Healthcare Improvement Scotland

Scottish Patient Safety Programme

Racialised Health Inequalities in Perinatal Services

Monday, 19 August 2024

Leading quality health and care for Scotland

NHS SCOTLAND

Aims of the webinar

- Describe how racialised health inequalities relate to the SPSP Perinatal driver diagrams.
- Explore the current context of racialised perinatal inequalities in Scotland within the global context.
- Understand the intrapartum care experience and outcomes for minority ethnic women and birthing people in Glasgow.

SPSP Perinatal introduction

Jo Thomson

Senior Improvement Advisor

Healthcare Improvement Scotland

Essentials of Safe Care Driver Diagram

Aim

To enable the delivery of Safe Care for every person within every system every time

Primary Drivers

- Person centred systems and behaviours are embedded and support safety for everyone
- Safe communications within and between teams
- Leadership to promote a culture of safety at all levels
- Safe consistent clinical and care processes across health and social care settings

Secondary Drivers

- Structures & processes that enable safe, person centred care
- Inclusion and involvement
- Workforce capacity and capability
- Skills : appropriate language, format and content
- Practice : use of standardised tools for communication
- Critical Situations : management of communication in different situations
- Psychological safety
- Staff wellbeing
- System for learning
- Reliable implementation of Standard Infection Prevention and Control Precautions (SICPS)
- Safe Staffing

Perinatal Driver Diagrams

What we are trying to achieve…

Reduction in stillbirth

Reduction in Neonatal Mortality and Morbidity

Reduction in harm from deterioration

Understand variation in caesarean births across NHS Scotland

Essentials of Safe Care

We need to ensure…

Person centred care* considers the Continuity of Carer approach

Which requires…

Inclusive care pathways which provide equitable and culturally appropriate access and treatment

Change Ideas…

Co-produced person centred care plans consider ethnicity, deprivation and individual communication needs

Social determinants addressed through onward referral to appropriate services

Staff afforded flexibility to provide care proportionate to need for those experiencing severe and multiple disadvantage

Provision of timely interpretation services support

Local education for staff to enable support for those experiencing severe and multiple disadvantage

Staff able to identify, challenge and change the values, structures and behaviours that perpetuate systemic racism

Scottish Government - Short life working group

- Work launched January 2023
- Multi-agency and multi-disciplinary representation
- 5 meetings across 2023-2024
- Outputs from the group being finalised

Disrupting the Future of Racialised Perinatal Disparities in Scotland

Isioma Okolo

Consultant Obstetrician & Gynaecologist

NHS Forth Valley

www.drisiomaokolo.com

No Conflict of Interest

- RCOG Race Equality Taskforce
- Scottish Government Short Life Working Group
- Director of KWISA
- Trustee AMMA Birthing Companions

Outline

- Important terminology
- Global statistics
- Scottish picture
- Evidence base & interventions
- My reflections
- Useful resources
- *jade summary slides

Learning Objectives

1. Describe patterns of racialised perinatal inequities in Scotland
2. Distinguish between race, ethnicity & class
3. Recognise racism as a structural determinant of perinatal health
4. Be aware of evidence base for interventions
5. Appreciate that racialised perinatal disparities are directly linked to safety and quality of care

Race ≠ Ethnicity ≠ Class

Social NOT biological classifications based on:

Race = artificially defined groups assigned in the 17th century around colonialism & eugenics.

Ethnicity = cultural ancestry, religion, language, diet, physical characteristics, affinity to racial categories.

Class = economic status, wealth, income, educational attainment, occupation.

A Quick Note on Intersectionality

- Our systems are set to a default
- You are more likely to experience adversity if you are not the default
- There is nothing innately wrong with Black and Brown bodies

Structural Determinants of (Perinatal) Health

SDH

The most important

80% of your life

Conditions in which you are born, educated, work and age.

*genetics
*access to health care

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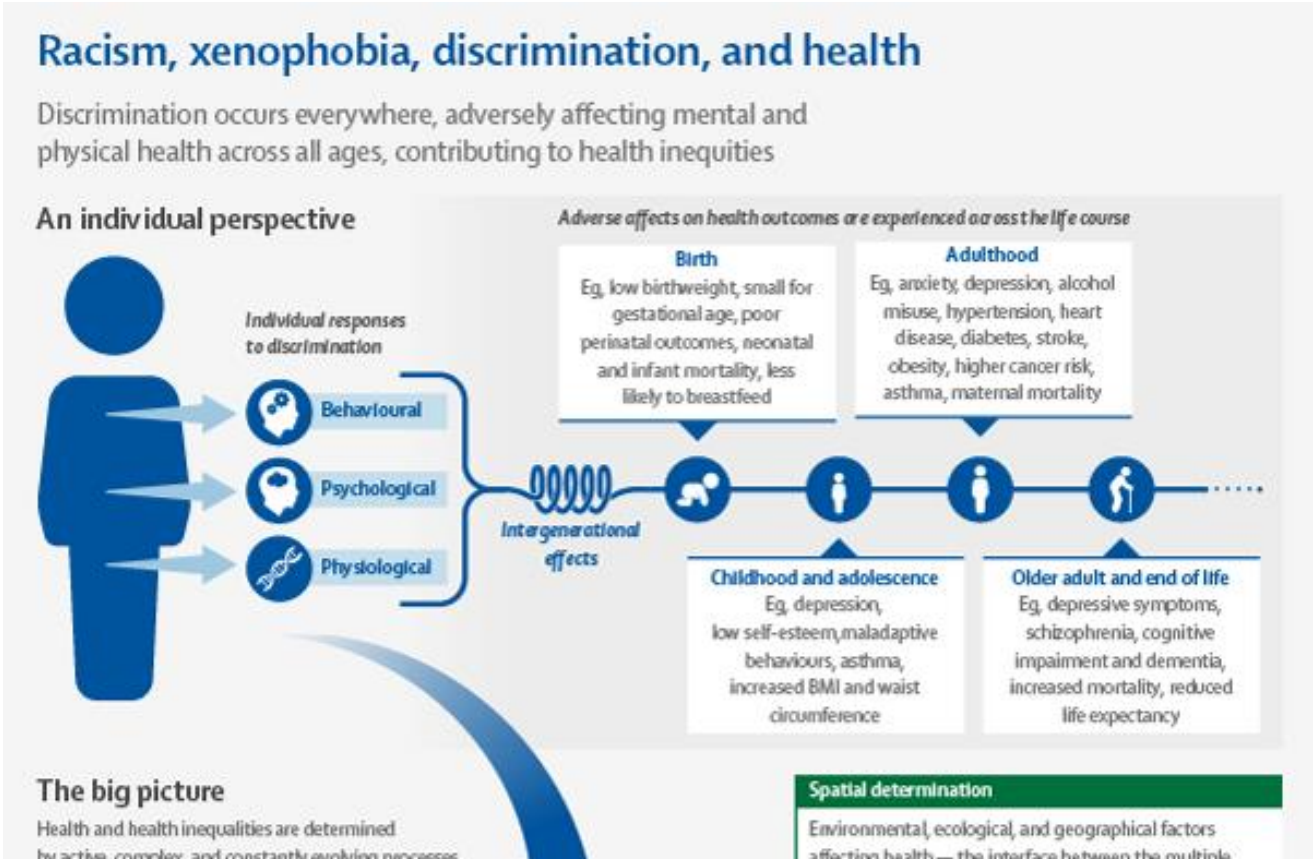
Racialised Perinatal Disparities are Linked to Racism



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The *Lancet* Series on racism, xenophobia, discrimination, and health

