Somerset Integrated Care System

Maternity Equity and Equality Strategy & Action Plan

2022 to 2027

Preface

This Maternity Equity and Equality Strategy and Action Plan demonstrates our commitment to giving every pregnant women/parent a pregnancy and birth where their needs are fulfilled. The outcomes of this strategy aims to ensure that babies and children in Somerset have the best possible start in life, by ensuring the care we provide during pregnancy and childbirth is safe, compassionate and personalised.

This strategy has been co-produced with partners across Somerset, including Maternity Voices Partnership, Somerset Diverse Communities, Public Health Nurses, Health Visiting, Equality & Diversity Leads, Public Health and Maternity Services. During our journey in producing this strategy, we have listened to women/ birthing people and their families.

In this Maternity Equity and Equality Strategy and Action Plan, we have set out how we as partner organisations in Somerset will work together to give all babies, no matter where they live, the best start in life. We know that for some of our communities there are health inequalities, in the access to, the experience of and in the outcomes from maternity care. We also know that these have been compounded by the pandemic and are likely to be impacted further by the worsening economic issues faced by many. As set out in this strategy addressing these health inequalities is a priority for us in Somerset and we will do this by working closely with the communities most affected.

I welcome the recommendations of this strategy, all of which are achievable for us as a health and care system.

Shelagh Meldrum
Chief Nursing Officer
Senior Responsible Officer for Maternity and Neonatal Services
NHS Somerset Integrated Care Board

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1. OUR AMBITION- MATERNITY VOICES PARTNERSHIP

Somerset Maternity Voices Partnership (MVP) is an independent organisation working alongside NHS Maternity and Neonatal services to develop and improve care. We gather feedback from the public and professionals and share this information anonymously at our Local Maternity and Neonatal System (LMNS) board meetings.

Somerset MVP chooses to function and operate in a very informal way in order to ensure everyone from our community feels comfortable and confident to join our conversations, contribute to meetings and support us to coproduce maternity and neonatal services.

The MVP have worked hard over the past 3 years to educate ourselves on racism, bias, cultural awareness, and inclusion. Whilst we have learnt so much, we still have a long way to go. We believe that our own learning and relationship building with underserved communities is integral to ensure we carry out true and meaningful engagement with community groups that have previously felt ignored. We strongly believe that people have not been included and listened to in a way that has been effective to make much needed changes.

We continually remind people to consider the needs of everyone and we strongly advocate for the changes and education that are needed in order to create equity and equality within healthcare and society.

The MVP service user voice committee meets regularly both face to face and online. We use WhatsApp for group communications, and this helps us to effectively coproduce work. A WhatsApp group allows us to have input from several voices in an easily accessible, flexible way without being too structured and formal, it also allows people to get involved at a time that fits around their commitments and life. Some of our members find it useful to use the voice notes rather than type. So far, we have found that all those who want to join the committee use WhatsApp, we would absolutely offer other ways to be involved if this is ever not the case.

Our MVP is functioning well, with good membership numbers and a very wide range of diversity and demographic. We do not take minutes and notes during our service user meetings, as we believe this can be a barrier to inclusion and increasing diversity for several

reasons. On the same basis, we do not ask our members for their ethnicity, gender identity, sexuality, postcode or to identify as living in an area of deprivation. We feel that our welcoming informal approach allows anonymity for those who wish to share their feedback, experiences, and ideas. By doing this we have built trusting relationships with our reps and the community of Somerset.

We strive to always share information in an accessible and easy to read format, in plain language, to ensure that everyone can understand it. We always look to include underrepresented people in our posters, leaflets, and public information.

We gently nudge our colleagues within the services to remember everyone and use inclusive and basic language in all they do, as well as advocating for a personal approach to care, to ensure everyone is treated and cared for in a way that is right for them.

We see people for who they are and we listen to them so we can find out what matters to them and how we can support them to help us. We feel this is the right method in order to prioritise and include people living in areas classed as 'areas of high deprivation', ethnic minority families and our whole community in Somerset.

Our current SUV (service user voice) committee has 30 members

Donna Butland (Chair)

Laura Perry (Vice Chair)

28 other members

2 Men/Dads and partners Reps

28 Women/people

Some of our members have chosen to share with us how they identify or who they represent, this includes.

- 3 people who represent ethnic minority people and communities
- 4 people who represent LGBTQ+
- 10 people with Maternal/Perinatal mental health and/or bereavement lived experience
- 3 people with experience of a Neonatal Journey
- 5 people who are neurodiverse (Autism, dyslexia, ADHD attention-deficit hyperactivity disorder, bipolar and OCD obsessive-compulsive disorder)

We hold various groups, meetings, and events where we support and listen to people about their maternity and neonatal experiences.

Here are some of our regular events which feed into our work:

- Dads breakfast Club
- Bump to Baby Care & Share Group
- Multicultural Maternity Voices
- Neonatal Voices
- LGBTQ+ focus groups

We welcome anyone who wishes to join our MVP!

You can find out more about us via our social media pages and website www.evolvingcommunities.co.uk/somerset-mvp or you can contact us via our email somersetmvp@evolvingcommunities.co.uk

Donna Butland

Independent Chair of Somerset Maternity Voices Partnership

OUR AMBITION - LOCAL MATERNITY AND NEONATAL SYSTEM

Somerset's Integrated Care System (ICS) footprint covers the county boundaries of Somerset with one Integrated Care Board (ICB), one Local Authority, two maternity and neonatal providers (Somerset NHS Foundation Trust and Yeovil District Hospital) and one mental health and community provider which is part of Somerset NHS Foundation Trust. Somerset women/people may also use services across the county borders into Bath and Dorset.

Somerset Local Maternity and Neonatal system (LMNS) has detailed data for the women/people that are looked after by our two Somerset trusts, so the detailed information provided in the supporting Somerset Equity Analysis is based mainly on their data. Women/people that go out of county are included in the analysis for the relevant LMNS for the NHS Trust responsible for their care.

Somerset's LMNS is part of the ICS and was set up in response to the report of the National Maternity Review, 'Better Births', published in 2016. The publication set out a vision for improvement in maternity services to ensure that women and babies receive excellent care that was safe and personalised, delivered by staff who provide woman/people centred care, in cultures which promote innovation and continuous learning across organisational and professional boundaries. The LMNS is system wide and includes maternity services, neonatal services, health visiting, perinatal mental health services, general practice, public health, Maternity Voices Partnership, and the voluntary and community sector.

The publication of the NHS Long Term Plan in January 2019 built on the recommendations of Better Births. As a result of this, we developed a 5 year strategic Local Maternity and Neonatal System plan for 2019-24 based on an analysis of need and in conjunction with clinicians, system partners, women/people and their families, and our Maternity Voices Partnership. It focuses on meeting the national Long Term Plan ambitions and local needs, including improving safety; postnatal and neonatal care, equity, diversity and inclusion; perinatal and infant mental health, prevention, personalised care, and improving the maternity experience.

To meet the aims of NHS England Equity and Equality Guidance in September 2021 we established an active working group of key stakeholders to develop a Maternity Equity and Equality Plan for those in Somerset experiencing the poorest outcomes in maternity. This group includes members from a range of organisations including, maternity, Health Visiting, Public Health and users of maternity services.

2. PARENT STORY

During the Covid pandemic the poorer health outcomes for people from a black and Ethnic Minority heritage became more apparent than ever before. This highlighted in general, and particularly in maternity services, that black and Ethnic Minority pregnant people and those from areas of deprivation are at a higher risk of maternal death and their babies of stillbirth and neonatal death. Improvements have been made to help address this. To make true meaningful change, we need to understand the maternity experience and where the differences in care can be found.

This personal account shared by a Somerset parent helps us to understand how services felt to a non-white woman:

It took many years after the birth of my third child to internalise that the events that transpired that day could actually have been due to the implicit bias of healthcare professionals because I am an Asian, Muslim woman. As a general rule, I always try to attribute external influences to explain people's behaviours rather than internal prejudices that may affect their actions. On this occasion, however I found it difficult to find such a justification.

Somerset has always been my home. I've never known anything different- Somerset is where I feel I belong. I also recognise that some people's perceptions of me is that I have no right to call this place home. You see to many I am viewed as someone who is oppressed by men because of my faith and someone who doesn't share the common values that unite us all. On the contrary, I am an advocate of social justice, a social worker, a community enabler, just trying my best to give the voiceless in our society, a voice around the table where decisions are being made about them. My birth experience taught me that when someone is at their most vulnerable, when those who are supposed to be caring for you choose not to listen, then even someone who stands up for the rights of others, can feel completely disempowered and voiceless themselves.

The labour was long and arduous. This being my third baby, I thought it may have been easier, but it just wasn't. My son was born, he was healthy, beautiful and I had survived. Yet all I remember of that day is not the first look at my baby or the first touch of his skin on mine, it was being ordered by the midwife to take a bath. It felt like I was in a Carry-On movie with the matron calling the shots. There was no choice. I tried to tell her that I was feeling dizzy and faint as I lay in bed. You would have thought the fact that I didn't want to even see my baby as I was feeling so wretched would have sounded alarm bells. Alas no, so I relented. What choice did I have? The professionals obviously knew what was best for me I assumed. As I entered the miniscule bathroom, I blacked out, narrowly missing the sink and awoke 4

to find myself lying in my own vomit. The first thing that came into my mind? 'I told you I wasn't lying, see I'm telling the truth, I really was feeling quite dreadful'. Surprise-surprise, no bath was demanded of me after this incident. Instead, I was whisked away to a dark, empty ward. No apology for not listening, no concern about how I was feeling, just a need to clear the room as soon as possible. There I lay. I could hear people laughing and chatting in the near-by staffroom, yet I dared not ring the bell, even though the pangs of hunger were becoming quite unbearable.

This was me at my most vulnerable. All the resilience and assertiveness I had developed over the years, seemed to have dissipated now. My baby was restless in the cot beside me, needing to be held and fed. I felt I physically couldn't lift my head, so I just tapped on the clear plastic of the cot that divided us, hoping this would soothe him for a while. Eventually a healthcare assistant walked past my derelict ward and I managed to catch her attention. She helped me sit on the edge of the bed and I scurried to the bathroom. I asked her to wait outside just in case I collapsed again. As bad luck would have it, I did collapse again but this time I managed to pull the red cord. I could hear the hustle, bustle around me as people described how I had gone completely pale and questioned what on earth could be wrong with me. Finally, I thought, some recognition of how ill I was feeling. I was still busy saying my prayers as I thought these were my last breaths, when it was decided that I should be taken back up to the labour ward and I was placed on a bed. I still remember the feeling of comfort in that bed and a thought crossed my mind- finally they will look after me now. It's all a bit hazy but it took about two days to get the results of the blood test to check my iron levels. It was 3.9. I was mobile at that point, but my iron levels were so low that I was ushered back into my bed just case I dropped my baby. I was given a blood transfusion and I started to feel half human again.

On reflection, there are many issues and questions that arise from my experience. The most pertinent for me is why wasn't I listened to? Did my ethnicity and faith play a role in the way I was treated? Muslim women, especially one who wears a hijab, are perceived to be submissive and docile. Did this unconscious bias play a role in the way I was being talked at instead of being talked to? Maybe I was left alone for so long because the perception is that the nature of Muslim women is one of passivity and therefore would not cause a fuss? I may never know the answer to these questions, but the fact remains that the negative experiences of that day will always haunt me.

3. OVERVIEW AND SUMMARY

Every parent and their baby/babies in Somerset should have the opportunity to live a full and healthy life. Fit for my future[1] is our joint health and care strategy for Somerset which sets out how we will ensure people are:

- Living healthier lives and feeling able to look after themselves
- Reducing inequalities so everyone gets support when they need it
- Giving children a better start in life
- Building on strong, connected communities where people support each other
- Recognising the strong links between mental and physical health
- Joining up health and care services in the community with the person at the centre

Somersets Improving Lives Strategy [2] sets out how we as a health and care partnership work together to improve the lives of our people. Our vision over the next ten years is to work together as a partnership to create:

- A thriving and productive Somerset that is ambitious, confident and focused on improving people's lives
- A county of resilient, well-connected and safe and strong communities working to reduce a variety of health inequalities
- A county infrastructure that supports affordable housing, economic prosperity and sustainable public services
- A county and environment where all partners, private and voluntary sector, focus on improving the health and wellbeing of all our communities

Our Somerset Approach

Our principles to improve the lives of pregnant people, parents, their babies and families/support network who live and work in Somerset are:

Equity: Provision of support and services should be proportional to need and targeted to the areas, groups and individuals that need them the most.

Accessibility: Services should be accessible to all, with factors including geography, opening hours, and physical access being considered.

Integration: Where the integration of services provides an easier system and better outcomes for people within the same overall cost, all relevant organisations should work together to maximise the local benefits.

Effectiveness: Activities and services should be evidence-based and provide value for money.

Sustainability: The work contributing to this strategy should be developed and delivered with due regard to the environmental, economic and social dimensions of sustainability.

Diversity: Activities and services should have due regard to the specific needs of protected groups and foster good relations between different people when carrying out their duties

Maternity care provides a unique window of opportunity to address some of the factors that perpetuate health and social inequalities, to make improvements in population health. This can be achieved through:

- Early identification and involvement in partnership with cases of clinical or social concerns
- Promotion of positive health behaviour change
- Provision of the information, care and support necessary for recovery from birth
- Parenting advice and family support

This maternity Equity and Equality Strategy and Action Plan sets out how every pregnant person accessing our maternity care should have a fair and just opportunity to access all information in the appropriate format, have a healthy pregnancy, and a healthy baby. Where you live, what race/religion you are, what your living circumstances are should not affect how you are treated or access care. The aim is for a safe, personalised, physically and mentally healthy pregnancy with a safe birth, healthy parent, and baby.

A personalised approach

Developing a personalised approach and care plan is central to ensuring that all parents receive the best and safest care possible. Personalisation and choice in maternity care is one of our key priorities within this strategy.

Taking a personalised approach means listening to all pregnant people within Somerset, understanding what they want and need, where they have genuine choice, informed by unbiased support and information. As an Integrated Care System (ICS), we support the national ambition, set out by Better Births [3] of reducing the rates of maternal and neonatal deaths, stillbirths, and brain injuries that occur during or soon after birth by 50% by 2025. We know that taking a personalised approach will help us to do this.

A quality improvement approach

Finally, within Somerset, we take a quality improvement approach at every opportunity to improve the safety and outcomes of maternal and neonatal care by reducing unnecessary variation and provide a high-quality healthcare experience for all parents, babies and families/support networks across maternity and neonatal care.

4. OUR SOMERSET POPULATION

An estimated 571,600 people live in Somerset (2021). Our population has risen by an average of 4,000 people per year over the last 5 years.

We know that 48% of our population live in a rural area compared to England at 18% (Census 2011). Please note, the full data set for the 2021 Census has not yet been fully published.

17.6% of our current population are children (0 to 15 years) with 5,224 live births in Somerset in 2018.

Of our Somerset residents 6% (31,761) were born outside the UK (Census 2011). Apart from the UK, the most common country of birth was Poland. In January 2020, 539 traveller caravans were counted in Somerset.

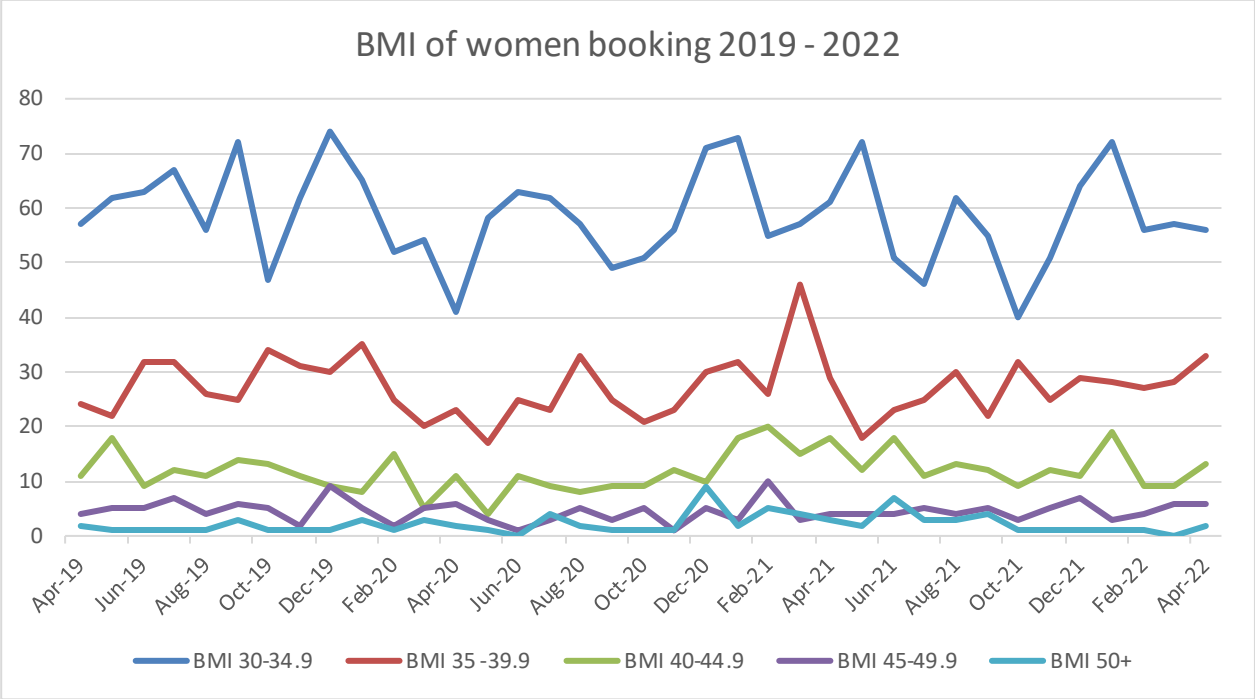
5. PREVENTION

Weight Management

Obesity is defined as a Body Mass Index (BMI) of 30 kg/m2 or more at the first antenatal consultation. The National Institute for Health and Care Excellence (NICE) guidance on the management of obesity and behaviour change[4], and the Foresight Tackling Obesities: Future Choices –Project Report [5], identify pregnancy as a critical period to address obesity in a woman/pregnant person's life course and to initiate behaviour change. However, caution is required to avoid compromising fetal growth.

