DEVON LOCAL MATERNITY & NEONATAL SYSTEM

EQUITY & EQUALITY | IMPROVING OUTCOMES

“Equal chances for a happy, healthy pregnancy and baby in Devon”

Published 2024

One Devon

Proud to be part of One Devon: NHS and CARE working with communities and local organisations to improve people’s lives

Document Control

Version History

Version	Updated By	Date	Updates
Draft V0.6	Charli Mardon, Melanie Winterburn Brannick & Kate Taylor	26/09/2022	Draft including action plans complete (narrative incomplete). Distributed to LMNS Board senior members.
V1.0	Submitted plan	October 2022	
V1.3	Charli Mardon	August 2023	Amendments following comms review
V1.7	Aggie Spzinda, Charli Mardon & Steve Clark	March 2024	Amendments following further review from Comms & Inclusion *Versions between 1.3 & 1.6 were subject to internal updates & changes and were not reviewed formally.*

Review

Version	Reviewed By	Date	Comments
V0.6	LMNS Board	September 2022	
V1.2	Steve Clark	June 2023	Comms review
V1.6	Steve Clark, Aggie Szpinda	Feb 2024	Comms review

Approval

Version	Approved By	Date	Comments
V1	LMNS Board	October 2022	
V2	Penny Smith	April 2024	Approval for publication

Control

The master copy of this document is held by the Devon LMS. To obtain the most recent version of this document, please contact Devon LMNS.

NHS Devon

Contents

Executive Summary

Our Equity & Equality Analysis showed us that there are a number of inequalities in Devon, and also a number of areas where we must work harder to gain an understanding of inequalities and the challenges facing certain communities and people.

The significant level of deprivation in Devon was highly evident. This is most obvious in the urban centres of Plymouth and Torbay, but also notable in rural and coastal areas. Impacts of deprivation such as high smoking rates and challenges with healthy weight are noted within our population.

Our geography is vast and challenging, with lengthy and slow transport networks in many areas, making access to healthcare time consuming and expensive for some people.

Devon has some specific populations that will require additional support and intervention to ensure that they receive equal and equitable experiences and outcomes. This includes military families and people from Gypsy, Roma, Traveller communities and Asylum seekers.

This document will outline the Devon Local Maternity & Neonatal System Equity & Equality Strategy for the next 5 years and a more detailed plan for the next 24 months.

Recognising the limitations of our knowledge and perspective, we have included recommendations from key publications with specialist interest or knowledge, or from national public engagement reports to ensure that we make best use of available information.

This plan includes links to resources and information that can support healthcare professionals provide personalised support to women, birthing people and families from diverse backgrounds.

We will take a listening, learning and co-production approach to understand other inequalities within our system and aim to provide reasonable adjustment to ensure care is accessible and equitable for all.

Equity means that all mothers, birthing people and babies will achieve health outcomes that are as good as the groups with the best health outcomes across Devon.

As the Chief Nurse and Senior Responsible Officer I support this document in establishing the context and ambitions that maternity and neonatal services will respond to each person's unique health and social situation.

If equity for mothers, birthing people and babies is to improve across the county then so must race equality for staff. Maternity and neonatal services contribute to the health & wellbeing of our diverse communities.

Good health in pregnancy significantly influences a baby's development in the womb which, in turn, influences long-term health and educational outcomes. Thank you to all those who have contributed; your input has made this work inclusive and far reaching setting our ambitions. We need ensure women, birthing people, and their families along with NHS staff work in partnership to design, improve and evaluate our services eliminating unwarranted variances. Everyone can help to achieve our equity and equality aims. Therefore we commit to work together to improve equity for mothers and babies with the best outcomes.

Penny Smith, NHS Devon Interim Chief Nurse & Senior Responsible Officer for Devon Local Maternity & Neonatal System

Devon Local Maternity & Neonatal System Strategy 2023-2028

Introduction

Following the publication of Equity & Equality: Guidance for Local Maternity Systems in 2021, Devon Local Maternity & Neonatal System (LMNS) has been undertaking data analysis, staff, service user and community engagement to understand the needs of our population and variation in outcomes for different groups.

The Coronavirus Pandemic has further highlighted the extent of inequalities in outcomes and experiences across health and care.

- In Maternity, we know that people from black & Asian backgrounds have significantly higher morbidity and mortality and poorer experiences of care.
- Women & birthing people over the age of 35 and under the age of 18 are at greater risk of poor outcomes.
- In addition to the above, those living in the most deprived areas of England are also more vulnerable to poor outcomes.

Whilst we focus here on reducing specific inequalities, we recognise that improving equality benefits us all and that listening to the experiences of women, birthing people and families improves care and the experience of delivering services for our workforce.

Our primary analysis was completed in May 2022, through this document we intend to expand the datasets we now have access to and ensure an improved consistency and confidence in data quality.

Over summer 2022 we held 2 workshops; first with staff in health and social care, and the second with a small group of service users. Our analysis and engagement has shown that a sustained commitment to engagement with all people who use our services is essential to ensure equitable outcomes and experiences for all.

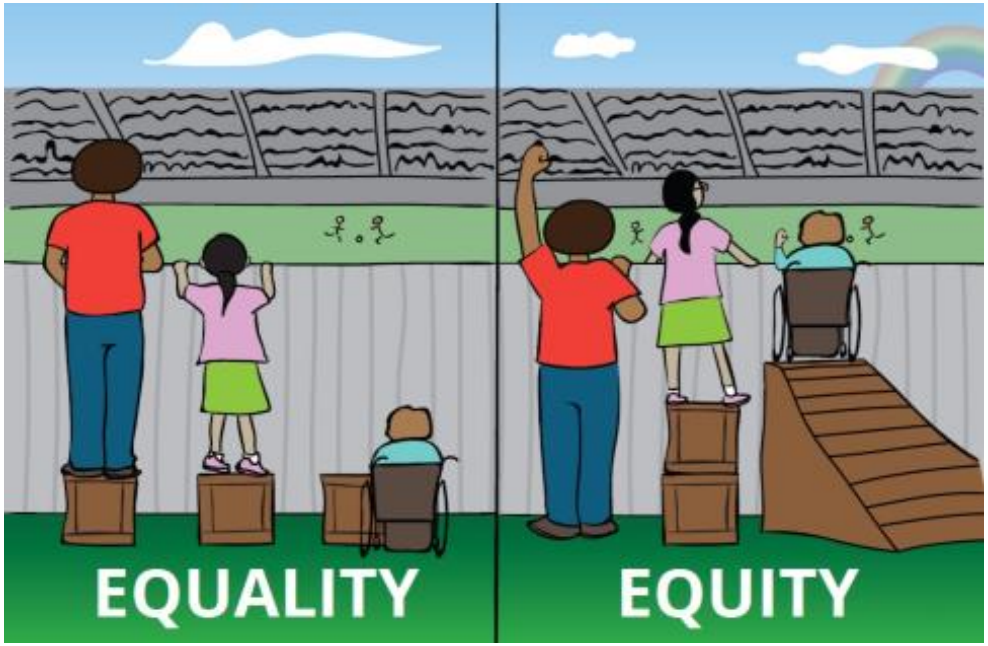
The NHS Devon Communication, Involvement and Inclusion team are developing an Equality and Diversity strategy. We will align the delivery of this strategy with the wider NHS Devon strategy.

This document is split into 2 sections:
Firstly, our Equity and Equality strategy - outlining the Devon approach to improving outcomes and experience over the next 5 years.
Secondly, an outline plan, addressing the immediate and essential actions to enable us to realise our vision for truly equitable services.

This strategy and plan identifies inequalities and inequities in maternity and neonatal care and the impact they can have.

In this document, we address the priorities and interventions outlined in *Equity & Equality: Guidance for Local maternity Systems*, but also include recommendations & insights from key national publications that have undertaken extensive reviews of adverse experiences and outcomes. These will guide our approach and prevent the need to ask the same communities the same questions.

Equity & Equality



Equity Vs Equality (youtube.com)

It is important that we recognise and draw the distinction and difference between an inequality or inequity and their impacts. *Equality* means each individual or group of people is given the same resources or opportunities.

Equity recognises that each person has different circumstances, and allocates the exact resources and opportunities needed to reach an equal outcome.

Inequalities are based on unbalanced circumstances, for example the differences between 'least' and 'most' deprived. Inequities are states of being 'unjust' or 'unfair', for example some people not being provided with what they need to enable the same outcome such as tailored advice that fits their needs and circumstances.

Notes to the reader:

'Devon' refers to the entire county area of Devon, coterminous with the Devon ICB and Devon LMNS.
'Devon County Council or DCC' refers to the geography of the DCC Local Authority. This excludes the unitary authorities of Plymouth City Council and Torbay District Council.

'Maternity Staff' includes the full range of maternity healthcare professionals. This includes midwives, maternity support workers (MSW's) and obstetricians (maternity doctors)

Throughout this plan we have included recommendations from key national publications to reduce the need to ask the same questions of the same groups once again- we recognise the feedback that underserved communities are often over-surveyed for their views.

References

Equity and equality: Guidance for local maternity systems (england.nhs.uk)
British Journal Of Midwifery - Ethnic health inequalities in the UK's maternity services: a systematic literature review
Say what you mean, mean what you say: inequality and inequity | The BMJ

Devon LMNS Population Background

A more detailed background is provided in the Devon LMNS Equity & Equality Analysis, with high level descriptions provided below.

Geography

Devon is the fourth largest county in England by area, and the seventh most sparsely populated (23% of the population live in 'Rural Isolation: Mosaic Group K'), compared with a 5% national average. Characteristics of the road and public transport networks pose a challenge to travel times to maternity and neonatal units, with significant change observed during peak holiday season.

Deprivation

Peaks of deprivation are clearly observed in urban areas such as Torbay and Plymouth, however less clear are significant pockets of deprivation in rural and coastal areas- these are often masked by proximity to affluent populations. Wage levels are generally low and often subject to seasonal change whilst house prices have seen a consistent and sharp increase in the last 2 years, posing a risk to secure housing, especially for lower income families.

Demographics & Public Health

Age

Around a quarter of the population are over 65, with life expectancy considerably shorter in the most deprived areas. We know that generally, women live longer but in poorer health than men. The average age of motherhood has increased to 30- with increased maternal age comes a reduction in the ability of grandparents to provide support and childcare.

Increased maternal age (>35) also has an impact on outcomes, with increased risk of complications. Similarly, births <18 years also poses an increased level of risk. In England the rate of births to under 18s is around 0.5%, however some areas of Devon can exceed 5% in a given month.

Healthy Weight

The latest obesity data (2017/18) shows that there are around two thirds of the Devon population who are overweight or obese and is in line with the England average. Those from deprived backgrounds, black ethnic backgrounds and with short pregnancy intervals are at greatest risk of increased BMI. Obesity is associated with increased risk of almost all pregnancy complications and additional interventions.

In September 2022 the NICE Guideline for Obesity (CG189) was updated, however it does not touch upon healthy weight guidance for pregnancy. General principles include personalisation of a tailored weight management programme and caution in the application of BMI measurements as it does not measure central adiposity.

Smoking

Smoking rates within the general population are significantly higher than the England average, with a range of 13.5%-17% across the 3 local authorities. Rates of smoking at maternity booking appointments can readily exceed this, at almost 50% in some areas.

Domestic Abuse

Our safeguarding database Datix does not consistently provide a category of domestic abuse or sexual violence (DASV). This lack of data collection is echoed across the health system. Because domestic abuse and sexual violence has not historically been recognised to be a 'health' concern there is a paucity of data collection in health settings.

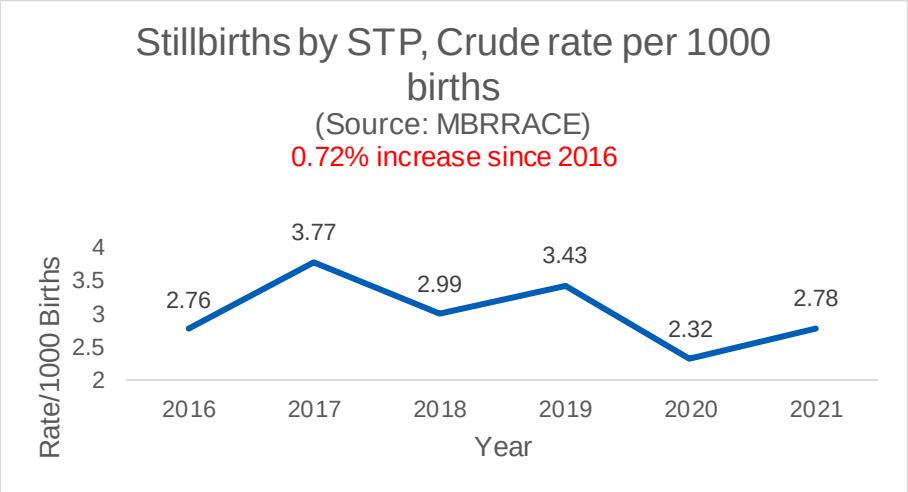
Health services are settings that women feel safe in and are locations where requests for support for DASV most commonly occur.

- 80% of women in a violent relationship seek help from health services and are often a woman's first, or only, point of contact.
- Victims of domestic abuse can be frequent users of hospitals.
- Local evidence has echoed national findings that GPs are the professional that victims most trust to disclose to, comparable only to friends and family.

Outcomes

Since 2016, Devon LMNS has been working towards the national ambition to reduce stillbirth, neonatal death, maternal death, intrapartum brain injury and preterm births.

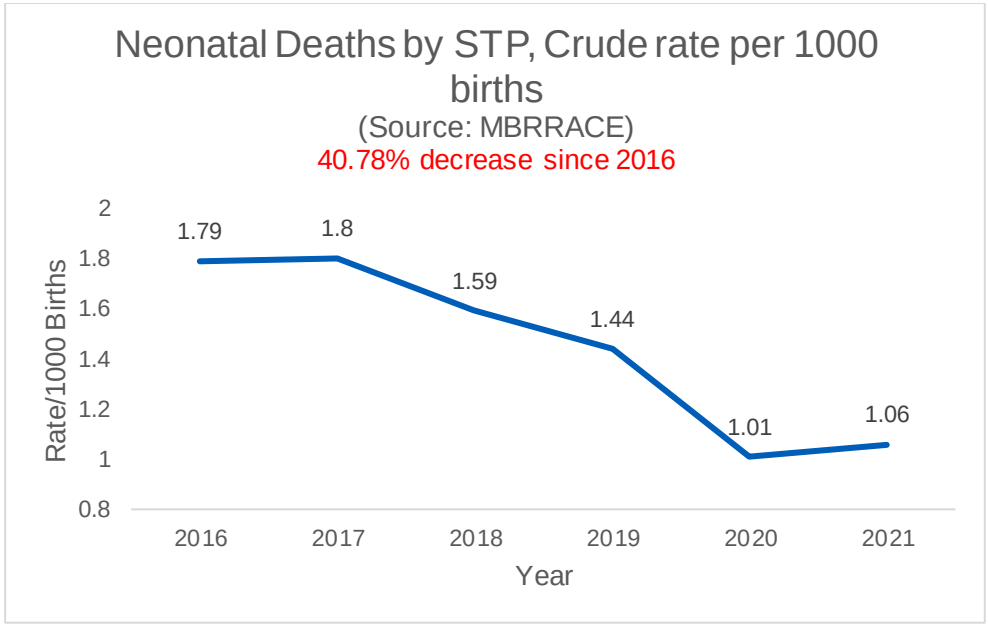
Inequalities and their impacts are directly related to ensuring good outcomes for women, birthing people and babies.



Stillbirth rates in Devon have increased since 2016.

A number of factors increase the risk of stillbirth, including:

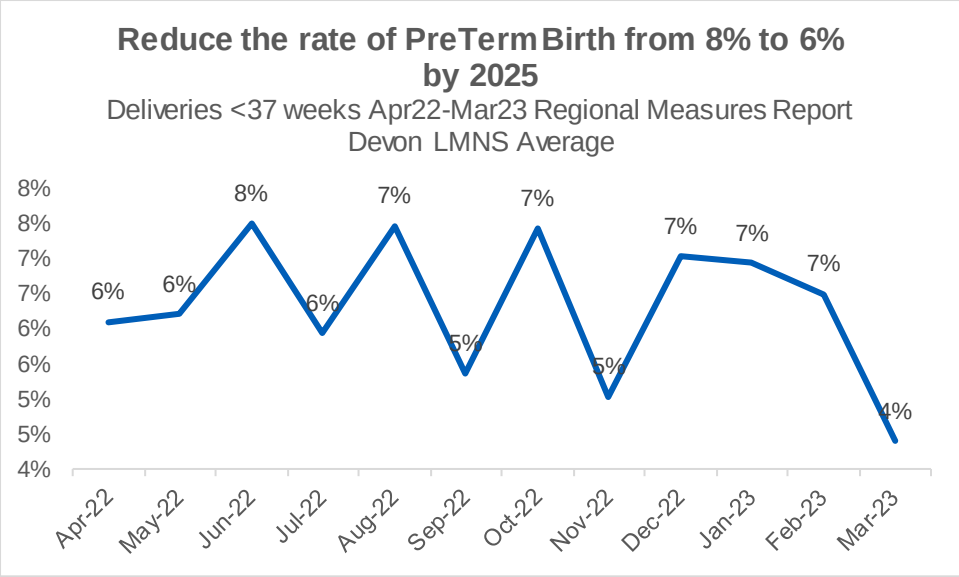
- Being over 35 years of age
- Smoking, drinking alcohol or drug misuse whilst pregnant
- Having a BMI over 30
- Having a pre-existing physical health condition
- Having a multiple pregnancy
- Having a baby who doesn't have normal development within the womb.