In Summary

1. Race is a social construct not a biological phenomenon

2. Systemic and institutional racism are structural determinants of health

    Behavioural changes

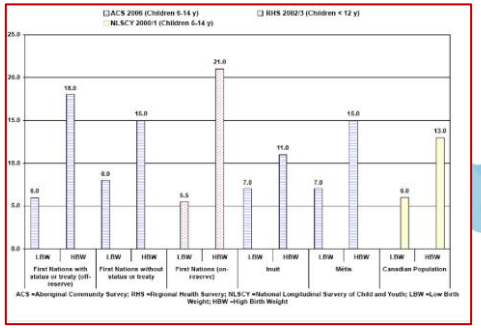
    Physiological changes: exposure to allostatic stress

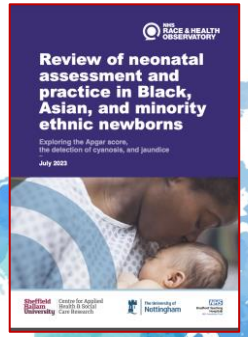
    Psychological changes

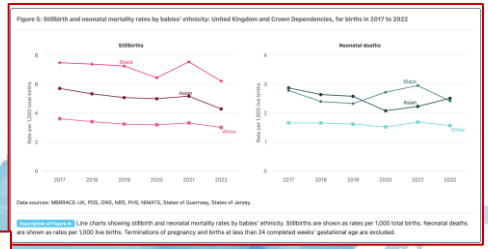
3. The way we treat pregnant womxn and people matters (during and beyond pregnancy)

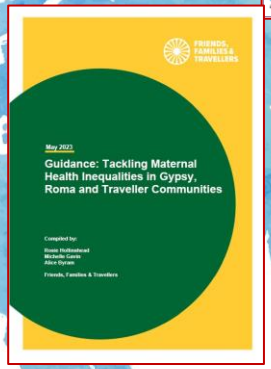
Differential access → Differential experience → Differential outcomes

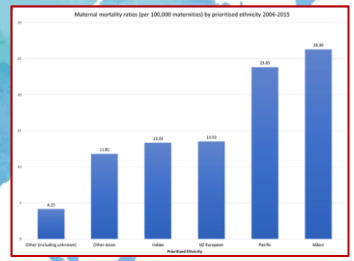
Global Picture of Perinatal Disparities

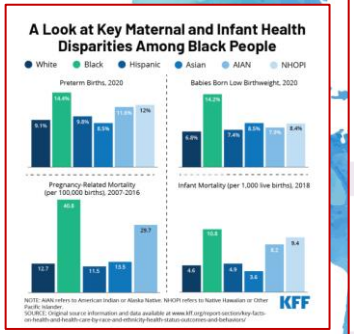


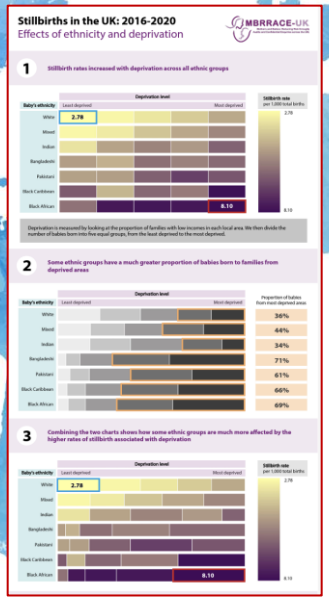




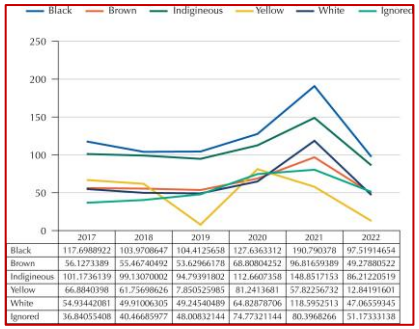




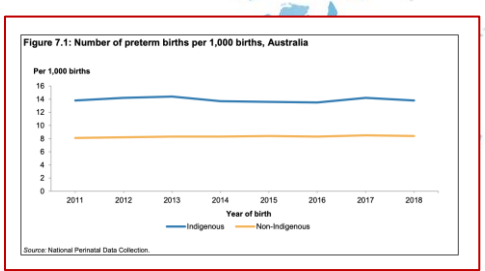




Maternal Mortality in Brazil per 100,000 livebirths



	2017	2018	2019	2020	2021	2022
Black	117.6988922	103.9708647	104.4125658	127.6363312	190.790378	97.51914654
Brown	56.1273389	55.46740492	53.62966178	68.80804252	96.81659389	49.27880522
Indigineous	101.1736139	99.13070002	94.79391802	112.6607358	148.8517153	86.21220519
Yellow	66.8840398	61.75698626	7.850525985	81.2413681	57.82256732	12.84191601
White	54.93442081	49.91006305	49.24540489	64.82878706	118.5952513	47.06559345
Ignored	36.84055408	40.46685977	48.00832144	74.77321144	80.3968266	51.17333138



Scotland: Birth Statistics (2023)

11% of maternities were ethnic minoritised womxn

- 5.4% Asian
- 2.2% African

Majority of these women cared for in NHS GGC (50%), Lothian and Grampian.

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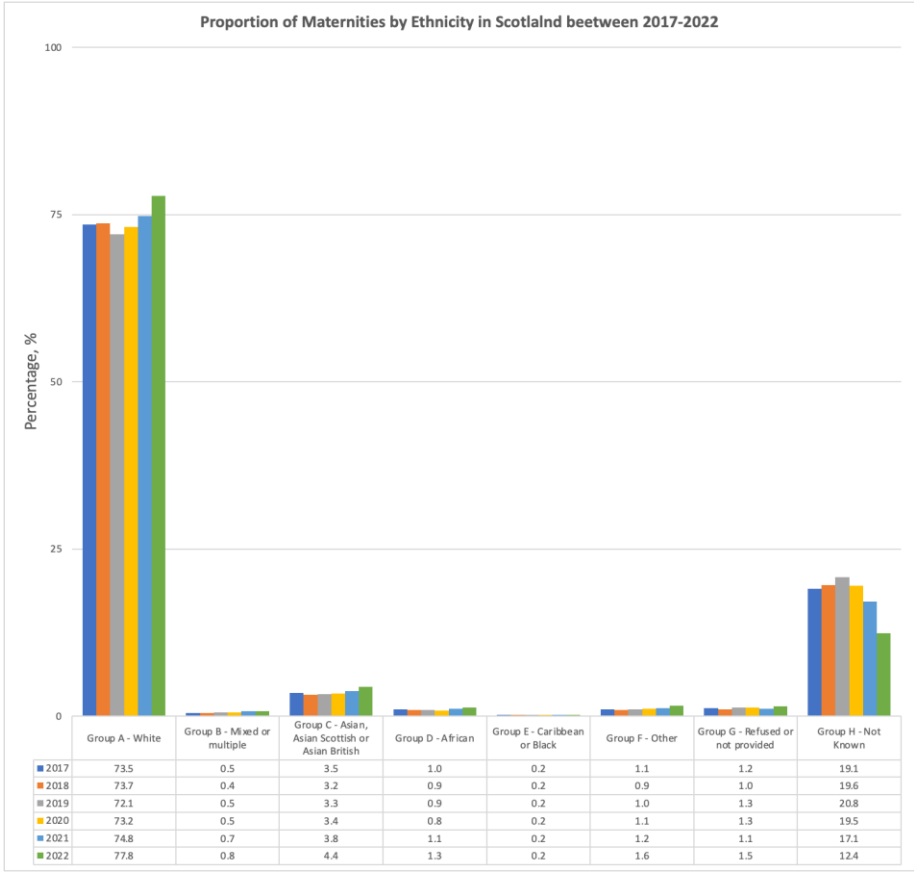
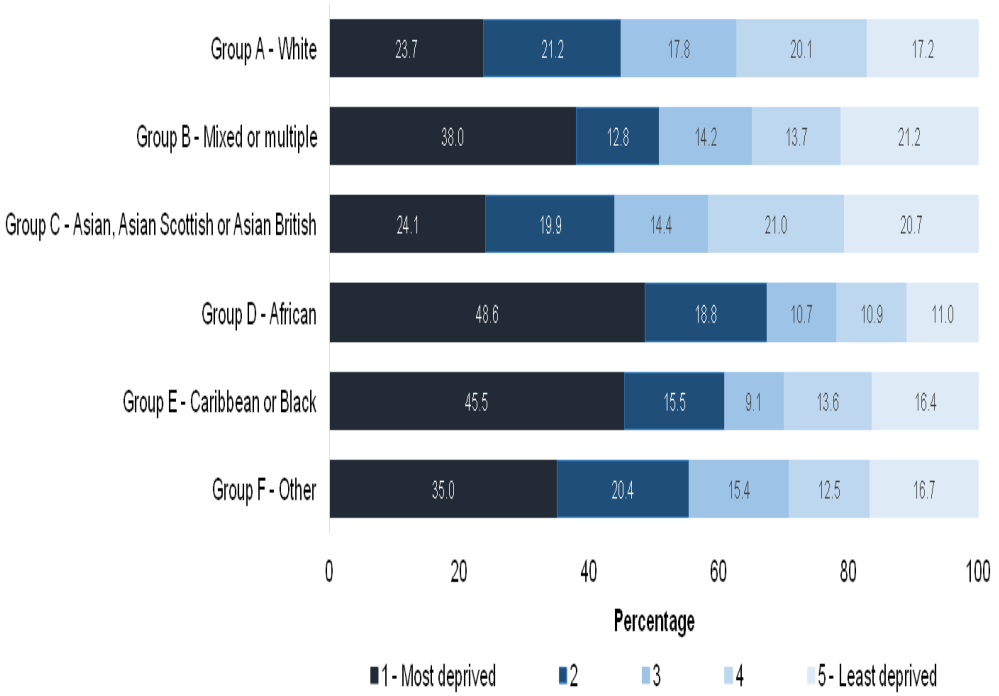


