

Health and Wellbeing Board

Thursday 14 November 2024

10.00 am

Ground Floor West - Southwark Council, 160 Tooley Street, London SE1
2QH

Membership

Councillor Evelyn Akoto (Chair)	Cabinet Member for Health and Wellbeing
Dr Nancy Kuchemann (Vice-Chair)	Co-Chair Partnership Southwark and Joint Chair of the Clinical and Care Professional Leadership Group
Councillor Jasmine Ali	Deputy Leader and Cabinet Member for Children, Education and Refugees
Councillor Maria Linforth-Hall	Opposition Spokesperson for Health
Althea Loderick	Chief Executive, Southwark Council
Toni Ainge	Acting Strategic Director of Environment, Neighbourhoods and Growth, Southwark Council
Hakeem Osinaike	Strategic Director of Housing, Southwark Council
David Quirke-Thornton	Strategic Director of Children's and Adults' Services, Southwark Council
Darren Summers	Strategic Director for Integrated Care & Health (NHS South East London)
Sangeeta Leahy	Director of Public Health, Southwark Council
Alasdair Smith	Director of Children and Families
Anood Al-Samerai	Chief Executive, Community Southwark
Peter Babudu	Executive Director of Impact on Urban Health, Guy's and St Thomas' Foundation
Cassie Buchanan	Southwark Headteachers Representative
Louise Dark	Chief Executive for Integrated and Specialist Medicine Clinical Group, Guy's and St Thomas' NHS Foundation Trust
Ade Odunlade	Chief Operating Officer, South London & Maudsley NHS Foundation Trust
Charlene Young	Chair, Healthwatch Southwark

INFORMATION FOR MEMBERS OF THE PUBLIC

Access to information

You have the right to request to inspect copies of minutes and reports on this agenda as well as the background documents used in the preparation of these reports.

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Contact

Maria Lugangira on email: maria.lugangira@southwark.gov.uk

Members of the committee are summoned to attend this meeting

Althea Loderick

Chief Executive

Date: 6 November 2024



Health and Wellbeing Board

Thursday 14 November 2024

10.00 am

Ground Floor West - Southwark Council, 160 Tooley Street, London SE1 2QH

Order of Business

Item No.	Title	Page No.
1.	WELCOME AND INTRODUCTIONS	
2.	APOLOGIES To receive any apologies for absence.	
3.	CONFIRMATION OF VOTING MEMBERS Voting members of the committee to be confirmed at this point in the meeting.	
4.	NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT In special circumstances, an item of business may be added to an agenda within five clear days of the meeting.	
5.	DISCLOSURE OF INTERESTS AND DISPENSATIONS Members of the committee to declare any interests and dispensation in respect of any item of business to be considered at this meeting.	
6.	MINUTES To agree as a correct record the open minutes of the meeting held on 18 July 2024.	To Follow
7.	PUBLIC QUESTION TIME (15 MINUTES)	
8.	SOUTHWARK MATERNITY COMMISSION	1 - 334
9.	HEALTH WEIGHT IN SOUTHWARK	335 - 371

Item No.	Title	Page No.
10.	HEALTH PROTECTION ANNUAL REPORT 2023/24	372 - 411
11.	SOUTHWARK JOINT HEALTH AND WELLBEING STRATEGY 2022-27 - PROGRESS REPORT: NOVEMBER 2024	412 - 442
12.	PARTNERSHIP SOUTHWARK HEALTH AND CARE PLAN REFRESH OF STRATEGIC PRIORITIES	443 - 448
13.	AIR QUALITY ANNUAL STATUS REPORT 2023	449 - 571
14.	PHARMACEUTICAL NEEDS ASSESSMENT (PNA) BRIEFING	572 - 576
15.	ANY OTHER BUSINES	

Date: 6 November 2024

Meeting Name:	Health and Wellbeing Board
Date:	14 November 2024
Report title:	Southwark Maternity Commission
Ward(s) or groups affected:	Residents who are planning pregnancies, families, children and young people
Classification:	Open
Reason for lateness (if applicable):	Not applicable
From:	Liz Brutus Assistant Director / Consultant in Public Health Southwark Council Layla Glover Senior Public Health Programme Manager Southwark Council

RECOMMENDATION(S)

1. That the Health and Wellbeing Board note the findings of the Southwark Maternity Commission report and its ten recommendations and agree to take on the oversight of this work which includes a five-year action plan involving a range of local partners including Southwark residents.
2. That the Health and Wellbeing Board receive an annual update on the progress of the Southwark Maternity Commission, a fuller three year interim review of progress in September 2027 and a final five year evaluation of progress in September 2029.

BACKGROUND INFORMATION

3. The Southwark Maternity Commission (SMC) was set up to assess and address inequalities in maternity care, particularly for families from a minority ethnic and/or socially disadvantaged background.
4. Over the course of nine months, from January to September 2024, SMC engaged with over 750 local residents, voluntary and community sector representatives, local maternity care service providers and local workforce.
5. It did so through engagement including six public meetings, extensive community engagement and stakeholder workshops.

KEY ISSUES FOR CONSIDERATION

6. The Southwark Maternity Commission identified five overarching themes:
 1. Tackling discrimination and better supporting women with specific needs.
 2. Making sure women are listened to and supported to speak up, whatever their language or background.
 3. Providing women with the right information at the right time in the right way.
 4. Joining up council and NHS services better around women's needs, and making sure care is consistent across borough borders.
 5. Supporting the workforce to remain in their roles and be able to give compassionate and kind care for all mothers.
7. These themes and the findings of the Commission were used to develop ten recommendations. The first three are asks of central government, while the remaining seven are targeted towards the local maternity system, voluntary and community sector organisations and Southwark Council.

The ten recommendations are:

1. Leadership in addressing racism that leads to unequal maternal health
 2. Develop a new national way of reporting maternal health
 3. Review the maternity workforce
 4. Evaluate the fairness of maternity services
 5. Listen to and empower families
 6. Preparation and support before pregnancy
 7. Give parents the right information, at the right time, in the right way
 8. Create a joined-up approach to families' needs between the NHS, southeast London boroughs, and voluntary and community sector
 9. Southwark Council to review their role in maternity care
 10. Review how feedback is dealt with.
8. An action plan is being developed by the Public Health Division within the Council, based on these recommendations, which will be finalised by April 2025. The action plan will then be implemented over the following two and a half years, with a view to all actions taking place by September 2029.

Policy framework implications

9. The Commission findings should be considered within the context of other local plans and policies designed to reduce inequalities and improve health and wellbeing in the borough.
10. The Commission should also inform and build upon existing plans of the South East London Integrated Care System's Local Maternity and Neonatal System.

Community, equalities (including socio-economic) and health impacts

Community impact statement

11. The report involved extensive engagement with residents, trust partners, and local voluntary and community sector organisations in its development. These community members will continue to be involved as the action plan is developed and implemented.

Equalities (including socio-economic) impact statement

12. A primary aim of the Southwark Maternity Commission was to assess inequalities in maternity care. Based on national data, this took a particular focus on women from a minority ethnic and/or socially disadvantaged background. The report takes into account how different communities are affected by poor maternal and infant outcomes.
13. This includes the protected characteristics outlined in the Equality Act 2010, along with considerations of how multiple characteristics may intersect to exacerbate inequalities.
14. The report recommendations and the subsequent action plan will aim to reduce the inequalities identified.

Health impact statement

15. The Southwark Maternity Commission was initiated to assess the inequalities in maternity health outcomes in the borough. Implementation of the report's recommendations should have a positive impact on maternal health and consequently infant health.

Climate change implications

16. There are no direct implications on climate change arising from this work.

Resource implications

17. The Southwark Maternity Commission to this point has been led by the Public Health Division on behalf of the Cabinet Member for Health and Wellbeing. It has required cross-council collaboration with other departments such as Communications and Community Engagement, Public Affairs, and the Constitutional team.
18. It is likely that full implementation of the recommendations will have resource implications, particularly for NHS partners who bear a large proportion of the responsibility for the recommended actions over the five years. Early response from the SEL LMNS (presented on 17 Oct 2024) welcomed the Commission's report and acknowledged the alignment with various existing or planned SEL LMNS activities with Commission recommendations. Furthermore, Southwark Stands Together welcomed the report and offered support of partnership working from various teams across Southwark Council.

Consultation

19. The Southwark Maternity Commission action plan will be co-produced and overseen by key partners across Southwark Council, NHS, VCS and residents. It is envisaged that each recommendation area will have its own sub- working group, which will receive oversight from a strategic steering group overseen by the Southwark Health & wellbeing Board.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
The Southwark Maternity Commission: Recommendations to tackle the inequalities in pregnancy and childbirth experienced by families in Southwark (2024)	Public Health Division, Children & Adults Department	Megan Velzian Megan.velzian@southwark.gov.uk

APPENDICES

No.	Title
Appendix 1	The Southwark Maternity Commission: Recommendations to tackle the inequalities in pregnancy and childbirth experienced by families in Southwark

AUDIT TRAIL

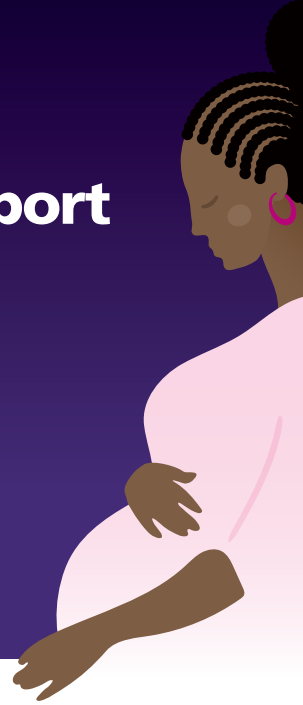
Lead Officer	Liz Brutus	
Report Author	Megan Velzian & Clodagh Cox	
Version	Final	
Dated	September 2024	
Key Decision?	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	Comments Sought	Comments Included
Assistant Chief Executive, Governance and Assurance	No	No
Strategic Director of Resources	No	No
Cabinet Member	Yes	Yes
Date final report sent to Constitutional Team	1 November 2024	

The
Southwark
Maternity
Commission

Summary of the Maternity Commission Report

September 2024

In the UK, Black and Asian women, as well as those living in the most deprived areas, have a higher risk of dying during and up to six weeks after pregnancy than White women¹.



Black and Asian women have a higher risk of dying in pregnancy



¹ Statistics from MBRRACE-UK 'Saving Lives Improving Mothers' Care 2023' report

Why the Commission was set up

It was set up to review the maternity care that families in Southwark get. It had the following aims:

- assess inequalities in maternity care access, experiences, and outcomes, focusing on parents from ethnic minorities and socially disadvantaged backgrounds
- evaluate how national recommendations for maternity services are being followed to improve access, experiences, and outcomes while reducing inequalities
- identify areas for further action and improvement for women in Southwark within the local maternity system

All means all

Families come in many forms, and this Commission stands in solidarity with all parents and families in our borough. In making our recommendations we wish to be clear about our inclusiveness.

Find out more at www.southwark.gov.uk/maternity-commission



The
Southwark
Maternity
Commission

Who has been involved in the Southwark Maternity Commission

Over 750 residents and maternity care professionals have been involved in this work, including those shown below.

Academics and field experts

Senior management and commissioners



Timeline of next steps for the Maternity Commission recommendations



September 2024

Organisations commit to change

October 2024 – April 2025

Development of the action plan

April 2025 – September 2027

Implementation of action plan

September 2027

Three-year interim review

September 2029

Five-year final review

Our work with the stakeholders outlined led to the development of five themes



Tackling discrimination and better supporting women with specific needs.



Making sure women are listened to and supported to speak up, whatever their language or background.



Providing women with the right information at the right time in the right way.



Joining up council and NHS services better around women's needs, and making sure care is consistent across borough borders.



Supporting the workforce to remain in their roles and be able to give compassionate and kind care for all mothers.

These themes were used to develop our ten recommendations, below and over the page.



Southwark Maternity Commission recommendations

1 to 3 Government asks

1 Leadership in addressing racism that leads to unequal maternal health

Introduce clear, evidence-based policies that address racism and inequalities in maternity care and the wider healthcare system. Include review and improvement in existing frameworks and systems, such as the NHS Workforce Race Equality Standard and ending charging migrants for maternity services.

2 Develop a new national way of reporting maternal health

Work with local authorities to introduce a way to record and respond to perinatal health data. Make sure all maternal health data is collected and reported in a standard way across all healthcare settings and focuses on ethnicity to highlight and address if people are getting unfair and different treatment.

3 Review the maternity workforce

Review the wider maternity healthcare system's capacity to support its workforce, with a focus on improving pay, conditions, and resilience. Provide healthcare professionals with training, resources, and a supportive work environment to improve compassion in care, particularly for Black and Asian mothers.

Continued overleaf...

Southwark Maternity Commission recommendations continued

4 Evaluate the fairness of maternity services

Review current services for Southwark residents with the highest levels of need. Develop and improve new and existing services to make sure they work for people with complex, overlapping needs.

5 Listen to and empower families

Create an inclusive environment where all family members are heard and have the information to make sure their needs are met. Improve communication by creating and promoting accessible resources so that families are fully informed and can navigate the healthcare system.

6 Preparation and support before pregnancy

Southwark partners (Local Maternity and Neonatal System, local authorities, voluntary and community sector and maternity care providers) raise awareness together of the importance of getting ready for pregnancy. Use all services and contacts so that women arrive at maternity services in the best possible health (in particular those at risk of poorer maternal health outcomes).

Give parents the right information, at the right time, in the right way

7 Southwark partners (Local Maternity and Neonatal System, local authority, voluntary and community sector and maternity care providers) work together on their communications across each stage of the perinatal period. Make sure women and their partners get the right, inclusive and culturally appropriate information.

8 Create a joined-up approach to families' needs between the NHS, south east London boroughs, and voluntary and community sector

Strengthen partnerships by creating a network for staff delivering care to Southwark residents. Share learning, facilitate integration across services and improve knowledge and resource sharing. Look for opportunities for co-commissioning with neighbouring boroughs to enhance and provide consistent services across borough borders.

Southwark Council to review their role in maternity care

9 Look at their role in assurance and scrutiny of the maternity care system and empower system leaders to hold people to account. Together with local NHS trusts review, identify and close gaps in maternity services. Consider their role in housing and cost of living services, and in collaborating with local voluntary, community, faith and social enterprise sector organisations.

Review how feedback is dealt with

10 Work with NHS trusts to review how they identify, share and respond to patient and staff complaints, particularly ones about racial discrimination. Embedding a culture where staff are encouraged and supported to speak up. Make sure that the context of reviews is appropriate and develop an integrated, borough-wide response to review findings.

Contents

Inclusivity statement.....	3
A message from the Southwark Maternity Commission Panel.....	4
Acknowledgements.....	10
Chapter One: An introduction to the Southwark Maternity Commission.....	12
Chapter Two: National and local context of health and service provision.....	17
Chapter Three: Maternity care in Southwark.....	27
Chapter Four: Hearing from the workforce.....	41
Chapter Five: Hearing from women	50
Chapter Six: Capturing the voices of fathers and male carers	78
Chapter Seven: Recommendations	84
Chapter Eight: Next steps	92
Glossary.....	96
Appendices	99

Inclusivity statement

All means all

Families come in many forms, and this Commission stands in solidarity with all parents and families in our borough. The inspiration for this Commission came from the courageous accounts of Black women using local maternity services. Their experiences drew us to look at local maternity services and to ask if these services were meeting the needs of our residents in a respectful, competent and positive way. We are deeply grateful for their openness and constructive contributions to help make local maternity services better, for all.

Southwark is a very diverse borough, including one of the largest lesbian, gay, bisexual, transgender communities in the country. In the course of the Commission's engagement and research, we also know there are parents who have felt marginalised or excluded because of their sexual or gender orientation. The reality is that some transgender and non-binary people go through pregnancy and childbirth, and they have an equal and absolute right to access good, high quality and safe support from our health services.

We really appreciate hearing about all these experiences, and it has been enlightening for us. In making our recommendations we hold all parents and families in mind, and we wish to be clear about our inclusiveness. In challenging and supporting local maternity services to be the very best that they can be, requires them to be fully inclusive and to treat all parents and families with the dignity and respect that they all deserve.

A message from the Southwark Maternity Commission Panel

Councillor Evelyn Akoto

Fifteen years ago, I gave birth as a Black woman living in south east London. My experience was traumatic and could have potentially resulted in the loss of my child, but the midwives shift change brought in a new person to care for me. The new midwife took time to listen to my concerns and acted on what she heard, her responsiveness ensured that I was not a statistic and that I was able to walk out of the hospital with my baby.

However, not everyone can and should have to rely on favourable circumstances to ensure their maternity story ends well. I never understood why my first midwife seemed so dismissive of my worries, however what is more upsetting is that I am still hearing similar stories over a decade later. Women are still experiencing not being listened to.

The UK is one of the safest places in the world to give birth, yet we continue to see appalling disparities in maternal deaths. And even more shocking is the persistent statistic that Black and Brown women continue to die at a higher rate than their White counterparts. But we also know that there are countless more women who survive childbirth but suffer from pregnancy-related complications. If we are going to have greater change in reducing maternal health inequalities, we need more data about the disparities in these “near-miss” cases. These stories, tied with the startling statistics on maternal mortality, meant that I could not keep quiet and has prompted me to act within my role as Cabinet Member for Health and Wellbeing at Southwark Council to ensure that we improve outcomes for women.

After acquiring officer support from the Council’s Public Health, Communications and Community Engagement teams, I set out to establish a panel of professionals who were experts either by profession or experience. This Commission is not about finding someone to blame, but about working in partnership to focus on Southwark women and the maternity services they are accessing; so that we can bring about tangible, practical solutions that can be delivered from our respective roles.

Since January 2024, the working group has grown along with the number of professionals and residents invested in the Southwark Maternity Commission.

Coincidentally, it has taken nine months to get to this point, wherein we’ve heard from the voices of mothers, fathers and male carers, the voluntary and community sector, the workforce, senior management representatives and research experts. These voices have each played a role in

shaping our final report and recommendations, which we hope will pave the way to reducing the maternal inequalities our residents face.

However, as with a pregnancy, the fun (and hard work) truly begins after nine months. We recognise a lot of work needs to be done to achieve commitment from local and national bodies to implement our recommendations, but this report is that first step.

Dame Professor Donna Kinnair

As a public health nurse, inequalities in health have been my concern for many years. I was delighted when Councillor Akoto asked me to co-chair this Commission. The last nine months has brought me back into a community, engaging with the people of Southwark, a place where I enjoyed working for many years. There are many inequalities in health facing this community. However, the plight of birthing women from the Black and ethnic minority communities remains a stubborn statistic that has failed to improve over many years.

It has been my pleasure to work and listen to the women of Southwark, as well as their families who have not only told us about their experiences, but have also taken the time to give us their views on how this stubborn statistic could be improved. We have attempted to capture their words and thoughts and it is my hope that the services in Southwark enact the recommendations we make, thus ensuring we improve the experience and outcomes for all of our women and their families.

About the Southwark Maternity Commission Panel

Dr Benedicta Agbagwara-Osuji

Dr Benedicta Agbagwara-Osuji is a Nurse and Midwife with over 20 years of experience in Healthcare. She has a diverse background in research, extensive clinical practice and policy development within the Nursing and Midwifery field.

Currently, Dr Agbagwara-Osuji is a Director of Midwifery and Gynaecology Nursing at Epsom and St Helier University Hospitals NHS Trust, an elected Board member of Royal College of Midwives and Care Quality Commission Specialist Advisor for Maternity.

As a Senior midwifery leader, she is driven by a vision of a maternity care system where every woman regardless of background or circumstances receives equitable care and experience throughout their pregnancy journey. Dr Agbagwara-Osuji has a profound commitment to reducing inequality in maternal outcomes, ensuring that all families have access to a service that is safe, responsive and high quality.

Omar Campbell

Omar Campbell is a dedicated advocate for maternal health and well-being. She brings extensive experience and diverse expertise to the Panel discussion. She is committed to fostering meaningful dialogue and exploring innovative solutions to advance maternity care practices and policies.

After giving birth to both her children at King's College Denmark Hill, and having been born there herself, she became dedicated to improving maternity care through co-production with service users. She became involved with the Maternity and Neonatal Voice Partnership (MNVP), going on to become the Lead for the MNVP and a Service User Rep for the London team.

She is deeply committed to addressing the challenges and inequalities faced by expectant mothers and improving access to high-quality maternity services for all. She has helped to implement an innovative infant feeding scum pilot project, worked on the gestational diabetes clinic and is dedicated to amplifying the voices of Black and Spanish speaking maternity services users with the establishment of dedicated working service user groups.

Sandra Igwe

Sandra Igwe is an impassioned advocate, dedicated to achieving health equity and dignity for Black mothers.

She is Chief Executive of The Motherhood Group, a leading organisation supporting the Black maternal experience through community events, training, peer support, policy, campaigning and more. Sandra intimately understands the gaps and barriers mothers of colour face in accessing quality, culturally competent maternity care.

With extensive experience uplifting marginalised maternal voices and driving institutional change, Sandra eagerly brings her expertise to the Southwark Maternity Commission. She believes authentic collaboration across community members, providers and policymakers is vital to illuminating experiences of inequality and charting an equitable way forward for Southwark's birthing families. Sandra is committed to ensuring the Commission's findings lead to meaningful commitments and reforms, honouring the basic human rights and dignity of all local mothers.

Becca Jones

Becca Jones is CEO of Home-Start Southwark, a local charity that provide 1-1 support to pregnant women and families with children under 5 through long-term, weekly home-visiting from trained peer volunteers and family support staff. 88% of the families Home-Start Southwark support are from global majority ethnicities, and face challenges and inequalities including poverty, disability and ill-health, domestic abuse, insecure immigration status and safeguarding concerns.

Becca has worked in the voluntary and community sector supporting children and families for over 20 years. Prior to managing Home-Start Southwark, she established the organisation's perinatal project "Bump to Babe" in 2016, in recognition of the importance of providing support during pregnancy, and that the earlier we start supporting families, the more impact we can make.

Becca is a mum of two and raising her family locally. She is passionate about supporting families through kind, empowering care, giving parents long-lasting confidence to provide the best possible futures for their children.

Jacqui Kempen

Jacqui Kempen is the Head of Maternity for South East London Integrated Care System and the Local Maternity and Neonatal System (LMNS). Jacqui started working in the NHS over 32 years ago as a student nurse, qualifying and working as a staff nurse before going on to train as a midwife.

After working as a midwife in various roles, Jacqui joined south east London LMNS as a project manager and then moved on to the Head of Maternity position in 2021. In addition to this role, she continues to work as a midwife on a regular basis.

Jacqui has a passion for ensuring women have the most up to date information to support them in making decisions about their care, and that care is accessible and equitable for all that need it.

Michele Misgalla

Michele lives locally and has been involved with supporting maternity services for many years, from when she was co-chair of the National Childbirth Trust Southwark and Lambeth branch. Through this work she became involved with King's Maternity and served on the first Caesarean Section Reduction group. This led to co-chairing what was then known as the Maternity Services Liaison Committee at King's. Michele was actively involved in the transition from the MSLCs to Maternity Voices Partnerships and now to MNVPs incorporating Neonatal.

Working alongside MNVP Lead Omar Campbell, Michele has represented King's service users shaping the future of maternity provision across London including to the London Maternity and Neonatal System, Maternal Medicine Network and the Public Health Working Group. She has also worked on gathering service user feedback to inform policy making and service improvement including in the Diabetes Clinic and on Labour and Postnatal wards at King's. Michele has also been a key part of the RELAX study team, using coproduction to develop a study into relieving anxiety in pregnancy, working particularly with marginalized groups locally to ensure input from seldom-heard voices.

She has three children, all born at King's or with King's renowned Home Birth teams. Through her work in the community, including supporting migrant and asylum-seeking pregnant people through the charity Neighbourhood Doulas, she is committed to amplifying the service user voice so that their experiences can directly shape policy and ensure that everyone has a positive and empowering birth and postnatal journey.

Cheryl Rhodes

Cheryl Rhodes represented Home-Start Southwark as a member of the Maternity Commission Panel, up until her departure from the organisation in May 2024. Home-Start continued to be represented on the Panel by its new CEO Becca Jones.

With a 25-year career dedicated to serving women, children, and families facing inequality, Cheryl's commitment to improving lives has remained steadfast.

In her role at Home-Start, Cheryl provided emotional and practical help to women throughout the perinatal period, as well as ongoing support until their children start school. Cheryl mentioned that the organisation sees on a regular basis how women from diverse ethnic backgrounds have a negative experience of pregnancy and birthing, especially when these challenges intersect with issues like poverty, immigration status, English as a second language, and mental health problems.

Home-Start is committed to advocating for and allying with those women who experience the effects of racism and prejudice. They believe in empowering them, valuing their journeys, and giving them a voice and agency over their future.

Acknowledgements

The Commission would like to thank everyone involved in this work, in particular the Southwark residents who attended one of the public meetings, whether to share their experiences or support others sharing theirs. We'd also like to thank every individual who took the time to participate in any of the Southwark Maternity Commission surveys.

Thank you as well to the mothers who took part in engagement sessions hosted by The Motherhood Group, as well as the fathers and male carers who attended the men's engagement session, supported by 1st Place Children and Parent's Centre and Future Men.

Thank you to the voluntary, community, faith and social enterprise sector organisations who helped bolster our engagement by allowing members of the Southwark Maternity Commission Working Group to come along and speak to the families they work with, or by carrying out the engagement themselves. These include:

Aainna Women's Group	Pecan Women's Group
Algerian Women's Group	SIDA
Aymara	Southwark Traveller Action Group
Bengali Women's Group	Southwark Disability Forum
Black Parent's Forum	Rockingham Pre-school
LOVO	Rockingham Nursery
Parent Action	

Thank you to the community venues who hosted us for our public meetings, Rye Oak Children's Centre and Peckham Library.

Thank you to the staff from Guy's and St Thomas', King's College Hospital and South London and Maudsley who used their valuable free time to attend public meetings and engage with this work, sharing your voices as well as listening to the families you support tell their stories too.

Thank you to Impact on Urban Health for their support and expertise, in particular Caesar Gordon who acted as guest panellist for two of the public meetings.

Thank you to Councillor Jason Ochere and Councillor Martin Seaton for facilitating a safe space for fathers to share their experiences of maternity care.

Thank you to the Southwark Maternity Commission Working Group, formed of Southwark Council employees from a number of different departments, for offering your expertise and support with this work. The Southwark Maternity Commission Working Group was led by Dr Liz Brutus and supported by:

Gargie Ahmad

Florence Igbokwe

Marcina Brown

Rahala Khalida

Elizabeth Crook

David Lee

Clara Fiti

Jessica Leech

Layla Glover

Catherine Simonds

Paula Hill

Zoe Silverthorne

Ginette Hogan

Virginia Wynn-Jones

Arthur Holmes

Thank you to additional Public Health colleagues who supported with or contributed to this work:

Lisa Colledge

Rebecca Sinnott

Bruce Kidd

Alexandra Quinn-Savory

Tom Seery

Report authors: Megan Velzian and Clodagh Cox

Chapter One: An introduction to the Southwark Maternity Commission

Southwark Maternity Commission

“The UK is one of the safest places in the world to give birth, yet we continue to see appalling disparities in maternal deaths. And even more shocking is the persistent statistic that Black and Brown women continue to die at a higher rate than their White counterparts.”

Councillor Evelyn Akoto, Founder of the Southwark Maternity Commission

The Southwark Maternity Commission was set up by Councillor Evelyn Akoto, Southwark's Cabinet Member for Health and Wellbeing, to examine maternity care in Southwark, in particular, the experience of Black, Asian and minoritised ethnic women. Cllr Akoto recognised the opportunities for Southwark Council to work more closely with the NHS and local voluntary, community, faith and social enterprise (VCFSE) sector organisations to understand the key challenges facing the system and Southwark's residents having babies, and to develop ways of working together to improve health outcomes and address inequalities. While the Secretary of State for Health and Social Care continues to have overall responsibility for improving the health of the nation, under the Health and Care Act 2012, local authorities are responsible for improving the health of their local population and to assure themselves of this.

To assist Cllr Akoto as Chair of the Maternity Commission, Professor Dame Donna Kinnair was invited to co-chair, and a panel of maternity experts by profession or experience was selected from the VCFSE sector and healthcare sector based on their knowledge of the local systems, expertise in inequalities and/or professional experience. A profile of the Panel is provided on page 6-9.

The Commission heard from a variety of stakeholders. Wider contributors included local midwives and maternity staff, the Local Maternity and Neonatal System (LMNS) and the Integrated Care System, GPs, Health Visitors, the Early Years workforce, Maternity and Neonatal Voices Partnerships (MNVP) and, most importantly, the residents themselves.

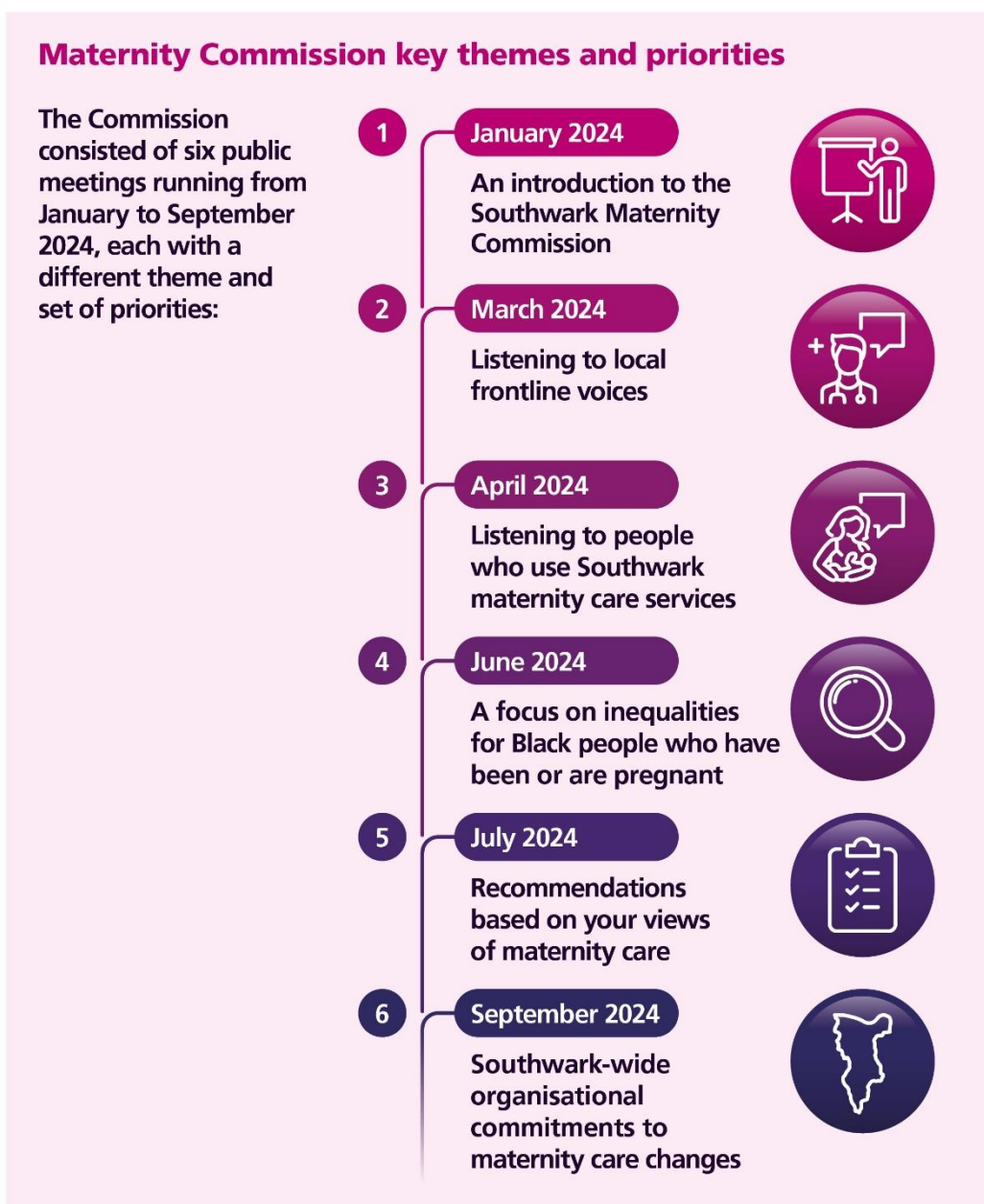
The Commission aimed to:

- Assess local inequalities in the access, experience and outcomes for maternity services, specifically for those parents from ethnic minorities and / or socially disadvantaged backgrounds.
- Assess the implementation of national recommendations for maternity services to improve access, experience and outcomes and reduce inequalities.

- Identify additional areas for action and improvement for Southwark women as part of the LMNS.

In undertaking its work, the Commission listened to:

- Southwark women and families on their experience of having a baby in the borough.
- The local midwifery and wider workforce that support women and families during pregnancy and the early years.
- Local maternity care providers' senior representatives from local trusts and the LMNS on the implementation of national best practice guidelines across local maternity and neonatal services.



Engagement

By the end of the Commission over 750 residents with recent (within five years) experience of local maternity care and members of the local workforce had been engaged in the work. Various approaches were used to gather information to supplement the six public meetings:

Engagement with residents

Method	Detail
Dedicated webpage	A dedicated Southwark Maternity Commission webpage (www.southwark.gov.uk/maternity-commission) was created providing information on the Commission itself and helpful national and local resources to support Southwark residents.
Questionnaire (short-form)	A brief questionnaire was shared widely which aimed to capture a breadth of voices and useful quantitative data about the antenatal, birth and postnatal experiences of residents receiving care from different trusts.
Questionnaire (long-form)	A more in-depth questionnaire covering different aspects of access, experience and outcomes through the antenatal, childbirth and postnatal journey.
Testimonies and statements	An inbox was set up, as well as an e-form, wherein residents were able to send in testimonies and statements to be shared anonymously, as well as express interest in other means of involvement.
Commissioned engagement	<p>Southwark Council commissioned The Motherhood Group to carry out qualitative research. The Motherhood Group is a social enterprise who focus on supporting the Black maternal health experience by delivering community-based events, workshops, peer-to-peer support, national campaigns and culturally sensitive programmes for Black mothers.</p> <p>The Motherhood Group have a team of researchers and staff with lived experience who carry out community engagement projects.</p> <p>The Motherhood Group engaged with the community by gathering and reporting maternal experiences within groups at higher risk of experiencing negative outcomes during and after pregnancy. 44 residents were recruited from these groups via a network of local VCFSE sector organisations. Experiences were captured via 1:1 interviews and focus groups, with the data collected analysed through an anti-racist lens. The Motherhood Group's report can be found in the appendix.</p>
Engagement session with fathers and male carers	A focus group and listening session for fathers and male carers was run off the back of an existing, well-attended Father's Stay and Play at 1 st Place Childrens and Family Centre, which is a group session run

	locally to facilitate parental skills and socialisation among fathers and male carers.
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Engagement with professionals

Method	Detail
Evidence submission	Each trust and the LMNS were asked to complete an evidence submission relating to their delivery of care and response to local and national guidance. These can be found in the appendix.
Questionnaire	A short questionnaire was shared among the early years workforce which aimed to gather views on provision and obstacles to care, opportunities for development, mental health, bereavement, and broader determinants of health.
Testimonies and statements, including anonymous submissions	A Maternity Commission inbox was set up, as well as an e-form, wherein professionals were able to send in testimonies and statements to be shared anonymously.
Workforce focus groups	The Motherhood Group were commissioned to conduct workforce engagement. 19 health and social care workers from local maternity services were recruited to take part in focus groups, capturing first hand experiences of delivering maternity care.
Evidence submission	Each trust and the LMNS were asked to complete an evidence submission relating to their delivery of care and response to local and national guidance. These can be found in the appendix.

Key outputs

The resulting evidence from the Commission led to three key outputs:

1. A report describing experiences of receiving and providing care within the local maternity services, including recommendations which will be used to support change to reduce drivers of inequality and underpin a local action plan.
2. Resources which will raise community awareness about how pregnant people can reduce their risk of unsafe pregnancies.
3. A message of solidarity to the population of Southwark to reassure residents that their voices are being and will continue to be heard.

Use of literature and best practice

The focus of the Commission was to listen to local voices to understand the issues and where available, the examples of what was working locally to improve maternal health. While not an exhaustive review of the literature, to help understand the local situation, this report draws heavily from various key national policies and reports relating to maternity care standards and outcomes including:

- LMNS Equity and Equality Strategy, 2023¹
- Better Births, 2016²
- The Black Maternity Experience report, 2022³
- MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) Perinatal Confidential Enquiry, 2023^{4,5}
- MBRRACE-UK Saving Lives, Improving Mothers' Care, 2023⁶
- MBRRACE-UK Perinatal Mortality Surveillance for 2022, 2023⁷
- Listen to Mums: Ending the Postcode Lottery on Perinatal Care, 2024⁸

Given the broad range of maternity-related evidence available, one of the key early tasks of the Commission's action plan will be to commission a targeted literature review if required, of what works best, based on recommendations that emerged over the course of the Commission.

¹ South East London Maternity & Neonatal System (2023) *Equity and Equality Strategy*

² National Maternity Review (2016) *Better Births: Improving outcomes of maternity services in England*

³ Five X More (2022) *The Black Maternity Experiences Survey: A Nationwide Study of Black Women's Experiences of Maternity Services in the United Kingdom*

⁴ MBRRACE-UK (2023) *Perinatal Confidential Enquiry: A comparison of the care of Asian and White women who have experienced a stillbirth or neonatal death*

⁵ MBRRACE-UK (2023) *Perinatal Confidential Enquiry: A comparison of the care of Black and White women who have experienced a stillbirth or neonatal death*

⁶ MBRRACE-UK (2023) *Saving Lives Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2019-21*

⁷ MBRRACE-UK (2024) *Perinatal Mortality Surveillance: Report for births in 2022*

⁸ The All-Party Parliamentary Group on Birth Trauma (2024) *Listen to Mums: Ending the Postcode Lottery on Perinatal Care*

Chapter Two: National and local context of health and service provision

National context

By global standards, giving birth in the UK is very safe. In 2019-2021, 241 out of 2,066,997 women giving birth in the UK died during or up to six weeks after pregnancy⁶, a figure relatively in line with other high-income countries⁹.

Although figures in the UK are low, some of these deaths are preventable; thrombosis and thromboembolism (VTE) continues to be the leading cause of direct deaths occurring within 42 days of the end of pregnancy, with the mortality rate from VTE remaining at a similar rate to previous years, suggesting several of these deaths could have been prevented with improvements to care. Further, nearly 40% of deaths occurring between six weeks and a year after the end of pregnancy are accounted for by mental health-related causes, with maternal suicide remaining the leading cause of direct deaths in this period. Although not all suicides are preventable, appropriate and timely mental health support can effectively reduce suicide rates.

In addition, when taking into consideration the previous Government's ambition to halve the rates of stillbirths, neonatal deaths and brain injuries by 2030, the UK falls short. In fact, once adjusted for deaths due to COVID-19, mortality rates in 2019-2021 remain similar to those in 2016, demonstrating a lack of progress. This lack of improvement highlights ongoing challenges within maternity services and raises concerns about the impact of growing inequalities and complexities.

Inequalities remain a significant problem when it comes to maternal outcomes, particularly those highlighted by the 2023⁶ and 2024⁷ MBRRACE reports:

- Women from Black ethnic backgrounds are four times more likely to die during pregnancy or up to six weeks after childbirth or the end of pregnancy, in comparison to White women.
- Women from Asian ethnic backgrounds are twice as likely to die during pregnancy or up to six weeks after childbirth or the end of pregnancy, in comparison to White women.

⁹ Tikkanen, et al. (2020) *Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries*

- Babies of Black ethnicity are more than twice as likely to be stillborn than babies of White ethnicity (Black: 6.19 per 1,000 total births; White: 2.99 per 1,000 total births).
- Babies of both Asian and Black ethnicity continue to have much higher rates of neonatal mortality than babies of White ethnicity (Asian: 2.50 per 1,000 live births; Black: 2.41 per 1,000 live births; White: 1.56 per 1,000 live births).
- Women living in the most deprived areas continue to have the highest maternal mortality rate when compared to those living in the least deprived areas.
- Stillbirth rates for babies born to mothers from the most deprived areas remain much higher than those born to mothers from the least deprived areas (Most deprived: 4.60 per 1,000 total births in 2022; Least deprived: 2.61 per 1,000 total births in 2022).
- 12% of women who died during or up to a year after pregnancy in the UK in 2019-21 had multiple severe disadvantages (including mental ill health, homelessness, substance use, domestic abuse and/or offending).

Health policy

In 2015, the National Maternity Review assessed the quality of maternity care across the country, considering how services should be developed to meet the changing needs of women and babies. The report of this review, *Better Births*² sets out the government's vision for maternity services across England. It had a clear objective: for maternity services across England to become safer, more personalised, kinder, professional and more family friendly; where every woman has access to information to enable them to make decisions about their care; and where they can access support that is centred on their individual needs and circumstances.

It identified key areas to improve outcomes of maternity services: personalised care, choice, continuity of carer, safer care, improved perinatal and postnatal mental healthcare, safer staffing, and integrated care. The continuity of carer model is a way of delivering maternity care so that women receive dedicated support from the same midwife team throughout pregnancy (see Figure 1). Local Maternity Systems were also formed out of the maternity review; the role of these systems is outlined on page 28.

Effective care continuity between midwifery and health visiting services

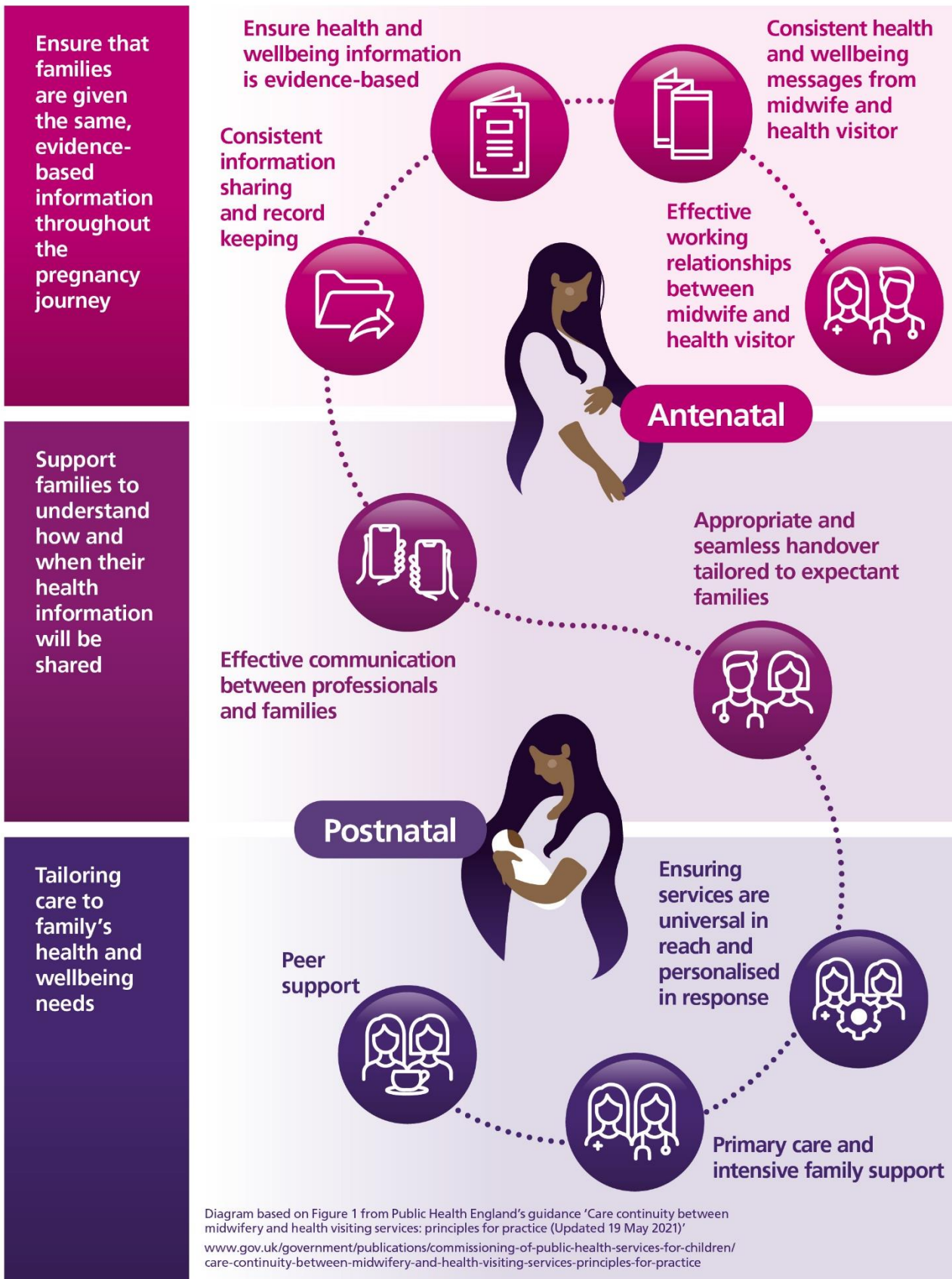


Figure 1. Diagram based on Figure 1 from Public Health England's guidance 'Care continuity between midwifery and health visiting services: principles for practice (Updated 19 May 2021)

The NHS Long Term Plan¹⁰, which was NHS England's response to changes in society and health needs, includes commitments based on measures set out in Better Births. These included ensuring continuity of carer for 75% of women from Black, Asian and minority ethnic communities and those from the most deprived groups by March 2024, and halving the rates of stillbirth and neonatal and maternal deaths by 2025. Initiatives to tackle health inequalities include prioritising continuity of carer for women from ethnic minority groups and other vulnerable groups. Other aims include increasing access to perinatal mental health services and increased support for breastfeeding and smoking cessation advice. It also commits to the digital transformation of maternity services to make it easier to share information.

The Three-Year Delivery Plan¹¹ for maternity and neonatal services outlines how the NHS will enhance care, making it safer, more personalised, and more equitable for women, babies, and families. Following several national plans and reports, the plan brings together the key objectives that that services are asked to deliver against over the next three years. In line with the Maternity Commission, this plan was informed by input from those who have used maternity services, the workforce, service leaders, regional stakeholders, and national stakeholders. There are numerous similarities between findings at a local level in Southwark and nationally. The objectives of the Three-Year Delivery Plan include:

1. Personalised care
2. Improved equity for mothers and babies
3. Collaboration with service users to enhance care
4. Workforce expansion
5. Valuing and retaining our workforce
6. Investment in skills
7. Fostering a positive safety culture
8. Continuous learning and improvement
9. Providing support and oversight
10. Setting standards to ensure best practices
11. Utilising data to drive learning
12. Enhancing the use of digital technology in maternity and neonatal services

The NHS Resolution's Maternity Incentive Scheme¹² is now in its sixth year of operation and continues to support safer maternity and perinatal care by driving compliance with ten safety actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025. The Maternity Incentive Scheme applies to all acute Trusts that deliver maternity services and are members of the Clinical Negligence Scheme for Trusts.

Safety Action number seven requires that Trusts work with their LMNS/Integrated Care Board to ensure a funded, user led MNVP is in place in line with the Three-Year Delivery Plan and MNVP

¹⁰ NHS (2019) *The NHS Long Term Plan*

¹¹ NHS England (2023) *Three-year delivery plan for maternity and neonatal services*

¹² NHS Resolution (2024) *Maternity (and perinatal) Incentive Scheme, Year Six*

Guidance including engagement and listening to families, strategic influence and decision-making and infrastructure. Safety Action number seven requires that Trusts work with their LMNS/Integrated Care Board to ensure a funded, user led MNVP is in place in line with the Three-Year Delivery Plan and MNVP Guidance including: engagement and listening to families, strategic influence and decision-making and infrastructure. Trusts must also ensure an action plan is coproduced with the MNVP following annual Care Quality Commission Maternity Survey data publication.

The COVID-19 pandemic caused wholesale disruption of health and care including maternity care services. There was at least partial, and in some cases, whole suspension of progress towards various objectives set out in Better Births. In line with Better Births, the NHS Long Term Plan committed to 35% of women being placed on a continuity of carer pathway by March 2020. However, in September 2022, NHS England announced that there would no longer be a target date for maternity services to deliver against this target of 35% until maternity services in England could demonstrate sufficient staff levels to be able deliver it¹³.

Staff recruitment and retention is a challenge in maternity services, particularly after the NHS Bursary Scheme in England was discontinued in 2017. Although student bursaries have since been reinstated in part, the effects of the temporary discontinuation are likely to have implications for future staffing levels. Recent reports, including the Ockenden Review¹⁴ and the Commons Health and Social Care Committee's inquiry into the safety of maternity services in England¹⁵, have underscored the persistent and severe staffing shortages in maternity care¹⁶. Midwives, maternity support workers, and other staff report struggling to find the time to adequately support women and families, provide timely information, and compensate for the lack of senior and experienced colleagues. The situation is particularly critical in England, where the shortage of midwives is currently estimated at 2,500.¹⁷

Midwives have also been a role under scrutiny over recent years, with the Ockenden review¹⁴, the Birth Trauma Inquiry⁸ and the case of the neonatal nurse found guilty of the murder of babies in her care making headline news. As a result, staff we engaged with reported feeling “demonised” by the media.

Where safe staffing is in place, NHS England continues to encourage rollout of midwifery continuity of carer, prioritising Black, Asian and Mixed ethnicity women, as well as those from the most deprived areas¹⁸.

¹³ NHS England (2022) *Midwifery continuity of carer*

¹⁴ Ockenden Report (2022) *Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust*

¹⁵ Department of Health and Social Care (2021) *The government's response to the Health and Social Care Committee report: safety of maternity services in England*

¹⁶ All Party Parliamentary Groups (2022) *Safe Staffing: The impact of staffing shortages on maternal and neonatal care*

¹⁷ RCM (2024) *How to fix the midwifery staffing crisis*.

¹⁸ NHS England (2022) *Priorities and operational planning guidance*

Wider socio-economic context

In addition to the pandemic, there have been considerable additional national economic challenges resulting in a cost-of-living crisis which has disproportionately impacted those on the lowest household incomes. It is well understood that socioeconomic factors, such as poverty, poor housing, unemployment or insecure employment status and racism, drive inequalities in health and wellbeing among populations, including maternal and infant health outcomes.

Widespread reporting of racial and ethnic health inequalities and the unequal impact of COVID-19 in the UK have brought significant national attention to the issue of racism, health inequalities and their broad implications. Reports on the impact of COVID-19 revealed inequalities, such as individuals of Bangladeshi ethnicity facing twice the risk of death compared to white British people, and those of Chinese, Indian, Pakistani, other Asian, Caribbean, and other Black ethnicities experiencing a 10-50% higher risk of death¹⁹.

Furthermore, the Black Lives Matter social movement gathered considerable international momentum following the murder of a Black American man, George Floyd, by a serving police officer. This has brought considerable national attention to racism and its widespread implications for wider society and public institutions in particular.

¹⁹ Public Health England (2020) *Beyond the Data: Understanding the Impact of COVID-19 on BAME Groups*

The local picture

Headline figures in Southwark

Infant deaths	Birth rate	Maternal deaths
In 2019-2021 there were an average of 13 infant deaths per year ²⁰	The number of births ²¹ have declined significantly in the last decade, from over 5,100 in 2010 to just under 3,400 in 2022	There have been no deaths with an underlying cause of "pregnancy" or "childbirth puerperium" recorded within the past ten years ²²

Although the birth rate is decreasing in Southwark, the needs and complexities of the birth cohort are increasing due to a variety of demographic and social factors.

Demographics and wider determinants of health

Age	Deprivation
<ul style="list-style-type: none"> The average age of Southwark mothers in 2022 was around 33 years²³, compared to 30.9 years in England and Wales²⁴. Mothers over the age of 35 are at increased risk of complications during pregnancy and childbirth e.g., pre-eclampsia, miscarriage, gestational diabetes, maternal mortality²⁵. Babies of older mothers face higher risks of high or low birth weight, stillbirth, preterm birth and chromosomal abnormalities²⁶. 	<ul style="list-style-type: none"> Southwark has high levels of deprivation across the north and centre of the borough²⁷. In 2022/23, 18.6% of under 16-year-olds in Southwark were in relative low-income families, a higher percentage than London (15.8%) but lower than England (19.8%)²⁸. Between 2018-2021, 30% of all stillbirths occurred in the five most deprived wards, over twice as many as to those in the five least deprived wards²⁹.

²⁰ NHS Digital (2018-21) *Birth registrations*

²¹ **Live births:** a baby that is born alive at any time, regardless of the length of the gestation period

²² Note: This data source only refers to deaths wherein a pregnancy-related cause is listed on the death certificate and coded as the underlying cause and so may not reflect the true picture of maternal mortality in Southwark

²³ JSNA Annual Report (2023) *Southwark's Joint Strategic Needs Assessment*

²⁴ Office for National Statistics (2024) *Birth characteristics in England and Wales: 2022*

²⁵ Correa-de-Araujo & Yoon (2021) *Clinical Outcomes in High-Risk Pregnancies Due to Advanced Maternal Age*

²⁶ Glick, Kadish & Rottenstreich (2021) *Management of Pregnancy in Women of Advanced Maternal Age: Improving Outcomes for Mother and Baby*

²⁷ Department for Levelling Up, Housing and Communities (2021) *English Indices of Deprivation 2019*

²⁸ Office for Health Improvement and Disparities (2024) *Child and Maternal Health*

²⁹ Southwark Council (2024) *Health Needs Assessment: The First 1,001 Days*

Country of birth

- Over half of all births in Southwark are to mothers born outside of England²⁹.
- Between 2018-2021, mothers' main non-UK countries of birth, were Nigeria, Sierra Leone, Ghana and the US.
- Local data reveals that stillbirth disproportionately affects women born in African countries²⁹.

Asylum Seeker and Refugee status

- There is no data on how many pregnant women are seeking asylum and housed in initial accommodation centres³⁰ (IACs) such as hotels in Southwark.
- National evidence suggests that pregnant people living in initial accommodation face a range of challenges, including poor nutrition, increased risk of mental health conditions, poor housing conditions, and being moved between IACs during pregnancy, often resulting in a need to change maternity services and midwives³¹.

Wider social determinants of health

- As of 2022/23, 22 per 1,000 (2.2%) of households including one or more dependent children in Southwark are owed a prevention or relief duty under the Homelessness Reduction Act. Local authorities owe prevention duties to help stop households at risk of homelessness losing their accommodation. This rate is substantially higher than that of London and nationally²⁸.
- Southwark Stands Together is Southwark Council's response to the inequalities exposed by COVID-19 and the events of 2020, as articulated by the Black Lives Matter protests. Engagement with residents through Southwark Stands Together highlighted one-third of residents from an ethnic minority background had experienced racial discrimination in health and care services, increasing to 41% among those from a Black ethnic background³².
- Of 2,600 children in need in Southwark at the end of March 2023, 5% had a primary need of parent's disability or illness, compared to 2% in England³³.
- An estimated 10% of Southwark women who had their booking appointment³⁴ in 2021/22 were deemed to be subject to complex social factors, such as poverty, substance misuse, asylum seeker and refugee status, age under 20, domestic abuse, difficulty speaking and/or understanding English³⁵.

³⁰ **Initial Accommodation Centres (IACs):** Lodgings for people who are awaiting the outcome of their claim for asylum. Some asylum seekers who have been granted support from the Home Office may remain in IACs until there is space in longer-term, temporary accommodation.

³¹ Maternity Action (2022) *Maternal Health: exploring the lived experiences of pregnant women seeking asylum*

³² Southwark Council (2021) *Southwark Stands Together – Findings from listening events, roundtables and online survey*

³³ Department for Education (2022) *Characteristics of Children in Need 2021/22*

³⁴ **Booking appointment: Refers** to the first midwife appointment, which should take place before ten weeks of pregnancy

³⁵ NHS Digital (2022) *Maternity Services Data Set*

- Southwark has a high number of women and girls found to have experienced female genital mutilation (FGM), with 160 Southwark resident women and girls recorded as having FGM, more than twice the rate for London and five times the rate for England³⁶. It is worth noting that the actual figure in Southwark is likely to be higher as many cases go unrecorded. FGM has long term physical and psychological health problems and can affect maternal and neonatal health including postpartum bleeding, increased risk of caesarean section and neonatal death.^{37, 37, 38}

The national and local data evidenced above highlights the stark inequalities impacting access, experiences and outcomes of women and their families accessing maternity and early years care, both in Southwark and on a larger scale.

Whilst there are gaps in local maternity data that need to be addressed, we know that Southwark has a very diverse population. Therefore, based on national maternity statistics regarding inequalities between ethnic groups and the least and most deprived areas, we can expect that a significant proportion of our borough's population are very likely to also be impacted by negative maternity outcomes.

Summary of local maternity services

In Southwark, maternity services are contracted by the South East London Integrated Care Board. The two main providers delivering maternity services to Southwark residents are Guy's and St Thomas' NHS Foundation Trust and King's College Hospital NHS Foundation Trust. The primary commissioned provider for perinatal mental health services is South London and Maudsley NHS Foundation Trust (SLaM).

The borough of Southwark is neighboured by Lambeth, and Lambeth residents seeking maternity and/or perinatal mental healthcare are likely to utilise the same three trusts as Southwark residents. Close borders and commonality of providers emphasise a need for consistency across both boroughs regarding community-based care.

In addition to NHS maternity and perinatal mental health services, there are many VCFSE sector organisations, as well as council-run and council-commissioned services, targeted at pregnant people and families during the early years of children's lives.

Women are advised to see a midwife or GP as soon as they find out they are pregnant. This is to ensure antenatal care is booked and women receive all the information and support needed. The initial midwife appointment should take place within the first ten weeks of pregnancy.

³⁶ Southwark Council (2023) *Health Needs Assessment: Female Genital Mutilation in Southwark*

³⁷ Forward (2023) *FGM in Europe: Exploring Young African diaspora women's views, experiences & activism*

³⁸ Rabiepour & Ahmadi (2023) *The effect of female circumcision on maternal and neonatal outcomes after childbirth: a cohort study*

In Southwark, women do not need to see their GP to book antenatal care; they are able to self-refer online via the website of their chosen hospital (see Fig. 2 for a map south east London hospitals). In practice over recent years, fewer Southwark GPs are involved in routine maternity care for their registered patients.

Over the past several years, the role of GPs in Southwark's maternity care has significantly diminished. Previously, GPs were central to regular antenatal care, working closely with midwives. However, the current model now routes pregnant patients directly to trusts, reducing GP involvement during pregnancy. This change, driven by policy shifts including the 2004 GP contract and the promotion of midwifery-led care, has led to a decline in routine antenatal visits at GP practices. Despite this, GPs continue to provide essential pre-pregnancy and postnatal care, particularly for women with complex medical or mental health needs. They remain responsible for the ongoing holistic care of women throughout their lives, including during pregnancy, but their involvement during the pregnancy itself has decreased.

The GP representative for the Commission explained how her role in maternity care has shifted over the past ten years and how this shift has limited the ability of GPs to engage in opportunistic conversations and maintain involvement during the course of pregnancy. The GP also pointed to the need for a focus on preventative care, ensuring that women are healthy before pregnancy, and considering how best to provide continuity of care with limited resources. She noted that while clear processes exist in primary care to raise concerns, broader communication from the council would be beneficial. The GP underscored the importance of understanding the patient journey, identifying main challenges, and agreeing on priority areas in partnership to improve care for women in Southwark.

Detailed information about the provision of maternity care in Southwark is in the next chapter.



Figure 2. Map of NHS maternity services across south east London.

Chapter Three: Maternity care in Southwark

Overview

London Borough of Southwark is part of the South East London Integrated Care System a partnership bringing together the organisations responsible for publicly funded health and care services in south east London.

The Integrated Care System consists of the Integrated Care Board, NHS, six local authorities (Southwark, Lambeth, Lewisham, Greenwich, Bromley, and Bexley) and organisations from the VCFSE sector. The system is responsible for allocating public money as well as planning and delivering a wide range of health and care services.

Within the South East London Integrated Care System sits the Local Maternity and Neonatal System (LMNS), which is a partnership between providers, commissioners, user representatives and other stakeholders working together to improve and transform maternity and neonatal services.

Meeting One: Hearing from providers of maternity care in Southwark

The focus of the first meeting was to introduce the Commission, as well as hear from senior Integrated Care System and hospital trust representatives about how their services are delivered, what they view as obstacles to delivery, their expectations of Southwark Council, and their response to national and local reports and guidance. Ahead of the meeting, the LMNS, GSTT, KCH and SLaM were asked to complete an evidence submission tailored to each service.

The purpose of the submissions and Panel questioning in the meeting was not to find fault or blame, but to pick out areas of strengths as well as concern, and identify how the system may be able to improve and develop.

Hearing from: Local Maternity and Neonatal Systems (LMNS)

The representative completing the submission and speaking at the Commission meeting on behalf of the LMNS was Head of Maternity, Jacqui Kempen, who is also a member of the Panel.

The Commission heard how Local Maternity Systems (LMS) were originally formed following the Better Births national maternity review conducted in 2016, with a primary focus on supporting service improvement. In more recent years, the remit of the LMNS has broadened to include responsibility for aspects of neonatal care and increased responsibility to ensure maternity services within the LMNS provide safe and quality services for those accessing them.

The LMNS has a governance structure supporting system-wide decision making to reduce variation and standardise care across the system. Decisions are informed by data which is submitted by each maternity unit into the Maternity Services Data Set.

This data is reviewed by the LMNS quality surveillance group every six weeks to identify any outliers and hold each trust to account, both regarding quantitative and qualitative data, such as complaints. It was acknowledged that local data quality has been an ongoing challenge but has been improving year on year. It was also flagged that crude data often provides a snapshot, meaning it is not appropriate to react immediately, but rather that trends should be observed over a period of time to inform decision-making.

A key point raised in the contributions by the LMNS was the importance of recognising the complexities of patients receiving care at GSTT and KCH. There are two large tertiary centres, Denmark Hill and St Thomas', which deliver care to Southwark residents. However, St Thomas' is likely to have increased rates of mortality because of higher risk patients from outside of London being transferred to benefit from the high-quality services and resource St Thomas' has at their disposal.

The LMNS was asked how they were identifying opportunities for working with Southwark Council to tackle issues. Their response was emphasising the need to do more before women become pregnant and empowering them to know what is available to them and engage with their healthcare professionals. The LMNS has recognised, following the development of integrated care systems, that better links with local authorities are required to address preconception and early pregnancy health.

Additionally, it was outlined that community services need to be improved around preparing women for pregnancy, with almost half of pregnancies nationally being unplanned or ambivalent. More needs to be done around educating people about pregnancy and maternal health before they become pregnant.

It is also important that local systems make use of and provide funding for grassroots community organisations that have the potential to support maternity services. These are organisations that women are more likely to trust, due to distrust in the NHS being prevalent among communities likely to experience poor maternal health outcomes. On top of this, Primary Care has a significant role to play in working together to support pre-conception health.

The LMNS work programme is large, however, below are some examples of work that has been done to date in an effort to reduce inequalities, including:

- A LMNS equality and equity strategy and action plan with an easy read version, available to the public, to increase accessibility
- Community engagement project – five community organisations commissioned to engage with local women from underrepresented groups to hear about their experiences and challenges faced when accessing maternity care
- The LMNS has an inequalities workstream with membership from providers and service users
- A LMNS/Southwark-based pilot of Maternity Mates – a peer-led programme providing support to women that may require advocacy
- LMNS Birth Choices project – information, resources, and recommendations for personalised maternity care, with the aim to give consistent evidence-based information in response to feedback from service users.
- Pilot of parent education in the top six spoken languages in south east London (Spanish, Portuguese, Somali, Arabic and French)
- Translation of various maternity resources in the top languages for each provider trust
- Bexley ‘Mumma’s Together’ pilot group – weekly group sessions for Black and Brown mothers with support from local midwives and the HELIX (Healing Experiences of Loss and Trauma) perinatal mental health team
- In collaboration with FiveXMore, funding to provide colourful wallets for Black and Brown women with advocacy messaging
- Provision of cultural sensitivity training for maternity staff from FiveXMore
- Working with Young Mums Support Network on how care can be improved

Hearing from: Guy's & St Thomas' NHS Foundation Trust

Guy's and St Thomas' Hospital NHS Foundation Trust (GSTT) provide maternity services at St Thomas' Hospital and local community services. The maternity service has over 6,000 births per year and is a Level 3 Neonatal Intensive Care Unit.

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. The most recent CQC inspection report for maternity services at GSTT took place in September 2022 and provided the following ratings:

CQC rating for Maternity Services at Guy's and St Thomas' (September 2022)

Overall rating for this service	Good ●
Are services safe?	Requires Improvement ●
Are services well-led?	Good ●

Possible ratings: Outstanding ●●; Good ●; Requires Improvement ●; Inadequate ●

The representatives at the meeting were Professor Eugene Oteng-Ntim (Clinical Director for Women's Health Services and Consultant Obstetrician) and Gina Brockwell (Chief Midwife).

GSTT opened with their main objective: for everyone to have safe, personalised and compassionate care throughout pregnancy. It was outlined that there is significant disparity of budget allocation coming from government within most women's health services, which creates disadvantages for women before they even begin to access services.

While the trust did not provide data in their submission, they offered case studies of how data is used to improve service provision. When asked for an example of where the service has analysed their data to pinpoint root causes for disparities in service uptake, representatives detailed a case where caseload midwifery³⁹ was used in an area with low service uptake and high infant mortality rates, leading to significantly reduced infant mortality rates in that area.

Another example of good practice provided by GSTT was the Lambeth Early Action Partnership, which is a place-based programme for families with children in a diverse area of Lambeth with a

³⁹ **Caseload midwifery:** A model of delivering maternity care that aims to ensure that the family receives all their care from one midwife or practice partner

higher level of need, funded by the National Lottery Community Fund. The programme includes targeted continuity of care midwifery, which resulted in a significant reduction in preterm birth rates (5.1% from 11.2%) and caesarean births (24.3% from 38%), including emergency caesarean delivery (15.2% from 22.5%)⁴⁰.

GSTT echoed the LMNS in emphasising the importance of pre-conception health; women are arriving into pregnancy with risk, which can be addressed pre-pregnancy. Significant risks in Southwark highlighted by GSTT at the meeting include comparatively high rates of sickle cell anaemia, maternal obesity, poor mental health and low levels of preparation for parenting.

Direct quote from Meeting One:

Panel Question: Of all the things you would like to work together on with both Local Authority and third sector partners, what would you prioritise?

(Professor Eugene Oteng-Ntim) "One key priority is having Women's Health Hubs for families to be able to visit regularly to receive things such as pre-pregnancy advice, early years intervention, and bringing the mothers and children together. The Council have access to estates, and being able to provide that for women's health will be key."

(Gina Brockwell) "I would also like to add one aspect which is accessibility of information. We really do want to work together on how we can make information easily accessible and easy to understand as a system across our partnerships."

Wider determinants of health impacting the outcomes of Southwark residents were discussed, and it was shared that a key factor keeping people in hospital when they don't need to be is poor quality or insecure housing, to which people are reluctant or unable to return. Representatives describe this issue as growing, as is the number of individuals seeking asylum, leaving the hospitals with high numbers of women who do not have secure or comfortable housing to which they can be discharged. Other safeguarding concerns were raised, such as cases where the baby has been removed from parents' care. This discussion led to emphasis of the value of continuity of carer.

Continuity of carer is evidenced to improve maternal outcomes, particularly for women from an area of high socio-economic disadvantage and/or from a Black, Asian or other minority ethnic

⁴⁰ Hadebe et al. (2021) *Can birth outcome inequality be reduced using targeted caseload midwifery in a deprived diverse inner city population? A retrospective cohort stud, London, UK*

background⁴¹. GSTT described the building up of a trusting relationship across the whole of the maternity journey. They also described how continuity of carer is easier to provide during pregnancy due to preplanning, whereas during labour, childbirth and postnatal care it can be harder to guarantee.

However, the benefits of providing continuity of carer beyond labour and into postnatal care are evident. Continuity of postnatal carer builds a safe relationship between the mother and care team. GSTT's priority is to strengthen the continuity of midwifery carer teams in areas where women experience poorer outcomes and inequalities.

When discussing challenges of providing continuity of carer, a more practical issue was highlighted by GSTT: caseload midwives are required to navigate parking, congestion charges and road restrictions, leading to delays attending appointments and responding to emergency situations. This is important to note, as providers could consider offering professional healthcare worker annual permits for each of their workers. Further discussions would be needed to clarify specific needs around where staff are usually parking, how often and the costs that are incurred, to ensure the recommended permits would suffice.

⁴¹ Homer et al. (2017) *Midwifery continuity of carer in an area of high socio-economic disadvantage in London: A retrospective analysis of Albany Midwifery Practice outcomes using routine data (1997-2009)*

Hearing from: King’s College Hospital NHS Foundation Trust (KCH)

The King’s College Hospital (KCH) has maternity services at both Denmark Hill and Princess Royal University Hospital sites. Denmark Hill is a Level 3 Neonatal Intensive Care Unit with a tertiary unit taking referrals for women with specific health conditions relating to pregnancy that require specialist care (such as foetal medicine, those with abnormally invasive placenta, hypertension, liver disease, renal disease and other co-morbidities⁴²). The trust is also a teaching centre for both medical and midwifery students.

KCH delivers around 8,000 babies per year, of which around 4,300 take place at the Denmark Hill site in Southwark.

The KCH maternity service offers women a choice of three different places of birth; the midwife-led unit, the consultant-led unit or home birth.

The most recent CQC inspection report for maternity services at King’s College Hospital took place in August 2022 and provided the following ratings:

CQC rating for Maternity Services at King’s College Hospital (August 2022)

Overall rating for this service	Requires Improvement •
Are services safe?	Requires Improvement •
Are services effective?	Requires Improvement •
Are services caring?	Good •
Are services responsive to people’s needs?	Requires Improvement •
Are services well-led?	Requires Improvement •

The representatives at the meeting were Dr Lisa Long (Clinical Director, Women’s Health and Obstetric Consultant) and Stephen McManus (Head of Maternity Governance, Compliance and Assurance).

⁴² **Comorbidities:** medical conditions that coexist alongside a primary diagnosis and affect your health and treatment.

KCH raised that, reflective of the national picture, the complexity of need is growing, with increased maternal age, body mass index, deprivation levels and social care needs. In addition, KCH emphasised difficulties in getting women to book into services before ten weeks of pregnancy, with this in part being due to KCH's internal system and processes, which was acknowledged as an area for improvement. Furthermore, a KCH audit into late booking of initial antenatal appointments revealed that mothers will often book at several different hospitals and then decide where they want to receive their care further down the line, contributing to later booking figures.

Other reasons for late booking include women not knowing they are pregnant, not understanding the importance of early booking, or the process of booking. For example, many women still believe that they need to see their GP to triage them into maternity services and are not aware they can self-refer. This emphasises a need to ensure the correct information is available to before they become pregnant, and when asked what the Council could do to support this, KCH emphasised helping to get the message across regarding early booking.

Similarly, and in parallel with issues raised by the LMNS and GSTT, KCH highlighted pre-pregnancy health, and mentioned identifying touch points wherein women have routine contact with health services, as an opportunity to get pre-pregnancy health messaging across.

Panel question: Of all the factors that affect the outcomes of our Southwark residents who are having babies, if you could change one thing what would it be?

(Dr Lisa Long) "I think being healthy before you come into pregnancy is key, so making sure you have access to healthy foods, you know your local services, you've already accessed care from your GP, and that you've optimised your health prior. I run the diabetic clinic so we know that less than half of mums with T1 and T2 come already on folic acid, have already stopped the medicines that they should have stopped before pregnancy and have been to a pre-pregnancy counselling clinic. That's less than half in Southwark and Lambeth, so knowing those things and those opportunities for you and planning your pregnancy would really help maternity give you a great start to your baby's life."

KCH echoed the challenges to continuity of carer outlined by GSTT, with 6% of their Black, Asian and minority ethnic background women receiving continuity of carer. However, KCH did highlight that women on their caseload are 1.5 times more likely to receive continuity of carer if living in deprived area. In addition, those who have experienced previous bereavement, severe mental health problems or substance abuse and complex medical needs are prioritised for continuity care. KCH acknowledged that their provision of continuity of carer falls short of their goals; however, this does demonstrate effort to reduce inequalities with the resources at hand. The benefits of

continuity of carer are clear from the evidence and buy-in at a senior level from commissioners and funders is essential to enforce and maintain the model of care.

In addition to continuity of carer, there is a desire to standardise the care being received across boroughs covered by the trust. There are clear disparities in the postnatal support being offered, particularly for infant feeding where some areas receive home infant feeding support in the first 28 days of life, while those outside of the community midwifery catchment areas are required to travel to breastfeeding drop in's which are run from children and family centres and Family Hubs.

Work is ongoing to offer effective, personalised care and to provide women with the tools they need to make decisions about their care. This includes personalised care programmes, workshops for midwives, posters and resources on decision making, and empowering women to ask the right questions. This work takes place in close partnership with the MNVP, to ensure all projects involve local women.

Following on from GSTT's comments about housing, KCH shared that 10% beds were being occupied by women who no longer require medical treatment, awaiting housing support, leading to a bed block with social care problems. This can have a significant impact on the workload and acuity of the maternity wards, which can have a negative impact on patient care. It prevents flow of patients through the unit and can delay parents receiving specialist care on our maternity wards as well as delaying discharges.

Hearing from: South London & Maudsley NHS Foundation Trust (SLaM)

SLaM provide the widest range of NHS mental health services in the UK, serving a local population of 1.3 million people in south London. SLaM's Southwark Perinatal Team offers assessment, treatment and intervention from preconception up to 24 months postnatally (usually 12-months outside of the pilot outlined below). The service includes a range of interventions, including parent-infant bonding and attachment.

The most recent CQC inspection report for perinatal services provided by SLaM took place in May 2021 and provided the following overall trust quality rating:

CQC rating for Maternity Services at King's College Hospital (May 2021)

Overall rating for this service	Good ●
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Good ●
Are services responsive to people's needs?	Good ●
Are services well-led?	Good ●

The representatives at the meeting were Samantha Chong (Clinical Service Lead for Community Perinatal Services) and Chris McCree (Parental Mental Health Lead).

SLaM reported careful consideration of any new evidence, report or policy, with new information shared with teams and at times presented at their Education and Quality in Practice (EQUIP) half day. This responsiveness to reports such as the 2023 MBRRACE publication has led to changes in practice to improve patient safety, such as using the Think Family framework to more effectively identify safeguarding concerns, as well as piloting the 24-month extension to the eligibility of women to receive treatment from the perinatal mental health service.

Previous EQUIP training days have included sessions on equality, diversity and inclusion, with a particular focus on the needs and experiences of Black and Asian families during the perinatal period. SLaM are also currently piloting the anti-racism framework: Patient and Carer Race Equality Framework (PCREF).

The Patient and Carer Race Equality Framework (PCREF)⁴³ was a key recommendation produced by the Independent Review of the Mental Health Act 2018⁴⁴. The PCREF is the first anti-racism framework launched by NHS England and forms a core part of the Advancing Mental Health Equalities strategy.⁴⁵ SLaM was selected as a PCREF pilot site for this anti-racism framework, which exists to eliminate the unacceptable disparity in the access, experience and outcomes that Black communities face and to significantly improve their trust in mental health services.

SLaM have reviewed service data which shows that people from Black African, Black Caribbean, Black Mixed and Black Other census categories are likely to have the poorest access, experiences and outcomes of mental health and have selected to focus attention on these groups. These inequalities are not limited to mental health services and are also evident in perinatal mental health services. Women from Black and Asian ethnic groups were less likely to be asked about their mental health, to be offered treatment or to receive support in the postnatal period⁴⁶.

This mandatory framework will support trusts and providers on their journeys to becoming actively anti-racist organisations, by ensuring that they are responsible for co-producing and implementing concrete actions to reduce racial inequalities within their services. It will become part of Care Quality Commission (CQC) inspections⁴¹.

The PCREF was not mentioned or discussed in the public meeting, however it is important to note for the purpose of this report.

Through data monitoring, SLaM have identified underrepresentation of South Asian women within the service and have made efforts to set up a focus group for these groups to identify key barriers to accessing mental healthcare. However, uptake of participation in focus groups was poor; linking SLaM with local South Asian VCFSE sector organisations is one way in which Southwark Council can strengthen partnership working with SLaM and improve service access. Despite low uptake among the South Asian population in Southwark, SLaM have been able to evidence improved access rates for other ethnic groups, including Black women.

⁴³ NHS England (2023) *Patient and Carer Race Equality Framework*

⁴⁴ Department of Health and Social Care (Use of Force Act) 2018: statutory guidance for NHS organisation in England and police forces in England and Wales

⁴⁵ NHS (2023) *Advancing mental health equalities - Patient and carer race equality framework*

⁴⁶ Redshaw & Henderson (2016) *Who is actually asked about their mental health in pregnancy and the postnatal period? Findings from a national survey*

Panel question: You mentioned some of the challenges that you're facing and we want to know what would help in improving the circumstances of your patients, particularly in terms of working with Southwark council?

(Chris McCree) "It's been really useful working with Southwark on the Start for Life work. We're also lucky to have a parental mental health team that is also a very useful pathway for perinatal so that women aren't just not meeting the threshold and getting excluded [women who are not meeting threshold criteria are not receiving support], there is a wealth of services that women can access. If we can increase our workforce and have some stability then we improve our ability to work in partnership... Start for Life is brilliant but we know it's short-term funding so how do we ensure that those things are embedded so that they become long-term so that we have some degree of stability and we know where women are and families are going to be referred to."

"...I think there's some work we can do with the Local Authority on developing resources and information for families to use that's child friendly and that helps explain emotional well-being. What we also know is our communities in Southwark distrust Mental Health Services significantly, both historically and currently, so we have to own that and we have to work with our partners... to help improve people's understanding about what emotional well-being looks like, what mental illness looks like, and that actually it's okay to come into a service and need help and support."

(Samantha Chong) "The hope also would be to have preconception clinics and also to go into Children and Family Centres, going to GPs so that the GP can assess whether something might be a perinatal case or provide advice around mother and baby."

Working group parties have been set up for equality, diversity and inclusion and lesbian, gay, bisexual, trans, queer, questioning and asexual (LGBTQ+), with SLaM recruiting staff to be involved in identifying gaps. However, loss of transformation funding from NHS England for the Maternity Transformation Programme in March 2024 is likely to have had an impact on the progress in these areas. SLaM described the loss of this funding as having a subsequent impact on clinical time for care coordinators to liaise with other agencies and taking clinical time away from mental health reviews and carrying out Mental Health Act assessments. This then impacted on wait times and excess data reporting, meaning reporting would not meet the Perinatal Quality Network deadlines where most community mental health teams are peer reviewed, constituting a barrier for mental health teams to go for accreditation.

Despite piloting a 24-month extension for perinatal mental health treatment from August 2023, SLaM received only one late referral (outside of the usual 12-month period) as of January 2024. The evidence behind the extension was a higher rate of maternal suicide after 12 months postnatal; however, if no referrals beyond 12 months are received then it is not possible to have a positive impact maternal suicide rates. SLaM described their intentions to link with Primary Care Networks and community mental health teams (CMHT) to ensure they are aware of the extension and work together to try to identify barriers to referral. The link SLaM felt was missing was the Health Visiting team, provided by GSTT, as they have struggled to identify who the team is, as well as the substance misuse team, CGL. Both of these services are commissioned by Southwark Council.

Common themes and actions

The first meeting highlighted the complex challenges faced by maternity services in Southwark, as discussed by representatives LMNS, GSTT, KCH and SLaM. Key issues identified include the need for better preconception care, the importance of continuity of care, and the necessity of addressing wider social determinants such as housing and accessibility to services.

The discussion emphasised the importance of collaboration between healthcare providers, local authorities, and community organisations to tackle inequalities and improve maternal health outcomes. Specific challenges such as staff recruitment and retention, resource constraints, and the need for culturally sensitive care were repeatedly mentioned.

The recruitment and retention of staff was raised by all three trusts as a persistent issue locally and nationally, impacting on their ability to intervene early. This was discussed in greater detail from a workforce perspective at Meeting Two (see page 17). Other key issues raised included estates, wherein each trust described difficulties finding suitable spaces in facilities to deliver services, particularly considering the needs of pregnant or new parents, such as making sure the space is baby-friendly with private rooms for breastfeeding.

Furthermore, all trusts acknowledged the need to make materials and appointments accessible for those who don't speak English and those with additional needs; however, they stated that in practice this is difficult due to capacity and resource restraints. Despite these challenges, the NHS has a legal responsibility to make sure that the services they provide are equally accessible to all sections of the community, and considering the complexities of Southwark's population, measures should be put in place to ensure translation and interpretation services are being provided as a priority.

Finally, at the time of the meeting both GSTT and KCH had moved over to a new electronic information system, which resulted in severe delays and complications in the collection, quality and reporting of data, and required all staff to complete training to use.

The meeting concluded with a shared recognition that while substantial work has been done to improve services and reduce inequalities, ongoing efforts and stronger partnerships are essential to ensure that all women receive the safe, personalised, and compassionate care they deserve.

Actions completed by Southwark Council taking place following the meeting:

- SLaM was linked up with the Lead Nurse for the 0-19 community service (Health Visiting)
- SLaM was linked up with Southwark's commissioned drug and alcohol service
- Southwark Public Health approached the Residents' Services team to engage with the Southwark Maternity Commission

Chapter Four: Hearing from the workforce

The focus of the second Maternity Commission meeting was to hear from those delivering maternity services in Southwark.

Hearing from the workforce is a crucial part of the Maternity Commission as professionals provide invaluable insights into the practical challenges and opportunities for improvement in maternity care. Their first-hand experiences and observations can identify areas of good practice, highlight gaps in services, reveal systemic issues and suggest solutions. Listening to those who support residents daily provided a realistic perspective of service delivery complementing the high-level insights of senior colleagues with varying areas of focus.