Neonatal deaths in Devon have reduced since 2016.

Neonatal deaths can occur for a variety of reasons:

- Medical conditions identified in the womb or at birth
- Extreme prematurity at birth
- Mother/birthing person aged under 20 or over 40
- Ethnicity of parents; babies born to Black or Asian parents have an increased risk of neonatal death
- Smoking during pregnancy
- Having a BMI over 30



Rates of preterm births (babies born early, at less than 37 weeks of pregnancy) are around the national target of 6%.

References

Poverty-and-Deprivation.pdf (devoncf.com)

Obesity in Pregnancy: Implications for the Mother and Lifelong Health of the Child. A Consensus Statement | Pediatric Research (nature.com)

https://www.bliss.org.uk/research-campaigns/neonatal-care-statistics/neonatal-mortality-in-the-uk-how-many-babies-die-in-their-first-28-days-of-life

https://www.nhs.uk/conditions/stillbirth/

Context

National Context

Recent NHS guidance has highlighted the need for Local Maternity & Neonatal Systems (LMNS) to refresh their understanding of their local population as part of their Equality and Equality Action Plans.

Reports from MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) on maternal and perinatal mortality show worse outcomes for those from ethnically diverse groups and those living in the most deprived areas. This has been further highlighted by COVID19, with black women & birthing people eight times more likely to be admitted to hospital with COVID-19 during pregnancy than white women & birthing people. Asian women & birthing people were four times more likely. As a result, the NHS has set out a key aim to improve equity for mothers and babies from ethnically diverse groups and those living in the most deprived areas.

In response the NHS aims to improve equity and equality in Maternity and Neonatal care, aligned to the five priorities as set out in the Long-Term Plan (LTP). Each priority will be realised through a set of underlying interventions implemented by LMNS, for example:

- Personalised Care and Support Plans
- Continuity of Carer
- Prevention
- Maternal Medicine Networks

We are also mindful that there are other areas of inequality that the report does not address, for example neurodiversity, learning difficulties and physical disability, that we may wish to investigate further as a LMNS.

Core 20PLUS5 is the NHS England approach to supporting the reduction of health inequalities at a national and system level. Maternity also features in the national Core 20Plus5 Programme, with specific reference to Midwifery Continuity of Carer.

https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/#:~:text=Core20PLUS5%20is%20a%20national%20NHS,clinical%20areas%20requiring%20accelerated%20improvement.

Local Context

Devon is England's fourth largest county covering 6,707 km2 (2,590 square miles) situated on the Southwest Peninsula of England and has a population of approximately 1.2 million. Devon County is England's seventh most sparsely populated county, with few major urban settlements and a dispersed rural population covering two national parks. Devon includes the cities of Exeter and Plymouth and more than 45 towns, both urban and rural. The conurbation of Torbay includes the largest town and its capital Torquay.

Devon has three Local Authorities: Devon County Council, Plymouth City Council and Torbay Council. NHS Devon ICB is the fifth largest in England and was formed in 2019 from two historical CCGs -NEW Devon CCG & South Devon & Torbay CCG. ONE Devon is a partnership of health and care organisations for the people of Devon, Plymouth and Torbay.
Devon has five Local Care Partnerships (LCPs) across the county: Northern, Western, Eastern, South & Plymouth.

In April 2022 the Royal Devon & Exeter Hospital Trust (RD&E) merged with North Devon Healthcare Trust (NDHT) to become Royal Devon University Healthcare Trust. Data reflects the RD&E & NDHT as separate organisations.

The variable ways of splitting the county over the last 5 years have led to challenges in identifying comparable data. Notably, this includes each Local Authorities Joint Strategic Needs Assessment (referenced later in this document) which do not align, and lack of historical data in our NHS Devon footprint.

Devon borders with Cornwall & Isles of Scilly LMNS to the west. A significant proportion of residents from eastern Cornwall access health services in Plymouth. In order to respond to this aspect of our healthcare population we will work closely with Cornwall & Isles of Scilly LMNS.

Readiness for change

Devon LMNS is well established and has remains committed to a 'Prevention first' approach to maternity care. The Equity and Equality Strategy will build on this approach, targeting interventions to populations and people where they can make the most difference. Governance of the LMNS has been refreshed in 2022 in line with the ambitions of the Equity & Equality Strategy and the Perinatal Quality Surveillance Model, placing equality and safety at the centre of our vision.

Strategy

Values

In line with national and regional guidance, we aim to provide:

- Equity for mothers and babies from ethnically diverse backgrounds
- Equity for mothers and babies living in the most deprived areas
- Race equality for staff, in alignment with a system workforce approach

Our strategy is guided by three **core values** as outlined in the national approach:

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

Vision

Our vision for women, birthing people and families is that there will be equal chances for a happy, healthy pregnancy and baby. This

> ***"Equal chances for happy, healthy pregnancy and baby in Devon"***

encompasses both outcomes and experience for those receiving maternity and neonatal care.

> ***"Staff in all roles and of all grades have equal opportunities to progress and to fulfil their role without discrimination or prejudice"***

Our vision for all our staff from all ethnicities and backgrounds is that they can fulfil their roles without unacceptable discrimination and harassment, are able to have a positive experience of work and progress in their careers without prejudice.

We will link our vision for equity and equality to the vision of NHS Devon and One Devon.

ORGANISATIONAL VISION

University Hospitals Plymouth (UHP)

- ✓ *To provide excellent care, with compassion, wrapped around people's individual needs*
- ✓ *Together with our partners, we will develop nationally leading integrated health and care, unlocking better outcomes and reducing inequalities, and develop UHP as a regional specialist centre to improve lives across Plymouth, Devon & Cornwall*

Torbay & South Devon (TSD)

- ✓ *Better health & care for all*
- ✓ *Everyone counts*

In addition to the above, TSD have also identified the following priorities

- ✓ *Reduce inequity and build a healthy community with local partners*
- ✓ *Build a healthy organisational culture where our workforce thrives*

Royal Devon University Healthcare (RDUH)

- ✓ *Inclusion*
- ✓ *Empowerment*

The golden thread through all strategies is personalisation of care and listening to the people they serve. By working together, we can share learning and take a preventative approach to poor outcomes and experiences, enabling us all to achieve our vision.

Devon LMNS is a collaboration of organisations and as such it is essential that we link our system strategy with organisational vision & values.

It is clear from all of our Devon hospital partners that inclusive, personalised care focussed on ensuring health equity and equality is a core theme of their Trust visions.

SWOT analysis

Assessing the strengths, weaknesses, opportunities and threats (SWOT) enables us to tailor our strategy to our local context and capacity by understanding what could impact our ability to achieve the vision.

Strengths	• The dedication of our staff to provide high quality and compassionate care for all people using our services • A national and local focus on improving equality and equity • The majority of our medical staff (56% medical & career grade doctors, 20% consultants) are from ethnically diverse backgrounds. • Devon has recently formed an Integrated Care Board (ICB), enabling us to work as a system across health and care sectors and to provide joined up care • Strong Voluntary, Community and Social Enterprise Sector • Engaged and active Maternity Voices Partnership • Local Authorities are committed to community-based initiatives
Weaknesses	• Workforce shortages make service delivery challenging, impacting our ability to undertake rapid transformation and change management • Changes that require funding are more challenging to implement • Unconscious bias affects us all- addressing deep seated institutional and personal bias requires cultural change and a long term sustained approach • Our overall maternity and neonatal workforce isn't representative of our population and may mean our organisational awareness of issues and inequalities is not well developed. • Deprivation is high in areas throughout Devon, increasing the likelihood of higher risk behaviours such as smoking and poor diet
Opportunities	• The NHS is committed to using the opportunity of post-pandemic recovery to make services better for all. Trusts are ready for change. • Improved research and data on inequalities is a clear focus of health and care locally and nationally • When we better address inequalities and inequity in maternity and neonatal care, we can improve outcomes later in life, improving people's lives and make savings for the NHS and Social Care

Threats	• Inequalities are likely to deepen as a result of increased cost of living
	• Periods of recession and austerity disproportionately impact women & girls.
	  ○ For our workforce, this means that staff may reduce their hours or leave their jobs due to the cost of childcare exceeding their salary or lack of available childcare
	  ○ For our women and birthing people, this may mean that we see an increase in people living in deprivation, struggling to attend appointments and lead healthy and happy lives

References
GenderDevelopmentNetwork.pdf (ohchr.org)

Success Factors

- ✓ Sustained meaningful engagement with women, birthing people and families to better understand the inequalities, inequities in our system and the impact of these on people's lives and experiences of care.
- ✓ Improved data access and quality, particularly in regard to triangulated data, allowing us to identify impacts of inequalities and characteristics, enabling strategic and operational planning to improve services.
- ✓ Long term commitment from partner organisations across the system to work together and close gaps in care
- ✓ Alignment of funding to our strategic vision and values, ensuring that focus is given to improving equality and equity, including parity of physical and mental health within maternity services and Making Every Contact Count (MECC).

Resources

LMNS funding will be targeted towards providing time and expertise to realise our vision for equal and equitable maternity and neonatal services.

This will include:

- Aligned systems approach to training for staff, for example motivational interviewing and cultural competency.
- Increased funded time for MNVP chairs and to remunerate women, birthing people and families for their time and ensure they are supported and comfortable to share their experiences.
- Leadership time, to ensure that the Equity and Equality vision is highly visible and prioritised by all LMNS partners and that actions are owned and embedded.
- Translation of materials & design of support information that is appropriate and accessible for all women and birthing people.
- Funding to improve the resilience and wellbeing of our workforce, enabling the recovery of services and staff recruitment and retention to ensure that Devon providers continue to deliver high quality services and are desirable places to work.

Interdependencies

Our approach to embedding Equity & Equality within the Devon LMNS is to review the maternity and neonatal transformation programme objectives in light of making services fair, accessible and safe for all.

Some elements of our plan have key interdependencies with external organisations, for example community hubs and breast/chest feeding strategies, which are best developed in collaboration with Public Health Nursing and the Local Authority. Working with the voluntary, community and social enterprise (VCSE) sector will be essential to understand what other support is available within communities. Collaboration with primary care is also essential when we consider improvements to prenatal supplementation uptake and management of diabetes.

We require a collaborative approach across the system and Trust workforce teams to support us in recruiting and retaining a diverse and sustainable workforce, and links with Trust education teams to ensure that training such as cultural competency becomes a core training requirement for all staff. We must also engage with higher education institutions (HEI's) to ensure that equity and equality becomes a part of midwifery training.

Our geography is challenging, and in some rurally isolated areas travel time to maternity & neonatal units can be significant. Working with Trust & ICS estate teams can enable maternity & neonatal services to access suitable community venues will help reduce this issue.

We are highly dependent on our diverse communities to tell us what they need; ensuring that we support and remunerate people for giving us their time is essential to ensure that we truly coproduce interventions for the future.

Devon has a significant military population; working with the armed forces to best support serving personnel and military spouses is required, appreciating the increased risk of perinatal mental health issues within this group.

High Level Strategic Plan

Ensuring that maternity care in Devon reflects the equality and equity desired in our values will require a long term sustained approach.

We recognise that where families have had a poor experience of care, or experienced poor outcomes that this will require a high level of trust in us as professionals to listen and act upon those experiences. We must ensure that we have in place the support mechanisms to address trauma such as Birth Afterthoughts. This service provides an opportunity for women, birthing people & families to speak with a healthcare professional about what happened during their birth and their experiences and have any questions answered.

Our Maternity & Neonatal Voices Partnership (MNVP) chairs undertake excellent work to gather and share insights about maternity experiences; there is an opportunity to review workplans and funding models in line with the increased needs for engagement within this plan.

We must also recognise that we are planning improvements to a service that have been severely impacted by the Coronavirus pandemic and that our workforce needs time to recover, both in numbers and in resilience.

The timeframes we have put in place stretch over five years, and many of the interventions coproduced in the early years of this strategy will take significant time to embed and for benefits to be realised. This is reflective of a desire to get things right for our communities and for our staff in a way that is sustainable.

2023: Building Relationships & Improving Data

- Engaging stakeholders within health, social care, and the community to build meaningful relationships that are based on trust and mutual respect.
- Improving the quality of the data currently available to us and devising new approaches to allow intelligence to be gathered and analysed on multifaceted issues.
- Continue to undertake stakeholder engagement utilising a range of formats.
- Revisit and review in greater detail the feedback we have received over the last 3 years to ensure that our plans align, and we are confident in our response, taking a 'You Said, We Did' approach.

2024: Coproducing Interventions & Planning Improvements

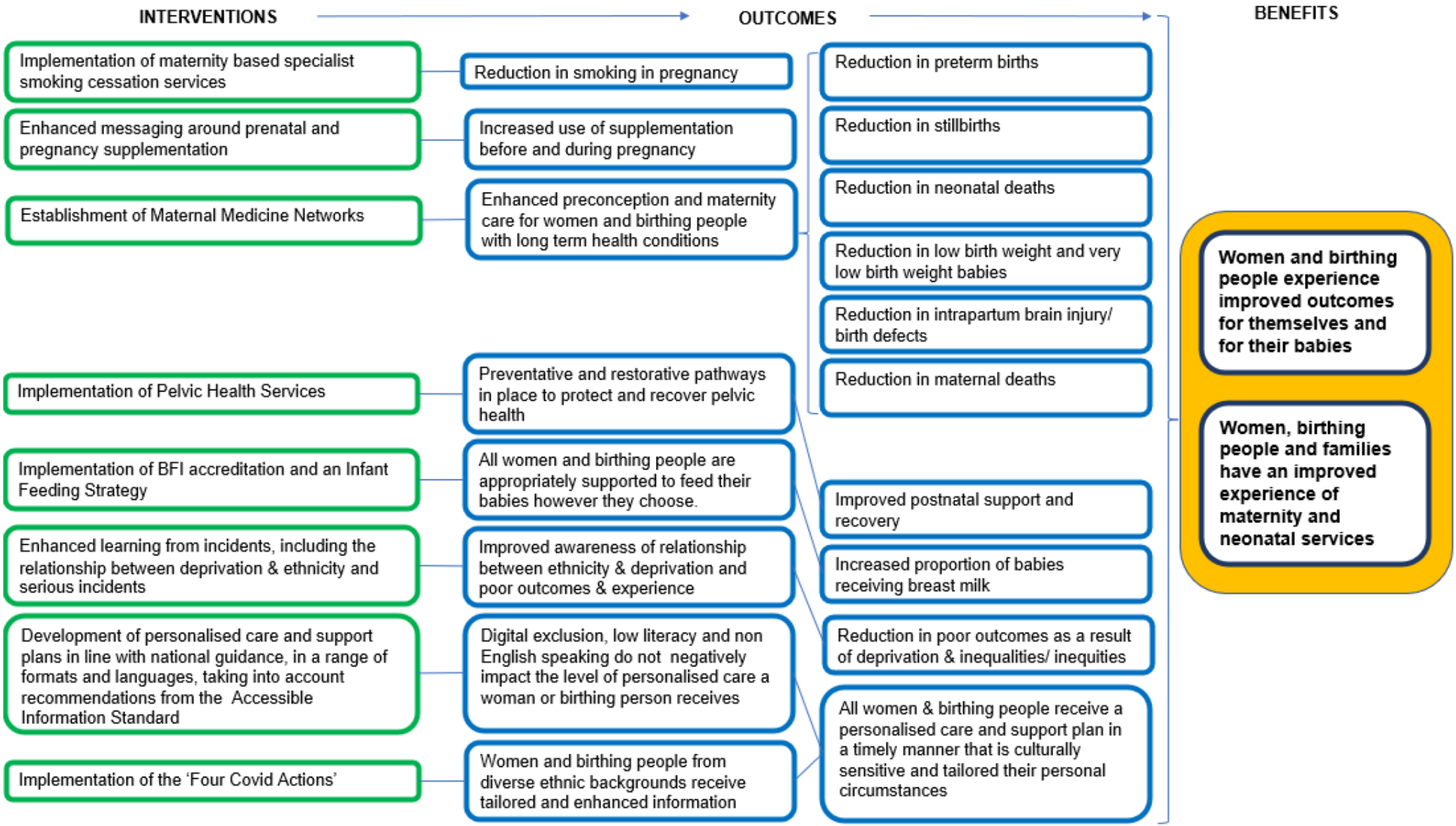
- Building upon the relationships established in the first year, secure multidisciplinary and community time to come together and map issues within maternity and neonatal pathways and identify gaps.
- Coproduce interventions to reduce the impact of inequalities, drawing on the lived experiences of our communities.