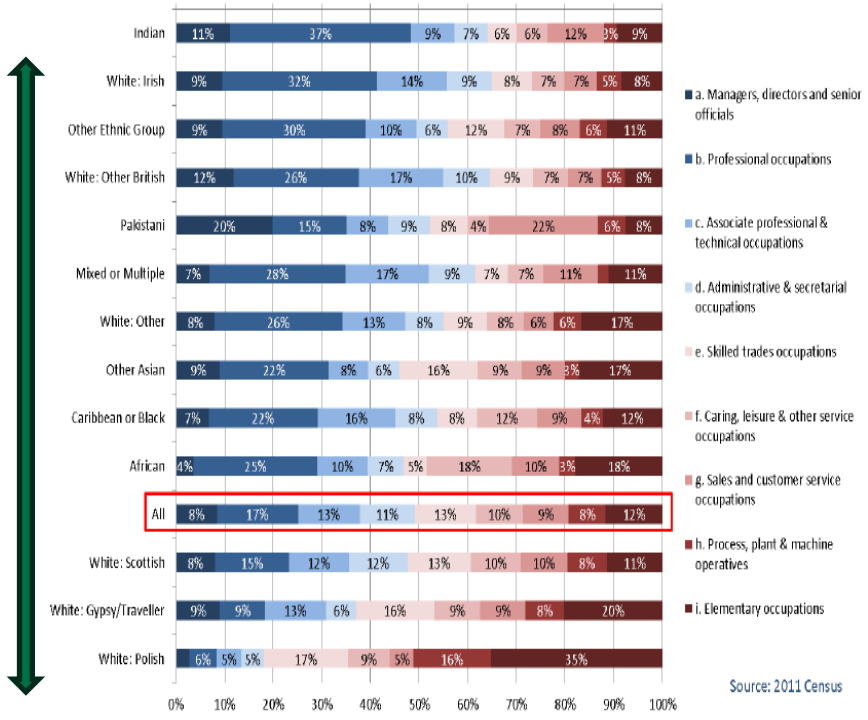
	Group A - White	Group B - Mixed or multiple	Group C - Asian, Asian Scottish or Asian British	Group D - African	Group E - Caribbean or Black	Group F - Other	Group G - Refused or not provided	Group H - Not Known
2017	73.5	0.5	3.5	1.0	0.2	1.1	1.2	19.1
2018	73.7	0.4	3.2	0.9	0.2	0.9	1.0	19.6
2019	72.1	0.5	3.3	0.9	0.2	1.0	1.3	20.8
2020	73.2	0.5	3.4	0.8	0.2	1.1	1.3	19.5
2021	74.8	0.7	3.8	1.1	0.2	1.2	1.1	17.1
2022	77.8	0.8	4.4	1.3	0.2	1.6	1.5	12.4

Public Health Scotland. Births in Scotland .Births in Scotland

Scotland: Birth Statistics (2022)