Engaging with the workforce throughout the entirety of the Commission aimed to foster collaboration between Southwark Council and those delivering services to create buy in from those delivering services at an early stage. The reflection of a realistic picture of patient facing care aimed to increase the likelihood of the Commission and its recommendations.

The Commission invited workforce feedback from four main sources:

- A public meeting was held in March 2024 focusing on the workforce, which captured an open discussion in a safe space for attendees. The meeting was facilitated by Cllr. Akoto and the Commission panel, it was recorded but not live streamed, allowing participants to recall any information they did not want to be shared and there was an allocated space for participants outside the meeting room, should participants feel overwhelmed by the subject topic.
- Southwark Council ran an online session consultation for professionals.
- The Motherhood Group facilitated a workforce engagement session which provided an opportunity for staff to share experiences, challenges and successes in delivering maternity care in the borough.
- Informal written or verbal contributions were left on the Commission's dedicated email and voicemail facility.

The public meeting featured local representatives from GSTT and KCH and voluntary organisations supporting those who give birth. The meeting featured a demographically and professionally diverse group of organised speakers and impromptu contributions from attending workforce members. The speakers represented a range of staff experiences, from students to experienced professionals in managerial roles, as well as ethnically diverse members. The mix included both qualified and trainees.

The survey results are based on 26 responses, which is a relatively small sample size and thus limits the generalisability of the findings. However, the results were largely consistent with other community engagement activities and the workforce meeting. Most responses came from professionals in maternity services, with additional input from individuals in general practice, obstetrics and gynaecology, safety and learning within the trusts, and women and child health

research. Responses were received from major maternity trusts, KCH and GSTT, and SLaM. The online consultation focused on the provision of and obstacles to care, maternal mental health, bereavement, opportunities for development, and broader determinants of health.

Emerging themes

The discussions of what workforce representatives were reporting at the meeting, as well as free text responses to the survey, are as follows:

Staffing and staff retention

Midwives and representatives from the maternity services workforce reported feeling overwhelmed, burned out, exhausted and unsupported due to consistent staff shortages. Representatives emphasised the negative impact of understaffing on quality of care frequently over the course of the meeting.

COVID-19 has had an extremely significant impact on staffing. The pandemic saw a large number of senior midwives retire, leaving newly qualified midwives and more junior staff without the senior support that is needed. The National Midwifery Council's Leavers Survey (2022)⁴⁷ found that 36.5% of respondents said that the COVID-19 pandemic had 'some' or a 'strong' influence over their decision to leave the register. Hospital midwives spoke how it is not uncommon for barely trained midwives to be training newcomers.

One student midwife representative reported that she and many of her midwifery cohort feel particularly unsupported and unwelcome in clinical placements due to the impact of staffing issues on midwives. The lack of staff increases responsibility and stress levels in turn creates a hostile workplace environment with limited time to support trainees. The student midwife discussed the lack of continuity on placements, limited support from senior staff and because of this, an inability to acquire and evidence the necessary skills in a timely way. Staffing issues were also highlighted by community services. Health visitors have had to change the service they provide due to a national shortage of staff with trusts creating rolling adverts for positions and relying heavily on agency staff to meet demand. Previously, health visitors saw people for antenatal care but that is no longer a universal offer due to lack of staffing capacity. Staff reported feeling stressed and overwhelmed but also felt that they were supporting families as best they could given the continuous limitations to the service.

“Despite everything going on, I think parents are still getting the care they need – though we need more staff, they feel stressed and overwhelmed”

Results from the online survey showed that 31% staff members felt that they had the capacity to deliver perinatal care to the highest standards. Of those who felt they could not, the main reasons were focussed on staffing, with staff reporting lone working when they should be delivering care in a team of up to four staff members as there was not enough staff or resources to provide necessary care. Staff highlighted that due to lack of staff on the ward, there is limit to standard of

⁴⁷ National Midwifery Council's Leavers Survey (2022) *Why do people leave the NMC register?*

care provided leading to readmissions of mothers and babies as staff unable to provide the necessary care.

Workplace culture and safety concerns

The discussions highlighted profound challenges faced by midwives and staff, emphasising a critical need for cultural transformation towards a more supportive and empowering workplace environment. One recurring theme was the gap between theoretical learning and practical application, particularly in fostering a culture where professional self-advocacy is ingrained from the outset of university learning and early career training.

The meeting highlighted a prevalent fear among midwives regarding speaking out against longstanding norms or reporting concerns. Those present who had experience of speaking out mentioned that this came with experience, personality type and confidence. Stories shared highlighted instances where staff faced negative repercussions or felt discouraged from raising alarms about poor practices they witnessed. This fear of reprisal or dismissal of concerns not only fosters a negative working culture but also has a direct impact on patient safety. A midwife representative reported that this reluctance stems partly from a stigma around vulnerability, where admitting uncertainty or questioning norms can be perceived as a sign of weakness rather than conscientiousness.

Stigma around vulnerability

At the meeting, conversations moved on to the stigma surrounding vulnerability in the workplace, especially for Black and ethnic minority staff. Many staff members feared that showing vulnerability or expressing concerns about safety would lead to punishment rather than support. This fear silences many voices and prevents the necessary dialogue that could lead to improvements in the workplace environment. There was a call for greater acceptance of vulnerability and the need to create a supportive culture where staff feel safe to speak up.

“You feel like if you speak up, you’ll get backlash”

A midwifery representative recounted a harrowing account when as a junior midwife, despite witnessing concerning practices, she felt unable to report this due to fear of repercussions or a perceived lack of support. She reported that the fear she experienced is rooted in a history of being unfairly targeted or disciplined, which creates a culture of silence and stress among ethnic minority staff members across the NHS. This vulnerability underscores the importance of building confidence and courage among midwives to raise concerns without fear of retribution, advocating for a kinder to care among the workforce. The need for a supportive culture shift was underscored as essential not only for the well-being of midwives but also for the quality and safety of patient care.

35% of the survey responses reported that they did not feel confident raising any concerns via internal procedures – staff reported that this is due to feeling victimised, a lack of confidence that this will have an impact and mishandling of complaints on previous occasions.

Meeting the complex needs of residents

Multiple speakers at the meeting referred to the increasing complexity of the people that they support. Over time, maternity and perinatal services have been forced to adapt to changes in political priority and the impacts these pose on families. Representatives highlighted how staff are completely overwhelmed by the complex family situations they are working with.

The Panel heard on multiple occasions how providing care has changed since they began their careers. Staff felt as though they were constantly managing crises which was becoming increasingly exhausting for them. One health visitor representative explained how meeting the needs of residents has become more difficult for her team, which has had a direct impact on the care provided because of time limitations.

Staff reported that they struggled to meet the needs of service users due to a lack of time, resources, staff and flexibility in appointments, particularly due to strict clinic timings, and lack of robust resources. The GP representative described how changes to the delivery of maternity services in primary care means that antenatal checks are only carried out when needed rather than for everyone as had previously been offered. These appointments allow GPs to carry out standard physical checks on the infant but also provide opportunity for GPs to discuss overall wellbeing and mood with new parents.

In addition, staff highlighted the impact language barriers have on the provision and standard of care they can provide. 77% of survey responses reported that they could make the necessary adaptations when working with patients where English is not their first language, however, although resources are available, there is no additional time given to these appointments. Taking the additional time to meet specific needs leads to over running in other areas and can be seen as non-essential and time consuming – reinforcing health inequalities across services.

Staff highlighted that midwives are frequently required to support with complex demands and social issues such as supporting families with housing issues, food banks and accessing universal credit due to increasing need among service users and a desire among healthcare professionals to provide support. The theme of housing was referenced multiple times in the online survey, with the impact of poor quality and insufficient housing posing a direct barrier to women's health. Participants mentioned that they spent significant amount of time supporting patients discharge back to insecure and/or unsuitable accommodation and trying to provide support with housing letters.

“Women are being discharged back to terrible accommodation for long periods of time which is having a direct effect on their mental health”

Across the UK, while overall birth rates are declining, the complexity of births is increasing²⁸. This rise in complexity is driven by various factors, including maternal age, number of previous pregnancies, existing health conditions, communicable and non-communicable diseases and social factors affecting health.

A significant contributor to this complexity is that women are choosing to have children later in life. The standardised mean age of mothers who gave birth in 2021 was 30.9 years – the highest on record since data collection began in 1938²⁴. In Southwark, the trends largely reflect those seen at the national level with the total number of babies born in Southwark decreasing year on year over the past decade, a total decrease of 35%. Despite the decline in birth rates, the average age of mothers giving birth in Southwark continues to rise. This reflects the broader trend of delayed parenthood, which contributes to the increasing complexity of pregnancies.

This decline in general fertility rate is observed across all age groups but is particularly pronounced among younger women with the average age of mothers having their first child in Southwark is 32.8 years, compared to 30.9 years in England²⁴.

In addition to health-related factors, the complexity of pregnancies is also increasing due to rising social needs. Issues such as housing instability, safeguarding concerns, and language barriers are becoming more prevalent, adding layers of complexity to the care that healthcare providers must deliver.

Southwark is also characterised by its diverse population. New mothers in the borough come from a wide range of backgrounds, with 55% being born outside the UK²⁹. The most common non-UK countries of birth for mothers are Nigeria, Sierra Leone, Ghana, Poland, and Somalia. This diversity adds another layer of complexity to maternity care, as different cultural, linguistic, and social needs must be addressed.

Harnessing community supports and organisations

The Commission heard from Southwark's VCFSE sector organisations who highlighted the important role that they can play in improving maternity services. These organisations, deeply embedded within the community, have a unique understanding of the specific needs and cultural sensitivities of local populations.

Representatives spoke of their unique position across the borough, accessing and delivering services through the borough's faith premises and community spaces. By collaborating with community groups, maternity services can enhance their outreach and support, ensuring that care is more inclusive and accessible, for example, using community groups as a way of disseminating key information to underrepresented groups.

Discussions at the meeting shone a light on a fractured relationship between the NHS and ethnic minority groups, who often rely on word-of-mouth and community networks for support rather than formal healthcare services. This distrust stems from historical and ongoing negative experiences, where Black and ethnic minority service users experience racism within the healthcare system and are treated with discrimination. One health visitor noted that building trust requires more than just policy changes; it requires genuine, sustained efforts to understand and address the specific needs of diverse communities.

A member of a local organisation set up to support pregnant and vulnerable women, acknowledged the stress and pressure maternity services are under and explained how the community organisations such as the one she represented, plays an essential role in listening, acknowledging and signposting vulnerable people.

VCFSE sector organisations at the meeting highlighted the invaluable position they hold and the importance of reaching people where the communities they serve are based to build relationships, empower mothers and break down structural barriers, opposed to expecting them to come proactively to services.

“You don’t have time to tell a new mother about all the things they need – we do! Send them to us, and we can support them”

The GP representative explained how the maternity support offer has changed over the last number of years, with primary care services being one aspect of a now bigger and wider offer. The GP reinforced the need to harness partnership working and appreciate and understand the roles of our VCFSE, community pharmacy, urgent services, community centres, family hubs as well as general practice and our local trust.

Mental health of the workforce

The online survey highlighted the impact of care provision on the workforce’s mental health which aligned with feelings of being overwhelmed and burnout that were expressed by staff in the meeting.

The online workforce survey provided an anonymous space for staff members to speak about the quality of care they can provide, the limitations to this and the wider determinants of health of women’s health. Responses indicated that workplace exhaustion had a direct negative impact on the quality of care that clinicians were able to provide to service users.

“I started having panic attacks and anxiety due to work related stress”

Staff reported experiencing stress, burnout, depression, anxiety, panic attacks and PTSD due to work related stress; 54% of participants who completed the workforce survey reported they had experienced poor mental health because of their job. Staff reported feeling left alone to deal with problems as senior colleagues and management are also overworked and unable to support junior staff. Similar research carried out by the Royal College of Midwives⁴⁸ across the UK, found that 64% of midwives and maternity support workers said they felt burned out or exhausted at the end of most or all their working shifts.

The survey also highlighted a lack of adequate rest between shifts. This is preventing a healthy work/life balance for a group who are already burnt out from the pandemic which saw increased pressures due to increased demand, redeployment and inadequate resources the pandemic, leading to a lack of emotional energy to support themselves and their patients.

The current strain on the workforce’s mental health was echoed in the meeting – where staff explained how they are burnt-out and overcome trying to meet the needs of residents.

⁴⁸ RCM (2023) *RCM surveys of midwives and MSWs in England – Overworked and underpaid*

Challenges to workforce retention in maternity services

Staff shortages and burnout were highlighted, making it difficult to maintain high-quality care and motivation which is then exacerbated by inadequate pay and recognition.

Participants felt undervalued and underpaid for the demanding work they perform, leading to low morale, an unkind environment and high turnover rates. Moreover, there are limited opportunities for career progression. For example, midwives who complete apprenticeships often remain stuck in lower pay bands instead of advancing, which further discourages staff from continuing in the profession.

One representative described beginning a career in midwifery as a way of following their passion, but that was becoming increasingly more difficult with university fees, lack of bursaries and limited support and encouragement from other midwives to follow such a career. With minimal financial incentives and a lack of experienced midwives to lead and encourage career development there is limited scope for passion in the future of pursuing a career in the area.

“There’s not enough incentives. I don’t think the work we do is appreciated”

Although the average number of midwifery students enrolled per university has increased over the past decade, the number of graduates does not match this rise in student enrolment. In 2021/22, there was only an average of 45.7 students graduating as midwives per institution with the most common reason for permanently leaving being a change of mind about the course and career⁴⁹.

Another representative spoke about joining the profession *“because we care”* but felt as though the humanity has been taken out of their job – the constant firefighting takes away the reason people come to these roles.

For staff currently working in maternity services, some reported they have limited opportunities for progression within their roles. Staff members who completed the survey highlighted a lack of discussion and support from senior colleagues on ways to progress and that they have not had a development review this year because their manager was unable or did not wish to do so.

Institutional racism

“I’ve been a midwife for over ten years now. If your face fits, you climb the ladder”

This poignant quote from a midwife captures reported institutional racism within the NHS. It reflects the implicit biases that impact career advancement, disproportionately disadvantaging Black and ethnic minority professionals.

Racism experienced by midwives, maternity support workers, and NHS staff in England is well-documented. The 2020 NHS Staff Survey⁵⁰ revealed that discrimination based on ethnicity remains the most common issue, with 42% of midwives who faced discrimination citing this reason. The

⁴⁹ RCM (2023) *State of Midwifery Education*

⁵⁰ NHS England (2021) *2020 NHS Staff Survey*

latest Workforce Race Equality Standard (WRES)⁵¹ report indicated that just 39.3% of staff from a Black background believed their trust provides equal opportunities for career progression or promotion.

These systemic issues not only hinder the careers of ethnic minority staff but also perpetuate a culture of racism within the NHS. The experiences of having to work harder and facing greater scrutiny than their White counterparts, as shared by many healthcare professionals, highlight the need for structural reform within the NHS to ensure equal opportunities for the workforce as a whole.

The Panel was informed that, although the NHS should support staff in freely expressing their concerns, the reality is starkly different. The entrenched fear of backlash and institutional racism creates significant barriers for Black and ethnic minority staff to speak out, ultimately impeding improvements in both patient care and staff well-being. Given that Black and ethnic minority staff are almost 20% more likely to enter the formal disciplinary process compared to their White counterparts, it is unsurprising that they fear potential repercussions⁵².

“Adopting racist actions from an institutionally racist structure”

The impact of this culture on patients and staff, in particular Black and ethnic minority staff groups, was brought by several representatives and highlighted the need for a supportive environment for staff which in turn helps patient to speak up and feel listened to.

One Black midwife shared her personal experience, recounting the distress she felt as a student when she tried to raise concerns about unacceptable practices. She described how her efforts to inform her mentor were ignored, and later, she was reprimanded for not speaking up. She acknowledged that speaking out often goes unrewarded and can lead to further isolation and repercussions.

Conclusion

In conclusion, the second Maternity Commission meeting illuminated the significant challenges facing the maternity care workforce, particularly in terms of staffing, workplace culture, and the increasing complexity of patient needs. The voices of the workforce have provided a crucial perspective on the realities of delivering maternity services in Southwark, highlighting systemic issues such as staff shortages, burnout, and a pervasive fear of speaking out - concerns that are often intensified for Black and ethnic minority staff due to experiences of institutional racism.

The discussions underscored the urgent need for a cultural shift within the healthcare system to foster a more supportive and inclusive environment. Addressing these issues is not only vital for the well-being of the workforce but also for the quality and safety of patient care. Additionally, the insights gathered emphasise the importance of collaboration between the NHS and community organisations, which play an essential role in reaching and supporting underrepresented groups.

⁵¹ NHS England (2024) *NHS Workforce Race Equality Standard – 2023 Analysis Report for NHS Trusts*

⁵² RCM (2021) *Racism in the workplace – Position Statement*

The findings from this meeting, though reflective of a relatively small sample size, resonate with broader challenges identified across the UK. They underscore the necessity for structural reforms, better support systems, and a renewed focus on staff retention and mental health. As the Commission continues its work, these insights will be integral in shaping recommendations aimed at improving maternity care in Southwark, ensuring that both staff and patients receive the support they need.

Chapter Five: Hearing from women

The focus of both the third and fourth Maternity Commission meetings held in April and June 2024 was to hear from Southwark residents who have used maternity care. The resident voice is central to the Maternity Commission as it is important that any recommendations made as a result of the work are informed by lived experience.

The MBRRACE report⁶ revealed an almost four-fold difference in maternal mortality rates amongst women from Black ethnic backgrounds and an almost two-fold difference amongst women from Asian ethnic backgrounds compared to White women. These disparities remain unchanged since 2018, indicating a lack of progress in reducing maternal health inequalities.

Southwark is one of the most diverse boroughs in the country. Data from the 2021 Census shows that just under half of Southwark residents (49%) have a minority ethnic background, compared to 19% nationally⁵³. The largest group other than White is 'Black, Black British, Caribbean or African', with 25% of Southwark resident reporting this as their ethnicity⁵³. This means that inequalities linked to ethnicity have a direct impact on a large proportion of residents.

Challenges with exploring racism

Racism can be a challenging subject to discuss. Meeting Four in particular, aimed to hear from Black Southwark residents who have used maternity care with a particular focus on inequalities experienced in care received. Meeting Four aimed to explore racial discrimination (although it is important to note that the theme of racism within the maternity care system was prevalent throughout all meetings and engagement work). Following this meeting, the Commission received feedback from a local charity group concerned that the theme of racism was not directly named or addressed, and this had potentially led to those at the meeting not feeling able to discuss racism explicitly. This was an unintended consequence of avoiding leading questions when asking participants about their experiences of maternity care and raises the concern that the discussion in Meeting Four did not allow for a full exploration of the issue of racism in maternity care as a result.

After receiving the feedback, the Southwark Maternity Commission Panel provided a formal response to the local charity group. Effort was subsequently made at future meetings to name racism, and this also constitutes a key recommendation.

Sources of information and their limitations

Residents' voices were captured through both meetings and the survey published on Southwark Council's Consultation Hub. The survey received a total of 503 responses, many of which included detailed and personal accounts of residents' experiences using maternity care and community services. Nine women shared their stories at the third public meeting in April 2024 and five women

⁵³ Southwark Council (2024) *Southwark JSNA Annual Report: 2024*

shared their stories at the fourth public meeting in June 2024. Both meetings were facilitated by the Southwark Maternity Commission Panel.

It is also important to caveat the experiences and themes outlined below by considering communities who did not share their perspectives. Despite trying to reach a broad range of women, the Commission found it difficult to hear from those with asylum seeker/refugee status. This is likely due to a combination of factors, including language barriers or management of immediate priorities, such as immigration status. There was also low representation of those affected by FGM, possibly due to stigmatising attitudes or lack of awareness of FGM making those affected less likely to come forward. Where voices were not heard directly, the evidence base has been reviewed to ensure the Commission's recommendations consider the specific needs of these groups.

Survey responses overview

A full analysis of the survey responses can be found in the appendix; some headline figures are outlined below:

- Out of a total of 503 total respondents, the majority (39.8%) were from White/White British ethnic groups, nearly one in five (17.9%) from Black/Black British groups, 1 in 14 (7.2%) from Asian/Asian British groups, 1 in 26 (3.8%) from Mixed ethnicity groups, and 1 in 18 (5.6%) from other ethnic groups, including Latin American (see Figure 1).

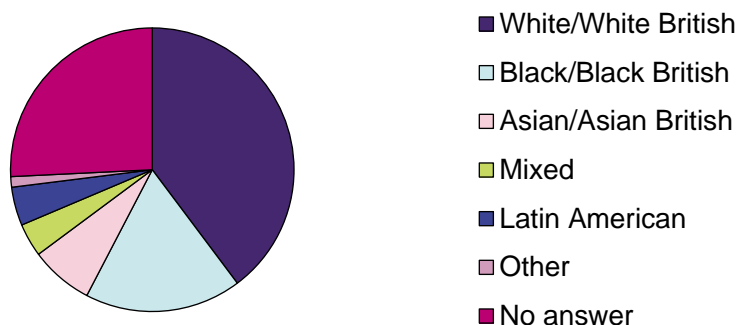


Figure 3. Survey respondents by ethnicity (%).

- Most survey respondents received maternity care either between 2-5 years ago (26.6%) within the last 6 months (24.5%), or 1-2 years ago (22.5%).
- The greatest proportion of survey respondents received maternity care at St Thomas's Hospital (50.3%), followed by King's College Hospital (37.2%).

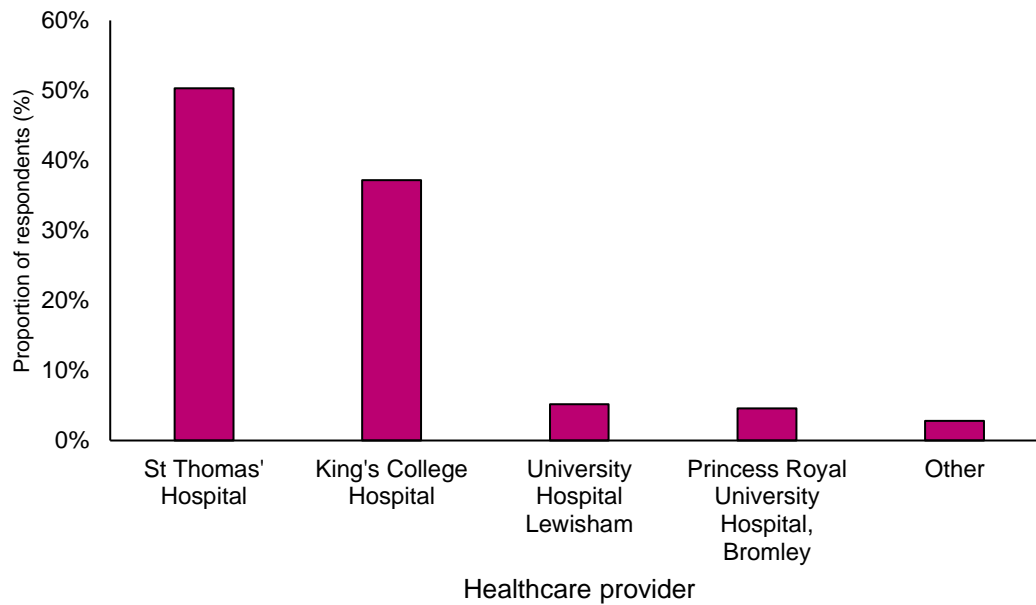


Figure 4. Proportion of respondents by provider of maternity care.

- The majority of respondents reported to have a 'positive' or 'very positive experience' of antenatal care (62.5%) and care during childbirth (63.4%). However, less than half of all respondents reported a positive or very positive experience of postnatal care (45.9%).
- Across the care pathway, proportions of 'positive' or 'very positive' responses were similar for ethnic minority groups (excluding White minorities) and those of a White ethnicity.

Experience	Antenatal Care	During Labour and Birth	Postnatal Care
Very negative	20 (4.0%)	35 (7.0%)	55 (10.9%)
Negative	68 (13.5%)	75 (14.9%)	81 (16.1%)
Neutral	100 (19.9%)	74 (14.7%)	136 (27.1%)
Positive	209 (41.6%)	184 (36.6%)	173 (34.4%)
Very positive	105 (20.9%)	135 (26.8%)	58 (11.5%)
Total	503 (100%)	503 (100%)	503 (100%)

Figure 5. Experience of care among respondents across the care pathway.

Emerging themes

The main themes and suggestions emerging from the Southwark research are as follows:

Access to the right information

Provision of and access to information was raised both at the meeting and throughout the engagement work. The majority of survey respondents either always (55.5%) or sometimes (22.9%) understood the information given to them by their doctor or midwife. However, respondents of ethnic minority groups were more likely to only sometimes understand the information provided to them.

Of respondents who did not, or only sometimes understood the information provided, and who shared further explanation, 35.5% related this to rushed or cancelled appointments, availability of staff, and/or difficulties navigating the maternity system and one quarter (25.8%) of respondents related this to conflicting information.

One woman described feeling abandoned during the wait between her positive pregnancy test and first appointment, relying on the internet for answers around diet and lifestyle. A concern with this is that women may not always be accessing the right information online, which could be detrimental to the health of the pregnancy. It was suggested that following the first booking email, antenatal information could be sent along with useful community and maternity contacts to alleviate the feeling of isolation, particularly for first pregnancies. The information received post-birth was reported to be helpful, with frequent updates on milestones and what is normal; a similar programme of updates could be useful in early pregnancy as well.

However, some information was described as difficult to understand, particularly for younger parents, those with learning difficulties or those for whom English is an additional language. Over one-tenth (12.9%) of survey respondents would have preferred to receive information in another language, with Spanish and Chinese most frequently listed.

Another woman who spoke at the public meeting said that there needed to be better postnatal information and support for those with pre-term babies as the general information and typical milestones do not always apply, with pre-term babies developing at a different pace.

Some received contradictory information from different members of staff, and were given a discouraging response when they brought this to staff members' attention. Others stated that they had no idea what they were supposed to be doing and no one supported them to understand, leaving them to find the answers themselves among family, friends and through research.

“I always looked up all the terms and regulations around my questions. Sometimes the midwives didn't seem to know what they were doing or why, but only followed protocol, without being able explain why and treated me like I wouldn't understand anyway”

Effective communication

Where communication was identified as good, women described feeling safe and recalled their interactions with staff positively.

However, lack of communication was raised frequently, particularly at meetings when the Commission heard from women. This referred to both communication between staff and patients, as well as communication between staff members themselves.

The Commission heard how women had received interventions, such as emergency caesarean sections and being kept under observation, without being told why, even after the event. Similarly, medication was administered without service users being told its purpose, sometimes putting women at risk concerning drug allergies and intolerances.

“No one would tell me what had happened to my own body”

Some women were referred to other services for conditions such as pre-eclampsia or gestational diabetes without prior discussion. There were many examples of women being left alone for long periods of time without being kept informed with what was going on or how their labour was progressing.

Other times women described feeling unable to ask questions about their pregnancy due to feeling as though they were being “bothersome”. This turned milestones which would ordinarily be momentous and exciting, such as initial scans, into uncomfortable experiences. In addition, poor communication led to many women feeling unable to open up about their own mental health concerns, meaning these issues were more likely to persist and require intervention further down the line.

“I shouldn’t have to concentrate on my pain and advocate for myself at the same time”

Communication between staff was also highlighted as an issue. It was emphasised that antenatal and postnatal teams need to communicate with one another, and some participants described waiting for significant lengths of time due to staff not being informed they had arrived to the postnatal ward.

One woman describes how she had her initial appointment at week 13 of her pregnancy, and then did not see another midwife again until week 28 due to a miscommunication between two midwifery teams. This meant crucial screenings and ultrasound scans, which should have taken place in this period, would have been missed, putting mother and baby at risk.

Dismissal of (women’s) concerns by healthcare staff

A recurrent theme both during the meeting and seen throughout engagement is that of dismissal. There were many examples of women’s symptoms being dismissed by maternity staff and GPs, resulting in negative outcomes. These include concerns about reopened wounds being dismissed leading to infection, symptoms of illness being overlooked as anxiety, and ignored labour pains resulting in one woman miscarrying alone in the toilet.

“My experience at the GP was dangerous, and being told that my very real illness was ‘all in the mind’ was very belittling. I believe that pregnant women are too often dismissed and patronised in this way.”

Women also felt their complications were normalised when they should have been treated as separate concerns and given appropriate attention by medical professionals, such as long-term impacts on their sex life, which subsequently negatively affected parental relationships.

One of the women speaking at the public meeting said that when her baby was born, she could see that her baby was not a healthy colour, indicating a lack of oxygen. This was dismissed by the midwife, until the service user's husband pushed the issue, and it transpired that their baby wasn't breathing properly.

“I was attentive, I was aware of what a healthy baby looked like—but if it was my first child, what would have happened then?”

Over two thirds of survey respondents felt sometimes (30.4%) or always (37.6%) listened to by their midwife; few (8.7%) felt they were not listened to. Therefore, it may be the case that some of the more concerning accounts heard were unusual occurrences which don't reflect the everyday experience of using maternity care. Nonetheless, they are worthy of attention and response by the Commission and are directly reflected in the recommendations.

Benefits of continuity of carer

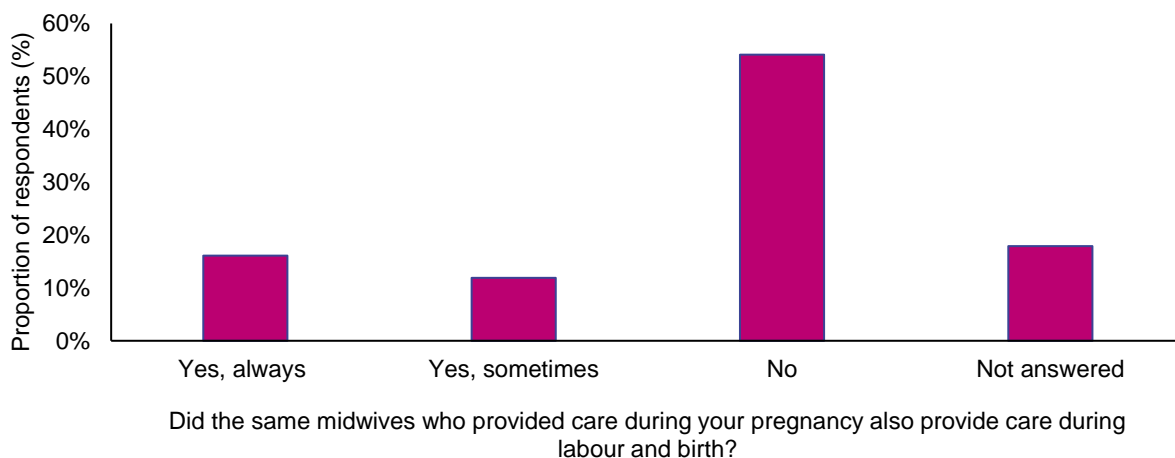


Figure 6. Proportion of respondents by continuity of maternity care.

As raised during Meeting One by senior representatives of the trusts, caseload midwifery and continuity of carer was mentioned by women throughout the course of the Commission, through public meetings, survey responses and community engagement. According to the survey responses, 54% of respondents did not receive any continuity of carer between antenatal care and labour and birth. A greater proportion of respondents reported to have different midwives across the continuity of care pathway at GSTT (64%) compared to KCH (52%).

Those who received continuity of carer reported feeling as though their needs were well attended, while those who did not felt their care was inconsistent and found themselves frustrated at having to introduce themselves to someone new at each appointment. This led to difficulties forming

relationships with staff and meant those delivering services to women were sometimes unaware of specific medical or cultural needs that had previously been disclosed to other members of staff.

“It was important to be able to see the same midwife in every check I went to... I felt really cared for.”

One younger mum felt disheartened by meeting so many different midwives at every appointment and felt uncomfortable opening up to them, with one of them laughing at her for asking so many questions.

One woman talked about receiving continuity of carer until the point of labour and birth, during which her experience completely changed. She described being dismissed by clinicians when discussing her pain and the progression of her labour.

A number of survey responses outlined that participants received care from a caseload midwifery team after being identified as having complex social factors, such as history of domestic violence and previous traumatic birth with poor outcome. Where this was the case, respondents report feeling that their delivery was safe and that they felt confident in the care they received. This indicates that the continuity of carer model supports improved outcomes and experiences for women, thus building trust in the maternity care system.

Discrimination and intersectionality

A recurrent theme throughout the Commission was that of discrimination. This included discrimination around age, marital/relationship status, race, and language. Other forms of discrimination should also be considered within the context of this work, including discrimination against non-cisheterosexual⁵⁴ gender identity and/or sexual orientation, disability and long-term conditions, and asylum seeker or refugee status. Although accounts from individuals identifying with these groups were limited, this is likely attributable to stigmatisation of these identities and not because they do not exist within the birthing population in Southwark.

The intersectionality of these characteristics is also important to consider. Intersectionality refers to how race, class, gender and other characteristics “intersect” with one another to exacerbate inequalities⁵⁵.

The Commission heard from the organisation Birth Companions at Meeting Five, who shared some of their work around social disadvantage and intersectionality. This included emphasis on the

⁵⁴ **Cis-heterosexual:** A person who identifies as the gender they were assigned at birth, and is attracted to people of the opposite gender

⁵⁵ Crenshaw (1989) *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics*

importance of providing care that works for the most vulnerable with severe and multiple disadvantage⁵⁶, including women:

- with involvement from children’s social care
- in the criminal justice system
- with asylum seeker or refugee status, including those who have been trafficked
- living in temporary, unstable or unsuitable housing
- not in a relationship with the father of their baby
- with historic or recent trauma
- living in poverty
- who have mental health concerns
- who have physical health conditions

One woman discussed how after multiple errors and mistreatment on the part of healthcare professionals, she felt she could not speak up or complain about her experience. She acknowledged that if she was receiving care in her home country, she would have felt more confident to challenge staff and ask more questions. She was uncertain whether she was discriminated against because of her race, language, shyness or whether it was a combination of these factors.

“I wouldn’t know, truly, if I was treated this way because I’m Black, or because I’m not a native English speaker, or because I was being shy and they can just push me to the side and move on to the next person, or a mix of all of these.”

Age

Survey respondents over the age of 35 were two times more likely to not be treated with respect compared to those aged 35 and under (11.8% vs 5.9%).

Older mothers felt uncomfortable with the technical language used to describe their pregnancy as “geriatric”, while a young mother described poor treatment when she accessed maternity care at the age of 15, with staff assuming she would be terminating the pregnancy. Referrals to social services were made without any discussion or forewarning, and she described being ignored and looked down upon by staff, even during childbirth.

Marital/relationship status

Where relationship status is concerned, some women described differential treatment dependent on whether they had come to appointments with their partner or alone, with those attending alone

⁵⁶ Birthrights & Birth Companions (2019) *Holding it all together*

being treated with less compassion, and it was felt that discrimination around both age and relationship status intersected with race.

Refugees, migrant and asylum seekers

NHS charges for 'overseas visitors' are known to deter migrants from seeking necessary healthcare. Although maternity care doesn't require upfront payment, the fear of hefty bills and Home Office sanctions for unpaid debts has a severe impact on affected women. Undocumented migrant women, without access to work or benefits, are among the most vulnerable in the UK, particularly during pregnancy.

Despite government guidelines, hospital charging practices often neglect the welfare of migrants, with those unable to pay being pursued by third-party debt collectors. This deters women from accessing maternity care, as reflected in 4.6% of respondents to the Commission survey stating that they avoided seeking maternity care due to worries in relation to the need to pay for care. Late access to care can negatively affect physical and mental health⁵⁷.

Engagement carried out by The Motherhood Group with the Latin American population identified language and communication as a key theme. Participants from this group described not being listened to, being dismissed and treated unfairly because they either do not speak English or speak English as an additional language. This is an important intersection to consider, tying in migratory status and ethnicity. One participant noted that her mother was told to “shut up” by a midwife when asking questions during birth. In addition, where family members were present who did not speak English, women in active labour were asked to translate for them, resulting in unnecessary frustration.

In addition, Southwark-based engagement work by the Latin American Women’s Rights Service (LAWRS) and the Indoamerican Refugee and Migration Organization (IRMO) heard from Latin American women who were not offered interpreters for their appointments, leaving individuals without reassurance that everything was well⁵⁸. In line with The Equality Act 2010, the NHS and wider public sector should have provisions in place for interpretation and translation services. It is the right of every patient to have a professional interpreter help them at every stage of care, and it is the responsibility of the provider to arrange this.

Work by Healthwatch Lambeth⁵⁹ similarly found that among Spanish and Portuguese speakers, not being able to express themselves left women feeling powerless, and some were unaware of the opportunities for interpreters. This same piece of work uncovered concerns around misinformation among maternity care professionals about migrant’s rights to access care. Women found it difficult to challenge or correct this misinformation which resulted in feelings of stress and fear.

⁵⁷ Feldman (2020) *NHS charging for maternity care in England: Its impact on migrant women*

⁵⁸ Latin American Women’s Rights Service and IRMO (2023) *The right to healthcare: A community-led approach to better health outcomes for the Latin American community*

⁵⁹ Healthwatch Lambeth (2024) *Exploring experiences of maternity care in women from Black, Asian and Minority Ethnic communities and women with a learning disability*

In a report on inequalities in maternity care experienced by migrant people and babies from Doctors of the World UK⁶⁰, key findings included that:

- A very small proportion of women had been taking folic acid before conception in comparison to the national average (6% vs. 26%).
- The majority of women had their first antenatal appointment late (after 10 weeks of pregnancy), with almost half not receiving any antenatal care until 16 weeks of pregnancy. Within this group, 45% of women with undocumented, uncertain, refuge or asylum seeker status accessed care after 16 weeks. The impact of late access to antenatal care is detailed under 'Complex social factors'.
- Mental health issues occurred in over a third of women, potentially exacerbated by the fact that over a third received a bill for their maternity care of up to £14,000.

Although Southwark evidence is sparse, it aligns with national evidence that highlights the need for action to address the inequalities experienced by migrant pregnant women and their babies. It also draws attention to the lack research into the needs of this population within the context of maternity care, which requires further investigation.

Disabilities and long-term conditions

Nearly 1 in 10 (8.0%) respondents reported having a disability; this is less than the wider population of Southwark residents (13.7% of residents reported to have a disability at the time of the 2021 Census). Of those who reported to have to have a disability, over half (55.0%) had either a severe mental health condition (e.g. severe depression or schizophrenia) lasting more than one year (27.5%) or a learning disability (27.5%). Nearly one-third (30.6%) of respondents did not answer the disability question.

There is limited evidence on the experiences of maternity care for women living with a disability and/or long-term condition, despite constituting almost a tenth of the birthing population and the increased likelihood of these individuals requiring more specialised care. Engagement with women with a learning disability carried out by Lambeth Healthwatch identified a key theme of loss of autonomy and control, highlighting the negative impact the involvement of social services can have on their sense of independence. These feelings were exacerbated by delays in processing paperwork leading to extended stays in hospital without suitable facilities for their support systems to stay. Women also detailed the stress resulting from having their abilities as a mother assessed after birth, feeling judged and discriminated against.

Research on women with physical disabilities by Malouf, Henderson and Redshaw⁶¹ found that emotional wellbeing and support, during and beyond pregnancy, is an area in need of improvement, although access to care was generally satisfactory for disabled women. Other research identified infant feeding and better communication in the context of individualised care as

⁶⁰ Doctors of the World UK (2022) *Inequalities in maternity care experienced by migrant pregnant women and babies*

⁶¹ Malouf, Henderson & Redshaw (2017) *Access and quality of maternity care for disabled women during pregnancy, birth and the postnatal period in England: data from a national survey*

areas of improvement, however there was evidence of specific groups appropriately receiving more care⁶². This mirrors some of the themes identified in the survey responses; among respondents, those with a recorded disability were 1.6 times more likely to either always or sometimes receive continuity of carer than those without, and those with a disability were more likely to know how to contact their local maternity service.

Complex social factors

An estimated 10% of Southwark women who had their booking appointment in 2021/22 were deemed to be subject to complex social factors³⁵. Complex social factors can impact pregnancy outcomes in different ways. For example, domestic abuse increases the risk of miscarriage, infection, preterm birth and injury or death to the foetus. It can also cause emotional and mental health problems for the mother, such as stress and anxiety, which can affect the development of the baby.⁶³

Timely access to maternity care is frequently inhibited by complex social factors. Pregnant women with complex social factors book later on average, and late booking is associated with poor obstetric and neonatal outcomes²⁸. Facilitating early booking is more important for these groups than the general population; however, in 2021/22 43% of women in Southwark had their booking appointment late, a rate similar to England³⁵. This illustrates the need for additional work to ensure timely access to early pregnancy care, particularly for vulnerable social groups.

Complex social factors are likely to intersect with other factors such as minority ethnic background and exacerbate inequalities and the impact these have on service users' access, experience and outcomes of maternity care.

LGBTQ+ identity

Although not explicitly mentioned in engagement work, the experiences of LGBTQ+ parents must be considered when discussing discrimination and intersectionality. A small number of survey respondents had a gender identity different to their birth sex registration, and almost 1 in 40 respondents identified as non-heterosexual; split fairly evenly between those identifying as lesbian/gay women and those identifying as bisexual or another non-heterosexual identity. Broadly, Southwark is ranked fourth in England for proportion of residents identifying with a non-heterosexual orientation, most frequently lesbian, gay or bisexual, and is the fifth highest ranking local authority in England for residents identifying as trans or non-binary.⁵³

There is a clear body of evidence that demonstrates that lesbian, gay, bisexual and trans people experience significant health inequalities in terms of outcomes, service provision and health risk factors in comparison to cisheterosexual populations⁶⁴. Research suggests that the mental health

⁶² Redshaw et al. (2013) *Women with disability: the experience of maternity care during pregnancy, labour and birth and the postnatal period*

⁶³ NHS (2021) *Domestic abuse in pregnancy*

⁶⁴ McDermott, Nelson & Weeks (2021) *The Politics of LGBTQ+ Health Inequality: Conclusions from a UK Scoping Review*

of lesbian, gay and bisexual people is worse than that of the general population, and there is very little high-quality evidence on the physical health of LGBT people⁶⁵.

Research into the experiences and educational needs of professionals delivering maternity services suggested that staff witness transphobia among colleagues and can be apprehensive about providing care to childbearing trans and nonbinary people. A cisheteronormative⁶⁶ model of care which lacks awareness of trans and nonbinary issues was reported, and educational needs included information about practicalities of childbearing, use of inclusive language, and creating policies and processes for supporting childbearing trans and nonbinary people⁶⁷.

Racism including lack of cultural sensitivity

Racism was explored in further detail at Meeting Four, however the theme of racism within the maternity care system emerged throughout all meetings and engagement work. Racism can take many forms; often the examples that come to mind are overt forms of racism such as slurs and hate crimes. However, racism is likely to be experienced in a less obvious way within the context of maternity care. Four key types of racism are⁶⁸:

Intrapersonal racism: when a person accepts stereotypes about themselves and those who share the same racial identities, while believing that members of other racial groups are superior.

Interpersonal racism: when a person's conscious or subconscious racial bias influences their interactions and perceptions of other people.

Institutionalised racism: the implicit or explicit practices and policies within an organisation that establish barriers for racial and ethnic minorities.

Structural racism: the way laws, policies, or practices are structured to advantage the group in power and disadvantage ethnic minorities, restricting access to services, opportunities, and resources.

Examples presented below mostly fit into institutionalised and/or structural racism, highlighting a need for structural and system-wide change as opposed to intervention at an individual level.

⁶⁵ Meads, Carmona & Kelly (2019) *Lesbian, gay and bisexual people's health in the UK: a theoretical critique and systematic review*

⁶⁶ **Cisheteronormative:** a belief that centres heterosexuality and a binary system of assigned sex/gender when there are two distinct ways of being: assigned-male-at-birth masculine men and assigned-female-at-birth feminine women.

⁶⁷ Pezaro et al. (2023) *Perinatal Care for Trans and Nonbinary People Birthing in Heteronormative "Maternity" Services: Experiences and Educational Needs of Professionals*

⁶⁸ Yearby et al. (2020) *Racism is a public health crisis*

Black, Asian and minority ethnic women

As highlighted throughout this report, Black, Asian and minority ethnic women are at a higher risk of dying during pregnancy, childbirth and postnatally, and of experiencing premature birth, stillbirth or neonatal death in comparison with their White counterparts.

One systematic review highlighted how the technocratic birthing system and discriminatory practices in NHS maternity services fail ethnic minority women⁶⁹. It outlined how in the context of persistent understaffing and heavy workloads there is more of a focus on measurements and procedures as opposed to provision of kind, patient-centred care. Overall, the review argues that ethnic minority women are being left in the dark about what to expect, their right and their choices throughout their pregnancy and postnatally.

Some specific issues raised such as limited interpretation services or cultural customs unfamiliar to maternity staff may be indicative of an overstretched workforce or a deeper and more generalised tendency to undermine and silence ethnic minority women in maternity care.

Another review⁷⁰ similarly identified themes of poor communication, lack of respect for the culture and lack of support, and found that Black, Asian and minority ethnic women's experiences were generally more negative and engagement with maternity services was poor.

Research into these inequalities often groups Black, Asian, Mixed and minority ethnic women together, potentially resulting in further marginalisation in healthcare as it does not account for the unique needs of different ethnicities. Therefore, the Commission engagement disaggregated ethnic groups on a local level where possible.

Black and Mixed-Black Participants

Survey respondents of a Black/Black British ethnicity were over 1.5 times more likely to detail a negative experience compared to any other ethnic group (55.0% vs 36.6%). One Black woman responding to the survey described feeling so poorly treated postnatally by a midwife that she begged to be discharged and felt so traumatised that she did not want to be seen by the midwife again. She said that her treatment made her feel as though, because of her complexion, she didn't deserve the right treatment. She gave examples of asking for help changing out of blood-stained clothes, assistance walking after her caesarean section, and a request for paracetamol. All of her requests were ignored.

“Other women were treated right, however, me being the only Black woman on that ward was just a horrible experience as a second time mum.”

⁶⁹ MacLellan et al. (2022) *Black, Asian and minority ethnic women's experiences of maternity services in the UK: A qualitative evidence synthesis*

⁷⁰ Drake et al. (2022) *The Experiences of Black, Asian and Minority Ethnic Women of Maternity Services in the UK*

One speaker described how it wasn't until they reflected on their experience that they understood how they were mistreated. The speaker told of how it was only through reading a memoir of other Black women's experience that she was able to identify similarities with her own treatment.

“Oh this isn't normal, I shouldn't have been treated the way I've been treated.”

A survey response completed on behalf of the mother highlighted a situation where they felt their partner was directly discriminated against due to their race. In this situation, the mother was asked personal and confidential questions in front of others in the waiting room, a practise they had not observed for White patients.

One of the women speaking at Meeting Three described the way she was treated after she had received the news following an early scan that her baby would have a birth defect. She recalled being given information about termination repeatedly, despite making it clear that due to her faith and culture, she would not be terminating the pregnancy. Staff continued to put pressure on her to end the pregnancy and provided no information or support on going through with the pregnancy, thereby respecting her choice and beliefs.

Another speaker at the meeting told of her experience of the subtle and pervasive nature of racial assumptions within the NHS. The speaker describes a situation where their baby's lighter skin tone, which is lighter than both parents, led staff to repeatedly suspect jaundice. She explained how each time a new nurse entered the room, they would assume the baby's skin tone was abnormal for the family's racial background, leading to repeated checks for jaundice.

“I thought, do I need to explain about Black genetics? My mother's lighter skinned than me”

The Motherhood Group's engagement work involved hearing from 20 Black and Mixed-Black Southwark residents. The Motherhood Group noted that participants from this group often did not explicitly discuss experience of NHS Trusts, whether positive or negative. Instead, they focused on systemic issues affecting themselves, their friends, and their family members, which were evident in NHS maternal healthcare services and the interpersonal relationships within them.

The Motherhood Group's community engagement highlighted positive care experiences among Black, Black British, Caribbean or African, and Mixed-Black participants, who described attentive and empathetic care that empowered them and provided knowledge, particularly regarding specific conditions and informed care plans. Advocacy, both self-advocacy and advocating for others, was central to these experiences, often shaped by the awareness that Black women are more likely to receive inadequate care.

In contrast, some Black participants reported negative experiences characterised by a lack of empathy, leading them to seek care outside their catchment area to ensure a higher standard. Some participants chose to rely on support from family and friends instead of healthcare professionals during pregnancy or postpartum, often due to feeling unheard by professionals or having had previous negative experiences. Case study examples are presented in the full The Motherhood Group report, found in the appendix.

Asian participants

In a survey response, one Asian woman cited cultural incompetence, wherein she was told to eat a curry to hurry the labour along, despite being an Asian woman and this being her usual diet.

Around 8% of responses to the survey were by Asian groups, and a small number of South Asian women were recruited by The Motherhood Group in their engagement work. Findings of note within this population group include a higher proportion of respondents of an Asian ethnicity reporting poor prenatal mental health in comparison to any other ethnic group. When this is considered alongside SLaM's statement that Asian women are underrepresented within their mental health services, there appears to be a gap which needs exploring.

The Motherhood Group heard from this group that they felt midwives were competent and were treated with respect, however this was often dependent on which midwife they were being seen by. There also appeared to be experiences of stereotyping based on their ethnic background, such as assumptions of health conditions which are more prevalent in those with an Asian ethnic background.

“I was also told your baby is big, you must have diabetes, everyone in your race has it and in the borough most people have it. Even though I did the test three times.”

Similarly, UK-based research into Black, Asian and minority ethnic women's experiences of maternity services refers to direct discrimination, stereotyping or racist comments, including suggestions that Asian women make a fuss and are unable to tolerate pain.⁷¹

One woman described how her emotions following the birth of her second child were perceived by professionals as signs of postnatal depression, suggesting a need for staff to be better equipped to accurately identify signs of mental health distress in minority ethnic groups. However, this example does demonstrate attentiveness and concern for the mother's wellbeing.

Gypsy, Traveller and Roma participants

Engagement with the Gypsy, Traveller and Roma (GRT) community was limited, and there appears to be a gap in the literature surrounding the experiences and outcomes of pregnant people within these ethnic groups in the UK. However, a systematic review into the perinatal maternal and infant health outcome of GRT women in European countries provided evidence that GRT women and children experience more negative outcomes than general populations⁷².

Research has identified lack of documentation and affordability as barriers to accessing healthcare. Additionally, GRT inequalities in health and engagement with health services are set against a background of widespread disadvantage and discrimination in their day-to-day lives such as lack of adequate housing, poverty, restricted access to employment and low education and literacy

⁷¹ MacLellan et al. (2022) *Black, Asian and minority ethnic women's experiences of maternity services in the UK: A qualitative evidence synthesis*

⁷² Ekezie et al. (2024) *Perinatal health outcomes of women from Gypsy, Roma and Traveller communities: A systematic review*

levels.⁷³ A local community group, Southwark Traveller Action Group, provided the Commission with responses from short version of the survey, arising from a focus group of ten participants they held internally. Though a small number, the majority (six out of ten) reported a very positive or positive antenatal and childbirth experience. This drops to half for postnatal experiences. Comments were mixed, however one individual commented on how care for their community could be improved.

"I did think they could do better with our community. Explained things better"

Latin American

Along with experiences linked with language and communication for Latin American women outlined under *"discrimination and intersectionality: refugees, migrant and asylum seekers"*, this group felt that they were not listened to and that their choices were not respected. One woman described how upon asking for breastfeeding support on the postnatal ward, following a caesarean section, the midwife was "very rude" and treated her as if she should already know what she was supposed to do.

Engagement by The Motherhood Group with Latin American women highlighted feeling stigmatised about going back to work after giving birth by health visitors. Two participants perceived the tone of questioning as judgemental or rude, undermining their ability to be employed and care for their child. One participant commented that there was an opportunity to follow up the conversation with information about organisations or services to support them, including Universal Credit, which was not utilised.

Compassionate care

Some women reported positive experiences of care, with compassionate midwives taking time to make them feel comfortable and safe. Many women scheduled to have a home birth describe their experiences as being "amazing", even when things did not go to plan, with homebirth midwives coming into the hospital to support their patients.

"The midwives who assisted with my delivery were awesome - really positive, reassuring and professional and really made me feel a lot more positive about overall experience."

However, a recurrent complaint was the attitude of reception staff. Women commented on a lack of eye contact and direct communication, describing staff as dismissive and rude. Some reception staff additionally gave unwarranted and inappropriate advice, and one woman made the decision to access private care due to poor treatment by reception staff.

"Receptionists visibly agitated by your presence when they had something to do on their phone or computer or continued their social conversation with other members of staff while ignoring you."

⁷³ UK Government (2022) *Gypsy, Roma and Irish Traveller ethnicity summary*

Many women also commented on lack of compassionate care by maternity staff, and 7.6% of survey respondents felt that they were not treated with respect. Of those who felt they were not, or only sometimes treated with respect, and who shared further detail, prevalent themes included: feeling incompletely heard and understood; lack of patient-centred care; and dismissal of concerns, including those related to pain. Other themes included: lack of patient confidentiality; discriminatory and culturally insensitive behaviour; concerns surrounding level of care and professionalism (often among noticeably overworked staff); and concerns regarding medical procedures conducted and consent prior to the procedure.

Some described feeling coerced into giving consent, and others mention vomiting in response to pain and being met with disgust and a lack of sympathy. Women asking for physical support after birth to go to the toilet or get food, including those who had received epidurals, were told off for asking for help. A particularly harrowing account describes being forced to look at her ultrasound after a pregnancy loss.

“(A sonographer was) ...forcing me to look at the screen to show me my empty uterus after the foetus had exited. "Look, look!" He said as he pushed the screen to my direction.”

One survey respondent recalled how she was intimidated by a doctor. Midwives on the labour ward forgot to check her newborn's blood sugar after birth. The mother had been taking an antihypertensive medication, which can lower a baby's blood sugar. When the baby's blood sugar reading was eventually taken, and was low, the mother was offered formula milk. She initially declined, wishing to try breastfeeding first, and the midwives agreed to check in later.

Later, baby's blood sugar had dropped again, and mother was advised to give formula milk immediately, to which she agreed. A registrar then spoke to the woman harshly, accusing her of not providing formula sooner and explained the risks of low blood sugar on brain development in what the respondent described as “a very patronising way”. The mother was left shaken and in tears.

Another example of a lack of compassionate care around pregnancy loss was given during the meeting, where one woman talked about being discharged to the postnatal ward after experiencing a miscarriage, which was distressing itself. However, staff then proceeded to refer to her “termination”, indicating they had not been informed by colleagues that this woman had just experienced a pregnancy loss. Considering approximately 1 in 6 (16.1%) of survey respondents reported experiencing pregnancy loss before 24 weeks' gestation, and national figures are estimated to be 1 in 5, appropriate and compassionate care for those experiencing pregnancy loss is important. However, of respondents reporting early pregnancy loss, only one-quarter (were offered bereavement support. Among respondents sharing further information about early pregnancy loss, common themes were lack of support, distress, lack of counselling, inappropriate or uncaring (sometimes cruel) behaviour from health staff, and subsequent antenatal appointments not being cancelled. Several responders also raised issues around lack of partner support and lack of appropriate clinical treatment. A small number of respondents shared experiences of good, caring support.

Birth plans and personalised care

A birth plan is a record of what an individual would like to happen during labour, birth, and after the birth. As labour and birth can be unpredictable, women are warned that they need to be flexible and

prepared to do things differently from their birth plan if complications arise with them or their baby, or if certain facilities such as a birth pool aren't available.

Overall, 74.8% of respondents reported to always, or sometimes be involved in decisions about their care during pregnancy. This decreased to 69.4% during labour and birth, and to 70.2% after their baby was born. Throughout the pathway, respondents of ethnic minority groups were less likely to always be involved in decisions surrounding their care compared to those from a White ethnicity.

One woman who contributed at the public meeting described her experience of maternity care having been diagnosed with severe tokophobia⁷⁴. As a result of this and other complex social factors, she was assigned to a multi-disciplinary team with a single point of access to support. Her experience of care was described as “incredible”, and she thanked the team of professionals who supported her, particularly those from SLaM. This is an example of where birth plans and personalised care works and leads to positive outcomes for mother and baby. However, her experience was not the case for several other women.

One woman recalled being warned of the risks of a natural birth due to her baby being in the breech position and was informed that the safest route to take would be a caesarean section, which she was concerned about. Despite warnings and being prepared for a caesarean section, her labour progressed rapidly, and she ended up delivering naturally safely. Her reflections at the public meeting were that she wished she had been told her options up front so she could have prepared, and avoided the undue panic once she realised she would be delivering naturally. Another complaint from the same woman was the fact there were around 15 individuals present as she gave birth, presumably trainee staff and students. She had not consented for that many people to be in the room and did not feel that she was given the opportunity to refuse them.

A survey respondent mentioned how she had specifically stated in her birth plan that she didn't want to labour on her back, and that she preferred to have as few people in the room as possible. However, her team placed her on her back during labour, and had a large number of people present. The labouring on her back and pressure to push when she wasn't feeling contractions led to a severe tear, damaging more than 50% of her anal sphincter, the aftermath of which she is still dealing with six months later.

Another woman talked about how she had specified the pain relief she wanted and had a vaginal birth after caesarean (VBAC) in her birth plan having experienced an emergency caesarean section in a previous pregnancy. However, when it came to her labour she was dismissed and left to progress with no supervision or pain relief until was finally administered an epidural at 8cm dilation (out of around 10cm) despite being told it was too late and was then rushed off for a caesarean section.

“I talked about VBAC...I thought we were preparing for this. Then the birth came—and everything you prepared for went out the window. They don't ask about your birth plan”.

⁷⁴ **Tokophobia:** Pathological fear of pregnancy

Maternal and infant morbidity⁷⁵

Labour or birth complications were reported by nearly 1 in 4 (24.1%) respondents. A similar proportion of respondents reported labour or birth complications between those of an ethnic minority group (28.9%; excluding White minorities) and those of a White ethnicity (29.5%). When respondents shared deeper information about their labour and birth complications, the most common themes were: substantial/severe blood loss; foetal cardiac distress; emergency C-section; obstructed delivery; need for assisted delivery; slow or failed progress of labour; and inadequate healthcare. Several respondents also reported problems around: substantial perineal tearing; newborn respiratory distress, meconium, uterine infection, and maternal hypertension/pre-eclampsia.

These are comparatively common complications, with the National Maternity and Perinatal Audit report on births between 2018-19⁷⁶ reporting that 25% of women had an episiotomy⁷⁷, 12% an assisted vaginal birth⁷⁸, and 3% third and fourth-degree tears. However, any complication carries significant risk and can, in some cases, be prevented with higher standards of care.

Some more serious complications were also referenced, including infections and damage to other organs during caesarean section leading to major surgery. The recovery from these complications impacted the early postpartum period and mothers' ability to bond with their baby. Many women were left feeling both emotionally traumatised by their experiences, and physically incapacitated during the postpartum period.

Several survey responses mention that their baby's head was injured during delivery, usually as a result of an instrumental delivery. Another survey response reported that her son had a severe hypoxic-ischaemic encephalopathy (HIE)⁷⁹ brain injury, causing hearing loss and global developmental delay⁸⁰ as a direct result of poor maternity care.

It has been challenging to determine how common maternal and infant morbidities are among Southwark residents, due to the lack of a robust model of measuring morbidity. Attempts have been made to develop an effective means of measuring maternal morbidity or "near misses", with the World Health Organisation (WHO) introducing a maternal near miss indicator to track severe pregnancy complications.⁸¹ However, implementation has proven difficult, particularly due to the need for additional data collection, presenting a burden that many healthcare environments cannot sustain.

An English Maternal Morbidity Outcome Indicator has been investigated, and it was concluded that routine hospital data can be used to generate an indicator to monitor trends in maternal morbidity

⁷⁵ **Morbidity:** ill-health and injury

⁷⁶ National Maternity and Perinatal Audit, 2022. *Clinical Report*

⁷⁷ **Episiotomy:** A cut in the area between the vagina and anus (perineum) during childbirth

⁷⁸ **Assisted vaginal birth:** Birth helped by use of a ventouse (vacuum cup) or forceps or both

⁷⁹ **HIE injury:** Hypoxic-ischaemic encephalopathy is a type of brain damage caused by a lack of oxygen to the brain before or shortly after birth. HIE is graded as mild (stage 1), moderate (stage 2) or severe (stage 3).

⁸⁰ **Global developmental delay:** a diagnosis given when a child has not reach two or more of their developmental milestones at an expected age

⁸¹ Chhabra (2014) *Maternal Near Miss: An Indicator for Maternal Health and Maternal Care*

during childbirth. The quality and reliability of this monitoring indicator would depend on the quality of hospital data.⁸² Issues with data, in part due to the introduction of a new electronic system at both GSTT and KCH, have been raised as a concern through the Commission.

⁸² Nair, Kurinczuk & Knight (2016) *Establishing a National Maternal Morbidity Outcome Indicator in England: A Population-Based Study Using Routine Hospital Data*

In-patient environment

Many women felt that they would have laboured and recovered better in a more comfortable environment and recalled frequent disturbances by cleaning staff. They described the labour and postnatal wards as feeling terrifying and unsafe, while other descriptions demonstrated a lack of cleanliness, with one woman describing how the main bathroom of the postnatal ward she was placed on was out of use due to urine in the sink for the duration of her stay.

“The shared wards are completely at odds with the rest and care mothers need following birth.”

The environment of the postnatal ward reportedly delayed recovery, with women unable to rest due to the noise and light of the labour ward at night. This inevitably impacts a mother’s ability to adjust to motherhood and facilitate the best start in life for her baby.

“Midwives on the mat [sic] ward were nice but I would have recovered much better in a less uncomfortable environment. I felt that there should have been a different provision for people who have to stay in for longer than a couple of days, i.e. not being disturbed every 10 mins by someone changing the bins or mopping etc.”

Wider support

Overall, a greater proportion of survey respondents felt unable to ask for help from their midwife about worries relating to housing, money or debt, employment issues in pregnancy, and domestic abuse, respectively, compared to those who felt able to ask. Across all four categories, a greater proportion of respondents of a White ethnicity reported to not want support compared to those of an ethnic minority group (housing: 56.5% vs 34.7%; money or debt: 56.5% vs 32.2%; employment issues: 55.5% vs 30.1%; domestic abuse: 59.0% vs 36.1%).

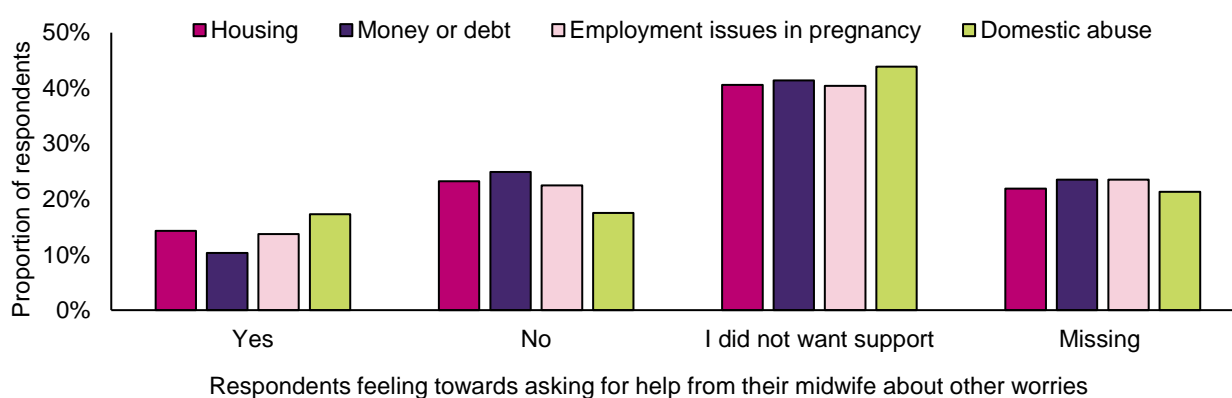


Figure 7. Respondents feeling towards asking for help from their midwife about worries related to housing, money or debt, employment issues in pregnancy, and domestic abuse.

Nearly two-thirds (64.0%) of respondents felt either always or sometimes able to speak to a midwife about concerns easily and quickly. Of those who felt unable to easily and quickly discuss

their concerns, and who provided additional explanation, the majority stated this was related to the availability of midwives and/or other members of staff.

One mother who gave birth at fifteen, when asked what the Council could have done to support her, replied that she wanted an advocate. She was also unaware of how to access benefits and what housing options were available to her.

Another woman emphasised the importance of all staff being well-trained to identify signs of domestic abuse and raise the issue with women at appropriate times. She commented on how vital this skill was for her and her baby's wellbeing.

“I would appreciate staff having training in domestic abuse recognition. If it wasn't for my midwife and doctor, we (mother and baby) wouldn't be here.”

Community care and support systems

Experiences of care outside of the hospital setting was mixed, ranging from very good to poor. Residents provided feedback on the care they received from a range of sources, including community midwives, health visitors, GPs and mental health practitioners.

Some women who had complications with their labour or birth were required to return to medical settings frequently for reviews. Practically, this can be a burden, particularly for women who have just had a caesarean section and are both recovering from surgery and adapting to life with a newborn baby. In addition, access to health centres and hospitals is not always easy and can be expensive with regards to parking costs or public transport, meaning those who are unable to make the journey are more likely to miss appointments and experience further complications down the line.

Those receiving home visits from the community midwife team labelled the experience as positive, with visits taking place the day after discharge and on weekends when issues arose, preventing the need for return trips to the hospital.

Other women did not have a positive experience of health visiting. Many describe them as “unresponsive”, while others say that their visit felt like a “tick box exercise”. One woman mentioned how she had wanted to ask for breastfeeding support, but the health visitor refused to deviate from the form they were using to structure the appointment. Another said that health visitors seem to base advice on their own personal experiences rather than medical guidance, and that there was a lack of consistency in the advice given.

“The health visitors were not able to advise on any matters and fundamentally always said to check with the GP.”

Women described having referrals made for them but not being followed up, including one woman who was referred to specialist infant feeding support by health visitors on several occasions but did not receive appropriate care, eventually choosing to go private and then receiving a diagnosis of a tongue tie, which was causing significant feeding problems. Eventually, a health visitor provided her with information about drop-in breastfeeding support, but this support came too late to be helpful.

Feedback regarding the care received at breastfeeding drop-ins was also overwhelmingly positive, emphasising the importance of accessible community support. However, there are inconsistencies between provision of breastfeeding support between Southwark and Lambeth, despite sharing a common provider of health visiting services. This may cause confusion, particularly for those living on borough borders, and lead to reduced access to services.

Some residents felt that the care they received from health visitors was good, but talked about additional support that would have been valuable. Awareness of community support was generally low, and where women were aware of postnatal classes and drop-in groups, they often felt isolated as a minority member of the group, whether due to their age or race.

“I don’t know if there’s postnatal classes as well, but I was the youngest at my group. I was the only Black woman there, the youngest person—it was a very isolating motherhood.”

Evaluation of the PACT project (now Parent Action) in Southwark concluded that community-organised and community-led interventions in collaboration with statutory health services can increase accessibility and can improve mothers’ mental health and other health-related outcomes.⁸³ Quality and availability of community-based care is particularly important when considering the number of maternal deaths, 311 between 2019-21 nationally, occurring between six weeks and one year after the end of pregnancy (late maternal deaths).

A common theme identified in the engagement work carried out by The Motherhood Group is that support was sought from family and friends, as well as online. One woman described how she had not expected to go online for support, however, was surprised by the number of other mothers who had similar experiences. Others chose to seek support from family and friends instead of healthcare professionals, usually because they felt they were not listened to by professionals or had previous negative experiences.

For many Latin American women, community groups and friendship provided pivotal support throughout their pregnancy, with support from those who did not work in healthcare being seen as

⁸³ Brown et al. (2020) *Can a Community-Led Intervention Offering Social Support and Health Education Improve Maternal Health? A Repeated Measures Evaluation of the PACT Project Run in a Socially Deprived London Borough*

more empathetic and detail oriented. One woman gave an example of where she was assisted by a stranger she met at the park, who provided her with information about organisations supporting parents.

Mental healthcare

17.3% of survey respondents reported experiencing poor mental health during pregnancy, while 24.5% reported poor mental health after their baby was born. Of those who reported poor mental health during pregnancy, the majority (58.6%) also experienced poor postnatal mental health.

Experience poor mental health	During their pregnancy, n (%)	After their baby was born, n (%)
Yes, n (%)	87 (17.3%)	123 (24.5%)
No, n (%)	211 (41.9%)	164 (32.6%)
Prefer not to say or missing	205 (40.8%)	216 (42.9%)
Total	503 (100%)	503 (100%)

Figure 8. Proportion of respondents experiencing poor mental health, during their pregnancy, and after their baby was born.

A higher proportion of respondents of an Asian ethnicity (27.8%) and of a Mixed ethnicity (36.8%) reported poor prenatal and postnatal mental health, respectively, compared to any other ethnic group. However, across all ethnic groups, a higher proportion of respondents reported poor postnatal mental health compared to during their pregnancy.

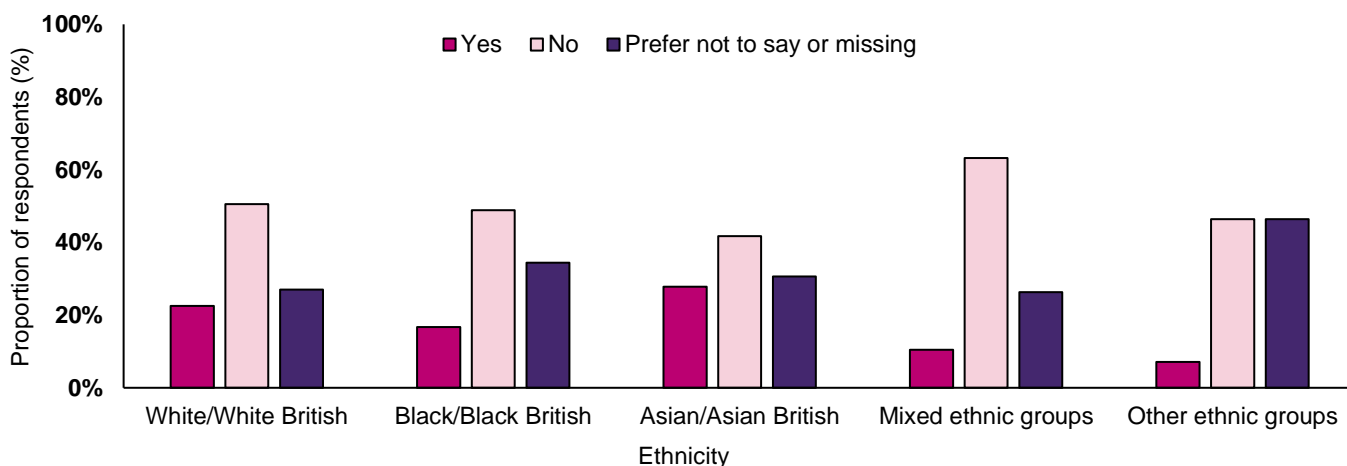


Figure 9. Proportion of respondents experiencing poor prenatal mental health by ethnicity.

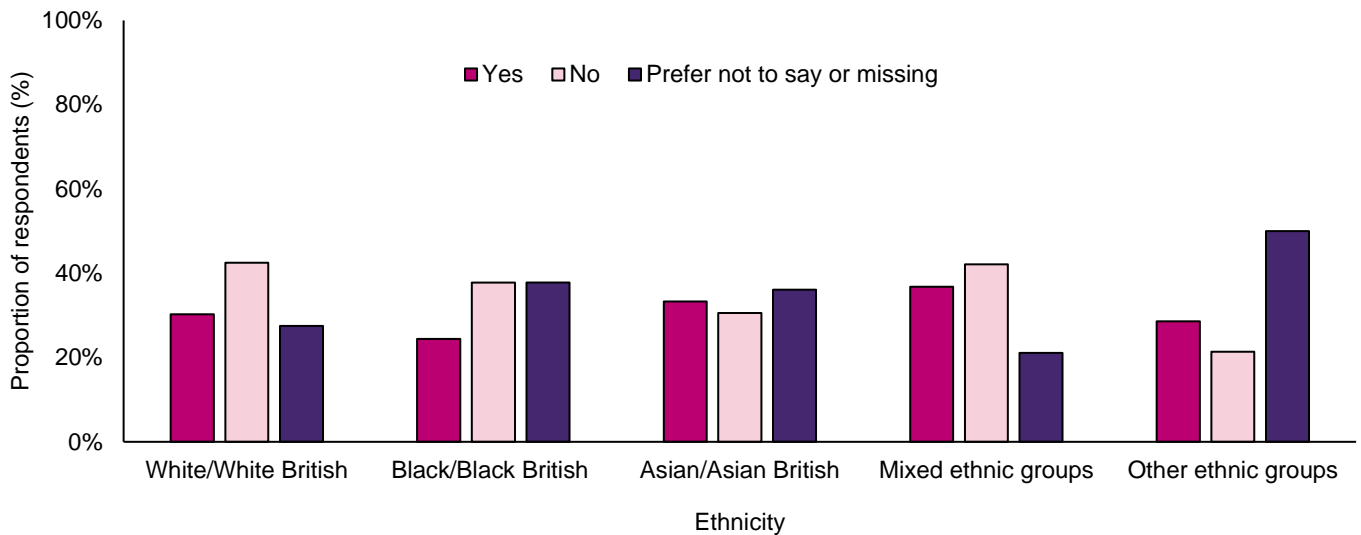


Figure 10. Proportion of respondents experiencing poor postnatal mental health by ethnicity.

Written responses around mental healthcare were mixed. Some went on to mention that their symptoms were identified quickly, and the appropriate treatment provided, whether this consisted of mental health services such as cognitive behavioural therapy (CBT), or enhanced support from GPs or health visitors. In other cases, the root cause of the mental health issues was identified and addressed, separately to clinical mental healthcare. For example, one woman mentioned that difficulties with breastfeeding impacted her mental health, which recovered with support from one of the community breastfeeding drop-in groups as well as her GP.

Others describe having their symptoms missed, and feeling left alone to cope with anxiety, depression and PTSD for years after their pregnancy. Some struggled with their mental health because of physical health complications from their birth, such as bladder issues and third- and fourth-degree tears, while some struggled during their pregnancy due to debilitating hyperemesis gravidarum⁸⁴ (morning sickness).

“I just felt like I had no one to help me or talk to.”

Bonding and parent-infant relationships were also raised, with parents feeling that their mental health impacted their ability to bond with their child.

Some mothers were able to identify their own symptoms quickly, with one contacting a private counsellor to speed up the process. However, she did also describe being offered access to free

⁸⁴ **Hyperemesis gravidarum:** a pregnancy complication that causes severe nausea and vomiting

counselling via the NHS relatively quickly. Other mothers described wishing to have another child but feeling so traumatised by their first birth that they felt unable to do so.

It is estimated that 3,000 people in Southwark who are pregnant or have a child under the age of 2 have perinatal mental health needs²⁹. Certain groups are at greater risk of psychiatric conditions during this period, with socioeconomic deprivation intersecting with ethnicity to magnify negative health outcomes for ethnic minority groups and those living in socioeconomic deprivation.⁸⁵

It is evident that mental health issues are significantly impacting some Southwark mothers, and access to and utilisation of services is inconsistent. However, where women are receiving support, it is from a variety of sources, including GPs and health visitors as well as mental health providers. This support network is valuable in identification and early, low intensity support before mental health issues escalate.

Impact of COVID-19

As with all areas of health, significant restrictions were enforced in maternity services during the COVID-19 pandemic in an attempt to reduce transmission of the virus. Impacts on experience included suspension of maternity services, including homebirth and midwifery-led centres, restrictions around visits, restricted access to pain relief and restricted access to maternal requested caesareans, in addition to loss of continuity of carer. There were also wider impacts of the pandemic on those from Black, Asian and minority ethnic communities and other marginalised groups, most notably excess mortality compared with the White British majority group.⁸⁶

One woman who was pregnant during the pandemic recalled how she had to travel by bus to access her allocated community care, despite living next to one of the health or children and family centres and felt this put her and her baby at undue risk of exposure to the virus. A survey respondent experienced a miscarriage during the pandemic and had to attend accident and emergency (A&E) alone.

Several women describe how difficult it was not being allowed to have their partners with them at appointments and the consequent lack of an advocate, with some finding that this exacerbated existing mental health issues.

“Very negative experience for my husband who was only allowed to visit for 2 hours a day during my 5 day stay in hospital due to COVID restrictions - allowing (him) in meant the risk entered the

⁸⁵ Womersley, K., Ripullone, K. & Hirst, JE. (2021) *Tackling inequality in maternal health: Beyond the postpartum*

⁸⁶ Platt & Warwick (2020) *COVID-19 and Ethnic Inequalities in England and Wales*

ward anyway so the policy... was nonsensical and significantly affected my physical and emotional recovery and his ability to bond with his new child."

Research into the impact on mothers' emotional wellbeing of changes to maternity care during the COVID-19 pandemic demonstrates the importance of ensuring learnings and the impact of the restrictions put into place are considered in planning for future crises. Necessary adaptations to care should minimise distress and ensure mothers are not deprived of social support during a time of vulnerability. Adaptations should also support the psychological wellbeing of staff, to ensure they are able to continue to deliver compassionate care during a time of immense pressure.⁸⁷

Recognising staffing difficulties

Many women acknowledged that some of the shortfalls in their care cannot be blamed on the staff themselves, who service users recognise as being overworked and under-supported. Many prefaced their feedback with admiration of the work that maternity staff do. As outlined in the previous chapter, issues of staffing, recruitment and retention, low pay and poor working conditions impact the quality-of-care healthcare staff are able to provide.

"The midwives on shift worked incredibly hard, and I was finally sent home 10 hours after I was marked ready for discharge, because my midwife who hadn't had a break all shift stayed on 2h at the end of her shift to fill out my discharge paperwork"

Conclusion

In conclusion, the findings from engagement with women throughout the Southwark Maternity Commission highlight several critical themes that impact the quality of maternity care experienced by residents. Access to accurate and relevant information is fundamental, as it empowers women to make informed decisions about their care. Effective communication between healthcare providers and patients is essential to ensure that women's concerns are heard and addressed, as many reported feeling dismissed by staff, which can significantly undermine their care experience.

The benefits of continuity of carer are evident, with consistent support leading to more personalised and compassionate care. However, discrimination and the complexities of intersectionality—encompassing factors such as age, marital status, refugee and migrant status, disabilities, and LGBTQ+ identity—have highlighted significant disparities that need to be addressed. Additionally, issues of racism and cultural insensitivity persist, affecting Black and Mixed-Black, Asian, Gypsy, Traveller, Roma, and Latin American communities, which highlights the need for greater cultural

⁸⁷ McLeish et al. (2022) *Learning from a crisis: a qualitative study of the impact on mothers' emotional wellbeing of changes to maternity care during the COVID-19 pandemic in England, using the National Maternity Survey 2020*

competence in care delivery, as well as a need for more robust data on the outcomes of these communities.

Moreover, the importance of compassionate care, individualised birth plans, and a supportive in-patient environment cannot be overstated, as these factors are directly linked to better maternal and infant health outcomes. The findings also emphasise the necessity of addressing wider support systems, including housing, financial stability, employment, and mental healthcare, which play a critical role in the overall well-being of mothers and families. Establishing resilient community care systems that prioritise mental and physical health and provide comprehensive support is equally essential.

Moving forward, it is imperative to incorporate these insights into actionable recommendations that aim to enhance the quality of maternity care, reduce disparities, and ensure that every woman receives the compassionate, respectful, and equitable care they deserve.

Chapter Six: Capturing the voices of fathers and male carers

During the progress of the Maternity Commission, it became clear that the voices of fathers and male carers had not been explicitly heard. Councillor Akoto found herself being approached by men with negative stories, with some stating that due to the difficult birthing experience of their partner and a lack of mental health support, they decided not to have any more children, leading to broken down relationships. Men wanted to talk and have their voices heard, and expressed feeling as though fathers are unfairly excluded from conversations around pregnancy, birth and early parenthood.

As a result, a meeting was organised in July 2024 to listen to their perspectives and gather recommendations. This meeting took place at 1st Place Children and Parents Centre and was integrated with the well-established Stay and Play Group for Fathers and Male Carers.

The session was facilitated by Councillor Jason Ochere and Councillor Martin Seaton, with the original Commission Panel not attending to preserve the safe space of the men's group. The meeting included a focus group with the Councillors and seven male residents, followed by informal discussions about the maternity journey from the male perspective.

Emerging themes

The main themes and recommendations from the meeting and focus group are as follows:

Lack of awareness of available support

Many men reported being unaware of the specific services available to them as fathers and male carers during their partner's pregnancy and postnatal period. This lack of awareness was evident in several areas, including paternity rights, mental health support, and participation in antenatal and postnatal workshops.

Fathers and male carers reported multiple times how the communication about these services was insufficient, with fathers not receiving adequate information through channels like posters, flyers, or direct contact with maternity ward staff. As a result, many fathers struggled to navigate fatherhood without the necessary support tailored to their needs, leading to feelings of isolation, anxiety, and depression.

Not being provided with adequate information was a common thread across the focus group and discussions. One male carer explained how his partner discovered she was pregnant relatively late. He explained how he felt that there was minimal information provided to both he and his partner, especially in the late stages, leaving them feeling uninformed and under prepared.

In line with themes from previous Maternity Commission meetings, some of the male carers highlighted that they experienced difficulty in accessing support where English was not their first

language. One father recounted how difficult it was for his partner, with limited English, to relay the information to him, and for both to access available support.

“There were no posters in any of the classes for me”

Feeling excluded from decision-making

There is an increasing body of research which highlights the role of fathers in maternal health and child development. A World Health Organization report on fatherhood and health outcomes in Europe⁸⁸ outlined that increased involvement of father during pregnancy and delivery results in better outcomes for women, babies and fathers and birthing partners.

However, the men who took part in the focus group frequently expressed feelings of isolation and feeling side lined throughout their partner's pregnancy and postnatal period. They found themselves out of place in parent groups, which were predominantly aimed at mothers, and reported being unaware of any support tailored specifically for fathers. One focus group participant reported his discomfort in attending a session which was targeted at all parents but only had mothers in attendance. He described feeling as though he was intruding on a mother's space.