2025-2027: Implementing improvement and sustaining coproduction for Equality and Equity

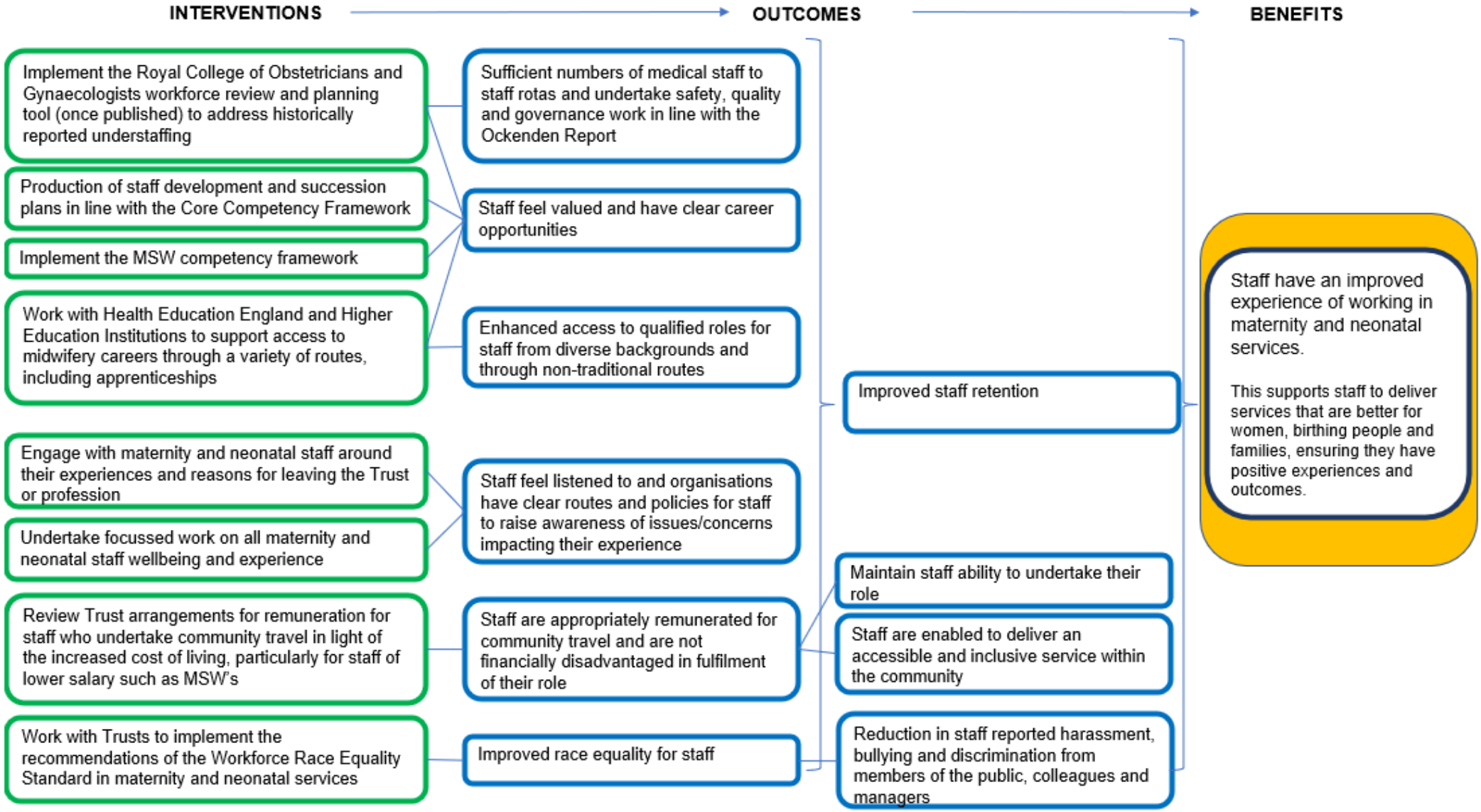
- Taking a quality improvement approach to implementing transformational change and monitoring performance and experiences
- Continuing to work with our communities and ensure that the interventions we have coproduced are effective and resulting in improved experiences

Benefits

In addition to benefits mapping, a full Quality & Equality Impact Assessment will need to be undertaken in line with NHS Devon policy.


INTERVENTIONS
OUTCOMES
BENEFITS
Implementation of maternity based specialist smoking cessation services
Enhanced messaging around prenatal and pregnancy supplementation
Establishment of Maternal Medicine Networks
Implementation of Pelvic Health Services
Implementation of BFI accreditation and an Infant Feeding Strategy
Enhanced learning from incidents, including the relationship between deprivation & ethnicity and serious incidents
Development of personalised care and support plans in line with national guidance, in a range of formats and languages, taking into account recommendations from the Accessible Information Standard
Implementation of the 'Four Covid Actions'
Reduction in smoking in pregnancy
Increased use of supplementation before and during pregnancy
Enhanced preconception and maternity care for women and birthing people with long term health conditions
Preventative and restorative pathways in place to protect and recover pelvic health
All women and birthing people are appropriately supported to feed their babies however they choose.
Improved awareness of relationship between ethnicity & deprivation and poor outcomes & experience
Digital exclusion, low literacy and non English speaking do not negatively impact the level of personalised care a woman or birthing person receives
Women and birthing people from diverse ethnic backgrounds receive tailored and enhanced information
Reduction in preterm births
Reduction in stillbirths
Reduction in neonatal deaths
Reduction in low birth weight and very low birth weight babies
Reduction in intrapartum brain injury/ birth defects
Reduction in maternal deaths
Improved postnatal support and recovery
Increased proportion of babies receiving breast milk
Reduction in poor outcomes as a result of deprivation & inequalities/ inequities
All women & birthing people receive a personalised care and support plan in a timely manner that is culturally sensitive and tailored their personal circumstances
Women and birthing people experience improved outcomes for themselves and for their babies
Women, birthing people and families have an improved experience of maternity and neonatal services


INTERVENTIONS
OUTCOMES
BENEFITS
Standardised framework and pathway for identifying and supporting women and birthing people with complex social needs
Reasonable adjustments & enhanced support and for women and birthing people with learning disabilities and autism
Implementation of Maternal Mental Health Services
Development of a Devon wide directory of evidence based information and services
Offer Motivational Interviewing training to staff to support them in undertaking challenging conversations
Staff are trained in cultural awareness
Improved recording of ethnicity and consistency data quality
Improved recording of mothers postcode
Increased representation of minority and vulnerable people in service user engagement and maternity voices partnerships
Implementation of community hubs in areas of deprivation
Complex social needs are identified and the right support and information is provided
Accessible and inclusive maternity and neonatal care for people with learning disabilities and autism
Robust support for women, birthing people and fathers experiencing mental ill health in the perinatal period
Women & birthing people are fully informed and counselled on choices and associated risks throughout the maternity journey
Increased awareness of the personal circumstances of the woman, birthing person and family
Enhanced signposting to relevant information and community services (assets)
High quality information/data supports commissioning and delivery of community appropriate services
Increased awareness of the experiences of minority and vulnerable people
Increased access and attendance at maternity and neonatal appointments
Improve the stability of the family unit & reduce the number of looked after children and those who have child protection plans in place
Reduction in poor neonatal outcomes*
Reduction in maternal deaths
Improved postnatal support and recovery
Women & birthing people are appropriately support to provide informed consent
All women & birthing people receive a personalised care and support plan in a timely manner that is culturally sensitive and tailored to their personal circumstances
Women and birthing people experience improved outcomes for themselves and for their babies
Women, birthing people and families have an improved experience of maternity and neonatal services
* Neonatal outcomes includes neonatal death, stillbirth, low birth weight, very low birth weight, intrapartum brain injury & preterm birth



To Note: The Core Competency Framework encompasses national standards for multidisciplinary training in maternity & neonatal services.

Stakeholder Engagement & Communications

High Level Communication Plan

Mapping undertaken below reflects current engagement levels. Further work is required for the LMNS to increase or enhance the level of the influence/ interest in line with our objectives and further develop and update our stakeholder map.

NHS Devon Communications department has well established communication channels to all stakeholder groups. Devon LMNS will work closely with them to ensure that we are using recognised and supported routes, in addition to those we need to develop over the coming years. We will use the NHS Devon Stakeholder List to identify further stakeholders.

Key Stakeholder Group	Influence	Interest	Approach/ Opportunity
NHS Devon	High	High	
NHS Cornwall & Isles Of Scilly (Inc. Local Maternity & Neonatal System)	Low	Moderate	
Regional: NHS England including specialist commissioning (Neonates)	High	High	
Regional: South West (SW) Neonatal Operational Delivery Network, SW Academic Health Science Network (Maternal & Neonatal Safety Improvement Programme), Health Education England	Low	Moderate	
Local Authorities: Devon County Council, Plymouth City Council, Torbay Council	Moderate	High	
Public Health Nursing	Moderate	High	
System Trusts: Royal Devon University Healthcare, University Hospital Plymouth, Torbay & South Devon Foundation Trust, Devon Partnership Trust, Livewell Southwest	High	High	
Trusts (Tertiary Children's Hospital): Bristol Royal Hospital for Children	Low	Low	Enhance
Primary Care: Devon Local Medical Council/ Local Care Partnerships, Primary Care Networks	Low	Moderate	Enhance
Higher Education Institutions (HEI): Plymouth University, Exeter University	Low	Low	Enhance
Monitoring organisations: Healthcare Safety Investigation Branch (HSIB), Care Quality Commission (CQC), Mothers & Babies: Reducing Risk through Audits and confidential Enquiries across the UK (MBRRACE)	High	High	
Maternity Voices Partnerships	High	High	
Service user groups, including Healthwatch Devon	High	High	
South West Ambulance Services Foundation Trust (SWASFT), Wales & West Transport for Children (WATCh)	Moderate	Low	
Voluntary, Community & Social Enterprise (VCSE, maternity & Neonates)	Moderate	High	
Voluntary, Community & Social Enterprise (VCSE, Community Support)	Moderate	Moderate	
South West Diabetes Operational Delivery Network	Low	Low	
Community Champions	Low	Low	Enhance

Roles & Responsibilities

Roles & proposed responsibilities have been outlined at a high level and will need to be further developed to enable the sustainable system wide vision and improvements we need to achieve.

We will need to engage with the groups and individuals listed to ensure that these responsibilities appropriately align with their roles. In regard to Trust board level engagement, discussion will need to take place to ensure we are engaging the right people at the right time.

Group/ Individual	Proposed Responsibilities
Devon LMNS	
Senior Responsible Officer	Ensure LMNS commitment to delivering the actions and outcomes outlined with the Equity & Equality (E&E) Plan
Programme Team	Develop, monitor progress against and monitor benefits realisation of the E&E Plan. Coordinate activities & stakeholders and provide support.
LMNS Strategic Board	Monitor progress overview, allocate funding appropriately, make decisions and have oversight of risks and issues relating to the E&E Plan
NHS Devon	
Workforce Teams	Engage with the LMNS in supporting recruitment and retention of staff and equality for all staff groups Engage with the LMNS in sharing and developing interventions to ensure equity & equality for staff
Communication, Inclusion & Involvement Teams	Review and support publication of the LMNS Equity & Equality Strategy & Plan Engaging with underserved communities in partnership with the VCSE when required
Trust Boards	
Board level Maternity Safety Champions	Ensure that equity and equality is reviewed as a key requirement for safety in maternity and neonatal services
Trust Teams	
Equality, Diversion & Inclusion	The EDI leads from provider organisations will support the LMNS in equity and equality for women, birthing people and families
Maternity & Neonatal Units	
Heads & Directors of Midwifery	Commitment to delivery of the E&E Plan and support for its deployment within maternity units
Transformation Midwives	Engagement with the Inequalities workstream and local delivery of E&E actions. Reporting progress to the LMNS
All maternity & neonatal staff	All staff have a responsibility to ensure that care is equal and equitable for all women and birthing people.
Maternity Voices Partnerships	
Chairs & Vice Chairs	Hold the LMNS accountable to coproduction values and outlined actions. Engage with service users and signpost the LMNS to appropriate groups. Identify volunteers with lived experience of inequitable care to understand their experience. Work with the LMNS in delivery of engagement & coproduction (workshops, surveys, outreach).

Monitoring & Evaluation

Regularly monitoring our system data against the metrics outlined in Equity & Equality: Guidance for Local Maternity Systems will allow us to track changes against key measures. Combined with a consistent engagement approach with women, birthing people and families we can understand whether we are achieving the vision laid out in this strategy. Initially, this will focus on process-based measures and how we are developing our capability. Later, this will be outcome based, and towards the end of our plan will review benefits realisation.

Monitoring progress against this plan will be undertaken on a quarterly basis to the LMNS Operational Programme Group. Higher level progress against process objectives will be monitored, and latterly performance against intended outcomes will be reviewed. This group will be attended by more senior members of the system, including Heads of Midwifery and Primary Care leads.

We will also provide assurance to the LMNS Strategic Board. Decisions on funding allocation and performance against high level objectives and intended outcomes will be reviewed. The vision for this group is that a transformation dashboard will be developed to provide a visual representation of progress against ambitions.

In addition to internal LMNS monitoring routes, this plan will also require NHS Devon oversight. We will work closely with the Devon ICB Equality, Diversity & Inclusion team to ensure that we are aligned in approach, and also to eliminate duplication and make the most efficient use of NHS funding.

Devon Local Maternity & Neonatal System Equity & Equality Plan 2023-2024

Priority 1: Restore NHS Services Inclusively

Disparities in access, experience and outcomes have widened during the pandemic for some groups. This has been of particular note for families from ethnically diverse communities. We anticipate that these disparities will continue to deepen during the forthcoming years for those experiencing deprivation, reflecting rise in the cost of living and recession.

Maternity services in Devon have committed to implementation of the Covid Four Actions as outlined by the national Maternity Transformation Programme in 2021:

- ✓ Increase support for at-risk pregnant women – for example, make sure clinicians have a lower threshold to review, admit and consider multidisciplinary escalation in women from ethnic minority groups.
- ✓ Reach out and reassure pregnant women & birthing people from ethnically diverse backgrounds with tailored communications.
- ✓ Ensure hospitals discuss vitamins, supplements and nutrition in pregnancy with all women. Women low in vitamin D may be more vulnerable to coronavirus so women with darker skin or those who always cover their skin when outside may be at particular risk of vitamin D insufficiency and should consider taking a daily supplement of vitamin D all year. Folic acid can help prevent certain birth defects, including spina bifida; it's recommended that women take a 400 micrograms folic acid tablet every day before pregnancy and until 12 weeks of pregnancy (*Folic acid helps form the neural tube and can help prevent some major birth defects of the baby's brain and spine*)
- ✓ Ensure all providers record on maternity information systems the ethnicity of every woman, as well as other risk factors, such as living in a deprived area (postcode), co-morbidities, BMI and aged 35 years or over, to identify those most at risk of poor outcomes.

Our analysis and service user feedback gathered through engagement events has shown us that we need to improve how we communicate with service users who don't speak English, or where it is not their first language. We have a strong commitment to extend our engagement to other groups who need communication support and adjustment for example people with a learning difficulty, visual or hearing impairment.

Risk assessment has been strengthened for all women and birthing people through the implementation of the interim Ockenden report, and implementation of robust personalised care plans will ensure that clinical care is appropriately influenced by a person's needs, views and risk factors.

We will also improve the recording of key information about demographics and folic acid compliance.

