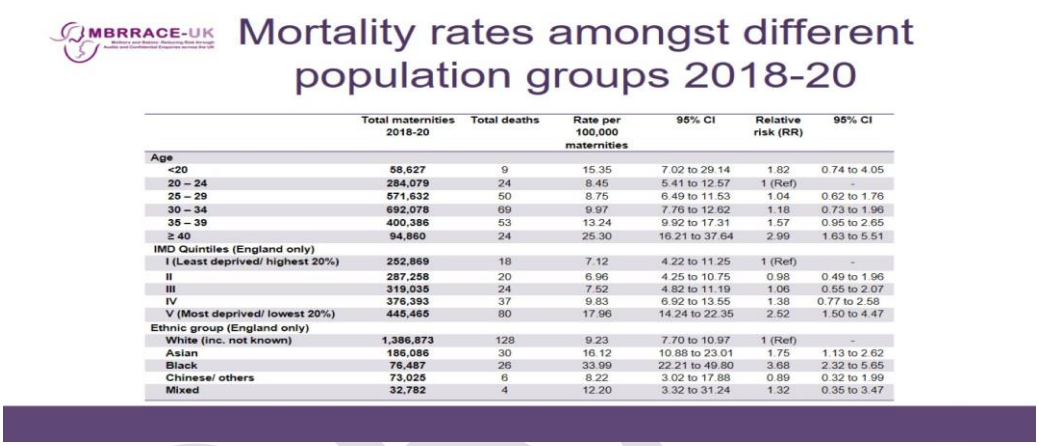
Addressing racial disparities in maternal outcomes for the population of Leicester, Leicestershire and Rutland (LLR)

Introduction

The MBRRACE-UK - Saving Lives, Improving Mothers' Care report (Knight M B. K., 2020) reviewed maternal deaths from 2016-2018, and provided firm evidence that women from Black ethnic groups are four times more likely to die in pregnancy when compared to White women.

A follow up report in 2022, 'Saving Lives, Improving Mother's Care' (Knight M B. K.-U., 2022) produced supplementary analysis which shows that this stark inequality persists despite widespread awareness. The report, the ninth MBRRACE-UK annual report of the Confidential Enquiry into Maternal Deaths and Morbidity, includes surveillance data on women who died during or up to one year after pregnancy between 2018 and 2020 in the UK. This shows that Black women remained 3.7 times more likely to die than White women, and Asian women 1.8 times more likely. Figure 1 demonstrates that women from the most deprived neighbourhoods were 2.5 times more likely to die compared to those from the least deprived, and this difference is increasing.



	Total maternities 2018-20	Total deaths	Rate per 100,000 maternities	95% CI	Relative risk (RR)	95% CI
Age						
<20	58,627	9	15.35	7.02 to 29.14	1.82	0.74 to 4.05
20 – 24	284,079	24	8.45	5.41 to 12.57	1 (Ref)	-
25 – 29	571,632	50	8.75	6.49 to 11.53	1.04	0.62 to 1.76
30 – 34	692,078	69	9.97	7.76 to 12.62	1.18	0.73 to 1.96
35 – 39	400,386	53	13.24	9.92 to 17.31	1.57	0.95 to 2.65
≥ 40	94,860	24	25.30	16.21 to 37.64	2.99	1.63 to 5.51
IMD Quintiles (England only)						
I (Least deprived/ highest 20%)	252,869	18	7.12	4.22 to 11.25	1 (Ref)	-
II	287,258	20	6.96	4.25 to 10.75	0.98	0.49 to 1.96
III	319,035	24	7.52	4.82 to 11.19	1.06	0.55 to 2.07
IV	376,393	37	9.83	6.92 to 13.55	1.38	0.77 to 2.58
V (Most deprived/ lowest 20%)	445,465	80	17.96	14.24 to 22.35	2.52	1.50 to 4.47
Ethnic group (England only)						
White (inc. not known)	1,386,873	128	9.23	7.70 to 10.97	1 (Ref)	-
Asian	186,086	30	16.12	10.88 to 23.01	1.75	1.13 to 2.62
Black	76,487	26	33.99	22.21 to 49.80	3.68	2.32 to 5.65
Chinese/ others	73,025	6	8.22	3.02 to 17.88	0.89	0.32 to 1.99
Mixed	32,782	4	12.20	3.32 to 31.24	1.32	0.35 to 3.47

Figure 1

A FiveTimesMore report in May 2022 (Peter M, 2022) also concluded that though both positive and negative experiences were reported, negative experiences far outweighed those in which black women were happy with the care that they had received. These negative experiences were found to fit within a framework overarched by three interrelated constructs centred around the healthcare professional (HCP):

– *Attitudes* (e.g., using offensive and racially discriminatory language; being dismissive of concerns),

– *Knowledge* (e.g., poor understanding about the anatomy and physiology of Black women; poor understanding of the clinical presentation of conditions in babies of Black women)

– *Assumptions* (e.g., racially based assumptions about the pain tolerance, education level, and relationship status of Black women).