Percentage of maternities with a known ethnicity, by deprivation category

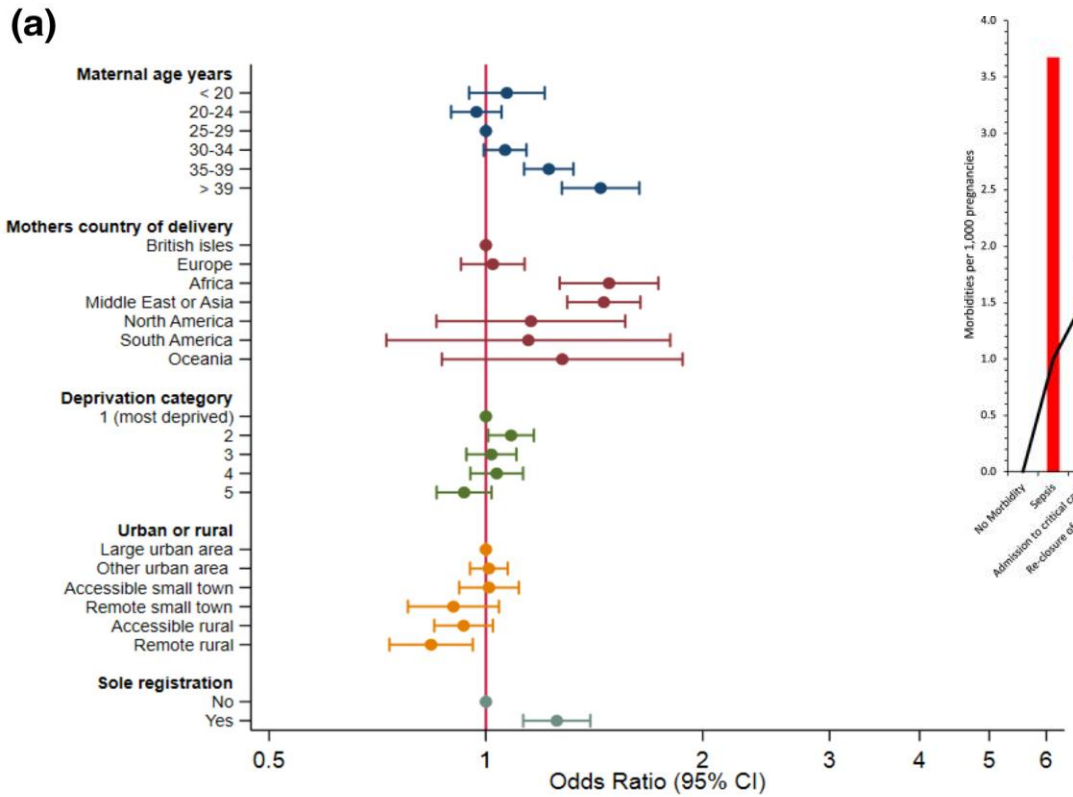


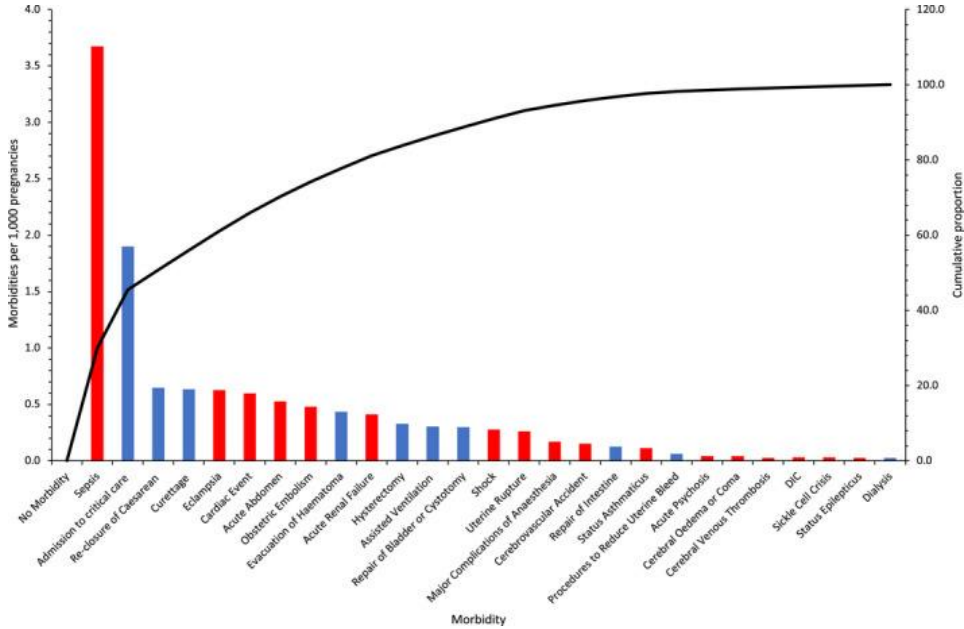


Ethnic Group by Occupational Group, people aged 16-74 in employment 2011 Census

Scotland: Severe Maternal Morbidity

Masterson JA, Adamestam I, Beatty M, et al. Severe maternal morbidity in Scotland. *Anaesthesia*. 2022;77(9):971-980. doi:10.1111/anae.15798





Pareto chart of the rates of 26 severe maternal morbidities per 1000 pregnancies, conditions (red) and procedures (blue). The black line is the cumulative proportion for all severe morbidities. DIC, disseminated intravascular coagulation.

Scotland: Health & Ethnicity Linkage Study (2014)

Ethnic minoritised womxn had **healthier maternal health behaviours**

- Non-smokers
- **Breast** feeding

Healthy Migrant Effect*

- Healthier than minoritised UK born womxn

More likely to live in economic deprivation

- **Older at booking** (except Pakistani womxn)
- **Overweight or** BMI
- Small for gestational age babies
- Pre-term birth

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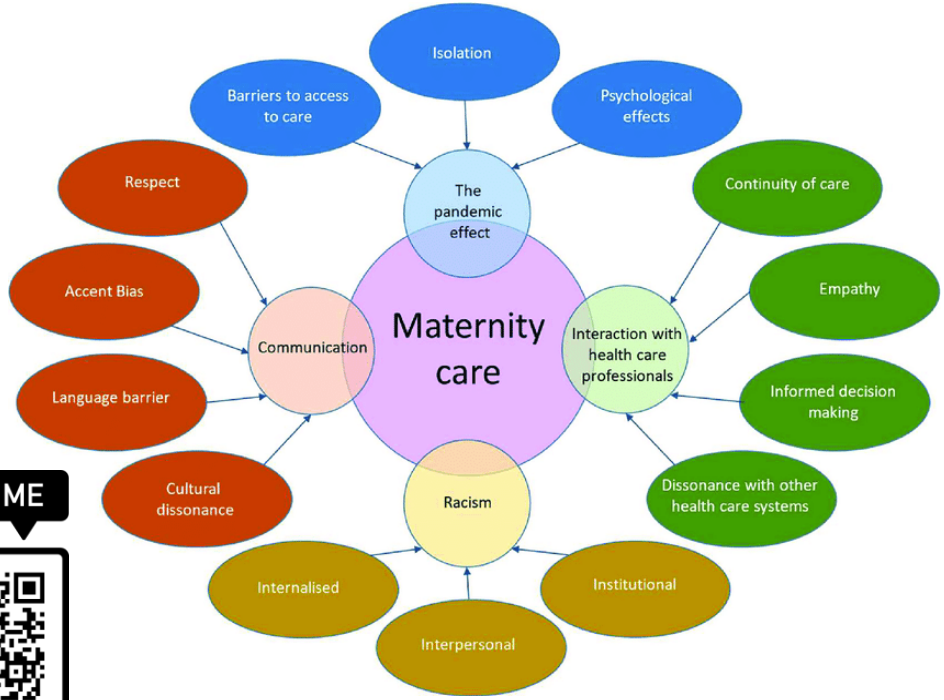
Scotland: Experience of Care

John JR, Curry G, Cunningham-Burley S.
Exploring ethnic minority women's experiences of maternity care during the SARS-CoV-2 pandemic: a qualitative study
BMJ Open 2021;**11:**e050666. doi: 10.1136/bmjopen-2021-050666



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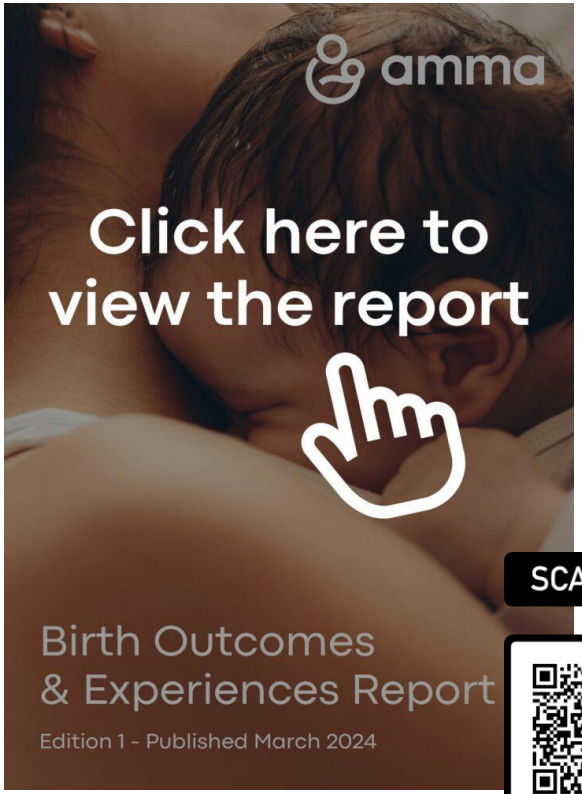

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In Summary

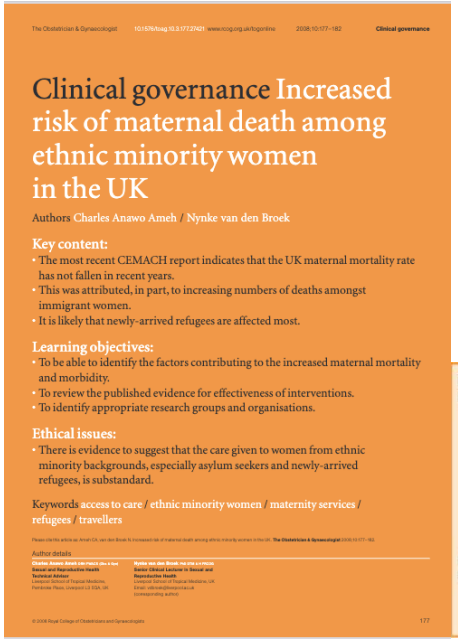
Pregnant womxn in Scotland are more likely to live in deprivation.