Male partners felt excluded from the decision-making process for critical decisions, such as opting for a caesarean section. Another attendee spoke of how he felt that key information had not been explained to him, such as his baby being in breech position and staff needing to deviate from the birthing plan.

One male carer felt side-lined as he was working full time and was thus not able to be present at every interaction between his pregnant partner and maternity services. He explained how he became increasingly anxious about striking the balance between being there to support his partner and new daughter versus ensuring they had enough money to pay rent and bills. Ensuring his job security caused this father to feel that he missed opportunities to care for his partner after a caesarean section and look after his baby.

This experience is supported by the literature; evidence from a national survey demonstrates that paternal engagement is highest in partners of primiparous⁸⁹ White women, those living in less deprived areas, and in those whose pregnancy is planned. The study demonstrated the considerable sociodemographic variation in partner support and engagement, and highlighted the importance of health professionals recognising that women in some sociodemographic groups may be less supported by their partner and more reliant on staff.⁹⁰

Many of the participants became fathers during the COVID-19 pandemic, with the impacts of the pandemic exacerbating feelings of isolation. The pandemic led to delayed appointments, reduced services, and increased stress on both healthcare providers and new families. Fathers reported that they were often left out of important discussions and updates due to the heightened restrictions and safety protocols on wards and in clinics, making them feel even more disconnected from the

⁸⁸ World Health Organization (2007) *Fatherhood and Health outcomes and Europe: a summary report*.

⁸⁹ **Primiparous:** A woman who has given birth once is primiparous

⁹⁰ Redshaw & Henderson (2013) *Fathers' engagement in pregnancy and childbirth: evidence from a national survey*.

process. One father spoke of staff being under high levels of stress and not having the time to explain information in detail in appointments and having to wait outside clinics and hospitals on other occasions.

Fathers felt that they should receive equal treatment and communication during the antenatal, birth and postnatal periods, emphasising that both parents should be regarded as equal partners in their baby's care and be treated as such. Fathers felt that services offered to mothers should be duplicated for fathers to ensure equal support and involvement.

“I was forgotten about – if nothing had gone wrong, they would have just come and told me that I have a new son.”

Support from local community services

Due to the challenges and feelings of isolation, many men highlighted the important support they received from community centres like 1st Place Children’s and Parents’ Centre and groups like the one they were attending. Many participants highlighted how these centres have played a crucial role in closing the gaps in NHS services, especially during the pandemic. Fathers found these hubs extremely helpful, providing essential assistance and guidance, particularly in cases involving language barriers and complicated birth situations.

One focus group participant detailed how community organisations (both council-run and voluntary sector) went above and beyond for him and his family in the weeks after his baby’s birth. Staff at the centre would call him to check in when he or his partner had not attended their usual groups. He said that staff were a huge help in supporting his partner to get out of the house following caesarean section, by offering physical assistance in bringing the baby’s buggy down several flights of stairs when he had to return to work.

The men repeatedly brought up how the community support offered by these centres was invaluable, helping fathers navigate the complexities of parenthood and access wider services they might not have otherwise known about, and support with the development of their child’s social integration. The male carers spoke highly of the supportive environment and proactive staff at these centres, both of which made a significant positive impact by alleviating some of the stress and isolation felt by fathers and male carers.

“They were there for us from the very beginning, if it wasn’t for them, I’d be in a very different situation”

Mental health needs and the support available

The focus group strongly supported the notion that postnatal depression in men is often overlooked. Participants mentioned frequently hearing about postnatal depression in women but felt it did not apply to them, despite it being a prevalent issue that often goes undiagnosed in both groups, with up to 1 in 10 new fathers become depressed after having a baby⁹¹. As a result of not

⁹¹ NHS (2022) *Overview - Postnatal depression*

being informed about postnatal depression in men, participants did not know their likelihood of experiencing it or how to manage it, if and when it did happen to them.

One participant spoke of his experience of anxiety and depression trying to manage work, parental leave, finances, and looking after his partner and baby. He reported feeling immense pressure to be a support system for his family but was struggling himself. Another father spoke of his and his partner's experience of PTSD after a traumatic birthing experience and the tragic loss of one of his two babies. The father spoke of feeling overwhelmed and not being aware of resources available to him and his family.

Fathers spoke of a perceived lack of availability of mental health support and reported not feeling supported by perinatal services through the pregnancy and birthing journey.

“Men tend to not talk about it, just get on with it.”

Listening to male partner's experiences of using perinatal sheds light on the question of how men are supported by NHS service or if services are not set up for fathers at all. Participants discussed, on multiple occasions, how they were supported or needs catered for during the maternity journey, identifying gaps in service delivery.

Informed consent

Male carers spoke of issues around providing consent on behalf of their partner during interactions with maternity care, particularly around the birth. Having to take responsibility for providing consent was reported as an extremely stressful experience, compounded by the experience of the birth itself being immensely emotional and stressful. One father reported that he found the experience of being a birth partner being overwhelming, with the added pressure of having to *“keep it all together”* by providing consent on his partner's behalf.

Midwives have a professional duty to uphold the NMC's Code⁹² and to practise within the law of the United Kingdom (UK) by upholding human rights in the care that they offer and provide⁹³. Midwives must provide women with the information and support that they need to make decisions about their care and must respect the decisions that women make. With the general principle that if a patient is unable to make their wishes known, treatment can be given without their consent in order to save their life or prevent serious deterioration in the patient's condition. If there is time, the patient's next-of-kin should be involved in decisions about their care.

A participant explained how he was told to wait on the ward and then was suddenly rushed to theatre, where his partner was undergoing a caesarean section with the midwifery team requesting his consent. He described feeling overwhelmed and under prepared, and highlighted importance of early education for fathers around consent in these situations.

⁹² Nursing and Midwifery Council (2018) *Professional standards of practice and behaviour for nurses, midwives and nursing associates*

⁹³ British Institute of Human Rights (2016) *Midwifery and human rights: a practitioner's guide*

Participants reported that it would be beneficial to discuss and agree upon consent issues before the birth, both between partners and with midwifery team. This would help to prepare both the mother and the birth partner for what to expect, and for the benefit of maternity services, include confirming the nature of the relationship between the birth partner and the mother, whether they are a partner, brother, cousin, or another close relation.

Ethnicity and racism

One Asian focus group participant shared his difficulties in managing his emotions and responsibilities as a new father after his partner gave birth. He explained that, within his cultural context, it is not typically acceptable for men to openly discuss feelings or acknowledge struggles which, combined with lack of awareness of resources specifically aimed at supporting men in their role as partners after birth, exacerbated feelings of overwhelm.

Similarly, as highlighted in previous meetings and the survey responses, fathers, particularly Black fathers and men with Black partners, reported instances where they and their partners felt ignored by maternity staff. One Black father recounted taking his wife to A&E because she felt she was about to give birth. However, the staff dismissed their concerns, insisting that she was not in labour. The father then took his wife to another hospital in the borough, where she gave birth shortly after. This incident echoes the experiences shared by women, particularly Black mothers, who also felt their concerns were not taken seriously.

Over the course of the Commission, the panel heard several cases of local Black women not being listened to, believed or concerns taken seriously. These issues have been identified on a national level also in Birthrights report⁹⁴ where the theme that echoed the inquiry's general findings was not being listened to – dismissal, lack of compassion and power dynamics in relation to a White partner being taken more seriously than the Black pregnant person.

Conclusion

The session focused on capturing the voices of Southwark's fathers and male carers has highlighted significant gaps in the maternity care experience from their perspective. These insights reveal a consistent theme of exclusion, whether through lack of information, insufficient mental health support, or being side-lined in decision-making processes during critical moments. The men shared a profound sense of isolation, often exacerbated by cultural norms, language barriers, and the unique challenges posed by the COVID-19 pandemic.

Yet, amidst these challenges, the invaluable role of community support emerged as a lifeline for many. Local centres like 1st Place Children's and Parents' Centre provided essential resources and emotional support, helping to bridge the gaps left by NHS services. These findings underscore the urgent need for a more inclusive approach to maternity care, one that actively involves fathers and male carers, recognizes their mental health needs, and ensures they are treated as equal partners in the journey of parenthood.

⁹⁴ Birthrights (2022) *Systemic racism, not broken bodies- An inquiry into racial injustice and human rights in UK maternity care*

The experiences shared in this session also highlight the broader issue of systemic inequality, particularly in relation to ethnicity and racism, with fathers from minority backgrounds reporting dismissive and discriminatory treatment. Addressing these disparities requires not only structural changes within maternity services but also a cultural shift towards truly listening to and valuing the voices of all parents. Many of the men and male carers present echoed themes and experiences from women highlighted in previous meetings and community engagement.

Moving forward, these insights must inform the Commission's recommendations to ensure that fathers and male carers receive the support and respect they deserve, ultimately leading to better outcomes for all families.

Chapter Seven: Recommendations

From January to August 2024, the Southwark Maternity Commission gathered information from a wide range of sources – from its public meetings, targeted community engagement activities, resident, family and staff surveys, written submissions and review of the literature.

Throughout the Southwark Maternity Commission, the Panel was particularly struck by, and grateful for, the moving personal testimonies from Southwark residents with recent experience of having a baby and those testimonies of the staff and organisations working hard to deliver high-quality, safe, kind and respectful care.

There is a huge amount of good work being delivered across Southwark by organisations within the Local Maternity and Neonatal System - much of which includes new initiatives to improve services and tackle recognised inequalities. However, the Panel also heard from both staff and residents where experiences fell short of the quality of care that service users have the right to expect.

The Southwark Maternity Commission identified five overarching themes (Fig. 11), used to develop the ten recommendations.

The Swithark Maternity Commission identified five overarching themes

These themes were used to develop our ten recommendations.



Figure 11. The Commission's five overarching themes

Recognising the significant impact of wider social, economic and environmental factors that affect the health of people having babies, the Commission set out to also understand where Swithark Council and other organisations might be able to support a maternity system under pressure. By working towards recommendations that incorporate a broader remit than the traditional maternity care partners, including Swithark Council, Primary Care partners and the VCFSE sector organisations, a more holistic approach can be taken to improving maternity care and outcomes in Swithark.

Strengths and limitations

It is important to acknowledge the strengths and limitations of this report, highlighting areas that could not be fully explored. While valuable insights were gathered, there remains a need for more comprehensive, local exploration of issues such as migrant charging and service avoidance, experiences of LGBTQ+ residents, as well as the perspectives of a broader range of birthing parents, fathers, and staff overall.

Additionally, the analysis would have benefited from more detailed ethnicity and socioeconomic status data. Data was requested from each trust and the LMNS at the start of the Commission in their evidence submissions, however due to reported capacity constraints and the introduction of a new information system, the data provided was limited. This meant the Commission relied on publicly available local and national data, data available to Southwark Council, and data arising from the engagement carried out as part of the Commission.

Hospital level data would have been beneficial, particularly through disaggregating categories to better understand known differences within specific groups, such as Black African, Caribbean, Mixed, and various South Asian communities. Furthermore, separating White British from White Other, which includes Latin American women in Southwark, would have provided a more nuanced understanding of the diverse experiences within the community. These limitations highlight the need for continued research and data collection to more effectively address the complex factors influencing maternity care.

Five key themes

1) Tackling discrimination and better supporting women with specific needs

The Commission identified themes of discrimination, particularly concerning racial discrimination, where women from Black, Asian, Latin American and other minority ethnic backgrounds were reporting more negative experiences and poorer outcomes.

In addition, residents spoke about feeling poorly treated due to factors such as their relationship status, as well as their age, wherein young mums did not receive compassionate and nurturing care when they needed it the most.

2) Ensuring women are listened to and supported to speak up, whatever their language or background

A recurrent theme was that of feeling unheard; many women experienced this when requesting pain relief, or when trying to follow their birth plan. Other women complained about not being believed about how far into their labour they were and being left to labour in waiting rooms. Many

survey respondents also referred to language barriers making it difficult for them to understand what was happening and communicate their circumstances to staff.

3) Providing women with the right information at the right time in the right way

Many women spoke about feeling left by themselves for the first weeks of their pregnancy as they waited for their initial appointment and felt this was a missed opportunity to share information about pregnancy. Another frequent complaint was around women having difficulties finding out what was available to them postnatally, with there not being one central location to find out about the local offer. In addition, health professionals highlighted that the state a woman comes into maternity services in with regards to her health can have huge implications on her experience and outcomes. They emphasise the need for pre-conception health education, both in education settings and throughout a woman's life.

4) Joining up council and NHS services better around the needs of women and helping standardise maternity care across Southwark and Lambeth

There is a clear need for a better join up of all services, from NHS primary care to maternity care to community services, in addition to Southwark Council and VCFSE sector organisation offerings. Many women and staff refer to a "postcode lottery", where one woman who has given birth at King's College Hospital may be offered community midwifery appointments at home, while a woman living across the road under a different postcode falls outside of their catchment and receives nothing. These inconsistencies in care worsen inequalities within Southwark, across Southwark-Lambeth borders and more broadly across southeast London as a whole.

5) Supporting the workforce to stay and be able to provide compassionate and kind care for all new mums

We heard from staff that there is little incentive to work in maternity care due to staffing constraints, loss of grants and long working hours. The Commission heard from staff that there is little incentive to work in maternity care due to staffing constraints, loss of grants and long working hours. There is a sense that the compensation is not aligned with the demands of the job. A number of staff describe a fear of speaking up, particularly for Black and Brown staff, and stigma around vulnerability.

Ten recommendations

Based on the outlined themes above, ten overarching recommendations have been developed by the Maternity Commission. These are based on an initial 37 specific recommendations, which have been condensed and clarified to ensure feasibility. The 37 recommendations will be used moving forwards to shape the action plan. The ten overarching recommendations are below:

No.	Recommendation	Lead agents of change
1	<p>Leadership in addressing racism that leads to unequal maternal health</p> <p>Introduce clear, evidence-based policies that address racism and inequalities in maternity care and the wider healthcare system. Include review and improvement in existing frameworks and systems, such as the NHS Workforce Race Equality Standard and ending charging migrants for maternity services.</p>	Central Government LMNS, GSTT, KCH, SLaM
2	<p>Develop a new national way of reporting maternal health</p> <p>Work with local authorities to introduce a way to record and respond to perinatal health data. Make sure all maternal health data is collected and reported in a standard way across all healthcare settings and focuses on ethnicity to highlight and address if people are getting unfair and different treatment.</p>	Central Government
3	<p>Review the maternity workforce</p> <p>Review the wider maternity healthcare system's capacity to support its workforce, with a focus on improving pay, conditions, and resilience. Provide healthcare professionals with training, resources, and a supportive work environment to improve compassion in care, particularly for Black and Asian mothers.</p>	Central Government, LMNS, GSTT, KCH, SLaM

4	<p>Evaluate the fairness of maternity services</p> <p>Review current services for Southwark residents with the highest levels of need. Develop and improve new and existing services to make sure they work for people with complex, overlapping needs.</p>	LMNS, GSTT, KCH, SLaM, GPs, Southwark Council, VCFSE organisations
5	<p>Listen to and empower families</p> <p>Create an inclusive environment where all family members are heard and have the information to make sure their needs are met. Improve communication by creating and promoting accessible resources so that families are fully informed and can navigate the healthcare system.</p>	LMNS, GSTT, KCH, SLaM, Southwark Council, VCFSE organisations
6	<p>Preparation and support before pregnancy</p> <p>Southwark partners (Local Maternity and Neonatal System, local authorities, voluntary and community sector and maternity care providers) raise awareness together of the importance of getting ready for pregnancy. Use all services and contacts so that women arrive at maternity services in the best possible health (in particular those at risk of poorer maternal health outcomes).</p>	LMNS, GSTT, KCH, SLaM, GPs, Southwark Council, VCFSE organisations
7	<p>Give parents the right information, at the right time, in the right way</p> <p>Southwark partners (Local Maternity and Neonatal System, local authority, voluntary and community sector and maternity care providers) work together on their communications across each stage of the perinatal period. Make sure women and their partners get the right, inclusive and culturally appropriate information</p>	LMNS, GSTT, KCH, SLaM, GPs, Southwark Council, VCFSE organisations
8	<p>Create a joined-up approach to families' needs between the NHS, south east London boroughs, and voluntary and community sector</p> <p>Strengthen partnerships by creating a network for staff delivering care to Southwark residents. Share learning, facilitate integration across services and improve knowledge and resource sharing. Look for opportunities for co-commissioning with neighbouring boroughs to</p>	LMNS, GSTT, KCH, SLaM, GPs, Southwark Council, VCFSE organisations

	enhance and provide consistent services across borough borders.	
9	<p>Southwark Council to review their role in maternity care</p> <p>Look at their role in assurance and scrutiny of the maternity care system and empower system leaders to hold people to account. Together with local trusts review, identify and close gaps in maternity services. Consider their role in housing and cost of living services, and in collaborating with local voluntary, community, faith and social enterprise sector organisations.</p>	Southwark Council
10	<p>Review how feedback is dealt with</p> <p>Work with NHS trusts to review how they identify, share and respond to patient and staff complaints, particularly ones about racial discrimination. Embedding a culture where staff are encouraged and supported to speak up. Make sure that the context of reviews is appropriate and develop an integrated, borough-wide response to review findings.</p>	LMNS, GSTT, KCH, SLaM, GPs, Southwark Council, VCFSE organisations

Improving outcomes: How will we know when we are successful?

It is important to note what these recommendations set out to achieve, and what Southwark women and people giving birth can expect to see and feel will improve within the next five years from September 2024 to September 2029.

As a result of the Commission's ten recommendations, we have the ambition for improvements around five key outcomes - reduced infant mortality, reduced maternal morbidity, increased reported positive experience of maternity care, increased staff satisfaction and reduced inequality, particularly through a deprivation and ethnicity lens, across each of these four outcomes.

Outcome 1: Reduced infant mortality

In the period 2019-2024, there were 191 deaths of infants and children under the age of 2.5 years in Southwark. Of 168 cases of these which have gone through the child death overview process, 45 (27%) were classified as having modifiable factors, meaning there were risk factors which could have been controlled or changed to reduce the likelihood of mortality. The Commission therefore sets a target to prevent all infant mortalities with *modifiable* factors by September 2029.

Outcome 2: Reduced maternal morbidity

There is a clear gap in collecting information about maternal morbidity, both locally and nationally. Exploring the work done on the English Maternal Morbidity Outcome set, Southwark Council will work with residents, LMNS and NHS Trusts to agree to establish and monitor a bundle of measures of maternal morbidity and demonstrate reduced maternal morbidity by September 2029. The bundle of measures might include, for example, local rates of severe blood loss; emergency C-section; substantial perineal tearing and poor perinatal mental health.

Outcome 3: Increased positive experience of maternity care

Throughout the Southwark Maternity Commission, we have clearly heard that women and people giving birth not only want good health outcomes for their babies and themselves but during this precious and important life event, that their experience of care is a positive one and free from discrimination. Southwark Council will work with residents, VCFSE, the LMNS and NHS Trusts to establish and monitor baseline measures of experience of maternity care including around racism and demonstrate improved experience by September 2029.

Outcome 4: Increased staff satisfaction

Throughout the Southwark Maternity Commission, we have also heard of the broad range of pressures facing staff delivering care across the course of pregnancy, birth and postnatally and the relationship between staff satisfaction and ability to deliver high quality and compassionate care. Southwark Council will work with the LMNS and NHS Trusts to establish a baseline bundle of measures of staff satisfaction including around racism and demonstrate improved experience by September 2029.

Outcome 5: Closing the health inequality gaps

By the five-year review of this work in September 2029, our ambition is to also demonstrate a reduction in *inequalities* of key outcomes 1-4 above. It is not enough that each key outcome 1-4 improves in absolute terms *on average* but that the gap between those having the best and the least good experience across each key outcome also closes. The risk is that, otherwise, the poor experiences of minority groups get lost in 'the average'.

Some of the most common inequality 'gaps' relate to ethnicity and socio-economic status however, the Commission has highlighted poorer outcomes and experience amongst other groups who also experience marginalisation including by disability, sexuality, age or relationship status. Not only is it important that organisations collect and share this data but it will be important to build trust with women and staff so they feel able to share important demographic information that helps both monitor and ultimately, by tailoring our approach, to close the health inequality gaps.

Chapter Eight: Next steps

The final meeting of the Southwark Maternity Commission will endeavour to secure commitment from all participating stakeholders (South East London LMNS, Integrated Care teams, KCH, GSTT, SLaM) to ensure a unified commitment to implementing the recommendations.

Prior to this meeting, participating organisations, trusts and resident groups were given the opportunity to review and provide feedback on recommendations through stakeholder engagement workshops. This crucial step involved presenting the draft recommendations and addressing any potential barriers, concerns or questions from stakeholders. A wealth of feedback was received and used to amend the recommendations, ensuring that the views of both professional and resident stakeholders, were carefully considered. Active participation and support from these trusts will be essential in translating the Commission's recommendations into tangible, positive changes in maternity services.

By obtaining endorsement at the final meeting, our ambition is that a sense of collective responsibility and enthusiasm for the initiatives will be fostered.

Commitment from Health and Wellbeing Board

Health and Wellbeing Boards are a statutory forum where political, clinical, professional and community leaders from across the health and care system collaborate to improve the health and wellbeing of their local population and reduce health inequalities. Southwark's Health and Wellbeing Board is a formal committee charged with promoting greater integration and partnership between bodies from the NHS, public health and local government within the borough.

Southwark's Health and Wellbeing Board will review and sign off on the Maternity Commission report and its constituent recommendations. Having the backing of Southwark's Health and Wellbeing Board will support the collective improvement of local maternity services through a more strategic and integrated approach.

The findings and recommendations from this report will be brought to Southwark's Health and Wellbeing Board on 14 November 2024 to seek approval from the Board to form a strategic steering group.

In addition, it is anticipated the report will be brought to the South East London LMNS Executive Board within three months of its launch.

Strategic steering group

One of the next key steps will involve establishing a strategic steering group to ensure the effective implementation of the Commission's recommendations. This group will consist of key stakeholders from the borough's major maternity and perinatal mental health providers (KCH, GSTT and SLAM), Southwark Council Public Health, VCFSE sector organisations, as well as the MNVP chairs to ensure the resident voice are included. The primary role will be to develop a comprehensive action plan, set clear objectives, and oversee the progress of recommendations and improvement in resident and staff outcomes. The strategic steering group will also facilitate collaboration across various sectors and monitor outcomes to ensure the Commission's objectives are being met.

Sub-groups for recommendation areas

In order to ensure the recommendations that have been set out are achievable and appropriate to those directly affected, smaller subgroups are recommended, separate from the strategic steering group, be established. These groups will focus on the key recommendation areas set out in the previous chapter. Subgroups will comprise of experts and stakeholders with relevant knowledge and experience in each area. Their tasks will include developing action plans based on the recommendations, identifying challenges and solutions, coordinating efforts, and reporting to the strategic steering group. Members will be selected based on level of expertise and a foundation to drive change in maternity care in Southwark and will include NHS providers, Southwark Council, VCFSE and resident representation.

Expectations around timelines

Establishing clear and realistic timelines for implementing the Maternity Commission's recommendations is essential for maintaining momentum and focus in the years to come. The action plan will consist of short, medium and long-term goals and will have allocated timelines for completion.

System wide change is a substantial piece of work and will take time to develop and embed in a sustainable manner. The Commission will be looking to observe clear, positive change in access, experience and outcomes of maternity service by 2034. Within the next five years, there are essential milestones that need to be met to ensure this is achievable.

- November 2024 – Commitment from Health and Wellbeing Board
- April 2025 – Development of action plan
- April 2025 to September 2027– Implementation of action plan

- Annual review each April
- September 2027 – Three-year interim review
- September 2029 – Five-year review

The short-term goals from the Commission will be largely focused around developing actions plans, allocating resources, information gathering and collecting data and assigning responsibility of stakeholders and partners. Each of the three providers and LMNS will be asked for their response to the Report and how they plan to embed the recommendations.

Systems of accountability will be laid out so Southwark residents know how they can remain involved and part of the work and hold the strategic steering group to account.

Evaluating the recommendations and impact of the Maternity Commission will be an ongoing process. The steering groups will agree and monitor data around the key outcomes including reducing infant mortality and maternal morbidity and increasing reported positive experience of care and staff satisfaction. In addition to these absolute changes, it will be important to reduce the inequalities seen across these key outcomes, particularly through a deprivation and ethnicity lens. Annual reviews, reported to the Health and Wellbeing Board, will track progress allowing for adjustments to strategies if required.

Five years after the launch of this report, there will be a comprehensive evaluation to determine whether the recommendations have been achieved, and the long-term impact. The evaluation will also establish whether the Maternity Commission itself (including ways of working and the allocation of responsibility for the recommendations) can be considered a success, which will inform future public health and system-wide work.

Conclusion

The Southwark Maternity Commission extends its heartfelt gratitude to all participants and stakeholders who have contributed to this significant work. It has been an enormous undertaking, requiring the collaboration, insight, and dedication of many individuals and organisations committed to improving maternity care within the community.

The complexity and importance of this Commission cannot be overstated, as it directly impacts the well-being of women, babies, and families—particularly in addressing and reducing the deep-rooted inequalities that persist in maternity care.

Armed with the valuable insights and recommendations from this report, the Commission is more committed than ever to making meaningful improvements. Additionally, it is hoped that this

innovative work will serve as a catalyst for positive change in other areas, setting new standards of care and equality.

Together, the Southwark Maternity Commission and its partners will work tirelessly to ensure that every parent and child in Southwark, regardless of background or circumstance, receives the highest standard of care and support they deserve. The Commission thanks everyone involved for their commitment to this vital cause.

Glossary

A&E	Accident and emergency
Assisted vaginal birth	Birth helped by use of a ventouse (vacuum cup) or forceps or both
ASR	Asylum seekers and refugees
CBT	Cognitive behavioural therapy
Continuity of carer midwifery	A model of delivering maternity care so that women receive dedicated support from the same midwife team throughout pregnancy
CQC	Care Quality Commission
EDI	Equality, diversity and inclusion
Episiotomy	A cut in the area between the vagina and anus (perineum) during childbirth
FGM	Female genital mutilation
GP	General practitioner
GSTT	Guy's and St Thomas' NHS Foundation Trust
HIE injury	Hypoxic-ischaemic encephalopathy is a type of brain damage caused by a lack of oxygen to the brain before or shortly after birth. HIE is graded as mild (stage 1), moderate (stage 2) or severe (stage 3)

HWBB	Health and Wellbeing Board
IAC	Initial accommodation centre
ICB	Integrated Care Board
ICS	Integrated Care System
KCH	King's College Hospital NHS Foundation Trust
LEAP	Lambeth Early Action Partnership
LGBTQ+	Lesbian, gay, bisexual, transgender, queer, questioning and asexual
LMNS	Local Maternity and Neonatal System
MBRRACE	Mothers and Babies: Reducing Risk through Audits and Confidential Enquires across the UK
MNVP	Maternal and Neonatal Voices Partnership
Morbidity	Ill-health and injury
Mortality	Death
NHS	National Health Service
NICU	Neonatal Intensive Care Unit

PTSD	Post-Traumatic Stress Disorder
SEL	South East London
SMC	Southwark Maternity Commission
SLaM	South London and Maudsley
Tokophobia	A marked fear of childbirth and sometimes pregnancy
VCFSE	Voluntary, community, faith and social enterprise

Appendices

Appendix 1: Analysis of the Southwark Maternity Commission Resident Survey – Gathering Evidence about the Experiences of Maternity Care in Southwark

Appendix 2: The Motherhood Group x Southwark Maternity Commission

Appendix 3: Meeting One evidence submissions

- Local Maternity and Neonatal System
- Guy's and St Thomas'
- King's College Hospital
- South London and Maudsley

Appendix 4: Resident survey

Appendix 5: Workforce survey

Appendix 1: Analysis of the Southwark Maternity Commission Resident Survey – Gathering Evidence about the Experiences of Maternity Care in Southwark

Public Health Intelligence Team

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Contents

Summary.....	102
Background.....	104
Limitations	104
Demographics.....	105
Survey Access	106
Healthcare Provision.....	107
Healthcare Access	108
Healthcare Experience.....	109
Maternal Outcomes and Support.....	113
Mental Health.....	114
Mental Health Support.....	116
Supporting Informed Decision-Making	116

Summary

- The majority (64.4%) of respondents reported being registered **female** at birth. Of respondents registered male at birth, 55.6% were answering the survey on behalf of a **partner or family member**.
- Lack of **contact and/or availability of appointments** represented a key theme among the majority (62.3%) of respondents who reported to have **not received maternity care within the first 10 weeks of pregnancy**. Those who did not receive care within this period were more likely to be of a White ethnicity (36.5%) than from an ethnic minority group (27.2%; excluding White minorities).
- Those with a recorded disability were 1.6 times more likely to either always or sometimes receive the same midwives across their **continuity of care pathway** than those without. A greater proportion of respondents reported to have different midwives across this pathway at St Thomas's Hospital (64.0%) compared to King's College Hospital (52.4%).
- Respondents of an ethnic minority group (excluding White minorities) were 1.9 times as likely to **avoid seeking care during their pregnancy** compared to respondents of a White ethnicity (19.7% vs 10.5%).
- Overall, respondents were twice as likely to avoid seeking care due to **worries about having a bad experience** compared to due **worries in relation to the need to pay for care** (9.9% vs 4.6%). Key themes related to avoidance of care included: **lack of patient-centred care** and/or patient specific knowledge; feelings of **disrespect and/or patronisation** from healthcare staff; and **poor treatment** due to, and/or **lack of consideration** towards **mental health**.
- The majority of respondents reported to have either a positive or very positive experience of antenatal care (62.5%), and care during childbirth (63.4%), respectively. However, over **one third** (38.8%) of respondents feedback detailed a **negative experience** of their overall maternity care.
- As respondents **progressed along the care pathway**, they were less likely to report always, or sometimes receiving help from their midwife or doctor when they needed it (during pregnancy: 73.8%; during labour/birth: 67.4%; after their baby was born: 64.2%).
- During pregnancy, and during labour and birth, respondents of an ethnic **minority group** (excluding White minorities) were **less likely to always get help** from their midwife or doctor when needed, **or always be involved in decisions** surrounding their care compared to those of a White ethnicity.
- Respondents over the age of 35 were over two times more likely to not be treated with **respect** compared to those aged 35 years and under (11.8% vs 5.9%). Overall, repeated themes related to feelings of **lack of respect** included: feeling incompletely

heard/understood; lack of patient-centred care; and dismissal of concerns, including those related to pain. Other key themes included culturally insensitive behaviour.

- Health literacy, knowledge, and language barriers presented as repeated themes among those who felt they were **unable to ask all the questions they wanted to**.
- The majority of survey respondents (58.9%) **raised a concern during their care**. A higher proportion of respondents of an ethnic minority group (75.2%; excluding White minorities) felt their concern was taken seriously compared to respondents of a White ethnicity (61.7%).
- Respondents of White ethnicity were 1.3 times more likely to either think about, or make a **complaint** compared to those of an ethnic minority group (37.0% vs 28.9% of respondents, respectively).
- A higher proportion of respondents from an ethnic minority group had subsequent antenatal **appointments cancelled following early pregnancy loss** compared to those of a White ethnicity (25.0% vs 22.3%)
- **A very small number of respondents shared experiences of good support following pregnancy loss**. Of those reporting pregnancy loss after 24 weeks gestation, 33.3% reported that after a review of the care they and their baby received, they did not receive the answers they needed.
- The majority of respondents (51.8%) who reported their baby was born before their due date felt **supported by the care received for their premature baby** (no: 16.9%; missing: 31.3%).
- A higher proportion of respondents of an Asian ethnicity (27.8%) reported **poor prenatal mental health** compared to any other ethnic group. A higher proportion of respondents wished for mental health support (and felt like they were not given enough support) after their baby was born compared to during pregnancy.
- Overall, three-quarters (68.6%) of respondents knew how to **contact their local maternity service for help**; respondents of an ethnic minority group were more likely to only sometimes understand the information provided to them (31.8%; always: 55.0%) compared to those of a White ethnicity (20.0%; always: 63.5%).
- Over one-tenth (12.9%) of respondents would have preferred to **receive information in another language**, with Spanish and Chinese most frequently listed.
- Across all four categories, a greater proportion of respondents of a White ethnicity reported to not want support compared to those of an ethnic minority group (housing: 56.5% vs 34.7%; money or debt: 56.5% vs 32.2%; employment issues: 55.5% vs 30.1%; domestic abuse: 59.0% vs 36.1%).
- Of those who felt unable to easily and quickly discuss their concerns, and who provided additional explanation, 68.3% stated this was related to the **availability of midwives**.

Background

The Southwark Council Maternity Commission Survey aimed to investigate experiences of maternity care in Southwark to inform evidence-based recommendations in relation to how services can better meet resident's needs. The target population included any resident who had utilised maternity services during the last five years, including women who have had a pregnancy, fathers and male carers, in addition families of those who were pregnant. Mixed-method research strategies were employed while survey recruitment techniques consisted of snowball and convenience sampling.

The Southwark Council Maternity Commission survey was completed by 621 respondents between April to July 2024. However, during data cleansing, approximately one-fifth (19.0%; n=118) of these responses were identified as suspected spam. Advice was sought from a number of different sources, with pattern identification deemed the most appropriate method to identify potentially fraudulent data. Spam responses were therefore identified based on naming convention, inconsistencies between name and email fields, and free text responses written in a way that contrasted from genuine responses and/or duplicated other fields. To ensure data integrity of the sample, suspected spam responses were removed.

Of the remaining 503 respondents, all gave written consent to the analysis of their information. This analysis present data on the 503 respondents for which written consent was received.

Limitations

The non-randomised sampling technique represents a key limitation of the Southwark Council Maternity Commission survey. Given this technique, whether the nature of responses among those who did not respond to the survey differs from those who did, in addition to determining the non-response rate, is unclear. Given the survey's voluntary nature, whether respondents with bias selected themselves into the sample must be considered. Statistical inferences can therefore not be validly made from these results, given the limited generalisability of these findings to the total population of Southwark maternity care users.

Furthermore, given that identification of spam responses was based on subjective criteria, it is not possible to determine whether all spam responses were removed from the cleaned dataset, nor whether any false positive or false negative spam responses were retained.

Demographics

Southwark respondents were asked which of eleven community areas they lived in. The most common areas were Peckham (13.5%), Dulwich (10.7%), Walworth (10.9%), and Camberwell (9.3%); 12.1% did not answer this question.

Most respondents were aged either 35–44 (38.2%) or 25–34 years old (31.6%). Few respondents were aged 16–25 years old (3.0%); 11.9% of respondents did not answer the question.

Two-fifths (39.8%) of respondents were from White/White British ethnic groups, nearly one-fifth (17.9%) from Black/Black British groups, 1 in 14 (7.2%) from Asian/Asian British groups, 1 in 26 (3.8%) from Mixed ethnicity groups, and 1 in 18 (5.6%) from other ethnic groups (including Latin American groups, who made up 1 in 23 [4.4%] of all respondents). Approximately two-thirds (61.5%) of respondents of a White ethnic group were White British, and over one-third (35.6%) of respondents from a Black ethnic group were from Black African groups. Over one in four (25.8%) respondents did not answer the ethnic group question.

Nearly 1 in 10 (8.0%; n=40) respondents reported having a disability; this is less than the wider population of Southwark residents (13.7% of residents reported to have a disability at the time of the 2021 Census). Of those who reported to have to have a disability, over half (55.0%) had either a severe mental health condition (e.g. severe depression or schizophrenia) lasting more than one year (27.5%) or a learning disability (27.5%). Nearly one-third (30.6%) of respondents did not answer the disability question.

Approximately two-thirds (64.4%) of respondents reported being registered female at birth; almost one-third (32.0%) of respondents did not answer the question or preferred not to say. Of respondents registered male at birth, over half (55.6%) answered the survey on behalf of a partner or family member. A small number of respondents (fewer than 5) had a gender identity different to their birth sex registration.

Although over half (58.9%) of respondents identified as heterosexual, almost 1 in 40 (2.2%) identified as non-heterosexual; this group was split fairly evenly between those identifying as lesbian/gay women and those identifying as bisexual or another non-heterosexual identity.

The question on religion was not answered by nearly two-fifths (38.4%) of respondents; one-quarter (25.3%) reported having no religion, and a further one-quarter stated a religion of (26.0%) Christianity; over 1 in 20 (5.2%) respondents were Muslim and 1 in 20 (5.0%) reported other faiths.

Total yearly household income was less than £15,000 for nearly 1 in 10 (9.1%) respondents, and between £15,000 and £30,000 for a further 1 in 10 (9.1%). Over 1 in 5 (22.1%) respondents had a

combined household income of £90,000 or above; 4 in 10 (39.2%) respondents did not answer the question.

Almost one-third (32.6%) of respondents had a mortgage, had shared home ownership, or owned their home outright. About 1 in 6 (15.7%) rented from the council or a housing association, and 1 in 10 (10.9%) rented privately. Over one-third (38.0%) of respondents did not answer this question.

Survey Access

The largest single proportion of survey respondents found out about the survey via email from Southwark council (25.0%) followed by Facebook (8.0%) and conversation with friends, neighbours and/or colleagues (7.2%); 32.8% of respondents did not answer this question. Over one in ten respondents (12.4%) reported to find out about the survey by two or more different mediums of communication (Supplementary Table 1).

Supplementary Table 1. Number and proportion of respondents, by means to which they found out about the survey.

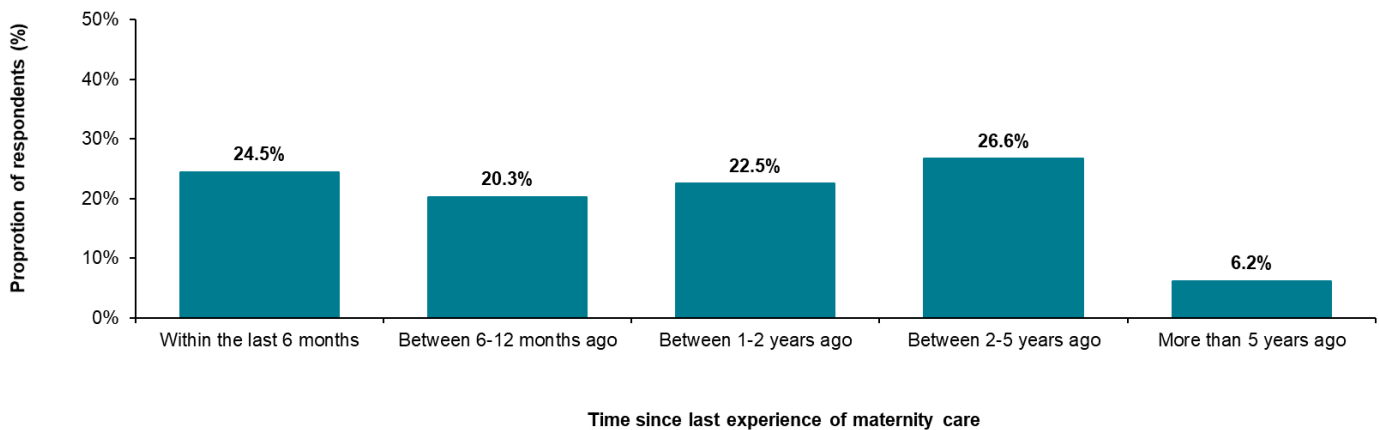
Communication Medium	Number	%
Email from council	126	25.0%
Facebook	40	8.0%
Conversation with friend/neighbour/family	36	7.2%
Twitter	32	6.4%
Southwark Council website	28	5.6%
Instagram	26	5.2%
WhatsApp message	21	4.2%
Conversation with council officer/councillor	20	4.0%
Media coverage (Southwark News, BBC London, South London Press etc.)	19	3.8%
Southwark Life magazine	17	3.4%
Poster	15	3.0%
Leaflet/flyer	11	2.2%
Other social media	8	1.6%
Other	21	4.2%
Not answered	41	32.8%

Footnote: One respondent may report multiple different mediums of communication. Denominator: N=503.

The vast majority (82.9%) responded to the survey on their own behalf (responding on behalf of their partner: 9.2%; behalf of a family member: 6.0%). Whether those responding on their own behalf relates to a maternity service user, or father, male carer or partner, is not specified. A greater proportion of individuals of ethnic minority groups responded on behalf of a partner or family member (17.4%) compared to those of a White ethnicity (7.5%).

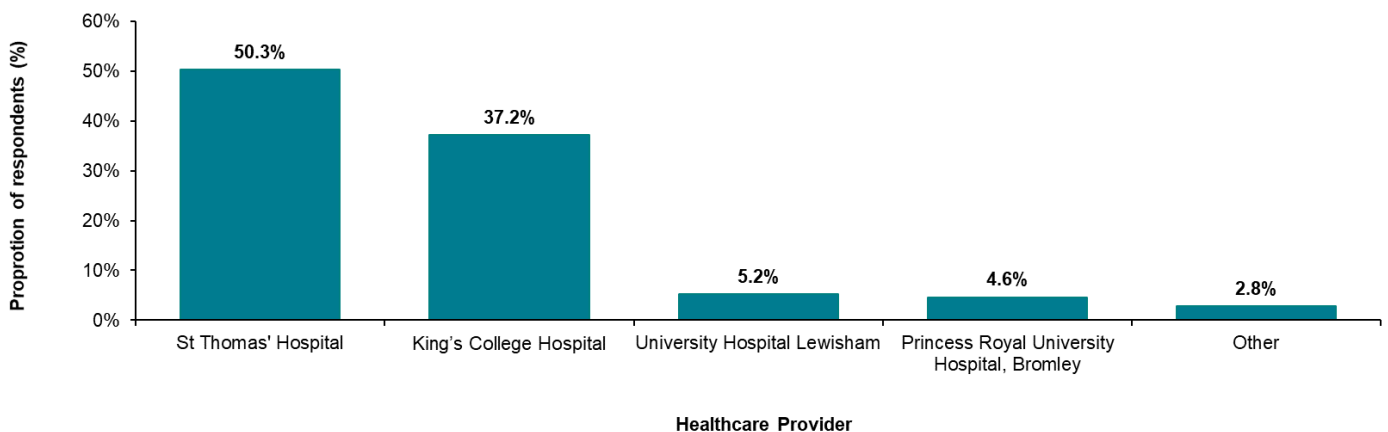
Healthcare Provision

Most survey respondents received maternity care either between 2–5 years ago (26.6%), within the last 6 months (24.5%), or 1–2 years ago (22.5%); few respondents received maternity care more than five years ago (6.2%; Supplementary Figure 1).



Supplementary Figure 1. Proportion of respondents by time since last experience of maternity care.

The greatest proportion of survey respondents received maternity care at St Thomas's Hospital (50.3%) followed by King's College Hospital (37.2%; Supplementary Figure 2); similar proportions were observed, by age and ethnicity, respectively, between these two hospital sites.

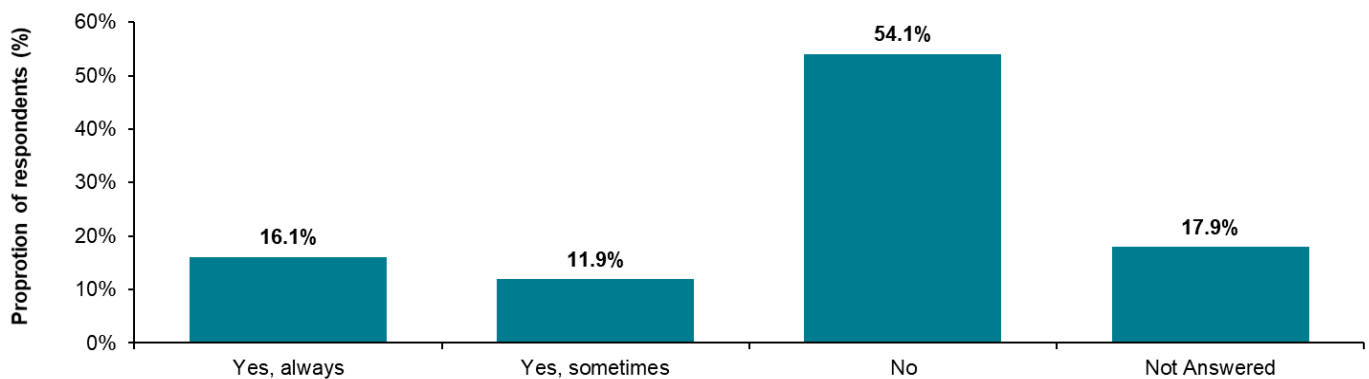


Supplementary Figure 2. Proportion of respondents by provider of maternity care.

By respondents area of residence, substantial variation in the proportion of respondents who received maternity care at King's College Hospital (highest: Peckham [20.9%], Dulwich [19.8%], Camberwell [16.0%]) and St Thomas's Hospital (highest: Walworth [18.2%], Bermondsey [12.3%], Rotherhithe [11.1%]), were reported. This may be expected given the proximity of certain areas within Southwark to specific providers of care.

More than half (51.1%) of respondents received maternity care within the first 10 weeks of pregnancy. Missing data was observed for approximately one in seven respondents (15.6%). A key theme among the majority (62.3%) of respondents who reported to not have received maternity care within the first 10 weeks of pregnancy, and who shared further explanation (n=61), was lack of contact and/or availability of appointments within this period. Other themes related to: uncertainty; travel; and personal preference. Those who did not receive maternity care within the first 10 weeks of pregnancy were more likely to be of a White ethnicity (36.5%) than from an ethnic minority group (27.2%; excluding White minorities).

Under one-third of respondents reported to either always (16.1%) or sometimes (11.9%) have the same midwives provide care during their pregnancy, and during labour and birth (Supplementary Figure 3). Those with a recorded disability were 1.6 times more likely to either always or sometimes receive the same midwives across their continuity of care pathway than those without. A greater proportion of respondents reported to have different midwives across the continuity of care pathway at St Thomas's Hospital (64.0%) compared to King's College Hospital (52.4%).



Did the same midwives who provided care during your pregnancy also provide care during your labour and birth

Supplementary Figure 3. Proportion of respondents by continuity of maternity care.

Healthcare Access

The majority of respondents (65.4%) stated that they did not avoid seeking care during pregnancy. However, respondents of ethnic minority groups (excluding White minorities) were 1.9 times more likely to avoid seeking care during their pregnancy compared to respondents of a White ethnicity (19.7% vs 10.5%).

Overall, 9.9% of respondents reported that they avoided seeking care due to worries about having a bad experience while 4.6% stated avoidance due to worries in relation to the need to pay for care. Data was missing for 17.9% of respondents.

Among respondents who shared further detail of their underlying reason related to potential avoidance of care (regardless of their prior answer; n=22), repeated themes included: perceived lack of patient-centred care and/or patient specific knowledge; feelings of disrespect and/or patronisation from healthcare staff; negative prior experiences with health care; poor treatment due to mental health and/or lack of consideration towards mental health; and heightened feelings of stress associated with care.

Healthcare Experience

The majority of respondents reported to have a positive or very positive experience of antenatal care (62.5%) and care during childbirth (63.4%), respectively. However, less than half of all respondents reported a positive or very positive experience of postnatal care (45.9%; Supplementary Table 2). Across the care pathway, proportions were similar between respondents of ethnic minority groups (excluding White minorities) and those of a White ethnicity (antenatal care: 60.1% vs 63.5%; during childbirth: 62.4% vs 64.0%; postnatal care: 45.1% vs 45.0%). Across all three periods, 5.6% of respondents reported to have a negative or very negative experience.

Supplementary Table 2. Experience of care among respondents across the care pathway.

Experience	Antenatal Care ^a	During Labour and Birth	Postnatal Care
Very negative	20 (4.0%)	35 (7.0%)	55 (10.9%)
Negative	68 (13.5%)	75 (14.9%)	81 (16.1%)
Neutral	100 (19.9%)	74 (14.7%)	136 (27.1%)
Positive	209 (41.6%)	184 (36.6%)	173 (34.4%)
Very Positive	105 (20.9%)	135 (26.8%)	58 (11.5%)
Total	503 (100%)	503 (100%)	503 (100%)

Footnote: Missing data is not reported for 1 (0.2%) of respondents.

Over one third (38.8%) of respondents (n=286) comments or feedback related to their experience of maternity care was categorised as detailing a negative experience; 17.8% of respondents detailed a positive experience, 30.8% a positive and negative experience, and 12.6% of respondents commented a neutral experience. Key themes included: lack of continuity of care; poor facilities and environment, including uncomfortable and crowded waiting areas; and overstretched, and often noticeable unsafe levels of staffing.

Overall, 73.8% of respondents reported to always, or sometimes receive help from their midwife or doctor when they needed it during their pregnancy. This decreased to 67.4% during labour and birth, and to 64.2% after their baby was born (Supplementary Table 3). A similar trend was observed when considering the proportion of respondents involved in decisions about their care, across the same pathway (Supplementary Table 4).

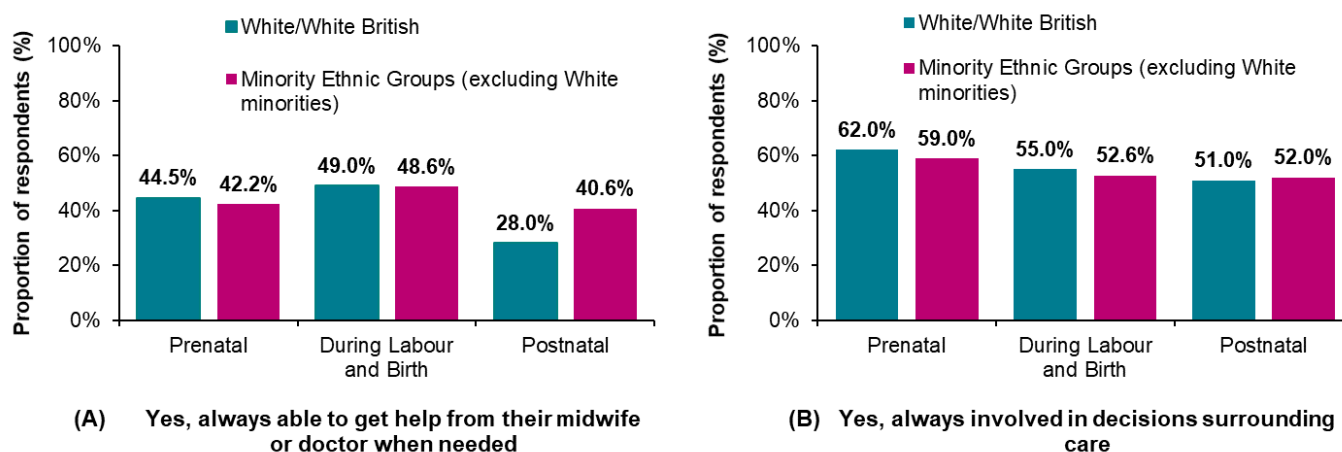
Supplementary Table 3. Proportion of respondents able to get help from their midwife or doctor when they needed it across the care pathway.

Experience	Antenatal	During Labour and Birth	Postnatal
No	31 (6.2%)	53 (10.5%)	68 (13.5%)
Yes, sometimes	163 (32.4%)	112 (22.3%)	163 (32.4%)
Yes, always	208 (41.4%)	227 (45.1%)	160 (31.8%)
Missing	101 (20.1%)	111 (22.1%)	112 (22.3%)
Total	503 (100%)	503 (100%)	503 (100%)

Supplementary Table 4. Proportion of respondents involved in decisions about their care across the care pathway.

Experience	Antenatal	During Labour and Birth	Postnatal
No	19 (3.8%)	43 (8.5%)	38 (7.6%)
Yes, sometimes	98 (19.5%)	100 (19.9%)	113 (22.5%)
Yes, always	278 (55.3%)	249 (49.5%)	240 (47.7%)
Missing	108 (21.5%)	111 (22.1%)	112 (22.2%)
Total	503 (100%)	503 (100%)	503 (100%)

For both indicators, proportions were generally similar at all three stages when considering those who received care at King's College Hospital and St Thomas's Hospital, respectively. During pregnancy, in addition to during labour and birth, respondents of ethnic minority groups were less likely to always get help from their midwife or doctor when needed, or always be involved in decisions surrounding their care compared to those a White ethnicity (Supplementary Figure 4).



Supplementary Figure 4. Proportion of respondents (A) always able to receive help from their midwife or doctor, or (B) always involved in decisions surrounding their care, by ethnicity.

Over two thirds of respondents felt sometimes (30.4%) or always (37.6%) listened to by their midwife; few (8.7%) felt they were not listened to. Proportions were generally comparable between ethnic groups. However, of those who felt listened to by their midwife, a small proportion (5.8%) felt that they were not treated with respect (all respondents: 7.6%). Respondents over the age of 35 were two times more likely to not be treated with respect compared to those aged 35 years and under (11.8% vs 5.9%).

Of respondents who either felt that they were not, or only sometimes treated with respect, and who shared further detail (n=65), prevalent themes included: feeling incompletely heard and understood; lack of patient-centred care; and dismissal of concerns, including those related to pain. Other themes included: lack of patient confidentiality; discriminatory and culturally insensitive behaviour; concerns surrounding level of care and professionalism (often among noticeably overworked staff); and concerns regarding medical procedures conducted and consent prior to the procedure.

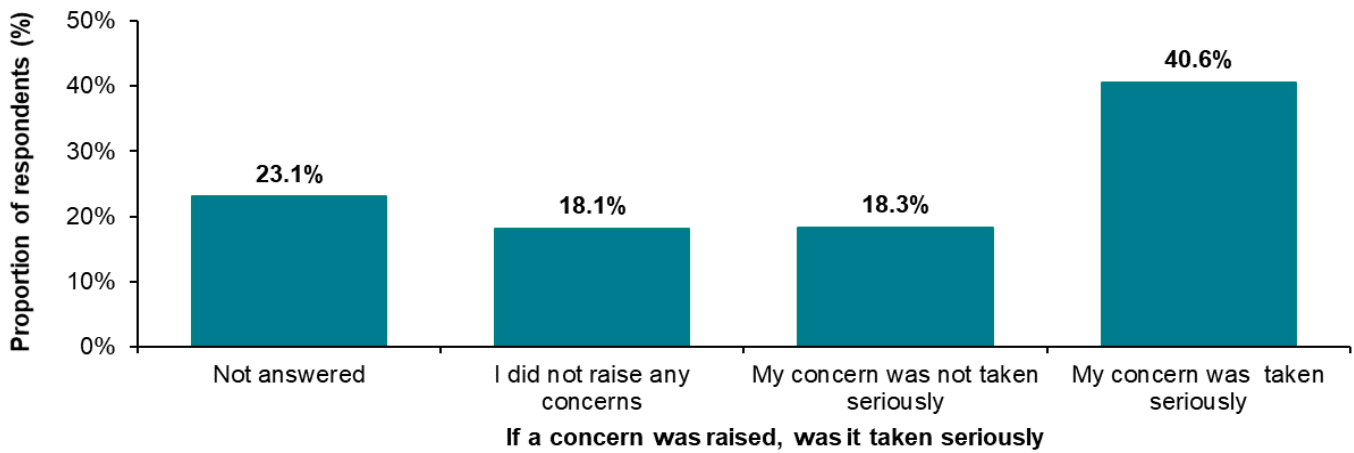
Nearly two thirds (64.0%) of respondents felt that they were able to ask all the questions they wanted to about their care (no: 14.3%; missing: 21.7%); proportions were lower among respondents of ethnic minority groups (66.5%; excluding White minorities) compared to those of a White ethnicity (71.7%). Among those with no ethnicity recorded, 50.0% reported that they were able to ask all the questions they wanted to about their care. Of those who felt like they were unable to ask all the questions they wanted to (n=48), key themes included: dismissal; lack of continuity between staff to build a repertoire of questions over time; and overstretched staff and/or lack of time to ask all questions. Other themes included: limited health literacy and knowledge; language barriers; and desire to not inconvenience others and/or themselves (often related to feelings of safety).

The majority of survey respondents (58.9%) raised a concern during their care; 18.1% did not raise any concerns while 23.1% of respondents did not answer this question (Supplementary Figure 5). Of those (n=296) who raised a concern, 68.9% reported that their concern was taken seriously (yes; 40.6% of all respondents [N=503]) while 31.1% reported that their concern was not taken seriously (no; 18.3% of all respondents). Among those who raised a concern, a higher proportion of respondents of an ethnic minority group (75.2%; excluding White minorities) felt their concern was taken seriously compared to respondents of a White ethnicity (61.7%).

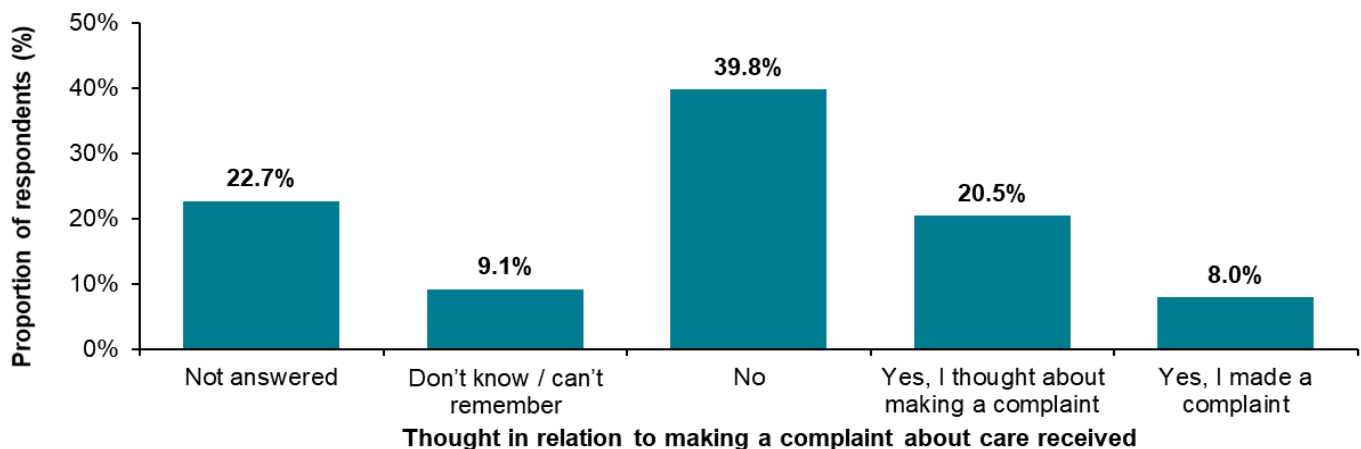
Less than one third of respondents (28.5%) either thought about making a complaint or made a complaint (Supplementary Figure 6). Respondents of a White ethnicity were 1.3 times more likely to either think about, or make a complaint compared to those of an ethnic minority group (37.0% vs 28.9% of respondents, respectively). The proportion of respondents who either thought about, or made a complaint were similar between the two most frequented providers of maternity care (St Thomas's Hospital: 28.5%; King's College Hospital: 31.0%).

Over one third (36.2%) of respondents who made a complaint, or thought about making a complaint, and who provided further detail (n=105), mentioned clinical care and/or the behaviour of

staff, respectively while 14.3% mentioned long wait times and/or uncertainty surrounding appointments.



Supplementary Figure 5. Proportion of respondents by if concern raised (if raised) was deemed to be taken seriously.



Supplementary Figure 6. Proportion of respondents by thoughts in relation to making a complaint about the care they received during their care journey.

Among respondents (n=85) who shared further comments regarding their experience of receiving the maternity care they needed, the largest single proportion (17.6%) related to either a desire for, or lack of, continuity of care and/or patient-centred care. Other themes included: gratitude; inability to easily contact maternity services and/or user-friendly technological infrastructure; and requests for support (such as mental health support, nutritional advice and new born care). These themes were mirrored among those (n=128) sharing their experiences of using local maternity services.

Maternal Outcomes and Support

A total of 81 survey respondents (approximately 1 in 6; 16.1%) reported experiencing pregnancy loss before 24 weeks' gestation. This is lower than national figures, where pregnancy loss through miscarriage is estimated to be experienced by 1 in 5 women.

Supplementary Table 5. Number and proportion of respondents reporting pregnancy loss before 24-weeks

Pregnancy loss before 24-weeks	Number	%
Yes	81	16.1%
No	287	57.1%
Blank or prefer not to say	135	26.8%
Total	503	100.0%

Of those respondents who reported early pregnancy loss, only one-quarter (24.7%) were offered bereavement support; proportions were similar among respondents of a White ethnicity (25.0%) compared to those of ethnic minority groups (23.3%). Only 1 in 4 (28.4%) of all respondents reporting early pregnancy loss had their subsequent antenatal appointments cancelled; levels were higher among respondents of ethnic minority groups (36.7%) compared to respondents of a White ethnicity (25.0%).

Among respondents sharing further information about early pregnancy loss, common themes were lack of support, distress, lack of counselling, inappropriate or uncaring (sometimes cruel) behaviour from health staff, and subsequent antenatal appointments not being cancelled. Several responders also raised issues around lack of partner support and lack of appropriate clinical treatment. A small number of respondents shared experiences of good, caring support.

Twelve respondents (2.4%) reported pregnancy loss after 24 weeks' gestation; nearly half (45.1%) of respondents did not answer or preferred not to say. Of respondents who reported pregnancy loss after 24 weeks' gestation, 64.6% reported their rights to maternity leave, parental bereavement leave, and maternity allowance were clearly explained to them; 66.7% were told where they could get support; 41.7% reported that the hospital had a service to acknowledge their loss; and 33.3% reported that after a review of the care they and their baby received, they received the answers they needed (33.3% reported that following review, they did not while 16.6% reported either their wasn't a review or they weren't informed of a review). Given the majority of respondents (66.7%) did not provide further detail of their experience related to provision of support, and the relatively low proportion of respondents who reported pregnancy loss after 24 weeks' gestation, to maintain respondents anonymity, thematic analysis and demographic data is not reported.

Nearly 1 in 6 (16.5%; 83) respondents reported their baby was born before the due date; levels were similar for respondents of ethnic minority groups (22.0%) and those of a White ethnicity (18.0%). Of all respondents reporting a premature delivery, 1 in 8 (12.0%; 10) had a delivery before 32 weeks of pregnancy (i.e. extremely or very premature delivery). Over half (51.8%) of respondents who reported their baby was born before their due date felt supported by the care received for their premature baby (no: 16.9%; missing: 31.3%). Repeated themes among respondents with a baby born before their due date, who felt that they did not receive support included: lack of support in relation to breastfeeding; perceived lack of support and/or check-ups due to seemingly healthy (but premature) baby; and lack of consideration to the physical and/or mental wellbeing of the mother.

Labour or birth complications were reported by nearly 1 in 4 (24.1%; 121) respondents. Nearly half (46.1%) of respondents did not reply or preferred not to say. A similar proportion of respondents reported labour or birth complications between those of an ethnic minority group (28.9%; excluding White minorities) and those of a White ethnicity (29.5%). When respondents shared deeper information about their labour and birth complications, the most common themes were: substantial/severe blood loss; foetal cardiac distress; emergency C-section; obstructed delivery; need for assisted delivery; slow or failed progress of labour; and inadequate healthcare. Several respondents also reported problems around: substantial perineal tearing; newborn respiratory distress, meconium, uterine infection, and maternal hypertension/pre-eclampsia.

When recovering from birth, only half (49.9%) of respondents felt supported (not supported: 27.8%; missing: 22.2%). Among those who did not feel supported while recovering, and who provided further detail (n=95), 49.5% stated reasoning of either poor, or lack of follow-up care and/or a perception of premature postnatal discharge. Other repeated themes consisted of: limited support in relation to breastfeeding and/or bonding; limited communication related to wound care and/or infection risk; and a perception of chaotic and understaffed postnatal wards, thought to inhibit recovery.

Among respondents who shared further detail about their experience following maternity care (n=117), no new themes were observed. However, the most common repeated theme, observed in 23.1% of comments, related to satisfaction with the service received.

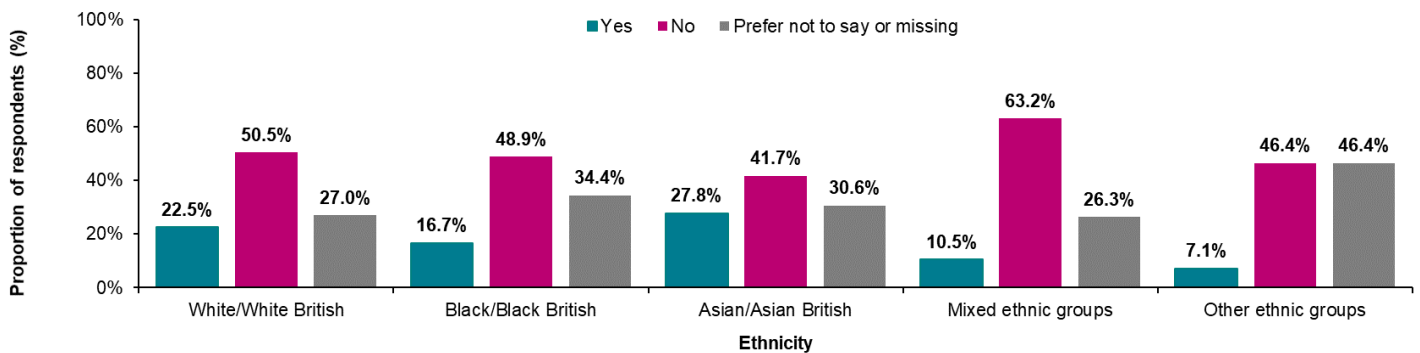
Mental Health

Over one in six respondents (17.3%) reported poor mental health during their pregnancy while one in four respondents (24.5%) reported poor mental health after their baby was born (Supplementary Table 6). Of those who reported poor mental health during pregnancy, the majority (58.6%) experienced poor postnatal mental health.

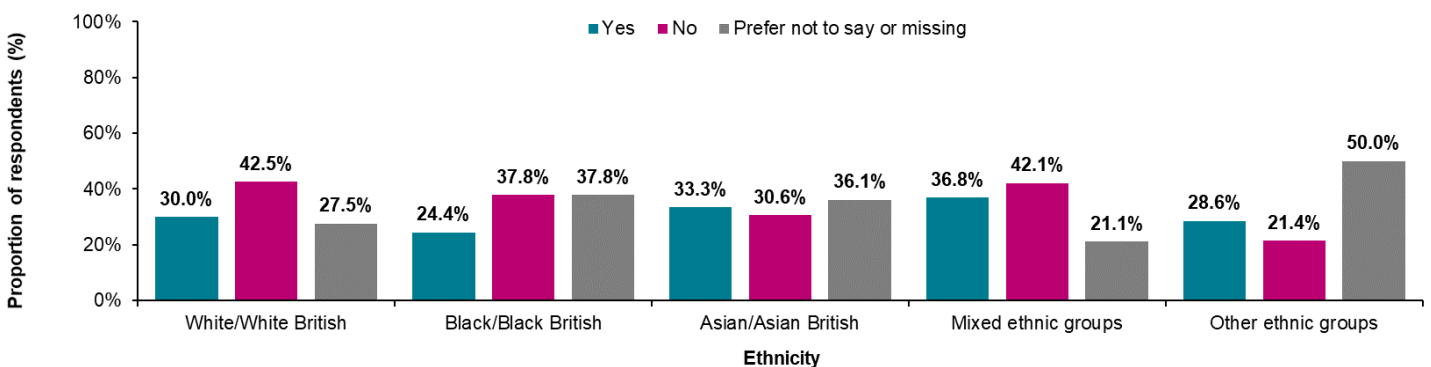
Supplementary Table 6. Proportion of respondents experiencing poor mental health, during their pregnancy, and after their baby was born, respectively.

Experience poor mental health	During their pregnancy, n (%)	After their baby was born, n (%)
Yes, n (%)	87 (17.3%)	123 (24.5%)
No, n (%)	211 (41.9%)	164 (32.6%)
Prefer not to say or missing	205 (40.8%)	216 (42.9%)
Total	503 (100%)	503 (100%)

A higher proportion of respondents of an Asian ethnicity (27.8%; Supplementary Figure 7) and of a mixed ethnicity (36.8%; Supplementary Figure 8) reported poor prenatal and postnatal mental health, respectively, compared to any other ethnic group. However, across all ethnic groups, a higher proportion of respondents reported poor postnatal mental health compared to during their pregnancy (percentage point change range: 5.6–26.3).



Supplementary Figure 7. Proportion of respondents experiencing poor prenatal mental health by ethnicity.



Supplementary Figure 8. Proportion of respondents experiencing poor postnatal mental health by ethnicity.

When considering completeness of data, across both periods, a higher proportion of missing data was generally observed among respondents of ethnic minority groups (excluding White minorities) compared to respondents of a White ethnicity; whether the proportion of respondents of ethnic minority groups reporting poor pre- and postnatal mental health, respectively, is underreported should be considered.

Overall, of respondents who experienced poor prenatal mental health, and who shared further experiences (n=47), key themes were: anxiety, including fear of complications and/or miscarriage; depression; and trauma associated with a prior pregnancy/birth (and often, associated pre-existing mental health conditions). Other themes included: poor familial relations; the impact of morning sickness, fatigue and/or pre-existing long-term conditions on mental health; and the development of psychotic like symptoms.

Of respondents who experienced poor postnatal mental health, and who shared further experiences (n=79), key themes were: depression, including low mood and/or feelings of despair; heightened levels of anxiety; and trauma associated with labour and/or (often lack of) follow-up care. Other frequently repeated themes included: postpartum sleep deprivation and fatigue; perceived lack of social and/or clinical support; and issues associated with the establishment of breastfeeding and/or bonding.

Mental Health Support

Over one third of respondents felt like they were given enough support for their mental health during their pregnancy, and after their baby was born, respectively (Supplementary Table 3). However, compared to during pregnancy, a higher proportion of respondents felt like they were not given enough support after their baby was born. This likely reflects the decrease in the proportion of respondents reporting that they did not want support across these two stages. The proportion of respondents reporting that they were not given enough support for their mental health were similar between those of an ethnic minority group (excluding White minorities) and those of a White ethnicity (antenatal: 19.6% vs 19.0%; postnatal: 28.3% vs 26.0%).

Supplementary Table 7. Proportion of respondents given enough support for their mental health, during their pregnancy, and after their baby was born, respectively.

Mental Health Support	During their pregnancy, n (%)	After their baby was born, n (%)
Yes	196 (39.0%)	182 (36.2%)
No	90 (17.9%)	122 (24.3%)
I did not want support	114 (22.7%)	92 (18.3%)
Missing	103 (21.0%)	107 (22.2%)
Total	503 (100%)	503 (100%)

Supporting Informed Decision-Making

Overall, three-quarters (68.6%) of respondents knew how to contact their local maternity service for help; proportions were similar among respondents of ethnic minority groups (73.4%; excluding

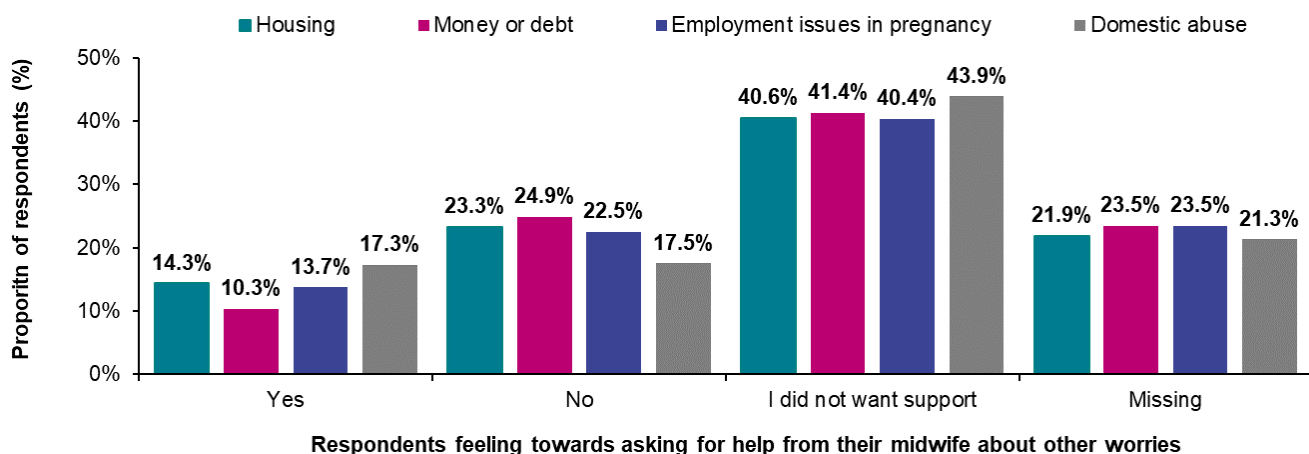
White minorities) compared to those of a White ethnicity (73.5%), but lower among respondents aged 35 years old and over (68.6%) compared to those aged 34 years old and under (77.6%). Respondents with a disability were more likely to know how to contact their local maternity service compared to those without (87.5% vs 75.2%).

The majority of respondents either always (55.5%) or sometimes (22.9%) understood the information given to them by their doctor or midwife. However, respondents of ethnic minority groups were more likely to only sometimes understand the information provided to them (31.8%; always: 55.0% compared to those of a White ethnicity (20.0%; always: 63.5%).

Of respondents who did not, or only sometimes understand the information provided, and who shared further explanation, 35.5% related this to rushed or cancelled appointments, availability of staff, and/or difficulties navigating the maternity system. One quarter (25.8%) of respondents related this to conflicting information while approximately one sixth (16.1%) of respondents related this to lack of staff knowledge and/or unbalanced communication of information; 9.7% of respondents stated they conducted their own research, either to validate (often fragmented) information provided or account for information not provided.

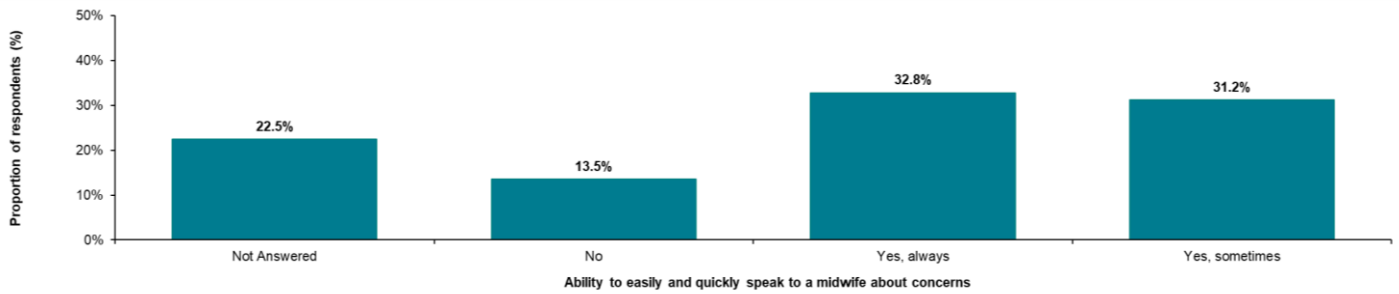
Over one-tenth (12.9%) of respondents would have preferred to receive information in another language, with Spanish and Chinese most frequently listed, respectively.

Overall, a greater proportion of respondents felt unable to ask for help from their midwife about worries relating to housing, money or debt, employment issues in pregnancy, and domestic abuse, respectively, compared to those who felt able to ask (Supplementary Figure 9). Across all four categories, a greater proportion of respondents of a White ethnicity reported to not want support compared to those of an ethnic minority group (housing: 56.5% vs 34.7%; money or debt: 56.5% vs 32.2%; employment issues: 55.5% vs 30.1%; domestic abuse: 59.0% vs 36.1%).



Supplementary Figure 9. Respondents feeling towards asking for help from their midwife about worries related to housing, money or debt, employment issues in pregnancy, and domestic abuse.

Nearly two-thirds (64.0%) of respondents felt either always or sometimes able to speak to a midwife about concerns easily and quickly (Supplementary Figure 10). Of those who felt unable to easily and quickly discuss their concerns, and who provided additional explanation (n=41), 68.3% stated this was related to the availability of midwives and/or other members of staff.



Supplementary Figure 10. Proportion of respondents who found it easy and quick to speak to a midwife about their concerns.

The Motherhood Group: Southwark Maternity Commission Engagement Report

INSIGHTS FROM BLACK AND ETHNICALLY DIVERSE
MOTHERS, PREGNANT WOMEN AND HEALTHCARE
PRACTITIONERS



Contents

Contents	120
Executive Summary	124
Introduction	126
Methodology	129
Ethnic Identification	132
TMG-Led Recruitment	133
Cross-Partnership Projects	133
Interviews	134
Focus Groups	135
<i>Latin American Community</i>	136
<i>Healthcare Professionals</i>	137
Workshop	139
<i>Disability and Neurodiversity</i>	140
Questionnaire	140
Intersectionality	141
Limitations	143
Strengths	143
Terminology	144
' <i>Healthcare Professionals</i> '	144
'Black and Mixed-Black'	144
'South Asian'	144
'Gypsy, Irish Traveller and Roma'	145
'Latin American'	145
Results	146
Black and Mixed-Black Participants	146
Treatment by NHS Midwives and Nurses in Pregnancy and Childbirth	147
Case Study: Advocacy and a Positive Birth Experience	147
Case Study: 'Knowing the NHS'	148
Case Study: Being 'Told' What to Do	150
Case Study: A 'Young' Mother	151
Treatment by Healthcare Professionals and Community Midwives After Childbirth	152

Support	153
Case Study: The Significance of Signposting	153
Case Study: Understanding Conditions	155
South Asian Participants	156
Treatment by NHS Midwives and Nurses in Pregnancy and Childbirth	156
Treatment by Healthcare Professionals and Community Midwives After Childbirth	157
Support	158
Gypsy, Irish Traveller and Roma Participants	159
Latin American Participants	160
Language and Communication	160
Treatment by NHS Midwives or Nurses During Pregnancy and Childbirth	164
Treatment by Healthcare Professionals and Community Midwives after Childbirth	164
Support	166
Healthcare Professionals	168
Time and Communication	168
Relationships with Services Outside of the NHS	170
Stigma	175
Creating Inclusive Healthcare Environments	176
Disability and Neurodiversity	183
Discussion	186
Advocacy and Agency	186
Service Users	186
Healthcare Professionals	188
Racism and Racialised Stereotyping	188
Service Users	188
Healthcare Professionals	189
Listening	189
Service Users	189
Healthcare Professionals	190
Stigma	191
Service Users	191
Healthcare Professionals	192
Strengthening Relationships with Other Services	193



Service Users	193
Healthcare Professionals	193
Continuity of Care	194
Service Users	194
Healthcare Professionals	194
Cultural Competence and Sensitivity	195
Service Users	195
Healthcare Professionals	196
Intimate Network Involvement and Support	196
Service Users	196
Supporting Equity and Justice	197
Recommendations	198
Appendix	200
Appendix 1: STAG Reponses Table	200
Appendix 2	201
Appendix 3	203

THU 06/06/24 11:45AM - 1PM

Maternity Care Professionals Virtual Lunch & Share

Calling all healthcare professionals who work at King's Hospital, Guy's and St Thomas' Hospital, Maudsley Hospital, or are residents in Southwark!

Join us for a virtual Lunch and Share workshop to discuss your experiences in providing maternity care and engaging with Black, Asian, and ethnic minority groups in Southwark. Your insights will help improve outcomes for mothers in our community.

By attending you can:

Share your experiences Provide input Contribute to improve Network

Register via Eventbrite
Don't miss this opportunity to make a difference in Southwark's Maternity Care






Virtual Lunch & Share Workshop for HCP

The Motherhood Group and Southwark Maternity Commission have partnered to make a difference in the lives of Black, Asian, and ethnic minority mothers in our community. We invite you to join our virtual Maternity Care Professionals Lunch and Learn Workshop on 6th June 2024 from 11:45am - 1pm. During this workshop, you'll have the opportunity to:

- Share your experiences, challenges, and successes in delivering maternity care 🗣️
- Provide valuable input on how to better engage with and support Black, Asian, and ethnic minority mothers 💡
- Contribute to the development of recommendations for improving maternity services in Southwark 🌍

203

Appendix 4

206

Citations and Resources

208

Executive Summary

This report details findings from Black and Mixed-Black, Latin American, South Asian, Gypsy, Irish Traveller and Roma communities, and healthcare professionals in Southwark as part of the Southwark Maternity Commission. Approximately sixty-seven participants engaged in the work, twenty from Black or Mixed-Black backgrounds, thirteen from Latin American, ten from Gypsy, Irish Traveller and Roma, and less than five from South Asian backgrounds. The remaining nineteen were healthcare professionals. A qualitative approach was utilised to investigate maternal experiences during pregnancy, childbirth and in the postpartum period, centring the quality of care received, communication and understanding between service users and providers, and the support networks women used during this time. The report finds eight key thematic areas emerging across the groups, informing the recommendations. These are: Advocacy and Agency; Racism and Racialised Stereotyping; Listening; Stigma; Strengthening Relationships with Other Services; Continuity of Care; Cultural Competence and Sensitivity; and Intimate Network Involvement and Support. As such, this report makes the following recommendations:

1. Strengthen community support

- a. Provide tailored group care in the antenatal and postnatal period
- b. Chart existing organisations already providing support and advice for women from diverse ethnic backgrounds in the borough
- c. Ensure funding and space for social gatherings to promote advocacy and knowledge exchange between mothers, healthcare professionals and wider support networks (including friends and family)
- d. Devise stigma reduction strategies with community groups and organisations representing marginalised populations in Southwark

2. Ensure availability of interpretation and translation services

3. Strengthen the capacity for healthcare professionals to advocate for service users

- a. Strengthen healthcare professionals' capacity to communicate and advocate across other Southwark Council services, including housing, Universal Credit or financial services, and child support
 - b. Ensure healthcare professionals have time to provide personalised care to service users, particularly those speak English as an additional language
 - c. Ensure continuity of care is available to those who need or request it, particularly those who speak English as an additional language
 - d. Implement mandatory anti-racism and cultural competency or sensitivity training for maternity staff across a range of departments (i.e perinatal mental health, obstetrics, midwifery, home visitation)
 - e. Provide tailored training on kindness, empathy and respect learning from the accounts of those in the community emphasising tone, language and questioning
 - f. Ensure information is provided sensitively and accurately to all service users, particularly when using remote communication devices such as telephones
- 4. Ensure robust breastfeeding support for all service users after birth**
- 5. Ensure robust mental health support at all stages of maternity care**
- a. Make sure signposting to services both in and outside of the NHS is clear and available

Introduction

The Motherhood Group (TMG) was tasked as part of the Southwark Maternity Commission with conducting qualitative research and writing a report outlining responses from a sample of Southwark's ethnically diverse population. The primary methods included focus groups and interviews, as well as a workshop and questionnaire, using cross-partnership projects with tailored community organisations to ensure representativeness.