Leicester City stands out as England's only plural city with 49.5% of its population being from non-White groups, in stark contrast to Leicestershire and Rutland, where non-White residents comprise 8.6% and 2.9% Black and Asian ethnicity respectively. Language diversity is also a notable factor; 27.5% of all Leicester City residents communicate primarily in a language other than English, a percentage

significantly higher than that of Leicestershire (3.8%) and Rutland (1.8%). With a dynamic population, which had grown by over 10% at the last census (ONS, n.d.), the number of women in their reproductive years (aged 15-44 years) is predicted to increase by 8% to reach 222,000 across the region by 2039.

Recognising the intersection between ethnicity and deprivation is vital. The prevalence of stillbirths among women of Black or Black British ethnicity living in more deprived areas and aged over 40 years is higher. Babies born to mothers facing these conditions disproportionately experience adverse outcomes. Leicester city is known to have some of the most deprived neighbourhoods in England. Between 2014-2021, the number of children living in relative poverty in Leicester city had increased by 11.7%, equivalent to 14,000 children (Cities, 2024).

In the realm of pregnancy, the amplified prevalence of obesity and diabetes within non-White communities in the United Kingdom has substantial implications for expectant mothers and their infants. The Leicester Health and Wellbeing Survey 2018 showed that 27% of women of childbearing age (16-44) in Leicester are overweight, with 19% classified as obese (Rigby & Wheeler, 2018). While the combined overweight and obesity rate of 45% is notably lower than the national average for England (52%), these figures must be understood within the framework of Leicester's diverse demographic landscape.

The babies of women with a pre-pregnancy BMI of over 35 have an increased risk of perinatal mortality compared with the general maternity population in the UK. Maternal complications associated with obesity include miscarriage, hypertensive disorders such as pre-eclampsia, gestational diabetes mellitus, infection, thromboembolism, caesarean section, instrumental and traumatic deliveries, wound infection, and endometritis (infection in the endometrium).

Adding to the complexity, diabetes rates underscore health disparities during pregnancy with variance visible between the two maternity sites of University Hospitals of Leicester NHS Trust. Data from Leicester Royal Infirmary illustrates disproportionately high rates among the Asian population (48%) and somewhat elevated rates in the White/other ethnicity (44%) population, with a comparatively lower rate in the Black community (8%). At Leicester General Hospital, diabetes rates are 73% for the Asian community, 22% for the White/other ethnicity, and 5% for the Black population.

What is the problem we are trying to solve?

Between 2016 and 2018, 34 Black women died among every 100,000 giving birth. The figure for Asian women was 15 and 8 white women died among every 100,000 giving birth (UK, 2021). Women from Black and minoritised groups have a higher maternal mortality rate than white women (Knight M B. K., 2020) . The overall wellbeing of the Black and minoritised populations are at higher risk of suffering health inequalities primarily because of systemic and institutional racism, direct and indirect discrimination, stigma, fear, and trust (PHE, 2020).

Racism is the biggest driver of health inequalities whilst also exposing other intersecting determinants of health such as low socio-economic states (Bhopal R, 2020). Structural racism further exacerbates the inequities faced by non-White women in maternity care. Socioeconomic factors, such as limited access to healthcare facilities, affordable transportation, and housing instability can create barriers to receiving appropriate prenatal and postnatal care. Additionally, racial bias and discrimination can influence decision-making processes during pregnancy and childbirth, leading to suboptimal treatment plans and increased risks for complications. This can also contribute to disparities in access to prenatal care, postpartum support, and mental health services.

Clinical bias, cultural differences and institutional racism within healthcare services derive from stereotypical behaviours. There is lack of knowledge among healthcare professionals on the diverse cultures non-White individuals are accustomed to. The lack of understanding of non-White individuals' experiences effects the quality of health services they have access to and their experience of those services. These historical based reasons and daily lived experiences of non-White communities contribute to suspicion, mistrust, and fear of not receiving equitable healthcare.

What do we want to achieve?

The aim of this report is to provide an overview of current actions being taken to address racial injustice in maternal outcomes for the people of LLR while making recommendations on how to advance this work.

The goal of this is to move towards equitable maternal healthcare provision across LLR, for all people who need it. This will be demonstrated in incremental improvements in data relating to access, experience and outcomes for people of non-White ethnicity in contrast to the current trends above.

The current interventions below are themed in alignment with the recommendations of the 2022 FiveTimesMore report (Peter M, 2022) under the heading of Knowledge, Attitudes and Assumptions. Further recommendations also follow the same themes.

What actions are being taken to address racial injustice in maternity for people in Leicester, Leicestershire, and Rutland (LLR)?

1. LLR Maternity Equity and Equality Action Plan - Knowledge, Attitudes and Assumptions

The LLR Maternity Equity and Equality Action plan (LLR Equity and Equality Action Plan 2022-2027, n.d.) was approved and published in public in 2022. In September 2021 NHS England/Improvement published The Equity and Equality Guidance for local maternity and neonatal systems (LMNS) setting out two aims relating to equity and equality for maternity and neonatal care:

• To achieve equity for **parents and babies** from Black, Asian and Mixed ethnic groups, and those living in the most deprived areas.
• To achieve equity of experience for staff from minority ethnic groups; the NHS People Plan states "…where an NHS workforce is representative of the community that it serves, patient care and patient experience is more personalised and improves" (Belonging in the NHS, n.d.).

