The Improving Me Partnership Cheshire and Merseyside
Women's Health Strategy - Call for Evidence-Written Submission

Improving Me (IME) is delighted to respond to this call out. It has galvanised Cheshire and Merseyside (C&M). We are deeply committed to contributing to this national endeavour with full ICS support. As an outward looking partnership of 27 NHS organisations across C&M we aim to improve the experience of all women and children through joint endeavour and exchange. Data gaps and a failure to listen all have devastating consequences for women throughout the life-course. This must end. Well placed at the intersections between *communities,* and between regions and the nation, **IME** is a huge resource to draw upon. Our strength lies in our connectivity. We have aligned our submission with others in C&M. We wish to make specific reference to Liverpool Women's Hospital's submission which we fully endorse. Through joint effort we will continue to collaborate, to drive the necessary clinical improvements and associated outcomes for all women's health throughout their life course. Going forward **IME's** priorities will include a radical **transformation** of the **Local Maternity System** and further investment in our **Gynaecology Network,** alongside a steadfast commitment to disrupt **health inequalities** and drive a **COVID-19 recovery.**

In 2016, **IME** was identified as a **Maternity Transformation Programme Early Adopter** site and a **Maternity Choice and Personalisation Care Pioneer Programme** – one of only two sites nationally to achieve both statuses; with a directive to drive improvement for change and test new ways to deliver care, we are uniquely placed to provide insight for this call out. We are the NHS Local Maternity System (LMS); well placed with a co-produced vision with women and families and those who work in maternity and interdependent services; all our work is underpinned by our extensive VCSE relationships. As an Early Adopter we pave the way for initiatives that deliver safer, more personalised care for all women and every baby, improve outcomes, and reduce inequality. The **Maternity Choice and Personalisation Pioneers** were developed to test ways of improving choice and personalisation for women accessing maternity services and empowering women to take control in decisions about the care they receive. We pride ourselves on our commitment to listening to and supporting women to find a voice, and in pushing boundaries to enable change.

This ethos drove our own women's health survey and a reach-out to our key partners through our extensive networks to co-produce this submission. We received over 113 individual responses in a two-week period and an additional 200+ commentaries in line with the national consultation core themes. Of the 113 women who responded, 83.2% said economic circumstance and work was pivotal for their health and wellbeing; followed by self-esteem and self-image (78.8%), with caring responsibilities carrying a heavy toll (77.9%) especially in lockdown. Mental ill health featured heavily (77%) with an astonishing 71.7% who said they were not listened to or taken seriously; whilst 54% of respondents identified access to information as problematic. These responses have shaped our response to the DHSC and sharpened our focus on the COVID-19 theme.

IME has a unique commitment to social prescribing as an NHS LMS with a focus on **social prescribing innovation** for women and children to reduce/ respond to health inequalities. During the NHS70, **IME** launched **a Social Prescribing Concordat for Creative Health** to improve prevention and protection as well as extend treatment and management opportunity. This reflects a concern to address the wider determinants of health and break the links between poverty, mental health and maternity mortality and preterm birth. We have forged international relationships to drive this work and we continually look for ways to transform our workforce into one focused on health creation. Social prescribing has provided new solutions for intractable problems.

COVID-19

IME continues to evaluate those women who birthed during the pandemic and ensure that all pregnant women are provided with access to mental health support and signposting to local services during pregnancy and in the postnatal period. Our national partnership with the Reading Agency, Libraries Connected, the Booktrust, ASCEL and the social prescribing network supported the creation of new resources for families in lockdown to drive mental health and recovery. Our innovations supplement a medical toolkit and seek to reduce pressures in the system. Likewise, we seek to capitalise on a flagship birth cohort study nested within a civic data linkage programme which will trace the lives of over 10,000 Liverpudlians to understand more about what influences the health and wellbeing of children and their families living in the region. The Children Growing up in Liverpool (CGULL) study will follow women in pregnancy and 20,000 babies and underpin our quest to provide better and fairer access to research trials and studies for women and babies.

IME drew heavily on women's voices to create a recovery plan. This underlined the value of strengthening women's voices via Maternity Voice Partnerships; the importance of gaining understanding of inequality and barriers to healthcare for Black Asian and Minority Ethnic women and the benefit amplifying these voices in the design and delivery of their care and the co-production of solutions.

We piloted imaginative stay and play ESOL provision for women and babies to pump prime self-care and self-management through language acquisition and crucially support early engagement. We work tirelessly with education partners to develop community learning to underpin health literacy. We invest in asset based working to bring community solutions to the fore and are piloting a new Maternity Support Worker model to drive this work forward.

