UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST,
Local Maternity and Neonatal System (LMNS)
LLR Integrated Care system (ICS)

REPORT TO: **Joint Health and Overview Scrutiny Committee**

DATE: **15th October 2021**

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SUBJECT: **Black maternal healthcare and mortality**

Introduction

MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries), is a collaboration appointed by the Healthcare Quality Improvement Partnership to run the national Maternal, Newborn and Infant clinical Outcome Review Programme. The Infant Mortality and Morbidity studies for MBRRACE are led by the University of Leicester by two local Professors. MBRRACE carries out a national programme of work conducting surveillance and investigating the causes of maternal, stillbirths and neonatal deaths. A confidential enquiry is a systematic process of multi-disciplinary, anonymous review of all or a sample of defined cases occurring in a defined geographical area during a defined period of time, all demographics should remain anonymous to avoid identification of person or place.

What the MBRRACE reports continue to highlight are multiple and complex problems that affect women who die in pregnancy, these can be a combination of Social, physical and mental or just one of these factors alone. The women who live in deprived areas continue to be at greater risk of dying during or after pregnancy. MBRRACE also have highlighted before the disparities in outcomes for women from different ethnic minority groups. The coronavirus pandemic has brought this disparity even more starkly to the fore, and we must not lose sight of the actions that are required to address systemic biases that impact on the care we provide for ethnic minority women.

MBRRACE-UK - Saving Lives, Improving Mothers' Care 2020[1], which reviewed maternal deaths from 2016-2018, has shown little difference in outcomes of mortality rates for women of a black ethnic background since the previous report from 2013-2015. There remains a more than four-fold difference in maternal mortality rates amongst women from Black ethnic backgrounds and an almost two-fold difference amongst women from Asian ethnic backgrounds compared to white women, emphasising the need for a continued focus on action to address these disparities.

A petition presented to the house of Commons in April 2021 was part of a debate on healthcare disparities and black Women's experiences in maternity care, followed by a programme on Channel 4 dispatches, called the 'Black Maternity Scandal' has all raised the profile of the experience of maternity care in Britain today and although we recognise there are greater risks in this population of pregnant women, listening to the women and how they felt and the description of personal experiences is sad and disheartening.

[1] 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 2016-18. National Perinatal Epidemiology Unit, 2020

Background

The cause of poorer outcomes for women and babies from Black and ethnic 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
- lack of proficiency in English
- Multiple vulnerabilities such as FGM or recent migrant status
- Policy of charging undocumented migrants for maternity care
- 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
- Cultural barriers combined with insufficient training of healthcare professionals in cultural sensitivity and knowledge

The National Requirement

The NHS Long Term Plan' (NHS England 2019)[2] set out that by 2024, 75% from Black and minority ethnic communities would receive continuity of care from the same midwife during pregnancy, birth and in the postnatal period. The benefits of this pathway of care are well researched and set out in Better Births (2016)[3]. It also documents the requirement to reduce health inequalities experienced by women of a Black and Minority ethnic background across England. Better Births (2016) set out a recommendation for personalised care for all women, which would address the contributory factor mentioned above 'the one size fits all approach' to maternity care. More recently the Ockenden report (2020)[4]

During the Covid Pandemic, MBRRACE published a rapid report, 'Learning from SARS-CoV-2-related and associated maternal deaths in the UK'[5] It reviewed maternal deaths over a 3 month period from 1st March 2020 to 31st May 2020 and reported a number of key messages, it is reported 10 women died in this period, the majority were from a minority ethnic background. This report identified existing guidance and some recommendations that had already been published that required improvement in implementation. These recommendations were for all pregnant women but highlighted in particular women of black or minority ethnic background (and women with other high risk health conditions) should be advised that they are at greater risk to seek help and advice as soon as possible if they have concerns about their health, either with a Covid Diagnosis or with symptoms

Following the report, the Local Maternity & Neonatal System (LMNS) received a letter advising all systems to ensure specific actions were taken in relation to the Black and minority ethnic women, during the ongoing pandemic, the response from the system is discussed below.

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[2] NHS Longterm Plan, NHS England, 2019

[3] Better Births. Improving outcomes of maternity services in England. A Five Year Forward View for maternity care. National Maternity Review, 2016

[4] Ockenden Report: Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust. Dec 2020

[5] MBRRACE-UK. Saving Lives, Improving Mothers' Care Rapid Report 2021: Learning from SARS-CoV-2-related and associated maternal deaths in the UK June 2020-March 2021. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2021

Public Health England made a number of recommendations in a report published in December 2020[6], they highlighted Maternity is a high impact area in achieving a universal approach to improving outcomes for mothers, babies and children and ensuring the best start in life. The report specifies six key topics that will impact outcomes based on research evidence, one of which is based on reducing the inequality of outcomes for women from a Black and minority ethnic background. All are based on improving outcomes for all women, there are large areas in England where there is social deprivation and these women are equally disadvantaged in terms of access to health care and achieving good outcomes.