Priority 1: Restore NHS Services Inclusively				
Analysis/ Engagement Findings/ Recommendations	**Actions**	**Milestones**	**Start Date**	**End Date**
Intervention 1: Continue to implement the covid four actions Ethnicity data quality is compliant, however recording of key demographic data has been disrupted by transition to digital notes formats Clinical staff require readily available support information about the presentation of conditions in non-white British populations. Devon LMNS does not have established connections with Ethnically diverse communities to be able to ask their views	• Ensure all Trusts prioritise and promote the recording of key demographic data *including* rationale of importance to frontline staff • Development of support information for clinical staff on the presentation of clinical conditions in black and brown skin • AHSN Perinatal Implicit Bias train-the-trainer courses to provide staff with the knowledge and skills to identify maternal and neonatal conditions/deterioration in black and brown skin. The AHSN will also provide evaluation of this training to share learning • *Link with priority 4a, Intervention 1*- proactively undertake outreach with minority ethnic communities to understand experience and needs • Work with Devon ICB Equality, Diversity and Inclusion team to link with ethnically diverse community groups	Key demographic data is always above 90% in all Trusts Perinatal Implicit Bias Training undertaken Outreach activities undertaken with minority ethnic communities	January 2023 September 2022 January 2023	Ongoing March 2023 Ongoing

Priority 1: Restore NHS Services Inclusively				
Analysis/ Engagement Findings/ Recommendations	**Actions**	**Milestones**	**Start Date**	**End Date**
Intervention 1: Continue to implement the covid four actions Recording of folic acid requires improvement in RDUH East. Folic acid promotion could be improved in all areas; however data shows 30.7% of women & birthing people in Devon take folic acid before pregnancy.	• Review latest data on Folic Acid to ensure that this is still an issue Targeted staff communications outlining importance. • Align folic acid & vitamin D messaging to antenatal education • Review Standard Operating Procedures on prenatal supplementation (Vitamin D) to ensure that this is still fit for purpose • Ensure links with the maternal medicine network to provide preconception counselling on supplementation • Review accessibility of prenatal supplementation (taking into account deprivation) • Engagement with primary care and community pharmacy to promote use of folic acid and prenatal supplementation • Make supplementation an immediate priority for the LMNS Prevention & Inequalities workplan. Transformation midwives to undertake rapid communications to staff around reinforcing the importance of supplementation in pregnancy and how to acquire these	Folic Acid & Vitamin D Supplementation is reinforced through antenatal contacts	January 2023	June 2023

FIVEXMORE

In 2018 MBRRACE published a report stating that black women are five times more likely to die in pregnancy, childbirth and the 6-week postnatal period. Social disadvantage and deprivation are often highlighted as contributing factors; however, these are not enough to explain the differences observed.

FiveXmore formed in 2019 to support improvement in maternal mortality rates and healthcare outcomes for black women. In 2022 they published the Black Women's Maternity Experiences Report to provide a voice to the lived experience of black women.

Reference: Perinatal Confidential Enquiry | MBRRACE-UK

Recommendations:

1. An annual maternity survey targeted specifically at Black women.
2. Increased knowledge on identifying and diagnosing conditions that are specific to and disproportionately affect Black women.
3. Improve the quality of Ethnic coding in health records.
4. More community-based approaches must be used to improve maternal outcomes.
5. An improved system for women to submit their feedback and/or complaints specifically for maternity.
6. Ensure that individuals involved in training health care professionals are aware and have an appreciation of the disparities in maternity outcomes.

References
https://www.fivexmore.com/blackmereport

Births Right-Systemic Racism, not broken bodies: An inquiry into racial injustice and human rights in UK maternity care

This report also follows on from the 2018 MBRRACE report and sought to uncover the stories behind black and minority ethnic people's experiences of maternity care

Recommendations:

1. Commit to be an anti-racist organisation
2. Decolonise maternity curriculums and guidance
3. Make Black and Brown women and birthing people decision-makers in their care and the wider maternity system
4. Create safe, inclusive workforce cultures
5. Dismantle structural barriers to racial equity through national policy change
6. Political commitment and target to end the ethnicity gap in maternal deaths – to achieve no difference in the rates of death for Black, Asian, Mixed and white ethnic groups by 2030.
7. Revise the Birthrate Plus tool to include ethnic and social need data in calculations for staffing need e.g. to allow for potential extra time due to language barriers and cultural and social needs.

References
https://www.birthrights.org.uk/wp-content/uploads/2022/05/Birthrights-inquiry-systemic-racism_exec-summary_May-22-web.pdf

MBRRACE: Saving Lives, Improving Care 2017-2019

The MBRRACE report published in 2021 outlines lessons learned from Maternal Deaths within the period 2017-2019. In this period, 191 women and birthing people died during or within 6 weeks after the end of their pregnancy in the UK, equating to 8.8 per 100,000. This is not a statistically significant change to maternal mortality rates in 2010-12.

Recommendations

1. Collate recommendations from relevant guidelines into a single definitive source of guidance on the care for older women in pregnancy, including both women planning assisted reproduction and those who conceive spontaneously (without assistance)
2. Develop guidance on single embryo transfer for older women undergoing in vitro fertilisation, particularly in the context of medical co-morbidities
3. Ensure that postgraduate medical and surgical curricula include training in the need for contraceptive advice to women of reproductive age and how to ensure that it is provided and pre-pregnancy planning to women of reproductive age with medical problems such as cancer
4. Develop clear guidance on imaging in pregnancy, including for both diagnosis and staging
5. Ensure there are clear and explicit pathways into specialist perinatal mental health care, which take into account all other aspects of perinatal mental health provision, including specialist roles within midwifery and obstetric services, in order to avoid any confusion over roles and
6. Ensure perinatal mental health services do not exclude patients on the basis of diagnosis, where they would ordinarily be seen by general adult mental health teams
7. Ensure specialist services have the capacity to assess and manage all women who require secondary care mental health services and be able to adjust for the altered (generally lowered) thresholds for assessment in the perinatal period [ACTION: Service Planners/Commissioners, Hospitals/Trusts/Health Boards].
8. Ensure local incident review teams are multidisciplinary in composition and that investigations are carried out across organisational structures where indicated [ACTION: Hospitals/Trusts/Health Boards].
9. 9. Develop a mechanism to ensure all VTE risk assessment tools used for pregnant and postpartum women are consistent with national guidance [ACTION: NHSE/I and equivalents in the devolved nations and Ireland]
10. Do not delay consultant appointments and evidence-based effective preventive interventions such as aspirin pending the results of investigations such as prenatal diagnosis
11. Recognise that 'post-pregnancy' counselling is as important as pre-pregnancy counselling for future pregnancies and for joining up obstetric and medical care to optimise a woman's long-term health
12. Consider previous history, pattern of symptom development and ongoing stressors when assessing immediate risk and management of women with mental health symptoms. Plans should address immediate, short-term and long-term risk
13. If psychotropic medication has been discontinued in advance of, or during, pregnancy, ensure women have an early postnatal review to determine whether they should recommence medication
14. Where a woman with severe postnatal illness has previously responded well to treatment then there should be an expectation of a good recovery from subsequent postpartum episodes. Ensure that it is recognised that discharge from inpatient care before recovery is achieved is likely to be associated with continued risk
15. While relatives provide invaluable support to the woman, complementing the care provided by universal and specialist services, they should not be given responsibilities beyond their capabilities or be expected to act as a substitute for an effective mental health response

16. Women with substance misuse are often more vulnerable and at greater risk of relapse in the postnatal period, even if they have shown improvement in pregnancy. Ensure they are reviewed for re-engagement in the early postpartum period where they have been involved with addictions services in the immediate preconception period or during pregnancy
17. Ensure symptoms of possible cancer are followed up postnatally
18. Ensure that assessment of adherence to administration forms part of the antenatal or postnatal assessment of women prescribed low molecular weight heparin

References

https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2021/MBRRACE-UK_Maternal_Report_2021_-_FINAL_-_WEB_VERSION.pdf

Priority 2: Mitigate against Digital Exclusion

National research by Ofcom outlines that prior to the Coronavirus pandemic 11% of households in the UK were digitally excluded (based upon home internet access), dropping to 6% as of their March 2022 review.

Their study outlines that digital exclusion should not only apply to whether a household has internet access, but additional measures of affordability, levels of device access (smartphone only vs alternative devices) and personal skills and confidence. Ofcom also detail particular demographics at greatest risk of exclusion, including older people, those out of employment, the financially vulnerable and those living with a condition that limits or impairs their use of communication services.

In addition to this, Devon LMNS recognises that exclusion from online information and resources regarding maternity and neonatal care will extend to women, birthing people and families who do not speak English, or where it is not their first language

The rurality of Devon impacts the quality of digital connections and access to superfast broadband, which must be considered when planning the use of virtual appointments.

Resources are available to support families navigate the varying digital routes used across Devon via the Healthwatch website.
Digital Project - Healthwatch Devon

References

Digital exclusion: a review of Ofcom's research on digital exclusion among adults in the UK

Currently, provision of personalised care and support plans is measured through a tick-box field on maternity information systems. Devon LMNS recognises that achievement of personalised care and support plans is not for us to confirm at the provider end, but to ensure that women, birthing people and families feel that they have experienced personalised care.

Transition to digital systems and services, such as those for child benefit, may also disadvantage those experiencing digital exclusion, and maternity and neonatal services should be aware of situations where digitisation of services may prevent access to support and financial assistance.

In the case of Child Benefit Forms, these are no longer provided in hard copy, however the forms themselves need to be printed, filled out and posted. Homes with digital access may be limited to smaller handheld devices, and not have printing facilities.

Priority 2: Mitigate against digital exclusion				
Analysis/ Engagement Findings/ Recommendations	**Actions**	**Milestones**	**Start Date**	**End Date**
Intervention 1: Ensure personalised care and support plans are available in a range of languages and formats, including hard copy PCSP's for those experiencing digital exclusion All Trusts in Devon are undergoing a transition to digital information systems, disrupting historical processes for provision of Personalised Care & Support Plans (PCSPs), or similar planning frameworks that predates national recommendations Current data on provision of PCSPs is limited and of low confidence. We need to understand experiences of personalised care & areas for improvement from the families perspective Review of contact types is required (e.g. face to face, phone, video) Communication languages and formats are not sufficiently supportive or inclusive for all women and birthing people	• Undertaking a benchmarking review of digital information systems to understand recording methodologies for personalised care and support plans • Undertake an audit in line with guidance provided in *Personalised care & support planning guidance for local maternity system March 2021* (Report template - NHSI website (england.nhs.uk)) • Review CQC survey reports of personalisation & choice • Personalised Maternity Journey workstream to be MNVP led • Data analysis of maternity and neonatal contact types (face to face, phone, or video) broken down by ethnicity, deprivation, and other protected characteristics • Service user feedback review of experiences using different contact types to inform improvement • Devon LMNS must undertake an analysis of the non-English languages spoken within the system and ensure that PCSP's are made available in these languages • Review of the Accessible Information Standard recommendations must be made, with appropriate adjustments made to documentation for women, birthing people and families. This includes easy read and hard copy formats	PCSP audit completed Business intelligence gathered on accessibility, acceptability and efficacy of non-face to face and virtual contacts PCSP's available in a range of languages and formats Accessible information standard reviewed and implemented throughout maternity & neonatal services	October 2022 January 2023 September 2022 September 2022	March 2023 June 2023 March 2023 September 2023

The Accessible Information Standard

The Accessible Information Standard (AIS) was published in 2017 and seeks to improve outcomes and experiences, and the provision of safer and more personalised care to individuals with communication and information support needs. The standard focuses primarily on users with sensory loss, learning disabilities or mental health conditions that affect their ability to communicate.

There are two main considerations in ensuring that all people can receive important information about their care:

1. **Accessible information**- information that can be read or received and understood by the individual or group for which it is intended
2. **Communication support**- support required to enable effective, accurate dialogue between a professional and a service user to take place.

The AIS should form part of our design of Personalised Care & Support Plans for the LMNS. Regarding the core elements this includes:

- ✓ Identification of needs
- ✓ Recording of needs
- ✓ Flagging of needs
- ✓ Sharing of needs
- ✓ Meeting of needs

In relation to considerations for developing services at a commissioning level, the following requirements should form a core part of commissioning services:

- ✓ Commissioning, procurement and monitoring of service delivery should reflect, enable and support compliance of the AIS.
- ✓ Commissioners should seek assurance from providers of compliance

References

https://www.england.nhs.uk/wp-content/uploads/2017/08/accessilbe-info-specification-v1-1.pdf

Priority 3: Ensure datasets are timely & complete

Ensuring that data sets are timely and complete is important to ensure that maternity systems can understand variance in health outcomes by geography and ethnicity, enabling prioritisation of interventions for those with inequalities and poorer health outcomes

Monitoring data on quality, safety, performance and outcomes tells us which groups are disproportionately experiencing negative outcomes, or where we need to prioritise improvements. It can also tell us if a change we have made is having the desired impact, or if we need to change how we provide care. Together with feedback from staff, women, birthing people and families, and data on how we can gain assurance that we are 'doing things right'.

Over the last 2 years maternity services within the Devon LMNS have transitioned from paper based maternity notes to digitised notes. This has the potential to give us access to significantly more information, however we must ensure that we have a robust plan for how we will use this and ensure that it is meaningful and informs change. No data that the LMNS uses is patient identifiable, and information sharing and handling is in keeping with information governance and data protection.

Devon LMNS recognises that we need to further develop not only our data access and quality as standalone metrics but develop our capability to triangulate these data points to draw conclusions and make improvements.

Devon LMNS has been developing a system wide dashboard aligned to the national Maternity Services Data Set (MSDS) to allow us to monitor performance and define improvements, as well as sharing learning across all Trusts. This is still in its development phase, however, will be prioritised to allow us access to these valuable insights and monitor them through our Safety & Governance processes.

Priority 3: Ensure datasets are timely and complete				
Analysis/ Engagement Findings/ Recommendations	**Actions**	**Milestones**	**Start Date**	**End Date**
Intervention 1: On maternity information systems, continuously improve the data quality of ethnic coding and the mother's postcode Our analysis demonstrates that recording of postcode data was complete for 100% (target 95%) of women & birthing people between April 2021 and January 2022. Recording of ethnicity coding was above 93% (target 80%) in all Trusts in the same period, meaning that they are compliant with the Clinical Negligence Scheme for Trusts mandate.	• Take action to reduce the number of not known or not stated responses to ethnic origin questions. These enquiries should form a core part of the family origins questionnaire. • Prioritise development of the Devon Dashboard to enable us to monitor progress and performance in a timely manner. • Communicate with staff about the purpose and use of data fields we are asking them to complete.	Valid ethnic code is completed for all maternity and neonatal bookings Implementation of the Devon Dashboard	January 2023 September 2022	June 2023 January 2023

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

4a: Understand your population & coproduce interventions

POPULATION INEQUALITIES & IMPACTS

Inequalities
Deprivation (urban, rural and coastal)
Rural Isolation

Impact of inequalities
High levels of obesity in early pregnancy (23.3%)
High levels of smoking in early pregnancy (16.2%), especially in Torbay
Higher levels of Under 18 conceptions in Torbay & Plymouth (15.9/1000 and 15.5/1000 respectively)
Higher levels of teenager motherhood in Torbay (1.5%)

Challenges
Growing population
Low level of infrastructure to support ethnically diverse communities
Transportation and road networks, especially during peak holiday seasons

Deprivation

Torbay & Plymouth have levels of deprivation significantly above the national average. Around 100,000 people (about 25% in these areas are living in the most deprived 20%. A further 40,000 (~5%) people in the Devon County local authority live in the two most deprived deciles.

In addition to this, there are pockets of rural and coastal deprivation masked by proximity to affluence. This manifests itself in challenges around transport poverty, digital exclusion and access to services.

Women & birthing people experiencing deprivation are at increased risk of poor maternity outcomes including:

- 3x higher risk of maternal death
- Higher risk of adverse maternal and perinatal outcomes
- Higher risk of preterm birth
- Higher proportion of teenage pregnancy, and higher proportion of teenage births
- Increased risk of low and very low birth weight babies
- Increased risk of having small for gestational age babies

The average salary in Devon is lower than the UK average, in addition to this, the average salary for a female is lower than that for a male. Unemployment rates are lower in most of Devon compared to the UK, but roughly comparable in Plymouth & Torbay. In 2021 the house price to earnings ratio for Local Authorities across Devon is greater than the UK average, including in some of the most deprived areas. Torbay's economy in particular is ranked amongst the weakest in England and has been further impacted by a rise in unemployment as a result of the Covid 19 Pandemic.

References
Devon Average salary and unemployment rates in graphs and numbers. (plumplot.co.uk)

Ethnicity

Ethnic diversity is lower in Devon when compared to the England average with around 4% (~400) of women and birthing people from black and minority ethnic backgrounds.

Rejecting the 'low numbers' narrative, we recognise that this poses an additional challenge as support services and tailored interventions appropriate to these communities will be at a lower level than in areas where these communities are larger.

We also recognise that our staff body is not representative of the population, and we must work harder to listen and learn from these communities

Suggested content: In the last census (2021) Devon's overall population was 95.8% white, 1.6% Asian, 1.5% mixed.

Estimates were made by the Office of National Statistics (ONS) in 2019 predicting that diversity in Devon had increased, with approximately 92% of the population being white British. The next largest group is estimated to be 'White-Other', followed by 'Asian/Asian British', 'Mixed ethnic groups' and 'Black/African/Caribbean/Black British'. These groups are formed of approximately 96,000 people.