IME has a strong community engagement team rooted in the community to support reach out initiatives. A dedicated member of staff supports Maternity Voices development and a sustainability and scalability agenda. This team run regular webinars within 'communities' and there is strong focus on co-production and engaging Black Asian and Minority Ethnic women. **IME** established Baby Week during lockdown 1 as a platform for workforce and carer engagement. This platform provided a bridge to other LMS partners and supported international conversations as well as providing a showcase for workforce transformation. It provided women with an opportunity to tell us what matters to them. Women share a platform with clinicians, et al. It creates a level playing field and helps to breakdown silo working. We will build on Baby Week in November 2021. We will also create a women's health campaign as part of IWD work in March 2022 and bring learning from this call for evidence to life.

COVID-19 Improving Me national partners: In 2020, **IME** initiated a COVID-19 social prescribing national partnership to address a 'women, inequality and access to justice' agenda as a direct response to COVID-19 impacts on women and children. It soon became apparent during lockdown 1 that this global public health crisis was quickly developing into a serious economic crisis which greatly exacerbated pre-existing inequalities in such a way that different groups of women were disproportionately and differently impacted and the repercussions for health became immense.

The partners: Catherine McClennan - Improving Me Director & Jo Ward - Improving Me Social Prescribing Lead; Dr Mary Ann Stephenson - Women's Budget Group Director; Dr Sophie Wickham, Jennifer Sigafoo & James Organ - University of Liverpool; Professor Dame Hazel Genn - PVC UCL; Tammy Boyce - Institute of Health Equity UCL; Ros Bragg - Maternity Action Director; Claire Mahoney - Liverpool CCG Social Health Commissioner; Jan Campbell & Christine Blythe - Thriving Communities Leads; Anna Barnish & Debbie Nolan - Wirral & Liverpool CAB Social Prescribing Leads DHSC Wellbeing Pilots and Liz Riley - Betknowmore.

IME continue to champion the plight of women who have been most affected by COVID-19 by working with partners to strengthen their voice; and increase opportunities for women to access health, social and economic opportunities and support. As part of a social prescribing workstream we will support a national ambition to embed link workers in every PCN and trailblaze specialist roles to support a maternity and children and young people (CYP) agenda; whilst integrating recommendations from the National Review of Care for Starting Well, Early Years healthy development and reducing inequalities led by Andrea Leadsom MP. This focus has necessitated the development and implementation of a C&M Black Asian and Minority Ethnic & Equity strategy and action plan which addresses the most significant barriers to health care, including language services, fear of clinicians and vaccinations and peer support via community advocates; an LMS enhanced pathway to support all vulnerable women and families from socially deprived areas to access individualised maternity and postnatal care; work with local partners on access to Bereavement Support for women and those families impacted by COVID-19 alongside access to justice work.

Our COVID-19 social prescribing partners' analysis: **IME** reached out to our COVID-19 partners to provide feedback on just how COVID-19 was impacting on women. This is what our partners told us:

1. Women and poverty

The **UK Women's Budget Group (WBG)** is an independent network of leading academic researchers, policy experts and campaigners that analyses the gendered impact of economic policy on different groups of women and men and promotes alternative policies for a gender equal economy.

The links between poverty and poor health outcomes are well established [1]Poverty creates barriers to accessing adequate housing and nutrition, factors which greatly impact on health. Poverty has psychological as well as material consequences, like stress, which is felt more keenly by women who are the 'shock-absorbers' of the family's poverty[2]. This is because women undertake most of the management of family poverty; stretching household income to manage budgets for food and pay the household bills. As such, a commitment to improve women's health must include a recognition of the social determinants of health and seek to address the poverty that women are more likely to experience across their life course. Reducing the level of women's poverty will lead to increased positive health outcomes.

Poverty is a gendered experience as women in the UK are slightly more likely to live in poverty than men when this is measured on the usual household basis (23% of adult women, compared to 21% of adult men in 2019-20) and female-headed households are poorer than comparable male-headed households[3]. For example, almost half (48%) of single-parent households are living in poverty, compared to a quarter (23%) of couple households with children[4]. In the vast majority (86%) of such households, the single parent is the mother[5]. In older age-groups, 27% of single female pensioners are living in poverty compared to 23% of single male pensioners[6].

Women face specific challenges in achieving financial security for themselves and their families including low paid work, unaffordable childcare, high housing costs and financial abuse. The position of women in the labour market, women's entitlement to benefits, and women's roles and expectations within the family all play a role in determining women's worse economic situation and their generally higher risk of living in poverty.

