Bath and North East Somerset, Swindon and Wiltshire Together

Equity and Equality Action Plan

co-produced to help achieve equitable maternity and neonatal outcomes

Bath & North East Somerset, Swindon and Wiltshire

LMNS

Local Maternity & Neonatal System (LMNS)

Produced in partnership with:
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Introduction

Tackling health inequalities is a priority for the NHS in order to improve health outcomes for pregnant people and give new-borns the best start in life. To do this, guidance[1] has been issued outlining five national priorities which need to form the basis of local action plans; these are:

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

This action plan has been informed by local maternity data[2] and by qualitative feedback from key stakeholders (n=16) across the Bath and North East Somerset, Swindon and Wiltshire (BSW) local maternity and neonatal system (LMNS) who took part in two co-creation workshops.

The aim was to identify key areas of focus that would inform the action plan, while ensuring alignment to national aims relating to equity and equality for maternity and neonatal care, which are to:

1. Improve equity for mothers and babies from Black, Asian, and Mixed ethnic groups and those living in the most deprived areas

2. Improve race equality for staff.

[1] Equity and equality: Guidance for local maternity systems. (2021). NHS England » Equity and equality: Guidance for local maternity systems

[2] Please note that at the time of writing this action plan, maternity outcomes data were available for Great Western Hospitals NHS Foundation Trust (GWH) from 2021-2022 and for Royal United Hospitals Bath NHS Foundation Trust (RUH) from 2021-2022. Data were not available for Salisbury Hospitals NHS Foundation Trust. However, as part of this action plan, gathering this data will be an immediate priority.

Four areas of focus were identified that affect several key groups including but not limited to people from ethnic minority backgrounds, people who do not speak English as a first language, asylum seekers and refugees, people from the Roma, Gypsy, Traveller, Showman and Boating community, young parents and people from deprived areas:

1. Improve data collection to better understand local needs
2. Language and communication
3. Accessibility to maternity services
4. Race equality among maternity and neonatal staff.

This plan starts by describing the local population (page 2 to 5) and then details the rationale for the four key areas of focus, how they map onto the corresponding five key national priorities and what steps will be taken to address them (page 6 to 21).

It is important to note that this is a **live, iterative document** which will be continuously updated to reflect the ongoing work within BSW LMNS to implement the actions detailed below and drive equitable outcomes for all service users and race equality for staff.

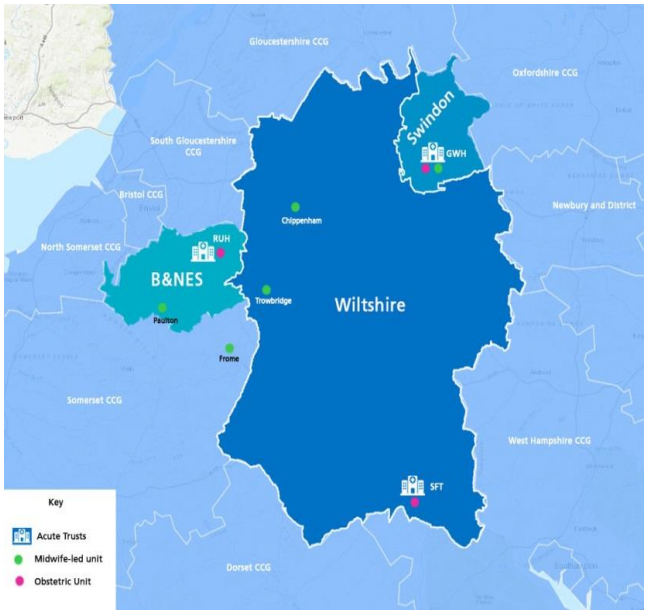
Understanding the local population

Maternity services in Bath and North East Somerset, Swindon and Wiltshire

BSW is made up of large rural areas (particularly the mid-Wiltshire Salisbury plain area) as well as urban centres (Swindon and Bath). The main hospitals that provide maternity care and the larger towns are located on the edges of the BSW system footprint (see Figure 1). However, around two-thirds of the local population live outside Swindon and Bath, in smaller towns, villages, hamlets, or isolated dwellings.