Obesity is associated with adverse pregnancy outcomes such as miscarriage, pre-eclampsia and gestational diabetes. As the BMI of the woman/pregnant person increases, the likelihood of Lower Segment Caesarean Section (LSCS) as an emergency procedure becomes greater and has been shown to increase the risk of having a life-threatening event such as haemorrhage and sepsis. Obesity also has potentially adverse outcomes for babies, including an increased risk of macrosomia and associated birth difficulties, congenital anomalies, stillbirths and an increased risk of obesity in later life.[6]

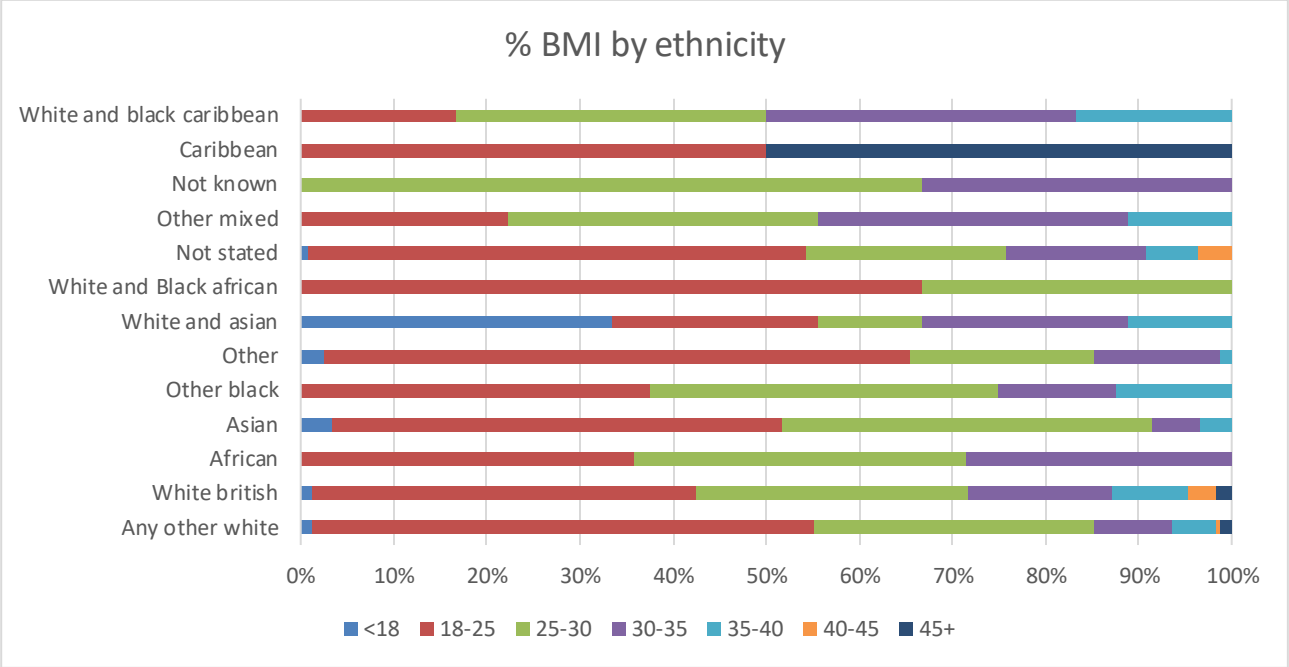
BMI rates of Somerset mothers at time of booking April 2019 – March 2022



Distribution of women in Somerset with BMI of >30 at time of booking April 2018 – March 2019

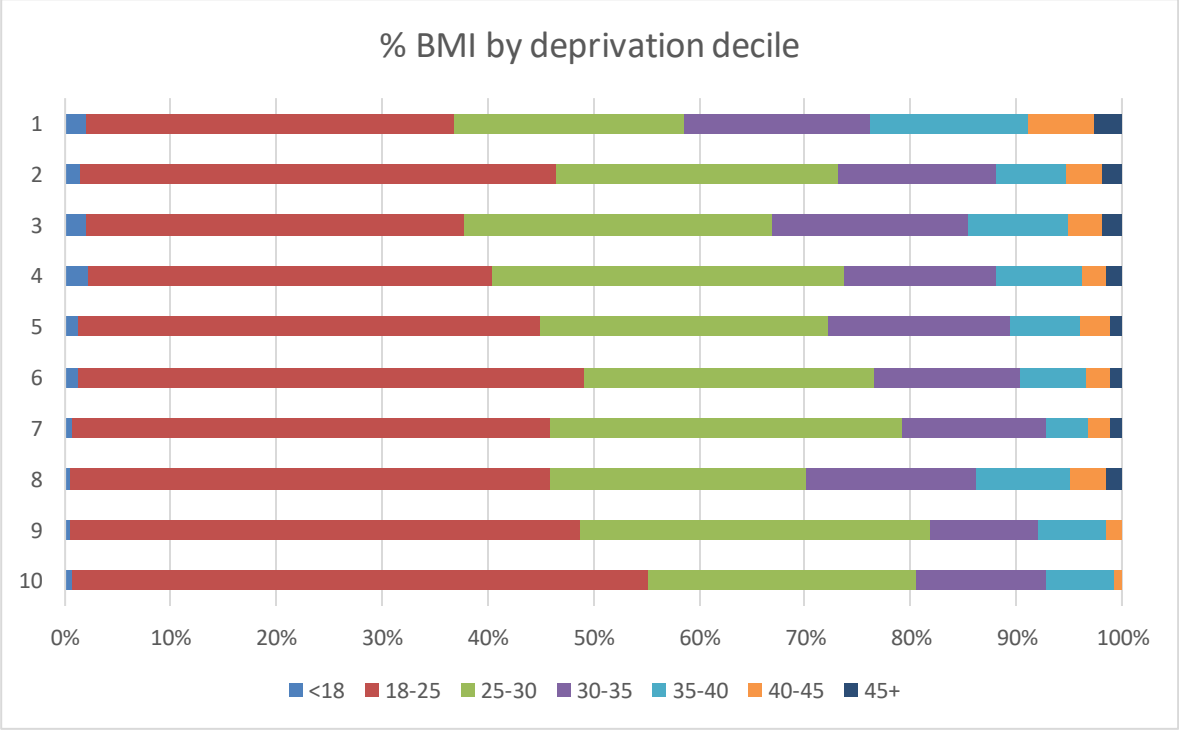
BMI	Taunton Deane	West Somerset	South Somerset	Sedgemoor	Mendip	Somerset /'/Total	OOA
<30	918	178	295	753	246	2390	342
	73.90%	73.80%	64.50%	69.20%	72.70%	71%	74.50%
30-34.9	156	41	37	185	37	491	48
	12.50%	17.00%	8.00%	17.00%	10.90%	14.60%	10.40%
35-39.9	82	12	18	57	18	195	33
	6.60%	4.90%	3.90%	5.20%	5.30%	5.81%	7.10%
40-44.9	26	4	8	29	8	79	10
	2.00%	1.80%	1.70%	2.66%	2.30%	2.35%	2.10%
45-49.9	8	1	4	14	4	30	3
	0.64%	0.41%	0.87%	1.28%	1.10%	0.89%	0.65%
>50	7	0	2	5	2	20	1
	0.56%	0%	0.43%	0.45%	0.59%	0.59%	0.21%
Total Bookings	1242	241	457	1087	338	3356	459

Percentage of BMI at booking range by ethnicity (Trust data 2020/21)



There is an interesting range when looking at BMI by ethnicity, however the very low number of some ethnicities needs to be considered as this may give an inaccurate picture, for example, 50% of Caribbean women had a BMI of greater than 45. This figure is based on a very small number so may not be representative of Caribbean women more widely.

Percentage of BMI at booking range by deprivation decile (Trust data 2020/21)



A clear link can be seen between high maternal BMI and deprivation. It is also worth considering the higher numbers of women in the lower deciles with a low BMI as well as the women beginning their pregnancy with a high BMI.

Women/pregnant people who are overweight or obese have increased risk of complications during pregnancy and birth including diabetes, thromboembolism, miscarriage, and maternal death. Babies born to obese women/pregnant people have a higher risk of fetal death, stillbirth, congenital abnormality, shoulder dystocia, macrosomia, and subsequent obesity.

Actions – Prevention (Weight Management)

Increase knowledge and reduce misconceptions through training and education of the specific cultural, dietary, and physical activity needs of pregnant women/pregnant people, and will include:

- Signposting from the first antenatal opportunity to local support available for women/pregnant people
- Increase uptake to the current Healthy lifestyle service for pregnant people that is currently being developed with service user input from the MVP

Smoking in pregnancy

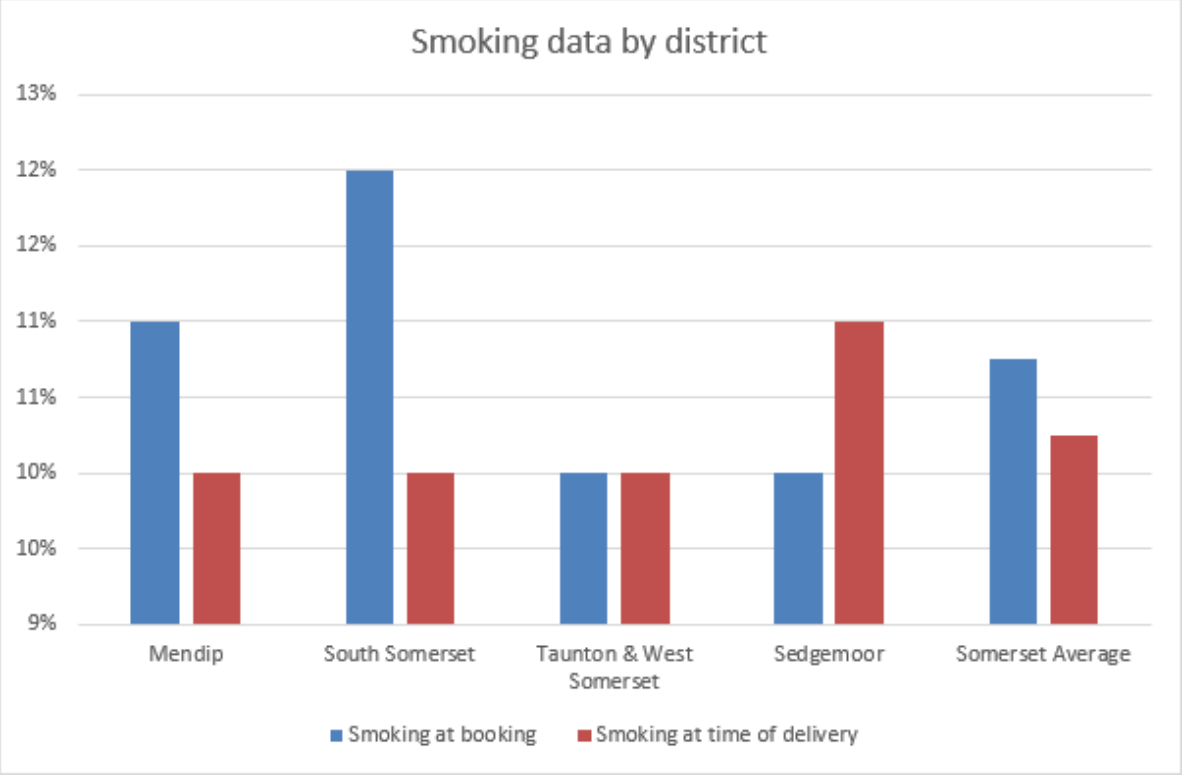
Since 2014, Somerset has adopted a multi-agency approach to reducing smoking in pregnancy with great success. The service has input from the ICS (former CCG), Trust midwifery services and the County Council 'Mums2Be Smokefree' stop smoking service. It is estimated that the programme has seen over 1,000 babies delivered to smokefree mums.

In Somerset, maternity services provide care for approximately 5,000 maternities each year, data from the maternity dashboard shows that in the year 2020-2021 Somerset Foundation Trust (SFT) booked 3,820 women/pregnant people/pregnant people for maternity care and Yeovil District (YDH) Hospital Trust 1,556. Of these women/pregnant people 670 (12.4%) were smokers at time of booking and 468 (10.9%) continued to smoke until their baby was born. Somerset are currently falling short of the national ambition to reduce the number of women/pregnant people smoking whilst pregnant to 6% or less.

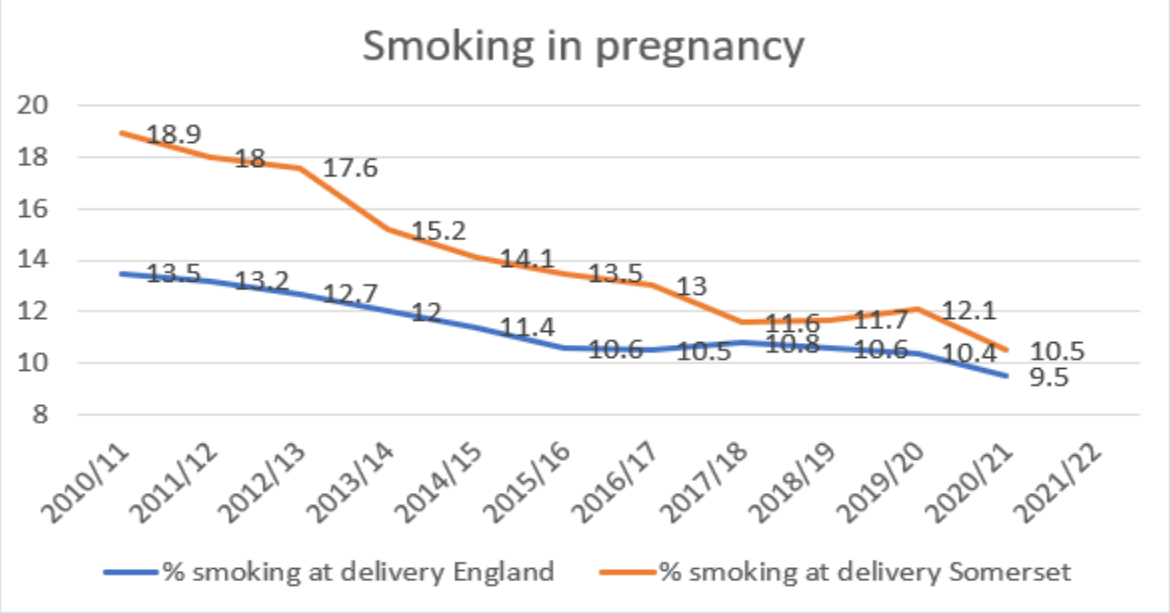
When a woman/pregnant person smokes during pregnancy, oxygen to the baby is restricted making the baby's heart work faster and exposing the baby to harmful toxins. As a result, smoking during pregnancy causes up to 2,200 premature births, 5,000 miscarriages and 300 perinatal deaths every year in the UK.[7] It is associated with a 47% increase in the odds of stillbirth[8].Women/pregnant people who smoke are less likely to breastfeed their baby and longer term are more likely to develop oral cancers, and coronary heart disease. Health risks for the baby include increased risk of congenital heart defects and asthma[9] .

Somerset reflects national trends which shows the Smoking At Time Of Delivery (SATOD) figures plateauing over recent years and, with a target of 4% by 2026, we have a challenge ahead. The steep decline from 2010 follows the 'Mums 2 Be Smoke Free' service being established. For the past four years we have seen this rate level off.

Smoking data by district (2020/2021)



Smoking in Pregnancy data from 2010/2022



Our current service provision sees maternity staff referring those who smoke during pregnancy (in addition to their partners, or family members) into a specialist service run by Somerset County Council. One of the challenges for the service is around sharing data with the Local Authority as we are unable to operate a truly 'opt out' model, meaning we are failing to capture a high number of women/pregnant people.

Cannabis is becoming more widely used and is usually smoked with tobacco, the risks to the baby are the same as smoking. There is limited research, however it is important to support women/pregnant people to discontinue smoking cannabis when pregnant in order to have the healthiest pregnancy.[10]

Smoking is not only the single most modifiable risk factor for improving pregnancy outcomes, but it is the largest driver of health inequalities in England. Smoking is more prevalent in populations with lower incomes, and the more disadvantaged someone is, the more likely they are to smoke and, consequently, to suffer long-term smoking related morbidities. The Womens Health Strategy also highlights smoking during pregnancy increases the risk of stillbirth, miscarriage and sudden infant death, while babies born to mothers who smoke are more likely to be born underdeveloped and in poor health and is working closely with NHS England on the long term plan commitment to embed stop smoking services within maternity services.[11]

Actions – Prevention (Smoking)

- To achieve the national ambition to reduce the number of women/pregnant people smoking whilst pregnant to 6% or less by end of 2025
- To develop a Somerset pathway for users of cannabis - preconception and during pregnancy by end of 2023
- To develop the skills of appropriate staff in the techniques of motivational interviewing/health coaching, so that effective care plans can be developed which support patients by April 2024
- Gaining further insights by working with communities understanding reasons for smoking and change ideas for smoking cessation by April 2024

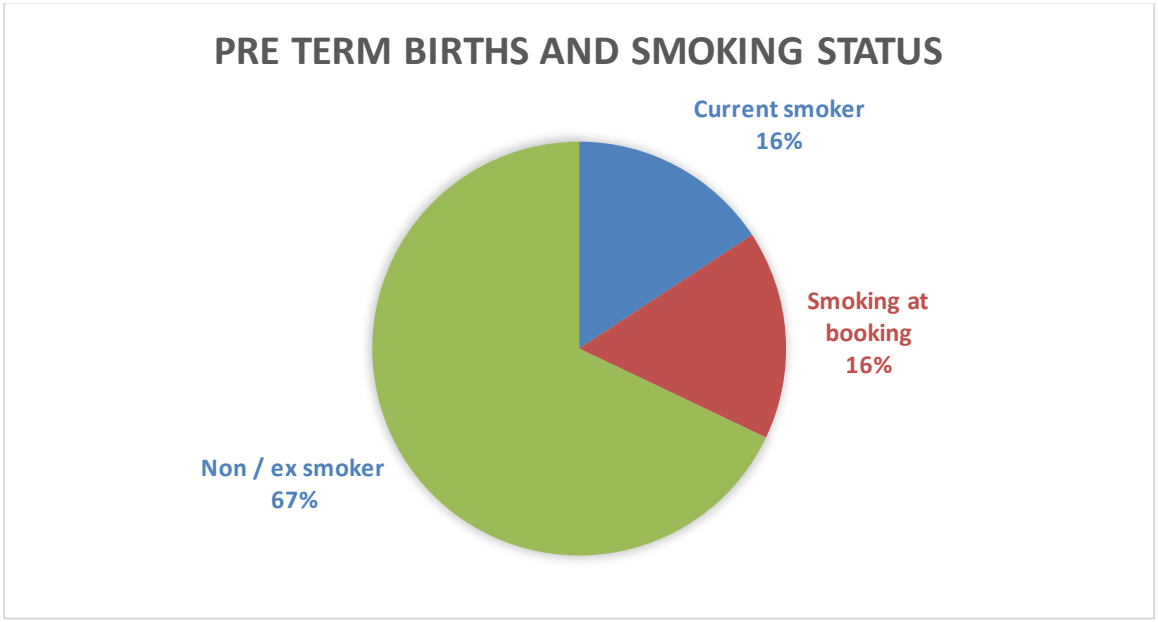
Pre-term Birth

Pre-term birth is defined as birth before 37 weeks gestation. Being born Pre-term is known to significantly affect a child's long term physical health, educational achievement, and social outcomes. Pre-term birth is the leading cause of mortality in children under the age of five[12]. The recent review published in to 'The contribution of Newborn health to Child Mortality' recommended improvements are required in perinatal care to reduce neonatally acquired conditions (e.g., reduction in preterm births, or brain injury sustained around the time of birth), or the impact of them (e.g., preterm brain injuries) are likely to have broad benefits to children, society, and healthcare institutions, across at least the first decade of life.[13]

A variety on health inequalities and lack of access to equitable maternity care are known contributary factors to the risk of preterm birth. Evidence shows that smoking increases the risk of preterm birth. Rates of smoking in pregnancy in the most deprived areas of England are nearly 6 times higher than in the least deprived areas.