How Has Covid increased women's poverty?

Childcare: The lack of formal childcare provision during COVID-19 has had 'the biggest impact on the poorest in childcare' with lasting impacts on the attainment gap[7]. One in three nursery estimated closures will be in poorer areas[8]. Continued underfunding, and the decision to stop funding at pre-COVID-19 attendance levels in January 2021, is threatening the survival of providers[9]. 58% of local authorities expect some childcare providers in their area to shut permanently[10]. 46% of mothers being made redundant said that lack of childcare was a factor in their selection for redundancy and 72% have worked fewer hours and cut their earnings due to lack of childcare[11].

Social security: Women are more likely than men to rely on social security for a larger part of their income because of their generally lower earnings, longer lives and greater caring responsibilities. The number of individuals on Universal Credit doubled to 6 million in January 2021 compared to March 2020.

Food bank use and lone-parent poverty are also increasing[12]. The Government has acted quickly to protect jobs but not enough has been done to reform the social security system to protect those out of work and/or on legacy benefits, with only a temporary reprieve to sanctioning (to July 2020), uplift for

[1] Marmot (2010) Fair Society, Healthy Lives
[2] WBG (2005) Women's and children's poverty: making the links cover.indd (wbg.org.uk)
[3] Figures from Stat-Xplore using HBAI 2019-20 dataset
[4] WBG (2018) The Female Face of Poverty Female Face of Poverty - spread design_v.indd (wbg.org.uk)
[5] WBG (2018) The Female Face of Poverty Female Face of Poverty - spread design_v.indd (wbg.org.uk)
[6] DWP (2018) Households Below Average Income – Percentage of individuals in low-income groups by various family and household characteristics (AHC), 1994/95-2016/17
[7] The Sutton Trust (Apr 2020) Social mobility and Covid-19 (https://bit.ly/3jYmAGe)
[8] The Sutton Trust (Jul 2020) Covid-19 impacts: Early Years (https://bit.ly/385hm9q)
[9] WBG (2021) Childcare, gender and COVID-19 Childcare-gender-and-Covid-19.pdf (wbg.org.uk)
[10] WBG (2021) Childcare, gender and COVID-19 Childcare-gender-and-Covid-19.pdf (wbg.org.uk)
[11] Pregnant Then Screwed (2020) COVID, Childcare and Career (https://bit.ly/3jUKu5p)
[12] WBG (2021) Social security, gender and Covid-19 Social-security-gender-and-Covid-19.pdf (wbg.org.uk)

those on UC/WTC (£20 per week to April 2021) and pegging of LHA to 30th percentile of rents (to April 2021)[13].

By the end of 2020, 546,000 women had made SEISS claims, compared with 1,376,000 men[14]. There was a clear gendered difference in actual take up rate, with only 51% of eligible women claiming, compared to 60% of eligible men[15]. A considerable problem with SEISS has been for women who have taken maternity leave within the past three years. SEISS payments are calculated based on average income over the past three-year period. Where women were taking maternity leave, this is counted, bringing down the average payment for mothers. It has been estimated that this has affected an estimated 75,000 women[16].

Employment: Women are the majority of employees in some of the most COVID-19 impacted sectors. Overall, more women than men have been furloughed across the UK, and young women have been particularly impacted. Since the furlough scheme only covers 80% of earnings, more women than men have taken a pay cut this year. Once the furlough scheme ends in September, many of these women will be at risk of redundancy. Black, Asian, and Minority Ethnic women began the pandemic with one of the lowest rates of employment[17]. In 2020 this was still the case, with Black, Asian, and Minority Ethnic women's employment at 62.5% and the highest rate of unemployment at 8.8% (compared with 4.5% for White people and 8.5% for Black, Asian, and Minority Ethnic people overall)[18]. Between Q3 2019 and Q3 2020, the number of Black, Asian, and Minority Ethnic women workers had fallen by 17%, compared to 1% for White women[19].

Debt: By the end of 2020, a third of households had reported a fall in income, 6 million people had fallen behind on at least one household bill, and 17% of the population had borrowed more or used credit as a result of the coronavirus outbreak[20]. COVID-debt is gendered: 30% of women report being negatively affected financially by the pandemic compared with 26% of men, with mothers, lone parents, Black, Asian, and Minority Ethnic women, young and disabled women are most at risk[21]. For example, in April 2020, a quarter of Black, Asian, and Minority Ethnic mothers reported that they were struggling to feed their children and 32% of young women reported finding it hard to pay for essentials[22].