Racially minoritised pregnant womxn make up a higher proportion of the pregnant population than the general population

Scotland shares similar patterns in perinatal inequities to other regions of the world despite racialised minorities making up a smaller proportion of the Scottish population than other parts of the world.

Evidence Based of Interventions

- 2009 systematic review (TOG)
- 2023 Scoping review (RHO)



Clinical governance Increased risk of maternal death among ethnic minority women in the UK

Authors Charles Anawo Ameh / Nynke van den Broek

Key content:

- The most recent CEMACH report indicates that the UK maternal mortality rate has not fallen in recent years.
- This was attributed, in part, to increasing numbers of deaths amongst immigrant women.
- It is likely that newly-arrived refugees are affected most.

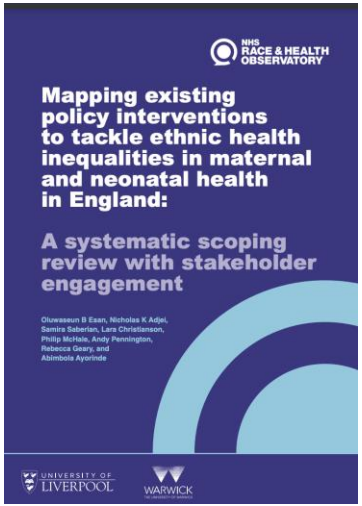
Learning objectives:

- To be able to identify the factors contributing to the increased maternal mortality and morbidity.
- To review the published evidence for effectiveness of interventions.
- To identify appropriate research groups and organisations.

Ethical issues:

- There is evidence to suggest that the care given to women from ethnic minority backgrounds, especially asylum seekers and newly-arrived refugees, is substandard.

Keywords access to care / ethnic minority women / maternity services / refugees / travellers



Effective or promising interventions	**Health advocacy for non-English speaking women** Effective in increasing the length of antenatal stay (reducing antenatal care dropout rate) and lowering the rates of induction of labour and elective caesarean section
	Link and bilingual workers Increases Asian women's satisfaction with services and may increase their knowledge of health services and healthy practices, particularly breastfeeding
	Prepregnancy defibulation for female genital mutilation Has the potential to reduce the risk of haemorrhage and severe pain during childbirth
	Training of lay women and multilingual pharmacists May result in increase in the uptake of health education messages
Interventions that have not been found to be effective	**Health advocacy** Unlikely to improve late booking, nonattendance at antenatal clinics and rates of low birthweight
	Link worker services Unlikely to improve the time of booking, gestational age at delivery and rates of low birthweight

Figure E1 Map of identified interventions and levels of the conceptual framework

Intervention	1. Patient	2. Provider	3. Microsystem	4. Organisation	5. Community	6. Policy
Vitamin D supplementation	1	0	0	0	0	0
Thalassaemia screening	2	1	0	0	0	0
Sweet Mother	0	1	0	0	1	0
SCT screening	1	0	0	0	0	0
Postnatal lay support	0	1	0	0	0	0
ORAMMA	1	1	1	1	1	0
Migrant maternity services	0	1	0	0	1	0
Link worker for Asian mothers and babies	1	0	0	0	1	0
Link worker for weaning Asian babies	1	1	0	0	0	0
Interpreter services	0	2	0	0	0	0
Health advocacy - Multi-Ethnic Women's Health Project	1	0	0	0	1	0
FMF First trimester screening	1	0	0	0	0	0
Culturally adapted CBT for South Asian women	1	0	0	0	1	0
Caseload midwifery	1	1	1	1	1	1
Baby steps	1	1	1	0	1	0
Antenatal education	2	0	0	0	0	0
Albany idwifery Practice Model	1	1	1	1	1	1

Framework

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Interventions: Alliance for Innovation on Maternal Health Safety Bundle (USA)

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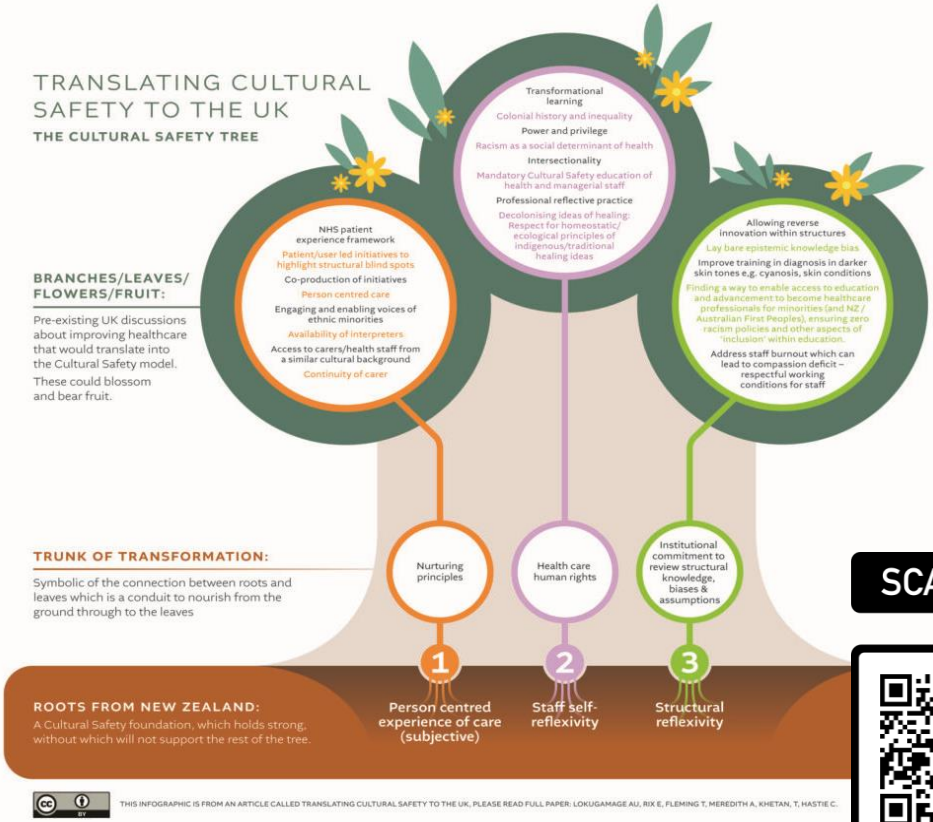
	Systems	Service User	Service Provider
READINESS	Medical records that capture race & ethnicity	Awareness on importance of race & ethnicity reporting Engage strategic users, families and community advocacy groups in quality and safety leadership initiatives	Awareness and education - Racial disparities and their root causes - Enquiry and documentation of demographics - Availability and use of interpreter services - Shared decision making
RECOGNITION & PREVENTION	Reporting mechanisms for examples of inequitable care, disrespect, racism for users and providers	Access to health records	Implicit bias training
RESPONSE	Timely response to reports of inequitable care Life course approach to contraception	Robust safety netting on discharge Provision of culturally, health literacy appropriate information leaflets	
REPORTING & LEARNING SYSTEMS	Disparity dashboards disaggregated by race, ethnicity that are regularly disseminated Apply equity lens in SAER reviews Develop QI projects aimed at reducing disparities in experiences, treatment, outcomes	Review complaint, compliments and litigation by race & ethnicity	Foster inclusive and psychologically safe work cultures

AIM

Interventions: Cultural Safety (Aotearoa New Zealand)

Irihapeti Ramsden



Applying Equity Lens & Systems Learning to Adverse Events Review

Consider the role of race, ethnicity, language, poverty, literacy and other complex social factors when conducting multidisciplinary reviews of severe maternal morbidity, mortality, complaints and other clinically important metrics.