Sixteen percent of all premature babies in Somerset were born to mothers that were recorded as a current smoker, a further 16% smoked at booking demonstrating a link between smoking and preterm births. This link is explored in the Saving Babies Lives v2 document which recommends taking action to reduce the numbers of women who smoke during pregnancy to reduce the risk of preterm birth.

Preterm births and smoking in Somerset



Factors that may increase risk for preterm labour and premature birth include:

- Ethnicity - Preterm labour and birth occur more often among certain racial and ethnic groups. The Office for National Statistics reports in 2020, Black Caribbean and any other black background ethnic groups had the highest percentage of preterm live births, at 10.6% and 10.2% respectively. While most ethnic groups had seen decreases in the percentage of preterm births, the black ethnic group was the only ethnic group to see an increase in the percentage of preterm births between 2019 and 2020, (8.5 % to 8.8% respectively).

- Age of the mother.
    - Women younger than age 18 are more likely to have a preterm delivery.
    - Women older than age 35 are also at risk of having preterm infants because they are more likely to have other conditions (such as high blood pressure and diabetes) that can cause complications requiring preterm delivery.

- Certain lifestyle and environmental factors, including:
    - Late or no health care during pregnancy
    - Smoking
    - Drinking alcohol
    - Using illegal drugs

The Department of Health national ambition is to reduce the national rate of pre-term births to 6% by 2025 through recognised programmes such as Saving Babies' Lives as part of the National Maternity Transformation Plan (Better Births). Preterm birth can lead to range of long-term health issues for the child and the link to the prevalence of special educational needs.

Action – Prevention (Preterm Births)

- Continue to work to support healthy women/people, healthy pregnancies and to keep within or below the preterm birth rate of 6% for Somerset by 2025. (Our preterm rate was 5.3% in 2021/22)
- Continue to provide peer support within neonatal units in Somerset
- Somerset Maternity Voices Partnership to provide a monthly support group for neonatal parents from September 2022 (see poster below)
- Make prevention of preterm birth a priority. Social initiatives to reduce or mitigate the social determinants (e.g., smoking, obesity, and deprivation) (see actions for weight management and smoking)
- Provide dedicated preterm birth clinics and implementation of evidence-based packages to predict and prevent preterm birth, as implemented through the Saving Babies' Lives Care Bundle by end of 2025
- As part of Better Births, to reduce the rate of maternal and neonatal deaths, stillbirths, and brain injuries that occur during or soon after birth by 50% by 2027

Email: Somersetmvp@evolvingcommunities.co.uk or WhatsApp: 07796951047

Lactation

The World Health Organisation and UNICEF recommend: early initiation of breastfeeding within 1 hour of birth; exclusive breastfeeding for the first 6 months of life; and introduction of nutritionally-adequate and safe complementary (solid) foods at 6 months together with continued breastfeeding up to 2 years of age or beyond.

The UK has one of the lowest rates of breast/chest feeding in Europe. An analysis of global breast/chest feeding prevalence found that in the UK only 34% of babies are receiving some human milk at 6 months compared with 49% in the US and 71% in Norway. In the UK breast/chest feeding initiation is around 81% at birth, this falls by 6 to 8 weeks of age when 17% of mothers/parents are exclusively feeding in England.

The prevalence of breast/chest feeding is particularly low among very young mothers/parents and disadvantaged socio-economic groups, potentially widening existing health inequalities and contributing further to the cycle of deprivation. Data from the 2010 Infant Feeding Survey showed that 46% of mothers/parents in the most deprived areas were breast/chest feeding, compared with 65% in least deprived areas. The Infant feeding survey was last taken in 2010 but will recommence in spring 2023.

There are clear benefits to children being breastfed/ chestfed, with improved physical health outcomes, reducing infections, obesity, diabetes, allergies, sudden infant death (SIDS) and cancers. In a current cost of living crisis, children who are breastfed or chestfed are taken out of food poverty while being fed by their parent. A mother or parent who breastfeeds/ chestfeeds will also have improved mental and physical health outcomes, with reductions in risks of breast and ovarian cancers, diabetes, osteoporosis and coronary heart disease.

Hauck et al (2011) found that exclusive breastfeeding reduces SIDS risk by 73%. Vennemann et al (2009) found that any breastfeeding in the first 6 months reduces SIDS risk by 50%. There are approximately 300 cases of SIDS in the UK each year. Rates of exclusive breastfeeding are 23% at 6 weeks and 1% at 6 months. At 6 months, 34% of mothers are doing any breastfeeding. Conservatively, it can therefore be estimated that over 100 deaths from SIDS could be avoided in the UK with optimal breastfeeding (exclusive breastfeeding to 6 months).

Renfrew et al (2012) estimated 361 fewer cases of Necrotising Enterocolitis (NEC) if, 75% of babies were breastfeeding in neonatal units at discharge. NEC has a mortality rate of 40–60%. Therefore, 100% breastfeeding on discharge would lead to approximately 250 deaths avoided.

Breastfed/ chestfed babies have 15% fewer GP consultations during their first 6 months of life than those who receive formula (Jones MBE, 2020). The NHS and WHO recommend exclusive breastfeeding to 6 months, then alongside appropriate complimentary food until 2 years or beyond.

UNICEF (United Nations International Children's Emergency Fund) tells us even a moderate increase in breastfeeding/ chest feeding rates to 45% exclusive feeding for the first four

months, and if 75% of babies discharged from neonatal units were receiving human milk on discharge every year, there could be a conservative saving of over £17 million with 10,637 fewer GP consultations for gastrointestinal related infections, 22,248 fewer GP consultations for lower respiratory tract infections, 21,045 fewer acute otitis media related GP consultations and 361 fewer cases of NEC with a saving of £6m alone (UNICEF, 2012).

Parents on a low income are more likely to have a sick or premature baby, but also the least likely to breastfeed/ chestfeed. Improving rates among disadvantaged families helps to reduce health and social inequality, giving children a better start. (UNICEF; PHE, 2016)

Breast / chest feeding has a lower carbon footprint and supports the NHS strategy to reduce their net carbon footprint to zero by 2040 (NHSE, 2022). In the UK alone, carbon emission savings gained by supporting parents to breastfeed/ chestfeed would equate to taking between 50,000 and 77,500 cars off the road each year (Joffe *et al*, 2019).

It is possible to improve breast/chest feeding with the use of interventions to support parents in their homes and communities and through our health services. Support can be offered by professional or lay/peer supporters, or a combination of both , generally face-to-face support is more likely to succeed. Parents can also be supported to reach their feeding goals by the health care professionals they are supported by, NG194 reminds clinicians:

Healthcare professionals caring for women/pregnant people and babies in the postnatal period should know about:

- breast milk production
- signs of good attachment at the breast
- effective milk transfer
- how to encourage and support women with common breastfeeding problems
- appropriate resources for safe medicine use and prescribing for breastfeeding women.

This should not be limited to the puerperium (6 week postnatal period), but for the duration of any feeding journey, including parents who feed to natural term which may be beyond two years of age.

Our aim is for over 80% of babies to have initiation of breast / chest feeding within Somerset. Our year-to-date figure for 2022/23 is currently 83%.

Parent Impact Story

After working incredibly hard to breastfeed my baby, with difficulties including tongue tie, having to express, oversupply and taking several months for baby to be able to latch, I felt great achievement. However, when I needed support the most, instead of help, I found barriers, refusal to prescribe safe medications to treat a severe rash which then spread, became infected and needed more medication than if I had been treated with the one medication in the first place, with more appointments than necessary and a lot of distress. Then most recently I have been refused diagnostic investigation because I'm breastfeeding, turned away on the day after having tried to share information in both pre-op appointments and on the day. While some HCPs were kind and wanted to help, others were not prepared to help me and were uneducated on prescribing in breastfeeding. It was suggested that I go back for the investigation when I finish breastfeeding, that could be another 2 years' time - the World Health Organisation recommend breastfeeding until age two years and beyond, how serious could my condition become by then?

Our aim is for over 75% of babies to be breastfed on discharge from hospital within Somerset. Our year-to-date figure for 2022/23 is currently 76%.

Actions – Prevention (Lactation)

- To ensure over 80% of babies in Somerset have initiation of chest/breastfeeding within Somerset – ongoing
- To ensure over 75% of babies in Somerset are chest/breastfed on discharge from hospital – ongoing
- Development of an LMNS Feeding and Nutrition Strategy by April 2023
- Signpost parents to Somerset Positive About Breastfeeding, Breastfeeding & medicines and Infant feeding support in Somerset
- Signpost clinicians to Medicines in pregnancy, children and lactation - NHS Somerset formulary page.
- Achieve UNICEF GOLD Award as a Somerset Integrated Care System
- Embed the Maternity Equity and Equality Strategy and action plan into Our Black Lives Matter Pledge - NHS Somerset

Safe prescribing in pregnancy and lactation

Prioritisation of safety of medications in pregnancy and lactation has not been high. We know that approximately 81.2% of pregnancies are exposed to at least one medication. In Somerset in 2019 we had approximately 5,155 pregnancies which means over 4,000 pregnancies exposed to medication. In March 2018 we saw a strengthened regulatory position on the use of valproate in people and children of childbearing age needing a Pregnancy Prevention Programme in place while having treatment.

According to MBRRACE-UK 2019, 13% of maternal deaths in pregnancy and the immediate period after giving birth were attributed to epilepsy or stroke. There has been a huge focus on valproate nationally, but we see little else with regards to the safety of medications in pregnancy.

In September 2019, we saw some significant concern with regards to the use of ondansetron in severe pregnancy sickness, Hyperemesis Gravidarum. With a background risk of orofacial cleft of 11 in 10,000 pregnancies. The risk with the use of ondansetron rises only 3 cases per 10,000 pregnancies exposed to ondansetron in the first 12 weeks of pregnancy. ondansetron should STILL be considered as an option for patients with severe vomiting where first line treatments have failed.[14]

A current safe prescribing project being undertaken in Somerset aims at:

- Reducing the prescribing of medication to people with teratogenic potential without appropriate contraception and counselling in place
- GP and clinician education and support on safe prescribing
- Improved patient interactions and pregnancy planning for those on long term medication/ with long term conditions
- Improve informed consent
- Improve our formulary resources on safe prescribing in pregnancy
- Medicines in pregnancy, children and lactation
- Increase prescribing competency in lactation to support parents to reach their infant feeding goals
- Co-produced webinar sharing Breastfeeding and Safety of Prescribing in Lactation
- Pregnancy Poster campaign for the public to be shared in primary care, pharmacy and other suitable providers.

NHS Somerset utilises a Minor Ailment Scheme in community pharmacy. In 2021, our first pregnancy related Patient Group Directive (PGD) for the use of aspirin in pregnancy to reduce the risk of pre-eclampsia was introduced and the Medicines Management team are also developing a second community pharmacy PGD for folic acid 5mg for people at high risk of neural tube defects. Aspirin PGD patient information leaflet can be accessed: Shared Care and PGDs - NHS Somerset

Actions – Prevention (Safe Prescribing)

- Ensure medicines access to preventative treatments in pregnancy by end of 2023
- Prescribing of effective contraception compatible with breast/chest feeding by April 2024
- Education on planning a pregnancy with long term conditions with prescribed medications by April 2024
- Access to timely treatment with evidenced based recourses – ongoing
- Signpost to medicine in pregnancy somerset formulary page – ongoing
- Signpost to Lactation and medicines - NHS Somerset formulary page- ongoing

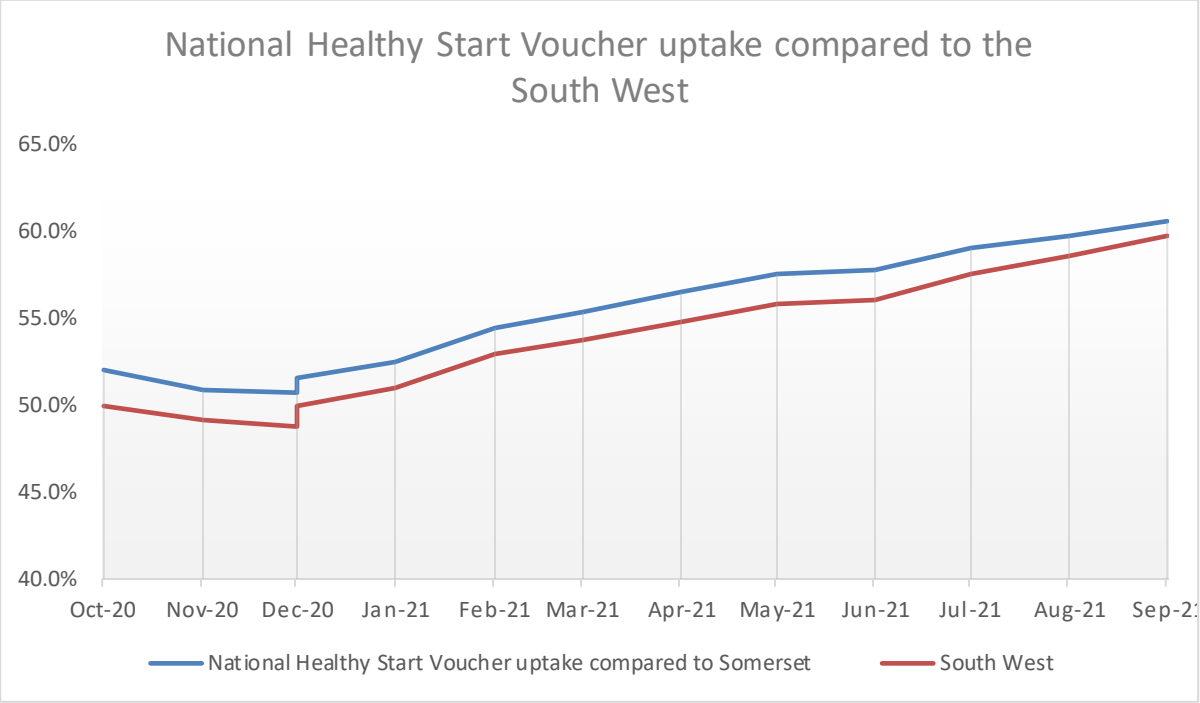
Healthy start Vitamins

Everyone needs vitamins to promote a healthy body. Vitamins are essential nutrients that the body needs in small amounts so that it can work properly. A balanced diet can achieve the levels of vitamins required, although there can be times when taking extra vitamins is recommended, such as when pregnant, a new parent or a small child.

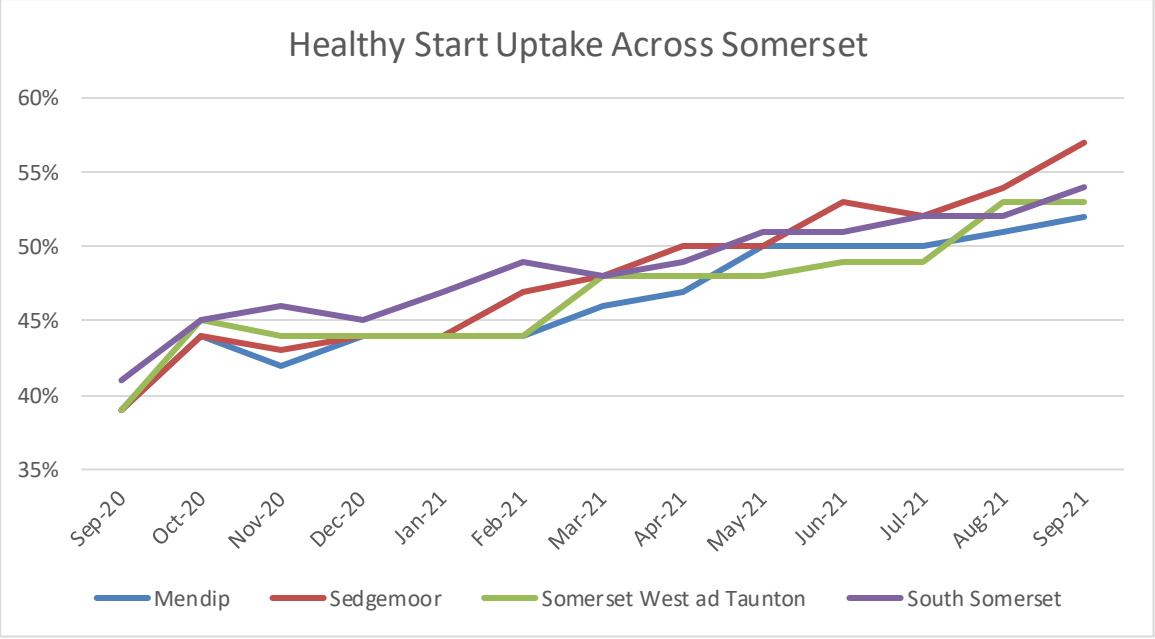
Healthy Start vitamins have been designed to include all vitamins promoted during pregnancy and while breastfeeding. These are available to buy across Somerset. There is a national scheme to provide the vitamins free of charge to eligible pregnant women.

Work has been ongoing to increase the uptake of Healthy Start vitamins in eligible pregnant women/people. Somerset is also supplying free of charge to all women/pregnant black and brown people, regardless of eligibility.

Healthy Start Voucher Uptake in Somerset vs South West

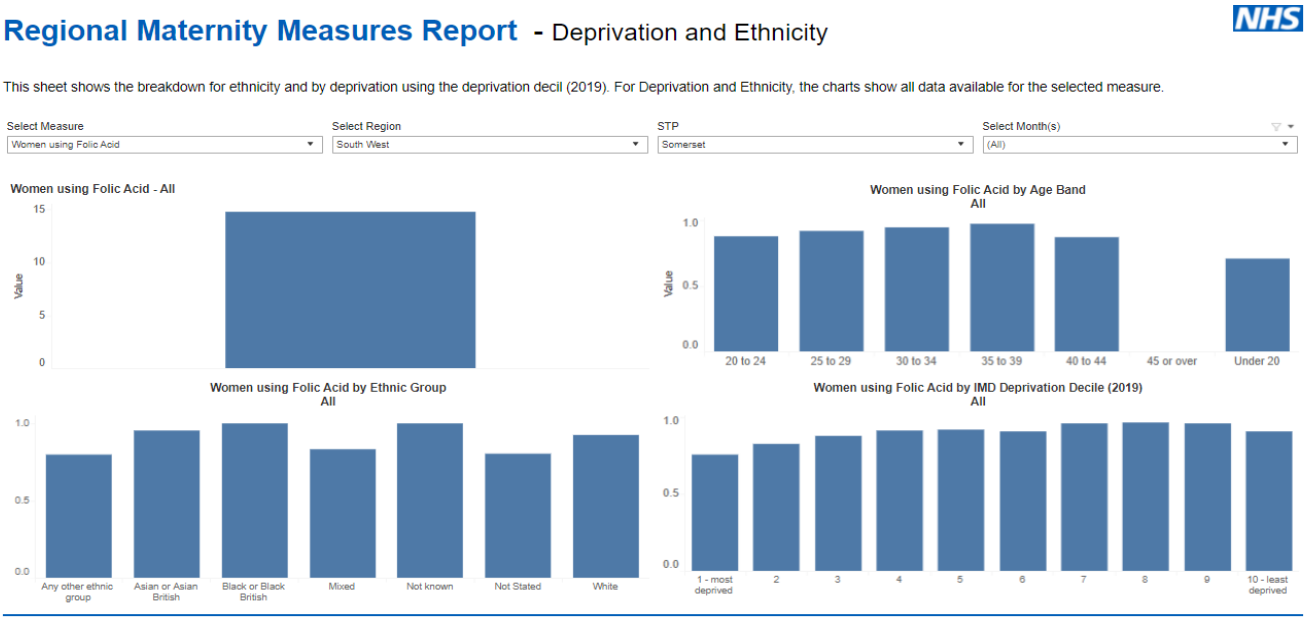


Healthy Start Uptake across Somerset by Locality



The data demonstrates a steady increase in uptake in Healthy Start since the four actions have been implemented.