Conclusions: As we emerge from this crisis, it is crucial that restrictions to social security are lifted, and rates of payment are permanently increased. Removal of the temporary £20/week uplift for those on Universal Credit and Working Tax Credits threatens to drag hundreds of thousands into poverty. Our recommendations included targeted job support and retraining for sectors hardest hit, funding childcare free entitlement hours to full cost of delivery and revision of childcare funding model in the medium term.

2. Access to Justice helps

Professor Dame Hazel Genn at the **Health Justice Partnership** is unequivocal in her analysis, "Social welfare legal problems are significant underlying causes of illness and have a substantial impact on physical and mental health and the social determinants of health. These problems can be addressed and resolved through specialist free legal advice and assistance in healthcare settings, such as in Health Justice Partnerships. Providing free legal assistance services in healthcare settings can both improve access to advice and support health services to manage non-clinical demand and reduce health inequalities."

Professor Dame Genn highlights mounting evidence that facing social issues with a legal dimension can cause stress-related or physical ill health and a cascade of social, family and employment crises in previously healthy people and social welfare legal problems have come to the fore for women during

[13] WBG (2021) Social security, gender and COVID-19 Social-security-gender-and-Covid-19.pdf (wbg.org.uk)
[14] WBG (2021) Women and employment during COVID-19 Women-and-employment-during-Covid-19-1.pdf (wbg.org.uk)
[15] WBG (2021) Women and employment during COVID-19 Women-and-employment-during-Covid-19-1.pdf (wbg.org.uk)
[16] WBG (2021) Women and employment during COVID-19 Women-and-employment-during-Covid-19-1.pdf (wbg.org.uk)
[17] WBG (2021) Women and employment during COVID-19 Women-and-employment-during-Covid-19-1.pdf (wbg.org.uk)
[18] WBG (2021) Women and employment during COVID-19 Women-and-employment-during-Covid-19-1.pdf (wbg.org.uk)
[19] WBG (2021) Women and employment during COVID-19 Women-and-employment-during-Covid-19-1.pdf (wbg.org.uk)

[20] WBG (2021) Household Debt, Gender and COVID-19 Household-debt-gender-and-Covid-19.pdf (wbg.org.uk)
[21] WBG (2021) Household Debt, Gender and COVID-19 Household-debt-gender-and-Covid-19.pdf (wbg.org.uk)
[22] WBG (2021) Household Debt, Gender and COVID-19 Household-debt-gender-and-Covid-19.pdf (wbg.org.uk)

COVID-19 presenting as significant underlying causes of illness, impacting on physical and mental health.

Provision of legal assistance services in healthcare settings linked to social prescribing developments and wider NHS property commitments through CSR can both improve access to advice and support health services to manage non-clinical demand.

Legal practitioners working across the entire range of social determinants to mitigate negative health impacts including low income, inadequate housing, homelessness, access to educational opportunities, employment security, family breakdown, discrimination, domestic and elder abuse. Professor Dame Genn concludes if legal problems are left unaddressed, they can cause a cascade of consequences that can ultimately push women into poverty or other harms such as family breakdown, and homelessness, which affect physical and mental health. Non-health laws passed by government and enforced at institutional and local level have direct positive and negative consequences on the health of the public, and disproportionately on the health and wellbeing of low income, vulnerable individuals and women and families. Evidence shows most services provided to help women who are victims of domestic violence do not impact the likelihood of abuse, whereas the provision of legal services significantly lowers the incidence of domestic violence.

3. Women, addiction and gambling harm in the pandemic – it's a public health issue!

When COVID-19 hit most gambling went on-line just as anxiety, stress and other triggers for addictive behaviours increased. Most women gamble in the home and COVID-19 confined women to that space with frequently devastating consequences. **Betknowmore** UK's mission is to prevent and reduce gambling harms. They provide support to people from diverse communities who are experiencing gambling harms, empowering them and building hope towards positive and sustained life changes. Their aims are to increase awareness of gambling harms, improve the health and wellbeing of the people affected, and strengthen the impact of people with lived experience. In January 2021, **Betknowmore** started a women's project, beginning with in-depth research into women's experiences of gambling support services. The research, entitled "Treatment and Support Services for Women Experiencing Gambling Harms: What Women Get and What Women Want", consisted of a literature review, online review of existing services and resources for women, and a series of six focus groups with 15 women with lived experience of gambling harms. This contribution is based on the preliminary findings of that research, plus insights from working with female clients. The research also captured the voices of women with lived experience of gambling harms.