Image of participants at the workshop.

This report focuses on the experiences and insights gleaned from Black, Mixed-Black, Latin American, Gypsy, Irish Traveller and Roma and South Asian women, as well as healthcare professionals living and working in Southwark. The methodology section details how interviews, a workshop, focus group, and a questionnaire were used, and the autonomy and independence given to other organisations better positioned to reach certain groups to support the project. The results section is split by group and topic area, offering a nuanced look at the qualitative accounts

received. This section makes use of direct quotations from those spoken to, summarising the intersectional features emergent through their biographical data and narrative accounts. The results are presented this way to reflect the specificity of the accounts and give logic to the discussion. As a growing body of critique has indicated, those from a variety of minority ethnic backgrounds have differing challenges, positive experiences and concerns when it comes to engaging with any service, including maternal health. Whilst the discussion section brings the diverse perspectives together in order to tailor recommendations, TMG wanted to preserve the particularity of each experience.

Approximately¹ forty-four service users and nineteen healthcare professionals were engaged across the groups and methods, totalling approximately sixty-seven individuals. Sometimes, the concerns raised draw in themes much wider than 'maternity care' in hospitals or clinics. For example, healthcare professionals raised concerns about housing services in the borough, and expressed frustration at not being able to help service users promote their general health through supporting their wider living arrangements. People had difficulties with housing, social services, employment, finance, mental health, disability and child support that they tethered to their responses. TMG felt it was important to capture the scope of these entanglements to ensure an awareness of what people bring to healthcare settings, and what they take out.

All images presented in this report were taken with the consent and knowledge of participants at the workshop. They are not named anywhere in the report.

¹ The approximation refers to the totalling of South Asian participants to five to protect the anonymity of this smaller sample.



TMG would like to thank all of the participants who engaged in this process from a range of communities, including healthcare professionals, in Southwark, as well as the organisations who provided vital assistance in recruitment and listening to their stories.

Methodology

The Motherhood Group conducted a workshop, focus-groups, interviews and a questionnaire. A qualitative approach was applied to ensure participants felt they were listened to and capture nuance and specificity in response across each demographic.

The table below outlines who was involved in each method by demographic, and the number of Southwark participants who attended the workshop and focus groups, were interviewed or completed the questionnaire. We spoke with approximately forty-four service users and nineteen healthcare professionals. The total number of people engaged was approximately sixty-seven².

Method	Black or Mixed-Black	Latin American	Gypsy, Irish Traveller and Roma	South Asian	Healthcare Professionals
Workshop	17	-	-	-	-
Focus Group	-	13	-	-	19
Interview	3	-	-	-	-
Questionnaire	-	-	10 ³	<5	-

TMG engaged in cross-partnerships projects with organisations more strongly connected to specific ethnic groups, including Gypsy, Irish Traveller or Roma communities, Latin American and South Asian communities in the borough.

² The South Asian group is rounded to five to protect anonymity of the sample.

³ Engagement from South Asian and Gypsy, Irish Traveller and Roma groups was facilitated by Southwark Travellers' Action Group (STAG) and The Rahman Group respectively. The Rahman Group directed their Southwark network to complete the questionnaire held by TMG. STAG composed of their own questionnaire, included in Appendix 1.



All mothers TMG engaged with were compensated for their time and contributions through vouchers and gift-bags. Those who attended the workshop were also given food or soft drinks during the day.

Each methodological approach centred the following set questions:

1. Have you ever lived or worked in Southwark?
2. Have you given birth at any of the following hospitals?
 - a. King's College Hospital
 - b. Guy's and St Thomas' Hospital
 - c. South London and Maudsley
3. Reasons for choosing the specific hospital
 - a. Overall experience at the hospital
 - b. Comparison between different hospitals (if applicable)
4. How were you treated by NHS midwives and nurses during pregnancy and childbirth?
 - a. Quality of care received
 - b. Communication and empathy from healthcare professionals
 - c. Cultural sensitivity and understanding
5. 4. How were you treated by healthcare professionals and community midwives after the birth of your child?
 - a. Continuity of care post-birth
 - b. Support for mental health and well-being
 - c. Accessibility and responsiveness of healthcare professionals
6. Did you feel you could ask for help during and after pregnancy and childbirth?
 - a. Where did you seek support?
 - b. Comfort level in seeking assistance



- c. Availability of support networks (family, friends, professionals)
 - d. Barriers to accessing support
7. Was there any support you felt you needed but did not receive?
- a. Identification of gaps in support services
 - b. Impact of unmet needs on the mother's well-being
 - c. Suggestions for improving support systems
8. Were there any unexpected forms of support during pregnancy, childbirth, and early motherhood?
- a. Positive surprises or experiences
 - b. Innovative or non-traditional support methods
 - c. Community-based initiatives or resources
9. Do you give consent for this information to be used, anonymously and confidentially, as part of The Motherhood Group's work on the Southwark Maternity Commission?
- a. Yes/No
10. Would you be willing to share your experience with the Southwark Maternity Commission in person (anonymously and confidentially)?⁴
- a. Yes/No

Sensitivity and discretion were central in shaping if and how the questions were asked. Through TMG coordinated events, we ensured distress protocols, including signposting to relevant organisations and the ability to withdraw consent or leave the engagement were communicated verbally to participants. Those who completed the questionnaire gave their consent via question nine, and participants at the Workshop were asked if they consented via the registration form. We

⁴ This question was included to give an opportunity for those who only used the questionnaire to be contacted for an interview. The anonymity and confidentiality refers to the presentation and storage of the data following participation.



partnered with several organisations to signpost following participation including Melanin Mothers, Tommy's, Mums Aid and those who collaborated in Cross-Partnership Projects.

Ethnic Identification

In the questionnaire and in interviews participants were asked to self describe their ethnicity. Participants were also asked about their ethnicity when registering for the workshop. A free text box was available for participants to write down their ethnicity. In interviews, participants were asked: "how would you describe your ethnic background?".

TMG did not use a drop-down or option format to allow participants to self-describe as they wished. This was aggregated according to broader identifications, drawing from the Census data, to bring together broader groups such as 'Black' or 'South Asian'.

In the interviews and at the workshop, Black participants described themselves as 'Black African', 'Mixed Black', 'Mixed race', 'Black Caribbean', 'African', 'AfroCaribbean', and 'Black British'. These identifications have aggregated under the 'Black and Mixed-Black' category.

The South Asian group also used a variety of terms to describe their ethnicity or ethnic background, some making national affiliations, not mentioned here to protect their anonymity.

TMG is aware that Southwark aggregates the data for Gypsy, Irish Traveller or Roma groups in their council reporting, and that STAG, who were given autonomy in their work, works with all three groups. The Latin American group was recruited in collaboration with LAWRS and LOVO, and data is held by them as to the variety of identifications made by those present.



TMG acknowledges the diversity of identification can be masked or obscured when grouped together. TMG also acknowledges the growing critique of compiling all information about 'Black and Minority Ethnic' (BAME) groups together. In this report, TMG has endeavoured to draw out the specificity of experience in each case.

TMG-Led Recruitment

TMG used a variety of methods to recruit participants into TMG-led sessions, and to work with partnered organisations to consider the possibility of carrying out more diverse focus groups – 'women-only' (Appendix 2) – with mothers. TMG and the partner organisations agreed, however, that the sessions should be kept separate to ensure the spaces were safe and people could feel open to share and to avoid the assumption experiences across groups would be shared.

For TMG-led engagements, including with Black and Mixed-Black groups, healthcare professionals and the Latin American focus group, recruitment was carried out through emails, social media, in-person events (such as the Black Mums' Fest) and flyers. Some examples are included in Appendix 3.

Cross-Partnership Projects

TMG's strengths lie in engagement with women of Black and Mixed-Black heritage or identification, but strong ties exist with other organisations. To reach Gypsy, Irish Traveller and Roma, South Asian and Latin American women, TMG partnered with a number of specialised organisations, some recommended by the Southwark team. These included: Southwark Travellers' Action Group (STAG), Ladies of Virtue Outreach CIC (LOVO) (Latin American), Latin American Women's Rights Service (LAWRS) and Rahman Group (South Asian participants).

Except with LAWRS and LOVO, the aforementioned organisations were given independence in the method of engagement, though all were encouraged to refer participants to the questionnaire. As such, the information gathered from each group varies in degrees of depth and extrapolation. With STAG, we received a spreadsheet including responses from ten women, overall perceptions of care received and short statements of extrapolation, outlined in Gypsy, Irish Traveller and Roma Participants results.

LAWRS and LOVO supported recruitment and translation for the focus group with Latin American participants. As such, the quotations provided in this result section sometimes refer to the participant in the third person, reflecting the interpretation received. Participants in the group were keen to share their stories and were grateful for the safe space, particularly due to linguistic congruence of the participants. It indicated some crossover between the themes commonly identified in the experiences of Black and Mixed-Black women identified by TMG, including the feeling of not being listened to or overlooked, and the importance of culturally resonant research teams.

The Rahman Group shared the questionnaire with their networks, encouraging those who lived or had given birth in Southwark to participate. In the first round of circulation, only two participants responded. TMG followed-up with the Rahman group for further engagement, incentivised with shopping vouchers for those who give dedicated and detailed responses.

Interviews

Interviews with Black and Mixed-Black women were conducted by a research assistant at the Black Maternal Health Conference. Some of those interviewed in their capacity as mothers were



also healthcare professionals. At times, this informs their experience and description of their care, however, they are featured here as mothers, rather than healthcare professionals, as this identity is what structured the interviews.

The researcher took detailed, typed notes during the interviews, using the questions above as a guide. The interviewee was able to see the researcher typing their responses, which in most cases prompted openness, as interviewees extended their descriptions of events or experiences for the interviewer to write down. The interview data was then compiled into a spreadsheet with the questionnaire data to facilitate the analysis.

Participants were informed verbally before the interview that any data would be made anonymous and kept confidential. They were then asked for their consent. Consent was recorded with each interview file by the researcher. Participants were told they could withdraw consent at any time through reaching out to The Motherhood Group via email or through social media.

Three in-depth interviews were carried out with Southwark residents. The interviews demonstrated the need to pay close attention to the individual behind the story, statistics and trends. Each case was unique and every participant wanted to talk and be listened to.

Focus Groups

Two focus groups were conducted online, one with women from the Latin American Community in Southwark, and the other with Healthcare Professionals and Practitioners working at Southwark hospitals including: King's College, Guy's and St Thomas', or South London and Maudsley.



Latin American Community

The focus group with the Latin American community was attended by two facilitators and a research assistant at TMG. A Spanish-speaking interpreter was present to ensure all questions, answers and messages in the Zoom chat function were translated and accessible for those in attendance. The questions were spoken by the facilitators in English before being translated by the interpreter. Some participants were English speakers. We collaborated with Latin American Women's Rights Service (LAWRS) for recruitment and translation.

The focus group was recorded and transcribed. The research assistant listened back in line with the transcript to ensure the accuracy of the quotations. Because in most cases the interpreter was translating the responses from participants, the quotations presented in the Results section note the interpretation, and sometimes refer to 'her' or 'she', rather than 'I' or 'me', because of the interpreter's style.

Thirteen participants attended the online focus group and held a range of experiences and backgrounds clustered around the Latin American identity. For example, some of the participants did not speak any English, others had a good grasp of the language. This proved to be important in participants' reflections of the care they received at several Southwark hospitals. The youngest child born a participant in this group was two months and the oldest was five years. This provided a good range of responses over time and many of the participants' memories were vividly recalled.

As a translator was being employed during the session, the focus group unfolded through a series of stories or accounts narrativized by one participant at a time. As explored in the Results section, recollections were often highly emotively charged and the women in the group provided support to one another as it unfolded, affirming through shared experiences, active listening and



responses through Zoom's various functions (reactions including applause or heart shapes and messages of solidarity in Spanish). The focus group lasted an hour and a half.

Healthcare Professionals

The focus group with healthcare professionals was attended by two facilitators and a researcher from TMG. The focus group was attended by a range of practitioners and professionals, including: bereavement nurses, perinatal mental health practitioners, midwives, nurses, therapists, obstetricians and community facing practitioners. The healthcare professionals consented to being identified by their profession in the report where relevant to ensure specificity of perspective. A list of the job titles or professions supplied by healthcare professionals when registering for the focus group can be found in Appendix 4.

A total of nineteen practitioners attended in total, each providing accounts in response to their professional position and understanding of effective care practices in Southwark and beyond, allowing tailored recommendations to be extracted from the accounts. The session had been scheduled to last an hour and fifteen minutes but was extended to an hour and a half because of the lively nature of the discussion. The session was recorded and transcribed. Some participants joined the online call in groups of two or three, sitting together to listen and engage in the focus group. The quotations presented in the Results section are directly drawn from the transcript and were double-checked through the audio file by the research assistant.

At the end of the focus group participants were asked to reflect on their experience. Many noted it had a positive effect to hear what others were doing from different roles and positions in hospitals and in the community.

The questions outlined above had to be altered for this focus group because of the positionalities of participants. Broadly, discussion centred the following questions, with participants encouraged to raise their thoughts on related topics and learning from within or outside of their place of practice. Questions were informed by what TMG had already gathered through interviews, the workshop, questionnaire responses and the focus group.

1. What barriers have you identified when providing maternity care with Black and ethnic minority service users?
 - a. What barriers do you face in providing care?
 - b. What barriers to Black and ethnic minority service users face when accessing maternity care?
2. How can we create inclusive and culturally resonant healthcare environments for diverse users?
 - a. How might we foster and maintain trust?
3. How can we build effective community partnerships?
4. What are your recommendations or thoughts on ways to improve maternity care for Black and minority ethnic groups in Southwark?

The focus group with healthcare professionals was attended by a diverse group of people occupying a range of ethnic identities. Two of the nineteen participants were men.

The table below outlines the aggregated ethnic identifications of participants drawn from their descriptions during the focus group and information provided during registration. The term 'British Asian' is used to reflect how some of these practitioners described their ethnicity:

Ethnic Identification	Black or Mixed-Black	South Asian or British Asian	White or White British
Number of Participants	10	<5	6

Workshop

The workshop was conducted at the Black Mums Fest at an in-person event held at a Black-owned venue in Peckham, South London. Of those who attended, seventeen lived in Southwark. Attendants were asked to give their postcodes and the hospital at which they sought care at their discretion when registering for the event. Those in attendance were sometimes accompanied by children, family or friends. Like in the interviews, some of the participants in the workshop were both mothers and healthcare professionals. Though they may make reference to the intersection of these identities, they are considered here primarily in their capacity as mothers. A free meal was provided to those who came.

Participants spoke about their experiences to the group at large or in smaller break out sessions. Several activities were organised to ensure they felt supported through the day given the sensitive nature of the conversations taking place. For example, Rochelle Love, midwife and founder of Melanin Mothers, an organisation supporting Black and mixed-ethnicity women in their pregnancy, ran a session encouraging participants to write supportive letters to other Black and Mixed-Black women, encompassing what they had learnt and shared on the day. Rochelle Love is a Tommy's charity midwife, supporting women with experiences of miscarriage or baby loss. She has experience supporting mothers in pregnancy and beyond, particularly those who have



struggled with traumatic experiences. Rochelle's present enabled participants to feel comfortable sharing as they were actively encouraged to speak to her about any of their concerns throughout the day.

The workshop could not be recorded due to the noise levels, participants were encouraged to bring children if they could not find childcare and the size of the room would have caused echoes. Instead, a researcher typed detailed notes whilst participants spoke, and another assistant was at hand to get involved in break out discussions.

Disability and Neurodiversity

One participant in the workshop lived with a physical disability. She was vague in her description of the disability, but alluded how the disability played a role in her care in hospital. Another participant in the workshop raised concerns about her child's educational support after he was diagnosed with severe learning difficulties in the early years. In the Latin American focus group, a mother spoke about hearing of a potential Down's Syndrome diagnosis over the telephone, which turned out to be false. She extrapolated on her son's autism. These cases are presented in the results section. TMG has included the mothers' concerns over their children's disabilities or neurodiversities to demonstrate the impact this can have on the overall maternal experience.

Questionnaire

A questionnaire was designed for use at the Workshop and at the Black Maternal Health Conference. The questions asked in the questionnaire were synonymous with those asked during interviews.

The questionnaire also acted as a format open for those TMG partnered with to share with networks. The South Asian respondents used this questionnaire, shared with them via the

Rahman Group. Participants could type as much or as little about their experience as they desired into a free text box. The questionnaire asked for postcode details, ethnicity, age and the hospital booked with during pregnancy or childbirth.



Image of a participant and her baby at the workshop.

Intersectionality

The American Black Feminist theorist and civil rights advocate Kimberly Crenshaw is largely cited as coining the term 'intersectionality'. The concept has now entered everyday use with growing

attention paid to the multiple sources of advantage and disadvantage tied to a person's social, structural, political and economic circumstances, among others. Crenshaw was initially concerned with the particular intersections of Black women's lives, in "the various ways in which race and gender intersect in shaping structural, political and representational aspects of violence against women of colour" (1991:1244). In doing so, Crenshaw acknowledges broader intersections, including "class, sexual orientation, age and colour" (1991:1244-1245n9). The origins of this theory are strongly linked to the political objectives of antiracism and feminism (1991:1243n4). Both of these objectives necessitate attention not only to intersectional disadvantage, but also to advantage and privilege: who holds power, and why. Intersectionality is now sometimes taken to refer only to the former – historical disadvantage – presenting and creating white identities as flat and without complexity.

In this report, intersectional positions participants hold are visible through their narratives, presented in quotations. These relate to, among others: age, religious disposition, migratory status, language, disability or neurodiversity, gender, ethnicity, class or economic status. It also becomes visible at times where a participant is detailing their perceptions of the intersectional position of another, often a caregiver, and how it impacted their care. In reading this report and recommendations, TMG suggests keeping in mind reflexivity. This involves thinking about who makes decisions based on the recommendations presented, how funds are allocated, how the teams of people responding, critiquing or implementing recommendations or policy are composed, and the embedded assumptions we might hold when reading about women of colour.

Sometimes, a person's or people's intersectional position is stated clearly in the presentation of the Results or Discussion. At others, quotations are used to demonstrate how the participant positioned themselves and the social or structural intersecting identities they find relevant to their care. This is part of our effort to reduce the impact of well-trodden assumptions about, as a primary



and pertinent example, 'the black, young, single mother'. Hearing participants describe their circumstances in their own voice is an effort to curb the perpetuation of harmful stereotypes or narratives built through years of deficit-based scholarship or research of minority populations.

Limitations

TMG aimed to involve fifty participants in the project. Although this number was exceeded with the inclusion of healthcare professionals, insights could have been strengthened through further engagement with service users. Additionally, the collaboration with STAG did not yield detailed insights about the experiences of Gypsy, Irish Traveller and Roma communities. Only one participant had a physical disability, and a further group specifically for those with disabilities would have been required to strengthen results at this intersection. Although some of the groups mentioned in the commission specification were not reached, TMG feels engaging across all of those expected with the agreed target of fifty participants may have provided thinner results in this report. Despite recruitment material emphasising the need for participants to be Southwark-specific, a greater number of participants than are recorded in this report attended the workshop who gave birth or lived in other, primarily South London, boroughs. Their presence at the workshop facilitated the range of topics discussed and added variety to the range of maternal experiences. They are excluded in this report to adhere to the commission's requirement for all participants to be Southwark residents.

Strengths

The strengths of this report lie in the nuanced and broad insights gleaned about the connectedness of maternity services to wider public services provided by the council – housing, mental health and financial support in particular. In the healthcare professional group, interviews,

the workshop, and the focus group with Latin American participants, those in attendance were grateful for the opportunity to share and contribute to the commission. Their insights are nuanced and provide a picture of the difficulties and the effective strategies for providing or receiving good care. Because of the detail of data recording, either written or transcribed, the report offers valuable data in the direct quotations from those TMG engaged with.

Terminology

'Healthcare Professionals'

The term healthcare professionals is used in this report to refer to all those who work in the maternal healthcare space. This includes midwives, specialised doctors, perinatal mental health specialists, health visitors, therapists and others. The term is sometimes used by mothers to encompass a range of positions. At others, they specify the professionals they are making reference to (i.e 'midwife').

'Black and Mixed-Black'

As indicated in 'ethnic identification', the term 'Black and Mixed-Black' refers to those who identify as belonging to a range of Black backgrounds. This might include 'African', 'AfroCaribbean', 'Black British', 'Caribbean', 'Mixed-race' among others.

'South Asian'

As indicated in 'ethnic identification', the term South Asian refers to those who identify as belonging to a range of South Asian backgrounds. This can include 'Indian', 'Bangladeshi',



'Pakistani', 'British Asian', 'Asian', among others. To protect the anonymity of the small sample, the specific terms used in identification are not disclosed.

'Gypsy, Irish Traveller and Roma'

Gypsy, Irish Traveller and Roma are separate communities. Learning from STAG, who work with each group, we use the encompassing term to reflect the range of those STAG engaged with to contribute to this report.

'Latin American'

'Latin American' refers to those who identify with backgrounds from the South American continent. This could include a range of national identities as well as ethnic groups. As the specific information about each participant is held by LOVO and LAWRS, 'Latin American' is used in this report to refer to those who identified with this call.

Results



Image of participants and their children at the workshop.

Black and Mixed-Black Participants

The results presented in this section are drawn from the Workshop and the Interviews conducted with Black and Mixed-Black participants.

To give depths to the illustrative quotations in this section, a number of case studies are presented reflecting the broader context of the experience under consideration.

Treatment by NHS Midwives and Nurses in Pregnancy and Childbirth

Positive experiences centred attentive and empathetic care, allowing participants to feel empowered and knowledgeable. At the workshop, participants emphasised being treated with care and dignity. Advocacy, for oneself and others, was central to this experience, framed by an understanding of the likelihood of receiving inadequate care as a Black woman. The sense that care might be unsafe or not up to par was linked to previous experiences, the media or the sharing of stories in networks. Those who worked as healthcare professionals but were spoken to in their capacity as mothers made visible the way that a knowledge or understanding of health information and the healthcare system was used to to advocate for themselves.

A participant at the workshop, who occupied the positionality of healthcare professional (she was a mother and had given birth and worked at St Thomas' hospital), spoke about the support her husband provided during her labour:

“My husband was there and was quite supportive. I gave him a long list of what he had to do and he was actually good at it”

Case Study: Advocacy and a Positive Birth Experience

A Black participant in the workshop gave birth at St Thomas' hospital. She is a doctor. She contextualised her profession to shed light on the intersection of class, ethnicity and gender, and how one's experience working in this field as a person of colour might work to improve care through the ability to advocate for oneself. She noted her midwife was

South Asian, which might have helped in communication, though she could not be sure. Having her husband there for support was described in the context of advocacy tools, as they had prepared, together, a list of requests and expectations whilst giving birth in the labour ward. This participant felt she was listened to by staff, for example, in delaying cord clamping or cutting and being given time with her family for an hour after birth. She did not tell her midwife she was a doctor because she did not want to be treated differently or have assumptions made about her.

(Participant from the Workshop)

One interviewee had anticipated being told what to do and ensured she was able to make her own decisions through self-advocacy. She noted about her experience giving birth at Kings’:

“It was nice to bring the baby up myself and bring him up to my chest. That is what motherhood feels and looks like. I didn’t allow things to just happen to me, you can’t trust the NHS to do everything for you. As a Black woman, you should know what you might experience and be sensitive and heightened to it if it doesn’t feel right, then do something about it”

Case Study: ‘Knowing the NHS’

Giving birth to her second child at King’s College Hospital, a participant spoke of the relief of being allowed time to bond with her child and bring the child up to her chest after birth. It made her feel like a true mother. However, this was not easily given. This participant emphasised that she had to advocate and ensure her choices were respected. She did

not just allow things to happen to her as she didn't trust the NHS because of what she knows about Black women's experiences with the institution.

In her first birth, this participant had taken the advice of a supportive Black midwife after meconium was found in her waters. The midwife suggested she have an epidural to focus on labour. The midwife told her, "don't be a hero, get an epidural". The interviewee describes: "I was like, right on sister!".

Her uneasiness with her second birth, about not letting things happen to her, was a result of the MBRRACE UK five times more statistics. This participant knew she would have to advocate for herself to ensure she was treated with dignity and respect.

For support before and after birth, she drew on family networks, including her mother, husband and friends, as well as a friend who is a midwife.

(Participant in an Interview)

A common theme among negative experiences was being told to do things by professionals with little direction or explanation. As one interviewee described:

"I was told I'd be induced and go to the labour ward, but I didn't know where it was. The midwife came four hours later and told me to get changed into a gown, no one had told me to do this. They broke my waters. I asked for an epidural but I knew it could cause paralysis, so then I asked for gas and air. I didn't understand how my midwife couldn't advocate for me, to give me pain relief and stuff. I was a nurse, so I knew there were options"

Case Study: Being 'Told' What to Do

In an interview, a participant spoke of not being given choices when she was giving birth at Kings' College Hospital. In the birth of her first child, she was "told" she was going to have a number of procedures, or to do certain things. This related to her induction of labour, changing into a gown, and having her waters broken. This participant was a nurse and had a good understanding of available pain medications and protocols for receiving them. Occupying this position allowed her to navigate her request for alternative relief, aside from an epidural. This participant gave birth to her first three children at the hospital where she worked. Despite her familiarity with the location, she felt she often had to chase staff to understand what was going on.

Because of her intimate connection with the hospital, having birthed and worked there, this participant described the care she received in the community positively. She felt they were empathetic and understanding of the struggles of new motherhood in particular a lack of sleep, and constant concern for the child.

This participant, being a healthcare professional, did not access any of the other available resources (except health visitation) following the births of her children. In part, she feels this was because she was not referred.

She sought support from her family and a best friend who is a midwife.

(Participant in an interview)

Another participant who had given birth at St Thomas' hospital at the age of twenty-one felt her age and background impacted the quality of care received during pregnancy and childbirth, leading to a stillbirth:

"I didn't feel I was heard when I had problems or questions. It was brushed off a lot. [...] I was twenty-one and perhaps because of age they brushed off concerns I had and didn't want to listen because I'm a young Black mum. I did have a stillbirth due to negligence of the hospital. [...] When I did go to hospital or midwife appointments most people were older than me and stuff so when I asked it was not like an eye roll, but just brushing off. [...] As a young woman, I believed everything and put my trust in them"

Case Study: A 'Young' Mother

A young Black woman who gave birth at St Thomas' hospital shared in the workshop that she felt brushed off by the practitioners, that they didn't listen to her primarily due to her age. She ended up having a stillbirth at the hospital caused by their negligence. After this experience, she feels she should not have trusted the practitioners so blindly.

The participant reflected on asking for further assistance from the midwives, but felt each time that they would reassure her everything was okay, without taking care to listen to her concerns. This is where she identified the negligence, as she felt further checks could have been taken at her request to avoid the loss of her child. Rather than being handed over to a doctor, she was often sent to triage by midwives where she received 'standard checks' without being asked for further details about her appearance there.

This participant was seen by a number of student midwives and felt happy to support their training. However, it was whilst she was being seen by a student midwife that she

remembers “key times” where things were missed. She felt qualified practitioners did not look over the students’ work accurately.



Image of participant sharing at the workshop.

Treatment by Healthcare Professionals and Community Midwives After Childbirth

In one interview, a participant had a good experience with her health visitor after she moved home following the birth of her child:

“With the community I’m in now it was brilliant. The health visitors were on the ball, they knew I wouldn’t be sleeping”



Support

Participants sought support from family networks, mothers, godmothers, partners, friends, lawyers, and online groups. They felt further support could include being with other women that could relate to their circumstances or perspective. As one interviewee notes:

“We need more groups for Black mothers, who a lot of the time feel alienated, with no one to talk to, no midwife to call you and check up on you. We need more information because often it depends who you know. It would also be good to have antenatal sessions with a group, speaking to a midwife with others.

Group sessions are very limited”

Case Study: The Significance of Signposting

In an interview, a participant noted her reliance upon and desire for more groups for Black mothers who are overlooked in the community. Despite having a good experience of pregnancy and childbirth, having a sense of empowerment in the birth of her second child after a miscarriage, she felt she did not know what support was available after the birth. This participant felt much of the support depended on who you know and who could refer you to relevant services, groups or applications. Building these connections was seen to be tied to meeting people in person.

This participant sought support primarily from her mother before, during and after giving birth.

(Participant in an Interview)

At the workshop, a participant described seeking support online as unexpectedly helpful:

“I found unexpected support on online spaces and I did not envision going online for support but there were times when I was Googling heavily about everything and was surprised by how many mothers had gone through a similar journey”

Others chose to seek support from family and friends instead of healthcare professionals during pregnancy or after the birth of a child. This was usually because they felt they were not listened to by professionals, or had previous negative experiences. A participant in the workshop noted:

“Postpartum, with my first, I had moments of struggle and I don’t think the doctor I spoke with was listening to me. [...] It was not useful to go to the doctor because in my pregnancy I had issues and they didn’t take it seriously and so that put me off. My Trust was tainted from the beginning”



Image of participant sharing at the workshop.

Case Study: Understanding Conditions

A participant in the workshop, who sought support from friends and family rather than healthcare professionals, linked this to her child's diagnosis of colic. The participant did not know what it was and felt the explanation from the doctor was not sufficient. She ended up crying to the doctor because she did not know what was wrong with her baby. This participant works as a therapist, and felt that her professional background allowed her to notice the doctor's avoidance of her questions. She was also surprised that the doctor did not endeavour to check on her mental health, not even providing her with the questionnaire she knows general practitioners use to survey a patient's mental health. In her second pregnancy, this participant felt nervous to go to the doctor and ask about her struggles, leading her to note: "My Trust was tainted from the beginning". This participant lived in Southwark but did not want to disclose the Trust where these experiences took place.

(Participant in the Workshop)

South Asian Participants

South Asian participants were recruited through The Rahman Group, they shared long form responses using the questionnaire. Because of the small sample size, recommendations informed by this group's insights are tentative, made through their correlation or relevance to those drawn from all other groups.

Treatment by NHS Midwives and Nurses in Pregnancy and Childbirth

From less than five responses, participants felt midwives were competent and were grateful for the birth of a healthy child as a result of their care. One participant noted she was treated "with respect", and another was "happy with the service". However, sometimes this was seen as dependent on who the midwife was due to a lack of continuity of care. Additionally, one respondent was specific about how she was treated by those in different roles and areas – between birth centre, labour ward and sonography.

"The midwives that I encountered with my second pregnancy were a mixed bunch. Those in the birthing suit I found listened a bit more and I could talk to them a little bit about my concerns. But those in the labour ward were very abrupt and somewhat impatient and I definitely couldn't speak with them about my concerns. For me, the sonographers were most impatient and one even referred to me as a 'fat cow'"

There seemed to be a desire for more empathy and support. This emerged from being stereotyped based on one's ethnic background. Intersectionality plays a part here, where medical or clinical professionals might hold stereotyped views of people depending on their age, gender and ethnicity. Sometimes, this can lead to false diagnoses, or mishaps, leading the person seeking care to feel overlooked and ignored. As one participant mentioned:

“I was also told your baby is big, you must have diabetes, everyone in your race has it and in the borough most people have it. Even though I did the test three times”

Treatment by Healthcare Professionals and Community Midwives After Childbirth

Some participants felt they received good information and signposting after the birth of the child from those who visited them at home. They received the support they needed. One participant noted she was treated “very well” and had the opportunity to ask questions.

“Just as good, and no problems. And I got information for children’s health”

In one case, there did seem to be a sense of miscommunication, or lack of understanding, after the birth of a child. In the questionnaire, a participant wrote:

“After the gift of my second child I had to stay in hospital for five days as he was early. I was very emotional as it had been a long and hard pregnancy. Due to my being emotional – overjoyed and relieved we were both safe – I was addressed by two midwives and a doctor who said they found my behaviour concerning and said I was showing signs of postnatal depression. This, to me, was a massive shock. I literally had given birth and three hours after they said this to me. They requested a psychiatric specialist to come see me the next day. [...] When the team saw me the next day they soon discovered this was not the case and that quite understandably I was exhausted and in need of rest”

The same participant did not feel there was enough breastfeeding support and “felt like [...] a bother” when asking for support.



Support

Overall, participants felt they could ask for support during pregnancy and after childbirth. They sought support from hospital and community midwives, hospitals and public health centres and some made complaints. Participants felt they could have been listened to with greater attention. None of the participants who filled out the questionnaire could identify unexpected forms of support.

Gypsy, Irish Traveller and Roma Participants

Southwark Travellers' Action Group (STAG) were given autonomy in conducting engagement for this commission. Unlike other groups, we received shorter form responses, outlined in this section. We received responses from ten participants.

For antenatal care: "Six participants experienced positive care during antenatal care, with two describing their care as "very positive". Two felt their care was neutral. One participant felt their care was negative."

For care during childbirth: "Eight participants felt their experience of care during childbirth was positive, with two describing their care as "very positive". Two described their experience as neutral. There were no negative experiences reported."

For postnatal care: "Six participants described their experience of postnatal care as positive, with one describing the care as "very positive". Three described their care as neutral and one as negative."

Further responses and the full table are outlined in Appendix 1.

Latin American Participants

Engagement with Latin American women in Southwark was supported by Ladies of Virtue Outreach (LOVO) and the Latin American Women's Rights Service (LAWRS). Participants shared their experiences and perspectives of the transformative impact of motherhood, childbirth and engagement with healthcare services in their lives. They discussed the challenges of balancing work and motherhood and the importance of support networks, as well as the impact of motherhood on their identities and sense of self. Participants explored their personal experiences of discrimination in healthcare settings in part due to language barriers. They emphasised the need for better maternity care and mental health support centring empathy, understanding and access to robust care for new mothers, including those with children with disabilities. Due to the centrality of language and communication, this part includes a dedicated section addressing this theme.

Language and Communication

"We are not treated equally, we cannot speak to the doctors and the nurses on the ward. They don't know anything and you are undermined because they think you can't speak the language. So I had my baby at St. Thomas' and the experience was terrible, and I have heard of many cases of mothers coming to have their baby there and they don't pay them attention. [...] In my case, when I went there they didn't pay me any attention and that broke my heart, and I was not feeling well and they sent me home. When I came back I had to have an emergency Caesarean, these things shouldn't happen, they should hear you, and even more when you speak a second language"

This mother's experience encompasses a central issue raised by the women in the Latin American group: of not being listened to, being dismissed and treated unfairly because they either



do not speak English or spoke English as a second language. This is a very important intersection to consider, which ties in migratory status, gender and ethnicity.

A participant noted her mother was told to 'shut up' when asking questions to a midwife during birth. Familial connections were important to this participant's story, having her mother there allowed for greater support during her pain. She told the midwife not to treat her mother like that because she didn't speak the language:

"They asked me to translate, but I was in pain. I couldn't focus on translation. So what I felt at the time
was a lot of frustration"

A woman who gave birth in King's College found her daughter had rubella after birth. They went to hospital for a week and when the mother asked for medication for pain resulting from her Caesarean to a nurse, explaining she was at the hospital because of her daughter, she felt disrespected by the nurse. It was only when a Spanish speaking midwife arrived that she was given medication.

"She explained that it was her daughter in the hospital, not her, so she couldn't give her anything. And when she insisted, even though she was speaking English the nurse said she didn't understand. Then
another nurse again came and ended up giving her the paracetamol"

(Translation by interpreter during focus group)

Another participant also gave birth at King's College and felt ignored. She pinned this to her language.



“She was at King’s College hospital, she said they never told her who her midwife was, there was a different midwife every time and she said she felt ignored because of the language. They told her she was going to receive the confirmation of an appointment by letter but it was two times that although she received the letter when she went there they told her the appointment was cancelled or she was not on the system. She had to show her passport to show she was on the system. [...] She even had to cry and they made her wait all day for a check-up.”

(Translation by interpreter during focus group)

This woman lost her child and felt if she had not been ignored and received check-ups on time she would not have lost her child. The gravity of this story was reflected in the focus group, where the woman cried as she recounted the events.

During one woman’s birth, expressions of emotion through tears seemed the only way to communicate with practitioners. She described:

“The birth was okay, but she didn’t know what was going on because they didn’t provide interpreters so she spent a lot of time crying for not understanding. So although she didn’t have any health complication she couldn’t understand what was going on”

(Translation by interpreter during focus group)

Another mother whose child was born in St. Thomas’ and has good comprehension of English noted that she knows others in her community struggle to receive care as practitioners are not patient.

“She says she’s seen other mothers struggling with the language. She says the staff at the hospital are not patient. They don’t take into account that the mothers are going through a very difficult experience because they are pregnant. She says she did notice the staff paying more attention to her because she



was able to communicate in English than with other women. She thinks they need more empathy with people that don't speak the language"

(Translation by interpreter during focus group)

Seeing others being treated differently because they did not speak the language was reflective of unempathetic care and seen as negative, even though this mother felt she had been taken care of. This is demonstrative of how witnessing disrespect of those in one's community can shape perceptions of the service as a whole. It demonstrates an important aspect of intersectionality – that the experiences of a minority are influenced in part by the actions and ideas held by the majority community.

One participant noted that even though her English is not fluent she was still able to communicate. However, communication with the midwife in terms of empathy and understanding was still difficult:

"She was having problems with breastfeeding. So she asked the midwife for advice and the midwife was very rude. She never treated her kindly, she was treating her like she should already know everything she was supposed to do. This was difficult as she was already in pain due to the Caesarean section."

(Translation by interpreter during focus group)

Overall, the need for competent interpreters or translation services came through strongly in the focus group with Latin American women. Additionally, there was a general sense that care was not empathetic enough to the wider circumstances and challenges they were navigating, as well as the particularity of their cases, explored in the following sections.

Treatment by NHS Midwives or Nurses During Pregnancy and Childbirth

Linked to Language and Communication, many of the participants in this group did not feel they were listened to or had their choices respected during childbirth. This often led them to carry these feelings for a long time. As one participant noted:

“It has been five years since I had my baby and I’m still very upset about what happened there”

Sometimes, negative experiences were tied directly to neglectful care or being ignored in care choices. Even when participants had understood childbirth might be ‘complicated’ following advice by professionals, there was a sense of frustration related to a lack of agency when giving birth in the hospital. A participant explained:

“I felt at that time a lot of frustration. My pregnancy got complicated. I have seven centimetres dilated and the baby had a rope around it. I asked for a C-section and they didn’t allow it. They ended up taking the baby out with forceps and it was a horrible experience.”

As Language and Communication indicates, there were also problems in midwife allocation and continuity leading to difficulties with understanding and increased stress when women had to describe time and time again what they had already been through.

Treatment by Healthcare Professionals and Community Midwives after Childbirth

One participant described unkind behaviour by health visitors who visited them at home after the birth of their child. After a difficult experience with her child’s sickness and access to pain relief, outlined in Language and Communication, this participant went on to describe the health visitor’s behaviour at her home:

“The health visitor visited her at her house. When she said she was a single mother, she asked if she was working. She replied, ‘yes’. And then the health visitor started questioning her: how was she going to take care of the child if she was working? And she started to scream at her. In the end she realised she was not behaving well and apologised, but after all of that...”

(Translation by interpreter during focus group)

Being asked about work by a health visitor in an insensitive way was shared by another participant:

“She said that the health visitor went to her house after the birth and it was also the case that she was asking about working, and what she was going to do after maternity leave. She said she works full time and was planning to return to work and the health visitor questioned her about how much money she had and how she was going to work and have children. She was alone, alone with the baby, so she started on her own to seek support. She said the health visitor never gave her information about organisation, where she could find clothes for the baby, she didn’t even tell her about universal credit”

(Translation by interpreter during focus group)

The participant above highlighted positive care when she went to the hospital because of her child’s allergies. She also noted she was treated well after the loss of a baby.

Breastfeeding advice was raised as important, and one participant noted the midwife was rude after the birth of her child when requesting breastfeeding assistance:

“She said the hardest part was after she had him, after a C-section. She was having problems breastfeeding and so she asked the midwife for advice. She said the midwife was very rude, she never



treated her kindly. She was treating her like she should already know everything she was supposed to do.

This didn't suit her and she was also already in pain from the C-section so very vulnerable"

(Translation by interpreter during focus group)

Support

For many, community groups and friendship provided pivotal support throughout maternity. Support from those who did not work in healthcare was seen as more empathetic and detail oriented, as one participant expressed:

"Being part of motherhood and witnessing it has changed how I recognise how much women need to support other women. Because there are so many things from healthcare that they just don't get. The details in the support, the empathy, in healthcare it's professionals. They're doing their work, they're doing the best they can. But there are certain things, like looking after a mums' emotions and helping her with little things in her life to make it easier."

One participant linked this to single motherhood, and the 24/7 nature of care. She felt providers would be able to give better support if they heard directly from mothers about their experiences.

"Your life changes in every sense. Up and down, your mood. Everything. And I think for the NHS, or maternity, it is very good to share and join with other mothers to share their experiences, whether their not good or fine"

Single motherhood was difficult when people did not have their family in the country, another participant noted:



“I am a single mother and motherhood has allowed me to discover a new phase of myself. Even though it can be very hard because I don’t have a family that is here, it is also very rewarding”

In one case, a participant was assisted by a stranger she met at the park. This was the woman who received no information about organisations, baby clothes or Universal Credit from her health visitor:

“After, thanks to a person she met in the park when she was in the playground with her kid, she got to know different organisations that support mothers and parents. After that, everything became easier. But, she felt she didn’t have support from the health visitor and it is very important that the health visitor is informed about support available and can signpost mothers”

(Translation by interpreter during focus group)

Another participant wondered whether certain information was only given to wealthy people.

Another noted:

“First of all, the NHS needs to give more information to mothers and treat them with respect”

(Translation by interpreter during focus group)

Healthcare Professionals

Participants discussed various strategies for improving maternity care, including personalisation, cultural sensitivity and community engagement. Overall, the discussion centred on personalised care – primarily through confidentiality and anonymity – and robust systems of emotional and practical support provided by healthcare professionals and community networks. Participants shared their own experiences of providing culturally competent care.

Time and Communication

Importantly, healthcare professionals were aware of the structural and systemic constraints facing those working in the NHS. The biggest barrier to providing a high standard of care was time. Time was felt to be short more acutely in instances where service users did not speak English with fluency. Not only did they have to try to find interpreters, there was also a sense that ideas, symptoms or beliefs might be missed due to an incongruence in language.

“Sometimes language is a barrier. We all speak English, but even the language I’m using and the dialect of the person I’m speaking to at a certain time can be hard. And I think we all come from areas with different health beliefs and trying to see everyone’s side of the story... Does that make sense? In a day to day basis that’s what I see when seeing mums and families”

When asked to expand on cultural beliefs posing a challenge in the provision of healthcare, the same practitioner, an obstetrician, noted:

“I think it sometimes comes up where birthing people, mums, really don’t want a Caesarean section for various reasons. And discussions about what would happen if that did happen, or was necessary. So

those things come up a little. And challenges around abnormal antenatal scans, when does your baby become too small or too big?”

Related to the question of language, ‘health literacy’ was raised as another potential barrier to the provision of care to black and minority ethnic groups in the borough.

“I think health literacy is a big component here in terms of the challenges we face. Sometimes their understanding of medical conditions and recommendations of treatment can sometimes pose a challenge. But again I think sometimes it does come down to cultural beliefs as well and really trying to unpick that with them. But it’s trying to have that time as well, to sort of, sit with women and actually unpick the things in a lot more detail and understand where they’re coming from and then sort of explain it, explain it in a way that they can also understand”

As this community midwife indicates, questions of understanding and communication in clinical or medical settings are made difficult by time constraints alongside language and “health literacy”. Health literacy is usually used to refer to an understanding of specific health terms or issues.

One practitioner expanded on the connection between time and communication through connecting the people she sees to wider services.

“For me it is usually around engagement with other services before they get to us. So big things being communicated, how messages are being put across, and judgement. It’s often things we can’t really help with which is really frustrating”

For this healthcare professional, who works with a community facing organisation supporting mothers in Southwark, barriers of communication were interlocked with the maternity services relationship to other support in the wider community, discussed further in the next section.

Despite many of the healthcare professionals speaking of “cultural beliefs”, there was little extrapolation as to what they encompass. However, one midwife did specify an example from the ward about communication and dialect:

“We had a mum who was talking loud, and people thought she was being aggressive, she was being loud. But I understood it’s not loud, it’s just her way of talking. When she talks to us, we could reassure her and remind her she’s on a ward [...] So she said she could relate to me because I understand her. This is not a mum that’s being aggressive or agitated, it’s just her presentation, the way she speaks and expresses herself”

Another practitioner noted it is important to have a diversity of culture working with all people to develop an understanding.

Relationships with Services Outside of the NHS

Healthcare professionals felt connections with broader services, including social services and housing, were inadequate. Many of them noted the connection between physical and mental wellbeing and quality of life outside of the immediate clinical encounter. Sometimes, they felt they were not equipped to ensure a service user's total wellbeing due to circumstances outside of their control and outside of the hospital.

A community-facing healthcare professional, mentioned in the previous section, expanded on difficulties of communication between different services, not always seen to be connected to maternity care. She explained:



“They may be having issues with, for example, housing, which is not our area. But you’ll hear about how they’re not properly being treated and it always shows there’s lots connected and lots that we really can’t do anything about and it’s really quite awful”

There was a shared feeling among participants that these wider issues – particularly of housing and mental health – were out of the remit of healthcare professionals. Although they cared about the wider lives of the service users, it was difficult to enact change or improve a person’s circumstances or experience of maternity services when they were perceived to be deeply connected to a much larger structural and political dilemmas in the community.

This “wider sense” of constraint in connection with other services was noted by this healthcare professional as pervasive across a number of South London and Southwark hospital districts. She explained:

“If you think of housing and the council and everything else, in my opinion working in different areas of South London is a difficult thing to do. The council doesn’t seem to be responsive or do things that garner that conversation as there are a lot of issues with a lot of people when it comes to housing, which obviously has been the main issue for a long time and is getting worse. So to have those platforms where you can have people from the general public come and have conversations where they can express stresses and grievances, I’ve just never heard of something like that being done. [...] Just if they could hear the among of women and birthing people that were coming through with these issues around housing”

Whilst conversations about housing and wider constraints in the council might seem to be outside of the scope of the maternity commission, it is vital to note the centrality of the ‘wider world’ in many of the narratives emerging from healthcare professionals and minority ethnic groups in TMGs research.

The most people felt they could do to support people with housing, finance or domestic violence – make a broad range of appeals to the council – was to write a letter of support.

A neonatal psychologist related the housing issue to single mothers from Black or Asian groups. She explained:

“This is just an observation, but a lot of the women I’ve seen, who are Black or Asian, are single mums, and they’re in temporary housing and moved around [...]. Often they’re living in hotel rooms with no cooking facilities with small children. Some of them want to work, they’re capable of doing it, but they can’t contribute because they’re living situation is unstable. So it is bound to have an impact on their mental health”

Alongside mental health, the impact of wider structural issues was said to affect physical health also. She expanded:

“I mean, there are things that maybe you wouldn’t even think of, like hydration, diet, sleeping properly. They all have an impact. And some people also have comorbid health conditions or they develop physical conditions as a result of maybe poverty and, you know, years of stress. It is complex”

Another participant, who works with Black mothers in the community providing self-help support through the organisation of pop-up events where women can speak about their wider struggles also noted the impact of structural issues on maternal health more widely. She also noted housing as a key problem facing many of the mothers and pregnant women she engages with in Southwark. She is quoted a length for the particularity and specificity of her example,

demonstrating the feeling of being stuck and its effect on maternity, particularly soon after the birth of a child:

“Some of the things I’ve been told is mostly to do with housing, the issue with housing is that they claim they have less housing, but some of them have even tried to get help from their MP and councillors and all of that. Even when they offer letters of support the council does not take that into consideration they just say ‘we’re sorry’, ‘we’re trying our best’, and they’ll say we have a high volume of people and they ‘understand’ but there’s ‘nothing they can do at present’. And that is actually making some women really ill. To go back to the example, imagine having just given birth, and you know, being put in a box. You can’t even take care of yourself. You’re being moved, and there’s a lack of stability, and that affects your work. Most of these women actually work, they’re not on benefits, you know. They’re not receiving help from the government. However, all they want is the opportunity but they’re always put in a box.

One particular lady, after having a child, was not given notice by her landlord. She was not prepared and these things can really affect you. So her mental health became very severe. She went to the council with the letters stating that and then on the day of her appointment nobody told her no one would see her. She was waiting and was never seen. At the end she was told they were short staffed. She had to return to the same condition, without anything being changed. Being a mum is already stressful, but adding something on top of it, it does not help at all. I just feel certain communities are marginalised in my opinion”

A senior midwife suggested that some of the structural constraints related to housing, finance and mental health were often dependent on the maternity unit itself, and what services were available.

“Depending if there are other factors which are, or make them eligible for one of our specialist teams, they’ll have more tailored care, longer appointments, and be referred to specialist services that are then able to sort of, link in with other community-based services. I know at King’s we have our maternal

medicines team, so they work with people who are high risk and have medical complexities in their pregnancy. They're already linked into a lot of sort of MDT [?] work with medical and healthcare professionals. We have the lotus team, so if someone's been diagnosed with a severe mental illness they'll be referred to the lotus team who work closely with other mental health services and other community services. Once maternity care has ended, they're already sort of plugged in with services to support their mental health and long term sort of, help in life"

This midwives understanding of the available services was closely linked to her role at King's. She was proud to share the work King's is doing, but it is worth considering who might fall through the net when services are tailored to particular expressions of mental ill health or medical complications. As explored in the next section, Stigma, it is not always possible for people to share their mental health concerns.

In addition to housing, a maternal mental health specialised raised the significance of fears of social services:

"I have worked with mums before who haven't wanted to disclose certain things because they're worried they're baby might be taken away, or other consequences. So in assessment, I might ask it as bluntly as that: 'do you have any worries about being linked in with services?', 'do you have any concerns about working with me'. That can be a good starting point where I can say 'yes, maybe we will have to bring other services in but I will always have that discussion with you first'. [...] I can't just assume someone is going to trust me, because that's not helpful for anyone"

The comments above tie in questions of trust and fear of punitive action by maternal healthcare services if connecting with social services.

Stigma

For some, stigma was a key issue affecting the delivery of maternity care, particularly in conversations around mental health.

“Just from a mental health point of view, I think that stigma is kind of central to engagement with services. And trauma, people who have been through traumatic events are the people we see most commonly. The combination of stigma and trauma can be quite debilitating and often people don’t feel they have support from their communities or families because of the stigma, they don’t feel they can feel how they should feel. And that can be culturally informed as well”

When asked to expand on the specificity of the stigmas this cognitive behaviour therapist who has worked with mothers and pregnant women had seen in the community, she explained:

“King of having, feeling depressed and postnatal depression, feeling like they can’t cope or struggling just with being a new mum or having you know, a lot of people with housing difficulties, financial difficulties, domestic violence. All of those can be really stigmatising especially in certain communities and certain groups. It’s quite broad but there’s a lot of ‘I shouldn’t be feeling like this’, ‘I’m a bad mum’, ‘I must be crazy’. So a lot of the work we do is around that”

Importantly, the cognitive behavioural therapist links the issues she is facing in providing maternity care from a mental health approach to wider structural issues, some of which are mentioned in the previous section. Housing, previously noted, was an important connection to mental health and maternal support in the perinatal period.

Here, understandings of cultural practices were raised in specific terms. Though the example was not addressing ‘stigma’, it spoke to this theme through noting how perceptions of cultural practices seen as ‘disruptive’ or ‘unreasonable’ by healthcare professionals might derive from a misunderstanding of their context. A midwife explained in relation to Pentecostal Christian expression:

“Okay, so this person was a religious Christian, and the way she was worshipping, I call it worshipping, they deemed it as something she was doing because she was paranoid or whatever. And I said no, I understand where she is coming from because I am a Pentecostal Christian, so I understand what she is doing, I get what she is doing, and it is nothing that should be taken out of context. So by advocating for that mother she was allowed to express openly. And I could see changes in other Christians, who were able to come and completely worship, free to do what they wanted in terms of reading the scripture and all of that.”

To address stigma, the cognitive behavioural therapist suggested ‘normalising’ mental illness, particularly trauma, in the community, a sentiment shared by a number of healthcare professionals. This is also related to the expression of certain cultural practices explored earlier, where characteristics of behavioural, emotional or linguistic expression can contribute to how a person is perceived by those working in healthcare.

Creating Inclusive Healthcare Environments

As this section indicates, creating inclusive healthcare environments requires more than a focus on ‘maternity’. It means expanding the connections between maternity services and wider community support – whether with housing, employment, finance or mental health.



A midwife at King's who also works with family hubs noted the importance of early outreach and engaging the wider family or network of support.

“Including birthing partners from the beginning and inviting them to any classes and to all appointments. I guess if you're in work, thinking about when your appointments are so that other birthing people can come knowing that ... obviously as the mum you can get time off work. But many of the birthing partners can't get time of work so feel less involved”

Her comment contributes to the discussion of Time and Communication. However, it also highlights how valuable support from lay-networks – friends, family, birthing partners – can be for birthing women and people.

Another midwife at King's noted they do specific antenatal classes specifically for Black and Mixed-Black heritage groups. This is delivered through a sign-up scheme marketed through signposting initiatives and posters with QR codes around the clinic. A college a community midwife offered an evaluation of the specific antenatal classes:

“I think there could be better attendance, but that's on our side in terms of advertising it and ensuring we have regular classes to become part of our normal scheduled parent education. It is not only those classes that have been effective, we're also just trying to promote uptake of our parent ed classes in general. With the Black and Black mixed we offer that in person. And it's not just about labour cases it's also about health advice, we go through stuff like the MBRRACE report and the stats. Just educate them about accessing care, a healthy pregnancy, diet and exercise. Partners are included in the classes that we run.”

Further, suggestions for promoting inclusive care were linked to Relationships with Services Outside of the NHS. The same community midwife at King's centred children's centres as key points of outreach and engagement:

"We are looking to go back into our children's centres a lot more. Being based in the local communities. We did sort of move away from it over the years and be centrally based in the hospital but our plan is to go back out into the children's centres so that we can actually link them very easily into other services that run from the children's centres, which we know are excellent. There are a lot of classes and mental health support there. So, we're trying to get back into that. And I know that family hubs are also moving back into Southwark as well. That will be another great space for maternity staff linking with mental health services and other community based services to provide holistic care for women accessing our service."

To address mental health needs, a perinatal mental health nurse emphasised the significance of personalised relationships with each service user. When asked about potential strategies to address the unique mental health needs of black, Asian and other minority ethnic mothers or pregnant women, he explained:

"The key thing is asking. That for me would be important for all our patients. The key thing, and I think people have talked about time, so it depends if people have time for it also. But I think with a lot of the efforts that people are making, to make the maternity service more inclusive, is that its about asking people about what they want and how they can be supported, it can be about asking on their perspective of mental health. Personally, I'm often quite wary of generalising too much. [...] Just because somebody comes from a particular culture or has a particular ethnicity doesn't mean, from my perspective, that they have a particular perspective on mental health. [...] So for me, it is just about trying to provide as individualised care as possible. So there needs to be a rigorous assessment of people's mental health experiences. And, I guess, there needs to be an understanding about how different people might communicate that. People from different communities might be more or less likely to communicate in



various ways. But it is really about trying to raise awareness of difference, that's probably the most important thing. [...] I think it is important to note that people's engagement with services is often based on the service's engagement with people."

There is a tension between the NHS efforts to provide personalised care and also be culturally competent that seems to emerge in this practitioners account. However, it is also interesting to note his challenge to the idea that it is the burden of the service user to engage with the service.

In response, a bereavement nurse stressed the importance of an intersectional approach.

"Always try to hold in mind intersectionality. We're thinking about race, but maybe we're also thinking about class, language, ability. And actually, all of those things are really important."

When speaking about building trust, a maternal mental health practitioner noted trust cannot be assumed. This was linked to Time and Communication. She noted:

"I think it is about time and not pushing too hard. It is also empowering someone to say, 'you know what, I don't want to talk about that right now'. I think that can be quite nice. Because it sets up something where they might need to bring it up in a week or two, but if it doesn't feel safe right now that's okay. There might be things to push more on if there are safety concerns but it is about deconstructing the power as much as possible. Of course, the power dynamic is always there."

A participant working in family hubs and midwifery noted how this dual role gave a perspective on the challenges "on both sides". Addressing creating more trustworthy and inclusive healthcare environments, she spoke about how healthcare professionals change roles frequently and how this might affect trust:

“When we look at health professionals, they change roles quite frequently. And actually, sometimes that can lead to distrust. But when you look at community leaders, it tends to embody who they are. So they tend to have really good, long lasting relationships with their communities. So obviously there has been a lot of talk around the commission with regards to us as healthcare professionals going into spaces that the community feels safe. Because actually, we’re asking them to come to us and they’re seeing a lot of different faces each time. They don’t want to have to retell their whole story over and over again, hoping that you will understand where they come from, where they are coming from.”

She noted a lack of capacity and funding, linked to structural issues explored in Relationships with Services Outside of the NHS, mean the NHS cannot always help those seeking wider care. In response, she suggested working more closely with community organisations “who actually know what they’re doing”.

A community based support worker expanded the point through suggesting promoting inclusive healthcare environments would require better staff training.

“We need to think about training the staff. [...] When you’re seeing women and birthing people and supporting birthing people, you need to be able to pick up on where people are coming from. You know when someone is talking to you because they really care, and when you know they’re like ‘okay, I just need to get, you know, I have another patient to see”

This was linked to questions of recruitment by the same practitioner, feeding into the notion that people do not get to see the same staff – the lack of continuity of care – might affect trust and openness from Black and minority ethnic communities. Working in the community was seen as potentially promoting better services:



“This goes into recruitment. Because, what X was saying around inconsistencies and people changing [...] in the community it is a different picture. [...] There is definitely a different kind of energy that comes with that and people will want to engage. I used to work with SureStart Centres and people really liked that, they could come there and talk to all types of professionals”

Related to recruitment, community and employment in creating inclusive healthcare environments was racial or ethnic congruence with practitioners. A perinatal nurse spoke about Black staff in nursing teams and the effect this has on openness and engagement with services:

“When I first started in the community we had only just one Black staff member on the nursing team. Now that seems to be changing. We had a discussion the other day and someone on my team, a senior nurse, we were talking about the benefits of having a more ethnically diverse team. Quite unintentionally, when we decide who is going to take on which mum, I think it is unintentional that I would more likely gravitate towards Black mums, and decide I was to take those on my caseload. I think that I can, you know, relate to them as well. It makes you feel good when you walk into these homes and see that Black mother. It makes you feel like you have a relationship with them as well, they understand your background and you understand where they're coming from”

This might also feed into questions of staff training, as well as some of the constraints outlined by healthcare professionals in relation to Stigma. However, the idea that racial or ethnic congruence builds trust was contested by some practitioners. Another community facing midwife who has worked inpatient noted in response to the above:

“Can I also say I've worked with mums in the inpatient setting that didn't want to work with someone that looks like them. And I suppose you have to think about every person as an individual, because this mum had a really negative experience with her own mother and so she didn't want anyone who looked like her mum”



The comments are somewhat reflective of those given by the perinatal mental health nurse, weighing out the tension between personalised and culturally competent care.

Many of the community facing healthcare professionals felt people felt more comfortable in their own homes, particularly when there is continuity of care.

“I think that the element of trust when you come into their home builds a really trusting relationship with them. And it does make them look forward to seeing you”

This was sometimes likened to feelings of friendship creating a sense of safety.

Overall, a perinatal mental health nurse wrapped up some of the key takeaways for creating inclusive healthcare environments drawn from the focus group. He noted:

“I find once people have an awareness, and once you give people that awareness of what’s happening to people and what people are up against... I just feel people innately have the tools to make that count. It is just about how we make all of this count. So that it actually matters”

Disability and Neurodiversity

At the workshop, one attendee from the Black and Mixed-Black group required the use of a walking stick, visibly indicating her disability and accommodations were made to ensure her comfort in participation. When speaking, she referred to her “condition” without explicitly naming it. The participant’s story related to the loss of a child at term. At 40 weeks and 10 days, the participant went to hospital after feeling she was about to go into labour. The midwives sent her home because she was not dilated enough and requested she come back the following day. She was required to pay for a taxi home, “despite [her] condition”:

“By the time I came back it was too late. I lost the heartbeat”

In the Latin American Focus Group, receiving information about health results during pregnancy was noted to have been delivered insensitively, without considering the kind of support a person might need when making crucial decisions. One participant offered the following specific example:

“During her third pregnancy, they made a blood test, and they called her to give her results. When they called her they didn’t ask if she was with any family members. They just called her over the phone and told her her son had Down’s Syndrome. Then they asked her whether she wanted to continue with the pregnancy or not. They said all of this over the phone, not making sure there was any family around”

(Translation by interpreter during focus group)

To make this situation more complicated, the participant decided to continue the pregnancy. After the birth of her child, she found he did not have Down’s Syndrome but was diagnosed with autism. This is an important consideration in relation to disability and neurodiversity, and the way testing results are delivered. After the child was born, and later diagnosed with autism, the participant felt

those she sought care from at King's College Hospital did not pay enough attention to her concerns. This was partly related to the need for interpreters, but the speaker also emphasised the need for people seeking care from the NHS to know their rights and what is available to them.

When the participant who received a false Down's Syndrome diagnosis over the phone had given birth to her child, he needed to be checked up. This participant went into the hospital for tests"

"She feels that they treated her baby poorly. They couldn't find the vein, and she saw them being rude to the baby. This was in King's College Hospital. When they wanted to do a blood test on the baby they were not treating the baby properly. There is no support for parents with children with disabilities, none for therapists or special schools. She said all the doors were closed to them and the family suffers in these circumstances because they don't know where to go. And she says then mothers tend to isolate themselves"

(Translation by interpreter during focus group)

It is important to stress that disability or neurodiversity of a child can affect the maternal experience. In the Black and Mixed-Black workshop, a mother shared that after finding out her child had severe learning difficulties in his early years she started independently researching the social impact of neurodiversity on black children. She described being led to do this research after hearing about "disparities and the long history of black women in medical care in general, the disparity of black men and mental health ...". This mother found that children with special educational needs and disabilities were more likely to face barriers at schools, or as she put it:

"Are not care for as much when they're black and at school"



This mother felt wider social inequalities affecting black children were likely to affect her child, causing anxiety about how best to advocate for his needs.

Discussion

This section summarises the findings from across the demographics reached and through each methodological approach. A thematic approach is taken to draw together the varied experiences of each participant group. The eight themes explored include: Advocacy and Agency; Racism and Racialised Stereotyping; Listening; Stigma; Strengthening Relationships with Other Services; Continuity of Care; Cultural Competence and Sensitivity; and Intimate Network Involvement and Support.

Advocacy and Agency

Through all groups, advocacy emerged as a central theme defining experiences, desires and understandings of the role of maternity services. This is sometimes configured around receiving support centring individual and collective experiences, including concerns about personalisation of care and patient advocacy needs.

Service Users

In the Black and Mixed-Black groups, having a midwife who was attentive to the birthing or mothering person's desires and emotions was highlighted as enabling positive experiences of care. Friends and family could also act as advocates in labour when the birthing person had devised a plan or list of expectations for how the process would unfold, and intimate support could ensure practitioners were reminded of the significance of the person's choices. Some of the Black and Mixed-Black participants noted the ethnicity of their midwife as having a potential impact on the quality of the care and communication received. To increase an ability to advocate for oneself, a participant in the Black and Mixed-Black group suggested the organisation of specific and tailored groups could empower people to form connections and share information that was

relevant to their shared and individual experiences. This is noted in the case study on the significance of signposting, where a participant reflects on a feeling that many services, organisations or networks remain unknown. Advocacy for oneself was also emphasised in the Black and Mixed-Black results, where an awareness of racial inequalities in maternal healthcare impacted how participants prepared for their interactions with healthcare professionals. Sometimes, this was linked to an intersectional experience drawing in one's profession, as in the case of those who occupied positions as both mothers *and* healthcare professionals. These participants sometimes had a better understanding of the resources available to them, whether pharmaceutical or therapeutic. However, self advocacy was not always an effective tool, as the case study of the 'young' mother indicates. Despite revisiting the hospital numerous times with concerns, she felt she was "brushed off", overlooked and did not receive adequate attention from a variety of practitioners working in different departments.

In the South Asian group, advocacy was shown to be supported through precise information about a child's health, contrasting with the Black mother who wished she could have received more information and attentiveness when her child was diagnosed with colic.

In the Latin American group, the shock of hearing of a child's potential Down's Syndrome diagnosis without consideration for how this information was communicated seems to echo how an inattentiveness to needs of the person receiving this information can lead to feelings of disempowerment and disrespect. Friends and family, alongside those in the wider community, were highlighted too by the Latin American group as able to advocate for a mother or birthing person. The Latin American group also felt language was a barrier to effective advocacy and desired better interpretation or translation skills to ensure someone was physically present to advocate for their needs. The Latin American group emphasised the need for better breastfeeding support in the postpartum period.

Some of the participants from the Gypsy, Irish Traveller and Roma group noted communication could have been better. A positive experience noted it was framed by an understanding of what was taking place.

Healthcare Professionals

One healthcare professional also expressed a desire to see public forums for people to talk about their stresses and grievances with the council as a whole – linking this their concern with housing and the difficulty of advocating for service users trying to appeal to housing services for a safe, comfortable and dignified place to live.

Racism and Racialised Stereotyping

Service Users

Across the Black and Mixed-Black, South Asian and Latin American groups a variety of experiences of racism or racialised stereotyping were made visible. A South Asian woman noted an assumption that she would have diabetes because of her background, a Black mother noted her age and ethnicity might have impacted her care when she was overlooked by numerous practitioners, and many of the Latin American women detailed being ignored, underestimated or treated differently to those around them because they did not speak English fluently.

Participants described rude behaviour or offensive comments from healthcare professionals – a South Asian participant was called a “fat cow”, a Latin American woman’s mother was told to “shut up”, and a Black mothers mental health was overlooked by her general practitioner after giving birth. This demonstrates the need for more awareness around the kind of language used to



communicate with those from ethnic minority backgrounds and how microaggressions can reflect and effect a perception of the racial inequalities in maternal healthcare.

Healthcare Professionals

Among healthcare professionals, cultural and religious modes of expression were raised as frequently misunderstood or pathologized by practitioners, whether praying or speaking at a certain volume. Some of the Black participants in the healthcare professional group felt their ethnic or cultural congruence with a person seeking care made them more attentive to the variations in cultural practices that might make themselves visible in healthcare settings.

Listening

Service Users

A lack of clear communication, being overlooked, or not being listened to, or being told what to do were highlighted as common themes among the groups. In the Black and Mixed-Black group, a participant lists a number of things that happened to her without being given choice nor explanation, despite being a healthcare practitioner herself. The young mother in the Black and Mixed-Black group had an experience defined by not being listened to in multiple instances, her concerns were overlooked and she characterises this as negligence. This participant wanted referrals to be made and more communication between doctors and midwives. It was also central that doctors and midwives ensured those they were speaking to understood what was being communicated, as some women indicated feeling unsure or not knowing what was taking place.

The mode of communication, of listening, speaking and being heard, was seen as an important factor in the experience of a South Asian participant. She felt her midwives spoke to her abruptly

and impatiently, leading her to feel she could share her own concerns. Another participant in this group described being “addressed” by two midwives and a doctor about her emotional response to the birth of her child. Despite not feeling depression, she was referred to a specialist in this area, causing a “massive shock”. This draws out the importance of asking and listening attentively, and understanding responses to any event in the reproductive experience might not always look the same.

In the Latin American focus group, the confusion and lack of attentiveness around appointment confirmations was raised by one participant. She struggled to know whether her appointments were being upheld, and when she went to check she found they had been cancelled, or was asked to show identity documents to confirm she was on their systems. Her child passed away, which she pinned to, like the ‘young’ mother in the Black and Mixed-Black group, negligence by hospital staff, who did not listen to her concerns.

It is important to emphasise modes of listening that are attentive to emotional expression, rather than only listening to the words a person says. In the Latin American groups, crying was a central mode of emotional expression through which participants reflected fear, uncertainty, or a lack of understanding where translators were not available. A participant in the Black and Mixed-Black group also described crying to her doctor when a clear description of colic’s effects on her child was not given.

Healthcare Professionals

For healthcare professionals, listening was linked to structural and systemic constraints facing those working in the NHS. One of their central concerns in terms of *being listened to* was in their efforts to mobilise other council services in support of service users, as explored thematically in

advocacy and strengthening relationships with other services. In the focus group, this demonstrated that healthcare professionals are listening to the concerns raised by service users and understand the shared responsibility of public services to address their needs.

Healthcare professionals also emphasised the difficulty of communicating with those who speak English as an additional language or ensuring a shared understanding even when there was linguistic congruence. This broadens listening to include communication, encompassing the experiences of providing advice and ensuring understanding. For example, the obstetrician noted that providing information about the necessity of certain procedures, in this case a Caesarean section, could be difficult when the birthing person did not want to undergo the procedure. In expressing this concern, the professional linked listening to advocacy, highlighting the competing expectations of service users and professionals. A potential mode of ensuring effective listening and communication was having time to gather details about a service user and understanding the source of their concerns. This could aid professionals when providing explanation and reduce ambiguity around whether a concept has been understood.

Listening involved moving beyond spoken language and into other modes of communication for healthcare professionals also. Some were conscious of the variety of cultural expressions that could be easily misinterpreted on the wards. This could be related to religious expression or even the volume of the voice.

Stigma

Service Users

Few participants in these groups mentioned stigma by name, but they did allude to its presence in their treatment. For example, in the case study from the Black and Mixed-Black group on

'knowing the NHS', the participant noted how the midwife's comment about the epidural made her feel more comfortable accepting this form of pain relief. This was linked in her narrative to the midwife herself being Black, as the participant evokes a 'sisterhood' in the midwife's concern for her pain and experience. Moreover, the 'young' mother felt practitioners saw her in a certain light influenced by her age, gender and ethnicity. The idea that everyone was older than her impacted how she was listened to demonstrates her feeling of being judged, or stigmatised, because of her pregnancy at the age of twenty-one.

The Latin American group highlighted feeling stigmatised about going to work after giving birth during home visitations. Two participants felt the mode of questioning by their visitors was judgemental or rude, undermining their ability to be employed and care for their child. One of the participants felt better information about organisations or services to support new mothers, including Universal Credit, would have been beneficial.

Healthcare Professionals

In the focus group with healthcare professionals, stigma surrounding postpartum mental health emerged as a central concern. This was seen to have a far-reaching effect on communities and families, leading to feelings of debilitation caused by a lack of information. Stigma could also emerge through wider factors in the maternal experience, linked to the next theme of 'strengthening relationships with other services' where issues with housing, finances or violence are perceived to make it more difficult for service users to seek care from healthcare professionals.

Strengthening Relationships with Other Services

Service Users

Strengthening relationships with other services was raised primarily in the healthcare professional group, but was also apparent in the Latin American and Black and Mixed-Black groups.

The Latin American group centred the need for more robust support networks outside of hospital settings – such as knowing where they can find resources to look after their children, or financial and housing assistance.

In the Black and Mixed-Black group, participants alluded to the need for support in paediatric services (such as the child's colic diagnosis) and mental health. It was also found that the relationships and experiences of Black people with a range of healthcare services affected how a person expected they might be treated in maternal healthcare services, whether it be schools, mental health support for Black men, or a wider history of negligence or discrimination against Black women in medicine. It was positive when community-facing professionals were attentive to Black women's needs.

Healthcare Professionals

The healthcare professionals emphasised housing as an area of concern and a sense of helplessness. They felt the council was not responsive to practitioners' requests to make available safe, dignified housing for the service users struggling to find a comfortable place to live. They also noted empathy for those who are living in temporary housing or hotel rooms where they cannot cook for their children. Temporary housing for new or expectant mothers was additionally seen as a barrier to gaining employment because of the uncertainty and instability of this condition.

As indicated through the theme of stigma, some participants felt healthcare professionals could have been better at signposting them to relevant services, including Universal Credit, to support them after giving birth.

Continuity of Care

Service Users

Particularly in the Latin American group, continuity of care emerged as a possible tool to ensure women felt cared for and treated with respect and dignity where language barriers were a concern.

This theme also emerged in the Black and Mixed-Black group, as in the story from the 'young' mother who saw many different healthcare professionals, all of whom seemed to overlook her needs. Continuity of care could be most pivotal for those who occupy intersecting positions of structural disadvantage.

Healthcare Professionals

This theme also made itself visible both in the accepted meaning of the term – seeing the same person each time – and in the more expansive definition – ensuring robust care is provided once a person has given birth, 'the care continues'. For healthcare professionals, this meant looking at how negatively health-impacting factors such as poor housing, lack of cooking provisions or financial difficulty can be strengthened for those service users who need it most.

Cultural Competence and Sensitivity

Service Users

Across the service user groups a need for greater attention to cultural competence and sensitivity from healthcare professionals emerged. This was indicated in the Latin American women's descriptions of how they noticed or felt others were treated better than them due to a range of factors centring language. In one case, when a participant's mother was told to 'shut up', the need for this competency and sensitivity to be extended to the service user's family, friends of other intimate networks was emphasised.

In the South Asian group, as explored in the section on racism and racialised stereotyping, the idea that diabetes was most common amongst this "race" demonstrates the need for more robust anti-racist and cultural sensitivity or competency training. If comorbidities are found to have a high prevalence among certain ethnic groups, work should be done to ensure the communication of this likelihood is delivered sensitivity and with respect for the dignity of the service user and their own understanding of their healthcare conditions.

Moreover, in the Black and Mixed-Black group, where some of the respondents worked in healthcare themselves, their ability to advocate for themselves was not always bolstered by this position – at times they felt more wary about how they would be treated, and thus paid more attention to the tools of advocacy – because of their knowledge of healthcare cultures. In the extreme case of the young mother whose child was stillborn, she ties her treatment to healthcare professionals' perception of her as a young black mother, and the societal tropes and stereotypes surrounding this intersection.

Healthcare Professionals

Healthcare professionals touched on the theme of cultural competence in reference to the beliefs or expressions of service users. They also found certain conditions, medical and otherwise, might be more stigmatised in certain ethnic groups, where approaching NHS services for assistance might be made difficult because of how they think they will be perceived. This was indicated in the cognitive behavioural therapist's insights.

Intimate Network Involvement and Support

Service Users

Many of the participants spoke about the role of their intimate network in providing support during their maternal experience. Whether this was one's husband, friend, or mother, or even a friend who was a midwife or a stranger in a park, participants utilised a range of social support networks in and outside of hospital settings. This highlights the need to be attentive to the role wider intimate networks play, and include them in efforts to address maternal health inequalities.

Supporting Equity and Justice

Significantly, this report provides vital information in supporting Southwark's goal to become a borough of equity and justice. First, the report highlights the connections between maternity care and other social provisions and support in the area including housing, mental health support, community groups and networks, language and interpretation services, social services, children's services, and health and cultural education. Listening attentively to the voices of those who participated places Southwark in a strong position to affect local police and ensure trust, accountability and openness in the borough.

To promote justice, it is central to consider the competing interests of those in a position to affect change and ensure equitable delivery. For example, as much as some of the participants in the Latin American group felt wider structural constraints affected their care and treatment, healthcare professionals sometimes felt immobile in addressing their key concerns. Many healthcare professionals take it upon themselves to learn how best to navigate the difficulties of working in the NHS in a context of short appointments, limited resources and wider social challenges. However, the healthcare professionals noted they cannot be solely responsible for ensuring good health and equitable treatment, when attempts to improve the overall health-impacting conditions of those they serve can be difficult or feel inadequate – such as writing a letter to no effect. Thus, in addressing the findings of this report, it is important to consider these connections and strive to empower each group through robust systems of support across the board.

Recommendations

6. Strengthen community support

- a. Provide tailored group care in the antenatal and postnatal period
- b. Chart existing organisations already providing support and advice for women from diverse ethnic backgrounds in the borough
- c. Ensure funding and space for social gatherings to promote advocacy and knowledge exchange between mothers, healthcare professionals and wider support networks (including friends and family)
- d. Devise stigma reduction strategies with community groups and organisations representing marginalised populations in Southwark

7. Ensure availability of interpretation and translation services

8. Strengthen the capacity for healthcare professionals to advocate for service users

- a. Strengthen healthcare professionals' capacity to communicate and advocate across other Southwark Council services, including housing, Universal Credit or financial services, and child support
- b. Ensure healthcare professionals have time to provide personalised care to service users, particularly those speak English as an additional language
- c. Ensure continuity of care is available to those who need or request it, particularly those who speak English as an additional language
- d. Implement mandatory anti-racism and cultural competency or sensitivity training for maternity staff across a range of departments (i.e perinatal mental health, obstetrics, midwifery, home visitation)
- e. Provide tailored training on kindness, empathy and respect learning from the accounts of those in the community emphasising tone, language and questioning
- f. Ensure information is provided sensitively and accurately to all service users, particularly when using remote communication devices such as telephones

9. Ensure robust breastfeeding support for all service users after birth

10. Ensure robust mental health support at all stages of maternity care

- a. Make sure signposting to services both in and outside of the NHS is clear and available

Appendix

Appendix 1: STAG Responses Table

Where did you receive maternity care?	When was your last experience of maternity care?	How was your experience of antenatal care?	How was your experience of care during childbirth?	How was your experience of postnatal care?	Please share any comments or feedback about your experience of maternity care here	What happened to you and your baby, how easy were services to use and what was your experience of maternity care?	Had you experienced poor mental health after your baby was born?	If yes, was it easy to get support for your mental health after your baby was born?
Bromley University Hospital	6-12 months ago	Very positive	Very positive	Very positive	I had great care.	They did contact me all the time.	No	N/A
St Thomas' Hospital	2-5 years ago	Very positive	Very positive	Positive	Some great views	We were contacted at all times	No	N/A
St Thomas' Hospital	6-12 months ago	Neutral	Neutral	Neutral	They weren't the best but I did receive after care	I had to ring them.	No, I don't think so.	N/A
St Thomas' Hospital	2-5 years ago	Positive	Positive	Positive	All good.	All good.	No	N/A

Lewisham	6-12 months ago	Negative	Negative	Negative	Not so good.	Not the best service	Yes	No
St Thomas' Hospital	1-2 years ago	Positive	Positive	Positive	I had some great experience and understanding	We were looked after	No	N/A
Bromley University Hospital	6-12 months ago	Neutral	Neutral	Neutral	It was OK	Fine	No	N/A
St Thomas' Hospital	1-2 years ago	Positive	Positive	Positive	It was fine.	We were looked after	No	N/A
Kings College Hospital	2-5 years ago	Positive	Positive	Neutral	I did think they could do better with our community Explained things better	Not too easy to use	Yes, some?	No, not really
St Thomas' Hospital	More than 5 years ago	Positive	Positive	Positive	It was fine, as expected	It was fine	No	N/A



The Motherhood Group - STAG 'Mums Connect' online sharing session



External Inbox



Faylisha Scott <faylisha@themothhoodgroup.com>

Fri, Apr 26, 2:04 PM



to manager, Sandra

Hi Alison,

I'm Faylisha from The Motherhood Group, a social enterprise supporting women on their maternal journey. We have an exciting opportunity for mums in Southwark to make a difference and earn a **£30 Amazon Gift voucher!**

We're partnering with Southwark Council to improve local healthcare by listening to the experiences of mothers like you and we'd love to hear from you and your mums.

Join us for a supportive, women-only online session on: Thursday, 16th May, from 10am-11am.

Share your story in a safe space and help shape better maternal care for the community.

To thank you for your time and valuable insights, we're offering a £30 Amazon Gift voucher to all participants who register and attend the session.

Interested in making a difference? Simply reply to this email with your name and email address, and we will send a calendar invite to join our session. Feel free to share this opportunity with other mums in your network who might want to contribute.

If you have any questions, please don't hesitate to reach out. We look forward to hearing from you and amplifying your voice to create positive change.

Best wishes,

Faylisha



Faylisha Scott | Project and Fundraising Manager
faylisha@themothhoodgroup.com

The Motherhood Group, Tripod, Lambeth Town Hall,
 1 Brixton Hill, London SW2 1RW
www.themothhoodgroup.org



Coordinators of:

New Message



Appendix 3



THU 06/06/24 11:45AM - 1PM

Maternity Care Professionals Virtual Lunch & Share

Calling all healthcare professionals who work at King's Hospital, Guy's and St Thomas' Hospital, Maudsley Hospital, or are residents in Southwark!

Join us for a virtual Lunch and Share workshop to discuss your experiences in providing maternity care and engaging with Black, Asian, and ethnic minority groups in Southwark. Your insights will help improve outcomes for mothers in our community.

By attending you can:

- Share your experiences
- Provide input
- Contribute to improve
- Network

Register via Eventbrite
Don't miss this opportunity to make a difference in Southwark's Maternity Care



THE MOTHERHOOD GROUP

Southwark Council

Virtual Lunch & Share Workshop for HCP

The Motherhood Group and Southwark Maternity Commission have partnered to make a difference in the lives of Black, Asian, and ethnic minority mothers in our community. We invite you to join our virtual Maternity Care Professionals Lunch and Learn Workshop on 6th June 2024 from 11:45am - 1pm. During this workshop, you'll have the opportunity to:

- Share your experiences, challenges, and successes in delivering maternity care 🗣️
- Provide valuable input on how to better engage with and support Black, Asian, and ethnic minority mothers 💡
- Contribute to the development of recommendations for improving maternity services in Southwark 🌍

[SUBSCRIBE TO THE NEWSLETTER](#)


Amplifying Voices: The Southwark Maternity commission Partnership

As part of our ongoing work with the Southwark Maternity Commission Partnership, we are committed to addressing inequalities in maternity care. The Motherhood Group is engaging with 50 mothers from diverse cultural backgrounds, while the Commission aims to reach 1,000 mothers through their survey.