LMNSs were asked to create the conditions to help achieve equity by considering the factors that will support high quality clinical care working with system partners and the Voluntary, Community and Social Enterprise (VCSE) sector to address the social determinants of health.

The LLR maternity equity action plan 2022 to 2027 is aligned to the five strategic priorities relating to health inequalities outlined by NHS England.

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

Community engagement was key to informing the LLR Maternity Equity and Equality Action Plan in addition to an in-depth equality analysis undertaken by the LLR Integrated Care Board. Some of the key themes relating to race-related disparities are summarised below:

- Gestational diabetes and diabetes is higher in certain ethnic groups (Asian, African and Chinese) across Leicester and Leicestershire.
- Maternal obesity is higher in White British, Asian British: Indian and other White Background.
- Premature births are higher within the Black or Black British: Caribbean ethnic group.
- Infant mortality for LLR overall for babies living in the most deprived areas is significantly higher than for those living in the least deprived areas.
- Infant mortality rates for LLR in Asian/Asian British, Black/Black British and babies from other ethnic groups is higher than for White babies.
- User experience: poor *for people of Black and Asian ethnicities* in the following areas, compared with the national position: time spent on antenatal discussions, involvement in antenatal care, responsive postnatal hospital care. Women reported feeling that they aren't heard or listened to, that services were difficult to access, and information was not explained.

The full LLR Maternity Equity and Equality Action Plan can be found here.

2. Addressing language as a barrier to care – Knowledge and Assumptions.

Data from the 2021 Census showed that just under 30% of the population of Leicester do not speak English as a main language (Open Leicster, n.d.). Language barriers in healthcare settings lead to miscommunication between patients and healthcare professionals, resulting in low levels of health literacy, diminished experience of care, poorer quality of care, higher frequency of healthcare interactions and poorer outcomes (Al Shamshi H, 2020). Recognising this, interventions are proactively underway in LLR to address language as a barrier to high-quality maternal care.

Written information is available in translated formats, however this does not equate to a healthcare conversation in an individual's main language and communities frequently report that reading proficiency is limited even in main spoken languages. Adapting to the cultural norms of different communities is also vital, for example enabling the provision of audio-visual sources of information in multiple languages, an area currently being explored by University Hospitals of Leicester NHS Trust (UHL).

Interpretation and translation is available to all individuals accessing maternity services at UHL for both planned and unplanned attendances. As part of a standard procurement exercise to renew the supplier of interpretation and translation services a survey of staff was carried out to explore user experiences and gaps in the current service provision. Although largely positive, there were notable instances of interpreters in particular languages being unavailable, difficulty accessing the technology needed and reliance on ad-hoc solutions such as online translation tools which are not validated for healthcare settings.

In response to the variable experiences of staff and service-users, a pilot study was successfully conducted with CardMedic, an app based interpreting tool to determine if availability of this additional resource would improve the patient and staff experience. This pilot demonstrated that 47% of midwives were able to use the app to relay short and simple instructions, 29% used the app when they didn't have time to access other translation services, and 24% used the app when they couldn't obtain an interpreter (University Hospitals of Leicester NHS Trust and CardMedic, n.d.) facilitating higher

quality care. UHL and LLR Integrated Care System are awaiting the outcome of a bid for funding to implement CardMedic.

The Janam App, developed by Prof Angie Doshani and midwife Jethi Karavadara, aims to address language barriers experienced by people of South Asian heritage during pregnancy and the perinatal period. It is an intuitive, comprehensive, singular information resource to support women in making informed decisions about their perinatal care. The contents are co-designed with patients, community representatives and healthcare professionals (primary and secondary care) based on the most recent evidence, guidelines, and expertise. The app interface supports multiple South Asian languages commonly spoken by the target South Asian patient population (English/Hindi/Punjabi/Urdu/Bengali, and Gujarati). Users can easily switch between languages to access content in their preferred language.

The JanamApp is unique in that it mainly presents content in the format of visual aids, graphics, and multimedia elements. Visuals can enhance understanding and transcend language and cultural barriers. Illustrations, diagrams, videos, or animations have been used to demonstrate medical procedures, symptoms, or treatment instructions.

The content includes:

1. Emergencies- (information on when and how to contact emergency services)
2. Your pregnancy journey (This section provides information on changes in pregnancy, what happens at the various midwife and hospital appointments and what you need to do or ask)
3. Problems in pregnancy (This section highlights the common problems that may occur in mum and baby during pregnancy e.g.: hypertension/diabetes/small baby/preterm labour/mental health problems)
4. Labour (This section discusses the various stages of labour, birth choices interventions that may occur, and pain relief options)
5. Postnatal care (What to expect after vaginal/instrumental and cesarean birth. Signs of complications/ sepsis, when and how to seek help)
6. The baby (NIPE)
7. Frequently asked questions.

The app has been recognised by the NHS Race Health Observatory and is an important step towards addressing racial inequity in maternal disparities in LLR.

<u>3. Addressing late booking for ante-natal care – Knowledge, Attitudes and Assumptions.</u>

'Booking' for antenatal care, when a person informs their healthcare provider of a current pregnancy, is a crucial step in pregnancy and impacts outcomes for mothers and babies; poor access to antenatal care is associated with poor maternal outcomes, including mortality (Knight M B. K.-U., 2022).