Over the past five years, the number of women reporting problems resulting from gambling has risen at more than twice the rate of men, according to figures from GamCare, yet the number of women experiencing gambling harms is thought to be significantly underestimated. Research for GambleAware shows that young women, women from ethnic minority communities and women from lower socio-economic groups are particularly prone to gambling harms.[23] The rise in the number of women experiencing these harms is directly attributable to the ease with which women can now gamble online, with a number of highly addictive products being directly marketed at women. The addictive nature of these products is explained by the opportunity they offer for quick and continuous play. Yet despite the growing numbers of women suffering from gambling harms, only about 1% of them receive help and support.

The COVID-19 pandemic and its resultant lockdowns have also impacted heavily upon women. Many of the drivers of harmful gambling by women have increased. These include higher rates of domestic violence and increased burdens of care, for example, through providing home schooling or having exclusive responsibility for the care of children with disabilities, all within the broader context of reduced family earnings and increased social isolation. Research from the University of Stirling shows that 17.3% of men and 16.5% of women started a new form of gambling during a three-month period of lockdown, while 31.3% of men and 30.3% of women increased their frequency of gambling on at least one activity. The study found that those who started a new form, or increased the frequency, of gambling during lockdown are potentially vulnerable to gambling harms.

[23] Gunstone, B. and Gosschalk, K. (2019) *Women in Focus: A Secondary Data Analysis of the Gambling Treatment and Support Study*, YouGov on behalf of GambleAware, London.

Gambling harms are the "adverse impacts from gambling on the health and wellbeing of individuals, families, communities and society".[24]

Harms that are known to be associated with problem gambling include: mental and physical health impacts (e.g., depression, anxiety, insomnia, intestinal disorders, migraine, suicidal ideation and other stress related disorders); effects on relationships (including neglect of family and divorce); financial impacts (such as debt, work absenteeism and bankruptcy); and criminal behaviour (including acquisitive crime and domestic and child abuse).[25] In research conducted by GamCare, high numbers of women who gamble or used to gamble mentioned suicidal thoughts and feelings and 100% of women who gamble identified a negative impact on their mental health and wellbeing.[26]

In addition to the harms suffered directly by the gambler, their actions negatively affect between five to ten other people in ways that range from the personal, interpersonal, financial, legal and community, through to the professional.[27] Women are more likely to be such "affected others" than men, experiencing harms such as family breakdown, financial hardship and loss of the family home. Affected others may also experience feelings of shame, isolation and desperation. There are few services dedicated to help them, for example providing specialist financial assistance to help them discover and manage the debt incurred by their partners within the context of the GDPR.

Research evidence consistently shows the interconnectedness of gambling harms and associated health issues. For example, compared to men, women who experience problem gambling are more likely to report co-morbidities such as anxiety and depression, co-occurring alcohol-related problems and greater psychological distress.[28] Systemic inequalities affecting the lives of women, such as lower and more insecure incomes, greater caring responsibilities and gender-based violence, are visible in their health problems and in the drivers of their gambling harms. Women spending long periods of time at home, such as those who are ill or disabled, and those with caring responsibilities, are particularly vulnerable to developing gambling problems through online gambling sites.[29] Women told Betknowmore' that the ability to gamble 24 hours a day via their phones facilitates addiction and acts as a barrier to recovery, as are the gambling adverts that target women in particular. Women also said that they don't feel able to openly admit to their gambling problems for fear of rejection and ridicule. Shame and stigma particularly affect women because their gambling results in impacts that contradict the societal image of women as dependable care givers. They fear loss of work and the breakup of close relationships with partners, family and friends. The reluctance of women to seek help may in part be explained by the fear of attracting unwanted investigation resulting in the removal of children by social services. Women can feel unable to access local support services for fear of being recognised and shamed by members of their own communities. Young women may feel that their gambling problems will not be taken seriously because of their age.

Women also reported that statutory services show little understanding of the drivers and nature of their harmful gambling behaviours. There is no recognition of how their reproductive roles have impacted upon their gambling, for example how feeling ill and low due to endometriosis or menstruation has led to gambling as a distraction and escape. Those with co-occurring mental health problems found that the services they reached out to failed to even ask about their gambling behaviours.

When women had confided in their GPs they were not signposted to appropriate services, tended to be offered anti-depressants and felt dismissed and misunderstood. Similar experiences were reported in interactions with social care teams. Such experiences compound the stigma, isolation and desperation that women feel. Women experiencing gambling said they want support from other women in a similar position.