By participating in this initiative, we will contribute to the Commission's goal of assessing local disparities in access, experience, and outcomes for ethnic minorities and socially disadvantaged groups, particularly those from Black ethnic backgrounds. The Commission will also evaluate the implementation of national recommendations and identify areas for improvement in Southwark's maternity and neonatal system.

Your voice matters - if you're a Southwark resident, hospital staff member, or healthcare professional, we invite you to complete the Southwark Maternity Commission's survey for a chance to win a £50 Love2Shop voucher and help shape a better future for mothers and babies in our community.

[Survey: Share your experience of maternity care](#)



Would you like to share your maternal experience to improve maternal health outcomes for Black Women?

We are looking for:

**Black and Black Mixed Heritage mothers
Who have given birth in Kings College or Guy's
St Thomas Hospital
Given birth in the last 5 years**

Thursday, 11th June 2024
12pm- 14:30pm
@ Peckham Library, 122 Peckham Hill Street, SE15 5JR

Childcare is available upon request

All participants will receive a £50 Love2Shop voucher

Email to register : faylisha@themotherhoodgroup.com



Appendix 4

The job titles or professions provided by the healthcare professionals who participated in the focus group included, excluding repetitions:

- 'Specialist Cognitive Behavioural Psychotherapist'
- 'SLP Perinatal Improvement Workstream – Health Inequalities (South London and Maudsley)'
- 'Engagement – South East London Integrated System (Partnership Southwark)'
- 'Healthcare Professional NHS'
- 'Clinical Service Lead, South London and Maudsley'
- 'Community Learning and Disability Nurse, Guys and St Thomas' NHS Trust'
- 'Consultant Obstetrician'
- 'Portfolio Manager – Impact on Urban Health'



- 'Nurse – South London and Maudsley'
- 'Perinatal Equity Lead'
- 'Advisory Specialist'
- 'Nurse'
- 'Specialist Health Visitor'
- 'Doula and Birth Support'
- 'Bank Midwife – Kings' College London'

Citations and Resources

APPG Birth Trauma. (2024). *Listening to Mums: Ending the Postcode Lottery on Perinatal Care*. APPG. Available at: https://www.theo-clarke.org.uk/files/2024-05/Birth%20Trauma%20Inquiry%20Report%20for%20Publication_May13_2024.pdf. Accessed: 4/6/24.

Crenshaw, K. (1991). Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Colour. *Stanford Law Review*, 43(6). Pp.2141-1299.

Birthrights. (2022). *Systemic racism, not broken bodies: An inquiry into racial injustice and human rights in UK maternity care. Executive Summary*. Birthrights. Available at: https://www.birthrights.org.uk/wp-content/uploads/2022/05/Birthrights-inquiry-systemic-racism_exec-summary_May-22-web.pdf. Accessed: 21/2/24.

The Breastfeeding Network. (2023). *Black Breastfeeding Week: Facing up to power and privilege*. TBN (online). Available at: <https://www.breastfeedingnetwork.org.uk/black-breastfeeding-week-facing-up-to-power-and-privilege/>. Accessed: 5/6/24

Peter, M. and Wheeler, R. (2022). *The Black Maternal Experience Survey: A Nationwide Study of Black Women's Experiences of Maternity Services in the United Kingdom*. FIVEXMORE. Available at: <https://fivexmore.org/embargoed-report>. Accessed: 2/1/23.

Southwark Public Health Division Children's and Adult's Services. (2023). *Census 2021 Results: Ethnicity, National Identity, Language and Religion*. Southwark Council. Available at: <https://www.southwark.gov.uk/health-and-wellbeing/public-health/southwark-health-data/our->



[population/census-and-](#)

[demographics?chapter=2#:~:text=In%20Southwark%2C%20just%20over%20half,one%2Dquarter%20of%20Southwark%20residents..">demographics?chapter=2#:~:text=In%20Southwark%2C%20just%20over%20half,one%2Dquarter%20of%20Southwark%20residents..](#) Accessed: 1/7/24.

Appendix 3

Southwark Maternity Commission 2023-24

WRITTEN EVIDENCE SUBMISSION: South East London Local Maternity and Neonatal System (LMNS)

Submitted: 17 January 2024

INTRODUCTION

The Southwark Maternity Commission has three key objectives:

- Assess local inequalities in the access, experience and outcomes for maternity services, specifically for those parents from ethnic minorities and / or socially disadvantaged backgrounds, in particular those from a Black ethnic background.
- Assess the implementation of national recommendations for maternity services to improve access, experience and outcomes and reduce inequalities.
- Identify additional areas for action and improvement for Southwark birthing people as part of the local maternity and neonatal system.

In undertaking its work, the commission will:

- Listen to the views and experiences of local women, birthing people and families.
- Listen to the views of our midwifery and wider workforce that support women, birthing people and families during pregnancy and the early years.
- Review progress on the implementation of national best practice guidelines across local maternity and neonatal services and progress on Local Maternity and Neonatal System (LMNS) wide action plans.

In order to support the commission to achieve its aims, we are asking each of our main providers of maternity care for Southwark residents to complete this written evidence submission. This will provide us with a background of how each organisation operates, and allow our Commission panel to form questions, based on their responses.

We are keen to hear from the LMNS in addition, to hear how commissioners, providers and service users are brought together to develop local strategy and provides oversight to each of the Trusts within the system. The questions are broken down into the following sections:

1. Local picture
2. Organisational practice
3. MBRRACE (2023) recommendations

If you have any questions, please contact MaternityCommission@southwark.gov.uk

Many thanks for your help in providing information to the Southwark Maternity Commission.

1. WHAT IS THE LMNS?

Function of the LMNS within South East London and Southwark

Please explain the role of the South East London Local Maternity and Neonatal System

The Local Maternity and Neonatal System (LMNS) is a partnership between providers, commissioners, user representatives and other stakeholders working together to improve and transform maternity and neonatal services. LMNSs have been in place for a number of years, with a number of different guises, but the role has changed significantly over time.

Local Maternity Systems (LMS) were originally formed following the publication of Better Births a national maternity review that was conducted in 2016, with an initial core focus to support service improvement. In more recent years and in response to the various reports such as Ockenden and East Kent, the LMNS as the maternity and neonatal arm of the ICB, remit has broadened. LMSs were changed to LMNSs to include responsibility for aspects of neonatal care and also greater responsibility to ensure that the maternity services they represent provide safe and quality services for all those that access them.

Please describe your relationship with the providers of maternity services in Southwark.

Due to the nature of the LMNS the relationship with the maternity and neonatal providers has been strengthened over the years. As key members, and working with all other stakeholders, the providers are collaborators and decision makers for the whole system. The LMNS has two clinical co-chairs, an obstetrician and a senior midwife and a lead neonatologist, who with the SRO, Head of Maternity and project management team provide leadership to the LMNS. The chair roles are two-year fixed term positions, this enables a rotation of senior clinical leaders across the LMNS to be involved and engaged.

The LMNS has a vast work programme of improvement, working closely with key provider leads to implement changes as required, whilst ensuring that we deliver on national and local expectations.

2. LOCAL PICTURE

Data requests

Please provide any relevant Southwark specific maternity data you hold, against the LMNS average, for up to the last five years where available.

Including:

- No. of Southwark residents giving birth at each Trust
- Maternal mortality rates
- Infant mortality rates
- Maternal morbidity rates (e.g. excessive blood loss, perineal tearing)
- Infant morbidity rates (e.g. intracranial haemorrhage, fractures, nerve damage)
- Average age
- Ethnicity
- Socioeconomic status
- Long term conditions
- Continuity of carer

Any other available and relevant data sets.

Making best use of data
How does the LMNS use demographic data to assess local need? (max 250 words)
<p>The LMNS uses both quantitative and qualitative data to assess local need. The LMNS has a data dashboard that is currently being updated by the ICB business intelligence team. The dashboard provides data on key outcome metrics and will have the ability to interrogate further and provide further intelligence about the communities that we serve.</p> <p>The LMNS also receives data directly from the three maternity and neonatal providers, this is shared as part of the six weekly quality surveillance group, and is discussed as a peer group, with support in place if any themes arise.</p> <p>The LMNS also collects qualitative data, working closely with our Maternity and Neonatal Voices Partnerships (MNVPs), community organisations and patient advisory groups. We are currently carrying out a large community engagement project with a number of community organisations around access and experience of maternity and neonatal care for those women and birthing people who are underrepresented in our communities.</p>
How does the LMNS share data on demographics and local need with other partners? (e.g. local authorities, partner organisations) (max 250 words)
<p>The LMNS is a system level entity that works to share and learn together to improve the experience and outcomes of women and birthing people, their baby's, and families. Membership is wide and inclusive. Data and feedback is shared in various formats. Because the LMNS historically worked to support improvements in provider services this is where strong relationships have been formed. We recognise now that this needs to include colleagues across the wider ICS, so we are now building wider relationships with local authorities and public health teams to enable a collaborative approach.</p>
Health inequalities
How does the LMNS use local data to identify health inequalities? (max 250 words)
<p>The LMNS uses both local and national data to identify health inequalities. The national data is from the MBRRACE (Mother and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) reports. These reports provide stabilised and adjusted data for regions and individual trusts.</p> <p>Local data quality can be a challenge but this has been improving year on year. As previously mentioned, we will be able to dig deeper with outcomes data cross referencing ethnicity, deprivation, smoking etc.</p> <p>We also use feedback from women and birthing people, this feedback is incorporated into appropriate actions plans.</p>
What steps do the LMNS take to reduce identified health inequalities? (max 250 words)
<p>Some examples of what we have implemented to reduce inequalities as an LMS are;</p> <ul style="list-style-type: none"> • A LMNS equality and equity action plan (update in progress) with a published public facing easy read version. • Community engagement project – five community organisations have been commissioned to engage with local women and birthing from underrepresented groups to hear about their experiences and challenges faced when accessing maternity care. • The LMNS has an inequalities workstream with membership from providers and service users and this is the working group that will lead on the E&E action plan.

- A LMNS/Southwark pilot of maternity mates – providing support to women and birthing people that may require advocacy. ‘Maternity mates are recruited from the communities and where possible will speak the same language as the mother-to-be. Maternity mates support the woman to help her understand the issues and decisions that affect her care, and that of her baby’
- LMNS Birth choices project – information, resources, and recommendations for personalised maternity care, with the aim to give consistent evidence-based information in response to feedback from service users.
- LMNS pilot – Parent education in different languages – top six spoken languages in SEL – Spanish, Portuguese, Somali, Arabic and French – resources and staff who can facilitate have been agreed.
- Translation of various maternity resources in the top languages for each provider trust.
- Bexley ‘Mumma’s Together’ pilot group – weekly group sessions for Black and Brown mums, talking all things motherhood, well-being, mental health, family, culture and more, with support from local midwives and the HELIX perinatal mental health team. Due to the success of this group, it is now being rolled out in Greenwich.
- In collaboration with FiveXMore funding to provide colourful wallets for Black and Brown women with advocacy messaging
- Provision of cultural sensitivity training for maternity staff from FiveXMore.
- Working with young Mums Support Network on how we can improve care and support for this group of women/birthing people.
- The providers also have a number of local projects/initiatives in place to support the reduction in inequalities such as LGT Pride in Practice award, cultural humility pledges, not charging women who have no recourse to public funds if they experience a pregnancy/baby loss. Local MNVP work to engage with local women and birthing people. GSTT anti-racist initiative, an action plan to be an actively anti-racist organisation. King’s working closely with the MNVP focusing on Black service users in particular those that have experienced loss with plans for Black listening events taking place early this year.

3. ORGANISATIONAL PRACTICE

Organisational culture
What measures are your organisation taking to ensure equality, diversity and inclusion for your staff? (<i>e.g. ensuring all receive the same opportunities to grow professionally</i>) (max 250 words)
ICB
What efforts are your organisation making to diversify your workforce? (<i>e.g. what hiring and retention policies exist?</i>) (max 250 words)
ICB
What measures are your organisation taking to ensure equality, diversity and inclusion for your patients? (<i>e.g. staff training on cultural and medical elements</i>) (max 250 words)
ICB
What measures are your organisation taking to understand and tackle institutional racism and how it operates in your organisation? (<i>e.g. is anti-racism and bias training mandatory for all maternity staff, and how often is this completed?</i>) (max 250 words)

ICB

Working with others to improve non-health factors that affect your patients' health

How do you work with and learn from other organisations to address the impacts of wider non-health factors affecting the health of your patients? (e.g. *Housing status, income maximisation, employment issues*) (max 250 words)

ICB

What roles in governance do organisations such as Maternal and Neonatal Voices Partnership (MNVP) and local groups working on black maternal health have? How are their voices and expertise used? (max 250 words)

The MNVPs are part of the LMNS. The chairs are remunerated for their work and we liaise closely with them around system wide and local complexities and issues.

Regulation of services

How do you support Guy's and St Thomas and King's College Hospital to act on the recommendations for improvement made in Care Quality Commission inspection reports? (max 250 words)

The LMNS has an oversight role regarding CQC reports. The trusts have action plans based on the CQC recommendations . Recommendations are picked up as part of the LMNS quality surveillance group.

4. MBRRACE RECOMMENDATIONS (2023)

“Saving Lives, Improving Mothers’ Care Core Report - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2019-21” – the MBRRACE 2023 Report. It highlighted that when deaths due to COVID-19 in 2020 and 2021 were excluded, maternal death rates were very similar over the last 2 reporting periods (2016-2018 and 2019-21), which suggests that an even greater focus on implementation of the recommendations of these reports is needed to achieve a reduction in maternal deaths (and morbidity).

How are you considering and addressing the recommendations made by the MBRRACE 2023 Report?

What processes do your organisation already have in place to consider the recommendations? (max 250 words)

MBRRACE recommendations are picked up through the various LMNS workstreams and within the equality and equity action plan but also through the various clinical networks in place, including the Maternal Medicine Network. The MBRRACE data provided is retrospective data, but it is stabilised and adjusted so provides us with the most robust data. If any of the provider trusts are an outlier for any of the datasets then they are asked by the regional maternity team to carry out a deep dive into the cases and if there were any particular themes or findings that can be improved on. This is then shared across the SEL LMNS for learning. If particular support can be given to a particular trust, then this is provided within the LMNS or escalated as appropriate.

How is your organisation planning to implement the recommendations? (max 250 words)

The LMNS will provide support and oversight of the implementation of the Maternity and Neonatal Three-Year Delivery Plan. This plan encompasses the roles and responsibilities of providers, LMNS/ICB and the national team in regards to national programmes and findings. Oversight of this sits with the LMNS quality surveillance group.

Appendix 3

Southwark Maternity Commission 2023-24

WRITTEN EVIDENCE SUBMISSION: Guy's & St Thomas NHS Foundation Trust

Submitted: 9 January 2024

INTRODUCTION

The Southwark Maternity Commission has three key objectives:

- Assess local inequalities in the access, experience and outcomes for maternity services, specifically for those parents from ethnic minorities and / or socially disadvantaged backgrounds, in particular those from a Black ethnic background.
- Assess the implementation of national recommendations for maternity services to improve access, experience and outcomes and reduce inequalities.
- Identify additional areas for action and improvement for Southwark birthing people as part of the local maternity and neonatal system.

In undertaking its work, the commission will:

- Listen to the views and experiences of local women, birthing people and families.
- Listen to the views of our midwifery and wider workforce that support women, birthing people and families during pregnancy and the early years.
- Review progress on the implementation of national best practice guidelines across local maternity and neonatal services and progress on Local Maternity and Neonatal System (LMNS) wide action plans

In order to support the commission to achieve its aims, we are asking each of our main providers of maternity care for Southwark residents to complete this written evidence submission. This will provide us with a background of how your organisation operates, and allow our Commission panel to form questions, based on your responses. The questions are broken down into the following sections:

1. Organisational practice
2. MBRRACE (2023) recommendations
3. Access
4. Experience
5. Outcomes

If you have any questions, please contact MaternityCommission@southwark.gov.uk

Many thanks for your help in providing information to the Southwark Maternity Commission.

1. ORGANISATIONAL PRACTICE

Keeping informed of national learnings

How does your organisation keep abreast of national learnings (e.g. MBRRACE reports, APPG, NICE guidelines etc.)? (max 250 words)

Following publication of national reports and recommendations the Trust Quality Team and the Maternity Clinical Governance Teams review national guidelines (NICE) and national reports. A gap analysis is carried out to measure compliance and areas for improvement. Learning from national reports (e.g; MBRRACE) is presented and discussed with the wider maternity team during mandatory training sessions and Clinical Governance multidisciplinary meetings. Maternity and neonatal guidelines are updated according to best practice recommendations.

The maternity service reports compliance through the Quality and Performance (Q & P) Board as well as the Trust Risk Assessment Committee (TRAC). We also report to the South East London (SEL) Local Maternity and Neonatal System (LMNS) via the Quality Surveillance Group and the Evelina London Clinical Group Performance Review Meetings and the Clinical Group Clinical Governance meetings.

Regional reporting of maternity and neonatal quality and performance metrics occurs via the London Perinatal Board to measure individual Trust and regional maternity and neonatal safety metric compliance with correlation to national recommendations.

How does your organisation decide which recommendations they will implement and then monitor progress of that implementation? (max 250 words)

All mandated national recommendations are implemented, and clinical audit carried out to measure compliance and identify areas for improvement.

Our organisation produces up to date guidelines which are reviewed regularly and if new guidelines are published our maternity Clinical Governance team will oversee the maternity guideline group to update the maternity guidelines.

The Clinical Governance Team and senior maternity leadership team will evaluate national recommendations and align with local feasibility, prioritisation and cost-effectiveness. The maternity service will then audit performance and compliance regularly to demonstrate adherence and quality improvement with improvement actions introduced when needed. This allow us to ensure successful implementation and optimal healthcare outcomes.

Organisational culture

What measures are your organisation taking to ensure equality, diversity and inclusion for your staff? (e.g. ensuring all receive the same opportunities to grow professionally) (max 250 words)

1. **Diverse Recruitment Practices:** Implementing inclusive recruitment strategies to attract candidates from diverse backgrounds, ensuring equal opportunities for all applicants. Maternity recruitment panels must consist of representatives from a global majority background.
2. **Training and Development:** Providing diversity training to employees and management teams to foster understanding, respect, and awareness of different cultures, perspectives, and identities. Additionally, offering professional development opportunities equally to all staff members, irrespective of their background. The maternity service has been highly commended for a Trust Kofoworola Abeni Pratt Fellowship Inclusion Award and is supporting midwives to undertake the Fellowship Programme to enhance EDI initiatives in the workplace and to support professional development.
Bespoke annual mandatory training is provided for all maternity staff by the Maternity Anti-Racism Implementation (ARIA) Group. The Trust maternity service was awarded the Capital Midwife Anti-Racism bronze accreditation, demonstrating commitment to addressing racism in maternity services. The Trust was one of two London Trusts to receive the Capital Midwife Accreditation award.
Another annual maternity training session delivers Equality, Diversity and Inclusion for staff, which supports discussion of issues and supportive programmes for staff.
3. **Supportive Work Environment:** Creating a workplace culture that values and respects diversity by establishing inclusive policies, support networks, and employee resource groups that encourage collaboration and understanding among diverse groups.
4. **Equal Opportunities for Advancement:** Ensuring fair and transparent promotion processes, mentorship programs, and leadership development initiatives that offer equal opportunities for career advancement to all employees. Career clinics are available for staff from the global majority with career pathways and coaching for employees encouraged. A reverse mentoring programme is also available for Trust employees, particularly for those in a leadership or management role.
5. **Regular Diversity Assessments:** Conducting regular assessments or surveys to measure diversity, equity, and inclusion within the organization and using this data to drive improvement initiatives. Workforce Race Equality Standard (WRES) data is used to measure employment of staff in all bandings and roles across the maternity service.
6. **Flexible Policies:** Implementing flexible work arrangements and policies that accommodate diverse needs, such as parental leave, flexible scheduling, and accommodations for disabilities.
7. **Leadership Commitment:** Having visible and committed leadership that champions diversity and inclusion, setting the tone from the top down and holding themselves accountable for creating an inclusive workplace culture.

These measures collectively contribute to fostering an environment where all staff members feel valued, respected, and provided with equal opportunities to thrive personally and professionally regardless of their background.

What efforts are your organisation making to diversify your workforce? (e.g. what hiring and retention policies exist?) (max 250 words)

1. **Inclusive Recruitment Strategies:** Implementing practices to attract a diverse pool of candidates, such as using diverse job boards and using inclusive language in job descriptions.
2. **Diverse Hiring Panels:** Ensuring diverse representation on hiring panels to mitigate bias and provide varied perspectives during the hiring process.
3. **Unbiased Selection Processes:** Implementing blind recruitment techniques (like anonymizing resumes) to focus solely on skills, experience, and qualifications rather than demographic information.
4. **Diversity Training:** Offering training to hiring managers and employees involved in the recruitment process to raise awareness about unconscious bias and foster a more inclusive hiring culture.
5. **Supportive Work Environment:** Creating an inclusive workplace culture that values diversity and provides support networks, mentorship programs, and resources for employees from various backgrounds.
6. **Retention Strategies:** Developing policies that prioritise inclusivity, equity, and career development opportunities for all employees to enhance retention rates across diverse groups within the organization.
7. **Regular Evaluation and Adjustments:** Continuously assessing diversity metrics, analysing retention rates, and seeking feedback from employees to identify areas for improvement and adjust strategies accordingly.

What measures are your organisation taking to ensure equality, diversity and inclusion for your patients? (e.g. staff training on cultural competence, medical implications, such as recognising shock in brown and black skinned patients) (max 250 words)

1. **Cultural Competence Training:** Providing staff with training to enhance cultural competency, ensuring they understand diverse cultural practices, beliefs, and values that may impact healthcare decisions and interactions with patients.
2. **Diverse Representation:** Ensuring diversity among healthcare providers to better reflect the patient population, which can enhance trust and communication between patients and providers.
3. **Language Access:** Offering interpreter services and multilingual staff to facilitate effective communication with patients who may have limited proficiency in the primary language used in the healthcare setting.
4. **Awareness of Medical Implications:** Providing education to healthcare professionals about medical conditions that may present differently based on ethnicity or skin tone, such as recognizing symptoms of certain illnesses or conditions that might manifest differently in diverse patient populations. An example of this is demonstrated by the maternity and neonatal services following the recommendations from the NHS Race and Health Observatory, Review of neonatal assessment and practice in Black, Asian, and minority ethnic newborns.
5. **Health Equity Policies:** Implementing policies that focus on health equity and reduce disparities in healthcare access and outcomes among different demographic groups. (eg: Lambeth Early Action Partnership, LEAP Caseload). The Chair of the Trust Maternity and Neonatal Voices Partnership (MNVP) works collaboratively with the services to improve equity in healthcare provision particularly those who have poorer health outcomes. Co-production of services occurs with the MNVP to implement recommendations from national reviews, such as the Fivetimes More Campaign to improve equity in healthcare for women and babies from a black ethnic background.

6. **Inclusive Healthcare Practices:** Developing inclusive practices that consider the needs of diverse patient groups, including those related to gender identity, sexual orientation, disability, and socioeconomic status.
7. **Patient-Centered Care:** Encouraging a patient-centered approach that respects and integrates patients' cultural beliefs, preferences, and values into their care plans.
8. **Regular Evaluation and Improvement:** Continuously assessing patient satisfaction, healthcare outcomes, and disparities among different groups to identify areas for improvement and adjust practices accordingly.

What measures are your organisation taking to understand and tackle institutional racism and how it operates in your organisation? (e.g. is anti-racism and bias training mandatory for all maternity staff, and how often is this completed?) (max 250 words)

1. **Anti-Racism Training:** Implementing mandatory training sessions for all staff members to raise awareness about institutional racism, unconscious bias, and ways to mitigate their impact. This is done through our PROMPT annual mandatory training.
2. **Policy Reviews and Revisions:** Conducting regular reviews of organizational policies, procedures, and practices to identify and address any systemic biases that may perpetuate institutional racism. This could involve evaluating hiring practices, patient care protocols, and interactions with diverse patient populations.
3. **Diversity Committees or Task Forces:** Establishing committees or task forces dedicated to diversity, equity, and inclusion initiatives. These groups can analyze data, propose changes, and advocate for strategies to address institutional racism within the organization.
4. **Cultural Competence Training:** Offering specialised training programs focused on cultural competence, especially in areas like maternity care, to ensure staff members are equipped to provide inclusive and respectful care to patients from diverse backgrounds. (PROMPT, Fivetimes More and the Maternity Anti-Racism Implementation Advisory Group (ARIA) training).
5. **Regular Assessments and Reporting:** Conducting regular assessments of diversity metrics, such as patient satisfaction, staff composition, and disparities in healthcare outcomes among different racial or ethnic groups. Organizations can use this data to measure progress and identify areas that need improvement. The Maternity and Neonatal Voices Partnership and SEL Local Maternity and Neonatal System (LMNS) works collaboratively with the maternity and neonatal services to assess and discuss views and experiences of women and families from the global majority to inform and improve care.
6. **Promotion of Equity-Centred Policies:** Implementing policies and practices that promote equity and inclusivity, such as ensuring equitable access to resources, opportunities, and healthcare services for all patients regardless of race or ethnicity.
7. **Encouraging Open Dialogue:** Creating a culture that encourages open discussions about racial biases, systemic racism, and their impact within the organization, fostering an environment where staff feel comfortable raising concerns and proposing solutions. Multidisciplinary discussions during annual mandatory training sessions regarding racism, unconscious bias and reducing inequalities in healthcare.

Working with others to improve non-health factors that affect your patients' health

How do you work with and learn from other organisations to address the impacts of wider non-health factors affecting the health of your patients? (e.g. Housing status, income maximisation, employment issues) (max 250 words)

1. **Partnerships and Collaborations:** Engaging with community organisations, government agencies, non-profits (NCB and Big Lottery, and social service providers to form partnerships). These collaborations allow for a more holistic approach to address social determinants of health (SDOH) like housing, income, and employment.
2. **Referral Networks:** Establishing referral networks or integrated care models that connect healthcare providers with social service agencies. This enables seamless referrals for patients requiring support with housing, income assistance, job training, or other social needs through specialist safeguarding midwives.
3. **Data Sharing and Analysis:** Sharing anonymised patient data (in compliance with privacy regulations) between healthcare organisations and social service providers to identify trends, gaps, and areas needing intervention related to social determinants of health.
4. **Care Coordination and Case Management:** Implementing care coordination programs that involve case managers or social workers within healthcare settings. These professionals work directly with patients to assess social needs, provide resources, and coordinate access to social services.
5. **Advocacy and Policy Initiatives:** Collaborating with other organizations to advocate for policy changes that address systemic issues impacting social determinants of health, such as affordable housing policies, living wage initiatives, or employment support programs.
6. **Community Outreach and Education:** Conducting community outreach programs to educate patients about available resources and how to access support for issues like housing stability, financial assistance, or job training programs.
7. **Cross-Sector Training and Workshops:** Offering training sessions or workshops that bring together healthcare professionals, social service providers, and community advocates to share knowledge, best practices, and strategies for addressing social determinants of health collectively.

What training do maternity staff receive in identifying these wider issues in patients and signposting appropriately? (max 250 words)

1. **Social Determinants of Health (SDOH) Awareness:** Training to understand how social factors such as socioeconomic status, housing, education, employment, and access to resources can influence maternal health outcomes. This includes recognising signs or indicators of these issues during patient interactions.
2. **Cultural Competence and Diversity Training:** Learning about cultural diversity and sensitivity, enabling staff to provide care that respects and aligns with various cultural beliefs, practices, and preferences of diverse patient populations.
3. **Effective Communication Skills:** Training on active listening and effective communication techniques that allow maternity staff to engage with patients, understand their needs, and discuss sensitive issues related to social determinants of health.
4. **Screening Tools and Assessment Techniques:** Education on using standardized screening tools or assessment methods to identify patients who might be at risk due to social determinants. This aids in early identification and intervention.
5. **Referral Procedures and Resource Awareness:** Understanding available community resources, social service agencies, and referral pathways to appropriately guide and support patients facing challenges related to housing, financial issues, mental health, substance abuse, or other social needs.

6. **Ethical and Legal Considerations:** Education on the ethical and legal aspects of addressing social determinants of health, including patient confidentiality, consent, and appropriate documentation of social issues in patient records.
7. **Continuing Education and Updates:** Continuous learning and updates on new developments, resources, or changes in policies and services that impact the referral and support systems available to patients.

What roles in governance do organisations such as Maternal and Neonatal Voices Partnership (MNVP) and local groups working on black maternal health have? How are their voices and expertise used?

1. **Advocacy and Policy Influence:** Our local MNVPs, advocate for policies that address disparities in maternal healthcare, especially concerning black maternal health. Our Trust MNVP co-wrote the Five times more report and co-chairs the group and work with lawmakers, healthcare institutions, and government bodies to push for legislative changes aimed at improving care and outcomes for black mothers and infants.
2. **Community Engagement and Education:** MNVP and local groups often engage with communities, raising awareness about issues related to black maternal health. They provide education, resources, and support to empower individuals to understand their rights, access healthcare services, and advocate for improved care. The SEL LMNS and the maternity service have successfully piloted information wallets (which hold a women's hand held maternity notes), for women from the global majority to provide information to raise awareness and empower women and birthing people.
3. **Collaboration and Partnerships:** MNVP and local groups collaborate with healthcare providers, policymakers, researchers, and community leaders to foster partnerships. They contribute their expertise, lived experiences, and perspectives to these collaborations, ensuring that diverse voices are heard and considered in decision-making processes.
4. **Advisory and Consultative Roles:** These organizations may serve in advisory or consultative capacities, offering guidance and recommendations to healthcare institutions, government agencies, and other stakeholders on strategies to address racial disparities in maternal healthcare.

Making best use of data

How do you use quantitative and qualitative data to improve your understanding of who is and who isn't taking up services? What reasons have you identified, and what would help resolve these? (max 250 words)

1. **Quantitative Data Collection:**
 - **Demographic Analysis:** Analyzing demographic data to understand who is using services and identifying any disparities among different groups based on factors like race, ethnicity, income, index of deprivation or geographic location.
 - **Utilization Rates:** Examining service utilization rates to identify patterns and discrepancies in service uptake among various demographic groups.
 - **Trend Analysis:** Tracking trends over time to identify changes in service uptake and exploring potential reasons behind these shifts.
2. **Qualitative Data Collection:**

- **Surveys and Interviews:** Conducting surveys or interviews with service users to gather qualitative insights. Exploring reasons behind service utilisation patterns, including barriers or challenges faced in accessing services.
 - **Focus Groups:** Organizing focus group discussions to delve deeper into specific issues affecting service uptake, allowing for nuanced understanding through group interactions.
3. **Data Integration and Analysis:**
- **Comparative Analysis:** Integrating both quantitative and qualitative data to gain a comprehensive understanding. This approach can reveal nuanced insights by triangulating information from different sources.
 - **Identifying Root Causes:** Analyzing both types of data to pinpoint underlying reasons for disparities in service uptake, such as cultural barriers, lack of awareness, accessibility issues, stigma, or systemic biases.
4. **Actionable Insights and Solutions:**
- **Developing Strategies:** Using insights gained from data analysis to devise targeted strategies and interventions aimed at addressing identified barriers. This might involve community outreach, improving accessibility, cultural competence training, or policy changes.
 - **Continuous Evaluation:** Implementing changes and continuously evaluating their impact through ongoing data collection and analysis to assess the effectiveness of interventions. This iterative process helps in refining strategies over time.
5. **Collaboration and Engagement:**
- **Engaging Stakeholders:** Involving stakeholders, including service users, community members, healthcare providers, and policymakers, in discussions to develop and implement solutions collaboratively.

Regulation of maternity services

How have you taken forwards recommendations for improvement made in your most recent Care Quality Commission inspection report?

1. **Review and Analysis:** After receiving the CQC inspection report, the directorate management team, carefully reviewed the findings, recommendations, and areas for improvement highlighted by the CQC inspectors. Specific areas for improvement include:
- i) Accessibility and timeliness of medical review in the Maternity Triage/Maternity Assessment Unit (MAU), and improvement of MAU facilities. A business case is in progress with the aim of improving the MAU environment and facilities and a review of midwifery and medical staffing levels.
 - ii) Recruitment and retention of midwifery and obstetric staff. A pro-active recruitment and retention action plan has been successfully implemented with reductions in staff vacancies and improved retention of staff from 2022 to 2023.
2. **Action Plan Development:** Based on the identified recommendations, the organisation developed a comprehensive action plan outlining specific steps, timelines, responsibilities, and resources required to address the highlighted issues.
3. **Implementation of Changes:** The organisation implements the action plan, making necessary changes and improvements in line with the recommendations provided by the CQC. This involved staff training, policy revisions, infrastructure enhancements, or process modifications.

4. **Monitoring and Evaluation:** Continuous monitoring and evaluation of implemented changes are crucial. The organisation tracks progress, assesses the effectiveness of interventions, and measures outcomes against the recommendations to ensure they're addressing the identified areas for improvement.
5. **Documentation and Reporting:** Throughout the process, the organisation maintains detailed records of actions taken in response to CQC recommendations. This documentation serves as evidence of compliance and progress made towards addressing the identified issues.
6. **Engagement with CQC:** Some organisations may engage with the CQC to provide updates on the progress made in addressing the recommendations. This can include submitting reports or evidence of improvements achieved.
7. **Continuous Improvement:** Even after addressing specific recommendations, organisations have adopted a culture of continuous improvement, striving to enhance services and standards beyond compliance with CQC regulations.

2. MBRRACE RECOMMENDATIONS (2023)

“Saving Lives, Improving Mothers’ Care Core Report - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2019-21” – the MBRRACE 2023 Report. It highlighted that when deaths due to COVID-19 in 2020 and 2021 were excluded, maternal death rates were very similar over the last 2 reporting periods (2016-2018 and 2019-21), which suggests that an even greater focus on implementation of the recommendations of these reports is needed to achieve a reduction in maternal deaths (and morbidity).

How are you considering and addressing the recommendations made by the MBRRACE 2023 Report?

What processes do your organisation already have in place to consider the recommendations?(max 250 words)

1. **Policy Review:** The guideline and governance group to review existing policies and guidelines in light of this report's recommendations.
2. **Implementation of Best Practices:** The directorate adopts new best practices recommended in the report, such as improved protocols for maternity care, training for healthcare professionals, or changes in procedures.
3. **Resource Allocation:** Allocating resources, such as funding for an obstetric procedure room and third operating theatre, technology (central fetal heart monitoring), staffing, and training, to areas identified for improvement based on the report's findings.
4. **Education and Training:** Providing additional education (e.g; Prompt, emergency skills drills and fetal wellbeing multidisciplinary training to ensure maternity staff are aware of and can implement recommended MBRRACE practices effectively.
5. **Public Awareness Campaigns:** Launching public awareness campaigns to inform pregnant individuals, families, and the general public about ways to reduce risks associated with maternal and perinatal health (e.g; smoking cessation).
6. **Continuous Monitoring and Evaluation:** Establishing systems to monitor progress and evaluate the effectiveness of interventions implemented based on the report's recommendations. Continuous analysis of safety data metrics occurs and is reviewed on a monthly basis in the form of a clinical performance dashboard and analysis at both Trust and system level via the SEL LMNS and quarterly by the London Perinatal Surveillance Committee.

7. Collaboration and Partnerships: Collaborating with stakeholders, healthcare professionals, researchers, and community organizations to ensure a comprehensive approach to implementing changes and addressing issues highlighted in the report. For example; the maternity service is the central hub for the South East London maternal medicine network and provides outreach maternal medicine services as well as leading the network across the region to provide evidence based maternal medicine services for women with complex medical disorders receiving maternity care. The maternity service also works in collaboration with the King's Health Partnership to lead clinical research with women's health having the second largest research portfolio within the Trust.

How is your organisation planning to implement the recommendations? (max 250 words)

1. Review and Analysis: We will thoroughly review the MBRRACE 2023 report to understand the specific recommendations, insights, and areas for improvement identified within our scope of influence.

2. Stakeholder Engagement: Engaging with relevant stakeholders including healthcare professionals, policymakers, community organizations, and affected individuals to gather diverse perspectives and insights.

3. Actionable Plans: Based on the report's recommendations, we will develop gap analysis and clear and actionable plans outlining steps to be taken, timelines, responsible parties, and resource requirements.

4. Implementation Strategies: Implementing changes in healthcare protocols, training programs, policy revisions, resource allocation, and technology enhancements as necessary to align with the report's recommendations.

5. Monitoring and Evaluation: Establishing mechanisms for ongoing monitoring and evaluation to track progress, assess the effectiveness of implemented changes, and make necessary adjustments.

6. Collaboration and Communication: Collaborating with other relevant organizations, Kings College Hospital, SEL LMNS, King's Health Partners, Health Safety Investigation Branch (HSIB) and service user charities and stakeholders to share best practices, insights, and lessons learned in implementing the MBRRACE 2023 recommendations.

In particular, what steps are you taking / have taken to promote the key messages for women and their families as outlined in the [MBRRACE 2023 Lay Summary](#)? (eg Raising awareness around sepsis, mental health, FiveXMore Six Steps)

1. **Understand the Lay Summary:** Familiarise yourself thoroughly with the key messages and findings in the MBRRACE lay summary. Ensure a clear understanding of the content, its significance, and its implications for the target audience of all those who work at GSTFT Women's health. SEL Maternal Medicine Network provided and circulated news letter to all who work with birthing people. Infographic one-page summary has been produced and circulated to all.
2. **Identify Target Audience:** Determine the primary audience for the messages. This included policymakers (commissioners, healthcare professionals, expectant parents,

the general public, or specific communities affected by the report's findings with plans to visit mosques and churches to further distil the message.

3. **Craft Key Messages:** The message have been distilled into infographics with clear pictures, concise, easy to understand key messages, simple and relevant to all. Maternity staff receive annual mandatory training which incorporates MBRRACE findings to ensure staff have the evidence based knowledge to implement recommendations.
4. **Choose Communication Channels:** Select appropriate communication channels to disseminate the key messages. This could involve a mix of mediums such as:
 - Social Media: Utilise platforms like Twitter, Facebook, LinkedIn, and Instagram to share key findings, infographics, or short videos.
 - Website/Blog: Create dedicated sections on websites or blogs to publish detailed information and summaries.
 - Press Releases: Issue press releases to reach traditional media outlets such as newspapers, TV, and radio.
 - Email Newsletters: If applicable, distribute newsletters to stakeholders, professionals, or interested parties.
 - Webinars/Workshops: Organize virtual or physical events to present findings and engage with the audience directly.
5. **Collaborate with Stakeholders:** Engage with relevant stakeholders including SEL LMNS and SEL Integrated Care Board, healthcare organisations, advocacy groups, professional associations, and government bodies. Collaborate to amplify the message through their networks and channels.
6. **Create Engaging Content:** Develop engaging content that resonates with the target audience. This might include compelling visuals, testimonials, case studies, and real-life stories to emphasize the importance of the findings.
7. **Use Infographics and Visuals:** Summarize complex information into easily digestible infographics, charts, and visuals. These help convey information quickly and effectively across various platforms.
8. **Encourage Discussion and Feedback:** Create spaces for discussions, forums, or Q&A sessions where people can ask questions, share their thoughts, and provide feedback. Engaging in dialogue helps clarify any misconceptions and reinforces key messages.
9. **Monitor and Evaluate:** Continuously monitor the impact of your communication efforts. Track metrics such as website traffic, social media engagement, media coverage, and audience feedback to assess the reach and effectiveness of your messages.
10. **Sustain Communication:** Maintain momentum by consistently reinforcing key messages over time. Use follow-up communications, updates, or related content to keep the topic relevant.
11. **Adapt and Evolve:** Be prepared to adapt strategies based on horizon scanning for best practice examples and policy recommendations, feedback from all stakeholders, audience response, or changes in the landscape. Flexibility and responsiveness are crucial in effective communication campaigns.

3. ACCESS TO MATERNITY CARE

Early access:

NICE recommends that all women and people are supported to access antenatal care by ten weeks of pregnancy. (NICE, 2021)

How successfully is your organisation achieving this? (max 250 words)

The maternity service was achieving the target set by NHS England Antenatal and Newborn Screening Committee with women and birthing people booked by 10 weeks of pregnancy and booked by 12 weeks of pregnancy. Women are able to self-refer for their maternity care which is known to improve the timeliness of the referral process. Alternatively, women and birthing people can be referred by their GP for maternity care.

The self-referral form is accessible on the maternity pages of the Trust website with the option of 12 different languages to improve accessibility and information when English is not the first language used.

A recent reduction in women being booked for maternity care by 10 weeks of pregnancy has occurred since October 2023 following the implementation of the new Trust patient information system- Epic. This is being closely monitored to resolve administration pathways within the Epic electronic system. Additional resources have been mobilised to reduce the backlog of antenatal booking appointments and follow up antenatal appointments. Work is underway to reduce the waiting times for antenatal appointments, but needs to be sustained. Due to the clinical risk in delayed appointments for maternity care daily triage of waiting lists is in place to reduce the risk of missed opportunities for antenatal screening uptake.

Where do you find you are encountering difficulties? (max 250 words)

We are encountering problems at the administrative level where we are attempting to book patients on to our electronic records system and then triage them to the correct midwifery clinics to offer antenatal screening tests including the combined test, to screen for chromosomal abnormalities. The delay in appointment times is being resolved, but needs to be sustained.

Adequate provision of pre-conception or early pregnancy information in more languages would benefit a greater number of women if this were to be available in the primary care setting, via G.P's, pharmacists or electronic platforms such as NHS websites and via social media.

What could help you to achieve this more effectively? (max 250 words)

We have already started to see a positive shift in resolving the backlog of antenatal booking appointments, as we have now recruited administrative support from our wider team as well as advertised for full time administrative staff to address this problem in the medium and long term. We are beginning to see the problem being resolved with increased resource and optimisation of the new electronic patient information system.

Improved communications between stakeholders with public health information easily accessible to all women in different languages and formats would improve information and health outcomes for all women and birthing people.

Maternity digital care records:

By 2023/24, all women will be able to access their maternity notes and information through their smart phones or other devices. (NHS Long Term Plan, 2019)

How successfully is your organisation achieving this? (max 250 words)

Our organisation has successfully launched a major Trust wide IT system call EPIC. This is now at stabilisation stage. The system communicates directly with patients, including access to their results. The women are able to access all their results electronically through their maternity record APP by signing up to their Epic electronic patient record accessible via a mobile phone.

The Trust is reviewing digital exclusion for some to improve personal access to records and information within the Epic system.

Where do you find you are encountering difficulties? (max 250 words)

Currently the EPIC IT system has been launched with minimal harm noted. Out labour wards, our theatres, our postnatal wards all are operating well. The two areas requiring optimisation are:

1. Booking appointments and follow up outpatient clinics and outcoming the patients after the consultation
2. Extracting electronic data for external/ internal reports

What could help you to achieve this more effectively? (max 250 words)

The maternity team are working with the Trust business intelligence team to ensure the maternity and neonatal reporting pathways are meeting internal and external reporting compliance standards since the implementation of the Epic electronic patient system.

Previously the maternity service used a different maternity records system called Badgernet, which provided a complete personalised record and accessibility of information for women and birthing people. The Epic, My Chart, hand held record needs to improve to provide the same level of information for women.

By having floor workers/digital champions in the outpatient clinics and encouraging super users to support in the clinics to improve data entry and navigation of the Epic system and implementation of optimisation strategies.

Regional collaboration to improve accessibility of information regarding maternity and neonatal care would be beneficial and standardise information provided and improve equity in care.

Postnatal care:

Improve access to postnatal physiotherapy to support women who need it to recover from birth. Women should also have access to their midwife as they require after having had their baby. Maternity services should ensure smooth transition between midwife, obstetric and neonatal care, and ongoing care in the community from their GP and health visitor.
(NHS Long Term Plan, 2019)

How successfully is your organisation achieving this? (max 250 words)

1. Pelvic Health

The maternity service hosts the SEL regional pelvic health lead midwife post to improve care for women experiencing pelvic health issues, particularly in relation to childbirth. Women and birthing people are referred for physiotherapy care prior during pregnancy or in the postnatal period working collaboratively with the Trust Uro-gynaecology team to improve pelvic health for women. Physiotherapists also review women's pelvic health within the postnatal and birth centres prior to discharge home with information provided to women to improve pelvic health following childbirth. Follow up obstetric physiotherapy care is also available in outpatient clinics when women are discharged home. The SEL Trusts and LMNS have received a

Royal College of Midwives award in 2023 in the Partnership and Teamworking category for successful implementation of the Pelvic Health national transformation initiative.

2. Team Midwifery

Women and birthing people are cared for by teams of midwives who work in the hospital and community settings to provide antenatal, intrapartum and postnatal care.

Community midwives work in teams in geographical areas of Southwark and Lambeth to provide antenatal care during pregnancy, intrapartum care for women who birth in their home and postnatal care to women following their baby's birth. Midwives are based in community hubs and provide postnatal care to women and babies in clinics or at home on average for 10 days following the birth, but may provide care up to 28 days depending upon the needs of the woman and baby(s).

Midwives work collaboratively with Health Visitors, GP's and NHS public health services to share postnatal maternity and neonatal care, which is also shared with the neonatal, midwifery, obstetric, obstetric medicine, physiotherapy and anaesthetic teams within the maternity service at the St Thomas' Hospital site when more acute postnatal care is needed. In addition midwives work with the Local Authorities to provide health promotion care, safeguarding services and liaise regarding social issues such as housing.

Maternity and neonatal care records are shared with Health Visitors and G.P's to communicate the woman and baby(s) health care needs following transfer of maternity care to primary care teams.

3. Neonatal Care

The midwifery and obstetric teams work closely with the fetal medicine and neonatal services to plan care for babies and to provide the recommended level of neonatal care for a baby who is well at birth to those babies requiring specialist neonatal intensive care. This includes babies who require specialist paediatric services such as cardiac care and cardiac surgery, with collaborative care provided between the Evelina Children's Hospital and Royal Brompton Hospital, who all form the Trust Evelina London Women's and Children's Clinical Group.

Where do you find you are encountering difficulties? (max 250 words)

Access to sufficient community space to provide antenatal and postnatal clinics is a significant restricting factor in providing optimum maternity care for women and babies. Cost of renting space is prohibitively high and a collaborative approach to provision of community based services would improve accessibility of care in the community, particularly for women and babies who are disproportionately disadvantaged due to lack of equity in care.

Infant feeding support is not equitable in the community settings between Lambeth and Southwark which has a negative impact upon health outcomes for women and babies, in particular regarding breastfeeding support.

Driving restrictions across London roads, including Southwark and Lambeth have affected community midwives being able to access women's homes for both planned and emergency care, such as home births. There can be a delay in arrival time from the midwife being called to attend a home birth to arrival time, as restrictions in driving down some roads has created increased traffic congestion and midwives are not able to bypass this as are not classed as an emergency vehicle, but are providing emergency care within the woman and baby's home.

Improved translation services in the community for both written, visual and verbal communication would also improve care for women, birthing people and families whose first language is not English and require translation services.

An increase in women and families reporting housing difficulties, including homelessness, is proving increasingly difficult to support with women and babies being well for discharge home from hospital having delayed discharges due to inadequate housing. This also impacts upon the bed availability for other women and babies which has a negative effect upon care for others due to delayed discharge from hospital when there are housing issues.

There is also an increase in delays in discharge for women and babies from hospital due to an increased time for legal proceedings to take place when safeguarding issues require a court hearing to provide adequate safeguarding protection for a woman and/or her baby.

What could help you to achieve this more effectively? (max 250 words)

Access to more community space where antenatal and postnatal care can be provided. Ideally in a multi-agency hub such as Children's Centres or G.P surgeries to enhance collaboration of care.

Driving restrictions across London roads, including Southwark and Lambeth have affected community midwives being able to access women's homes for both planned and emergency care, such as home births. If midwives had permission for their vehicle to be classed as an emergency vehicle with access to restricted roads this would improve delays and response times to attend a women's home.

Increased infant feeding support in Southwark, particularly to support women in breastfeeding their baby(s) as this is known to positively improve health for both women and babies.

Pre-conception through to the postnatal period requires improved translation of information for women and families, which should be easily accessible and produced collaboratively with community groups.

Increased support from the Local Authority housing and homeless peoples teams would assist clinicians provided maternity and neonatal care to focus time spent in supporting medical and psychological care rather than the amount of time which is now spent in liaising regarding housing issues. This would also improve delays in discharge from hospital.

Language:

A large proportion of birthing people in Southwark do not speak English as a first language or do not have access to digital services, meaning they don't always receive the information they need. The South East London LMNS Equity and Equality Strategy established the need to review the information currently provided to birthing people across the system, gather information on the most spoken languages across the boroughs and providers, and work together with birthing people to create information that works for them. *(SEL LMNS Equity and Equality Strategy, 2023)*

How successfully is your organisation achieving this? (max 250 words)

<p>The maternity service uses either face to face translation services, or a virtual interpreter support system which is very effective by using a mobile computer system that allows a virtual translation of all the languages, including British Sign Language, and it can be used by women and families with clinicians seeing the interpreters face virtually on an IPAD screen. The virtual interpreting service is also available via a mobile phone APP in the community, for use in clinics or within the home.</p>
<p>Where do you find you are encountering difficulties? (max 250 words)</p>
<p>Since the virtual translation system has been commissioned by the maternity service, we have not encountered any problems from using the interpreter service. The advantage of this virtual service is that translation services are easily accessible 24/7 which is particularly helpful in maternity care when women and families may attend at any time of day or night for care.</p> <p>Information available in different languages either in written format or virtually, particularly prior to or during early pregnancy, could be enhanced to improve equity of care and thereby health outcomes.</p>
<p>What could help you to achieve this more effectively? (max 250 words)</p>
<p>Communication of information generally can be improved as there needs to be more visual illustrations, such as use of information films with sub-titles and digital and written communication more readily available in community settings where women and birthing people have access such as in homes, community centres, faith centres, local pharmacies, G'P surgeries and via digital platforms for those who have digital access.</p>

4. EXPERIENCE OF MATERNITY CARE

Continuity of Carer:

By March 2021, most women receive continuity of the person caring for them during pregnancy, during birth and postnatally. This will be targeted towards women from black and minority ethnic groups and those living in deprived areas, for whom midwifery-led continuity of carer is linked to significant improvements in clinical outcomes.

A target of 75% of women from these groups to be receiving continuity of care by 2024 was set out in the NHS Long Term Plan. (*Better Births, 2016; NHS Long Term Plan, 2019*)

<p>How successfully is your organisation achieving this? (max 250 words)</p>
<p>Providing midwifery continuity of carer has been challenged during the pandemic due to staffing issues, but the maternity service has maintained continuity of carer for women requiring specialist obstetric and midwifery services during pregnancy and postnatally. This includes women from the global majority and those living in areas of deprivation.</p> <p>Continuity of midwifery carer during a woman's labour and baby's birth is more challenging to achieve, but is supported for some women by midwifery teams offering care for home and hospital births.</p>
<p>Where do you find you are encountering difficulties? (max 250 words)</p>
<p>Recruitment and retention of midwives has improved, but to provide an enhancement for midwives to work in a continuity of carer model, which also includes intrapartum care for labour and birth, with increased demands on midwives work-life balance this model of care should receive an enhanced rate of pay which is not factored into maternity budgets currently.</p>

What could help you to achieve this more effectively? (max 250 words)
<p>Ring fenced funding for midwifery models to increase continuity of carer from central funds.</p> <p>Improved access to community based space to increase numbers of clinics and health promotion activities in multi-agency hubs.</p> <p>Improved transport facilities such as more hire pool cars and access to restricted roads to provide more effective and sustainable midwifery care in an inner London setting.</p>
<p>Personalised care: Everyone woman should develop a personalised care plan, with her midwife and other health professionals, which sets out decisions about her care. Women should also be able to choose the provider of their antenatal, intrapartum and postnatal care and where they would prefer to give birth. (<i>Better Births, 2016</i>)</p>
How successfully is your organisation achieving this? (max 250 words)
<p>All women discuss their preferences with recommendations for their care with midwives and obstetricians from booking for antenatal care in early pregnancy through to transfer of care to the Health Visitor and G.P. Plans of care are agreed with women and adjusted according to care needs and the womans wishes. This includes personalised care plans for women who request care which is not recommended within local and national guidance to ensure women feel listened to and supported and receive care which is as safe as possible.</p> <p>All women can self-refer to the maternity service and choose which NHS Trust they would like to receive care from. The maternity service offers all birth options to women, which includes birth at home with experienced community midwives, birth in the alongside Home from Home Birth Centre at St Thomas' Hospital and birth with the medical and midwifery teams in the Hospital Birth Centre at St Thomas' Hospital.</p> <p>Women who responded to the 2023 CQC National Maternity Survey reported higher levels of choice being offered regarding birth place choices compared to the national average of other maternity services in England.</p>
Where do you find you are encountering difficulties? (max 250 words)
<p>Personalised care is generally being met, but improved multi-agency liaison would improve this further.</p>
What could help you to achieve this more effectively? (max 250 words)
<p>Improved listening events with women and families involving maternity services and relevant agencies would also enhance personalised care, particularly to ensure feedback is heard from the global majority and those groups disproportionately affected by equity in healthcare. There have been some SEL listening events and surveys commissioned, but results are awaited to strengthen care provision where needed.</p>

Neonatal critical care:

From 2021/22, care coordinators will work with families within each of the clinical neonatal networks across England to support families to become more involved in the care of their baby and invest in improved parental accommodation. *(NHS Long Term Plan, 2019)*

How successfully is your organisation achieving this? (max 250 words)

Care Coordinators are in place to support families, but parental accommodation is very restricted due to the estate available, both within the St Thomas' Hospital site and externally within the local community.

Increased accommodation for parents within close proximity to the hospital and neonatal unit would significantly enhance the experience of families. Particularly as some families may live a distance from the hospital.

Where do you find you are encountering difficulties? (max 250 words)

Limited estate and cost of renting accommodation for families outside of the hospital grounds is the limiting factor.

What could help you to achieve this more effectively? (max 250 words)

Collaboration with the Local Authority to provide appropriate accommodation within easy access to the neonatal unit for parents.

5. OUTCOMES OF MATERNITY CARE**Saving Babies' Lives Care Bundle:**

Aim to roll out the care bundle across every maternity unit in England in 2019.
(NHS Long Term Plan, 2019)

How successfully is your organisation achieving this? (max 250 words)

The maternity and neonatal services have successfully implemented the original 2019 Saving Babies Care Bundle (SBLCB), but are now implementing the 2023 revised SBLCB version 3.

Where do you find you are encountering difficulties? (max 250 words)

Increased central resources to support increased fetal surveillance such as ultrasound scanning and specialist services, such as pre-term birth surveillance and prevention.

Smoking cessation services were previously restricted, but have now received some investment to provide specialist midwifery posts to support smoking cessation.

Availability of sufficient neonatal intensive care cots and maternity beds across London is challenging to ensure very pre-term babies (<27 weeks gestation) are born in a tertiary level neonatal service such as at St Thomas' Hospital.

What could help you to achieve this more effectively? (max 250 words)
<p>Increased financial resources to target the increased fetal ultrasound scanning, financial backfill of cost for increased staff training to implement SBLCB3 and pre-term birth surveillance.</p> <p>Increased maternity beds and Neonatal Intensive Care cots across the London region to ensure all babies born at < 27 weeks gestation are delivered in a neonatal service providing level 3 neonatal intensive care.</p>
<p>National Maternal and Neonatal Health Safety Collaborative: By spring 2019, every trust in England with a maternity and neonatal service will be part of the National Maternal and Neonatal Health Safety Collaborative. Every national, regional and local NHS organisation involved in providing safe maternity and neonatal care has a named Maternity Safety Champion. <i>(NHS Long Term Plan, 2019)</i></p>
How successfully is your organisation achieving this? (max 250 words)
<p>The maternity and neonatal services have both departmental and Executive Board level maternity and neonatal safety champions. The Trust Board level safety champions have a Non-Executive Director (NED) in a Safety Champion role as well. These roles report to the Trust Board and also link to the regional and national maternity and neonatal champion roles. Feedback from staff and in regards to quality and safety issues are therefore heard from ward to Trust board level.</p>
Where do you find you are encountering difficulties? (max 250 words)
<p>National initiatives and policy changes do not always coordinate as effectively with the provision of services. At times unintended consequences occur as a result of changes in national maternity policy and the effect in resource provision at the provider level. For example; an increase in women undergoing induction of labour to reduce perinatal morbidity and mortality has not received adequate resource and maternity bed capacity to facilitate this as effectively as possible which also affects women's experience of care.</p>
What could help you to achieve this more effectively? (max 250 words)
<p>Improved collaboration between national policy changes and local providers to reduce the impact of unintended consequences.</p> <p>The role of the NED Maternity and Neonatal Safety Champion has increased significantly over the past few years, as has the expectation of the Maternity and Neonatal Voices Partnership, with no further resource provided to implement the increased responsibility for these roles.</p>
<p>Perinatal Mortality Review Tool: How effectively is this tool implemented and used to improve the way your Trust learns lessons where things go wrong, and minimise the chances of them happening again? <i>(NHS Long Term Plan, 2019)</i></p>
How successfully is your organisation achieving this? (max 250 words)

GSTFT use these tools to analyse cases of perinatal mortality comprehensively, aiming to understand the circumstances, clinical decisions, and systems involved, with the ultimate goal of preventing similar incidents in the future through learning from best practice. We envisage due to our approach of using the tools, our safety metric data outcomes are as expected for a tertiary level maternity service which also cares for women and babies with cardiac anomalies, and we continue to focus on all incidents to ensure learning is implemented and avoidable harm is reduced.

GSTFT employ perinatal mortality review tools as part of a multidisciplinary approach involving obstetricians, neonatologists, midwives, at times pathologists, and other relevant specialists and reports to our Trust safety champion meetings and governance meetings alongside the regional SEL LMNS Quality Surveillance Committee, SEL LMNS Board the London Perinatal Surveillance Committee. Our process involves:

1. **Data Collection:** Gathering detailed information about the circumstances surrounding each perinatal death, including antenatal, intrapartum, and postnatal factors. This may involve medical records, discussions with healthcare professionals involved, and families (with consent and sensitivity).
2. **Analysis and Review:** Reviewing the collected data to identify contributing factors to reduce avoidable harm such as clinical decisions, communication breakdowns, system failures, and any other relevant issues.
3. **Identifying Lessons:** Determining key lessons from the analysis, including both specific aspects related to the individual case and broader systemic issues that could impact future care.
4. **Implementing Changes:** Implementing recommendations and changes based on the lessons learned. This might involve changes in clinical guidelines, enhanced staff training, improvements in communication, or modifications to healthcare systems and processes.
5. **Monitoring and Evaluation:** Continuously monitoring the effectiveness of implemented changes and evaluating their impact on reducing perinatal mortality rates.

GSTFT effectively learn lessons from perinatal mortality reviews, considering several crucial factors:

- **Duty of Candour:** Openness and transparency with families is vital in informing the review and in ensuring lessons are learnt to reduce future avoidable harm.
- **A Culture of Learning:** A culture that encourages open discussion, transparency, and learning from mistakes rather than assigning blame.
- **Multidisciplinary Approach:** Involvement of various healthcare professionals and stakeholders to gain diverse perspectives on cases and potential improvements.
- **Actionable Recommendations:** Ensuring that the recommendations from reviews are specific, actionable, and implemented effectively.
- **Continuous Improvement:** Regularly revisiting cases and reviewing outcomes to assess the effectiveness of implemented changes and identify further areas for improvement.

Where do you find you are encountering difficulties? (max 250 words)

1. **Data Collection Challenges:** Obtaining complete and accurate information for each case of perinatal mortality can be challenging. Incomplete medical records, lack of standardized data collection processes, and difficulties in obtaining consent from grieving families may hinder comprehensive data collection.
2. **Cultural and Communication Barriers:** A culture that is resistant to open discussion about errors or a lack of effective communication among healthcare professionals involved in the review process can impede the sharing of critical insights and hinder

the implementation of recommendations. In addition, provision of translation services for families when needed is vital in ensuring clear communication of information is maintained for patients and the maternity service.

3. **Complexity of Systemic Issues:** Identifying and addressing systemic issues contributing to perinatal mortality can be complex. These issues might involve multifaceted factors such as organisational structures, resource allocation, communication pathways, and clinical protocols, making solutions multi-factorial to implement.
4. **Sustainability of Changes:** Implementing changes based on review recommendations is critical, but sustaining these changes over time is crucial. Without ongoing monitoring, support, and reinforcement, improvements might regress or not produce the intended long-term effects.
5. **Emotional and Psychological Impact:** Reviewing perinatal mortality cases can be emotionally taxing for healthcare professionals and families involved. Providing adequate support, guidance, and counselling for the individual families involved in the review process is essential to manage emotional distress.

What could help you to achieve this more effectively? (max 250 words)

The below actions are in place, but must be sustained to ensure effective learning and care provision:

1. **Leadership Support and Commitment:** Strong leadership commitment to patient safety and quality improvement is crucial. Leaders should endorse and actively participate in the review process, ensuring that resources and support are allocated for its success.
2. **Establishing a Robust Review Process:** Develop standardised Patient Safety Incident Response Framework (PSIRF) guidelines for conducting perinatal mortality reviews. This includes clear procedures for data collection, analysis, and dissemination of findings.
3. **Multidisciplinary Collaboration:** Engage a diverse team of healthcare professionals (obstetricians, neonatologists, midwives, pathologists, etc.) in the review process. Each perspective contributes valuable insights into understanding and addressing contributing factors.
4. **Education and Training:** Provide ongoing education and training for staff involved in perinatal care and mortality reviews. This includes training on the review process, communication skills, and understanding the importance of learning from adverse events with openness and honesty with families.
5. **Improving Data Collection and Documentation:** Ensure comprehensive and accurate data collection through standardized documentation practices. Enhance electronic health records to facilitate easier data retrieval and analysis.
6. **Transparent Communication:** Foster a culture of open communication where healthcare professionals feel comfortable discussing cases, sharing insights, and implementing recommendations without fear of blame or repercussions.
7. **Family Involvement and Support:** Involve families in the review process sensitively and with their consent. Their perspectives can provide valuable insights and contribute to improvements in care delivery.
8. **Feedback and Continuous Improvement:** Establish mechanisms for providing feedback to staff involved in the review process and regularly assess the effectiveness of implemented changes. Continuously refine and adapt the review process based on lessons learned.

9. **Integration into Clinical Governance:** Ensure that perinatal mortality reviews are integrated into the broader clinical governance framework of the institution. This includes aligning review findings with quality improvement initiatives and policies.
10. **Research and Benchmarking:** Encourage and support research initiatives that stem from review findings. Benchmarking against other institutions or national/international standards can provide insights into best practices.
11. **Addressing Emotional Impact:** Provide emotional support and resources for healthcare professionals involved in the review process. Addressing the emotional impact of reviewing perinatal mortality cases is crucial for staff well-being.

Antenatal and Newborn Screening: The NHS population screening standards set out performance thresholds for Fetal anomaly screening programme (FASP), Infectious diseases in pregnancy screening (IDPS), Newborn blood spot (NBS) screening, Newborn hearing screening programme (NHSP), Newborn and infant physical examination (NIPE) and Sickle Cell and Thalassaemia Screening Programme (SCT) (*Public Health England, 2019*).

Please outline how successfully your organisation is achieving these performance thresholds (max 250 words)

1. **Ensure Comprehensive Screening Offered:** GSTFT offers a range of antenatal screening tests to pregnant women according to the NHS Fetal Anomaly Screening Programme (FASP). This includes screening for conditions like Down syndrome, Edwards' syndrome, Patau's syndrome, and others.
2. **Inform and Educate:** Provide clear and comprehensive information to pregnant individuals about the purpose, benefits, limitations, and potential outcomes of the screening tests. This is essential to allow informed decision-making regarding whether to undergo the screenings.
3. **Adhere to Protocols and Guidelines:** Follow NHS guidelines and protocols for conducting antenatal screening tests, ensuring accuracy and reliability in the process. This involves maintaining proper standards in sample collection, testing, and result interpretation with feedback to families.
4. **Maintain Confidentiality and Consent:** Respect patient confidentiality and ensure that informed consent is obtained before conducting any screening tests. Respect the autonomy of pregnant individuals in making decisions about their care.
5. **Training and Quality Assurance:** Ensure that healthcare professionals involved in conducting or interpreting the screening tests receive appropriate training and regular updates to maintain high-quality standards. Regular audits and quality assurance measures are essential to guarantee accuracy and consistency with oversight from the National Antenatal and Newborn Screening Committee.
6. **Equity and Accessibility:** Strive to ensure that antenatal screening services are accessible to all pregnant individuals, regardless of socio-economic status, ethnicity, or geographic location. Efforts to minimize barriers to access play a crucial role in meeting screening standards.
7. **Continual Improvement:** Regularly review and update protocols and practices based on scientific advancements, technological improvements, and feedback from patients and healthcare professionals. This helps to continually improve the effectiveness and efficiency of antenatal screening services.

Where are difficulties achieving these performance thresholds are arising? (max 250 words)

1. **Awareness and Information:** Limited awareness among pregnant individuals about the availability, importance, and implications of antenatal screening tests can lead to lower uptake. Insufficient dissemination of information or misconceptions about the tests might hinder participation.

2. **Equity and Accessibility:** Disparities in access to healthcare services based on geographical location, socioeconomic status, ethnicity, or language barriers can affect the equitable delivery of screening services. Some individuals might face challenges in accessing facilities offering these screenings.
3. **Informed Decision-making:** Balancing the need to provide comprehensive information for informed decision-making with avoiding information overload or causing unnecessary anxiety among expectant parents poses a challenge. Ensuring individuals make informed choices while not overwhelming them is crucial.
4. **Health System Constraints:** Resource limitations, including staffing, infrastructure, and funding, might impact the capacity of healthcare facilities to deliver screenings efficiently and in a timely manner. This could lead to delays or backlogs in screening services.
5. **Quality Assurance:** Maintaining consistent quality across different healthcare providers and regions might be challenging. Ensuring all facilities adhere to the same standards and protocols for conducting screening tests requires continual oversight and support.
6. **Cultural and Ethical Considerations:** Addressing cultural beliefs, ethical concerns, and personal preferences regarding screening tests can be complex. Respecting diverse cultural perspectives while providing evidence-based information poses a challenge in ensuring comprehensive and culturally sensitive care.

What would help you to achieve these thresholds more effectively? (max 250 words)

1. **Enhanced Education and Awareness:** Implementing robust education campaigns targeting both healthcare providers and expectant parents is crucial. Providing clear, accessible, and culturally sensitive information about the purpose, benefits, and limitations of antenatal screenings can encourage informed decision-making.
2. **Accessible Services:** Improving access to antenatal screening services by ensuring geographic availability, reducing financial barriers, and accommodating diverse linguistic and cultural needs can enhance participation rates among different demographics.
3. **Streamlined Processes and Resources:** Adequate allocation of resources, including staff training, technological advancements, and efficient processes, can help healthcare facilities manage increased demand for screenings, reducing waiting times and improving overall service quality.
4. **Tailored Communication:** Personalized communication strategies that consider individual preferences, cultural backgrounds, and health literacy levels can facilitate understanding and acceptance of screening tests. This might involve using different formats, languages, or support systems to relay information effectively.
5. **Collaboration and Partnerships:** Collaborating with community organizations, advocacy groups, and local stakeholders can strengthen outreach efforts and ensure that messages about antenatal screenings reach the intended audience.
6. **Continuous Quality Improvement:** Regular audits, evaluation, and feedback mechanisms within healthcare systems can identify areas for improvement, allowing for adjustments to protocols and practices to maintain high standards with external Trust oversight and scrutiny.
7. **Ethical Considerations and Support:** Providing counselling services and support for individuals navigating the decision-making process surrounding antenatal screening can address ethical concerns, ensuring individuals feel supported in their choices.
8. **Technology Integration:** Leveraging technological advancements for telemedicine, online resources, and digital communication can improve access, streamline

processes, and enhance the overall experience for both healthcare providers and patients.

Appendix 3

Southwark Maternity Commission 2023-24

WRITTEN EVIDENCE SUBMISSION:

King's College Hospital NHS Foundation Trust

Submitted: 12 January 2024

INTRODUCTION

The Southwark Maternity Commission has three key objectives:

- Assess local inequalities in the access, experience and outcomes for maternity services, specifically for those parents from ethnic minorities and / or socially disadvantaged backgrounds, in particular those from a Black ethnic background.
- Assess the implementation of national recommendations for maternity services to improve access, experience and outcomes and reduce inequalities.
- Identify additional areas for action and improvement for Southwark birthing people as part of the local maternity and neonatal system.

In undertaking its work, the commission will:

- Listen to the views and experiences of local women, birthing people and families.
- Listen to the views of our midwifery and wider workforce that support women, birthing people and families during pregnancy and the early years.
- Review progress on the implementation of national best practice guidelines across local maternity and neonatal services and progress on Local Maternity and Neonatal System (LMNS) wide action plans

In order to support the commission to achieve its aims, we are asking each of our main providers of maternity care for Southwark residents to complete this written evidence submission. This will provide us with a background of how your organisation operates, and allow our Commission panel to form questions, based on your responses. The questions are broken down into the following sections:

6. Organisational practice
7. MBRRACE (2023) recommendations
8. Access
9. Experience
10. Outcomes

If you have any questions, please contact MaternityCommission@southwark.gov.uk

Many thanks for your help in providing information to the Southwark Maternity Commission.

1. ORGANISATIONAL PRACTICE

Keeping informed of national learnings

How does your organisation keep abreast of national learnings (e.g. MBRRACE reports, APPG, NICE guidelines etc.)? (max 250 words)

Delivering excellent health outcomes for our patients is core to King's Outstanding Care vision and the Strong Roots, Global Reach, King's Strategy 2021 - 2026. Along with the patient outcomes team at KCH maternity has a lead clinician and audit and governance midwifery lead to keep abreast of national learning within maternity and disseminate this to Staff.

The King's NICE Policy details the process for the dissemination, implementation and monitoring of National Institute for Care Excellence (NICE) guidelines. The process described in this policy are mandatory to all clinicians using the different types of guidelines and are aimed at ensuring that King's patient care is evidence-based and delivered in line with national guidelines.

How does your organisation decide which recommendations they will implement and then monitor progress of that implementation? (max 250 words)

The Patient Outcomes Team is to support continuous improvement in patient outcomes at King's, as set out in the King's strategy 2021 - 2026: Strong Roots, Global Reach.

Our key objective is to develop outcomes-based, patient-centred health care at King's by:

- collaborating with clinicians to identify and use robust patient outcomes measures as key indicators care quality and effectiveness
- supporting patient outcomes projects
- supporting related workstreams, such as implementation of NICE guidance and participation in national clinical audits
- supporting investigations into areas where King's might be a negative outlier
- collaborating with colleagues in other quality improvement teams to ensure continuous improvement in the outcomes we deliver for patients.

Organisational culture

What measures are your organisation taking to ensure equality, diversity and inclusion for your staff? (e.g. ensuring all receive the same opportunities to grow professionally) (max 250 words)

In 2021 our Trust strategy 'Strong Roots, Global Reach' embedded our commitment to diversity, equality and inclusion by making it one of our four headline ambitions in our BOLD vision (brilliant people, outstanding care, leaders in research, innovation and education and diversity, equality and inclusion at the heart of everything we do).

In 2022 we published our plan to ensure we turn our ambitions into real, meaningful improvements for colleagues, patients, and everyone connected to King's.

By the end of 2024, we are committed to have made a marked difference in:

- Improving representation of staff, especially at senior levels which reflect the diversity of our communities;
- Strengthening and embedding our inclusive values at all levels which will result in a marked reduction in our bullying, harassment and disciplinary numbers;
- Ensuring our leaders are visible and active champions of EDI which will be evidenced by improved staff satisfaction across the Trust.

We offer a range of training programmes which are self-accessible:

Active Bystander

Calibre Leadership Programme

CQ (Cultural Intelligence) Programme

King's Ambassadors Scheme
Skill Boosters
Reciprocal Mentoring
Inclusive Recruitment Training

What efforts are your organisation making to diversify your workforce? (e.g. what hiring and retention policies exist?) (max 250 words)

Inclusive recruitment

Inclusive recruitment is one of our headline EDI commitments. Our 1-to-1.5-hour training session has been attended by over 600 staff since 2022 and explains why equality, diversity and inclusion in recruitment matters, techniques that will improve decision making, and King's recruitment process.

The training helps implement findings of an external recruitment audit conducted by *Resource Solutions* which established over 20 recommendations for King's to incorporate. The audit was shortlisted for the Personnel Today Awards 2022 for Innovation in Recruitment.

Positive action

We have run career development sessions for ethnic minority staff on topics such as: career success, job application and presentation/interview skills. Around 100 staff have attended the workshops in the past 12 months.

We have partnered with the Calibre leadership programme and delivered a talent development and leadership programme for staff who identify as neurodiverse or disabled, or who have a long term physical or mental health condition for 15 members of staff.

Widening participation programme

We recently 'soft launched' our Social Mobility scheme with more than seventy staff signing up to become 'Social Mobility Champions.' Throughout 2024 we will continue to recruit more staff to the initiative, who will begin responding to requests from local schools and colleges to support educational activities in early Spring.

Talent management strategy

Began development of a wider talent management strategy for King's which is scheduled to launch by June 2024.

What measures are your organisation taking to ensure equality, diversity and inclusion for your patients? (e.g. staff training on cultural competence, medical implications, such as recognising shock in brown and black skinned patients) (max 250 words)

For Black and minority ethnic parents specifically we have -

- Colourful Wallets started April 2021 and continue to be used at KCH and PRUH [Local Maternity and Neonatal System - South East London ICS \(selondonics.org\)](https://selondonics.org)
- Parent Education group for Black and Black Mixed Heritage service users runs in person at Stork on the Hill with a total of 143 attendees over 21 sessions in the past two and a bit years, the first session was October 2021 with RM Dawn Litchmore
- Black Maternal Mental Health webinar with 27 attendees last year during Black maternal mental health week with Perinatal RM Georgina Leech

- Support and cross-promotion of black maternal health issues with [Southwark Black Parents Forum – Empowering African and Caribbean Parents, Guardians and Carers](#) and [About — FIVEXMORE](#) on social media and FiveXMore [linked to on our Trust website](#)
- Promoting studies in support of improving Black and minority ethnic maternity experience, including the current study attached which looking at birth experiences of women 6-12 weeks post birth and the impact of ethnicity and PTSS. Posters are in clinical areas and will soon be promoted across social media
- Images of birthing people are inclusive in gender identity, race, ethnicity, disability and we consciously use a diverse range of photos and images in our patient information content to reflect our diverse population. We've purchased rights to a range of images from here [The Educated Birth - Inclusive Reproductive Health & Childbirth Ed](#)

	Sum of tickets sold
Black & Black Mixed Heritage Antenatal Education, Support & Networking	104
King's College Hospital Black and Minority Ethnic Support Group	39
King's Maternity Black Maternal Mental Health Webinar	27

For our LGBTQ+ parents we host a specific parent education workshop to support those within the LGBTQ+ community.

We have also started hosting EDI bite sized training sessions throughout our maternity services and have places for further education from the LGBT foundation.

Community Midwives received 45-minute EDI training over a 7 week period in summer 2023 with over 60 attendees. The programme will re-commence in spring 2024.

The EDI Team and Trust's LGBTQ+ are scoping a training session for Consultant's on the topic of same sex couples.

What measures are your organisation taking to understand and tackle institutional racism and how it operates in your organisation? (*e.g. is anti-racism and bias training mandatory for all maternity staff, and how often is this completed?*) (max 250 words)

Cultural Intelligence

In November 2023, our Cultural Intelligence programme was approved by the CPD Certification Service as a fully accredited workshop, meaning participants can gain up to 6 CPD points after attending.

The full day accredited workshops are scheduled for delivery from January 2024 and the overall objectives are to equip staff with an in-depth understanding of Cultural Intelligence (CQ) as well as how it applies to inclusive leadership, managing and engagement via a personalised CQ assessment.

Learning outcomes will also enable attendees to:

- Embed understanding of Equality, Equity, Diversity, Inclusion and Belonging.
- Understand the Trusts' journey to becoming a truly inclusive organisation through the ambitions in our BOLD strategy and Roadmap to Inclusion.
- Gain an in-depth understanding of Cultural Intelligence (CQ) and how it applies to inclusive leadership, managing and engagement.
- Develop understanding of the outcome of CQ assessment and what it means for effectiveness in multicultural situation and contexts.

- Develop understanding about the importance of CQ in creating a compassionate and inclusive workplace at King's.
- Feel confident and equipped to engage with others and talk about the value that inclusive engagement through the CQ lens can bring to all aspects of workforce and patient equity.

Working with others to improve non-health factors that affect your patients' health

How do you work with and learn from other organisations to address the impacts of wider non-health factors affecting the health of your patients? (e.g. *Housing status, income maximisation, employment issues*) (max 250 words)

Best Beginnings

Charity which has developed an excellent app called 'Baby Buddy'. Baby Buddy is personalised to the woman, allowing her to input information about her pregnancy, and getting information and support in return. There are numerous supportive videos within the app (breastfeeding, bottle-feeding, weaning, health, mental health, twins, and lots more!), and there are tools to allow women to make an electronic baby book including photos and milestones.

Doula Access Fund

This fund provides free Doula support to women experiencing financial hardship and disadvantage including poor perinatal mental health. Healthcare professionals can make a referral on the link attached. Family Lives

A charity offering trained one to one family support workers who offer support in person or on the phone, for issues around parenting, relationships and daily family challenges. See website for details.

Early intervention health visiting team

Our early intervention health visiting service provides intensive support to families with additional support needs during and after pregnancy to improve health outcomes and safeguard children. They help parents to be the best they can be in order to meet the physical, social and emotional needs of their child.

What training do maternity staff receive in identifying these wider issues in patients and signposting appropriately? (max 250 words)

All maternity staff are trained in safeguarding; adults and children, levels 1, 2. Midwives and obstetric staff are also required to complete safeguarding adults and children level 3, which is an all day face to face/virtually taught module.

Additional specialist training is offered and available from the safeguarding team to all maternity staff called SPRINT, this is an hour every week covering different topics of safeguarding and specialist signposting.

The safeguarding team are present in the twice daily huddles and have clinical presence in all areas of maternity services for further support and advice.

A specialist continuity of care team has been set up within the community midwifery services. These staff members are offered specialist training in perinatal mental health and safeguarding, vulnerable factors as and when training is available from external agencies and organisations.

What roles in governance do organisations such as Maternal and Neonatal Voices Partnership (MNVP) and local groups working on black maternal health have? How are their voices and expertise used?

King's Denmark Hill MNVP is a collaborative working group dedicated to enhancing maternity care through the establishment of a dynamic and inclusive platform for the voices of expectant parents and healthcare professionals. The MNVP has made significant strides in fostering a culture of open communication, shared decision-making, and continuous improvement within the realm of maternity services.

King's Denmark Hill Maternity & Neonatal Voice Partnership (MNVP) has had an active year and remains committed to its mission of amplifying the voices of those involved in maternity care which is consistent with the key theme of the Three-Year Delivery Plan of listening to and working with women and families with compassion. Key future initiatives include expanding community outreach, strengthening partnerships with healthcare institutions, and leveraging technology to enhance communication channels.

In the past year we have conducted 15 steps reviews of wards and clinics, Walk the Patch- including the edition of a night version, and worked with the Training team providing specific feedback on particular themes to enhance staff training and skills as set out within the Three-Year Delivery plan and is also in line with the CQC recommendations. They have also started to build links with neonatal service users and built relationships with clinicians and relevant organisations and charities including the Parent Advisory Group.

Making best use of data

How do you use quantitative and qualitative data to improve your understanding of who is and who isn't taking up services? What reasons have you identified, and what would help resolve these? (max 250 words)

From a recent survey the main characteristics of the King's maternity patients? Over 40% of the King's patients live in the 40% most deprived areas in England. This is less deprived than the local population. The maternity patients have a higher proportion of Black and Asian patients than other King's services. 3% of patients in maternity are disabled. This is lower than the London rate of 14%. Disability is defined as having a long term impairment lasting more than 12 months. 1 in 4 maternity patients has a mental health condition. This is in line with the national average.

There is low data quality for certain protected characteristics: sex, sexual orientation, gender reassignment and marriage and civil partnerships. For groups of protected characteristics for which data is available, there is some variation in access to appointments, particularly for those of white ethnicity and those of Black ethnicity. However, there is no significant variation for age, disability, mental health, or sexuality.

Rate of access to emergency C-sections is consistent across ethnicities.

Still births are more prevalent in birthing parents over 40, no other variations between protected characteristics were identified.

Black British parents are more likely to report poor to very poor patient experiences as part of the Family and Friends Test (2.4% of those completing the survey). No other significant disparities were identified between groups.

There are no statistically significant differences in Covid rates across protected groups in the birthing population at King's.

Only 6% of all birthing parents at King's have continuity of carer. While the parliamentary target of 75% of continuity of carer has been removed there is an expectation that resource should be targeted at groups most at risk (i.e. BAME and those in the most deprived postcode areas. Continuity of carer stands at 6% for Black birthing parents and at 3% for Asian birthing parents. Birthing parents from the most deprived postcode areas are 1.5 times more likely to receive continuity of carer but disabled parents were 3 times less likely to receive continuity of carer.

The Trust regularly engages with representative protected characteristic groups and findings from this engagement is used to improve services.

The Trust works closely with a number of local voluntary and community sector organisations to improve the experiences of patients from underrepresented groups and regularly signposts to these.