In regard to predictions around religion, Christianity is estimated to be the most prevalent, followed by 'None/Not Stated' and 'Other'. Following this are Muslim, Buddhist, Sikh & Hindu. Cultural competency must also take into account religious beliefs and preferences.

Gypsies & Travellers

Devon has a significant Gypsy, Roma & Traveller (GRT population, estimated at around 5000 people (2013)), although this fluctuates seasonally. They are mainly English Romany Gypsies, New Travellers, Irish Travellers & Showmen.

Gypsies and Travellers experience significant discrimination, which can impact on their engagement with, and experiences of healthcare services. The life expectancy of Gypsy, Roma & Traveller communities is 10 years less than the average, equivalent to the most deprived areas in Devon. Women and birthing people of Gypsy, Roma & Traveller communities backgrounds are 20x more likely experience the death of a child.

Lifestyle and cultural practises within this community are often not understood by healthcare, which can lead to issues in access, for example GP registration.

Attitudes towards pregnancy, the postnatal period and breastfeeding are specific to different traveller ethnicities and generalisations shouldn't be made. Feedback from Kernow MNVP's work with the Wheal Jewel Traveller site indicates that Gypsy, Roma & Traveller communities' women and birthing people require a bespoke, personalised and family centred approach that enables their cultural needs to be met. There are now two midwives caring for women & birthing people at the site.

References

Devon Census 2021. (plumplot.co.uk)
Gypsies and Travellers - About Gypsies and Travellers - Teignbridge District Council
Racism towards Gypsies and Travellers.pdf (newdccg.nhs.uk)
Handbook for managing unauthorised encampments – Education and Families (devon.gov.uk)
The Experience of Pregnancy in the British Gypsy, Roma and Traveller Communities | AIMS

Engaging with our communities

Over summer 2022 we planned and held initial engagement workshops. These workshops were planned with the following aims in mind:

- Strengthening relationships with wider communities to provide a service where people no longer experience challenges in accessing the service.
- Listening to and understanding the experience of people who use our services, especially under-served groups.
- Improving understanding of population health and maternity outcomes, at Devon & Locality levels.
- Designing services and delivering interventions in a way that will have the greatest impact on reducing inequalities.
- Understanding how we can level up our services to ensure true personalisation and choice is available to all people in a way that they can understand.

Professional Workshop: Themes

"In your experience, what are the most significant inequalities for pregnant women and birth people in Devon?"

Access to information
- Consistency & accuracy.
- Accessibility, including multiple languages.
- Access to interpreters.
- Antenatal education.

Socioeconomic deprivation
- Impact on mental & physical health.
- Impact on access to services & information.
- Connection between financial deprivation and children in care.

Rural deprivation
- Travel can be lengthy and expensive.
- Lack of community healthcare hubs.

Cultural awareness
- Provision of cultural awareness & perinatal bias training.

Health risks
- Increased likelihood to smoke.
- Challenges in affording well balanced nutritious meal.
- Access to healthier lifestyle.
- Understanding the impact of learning disabilities and long term health conditions

System issues (inconsistency of services)
- Issues with parity of service across Devon

Service User Workshop

"What improvements need to be made to Maternity Services to ensure that everyone has equal access to good and safe care?"

Clear, compassionate communication
- Clarity.
- Compassionate language.
- Informed consent.
- Language should be consistent across all appointments (scans, midwifery, doctors).

Consistent information and services
- Clear pathways of care.
- Consistent antenatal education.
- Consistent postnatal care.
- Provider led follow ups.

Enabling partner support

- Options to remotely involve partners, especially during scans.

Mental health support

- Access to perinatal mental health & birth trauma support.
- Clear pathways of care.
- Access to birth debrief/afterthoughts.

Physical health support

- Physical health support in the immediate postnatal period.
- Support for breastfeeding issues
- Access to pain relief.

Service User Emails 2021/22

Devon MNVP regularly receive emails from women and birthing people regarding their care. Similar themes observed in the workshop are reflected within these emails, focussed on improving the following areas:

- Compassionate communication.
- Postnatal care.
- Breastfeeding support.
- Partner support.
- Personalisation.

"Let's Talk" Workshops

Throughout August 2022 Devon MNVP ran an outreach programme at a Children's centre as part of a targeted intervention.
The families involved range in age and socioeconomic demographic with babies aged between 10 weeks and 2 years, as well as some older siblings.

Positive feedback from these families' experiences include:

- Positive antenatal experience
- Excellent communication between hospitals when there are complications requiring specialist intervention, never having to repeat their history.

These families feel that the greatest improvements could be made to:

- Provision of free, non-digital antenatal education.
- Listening to women and birthing people.
- Ensuring families are fully informed.

Other areas for improvement include:

- Bottle feeding information & support.
- Improved information about what to expect during induction.
- Listening to and believing women and birthing people when they describe their pain or any changes.
- Improved knowledge of a woman or birthing persons history during labour.
- Postnatal support.

Devon MNVP have identified the following themes from their full body of work over the last 12 months:

- Use of language.
- Poor communication.
- Postnatal support and care.
- Antenatal education.
- Informed care and consent.
- Trauma informed care and support.
- Personalised care.
- Continuity of Carer.

We will work with our Maternity Voices Partnership Chairs to design, coproduce and implement interventions that will support improvements in these areas. An action plan to address areas of feedback received prior to the pandemic is currently under development.

We would like to thank our Maternity Voices Partnership Chairs & Vice Chairs for all their hard work and the candour of women and birthing people in providing valuable feedback to help us improve our services.

OTHER FEEDBACK

The Coronavirus Pandemic had a negative impact on our ability to engage with service users face to face, as well as hearing feedback from underserved groups who better benefit from outreach approaches. We have reviewed feedback received prior to the pandemic and included it within this report.

Feedback themes

- Lack of antenatal education & information
- Breastfeeding support
- Empowering choice
- Postnatal support
- Lower-level perinatal mental health support
- Partner support
- Coproduction
- Support for loss and bereavement
- Better use of digital and virtual technologies
- Accessible care locations

Gender Bias in Healthcare

We have made significant improvements in listening to women & birthing people's feedback through the Maternity Voices Partnership, however it is clear that we need to do more when listening to women and birthing people 'in the moment' when they are receiving healthcare- a theme also identified within the Ockenden Report.

Understanding women & birthing peoples feedback about their experiences in maternity services reflects a view that is echoed in the 2022 publication of the Women's Health Strategy for England: "Healthcare, in general, is not very good at listening to women."

It is worth noting that healthcare professionals do not set out to ignore women's voices, but forms of unconscious gender bias and structural gender inequalities that precipitate through healthcare have been shown to have a negative impact on experience and outcome.

Research indicates that gender stereotypes in healthcare can lead to women's pain being taken less seriously- pain tends to be underestimated and undertreated and in other care settings can be treated as psychological instead of physical. A 2018 study (Wesolowicz et al.) demonstrated that many healthcare professionals believe women exaggerate their pain- in this research 40% of the healthcare professionals surveyed were women themselves. Insufficient access to pain relief has been highlighted in our feedback from women and birthing people in Devon. We must ensure that maternity services support women and birthing people to express their needs and choices about pain relief and provide personalised care in line with this.

How women are treated outside healthcare environments can also have an impact on how they behave within them. A review published in 2018 (Betron et al.) looked at the impact of gender inequalities and unequal power dynamics in the health system and how it can undermine quality of care or obstruct women's and birthing people capacity to exercise their rights, both as users and providers of maternity care.

The review highlighted that not all women and birthing people feel empowered to advocate for themselves as a result of expectations of women's behaviour within society. This was particularly evident in articles about women from black and ethnically diverse backgrounds. As a maternity and neonatal service, we must ensure that all women feel safe and empowered to make decisions about their bodies and their care.

The review also details how socioeconomic status can lead to 'social distance' between providers and service users, impacting the provision of respectful maternity care. Differences in educational or class status contributed to women not advocating for themselves.

Intersectionality between gender, ethnicity, culture and deprivation should be taken into account when planning improvements to maternity and neonatal services, with an awareness of the impact of cultural differences in self-advocacy for women and birthing people and how we can best support them to do this.

References

Women's Health Strategy for England August 2022 (publishing.service.gov.uk)
Findings, conclusions and essential actions from the indepedendent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust - final Ockenden report (publishing.service.gov.uk)
Analysis: Women's pain is routinely underestimated, and gender stereotypes are to blame | UCL News - UCL – University College London
The roles of gender and profession on gender role expectations of pain | JPR (dovepress.com)
Expanding the agenda for addressing mistreatment in maternity care: a mapping review and gender analysis | Reproductive Health | Full Text (biomedcentral.com)

Sexuality and Gender Inclusion

Barriers and issues with accessing healthcare are reported by many people from the LGBTQIA+ community, with 14% reporting that they avoid healthcare altogether due to fear of discrimination.

A June 2020 article by Bunty Lai-Boyd (Practise Development Midwife) highlights that there is limited research available on the experiences of LGBTQIA+ people within maternity services, but what is clear is that people from this community want further education for maternity staff and receive individualised care for a more inclusive healthcare system.

Recommendations

- More qualitative research in this area will aid a better understanding of what LGBTQ+ parents want from their healthcare professionals.
- Providing maternity training specific to LGBTQ+ people will improve inclusivity.
- Using inclusive language and addressing discriminative language will make LGBTQ+ people feel more comfortable in maternity.
- Individualised care is pivotal in improving experiences for LGBTQ+ parents.
- Development of a LGBTQ+ inclusivity lead midwife is an area for consideration in the NHS

Whilst recognising that the majority of midwives and service users are cis women and identify as such, the Royal College of Midwifes (RCM) has taken steps to recognise and affirm diverse gender identifies. Their research recognises that many different approaches to inclusive language are taken and are variable between individuals.

Work has been undertaken at Brighton and Sussex University Hospital by their Gender Inclusion Team. They have made their core documents available for download by other maternity services to support their journey towards becoming a gender inclusive healthcare environment. These are available in the link below.

Gender Inclusion - BSUH Maternity

References

Maternity Care for LGBTQ+ People - How can we do better? | All4Maternity
Inclusive language in maternity care to address inequalities (rcm.org.uk)

Priority 4: Accelerate preventative programmes that engage those at greatest risk of poor outcomes 4a: Understand your population & coproduce interventions				
Analysis/ Engagement Findings/ Recommendations	**Actions**	**Milestones**	**Start Date**	**End Date**
Intervention 1: Understand the local populations maternal and perinatal health needs (including the social determinants of health) We recognise that our initial analysis has limitations and doesn't take into account the full range of inequalities experienced within our populations. The first year of our equity and equality plan will focus on building relationships and understanding the experiences of underserved communities. Our MNVP chairs regularly speak with women & birthing people who have had negative experiences of care and require additional support to enable them to have these conversations. To achieve this, we must work closely with the ICS Equality, Diversity & Inclusion team.	The following groups must be engaged with to understand their experiences ad needs: • Diverse ethnic communities • Gypsy & traveller communities • Military personnel and spouses • LGBTQIA+ communities, including their access to commissioned fertility support • People with learning disabilities/difficulties • People with long term health conditions • People with sight or hearing impairment. • People experiencing mental health difficulties This will help us to identify **what** needs to change. • Review signposting routes towards birth afterthoughts services, who should have training in trauma-informed conversations • Consider inclusion of questions about maternity experience in final postnatal contact, enabling signposting to MNVP, afterthoughts or pelvic health services • Review available data on ethnicity, deprivation and education levels of teenagers and young people; this will allow us to strategise about future service need and planning based upon trends identified nationally. • Birth rate is dropping nationally. It would be beneficial to understand what is driving this at a local level.	Service user steering group established with representatives from minority communities across Devon Data obtained regarding the number of pregnant women and birthing people with the listed experiences All maternity providers have a visible and easily accessible birth afterthoughts service & MNVP's are able to signpost Devon LMNS will have a forward view of the next generation of women, birthing people and families to support strategic planning and investment	September 2022 September 2022 December 2022	March 2024 March 2023 Ongoing

Priority 4: Accelerate preventative programmes that engage those at greatest risk of poor outcomes 4a: Understand your population & coproduce interventions				
Analysis/ Engagement Findings/ Recommendations	**Actions**	**Milestones**	**Start Date**	**End Date**
Intervention 2: Map the community assets which help address the social determinants of health Initial asset mapping was undertaken as part of our Equity & Equality Analysis. Further work is required to physically *map* these services, understanding areas that are underserved by health, care & the VCSE sector. This should inform the future commissioning of services. Secondly, making this information accessible to women, birthing people and families is required to ensure that these services are known to the population is essential.	• Using the SHAPE tool, map the locations of support available. • Identify areas that are 'support deserts', and work with the whole health and care system to address underserved areas. • Develop a Devon wide directory of services which can be used by professionals, women & birthing people and families to find services in their local areas. Providing this through the NHS will support user confidence in services listed. This may be developed as a website.	Services are visually mapped and this is used in the planning of new services Devon Maternity & Children's Directory is developed and implemented	 March 2023	 March 2024

Mothers Voices: New report on maternal health inequalities and how community organisations can help

This report by Maternity Action, funded by Public Health England, outlines the experiences of maternity and health in low-income women and children from diverse ethnic backgrounds.

The report outlines a reduction in access for ethnically diverse women and birthing people compared to their white counterparts and focusses on VCSE approaches to addressing health inequalities and social factors, as well as overcoming barriers to accessing support.

Recommendations

- Sustainability and Transformation Partnerships (STPs) Integrated Care Systems (ICSs) and Local Maternity Systems (LMSs) should invest in the development of community development skills, locating this within their system as part of their approach to co-production and co-delivery of services with local VCSEs.
- Commissioners and NHS organisations should develop an understanding of local VCSE assets in relation to identifying and signposting vulnerable pregnant women and new mothers from black and minority ethnic backgrounds with mental health issues and consider supporting organisations carrying out this role through training and local knowledge-sharing.
- Commissioners should fund VCSE organisations working with low income BME women to build capacity and expertise to link women with statutory services through bridging, signposting and advocacy.
- Commissioners should explore strategies to support local VCSEs to better demonstrating their impact, recognise the limited resources of local VCSEs and the costs of undertaking effective evaluations.
- Commissioners should ensure that interpreting and language services are available to low income BME women accessing health services and that the models of language support used reflect local needs.
- Commissioners should ensure that place-based approaches accommodate the needs women who move between places, including Gypsy and Traveller women with a traditional nomadic lifestyle; dispersed asylum seekers who are moved at short notice on a no-choice basis; and homeless women living in temporary accommodation.
- Commissioners should ensure that information about migrants in JSNAs is disaggregated by gender as well as ethnicity or nationality and that information about women takes note of their migration situation, as this affects access to health and other services.
- Commissioners should recognise the resource implications for VCSEs of collating information for the JSNA process. Commissioners should provide funding and/or practical support to enable VCSEs working with low income BME women to research the needs of seldom heard communities and feed this into the JSNA process.
- Commissioners should facilitate asset-based commissioning by engaging with the VCSE sector through existing local infrastructure such as CVS, local and regional social prescribing networks and Healthwatch and to support the development of such infrastructure.
- In order to include smaller VCSEs who may lack capacity to deliver large-scale public-sector contracts, commissioners should consider a variety of approaches to procurement, including grant funding and alliance contracting.
- Commissioners should consider joined up approaches to service delivery across ‘silos’ (i.e. CCGs and Local Authorities) in order to support families using maternity and community services. 13. Commissioners should work with VCSE sector organisations in their local area in order to identify and address training needs in the local workforce.

References

https://maternityaction.org.uk/wp-content/uploads/MothersVoices2018-FINAL.pdf

Priority 4: Accelerate preventative programmes that engage those at greatest risk of poor outcomes 4a: Understand your population & coproduce interventions				
Analysis/ Engagement Findings/ Recommendations	**Actions**	**Milestones**	**Start Date**	**End Date**
Intervention 3: Conduct a baseline assessment of the experience of maternity and neonatal staff by ethnicity by using WRES indicators 1-8 **Key headlines:** High numbers of staff approaching retirement age (18.7% >55 years, 17.5% as of July 2022) especially within clinical roles. Staff ethnicity is not representative of the population, and is poorly recorded Limited information on ethnically diverse staff experience is available due to supressed small numbers & protecting confidentiality.	**In regard to data:** Improve the recording of staff ethnicity **In regard to workforce:** • Ensure that staff development and succession plans are in place to prevent a skills shortfall due to retirement. • Take action on a sustainable pipeline of maternity staff, including engagement with Health Education England (HEE) and Higher Education Institutions (HEI) • Gain a better understanding of why staff are leaving the profession and what we can do to support sustained service. • Other inequalities in the lives of our staff that impact their ability to undertake their roles should be understood so support can be provided. This includes disability, sexuality, and deprivation. • Link with ICB Workforce team Retention Leads to share learning	Staff ethnicity for maternity and neonatal staffing is accurate Staff development and succession plans are developed in all Trusts The Local Maternity & Neonatal System, HEE & HEI's meet regularly to plan the future maternity and neonatal pipeline collaboratively	March 2023 January 2023 March 2023	March 2024 March 2024 March 2024

The NHS Workforce Race Equality Standards assessment reviews the experiences of staff and compares outcomes and experiences of white and ethnically diverse staff.