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[24] WHO (2020) Addictive behaviours, World Health Organization, www.who.int/health-topics/addictive-behaviours#tab=tab_2
[25] Kerr, J., Lynch-Higgins, S., Thompson, B., Dinos, S., Khambhaita, P. and Windle, K. (2019) *A Needs Assessment for Treatment and Support Services*, NatCen for GambleAware, London.
[26] GamCare (2020) *Women's Programme, Year One Report: 2019/20*, GamCare, https://d1ygf46rsya1tb.cloudfront.net/prod/uploads/2020/11/GamCare-Women%E2%80%99s-Programme-Report-Year-One-2019-20.pdf
[27] Pulford, J., Bellringer, M., Abbott, M., Clarke, D., Hodgins, D. and Williams, J. (2009) Reasons for seeking help for a gambling problem: the experiences for gamblers who have sought specialist assistance and the perceptions of those who have not, *Journal of Gambling Studies* 25: 19–32.
[28] Gunstone and Gosschalk (2019).
[29] Corney, R. and Davis, J. (2010) The attractions and risks of Internet gambling for women: a qualitative study, *Journal of Gambling Issues* 24: 121–139.

They want support services to offer them hope through positive role models of women who have recovered from gambling problems. Women also said that the services they need must be sufficiently varied to address their varying circumstances, with some needing a drop-in centre with a crèche, some not wanting to share a recovery space with men, and others wanting the ability to, for a while, leave their homes and their communities to find space to recover. Not knowing and understanding the choices of support and treatment open to them left women feeling alone and underserved, while having to wait for help left them feeling desperate. Women have also told us that over time, they have realised that recovery is an ongoing process and their support needs change; most have experienced relapses and finding the help they needed took time, energy and determination, just when they were feeling at their lowest point and lacking in resilience. From statutory services, women want GPs, health workers and social workers to recognise and understand gambling harms and know how and where to refer them.

Conclusions: A public health approach to these problems is one that focuses on "opportunities to reduce gambling-related harms by intervening across the whole gambling pathway".[30] This includes the regulation of access to gambling; actions to increase societal and institutional understandings of gambling harms and reduce the shame and stigma that is especially felt by women; better screening for women at risk; and improved services for women that place lived experience at their core, focus upon giving women hope, and enable them to make positive contributions to their communities once more.

4. Taking action to improve the health and wellbeing of Black, Asian, and Minority Ethnic women

Maternity Action is the UK's maternity rights charity dedicated to promoting, protecting and enhancing the rights of all pregnant women, new mothers and their families to employment, social security and health care. **Maternity Action** and the women, inequality and access to justice partnership wish to highlight maternal mortality rates for Black, Asian and mixed race, Ethnic Minority women as a major issue and concern for the LMS. Mortality rates for black women in pregnancy are five times higher than the rest of the population. Black Asian and mixed race, minority pregnant women also have a higher incidence of hospital admissions for COVID-19 than other ethnic groups.

The causes of racial disparities in maternal health outcomes are the subject of much debate. Maternity Action and the Improving Me COVID-19 women, inequality and access to justice partnership believe it is very clear that racism is a major factor, with changes needed in policy, practice and attitudes to improve access to care and quality of care for Black, Asian and mixed race, minority women.

Maternity Action and the women, inequality and access to justice partnership believe that health inequalities are rooted in current and past disparities in wealth, power and resources for health, along with differential exposure to health-damaging environments and risks.

Maternity Action cite the emergence of occupational risk as a significant issue in the pandemic. Their COVID-19 analysis focuses on occupational risk and socio-economic factors which impact on maternal health for Black, Asian, and Minority Ethnic women. This is in addition to work they are undertaking with the Race Equality Foundation to address institutional racism within the health system and within our own organisations.

Maternity Action highlight socio-economic factors and occupational risk emerging as significant concerns in the recent Public Health England engagement with Black, Asian and Minority Ethnic communities.

Research with low income Black, Asian, and Minority Ethnic women similarly identified a range of factors which impacted on maternal health, including housing and low income. This was particularly evident for asylum seeking women and women with no recourse to public funds.

Occupational health affects infection rates amongst all income levels and is of particular concern to key workers. Black, Asian, and Minority Ethnic women are much more likely to be key workers than the white population and are more likely to work in health and care roles.

Black, Asian, and Minority Ethnic women are disproportionately likely to be on lower incomes. Poverty and low income impacts on women's general health across the life course and affects their risk of

[30] Blank, L., Baxter, S., Buckley Woods, H and Goyder, E. (2020) Interventions to reduce the public health burden of gambling-related harms: a mapping review, *Lancet Public Health* 6: e50–e63.