The Local Maternity and Neonatal System (LMNS) is part of the BSW Integrated Care Board (ICB)[3]. It is made up of all maternity providers, commissioners and associated services across the maternity pathway. There are three providers of maternity care in the area. These are the Great Western Hospital (GWH) in Swindon, The Royal United Hospital (RUH) in Bath and Salisbury Hospital (SFT) in Wiltshire. Each also provides antenatal care in the form of obstetric units and local neonatal units alongside community hubs and midwife services distributed across the BSW footprint to cover areas of deprivation and rural areas.

Figure 1: Map of LMNS services across BSW



[3] To find out more information about all health and care services provided by BSW ICB go to https://bsw.icb.nhs.uk/your-health/which-nhs-service-should-i-use/

In 2020/21 there were 10,356 births across BSW with 10,311 people giving birth.[4]

Rate of teenage pregnancies in BSW is below UK average.

In 2019, the numbers of under 20 year old women giving birth in BSW[5] is just below the United Kingdom (UK) average (2.8%) which reflects the work done to reduce pregnancies in teenage women over the past 10 years. The numbers of women over 40 giving birth in BSW is below the national average of 4.6% as well. This is important to note because women in these groups are potentially at a greater risk of complications in pregnancy. Teenage pregnancies have been associated with poorer outcomes for young parents and their children. This is due to teenage mothers being less likely to finish their education, more likely to bring their children up on their own and suffer financial hardship as well as having a higher risk of mental health problems. Furthermore, as reported in the MBRRACE report (2019)[6] mothers under the age of 20 years are at a 33% increased risk of stillbirth and 75% increased risk of neonatal deaths compared to mothers aged 30 – 34 years.

Fewer babies from ethnic minority groups were born is BSW compared to UK average, however they remain at increased risk of stillbirth and neonatal death.

In 2019, 22.5% of babies from ethnic minority groups in the UK were born at 24 weeks or later. At GWH, the proportion of babies from ethnic minority groups born at > 24 weeks was slightly lower (19.2%) than the UK average; however, the proportion at SFT and RUH was considerably lower at 9.2% and 5.3% respectively.

In BSW the stillbirth rate[7] is below the national average of 3.3% in England. Nevertheless, the MBRRACE-UK Perinatal Mortality Surveillance Report published in October 2021 details that mortality rates remain much higher for babies of Black and Black British ethnicity with stillbirth rates being over twice those for babies of White ethnicity in the UK. Neonatal death rates are also 43% higher for this group of babies. Similarly, stillbirth and neonatal death rates are around 60% higher for babies of Asian and Asian British ethnicity

[4] Equity and Equality Needs Analysis. Available on request.
[5] Proportion of women under 20 years of age in Swindon is 2.10%, in BaNEs is 1.90% and in Wiltshire is 2.60%.
[6] Draper ES, Gallimore ID, Smith LK, Fenton AC, Kurinczuk JJ, Smith PW, Boby T, Manktelow BN, on behalf of the MBRRACE-UK Collaboration. MBRRACE-UK Perinatal Mortality Surveillance Report, UK Perinatal Deaths for Births from January to December 2019. Leicester: The Infant Mortality and Morbidity Studies, Department of Health Sciences, University of Leicester. 2021.
[7] Stillbirth rate for Swindon is 2.92%, for BaNEs is 2.98% and for Wiltshire is 3.01%, based on data from MBBRACE-UK, 2019.

Swindon has the highest deprivation score and the highest proportion of births in the most deprived area in BSW.