- ✓ Did the individual affected in this case have an equity risk factor? YES/NO/MAYBE
  (If yes please tick all that apply
- ✓ Did any of these equity risk factors contribute to their outcome?YES/NO/MAYBE
  (If yes please tick all that apply
- ✓ If so, are there systems changes that can be implemented to change things?

GRADE 4 Evidence: expert opinion

Prusova, K & Tyler, A & Churcher, L & Lokugamage, Amali. (2014). **Royal College of Obstetricians and Gynaecologists guidelines: How evidence-based are they?.**

Journal of obstetrics and gynaecology : the journal of the Institute of Obstetrics and Gynaecology. 34. 1-6. 10.3109/01443615.2014.920794.

40% of evidence from RCOG guidelines were lowest grade E-based on "expert opinion"

Table II. The classification scheme for the recommendations by the Royal College of Obstetricians and Gynaecologists.

	Classification scheme for recommendations by the Royal College of Obstetricians and Gynaecologists
Pre-December 2007	
A	At least one randomised controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation.
B	Requires the availability of well controlled clinical studies but no randomised clinical trials on the topic of recommendations.
C	Requires evidence obtained from expert committee reports or opinions and/or clinical experiences or respected authorities. Indicates an absence of directly applicable clinical studies of good quality.
D	Recommended best practice based on the clinical experience of the guideline development group.
Post-December 2007	
A	At least one meta-analysis, systematic review or randomised controlled trial rated as 1++ directly applicable to the target population and demonstrating overall consistency of results. A systematic review of randomised controlled trials or a body of evidence consisting principally of studies rated as 1+ directly applicable to the target population and demonstrating overall consistency of results.
B	A body of evidence including studies rated as 2++ directly applicable to the target population, and demonstrating overall consistency of results. Extrapolated evidence from studies rated as 1++ or 1+.
C	A body of evidence including studies rated as 2+ directly applicable to the target population and demonstrating overall consistency of results. Extrapolated evidence from studies rated as 2++.
D	Evidence level 3 or 4. Extrapolated evidence from studies rated as 2+.
E	Recommended best practice based on the clinical experience of the guideline development group.

The expert is either always in the room or never in the room

Community participation: NHS Lothian

- Cultural safety
- Relationship (trust) building
- Bidirectional education
- Power
- Working within the system

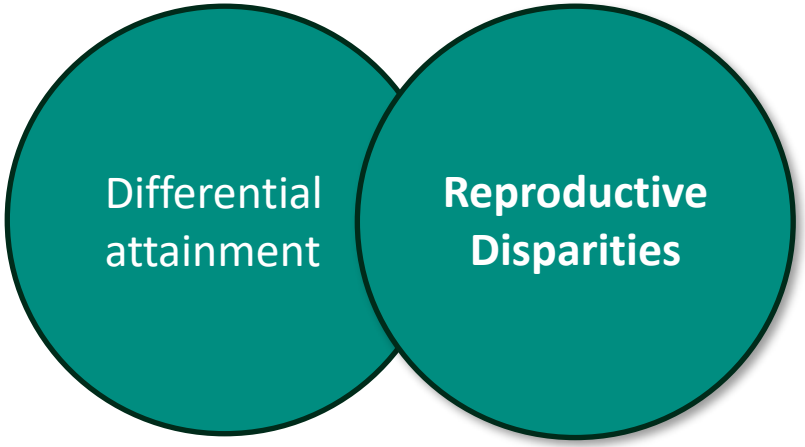
What did the Women Share With Us?

- Feeling alone and unsupported
- Not being given basic information about what was happening to them during induction, labour, difficult delivery, and miscarriage
- Not being listened to when their instinct was telling them something was wrong
- No being given any choice and no involvement in the decisions
- Bad pain management especially during and after C section and for tear repair
- Challenges of being alone on the PN ward and after leaving hospital - limited follow up
- No family support to fall back on
- Financial insecurity
- A few women had positive experiences because their midwife supported them fully, providing empathy, humanity and compassion which helped them feel in control and supported even through difficult and potentially traumatic births.

What Matters to You?

The NHS is an ANCHOR Institution (can level the playing field)

- Employment (income)
- Differential attainment
  - Recruitment, progression, retention
- Healthy workplace culture
  - Discrimination & racism
  - Psychological safety
  - Inclusion & belonging



Achieve Accountability with Clinical Governance

1. Multi-disciplinary and cross sector collaboration
   - Including patients, and community groups
   - Co-creation through engagement NOT consultation
2. Data
   - Disaggregated
   - Linked to KPIs, SAER, Complaints & compliments
   - Proactively tracked (disparity dashboard & audits)
3. Education
   - Training (case based, simulation, multi-disciplinary, mandatory)
   - Cultural safety and anti-racism
   - Guidelines
   - Patient information leaflets
   - Bidirectional
4. Innovate using QI and research

In Summary

Racialised perinatal inequalities are examples of unsafe and poor-quality care.

Race is a social construct not a biological phenomenon(distinct from ethnicity)

To tackle racialised perinatal disparities we must address structural determinants of perinatal health including racism

To advance we must disaggregate, monitor, respond to and learn from disparities

Clinical governance is the accountability key to move

Solutions should combine lived and professional expertise

Useful Resources

Terminology

Glossary of terms relating to ethnicity & race

Risky Bodies & Risk Assessments: melanin is not a risk factor — DR ISIOMA OKOLO

A race to the finish line (wiley.com)

Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition | International Journal for Equity in Health | Full Text (biomedcentral.com)

Global Statistics

The Lancet Series on racism, xenophobia, discrimination, and health

https://www.npeu.ox.ac.uk/mbrrace-uk/reports (UK)

https://www.kff.org/racial-equity-and-health-policy/slide/a-look-at-key-maternal-and-infant-health-disparities-among-black-people/ (USA)

Monitoring racialised health inequalities in Scotland 30 May 2023 - Monitoring racialised health inequalities in Scotland - Publications - Public Health Scotland

SciELO - Brazil - Racial disparities and maternal mortality in Brazil: findings from a national database Racial disparities and maternal mortality in Brazil: findings from a national database (Brazil)

Figure 1 from Indigenous Birth Outcomes in Australia, Canada, New Zealand and the United States – an Overview | Semantic Scholar (Canada)

Interventions

https://www.ihi.org/resources/publications/black-maternal-health-reducing-inequities-through-community-collaboration#downloads

Translating Cultural Safety to the UK (bmj.com)

https://www.nhsrho.org/research/mapping-of-existing-policy-interventions-to-tackle-ethnic-health-inequalities-in-maternity-and-neonatal-health-in-england-a-systematic-scoping-review-with-stakeholder-engagement/

https://saferbirth.org/psbs/archive-reduction-peripartum-disparities/

https://www.ihi.org/resources/publications/black-maternal-health-reducing-inequities-through-community-collaboration#downloads

Intrapartum care experience and outcomes for minority ethnic women and birthing people in Glasgow

Nicola O’Brien

Midwife Led Intrapartum Care Project Midwife

Princess Royal Maternity, NHS Greater Glasgow & Clyde

Ethnicity and Healthcare

Pregnancy in the UK remains safe, however inequities in care still exist. Women from minority ethnicities and those living in the most deprived areas still have higher rates of morbidity and mortality within maternity.