COVID-19 infection. Pregnant women living in crowded accommodation or hostels shared with other asylum seekers have and do find it more difficult to follow social distancing guidance.

Maternity Action make a number of recommendations which can be immediately implemented by the Government. Most changes can be made through regulations or guidance, rather than primary legislation. The Government's swift work to establish the Coronavirus Job Retention Scheme and the Self-Employed Income Support Scheme show the speed at which Government can work when they so choose.

Pregnant Black, Asian, and Minority Ethnic women should have safe working environments: Maternity Action and the women, inequality and access to justice partnership all agree pregnant BAME women need clear, effective health and safety protections at work and the support to exercise their rights. Leaving women to pursue costly and time-consuming employment tribunal claims is no way to protect women's health. Excluding gig economy workers from basic employment protections leaves many Black, Asian, and Minority Ethnic women at greater risk of infection. Furthermore, the partnership suggest all pregnant women facing health and safety risks at work should have the right to a suitable, safe, alternative role or else suspension on full pay as a day one right. This right should be extended to all workers, including agency workers, bank workers, casual workers and women on zero hours contracts. The Government should establish a mechanism for pregnant women to report health and safety breaches and get a swift remedy. Government should consider reimbursing smaller employers suspending pregnant women on full pay.

Pregnant women should have access to a welfare safety net which enables women to live healthily during pregnancy and new motherhood: Women should not live in fear of destitution or homelessness. Women should not feel compelled to compromise on health and safety protections at work because they can't afford to lose their jobs. Women with gig economy jobs should not face lower rates of maternity pay and benefits. Women should not be living in sub-standard, crowded accommodation which increases the risk of COVID-19 transmission.

Solutions: Maternity Action and the women, inequality and access to justice partnership concur that there is a need to end 'No Recourse to Public Funds' rules which excluded migrants from access to Housing Benefit, Universal Credit, Child Benefit and other critically important benefits. End the five week wait for Universal Credit and make all advance payments non-repayable. Give all claimants the option of fortnightly payments. This will reduce the number of women who begin their Universal Credit claim in debt. End the unfair treatment of Maternity Allowance under Universal Credit regulations. Gig economy workers are more likely to receive Maternity Allowance than Statutory Maternity Pay and can receive up to £5,000 less in Universal Credit as a result. Immediately increase Child Benefit by £10 per week. This is the most effective way to get support to low income families with children. Ensure that welfare benefits support all women and all children. Remove the first child and first multiple births limit on the Sure Start Maternity Grant. Remove the two-child limit in Universal Credit. Substantially increase the cap on Universal Credit so that larger families are not disadvantaged. Remove restrictions on Healthy Start vouchers so that all pregnant women receive support to purchase milk, fruit and vegetables. End migration-related restrictions on local authority housing. Pregnant women should not be excluded from mainstream housing provision, irrespective of their immigration status. Women should not have to pass a 'human rights test' to avoid homelessness.

Pregnant Black, Asian, and Minority Ethnic women should have access to free NHS care: Maternity Action and the partnership strongly suggest the immediate suspension of charging for NHS maternity care. Likewise, the reporting of NHS debt to the Home Office must stop and pursuance of outstanding debts to the NHS from women living in the UK should cease.

Women with insecure immigration status are charged £7,000 or more for standard NHS maternity care, deterring women from attending for care which undermines the safety of the women and an unborn child. Women affected by charging face significantly increased risk of maternal mortality, reduced

access to safeguarding and support, and increased stress and anxiety. Exemptions from charging for COVID-19 testing and treatment are ineffective if women fear reporting to the Home Office.

Pregnant Black, Asian, and Minority Ethnic women in the asylum system should be supported to live healthy lives: Asylum seeking women are more likely to have pre-existing conditions which place them at additional risk. Many have faced trauma in their home country and on their journey to the UK. Additional measures are required to protect asylum seeking women's health and wellbeing during pregnancy. This should be supported by the cessation of the dispersal (relocation) of pregnant women multiple times during pregnancy and following birth. Pregnant women should be offered housing suitable to a mother and baby which enables them to follow social distancing and shielding guidance. The location should enable women to access the same maternity service throughout their pregnancy. In addition, the following will be beneficial: increasing rates of asylum support by reinstating the link with mainstream benefits, and with an immediate increase of £20 per week; removal of the unreasonable restrictions on the use of the pre-paid ASPEN card so that asylum seekers can make purchases online; extension of financial support and cessation of evictions for women whose asylum claim has been refused.