Overall, BSW has a more affluent population than most of the UK; however, there are pockets of deprivation. Swindon has the highest deprivation score of the three local authority areas, with 12 neighbourhoods in the most deprived deciles (LSOA)[8]. This compares to Bath and North East Somerset (BaNES) where only two neighbourhoods are in the most deprived decile and only one in Wiltshire.

The percentage of births in the most vs the least deprived areas is shown in Table 1.[9]

Table 1: Breakdown of proportion of births by level of deprivation in BSW.

Area	% of births in most deprived area	% of births in least deprived area
UK average	20%	20%
RUH	3.3%	31.7%
SFT	2.6%	40%
GWH	7.7%	30.6%

Data indicates that people who live in a deprived area have worse outcomes. For instance, evidence suggests that babies born to mothers living in the most deprived area are twice as likely to be stillborn and at a 73% excess risk of neonatal death compared to babies born to women living in the least deprived areas.[6]

People from a minority ethnic background, aged over 35 years and who live in a deprived area have worse outcomes

National MBRRACE- UK data[6] identifies that the multiple impact of ethnicity, mother's age and deprivation is highlighted by a stillbirth rate in the UK of 10.54 and 6.91 per 1000 total births for mothers of Black and Black British ethnicity and Asian and Asian British ethnicity born to mothers aged over 35 years living in the most deprived areas.

Neonatal mortality rates were over 3 per 1000 live births for babies of Black and Black British ethnicity and Asian and Asian British ethnicity born to mothers under 25 and over 35 years living in the most deprived areas. These mothers are disproportionately affected by higher rates of stillbirths associated with deprivation.

Please note, currently there is gap in available local data to fully examine the relationship between ethnicity, age, deprivation and maternity outcomes in BSW. This has been identified as a key action in the plan below.

[8] LSOA – 'Lower layer super output area' is a small area within localities which is used to calculate and measure the area's deprivation decile (category) which can range from 1 (most deprived) to 10 (least deprived).

[9] Data is based on postcode of the mother's residence and using the Children in Low-Income Families Local Measure.

Proportion of babies born extremely pre-term in BSW is lower than the national average.[6]

In 2019, 0.2% of babies at each BSW hospital were born prematurely at 24-27 weeks which is lower than the national average (0.4%). This is a positive considering that data suggests babies who are born prematurely are much more likely to be stillborn and account for three in four of both stillbirths and neonatal deaths. The number of births post term (42 weeks or greater) at GWH was below the national average of 1.9%, at SFT was the same as national average, and much higher at RUH (6%).

Breastfeeding initiation rates are higher than the England average in both BaNEs and Wiltshire.

Data[10] shows that the proportion of women who initiated breastfeeding in both BaNEs (83.2%) and Wiltshire (79.6%) is higher that the England value of 67.4%. However, the proportion of women in Swindon (63.7%) is below the England value.

Smoking in pregnancy is higher among white women and younger parents under 25.

Rates of smoking in early pregnancy and at time of delivery are similar to the national average in Swindon and Wiltshire but lower in BaNES. At the time of the birth of the baby:

- 1 in 15 new mothers smoke in BaNES
- 1 in 10 new mothers smoke in Wiltshire
- 1 in 9 new mothers smoke in Swindon.

Weighted maternity data in GWH also identified that of the current women smoking in pregnancy less than 1% (0.72%) of women from ethnic minority groups smoked compared to over 10% of women from white background. Furthermore, data from GWH showed that one in five (20.74%) of women under 25 years of age smoked during pregnancy, compared to only 6.46% of women 25-44 years of age, and no women aged 45 and over smoked during pregnancy.

[10] Public Health England. Fingertips Data from 2018/19 about breastfeeding.

Action Plan

1. Improve data collection to better understand local needs

The data analysis so far indicates that missing data is an obstacle to understanding the true extent of inequity and inequality in relation to maternity outcomes. Without a clear picture of which groups have the poorest outcomes and what factors are influencing these outcomes, actions cannot be taken to address these factors and improve maternity outcomes.