Women from these groups continue to have higher rates of:

- Preterm birth before 32 weeks
- Stillbirth
- Neonatal Death
- Caesarean births
- Post partum Haemorrhage > 1500ml

Relative rate of poverty in Scotland:

- 50% of Asian or Asian British
- 51% of Mixed, Black or Black British
- 22% for White – other
- 18% White British

MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

NMPA
National Maternity & Perinatal Audit

Cultural Safety

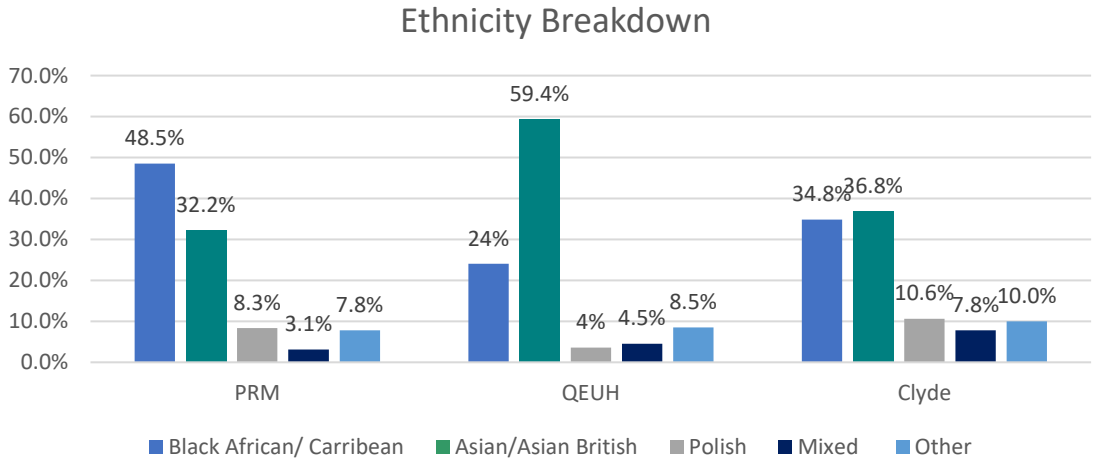
Cultural Safety can be described as a set of principles which includes behaviours, attitudes and policies within a system or profession that enables effective working in cross-cultural situations

It is an ongoing process in which health and care service providers and professionals actively work to provide for the needs of the individual, family or community in a way that recognises and incorporates an appreciation of their diverse beliefs, values and expectations. (Campinha-Bacote J, 2002)

Greater Glasgow and Clyde

Greater Glasgow and Clyde has one of the largest populations of Black, Asian and minority ethnicity families in Scotland.

Within our Glasgow maternity units, over 31% of our population descends from minority ethnicities




Artisan Artworks: Princess Royal Maternity Hospital

Focus Groups

8 Focus groups with a total of 33 women and 14 support workers from Amma Service, British Red Cross and Roma Workers. 2 focus groups with 15 midwives in 2022

"When we are alone without the birthing partners they do not listen to us" – Mixed ethnicity

"NHS staff should understand different communities and cultures instead of making assumptions." – Mixed ethnicity

'women have said ''they don't feel valued" and "tone of voice different when speak to white women" by some reception area staff' - Midwives

'…interpreter phone based system is a barrier for emergencies. Staff reports of interpreters lack of availability (for Vietnamese, Amharic, Tigrinya, Omaro).' – Midwives

"Midwifes don't check if patient can read and write English or their own language. Information often handed over without checking if they will be able to read the material". – African group

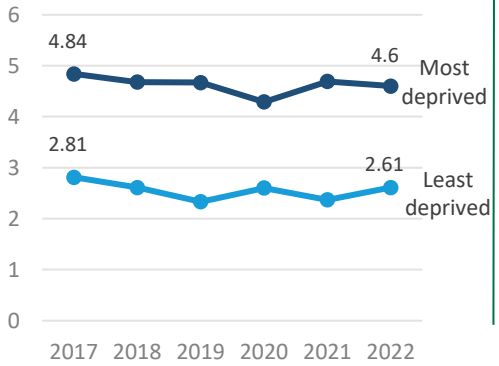
"They do not believe the pain we were going through and did not provide any pain relief. Unless the support workers intervene and ask on our behalf"- African group

Perinatal Outcomes

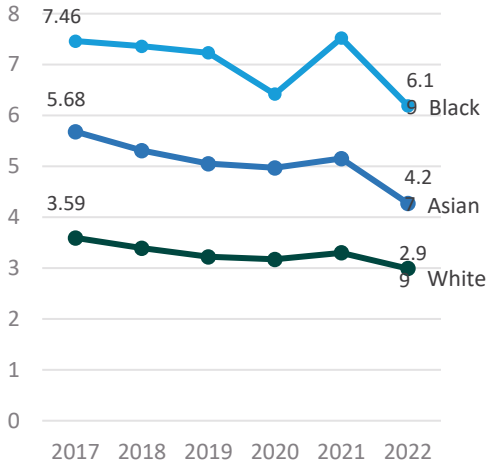
MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

UK Stillbirth rate per 1,000 births

Deprivation



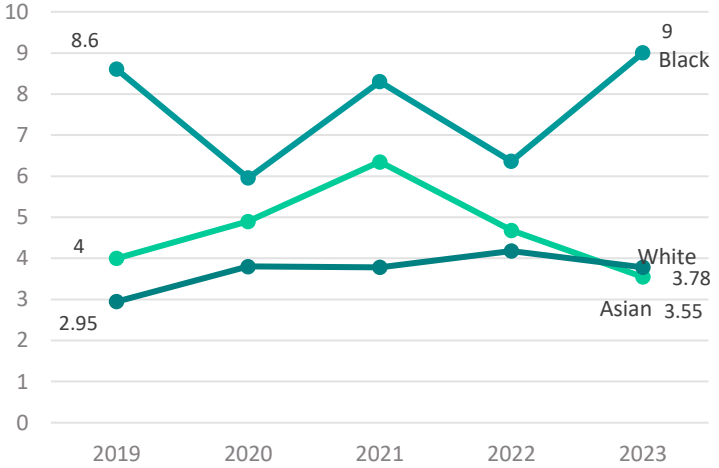
Ethnicity



NHS Greater Glasgow and Clyde

GGC Stillbirth rate per 1,000 births

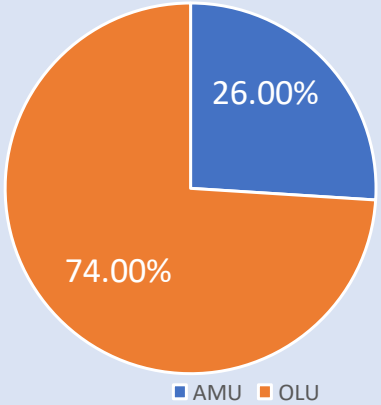
Ethnicity



PRM Low Risk Intrapartum Care

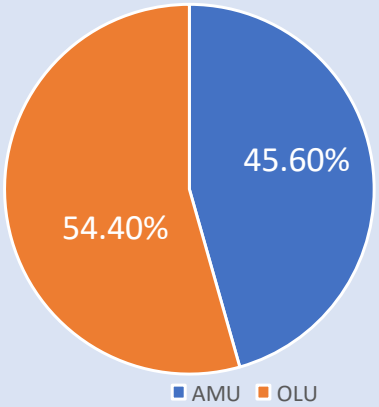
13.8% of our minority ethnic population in the Princess Royal were identified as low risk compared to 14.3% of White British women.