Pregnant Black, Asian, and Minority Ethnic women should be free from domestic abuse: Women should have access to refuges and other support services when they need them. It is important to ensure that specialist Black, Asian, and Minority Ethnic refuge services and the wider refuge sector have funding to accommodate women who are not entitled to Housing Benefit or other social security payments.

Pregnant Black, Asian, and Minority Ethnic women should have access to the advice and support that they need: The pandemic has followed a decade of austerity politics which have reduced funding and resources available to voluntary organisations. These are of critical importance in providing pregnant Black, Asian, and Minority Ethnic women with advice and support and in improving access to health and related services. An investment in voluntary organisations run by and for Black, Asian, and Minority Ethnic women is key and could link to development s in social prescribing. It is equally essential that local organisations embedded in their communities are resourced.

Going forward **IME** has two additional priority areas which will run alongside our **COVID-19 Recovery** plans and commitment to reducing **Health Inequalities**, these include:

- **C&M Local Maternity System**
- **C&M Gynaecology Network**

The programme areas include several nationally mandated LMS KLOEs which will further underpin system learning about women's needs:

- **Ockenden recommendations**
- **Continuity of Carer**
- **NHS Resolution Investment Scheme**
- **Saving Babies Lives Care Bundle v2**
- **Personalisation and Choice for all women across C&M.**

As part of our detailed COVID-19 recovery plan **IME** has identified a number of specifics going forward which include:

- Domestic violence and safeguarding support
- Prioritising women's mental health and perinatal mental health
- Promoting cohesive support services which will help to prevent further inequity
- Resumption of treatment plans and care for women with all stages of gynaecological cancer but especially those whose treatment was paused during COVID-19
- Reintroduction of cancer screening to enable early diagnostics and treatment
- Further strengthening the voices of women
- Greater understanding of the inequality and barriers to health and social care

- Improved equitable access to menopause services for all women across C&M
- Improvement in sexual health awareness for younger women as we move out of lock down and social encounters increase.
- Tackling inequity of access for conditions like endometriosis that have high historical
- Integration of women's care at place level through local PCNs and the VCSE
- Addressing inequality of access to fertility treatments and impacts on mental health services
- Utilisation of digital innovations to broaden and widen access to services
- Better understanding health issues for trans men and women who are at the highest risk of suicide, linking in to the CMagic project
- Better and fairer access to research trials and studies across C&M
- Continue to prioritise personalised care at place for the most vulnerable and high-risk women within our communities.

This will all involve initiating a communications and engagement campaign across all places to ensure that support services, signposting and outreach is enhanced for all families within C&M as well as increasing the awareness of the benefits of vaccination and routes to expert clinical advice for young women and those fearful of the impact of vaccinations on fertility.

IME is also committed to establishing a Gynaecology Network with clinical leadership; alongside a gap analysis of services across C&M and a co-produced (5 year) improvement plan with women which will:

- Improve access to diagnostic services for endometriosis conditions for all women
- Reduce unwarranted variation in outcomes as a system for gynaecological conditions and cancers
- Raise awareness of the economic, social and emotional impact of the menopause for women in C&M with a plan to prioritise support and consistent services across all 9 places
- Develop system wide gynaecological pathways, training and shared resources to provide safe, consistently high quality services across all places
- Offer specialist and general gynaecology treatments closer to home
- Produce a workforce development plan to improve skills and ensure sustainability of services.

IME is committed to delivering an equity analysis and co-produced Equity Action Plan on health outcomes, community assets and staff experience following the publication of a national Perinatal Equity Strategy, the C&M LMS will develop and submit this by Dec 2021. This will ensure action is taken to improve the culture of maternity and neonatal services as a building block for safe, personal and more equitable care. It will include the:

- Co-design and implementation of a vision for local maternity and neonatal services with local women through Maternity Voices Partnerships
- Development of an enhanced model of continuity of carer which provides for extra midwifery time for women from the most deprived areas.

During 2021, **IME** will take forward a series of partnership projects most notably a commitment to the Cancer Alliance to work innovatively to reduce smoking in pregnancy. This project will create a dynamic interface with women and continue to build understanding of women's health needs and generate new kinds of solutions.

IME is on a quest for knowledge to improve everything we do in order to ensure we provide better care for all women not some.

We wish to share this learning by embracing partnership, collaboration and innovation.

We will work closely with all our providers to align our work and seek out those equally committed to making this journey of change.

Above all else we will listen to all our women. And hear And act!