Several challenges were identified:

- Limited understanding of the extent to which interrelated risk factors (e.g. ethnicity, deprivation and age) contribute to poorer outcomes. Currently, data about maternity outcomes is limited particularly when identifying links between ethnicity and deprivation related to clinical outcomes.
- Maternity data is not recorded consistently by providers, which makes it difficult to tease out similarities and differences in outcomes across the three providers.

Key actions

To help overcome these challenges, stakeholders identified 3 first steps to help improve data collection and increase understanding of the local population.

Action	Description	Alignment to national priority & key indicators
1. Consistent recording of service user demographic information.	LMNS to collect demographic information about service users, including ethnicity and postcode, in the same manner and consistently to reduce gaps in the data and allow for comparison across groups to identify which service users are most at risk of poorer outcomes.	National priority 3
2. Consistent recording of maternity outcomes for all service users.	LMNS to record maternity outcomes data in the same way to allow for comparison between hospitals, and to allow for segmentation analysis to identify influence of cross cutting factors.	National priority 3 National priority 4a
3. Undertake further qualitative research with service users to understand their needs in-depth.	Qualitative insights can complement the data by helping to identify what is driving behaviour (e.g., smoking, baby feeding choices) and what can be done to support women to change their behaviour. For example, quantitative data can tell us that more women from a white background (10.34%) smoked in pregnancy compared to women from ethnic minority backgrounds (0.72%) and a higher proportion of under 25 year olds (20.74%) smoked in pregnancy compared to 6.46% of those aged 25-44 years. However, there is limited understanding of why they smoke in pregnancy and what would motivate them to become smoke-free.	National priority 4a National priority 4c National priority 4e

2. Language and communication

This area of focus is split into two types of service users:

1. **Service users who face language barriers**
2. **Service users who have additional communication needs.**

The first focuses on the needs of people who do not speak English as a first language, including people from ethnic minority groups, asylum seekers and refugees and people who are deaf. The second addresses the needs of people with additional communication needs such as those who have learning disabilities and/or learning difficulties.

2.1. Service users who face language barriers

Across BSW, some families do not speak English as a first language. The most common non-English languages spoken are listed in

Table 2 below.

Table 2: List of most common languages spoken across BSW split by locality.

Most Common Language	WILTSHIRE	SWINDON	BATH
	Polish	Konkani (Goan)	Polish
	Nepalese	Polish	Spanish
	Fijian	Portuguese	French
	Romanian	Nepalese	Italian
	Bengali		German
Least Common Language			Arabic

Qualitative feedback suggests that the language barrier experienced by those who cannot speak English may contribute to worse outcomes than those who can. Without adequate interpretation provision in place, service users are unable to understand and discuss the details of their care or communicate their needs and preferences.

The key challenges facing this group are:

- Difficulties accessing professional interpretation services due to limited resource, long waiting times and cost.
- Telephone interpretation is the default option, which may be impersonal/inappropriate for discussing some aspects of maternity care.
- Service users may know the interpreter who is part of their 'community' and be hesitant to discuss their care with them – they do not know that interpreters are bound by a duty of confidentiality.
- Using family members to interpret complex medical information poses risks as the family member may translate inaccurately.
- Information and support (e.g. educational videos, antenatal classes) are not always available in multiple languages making them inaccessible to this group. Please note, GHW currently provide antenatal education in five different languages which is a positive step in the right direction.

Key actions

To help overcome these challenges, stakeholders identified 3 first steps to help meet the communication needs of those who don't speak English.