In 2018 NICE[7] published guidance around Promoting health and preventing premature mortality in black, Asian and other minority ethnic groups, this was not specific to pregnancy and childbirth but in particular the statement in relation to equality and diversity considerations is well evidenced in maternity specific publications. Due to language and communication difficulties and poor past experiences of racism and perhaps prejudice, some people from black, Asian and other minority ethnic groups may not engage with services and increase their risk of poor health outcomes, health professionals in maternity services must recognise and promote this when planning services, using a system wide approach.

There are specific recommendations published in September 2021 following the NHS 2021/22 Priorities and operational planning guidance produced in March 2021, called Equity and Equality: Guidance for local Maternity systems[8]. This document describes six interventions for the LMNS to take action on and shows which ethnic group will benefit most from the intervention, this also covers vulnerable groups and socially deprived groups of women. Plus the four pledges made by the NHS to improve equity for mothers and babies and race equality for NHS staff[9] in which they make four pledges. On the back of this each LMNS is required to complete and submit an equity analysis (covering health outcomes, community assets and staff experience) and a coproduction plan by 30th September 2021, and then Co-produce an Equity Action Plan by 31st December 2021

Current position in Leicester, Leicestershire and Rutland

This report is to describe what the local maternity & neonatal system is doing in relation to all the national evidence and guidance for health inequalities and poor outcomes for women of a black and minority ethnic background.

Below is a snapshot of the local population by ethnic group, the information describes by ethnic group the percentage of the population who fall in that group up to the age of 24 years. It is very reflective of the population of Leicester as a whole. The national statistics in terms of maternal deaths and ethnicity and the local data that UHL has collected in relation to maternal deaths up to 42 days of birth, all mothers were black Asian or mixed race.

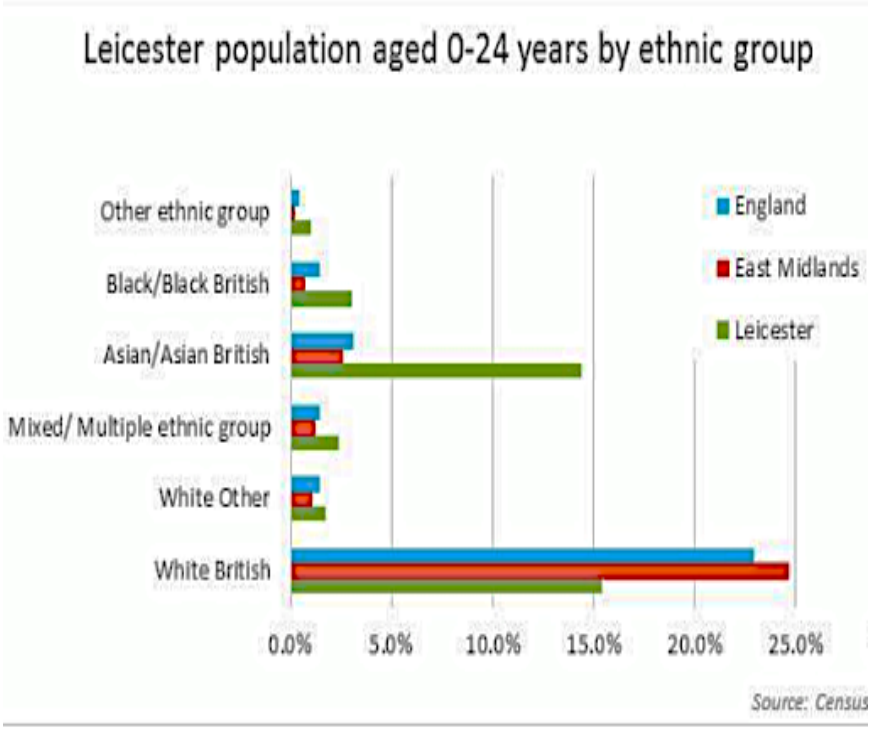
[6] Reducing the inequality of outcomes for women from Black, Asian and Minority Ethnic (BAME) communities and their babies, 2020

[7] Promoting health and preventing premature mortality in black, Asian and other minority ethnic groups. NICE(2018)

[8] NHS, Equity and Equality: Guidance for local Maternity Systems, 2021

[9] NHS pledges to improve equity for mothers and babies and race equality for staff , September 2021, NHS

What is clear when reviewing ethnicity that compared to the rest of the East Midlands and England, there is a significant difference to the national average, of Asian and Asian British group and also larger black and black British group. This suggests that LLR Local maternity system have the opportunity to make a difference in the lives of the women who receive maternity care with the UHL maternity service either in the provider Trust sites or in community. This is not just the responsibility of midwives and obstetricians but the system as a whole, to ensure robust implementation of guidance to improve outcomes.