Presently, early booking is considered to be prior to 10 weeks gestation (NICE, 2021). Approximately 78% of people who give birth in UHL book prior to 10 weeks. However, on average 57% of Black (-African and Caribbean) people booked after 10 weeks' gestation and 34% of those of Asian (-Indian, -Pakistani and -Bangladeshi) ethnicity booked after 10 weeks' gestation between 2021-2023. From a review of those with suboptimal outcomes in pregnancy for the black population one third booked late.

Methods of booking are direct contact with healthcare professionals via GP services or via Maternity Assessment Units if seen for a pregnancy related problem. Booking can also be performed remotely

by an online enquiry form but relies on digital system access and pertinent information such as a home address and GP are required. This form applies Google technology to translate the form to the language of the user.

Suggested barriers to early booking using the current system include lack of access to and/or awareness of GP or maternity services (for example if new to the country or of more deprived background), lack of a home address, lack of access to technology or digital literacy skills, language or literacy barrier.

A clinical project exploring the reasons why Black people book later for antenatal care is being undertaken at UHL with the support of the Institute for Healthcare Improvement (IHI). The aim of this work is to understand the root causes driving late bookings for care to enable co-design of appropriate solutions to improve early antenatal booking rates for those in the Black population. Partnering with the IHI in this work has enabled a quality improvement, evidence-based approach to this work and has highlighted racial equity work that is imperative to enable sustainable change.

4. Pre-conception education: The STORK Programme; delivering better health for babies.

Parents, carers and families in Leicester are benefitting from a programme designed to narrow neo-natal healthcare inequalities in the area.

Together with local partners and communities, UHL has developed and implemented an education and training programme for new and expectant parents which seeks to raise awareness around infant mortality; embedding neonatal public health messaging within hospital-based care. The STORK programme which stands for, Supportive Training Offering Knowledge and Reassurance aims to narrow the healthcare inequalities experienced by local people living in areas of high deprivation or from non-White groups who are at higher risk of their babies dying.

Nearly half of babies born into UHL neonatal services are of non-White heritage and Leicester city is within the lowest 10% of the most socio-economically deprived local authorities in England. UHL also has amongst the highest infant mortality rates in England.

All parents and families with babies in neonatal services, both in hospital and the community, are offered the opportunity to take part in the programme. Groups at risk of experiencing healthcare inequalities, including those from non-White communities, teenage pregnancies, people who recreationally misuse substances, people experiencing homelessness and those with mental illnesses, are also targeted by the Trust's midwifery team.

The STORK Programme embeds a public health initiative into the fabric of the Trust. Two facilitators run the programme which is delivered in person and via an online app, covering topics including recognising signs of illness in babies, safe sleeping, and how to reduce the risk of sudden infant death. Other topics include healthy lifestyles, smoking cessation, coping with a crying baby, perinatal mental health support and breastfeeding support. There are also practical sessions on basic life support and responding to a choking baby.

The programme seeks to establish behavioural changes amongst new and expectant mothers and their families which will support healthier lifestyles and help to reduce infant mortality. It meets key recommendations around provision of support for parents of preterm and sick babies and for bystander basic life support.

The power of this initiative extends beyond infancy and will help families to adopt healthier lifestyle approaches which will benefit them both now and in the future.

5. Creating a Culture of Speaking Up – Attitudes and Assumptions

The NHS People Plan (Employers, n.d.) states, "We all need to feel safe and confident when expressing our views. If something concerns us, we should feel able to speak up. If we find a better way of doing something, we should feel free to share it. We must use our voices to shape our roles, workplace, the NHS, and our communities, to improve the health and care of the nation… When our people speak, we must listen and then take action."

Maternity services at UHL, embarked on the Empowering Voices programme in 2022. An independent Coach and Mentor was assigned to complete individual and group fact finding sessions enabling staff to speak freely about their experiences working for UHL and the NHS. Staff were unsure of the process initially but soon embraced having the time to talk about their experiences and any inequalities they had personally experienced or witnessed.

As a result, key themes and actions identified, which the trust is addressing through the Maternity and Neonatal Improvement programme group (MNIP) who provide assurance and support. All staff are actively encouraged to speak up to the trust's Freedom to Speak Up guardians if they have any concerns or the maternity Safety champions for clinical issues. The trust is actively supporting safe spaces where colleagues of the Global Majority can report any issues of racism.

The maternity department have recently employed 21 international midwives and nurses who do not have a dedicated support network once they have completed professional registration and their supernumerary status. Consultant Midwives are actively undertaking a scoping exercise to determine how best to support newly recruited international colleagues.

6. Hearing the voices of non-White women and birthing people in LLR

LLR Maternity and Neonatal Voices Partnership was launched in June 2018, to address the significant gap in helping new mothers to speak up and ensure that their experience voices are heard. Since inception the LLR MNVP has become an established local network whilst also linking other regional MNVPs in national partnership. Leicester Mammas was invited to deliver the MNVP programme following a formal tender process from April 2023.