Folic acid uptake by age, ethnicity, and deprivation for Somerset



Actions – Prevention (Healthy Start and Folic Acid)

- To continue to promote Healthy Start Vitamins and benchmark above the South West – ongoing
- To increase uptake of Folic Acid for those living in IMD 1 and 2 within Somerset by 2024
- To increase uptake and continuation of national scheme and use of healthy start vitamins and access to healthy foods

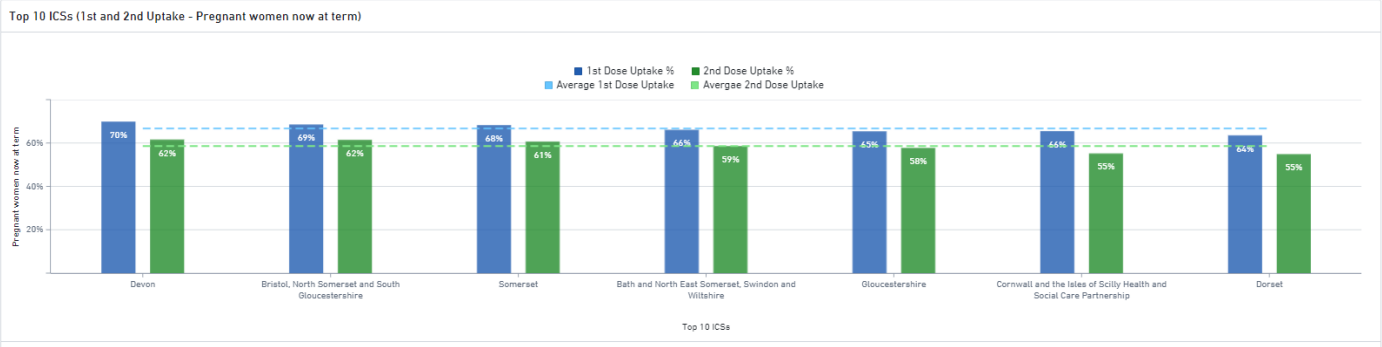
Vaccinations

On 16 December 2021, the Joint Committee on Vaccination and Immunisation (JCVI) announced that pregnant women/pregnant people are now considered a 'vulnerable' group within the COVID-19 vaccination programme, emphasising the urgency of them receiving COVID-19 vaccination and booster doses.

Vaccination is the best way to protect against the known risks of COVID-19 in pregnancy for both women/pregnant people and babies, including admission to intensive care and premature birth.

In January 2021, 68% of our pre-term population had received a 1st dose of COVID-19 vaccination and 61% a second dose. England vaccination uptake is 67% and 59% for 1st and 2nd dose respectively.

COVID-19 vaccination uptake by systems in the south west



The Somerset health and care system will continue to promote the COVID-19 vaccination for all women/pregnant people considering and in the early stages of pregnancy. Somerset has successfully implemented the four specific actions which will minimise the additional risk of COVID-19 for black and Minority Ethnic women/pregnant people and their babies. These consist of providing additional support, tailoring communications, recording ethnicity and improving nutrition, specifically Vitamin D.

There is good evidence that pregnant women have a higher chance of developing complications if they get influenza (flu), particularly in the later stages of pregnancy. One of the most common complications of flu is bronchitis, a chest infection that can become serious and develop into pneumonia. Having flu whilst pregnant could cause a preterm birth, low birthweight, and may even lead to stillbirth or death in the first week of life.[15] All pregnant women/people can access influenza immunisation from their GP practice or a community pharmacy and Maternity service providers.

Of concern is the rising number of babies with whooping cough, babies who are too young to start their vaccinations are at greatest risk. Expectant mothers/people can help protect their babies by getting themselves vaccinated against whooping cough from 16 weeks. The vaccine is sometimes offered after the mid-pregnancy scan around 18 to 20 weeks.[16] All pregnant women/people can access the whooping cough vaccination from their GP practice and in some instances from their Maternity service providers.

On the 4th July 2022 the Medicines & Healthcare products Regulatory Agency (MHPRA) alerted to an observed sustained rise in rates of respiratory syncytial virus (RSV) infection, acute trusts / health boards in England, Scotland and Wales are asked to immediately offer a programme of monthly doses of Palivizumab, administered as a intramuscular injection, for a period of up to 7 months to provide protection against respiratory syncytial virus (RSV) for at risk infants as defined in the green book. On that basis, the Somerset system has rolled out a programme for:

- Babies under six months of age at the onset of the RSV season

- Children under two years of age and requiring treatment for bronchopulmonary dysplasia within the previous six months
- Children under two years of age and with haemodynamically significant congenital heart disease
- Children born at 35 weeks or less of gestation and under six months of age at the onset of the RSV season

Recommendations – Prevention (Vaccinations)

- Continue to support vaccination programmes recommended during pregnancy, including working with Health Champions in areas with a lower uptake within Somerset – ongoing

- Established a working group to roll out programme of Palivizumab for RSV by 1st September 2022

Cardiovascular Disease

Women/pregnant people who are older, obese, smoke, have diabetes or a family history may be at greater risk of heart disease. The rate of maternal deaths due to cardiovascular disease is also increasing year-on-year and is highest amongst those aged 30 to 39 years of age. Cardiovascular disease is the leading cause of women/pregnant people's deaths during or after pregnancy in the UK and Ireland. There has been no reduction in the maternal mortality rate from heart disease in the UK for more than 15 years.

Cholesterol and triglyceride levels naturally rise during pregnancy as they're needed for the growth and development of the baby. Cholesterol is also needed to make the hormones oestrogen and progesterone which play a key role during pregnancy. Blood cholesterol tends to stay high for at least a month after giving birth. Triglycerides can also stay high for up to a month but might go back to normal sooner in parents who breast feed /chest feed.

Some women/people get swollen and sore gums, which may bleed, during pregnancy. Bleeding gums are caused by a build-up of plaque on the teeth. Hormonal changes during pregnancy can make your gums more vulnerable to plaque, leading to inflammation and bleeding. This is also called pregnancy gingivitis or gum disease.[17]

There is growing evidence of specific links between oral health and heart disease. Recent studies show that if a person has gum disease in a moderate or advanced stage, there is greater risk for heart disease and type 2 diabetes than someone with healthy gums. Oral health and heart disease are connected by the spread of bacteria and other germs from your mouth to other parts of the body through the blood stream. When these bacteria reach the heart, they can attach themselves to any damaged area and cause inflammation. This can result in illnesses such as endocarditis, an infection of the inner lining of the heart.

Other cardiovascular conditions such as atherosclerosis (clogged arteries) and stroke have also been linked to inflammation caused by oral bacteria. Patients with chronic gum conditions such as gingivitis or advanced periodontal disease have the highest risk for heart disease caused by poor oral health, particularly if it remains undiagnosed and unmanaged.[18]

Actions – Prevention (Cardiovascular Disease and Oral Health)

- Explore commissioning programme for oral health improvement – issue fluoride/tooth paste by April 2024 (please note ICBs will not be responsible for dentistry until April 2023)
- Increase awareness of Maternity exemption for dental care – ongoing
- Increase awareness that heart disease can and does affect young women/pregnant people, and that the additional strain that pregnancy places on the heart can reveal cardiac complications for the first time by end of 2023
- Cholesterol management in young women and people of childbearing age by end 2025

Mental Wellbeing

It is understood that women/pregnant people with previous mental health problems, complex lives, chronic disease and/or a traumatic birth are at an increased risk of perinatal mental health problems. In Somerset, we recognise that whilst being pregnant is often a very exciting time, for some people however this brings about feelings of anxiety or low mood. Up to 1 in 5 women/pregnant people need help with emotional and mental health problems during pregnancy, and we know that many people often suffer in silence. People who require additional support throughout their pregnancy may be referred to Somersets Perinatal Mental Health team. The team provides mental health assessments, pre-conception advice and treatment for pregnant women/people and those who have given birth within the last 12 months across Somerset.[19]

Safeguarding

Maternity services have a key role in in relation to the early identification of safeguarding concerns and the needs of expectant parents / care givers, this includes fully considering the significant role of fathers/partners and wider family members in supporting the pregnancy and care after birth.

For pregnant women/ people facing multiple adversity, changes in frequency or nature of presentations may reflect worsening mental state or the emergence of new complications (such as alcohol or substance misuse, domestic violence and potential safeguarding concerns), and should prompt renewed attempts at engagement, diagnosis and care co-ordination. Disengagement from maternal care should be regarded as a potential indicator of worsening mental state and / or a potential precursor to safeguarding concerns. All professionals involved in the woman/pregnant persons care should be informed of non-attendances and attempts of assertive follow-up to consider the need of safeguarding involvement.

Specialist midwives across Somerset's maternity services have come together to launch a new service for vulnerable people with additional needs during their pregnancy. Yeovil Hospital's Acorn team and Somerset NHS Foundation Trust's Juniper team have combined to form the 'Women Requiring Extra Nurturing Service' – also known as WREN. The team supports people who are struggling with issues relating to substance or alcohol abuse, domestic violence, have learning needs or are under the care of social services. It can provide support with various issues faced by people and their families, including finance, housing and additional health support. It also provides specialist care for young parents under the age of 19 throughout their pregnancy, as well as being a vital link to social services and perinatal mental health teams.[20]

The Somerset safeguarding children's partnership (SSCP) in partnership with relevant agencies, including maternity have developed clear procedures in relation to the pre-birth period and safeguarding unborn babies. This supports practitioners to work together with families to safeguard unborn babies and support expectant parents where vulnerability and risk factors are identified.

Safeguarding unborn babies is considered a key driver for improved early identification of needs and safeguarding concerns giving people "the right support in the right place at the right time". The Somerset Pre-birth Workbook and Effective support guidance sets out identification of needs / risks, how to respond to concerns for unborn babies, with an emphasis on clear and regular communication between professionals working with the mother, father and family.

The SSCP alongside relevant agencies remain committed to providing education, review, and training to support these tools and guidance in supporting safeguarding practice in Somerset for children.

Actions – Prevention (Safeguarding and Mental Wellbeing)

Increase knowledge and reduce misconceptions via training and education to all about the specific needs of pregnant women/pregnant people by end of 2023, and will include:

- Implicit Bias Training
- Cultural Competency Training
- Trauma Informed Approach
- Race and Diversity
- Intersectionality
- Violence Against Women/Pregnant People
- Domestic Violence

Public Health / Sexual Health / School Age Prevention

Most teenage pregnancies are unplanned and around half end in a termination. Evidence shows that teenagers who undergo a termination are likely to suffer shame, guilt, anxiety, depression and long-term emotional distress. School aged interventions to prevent unwanted pregnancies, could reduce the number of teenagers presenting for terminations and reducing associated life long mental ill health.

While for some young women/pregnant people having a child when young can represent a positive turning point in their lives, for many more teenagers bringing up a child is extremely difficult and often results in poor outcomes for both the teenage parent and the child, in terms of the baby's health, the person's emotional health and well-being and the likelihood of both the parent and child living in long-term poverty.

Under 18s conception rate across the south west

Under 18s conception rate / 1,000 New data 2019 — Crude rate - per 1,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	14,019	15.7	15.5	16.0
South West region	↓	1,091	12.8	12.0	13.6
Swindon	→	68	19.1	14.8	24.2
Torbay	→	37	18.8	13.2	25.9
Plymouth	→	65	17.2	13.3	21.9
North Somerset	→	55	15.9	12.0	20.7
Dorset	→	80	13.8	10.9	17.2
Cornwall	→	114	13.4*	11.1	16.1
Bournemouth, Christchurch and Poole	↓	72	12.8	10.0	16.2
Bristol	↓	79	12.7	10.0	15.8
Somerset	↓	110	12.4	10.2	15.0
Devon	↓	134	11.7	9.8	13.8
Gloucestershire	↓	115	10.9	9.0	13.1
Wiltshire	→	93	10.9	8.8	13.3
South Gloucestershire	→	42	9.7	7.0	13.2
Bath and North East Somerset	→	27	9.6	6.3	14.0
Isles of Scilly	–	-	*	-	-

In Somerset the development of the Enhanced Parenting Pathway (EPP) is currently led by Public Health Nursing Services and the aspiration is to design it in partnership with families and collaborate with key partner agencies such as Maternity and Children's Services. It will align with wider health and support services, and system wide strategic priorities, to provide a personalised support pathway to families identified through universal service provision.

Current evidence informs us that early intervention is important as disadvantage begins early in life with the effects being cumulative, lasting the life course and often effecting one generation to the next. The aim is to offer a clear, multi-professional and seamless pathway for families with additional needs, who are vulnerable to poorer outcomes during the critical period from pregnancy up to a child turning 2.5 years. "The days from conception to 2 years are a unique period for a baby that sets the foundations for lifelong emotional and physical wellbeing".[21]

Throughout the EPP all parents will be valued and included. The role of fathers and partners must be considered in every family, and the contribution that fathers and partners make to their child's health, development and wellbeing is hugely important and profoundly influences the health and wellbeing of both mother and child in positive and negative ways (Department of Health and Social Care, 2009)

Families will be supported through key Healthy Child Programme, Health Visiting and Midwifery contacts. In addition, group contacts provided by Health Visiting and partner agencies. The pathway aims to improve the experience of receiving parenting support and give every family the opportunity to be the best parents they can be, improving health, social and educational outcomes for them and their children. Families will be empowered to access targeted support to meet their needs, including, learning and development, parenting,

housing, mental health, substance misuse, stop smoking, relationship and parental conflict support, healthy weight and health improvement interventions, and oral health, and sexual health advice.

Actions – Prevention (Public Health / Sexual Health / School Age Prevention)

- Development of a co-produced Enhanced Parenting Pathway supporting young parents in South Somerset by April 2023
- Through development of Enhanced Parenting Pathway identify if under 20-year-olds would attend group sessions by April 2023
- Role of fathers and partners to be considered in every family, and the contribution that fathers and partners make to their child's health, development and wellbeing by end of 2023 (Please note this forms part of a quality improvement project funded by Safer Somerset Board)

6. EQUITABLE ACCESS TO MATERNITY AND NEONATAL SERVICES

We know that some communities in Somerset have poorer outcomes. The first step in looking at equity and addressing its barriers is to know our population. For example: have specific areas or populations in our area have significantly higher levels of poor outcomes?

NHSE's Equity and Equality Guidance for Local Maternity Systems sets out an ambition to improve equity in outcomes for all mothers/birthing people and babies, from black, Asian and mixed ethnicity groups and those living in the most deprived areas. It also highlights evidence that demonstrates race inequality for staff from ethnic minority backgrounds in the NHS. The Somerset Local Maternity and Neonatal System Equity Analysis, April 2022 is based on a preliminary analysis of data to determine health outcomes for women/pregnant people and babies in Somerset. The analysis will support our understanding and identification of those mothers and babies at greatest risk of poor health outcomes across the county. In addition, it has looked at our local workforce race equality staffing data. This information will be used to co-produce local interventions to improve equity for mothers/birthing people and babies and race equality for staff.

In maternity, there is a particular focus on women/pregnant people from black and other ethnic minorities and those living in the most deprived areas. These women/pregnant people often have a higher risk of stillbirth and maternal and neonatal death. These risks have been amplified by the Covid-19 pandemic where evidence shows worse outcomes for women/pregnant people living in these local communities.

We also know that single women/pregnant people and women/pregnant people from ethnic minority groups are more likely to access services late, have poorer outcomes and report less positive care experiences, while women/pregnant people with self-reported disabilities can experience poorer care in relation to communication, trust, respect and support and involvement in decision making about their care.

This strategy addresses the issues of equity in accessing maternity support and services and explores the groups and local communities who disproportionally have the poorest outcomes.

Deprivation

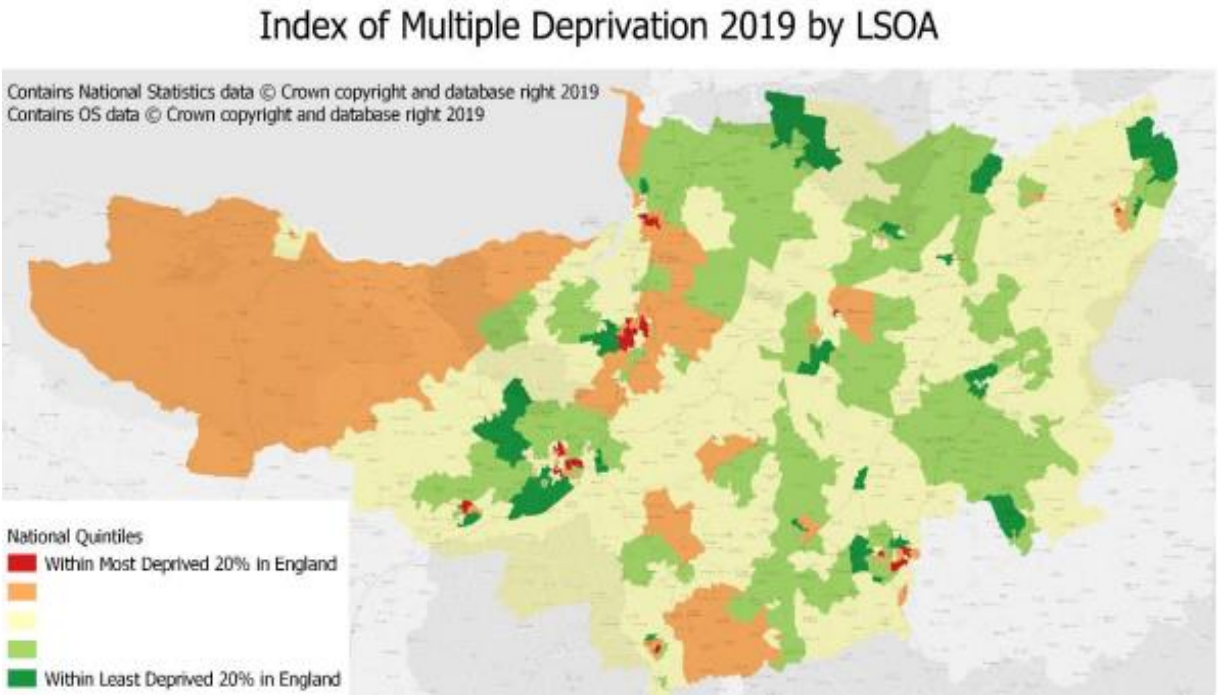
Somerset generally is better than the national average in terms of overall levels of deprivation.