National Statistics

	Ethnic group				Quintiles of deprivation	
	Black	Asian	Mixed	White	Most deprived	Least deprived
Maternal mortality rate per 100,000 maternities[4]	34.27	14.65	25.14	7.87	15.27	5.70
Number of maternal deaths 2016–18	28	28	8	117	74	15
Relative risk of maternal death	x4	x2	x3	Reference	x3	Reference

Local Data for the past 5 years of maternal Deaths (pregnancy-42 days)

Year	No of deaths	Ethnic group			
		Black	Asian	Mixed	White
2016	2	1	1		
2017	1			1	
2018	1		1		
2019	0	-	-	-	-
2020	1	1			
2021	2	1	1		

Over the past eighteen months these are the actions the maternity system has taken in response to the pandemic and national guidance, in relation to Black women's healthcare equity.

- Launched a continuity of carer team based at a city GP practices, the majority of women in this area are from an Asian or Indian background.
- Produced an informatics poster aimed at women whose first language is not English to encourage them to attend a health professional as soon as possible with any symptoms of Covid, working with members of the Maternity Voice Partnership (MVP)
- Produced a UHL Standard operating procedure to incorporate all the recommendations from the MBRRACE rapid report findings.
- A webinar to raising awareness and discussing health concerns and offering advice in relation to COVID-19 and other health concerns, encouraging women to attend for health and maternity care as soon as possible, this was run by a consultant obstetrician ,matron for community and midwives from the continuity team and discussed in 3 different languages
- Development of a Black and Minority dashboard. In conjunction with mental Health services' Public Health and Neonates, this group was started to identify and understand issues by analysing the local population, understanding the root cause of any disparity and then use the information and learning to design/target interventions accordingly. We believe LLR is the first in the region to undertake this work.
- Raised awareness of the use of interpreters throughout the service, reviewed many different ways of aiding communication with women whose first language is not English. There is now a midwife who is completing a chief nurse fellows programme, the project she is working on is improved communication and interpreting in maternity care
- The LMNS are completing the Equity and Equality analysis following the publication of the four pledges the NHS made to improve equity for mothers and babies and race equality for NHS staff in September 2021. This is to cover health outcomes, community assets and staff experience and set out how we will work in partnership with women and their families to draw up the plans to be completed by the end of November 202. Then submit an Equity and Equality action plan by February 2022
- Following the Channel 4 programme 'Despatches-Black Maternity Scandal' The community midwifery matron and An MVP member were interviewed on the radio to try and assure the local population of the maternity care in LLR and encourage them to seek maternity care early, discuss their concerns and seek interpreting help if needed.

- The Community midwifery matron recorded a video on the benefits of the Covid-19 vaccine with LPT which is on social media (U-Tube)
- The UHL maternity website is in the process of been upgraded, however the current one can be converted into other languages. The upgrade will ensure it is more accessible to all women
- As a system we are committed to delivering the governments ambition 'The Best Start in Life: The First 1001 Critical Days'-The importance of the conception to age two period' and plan to hold our first stakeholder event on the 10th November 2021.

Summary and next steps

A maternal death is a catastrophic event for the family, children are left without a mother and it has long reaching effects on families and also on health professionals, it is a rare event, the mortality rate been around 82 mortalities per 100,000 maternities. In a period of three years, 181 deaths occurred nationally. From the table above in that same 3 year period, there were 4 maternal deaths attributed to the LLR maternities. There is no indication LLR is an outlier for maternal death rates, given the local population.

It is not possible to pin point exactly why maternal mortality rates are higher in women from black and minority groups, there is no one factor that increases the risk. As shown above it is a complex combination of factors, social, physical and psychological. Women must have confidence in maternity services to access care earlier and maintain attendance, they must be facilitated to access health information and encouraged to seek advice.

How the Maternity system do this above and beyond what has been achieved so far, will be led by the results of the Equity and Equality analysis, we will work together to complete a comprehensive action plan and work as a system to implement the actions. When comparable data becomes meaningful from the ethnic Minority Dashboard we can incorporate findings and new indicators and measure results and review if LLR Maternity System is making a difference to the mortality and morbidity of Black and ethnic communities and to the lives and maternity care of vulnerable and socially disadvantaged women. The overall aim is to eliminate maternal deaths, improve the experience of Black and minority ethnic women in maternity services and continue to monitor and embed evidence based research in relation to this population of women