Action	Description	Alignment to national priorities
1. Translate resources	Translate all resources (online and physical), including personalised care and support plans (PCSPs), into different languages to make them accessible to all.	National priority 1 National priority 2 National priority 4b
2. Conduct further research to understand their needs and preferences.	Conduct qualitative research with people who do not speak English to understand service users' preferences and when it is and is not appropriate to use remote interpretation services. This will help inform an approach that is both desirable for service users and feasible and viable for the LMNS to deliver.	National priority 4a
3. Upskill staff and utilise their language skills	Ensure all staff are aware of translated resources and identify staff who speak different languages and opportunities to upskill them so they can provide 'in-house' translation services.	National priority 1

2.2. Service users who have additional communication needs

Service users including those with learning disabilities and/or who are neurodiverse may face communication barriers when trying to access maternity services which may contribute to poorer outcomes for this group.

Key challenges facing this group are:

- The ability to understand complex medical information during pregnancy in a way that is tailored to their needs and learning styles.
- The absence of a formal diagnosis among some service users (e.g. Autism, ADHD, etc.) makes it difficult for staff to know who has additional communication needs and what support would help them.

Key actions

To help overcome these challenges, stakeholders identified 3 first steps to help meet the needs of service users who have additional communication needs.

Action	Description	Alignment to national priorities
1. Equip staff to be able to identify and support service users with additional language and communication needs	Raise awareness that some service users may be neurodivergent without a formal diagnosis. Educate staff on the 'common signs' to look out for and ways to accommodate different communication needs. This is applicable to not only those with a learning disability or who are neurodiverse, but also people who are deaf, have low literacy skills or learning difficulties (e.g. dyslexia).	
2. Conduct further research to identify what support users need	Conduct qualitative research with people with learning disabilities, learning difficulties, who are deaf and/or who have low literacy skills to explore what support and information would help meet their communication needs during pregnancy.	National priority 4a
3. Create information in alternative formats	Informed by the research findings, co-create information in alternative formats (e.g., 'easy-read' booklet, videos with accompanying sign language) to provide different ways for service users to digest information. There may be an opportunity here to work with local universities and colleges to develop these resources.	National priority 4a

3. Accessibility to maternity services

Many population groups face challenges accessing maternity services. This includes people from the Roma, Traveller, Showman, and Boating community, those living in rural areas who find it difficult to physically get to appointments/clinics and women from ethnic minority groups who face cultural barriers that prevent them from wanting to engage with services.

Two key themes are discussed in relation to access: physical access and digital access.

3.1 Improving physical access to services

Many service users including people from the Roma, Traveller, Showman and Boating community and people living in rural and/or deprived areas face challenges in physically being able to get to appointments. Women who cannot access maternity services as easily as those who have a car or live near the hospital/clinics, may experience worse outcomes as a result of presenting late and missing appointments and scans.

Key challenges facing these groups are:

- Many service users – including those who live in the most deprived areas and asylum seekers and refugees – do not drive and cannot always afford bus/taxi fare to travel to appointments.
- Some women find it difficult to access appointments at certain times of the day because of other commitments including school/college (teenage parents specifically), childcare or work. For example, service users from ethnic minority groups face specific challenges around requesting time off work for maternity appointments and scans. Therefore if certain appointment times are not accommodated this may result in skipped appointments.
- Lack of representation of service users from ethnic minority backgrounds in antenatal classes.
- Data from RUH also indicates that the two key reasons for booking late are due to 'transferring in from other maternity health care providers' (34.54%) and 'recently moving into the area – with no previous antenatal booking appointment' (32.53%).[11] Additionally, 18.58% of women from ethnic minority groups booked late compared to 8.14% of women from a white background.[12]
- Women who are pregnant for the first time, especially young women, asylum seekers/ refugees, and women transferring from providers or moving into the area, may not know how or when to access services which may explain and contribute to late bookings.
- Localised midwifery care in the community is inconsistent and not delivered from the same 'hub' all of the time. This makes it difficult for service users to keep track of where to go for their appointments and can lead to an increase in missed appointments.
- While some service users would benefit from a consistent service held in the same place, those from Travelling and Boating communities would benefit from having flexibility to access services across BSW depending on where they are located at any given time during their pregnancy.