Since 2015, there has been a slight shift towards greater deprivation in Somerset relative to the rest of England, particularly in relation to the quality of housing.

The number of 'highly deprived' neighbourhoods in Somerset (categorised as being within the 20% most deprived in England) increased to 29 in Index of Multiple Deprivation IMD 2019, up from 25 at the time of IMD 2015.

Around 47,000 Somerset residents live in a neighbourhood (LSOA) identified as one of the 20% most deprived in England.

The most deprived area of Somerset is the Highbridge, South West area of Sedgemoor.



Actions – Equitable Access (Deprivation)

Our priority over the next 12 months is to develop a Population Health Hub. The Population Health Hub will provide system leadership for Population Health Improvement, Population Health Management, Tackling Health Inequalities and Prevention.

It will deliver:

- System Leadership to inspire and achieve cultural change and practice within the workforce – aiming to achieve dispersed leadership over time
- A Virtual Centre of Excellence providing a source of specialist population health advice and support to the system, helping to understand, develop and use population health data and evidence
- Provision of support/training/guidance/challenge to individuals across the Somerset ICS

As part of this work, we will be able to begin to address the social determinants of health inequalities for those of childbearing age by April 2024

Transport

Somerset is a large rural county whereby 48% of our population live in a rural area (England: 18%) (Census 2011).

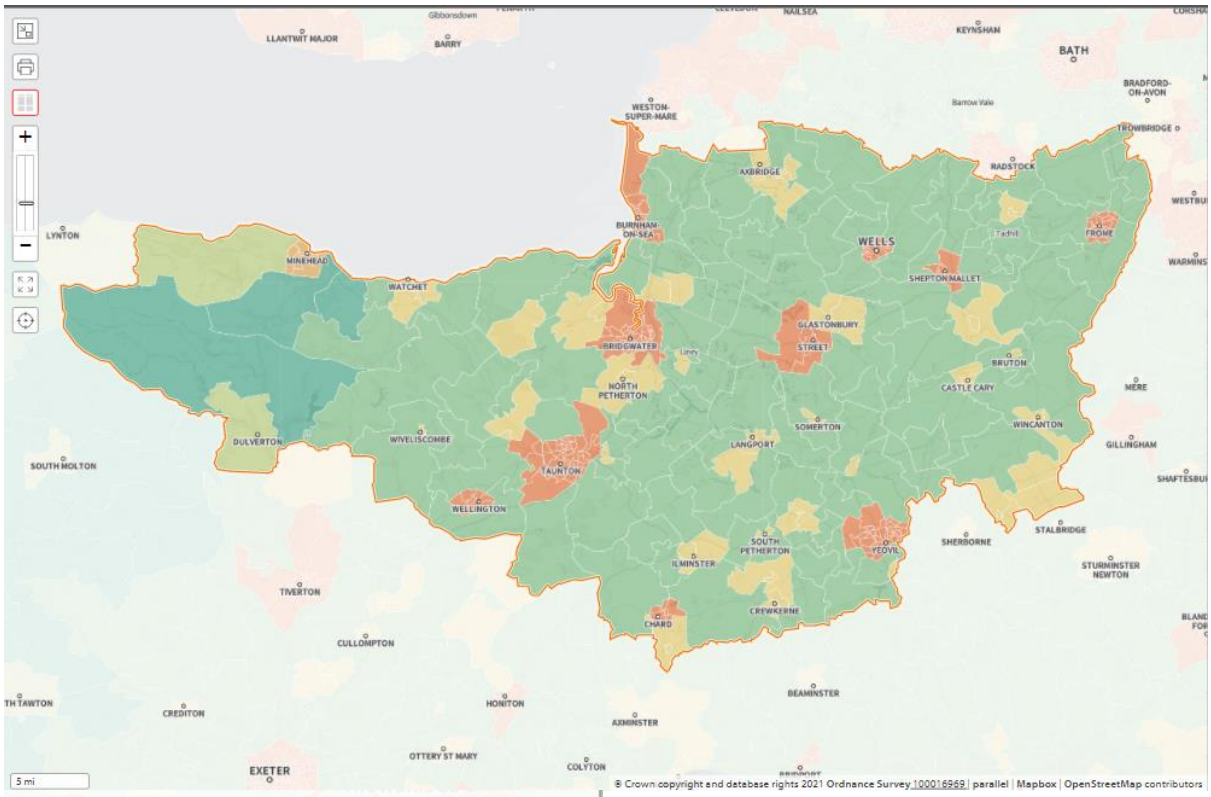
Households without access to a car or van can be at risk from isolation, including social isolation. This can also pose a risk when it comes to women/pregnant people being able to attend important appointments throughout their pregnancies. There have been examples in Somerset of pre-term babies coming to harm due to not being able to access transport in a timely way i.e. with reduced fetal movements.

When transport issues are identified as a barrier to accessing maternity, community and hospital midwives will source support via village agents, voluntary and community organisations or occasionally the ordering and payment of taxis.

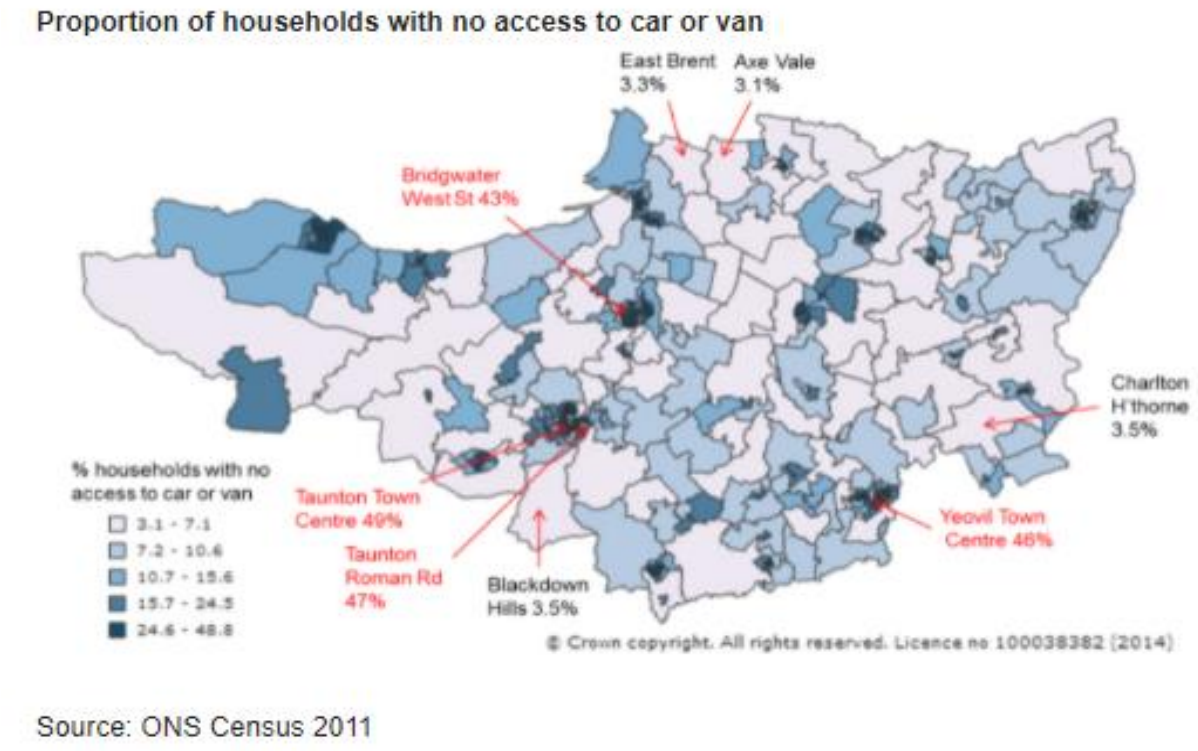
We know areas such as Exmoor and the town of Minehead have difficulties in accessing maternity services in Taunton. Due to difficulties in affordability, length of time taken to travel, we ask outpatient and scanning departments to be flexible regarding attendance at appointments, where possible.

Nurses and midwives arriving to the UK from across the globe are faced with the challenge of adapting to working in the NHS and adjusting to a new culture. In Somerset we look to support international staff when relocating and consider the impacts of transport for them moving to a large rural county.

Rural deprivation in Somerset



Access to transport in Somerset



Source: ONS Census 2011

Actions – Equitable Access (Transport)

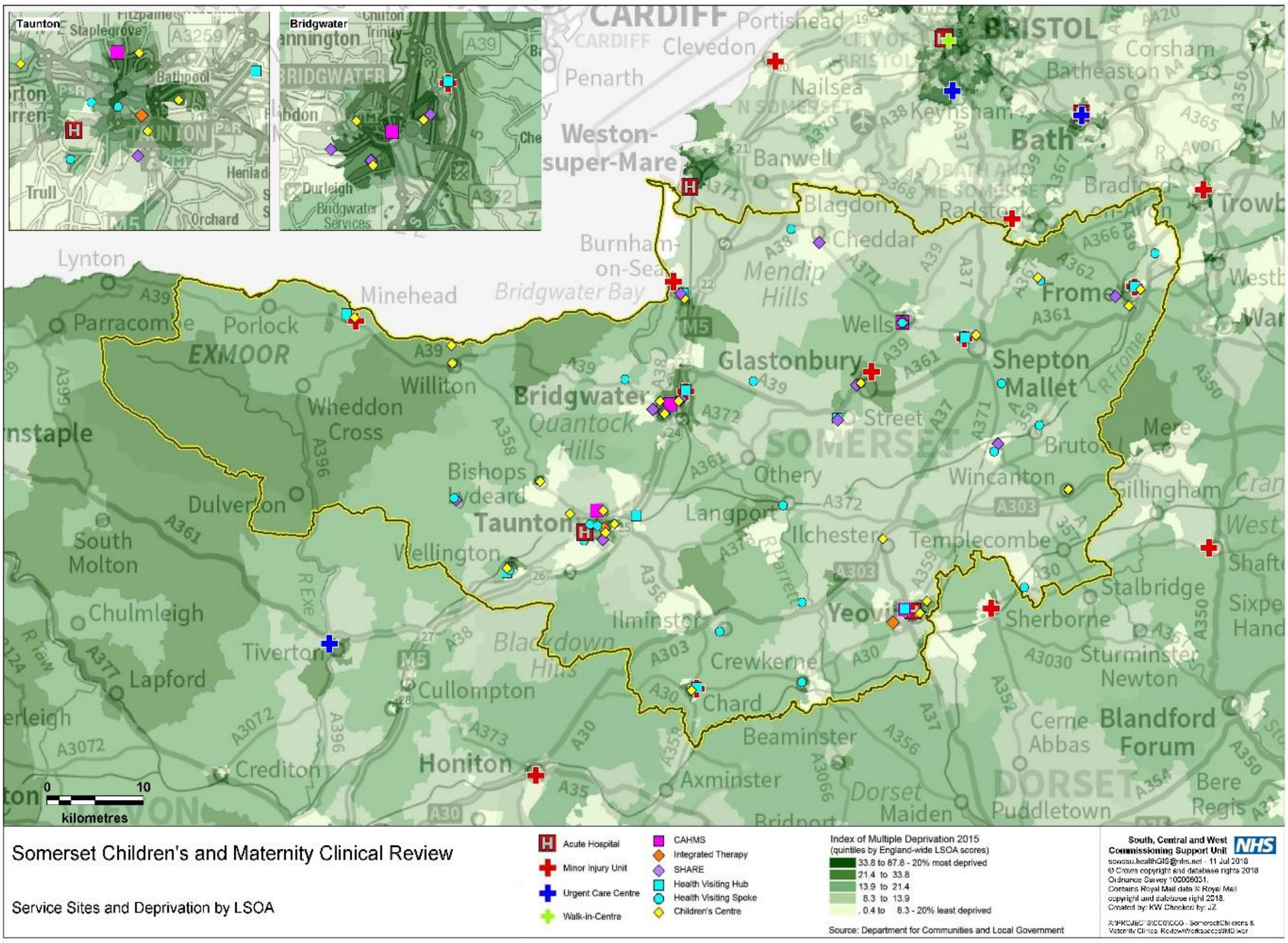
We will continue to support women/pregnant people with transport issues during pregnancy and the postnatal period, including those who cannot use public transport independently due to access, disability or health problems and/or have no reasonable access to private transport.

- Set up a charitable fund for maternity assisted transport in Somerset by end of 2024

Community assets for pregnant women/pregnant people and new mothers/parents

Aside from the usual pathways of support via primary care and public health services, there are several voluntary and charitable organisations supporting pregnant and new mothers. These include breast/chest feeding support groups, bereavement support and emotional health and wellbeing. In Somerset, directories of support groups are held by community support groups including Health connections in Mendip, Homestart in West Somerset and Spark Somerset which is county wide. We also have a rural communities group with village agents and talking cafes to offer support and signposting.

Somerset centres for maternity and children



Across Somerset, maternity services are currently utilising GP surgeries, Children's Centres and Community Hospitals to run their services, in addition to this some services are still operating remotely, such as antenatal education.

The Public Health Nursing team continue to run clinics out of the Children's Centres and make use of local facilities where these may not be running.

Actions – Equitable Access (Community Assets)

- Mapping of support groups since suspension of groups due to Covid by March 2023
- Gaining insights from local communities (identify barriers) by April 2023
- Working with community representation – ongoing

Protected Characteristics

Understanding gender diversity and diversity in sex characteristics enhances safe practice. Within this strategy, we present some of the considerations for healthcare professionals delivering care to transgender, non-binary and intersex (TNBI) individuals.

People are all different and have personal health and care needs. We want to ensure our health and care staff develop competent skills to recognise and support those needs. Some people experience social exclusion due to their sexual orientation, gender identity or physical variations in sex characteristics (VSC). This may put them at increased risk during their pathway including diagnostic imaging, nuclear medicine or radiotherapy. Well-trained, informed and non-judgemental health professionals, including radiographers can be advocates for the safe navigation of patients through their diagnostic and treatment journeys. Clinicians should remember that the choice of descriptor may be a highly sensitive issue for their patients, and that misuse of language, and particularly deliberate misuse of language associated with the sex assigned at birth (misgendering), may cause profound offence. We are committed to commissioning health services in Somerset that are accessible to everyone and do not discriminate on the grounds of a person's characteristics.

The Equality Act 2010 requires us, like most organisations, to not discriminate or harass anyone on the grounds of the "Protected Characteristics". We take a wide view when considering the impacts of our services across the communities of the county. We actively seek to include people from a variety of communities in all aspects of our work. In Somerset we believe that equality should be embedded in public engagement and vice versa.

Actions – Equitable Access (Protected Characteristics)

- We plan to improve understanding of the complexities associated with the health and care needs of two distinct groups: those with gender diversity and those with diversity in their physical sex characteristics by end of 2023
- We want to ensure the language and behaviours we use are recognised as respectful and compassionate – ongoing

Pregnancy Choices

Everyone using maternity services has the right to have genuine choice about their pregnancy and the care they receive.

All women/people should have the right to exercise choice including whether to continue with a pregnancy or not and should have access to the necessary information to make an informed decision. In Somerset we believe it is fundamental that women/pregnant people have access to safe, legal and regulated abortion services under the 1967 Abortion Act no matter where they live.

Unassisted birth is often called 'free birth'. It means deciding to give birth at home or somewhere else without the help of a healthcare professional such as a midwife. Unassisted birth does not mean giving birth at home before the planned midwife had time to arrive. This is called 'born before arrival'. Women/pregnant people may choose to have a member of the family or a doula with them in a supportive capacity for an unassisted birth.

Whist it is lawful to not accept any medical or midwifery care or treatment during childbirth, we want to ensure the safety of the mother/pregnant person and her baby during and after birth. Somerset has several free births that take place each year, mostly centred around the Glastonbury area. We take a proactive approach by working closely with this community on a number of health and care issues.

Underpinning birth choices outside of guidelines is the principle of women's and birthing people's basic human right to autonomy and choice, including freedom from coercion and to be treated with dignity and respect.[22] The skills to genuinely engage service users in decisions about their care requires a fresh perspective and fundamental shift in the relationship between service users and service providers. In Somerset we are co-producing a guideline to support birth choices outside of clinical guidance.

Actions – Equitable Access (Pregnancy Choices)

- Continue to commission consistent, comprehensive, effective, accessible, legal, and appropriate abortion services in Somerset – ongoing (service was recently re-procured in Somerset)

- Establish a co-produced guideline for Somerset to support women/birthing people and their partners to make personalised, confident, and informed decisions when planning their birth – From September 2022

Fertility Care

Infertility is when a person is unable to conceive due to a reproductive system of either partner. In England around 1 in 7 couples may have difficulty conceiving. In Somerset we recognise this important issue and are committed to making best use of limited resources for fertility assessment and treatment to enable couples in a stable relationship, without a child a chance to conceive. Furthermore, people receiving oncology and other medical interventions that may compromise fertility or the management of post-treatment fertility problems; the opportunity to store sperm, oocytes and embryos until a later date.

Infertility can be primary, in couples who have never conceived, or secondary, in couples who have previously conceived. There are many possible reasons why conception may not happen naturally for either partner. Somerset ICB will fund fertility treatment with either: Intra-uterine Insemination, ovulation induction medication or donor insemination including IVF treatment if necessary, for patients who meet the specific criteria that reflects their current status.

Transgender individuals in Somerset preparing for gender identity interventions should be offered cryopreservation prior to commencing hormone replacement therapy and transgender re-assignment surgery as appropriate to their status.

Whilst fertility care within the NHS has its limits we welcome the recommendations from the governments first Women's Health Strategy for England [23] to review geographical variation and improve information provision and to create equality in access to fertility services.

Actions – Equitable Access (Fertility Care)

- Support people through high-quality information and education to make informed decisions about their reproductive health – ongoing
- Women's Health Strategy - Work with NHS England to address the current geographical variation in access to NHS-funded fertility services across England to ensure access to NHS-funded fertility services are more equitable by end of 2023

Neonatal support, Stillbirth and Neonatal Mortality

The ATAIN programme aims to reduce the harm caused by separation of mother and baby soon after birth.[24] There is overwhelming evidence that separation of mother and baby so soon after birth interrupts the normal bonding process, which can have a profound and lasting effect on maternal mental health, breastfeeding, long-term morbidity for mother and child. The main areas identified for reductions in admissions are:

- respiratory conditions
- hypoglycaemia
- jaundice
- asphyxia (perinatal hypoxia-ischaemia)

This makes preventing separation, except for compelling medical reasons, an essential practice in maternity services and an ethical responsibility for healthcare professionals. Maternity units are expected to keep term admissions to below 5% of all neonatal admissions.