The MNVP is designed to be a co-production forum, working with communities impacted by inequalities, to address the barriers and disparities experienced by new parents and their babies. The work focuses on five key principles:

i. Work creatively, respectfully and collaboratively to co-produce solutions together.
ii. Work together as equals, promoting and valuing participation. Listen to, and seek out, the voices of women, families and carers using maternity and neonatal services, even when that voice is a whisper. Enabling people from diverse communities to have a voice.
iii. Use experience, data and insight as evidence.
iv. Understand and work with the interdependency that exists between the experience of staff and positive outcomes for women, parents, families and carers.
v. Pursue continuous quality improvement with a particular focus on closing inequality gaps.

Leicester Mammas was founded in 2008 to ensure that the experiences of parents from under-served communities play an instrumental role in improving services. The initial focus of the organisation was to support breastfeeding parents, however an intentional move to embrace all feeding methods has enabled Leicester Mammas to become a more inclusive support service with a focus on those in the most deprived communities. Over the past five years Mammas' scope has widened to encompass the

'First 1001 Days' (The best start for life: a vision for the 1,001 critical days, n.d.). Membership of Mammas is diverse and broadly represents that wider LLR region, with work to do to improve representation by some ethnic groups.

A core aim of the MNVP led by Leicester Mammas is to hear the voices of women who are least likely to feel, or recognise, that their experiences matter. A concerted effort has been made to establish trusted links with local community organisations and the VCSE sector. This has been achieved through attending planned events as well as hosting listening events. Leicester Mamma's also work closely with clinical teams on specific improvement projects that aim to address racial disparities in maternal care. The full MNVP annual report for 2023/24 can be found here.

In addition to the work of the MNVP, UHL's Patient and Community Engagement team are also key to building trusted relationship and giving platform to those communities who are under-represented and subject to inequity. Similarly to Leicester Mammas, this small team has provided dedicated support to projects focusing on addressing racial disparities in maternal care that are detailed elsewhere in this report.

What more do we need to do to address racial injustice in maternity for people in LLR?

Outlined below are six key areas of intervention that the group membership believe are important to drive forward action on racial injustice in maternal health for the people of LLR. These are grouped under the themes referenced in the FiveTimesMore report:

Knowledge:

1. Use data to define the problem explicitly and specifically for the population.
2. Embed quality improvement (QI) methodology as a strategic enabler of addressing health inequalities and work with academic partners to deliver inclusive research.

Attitudes:

1. Confront and address systemic and institutional racism through learning.
2. Focus on maternal mental health to deliver integrated services to meet service users' multifactorial needs.

Assumptions:

1. Discover and understand the upstream causes of race-related disparities specific to the population through cross-sector, inter-disciplinary collaboration.
2. Amplify the voices of non-white women and birthing people, focusing intentionally on black communities.

Knowledge:

1. **Use data to define the problem explicitly and specifically for our population.**

MBRRACE reports provide healthcare providers with an oversight of the experiences and outcomes of the populations that they serve. Clinicians at UHL are developing a maternal health inequalities dashboard through which local data analysis can drive decision making through data intelligence.

The Ockenden report into Maternity services in the Shrewsbury and Telford NHS Trust (2022) highlighted that:-

"Pregnancy is a well-known catalyst that can exacerbate maternal vulnerability and inequalities that already exist in some women's lives."

The Perinatal Inequality Dashboard is an innovative tool that combines demographic data on Race, Ethnicity, postcode, preferred language, with adverse pregnancy outcome data such as Stillbirths, early neonatal death, severe perineal trauma (3rd and 4th degree tear rates), major haemorrhage and referral rates to the perinatal mental health team. The interactive dashboard enables the population to be subdivided into smaller groups, and the outcomes of the examined group to be assessed against the baseline for the population. The dashboard has been created collaboratively by the obstetric, neonatal and perinatal mental health to illustrate differences in healthcare outcomes based on ethnicity and deprivation scores. As the data is displayed over time, as interventions are being introduced, we hope that we can observe the impact of that intervention on various outcome parameters being measured.

An example of this is how the maternity dashboard highlights that Leicester is an outlier for its rates of severe perineal trauma after child birth (3rd/4th degree tears). The Perinatal Inequality Dashboard highlights that third- and fourth-degree tears rates, are significantly more common in Asians than in other Race/Ethnic groups. When the groups are further categorised into English speaking and non-English speaking, the rates in the non-English speaking groups are almost five times higher than the English-speaking groups. Through raising awareness and lowering the bar for interventions in this cohort (such as being ready to conduct an episiotomy, reducing lithotomy positioning in labour, and encouraging this group of women to use warm compresses and perineal massage antenatally) may improve outcomes. All these characteristics have been found to minimise the chance of tears, but we recommend focusing resources on the subset of women who are most likely to benefit before expanding to the entire maternity community.

Additionally, the group have worked with social scientists and conducted focus group interviews, to have a deeper review of the root cause of the disparity and start to coproduce guidelines and patient information resources to ensure that the care provided is equitable. A recent audit has shown that over the past 6 months the rates of third and fourth degree tears is now below the national average.

The objective is that by making the dashboards interactive, relevant, informative and current, the impacts of any new measures to eliminate inequity can be followed in real time. Furthermore, by integrating key parameters within the dashboard the necessity for lengthy audits can be avoided.

2. Embed quality improvement (QI) methodology as a strategic enabler of addressing ethnicity driven health inequalities and work with academic partners to deliver inclusive research.