Please note, outreach services are delivered to some groups who not only face physical barrier to access but experience cultural challenges too (e.g., asylum seekers/refugees). Alternative service provision could be expanded to accommodate other groups such as those from ethnic minority groups. For instance, Somali women are not used to attending pre-set appointments and prefer to 'just turn up' to an appointment instead. Additionally, in the Somali community, husbands can override their wife's decision and restrict access to services.

[11] Please note, there was a large amount of missing data, so the statistics included are for a sample of 249 women.
[12] Please note, there was a large amount of missing data, so the statistics included are for a sample of 206 women.

Key actions

To help overcome challenges related to physical access, 4 key steps were identified by stakeholders.

Action	Description	Alignment to national priority
1. Review midwifery care in the community for each locality.	Localised midwifery care in the community needs to be reviewed for each locality, alongside the specific needs of the key groups there. Actions then should be put in place to establish a permanent 'hub' with a particular focus on providing easily accessible services in rural and deprived areas that meet the specific needs of the population.	National priority 3 National priority 4e
2. Review the pathway for key groups.	Service pathway needs to be reviewed for each group, identifying what works well, and what needs to be done differently to meet their needs. For example, providing outreach support for asylum seekers/refugees works well, and anecdotally enabling Travellers, to access different clinics across the locality.	
3. Increase awareness of how to access services among key groups	Develop and disseminate targeted messages to key community groups (e.g., asylum seekers/refugees, people from ethnic minority groups, young parents/first time parents, and people moving into the area) to increase awareness and knowledge of how to self-refer and encourage early referral.	

4. Consider alternative ways to reach ethnic minority groups who may face physical and cultural barriers to access	Staff should consider creative ways of reaching ethnic minority groups. For example, attending community/ faith events to reach: • People from the Goan community in Swindon • People from the Polish community in Wiltshire and Bath • People from the Afghan community in refugee accommodation in Swindon. During these events important maternity checks should be offered to pregnant women to increase engagement and uptake, alongside with increasing awareness of services.	National priority 4e

3.2 Digital access

Accelerated by the COVID-19 pandemic, there has been a significant rise in the use of digital tools and online resources to support the delivery of healthcare services. Yet, one in ten (10.20%) people living in the South West of England don't use the Internet[13] and just under one in ten (9.00%) don't have the basic digital skills.[14]

Digital poverty may contribute to worse maternity outcomes if service users cannot access support that is provided online.

Key challenges facing this group are:

- Access to a phone/laptop, access to the Internet and access to a quiet space where they can use online resources and attend virtual education classes in private.
- Alternative options (e.g. printed materials) are not always available due to the cost involved with printing resources that quickly become outdated.

[13] Office for National Statistics - Internet Users, Labour Force Survey (2018). https://www.ons.gov.uk/peoplepopulationandcommunity/householdcharacteristics/homeinternetandsocialmediausage/articles/exploringtheuksdigitaldivide/2019-03-04
[14] Lloyds Bank UK Consumer Digital Index. (2018). https://www.ons.gov.uk/peoplepopulationandcommunity/householdcharacteristics/homeinternetandsocialmediausage/articles/exploringtheuksdigitaldivide/2019-03-04

Key actions

To help overcome challenges related to digital access, 3 key steps were identified by stakeholders.

Action	Description	Alignment to national priority
1. Make it easy and attractive for service users to access digital support in the community.	Within community maternity hubs: • Set up private rooms/areas • Provide free Wi-Fi access • Provide tablets/laptops • Have a community worker 'on hand' to offer support. This will allow service users to watch educational videos and access online resources in private. The community worker can also provide support for those people who have very little to no digital skills.	National priority 2
2. Upskills service users to be able to use digital resources.	Upskill service users by offering educational workshops within community maternity hubs, aiming to improve their essential digital skills. These workshops can be underpinned by the Essential Digital Skills Framework[15] which provides a guide on what the digital skills for life and work are and what service users need to know to achieve them. Whilst the focus should be on upskilling service users to provide a long term solution to digital exclusion, print outs of key information should still be offered on a case-by-case basis.	National priority 2
3. Explore possible use of non written resources for those who do not read	Explore use of videos, stories and graphics/animations and additional non-written forms of communication particularly in relation to communities who have traditions of oral communication.	