An ambition was set in the NHS Long Term Plan [25] to achieve a 50% reduction in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025.

The Somerset baseline in 2015 for combined stillbirth, maternal and neonatal death was 4.07 per 1000 births, which was considerably lower than many areas due to Somerset being an Early Adopter of the original Saving Babies Lives care bundle which was implemented in 2014. This has made achieving the 50% target more challenging for Somerset, but we continue to make safe care an absolute priority with the implementation of Saving Babies Lives v2, the PeriPrem care bundle and robust and transparent investigation into every serious incident to ensure all learning is identified and acted upon.

Actions – Equitable Access (Atain programme)

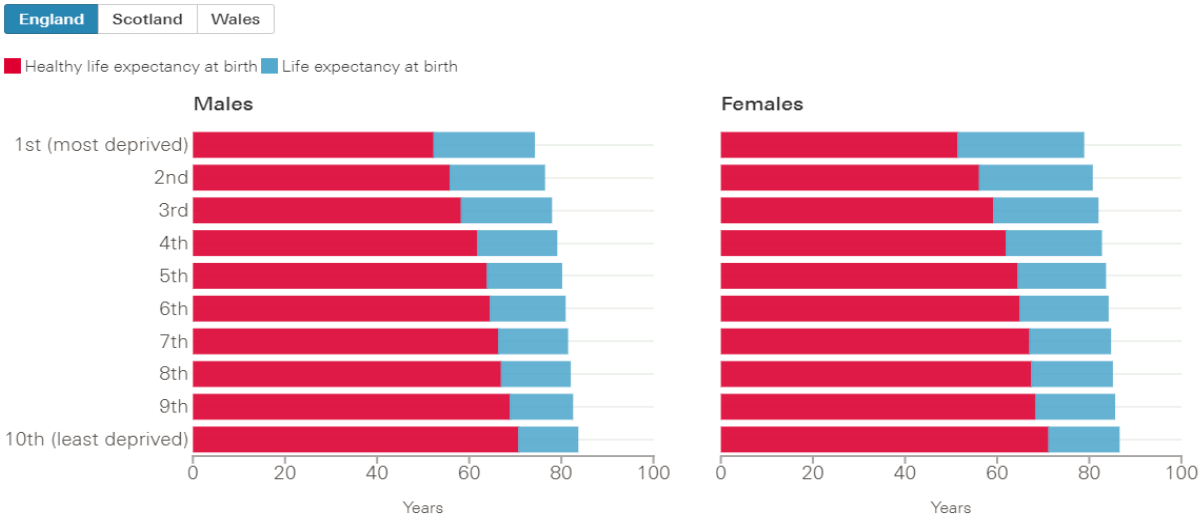
- To ensure as an LMNS we continue to ensure review, learn and improve upon the reasons for any separation of mother and baby following birth – ongoing

7. HEALTH INEQUALITIES

Health inequalities can be defined as 'unfair and avoidable differences in health across the population, and between different groups within society'.
Health inequalities will shape how long individuals will live, health conditions they may experience and what access they have to health care services. (The King's Fund 2022)

Life expectancy is used as a measure of overall population health.
It shows that individuals who live in the most deprived areas in the UK are expected to live shorter lives and spend more of their life in poor health compared that those who live in the least deprived areas. See table below

Life expectancy & healthy life expectancy at birth by deprivation decile: Great Britain, 2017–19



(The Health Foundation 2022) Life expectancy and healthy life expectancy at birth by deprivation - The Health Foundation

The Coronavirus pandemic (Covid-19) has brought the topic of health inequalities back to the top of the political agenda. Data collected during the pandemic has demonstrated that Covid-19 has taken a disproportionate toll on those groups already facing the worst health outcomes in society. Ethnic minorities, people of older age and those living in deprived areas were more likely to experience higher levels of Covid-19 infections, higher rates of morbidity and increased mortality rates. (The King's Fund 2021)

Consideration is also required with regards the current economic crisis which has been a major shock not only to the economic sector, but also to the rest of society and the impact of a predicted recession later this year.[26] It is evident that an increase in health inequalities during periods of economic crisis have been seen in different health variables: mortality, mental health, self-perceived health, excessive alcohol consumption, health-related quality of life, long-standing illness, and disability.[27]

Age

Increasing maternal age has been associated with improved health and development for children up to 5 years of age. Sutcliffe et al (2012)[28] identified the risk of children having unintentional injuries requiring medical attention or being admitted to hospital, both declined with increasing maternal age. However, the impact on the woman/pregnant person during pregnancy increases with age as does complications in pregnancy and babies born with life limiting conditions. Babies born to older parents have a higher risk of certain chromosomal conditions, such as Down syndrome, Edwards' syndrome or Patau's syndrome.

Women/pregnant people aged 45 years old and older are at a higher risk of adverse outcomes during birth. Complications can include caesarean delivery, pre-eclampsia, postpartum haemorrhage, gestational diabetes, thrombosis and hysterectomy. Severe morbidity is 3 times higher for women/pregnant people aged 45 to 54 years compared with women/pregnant people aged 25 to 29 years.

The average age of women/pregnant people in Somerset giving birth to their first baby in 2020 was 29.7 years. In general, the ages of the mothers of babies born in Somerset are similar to that of the UK as a whole.

The table below shows the age of mothers/pregnant people at the birth of their baby in five-year age bands in 2020. The highest proportion of births were to women/pregnant people aged 25-29. Births to mothers in age bands 20-24 and 25-29, account for a slightly higher proportion of total births in Somerset than they do nationally, whilst those to mothers aged and 35-39 accounts for a lower proportion.

The figure below shows the distribution of live births across age.

Live births in England and Wales: birth rates down to local authority areas
ONS Crown Copyright Reserved [from Nomis on 12 May 2022]

2020

measure	Mendip	Sedgemoor	Somerset West and Taunton	South Somerset	Somerset	England
Live births	947	1,095	1,361	1,505	4,908	585,195
Age specific fertility rate : Aged under 18	1.4	2.5	1.7	4.5	2.6	3.8
Age specific fertility rate : Aged under 20	5.8	10.8	8.1	12.5	9.5	9.8
Age specific fertility rate : Aged 20-24	49.3	66.8	57.8	70.4	61.8	44.6
Age specific fertility rate : Aged 25-29	94.7	116.3	111.4	116.4	110.8	84.7
Age specific fertility rate : Aged 30-34	104.0	89.5	101.3	101.3	99.2	103.1
Age specific fertility rate : Aged 35-39	50.0	44.5	45.1	49.5	47.3	60.4
Age specific fertility rate : Aged 40-44	15.7	12.9	14.6	11.4	13.5	15.0
Age specific fertility rate : Aged 45 and over	1.5	0.3	0.6	0.6	0.7	1.2
Standardised mean age of mother	30.4	29.4	29.8	29.4	29.7	30.8

At district level South Somerset has a higher number of births overall and a higher proportion of births to mothers/pregnant people aged under 20 (12.5%) higher than the England average. Teenage pregnancy is considered a key indicator of adolescent health for good reason. The associations between teenage births and mortality, morbidity, and social and economic hardship for the mother and child are well established.[29] Somerset's Young Parent Health Visiting Programme[30] is available for anyone aged up to 19 years old, 25 if leaving care (at booking) and is delivered by Young Parent Health Visitors who will work with young parents from when they are first become pregnant until the child has their 2 1/2 year developmental review.

Actions – Health Inequalities (Age)

- To deliver a targeted and co-produced community approach to young parents in South Somerset by April 2023
- To deliver a targeted and co-produced approach for expectant parents in South Somerset by April 2023

Black and Asian Women/Pregnant people

The report by Sandra Igwe [31] identified there was a disparity in the care given and received by black women/pregnant people. This was based on lack of trust between black women/pregnant people, healthcare services and the Government. The report raised the need for black women/pregnant people to be offered the support or encouragement they need to be able to talk about their pregnancy, birthing fears or mental health problems.

Sandra Igwe co-chaired the Birthrights inquiry and this reported there was a cultural assumption sometimes that black women/pregnant people are very strong, in terms of physical or emotional pain. The report identified the need for better training for clinicians around unconscious bias to better understand how black women/pregnant people respond to pain, their emotions, and opportunity to discuss any complications and individual circumstances. It is also recommended that more diversity in the resources and support groups is available. Experiences were of being the only black woman/pregnant person in a mum and baby group, making it difficult to connect. This also extended to social media, where most mum groups and bloggers and vloggers were white, middle-class women/people.

We know that women/pregnant people from minority ethnic backgrounds or those who live in deprived areas have an increased risk of stillbirth and benefit from closer monitoring and

additional support. The MBRRACE-UK report showed that across all births (not just those induced):

Compared with white babies (34/10,000), the stillbirth rate is

- more than twice as high in black babies (74/10,000)
- around 50% higher in Asian babies (53/10,000)

The stillbirth rate increases according to the level of deprivation in the area the mother lives in, with almost twice as many stillbirths for women/pregnant people living in the most deprived areas (47/10,000) compared with the least deprived areas (26/10,000).

A systematic literature review of Ethnic health inequalities in the UK's maternity services [32] highlighted five persistent themes which impacted black, Asian and women/pregnant people from ethnic minorities' experiences and use of services. These themes were

- communication
- midwife-woman relationship
- maternity services and systems
- culture
- social needs

Ethnicity based health inequalities can lead to differences in health status and access to services in multiple areas of maternity care. In Somerset there are a number of things being done to help raise awareness and advocate change for black, Asian and women/pregnant people from ethnic minorities, including-

In Somerset Yeovil District Hospital has launched new training aiming to raise awareness of inequalities seen through pregnancy, birth and beyond. The reasons for this are many but Yeovil Midwives recognised that their midwifery training predominantly focused on white mothers and babies, from text books to training mannequins. Each training session focused on implicit bias, stereotyping, jaundice and reviewing advice for parents once they are discharged from the unit. The training will be rolled out with the maternity team at Somerset NHS Foundation Trust and, moving forward, they hope to secure funding to roll out the training across the UK, furthering the skills and knowledge of midwives nationwide.[33]

Core20PLUS5 is a national NHS England and NHS Improvement approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement. Specific to Maternity: ensuring continuity of care for 75% of women from black, Asian and minority ethnic communities and from the most deprived groups.

The charity, FiveXMore is dedicated to finding answers to help raise awareness and advocate change for black, Asian and women/pregnant people from ethnic minorities. while supporting mothers in the black community who have faced healthcare inequalities in their journey to motherhood and have published a nationwide study of black women's experiences of maternity services in the United Kingdom.[34] The findings in this report highlight the urgent work needed to ensure that rapid improvements are made – because a positive birthing experience is deserved not just by some, but by all.

Actions – Health Inequalities (Black and Asian Women/Pregnant people)

- To deliver unconscious bias, cultural awareness/competence, anti-racism and implicit bias training for all by end of 2023
- Investigating a viable way forward so that ethnically diverse women have continuity of care to ensure that women are seen by the same midwife from pregnancy, childbirth through to post-natal care by end of 2023
- Work with Somerset Trusts to plan longer antenatal appointments by end of 2023
- Align with National programmes by end of 2023:

  - Increased knowledge on identifying and diagnosing conditions that are specific to and disproportionately affect black women

  - Improved system for women to submit their feedback and/or complaints specifically for maternity

  - Improve the quality of ethnic coding in health records

Gestational Diabetes

In the UK gestational diabetes affects 4-5% of all pregnancies. This condition in most cases will resolve once the baby has been born. Gestational diabetes increases the risk of maternal and neonatal morbidity and mortality (Premature birth, pre-eclampsia and stillbirth) (Diabetes UK 2022).

Women/pregnant people who have been diagnosed with gestational diabetes are more likely to suffer long term metabolic disease or cardiovascular disease in later life. Data shows that 50% of gestational diabetes will develop type 2 diabetes. (NHS Choices website 2022) Many cases of Type 2 diabetes are preventable and there is strong evidence that behavioural interventions can significantly reduce the risk of developing the condition, through reducing weight, increasing physical activity and improving the diet of those at high risk, this is supported in the NHS Diabetes Prevention Programme Long term plan.

Black and South Asian women are up to three times more likely to develop certain long-term health conditions following a diagnosis of gestational diabetes compared to white women. South Asian women were nearly twice as likely to develop Type 2 diabetes when compared to white women. Black women were nearly 1.5 times more likely to have recurrent gestational diabetes when compared to white women. Black women were nearly 3 times more likely to have hypertension when compared to white women (University of Leicestershire March 2022).

Actions – Health Inequalities (Gestational Diabetes)

- Ensure appropriate referral pathways in place for Antenatal and Postnatal people by April 2023
- Prevention for long-term impacts on health (Cardiovascular disease/Type2 Diabetes) by 2025
- Increase awareness for Health Visitors and Primary Care of current NHS Diabetes programme that target high risk individuals by April 2023

LBGTQ+ Community

There are significant, persistent health inequalities for mothers and babies by ethnicity and deprivation (MBRRACE). Over the last few years, LGBTQ+ pregnancy and parenthood has been more publicly discussed and researched, highlighting many disparities for LGBTQ+ people. One of those disparities relates to accessing health and social care services, including gynaecological, fertility and pregnancy services.[35] As part of the National LGBT Action plan, NHS England and NHS Improvement continue to work to reduce LGBT health inequalities and improve access and experience.

It is often the case that pregnant people who identify as transgender or non-binary are most in need of healthcare support, increasing language inclusivity in maternity services will help to reduce discrimination experienced by transgender and non-binary patients and contribute to a fulfilled and more diverse workforce.[36]

Trans men and non-binary people often report challenges when navigating medical services, due to the gendered language used within these spaces, or because of the common occurrences of personal misgendering by healthcare professionals. Additionally, there are also instances where healthcare professionals have not had opportunities for LGBT+ competency training and may not have considered that trans men and non-binary people may want or need to access their services (e.g. cancer screenings, gynaecology, fertility and pregnancy services).

Making trans and non-binary people explain, or having to 'out' themselves repeatedly, can:

- have a detrimental effect on their mental health;
- make them feel unsafe and legally unprotected' and
- potentially prevent them from accessing vital medical care in the future

Everyone deserves and has the right to equal access to services and the opportunity to be the happiest and healthiest that they can be, which is why more needs to be done to highlight and transform trans and non-binary experiences in our society.[37]

In 2021, Brighton & Sussex University Hospitals NHS Trust publicly announced and shared their gender inclusion policy in maternity care, which gives clear guidance to pregnancy care professions on how to care for LGBTQI+ service users. Their Gender Inclusion Team is able to offer specialist care to LGBTQI+ parents and also to provide support and training to other medical professionals on how to care for LGBTQI+ people appropriately.[38]

It is important to acknowledge the additional challenges for LGBTQ+ people that gender identity can have on a pregnancy, birth and infant feeding and to recognise the importance of providing inclusive, respectful care to all pregnant people and their families

In Somerset a partnership Pilot project piece has been proposed, with the aim to work towards substantiable System awareness. Offering key maternity & nursing staff a bespoke workshop based, training package, delivered by a local organisation with lived experience. The aim is to launch as a pilot which will be evaluated to assess long term measurable sustainability across the somerset ICS. This workshop will be focused on the experiences of those within the LGBT community and offer basic competency awareness and guidance to more advanced clinical lactation knowledge within the LGBT community.

In somerset we have a range of LGBTQ+ groups and support including Out in Somerset, Yeovil diversity project, 2BU, Pridewest and Galapagos a local parent and child group based in Yeovil. As a system we have the opportunity to identify areas for development of our services and share the resources available.

Actions – Health Inequalities (LBGTQ+ Community)

- Somerset pilot project - The LGBT maternity Journey training package for midwives and other health professionals by end of 2023
- Inclusive Culture where all staff are valued and heard – ongoing
- Explore Inclusion Midwife role and Inclusion policy – by end of 2024
- Connecting with the local trans and non-binary community by April 2023
- Developing our services and environment to be more inclusive – ongoing
- Producing guidance on inclusive language and communication by end of April 2023

Gypsy, Roma and Traveller Communities

Gypsy, Roma and Traveller (GRT) communities have higher levels of maternal mortality, compared to women/pregnant people from non-ethnic minority groups.[39] The communities are known for having a higher level of possible hazardous environmental conditions which increases the potential for miscarriage and stillbirths, neonatal deaths and high rates of maternal death during pregnancy and after childbirth.[40]

Women/pregnant people from GRT communities are also 20 times more likely to experience the death of a child. The unauthorised encampments where Gypsy, Roma and Traveller women/pregnant people frequently live may be hazardous, for example, encampments next to canals risk waterborne contamination, rubbish tips may have rat infestations and waste ground can have an increased chance of fly-tipping. Moreover, there is often a lack of amenities such as clean water and cleaning and toilet facilities. Children are at higher risk of injury and illness compared to any other group.

In the UK, GRT communities have the highest rates of illiteracy of any ethnic group[41] this in turn means many people cannot read prescriptions, information leaflets, and letters and may miss appointments. It should not be assumed that they can read and write, and this may not be disclosed when asked.

Many Gypsies and Travellers experience multiple disadvantages including enforcement actions making it difficult to access local health care prior to being moved on. Barriers to accessing primary care services, usually due to lack of a 'permanent' residence, combined with low or no literacy lead can to digital exclusion. This means people do not access support for fear of appearing vulnerable and also the fear that their children will be taken away from them, if statutory services become involved in their personal lives.[42]

According to the DCLG count in July 2017, there were 571 Gypsy and traveller caravans in Somerset, however as travellers it's difficult to capture real-time numbers as this will change from one day to the next. For people from the Gypsy, Roma and Traveller (GRT) communities visiting, living or travelling through Somerset there is information to support health and access needed, whether living in Somerset or are passing through.[43] Somerset also has two Gypsy Liaison Officers who are available for support.