NHS England » Workforce Race Equality Standard 2020

Priority 4: Accelerate preventative programmes that engage those at greatest risk of poor outcomes 4a: Understand your population & coproduce interventions				
Analysis/ Engagement Findings/ Recommendations	**Actions**	**Milestones**	**Start Date**	**End Date**
Intervention 4: Set out a plan to coproduce interventions for mothers, babies and race equality for staff Further work needs to be done to develop partnerships with underserved communities and understand their needs. Linking with Intervention 1, In year 1 we will develop these relationships and sustain them to work in partnership, designing services for the future. Coproducing interventions for families will be the focus of year 2. Following engagement sessions with women, birthing people and families we will ensure that we always feedback what we have heard, what we are already doing and what we plan to do.	• Work with community champions and service user representatives to map pathways and understand the gaps in provision for different groups. It is essential that our LMNS budget is redirected to support this. • With support of our diverse communities, understand what elements of antenatal education will make the most difference to experience and outcomes • This will help us identify **how** things need to change. • Review available antenatal education, ensuring that it is suitable for all women and birthing people • Review how postnatal care is deployed, and what improvements need to be made to address inequalities (for example, transport poverty). *Actions on achieving race equality for staff are found in Intervention 4d.*	LMNS budget is planned to support targeted coproduction Service gaps are mapped Equity steering groups have identified interventions to address service gaps/inequalities Implementation of targeted interventions to reduce inequalities Development of a coproduced package of antenatal education that can be tailored to the needs of the woman, birthing person and family Postnatal Improvement Plan activities are reprioritised and refreshed in light of Equity & Equality (*to note, these activities were paused during the pandemic)*	April 2023 March 2024 March 2024 *April 2025* January 2023 December 2022	Ongoing March 2025 March 2025 *April 2027* January 2025 December 2024

Priority 4: Accelerate preventative programmes that engage those at greatest risk of poor outcomes 4b: Action on maternal mortality, morbidity & experience				
Analysis/ Engagement Findings/ Recommendations	**Actions**	**Milestones**	**Start Date**	**End Date**
Intervention 1: Implement maternal medicine networks to help achieve equity.	• Assessment of the Maternal Medicine Network activities against the Health Inequalities Programme matrix to review how well it is addressing health inequalities.	The Maternal Medicine Network is monitoring the numbers of women and birthing people using the service who are from an ethnic minority background or are experiencing deprivation.	December 2022	Ongoing

4b: Action on maternal mortality, morbidity & experience

Maternal Medicine Networks provide targeted support and care for women and birthing people with a range of conditions. This includes, but is not limited to:

- Cardiac disease
- Respiratory disease
- Renal disease
- Haematological disease
- Rheumatological disease
- Endocrine disease
- Gastrointestinal and liver disease
- Neurological disease
- Skin disease
- Cancer

The Southwest Maternal Medicine Network (SW MMN) was formally established in September 2022 and Trusts in Devon are well engaged. North Bristol is the regional Maternal Medicine Network Centre and local consultants are engaged in the process.

Key performance indicators are under development and will be aligned to the national service specification. There is an intention for the network to either develop its own equity and equality plan for maternal medicine or to integrate this into local Equity & Equality Plans.

The SW MMN is developing videos on conditions in pregnancy that would result in referral. This is being translated into 4 languages and British Sign Language. This includes:

- Polish
- Urdu
- Turkish
- Somali

Priority 4: Accelerate preventative programmes that engage those at greatest risk of poor outcomes 4b: Action on maternal mortality, morbidity & experience				
Analysis/ Engagement Findings/ Recommendations	**Actions**	**Milestones**	**Start Date**	**End Date**
Intervention 2: offer referral to the NHS Diabetes Prevention Programme to women with a past diagnosis of gestational diabetes mellitus (GDM) who are not currently pregnant and do not currently have diabetes	• Collect data on the proportion of women and birthing people with a diagnosis of Gestational Diabetes. • Ensure that women who receive a diagnosis of GDM are informed about their future risks. • Ensure that GP notification is undertaken for all women and birthing people diagnosed with GDM so that the primary care pathway can be followed. • Ensure that pathways are in place to offer referral to the NHS Diabetes Prevention Programme for women and birthing people with a previous diagnosis of gestational diabetes in the postnatal period. In relation to elevated BMI: • Work as a system to enhance the support offer to women and birthing people who have an elevated BMI, developing clear guidance on activity levels in pregnancy and postnatally. This will also be linked to future pelvic health services development. • Engage the voluntary sector to identify support or activities offered to women and birthing people (and families) with elevated BMI. • Address obesity as a priority in engagement workshops. • Engage with children's service to provide an integrated view on maternal and child obesity, linking with the childhood obesity agenda. • Engage with the ICS to ensure alignment with the wider ICS NHS Long Term Plan ambitions and programmes for healthy weight and diabetes in children and adults.	Strengthen links with primary care, in line with the Postnatal Improvement Plan- Handover to GP & Health Visitor Pathways for referral to NHS Diabetes Prevention Programme are in place in all Trusts	January 2024	*January 2025*

Priority 4: Accelerate preventative programmes that engage those at greatest risk of poor outcomes 4b: Action on maternal mortality, morbidity & experience				
Analysis/ Engagement Findings/ Recommendations	**Actions**	**Milestones**	**Start Date**	**End Date**
Intervention 3: Implement NICE CG110 antenatal care for pregnant women with complex social factors There is no standardised definition of 'complex social factors' (CSF) across Devon, and data is not comparable. Booking by 70 days gestation for all women and birthing people could be improved. This ranged from 76% to 70% across all providers in 2021/22. There is disparity between women and birthing people from white and black ethnic groups, with booking within 70 days at 73.6% and 49.4%. Timeliness of booking appointments for women and birthing people with complex social factors (to note that this is not a standardised definition across providers) is also poorer than women and birthing people who have not been identified to have complex social factors at 62.9% booked by 10 weeks compared to 73.2% for those without CSF. Data on attendance at the recommended number of antenatal contacts was not available	• Working with Public Health & Safeguarding, develop a standardised definition of complex social factors in Devon based on CG110 • Complex social factors will be included in planning of Enhanced Continuity of Carer models • Risk assessment includes assessment for complex social factors to identify women and birthing people requiring additional support • Women and birthing people with complex social factors should be specifically asked about their experiences of care, with responses used to guide service development • Gain insight on the causes of delayed booking and improve the proportion of black women and birthing people booking by 70 days • Scope potential for Devon wide Maternity Single Point of Access, including service user engagement	Standardised definition of complex social factors is in place, supporting delivery of enhanced continuity of carer models and enabling development of a system wide strategy Implement interventions to reduce the proportion of women booking later than 70 days, following investigation of causes	June 2023 March 2024	December 2023 *March 2025*

Priority 4: Accelerate preventative programmes that engage those at greatest risk of poor outcomes 4b: Action on maternal mortality, morbidity & experience				
Analysis/ Engagement Findings/ Recommendations	**Actions**	**Milestones**	**Start Date**	**End Date**
Intervention 3: Implement NICE CG110 antenatal care for pregnant women with complex social factors Cont'd.	• Further investigate the reasons why women with CSF book later than those without, and identify routes through which they could book sooner to support improved outcomes • Develop guidance for providing maternity care to women and birthing people who routinely do not attend antenatal appointments. • Obtain data on the percentage of termination of pregnancy in under 18s in all areas to understand the relationship between access to these services and deprivation in all areas. • Engagement with primary care and sexual health services should be sustained to ensure that systems are in place to address equitable access to contraceptive products, advice and support.	Enhanced support is offered to all women with complex social factors in line with NICE CG110	December 2023	Ongoing

PAUSE

Pause was founded in 2013 in Hackney to support women with multiple and complex vulnerabilities who due to their circumstances, were coming to the attention of children's social care, often resulting in their children being placed in care.

A feasibility study was completed in 2011 which identified a number of risk factors for the removal of children including:

- Domestic Abuse
- Drug & Alcohol dependency
- Homelessness
- Experience of growing up in care
- Criminal justice involvement

The core objectives of the core programme are to create a space and enable change to take place.

Devon ICS is implementing this approach more widely with the recruitment of a Children, Young People & Families Inequalities Lead.

Recruitment into this role is an 'invest to save' business case to implement the PAUSE programme consistently across the ICS. Currently PAUSE is delivered in Plymouth by Trevi - a local VCSE organisation with many years of experience in providing support to vulnerable women. The programme first started in April 2019 and has successfully supported 40 women to complete the programme with many of them choosing to stay in contact receiving 'Next steps' support.

It is delivered as a licenced, trauma-informed model of therapeutic, practical and behavioural support offered to women for a period of 18 months who have experienced (or are at risk of experiencing) a cycle of recurrent care proceedings leading to removal of their children into local authority care. Vulnerable women in contact with the programme are particularly impacted by accessing Housing, Domestic Abuse and Drug Treatment.

The programme aims to address this and give

- Women greater control over their lives, including their reproductive health.
- Women create the foundations on which to move forward to a more positive future.
- More integrated and responsive services which are better able to support women at risk of experiencing a cycle of repeated care proceedings.
- Fewer children are taken into care.

Devon Maternal Mental Health Services

Devon LMNS is an early implementer of Maternal Mental Health services (MMHS). A joint bit was submitted by Devon Partnership Trust & Livewell Southwest and the service launched in January 2021. These services provide care for women & birthing people who are experiencing moderate/severe/complex mental health difficulties (or difficulties which are at a level that mean day to day life and/or the new parenting relationship/decisions around fertility are significantly affected). The service provides interventions for women and birthing people experiencing trauma, loss, removal of their children, tokophobia and fear of fetal medicine following previous loss of trauma.

Devon MMHS takes an individualised approach to providing care for women and birthing people experiencing inequalities. The service recognises that each family is different and has an individual story and that their care must be appropriately tailored to support them most effectively and compassionately. When referrals are received risk of inequalities or inequities are identified so that more intensive support of signposting can be provided, taking a 'no wrong door' approach. This may include additional assessment or support navigating signposted services, and keeping women, birthing people and families on caseloads for slightly longer to ensure they receive the correct support. At this time there is no route to proactively identify people experiencing inequalities and perinatal mental health concerns to undertake targeted outreach.

Staff delivering MMHS have undertaken significant cultural and diversity training, which has led to meaningful change and adaptation of tailored practise for women and birthing people from ethnically diverse backgrounds. Additional support may include translation of materials or use of face-to-face interpreters where required. Additional interventions are tailored and provided to support women and birthing people who may be experiencing barriers to intervention and recovery due to feelings of cultural shame.

Training has also been undertaken to provide tailored support to families from LGBTQIA+. A personalised approach is taken, and use of language is adapted to reflect the families' personal identities and preferences. It is noted that there is an increase observed in the number of families presenting to MMHS from LGBTQIA+ backgrounds.

Considering the high proportion of military families in Devon, the MMHS has significant experience in providing support to military personnel and spouses using maternity and neonatal services. As with all women, birthing people and families in the service, support is tailored and the MMHS links closely with military support services and medical teams. These teams are enabled to raise referrals to MMHS for more specialist support. The MMHS proactively liaises military services to provide appropriate supportive approaches such as delayed deployment.

For more severe and enduring concerns, Jasmine Lodge Mother & Baby Unit (MBU) is based in Exeter and enables women who are detained under the Mental Health Act to stay with their babies where possible. There are 8 beds within the unit, serving Devon, Cornwall & Somerset populations

Inequalities in Perinatal Mental Health

Ethnicity

A National study published in 2020 concluded that women and birthing people from Black, Asian and white non-British/Irish groups have statistically significant lower access rates to community mental health services and a high proportion of involuntary admissions.

Outreach to these communities, provision of appropriate linguistic support, representative staff and monitoring of access, outcomes and experience is recommended to improve this.

Maternal Age
Data from Public Health England suggests that teenage mothers and fathers are at increased risk of perinatal mental health concerns and its impacts:

- x3 more likely to experience postnatal depression
- suffer poorer mental health up to three years post-birth
- have a relationship breakdown in that period
- x3 less likely to start breastfeeding
- x3 more likely to smoke throughout pregnancy

Close links with community organisations that support young families and children and young people's mental health services is important to mitigate this. Providing a personalised approach to care for these families can support them to have a better experience and outcomes- this includes providing information in relevant formats for young people. Increased risk factors such as experience of growing up in care and childhood abuse should be recognised and mitigated through multi-agency working and tailored support plans.

Deprivation
Women and birthing people living in deprived areas may be less likely or less empowered to access mental health services. Often women and birthing people experiencing deprivation may also face multiple disadvantage and complex social factors including homelessness, substance misuse and contact with the criminal justice system. Digital exclusion and levels of literacy & educational attainment may also contribute to barriers in accessing and benefitting from interventions.

Close working relationships with community organisations and other agencies is important to best support these women and birthing people. Provision of trauma informed care is especially important when providing support for complex social factors, and provision of information in easy read and plain English formats can help mitigate some barriers.

NHS England Perinatal Mental Health Network lists the following characteristics for providing inclusive and equitable mental health services:

- **Disability** Physical, sensory and learning impairment; long-term conditions
- **Carers** Paid/unpaid, family members
- **Religion and belief** People with different religions or beliefs, or none.
- **Sexual orientation**
- **Gender identity**
- **People living in remote locations** Including rural and island locations
- **Gypsy, Roma and Traveller communities**
- **Armed forces/veterans**
- **Single mothers**

Complex Characteristics
- **Mothers subject to multiple removals of children**
- **Sex workers**
- **Those experiencing modern slavery**
- **People with addictions and/or substance misuse issues**
- **Those involved in the criminal justice system** Offenders in prison/on probation, ex-offenders
- **Homeless people** Rough sleepers, people staying temporarily with friends /family; lodgers
- **Refugees and asylum seekers**

Perinatal Mental Health & Military Families

The majority of regular military service personnel and Ministry of Defence civilian personnel are located in the South West (38,500 and 21,830 respectively). This includes navy, army, marines and RAF personnel. In addition to this there are a significant number of veterans within our population.

Both female personnel and spouses of serving personnel are at increased risk of perinatal mental health concerns. Often these groups are not based in an area where they have a familial support network.
In regard to female serving personnel, they are likely to move from Defence Medical Services (DMS) to NHS maternity services when pregnant raising potential risks through a lack of continuity of care and awareness of pre-existing mental health concerns, especially with regard to service-related post-traumatic stress which may be retriggered during birth.

For women and birthing people in relationships with serving personnel, spousal deployment has been identified as an enhanced risk factor for poor perinatal mental health (Godier-McBard et al).

The 2019 South West Peninsula Veterans Joint Needs Assessment outlined some key points that maternity and neonatal services should be aware of. Whilst this assessment focusses on all military veterans and not just women and birthing people the findings remain relevant for providing equitable and tailored care for armed forces personnel and spouses

- 3x more veterans claim armed forces compensation for mental health disorders than those currently serving (12% and 4% respectively)
- Veterans are more likely to have smoked, and these rates increase in veterans with PTSD
- Both male and female veterans may have higher rates of hazardous alcohol use
- Combat can result in post deployment physical aggression and violence in around 13% of military personnel, which may increase the risk of domestic violence or abuse.

Maternity and neonatal services should work with military services and bases across Devon to ensure that services are aligned and personalised care is tailored to serving personnel and military spouses individual needs.