Quality Improvement

University Hospitals of Leicester (UHL) have recently created a maternity and neonatal quality improvement team involving both clinical and non-clinical staff to drive improvement forward based on both national drivers and local recommendations.

The team involves multidisciplinary colleagues from within maternity and neonatal services to be involved and shape improvements in their department. Targeted task and finish groups and working parties have been formed to aid prompt progression and momentum and clinical medical, midwifery and nursing leads are assigned to work streams. A team of Project Support Officers use the IT system 'Monday.com' to collate evidence and monitor action trackers relating to specific work streams.

A monthly forum called QUAIL (QUAlity, Improvement & Learning) in Action is led by the Maternity and Neonatal Quality Improvement team where updates are shared and staff present their own QI projects; influencing and motivating others to get involved in quality improvement. There is also a monthly newsletter which is produced for staff to celebrate achievements to encourage and improve staff engagement in QI work.

Maternity have built strong partnerships with the local Maternity and Neonatal Voices Partnership (MNVP) so service users are involved in quality improvement work streams for example, Induction of Labour. Maternity at UHL also have strong relationships with the Trusts QI and Audit teams for support and advice.

Within the last year there have been multiple examples of improvements made to services within maternity including:

- The Janam App: a virtual information guide which includes videos and animations relating to pregnancy, birth and beyond in multiple languages (English, Urdu, Gujarati, Hindi, Punjabi and Bengali).
- 'My Maternity Journey – a personalised care plan': a paper booklet for women/birthing people to document their preferences regarding their pregnancy and birth.
- Creation of the East Midlands Maternal Medicine Network: monitoring and caring for women/birthing people who have pre-existing medical conditions.
- Pain relief in labour information: posters have been developed with QR codes in different languages to provide information about pain relief and epidural analgesia.

Inclusive Research

The recent NHS Race and Health Observatory's (Esan O, Adeji N, Saberian S, Christianson L, M Philip, Penningotn A, Geary R, Ayorinde A, 2023) report on existing policy interventions highlights a significant gap in addressing ethnic health inequalities in maternity and neonatal care in England. It reveals a concerning scarcity of interventions at organizational levels that target the structural and institutionalized processes perpetuating racism and ethnic inequalities. Notably, specific interventions for underrepresented groups such as Black African, Black Caribbean, Roma, Gypsy, and mixed ethnic groups—as well as migrants, refugees, and asylum seekers—are limited. This shortfall is particularly acute outside London, with no completed research evaluations to substantiate the impact of existing interventions.

This report accentuates the urgent need for investment in research aimed at reducing ethnic health disparities in maternal and neonatal health. It stresses the importance of understanding the intersectional factors affecting patients' access to care, including socioeconomic contexts and community environments. However, evidence of effective interventions in reducing maternal health inequalities remains scant, signalling a pressing need for co-produced research and interventions involving women from ethnic minority groups. This is echoed in findings from multiple reports, such as the House of Commons Committee Black Maternal Health Report (House of Commons Women and Equalities Committee, 2023) and the Fivexmore report (Peter M, 2022), which highlight a distinct lack of research into the maternity experiences of Black women. These gaps indicate that the nuances of how Black women perceive care during maternity are poorly understood, emphasising the need for more inclusive and participatory research methodologies.

In response to these critical insights and following recommendations from the Fivexmore Report (Peter M, 2022), a collaborative research project has been developed. This project, funded by the

University of Leicester's LIAS and conducted in partnership with the University of Leicester and Public Health, aims to examine the historical and current maternity experiences of Black and Mixed Black women in Leicester and Leicestershire. The research focuses on collecting qualitative oral histories from women in the region, thereby enriching our understanding of how past experiences influence current perceptions of the NHS and advice shared within communities.

Moreover, this initiative is part of a broader effort involving multiple maternal health organizations and support groups across the UK to address maternal inequalities. An application for the NIHR Maternity Challenges consortium funding (£50 million) is underway to co-design further research with underserved groups. This consortium aims to deeply understand the experiences of ethnic minority women along the maternal health pathway and develop interventions to improve inequities in access, experience, and outcomes. A cross-cutting theme that focuses on addressing inequalities and inequities in care across the maternal health pathway for ethnic minority women, in partnership with UHL to further our work in this area will be a significant area of focus.

Finally, as part of our commitment to broader research inclusion, training must be co-produced with people from underserved groups in their community settings, targeting inclusive research practices across various health inequalities. An approach to this has been established in LLR an provides a model for co-produced training with underserved groups. The goal for future co-design training is to enhance healthcare professionals' and researchers' understanding and improve the quality of maternal care for all ethnic groups. With this approach and work package in mind, we have drafted the NIHR Maternity Challenge grant consortium application, aiming to secure funding to further develop this research and training initiative.

Attitudes:

1. **Confront and address systemic and institutional racism through learning.**

(i) Decolonise midwifery.

It is suggested that a collaborative partnership with the University of Leicester and practice partners clinical practice educators be established to review current content of mandatory training for all grades of employees involved in maternity care. The aim is to encourage a greater understanding of the needs of women and families, current and future workforce from all races, ethnicities, cultures and backgrounds while re-constructing education from a global perspective to produce a robust and accurate evidence-based curriculum.