Actions – Health Inequalities (Gypsy, Roma and Traveller Communities)

- Meeting access needs of somerset population – ongoing
- Ensure appropriate information giving using as many pictures as words and link in with outreach services to help you promote services – ongoing
- Support primary care services with inclusion and continuity – ongoing
- Improve the quality of coding in health records to include GRT community – by end 2026

Learning Disabilities

There has been a rise in the number of people with a learning disability in the UK becoming pregnant. This has been attributed to changing attitudes in society, social integration, more independent living and recognition of an individual's right to have a child. Evidence shows that women with learning disabilities are less likely to seek or attend regular antenatal care. This population will experience decreased levels of maternal wellbeing and poorer pregnancy outcomes (including preterm and low-birthweight babies).[44]

Data shows that 7% of adults with a learning disability are parents whose children reside with them. Many individuals in this group will not have a formal diagnosis of a learning disability, as impairment is mild to moderate. 40% of parents with a more significant learning disability do not reside with their children. Children who are born to parents who have a learning disability represent the group most likely to be removed from parental care (Best Beginnings 2022).[45]

Mothers/parents with learning disabilities in England are more likely than other parents to be single, affected by poverty and have significant mental health problems. They are more likely to suffer social isolation, give birth at a young age, to smoke during pregnancy and less likely to breastfeed. 30-50% of children who are born to parents who have a learning disability are at risk from developmental delay, when compared to children from similar socio-economic groups. They are also more likely to be born with a learning disability, have behavioural problems and lower IQ. (Best Beginnings 2022).[46]

In Somerset the development of the Enhanced Parenting Pathway (EPP) as previously discussed within the Public Health Section of Somersets Maternity Equity Strategy, which is currently led by Public Health Nursing Services. Has the aspiration to design a pathway in partnership with families and collaborate with key partner agencies such as Maternity and Children's Services. This will align with wider health and support services, and system wide strategic priorities, to provide a personalised support pathway to families identified through universal service provision including parents with learning disabilities.

Actions – Health Inequalities (Learning Disabilities)

- Following best practice guidance for Parents with Learning Disabilities – ongoing
- Development of a co-produced Enhanced Parenting Pathway by end 2023
- Planned Gap analysis for support to pregnant women/people and/or partners with special educational needs and disabilities by end 2023
- Ensure resources already in Public domain are utilised to aid decision making How to help women with learning disabilities access antenatal and newborn screening - PHE Screening (blog.gov.uk) - ongoing

Physical Disabilities

We know from our Somerset Equity Analysis that there are nearly 9,000 households (3.9% of all households in Somerset) containing at least one adult with a long-term disability or health condition and dependent children. Therefore, we can acknowledge a percentage of these will have been pregnant people who use Somerset Maternity services.

A Birthrights (2018) study re-confirmed the need for healthcare professionals to recognise that women who have a disability expect and need to be heard. They should be respected as experts about their bodies and their own health and or social care needs. Many will have lived/grown up with their individuality and just need others to recognise that they are the experts but may need help to adjust to their new lived experience of being pregnant, in labour or being a new parent.

A quarter of women/pregnant people felt they were treated less favourably because of their disability, and more than half (56%) felt that health care providers did not have appropriate attitudes to disability. Some found birth rooms, postnatal wards, or their notes and scans "completely inaccessible".[47]

The research suggests that maternity services need to adapt to provide high quality individualised care to all disabled women. This includes improving both attitudes and knowledge of disability and disabled women among maternity professionals. Ensuring all disabled women receive continuity of carer, have additional time to discuss their needs, preferences and choices. Service providers should be auditing access and ensuring that reasonable adjustments as required under the Equality Act 2010 are made available.[48]

Actions – Health Inequalities (Physical Disabilities)

- Meeting access needs of somerset population including those with a disability – ongoing
- Ensure appropriate information giving – ongoing
- Enable women/pregnant people to participate equally in all decision-making processes and to make informed choices about their care – ongoing

Non-English speaking or English as an additional language

Data on languages spoken in Somerset from the 2011 census (more up to date information will begin being released from 2022) shows in over 97% of Somerset households English is the main language of all adult residents. However, there are an estimated 3,404 households (13,599 people aged 3 or more) in which no-one has English as a main language. Around 4 out of 5 residents whose main language is not English can speak English 'well' or 'very well'. An estimated 2,382 residents cannot speak English well, and a further 410 cannot speak English at all.

Pregnant women/people who do not speak English are at increased risk of poor birth outcomes, when compared to similar population of people who speak English fluently.[49] It should be recognised that this population are also likely to face additional factors which increase health inequalities, such as experiencing poverty, living in poor housing, having poor mental health and facing exclusion and or discrimination .[50]

Women who are unable to effectively communicate with their healthcare provider, may be unable to communicate their health needs, these will then remain unknown and unmet.

Consideration should be given to people who speak English but cannot read English and people who are profoundly deaf. A person with good conversational fluency in English may not be able to understand, discuss or read health-related information proficiently in English. They may be reluctant to request or accept professional interpreting and translation services due to fear of costs, inconvenience, or concerns about confidentiality.

Language and cultural barriers have previously been identified as factors affecting access to medical services for ethnic minority populations. These issues can be addressed by providing culturally appropriate services to meet the need for multicultural genetic counselling to acknowledge and incorporate familial beliefs and customs. Culturally sensitive genetics services. Among unrelated couples, 2–3% of all births have a congenital abnormality, for first cousin couples this is around 6%.[27] In some populations the higher risk of recessive genetic disorders accounts for some of the increased rate of congenital abnormality, infant and child mortality and serious illness. The population in Somerset for people meeting the needs of this support will be of low numbers therefore adopting a personalised care plans along with proactive genetic counselling and education is paramount to optimise reproductive options.

Actions – Health Inequalities (Non-English speaking or English as an additional language)

- Promotion of consistent use of professional translation services – ongoing
- Promotion of standardised Material/leaflets – ongoing
- To deliver unconscious bias, cultural awareness/competence, anti-racism and implicit bias training for all by end of 2023
- Investigating a viable way forward so that ethnically diverse women have continuity of care to ensure that women are seen by the same midwife from pregnancy, childbirth through to post-natal care by end of 2023,
- Personalised care and support planning in both digital and hard copy, available in a range of languages and formats by end of 2024

8. MATERNAL AND NEONATAL WORKFORCE WELLBEING

Somerset acute trusts staff ethnicity data

The table below shows the ethnicity of all staff at the two Somerset acute trusts and also within the Maternity and Neonatal workforce. Somerset's ethnic minority (excluding White minorities) population* is approximately 2.9% of the total county population, so the trust staff ethnic minority population at 5-7%% is more diverse than the general population of Somerset.

Within the National WRES Programme 'BME' is the category that is used in the national analysis. This definition includes any staff from a black, Asian or dual heritage ethnic background.[51]

**'Ethnic minorities' when mentioned throughout this section refers to 'ethnic minorities excluding white minorities'*

Staff numbers and percentages by ethnicity in Acute trusts and the maternity and neonatal workforce (2020 WRES data)

Ethnicity	Acute Trusts	Maternity and Neonatal
White	90.4%	91.1%
Black and Minority Ethnic	7.3%	5.04%
Unknown	2.3	3.84%

Ethnicity data limitations

- It should be noted that returns are limited so interpretation of the data is difficult.
- Data is only available as percentages of White and Black / Minority ethnicity so no further breakdown is possible at this moment
- There are a number of staff where ethnicity is unknown.

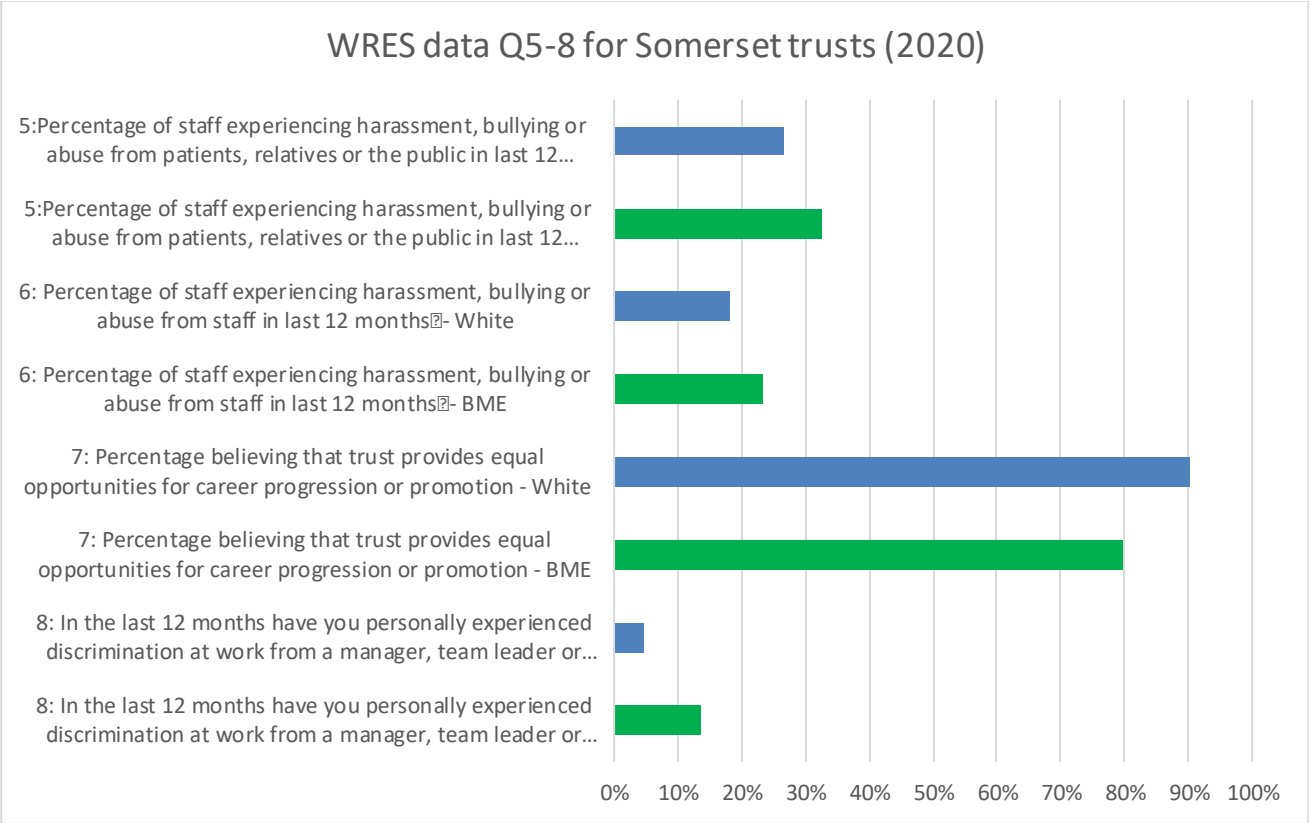
Somerset Acute Trusts: WRES Survey 2020

The WRES data is a return of specific questions about ethnicity and equalities in the workplace asked within the staff survey and is an annual return that the Trust must make.

The WRES data presented reflects returns from the acute Trusts as a whole. We have been unable to access specific maternity and neonatal data due to concerns around confidentiality as there are low numbers of staff from an ethnic minority background. This data, therefore,

is incomplete for all staff involved in maternity and neonates and this should be considered when interpreting data.

Trust responses to WRES questions 5-8



Staff responses to the survey questions can be seen below. Standards 1-4 refer to total Trust data. We have been unable to access specific WRES data for maternity and neonatal staff, so we have included the staff survey results for this group to gain some understanding of how the workplace feels for our colleagues. We are assured that the responses from neonatal and maternity reflect the overall picture in the Trusts.

WRES Standard / Staff survey question	Somerset acute trusts	Maternity and Neonatal
		From 2021 staff survey so unable to analyse by ethnicity
WRES 1: Proportion of White vs ethnic minority staff in bands	**Clinical staff** (excluding medical), band 8A and above: White 95.1%; ethnic minorities 1.5% Very Senior Managers: White 100% **Non-clinical staff**, band 8A and above: White 97%; ethnic minorities 0.3% Very Senior Managers: White 87.5%; ethnic minorities 12.5%	
WRES 2: Relative likelihood of appointment from shortlisting	White 30% Ethnic minorities 20%	
WRES 3: Relative likelihood on entering formal disciplinary process	White 0.4% Ethnic minorities 0.6% Numbers too small for meaningful analysis	
WRES 4: Relative likelihood of staff accessing non mandatory training and CPD	White 78% Ethnic minorities 84%	
Staff survey: My organisation acts fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age.	63%	64%
Staff survey: In the last 12 months I have personally experienced discrimination at work from patients / service users, their relatives or other members of the public.	5%	2%
Staff survey: In the last 12 months I have personally experienced discrimination at work from a manager / team leader or other colleagues.	7%	8%
Staff survey: **Experienced discrimination on grounds of ethnic background.**	18%	0%

Analysis for Trust and Divisional staff

- Standard 1: Ethnic minority staff are under-represented at higher bands in the Trust
- Standard 2: Ethnic minority staff are less likely to be appointed even when shortlisted
- Standard 3: Numbers are too small to be meaningful as very low number of responses.
- Standard 4: Ethnic minority staff are more likely to access non-mandatory training
- Staff survey question on being treated fairly by the organization: The response from maternity and neonatal staff is better than the trust average.
- Staff survey question on experiencing discrimination by patients and /or service users: very low numbers of maternity and neonatal staff report experiencing discrimination from this group, lower than the trust average.
- Staff survey question on experiencing discrimination by colleagues or managers: maternity and neonatal staff are reporting higher than the trust average for this question, and this is an area which needs investigation.
- Staff survey question on experienced discrimination due to their ethnic background: No maternity or neonatal staff report being discriminated against due to their ethnicity, which is greatly lower than the trust as a whole.

We have been limited due to our inability to access this meaningful data. However, the staff survey gives some useful indicators where improvements need to be made and we look forward to continuing to monitor the staff experience for black and minority ethnic colleagues. In Somerset we will support staff to give culturally competent care and ensure that their skill and dedication is recognised, irrespective of their ethnic group.

Based on the evidence, NHS England [52] highlighted there are two important principles which will support the retention of nurses and midwives; namely:

1. Targeted intervention for different career stages: There are different risk points related to job satisfaction and retention of nurses and midwives at these stages, and our response and support needs to be tailored accordingly.

2. Bundles of high-impact actions are more effective than single action: A bundle approach is needed to deliver sustained gains, applied to the different career stages and informed by evidence of what drives job satisfaction, experience and therefore retention.

Feedback shared by Heads of Midwifery from each Trust:

Somerset Foundation Trust (SFT) actively encourage any staff member who takes retirement to return, with a large proportion of our senior leads returning on reduced hours and remaining in their band 7 positions. Flexible working is encouraged to accommodate working patterns following maternity leave and other requests and are regularly reviewed.

Two senior midwives are leads for wellbeing who hold monthly forums for staff to discuss any concerns and then feedback to managers with any themes arising. They also support junior staff in clinical practice working with them to achieve their competencies and preceptorship. They have rolled out thank you boxes for both families and staff to write comments on giving feedback to staff which is then displayed on notice boards around the unit.

Our retention lead midwife has a dual role and is also our practice development lead she links in with the University link lecturer in regard to our student midwives as well as attending regional meetings regarding retention.

Somerset Foundation Trust have recruited all of their third year students in early in May to give them the security of employment whilst they are finishing their course. There is current consideration as to similar early recruitment with the current second year students. The first overseas pre-registration midwife has also been welcomed to Somerset, who started in August 2022 and have an ongoing plan to recruit five more who will be supported by the practice development team.

Due to the National shortage of neonatal nurses, Somerset Foundation Trust have also recruited overseas nurses and currently have four working on the unit who we will support and train so they can pass their QIS training and progress into a band 6.

The Professional Midwifery Advocates and Professional Nursing Advocates team has grown to give support and lead on hot debriefs when any incident or event occurs and will be focusing on wellbeing and team building sessions with all staff on their mandatory study days which will be off site.

Yeovil District Hospital (YDH) have a team of 10 Professional Midwifery Advocates (PMA), with a further 2 midwives about to undertake their training. We offer Restorative Clinical Supervision (RCS) sessions each Friday to any member of the maternity team. We also undertake group PMA sessions for our community based teams alongside our student midwives and preceptorship midwives. Staff are reminded they can book onto these sessions by weekly emails or line managers who will also advocate for their staff to access this service. We have started to work alongside the PMA team at Somerset Foundation Trust to join forces and utilise the support from each other.

Alongside the PMAs we have one midwife who is paid for by Bournemouth university one day a week as the link tutor for YDH. As Yeovil is a fair distance from the university campus and having support through clinical practice has received excellent feedback. This readily

gives students on site access to support. There are 2 midwives who also have one day a week each for pastoral support which is ward based and available to all staff.

We know newly qualified midwives are more vulnerable and we have prepared a robust preceptorship package to support their transition. Having trained through the covid pandemic, where some students were removed from practice, they may have greater anxiety and less experience than students before them. To ensure they remain in the profession we make sure they have regular team days, including RCS with their named PMA and we have gained valuable feedback from previous groups as to what we could improve. The new starters information pack now contains so much more information and has received great praise. Prior to the update it had a check list of what clinical objectives were needed, along with dates for a review of how they were getting on. It now comprises of an introduction to some of the team, process for uniform/car parking/pay/annual leave, as well as a map so they know where to find the canteen and toilet. These small additions have been able to reduce unnecessary stress. The newly qualified midwives have now been offered to complete their preceptorship in 12- 18months rather than just the 12 months previously offered.

We have recently taken on 2 overseas midwives. They have joined us in July and are settling in well. They will complete their OSCEs in November and then join the preceptorship team of midwives. They have met with their line manager who has designed a bespoke training package as they already possess many clinical skills but may need to focus on a different area for development e.g. community. We plan to take another 2 international recruits in 6 months' time.

We have advertised for band 5 and 6 midwives, with very few experienced midwives applying for jobs. We have employed more preceptorship midwives over the last 2 years than previously and are keen to improve the support they receive in clinical practice. We are undertaking a review of our Practice Educator role at YDH and how this role may support midwives on the wards.

In order to support the reduced midwife numbers, we made changes to support the development of our maternity support workers (MSW). Yeovil maternity unit had limited domestic support throughout the unit, with the MSW serving the meals, emptying bins, cleaning of labour rooms and theatres after use etc. We now have domestic support which brings us in line with the rest of the hospital. This has allowed our MSW to support the midwives in practice and help with women centred care. We have offered band 3 training to our current support staff (all band 2) as well as advertise for band 3 MSWs to enable postnatal care to be more efficient on the wards as at the level 3 they are able to help with skills such as neonatal observation/blood sugars as well as supporting women to be discharged.

On a personal note we try and send every midwife and support worker a whatsapp message on their birthday. This is noticed by staff and well received. We have also started offering quarterly social gatherings for all staff and their families (now we are allowed following restrictions of the pandemic) so far we have had a Refresh and Ramble at Hamhill, followed

by Paddleboarding & a Picnic on the river Parrot, we have had a great turnout with partners, children and pets included. We have a private staff Facebook group (for those who choose to join) where we can keep everyone posted on what's happening. To support the health and wellbeing of the team the trust have provided staff with 2 wellbeing days for 2021 & 2022. (an extra days leave) over the pandemic.

