the model has now been extended beyond the Better Start area. All future local authority commissioning will now involve parents in service redesign.

Associated tools and guidance

Information, resources and best practice to support frontline health professionals, providers and commissioners working in Local Maternity Systems

Intelligence toolkits and outcomes frameworks

Relevant indicators can be found in the Pregnancy and Birth Profile in the Child and Maternal Health section of PHE's Fingertips Platform. These indicators are presented in a standardised format showing trends over time, local benchmarking and relevant inequalities. This profile will be enhanced to include the new indicators which are under development and to provide a downloadable report (stocktake of progress) against the high impact areas.

Resources for women

- Maternity Action: Women concerned about being charged for maternity care: Telephone advice: 0808 800 0041 (Freephone)
- An easy guide to introducing solid foods, information from NHS Scotland in Chinese, Farsi, Polish, Russian and Urdu

Resources for frontline healthcare professionals

All NHS practitioners:

- Migrant Health: Resources for professionals working with migrant populations in pregnancy
- NHS Education England: Cultural competency training
- Best Beginnings: Resources available in different languages
- Maternity Action

Obstetricians (RCOG log-in required):

- Communication skills

Midwives (RCM log-in required):

- Understanding asylum seekers and refugees
- Care Certificate Standard 4 – Equality and Diversity
- Female Genital Mutilation
- Health inequalities and the social determinants of health

- Women affected by forced marriage
- Human rights in maternity care: advocating for women
- Continuity of Care

Health visitors (iHV log-in required):

- Multicultural work
- Working with victims and survivors of forced marriage
- Working with minority groups
- Working with victims of forced domestic servitude

Co-production / engagement tools:

- Coalition for Collaborative care
- Coram Family and Childcare have information about how to set up a Parent Champion network
- CQC Equalities and Human Rights Impact Assessment tool
- HealthWatch
- NHS England: Involving People in Health and Care
- Pregnancy and complex social factors: a model for service provision, NICE, 2010
- Promoting Health and Preventing Premature Mortality in Black, Asian and Other Minority Ethnic Groups, NICE, 2018
- Public Health England Fingertips

Policy

- Better Births. Improving outcomes of maternity services in England. A Five Year Forward View for maternity care. National Maternity Review, 2016
- First 1000 days committee report and Government response, UK Parliament, 2019
- Healthy Child Programme: Pregnancy and the first five years of life. Department of Health and Social Care, 2009
- Healthy Lives, Healthy People: A call to action on obesity in England. Department of Health, 2011
- Healthy start, accessed December 2019
- MBRRACE-UK: Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015-17. National Perinatal Epidemiology Unit, 2019
- National Maternity Transformation Programme, NHS England, 2016
- NHS Longterm Plan, NHS England, 2019

Research

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Guidance

- Assessing new patients from overseas: migrant health guide: Advice and guidance on the health needs of migrant patients for healthcare practitioners. Public Health England, 2014
- Guidance for NHS Commissioners on equality and health inequalities. NHS England, 2015
- Health matters: reproductive health and pregnancy planning. Public Health England, 2018
- Health of women before and during pregnancy: health behaviours, risk factors and inequalities. Public Health England, 2018
- Health visiting and midwifery partnership – pregnancy and early weeks, Department of Health and Social Care and Public Health England, 2015
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