Coproduction approaches are fully embedded in the approach of King's maternity services and joint actions plans are developed between staff and patients to improve outcomes for at risk groups. The Trust regularly uses insights and learning from engagement and coproduction activities, to influence its partners and improve the experience of those from protected groups.

Regulation of maternity services

How have you taken forwards recommendations for improvement made in your most recent Care Quality Commission inspection report?

As a result of the CQC inspection in August 2022, an action plan encompassing 43 actions was developed; progress against this has been regularly monitored by the maternity quadrumvirate. Of the 43 actions, 3 are still in progress for long term solutions, although appropriate measures have been put in place to give short term solutions and mitigations for safety, and the remaining 40 are complete with long term changes being embedded.

The outstanding long term measures include the topics of:

1. Assessment & management of environmental risk e.g. ligatures Risk assessment of environment is undertaken before high-risk women are allocated a room
2. Security of clinical areas - general reception/administration recruitment is ongoing for 24hr reception staff at PRUH Vacant positions currently covered by bank and agency staff to support a 24hr model, in lieu of substantive recruitment. Denmark Hill site is compliant with 24 hour model of administration staff and security measures in place.

2. MBRRACE RECOMMENDATIONS (2023)

"Saving Lives, Improving Mothers' Care Core Report - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2019-21" – the MBRRACE 2023 Report. It highlighted that when deaths due to COVID-19 in 2020 and 2021 were excluded, maternal death rates were very similar over the last 2 reporting periods (2016-2018 and 2019-21), which suggests that an even greater focus on implementation of the recommendations of these reports is needed to achieve a reduction in maternal deaths (and morbidity).

How are you considering and addressing the recommendations made by the MBRRACE 2023 Report?

What processes do your organisation already have in place to consider the recommendations?(max 250 words)

- All category 4 caesarean section lists are managed separately from more urgent caesarean sections to ensure these operations are not delayed to late in the day, with separate teams
- Updated major obstetric haemorrhage - Point-of-care coagulation testing during Major Obstetric Haemorrhage leading to appropriate use of blood products and can reduce blood loss and use of blood products. PROMPT course teaching on major obstetric haemorrhage and use intre-uterine balloons
- KCH provides specialised maternity care for women suspected of, and diagnosed with, abnormally invasive placenta (AIP). NHS England commissions specialist maternity care services for women suspected of, and diagnosed with, AIP from AIP Centres. This includes specialist prenatal diagnosis, risk assessment and definitive treatment of AIP by a multidisciplinary team (MDT) with expertise in complex pelvic surgery. AIP Centres have antenatal imaging (fetal medicine or radiology), adult intensive care, level three neonatal intensive care services and immediate access to blood products.
- There are lots of research projects running in maternity at King's College Hospital NHS Foundation Trust [Maternity leaflets and resources | King's College Hospital NHS Foundation Trust \(kch.nhs.uk\)](https://www.kch.nhs.uk/maternity-leaflets-and-resources)
- KCH is part of the South East London Maternal Medicine Network (MMN), and provide advice and care for pregnant individuals who have significant medical concerns and are at a higher risk. We hold specialist medical clinics, 24/7 access to an obstetric physician and are a centre of specialist care for diabetes, neurology and liver diseases in pregnancy.

How is your organisation planning to implement the recommendations? (max 250 words)

Sharing lessons learnt from incidents

- Learning Events have been running since August 2022 where adverse incidents are presented to all obstetric and midwifery staff, often with statements from the clients involved. This approach has promoted multidisciplinary discussion and learning and has received good feedback. Simulation training has also taken place, particularly in the management of postpartum haemorrhage, swab safety and diabetic hypoglycaemia. This is led by our education team and practice development midwives.
- Message of the Week is discussed at every handover and disseminated via email. These are often informed by learning from adverse incidents or emerging issues. In addition, ad hoc 'All Safety Alerts' are disseminated by Patient Safety Managers in response to specific safety concerns.
- Live Drills are facilitated by the training faculty with the wider MDT team in the immediate management of obstetric and neonatal emergencies in clinical practice; these are often informed by reported clinical incidents
- Monthly Patient Safety Meetings are held and all maternity staff are invited. Recent patient safety themes are presented as well as learning from recent After Action Reviews.
- The Magpie, the monthly care group newsletter, regularly includes highlights from patient safety.

In particular, what steps are you taking / have taken to promote the key messages for women and their families as outlined in the [MBRRACE 2023 Lay Summary](#)? (eg Raising awareness around sepsis, mental health, FiveXMore Six Steps)

At KCH we have a Specialist Midwife for Perinatal Mental Health and Specialist Obstetrician who run a weekly specialised clinic. Within this team we offer enhanced antenatal care with continuity of midwifery carer and referral to Specialist obstetricians for discussion around any ongoing medication or management issues

This team works closely with the Southwark Community Perinatal Mental Health Team (CPMHT) which is based at the Maudsley Hospital site near Kings College Hospital.

The core functions of the team are:

- To undertake the assessment, care and treatment of women with new-onset or pre-existing serious and/or complex mental illness during pregnancy and the first postpartum year
- To provide assessment and care to pregnant women who are currently well but are at risk of developing a serious mental illness following delivery.
- To provide liaison and/or specialist advice to maternity, primary care and psychiatric services.
- To offer pre-conception counselling for women with current or previous severe mental illness, including advice and guidance on psychotropic use in pregnancy
- The team includes psychiatrists, specialist nurses, psychologists, nursery nurses, occupational therapists and administrative staff. Women are offered a range of specialist interventions, as well as advice and guidance on psychotropic use in pregnancy. We work closely with the maternity service, primary care and Children's Services. We work collaboratively with women and their families.

Training around sepsis is part of all clinical staffs mandatory training as part of PROMPT (practical obstetric multiprofessional training) all day training session and forms one of the live drills we do within the clinical settings.

3. ACCESS TO MATERNITY CARE

Early access:

NICE recommends that all women and people are supported to access antenatal care by ten weeks of pregnancy. (NICE, 2021)

How successfully is your organisation achieving this? (max 250 words)

At present 62% of birthing people are booked at or prior to 10 weeks gestation. This increases to 80% by 12+6 weeks. At the Denmark Hill site we currently book 450 women per month. Nationally the Maternity Services Monthly Statistics, Final September 2023 showed 58% of booking appointments were at or before 10 weeks' gestation. Booking after more than 20 weeks of pregnancy accounted for 8% per cent of booking appointments.

We have used ad hoc weekend antenatal booking clinics during periods of high acuity to increase compliance to the National standard.

We are on a journey of improvement with the Kings maternity patient facing website, and have improved information for parents on how to access antenatal booking appointments.

Where do you find you are encountering difficulties? (max 250 words)

- Birthing people presenting late for maternity care
- Birthing people referring themselves to multiple hospitals for care, and DNA rates
- Reduced clinic space capacity for booking appointments

What could help you to achieve this more effectively? (max 250 words)

- A proportion of our patients are unaware of the importance of the benefit of booking early for midwifery care, and would benefit from a joint communication venture with community services.
- Capacity of clinics is limited due to space on the Denmark Hill site and reduced access to GP practices and children's centres.

Maternity digital care records:

By 2023/24, all women will be able to access their maternity notes and information through their smart phones or other devices. (NHS Long Term Plan, 2019)

How successfully is your organisation achieving this? (max 250 words)

MyChart is a new online web portal and mobile app that connects our patients to their medical information at King's and Guy's and St Thomas'. MyChart is part of our Epic electronic health record implementation and our wider Apollo programme, which aims to transform the way we deliver care.

With MyChart, our patients' health records are stored in one, easy place. This means they will never lose important test results or letters. And, by telling us what we need to know before their appointment, they will get more time to talk to us about the things that matter. MyChart allows patients to have more control over their own care than ever before. They will be able to:

- Find test results, letters and future appointments in one, easy place
- Get more from their appointments by telling us what we need to know beforehand
- Save time travelling by having a video appointment
- Keep their medical information up to date
- Share their health record with the people who matter to them
- Support their friends and family by helping to manage their healthcare

Depending on which team is providing care, our patients may also be able to:

- Save time calling by booking and cancelling appointments online
- Message their healthcare team

These exciting changes mean:

- Our patients will have greater and more convenient access to their health information
- We will reduce our reliance on paper letters and the number of telephone queries we receive from patients
- Time can be saved in clinic for both patients and clinicians, improving quality and efficiency
- We have the potential to reduce our 'did not attend' (DNA) rates as patients will be able to access appointment details, cancel and select appointment times (if enabled by the service)

We are developing our maternity patient website which will include information within the common non-English languages spoke at Kings College Hospital.

Where do you find you are encountering difficulties? (max 250 words)

Reduced access of care for birthing people who's first language is not English and/or do not have access to a smart phone/digital device as they are unable to access My Chart.

What could help you to achieve this more effectively? (max 250 words)

- Developing My Chart for use in other languages
- Accessing charities to provide smart devices within the course of maternity care

Postnatal care:

Improve access to postnatal physiotherapy to support women who need it to recover from birth. Women should also have access to their midwife as they require after having had their baby. Maternity services should ensure smooth transition between midwife, obstetric and neonatal care, and ongoing care in the community from their GP and health visitor.
(NHS Long Term Plan, 2019)

How successfully is your organisation achieving this? (max 250 words)

South East London Perinatal Pelvic Health Service:

In April 2021 SE London became one of 14 pilots to develop perinatal pelvic health services across our three maternity providers. The aim of this service is to support every woman and birthing person receiving maternity care to be able to access a pelvic health service throughout their pregnancy, which includes providing exercises that can help to prevent problems from developing in the first place.

Specialist Pelvic Health Midwives and Physiotherapists have been employed as part of this pilot to support the existing workforce and embed pelvic health services across the three maternity providers. More than three hundred GPs, Health Visitors, Obstetricians and Midwives across Kings College Hospital, Guys and St Thomas Hospital and Lewisham and Greenwich have attended pelvic health awareness sessions.

Pelvic Health dedicated classes are now available for women who are at risk of pelvic floor dysfunction at Guys and St Thomas Hospital <https://www.guysandstthomas.nhs.uk/our-services/maternity-care-during-pregnancy/antenatal-classes> and Kings College Hospital <https://www.eventbrite.co.uk/o/kings-college-hospital-maternity-28026537005>.

The SE London Perinatal Pelvic Health Pilot was also presented at the International Continence Society held in Vienna in September 2022
<https://www.ics.org/2022/session/7478>

KCH deliveries postnatal clinic for complex medical patients, those with hypertension through pregnancy, and is piloting a postnatal clinic for women who developed gestational diabetes in pregnancy. These clinics provide a pivotal role in providing expert knowledge to support postnatal care within the community. From February we are trialling new postnatal clinics that will run from childrens' centres and GP practices with the aim to improve links and communication in the postnatal care settings.

We use Neighbourhood Doula's which is a free, fully funded service providing continuity support through pregnancy, birth preparation, labour and the postpartum period. We work across London. They provide trauma-informed support to those that have no birth partner, who could not afford to pay for a private doula service, and with one or more of the following factors: perinatal mental health, from a racially marginalised community or speaks English as a second language.

We have strong links with local health visitor teams who early intervention and support for those women requiring additional support. As a team we also can offer extended midwifery postnatal care up to 28 days postnatally.

Our infant feeding team provide inpatient and community care. The team has grown within the last 2 years as we work towards Baby Friendly level 2. They offer additional feeding support to all parents including out of area parents whose baby's are within the neonatal intensive care unit.

Where do you find you are encountering difficulties? (max 250 words)

The Squeezy app is a tool that providing support and information for women who are suffering from pelvic health issues in the perinatal period and has been used across our other two maternity providers in SEL. It is also part of the NHS Library and now used by multiple pilots and across England. Digital apps are a huge part of supporting adherence to pelvic floor exercises and this is recognised in the New Service Specification for services which sets how these services are provided across maternity services from March 2024. The DPIA application was made over a year ago to use the Squeezy app for Perinatal Pelvic Health Service which is an NHS Funded pilot across SE London Local Maternity and Neonatal System, and we are waiting for approval from the Governance team at KCH.

What could help you to achieve this more effectively? (max 250 words)

Streamlining postnatal services across south-east London, with all hospitals in the SE London sector providing the same services. This will provide equitable care across our sector including contraception, postnatal care and infant feeding support.

Language:

A large proportion of birthing people in Southwark do not speak English as a first language or do not have access to digital services, meaning they don't always receive the information they need. The South East London LMNS Equity and Equality Strategy established the need to review the information currently provided to birthing people across the system, gather information on the most spoken languages across the boroughs and providers, and work together with birthing people to create information that works for them. *(SEL LMNS Equity and Equality Strategy, 2023)*

How successfully is your organisation achieving this? (max 250 words)

2023 most spoken languages (taken from the number of women were recorded as needing an interpreter)

For DH were:

Spanish (62)
Portuguese (18)
Tigrinya (14)
French (12)
Arabic (9)

And for PRUH:

Albanian (17)
Portuguese (8)
Romanian (6)
Arabic (5)
Turkish (5)

What we are doing successfully:

Audit of most common languages spoken in view of targeting resources and support for these groups

Staff communications to support the use of Language Line (via translator on wheels, telephone or app) in clinical areas, newsletters and email updates

Sharing of resource pack via MS Teams group and I'll also direct staff to this via the next edition of the MAGPIE

Website updates - we are now referencing and linking to more external trusted resources that have information in other languages [Maternity leaflets and resources | King's College Hospital NHS Foundation Trust \(kch.nhs.uk\)](#) and this will be expanded upon in Phase 2 of the website updates

['Feeling your baby move is a sign that they are well'](#) poster by Tommy's in DH and PRUH top 4 languages are displayed in antenatal waiting rooms and antenatal wards

Do you need a translator? poster is displayed in clinical consultation rooms, waiting rooms and reception areas

Rolling out foreign language parent education across our LMNS based on the KCH parent education classes - we have bespoke classes in Spanish and Portuguese.

Interpreter in your pocket

Staff can now download the **InSight app** onto your mobile phone to access the **Language Line** interpreter service.

Where do you find you are encountering difficulties? (max 250 words)

When staff are time pressured it has been known that a birth partner or husband is used as interpreter

Clear guidance around using staff as interpreter, communication around which staff members are able and willing to translate

Providing written information and the use of EPIC, we have more to learn about what it can do to support non-English speakers

LMNS: Issues include multi-hospital staff rota and pay management, access to suitable technology to run and host the classes, training and development for staff to be confident and competent hosting workshops online

Loss of physical space for groups to meetup. Those who speak a language other than English may find this more accessible than an online format

Access to interpreters via Language Line for some specific languages can be difficult

What could help you to achieve this more effectively? (max 250 words)

New starters/MMT training to include how to access interpreters and when to use
Resources to support rolling out LMNS and sharing of learning

4. EXPERIENCE OF MATERNITY CARE

Continuity of Carer:

By March 2021, most women receive continuity of the person caring for them during pregnancy, during birth and postnatally. This will be targeted towards women from black and minority ethnic groups and those living in deprived areas, for whom midwifery-led continuity of carer is linked to significant improvements in clinical outcomes.

A target of 75% of women from these groups to be receiving continuity of care by 2024 was set out in the NHS Long Term Plan. (*Better Births, 2016; NHS Long Term Plan, 2019*)

How successfully is your organisation achieving this? (max 250 words)

Following guidance from NHS England there is no longer a target date for services to deliver Midwifery Continuity of Carer (MCoC) and local services will instead be supported to develop local plans that work for them.

Specialist continuity of carer teams are present within Kings.

Lotus midwifery team are a team of specialist midwives with a named consultant that looks after birthing people with substance misuse, young parents and severe mental illness.

The maternal medicine team looks after birthing people with complex medical needs. They form part of the SE London maternal medicine network that provides comprehensive care for women with pre-existing medical conditions who are pregnant or planning a pregnancy, as well as those who develop medical complications during their pregnancy.

Our bereavement midwifery team works with birthing people who have experienced loss. They work closely and refer to Helix which is a specialist therapeutic service for women and

birthing people who live in Croydon, Lambeth, Lewisham or Southwark and who are experiencing emotional distress, or mental health difficulties following a perinatal loss. They work with people who have experienced: Pregnancy loss (this may include loss associated with fertility treatment, miscarriage that has occurred at any stage, or terminations including termination of pregnancy for fetal anomaly), stillbirth or death of a baby

We have two case-loading midwifery teams for parents within the Denmark Hill catchment area that support those women planning homebirth, and also support women who have experienced a previous fetal loss.

Where do you find you are encountering difficulties? (max 250 words)

Like all NHS hospitals recruitment and retention of midwives remains a concern and has a significant impact on the roll out of the CoC model. This is a complex model of care that nationally is being discussed in depth.

What could help you to achieve this more effectively? (max 250 words)

- Workforce planning and retention
- Appropriate workforce engagement with the model of care

Personalised care:

Everyone woman should develop a personalised care plan, with her midwife and other health professionals, which sets out decisions about her care. Women should also be able to choose the provider of their antenatal, intrapartum and postnatal care and where they would prefer to give birth. (*Better Births, 2016*)

How successfully is your organisation achieving this? (max 250 words)

We hold Informed Choice Forums: Every 6 weeks the consultant midwives and the MDT meet in a supportive environment to discuss personalised care plans, working outside of guidelines and how we can share learning from complex birth plans.

Maternity staff attended a Cultural Awareness Open Dialogue Workshop to help create and embed effective maternity continuity of care pathways for all communities across London in May 2023.

Consultant midwives worked with volunteers from our Maternity Voices Partnership to produce posters, as part of a larger body of work around choice surrounding induction of labour. You will see them in the inpatient wards as well as antenatal clinics. Staff and birthing people are using this tool to support informed choice and personalised care with our service users.

As part of a SE London project we are developing booklets for the key decision making outcomes within birth such as instrumental delivery and caesarean section.

Tokophobia pathway pilot: Tokophobia is a severe fear of childbirth that effects around 14% of women and birthing people. Anecdotally what is seen in practice, is that women and birthing people may not disclose this fear of birth until around 34 weeks or later, when their midwife may suggest they start their birth plan or attend antenatal classes. This makes it quite difficult to plan for the birth and signpost to psychological therapy. A two question score was chosen to screen at 16 week appointment. Of those asked, 15% met threshold for further support, which was very close to the 14% average. 9% had a referral to see the consultant midwife and 6% were referred to birth with confidence classes. Colleagues in

IAPT (talking therapies) did not have a way to monitor those who were referred to their service for tokophobia but this is now being developed for better monitoring. Of those in the pilot, we do know that 4% were referred to IAPT. Next steps are to roll this out to two further teams on each site and we are working with IT midwives and EPIC team to see how these questions can be embedded for midwives to use more easily.

We have recently developed a maternal choice caesarean section workshop for those parents exploring a primary caesarean section.

Our consultant midwives provide an update to all midwifery teams within Mandatory training around personalised care, and how we support birthing people within this.

Where do you find you are encountering difficulties? (max 250 words)

Due to medical and mental health complexities increasing there needs to be further information and support in aligning and adjusting appropriate birth planning. This requires additional workforce planning to provide additional clinical support and guidance for complex birth planning.

Currently we have a 2 bedded midwifery led unit at the Denmark Hill site and our vision would be to increase this space to give additional opportunities for birthing people who would want to birth in a low risk hospital setting.

What could help you to achieve this more effectively? (max 250 words)

Additional environmental space
Re-alignment of midwifery roles to support personalised care for complex birthing needs

Neonatal critical care:

From 2021/22, care coordinators will work with families within each of the clinical neonatal networks across England to support families to become more involved in the care of their baby and invest in improved parental accommodation. (*NHS Long Term Plan, 2019*)

How successfully is your organisation achieving this? (max 250 words)

Both LCH and GSTT have committed to introducing PERIPrem (Perinatal Excellence to Reduce Injury in Premature Birth) passports which empower families to be part of care of their premature baby. PERIPrem is a new perinatal care bundle to improve the outcomes for premature babies across London. The bundle consists of a number of interventions that demonstrate significant impact on brain injury and mortality rates amongst babies born prematurely.

The Care Coordinator role has supported both units in ensuring that there is accessible education for staff regarding family integrated care. The coordinators have been active in the Family Integrated Care and Developmental study days. This in turn has resulted in empowerment of the Neonatal team to support parents, carers and family in embedding the practices of Family –integrated Care in both units. Whilst it is recognised that improving provisions for parental accommodation is a challenge due to space limitation, the coordinators have provided suggestions on how we can improve on the existing facilities parent facilities to improve on parent experience. Their visits enable collaborative working on the areas to optimise family experience in the units during the most difficult times in their life. It provides a source of networking, sharing best practices and benchmarking across the

network to minimise variations. There has been valuable contribution from the Care Coordinators in the units drive to achieve Unicef Baby Friendly stage 1 accreditation.
Where do you find you are encountering difficulties? (max 250 words)
It is challenging to release staff for training. Space remains an issue in terms of providing parent accommodation on the KCH site. Locally Ronald McDonald House Camberwell has provided free accommodation to the families of children staying at King's College Hospital since April 2000. The House is equipped with 24 bedrooms, communal areas and a children's play area, which provides a charity solution to parental accommodation.
What could help you to achieve this more effectively? (max 250 words)
It would be helpful if Care coordinators spent a day in the units supporting bedside training to staff on areas on Family Integrated Care and BFI.

5. OUTCOMES OF MATERNITY CARE

Saving Babies' Lives Care Bundle: Aim to roll out the care bundle across every maternity unit in England in 2019. <i>(NHS Long Term Plan, 2019)</i>
How successfully is your organisation achieving this? (max 250 words)
<p>SBL will not be fully implemented by March 2024 however, the national implementation tool is in use and has been shared with both the LMNS and via quarterly reports to Board. Providers are required to demonstrate:</p> <ul style="list-style-type: none"> · Implementation of 70% of interventions across all 6 elements overall · Implementation of at least 50% of interventions in each individual element <p>Element 1 Smoking in pregnancy Not compliant Element 2 Fetal growth restriction Not compliant Element 3 Reduced fetal movements Compliant Element 4 Fetal monitoring in labour Not compliant Element 5 Preterm birth Compliant Element 6 Diabetes Compliant</p> <p>An action plan is included in the Board Declaration Form and will be a priority to deliver compliance over the coming months.</p>
Where do you find you are encountering difficulties? (max 250 words)
<p>Element 1 remains non-compliant due to the lack of a dedicated in-house resource for smoking cessation; the Trust plans to recruit a smoking cessation midwife. Although a dedicated in-house resource would be in line with other Trusts in the region and therefore provide parity of service, there are alternative approaches to meet this requirement. We have funding in place for recruitment for a dedicated smoking cessation midwife and the aim is for this element to be completed in 2024.</p> <p>The Harris Birthright fetal medicine unit is a world renowned centre of excellence within fetal medicine. The team have committed in 2024 to provide robust data to meet the requirements of the SBL bundle.</p> <p>We have lead obstetricians across both sites that lead fetal monitoring alongside a midwifery colleague. The job specifications and dedicated time is being reviewed within the Trust.</p>

What could help you to achieve this more effectively? (max 250 words)
<p>We have created a new senior head of midwifery role for compliance who will oversee the ongoing action plans and evidence collection.</p> <p>A dedicated audit and guideline midwife who will improve compliance to data collection and evidence to assure compliance to the care bundle.</p>
<p>National Maternal and Neonatal Health Safety Collaborative: By spring 2019, every trust in England with a maternity and neonatal service will be part of the National Maternal and Neonatal Health Safety Collaborative. Every national, regional and local NHS organisation involved in providing safe maternity and neonatal care has a named Maternity Safety Champion. (NHS Long Term Plan, 2019)</p>
How successfully is your organisation achieving this? (max 250 words)
<p>Our maternity safety champions have been busy visiting the inpatient wards cross-site. They meet every month and go to all areas in maternity. With a focus on risk, safety and governance, those staff on duty have an opportunity to speak directly to members of the Executive Board, who will take our concerns and work together with us to champion maternity improvements within the wider Trust agenda.</p> <p>Maternity Safety Champions</p> <ul style="list-style-type: none"> - Tracey Carter, Chief Nurse - Dame Christine Beasley, Non-Executive Director - Lisa Long, Obstetric Consultant - Ravindra Bhat, Consultant Neonatologist
Where do you find you are encountering difficulties? (max 250 words)
<p>We are a large site within maternity which spans community settings and the Princess Royal University Hospital. A programme has been set up to increase the visibility of the safety champions across all areas and posters are in all areas with information on how to contact the safety champions.</p>
What could help you to achieve this more effectively? (max 250 words)
<p>This is an established model of safety at Denmark Hill site and is running effectively. We have engagement from all members and the non-executive director and chief nurse plays a chief role within this service.</p>
<p>Perinatal Mortality Review Tool: How effectively is this tool implemented and used to improve the way your Trust learns lessons where things go wrong, and minimise the chances of them happening again? (NHS Long Term Plan, 2019)</p>
How successfully is your organisation achieving this? (max 250 words)

The PMRT meetings are an open forum where all registered staff can attend for sharing of learning. Any significant care issues that impact outcomes are highlighted during the meeting. If necessary, this is shared with individuals for supportive reflection and learning, or with the wider team if trends in issues are highlighted, although we rarely have repeated issues.

For care issues that have not impacted the outcome, reminders are sent to the wider teams about expectations of care, and the appropriate guidance to follow.

We meet monthly to discuss recent cases and are very rarely cancel meetings. We have good membership across midwifery, obstetric and neonatal teams and a lead for each staff group on each site.

Parents are always invited to share their feedback and this is always treated with the utmost respect and dignity, and shared with staff where appropriate.

There is cross site support for PMRT.

Where do you find you are encountering difficulties? (max 250 words)

The service is being lead by bereavement team so there is a conflict of interest. Handover process to patient safety team began in January 2024 to ensure this conflict of interest is addressed.

Currently there is no admin support therefore producing agendas, robust minutes and tracking of actions is difficult. As the patient safety admin will take on this role from January 2024, this will be resolved.

What could help you to achieve this more effectively? (max 250 words)

There is a robust plan for this service to be in the risk and governance portfolio which will be able to

Antenatal and Newborn Screening: The NHS population screening standards set out performance thresholds for Fetal anomaly screening programme (FASP), Infectious diseases in pregnancy screening (IDPS), Newborn blood spot (NBS) screening, Newborn hearing screening programme (NHSP), Newborn and infant physical examination (NIPE) and Sickle Cell and Thalassaemia Screening Programme (SCT) (*Public Health England, 2019*).

Please outline how successfully your organisation is achieving these performance thresholds (max 250 words)

The Trust has consistently met the achievable KPI threshold for the proportion of pregnant women eligible for SCT, IDPS and FASP for whom a confirmed screening result is available at the day of report. Screening for Sickle cell and Thalassaemia (SCT), Infectious Diseases in pregnancy (IDPS) screening and the Fetal anomaly (FASP) screening programmes. The proportion of pregnant women having antenatal sickle cell and thalassaemia screening for whom a screening result is available ≤ 10 weeks + 0 days gestation performance has been consistently within the acceptable threshold, performance for this KPI reflects the percentage of the gestational age of the women presenting early for antenatal care at < 10 weeks.

The proportion of antenatal SCT samples submitted to the laboratory accompanied by a completed family origin questionnaire – the trust has also consistently met the achievable KPI.

Under the newborn screening programmes the trust performance has consistently been in the acceptable threshold– NIPE KPI Standard 01 - proportion of babies eligible for the

newborn physical examination who are tested for all 4 components (3 components in female infants) of the newborn examination within 72 hours of birth.

Where are difficulties achieving these performance thresholds are arising? (max 250 words)

The Trust has not been able to achieve the achievable KPI target because > 40% of women present late for booking or transfer their antenatal care late to King's. Other factors that affect performance include – non-contact of women who screen positive – several attempts to call but no responses, DNA of appointments with the specialist Nurse counsellor and a reluctance/decline to disclose baby's biological father details which is a recurring issue with most of identified population of screen positives.

NP2 – performance has consistently been under acceptable threshold due to the significant number of very sick or extreme prematurity of our newborn cohort who cannot have a NIPE within 72hours, a significant number of babies also get transferred in from other units. For the NP3 NIPE-S03 timeliness of ultrasound scan of the hips for developmental dysplasia Criteria: The proportion of babies with a screen positive newborn hip result who attend for Ultrasound scan of the hips within the designated timescale. A significant number of babies approximately > 30% do not attend timely offered appointments by their parents, these appointments get rescheduled but the radiology USS department but these rebooked appointments after the national timescale of 4 to 6 weeks from the date of referral.

NB2 – The proportion of first blood spot samples that require repeating due to an avoidable failure in the sampling process; unfortunately, the Trust has consistently not met the KPI for this screening programme, since the introduction of the new bloodspot cards, the number of compressed samples rejected had increased, currently seeing a growing number of avoidable repeats from incorrect sampling technique. On a local level we have put an improvement action plan with active monitoring of the avoidable repeats.

What would help you to achieve these thresholds more effectively? (max 250 words)

GP surgeries and other community health forums to consider campaigns to encourage early access to antenatal care to further improve the sickle cell and Thalassaemia screening pathway.

- Parent information leaflet on the importance of babies' attendance to the 4 – 6 week Hip USS appointments to rule out Developmental Dysplasia of the hips (national leaflet in progress).
- Local screening team to continue to network with other external Trusts for shared practice on reducing the number of avoidable repeats for bloodspots.
- Local screening to carry out regular audits on avoidable bloodspot repeats and take robust actions to effect improvement.
- Local screening team to continue to work in collaboration with the Director of the SE Thames newborn screening lab for support with regular teaching sessions for the midwives and arranging more lab visits for repeat offenders to see how samples get processed in the lab and why it is important to have adequate bloodspot samples.
- Local screening team to continue monthly training sessions for all the midwives/maternity support workers and induction training sessions for relevant staff on all the antenatal and newborn screening programmes to continue to raise awareness of standards/pathways.
- All staff to be aware for regular updates on antenatal and newborn screening on the eLearning link in the Health Education England site located in - <https://portal.e-lfh.org.uk/login>

The NHSP (Newborn Hearing Screening Programme) population screening standards set out performance thresholds for Q2 – 2023-2024.

South East London (SEL) Newborn Hearing screening Programme met the Acceptable and Achievable target for all the standards in Q2.

For the individual sites DH (Denmark Hill, PRUH (Princess Royal University Hospital) and STT (ST Thomas's Hospital) they all met the targets with the exception of DH that had a slight increase in referrals in Q2 with 22 babies out of the cohort of 810 babies screened. So, they did not meet the acceptable target in Q2.

We are achieving the result but making sure that the sites are covered at with sufficient staffing run clinics weekly and are able to open up mop up clinics if needed to make sure that we are able to see the homebirths, early discharges and incomplete screened babies within the 4-week KPI1 timeframe.

The screening teams are really good at making sure all babies born are offered a Newborn Hearing screen and in most cases the screen of babies born in the Hospital has their screen completed before discharge.

The hours on the ward when screen can be offered are between 8 am and 4.30 pm. Babies that are discharged without a screen outside of these hours are picked up as outpatient.

Babies that are residential outside of the SEL catchment area will be offered an appointment if needed by their local screening teams. We have a strong and tight, communication pathway for these babies.

Appendix 3

Southwark Maternity Commission 2023-24

WRITTEN EVIDENCE SUBMISSION: South London and Maudsley NHS Foundation Trust

Submitted: 9 January 2024

INTRODUCTION

The Southwark Maternity Commission has three key objectives:

- Assess local inequalities in the access, experience and outcomes for maternity services, specifically for those parents from ethnic minorities and / or socially disadvantaged backgrounds, in particular those from a Black ethnic background.
- Assess the implementation of national recommendations for maternity services to improve access, experience and outcomes and reduce inequalities.
- Identify additional areas for action and improvement for Southwark birthing people as part of the local maternity and neonatal system.

In undertaking its work, the commission will:

- Listen to the views and experiences of local women, birthing people and families.
- Listen to the views of our midwifery and wider workforce that support women, birthing people and families during pregnancy and the early years.
- Review progress on the implementation of national best practice guidelines across local maternity and neonatal services and progress on Local Maternity and Neonatal System (LMNS) wide action plans.

In order to support the commission to achieve its aims, we are asking each of our main providers of maternity care for Southwark residents to complete this written evidence submission. This will provide us with a background of how your organisation operates, and allow our Commission panel to form questions, based on your responses. The questions are broken down into the following sections:

4. Organisational practice
5. MBRRACE (2023) recommendations
6. Perinatal mental health guidance

If you have any questions, please contact MaternityCommission@southwark.gov.uk

Many thanks for your help in providing information to the Southwark Maternity Commission.

1. ORGANISATIONAL PRACTICE

Keeping informed of national learnings
How does your organisation keep abreast of national learnings (e.g. MBRRACE reports, APPG, NICE guidelines etc.)? (max 250 words)
<ul style="list-style-type: none"> • Circulated to teams with further discussions in business meeting • Informs training plan within EQUIP (Education and Quality in Practice) training • Perinatal and trust wide policies are updated to accommodate updates and reflect learning • Training to staff • Induction resource pack • MS Teams channel – storing of information and induction resources
How does your organisation decide which recommendations they will implement? (max 250 words)
<p>We take all recommendations relevant to perinatal mental health and consider what amendments or implementations to service delivery are required.</p> <p>Any significant service change will be discussed through relevant leadership, governance and quality meetings within the trust, PMOA directorate and specialist perinatal pathways.</p>
Organisational culture
What measures are your organisation taking to ensure equality, diversity and inclusion for your staff? (e.g. ensuring all receive the same opportunities to grow professionally) (max 250 words)
<ul style="list-style-type: none"> • Diversity in recruitment for band 8a and above sit on interview panels and can be invited to participate in band 8a and below • Expert by experience sits on interview panels
What efforts are your organisation making to diversify your workforce? (e.g. what hiring and retention policies exist?) (max 250 words)
The Trust has a Recruitment policy in place.
What measures are your organisation taking to ensure equality, diversity and inclusion for your patients? (e.g. staff training on cultural and medical elements) (max 250 words)
<ul style="list-style-type: none"> • Service-wide training (EQUIP) has included sessions on equality, diversity and inclusion, particularly the needs and experiences of Black and Asian families in the perinatal period. • SLaM is a pilot site implementing the Patient and Carer Race Equality Framework (PCREF). • Revised Performance Improvement Policy. The Trust has an Antiracism Action Plan as part of the Trust Strategy and antiracist discussion is included in all appraisals.

- Freedom to Speak Up
- Perinatal working group/ QI work on Equality, Diversity and Inclusion and LGBTQ+
- Equality Objectives for Perinatal Psychology and Psychotherapy which has evidenced improvements in access rates for different ethnic groups more in line with the local population. Routine consideration of diversity in psychological therapy, supervision and business meetings. Sharing of resources about cultural and other adaptations to assessment and therapy.

What measures are your organisation taking to understand and tackle institutional racism and how it operates in your organisation? (e.g. is anti-racism and bias training mandatory for all maternity staff, and how often is this completed?) (max 250 words)

- Seni Lewis training (mandatory for all staff)
- Time to talk sessions (Trust wide)
- Equality, diversity and human rights (mandatory training)
- Diversity and recruitment champions in place to support fair recruitment across the trust

Working with others to improve non-health factors that affect your patients' health

How do you work with and learn from other organisations to address the impacts of wider non-health factors affecting the health of your patients? (e.g. Housing status, income maximisation, employment issues) (max 250 words)

Strategic:

- South London Network Meeting; part of provider collaborative
- Pan London Network Meetings
- Links with other services in the borough - third sector organisation / housing / Citizens Advice Bureau

Service wide:

- Essential part of the assessment includes enquiries around social circumstance of the family Accessible Information Need on ePJS (mandatory field)
- Interface with relevant organisations and services where appropriate

Resulting Challenges:

- Significant amount of time taken up for care coordinators to liaise with Housing and Benefits issues
- Hard for some of our patients to access help from external agencies and need a lot of support to access housing or benefit agencies
- Significant housing issues in the borough that impact on women/families' mental health increasing the risk e.g. overcrowded flats; mould; pests

What training do staff receive in identifying these wider issues and signposting appropriately? (max 250 words)

- Induction packs provided to new staff include some information on these issues.
- No formal training is provided and learning around this is on the job e.g. liaising with third sector.
- Safeguarding Children and Adult (Level 3) mandatory to all perinatal staff.
- Safeguarding Supervision provided to all teams once a month.
- Mandatory training on equality, diversity and human rights.

What roles in governance do organisations such as Maternal and Neonatal Voices Partnership (MNVP) and local groups working on black maternal health have? How are their voices and expertise used?

- Seni Lewis Training
- PCREF
- Black Thrive
- Black Maternal Mental Health Week
- Contacts with APP, Amplifying Maternal Voices Project and Maternal Mental Health Alliance
- Service User and Carers Group (SUCAG)
- Women like us
- Five times more
- Expert by experience engagement and co-production in developing services
- All SLAM policies are reviewed in line with the Accessibility, Equality and Diversity

Making best use of data

How do you use quantitative and qualitative data to improve your understanding of who is and who isn't taking up services? What reasons have you identified, and what would help resolve these? (max 250 words)

Data on ethnicity have been collated and presented e.g. at service wide EQUIP training. Psychology & Psychotherapy annual report specifically analyses quantitative and qualitative data on ethnicity in relation to access rates and service user satisfaction.

In Southwark in 2022/23, Asian service users were under-represented relative to the local population. Black service users were represented in the same proportion as in the local population. Mixed and other ethnic groups were slightly over represented. We have tried to set up a focus group or one to one interviews to understand what might make it difficult for Asian families to access our service: this is still in progress. We have linked with third sector organisations such as the Asian Resource Centre in Croydon in order to establish closer working relationships.

Ongoing monitoring of attendance at group interventions to review accessibility of groups.

Regulation of perinatal mental health services

How have you taken forwards recommendations for improvement made in your most recent Care Quality Commission inspection report?

2. MBRRACE RECOMMENDATIONS (2023)

“Saving Lives, Improving Mothers’ Care Core Report - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2019-21” – the MBRRACE 2023 Report. It highlighted that when deaths due to COVID-19 in 2020 and 2021 were excluded, maternal death rates were very similar over the last 2 reporting periods (2016-2018 and 2019-21), which suggests that an even greater focus on implementation of the recommendations of these reports is needed to achieve a reduction in maternal deaths (and morbidity).

How are you considering and addressing the recommendations made by the MBRRACE 2023 Report?

What processes do your organisation already have in place to consider the recommendations?(max 250 words)

- Safety questions around domestic violence and abuse are being asked in initial assessments and throughout reviews with clinicians.
- SLAM electronic system’s risk assessment currently captures information on domestic violence and abuse; child(ren) safeguarding and information on current and past mental health history.
- The team works in partnership with maternity services, GP, Children Social Care and Health Visiting teams.
- Clinicians routinely question physical health/wellbeing to identify risks and trauma. Clinicians also enquire about 8 weeks post-natal review with GP.
- Pre birth planning meeting is arranged for all antenatal women; this is facilitated in collaboration with maternity and CSC (if involved).
- The service has a Senior Nurse representative on pan London review panel to review maternal death guidance.
- The service shares practice with other Trusts.

How is your organisation planning to implement the recommendations? (max 250 words)

- The importance of professional curiosity and safety questions are reiterated at supervision – group and individual.
- DATIX and STEIS – maternal deaths are reported as per our Supporting Pregnant Women with Severe Mental Illness (SMI) to inform MBRRACE and any Pan london maternal death review
- Curiosity around safeguarding for families are now being recognised and discussed at individual supervision session using a Think Family framework.
- Group safeguarding supervision – being minuted to capture discussion points and individual patients notes are also being documented on the electronic system.

In particular, what steps are you taking / have taken to address the following recommendation as outlined in the MBRRACE 2023 Lay Summary?:

Treat pregnant, recently pregnant and breastfeeding women the same as a non-pregnant person unless there is a very clear reason not to

- Prepare a route for rapid delivery of advice and data on new treatments
- Tailor care after pregnancy to a woman’s individual needs
- Ensure staff in maternal medicine networks have the skills to care for complex physical, mental and social care needs
- Develop training resources to promote shared decision making and counselling on medication use

What processes do your organisation already have in place to consider this recommendation? (max 250 words)

Duty worker triages calls to women at point of referral if there is a concern. This is to determine if an urgent assessment is needed and to safety plan. The duty system is also for professionals to contact to discuss appropriateness of referrals.

Thresholds for assessment and interventions are lower in comparison to working age services (e.g. a woman in remission with SMI diagnosis and being managed in primary care).

Preconception counselling - advice on medication specifically with women with serious mental illness.

Women under the service will have their own personalised care plan; this includes pre birth care plan and a mental health care plan to support with the treatment and intervention received.

To meet individual needs, ante/post natal groups are available for women to attend.

Mental health midwives are invited to service's EQUIP (internal CPD training). They are also invited to weekly MDT meetings where information are shared openly

Junior drs (CT) will be joining midwife/perinatal service for training (PROMPT) for medication queries

Updated guidance around Sodium Valproate for child bearing age women being developed and discussed at Trust level as per MHRA updated policy.

Training being offered to working age CMHT and acute wards to raise profile on maternal mental health being planned as well as caring for pregnant women with serious mental illness.

All perinatal staff have access to perinatal specific training via funding from HEE or SLAM.

Sharing practice in specific perinatal conferences e.g. Marce

How is your organisation planning to implement this recommendation? (max 250 words)

Using training platform – EQUIP. This is monthly, where clinicians share learning from maternal death; child practice learning reviews and / or lessons learnt from Serious Incidents.

Teams have weekly MDT meetings where maternity and or health visiting come together with perinatal team to share information and discuss outcome of initial assessments.

Referrals are triaged daily with members of the MDT. The duty worker undertakes the tasks of phone screening referrals that might need additional information or when there is a concern, and a safety plan would need to be discussed as an interim measure.

- Maternity safeguarding groups – weekly; facilitated by named safeguarding midwife
- Safeguarding supervision groups – monthly; facilitated by safeguarding lead
- Complex case discussions – monthly; facilitated by the team psychologist
- Training / development – monthly
- Working in partnership with local services (e.g. Start for Life) - provision of training

3. PERINATAL MENTAL HEALTH SPECIFIC GUIDANCE

Increasing access to evidence-based care for women with moderate to severe perinatal mental health difficulties and a personality disorder diagnosis. Care provided by specialist perinatal mental health services will be available from preconception to 24 months after birth. (NHS Long Term Plan, 2019)

How successfully is your organisation achieving this? (max 250 words)

Number of referrals in 2023 - 385

Total initial assessments in 2023 – 349

Number of referrals since piloting 24m extension (Aug 2023 – Dec 2023) - 146

Where do you find you are encountering difficulties? (max 250 words)

- Staff workforce
- Difficulty in receiving referrals from health visiting teams and working age CMHTs. 24m extension is being piloted in Southwark, and an email informing other teams about this had been sent.
- Referrals from 'hard to reach' women group.

What could help you to achieve this more effectively? (max 250 words)

- Increase in staff workforce as caseload increasing with 24m extension.
- To arrange focus groups with BAME community.
- Plan to attend business meetings for Primary Care Networks to raise profile with available service from preconception to 24 months.
- Close links to Parental Mental Health Team (discharge pathway)
- Audits of caseload and referrals
- Women like Us (service user group) – themes captured
- Co-produce workstreams
- Challenges; women accessing external services in particular women with no recourse to public funds

Expanding access to evidence-based psychological therapies within specialist perinatal mental health services so that they also include parent-infant, couple, co-parenting and family interventions (NHS Long Term Plan, 2019).

How successfully is your organisation achieving this? (max 250 words)

Perinatal Psychology and Psychotherapy (P&P) have expanded access to a range of evidence-based perinatal psychological therapies with a robust governance framework in place in line with national guidance (NHS England Implementation Guidance for Perinatal Psychological Therapies).

The offer includes:

Parental Mental Health: Cognitive Behaviour Therapy (CBT), Interpersonal Therapy (IPT), Eye Movement Desensitisation Reprocessing (EMDR), Dialectical Behaviour Therapy in form of a Coping With Emotions skills group.

Couples and Families: Systemic Family Therapy clinics running in all 4 SLAM boroughs. Couples Therapy for Depression (CTfD) and Behavioural Couples Therapy (BCT) are currently in development with staff attending training in 2023/24.

Parent-Infant Interventions: Circle of Security groups (an attachment-based psychoeducation intervention) and Baby and Us (postnatal) and Baby Chat (antenatal) groups are running on a regular programme, Video Interaction Guidance (VIG) is well-established and further staff are training in Video Intervention for Positive Parenting (VIPP), Parent Infant Psychotherapy.

Model-specific supervision is in place for all these therapies. There is robust evaluation with an annual audit and report. This has shown highly effective therapies with a large effect size measured using the CORE-OM questionnaire. Perinatal P&P have a strong focus on inclusion and equalities. In particular, Equality Objectives work around ethnicity and access to psychological therapies has demonstrated significant improvements in access in line with the local population in each borough and indicated further areas for specific work.

Where do you find you are encountering difficulties? (max 250 words)

There are challenges with recent changes in parent infant psychotherapy staff and recruitment in progress.

It is a challenge to deliver such a large number of therapies with a relatively small number of P&P staff. Waiting times are often in excess of the NICE quality standard (6 weeks from referral to treatment) and increase quickly in response to any vacancy or staff absence. Some supervision is sourced externally as there is not yet sufficient expertise of all the models within the Trust.

What could help you to achieve this more effectively? (max 250 words)

Additional investment in P&P staff e.g. 1.0wte band 8a per borough would provide greater capacity for delivery of the full range of therapies with scope to develop in house supervision.

Offering fathers/partners of women accessing specialist perinatal mental health services and maternity outreach clinics evidence-based assessment for their mental health and signposting to support as required (*NHS Long Term Plan, 2019*).

How successfully is your organisation achieving this? (max 250 words)

Working to embed SLAM Think Family Strategy

Transformation workstream developed to support with long term plan. Workstream meet quarterly.

To date, resource pack has been developed for fathers, partners and significant other (FPSO).

Conversation tool has been developed for staff to aid interaction with FPSO.

Fathers group commissioned from EPEC; this is a peer led fathers' group (Baby and Us for Father's). It is a 9 week programme and runs on termly basis. MBU also invited to join this group.

The workstream is currently developing a strategy and will bring this together to share across service.

Family Therapy clinic offered to families within the service.
Where do you find you are encountering difficulties? (max 250 words)
<p>Seeking consent from index patient to contact fathers/partners and significant others to have a conversation.</p> <p>Documentation on electronic system – Confidentiality? Conversation can be documented under index patients carers tab but where do we document should there is a crisis or a mental health need?</p> <p>Time – additional responsibility on clinicians and workforce challenges.</p>
What could help you to achieve this more effectively? (max 250 words)
<p>Assistant Psychologist recruited to lead and support workstream and Senior Leadership Team (fixed term for 12 months)</p> <p>EQUIP – able to plan a session on fathers mental health last year and there is a plan to arrange another one for this year</p> <p>Family event to be planned by the service for include fathers, partners and significant others. Staffing with specific interests</p>
<p>Increasing access to evidence-based psychological support and therapy, including digital options, in a maternity setting. Maternity outreach clinics will integrate maternity, reproductive health and psychological therapy for women experiencing mental health difficulties directly arising from, or related to, the maternity experience (<i>NHS Long Term Plan, 2019</i>).</p>
How successfully is your organisation achieving this? (max 250 words)
<p>The Helix Service (MMHS) opened to Southwark, Lambeth and Croydon in 2023. We are receiving referrals, assessing and treating women and birthing people using evidence based psychological therapy. We see people remotely and face to face. We are also setting up therapy groups. The service has been set up with coproduction as a core principle throughout every stage of the process.</p> <p>We have a Health Inequalities Working Group which we have set up with neighbouring MMHS services. This is to monitor our access rates regarding ethnicity and other protected characteristics. This is designed to shape our outreach strategy so we can identify where we may be falling short and act to remedy this.</p> <p>We are offering teaching and training to student midwives and other professionals regarding perinatal loss and trauma-informed care.</p> <p>We are offering reflective spaces to maternity staff (chiefly midwives) to support the aims of MMHS. One of our senior midwives is setting up a clinic at Kings for people who have experienced an early loss as this is currently an unmet need within maternity. We have also been working with Trusts to facilitate setting up Rainbow Clinics for women and birthing people who have experienced perinatal loss.</p>
Where do you find you are encountering difficulties? (max 250 words)

1. We don't currently have a team administrator which is proving problematic. This is impacting on clinician time and availability
2. Estates has also been challenging. We do not currently have access to dedicated clinical space in Southwark to see clients. We have until recently had access to rooms at the Tessa Jowell Centre which has worked very well. It is community based, accessible, non-stigmatising (i.e. not based in a mental health building), trauma-informed and we have great feedback from clients about the space. Unfortunately, our access to these rooms has been significantly reduced as the team we were 'borrowing' rooms from now needs more access to these rooms as they are working more face to face. For the space to be workable for our team, we need to be able to block book, which we can't currently do. This impacts our capacity to offer face to face appointments to Southwark clients.
3. Due to limited capacity we are unable to meet the need for reflective practice spaces for maternity staff as part of our remit for indirect working with maternity. We are currently offering some reflective spaces to Southwark midwives, however the demand outstrips supply. The spaces are well used and very much appreciated by midwives. We would like to offer more but are at capacity.
4. We do not currently offer a self-referral route into the service. Offering this with the current staffing levels would likely result in longer wait times for assessment and treatment.
5. We are not currently commissioned to offer assessments or intervention to partners/fathers. However this is an important part of supporting families following loss.
6. Currently the criteria does not include removal of their child.
7. Attendance at sessions/engagement in therapy is compromised by lack of childcare. Many clients have had to discontinue therapy as they do not have childcare support and cannot engage in trauma work whilst a child is in the room with them. It is likely to be those clients who are the most deprived and socially disadvantaged who face these issues. This barrier perpetuates those issues – keeping them stuck and unable to move forward and recover.

What could help you to achieve this more effectively? (max 250 words)

1. An administrator as part of team establishment. We do not currently have allocated funding for a team administrator.
2. Dedicated space in Southwark.
3. Additional psychology staff
4. Change to commissioning regarding this and also rethink what data gets counted as part of the national data set. Currently only contacts with females gets counted.
5. Loss via removal by safeguarding is a complex issue and would need a lot of thought as to how to set up this pathway in a useful, sustainable and meaningful way. It would require additional staff and funding. We receive enquiries for this pathway but have to decline them.
6. Provision of childcare support for clients so they can engage in therapy.

Appendix 4: Resident survey

Southwark Maternity Commission - Resident Survey Gathering evidence about the experiences of maternity care in Southwark

Instructions

- Write as **clearly** as you can— these forms might be scanned
- Write your answers in the same language as this form

Privacy statement

Please confirm your consent for us to collect and use your data in the ways described above (without your consent, we are unable to use any information that you provide).

Yes, I consent

How did you find out about this survey (optional)

*Choose as many as you like

- Leaflet or flyer
- Southwark Life magazine
- Poster
- Future Men
- Media coverage (Southwark News, BBC London, South London Press etc)
- Conversation with council officer/councillor
- Conversation with friend/neighbour/family
- Email from council
- Southwark Council website
- Whatsapp message
- Facebook
- Twitter
- Instagram
- Other third sector organisation
- Other social media
- Other

If you picked 'Other', what are you thinking of?

Are you responding to this survey on behalf of your partner or family member?

- No-I am responding as someone who has used maternity services
- No - I am responding as a father, male carer or partner
- Yes - I'm responding on behalf of my partner
- Yes - I'm responding on behalf of a family member

Where did you receive maternity care?

- Guy's & St Thomas' Hospital
- King's College Hospital
- Princess Royal University Hospital, Bromley
- University Hospital
- Lewisham Other

Other (optional)

If other, please specify here

When was your last experience of maternity care? (Required)

- within the last 6 months
- between 6-12 months ago
- between 1-2 years ago
- between 2-5 years ago
- more than 5 years ago

How was your experience of antenatal care

(Care you received while pregnant until birth)?

- Very negative
- Negative
- Neutral
- Positive
- Very positive

How was your experience of care during childbirth?

- Very negative
- Negative
- Neutral
- Positive
- Very positive

How was your experience of postnatal care?

(Care you received after childbirth up until the first year)

- Very negative
- Negative
- Neutral
- Positive
- Very positive

If you are responding as a father, male carer or partner, were there any services, groups or resources that you found useful during and after pregnancy? (optional)

These might include non-traditional sources such as charities or faith-based sites.

Please feel free to share any comments or feedback about your experience of maternity care here (optional)

Do you wish to continue with the long version of the survey

- Yes- I wish to continue
- Yes - but I would like to skip to the getting access to services questions
- No -I would like to end the survey here

Have you experienced pregnancy loss before 24 weeks of pregnancy?

- Yes
- No
- Prefer not to say

Is this your first pregnancy loss before 24 weeks of pregnancy? (optional)

- Yes
- No, I have had another pregnancy loss before 24 weeks
- No, I have had more than two other pregnancy loss before 24 weeks

Thinking about your experience of pregnancy loss before 24 weeks:

(optional)

*Choose as many as you like

- Were you offered bereavement support?
- Were your other antenatal appointments cancelled?
- If you have had three or more pregnancy losses before 24 weeks, have you received further support?

Further Comments (optional)

Do you have any other comments about your care after pregnancy loss before 24 weeks?

The following questions will be about pregnancy loss after 24 weeks of pregnancy.

Do you wish to continue?

- Yes-I would like to continue
- No- I would like to skip to the getting access to services questions
- No-I would like to end the survey here

Did you experience a pregnancy loss after 24 weeks of pregnancy?

- Yes
- No
- Prefer not to say

Were you told where you could get support? (optional)

- Yes
- No
- I don't know
- Prefer not to say

If yes, did you feel supported by the care you received after your pregnancy loss after 24 weeks of pregnancy? (optional)

Please share your experience below

Were your rights to maternity leave, parental bereavement leave and maternity allowance clearly explained to you? (optional)

- Yes
- No
- I don't know

Did the hospital have a service to acknowledge your loss e.g. Garden of Remembrance? (optional)

- Yes
- No
- I don't know

When a baby dies before, during or after birth, the hospital should review what happened, and the care the person who gave birth and baby received. Did your hospital provide you with information following this review?

(optional)

- Yes, and I got the answers I needed
- Yes, but I didn't get the answers I needed
- No, I wasn't informed
- No, there wasn't a review
- I don't know
- Prefer not to say

Was your baby born earlier than its due date? (optional)

- Yes
- No
- I don't know
- Prefer not to say

How premature was your baby? (optional)

- Extremely preterm (born before 28 weeks of pregnancy)
- Very preterm (born between 28 and 32 weeks of pregnancy)
- Moderately preterm (born between 32 and 34 weeks of pregnancy)
- Late preterm (born between 34 and 36 completed weeks of pregnancy)

Did you feel supported by the care you received for your premature baby?

(optional)

- Yes
- No

If no, please could you explain why you did not feel supported: (optional)

Were there complications with your labour and the birth of your baby?

(optional)

(For example, did you lose excessive amounts of blood, did your baby have an abnormal heart rate, did their shoulder get stuck or did the baby have difficulty breathing?)

- Yes
- No
- Prefer not to say

If yes, please share the complication(s) you experienced (optional)

Have you experienced poor mental health during your pregnancy? (optional)

- Yes
- No
- Prefer not to say

Have you experienced poor mental health after your baby was born? (optional)

- Yes
- No
- Prefer not to say

If you wish, please share how your mental health has been affected.

(optional)

Do you have any comments about what happened to you and your baby after your experience of maternity care? (optional)

If there is anything else you would like to share, please do so here.

Did you know how to contact your local maternity service for help? (optional)

- Yes
 No

Did you receive maternity care before 10 weeks of pregnancy? (optional)

- Yes
 No

If no, please explain why. (optional)

Did you understand the information given to you by your doctor or midwife? (optional)

- Yes, always
 Yes, sometimes
 No

If no, please explain what difficulties you had understanding the information you were given (optional)

Would you have preferred the information in another language?

- Yes
 No

If yes, please share which language(s) (optional)

Were you given enough support for your mental health during your pregnancy? (optional)

- Yes
- No
- I did not want support

Were you given enough support for your mental health after your baby was born? (optional)

- Yes
- No
- I did not want support

Did the same midwives who provided care during your pregnancy also provide care during your labour and birth?

- Yes, always
- Yes, sometimes
- No

Did you avoid seeking care during your pregnancy for any reason?

*Choose as many as you like

- No
- Yes, I was worried I would have to pay for my care
- Yes, I was worried about having a bad experience
- Yes, Other

If you selected yes - other, please could you explain why you avoided seeking care. (optional)

Did you feel you could ask for help from your midwife about other worries including Housing? (optional)

- Yes
- No
- I did not want support

Did you feel you could ask for help from your midwife about other worries including money or debt? (optional)

- Yes
- No
- I did not want support

Did you feel you could ask for help from your midwife about other worries including employment issues in pregnancy? (optional)

- Yes
- No
- I did not want support

Did you feel you could ask for help from your midwife about other worries including domestic abuse? (optional)

- Yes
- No
- I did not want support

Do you have any further comments about your experience of getting the maternity care that you needed? (optional) Please share your comments below

Were you able to get help from your midwife or doctor when you needed it during your pregnancy? (optional)

- Yes, always
- Yes, sometimes
- No

Were you able to get help from your midwife or doctor when you needed it during your labour and birth? (optional)

- Yes, always
- Yes, sometimes
- No

Were you able to get help from your midwife or doctor when you needed it after your baby was born? (optional)

- Yes, always
- Yes, sometimes
- No

Were you involved in decisions about your care during your pregnancy? (optional)

- Yes, always
- Yes, sometimes
- No

Were you involved in decisions about your care during your labour and birth? (optional)

- Yes, always
- Yes, sometimes
- No

Were you involved in decisions about your care after your baby was born? (optional)

- Yes, always
- Yes, sometimes
- No

Did you feel listened to by your midwife? (optional)

- Yes, always
- Yes, sometimes
- No
- I don't know

Were you treated with respect? (optional)

- Yes, always
- Yes, sometimes
- No

If you selected no please share how you did not feel respected, if you feel comfortable doing so. (optional)

Did you feel able to ask all the questions you wanted to ask about your care? (optional)

- Yes
- No

If no, please share why (optional)

Did you feel supported when recovering from birth? (optional)

- Yes
- No

If no, please share what support you would have liked to receive (optional)

Were you able to speak to a midwife about any concerns easily and quickly? (optional)

- Yes, always
- Yes, sometimes
- No

If no, please explain which barriers you faced (optional)

If you raised a concern during your care, did you feel that it was taken seriously? (optional)

- Yes
- No
- I did not raise any concerns

At any point during your maternity care journey, did you think about making a complaint about the care you received? (optional)

- No
- Don't know / can't remember
- Yes, I thought about making a complaint
- Yes, I made a complaint

If yes, could you please explain why you wanted to complain. (optional)

Do you have any comments regarding your experience of using local maternity services? (optional) Please share your experience below

If there is anything else you would like to share, please do so below.
(optional)

Would you like to have further involvement with Southwark Maternity Commission? (optional)

- Yes
 No

Prize draw for a £50 Love2shop voucher for completing the survey
(optional)

To thank you for sharing your experiences, you can enter a prize draw, with five £50 Love2shop vouchers available. If you wish to enter the draw, provide your email address below.

Please tell us how you would like to be involved - further (optional)

*Choose as many as you like

- Attend the public commission meetings to share your own experience
- Attend the public commission meetings to hear others share their experience
- Attend a focus group discussion to share your own experience with a small group
- Share your experience via a face to face meeting
- Share your experience via phone/ video call
- Share your experience via
- email Other

If you picked 'Other', what are you thinking of?

Your name (optional)

Your email address (optional)

Your contact number (optional)

If you live in Southwark, which community area do you live in? (optional)

- Bermondsey
- Borough & Bankside
- Camberwell
- Dulwich
- Elephant and Castle
- Nunhead
- Peckham
- Rotherhithe
- Walworth

Age (optional)

- Under 16
- 16-17
- 18-24
- 25-34
- 35-44
- 45-54
- 55-64
- 65-74
- 75-84
- 85-94
- 95+

What is your ethnic background? (optional)

- Arab
- (Asian) Bengali
- (Asian) British
- (Asian) Chinese
- (Asian) Filipino
- (Asian) Indian
- (Asian) Pakistani
- (Asian) Vietnamese
- (Asian) Other
- (Black) British
- (Black) Caribbean
- (Black) Ghanaian
- (Black) Nigerian
- (Black) Sierra Leonean
- (Black) Somali
- (Black) Other African
- (Black) Other
- Gypsy, Roma or Irish Traveller
- Latin American
- Mixed White/Asian
- Mixed White Black African
- Mixed White/Black Caribbean
- Mixed Other background
- (White) British
- (White) English
- (White) Irish
- (White) Northern Irish
- (White) Scottish
- (White) Welsh
- (White) Other European
- (White) Other
- Other ethnic background

If you picked ' Other ethnic background', what are you thinking of?

Are you disabled? (optional)

- Yes
- No
- Prefer not to say

Please select the box or boxes below that best describe your disability:
(optional)

*Choose as many as you
like

- Hearing / Vision (e.g. deaf, partially deaf or hard of hearing; blind or partial sight)
- Physical / Mobility (e.g. wheelchair user, arthritis, multiple sclerosis etc.)
- Mental health (lasting more than a year. e.g. severe depression, schizophrenia etc.)
- Learning disability (e.g. dyslexia, dyspraxia etc.)
- Long-term illness or health condition (e.g. Cancer, HIV, Diabetes, Chronic Heart disease, Rheumatoid Arthritis, Chronic Asthma)
- Prefer not to say
- Other

If you picked 'Other', what are you thinking of?

What is your sex as recorded at birth? (optional)

- Male
- Female
- Prefer not to say
- Other (Please specify if you wish)

If you picked 'Other (Please specify if you wish)', what are you thinking of?

Is the Gender you identify with the same as the sex you were recorded at birth?

(optional)

- Yes
- No
- Prefer not to say

If no, how would you define your gender identity? Please specify if you wish

(optional)

Which of the following best describes your sexual orientation? (optional)

- Heterosexual/straight
- Lesbian/Gay woman
- Gay man
- Bisexual
- Prefer not to say
- Other
- Please specify further if you wish

If you picked 'Please specify further if you wish', what are you thinking of?

What is your religion or belief? (optional)

- Christian
- Sikh
- Hindu
- Muslim
- Jewish
- Buddhist
- No religion
- Other, please specify further if you wish

If you picked 'Other, please specify further if you wish', what are you thinking of?

Approximately, what is your household income (the combined income of all the people in your home)? (optional)

- Under £15,000 per year
- £15-29,999 per year
- £30-44,999 per year
- £45-59,999 per year
- £60-74,999 per year
- £75-89,999 per year
- £90,000 or above

What is your current housing situation? (optional)

- I own my home outright
- I am buying my home with the help of a mortgage
- Shared ownership
- I rent from the council/housing association
- I rent from a private landlord
- I live with family/friends/rent free

Would you be interested in being notified about future surveys and consultations in any of the following areas? (optional)

(we would add your email address to a specific mailing list - you could request that your name be removed at any time by writing to community.engagement@southwark.gov.uk)

*Choose as many as you like

- Housing and regeneration
- Health and social care
- Transport and Highways
- Culture
- Sport and Leisure
- Parks
- Crime and policing
- Communities
- Schools
- Employment
- Youth services
- Funding
- Engagement

What is your email address? (optional)

Please make sure you have provided an email address if you wish to be added to our mailing lists.

Appendix 5: Workforce survey

Southwark Maternity Commission - Workforce Survey

Workforce Survey

Instructions

- Write as **clearly** as you can— these forms might be scanned
- Write your answers in the same language as this form

Privacy Statement

Please confirm your consent for us to collect and use your data in the ways described above (without your consent, we are unable to use any information that you provide). I consent for you to collect and use my data as described above. Yes, I consent

Finding out about this project (optional)

How did you find out about this survey?

*Choose as many as you like

- Leaflet or flyer
- Southwark Life magazine
- Poster
- Media coverage (Southwark News, BBC London, South London Press etc)
- Conversation with council officer/councillor
- Conversation with friend/neighbour/family
- Email from council
- Southwark Council website
- Whatsapp message
- Facebook
- Twitter
- Instagram
- Other

If you picked 'Other', what are you thinking of?

Which organisation do you work for? (optional)

We are asking this question to understand different experiences of staff and volunteers from different organisations, so we can understand how to improve services in future. Please note, your answers are completely confidential.

Even if you choose to share your contact details with us to follow up with you about the Commission, your responses to this survey will be kept confidential, and will not be used to identify you.

- Guy's and St Thomas' NHS Foundation Trust
- King's College Hospital NHS Foundation Trust
- South London and Maudsley NHS Foundation Trust
- Southwark Council
- Other

If Other, please specify (optional)

Which department do you work in? (optional)

Do you feel that you have the capacity to deliver perinatal care to the highest of standards? (optional)

- Yes
- No
- Uncertain
- N/A (I don't deliver perinatal care)

If no, please share why not: (optional)

What, if any, do you think are the barriers to providing higher standards of care? (optional)

Please share your comments below

Cost of living support (optional)

- Very aware
- Aware
- Not sure
- Somewhat aware
- Not aware at all

Benefits (optional)

- Very aware
- Aware
- Not sure
- Somewhat aware
- Not aware at all

Housing (optional)

- Very aware
- Aware
- Not sure
- Somewhat aware
- Not aware at all

Domestic abuse (optional)

- Very aware
- Aware
- Not sure
- Somewhat aware
- Not aware at all

Stop smoking support (optional)

- Very aware
- Aware
- Not sure
- Somewhat aware
- Not aware at all

Physical activity and healthy eating (optional)

- Very aware
- Aware
- Not sure
- Somewhat aware
- Not aware at all

Free vitamin D scheme (optional)

- Very aware
- Aware
- Not sure
- Somewhat aware
- Not aware at all

Careers advice (optional)

- Very aware
- Aware
- Not sure
- Somewhat aware
- Not aware at all

Help with childcare costs (optional)

- Very aware
- Aware
- Not sure
- Somewhat aware
- Not aware at all

Are you aware of necessary protocol if you have safeguarding concerns?

(e.g. domestic abuse, financial abuse)

- Yes
- No
- Partly

How confident do you feel referring to/ reporting safeguarding concerns?

- Very confident
- Confident
- Not sure
- Somewhat confident
- Not confident at all

Do you feel equipped to support patients through bereavement?

- Yes
- No
- Partly
- N/A

Do you feel you can make the necessary adaptations when working with patients where English is not their first language? (optional)

- Yes
- No

If no, please share why (optional)

Have you had the opportunity to complete Equality, Diversity and Inclusion training? (optional)

- Yes
- No
- I don't know

If yes, do you think this has been beneficial to the service you provide? (optional)

- Very beneficial
- Beneficial
- Somewhat beneficial
- Not beneficial at all
- N/A: I have not completed Equality, Diversity and Inclusion training

Do you feel you can provide sufficient mental health support within your remit to patients? (optional)

- Yes
- No
- No, but I'm aware who I can refer to
- No, because I don't know who I can refer to/services available
- No (other)
- N/A

If no (other), please tell us more (optional)

Have you experienced poor mental health because of your job? (optional)

- Yes
- No
- Uncertain
- Prefer not to say

If yes, please tell us more if you are comfortable doing so (optional)

Do you feel supported by management to deliver the best care to all patients/ residents? (optional)

- Yes
- No
- Prefer not to say

If no, why not? (optional)

Are you aware of health inequalities in the area of maternity services? (optional)

- Yes
- No
- N\A

If yes, please tell us which inequalities you are aware of: (optional)

Do you feel everyone in your organisation receives the same opportunities to grow professionally? (optional)

- Yes
- No
- Uncertain

If no, please share more detail as to why you feel this way: (optional)

Do you feel confident raising any concerns within your organisation/ Trust via your organisation's internal procedures? (optional)

- Yes
- No

If no, please tell us why: (optional)

Is there is anything else you would like to share? (optional)

Please do so here

What is your email address? (optional)

If you live in Southwark, which community area do you live in? (optional)

- Bermondsey
- Borough & Bankside
- Camberwell
- Dulwich
- Elephant and Castle
- Nunhead
- Peckham
- Rotherhithe
- Walworth

Age (optional)

- Under 16
- 16-17
- 18-24
- 25 – 34
- 35 – 44
- 45 – 54
- 55 – 64
- 65 – 74
- 75 – 84
- 85 – 94
- 95+

What is your ethnic background? (optional)

- Arab
- (Asian) Bengali
- (Asian) British
- (Asian) Chinese
- (Asian) Filipino
- (Asian) Indian
- (Asian) Pakistani
- (Asian) Vietnamese
- (Asian) Other (please specify if you wish below)
- (Black) British
- (Black) Caribbean
- (Black) Ghanaian
- (Black) Nigerian
- (Black) Sierra Leonean
- (Black) Somali
- (Black) Other African
- (Black) Other (please specify if you wish below)
- Gypsy, Roma or Irish Traveller
- Latin American
- Mixed White/Asian
- Mixed White Black African
- Mixed White/Black Caribbean
- Mixed Other background (please specify if you wish below)
- (White) British
- (White) English
- (White) Irish
- (White) Northern Irish
- (White) Scottish
- (White) Welsh
- (White) Other European
- (White) Other (please specify if you wish below)
- Other ethnic background (please specify if you wish below)

If Other, please specify further if you wish (optional)

Are you disabled? (optional)

- Yes
- No
- Prefer not to say

Please tick the box or boxes below that best describe your disability:

(optional)

*Choose as many as you like

- Hearing / Vision (e.g. deaf, partially deaf or hard of hearing; blind or partial sight)
- Physical / Mobility (e.g. wheelchair user, arthritis, multiple sclerosis etc.)
- Mental health (lasting more than a year. e.g. severe depression, schizophrenia etc.)
- Learning disability (e.g. dyslexia, dyspraxia etc.)
- Long-term illness or health condition (e.g. Cancer, HIV, Diabetes, Chronic Heart disease, Rheumatoid Arthritis, Chronic Asthma) Prefer not to say

Other, please specify if you wish (optional)

What is your sex as recorded at birth? (optional)

(A question about Gender Identity will follow)

- Male
- Female
- Other (please specify if you wish)
- Prefer not to say

If Other, please specify further if you wish (optional)

Is the Gender you identify with the same as the sex you were recorded at birth? (optional)

- Yes
- No
- Prefer not to say

If no, how would you define your gender identity? Please specify if you wish (optional)

Which of the following best describes your sexual orientation? (optional)

- Heterosexual/straight
- Lesbian/Gay woman
- Gay man
- Bisexual
- Other
- Prefer not to say

If Other, please specify further if you wish (optional)

What is your religion or belief? (optional)

- Christian
- Sikh
- Hindu
- Muslim
- Jewish
- Buddhist
- No religion
- Other

If Other, please specify further if you wish (optional)

Approximately, what is your household income (optional)

(The combined income of all the people in your home)?

- Under £15,000 per year
- £15-29,999 per year
- £30-44,999 per year
- £45-59,999 per year
- £60-74,999 per year
- £75-89,999 per year
- £90,000 or above

What is your current housing situation? (optional)

- I own my home outright
- I am buying my home with the help of a mortgage
- Shared ownership
- I rent from the council/housing association
- I rent from a private landlord
- I live with family/friends/rent free

Mailing List (optional)

Would you be interested in being notified about future surveys and consultations in any of the following areas? (we would add your email address to a specific mailing list - you could request that your name be removed at any time by writing to community.engagement@southwark.gov.uk)

*Choose as many as you like

- Housing and regeneration
- Health and social care
- Transport and Highways
- Culture
- Sport and Leisure
- Parks
- Crime and policing
- Communities
- Schools
- Employment
- Youth services
- Funding
- Engagement

Email address (optional)

Please make sure you have provided an email address if you wish to be added to our mailing lists.

Southwark Maternity Commission Health and Wellbeing Board

14 November 2024



Request that the Health and Wellbeing Board:

- Note the findings of the Southwark Maternity Commission report and its recommendations;
- Agree to take on the oversight of this work;
- Receive the following updates and reviews:
 - Annual update on progress
 - Three-year interim review in Sep 2027
 - Five-year evaluation in Sep 2029

The Maternity Commission journey

There has been a huge amount of work taken place over the past nine months, including six public meetings, community engagement and stakeholder workshops.



What we hoped to achieve

The aim was for the Commission's resulting evidence to lead to three key outputs:

1. **A report and recommendations** which will be used to support **action planning** and change in the systems needed to reduce drivers of inequality
2. **Awareness resources** which will aim to raise community awareness about having a safe pregnancy and childbirth, including advice as to how to self-advocate during pregnancy
3. **A message of solidarity** to the population of Southwark to reassure residents that their voices are being heard

Key themes

Our work with stakeholders led to the development of five themes



Tackling discrimination and better supporting women with specific needs.



Making sure women are listened to and supported to speak up, whatever their language or background.



Providing women with the right information at the right time in the right way.



Joining up council and NHS services better around women's needs, and making sure care is consistent across borough borders.



Supporting the workforce to remain in their roles and be able to give compassionate and kind care for all mothers.



The Commission Recommendations

1

Leadership in addressing racism that leads to unequal maternal health

Introduce clear, evidence-based policies that address racism and inequalities in maternity care and the wider healthcare system. Include review and improvement in existing frameworks and systems, such as the NHS Workforce Race Equality Standard and ending charging migrants for maternity services.

Lead agents of change
Central government, LMNS,
GSTT, KCH, SLaM

The Commission Recommendations

2

Develop a new national way of reporting maternal health

Work with local authorities to introduce a way to record and respond to perinatal health data. Make sure all maternal health data is collected and reported in a standard way across all healthcare settings and focuses on ethnicity to highlight and address if people are getting unfair and different treatment.

Lead agents of change
Central government

The Commission Recommendations

3

Review the maternity workforce

Review the wider maternity healthcare system's capacity to support its workforce, with a focus on improving pay, conditions, and resilience. Provide healthcare professionals with training, resources, and a supportive work environment to improve compassion in care, particularly for Black and Asian mothers.

Lead agents of change
Central government, LMNS,
GSTT, KCH, SLaM

The Commission Recommendations

4

Evaluate the fairness of maternity services

Review current services for Southwark residents with the highest levels of need. Develop and improve new and existing services to make sure they work for people with complex, overlapping needs.

Lead agents of change
LMNS, GSTT, KCH, SLaM,
GPs, Southwark Council,
VCFSE organisations

The Commission Recommendations

5

Listen to and empower families

Create an inclusive environment where all family members are heard and have the information to make sure their needs are met. Improve communication by creating and promoting accessible resources so that families are fully informed and can navigate the healthcare system.

Lead agents of change
LMNS, GSTT, KCH, SLaM,
Southwark Council, VCFSE
organisations

The Commission Recommendations

6

Preparation and support before pregnancy

Southwark partners (Local Maternity and Neonatal System, local authorities, voluntary and community sector and maternity care providers) raise awareness together of the importance of getting ready for pregnancy. Use all services and contacts so that women arrive at maternity services in the best possible health (in particular those at risk of poorer maternal health outcomes).

Lead agents of change
LMNS, GSTT, KCH, SLaM,
GPs, Southwark Council,
VCFSE organisations

The Commission Recommendations

7

Give parents the right information, at the right time, in the right way

Southwark partners (Local Maternity and Neonatal System, local authority, voluntary and community sector and maternity care providers) work together on their communications across each stage of the perinatal period. Make sure women and their partners get the right, inclusive and culturally appropriate information

Lead agents of change
LMNS, GSTT, KCH, SLaM,
GPs, Southwark Council,
VCFSE organisations

Create a joined-up approach to families' needs between the NHS, south east London boroughs, and voluntary and community sector

Strengthen partnerships by creating a network for staff delivering care to Southwark residents. Share learning, facilitate integration across services and improve knowledge and resource sharing. Look for opportunities for co-commissioning with neighbouring boroughs to enhance and provide consistent services across borough borders.

Lead agents of change
LMNS, GSTT, KCH, SLaM,
GPs, Southwark Council,
VCFSE organisations

The Commission Recommendations

9

Southwark Council to review their role in maternity Care

Look at their role in assurance and scrutiny of the maternity care system and empower system leaders to hold people to account. Together with local trusts review, identify and close gaps in maternity services. Consider their role in housing and cost of living services, and in collaborating with local voluntary, community, faith and social enterprise sector organisations.

Lead agents of change
Southwark Council

The Commission Recommendations

10

Review how feedback is dealt with

Work with NHS trusts to review how they identify, share and respond to patient and staff complaints, particularly ones about racial discrimination. Embedding a culture where staff are encouraged and supported to speak up. Make sure that the context of reviews is appropriate and develop an integrated, borough-wide response to review findings.

Lead agents of change
LMNS, GSTT, KCH, SLaM,
GPs, Southwark Council,
VCFSE organisations

Signs of success

As a result of the Commission's ten recommendations, we have the ambition for improvements around five key outcomes within the next five years:

Outcome 1: Reduced infant mortality

Outcome 2: Reduced maternal morbidity

Outcome 3: Increased positive experience of maternity care

Outcome 4: Increased staff satisfaction

Outcome 5: Closing the health inequality gaps



Next steps – the Commission

Timeline of next steps for the **Maternity Commission recommendations**



- A strategic steering group consisting of key stakeholders will be formed.
- The strategic steering group will oversee and support sub-groups for recommendation areas.
- Resident involvement will continue to be prioritised at every level.

Next steps – the Commission

Phase 1

- Assess inequalities locally
- Engage stakeholders
- Publish findings and key recommendations

Period	Jan- Sept 2024
Status	Complete

Phase 2

- Establish governance
- Establish actions
- Identify synergies with other work areas
- Develop evaluation framework
- Embed “quick win” actions

Period	Sept 2024- Apr 2025
Status	Ongoing

Phase 3

- Embed actions
- Monitoring and oversight
- Annual reporting

Period	Apr 2025- Sept 2027
Status	Not started

Phase 4

- Evaluation of actions and impact on outcomes
- Three-year and five-year reports

Period	Sept 2027- Sept 2029
Status	Not started

In the media

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Maternity report calls for clear policies and 'urgent action' to tackle racism

A report by the Southwark Maternity Commission spoke to 750 women, families and healthcare professionals and urges the government to introduce leadership roles and review existing frameworks to tackle racism.



Shamaan Freeman-Powell
News correspondent @Shamaan_SkyNews

Monday 30 September 2024 14:52, UK



The Southwark Maternity Commission took place today lead by Cllr Evelyn Akoto

NEWS POLITICS FOOTBALL CELEBS TV STRICTLY SHOPPING ROYAL

EXCLUSIVE: Major inequalities in maternity care for Black, Asian and minority ethnic women

The Mirror went to Southwark Council to report on its commission that set out to fix maternity inequality when it comes to Black and Asian mothers

By **Serena Richards**, Journalist
19:16, 30 Sep 2024

Facebook Twitter WhatsApp Email 4 | BOOKMARK

Southwark Council has unveiled a plan to improve maternity care for Black, Asian and minority ethnic women. It came after a nine-month investigation that highlighted inequalities in maternity care and experience.

The report, which came out today, shed light on concerns regarding the quality of care, communication, and cultural sensitivity across local maternity services.

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NEWS SOUTHWARK

Council sets out plan to tackle stark inequalities in maternity care

30 September 2024 Claudia Lee

Southwark council has unveiled a plan to improve **maternity outcomes for black**, Asian and minority ethnic women after a nine-month investigation revealed stark inequalities in maternity care in the borough.

In January, Southwark council established a maternity commission after a national report published last year revealed that women from black ethnic groups were four times more likely to die in pregnancy than those from white groups, and women from Asian ethnic backgrounds almost twice as likely.

The **Southwark Maternity Commission**, co-chaired by councillor Evelyn Akoto, Cabinet Member for Health and Wellbeing and professor Dame Donna Kinnair, published its final report today.



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- Standing desks may increase risk of swollen veins and blood clots, says study
- More than a third of women did not take up breast screening offer last year
- Clearing asylum backlog could see 62,000 more migrants recognised as refugees
- I tested the app that's seen people lose 5 stone as part of my weight loss journey
- Safe access zones around abortion services come into effect

News South London News Black Communities

South London borough fighting to stop refugees being charged £14k to give birth in England

Pregnant women fear being chased by debt collectors so many are avoiding seeking help, making them more likely to die in childbirth

By **Robert Firth** Local Democracy Reporter

WIRE 1 OCT 2024

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Next steps – Southwark Health and Wellbeing Board

Request that the Health and Wellbeing Board group considers:

- Note the findings of the Southwark Maternity Commission report and its recommendations;
- Agree to take on the oversight of this work;
- Receive the following updates and reviews:
 - Annual update on progress
 - Three-year interim review in Sep 2027
 - Five-year evaluation in Sep 2029

Questions for the board

- What are your observations and reflections on this work?
- Which partner(s) is best placed to take the lead on oversight on behalf of the HWBB?
- Is the HWBB content with the reporting schedule?
- How best can the HWBB work alongside OSC to optimise delivery of the Commission recommendations?

Thank you



Meeting Name:	Health and Wellbeing Board
Date:	14 November 2024
Report title:	Healthy Weight in Southwark
Ward(s) or groups affected:	All
Classification:	Open
Reason for lateness (if applicable):	Not applicable
From:	Sangeeta Leahy Director of Public Health, Southwark Council

RECOMMENDATION(S)

1. The Health and Wellbeing Board notes the healthy weight profile for the child and adult population in Southwark (paras 3 – 8), the progress made in implementation of the Southwark Healthy Weight Strategy (paras 13 -17) and the potential areas for further development (para 23).
2. That the Health and Wellbeing Board provide feedback on the areas for further development (para 23) and opportunities for innovative approaches and collaboration, particularly in relation to the systems approaches required and partnership implications for:
 - Streamlining sign posting to all national and local support services for adults living with obesity, strengthening the range of interventions and increasing awareness of available services to support healthy weight among the general population.
 - Enhancing the systems focus on people who are inactive. Work with other HWB partners to support people who are physically inactive to be active.