[15] Essential Digital Skills Framework. (2018). Essential Digital Skills Framework (publishing.service.gov.uk)

4. Race equality among maternity staff

A key national aim is to improve race equality among staff as it is recognised that a diverse and inclusive workforce will help improve patient outcomes. The NHS People Plan[16] states that '*…where an NHS workforce is representative of the community that it serves, patient care and… patient experience is more personalised and improves*'. The importance of this is acknowledged by the BSW ICB as each of its Hospital Trusts has an action plan in place aiming to improve race equality among staff which also includes maternity and neonatal staff. Thus, the actions proposed in this section will further add to and compliment the work already happening more broadly across the ICB.

Several challenges were raised in relation to achieving race equality within the maternity workforce:

- Ethnic profile of staff is not representative of the BSW population.
- Unconscious biases and institutionalised racism are prevalent in wider society and within healthcare. Stakeholders said it is not always treated with the 'seriousness it needs' – for instance, training to address institutionalised racism is not compulsory for staff which perpetuates the perception that is it not so much of an issue.
- Not all staff are mindful of the fact people from ethnic minority groups may have had previous negative experiences with statutory services, which have impacted on their trust of healthcare professionals.
- There is a lack of students from ethnic minority backgrounds studying midwifery which limits the pool of staff to recruit from.

[16] NHS People Plan. (2020). NHS England » We are the NHS: People Plan for 2020/21 – action for us all

Key actions

To help achieve race equality across maternity services, 3 key first steps were identified.

Action	Description	Alignment to national priority
1. Make training compulsory.	It is critical to make training aimed at addressing unconscious bias and institutionalised racism compulsory for all staff as part of efforts to tackle the stigma. This requires not only educating staff about unconscious bias but also on steps they can take to mitigate its influence on the care they deliver. This will improve experiences for women from ethnic minority backgrounds including asylum seekers/refugees and women who do not speak English as a first language.	National priority 4d
2. Provide anti-racism training to staff.	Anti-racism training for staff will help to increase their awareness, knowledge and understanding of the experiences of people from different cultures. This will enable staff to interact effectively with people from all backgrounds through a lens of diversity, inclusion, and belonging.	National priority 4d
3. Employ more staff from ethnic minority backgrounds.	To make the LMNS workforce reflective of the service user population, more staff from ethnic minority backgrounds need to be recruited. Also, it needs to be ensured that equal opportunities are in fact provided to all staff.	National priority 4d

Final actions

In addition to the specific areas of focus, three overarching action points have been identified as key to include within the action plan:

1. We aim **to maintain a focus on planning for implementation of Continuity of Carer modes of care once the building blocks are in place**, including staffing levels; with the aim to make maternity services safer, more personalised, kinder, more professionals and more family friendly.

2. While LMNS Programme board is the responsible owner for all actions, there is a need to **establish timescales, monitoring arrangements and a named owner for each action**.

3. **Develop a high-level stakeholder communication plan** to raise awareness of this action plan - the first step being taken to on this journey.

Closing remarks

This action plan has been co-created by key stakeholders who have identified the most important f**irst steps** to help achieve equitable actions for all. Five key areas of focus have been identified which align with the five national priorities targeting health inequalities. More specifically, this action plan aims to improve equity for key groups of people, including those from ethnic minority backgrounds and those living in deprived areas.

It is important to note that this is a **live, iterative document** which will be continuously updated to reflect the ongoing work within BSW LMNS to implement actions and drive equitable outcomes for all service users and race equality for staff.

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