This will be achieved by embedding recommendations from the Royal College of Midwives (RCM) Decolonising Midwifery Education Toolkit (RCM, 2023) on recruitment, curriculum, assessments and practice. It can reasonably be expected that this will increase racial concordance, racial literacy and decolonise midwifery education to encourage a greater understanding of the needs of women and families from all races, ethnicities, cultures and backgrounds, in line with the Nursing and Midwifery Council (NMC) Standards of proficiency for midwives (NMC, Standards of proficiency for midwives, 2019) and the Nursing and Midwifery Code (NMC, The Code, 2018).

(ii) Recognise ethnicity related workplace trauma.

Colleagues who are of non-White ethnicity experience race related discrimination and trauma as evidenced by local Workforce Race Equality Standard data. Race and ethnicity are still felt to be a taboo subject for colleagues to discuss and it is felt that cultural awareness and competency training

should be prioritised. Learning from others, clinicians at Leicester Partnership Trust have engaged with Birmingham and Solihull Perinatal services to learn how they have begun to address ethnicity related barriers to improvement within their services.

Ethnicity related workplace trauma may traditionally be ascribed to experiences of racial discrimination or profiling. It may also be the consequence of adaptation to the workplace environment with the intention of creating a sense of belonging and the unintended consequence of vicarious trauma. UHL have begun initial conversations about exploring and understanding the heritage of colleagues' names, the meanings these have and how these contribute to a sense of self and even purpose. Though in the early stages of development, this piece of work aims to recognise the trauma of mispronounced, anglicised or changed names and how these impact on the workplace experience and ultimately patient care.

(iii) Embed inclusive leadership.

In collaboration with Leicester Partnership Trust (LPT) and the LLR Integrated Care System (ICS), UHL have formed the LLR ICB Nursing, Midwifery & Allied Health Professionals Inclusion leadership group, with a specific maternity representative in the group.

This group has been established to promote inclusive recruitment practices free from bias including, but not limited to, embedding diverse interview panels throughout the organisation. There will be a focus on strengths-based recruitment, moving away from traditional recruitment models which are known to adversely impact non-White candidates. In order to promote this, the Developing you, Developing Me Talent Acceleration Programme was launched in October 2023. The programme aims to ensure personal development through mentorship and is aimed specifically at non-White colleagues.

Further work of the group will include reviewing Workforce Race Equality Standards (WRES) data and NHS staff survey reports when published to ensure appropriate and impactful responses to discrimination which are aligned to the Trust's broader action plan.

Two newly recruited Consultant Midwives with a portfolio for inclusion in maternity care have also recently been recruited and commenced work with the specific remit of improving inclusion in midwifery and tacking health inequalities. The Consultant midwives are also visiting lecturers to the University of Leicester and De Montfort University, strengthening links to research and promoting inclusion in maternity and neonatal research and undergraduate education.

(iv) Embed inclusive recruitment and retention.

Over 80% of the midwifery workforce is of White British ethnicity though there has been a notable increase is non-White recruits since 2020. Similarly, 75% of midwifery support staff are white British, though there has been a 9% increase in non-White midwifery support staff between 2019-2023. Given the diversity of the population of Leicester, ensuring that our workforce represents our communities is paramount.

A newly established programme to increase international recruitment of midwives with support from NHS England has seen 14 international midwives recruited to UHL in 2023. An Education and Practice Development midwife for international recruitment has been employed to continue to develop this pipeline of recruitment. This midwife liaises closely with the Recruitment, Retention and Pastoral Care team (see below) when midwives join the professional register following a successful conversion programme to sustain support. Recruits are offered support with accommodation and relocation costs.

Non-white colleagues are proportionately more likely to be un-registered ie not on a professional register and in a 'non-skilled' role. Non-traditional training routes will support increases in inclusive recruitment into midwifery and allied professions. A focus on apprenticeships and development from bands 2 and 3 to band 4 with a new initiative of nurse associate trainees in maternity will support this.

UHL have have employed three Recruitment, Retention and Pastoral Care Midwives and a Safe Staffing Matron. Their role is to support newly qualified and new to the trust midwives to achieve UHL competencies and to provide staff well-being support and advocacy when required. The team carry out stay and exit interviews and share reports with the midwifery senior leadership team.

Sustained outputs from the Empowering Voices programme to address cultural microaggressions and improve cultural competency will support recruitment and retention of non-White colleagues. Unconscious bias training is now mandatory for all registered and non-registered staff.

2. **Focus on maternal health to deliver integrated services to address individual and multifactorial needs.**

The separation of services across multiple sites and trusts increases the challenge of delivering holistic healthcare, the impact of which is exacerbated in vulnerable groups, including those at risk of health inequity. Using perinatal mental health as a case study we propose that deeper integration of services and joining up of care is vital to ensuring that inequalities in maternal outcomes are addressed. This will also have long standing benefits to the healthcare system more broadly.

The Perinatal Mental Health Service is a psychology-led, trauma-informed service. The team is made up of Mental Health professionals that provide personalised and specialist care to people living in Leicester, Leicestershire and Rutland who have complex or severe mental health problems relating to pregnancy, childbirth and the first year following a child's birth (also known as the Perinatal Period). The team has been going through a process of change with expansion of the service and aiming to advertise the service to the general community and professionals such as GPs, Midwives, Health Visitors and community support groups. The service covers a wide variety of needs, including: pre-conception and early pregnancy advice, medication advice and monitoring, safeguarding, breastfeeding support and much more.