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Priority 4: Accelerate preventative programmes that engage those at greatest risk of poor outcomes 4b: Action on maternal mortality, morbidity & experience				
Analysis/ Engagement Findings/ Recommendations	**Actions**	**Milestones**	**Start Date**	**End Date**
Intervention 4: Implement maternal mental health services with a focus on access by ethnicity and deprivation	• Improve data collection on women with mental health diagnoses, including serious mental illness • Design integrated mental and physical health pathways specifically for women and birthing people with serious mental illness to reduce the risk of obstetric near miss at the time of birth • Review the Perinatal Mental Health dashboard to understand the incidence of mental health issues by deprivation and ethnicity • Families with babies in the neonatal unit should not disadvantaged in regard to attachment. Scope the implementation of Infant Mental Health protocols such as Brazelton	Robust understanding of maternal mental health service needs, with data disaggregated by ethnicity and deprivation Infant mental health support, scoped, especially for babies in the neonatal unit.		
Intervention 5: Ensure personalised care and support plans are available to everyone	• *Actions outlined in Intervention 1* • Impact of parent's culture, ethnicity and language is discussed and considered during the antenatal risk assessment process, initial assessment and follow up	Culture & background forms a keystone of personalised care and support plans and personalised conversations	March 2023	October 2023
Intervention 6: Ensure the MNVP's in your LMNS reflect the ethnic diversity of the local population, in line with NICE QS167 Data on ethnicity of MNVP members is not currently available	• *In line with Priority 4a* • When engaging with diverse communities ensure that offers of membership to the Devon MNVP are made	MNVP diverse membership is enhanced, and service users with lived experienced of inequalities are engaged with maternity and neonatal services	Ongoing	Ongoing

Personalised Care: Learning Disabilities & Autism

A 2013 study (Wilson et Al.) estimated that between 40 & 60% of parents with a learning disability have their children removed from their care due to being assessed as unable to provide an adequate standard of parenting. Women and birthing people with learning disabilities should have the same rights as those without and these parents must be better supported in their journey to and experience of parenthood.

HealthTalk have published feedback from mothers on their maternity and motherhood journey (2017). The experience of women and birthing people with learning disabilities can be different to that of other women and birthing people and some report being treated differently by professionals and that assumptions are often made. Provision of adequate information (to a level that may be different from other women and birthing people) to support informed choice is not always evident.

Most women and birthing people felt that midwives require further training to better understand the needs of women with learning disabilities.

'Good Practise' Guidance on working with parents with a learning disability' published by the University of Bristol sets out five features of good practise:

1. Accessible information and communication
2. Clear and coordinated referral and assessment procedures and processes, eligibility criteria and care pathways
3. Support designed to meet the needs of parents and children based on assessments of their needs and strengths
4. Long-term support where necessary
5. Access to independent advocacy

In Devon, every service has a Learning Disabilities (LD) & Autism champion, supported by information provided regionally. All GP practises in Devon also have an LD champion. Webinars are held quarterly for primary care colleagues.

Often people with diagnosed LD receive additional support from other health and social care departments and liaison nurses, however there is no pathway for women and birthing people without a diagnosis; once they are within the maternity service there is limited time to achieve formal assessment and diagnosis.

We will work with the learning disabilities team in NHS Devon and service users to understand the service need. We will begin this work focussing on learning disabilities and then develop our approach to other Neurodivergent people. An initial approach has been defined below:

- Review available data and identify gaps. This will include the level of need within Devon, understanding the reasons children are removed from parents, and any links between incidents or HSIB investigations and learning difficulties.
- Work with women and birthing people to review outcomes and experiences
- Identify 'quick wins' that can be implemented to make a difference immediately & what needs to be commissioned for the long term
- Establish a working group with a multiagency approach focussed on LD & maternity/neonates

In addition to learning disabilities & difficulties, we must also focus on providing improved support for women and birthing people with autism and other neurodivergence.

Historically research has suggested that autism is significantly more common in males than females (a ratio of about 16:1). The most recent data suggest this is closer to 3:1. There are a number of theories about why this is, but differences in how autism presents in

women compared to men may contribute to many women reporting being diagnosed later in life than their male counterparts.

A 2021 literature review (McDonnell & DeLucia) reports that autistic adults experience difficulties and dissatisfaction communicating with healthcare providers throughout pregnancy and birth, are more likely to experience depression during and after pregnancy and experience higher rates of complications such as preterm birth, caesarean section and pre-eclampsia. One limitation identified is the lack of sociodemographic diversity, which may present further challenges.

Research is underway at the University of Birmingham to identify what maternity providers need to do to improve services for autistic people. A recent study has demonstrated that maternity services may not have the skills required to support autistic women and birthing people.

One way that Devon maternity and neonatal services could begin to identify challenges with learning disability/difficult and autism is to include a question within personalised care journals about any perceived barriers to women and birthing people attending appointments or accessing information so that care can be delivered in times and places that support personalisation and choice.

References

Pregnancy and learning disability | Womens health | Royal College of Nursing (rcn.org.uk)
Pregnancy - Learning disability and pregnancy (healthtalk.org)
FINAL 2021 WTPN UPDATE OF THE GPG.pdf (bristol.ac.uk)
https://www.autistica.org.uk/our-research/research-projects/maternity-services-for-autistic-women#:~:text=Autistic%20people%20may%20have%20difficulty,experience%20isolation%2C%20anxiety%20and%20depression.
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https://www.liebertpub.com/doi/10.1089/aut.2020.0046#:~:text=The%20findings%20show%20that%20autistic,pregnancy%20complications%2C%20including%20preterm%20birth%2C

The Together Project

The Together Project has been established by the University of Surrey and aims to support the delivery of good practise in maternity services for parents with learning disabilities. They have produced 2 resources which are freely available online:

1. The Together Toolkit for professionals working in maternity services, to support the delivery of good care for people with learning disabilities during their pregnancy.
2. A Maternity Passport to be held by people with learning disabilities who are pregnant and to include the relevant information needed by the professionals who support them.

Resources are not always available for parents with learning disabilities, and the toolkit aims to provide this.

Electronic records are not best practice for parents with learning disabilities who may find paper notes more accessible. The passport can be completed and held by parents with learning disabilities and will enable consistent and individualised information sharing with professionals, as well as informal supporters/carers.

The toolkit and passport are available for free download at the link below.

References

https://www.surrey.ac.uk/research-projects/together-project-supporting-delivery-good-practice-maternity-services-parents-learning-disabilities

The Together Project Toolkit

1. Identifying need (requiring awareness of learning disabilities; thinking beyond existing diagnoses; assuming a positive attitude; and asking key questions);

2. Preparing for parenthood (adjusting communication and information to meet individual needs of parents with learning disabilities; and adjusting time and space so parents are not rushed when information is shared, and their engagement is meaningful);

3. Supporting the journey to baby and beyond (emphasising the importance of professionals working together; of building trust with parents; identifying and filling gaps in support needed by parents; and enabling parents to have a voice and be involved in decision making).

Personalised Care: Physical disability or sensory impairment

The Equality Act 2020 defines disability as:

- physical or mental impairment, and
- the impairment has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities.

In 2018, Birth Rights funded research into the human rights and dignity experience of disabled women during pregnancy, childbirth and early parenting. Most women who participated reported physical or mobility impairment.

Whilst around 70% of women and birthing people reported they were satisfied with care provided by midwives, more open-ended survey questions yielded responses that indicate there are many areas of improvement within maternity care:

- Limited understanding about conditions & their impact
- Perception of reduced choice & choices being overruled
- A need for continuity of carer & awareness of medical history
- Reasonable adjustment to enable attendance at appointments

Women and birthing people with physical disability should be provided with individualised care and respected as the experts about their own body's capabilities and where appropriate, limitations. Research (Bellil et al) concludes that advanced planning and use of disability related interdisciplinary teams can improve quality of care for women and birthing people with physical disabilities.

A recent review (2021) highlights that women and birthing people with disabilities often have limited access to sexual and reproductive health services. Improved signposting to resources around pregnancy and physical disability would be supportive in enabling women and birthing people to plan their pregnancy and understand what adjustments can be made to support them.
The preferred language used around an individual's disability, difficulty, long term condition of impairment can vary should be confirmed with the women or birthing person.

Blindness and Visual Impairment

Visual impairment covers a wide range of presentations ranging from complete blindness to mild impairment with 'less than normal' vision. It is important to note that this may not always be viewed as a disability.

Some women and birthing people may also experience temporary changes to their vision due to pregnancy hormones. Blurry vision that comes on during pregnancy should always be reported to the midwife or healthcare professional overseeing your maternity care.

Recommendations

Enable sighted companions to assist, including guide dogs

- Ensure women and birthing people are asked what they need to make reasonable adjustment.
- Providing opportunities to touch instruments used during examinations to reduce fear and anxiety.
- Tours of clinics or birthing environments to enable self-orientation.
- Verbal introduction of healthcare professional name and function, appreciating that name tags may not be visible or readable.
- Detailed verbal descriptions of newborns may support attachment.
- Consideration of alternative information formats.

Deaf, Hard of Hearing and Hearing Impairment

Hearing impairment ranges from mild to profound and can have many causes.

Research (Mitra et al) suggests that women and birthing people who are deaf or hard of hearing may have a higher risk of complications such as gestational diabetes and blood pressure disorders and may also be at increased risk of preterm birth or having a low birth weight baby. Whilst the cause of this is yet to be determined, it is believed that communication with healthcare professionals may be a significant contributing factor.

Recommendations

- Offer for deaf women to hold the Sonicaid to feel the fetal heartbeat.
- Inform the reception staff if you are expecting a deaf or hard-of-hearing person so they may guide them to sit where you can be seen when you come out to call names.
- Services for booking and changing appointments should have a text or online/email options.
- Hospital policies range in time needed to book BSL interpreters - this can sometimes take three weeks.
- Some pain relief options may make it difficult to lip read or watch online interpreters.
- Guidance during pushing stages may need to be tactile (in prior agreement with the women). For example, partner to squeeze hand for push and release hand for stop pushing.
- A dedicated person in theatre to repeat what is being said by staff who are wearing masks.
-

References

Birthrights-Bournemouth-Liverpool-Human-Rights-and-Dignity-Experiences-of-Disabled-Women-during-Pregnancy-Birth-and-Early-Parenting-1-1.pdf
Disability and long-term health conditions and maternity care - Birthrights
The Impact of Physical Disability on Pregnancy and Childbirth - PMC (nih.gov)
Maternity care experiences of women with physical disabilities: A systematic review - ScienceDirect
Pregnancy and blindness and vision Impairment | Womens health | Royal College of Nursing (rcn.org.uk)
Supporting the pregnant woman who is visually impaired - guidelines for health professionals | Disability, Pregnancy & Parenthood (disabledparent.org.uk)
Science Update: Pregnancy, birth complications higher among deaf and hard of hearing women, suggests NIH-funded study | NICHD - Eunice Kennedy Shriver National Institute of Child Health and Human Development
Pregnancy and deafness | Womens health | Royal College of Nursing (rcn.org.uk)

Health Matters: Reducing health inequalities in mental illness

Whilst this report focuses on severe and enduring mental illness, many of the actions outlined will be of benefit to all people experiencing mental illness, whether this is a pre-existing condition or a perinatal mental health condition.

- People experiencing mental illness are more likely to experience higher rates of poverty, homelessness, incarceration, social isolation and unemployment.
- Smoking prevalence is significantly higher in adults with severe mental illness, in addition to misuse of alcohol and drugs.
- People from minority ethnic backgrounds are at greater disadvantage when experiencing mental illness and are less likely to recover.
- Optimal support in preconception, pregnancy and postnatal care are required to improve health outcomes for women

Recommendations

1. Understand the local population need
2. Address the social determinants of poor health
3. Build stronger communities and social connections
4. Early detection and intervention for physical health risks
5. No wrong door: support available through every contact point

References

https://www.gov.uk/government/publications/health-matters-reducing-health-inequalities-in-mental-illness/health-matters-reducing-health-inequalities-in-mental-illness

Neonatal Peer Support

Parents of babies admitted to neonatal units may struggle to cope with a wide range of emotions that they were not prepared for. Parents of babies in neonatal units are at increased risk of perinatal mental health concerns which may have an impact on attachment.

In addition to professional neonatal support and psychological support, parents can benefit from support provided by other 'veteran' parents of NICU babies. Research (Hall et al) summarises that peer support in neonatal settings can provide the following benefits:

- Increased parental confidence, self esteem & wellbeing.
- Improved problem solving capacity & adaptive coping.
- Enhanced perception of social support.
- Parents feel more empowered to engage with and care for their babies and visit more frequently, which can contribute to a reduced length of stay.
- Parental stress and mental health issues are reduced.

References

Recommendations for peer-to-peer support for NICU parents | Journal of Perinatology (nature.com)

4c: Action on perinatal mortality and morbidity

Priority 4: Accelerate preventative programmes that engage those at greatest risk of poor outcomes 4c: Action on perinatal mortality, morbidity & experience				
Analysis/ Engagement Findings/ Recommendations	**Actions**	**Milestones**	**Start Date**	**End Date**
Intervention 1: implement targeted and enhanced continuity of carer, as set out in the NHS Long Term Plan. Data on implementation of continuity of carer is of low quality and not sufficiently robust to enable conclusions to be drawn. The 'woman reported continuity of carer' measure demonstrates a rate of 18.7%	• Address issues with Continuity of Carer data quality to enable monitoring of implementation • Ensure that the enhanced continuity of carer model is integrated with the approach to preterm birth clinics and preterm birth risk assessment for black, Asian and mixed ethnic groups • Work with business intelligence to identify those post codes with the greatest proportion of deprived and ethnically diverse women and birthing people, enabling development of geographical continuity of carer models • Define a 'geography plus' prioritisation model where criteria-based assessment for care under continuity of carer teams includes those experiences inequalities where it is **not** identified in geographical postcode modelling. This will mitigate the risk of gaps in IMD and population-based mapping •	Continuity of Carer data is of sufficient quality to reliably monitor implementation Define additional criteria for inclusion in initial Continuity of Carer team roll out that is not based solely on geography	*NA* *NA*	*NA* *NA*

To Note: As per the letter of 21st September 2022 safe care and sufficient staffing will be prioritised, and time bound actions and targets relating to Continuity of Carer have been removed.

Priority 4: Accelerate preventative programmes that engage those at greatest risk of poor outcomes 4c: Action on perinatal mortality, morbidity & experience				
Analysis/ Engagement Findings/ Recommendations	**Actions**	**Milestones**	**Start Date**	**End Date**
Intervention 1 (Contd): implement targeted and enhanced continuity of carer, as set out in the NHS Long Term Plan. Providing continuity of carer to vulnerable women and birthing people has been shown to reduce preterm birth numbers. In 2021/22 Devon had an average of 6% preterm births. Deliveries under 27 weeks should also take place in a maternity unit with an on-site NICU. In 2021/22 this was true for 77% of babies born at less than 27 weeks, 8% short of the 85% target. The rate of low and very low birth weight babies was 6.4% and 1.05% respectively. These rates were highest in Torbay, but lowest in women of white ethnic origin.	• Establish a robust process for exception reporting of babies born at less than 27 weeks in a unit without an appropriate level 3 neonatal unit. This will likely be through the LMNS Perinatal Quality Surveillance Group (PQSG) • Triangulate data sources of ethnicity **and** deprivation to understand if there are more extreme differences in women of minority ethnic background who are deprived, and target interventions appropriately • Neonatal ethnicity data collection requires improvement	Devon LMNS has oversight of all <27-week births in sites without a NICU Continuity of Carer teams are rolled out to areas with the highest deprivation and great number of black, Asian and minority ethnic women and birthing people	September 2022 *NA*	Ongoing *NA*

Priority 4: Accelerate preventative programmes that engage those at greatest risk of poor outcomes 4c: Action on perinatal mortality, morbidity & experience				
Analysis/ Engagement Findings/ Recommendations	**Actions**	**Milestones**	**Start Date**	**End Date**
Intervention 2: implement a smoke-free pregnancy pathway for mothers and their partners	• Prioritised roll out of specialist stop smoking pathways within maternity should be targeted towards the most deprived areas where smoking rates in pregnancy are higher	All women and birthing people are offered specialist maternity smoking cessation advice (already commenced) Signposting to stop smoking services is in place for partners	May 2022 *Already in place*	Ongoing

Smoking Cessation

Devon LMNS is working closely with the ICB Tobacco Dependency workstream. A collaborative smoking cessation pathway is being developed, prioritising interventions in Torbay, an area of high deprivation and high smoking in pregnancy.

In Devon there is a named lead within each provider working towards the smoking agenda. These leads are part of the ICB Tobacco Dependency Board and attend the LMNS Prevention workstream to ensure that activities are aligned.

Funding has been invested to assist in communications, training and engaging with third sector stop smoking services.

Maternity pathways are being reinforced to meet the actions of the national Maternity Specialist Smoking Cessation model, including CO monitoring, Very Brief Advice (VBA) and advice.

Motivation and ambition of all staff to reduce smoking in pregnancy rates across Devon is a significant strength, with all staff committed to supporting women and birthing people to have the healthiest pregnancy possible.

Infant Feeding

Devon LMNS is committed to developing an infant feeding strategy that will provide personalised support to all women and birthing people, regardless of how they feed their babies.

Whilst breastfeeding is beneficial for many reasons, we recognise that there are groups of women and birthing people who choose not to breastfeed, are unable to due to conditions that they or their baby may have, and women who cannot continue with breastfeeding as a result of limited support. Our engagement with women and families reinforces that improved breastfeeding support should be a priority.

We will work together to develop a system wide infant feeding strategy, with standardised, evidence-based information and provide a service that is adequately resourced.