BACKGROUND INFORMATION

3. Obesity continues to be a significant public health challenge world over. The term 'obese' describes a person who has excess body fat. [Body Mass Index \(BMI\)](#) is a measure of whether one is a healthy weight for their height. For most adults, having a BMI of 18.5 to 24.9 is considered to be a healthy weight. A BMI of 25 to 29.9 (23 to 27.4 for Asian, Chinese, Middle Eastern, Black African or African-Caribbean family background) is considered to be overweight, and a BMI over 30 (27.5 or above for Asian, Chinese, Middle Eastern, Black African or African-Caribbean family background) is considered to be obese.
4. Childhood obesity is increasing across the UK. [The Office for Health](#)

[Improvement and Disparities \(OHID\)](#) data shows that in 2022/23, 21.3% of 4- to 5-year-olds in England were overweight or living with obesity and 36.6% of 10 to 11 year olds were overweight or living with obesity. In addition, 64% of adults aged 18 years and over in England were estimated to be overweight or living with obesity.

5. Whereas the prevalence of overweight and obesity in Southwark has been relatively stable in recent years, it has remained high and this has a significant impact on our residents' health and wellbeing, our economy and our community as a whole.
6. In 2022/23, 21.7% of Reception children in Southwark were classed as having excess weight (overweight or obese), this rose to 42% for children in Year 6. Similarly, 56.5% of adults were classed as overweight or obese. Marked inequalities persist with areas of high deprivation and people from Black ethnic backgrounds having higher rates of obesity.
7. Obesity is closely associated with the development of several life-limiting chronic health conditions including Type 2 Diabetes, Hypertension, Cardiovascular disease, and poor mental health. The latest [Health Survey for England](#) shows that nationally, 35% of adults with obesity reported a limiting longstanding illness compared with 20% of those who were not overweight nor obese.
8. Levels of physical activity among adults in Southwark are generally higher than the regional and national averages, with 72.6% of adults reporting to be meeting national physical activity goals. The available local primary care data, though insufficient across different ethnic groups, suggests that the levels of physical activity are considerably lower (47.2) amongst Black adult residents aged over 45 years compared to White British (79.9%) and other White (81.1%) adults in Southwark. Work is taking place to strengthen local data collection and analyses by age, ethnicity, social gradient and geography.
9. The landmark 2007 Foresight report [Tackling Obesities: Future Choices](#) highlighted the complex multifaceted system of determinants of obesity as well as the role of the obesogenic environment (range of social, cultural and infrastructural conditions that influence an individual's ability to adopt a healthy lifestyle). The report called for a Whole Systems Approach to tackling obesity, which emphasizes that actions are needed at multiple levels, with various stakeholders working together and reinforcing each other to reshape what people eat and drink and the activity they do. Alignment with other major policy issues is vital in maximising the engagement of a broad range of stakeholders.
10. The government [childhood obesity plan](#) launched in 2016 outlined the actions that the government would take towards its goal of halving childhood obesity and reducing the gap in obesity between children from the most and least deprived areas by 2030. The plan set out a number of actions primarily focused on reducing sugar consumption and increasing physical activity among children. There has also been work on advertising, with restrictions in place around advertising products high in fat, salt and sugar (HFSS), especially on

supermarket shelves. On 1 October 2025, further restrictions on advertising identifiable unhealthy food and drink on TV and online will come into force UK-wide: a 9pm TV watershed and a 24-hour restriction on paid for advertising online.

11. The Mayor of London's commitment to addressing child obesity in the capital led to the formation of the London Child Obesity Taskforce in 2018, whose vision was that every child in London grows up in a community and an environment that supports their health and weight. Their recommended ideas and actions were set out in '[Every Child A Healthy Weight – Ten Ambitions for London](#)' aimed at transforming aspects of the daily lives of children and their parents through changes in resources availability, the environment, and care and emotional support. In January 2022, London's Child Obesity Taskforce transitioned into the Mayor's Advisory Group on Child Healthy Weight (MAGCHW) to provide the Mayor of London with expert advice on action needed to support the health and weight of London's children post COVID-19 and this was set out in their 2022 publication '[Every Child a Healthy Weight - Still a Critical Priority for London.](#)'
12. A 2022 [review](#) undertaken by the National Institute for Health Research identified 143 NIHR-funded studies on obesity that are relevant to local authorities. An array of interventions, settings, and study types were considered. The review highlighted the following evidence-based actions that local authorities, working with their local partners, can take to reduce obesity in their communities: Influencing what people buy and eat, encouraging healthy schools, expanding access to public sports and leisure services, promoting active workplaces, providing weight-management programmes, designing built and natural environments, enabling active travel and public transport, preventing obesity in children and families and embracing system-wide approaches.
13. The approach to tackling obesity in Southwark is laid out in the [Southwark Healthy Weight Strategy \(2022-27\)](#), a partnership between Southwark Council, the South East London ICB (Southwark) and VCS. The strategy adopts a whole systems approach, working with partners across the borough's healthy weight network to deliver effective prevention and treatment services that aim to reduce inequalities and improve health.
14. Inequalities within obesity rates in Southwark have informed the identification of the 5 population groups prioritised in this strategy: Maternity and early years, Children and young people, Black, Asian and minority ethnic groups, People experiencing food insecurity, Men aged 45 years and above. A set of bold ambitions and related planned actions have been developed for each priority group and are reviewed annually. The strategy is currently in year 3.
15. There are already many examples of good practice in promoting healthy weight in Southwark which can be divided into: 1) place-based and 2) people-focused interventions.
16. The place-based interventions include: the [Southwark School Meals](#)

[Transformation Programme \(SMTP\)](#), School Superzones, Good Food Retail Project, advertising policy for foods high in fat, sugar and salt, Hot Food Takeaway exclusion zones. Some of the year 3 action plan priorities for these interventions include:

- Work with a fast food outlet to improve offer to secondary school children in a Superzone
- Deliver one VCS/business led application for Thriving Highstreets 2024 which supports healthier food environments, supporting Superzones
- Align healthy weight priorities with the wider Southwark SMTP

17. The people-focused interventions include targeted adult weight management programmes, *Alive N Kicking* (child weight management programme) in schools, offering Healthy Start and Alexander Rose voucher schemes to vulnerable families, as well as offering healthy weight training to a variety of healthcare and non-healthcare professionals. We are also working to support individuals to be more physically active through our free swim and gym offer, bike hire schemes, walking groups, as well as offering incentives for active travel through the BetterPoints Southwark app. Active travel is key priority for the Mayor of London, the [Southwark Plan](#) and [Streets for People](#). Year 3 action plan priorities for these interventions include:

- Additional promotion of healthy weight training to professionals in maternity settings
- Extend Alive N Kicking to more school settings
- Enhancing the weight management provision for targeted groups such as Latin American, Men aged over 45 years (especially from Black ethnic backgrounds) and Black-majority Faith groups
- Pilot the use of the BetterPoints Southwark app for a wider range of public health interventions to support a whole person approach
- Increase uptake and access to Healthy Start and Rose Vouchers.

KEY ISSUES FOR CONSIDERATION

18. Although there is much work taking place in Southwark to support physical activity, these opportunities are more likely to be taken up by people who are already active. In Southwark, a scoping exercise undertaken by the public health team indicates that the groups of people least likely to be active include: adults aged over 45 years, Black African and Caribbean residents and Council tenants, and people at transition stages i.e. children leaving home, retirement, becoming a carer, being diagnosed with a condition.
19. There are generally a complex set of drivers and barriers that encourage or discourage an active life whether locally or nationally, and these relate to people's environment, daily routines, physical ability, as well as cultural influences. These drivers and barriers are a particularly important consideration when focusing on those groups most likely to be mostly inactive. The [Active Lives Adult Survey report \(2024\)](#) showed that these groups include: unemployed people (45% inactive), disabled people (41%), those aged 75+ (45%), Asian females (37%) and transgendered people (34%).

20. In 2023, the Department of Culture, Media and Sport (DCMS) published a sport strategy, [Get Active: a strategy for the future of sport and physical activity](#) which sets out how the government will work with the sport and physical activity sector to achieve the aims of building a healthier nation through tackling high levels of inactivity by ensuring that everyone has the opportunity to be active. The 3 core priorities of this strategy are:
- Being unapologetically ambitious in making the nation more active, whether in government or in the sport sector.
 - Making sport and physical activity more inclusive and welcoming for all so that everyone can have confidence that there is a place for them in sport.
 - Moving towards a more sustainable sector that is more financially resilient and robust.
21. In April 2024, the Association of Directors of Public Health, made [recommendations](#) to the National Physical Activity Taskforce on how the Department for Culture, Media and Sport can work jointly with Directors of Public Health (DsPH) and local authorities to help people to be more active. They recommend a demographic and life course-based approach as well as resourcing leisure centers among others. Any sustainable programme of work among identified priority groups must involve co-production, co-design and (most importantly) co-delivery. The use of grants, community champions and a willingness to think (or at least let communities think) outside the box can deliver sustainable improvements that are fully owned by the people that benefit from them.
22. According to the [NHS](#), living with obesity can increase one's risk of developing many potentially serious health conditions, including: type 2 diabetes, high blood pressure, asthma, several cancers, sleep apnoea, liver disease and so on. It has been noted that the SEL Tier 2 weight management programme has seen an increase in people presenting with multiple morbidities. This has created a challenge in the management of these patients hence the need for the development of clearly defined patient-centered referral pathway for use by clinicians.
23. Considering the evidence base summarized above and the current work, potential areas for further development may include:
- Adult obesity and common long-term conditions often co-exist. There is need for the development of a patient-centred referral pathway for use by clinicians in the management of these people.
 - Focus on people who are inactive. Work with other HWB partners to support people who are physically inactive to be active, including support for women and birthing parents during the preconception, pregnancy and postnatal periods, considering culturally appropriate services where necessary.
 - Refresh the Healthy Schools/Healthy Early Years programme in Southwark, including rolling out the Alive N Kicking programme in more schools and ensuring that the Public Health offer for schools is widely promoted across the borough.

- Promote the BetterPoints Southwark app widely and use the data collected to clarify which groups engage with active travel and how it addresses health inequalities.
- Streamline sign posting to all national and local support services available for adults living with obesity, as well as increasing awareness of available services to support healthy weight among the general population.
- Increasing capacity in tier 3 weight management support for Children and Young People in Southwark and across SEL.
- Further work on the most suitable delivery model for weight loss drugs in SEL, ensuring appropriate wrap-around care.

Policy framework implications

24. The [South East London \(SEL\) Integrated Care System](#) has a focus on protecting health and wellbeing and supporting people to stay healthy. Southwark Council, as outlined in the [Council Delivery Plan](#), is committed to a healthy environment for its residents, supporting families and investing in our communities. In addition, the SEL Vital 5 programme focuses on reducing obesity and harmful drinking, stopping smoking, controlling blood pressure, and identifying and improving poor mental health which will help in preventing ill health, promoting good health, as well as improving detection, management and treatment of existing conditions.
25. Healthy employment and good health for working age adults' is one of the five drive areas in [Southwark's Joint Health and Wellbeing Strategy](#). An aim within the strategy is to 'enable people to lead healthy lifestyles building on the already strong work on the Vital 5 and promote and maximise access to leisure and physical activity.
26. The Southwark Vision for 2030 sets the council priorities and commitments to the people of Southwark until 2030
 - Three Principles: Empowering people, Reducing Inequalities, Investing in Prevention
 - Six Goals: Decent Home For All, Good Start In Life, Safer Southwark, Strong and Fair Economy, Staying Well, Healthy Environment
27. The council has now taken back control of the leisure services and there are plans to reshape the Free Swim and Gym programme to make it more targeted and impactful. This is directly linked to the council's commitment to a 'Fairer future for all', in particular 'breaking down barriers that prevent people from thriving in Southwark, so that whatever your background you can live a healthier life.'
28. Southwark Council [Transport Strategy](#) sets out a bold vision and a firm commitment to improve our residents' quality of life and take action on climate change, by changing how we all travel and use streets in our borough. In particular, the strategy supports healthy travel options like walking, cycling or wheeling.

29. The [Southwark Sustainable Food Strategy](#) envisions a sustainable food system in Southwark to improve health and wellbeing for our population, to reduce inequalities and to protect the planet.
30. The Southwark and Lambeth School Nursing service delivers the National Child Measurement Programme in schools, one of the statutory requirements for the local authority and a priority of the Healthy Weight Strategy. The school nursing service supports the delivery of advice and support on a range of topics, including healthy lifestyles.
31. The healthy weight strategy contributes to Southwark Stands Together (SST) recommendations, in particular: commission and co-produce health services and interventions with Black, Asian and minority ethnic communities including working with key partners to ensure health services and initiatives are culturally appropriate and accessible for Black, Asian and minority ethnic residents.

Community, equalities (including socio-economic) and health impacts

Community impact statement

32. Tackling obesity across the system requires close working with communities to ensure activities are tailored towards those individuals, groups and communities most at risk.
33. The [evidence](#) suggests that any approaches that local authorities take to tackle obesity must resonate with their local communities and the challenges they face. Moreover, in any given local authority, the approach taken may differ from one neighbourhood to another.

Equalities (including socio-economic) impact statement

34. People in deprived areas often face significant barriers to accessing affordable, healthy food and to taking regular exercise. These wider determinants hinder maintaining a healthy weight and can cause variation in people's ability to follow weight management advice and recommendations.
35. It is a council priority to tackle health inequalities and improve health and wellbeing across the life course, focusing on prevention and early intervention. This includes reducing the prevalence of excess weight and commissioning accessible and targeted services. The Healthy Weight Strategy contributes to these aims.
36. Healthy weight interventions across Southwark strive to tackle inequalities through targeting of populations that have the poorest outcomes, with a focus on the most disadvantaged neighborhoods and communities in Southwark. The Healthy weight Strategy adopts a whole systems approach, working with partners to address inequalities.

Health impact statement

37. Overweight and obesity are linked to a wide range of diseases, most commonly: type 2 diabetes, hypertension, some cancers, heart disease, stroke and liver disease, and can also be associated with poor psychological and emotional health, and poor sleep. Overweight children are more likely to become overweight as adults. This could lead to long-term conditions such as type 2 diabetes.
38. Physical activity decreases the risk of premature death and lowers the risk of some common long-term conditions such as diabetes and cardiovascular disease. Such conditions reduce people's quality of life and also put a financial burden on the NHS.
39. The Healthy Weight Strategy considers the direct and indirect influences on obesity in the borough i.e., health and its wider determinants.

Further guidance

40. Not applicable

Climate change implications

41. Promotion of physical activity, especially active travel through walking, cycling and wheeling has a positive impact on the environment due to lower emissions. Southwark has many primary schools in close proximity to one another and we actively encourage children to travel to school on foot, by bicycle or on public transport.
42. Consumption of more climate-friendly diets (plant-based) and reduction in red meat consumption not only have health benefits, but also lead to reduced carbon emissions.

Resource implications

43. According to the [Department of Health and Social Care](#), it is estimated that the NHS spends £6 billion per-year on obesity-related health care. This figure is expected to rise to over £9.7 billion each year by 2050; the total [NHS budget](#) was £168.8 billion for 2023/24.

Consultation

44. The healthy weight strategy and action plan was produced through comprehensive workshops and conversations with residents, NHS colleagues and partners, The Healthy Weight Network, The Southwark Food Action Alliance, Council colleagues, including from Transport, Early Help, Planning and Leisure, local organisations and charities, including Guy's and St Thomas' Trust, Impact on Urban Health and Bite Back 2030. The Healthy Weight Task Force meets every six weeks to ensure that the action plan is on track.

SUPPLEMENTARY ADVICE FROM OTHER OFFICERS**Head of Procurement**

45. Not sought

Assistant Chief Executive, Governance and Assurance

46. Not sought

Strategic Director of Resources

47. Not sought

Other officers

48. Not sought

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
Southwark Healthy Weight Strategy Healthy weight strategy refresh 2022-2027 overview 25.10.22 (15).pdf	Public Health Division, Children and Adults Department Rebecca Harkes, 020 7525	Sheila Katureebe 020 7525 5514
ADPH summary report to National Physical Activity Taskforce	The Association of Directors of Public Health (UK) Hamilton House 1 Temple Avenue London EC4Y 0HA	policy@adph.org.uk Sheila Katureebe 020 7525 5514
How can local authorities reduce obesity? Insights from NIHR research How can local authorities reduce obesity? - NIHR Evidence	National Institute for Health and Care Research	Sheila Katureebe 020 7525 5514

APPENDICES

No.	Title
Appendix 1	Healthy Weight in Southwark (Power Point presentation)

AUDIT TRAIL

This section must be included in all reports.

Lead Officer	Sangeeta Leahy, Director of Public Health	
Report Author	Sheila Katureebe, Policy and Programme Officer (Healthy Weight and Physical Activity)	
Version	Final	
Dated	01/11/2024	
Key Decision?	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	Comments Sought	Comments Included
Assistant Chief Executive, Governance and Assurance	No	No
Strategic Director of Resources	No	No
List other officers here	n/a	n/a
Cabinet Member	No	No
Date final report sent to Constitutional Team	1 November 2024	

Healthy Weight in Southwark

Health and Wellbeing Board

Public Health Division

14 November 2024

Contents

- Introduction
- Prevalence of excess weight in Southwark (children and adults)
- Systems approach to tackling obesity
- Southwark Healthy Weight Strategy 2022-27
- Local interventions to tackle obesity
- Cases Studies: Resident experience
- Moving forward: areas for development

Introduction

We are working to increase opportunities for residents to be healthy and tackle the obesogenic environment

The levels of obesity in Southwark are of concern; this has a significant impact on our residents' health and wellbeing, our economy and our community as a whole.

- Obesity is one of the five significant risk factors for premature death.
- Council and ICB strategies are focusing on addressing the '**Vital 5**' factors of healthy weight, smoking, harmful drinking, blood pressure and mental health and wellbeing.
- Addressing obesity requires focus not only on prevention and treatment services but also on improving the environments we work, study and grow up in.

Prevalence of excess weight in Southwark

Childhood obesity

Prevalence of overweight and obesity has remained high, but relatively stable in recent years

- In 2022/23, 21.7% of Reception children were classed as having excess weight (overweight or obese) , this rose to 42% for children in Year 6¹.
- Gender has little effect on weight status overall, however boys in Year 6 are more likely to be living with obesity compared to girls.
- Children from a black ethnic background are more likely to be living with obesity than those from a white ethnic background and this increases with age; children from Asian, mixed or other ethnic backgrounds fall in the middle.
- Children living in the most deprived areas are more likely to be overweight or obese compared to those living in the least deprived areas.

The number of Southwark children with excess weight is still higher than the national average

Year 6 children are twice as likely to be overweight or obese than children in Reception

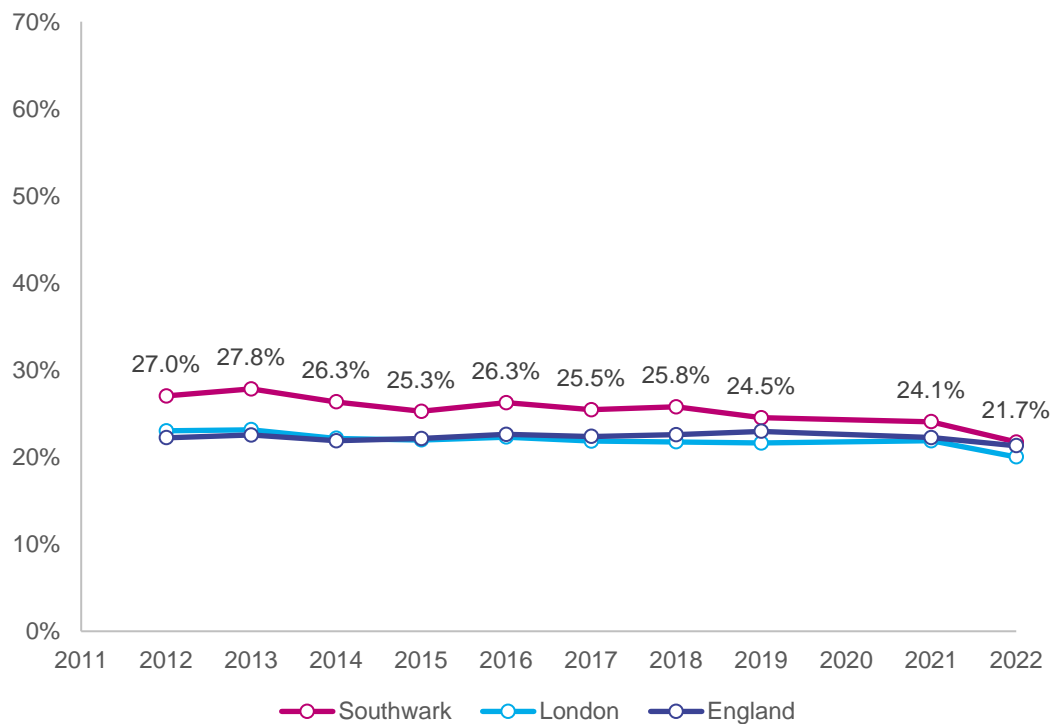


Figure 1: Trends in the excess weight of children in Reception (2012/13-2022/23)¹

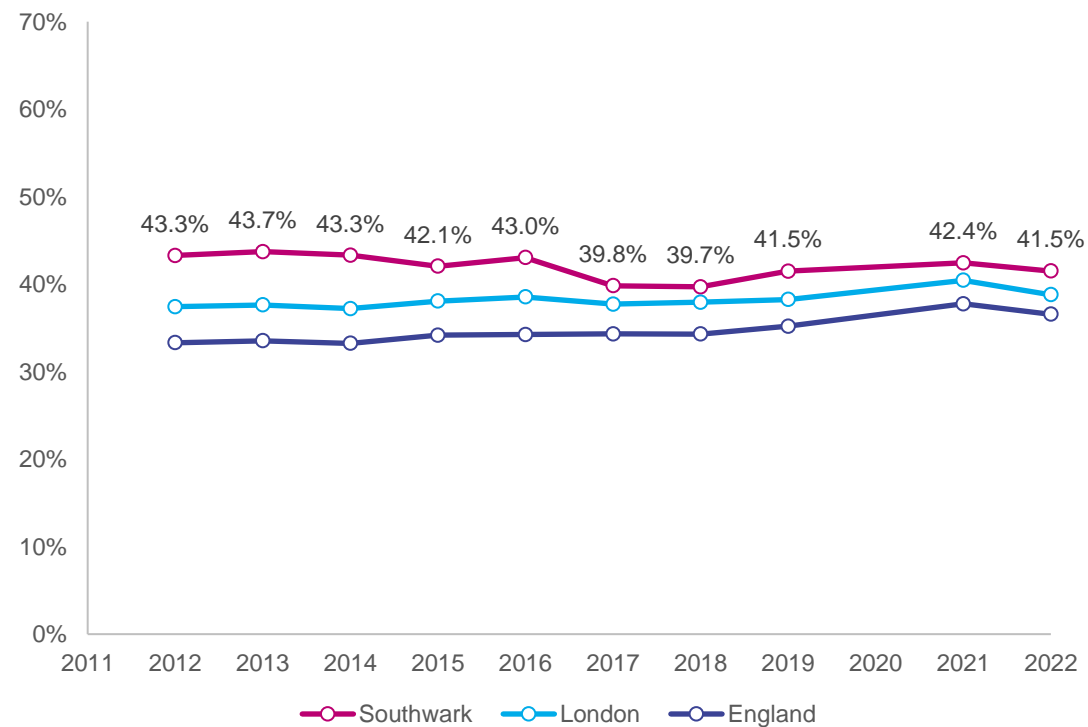


Figure 2: Trends in the excess weight of children in Year 6 (2012/13-2022/23)¹

Ward of pupil residence: excess weight

Areas of high deprivation are associated with higher rates of obesity

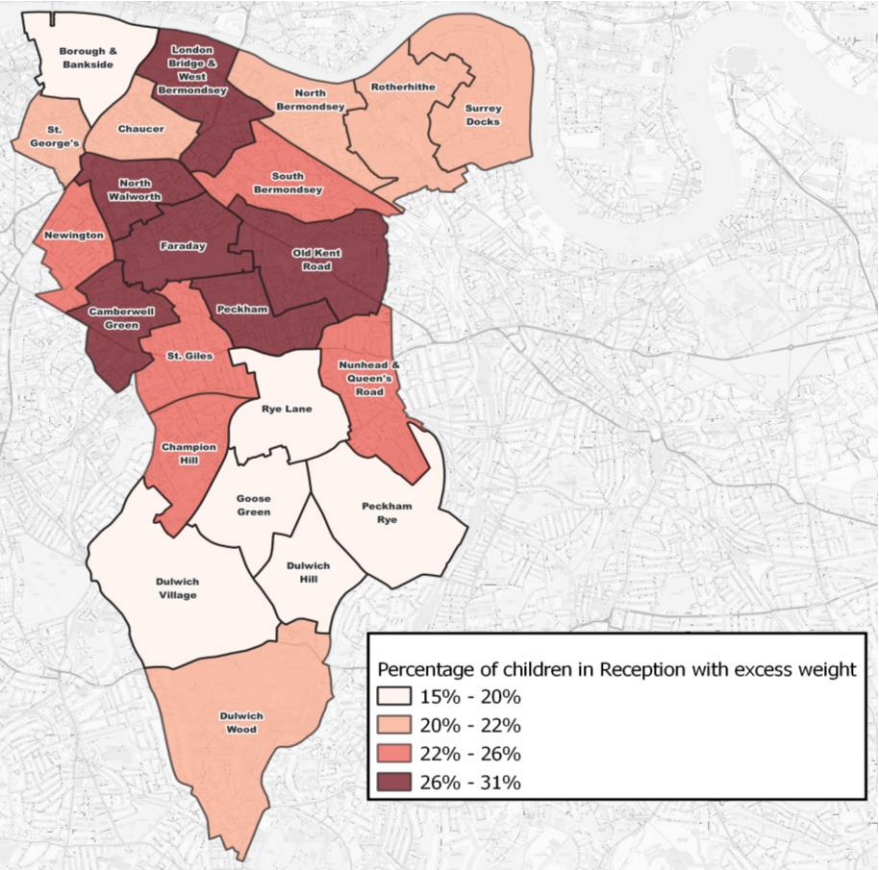


Figure 3. Proportion of Reception pupils with excess weight by ward of pupil residence: 3-year data 2018-2022 (excl. 2020/21)²

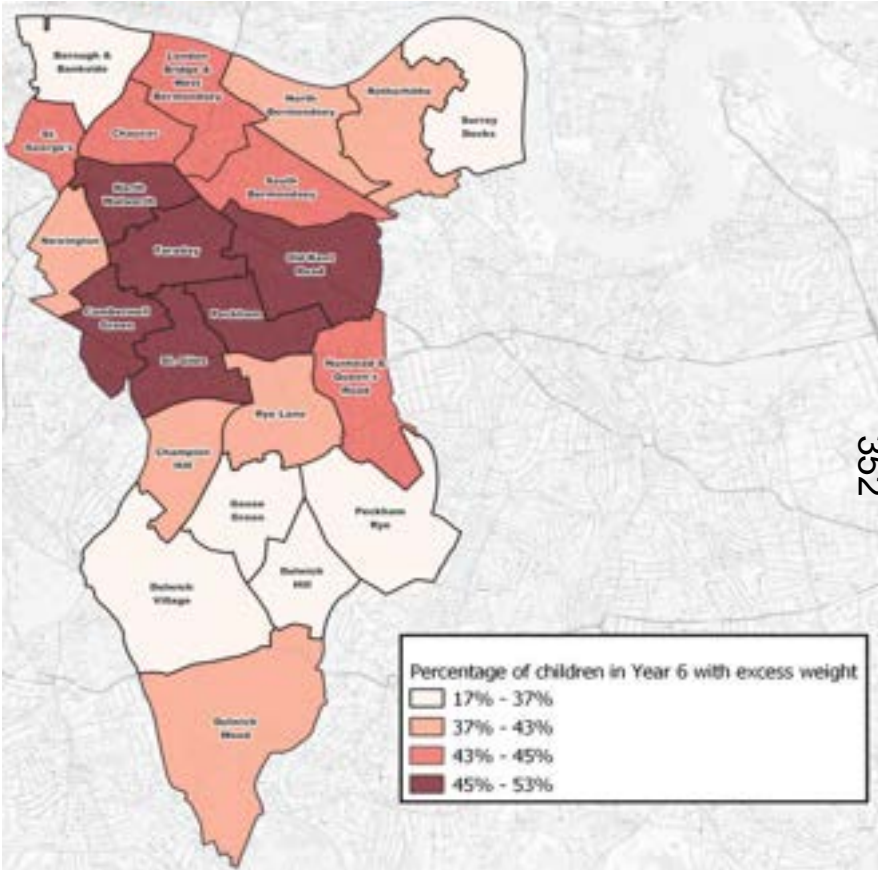


Figure 4. Proportion of Year 6 pupils with excess weight by ward of pupil residence: 3-year data 2018-2022 (excl. 2020/21)²

352

Adult obesity

Southwark has similar rates of excess weight in adults compared to the rest of London, but lower than England.

- In Southwark, the prevalence of excess weight amongst men aged between 45-74 years is the highest of any age group.³

Rates of obesity during early pregnancy are lower in Southwark (17%) than London and England.¹

Nationally 66% Black women are overweight & obese in early pregnancy.⁴

- Work is taking place to improve local data collection and analyses.

Obesity is closely associated with the development of several life-limiting chronic health conditions

- Nationally, 35% of adults with obesity reported a limiting longstanding illness compared with 20% of those who were not overweight nor obese.⁵

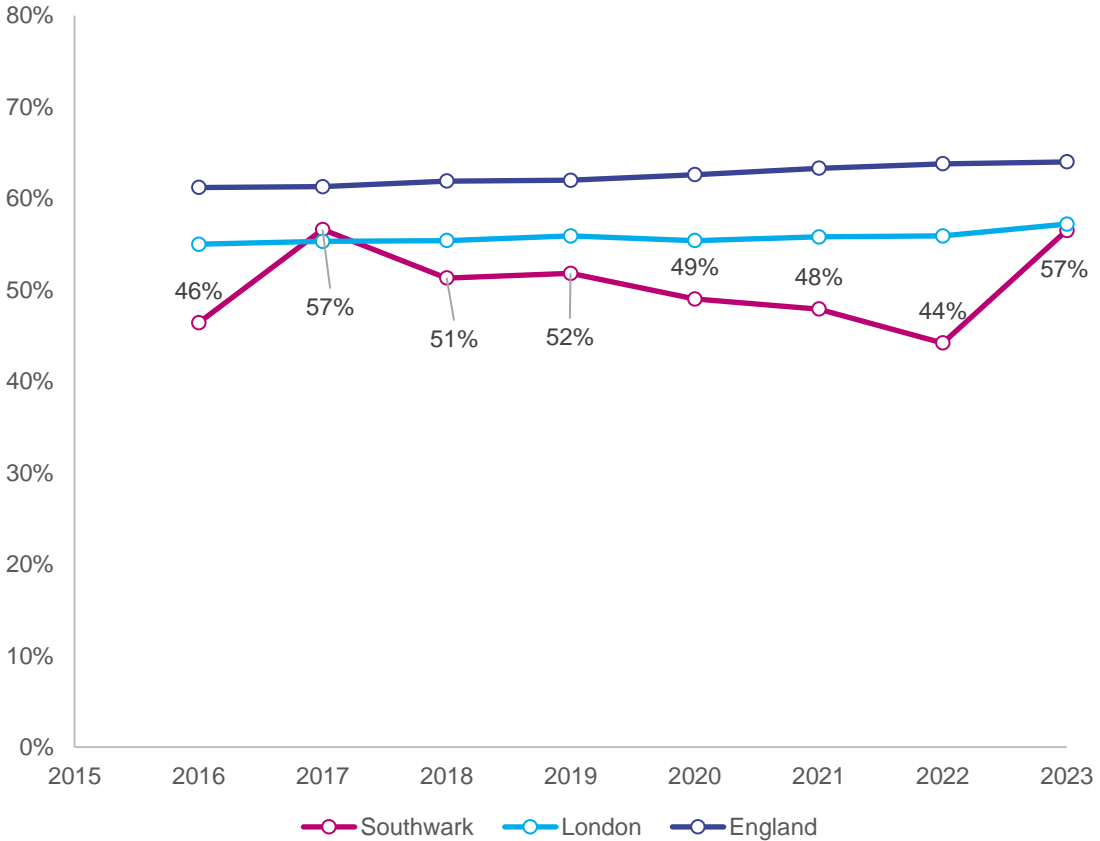


Figure 5. Trends in the proportion of adults (18+) classified as overweight or obese¹

Physical activity

Levels of physical activity across Southwark are higher than the regional and national averages, with trends showing levels are returning to levels seen in 2018 when it peaked at 74%¹

- The CMO currently recommends that adults undertake a minimum of 150 minutes of moderate physical activity per week, or 75 minutes of vigorous physical activity per week or both.

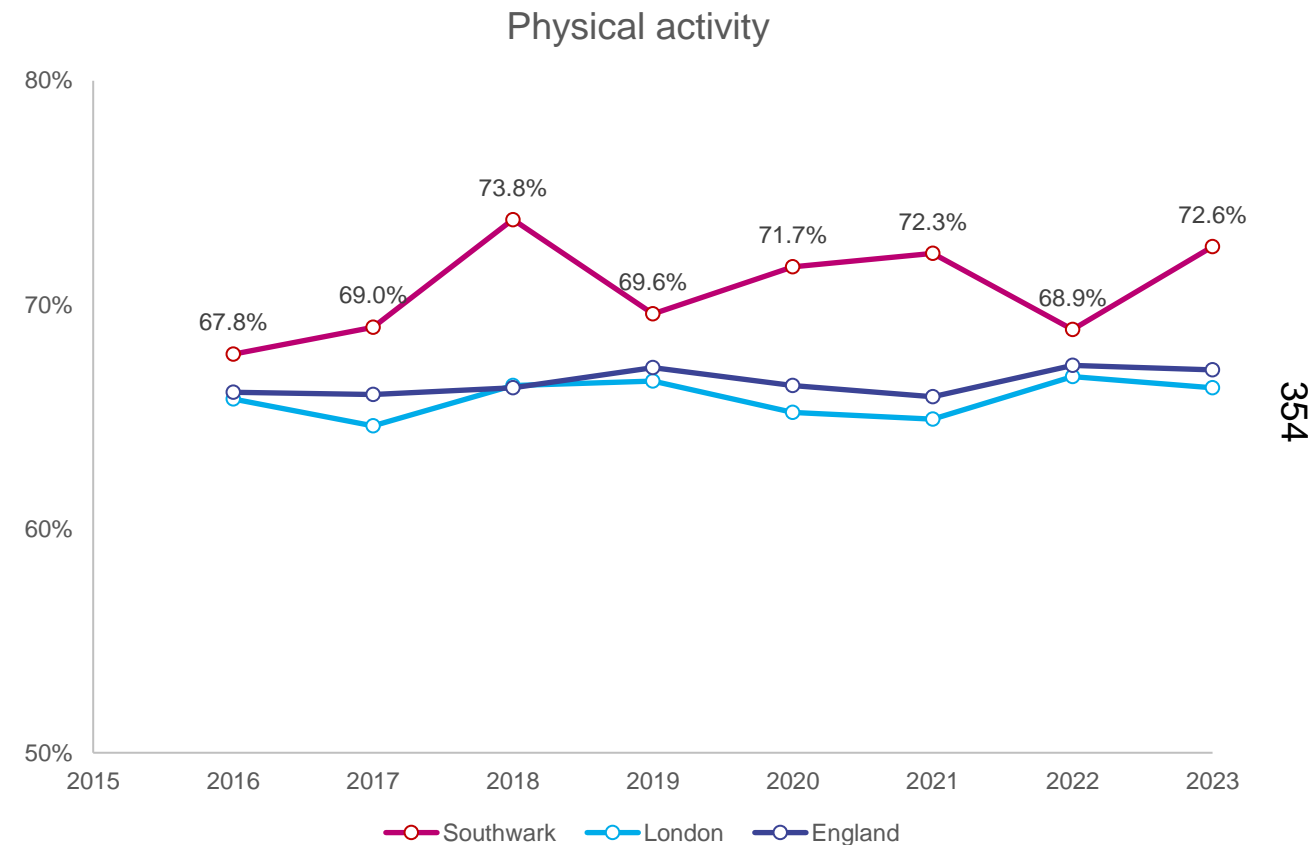


Figure 6. Trends in the proportion of adults reporting to be meeting physical activity goals (2015/16-2022/23)

Physical activity amongst adults (>45years) in Southwark

Levels of physical activity are considerably lower amongst Black residents in comparison to White British and other White adults in Southwark.

- There's however insufficient data coverage across different ethnic groups, and it is not possible to disaggregate the data by age and ethnicity.
- Work is taking place to strengthen local data collection and more in-depth analyses by age, ethnicity, social gradient and geography.

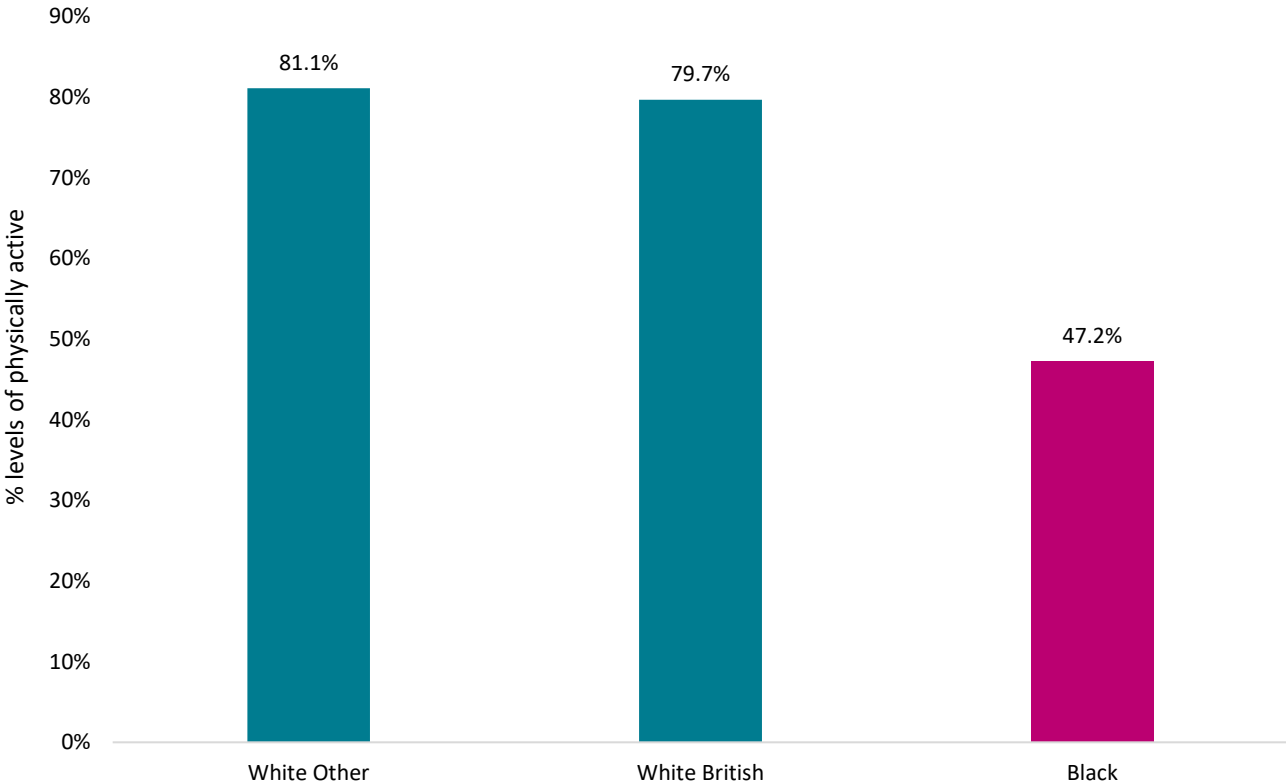


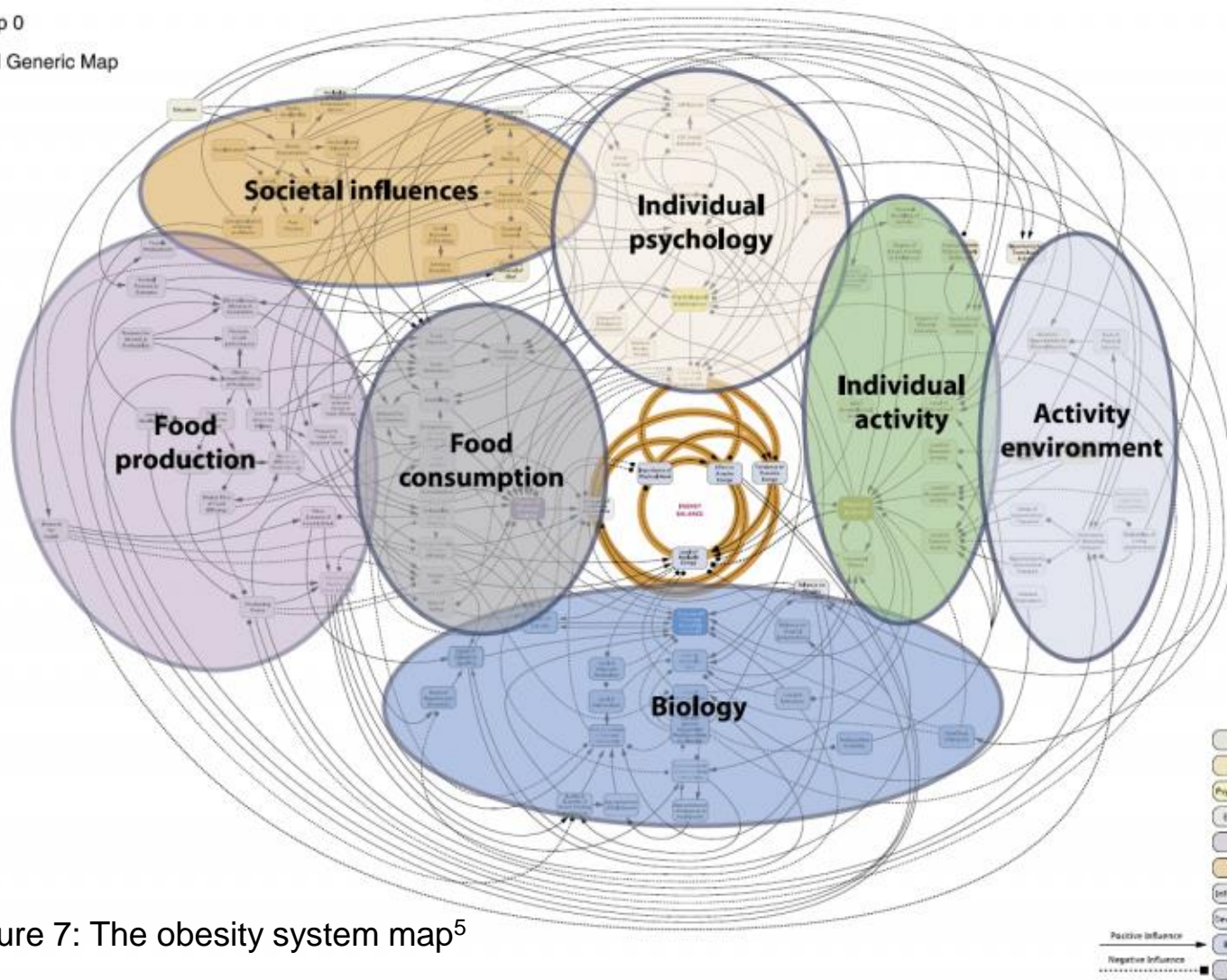
Figure 7. Proportion of adults surveyed reporting to be physically active (150 minutes or more of physical activity) in Southwark (November 2022/23), by broad ethnic group.

Systems approach to tackling obesity

Tackling Obesities: Future Choices

Map 0

Full Generic Map

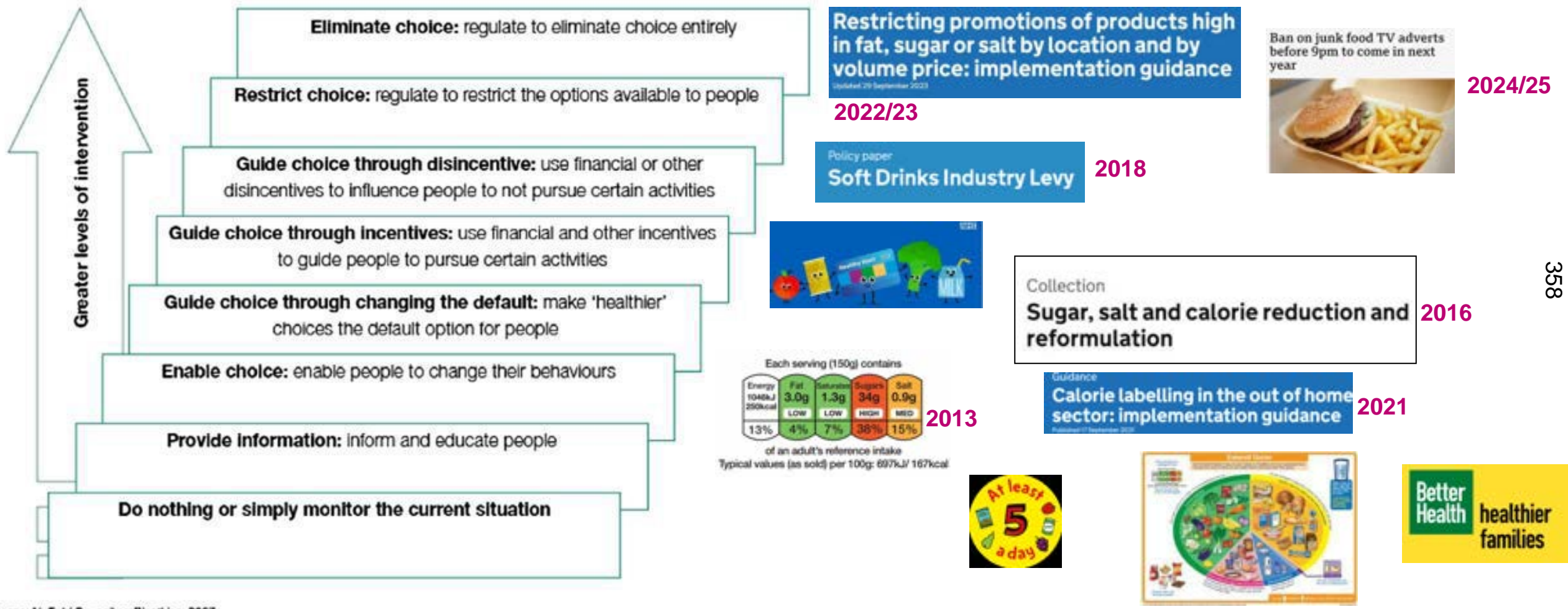


- Robust reference tool that underpins a lot of obesity-related interventions in the UK.
- **Complex multifaceted system of determinants** (causes) of obesity; focusing on single initiatives will not achieve the scale of change needed to reduce levels of obesity.
- Visualises the concept of a **Whole Systems Approach** which is critical in tackling obesity.
- **Obesogenic environment** ; range of social, cultural and infrastructural conditions that influence an individual's ability to adopt a healthy lifestyle.
- Partnership working is vital.

357

Figure 7: The obesity system map⁵

Public health policies to tackle obesity at national level using the Nuffield Balanced Intervention Ladder categories



358

Source: Nuffield Council on Bioethics, 2007

Tackling obesity in London

LONDON'S CHILD OBESITY TASKFORCE

Established in 2018 as part of the Mayor's commitment to address child obesity



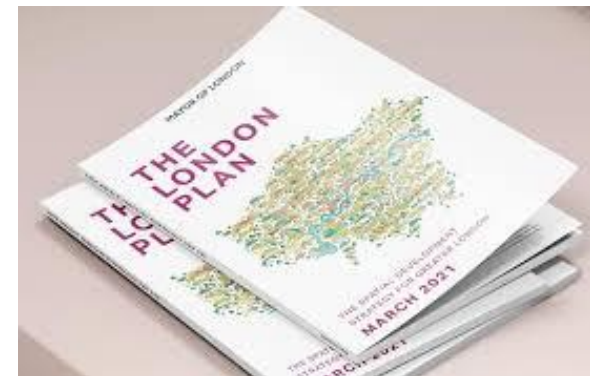
The London Food Board (LFB) advises the Mayor of London and the GLA on the food matters that affect Londoners

359

Healthy Early Years London

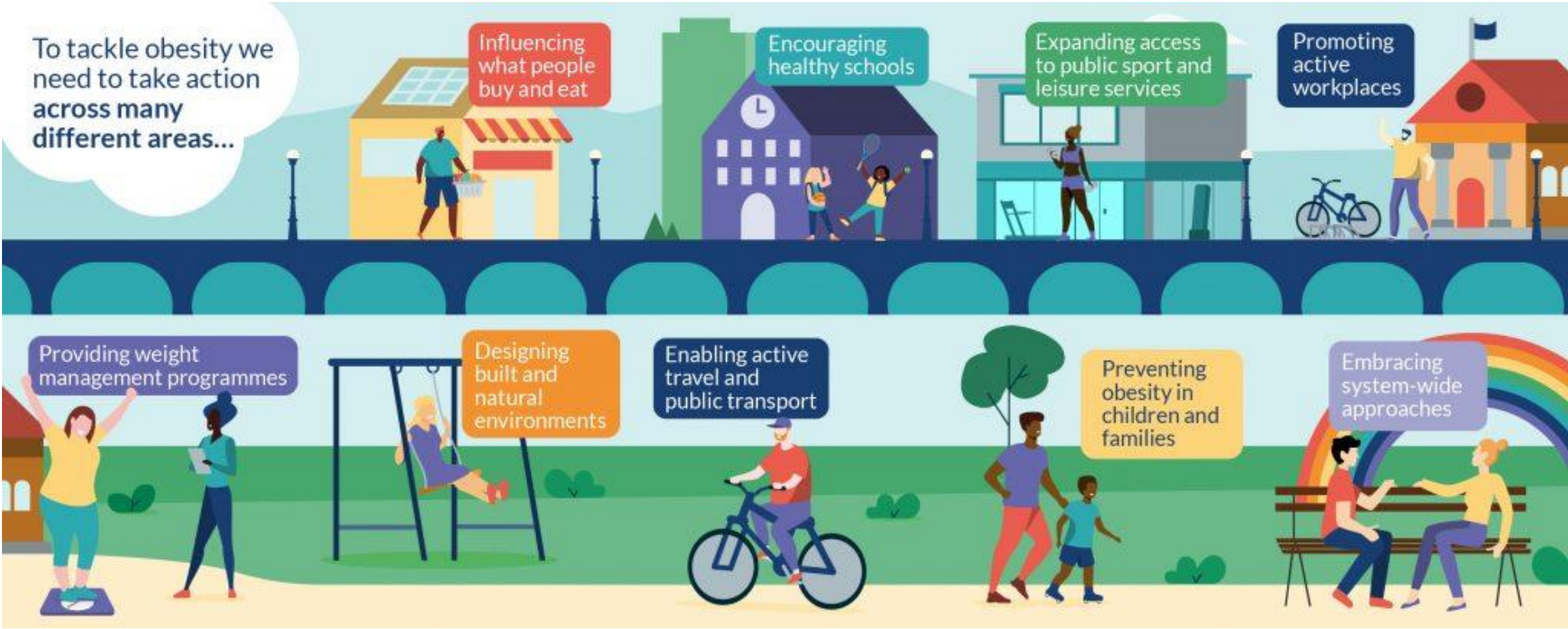
Healthy Schools London

Both programmes are currently being updated and aligned to be relaunched Sept 2025



Recognises that Londoners' physical and mental health is largely determined by the wider environment ; includes policies on developing a healthy city to enable health to flourish

How can Local Authorities reduce obesity? Insights from NIHR research



**Our approach to tackling obesity:
Southwark Healthy Weight Strategy
2022-27**

Southwark Healthy Weight Strategy 2022-27

- Partnership between Southwark Council, the South East London ICB (Southwark) and VCS.
- Adopts a whole systems approach, working with partners across the borough's healthy weight network to deliver effective prevention and treatment services that aim to reduce inequalities and improve health.
- Inequalities within obesity rates in Southwark have informed the identification of the 5 population groups prioritised in this strategy:
 - Maternity and early years
 - Children and young people
 - Black, Asian and minority ethnic groups
 - People experiencing food insecurity
 - Men aged 45 years and above

A set of ambitions have been developed for each priority group and related actions are reviewed annually.

Local interventions to tackle obesity

Place-based interventions examples



Advertising of high fat, salt or sugar (HFSS) products in the borough has been banned on council-owned advertising sites

products in the borough has been banned on council-owned advertising sites

Hot Food Takeaway (HFT) restrictions

Addresses density in shopping parades and new hot food takeaways near schools



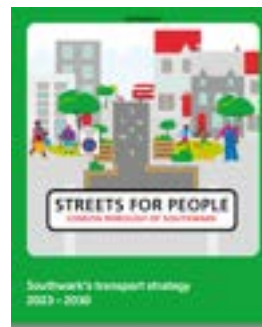
School Superzones

place-based interventions around schools in areas of greatest disadvantage.



Active travel

Council infrastructure and initiatives to promote walking and cycling



Southwark School Meals Transformation Programme



Good Food Retail

42 stores involved in Good Food Retail, with a 22% increase in healthier food stocked

Parks and green spaces

Protection and creation of new green spaces for everyone



Sports and leisure opportunities

Strengthening the council's offer for physical activities, especially those who are inactive or would benefit most

People-focused interventions examples

Weight management programmes (including targeted)

- Men aged over 45 years
- Latin American
- Healthy Church Initiative (Black-majority churches)
- Weight Watchers
- Child and Family Weight Management
- Exercise on Referral
- NHS Tiers 2 and 3 interventions



Free swim and gym offer

- Free swim and gym offer to support people to be active
- Free swimming classes
- Various classes for all abilities



Training and sign posting

- Southwark Healthy Weight Training for HCPs and non-HCPs
- Maternity Healthy weight training
- Signposting and training for Health Ambassadors, Health Promotion Van and VCS



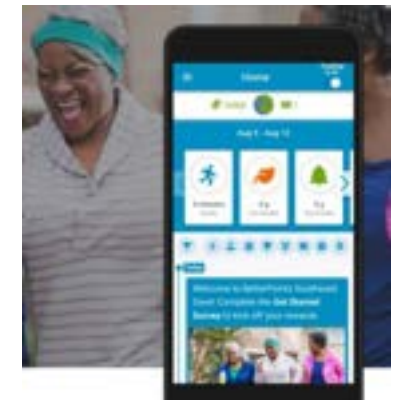
Rose Vouchers

Supported 1,447 children from 724 families in Southwark between April and July 2024, and provided vouchers for over 4,500 children since 2018



BetterPoints Southwark app

Rewards for being more active and for completing health improvement interventions



Resident experience

Child weight management programme (Alive N Kicking)

“We learnt a lot about physical activities and how often an individual should be training a week. As mum and son, we now sit together and plan our food shopping together. This has led to us to eating spending more time to together as a family. We cook more together than getting a takeaway. As a mother this programme has been very beneficial to me on the number of different topics we have covered. I especially enjoyed doing the programme alongside my son, being able to go to the gym with him has made us closer and I have seen an improvement in myself as well.”



“I wanted to improve my knowledge of label reading and healthy eating which has increased drastically, due to the info I received from the Alive N Kicking team. Screen time between the weekday and weekend had increased due to lock down. Surprisingly, the family has been doing workouts created by the physical activity specialist. Even I have increased my efforts to be active with the children at home.”

Men 45+ years weight management programme



"The 12 weeks of Men's Health Engineers has encouraged me, allowed me to talk, to feel normal and accepted - to give me a hope for the future. It has been led in kindness and understanding. To know that my weight gain is manageable to lose and as a result my confidence has started to return. I am starting to see 'me' again in the mirror."

Moving forward: Areas for development

Moving forward: Opportunities for potential development

- **Adult obesity and common long-term conditions:** need for the development of a patient-centred referral pathway.
- **Focus on people who are inactive:** Work with other HWB partners to support people who are physically inactive to be active.
- **Healthy Schools/Healthy Early Years programme:** consider how this could be strengthened in Southwark including promotion of the Public Health offer for schools.
- **BetterPoints app:** wider promotion and use of data collected to assess and address inequalities.
- **Sign posting and increasing awareness of national and local support services:** streamlining referral pathways available for people living with obesity.
- **Tier 3 weight management services:** increase capacity and support for Children and Young People.
- **Weight loss drugs:** work with partners to determine the most suitable delivery model in SEL.

Feedback from the Health and Wellbeing Board

Discuss potential areas for further development and opportunities for innovative approaches and collaboration, particularly in relation to the systems approaches required and partnership implications for:

- **Streamlining sign posting to all national and local support services** for adults living with obesity, **strengthening the range of interventions** and **increasing awareness of available services** to support healthy weight among the general population.
- **Enhancing the systems focus on people who are inactive.** Working with other HWB partners to support people who are physically inactive to be active.

Meeting Name:	Health and Wellbeing Board
Date:	14 November 2024
Report title:	Health Protection Annual Report 2023/24
Ward(s) or groups affected:	All
Classification:	Open
Reason for lateness (if applicable):	Not applicable
From:	Sangeeta Leahy, Director of Public Health Southwark Council

RECOMMENDATION(S)

1. The Southwark Health and Wellbeing Board notes the Health Protection Annual Report 2023/24 and health protection activity across the system during this period.
2. The Board agree to receive a health protection report annually.

BACKGROUND INFORMATION

3. Oversight and assurance of the local health protection system is via the Health Protection Board, established in July 2022 and chaired by the Director of Public Health.
4. The Health Protection Board approved the Health Protection Annual Report 2023/24 in September 2024.
5. This report provides an overview of activity, incidents, risks and achievements relating to health protection, infectious diseases, environmental risks and screening programmes in Southwark.

KEY ISSUES FOR CONSIDERATION

6. The scale of potential health protection threats faced locally and globally is significant, ranging from emerging illnesses to adverse weather, antimicrobial resistance and chemical hazards. The impact of climate change is likely to amplify many of these threats.
7. The impacts of the pandemic continued in 2023/24, which exacerbated some health protection risks. Low vaccination rates, partly due to vaccine fatigue,

increased the risk of measles and whooping cough cases and outbreaks, and other infections remained in circulation, such as mpox and Group A Streptococcus.

8. There are many underlying and connecting themes, of which inequality and inclusion is particularly important. Addressing health inequalities and working closely with our communities is critical to improving and protecting the whole population.
9. It is evident that close partnership working promotes more effective management and mitigation of the impacts of health protection incidents. This is illustrated by the array of successful partnership working in place across the health protection system.
10. Horizon scanning and preparedness to mitigate the impacts of emerging infections and other health protection hazards remains of utmost importance.

Policy framework implications

11. The UK Health Security Agency (UKHSA) - the lead agency responsible for infectious diseases, chemical, biological, radiological and nuclear incidents - highlight three main goals in their 2023-26 strategy:
 - To be ready for and prevent future health security hazards.
 - To save lives and reduce harm through an effective response.
 - To build the UKs health security capacity.
12. The Future of the Health Protection System (FHPS) is a national collaboration between Health Protection strategic system partners to enhance the resilience, effectiveness & scalability of the national and local health protection system. It has a vision to enhance the current system to ensure it is locally delivered, regionally enabled, and nationally supported. Its ambition is to design, develop and deliver improvements to achieve a joint ambition of having the best possible health protection system for England.
13. This national vision and emphasis on effective and resilient health protection systems aligns with the local aim to support the UKHSA in protecting our residents, workforce and visitors to the borough against health protection threats.
14. The national risk register outlines some of the most serious risks facing the UK, including health protection threats such as pandemics, zoonotic illnesses and adverse weather. It highlights the importance of preparation and supporting communities.
15. More locally, the South East London Integrated Care System has a focus on protecting health and wellbeing and supporting people to stay healthy. Southwark Council is committed to a healthy environment for its residents, supporting families and investing in our communities.

Community, equalities (including socio-economic) and health impacts

Community impact statement

16. Health protection action across the system requires close working with communities to ensure activities are tailored towards those individuals, groups and communities most at risk.
17. Throughout 2023/24 there are numerous examples of work done to collaborate with and understand the needs of communities, particularly more marginalised groups, to make our health protection response accessible and acceptable.

Equalities (including socio-economic) impact statement

18. Health protection programmes across Southwark strive to tackle inequalities of access and outcome at every opportunity.
19. Using a hyper-local approach, additional support and actions to mitigate impacts are taken with populations that have the poorest outcomes, with a focus on the most disadvantaged neighborhoods and communities in Southwark.

Health impact statement

20. The aim of all areas of work contained in this report is to protect our residents, our workforce and visitors to the borough against health protection threats.

Climate change implications

21. The impact of climate change is likely to amplify many health protection threats faced locally and globally making it essential to prepare for and respond to threats and risks as they arise.

Resource implications

22. There are no direct resource implications arising as a result of this report.
23. Responding to emergencies and incidents as they arise requires additional staff time and resource across the system to support the response. The amount of resource required will vary depending on the incident.

Consultation

24. The report was produced in collaboration with teams across the system, and relevant individuals and organisations were consulted with.

SUPPLEMENTARY ADVICE FROM OTHER OFFICERS**Head of Procurement**

25. None sought.

Assistant Chief Executive, Governance and Assurance

26. None sought.

Strategic Director of Resources

27. None sought.

Other officers

28. None sought.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
None		

APPENDICES

No.	Title
Appendix 1	Southwark Health Protection Annual Report 2023/24

AUDIT TRAIL

This section must be included in all reports.

Lead Officer	Sarah Robinson, Senior Public Health Programme Manager (Health Protection and Screening)	
Report Author	Sarah Robinson, Senior Public Health Programme Manager (Health Protection and Screening)	
Version	Final	
Dated	September 2024	
Key Decision?	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	Comments Sought	Comments Included
Assistant Chief Executive, Governance and Assurance	No	No
Strategic Director of Resources	No	No
Cabinet Member	No	No
Date final report sent to Constitutional Team	1 November 2024	

Southwark Health Protection Annual Report 2023/24

Southwark Public Health Division

September 2024

Report title:	Southwark Health Protection Annual Report 2023/24
Status:	Public
Prepared by:	Sarah Robinson
Contributors:	Liz Brutus, Marek Zmroczek-Sterenber, Charlotte Miller, Earl Legister, Isabel Mansfield, Natalina Sutton, Brid Nicholson
Approved by:	Sangeeta Leahy
Board approval:	Health Protection Board (September 2024)
Presented to:	This report will be presented to the Health & Wellbeing Board at its November 2024 meeting
Contact details:	publichealth@southwark.gov.uk

CONTENTS

▪ Executive summary	4
▪ Introduction	
▪ Context	7
▪ The Health Protection Board	8
▪ Infectious diseases	
▪ Tuberculosis	10
▪ Sexually transmitted infections	12
▪ Infectious disease control	16
▪ Food safety	17
▪ Vaccination programmes	18
▪ Screening programmes	23
▪ Health protection in vulnerable settings	
▪ Adult social care	26
▪ Inclusion health settings	27
▪ Environmental hazards	
▪ Adverse weather	29
▪ Air quality	30
▪ Conclusions	33
▪ Health protection in 2024/25	
▪ Emerging issues	34
▪ Priorities	35

Executive summary

This report covers the period 1 April 2023 to 31 March 2024 and provides an overview of activity, incidents, risks and achievements relating to health protection, infectious diseases, environmental risks and screening programmes in Southwark. It includes work delivered by public health, environmental health, NHS, emergency planning and VCS.

A higher level of health protection activity continues to persist following the COVID-19 pandemic and we continue to see incidents occurring. Following an increase in measles cases, the UKHSA raised its incident response level in January 2024, and there was a significant and on-going increase in pertussis (whooping cough) cough cases. Both incidents have required significant and on-going local response.

Oversight of the local health protection system is via the Health Protection Board, chaired by the Director of Public Health, and as a multiagency partnership it seeks to ensure that arrangements are in place to prevent, reduce or manage health protection risks to the local population.

Infectious diseases

- England remained a low incidence country for TB in 2022, although incidence in London increased in 2023.
- Rates of STIs remain high, although there has been some reduction and STI testing rates have increased.
- In 2022, the number of Southwark residents newly diagnosed with HIV was 62 (a 29% decrease over five years).
- There were 225 notifications of infectious disease in Southwark during 23/24, managed by the UKHSA.

Executive summary

Food safety

- 96% of all food businesses in Southwark were deemed broadly compliant with food hygiene requirements.
- There were no outbreaks of food poisoning during the period.
- Food safety inspections have been impacted by the pandemic and a national shortage of qualified officers.

Vaccination programmes

- Falling rates of MMR vaccination increased the risk for measles outbreaks in 2023/24, with cases beginning to rise significantly in Southwark from January 2024. A combination of cyclical factors and falling prenatal vaccination uptake drove a huge rise in whooping cough cases.
- Seasonal and school age vaccinations saw significant declines in coverage in 2023-24, while early data suggests childhood immunisation coverage may have stabilised following years of decline.

Screening programmes

- In 2023-24, breast screening and bowel cancer screening coverage remained low, with inequalities existing in more deprived communities, those of non-White ethnicity, those from Latin American background and those with a learning disability.
- Challenges exist for coverage of non-cancer screening programmes, and work has started to review antenatal and newborn screening inequalities.

Executive summary

Health protection in vulnerable settings

- Health protection in adult social care settings are monitored and managed via a council / ICB group and work has included management of outbreaks, infection, prevention and control and catheter care in the community.
- We have continued to work closely with our initial accommodation centres and homeless settings, providing vaccination support, health events and guidance on adverse weather and other health protection issues.

Environmental hazards

- Local work took place to improve resilience against adverse weather, particularly in light of the cost-of-living crisis.³³
- Adverse weather alerts and guidance were cascaded to hundreds of council teams, health & social care providers and voluntary organisations. Four heatwave alerts were issued in 2023 and two cold weather alerts over winter.
- A comprehensive action plan is in place to reduce air pollution in Southwark to around or below nationally set limits. Although air quality in Southwark is improving, it remains poor in the north-east, and along arterial roads.

Conclusions and priorities for 2024/25

- Health protection activity remained high in 2023/24, but we were able to respond to issues as they arose, and we continued to build successful partnerships. Risks continue in Q1 24/25 including for measles, pertussis and mpox.
- Programmes of work across all areas of health protection will continue in 2024/25, with stakeholders working to prevent and respond to risks and working with our communities to ensure an equitable response and outcomes.

Health protection threats remain high, ranging from emerging illnesses, outbreaks, adverse weather and other hazards

This report covers the period 1 April 2023 to 31 March 2024 and provides an overview of activity, incidents, challenges and achievements relating to infectious diseases, environmental risks and screening programmes in Southwark. It includes work delivered by public health, environmental health, the NHS, emergency planning and VCS organisations.

Context

- The scale of potential health protection threats faced locally and globally is significant, ranging from emerging illnesses, to adverse weather, antimicrobial resistance and chemical hazards. The impact of climate change is likely to amplify many of these threats.
- There are many underlying and connecting themes, of which inequality and inclusion is particularly important. Addressing health inequalities and working closely with our communities is critical to improving and protecting the whole population.
- A higher level of health protection activity continues following the COVID-19 pandemic. Following an increase in measles cases, the UKHSA incident response level was raised in January 2024. There was also a significant increase in whooping cough cases. Both incidents required significant and on-going local response.

Oversight of the local health protection system is via the Health Protection Board, chaired by the Director of Public Health

As a multi-agency partnership, the Health Protection Board (HPB) seeks to ensure that arrangements are in place to prevent, reduce or manage health protection risks to the local population.

Functions of the HPB

1. To provide challenge and oversight of local health protection arrangements.
2. Ensuring inequalities are considered and addressed in all arrangements that reduce or manage risks.
3. Providing assurance to the Health and Wellbeing Board on health protection issues and escalate as appropriate.
4. To oversee the continual improvement and development of the health protection function in Southwark.
5. To receive updates and reports from sub-groups, partners and lead officers and make recommendations for action as necessary.
6. Ensuring clear lines of communication with all appropriate agencies in planning and response.
7. Ensuring appropriate communication with all staff and the local population as necessary.
8. Reviewing learning from health protection incidents.
9. To present an annual report to the Health and Wellbeing Board.
10. To provide a governance and assurance framework for local vaccination and screening programme delivery.

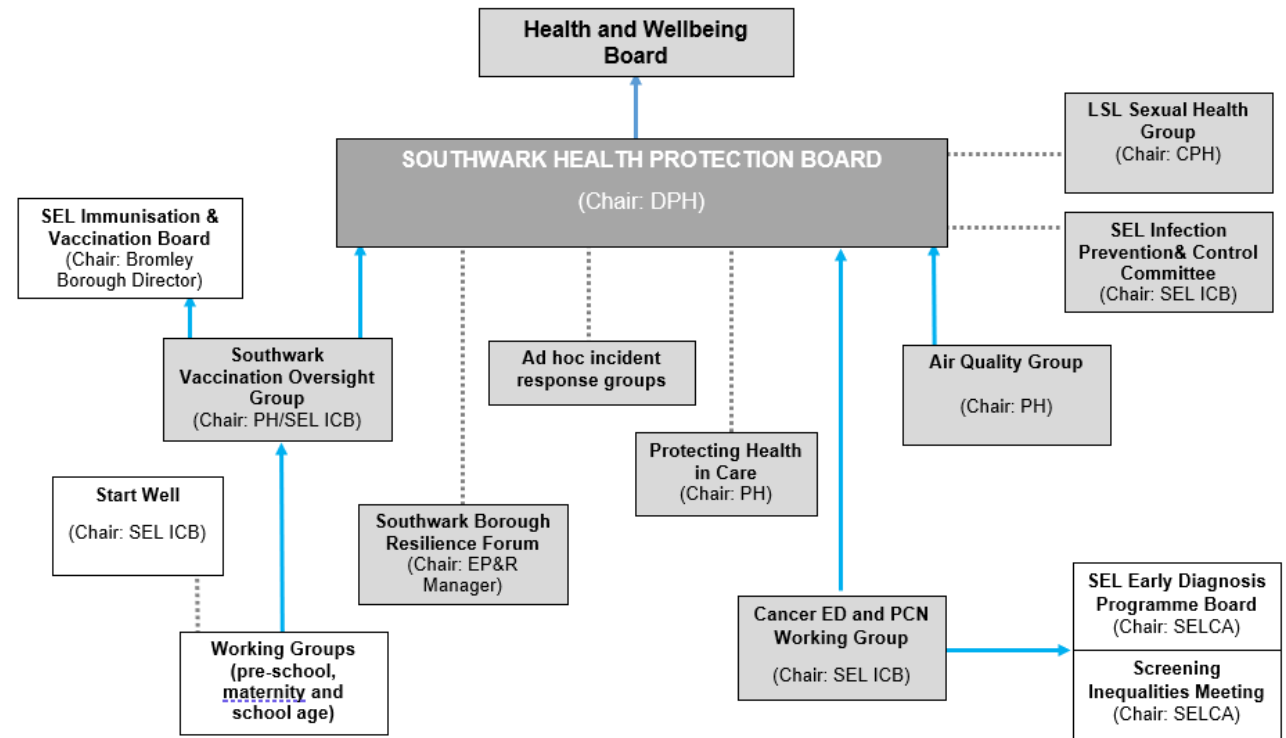
Groups and leads from across the health protection system contribute to the Health Protection Board

Membership of the HPB includes representation from across the health protection system, with groups and leads relating to health protection feeding in and providing regular updates.

Membership of the Health Protection Board

- SEL ICB
- Public Health
- UKHSA
- Environmental Health
- Emergency Planning
- Regulatory Services
- Infection, Prevention and Control
- Communications
- Clinical and Care Professional Leads
- Health & Safety
- Medicines Optimisation

Figure 1: Health Protection Board Structures, March 2024



TB incidence in England remains low but we are not on target to achieve the WHO elimination commitment by 2035

Tuberculosis (TB) is a notifiable, infectious disease, caused by Mycobacterium tuberculosis bacteria. It usually affects the lungs (pulmonary TB) but can infect any part of the body. Two TB related conditions exist: latent TB infection and active TB disease.

Globally, TB remains the second leading single agent infectious killer after COVID-19, with more than 10 million people falling ill with TB every year and 1.4 million dying globally.

WHO established a global End TB Strategy in 2015¹, which aims to end the global TB epidemic by 2035 as part of the United Nations (UN) sustainable development goals. Although England remains a low incidence country for TB, we are not on target to reach the commitment in the WHO strategy to reduce TB incidence by 90% by 2025 and TB rates have diverged further from the trajectory required to reach elimination.

TB can be treated with antibiotics, and there is a vaccine available (BCG), offered to those most at risk, including:

- Some babies and infants (those who live in a high incidence area in the UK or if they have a parent/grandparent born in a high-risk country or if they are in close contact with someone who has TB).
- Some travellers.
- People at risk through their work.

1. <https://www.who.int/publications/i/item/WHO-HTM-TB-2015.19>

TB rates are highest in large urban areas and the disease disproportionately affects the most deprived populations

Provisional data for London shows a 10% increase in TB notifications in the second quarter of 2023 (April to June) compared with the first quarter of 2022 (Figure 3).

- TB rates are highest in large urban areas, with London region having the highest notification rate at 17.9 per 100,000 population (2022 data). In Southwark, the three-year average 2020 to 2022 was 14.5 per 100,000 population (figure 2).
- Provisional data for London shows a 10% increase in TB notifications in the second quarter of 2023 (April to June) compared with the first quarter of 2022 (Figure 3).
- Almost 80% of active TB notified in England was in people born outside the UK in whom rates remained high and steady, while rates of new TB notifications continued to slowly fall in those born in the UK
- TB in England disproportionately affects the most deprived populations, including groups at risk of exclusion and other health inequalities.
- Drug misuse was the most common social risk factor in those born in the UK (15.3%), compared with homelessness (6.5%) and being an asylum seeker (6.4%) in the non-UK born population

Figure 2: Three-year average TB notification rates by London LA, 2020 to 2022²

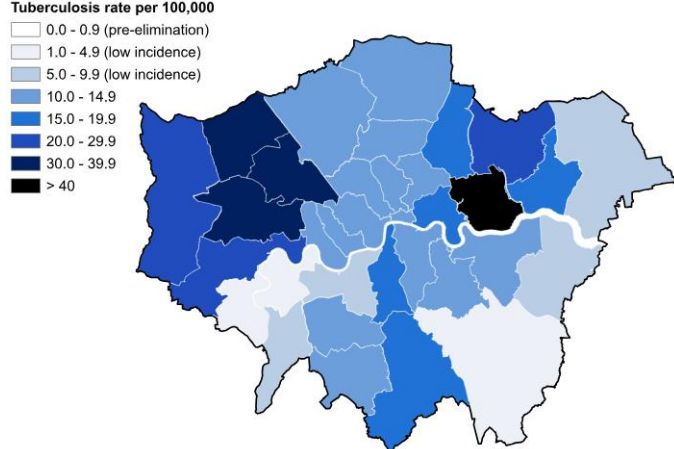
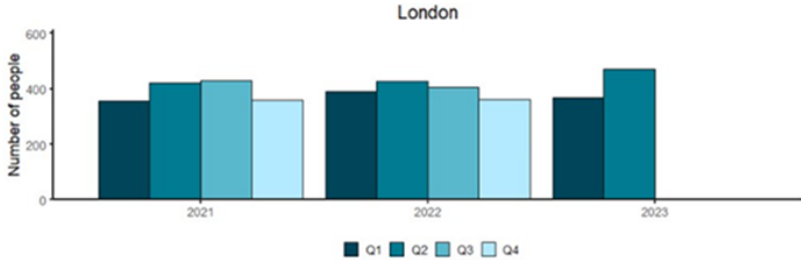


Figure 3: Number of TB notifications (provisional data), London 2021 to Q2 2023³



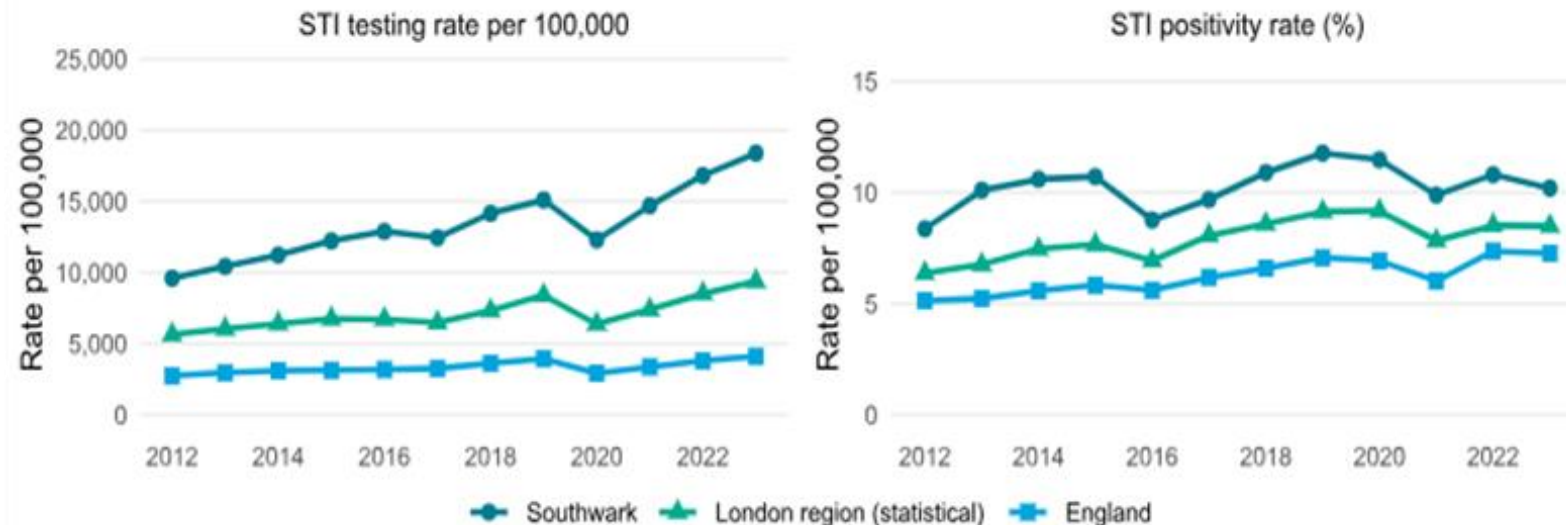
1. Tuberculosis (TB): action plan for England - GOV.UK (www.gov.uk)
2. TB incidence and epidemiology in England, 2021 - GOV.UK (www.gov.uk)
3. National quarterly report of tuberculosis in England: Quarter 2, 2023 provisional data - GOV.UK (www.gov.uk)

STI diagnoses remain high, however there has been some reduction in STIs and STI testing has also increased

In 2023, Southwark had the second highest rate of new STIs diagnoses in England, with a 4% increase in new STI diagnoses compared to 2022.

Despite the slight increase in STI diagnoses, this should be considered in the context of high STI testing rates in Southwark. In 2023, the rate of STI testing in Southwark increased by 9% compared to 2022, which is considerably higher than the rate of testing in England (18,289 per 100,000 vs 4,111 per 100,000).¹

Figure 4: STI testing rate and positivity rate (excluding chlamydia in under 25 year olds) per 100,000 population by year in Southwark and England: 2012 to 2023



Southwark has high rates of syphilis, gonorrhoea and chlamydia, all of which have health impacts if not treated

Southwark has the third highest rate of syphilis and the second highest rate of gonorrhoea in England.

Syphilis and gonorrhoea

- Southwark has the third highest rate of syphilis in England; however, this is improving as rates of syphilis declined by 10% from 2022-2023.¹
- Southwark has the second highest rate of gonorrhoea, which increased by 5% from 2022 to 2023.¹
- Across London, there remains high rates of syphilis and gonorrhoea, which suggests the need for a pan-London approach to reduce rates.
- The high rates of syphilis and gonorrhoea are of high concern due to health risks of untreated syphilis and anti-microbial resistant gonorrhoea.

Chlamydia

- Southwark has the third highest rate of chlamydia in England. In 2023, chlamydia rates in Southwark increased by 3% compared to 2022.
- Chlamydia often does not have symptoms, so asymptomatic testing is important for detecting it. Detection in Southwark has fallen recently, which may be associated with reduced testing in communities where the infection is most prevalent. However, the detection rate is still high and in line with England's detection rate.

Southwark has the second highest rate of HIV in England, although new diagnoses are significantly decreasing

In 2022, the number of Southwark residents aged 15 years and older who were newly diagnosed with HIV was 62; this represents a 29% decrease in the last 5 years.

Human immunodeficiency virus (HIV)

- In 2022, the number of Southwark residents aged 15 years and older who were newly diagnosed with HIV in the UK was 62. The rate of new diagnoses per 100,000 residents was 20.2 (compared to an England rate of 4.3 per 100,000). This represents an 11% decrease since 2021 and a 29% decrease in the 5 years since 2017.
- Southwark has a higher number of residents who are at risk of HIV who would benefit from taking PrEP to prevent HIV. In 2022, 21.8% of HIV-negative people accessing sexual health clinics in Southwark were defined as having PrEP need. Among these, 79.4% initiated or continued PrEP.
- Late diagnosis is the most significant predictor of HIV-related morbidity and short-term mortality. In Southwark, the percentage of late HIV diagnoses between 2020 - 22 was 40.9%, similar to 43.3% in England. In Southwark, late diagnosis is higher amongst heterosexual men than Gay, Bisexual and Men who have Sex with Men.

Local action for HIV and STIs have focussed on prevention, reducing stigma and identifying undiagnosed cases

Local action taken has aimed at prevention and reducing inequalities.