However, there are notable gaps and areas of improvement needed including, but not limited to: the workforce does not reflect the diversity of the population and the service user cohort does not reflect the diversity of the population. Integrated provision of services will allow resource and expertise to be brought together to ensure focused work to ensure disparities are addressed.

Assumptions

1. **Discover and understand the upstream causes of race-related disparities specific to the population through cross-sector, inter-disciplinary collaboration.**

In an effort to show progress, it would be easy to move towards a solution focussed approach to maternal disparities and health inequalities more broadly. However, key to sustainability is ensuring that both the 'why?' and 'what?' are addressed. Why do disparities exist? What is the specific disparity affecting the population in question?

Taking a quality improvement approach to service improvement and ensuring that clinical research is inclusive, as described above, will be vital, in particular for addressing the 'what?' and will enable health specific solutions to be hypothesised. Understanding why disparities exist however is entangled

with the root causes of social determinant factors such as education status, employment status and housing status. While healthcare only contributes to 20% of inequalities, it influences the wider determinants of health more broadly and it is widely accepted that the intersection between wider determinants impacts on individuals' health status. Further cross-sector, inter-disciplinary research is desperately needed to understand why specific communities experience disparities compared to others before targeted solutions can be co-designed and co-implemented with communities themselves.

A project bringing together the University of Leicester's Population Health Sciences, Sociology and Medical School, UHL and Leicestershire County Council Public Health division has recently been given a small amount of seed funding to explore and develop an Historical Understanding of Black Maternity and Motherhood Health Experiences in Leicestershire".

Collaborative work of this nature underpins sustainable change but is largely absent from the academic evidence base in maternal disparities. Sensitive exploration of historical experiences contextualise today's disparities and support confronting and difficult conversations about systemic and institutional racism, without which race related disparities cannot be addressed.

2. **Amplify the voices of non-white women and birthing people, focusing intentionally on black communities.**

As stated previously, the NHS people plan points out that when the workforce represents the population, quality and experience of care improves with positive impact on outcomes (Belonging in the NHS, n.d.). Similarly, it is accepted that focused and intentional community engagement positively influences health related behaviours (Cyril, Smith, Possamai-Inesedy, & A, 2015). For community engagement to be impactful it too must be representative of the community in question *citation*.

Through careful quality improvement work, using data insights as described above, engaging with specific communities will enable partner organisations across LLR to work with communities to develop understanding of disparities and solutions to problems identified by communities specifically. Targeted work is already underway in LLR, for example work to address late bookings for antenatal care in Black communities, as described above.

However, trust remains low within non-White communities and emphasis must therefore be placed on establishing relationships and fora that enable mutual accountability for actions to address disparities. UHL will launch the UHL Health Equality Partnership in the summer of 2024 with a view to continuing work that has already happened to build bridges, however it is recognised that this is a small step in what will be a long and difficult journey, owing to the years of dis- and mistrust that has become embedded. In view of this, focusing on specific relationships with leaders of the Black community will be a key action through the work described above to address maternal disparities for these communities.

Conclusion

This report and framework was established to answer the specific question, "what is happening in Leicester to address the disparities experienced by black women and people during pregnancy and childbirth?" In drawing together a number of experts across disciplines, it is clear that there is already a significant drive to address this problem, with multiple individual workstreams to address various

facets. However, it is also fair to say that more needs to be done, especially if the work that is happening is to move from a reactive state to a proactive and sustainable change.

Important practical and process-based improvement will undoubtedly help, for example work to understand why black people book later for antenatal care. However, authentic and meaningful improvement in disparities experienced by non-White women will only happen if the foundational work to understand upstream causes of disparities is given due priority and urgency. Similarly, increasing representation in the workplace will have limited impact without concurrent work to address systemic and institutional racism alongside personal bias through efforts to improve cultural competency across the workforce.

The 2022 Fivetimesmore report provides a useful thematic framework for the recommendations outlined above and summarised below. It is important to recognise and accept that while some change may happen at pace, longer lasting change will take time. The authors strongly believe that persistent focus on these actions will lead to improvements in outcomes for non-White people and their babies, with sustained, embedded change that has the potential to influence health and healthcare more widely.

Knowledge:

1. Use data to define the problem explicitly and specifically for the population.
2. Embed quality improvement (QI) methodology as a strategic enabler of addressing health inequalities and work with academic partners to deliver inclusive research.

Attitudes:

1. Confront and address systemic and institutional racism through learning.
2. Focus on maternal mental health to deliver integrated services to address individual and multifactorial needs.

Assumptions:

1. Discover and understand the upstream causes of race-related disparities specific to the population through cross-sector, inter-disciplinary collaboration.
2. Amplify the voices of non-white women and birthing people, focusing intentionally on black communities.

This report intentionally focuses on key themes that should underpin work to address maternal inequalities, particularly for Black women and birthing people. For the impact to be felt most deeply, these themes should be aligned to key areas of clinical focus that any organisation highlights as a source of maternal inequality.

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