All Trusts maternity & neonatal units are working towards UNICEF Baby Friendly Initiative (BFI) Accreditation, and most units currently have some level of compliance.

All trusts offer information, support and equipment to facilitate hand antenatal hand expressing and colostrum collection. This is particularly important for women and birthing people who are at increased risk of preterm labour, and for women who have an induction or caesarean section where babies may be more reluctant to feed.

The Coronavirus pandemic has had a negative impact on Trusts ability to deliver infant feeding services due to redeployment of staff and workforce shortages, and progress towards BFI accreditation has also been disrupted.

Infant feeding services in Devon are vulnerable to staffing pressures and often have a single person leading the service.

Infant feeding leads across Devon have identified 4 priority areas to support delivery of a high-quality infant feeding service:

- ✓ **Time:** Sufficient time to deliver care and interventions
- ✓ **Team**: Sufficient team to deliver the service
- ✓ **Training:** Training for staff and also for families
- ✓ **Tongue Tie:** Sufficient capacity to support Frenulotomy (tongue tie intervention) within maternity services, enabling breastfeeding advice to be provided at the same time.

Priority 4: Accelerate preventative programmes that engage those at greatest risk of poor outcomes 4c: Action on perinatal mortality, morbidity & experience				
Analysis/ Engagement Findings/ Recommendations	**Actions**	**Milestones**	**Start Date**	**End Date**
Intervention 3: implement an LMS breastfeeding strategy and continuously improve breastfeeding rates for women living in the most deprived areas. The women and birthing people least likely to breastfeed are under 20, white, left full time education under 18, are deprived and within a lower socioeconomic group. An average 77% of babies in Devon received breastmilk at their first feed in 2021/22	• Develop a breastfeeding strategy that includes analysis of feeding trends across the LMNS. This should be aligned to areas of higher deprivation • Additional support should be considered for women and birthing people less likely to breastfeed • All documentation and breastfeeding counselling approaches must recognise that some women have chosen not to breastfeed and that others are unable to breastfeed due to medical or health conditions • The LMNS will continue to support Trusts to achieve BFI accreditation • Consider provision of outreach breastfeeding support in the most deprived areas • Data collection and recording of breastfeeding initiation and breastfeeding at 6-8 weeks must be improved. UNICEF BFI have a recommended dataset which could be implemented to support this action. • Enhance demographic data on pregnant women especially around accessing services to support identification of areas of inequality and target interventions to support these groups	Development of a Devon system wide Infant Feeding Strategy All Trusts working towards BFI accreditation	September 2022	March 2024 March 2024

Priority 4: Accelerate preventative programmes that engage those at greatest risk of poor outcomes 4c: Action on perinatal mortality, morbidity & experience				
Analysis/ Engagement Findings/ Recommendations	**Actions**	**Milestones**	**Start Date**	**End Date**
Intervention 3: implement an LMS breastfeeding strategy and continuously improve breastfeeding rates for women living in the most deprived areas Cont'd.	• Collecting feedback on why women stop breastfeeding in the first 6-8weeks • Identify community-based support, including voluntary and third sector and peer support, and ensuring clinicians are able to signpost people to these resources • Improving links between maternity care pathways (antenatal, postnatal and community) and public health nursing to ensure consistent messages as provided to breastfeeding people • Engaging with and supporting wider community engagement initiatives that breakdown the societal and cultural barriers to breastfeeding • Engagement with early years providers to support mothers to continue providing breastmilk • Understanding of breastfeeding information provided in educational settings e.g., PSHE	*See above, strategy*		

4d: Support for maternity & Neonatal Staff

In addition to taking action on race equality for staff, we must take action to improve the recruitment and retention of midwives. The Coronavirus pandemic has had a severe impact on all NHS staffing.

There is a wider system focus on retention of staff that we will ensure we are aligned with.

Retention case study:
Significant work has been undertaken in Torbay & South Devon (TSD) NHS Foundation Trust to understand the contributing factors to staff leaving the profession. In a recent (2021) Royal College of Midwives (RCM) annual members survey 57% of respondents stated they are considering leaving the NHS within the next year. In TSD the Retention Midwifery team (Jacquelyn Crow & Josephine Ash) asked midwives for their feedback via survey and focus groups:

- Disillusionment with the role of midwives- no longer the role they trained for.
- Lack of flexible working.
- Pressure to implement Continuity of Carer with higher than recommended caseload.
- Limited career pathways.
- Significant proportion of complex women opting for birth outside guidance.
- In some circumstances increased medical intervention is sometimes necessary during birth to support enhanced safety. Some women & birthing people may be exposed to increased levels of morbidity and traumatic experiences. Midwives have varying experiences regarding this and it can contribute towards them feeling accountable for poor outcomes.

When asked what would help them feel better supported:
- Recruitment and retention of staff to uplift workforce levels.
- Opportunities for career development.
- Developing a connection with colleagues outside day-to-day work (socially, and professional away days).
- Developing the team.
- Ensuring staff feel valued.

In order to support staff retention and wellbeing, TSD has established a professional midwifery advocate (PMA) service, delivering support to staff of all levels:
- Allocated PMA buddies to every student and preceptee midwife
    - Offering 1:1 sessions every 3 months.
- Group restorative clinical supervision (RCS) sessions at least once every 6 months for midwives and MSW's.
    - Identifying common themes and undertaking group RCS.
- Away days facilitated by a psychologist.
- Planned pilot (Nov-Dec 2022) to provide psychological support in the workplace.
- Twice monthly funded staff reflexology sessions.
- Refurbishment of staff rooms.
- All staff provided with wellbeing bags, including signposting to help and support (finances, mental health etc.).
- Appointment of a Legacy midwife to support preceptees.
- Launch of Birth Afterthoughts service for women with traumatic birth experiences.

Finances

In 2020 the Health Foundation published an article outlining that 40% of NHS staff earn less than £24,000 (Although, this is likely to have changed since publication)

There is an increase in staff reporting concerns about personal finances, including challenges with affordability of community work when travel reimbursements have not scaled with the cost of fuel.

There is also an additional challenge for students who must travel for placements within hospital settings.

Staffing the full rota can be challenging when often staff rely on unsociable hours to obtain a sufficient income.

In Torbay & North Devon, noted previously in this report as areas of higher deprivation, many maternity staff are the primary wage earner in their households. RDUH North has begun to run a foodbank for their staff.

NHS England & NHS Employers have published guidance on supporting staff and their financial wellbeing.

References

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https://www.health.org.uk/news-and-comment/blogs/valuing-the-health-and-wellbeing-of-lower-paid-nhs-staff
https://www.england.nhs.uk/supporting-our-nhs-people/how-to-guides/financial-wellbeing/
https://www.nhsemployers.org/topics/staff-experience-culture-and-change/supporting-staff-rising-cost-living-good-employment

Priority 4: Accelerate preventative programmes that engage those at greatest risk of poor outcomes 4d: Support for Maternity & Neonatal Staff				
Analysis/ Engagement Findings/ Recommendations	**Actions**	**Milestones**	**Start Date**	**End Date**
Intervention 1: roll out multidisciplinary training about cultural competence in maternity and neonatal services. We do not have any data on completion of cultural competence training, but can see that when Equality, Diversion and Inclusion training is mandatory over 90% of staff complete it.	• Align cultural competency training with wider organisational approach at both Trust & System level. • Ensure that the Cultural Competence E Learning Tool devised by HEE and RCM is available on all Trusts training portals and that data on completion is monitored and provided to heads of service. • Deliver cultural competency training to all staff in maternity and neonatal settings. This includes obstetricians and neonatologists.	All staff are trained in cultural competency as part of their mandatory annual training schedule	March 2023	Ongoing
Intervention 2: When investigating serious incidents, consider the impact of culture, ethnicity and language. 54% of serious incidents in maternity services in Devon do not feature a valid ethnic code for the women or birthing person. It is likely, however has not been reviewed, that Perinatal Mortality Review Tool (PMRT) Perinatal Mortality Review Tool cases have similarly low compliance with ethnic codes	• Ensure that all serious incidents have a valid ethnic code • Ensure that all PMRT cases have a valid ethnic code • Undertake a quarterly review of serious incidents where ethnicity, language or culture are an element • All maternal deaths involving people from ethnic minority backgrounds should be assessed against the 9 factor adjustment: medical co-morbidities, maternal age, antenatal care provision, previous pregnancy complications, substances misuse, anaemia, diabetes, multiple pregnancy and unemployment (*see page 21 of Equity guidance for local maternity systems)* • More detailed review of perinatal mortality data in all providers is required. This will be enabled through the implementation of the Ockenden recommendations and the Perinatal Quality Surveillance Model, notably via the Devon LMNS PQSG	Review of serious incidents by ethnicity, culture and language is a standing item on LMNS Safety & Governance meetings	December 2022	Ongoing

Priority 4: Accelerate preventative programmes that engage those at greatest risk of poor outcomes 4d: Support for Maternity & Neonatal Staff				
Analysis/ Engagement Findings/ Recommendations	**Actions**	**Milestones**	**Start Date**	**End Date**
Intervention 3: implement the Workforce Race Equality Standard (WRES) in maternity and neonatal services. Please see Priority 4a, Intervention 3 for details	• *Linked with Priority 4a, Intervention 3* • Review WRES reports in greater detail for each Trust, and ensure that action plans are in place to address inequalities • The LMNS should review the People Pulse survey and working with the Best Place to Work Pillar to best understand the experience of ethnically diverse employees • Review the new workforce cultural dashboard	All maternity and neonatal units have implemented the recommended WRES actions	March 2023	March 2024

4e: Enablers

Priority 4: Accelerate preventative programmes that engage those at greatest risk of poor outcomes 4d: Support for Maternity & Neonatal Staff				
Analysis/ Engagement Findings/ Recommendations	**Actions**	**Milestones**	**Start Date**	**End Date**
Intervention 1: establish community hubs in the areas with the greatest maternal and perinatal health needs.	*Link with Priority 4a, Intervention 2* • Scope community hub work currently underway in all Trusts • Work with local authorities to collaborate & realise our respective vision for community hubs and family hubs, providing a trusted and safe environment from pregnancies throughout the early years • Devise a multidisciplinary approach within community hubs, and referral and signposting should be completed at point of contact enabling a fast and effective referral service and eliminating issues with follow on letters. • Understand the distribution of women and birthing people who do not attend the recommended number of antenatal appointments and the reasons for this • Development of community hubs should be especially supported in North Devon, which has a large proportion of rural and coastal isolation.	Devise an adaptable outreach approach for women and birthing people who struggle to attend appointments in centralised locations.	January 2023	January 2025

Priority 4: Accelerate preventative programmes that engage those at greatest risk of poor outcomes 4d: Support for Maternity & Neonatal Staff				
Analysis/ Engagement Findings/ Recommendations	**Actions**	**Milestones**	**Start Date**	**End Date**
Intervention 2: work with system partners and the VCSE sector to address the social determinants of health.	*Links with Priority 4a, Intervention 1 & 4* • Identify community champions and social prescribing interventions within the community that women, birthing people and families can be signposted to • Work with local authorities to deliver preconception and postnatal contraception support and advice • Ensure that any working groups established to improve include public health and local authority representation • Align with Best Start for Life programme and their development of a directory of services for 0-5 years	Signposting to community organisations and social prescribing is developed as part of the directory of services for women, birthing people and staff	March 2024	*March 2026*

Metrics

Metrics have been outlined in Equity & Equality: Guidance for Local Maternity Systems. These have been listed below. This framework will also require additions as more data becomes available and targeted interventions are coproduced.

Priority/ Intervention	Process Indicators	Source	Outcome Indicators	Source
Priority 1: Restore NHS Services Inclusively				
Intervention 1: Continue to implement the covid four actions	Implementation of the COVID-19 four actions	Local Data	Women using folic acid	Regional Measures Report
Priority 2: Mitigate against Digital Exclusion				
Intervention 1: Ensure personalised care and support plans are available in a range of languages and formats, including hard copy PCSP's for those experiencing digital exclusion	• The number of women with a Personalised Care and Support Plan which covers: - antenatal care by 17 weeks gestation - intrapartum care by 35 weeks gestation - postnatal care by 37 weeks gestation • The numbers of women who had all three of the above in place by the gestational date	Local Data Local Data	None	
Priority 3: Ensure datasets are timely & complete				
Intervention 1: On maternity information systems, continuously improve the data quality of ethnic coding and the mother's postcode	• Safety action 2, category 9: data submitted to Maternity Services Data Set (MSDS) contains valid postcode for mother at booking in 95% of women booked in the month. • Ethnicity data quality • Safety action 2, category 10: data submitted to MSDS includes a valid ethnic category for at least 80% of the women booked in the month. Not stated, missing and not known are not valid records.	MSDS/ CNST Regional Measures Report MSDS/CNST	None	

Priority/ Intervention	Process Indicators	Source	Outcome Indicators	Source
Priority 4: Accelerate preventative programmes that engage those at greatest risk of poor outcomes				
4a: Understand your population & coproduce interventions				
Intervention 1: Understand the local populations maternal and perinatal health needs (including the social determinants of health)				
Intervention 2: Map the community assets which help address the social determinants of health				
Intervention 3: Conduct a baseline assessment of the experience of maternity and neonatal staff by ethnicity by using WRES indicators 1-8				
Intervention 4: Set out a plan to coproduce interventions for mothers, babies and race equality for staff				

Priority/ Intervention	Process Indicators	Source	Outcome Indicators	Source
4b: Action on maternal mortality, morbidity & experience				
Intervention 1: Implement maternal medicine networks to help achieve equity	The Maternal Medicine Network is implementing the KPIs in the non-mandatory national service specification. They are broken down by level of deprivation of the mother's postcode and ethnicity			
Intervention 2: offer referral to the NHS Diabetes Prevention Programme to women with a past diagnosis of gestational diabetes mellitus (GDM) who are not currently pregnant and do not currently have diabetes				
Intervention 3: Implement NICE CG110 antenatal care for pregnant women with complex social factors	Booking at <70 days gestation Proportion of women with complex social factors who attend booking by 10 weeks, 12+6 weeks and 20 weeks For each complex social factor grouping, the number of women who: attend for booking by 10, 12+6 and 20 weeks; and attend the recommended number of antenatal appointments	Regional Measures Report Local Data		

Priority/ Intervention	Process Indicators		Outcome Indicators	Source
4b: Action on maternal mortality, morbidity & experience				
Intervention 4: Implement maternal mental health services with a focus on access by ethnicity and deprivation				
Intervention 5: Ensure personalised care and support plans are available to everyone	% of women attending the booking appointment who are from ethnic minority groups Ethnicity Data Quality	Regional Measures Report		
Intervention 6: Ensure the MNVP's in your LMNS reflect the ethnic diversity of the local population, in line with NICE QS167	% of parent members of the MNVP who are from ethnic minority groups	Local Data		

Priority/ Intervention	Process Indicators	Source	Outcome Indicators	Source
4c: Action on perinatal mortality and morbidity				
Intervention 1: implement targeted and enhanced continuity of carer, as set out in the NHS Long Term Plan. This means that, as continuity of carer is rolled out to most women, women from Black, Asian and Mixed ethnic groups and women living in deprived areas are prioritised, with 75% of women in these groups receiving continuity of carer by 2024. It also means ensuring that additional midwifery time is available to support women from the most deprived areas.	Placement on a continuity of carer pathway – Black/Asian women Placement on a continuity of carer pathway – women living in the most deprived areas	Regional Measures Report		
Intervention 2: implement a smoke-free pregnancy pathway for mothers and their partners			Low birth weight (<2,500g for term births) Deliveries under 27 weeks Deliveries under 37 weeks	Regional Measures Report
Intervention 3: implement an LMS breastfeeding strategy and continuously improve breastfeeding rates for women living in the most deprived areas.	Baby Friendly accreditation	Regional Measures Report	Breast milk at first feed	Regional Measures Report

Priority/ Intervention	Process Indicators	Source	Outcome Indicators	Source
4d: Support for maternity & Neonatal Staff				
Intervention 1: roll out multidisciplinary training about cultural competence in maternity and neonatal services.	% of maternity and neonatal staff who attended training about cultural competence in the last two years	Local Data		
Intervention 2: when investigating serious incidents, consider the impact of culture, ethnicity and language.	% of maternity and neonatal Serious Incidents relating to patient care with a valid ethnic code % of Perinatal Mortality Review Tool (1) cases with a valid ethnic code	StEIS Data Local Data		
Intervention 3: implement the Workforce Race Equality Standard (WRES) in maternity and neonatal services.			WRES indicators 1 to 8 for midwives and nurses in maternity and neonatal services	WRES
	4e: Enablers			
Intervention 1: establish community hubs in the areas with the greatest maternal and perinatal health needs.				
Intervention 2: work with system partners and the VCSE sector to address the social determinants of health.				