9. MATERNITY EQUITY ACTION PLAN

Recommendation / Action	Timeframe / Ambition	Project Owner(s)	Outcome / Measure
Prevention (Weight Management)			
Increase knowledge and reduce misconceptions through training and education of the specific cultural, dietary, and physical activity needs of pregnant women/pregnant people, and will include:			
• Signposting from the first antenatal opportunity to local support available for women/pregnant people	Ongoing	Public Health Somerset	Increase uptake to a healthier lifestyle
• Increase uptake to the current Healthy lifestyle service for pregnant people that is currently being developed with service user input from the MVP	Ongoing	Public Health Somerset	Increase uptake to a healthier lifestyle
Prevention (Smoking)			
• To achieve the national ambition to reduce the number of women/pregnant people smoking whilst pregnant to 6% or less	End of 2025	Public Health Somerset	Reduction in smoking at preconception and during pregnancy
• To develop a Somerset pathway for users of cannabis - preconception and during pregnancy by	End of 2023	Public Health Somerset	Reduction in smoking cannabis at preconception and during pregnancy
• To develop the skills of appropriate staff in the techniques of motivational interviewing/health coaching, so that effective care plans can be developed which support patients	April 2024	YDH and SFT	Reduction in smoking at preconception and during pregnancy
• Gaining further insights by working with communities understanding reasons for smoking and change ideas for smoking cessation	April 2024	Public Health Somerset	Reduction in smoking at preconception and during pregnancy
Prevention (Preterm Births)			
• Continue to work to support healthy women/people, healthy pregnancies and to keep within or below the preterm birth rate of 6% for Somerset (Our preterm rate was 5.3% in 2021/22)	By 2025	YDH and SFT	Keep within or below the preterm birth rate of 6% for Somerset
• Continue to provide peer support within neonatal units	Ongoing	YDH and SFT	NA
• Somerset Maternity Voices Partnership to provide a monthly support group for neonatal parents	From September 2022	MVP	NA

• Make prevention of preterm birth a priority. Social initiatives to reduce or mitigate the social determinants (e.g., smoking, obesity, and deprivation) (see actions for weight management and smoking)	Ongoing	Public Health Somerset	Keep within or below the preterm birth rate of 6% for Somerset
• Provide dedicated preterm birth clinics and implementation of evidence-based packages to predict and prevent preterm birth, as implemented through the Saving Babies' Lives Care Bundle	By end of 2027	YDH and SFT	Keep within or below the preterm birth rate of 6% for Somerset
• As part of Better Births, to reduce the rate of maternal and neonatal deaths, stillbirths, and brain injuries that occur during or soon after birth by 50%	By 2025	YDH and SFT	Keep within or below the preterm birth rate of 6% for Somerset
Prevention (Breast/Chest Feeding)			
• To ensure over 80% of babies in Somerset have initiation of chest/breastfeeding within Somerset	Ongoing	YDH and SFT	80% of babies in Somerset have initiation of chest/breastfeeding
• To ensure over 75% of babies in Somerset are chest/breastfed on discharge from hospital	Ongoing	YDH and SFT	Over 75% of babies in Somerset are chest/breastfed on discharge from hospital
• Development of an LMNS Feeding and Nutrition Strategy	April 2023	Public Health Somerset	NA
• Signpost parents to Somerset Positive About Breastfeeding and NHS Somerset Infant Feeding Team	Ongoing	All system partners	NA
• Signpost parents to Medicines in pregnancy, children and lactation - NHS Somerset formulary page	Ongoing	All system partners	NA

Prevention (Safe Prescribing)			
• Ensure medicines access to preventative treatments in pregnancy	End of 2023	Medicines Optimisation Teams	NA
• Prescribing of effective contraception compatible with breast/chest feeding	April 2024	Sexual Health Services, Maternity and General Practice	NA
• Education on planning a pregnancy with long term conditions with prescribed medications	April 2024	General Practice and Specialities	NA
• Access to timely treatment with evidenced based recourses	Ongoing	All system partners	NA
• Signpost to medicine in pregnancy somerset formulary page	Ongoing	All system partners	NA
Prevention (Healthy Start and Folic Acid)			
• To continue to promote Healthy Start Vitamins and benchmark above the South West	Ongoing	YDH and SFT	Increased uptake
• To increase uptake of Folic Acid for those living in IMD 1 and 2 within Somerset	2024	All system partners	Increased uptake
Prevention (Vaccinations)			
• Continue to support vaccination programmes recommended during pregnancy, including working with Health Champions in areas with a lower uptake within Somerset	Ongoing	All system partners	Increased uptake
• Established a working group to roll out programme of Palivizumab for RSV	By 1st September 2022	YDH and SFT neonatal teams	Programme plan in place
Prevention (Cardiovascular Disease and Oral Health)			
• Explore commissioning programme for oral health improvement – issue fluoride/tooth paste	April 2024	All system partners	NA
• Increase awareness of Maternity exemption for dental care	Ongoing	All system partners	NA
• Increase awareness that heart disease can and does affect young women/pregnant people, and that the additional strain that pregnancy places on the heart can reveal cardiac complications for the first time	End of 2025	Public Health Somerset	Increased awareness

Prevention (Safeguarding and Mental Wellbeing)			
Increase knowledge and reduce misconceptions via training and education to all about the specific needs of pregnant women/pregnant people, and will include: • Implicit Bias Training • Cultural Competency Training • Trauma Informed Approach • Race and Diversity • Intersectionality • Violence Against Women/Pregnant People • Domestic Violence	By end of 2023	All system partners	Uptake of training
Prevention (Public Health / Sexual Health / School Age Prevention)			
• Development of a co-produced Enhanced Parenting Pathway supporting young parents in South Somerset	April 2023	Public Health Somerset	Production Enhanced Parenting Pathway
• Through development of Enhanced Parenting Pathway identify if under 20year olds would attend group sessions	April 2023	Public Health Somerset	Enhanced Parenting Pathway
• Role of fathers and partners to be considered in every family, and the contribution that fathers and partners make to their child's health, development and wellbeing (Please note this forms part of a quality improvement project funded by Safer Somerset Board)	End of 2023	Safeguarding leads, SFT and YDH	Reduction in non-accidental injuries
Equitable Access (Deprivation)			
Our priority over the next 12 months, as we transition into an ICS, is to develop a Population Health Hub. As part of this work, we will be able to begin to address the social determinants of health inequalities for those of child bearing age	By April 2024	Public Health Somerset	Creation of a Population Health Hub
Equitable Access (Transport)			
We will continue to support women/pregnant people with transport issues during pregnancy and the postnatal period, including those who cannot use public transport independently due to access, disability or health problems and/or have no reasonable access to private transport.	Set up a charitable fund for maternity assisted transport in Somerset by end of 2024	SFT and YDH	Creation of a charitable fund
Equitable Access (Community Assets)			
• Mapping of support groups since suspension of groups due to Covid	End of 2023	MVP	NA

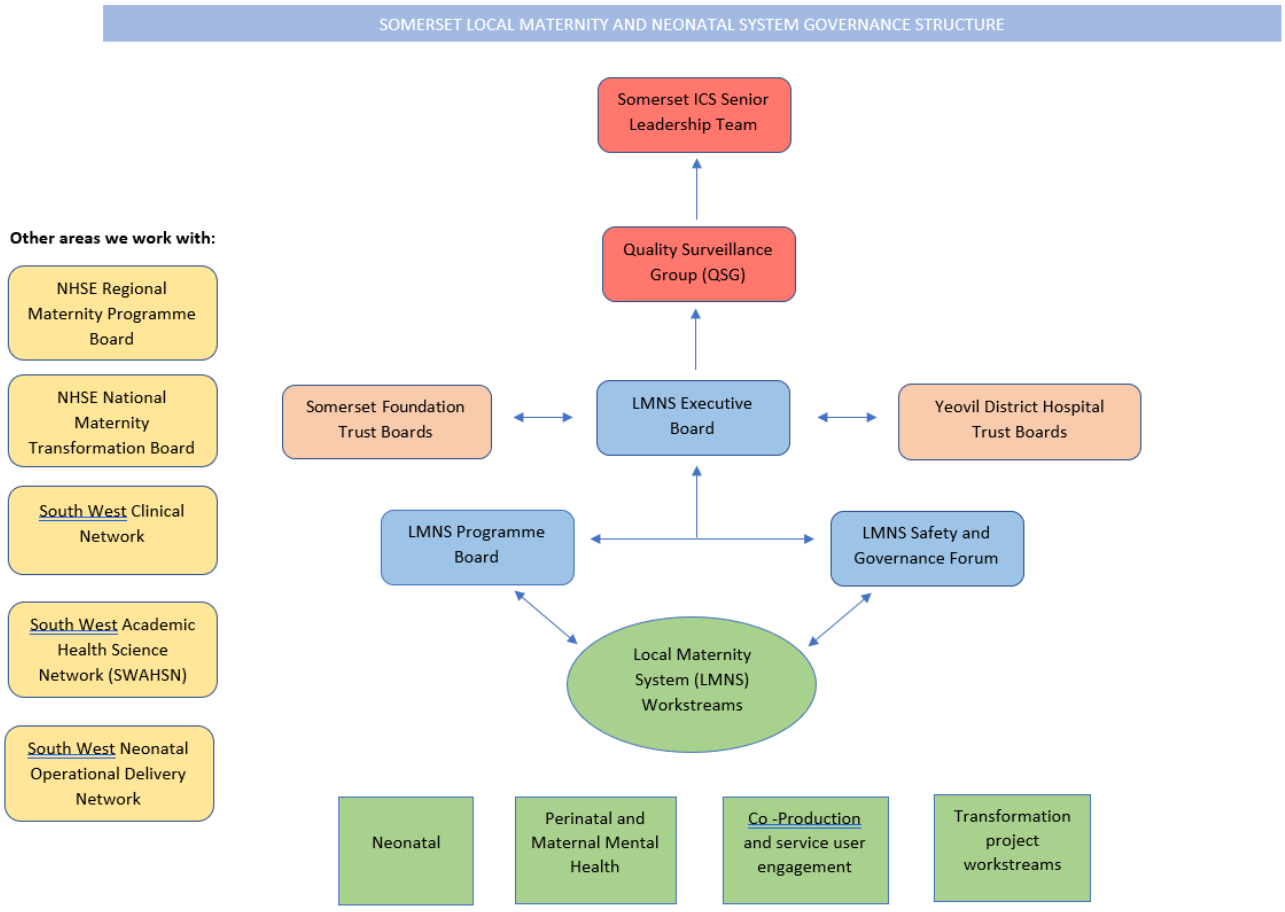
• Gaining insights from local communities (identify barriers) • Working with community representation	April 2023 Ongoing	SCC and MVP SCC and MVP	NA NA
Equitable Access (Protected Characteristics)			
• We plan to improve understanding of the complexities associated with the health and care needs of two distinct groups: those with gender diversity and those with diversity in their physical sex characteristics • We want to ensure the language and behaviours we use are recognised as respectful and compassionate	End of 2023 Ongoing	MVP All system partners	NA NA
Equitable Access (Pregnancy Choices)			
• Continue to commission consistent, comprehensive, effective, accessible, legal, and appropriate abortion services in Somerset – ongoing (service was recently re-procured in Somerset) • Establish a co-produced guideline for Somerset to support women/birthing people and their partners to make personalised, confident, and informed decisions when planning their birth	Ongoing From September 2022	Somerset ICB All system partners	NA NA
Equitable Access (Fertility Care)			
• Support people through high-quality information and education to make informed decisions about their reproductive health • Women's Health Strategy - Work with NHS England to address the current geographical variation in access to NHS-funded fertility services across England to ensure access to NHS-funded fertility services are more equitable	Ongoing End of 2023	All system partners NHSEI and Somerset ICB	NA Equitable access
Equitable Access (Atain programme)			
• To ensure as an LMNS we continue to ensure review, learn and improve upon the reasons for any separation of mother and baby following birth	Ongoing	All system partners	Ensure mother and baby remain together following birth

Health Inequalities (Age)			
• To deliver a targeted and co-produced community approach to young parents in South Somerset	April 2023	SFT, YDH and SCC	NA
• To deliver a targeted and co-produced approach for expectant parents in South Somerset	April 2023	SFT, YDH and SCC	NA
Health Inequalities (Black and Asian Women/Pregnant people)			
• To deliver unconscious bias, cultural awareness/competence, anti-racism and implicit bias training for all	End of 2023	YDH and SFT	Implicit bias training for all
• Investigating a viable way forward so that ethnically diverse women have continuity of care to ensure that women are seen by the same midwife from pregnancy, childbirth through to post-natal care by	End of 2023	YDH and SFT	75% of black and ethnically diverse women had continuity of care
• Work with Somerset Trusts to plan longer antenatal appointments	End of 2023	YDH, SFT and Somerset ICB	Longer antenatal appointments
• Align with National programmes by: - Increased knowledge on identifying and diagnosing conditions that are specific to and disproportionately affect black women - Improved system for women to submit their feedback and/or complaints specifically for maternity - Improve the quality of Ethnic coding in health records	Ongoing	All system partners	NA
Health Inequalities (Gestational Diabetes)			
• Ensure appropriate referral pathways in place for Antenatal and Postnatal people	April 2023	YDH, SFT and Endocrinology	Support for those with gestational diabetes
• Prevention for long-term impacts on health (Cardiovascular disease/Type2 Diabetes)	By 2025	Public Health Somerset, Somerset ICB	Reduction in CVD and diabetes related complications
• Increase awareness for Health Visitors and Primary Care of current NHS Diabetes programme that target high risk individuals	April 2023	Somerset ICB	Increased awareness

Health Inequalities (LBGTQ+ Community)			
• Somerset pilot project- The LGBT maternity Journey training package for midwives and other health professionals	End of 2023	Somerset ICB and MVP	Increased awareness
• Inclusive Culture where all staff are valued and heard	Ongoing	All system partners	NA
• Explore Inclusion Midwife role and Inclusion policy	End of 2024	YDH and SFT	NA
• Connecting with the local trans and non-binary community	April 2023	MVP and SCC	NA
• Developing our services and environment to be more inclusive	Ongoing	All system partners	NA
• Producing guidance on inclusive language and communication	End of April 2023	All system partners	NA
Health Inequalities (Gypsy, Roma and Traveller Communities)			
• Meeting access needs of somerset population	Ongoing	All system partners	NA
• Ensure appropriate information giving using as many pictures as words and link in with outreach services to help you promote services	Ongoing	All system partners	NA
• Support primary care services with inclusion and continuity • Improve the quality of coding in health records to include GRT community	Ongoing By end 2026	All system partners	NA
Health Inequalities (Learning Disabilities)			
• Following best practice guidance for Parents with Learning Disabilities	Ongoing	All system partners	NA
• Development of a co-produced Enhanced Parenting Pathway	End 2023	All system partners	NA
• Planned Gap analysis for support to pregnant women/people and/or partners with special educational needs and disabilities	End 2023	YDH and SFT	NA
• Ensure resources already in Public domain are utilised to aid decision making How to help women with learning disabilities access antenatal and newborn screening - PHE Screening (blog.gov.uk)	Ongoing	All system partners	NA

Health Inequalities (Physical Disabilities)			
• Meeting access needs of somerset population including those with a disability	Ongoing	All system partners	NA
• Ensure appropriate information giving	Ongoing	All system partners	NA
• Enable women/pregnant people to participate equally in all decision-making processes and to make informed choices about their care	Ongoing	All system partners	NA
Health Inequalities (Non-English speaking or English as an additional language)			
• Promotion of consistent use of professional translation services	Ongoing	All system partners	NA
• Promotion of standardised Material/leaflets	Ongoing	All system partners	NA
• Personalised care and support planning in both digital and hard copy, available in a range of languages and formats by end of 2024			

10. MATERNITY GOVERNANCE ARRANGEMENTS



11. GLOSSARY

Term	Definition
Accessibility	The quality of being easy to obtain or use
Asphyxia	A condition arising when the body is deprived of oxygen, causing unconsciousness or death; suffocation
Bereavement	Bereavement is the period of grief and mourning after a death
Bronchopulmonary dysplasia	The result of a newborn's lungs not developing normally while the baby is growing in the womb, or not developing fully if the baby was born premature
Cardiovascular disease	a general term for conditions affecting the heart or blood vessels
Chest feeding	Feeding your baby with milk from your chest
Cholesterol	A waxy, fat-like substance made in the liver, and found in the blood and in all cells of the body.
Commissioning	Is the continual process of planning, agreeing and monitoring services.
Congenital abnormality	A wide range of abnormalities of body structure or function that are present at birth and are of prenatal origin
Deprivation	The state of being kept from possessing, enjoying, or using something
Discrimination	The unjust or prejudicial treatment of different categories of people, especially on the grounds of race, age, sex, or disability.
Diversity	The practice or quality of including or involving people from a range of different social and ethnic backgrounds and of different genders, sexual orientations, etc.
Endocarditis	A life-threatening inflammation of the inner lining of the heart's chambers and valves

Equity	Justice according to natural law or right specifically: freedom from bias or favouritism
Gestation	The process or period of developing inside the womb between conception and birth
Hyperemesis Gravidarum	Excessive nausea and vomiting and often needs hospital treatment.
Hypoglycaemia	Is where the level of sugar (glucose) in your blood drops too low.
Inequity	Lack of fairness or justice
Informed consent	Permission granted in full knowledge of the possible consequences, typically that which is given by a patient to a doctor for treatment with knowledge of the possible risks and benefits.
Integration	The act or process of uniting different things
Intersectionality	Is the acknowledgement that everyone has their own unique experiences of discrimination and oppression
Lactation	The secretion of milk by the mammary glands
Macrosomia	Term used to describe a newborn who's much larger than average
Necrotising Enterocolitis	Necrotising enterocolitis (NEC) is a serious condition that can affect newborn babies, where tissue in the bowel (small and large intestines) becomes inflamed
Ondansetron	Is a medication used to treat severe cases of sickness
Orofacial cleft	Cleft lip and cleft palate are birth defects that occur when a baby's lip or mouth do not form properly during pregnancy. Together, these birth defects commonly are called "orofacial clefts"
Osteoporosis	Osteoporosis is a health condition that weakens bones, making them fragile and more likely to break
Palivizumab	Palivizumab injection is used to prevent serious lung infection in children and babies caused by respiratory syncytial virus (RSV).

Periodontal disease	Are mainly the result of infections and inflammation of the gums and bone that surround and support the teeth
Preconception	The time before a woman/person becomes pregnant
Pre-eclampsia	Is a condition that causes high blood pressure during pregnancy and after labour. It can be serious if not treated
Protected Characteristics	Having a protected characteristic means you have a right not to be treated less favourably, or subjected to an unfair disadvantage, by reason of that characteristic, for example, because of your age, race, religion, sex or sexual orientation
Shoulder dystocia	A birth injury (also called birth trauma) that happens when one or both of a baby's shoulders get stuck inside the mother's pelvis during labour and birth
Socio-economic	Relating to or concerned with the interaction of social and economic factors
Sustainability	Sustainability consists of fulfilling the needs of current generations without compromising the needs of future generations, while ensuring a balance between economic growth, environmental care and social well-being
Teratogenic potential	Some medicines are known or suspected to have the potential to increase the risk of birth defects and development disorders
Thromboembolism	A circulating blood clot that gets stuck causing obstruction
Triglyceride	Triglycerides are a type of fat. They are the most common type of fat in your body
Valproate	Sodium valproate is a medication used to treat epilepsy and bipolar disorder. It's occasionally used to prevent migraine headaches

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13. Appendix

Appendix 1- Somerset Equity and Equality Action Plan Overview