% OF LOW RISK MINORITY ETHNIC WOMEN ADMITTED TO OLU VS AMU



55.9% of low risk minority ethnicities were incorrectly risk assessed vs 24.4% of low risk white women

% OF LOW RISK WHITE BRITISH WOMEN ADMITTED TO OLU VS AMU



Care Outcomes

Intrapartum/ Birth	Minority Ethnicities	White British
CTG no indication	43%	18%
Fetal Scalp Electrode	17%	15.4%
Intrapartum Syntocinon	9%	6.9%
Spontaneous Vaginal Birth	86.8%	81.6%
Unplanned Caesarean Births	6%	5%
PPH > 1000mls	7.5%	8.8%
Episiotomy	16.9%	10%
$3^{rd}/4^{th}$ Degree tear	7.5%	7.3%

Neonatal	Minority Ethnicities	White British
Neonatal Resuscitation	5.7%	4.4%
Low Cord PH	3.7%	1.5%
Neonatal Admissions	1.8%	0%

Common Themes

- Incorrectly labelled as ‘Late booker’
- Previous FGR or LGA baby but growth normal this pregnancy
- Asylum seeker or doesn’t speak English
- Incorrectly labelled as ‘Induction’
- Poor Communication

Antenatal Case Studies

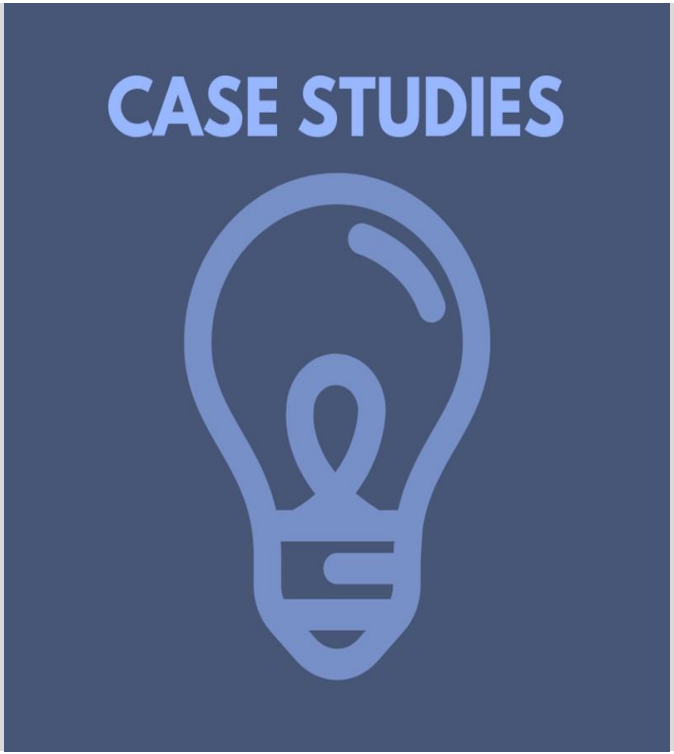
1

Fatima Afzal

33 yr. old 1+0
2020: SVB at 40+1. 2524g at birth (<3rd Centile)

Booked in GGC at 33 weeks. Originally from Somalia. Had initial antenatal care in London. Speaks Arabic. BMI 17.5

Risk Assessment:
Previous baby < 3rd centile. Asylum Seeker with limited English. BMI < 18 at booking.



2

Blessing Abioye

18 yr. old 2+0
2022: SVB at 40+6. 4.5kg (99th Centile)
2023: DCDA Twins at 36+5. T1 SVB 2600g (34th centile) T2 Vaginal Breech 2502g (20th centile)

Booked in GGC at 28 weeks. Had antenatal care in Nigeria. BMI 31

Risk Assessment:
Previous baby > 90th centile. Previous Multiple birth, previous premature birth less than 37 weeks, Sickle cell trait, BMI > 30, Diabetes (first degree relative)

Both should be recommended Red pathway, Shared care

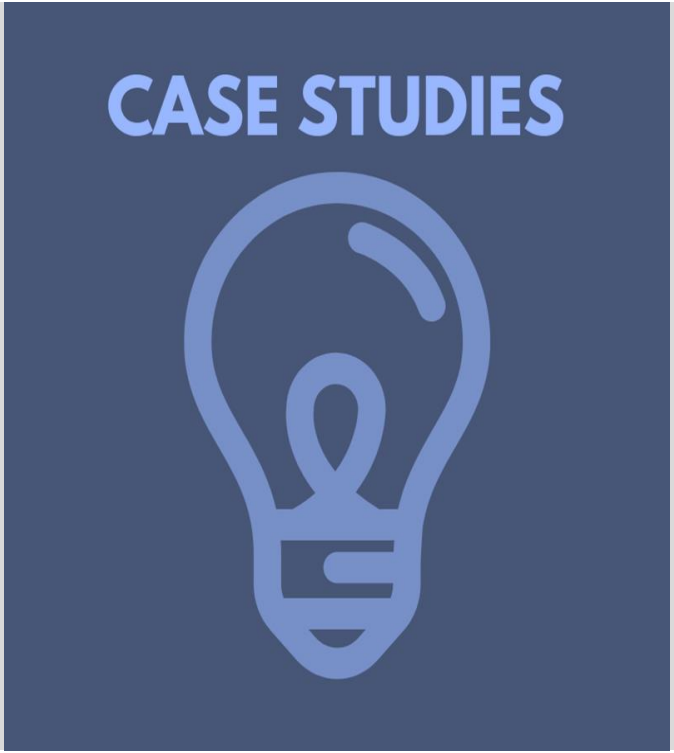
Intrapartum Case Studies

1

Fatima Afzal

Triage at 40+5. Growth USS > 25th centile, LV normal, Current BMI 19.2

5cm, Intact membranes, UA 3:10. Fetal movement and observations normal. Discussed via Arabic Interpreter.



2

Blessing Abioye

Triage at 39+5. Growth > 75th centile, LV normal, Current BMI 35.82
Admitted to antenatal ward at 2cm, UA in-coordinate, Intact membranes.

Settled overnight after morphine, review on ward round: No change. Consented for Induction for long latent phase when space.

Due to workload, admitted to labour ward 5 hours later. On admission 6cm, Intact membranes, UA 3:10

Can should be recommended Green pathway, Midwife led care with intermittent auscultation

Actions

- Cultural safety education for staff
- Updated antenatal and intrapartum guidelines
- Engagement with women
- Engagement with 3rd sector groups
- Interpreting services
- Information provision

Outcomes

Intrapartum/ Birth	Minority Ethnicity	White British
CTG no indication	21.5% (< 50%)	13% (< 28%)
Fetal Scalp Electrode	9% (< 47%)	15.5% (> 0.6%)
Intrapartum Syntocinon	8.8% (< 2.2)	11.7% (> 69.5%)
Spontaneous Vaginal Birth	82.4% (< 5%)	75% (< 8%)
Unplanned Caesarean Births	4.5% (< 25%)	4.6% (< 8%)
PPH > 1000mls	13% (> 73%)	9.35% (> 6.3%)
Episiotomy	8.8% (< 47.9%)	6.7% (< 33%)
$3^{rd}/4^{th}$ Degree tear	9.25% (>23.3%)	7.4% (> 1.3%)

Neonatal	Minority Ethnicity	White British
Neonatal Resuscitation	2.9% (< 49%)	4.8% (> 9%)
Low Cord PH	1.3% (< 64.8%)	1.2% (< 20%)
Neonatal Admissions	0% (< 100%)	0.8% (> 0.8%)

Final Thought

Throughout the antenatal, intrapartum and postnatal period, we need to:

- consider the influence of an individual's cultural, social, political and religious beliefs
- gain knowledge and awareness and explore how this may impact the way women make decisions and respond to recommended treatment options
- Provide individualised, risk assessed, high-quality care with particular emphasis on reducing health inequalities (NMC, 2019)
- All women should be treated with dignity and receive care which is respectful of and supports their individual values and beliefs.
- Our professional standards are explicit, in that professionals have a duty and are accountable for providing unbiased, non-judgmental and safe care which promotes the health and wellbeing of all those in our care (NMC, 2018)

Keep in touch

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