- A new local HIV prevention and testing project targeted at Black communities has engaged over 50 Black residents in its first month and supported residents to reduce their HIV risk, including referring eligible residents to the sexual health clinics for PrEP.
- Two GP HIV champions were funded to work with primary care colleagues to reduce HIV stigma and increase HIV testing in primary care. The champions have also been working with the Terence Higgins Trust to deliver HIV awareness training to Healthcare Assistants.
- The Public Health team have funded a PrEP advocacy project, which is training Black residents in Southwark to confidently talk to their communities about HIV and prevention, including the benefits of taking PrEP.
- Southwark, Lambeth and Lewisham councils commissioned The Love Sex Life partnership to help reduce sexual health inequalities among Black communities living in the boroughs. This champions and advocates for culturally specific and sensitive sexual health services that represent the Black communities to provide care that is relevant to their lived experience, which included support to increase awareness of STIs and provision of condoms.
- An interim young person service was commissioned, which engaged diverse young people across the borough, teaching them about STIs, HIV and how to reduce risky sexual behaviour and prevent STIs and HIV. Similarly, Southwark funded a condom distribution scheme for young people to support young people to reduce their risk and engage in safer sex practices.

There were 225 notifications of infectious disease in Southwark during 23/24, managed by the UKHSA Health Protection Team

Environmental Health (EH) Services contribute to a number of key health protection functions, such as infectious disease control, food safety, health and safety, private sector housing standards and environmental protection.

Infectious disease control

- UK legislation identifies specific infectious diseases which must be notified to the authority, and officers in the Food Safety Team deliver this function in partnership with the UKHSA South London Health Protection Team.
- During the period 2023/24, there were 225 infectious disease notifications¹ received and processed in Southwark.
- Notified infections are received and managed by the UKHSA South London Health Protection Team. Management will include actions to prevent the spread of infections, limit its effect on the population and protect high risk contacts.
- The local EH team provide support to the UKHSA for the follow up of gastro-intestinal infections.

The food safety function aims to protect against food related illness and is the responsibility of Environmental Health

The primary aim of the food safety service is the prevention of food-related illness, best achieved by encouraging effective management by those responsible for preparing and supplying food.

- The service checks business compliance with food law requirements, primarily through a series of routine inspections of food businesses and responding to complaints about food and allegations of food borne illness.
- UK food law require all food businesses to be registered with the local authority and are given a risk classification ranging from category A to E (A highest risk; E lowest). Higher risk businesses are inspected more frequently.
- In 2023/24, the service carried out 936 food safety inspections, which included all high-risk food businesses.
- Owing to the cumulative impact of the pandemic, a significant number of food businesses in the lowest risk category are overdue an inspection. Measures are in place to realign with the expected inspection frequency and the Food Standards Agency (FSA), the government agency responsible for food safety, is aware of our position.
- There is a national shortage of suitably qualified and experienced officers available to deliver food safety regulation. This is a challenge for the service.
- 96% of all food businesses were deemed broadly compliant with food hygiene requirements, exceeding the national target of 75% set by the FSA. Well-regulated and compliant food businesses means there is less likelihood of food poisoning from food purchased from these businesses.
- 213 complaints of food poisoning were received during 23/24. There were no outbreaks of food poisoning.

2023/24 saw very high levels of measles cases in Southwark and across London, which required local action

Falling rates of MMR vaccination increased risk for measles outbreaks in 2023/24, with cases beginning to rise significantly in Southwark from January 2024.

Measles incident and the MMR vaccination programme

- UKHSA modelling in spring 2023 predicted large measles outbreaks in London due to low MMR vaccination uptake post pandemic.
- In response, Southwark, SEL and London systems launched campaigns to promote measles vaccination, including a primary school catch-up model delivered by school age immunisations providers, a range of communications activity, and a Southwark small grants programme to promote vaccine confidence.
- Southwark & London did not see significant numbers of measles cases until January 2024, following a large outbreak in the West Midlands which began in autumn 2023. UKHSA declared a national incident in response to rising measles cases in January 2024.
- Measles cases were more common in more deprived areas, largely due to vaccine inequalities.
- Locally, a measles response strategy was developed in partnership with primary care, SEL ICB and the South London Health protection team.
- As part of the response, local action included delivering training on MMR vaccination to community health ambassadors, and pop-up vaccination clinics were organised in a range of Southwark libraries and children & family centres.

A mixture of cyclical factors and falling prenatal vaccination uptake drove a huge rise in whooping cough cases in 2023/24

Whooping cough tends to spike on a 4 to 5 year cycle, but the impact of the pandemic and falling prenatal vaccination rates led to unusually high numbers of cases in 2023/24.

Whooping cough (pertussis) incident:

- Whooping cough prenatal vaccination protects newborns from whooping cough until they are old enough to get the 6 in 1 vaccine.
- The 6 in 1 vaccine and the pre-school booster vaccine give children good protection against whooping cough, and particularly from severe disease, however immunity wanes over time, so the vaccine provides limited protection from transmission in teenagers and adults.
- Across England, between January and March 2024, there were 2,793 laboratory confirmed cases of pertussis, compared with 858 in the whole of 2023.
- Across England, and to June 2024 10 infants have unfortunately died in this current outbreak since November 2023¹. As far as we are aware, no infants have died in Southwark.
- In response to the rising pertussis cases, a South East London maternal vaccinations working group was stood up, and a range of communications and engagement activity with pregnant people took place.

394

Robust oversight arrangements are in place that provide assurance and support for all vaccination programmes

In 2023-24, all vaccination programmes continued to be commissioned by NHS England regional teams, with the Director of Public Health (DPH) responsible for assuring vaccination programmes and promoting actions to tackle inequalities.

Vaccination programmes in Southwark are overseen by a Vaccinations Oversight Group, reporting to the DPH via the Health Protection Board, and to the Director of Partnership Delivery and Sustainability and senior management team of Partnership Southwark.

Table 1: Vaccination programme providers and changes in 2023/24

Vaccination programme	Provider	Changes in 2023/24
Prenatal vaccinations (including pertussis, and seasonal flu & COVID-19)	Maternity services; primary care	None
Routine childhood immunisations (0-4s)	General practice	None
School age immunisations (HPV, DTP, MenACWY, school flu)	Hounslow & Richmond Community Healthcare	Years 9–11 added to school flu programme (so now reception to year 11)
Adult vaccinations (shingles, pneumococcal; seasonal)	Primary care	Flu & COVID-19 autumn booster limited to 65+ (previous year was 50+)

Note: The Health Inclusion Team at GSTT provide vaccinations to asylum seekers and homeless populations.

Coverage of MMR is around the London average, but lower than the level required to achieve community (herd) immunity

Early data suggests childhood immunisation coverage may have stabilised following years of decline.

- Final annual data for most childhood immunisation programmes is published in September 2024, but Q4 data suggests that Southwark 6 in 1 coverage was around the London average, while MMR coverage was higher than the London average.
- Both remain well below the 95% target set by WHO (95% coverage is required to achieve herd or community immunity).
- Work to reduce inequalities this year included pop-up MMR clinics; a small grants programme to fund community groups tackling vaccine hesitancy, and an immunisation health equity audit.

Table 2: MMR & 6 in 1 (polio, diphtheria, hepatitis B, tetanus, pertussis, hib) (Q4 23/24 data)

Vaccine	Coverage at 24 months		Coverage at 5 years	
	Southwark	London	Southwark	London
MMR 1	84.5%	81.4%	86.7%	85.2%
MMR 2	-	-	81.1%	73.6%
6 in 1	87.2%	87.5%	87.8%	87.2%

1. Quarterly vaccination coverage statistics for children aged up to 5 years in the UK (COVER programme): January to March 2024 - GOV.UK (www.gov.uk)
 2. Human papillomavirus (HPV) vaccination coverage in adolescents in England: 2022 to 2023 - GOV.UK (www.gov.uk)

Vaccination coverage declined in Southwark in 2023-24, while work continued to address inequalities

Seasonal and school age vaccination coverage saw significant declines in 2023-24.

- **Maternity immunisations:** Coverage in Southwark and South East London was below the London average across all maternal programmes.
- **School age immunisations:** Coverage of the HPV vaccine has dropped recently and is lower than the London average (table 3). Work took place with schools and the provider to improve the vaccination process and engage with parents and children about the HPV offer. Coverage of school-aged flu vaccination also fell significantly in Southwark (although remained at around the London average).
- **Seasonal immunisations:** In line with London trends, seasonal flu and COVID autumn booster uptake was lower than in previous years, despite significant outreach work and communications activity.

Table 3: HPV vaccination coverage (22-23 academic year)

Vaccine coverage	Southwark	London	England
HPV1 in year 8 females	52.7%	59.0%	71.3%

The Southwark Cancer Working Group oversees projects focussing on improving uptake and reducing inequalities

In 2023-24, all cancer screening programmes continued to be commissioned by NHS England London. The Director of Public Health has a statutory duty to assure local screening programmes and promote action to reduce health inequalities.

Cancer Working Group

- The Cancer Working Group drives action for cancer screening and early diagnosis programmes to improve coverage and tackle inequalities, alongside managing operational challenges, and living with cancer actions.
- The group reports into the Health Protection Board, the Director of Public Health and has strong links with NHSE and the SEL Cancer Alliance.

Local public health work

- Three bids for funding from the SEL Cancer Alliance were successful in 2023/24:
 - To run a series of in-depth cancer workshops with an interpreter, with the first four being delivered during 23/24 in Spanish, Tigrinya and Arabic.
 - To develop cervical screening videos with the London School of Communications, aimed at young women.
 - The mandatory integration of cancer early diagnosis discussion into all NHS health checks.
- Small grant project work continued with local VCS groups including IRMO, SRCF and Flashy Wings.
- Outreach work also continued this year with key events including World Cancer Day and Carnival Del Pueblo.

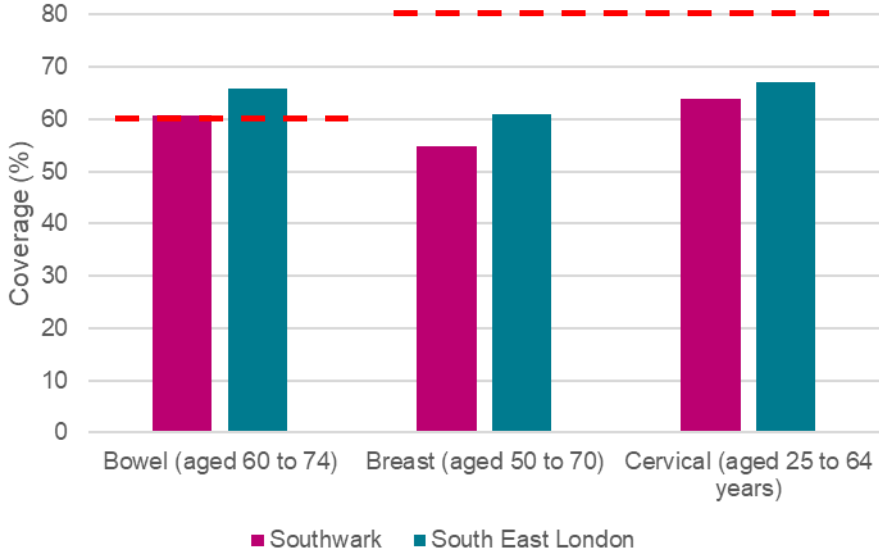
Southwark cancer screening coverage for breast and bowel screening remained below national standards in 2023/24

In 2023-24, breast screening coverage in particular remained low with inequalities relating to deprivation.

Current screening coverage

- Current coverage is low for breast and cervical screening programmes; although bowel screening meets the national operational target (figure 5).
- Coverage is lower in more deprived communities, those of non-White ethnicity, those from Latin American background and those with a learning disability.
- Coverage for people with autism and severe mental illness vary depending on screening programme, but in general tend to be lower.

Figure 5: Cancer screening coverage, Apr 23
(Red dashed line shows UK operational standard)



Other early cancer diagnosis programmes

- The targeted lung health check programme visited Southwark during 23/24.
- On-going promotion for men with a family history of prostate cancer and Black men to discuss testing with their healthcare professional.

1. SEL ICS BI Team (2024). South East London Cancer Screening Dashboard. <https://sus.sharepoint.com/sites/SELANalyticsInsight/SitePages/Cancer%20Screening.aspx> (Accessed: 18 June 2024).

Challenges exist for non-cancer screening, and work has started to review antenatal and newborn screening inequalities

NHSE commission abdominal aortic aneurysm (AAA), diabetic eye (DESP) and antenatal and newborn (ANNB) screening programmes; SEL ICB commission school-aged vision screening.

Coverage

- There are some concerns regarding coverage and inequalities for AAA screening and DESP. Unpublished data shows that coverage for AAA screening in Southwark is among the lowest in SEL.
- School-aged vision screening has good coverage as it is an opt-out programme, delivered at school in reception.
- Coverage is within acceptable or achievable range for all ANNB programmes, however concerns around inequalities prompted a preliminary ANNB inequalities review.

Preliminary ANNB Screening Inequalities Review

- Published national literature and local data on ANNB screening inequalities is limited, however what is available suggest there are inequalities regarding ethnicity, deprivation and disability status.
- Language barriers, lack of public awareness of the benefits of screening / early presentation, and fear of accessing health services are likely to contribute to inequalities for all programmes.
- Initial recommendations include improved data sharing and monitoring, engagement and communication around the importance of ANNB screening and early presentation to maternity services, review of protocols and support for health inclusion groups, improved staffing and training for staff. This work will be continued in 24/25.

Health protection issues in vulnerable adult social care settings are monitored and managed via a council / ICB group

During the pandemic, a group was set up to monitor and mitigate health protection risks in adult social care; this has continued as the Protecting Health in Care Group, chaired by Public Health.

The aim of the Protecting Health in Care Group (PHIC) is to promote joint working between Southwark Council Public Health, Adult Social Care and Commissioning teams, the SEL ICS Community Infection Prevention and Control (IPC) team and the QHS GP care home service, on issues related to health protection in adult social care settings, which includes care homes, domiciliary care and supported living.

During 2023/24 the following was achieved:

- Reflected on lessons learned during the pandemic to inform future preparedness and resilience.
- Continued to monitor and provide guidance and manage outbreaks of infectious diseases, including COVID-19.
- Contributed to winter and summer planning, preparedness and operational response.
- Managed issues arising from IPC audits in care homes and other IPC guidance.
- Development of branded temperature cards plus advice for distribution to those receiving home care.
- Considered views of staff to support improvements in vaccination rates among care home staff.
- Started work on catheter care needs in the community, including data collection and training for domiciliary care staff to improve catheter care.
- Supported good practice guidance around family/resident engagement.

There are ongoing risks of infectious disease spread in initial accommodation centres due to living in close quarters

We have continued to work closely with our inclusion health settings, including initial accommodation centres for asylum seekers and homeless hostels.

The Southwark borough asylum seeker and refugee health and wellbeing group reports health protection issues into the Health Protection Board. The Public Health, Inclusion Health Group meets monthly to provide updates on work with inclusion health groups and identify areas for collaboration.

Health protection concerns in IACs

- The response to high risk of diphtheria in asylum seekers arriving via the channel continued. A large surge in arrivals requiring prophylaxis put huge pressure on accommodation providers, GPs and the Health Inclusion Team (HIT). A surge plan was developed, and in November 2023 the UKHSA advised the risk level had reduced and there were more robust systems for testing and treatment at initial reception centres, eg Manston. The focus of local authority level response would be on timely GP registration, health assessments and vaccine catch up.
- An outbreak of chickenpox occurred at a Southwark IAC with 14 cases identified. The response was managed by the South London Health Protection Team.
- There is an ongoing risk of infectious disease spread in IACs due to families living in close quarters and an increase in room sharing among single residents since Operation Maximise (Home Office initiative to increase bed spaces available in asylum accommodation). Additionally, people who are ASR are in a poorer health state¹.

402

We regularly support vaccination and wider health and wellbeing clinics and events in inclusion health settings

Various vaccination and wider health and well-being events were held in initial accommodation centres and homeless settings during 2023/24.

Vaccine clinics in IACs

- The Health Inclusion Team (HIT) ran vaccine catch up clinics in the IACs which focused on MMR and pertussis vaccines in response to the high rates of these infections.
- In addition, the HIT ran winter vaccination clinics in the IACs offering COVID-19 and flu vaccines to those eligible, including school age children who did not receive the vaccine at school.

Health and wellbeing events in homeless settings

- Four health and wellbeing events were held in homeless settings in Autumn 2023 to promote and deliver COVID-19 and flu vaccinations. Alongside vaccine delivery there was a wider health and wellbeing offer including TB and blood-borne-virus screening.
- There was positive feedback from the service providers and clients who attended the events with more similar events planned for the coming year.

Local work took place to improve resilience against adverse weather, particularly in light of the cost of living crisis

UKHSA produce an adverse weather & health plan, which is operationalised locally by local authorities and the NHS, principally through a weather health alert cascade

Adverse weather

- The Public Health team administer the alert system for Southwark, with alerts and planning guidance cascaded to hundreds of council teams, health & social care providers and voluntary organisations.
 - During summer 2023, 1 amber heat health alert and 3 yellow heat health alerts were issued for London.
 - During winter 2023-24, 1 amber cold health alert and 1 yellow cold health alert were issued for London.
- Further work took place to improve resilience to adverse weather, including:
 - A cold weather emergency planning exercise
 - Signposting webinars to improve frontline staff's ability to signpost to services such as cost of living support, fuel poverty support and vaccinations which improve winter resilience
 - Targeted work with GPs to improve the hot weather action cards for primary care.
- An in-depth needs assessment will be conducted in 24/25 to gather evidence of the health impacts of hot weather and assess the vulnerability of Southwark residents and the built environment to overheating.

A comprehensive action plan is in place to reduce air pollution in Southwark to around or below nationally set limits

A UK government framework sets out air quality standards and objectives for key pollutants, and where the objectives are unlikely to be met, the local authority must declare an Air Quality Management Area and identify and publish actions to reduce air pollution.

Air quality

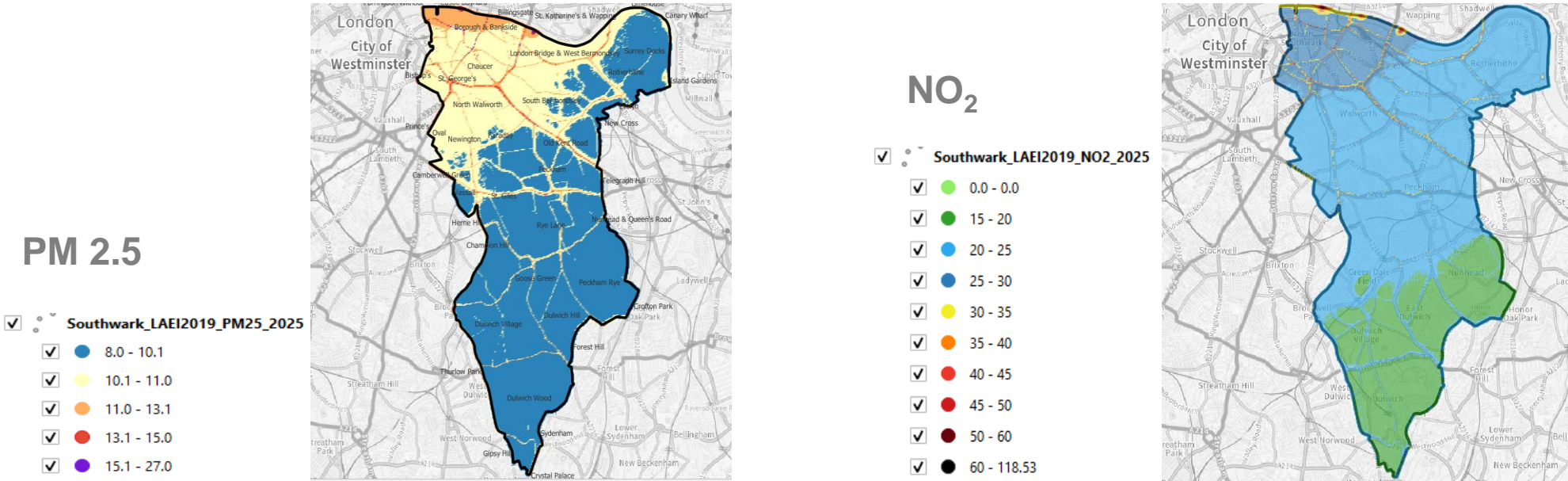
- The majority of Southwark was declared an Air Quality Management Area in 2003. However, since January 2023, this applies to the entire borough.
- There is an Air Quality Action Plan (AQAP) in place to monitor and reduce air pollution, and to help avoid exposure. Delivery of the AQAP is overseen by Air Quality Steering Group (AQSG). The steering group which meets quarterly, identifies the air quality challenges that Southwark faces, determines priority air quality matters for attention and monitors the authority's progress delivering the AQAP.
- All of the monitoring and core statutory duties in the Air Quality Action Plan were completed. However, few actions targeted for completion in the period 2023/24 were delayed owing to external factors such as reliance on third party providers and financial constraints, these will be completed during 2024/25.

Air quality in Southwark is improving, but remains poor in the northwest of the borough and along arterial roads

The maps show the projected improvement in air quality by 2025.

- Highest levels of fine particulate matter (PM2.5) and Nitrogen Dioxide (NO2) remain in the northwest of the borough and along arterial roads.
- Compared to previous years, this shows an improvement in air quality.

Figure 6: Modelled air quality for 2025 (PM 2.5 and NO₂)



The cross-cutting Air Quality Action Plan is targeting key features of air pollution in Southwark

A number of projects aimed at improving air quality were either completed, in progress or started during 2023/24.

Table 6: Current and on-going air quality projects

Air quality projects	
Working with schools; air quality audits, a starter grant and heating system upgrade	Assessing potential air quality improvements and obtaining permits for Southwark Energy Centres
Asthma awareness raising and indoor air quality monitoring	Pan-London wood burning campaign
Bookable permit holder only loading bays	Pan-London anti-idling campaign
Updating Southwark's pool cars and commissioning cargo bikes	Pan-London Non-Road Mobile Machinery at events, road works, and waste sites
Assessing the potential for freight consolidation	Multi-borough canal boats engagement project
Kerb Dock trial	Extending the Smoke Control Area to waterways
airTEXT air pollution alerts redevelopment	Modelling and reporting tool development
Asthma clinic housing inspection referrals	

407

Conclusions

Health protection activity remained high, bringing various challenges in 2023/24, but there have been many successful partnerships built and areas of work completed.

- The impacts of the pandemic continued, which exacerbated some health protection risks in 2023/24. Low vaccination rates, partly due to vaccine fatigue, increased the risk of measles and whooping cough cases and outbreaks, and other infections remained in circulation, such as mpox and Group A Streptococcus.
- We continued, however, to build on opportunities. This included the benefits of close working with communities to tailor our preparedness activities as well as our response to promote equity, tackle inequalities and to ensure our response is accessible, understandable and acceptable to our residents.
- It is evident that close partnership working across the council, SEL ICB, local VCS and national bodies, promotes more effective management and mitigation of the impacts of health protection incidents. This is illustrated by the array of successful partnership working in place across the health protection system.
- Horizon scanning and preparedness to mitigate the impacts of emerging infections and other health protection hazards remains of utmost importance, especially given the international diversity of our borough at the heart of a such a global city.

Emerging issues in Q1 and Q2 of 2024/25

In the first half of 2024/25, we have continued to respond to increased numbers of measles and whooping cough infections, and a new strain of mpox has emerged in parts of Africa.

- Continued high transmission of measles has occurred between April and September 2024, with an additional national back to school campaign amid concerns of a further surge in cases as children go back to school.
- Extremely high number of whooping cough (pertussis) case notifications also continued, particularly during quarter 1 of 2024/25.
- In August 2024 the WHO declared the upsurge of mpox (clade I) in the Democratic Republic of Congo and a growing number of countries constitutes a public health emergency of international concern¹. In London, vaccination continues to be offered to high-risk men (GBMSM) attending sexual health clinics.
- A new vaccination programme was rolled out from 1 September for older adults aged 75 to 79 and pregnant women, to protect against respiratory syncytial virus (RSV). RSV is a common virus causing coughs and colds, that can make babies and older adults seriously ill.
- Other emerging issues include the rise of antibiotic resistance gonorrhoea cases in England and the on-going threat of vector-borne diseases (illnesses that can be transmitted to humans by other living organisms such as mosquitoes and ticks).

1. <https://www.who.int/news/item/14-08-2024-who-director-general-declares-mpox-outbreak-a-public-health-emergency-of-international-concern>

Health Protection priorities in 2024/25

Programmes of work in 2024/25 will continue to build on achievements of previous years, with stakeholders working across the health protection system to prevent and respond to various risks and working with our communities to ensure an equitable response and outcomes.

Health Protection priorities for 2024/25 include:

- A focus on developing robust and tested frameworks and plans to improve system preparedness for potential health protection threats, including pandemics, outbreaks and incidents.
- Contributing to the national Future of the Health Protection System (FHPS) work. This is a collaboration between Health Protection strategic system partners to enhance the resilience, effectiveness & scalability of the national and local health protection system. FHPS has a vision to enhance the current system to ensure it is locally delivered, regionally enabled, and nationally supported, to achieve a joint ambition of having the best possible health protection system for England.
- Exploring new and innovative ways to work better with our communities, particularly those who might be more vulnerable to health protection threats.
- Continuing to provide an effective system-wide response to health protection risks and hazards as they arise.

Find out more at:
www.southwark.gov.uk/publichealth

Meeting Name:	Health and Wellbeing Board
Date:	14 November 2024
Report title:	Southwark Joint Health and Wellbeing Strategy 2022-27 – Progress Report: November 2024
Ward(s) or groups affected:	All
Classification:	Open
Reason for lateness (if applicable):	Not applicable
From:	Sangeeta Leahy, Director of Public Health Southwark Council

RECOMMENDATION(S)

1. The Southwark Health and Wellbeing Board notes progress against actions contained within the Joint Health and Wellbeing Strategy and areas that may require further development and focus.
2. The Board agrees to the development of a new action plan to cover the years 2025-27 and agrees to receive the new action plan in March 2025 after a period of engagement.
3. The Board discusses the recommendations on page 26 of the attached Progress Report regarding the development of new actions.
4. The Board agrees that the process of receiving updates to actions contained within a refreshed action plan will be determined at future meetings.

BACKGROUND INFORMATION

5. The Joint Health and Wellbeing Strategy 2022-27 was approved by the Board in November 2022.
6. The strategy sets out five 'Drive' areas that are the focus of the strategy delivery:
 - Drive 1 – A whole-family approach to giving children the best start in life
 - Drive 2 – Healthy employment across the health and wellbeing economy and good health for working age adults
 - Drive 3 – Early identification and support to stay well
 - Drive 4 – Strong and connected communities
 - Drive 5 – Integration of health and social care

7. Each of these drive areas has a series of accompanying actions. The Board most recently received an update on each action in November 2023.
8. The Public Health Division have worked with partners across the system to gather new updates for each of the actions.

KEY ISSUES FOR CONSIDERATION

9. The attached report includes an overview of progress against all the actions outlined within the Joint Health & Wellbeing Strategy, grouped into the five drive areas.
10. Most actions have been completed or are on-track for completion soon. The action plan will be refreshed by March 2025 to ensure it reflects current local priorities and is aligned with other relevant strategy, including Southwark's vision for 2030.
11. Recommendations are provided on page 26 of the attached report regarding the scope of potential new actions to aid discussion on the development of a refreshed action plan.

Policy framework implications

12. There is a statutory responsibility for the Board to produce a Joint Health and Wellbeing Strategy that addresses the needs and improves the health of our population.
13. The strategy and action plan were provided to colleagues developing the South East London Integrated Care Strategy to ensure local priorities are fed into these system-wide priorities.

Community, equalities (including socio-economic) and health impacts

Community impact statement

14. The action plan includes a section around strong and connected communities, focused on collaboration and co-design, accessibility of services to marginalised groups and reducing social isolation and loneliness. These actions reflect what people have said are important to them during community engagement which helped to shape the strategy.
15. Community empowerment and co-production is a key principle underpinning the strategy as set out in the executive summary, and delivery of the action plan will ensure that communities are a key part of driving change.

Equalities (including socio-economic) impact statement

16. The strategy aims to tackle health inequalities that lead to differences in health and life expectancy within the borough. The strategy takes a community and place focus, which involves providing additional support to the population groups that have the poorest outcomes and focusing on the most disadvantaged neighbourhoods in Southwark.

Health impact statement

17. The action plan is focused on improving health through five key areas. Once a refreshed action plan has been developed and implemented, new actions will continue to be monitored through progress updates to the Partnership Southwark Delivery Executive and the Health & Wellbeing Board. Changes in population health outcomes will continue to be monitored through the Joint Strategic Needs Assessment Annual Report.

Further guidance

18. The strategy and action plan fulfil one of the Board's statutory duties to prepare and publish a Joint Health & Wellbeing Strategy.
19. Any financial decisions that relate to the delivery of the action plan will be taken separately and through the relevant partner governance mechanisms.

Climate change implications

20. A principle in the strategy is that sustainability and tackling climate change should be an integral part of protecting and improving health. This should be taken into account in delivery of the action plan.

Resource implications

21. Officer time in each organisation will continue to be required to support the delivery of the action plan.
22. Any new projects/initiatives that arise through the action plan that require additional or reallocation of funding would need to be considered through the appropriate budget, monitoring and governance processes.

Consultation

23. The progress update has been compiled with input from all service leads responsible for actions in the strategy. The Joint Health & Wellbeing Strategy was originally shaped by extensive community engagement, including listening and engagement exercises conducted through Southwark Stands Together, South London Listens and the 'Understanding Southwark' research. In addition, community researchers have worked with the Public Health Division and colleagues in Partnership Southwark to identify opportunities to work with local communities in driving health improvements and strengthening community engagement.

SUPPLEMENTARY ADVICE FROM OTHER OFFICERS**Head of Procurement**

24. None sought.

Assistant Chief Executive, Governance and Assurance

25. None sought.

Strategic Director of Resources

26. None sought.

Other officers

27. None sought.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
Southwark Joint Health & Wellbeing Strategy Executive Summary	Public Health / Southwark Council	Rosie Dalton-Lucas
https://www.southwark.gov.uk/sites/default/files/2024-10/Southwark%20Joint%20Health%20Wellbeing%20Strategy%20Executive%20Summary%202022%20to%202027.pdf		
Southwark Joint Strategic Needs Assessment Annual Report 2024	Public Health / Southwark Council	Rosie Dalton-Lucas
https://moderngov.southwark.gov.uk/documents/s121610/Appendix%201%20-%20Joint%20Strategic%20Needs%20Assessment%20JSNA%20Annual%20Report%202024.pdf		
Southwark Joint Health & Wellbeing Strategy Progress Report: November 2023	Public Health / Southwark Council	Rosie Dalton-Lucas
https://moderngov.southwark.gov.uk/documents/s117146/Appendix%201%20-%20Southwark%20Joint%20Health%20and%20Wellbeing%20Strategy%202022-27%20Progress%20Update%20November%202023.pdf		

APPENDICES

No.	Title
Appendix 1	Southwark Joint Health and Wellbeing Strategy 2022-27 – Progress Report: November 2024

AUDIT TRAIL

Lead Officer	Rosie Dalton-Lucas, Head of Place & Partnerships	
Report Author	Dominic Dee, Public Health Specialty Registrar	
Version	Final	
Dated	31 October 2024	
Key Decision?	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	Comments Sought	Comments Included
Assistant Chief Executive, Governance and Assurance	No	No
Strategic Director of Resources	No	No
Cabinet Member	No	No
Date final report sent to Constitutional Team	1 November 2024	

Southwark Joint Health & Wellbeing Strategy 2022-2027

Progress Report: November 2024

Contents

Southwark Joint Health & Wellbeing Strategy 2022-2027	1
Background.....	3
Summary.....	4
Examples of success from residents	6
Priority 1: A whole family approach to giving children the best start in life	7
Priority 2: Healthy employment and good health for working age adults.....	10
Priority 3: Early identification and support to stay well	14
Priority 4: Strong and connected communities.....	19
Priority 5: Integration of health and social care	22
Recommendations	26

Background

Southwark's **Joint Health & Wellbeing Strategy 2022-27** was approved by the Health & Wellbeing Board in November 2022. The strategy provides the strategic vision for both improving health & wellbeing and reducing health inequalities in the borough.

The strategy outlined **five priority areas**:






1. A whole-family approach to giving children the best start in life
2. Healthy employment and good health for working age adults
3. Early identification and support to stay well
4. Strong and connected communities
5. Integration of health and social care

The last progress update was reviewed by the Health & Wellbeing Board in November 2023. This report **outlines progress to date** in delivering all actions and **gives recommendations** for progressing to a refreshed action plan for 2025-27.

Summary

On discussion with action owners, it is recognised that the original action timelines were ambitious and that organisational restructuring within South East London Integrated Care Board since launching the Joint Health and Wellbeing Strategy has delayed several actions. However, most actions have progressed and this report outlines what has been achieved, summarised both quantitatively and qualitatively and then in more detail by action.

The table below outlines the five categories used to assign an updated status to current actions, with associated colours used throughout this document. Of 53 actions, 28 have been completed, 15 are ongoing and on track, 6 are ongoing with some concerns or minor delays, 2 have not progressed or have experienced significant delays and 2 have been closed after consideration. Figure 1 summarises action status across the five priority areas and Figure 2 outlines several key measures associated with action progress. A selection of testimonies from residents is shown on Page 6.

Action colour	Action status
	Completed
	Ongoing: work on track
	Ongoing: some concerns or minor slippage to timeline but fully recoverable
	No progress or significant delays to timeline
	Action closed after consideration

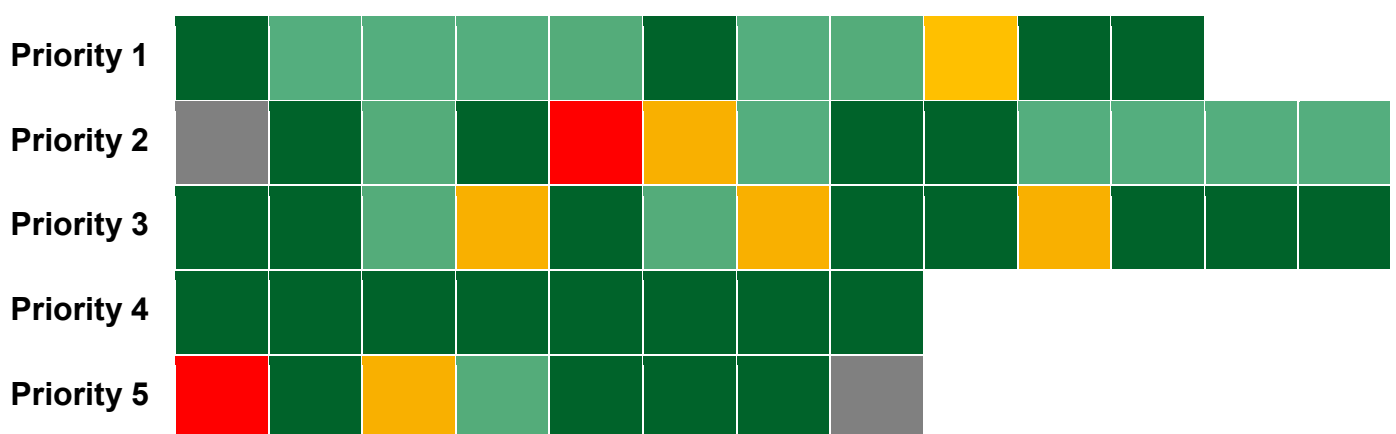


Figure 1. Action status as of November 2024 for 53 actions of Southwark's Joint Health and Wellbeing Strategy 2022-2027.

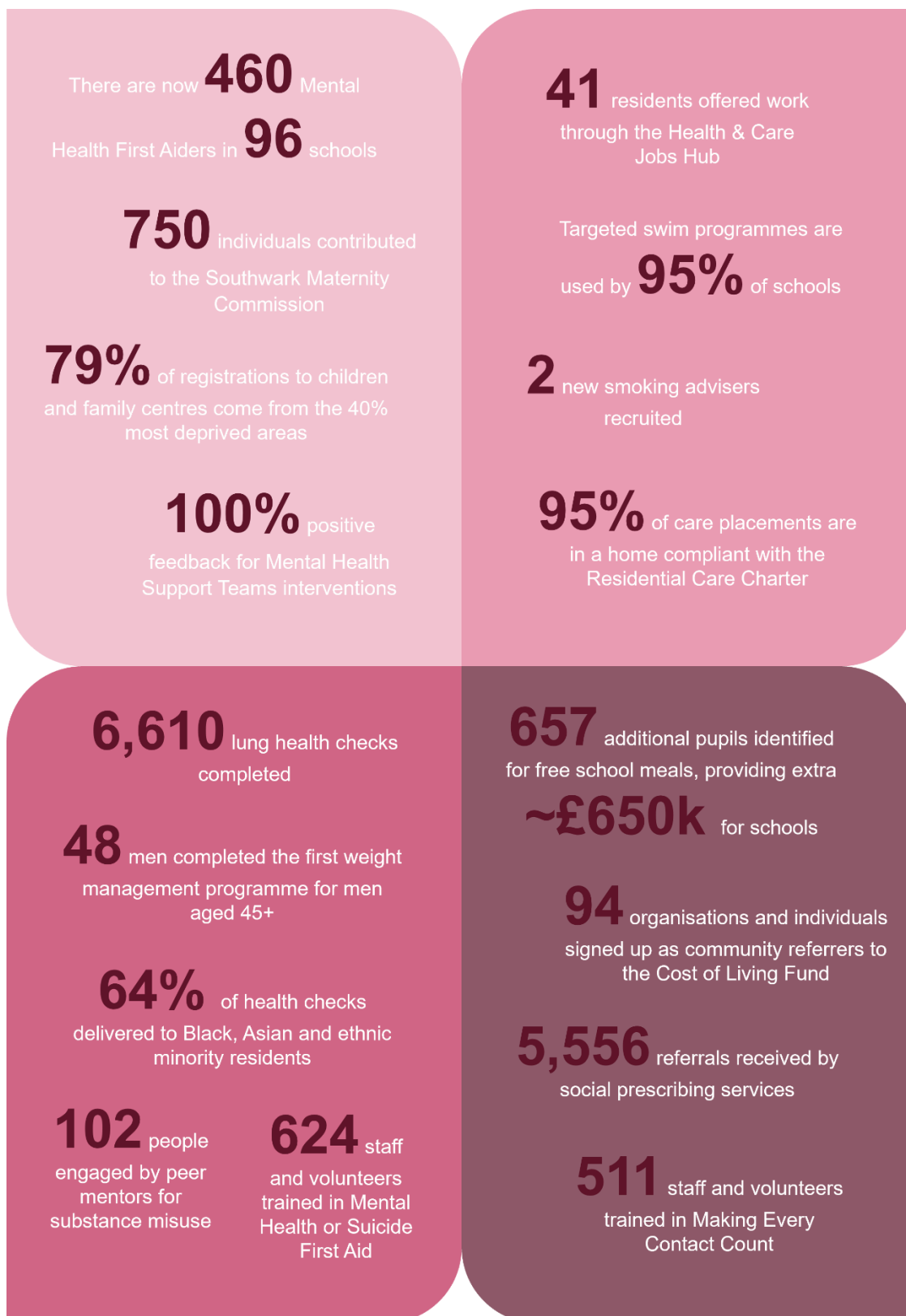


Figure 2. A summary of key measures recorded against actions in Southwark's Joint Health and Wellbeing Strategy.

Examples of success from residents

Mental Health Support Teams

Mental Health Support Teams deliver interventions in schools to improve the mental health and emotional wellbeing of young people. Of those participants who completed a questionnaire on their experience, 100% agreed with the statement “Overall the help I received was good.” Two participants said of the interventions:

“They listened to my problems no matter what. It really helped to improve how I felt and I am grateful”.

“It helped me to think differently. Taught me different ways and strategies on how to support my daughter. I have made small changes but they've led to big changes for my daughter. Helped me to manage my stress as well.”

Health & Care Jobs Hub

The Health & Care Jobs Hub supports residents to gain the skills needed to access good work in Health and Care, with a focus on unemployed and underrepresented groups. To date, 41 Southwark residents have been offered work opportunities through the programme. One resident, who was offered employment at a local GP surgery, said:

“Before I did the course, I had lost confidence... I learned a lot through the course... I have climbed and will continue to climb this stairway to success and the course was the first step to reaching that final goal. The goal to a better successful career.”

The Avon Unit

The Avon Unit, a new nursing care unit in Southwark, is now fully operational, increasing nursing care and reablement capacity in the borough. The service has seen a reduction in care needs of clients on discharge compared to admission. Two patients said of their experience:

“After I fell over, I'd lost all confidence. I wouldn't have even have tried to get out of bed if I had gone straight home. Coming here was the best thing that could have happened to me, its set me up perfectly to go home.”

“I didn't think I would ever walk again, I was very frustrated day to day. I didn't want to go initially, but I'd go back there tomorrow if could! Its done so much for me and helped me build up my confidence. I can't thank the team enough for all their support.”

Priority 1: A whole family approach to giving children the best start in life

Aim: Ensuring all families benefit from access to good quality maternal care and support to maximise maternal wellbeing and reducing differential outcomes for Black women in maternity care

Action	Owner	Progress Update	Status
Review causes of inequalities in and between maternal access, outcomes and experience	Public Health	The Southwark Maternity Commission launched its report in September 2024, following a nine-month investigation highlighting disparities in care and experience of women during pregnancy, childbirth and the early years. A Southwark Maternity Commission Panel was established to oversee the investigation and over 750 residents and maternity care professionals contributed. Recommendations have been put forward and an action plan is currently under development with a plan to finalise this and begin implementation from April 2025. A strategic steering group will be established to take ownership of actions developed.	
Scope and develop a collaborative maternity partnership group within Southwark to oversee the aim			
Development of action plan on tackling local inequalities based on recommendations on maternal access, outcomes and experiences			
Deliver action plan to implement national recommendations on maternity services	South East London Maternity & Neonatal system	Leading on from the ten recommendations of the Southwark Maternity Commission, an action plan is now being developed. Implementation of this action plan is due to start in April 2025 with a 5-year timeline through to September 2029.	

Aim: Build resilient families by ensuring there is holistic support and care during pregnancy and the first years of life

Action	Owner	Progress Update	Status
Develop children and family centres to facilitate multi-disciplinary working in geographical areas with	Children & Family Services	The Family Hub Transformation programme is progressing well. A facilities and locality review has been completed and proposals developed for the designation of our primary Children &	

the highest levels of deprivation		Family Hub sites. This will include 5 primary hubs across the borough. Registrations for centres are reflective of the overall population. 79% of registrations come from the 40% most deprived areas. Positive progress is being made with partnership services to scale up the level of integration of services with Hubs. For example, Midwifery teams are now co-located in the Dulwich Wood Children & Family Hub. Further progress is being made with a view to greater integration of health services within hubs, such as Speech and Language Therapy Teams, social prescribers, as well as a range of other council and voluntary organisations.	
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Aim: Improve the mental health and wellbeing of families, children and young people, ensuring 100% of children and young people who need support can access services

Action	Owner	Progress Update	Status
Increase the number of Mental Health Support Teams in schools	Children & Young People Mental Health Working Group	The number of schools with Mental Health Support Teams has increased to 26, with 233 interventions completed. Successes include the delivery of parent carer workshops, development of whole school approaches to mental health and wellbeing and work with schools to address emotionally based school avoidance. Of participants completing a service questionnaire, 100% were positive. Ongoing community engagement is being used to adapt services.	
Ensure that the improving mental health in schools (IMHARS) support package and Mental Health Support Teams offer is comprehensive and equitable	Children & Young People Mental Health Working Group	The improving mental health resilience in schools (IMHARS) support package is being delivered to all schools in Southwark. There are now over 460 Mental Health First Aiders across 96 schools, benefitting over 36,000 children and young people. At least 140 delegates from at least 70 schools have participated in "Wellbeing First: IMHARS" training or workshops and 28 headteachers are accessing leadership coaching to support school effectiveness.	

Aim: Keep children and young people safe through early identification and support for families at risk of adverse childhood experiences

Action	Owner	Progress Update	Status
Redevelop an early identification and prevention approach to Adverse Childhood Experiences in Southwark	Partnership Southwark: Start Well	The Family Hub programme is developing stronger place-based networks of universal and targeted support providers and the VCS. This will create a seamless offer of help and support for communities that is based on better relationships between trusted professionals. Development of a new Early Help Strategy is due by March 2025.	
Identify opportunities to strengthen how data on adverse childhood experiences is shared between services	Partnership Southwark: Start Well	The first iteration of the modern data platform is active. Development of the platform is progressively bringing more multi-agency data together to understand the profile of need in the area based on adverse childhood experiences. It is anticipated this work will be completed by March 2025.	

Aim: Accelerate the reduction in childhood excess weight and obesity in Southwark

Action	Owner	Progress Update	Status
Extend the motivational interviewing work which supports pathway into child weight management programme	Public Health	Motivational interviewing has been embedded into standardised scripts that Everyone Health staff use when contacting eligible families after the annual National Child Measurement Programme (NCMP). For the NCMP completed between June-August 2023, contact was attempted for all 937 eligible families, of which 36% booked onto the child weight management programme. For the most recent NCMP in October 2023, so far 26% of the 1,417 referrals have been contacted between April and July 2024 and 9% have been booked onto the programme.	
Strengthen National Child Measurement Programme (NCMP) pathway, building on best practice in other areas	Public Health	Based on the review into the NCMP, completed in 2023, several recommendations have been implemented. Relationships between Public Health, School Nursing and Everyone Health have been strengthened through a working group that continues to meet regularly. Quality of family contact data shared from School Nursing to Everyone Health has been improved. An independent evaluation of the Everyone Health programme, including NCMP, is in progress.	

Priority 2: Healthy employment and good health for working age adults

Aim: We will increase access to good quality jobs, creating new routes to employment and providing support to those facing barriers to good quality jobs, including those facing systemic inequality such as ethnic minorities, older people, and others.

Action	Owner	Progress Update	Status
Explore opportunities to use the apprenticeship levy in Partnership Southwark and voluntary and community sector roles	Partnership Southwark: Delivery Executive	There has been no tangible progress to date in developing the apprenticeship programme in Partnership Southwark. However, there has been a review of the local apprenticeship offer across key partners in the borough including NHS trusts, Integrated Care System and Council.	
Develop an inclusive apprenticeship programme within the social care workforce, focusing on staff who may have been excluded from traditional university routes	Adult Social Care	The Social Work and Occupational Therapy apprenticeship programmes have been advertised and recruited to for three successive years from 2022 to 2024. Applications were accepted from within our existing workforce in an effort to 'grow our own'. Interviews were inclusive and in line with current EDI policies. There are currently 4-5 Assistant Practitioners enrolled on the programme and there is a plan underway to review the programme in 2025.	
Implementation of Workforce Race Equality Standard in Adult Social Care as an early adopter local authority	Adult Social Care	In 2023 the Department of Health & Social Care announced it would not be continuing to lead the WRES and the leadership/management would transfer to Skills for Care. Following that announcement, a stocktake of WRES engagement was undertaken and this work is now being progressed through the Southwark Stands Together programme and Adult Social Care Action Plan.	
Support the development, delivery and utilisation of the Health & Care Jobs Hub to provide targeted support towards employment in the health economy	Partnership Southwark: Delivery Executive	The Health & Care Jobs Hub is being delivered, focussing on supporting unemployed and underrepresented groups to gain skills required to access good work in Health and Care. In Southwark, the hub partners with stakeholders including Southwark Works and GSTT. The 6-week Health & Care Sector Based Work Academy Programme, which includes a	

		guaranteed interview at the end of the programme, is ongoing and, to date, 41 Southwark residents have been offered work in health and care.	
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Aim: Promote health and wellbeing across the health and wellbeing economy, through improving access to wellbeing and employment support

Action	Owner	Progress Update	Status
All anchor institutions to proactively provide accessible information for wellbeing and employment support, such as information on the Keeping Well Hub	Partnership Southwark: Delivery Executive	Our Anchor Alliance involves the South East London Integrated Care Board, King's College London and NHS trusts and local authorities across south east London. In summer 2023 an engagement campaign was launched to shape the priorities and objectives for the anchor programme's work and to ensure the needs and voices of local communities are heard and responded to. Further work is required to progress this action following the ICB reorganisation.	

Aim: Lead by example by promoting good health and wellbeing across our workforce, and supporting this through our procurement practices

Action	Owner	Progress Update	Status
Roll out Residential Care Charter to ensure fair pay for care staff	Commissioning	Of 15 adult residential care homes in Southwark, 6 have signed up to the Residential Care Charter (RCC). All six are older persons care homes. As of September 2024, this represents 95% (332 of 348) of in-borough Council funded placements being in a Charter compliant home. In terms of staff, 570 people (74%) are working in homes that are fully compliant. Discussions are underway with the final older persons care home to sign up to the RCC. Plans are underway to re-open conversations with the other care homes in Southwark to sign up to the RCC. Officers will be meeting to discuss concerns and challenges for these remaining homes.	

Aim: Support people to lead healthy lifestyles that keep them well, working with population groups and communities where lifestyle risk factors are clustered

Action	Owner	Progress Update	Status
Evaluate stop smoking provision and implement recommendations to improve access and outcomes for at risk groups	Public Health	Several changes have been made to stop smoking provision locally. Maternity services now have an in-house stop smoking service to increase access among pregnant women. A specialist tobacco dependence adviser will be recruited to support individuals with a mental health condition in the community. Two new smoking advisers have been recruited using the OHID grant. They will focus on an outreach model of support to engage with priority groups, including weekly visits to supported accommodation settings and linking to drug and alcohol services. Evaluation of an insight research and marketing campaign will be available soon with data indicating an increase in stop smoking service uptake amongst routine and manual workers and young adults.	
Provide specialist training to non-alcohol specialist healthcare professionals on initiating conversations about alcohol use	Drug & Alcohol Action Team	Change Grow Live has delivered online training sessions for primary care colleagues about initiating conversations with patients about alcohol use, but these are no longer ongoing. From 2024, as part of a South-East London consortium, Southwark Council are offering free online training to colleagues to increase confidence around engaging with people who have drug and/or alcohol related challenges.	

Aim: Maximise access to leisure, daily movement and physical activity, ensuring that financial circumstance does not limit access

Action	Owner	Progress Update	Status
Undertake collection of data across communities and groups to inform and understand current levels of participation and engagement in	Leisure Services	Since insourcing of services in 2023, data quality and completeness has vastly improved. A profile of participants using leisure services has been completed, with breakdowns by demographic groups. Work is underway to address gaps of up to 50% in data categories that are not mandatory for participants, including ethnicity and disability. This limits the ability to understand the populations	

physical activity and sport		using leisure services and work is underway to fill gaps where possible and build the trust of service users providing data.	
Connect communities and promote opportunities to engage in physical activity and sport, particularly for unrepresented groups and those in greatest need	Leisure Services	Leisure Services have offered several successful programmes since June 2023, including targeted swim programmes used by 95% of schools in Southwark. The Move Games free activity programme in summer 2024 provided free activities to local young people. The well-received Free Gym and Swim offer continues and a pilot scheme of free, supported swimming lessons with the Inclusive Swimming Association has received exceptional feedback from participants. Open water swimming sessions have been running July – October 2024, with positive attendance particularly with older women. There is work ongoing to collaborate with libraries, parks and youth centres to offer services in alternative settings.	
Improve the signposting and promotion of the Council's sport and leisure offer by the wider health & care system	Leisure Services	Leisure Services continues to work with Everyone Health for referral into leisure centres. Southwark Leisure has a strong online and social media presence to ensure services are promoted to a wide audience. Active partnerships have been built across the wider council, including Public Health, Education, libraries and Social Care.	
Review the current targeted leisure offer, following insourcing of leisure provision in June 2023, with a view to further promoting services to target those who are least active, have poorer health or greater health risks	Leisure Services	Work is ongoing to make services available for everyone in the borough. There are plans to review the Free Swim and Gym offer to make it more targeted to those with greatest need. A new, fully accessible leisure centre in Canada Water will be completed in Spring 2025, including facilities for people with additional needs. Work is needed to improve service user data completeness so that services can be better targeted.	
Evaluate access to Exercise on Referral ensuring services is reaching target groups	Public Health	Exercise on Referral is part of the wider Integrated Healthy Lifestyle Service. In response to the annual review of services completed in June 2024, two weight management services, for men over 45 years and for the Latin American population, were launched in April 2024. The services are being externally evaluated, which will provide a detailed assessment of impact and contribute to the development of future services.	

Priority 3: Early identification and support to stay well

Aim: Ensure that there are effective and accessible services that help prevent illness, including immunisations, screening and measures to tackle “The Vital 5”

Action	Owner	Progress Update	Status
Increase uptake of NHS health checks by those with greater risks along with risk reduction interventions	Public Health	Southwark takes a targeted approach to NHS Health Checks and prioritises offers to residents with a higher predicted risk of developing cardiovascular disease or Type 2 diabetes. In 2023/24, providers exceeded targets, with 64% of health checks delivered via the core programme to Black, Asian and ethnic minority residents (against a target of 55%). The providers also exceeded the 25% target of case-finding those with high risk for CVD and/or Type 2 diabetes, at 31%. The programme has now been embedded into new contracts for NHS Health Checks and performance monitoring will continue.	
Extend the Community Health Ambassadors Programme, empowering more people to increase uptake of vaccinations and cancer screening and health improvement opportunities	Public Health	Community Health Ambassadors continue to be recruited and have been involved in projects such as the Health Outreach Programme, targeting health checks to communities with the poorest health outcomes. Ambassadors supported 64 events in 2023/24 and have already supported 81 in Q1 and Q2 of 2024/25. There has been consistent focus on vaccination, cancer awareness, mental health and cost of living support. Ambassadors have supported projects such as a Safe Surgeries audit, a long-COVID training course pilot and the South East London Cancer Alliance breast screening awareness campaign. The current target to maintain at least 150 ambassadors is being met, with 168 in total and 44 new ambassadors recruited in 2023/24. 74% of Ambassadors who provided ethnic background data selected a Black, Asian or minority ethnic group.	

Pilot and evaluate a weight management programme for men aged 45+, targeting Black, Asian and minority ethnic groups	Public Health	After a successful pilot and evaluation, a new weight management programme targeted to men aged over 45 years from Black ethnic groups was implemented in June 2024. 48 men completed the first 12-week programme, of whom 82% lost weight, 21% were from a Black ethnic background and 75% were from areas of high deprivation. The second cohort is now in progress and an impact evaluation is planned. A weight management programme for people of Latin American background was also implemented in May 2024 in conjunction with two community organisations.	
Develop and pilot healthy eating and physical activity interventions with faith groups and evaluate the outputs and outcomes	Public Health	A pilot health promotion programme is due to be implemented in two churches in Southwark from November 2024. There have been delays due to challenges with engagement. Outcomes from this initial pilot will be available in early 2025.	
Develop and deliver a Targeted Lung Health Check programme for people aged between 55-74 years who are current or ex-smokers	Guys and St Thomas' NHS Foundation Trust	The Targeted Lung Health Check programme in South East London launched in Southwark in November 2022. All residents aged 55-74 years who have ever smoked were invited throughout 2023. The mobile unit has been based in the Asda car park in the Old Kent Road and the programme will return every 2 years as an on-going screening programme. To date, 26,377 Southwark residents have been invited, 6,610 lung health checks completed and 2,523 scans. Of 158 referrals to stop smoking services, 115 set a quit date and 47 were smoke free at 4 weeks (41%).	
Evaluate peer mentor programme for substance misuse in hostel and hospital settings	Drug & Alcohol Action Team	Peer mentors are established at King's, in several hostels and a care home, including new programmes for 2024 in David Barker House and Aspinden Care Home. To date, 102 clients and patients have been engaged through therapeutic groups, 416 hours of activities and 11 campaigns, including stop smoking, naloxone, suicide awareness and breast care. An evaluation of the programme is due to be completed by March 2025.	

Aim: Promote good mental health by supporting wellbeing and early detection

Action	Owner	Progress Update	Status
Complete system-wide scoping activity to identify opportunities to integrate mental health in all policies, to improve the social determinants of poor mental health	Public Health	Mental health has been incorporated into various work programmes. By September 2024, 624 staff or volunteers in Southwark have received training in mental health first aid or suicide first aid, equipping frontline teams to support residents with their mental health. A mental health questionnaire and signposting to relevant services has been included in Vital 5 checks delivered through Southwark's health promotion programme and NHS Health Checks delivered in Southwark. A Public Mental Health stocktake is in development which will set out the evidence base for public mental health, capture local activity around prevention of poor mental health and provide recommendations for action. This is expected to be finalised by the end of 2024.	
Develop and implement an evidence-based suicide prevention strategy and action plan to reduce risk of self-harm and prevent incidences of suicide	Public Health	The Preventing Suicides in Southwark Strategy 2023-2028 was approved by the Health & Wellbeing Board in November 2023. The strategy was developed and will be delivered by the Southwark Suicide Prevention Stakeholder Group, led by Public Health. From the strategy, a mental health first aid and suicide first aid training programme is being delivered. Guidance and a new training course for council staff responding to at risk residents has also been launched. A first specialised suicide prevention training session for professionals in the hair and beauty industry was delivered in July 2024, with a further session planned in late 2024.	

Aim: Focus on preventing admission to hospital for falls

Action	Owner	Progress Update	Status
Deliver public awareness campaign focused on how to reduce falls risk and services that can reduce risk	Guys and St Thomas' NHS Foundation Trust	The falls prevention public awareness campaign is now moving to business as usual, after a second print run of 5,000 updated leaflets. These are being distributed to, and awareness events delivered at, GP surgeries and VCS organisations. The programme will be transferred to the falls prevention team at GSTT and new funding will be required for reprinting of leaflets. Falls monitoring is ongoing in Southwark with most metrics currently on target. Southwark has moved positively amongst London boroughs for falls-related hospital admissions.	
Deliver education and training on falls risk and availability of local services and prevent incidences of suicide	Guys and St Thomas' NHS Foundation Trust	An e-learning package was completed and loaded on the Southwark learning resource site in November 2023. Council staff are able to use the service but there are technical issues for external users trying to access it. This means the service has not formally launched and the publicity campaign is on hold. Work is ongoing to find an appropriate external partner to host the resource so that this can progress.	

Aim: Provide the right support to help people to recover from admission to hospital

Action	Owner	Progress Update	Status
Further embed the hospital discharge and community support guidance throughout the Southwark system	Partnership Southwark: Age Well	The Avon Unit is now fully operational, with half of its beds for reablement and half for Discharge to Assess. The service has seen a reduction in care needs of clients on discharge. Most hospital discharge workstreams have progressed to business as usual. The focus of work currently is on discharge to nursing care and ongoing service improvement. A multi-disciplinary team is being trialled as a project to improve the patient journey between hospital and care home. Community research has been completed resulting in the agreement for co-	

		produced documents and videos to improve the hospital discharge experience.	
Pilot a 'Hospital Buddies' programme offering volunteer support to older people before and after elective surgery	Partnership Southwark: Age Well	The 'Hospital Buddies' programme was piloted and a review completed in April 2024. There were limited referrals to the service during the pilot period and therefore the decision was made not to progress further with the programme. The funding has been used instead to focus on creating multi-disciplinary teams for improving the patient journey between hospital and care home.	

Aim: Support carers and families to look after their own wellbeing

Action	Owner	Progress Update	Status
Develop the signposting to Ageing Well Southwark to ensure that a greater number of carers know how to access support	Adult Social Care	The Council continues to work with Southwark Carers and other voluntary organisations. New leaflets and posters have been printed for use in GP surgeries to signpost to Ageing Well Southwark and a refreshed Carers Strategy is in development. A new 12-month contract was started in May 2024 with Mobilise, who provide online support to unpaid carers. In the first 11 weeks, they have engaged with 410 people and supported 311 of those, all who were previously unknown to the Council. The service signposts to Ageing Well Southwark and other services and will help to create a more joined up offer.	

Priority 4: Strong and connected communities

Aim: Ensure that services are accessible to and meet the needs of all

Action	Owner	Progress Update	Status
Mental health practitioners to be embedded in communities and neighbourhoods through Be Well Hubs	Community Mental Health Transformation Programme Delivery Group	Mental health practitioners have been embedded in communities in both North and South Southwark practices. There is a Clinical Service Lead for the programme and monthly touchpoint meetings including primary care and SLaM colleagues provide opportunities for development.	
Complete needs assessment to better understand health needs of refugees, asylum seekers and vulnerable migrants in the borough	Public Health	A needs assessment was completed in 2023, which directly informed work to successfully make Southwark a Borough of Sanctuary. Work is now underway to progress recommendations in the form of Southwark's Borough of Sanctuary Framework 2024-2027 and associated action plan, which was approved in September 2024.	

Aim: Reduce social isolation and loneliness, by creating a place where people feel connected and where loneliness is tackled as early as possible

Action	Owner	Progress Update	Status
Support model of social prescribing that helps to connect local residents to relevant services that can tackle loneliness and social isolation	Partnership Southwark: Delivery Executive	The social prescribing service was implemented in March 2020, with a broad scope supporting wider determinants of health including social isolation, finance, housing and mental well-being. Overall referral numbers across North and South Southwark teams increased from 3,880 in 2020-21 to 5,556 in 2022-23. Recent successes include specialist roles (e.g. a focus on children and housing); strong partnership working with VCS organisations and statutory services (e.g. Citizens Advice and Adult Social Care); a community outreach	

		programme; and innovative projects focusing on different population needs (e.g. monthly peer support for informal carers). Future priorities include developing an integrated neighbourhood approach and continuing to embed the principles and role of social prescribing in the wider health and wellbeing system.	
Delivery of Making Every Contact Count training to staff working regularly with people at risk of severe loneliness or isolation	Public Health	After the first 6 months of the programme, 511 staff and volunteers in Southwark have been trained in Making Every Contact Count, over half the overall target of 1,000 by 24 months. 97% of attendees stated they would recommend the training to others and 82% of those completing three-month post-training feedback reported their conversations had increased in quality. Specific content has been developed on social isolation and loneliness with attendees coming from a range of organisations. A full evaluation is planned after the end of the contract in 2025.	

Aim: Improve access to affordable, healthy food by adopting a Right to Food approach

Action	Owner	Progress Update	Status
Develop and implement a Right to Food Action Plan. This will include: <ol style="list-style-type: none"> 1. Children's food 2. Food for older and disabled people 3. Healthy food neighbourhoods and physical access to food 4. Cash first approaches 	Public Health / Southwark Food Action Alliance	The Sustainable Food Strategy, with actions integrated from the Southwark Right to Food action plan, was published in June 2023. Implementation of the strategy's year 1 action plan for 2023-2024 is underway. Successes this year include strengthening cross-council governance and oversight of the strategy delivery, offering free secondary school meals to all families who receive Universal Credit, and introducing benefits related Free School Meals auto-enrolment, which identified an additional 657 pupils for registration and means approximately £650,000 in additional Pupil Premium funding for Southwark schools.	

Aim: Work together to mitigate the impacts of the cost of living crisis for people in Southwark

Action	Owner	Progress Update	Status
Undertake analysis of the likely health impacts of the cost of living crisis, identifying those who will be most impacted	Public Health	Four reports were completed on the impact of the cost of living crisis and the population groups affected, in July 2022, October 2022, April 2023 and November 2023. These reports fed into the support offer put in place by the Council for local residents. Sections on the cost of living crisis were included in the 2023 and 2024 JSNA annual reports, demonstrating that this issue has become a key part of regular monitoring. Now, a poverty fact sheet is in development as part of this year's JSNA programme, widening the focus from solely the cost of living.	
Ensure those working directly with residents most affected are aware of the support offer available in Southwark	Public Health	Public Health has funded and disseminated a cost-of-living booklet, reaching over 100 organisations in the borough. Winter signposting webinars were delivered in 2023, which Exchequer Services and Children and Adult Services presented at to 105 organisations. Cost of living information has also gone out to 101 adult social care providers, and 60 older adult VCS providers. The Ambassador Network was trained in Advice First Aid in October 2023 and June 2024. There has been regular promotion of support services and schemes via Ambassador communications. Regular Citizens Advice / cost of living surgeries have also been organised in community centres and faith settings.	
Identify health and wellbeing partners who can refer people into the Southwark Council Cost of Living Fund	Public Health	Overall, Exchequer Services signed up 94 organisations or individuals as community referrers to the Cost-of-Living fund last year. Of these, 19 were categorised easily as health and wellbeing partners including the two social prescribing teams and 12 Community Health Ambassadors.	

Priority 5: Integration of health and social care

Aim: Ensure joined-up care is delivered close to home, including exploring where care can be developed at a neighbourhood level

Action	Owner	Progress Update	Status
Develop and pilot approaches to co-located multi-disciplinary teams (including primary care, secondary care, social care) in neighbourhood settings.	Partnership Southwark: Delivery Executive	The delivery group for neighbourhood working has been paused due to the impact of the management cost reduction programme in the ICB, which led to a 30% reduction in the running cost allowance and pausing of certain projects. Neighbourhood working remains a key priority and there was renewed commitment at the Partnership Southwark board development meeting in October 2024. Work is underway to refresh the neighbourhood working proposal, but this will not be completed by April 2025; a revised timeline will be provided to the Health & Wellbeing Board.	
Develop and implement a person-centred model for community mental health, based around primary care networks and neighbourhoods	Community Mental Health Transformation Delivery Group	The Community Mental Health Transformation Programme was completed in March 2024 and most workstreams have now moved to business as usual with the service model being further developed. An evaluation has been drafted and should be completed by early 2025. The outcome framework and a dashboard have been developed.	
Increase nursing care provision in the borough	Children & Adult Services Commissioning	Nursing beds have increased in Southwark thanks to several changes. Tower Bridge Care Home was purchased by the Council and as part of the new care provider contract, the nursing bed block has increased, as well as several beds converting from residential to nursing. The Avon Unit provides nursing assessment beds. Waterside Care Home beds are in the process of converting from residential to nursing. A new nursing home is planned for construction in Southwark, a site has been identified and work is ongoing with Sustainable Growth to determine the best approach to design, build and provide support in the home.	

Aim: Strengthen how we involve local communities to help us better understand their needs and to co-design and implement services to meet their needs

Action	Owner	Progress Update	Status
Establish a new approach to embedding community voices in shaping and implementing health and care priorities	ICB Communications & Engagement Team	Southwark continues to embed the community voice through membership of VCS and service users in boards and steering groups, including Partnership Southwark Strategic Board; the Health & Wellbeing Board; Start Well leadership group; Live Well leadership group; Age & Care Well leadership group; and the Clinical and Care Professional Leadership team. Board meetings are also regularly open to public attendance. Extensive engagement and codesign work with VCS representatives and service users has been further developed, tested, and implemented across 2023/24 when delivering Health and Care Plan priorities. Examples include the 1001-days work to design an early prototype neighbourhood model for 0-2s and delivery of the community mental health transformation programme. An integrated Frailty pathway with involvement of the VCS is currently in development.	
Pilot a new approach to engagement and neighbourhood working through the We Walworth programme and a second neighbourhood pilot	Partnership Southwark: Delivery Executive	The evaluation report of the pilot is due imminently. The Social Model of Health/ Walworth Living Room team has submitted a proposal for the Health Inequalities Fund for further developments which is currently under consideration. Walworth Living Room recently received National Lottery funding for the next three years and is undergoing recruitment for neighbourhood and events roles.	

Aim: Ensure partners are able to hold each other to account in delivering good care to our residents

Action	Owner	Progress Update	Status
Establish transparent governance arrangements following the formation of the Local Care Partnership	Partnership Southwark: Delivery Executive	Our Local Care Partnership, Partnership Southwark, was established in July 2022 following the national reorganisation of the NHS and is now well embedded within the health and care system. The partnership holds bi-monthly public meetings, with membership from across the system and voluntary and community sector. In addition, a joint Strategic Director post has now been established between Southwark Council and South East London Integrated Care Board. The post is responsible for driving forward the integration of the planning and delivery of local health services for the benefit of local residents.	

Aim: Align budgets where possible to make the best use of the “Southwark pound”

Action	Owner	Progress Update	Status
Set out how budgets can be aligned and or pooled under the Partnership Southwark Health and Care Plan	Partnership Southwark: Delivery Executive	The Health & Care Plan was approved at the Partnership Southwark Strategic Board in July 2023. Through the Joint Commissioning Oversight Group, Better Care Fund Planning Group and Partnership Southwark Strategic Board, the partnership continue to identify opportunities to align and / or pool budgets across the health and care system to support the delivery of priorities set out in the Health & Care Plan and achieve the best outcomes for our residents. These discussions will continue, with future proposals brought to the Partnership Southwark Strategic Board or Health & Wellbeing Board as appropriate.	
Increase voluntary contributions to the Better Care Fund (BCF)	South East London Integrated Care Board	It was agreed not to increase voluntary contributions to the Better Care Fund above the 2022/23 baseline. This was due to the administrative delays and restrictive planning and assurance requirements that are	

	& Adult Social Care	associated with the Better Care Fund processes. Instead, it was decided that any further expansion of budget alignment is best pursued using bespoke local pooling or collaboration arrangements outside the Better Care Fund framework. This was discussed at the Health & Wellbeing Board in January 2023.	
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Recommendations

Progress has been made in most of the 53 actions in Southwark's Joint Health and Wellbeing Strategy 2022-2027. There is now an opportunity to refocus priorities for the next two years, building on successes to date, learning from challenges and aligning with other important local policy and strategy, including Southwark's vision for 2030. We therefore make the following recommendations to the Health and Wellbeing Board:

1. A new action plan should be developed for 2025-2027, for approval by the Health and Wellbeing Board in March 2025.
2. New actions should be fewer in number but larger in scope and potential for impact.
3. Actions should be ambitious, with a focus on where partners can work together to go over and beyond "business as usual".
4. A new outcomes framework should be developed with partners to monitor the impact of new actions.
5. The new action plan should align strongly with Southwark's vision for 2030.

Meeting Name:	Health and Wellbeing Board
Date:	14 November 2024
Report title:	Partnership Southwark Health and Care Plan refresh of strategic priorities
Ward(s) or groups affected:	All
Classification:	Open
Reason for lateness (if applicable):	Not applicable
From:	Rebecca Jarvis, Director of Partnership Delivery and Sustainability (Southwark)

RECOMMENDATION(S)

1. That The Health and Wellbeing Board notes the five refreshed strategic priorities of the Partnership Southwark Health and Care Plan and the work underway to develop delivery plans for each priority.

BACKGROUND INFORMATION

2. The Partnership Southwark Health and Care Plan was approved on 6 July 2023 and sets out the priorities for the Local Care Partnership over five years. The plan was informed by public engagement work by all partners, and aligns with partner plans and priorities such as the Health and Wellbeing Strategy of Southwark Council and the Forward View of NHS South East London.
3. A one year review was carried out in August 2024 which identified that although there had been some significant areas of success, the plan covered numerous actions which were difficult to resource effectively, keep track of and demonstrate impact. As such, the Partnership Southwark Strategic Board agreed to undertake a refresh of the strategic priorities with the aim of reducing the number of priorities and actions and to direct resource at the areas where there could be the biggest impact by working in partnership.
4. The purpose of this report is to provide an update on the work underway to refresh the strategic priorities and develop plans to support delivery of these priorities for the next 12-18 months.

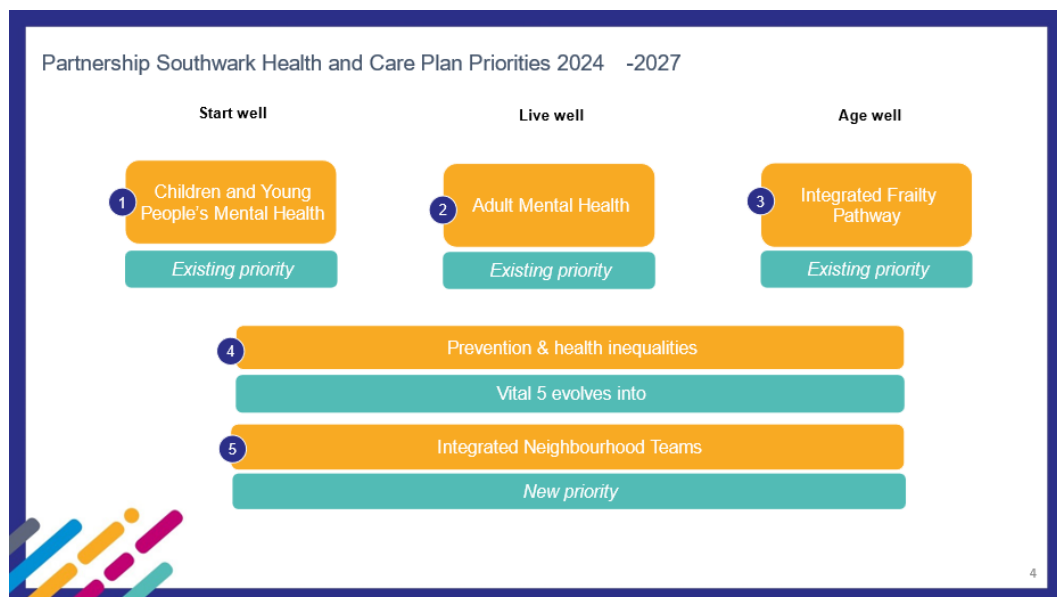
KEY ISSUES FOR CONSIDERATION

5. The relevant strategic plans and strategies of Southwark Council and the Southeast London Integrated Care Board were reviewed, including the Joint Health and Wellbeing Strategy and Southwark 2030. It was identified that there is commonality of priorities across the plans and strategies and strong

alignment with the Partnership Southwark 'Wells' structure (Start Well, Live Well, Age and Care Well).



6. Consideration was also given to the national context, specifically The Next Steps for Integrating Primary Care – The Fuller Stocktake Report, the Labour Party manifesto and the King's Speech. The findings from the Darzi investigation had not been published at the time of the review although the priorities proposed support the recommendations of the review.
7. A workshop was held with the Partnership Southwark Strategic Board members to agree areas where there could be a greater impact by working in partnership. This resulted in five strategic priorities being proposed:



8. There is strong alignment of these strategic priorities with the priority areas outlined in the Joint Health and Wellbeing strategy:

Joint Health and Wellbeing Strategy	Partnership Southwark Health and Care Plan Priorities				
	Children and Young Peoples Mental Health	Adult Mental Health	Prevention and Health Inequalities	Integrated Frailty Pathway	Integrated Neighbourhood Teams
A whole family approach to giving children the best start in life	✓		✓		✓
Healthy employment and good health for working age adults		✓	✓		✓
Early identification and support to stay well		✓	✓	✓	✓
Strong and connected communities	✓	✓	✓	✓	✓
Integration of health and social care		✓	✓	✓	✓

9. For each strategic priority, teams have come together to review existing work programmes and identify areas of focus to develop delivery plans for each priority area for the coming 12-18 months. Using existing forums such as the Wells groups and bespoke workshops, they have been asked to:
- Agree an 'ambition statement' to describe what will be different for Southwark residents in three years' time
 - Agree a set of outcome measures to monitor and demonstrate progress
 - Develop a delivery plan which describes the activities to be undertaken with timeframes
- This work is currently in development and will be finalised by January 2025.
10. It's important to note that although prevention and health inequalities and integrated neighbourhood teams are standalone priorities, these are themes which are relevant to all five priorities and need to be considered when developing plans in all priority areas.
11. The priorities will be delivered through the 'Wells' structure, recognising that there are wider programmes of work underway in each of the Wells themes. The Drive, Sponsor, Observe framework is being used to help determine how the programmes of work should be resourced, for example:
- Drive - Partnership Southwark actively steers key activities, with dedicated resource, to ensure progress and delivery of outcomes. Teams will **drive** the delivery of the strategic priorities with dedicated resource from the Partnership Southwark delivery team.
 - Sponsor - Partnership Southwark formally endorses the initiative, with potential opportunities for funding support
 - Observe - Partnership Southwark takes a supportive interest in initiatives of high relevance, being delivered in other parts of the system.

Policy framework implications

12. The Partnership Southwark Health and Care Plan supports delivery of relevant areas of the Joint Health and Wellbeing Plan and Southwark 2030.

Community, equalities (including socio-economic) and health impacts

Community impact statement

13. Community engagement in development of key strategic documents which informed selection of Partnership Southwark strategic priorities.

Equalities (including socio-economic) impact statement

14. Reducing inequalities is one of the five strategic priorities of the Health and Care Plan and is a key component across all priorities. When developing delivery plans for each of the priority areas, consideration is being given to how to work with different population groups to reduce health inequalities. This includes the protected characteristics outlined in the Equality Act 2010, along with other factors such as socio-economic status.

Health impact statement

15. The Partnership Southwark Health and Care Plan is designed to improve the health outcomes of the population of Southwark.

Climate change implications

16. The Partnership Southwark health and care plan aims to reduce the environmental impact of health and care services in the Borough by reducing activity (for example reducing the need for carbon intensive health and care services by preventing ill-health and/or the need for more intensive services) and reducing the impact of health and care activities such as through use of low carbon alternatives and the elimination of waste.

Resource implications

17. Delivery of the Health and Care Plan priorities will be resourced from the Partnership Southwark delivery team and Clinical and Care Professional Leads (CCPLs). There is an expectation that partners will play an active role in the delivery of activities within their area of expertise.

Consultation

18. The delivery plans for each priority area are being developed with the engagement of key stakeholders across the Local Care Partnership. Programme leads will ensure that partners and residents are engaged in the delivery of these plans and any new services or solutions are co-produced.

SUPPLEMENTARY ADVICE FROM OTHER OFFICERS

Assistant Chief Executive, Governance and Assurance

19. None sought

Strategic Director of Resources

20. None sought

Other officers

21. This report is for noting, and no advice has been sought from other officers.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
Southwark Joint Health and Wellbeing Strategy 2022-2027	Public Health Southwark Council 160 Tooley Street SE1 2QH	Public Health 020 7525 5000
Southwark's Joint Health & Wellbeing Strategy 2022-27		
Southwark 2030	Strategy & Communications Southwark Council 160 Tooley Street SE1 2QH	Strategy and Policy Manager 020 7525 5000
Southwark Council - Agenda for Cabinet, Monday 22 July 2024, Item 9 - Southwark 2030		
Southeast London Integrated Care System Strategic Priorities 2023-28	South London ICS 160 Tooley Street London SE1 2TZ	contactus@selondonics.nhs.uk
Integrated Care Strategic Priorities for 2023-28		
The Next Steps for Integrating Primary Care – The Fuller Stocktake Report (2022)	NHS England	england.contactus@nhs.net
NHS England » Next steps for integrating primary care: Fuller stocktake report		
Independent Investigation of the National Health Service in England (Lord Darzi, Sept 2024)	Department of Health and Social Care	darzi2024evidence@dhsc.gov.uk
Independent Investigation of the National Health Service in England		

AUDIT TRAIL

This section must be included in all reports.

Lead Officer	Darren Summers, Strategic Director for Integrated Care & Health (NHS South East London Integrated Care)	
Report Author	Rebecca Jarvis, Director of Partnership Delivery and Sustainability	
Version	Final	
Dated	01/11/2024	
Key Decision?	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	Comments Sought	Comments Included
Assistant Chief Executive, Governance and Assurance	No	No
Strategic Director of Resources	No	No
Cabinet Member	No	No
Date final report sent to Constitutional Team		1 November 2024

Meeting Name:	Health and Wellbeing Board
Date:	14 November 2024
Report title:	Air Quality Annual Status Report 2023
Ward(s) or groups affected:	All
Classification:	Open
Reason for lateness (if applicable):	Not applicable
From:	Head of Regulatory Services

RECOMMENDATION(S)

1. That the Health and Wellbeing Board note the contents of the Southwark Annual Status Report 2023 (ASR 2023), presented as Appendix 1.
2. That the Health and Wellbeing Board has oversight of the Air Quality Action Plan, through the Director of Public Health and the Air Quality Delivery Board. This enables policies and plans that impact on air quality, to be considered by the Board's membership ensuring a comprehensive strategic approach to air quality in Southwark.

BACKGROUND INFORMATION

3. The Environment Act 1995 required the UK Government to produce a national air quality strategy containing standards and objectives for improving air quality. The first national strategy was published in 1997.
4. The government last revised the national air quality strategy in January 2019. This revised the framework for achieving improvement in ambient air quality in the UK. It set UK air quality standards for 8 atmospheric pollutants with short and medium term objective levels. The national strategy identified actions at local, national and international level to improve air quality; this includes actions for local government.
5. The Environment Act 1995 introduced local authority duties for Local Air Quality Management (LAQM). Southwark completed the initial review and assessment and concluded the air quality objectives for large Particulates (PM₁₀), Nitrogen Dioxide (NO₂), and Benzene would not be met in the borough by the respective compliance dates of 2004 and 2010 without the creation of an Air Quality Management Area (AQMA).

6. An AQMA was formally declared in Southwark in January 2003 for large Particulates (PM₁₀), and Nitrogen Dioxide (NO₂) in the whole of Southwark apart from the then College ward. A further assessment showed that Southwark was compliant for Benzene by this time. The AQMA was since expanded 1 January 2023 to include the whole borough.
7. With a declared AQMA, Southwark is legally required to produce an Air Quality Strategy (AQS) and a five-yearly Air Quality Action Plan (AQAP). The latest version of the AQAP is for the five years 2022 - 2027. That plan commits the Council to 65 initial actions to improve local air quality and work towards meeting all the national air quality objectives in Southwark.
8. As Southwark is declared an Air Quality Management Area (AQMA), the authority is required to produce an Annual Status Review (ASR) of air quality each year. This report includes the air quality monitoring data for the previous year and details of our progress against the AQAP commitments. Air quality improvement policy ideas and technological advances evolve rapidly, the ASR is an opportunity to add new actions to the AQAP and include actions that have been developed and/or delivered over the last year that were not listed in the original AQAP.
9. The ASR 2023 was submitted to the Greater London Authority (GLA) and the Department for the Environment Food and Rural Affairs (Defra) for their information and comment (Appendix 2). The report was approved with minor changes.
10. Southwark's AQS & AQAP contribute to the Council's objectives of making Southwark safer, cleaner and greener and to improving the health of the borough.
11. Southwark currently meets the national air quality objectives for all pollutants listed by the government with the exception of Nitrogen Dioxide (NO₂) at certain hotspots in Southwark. This is invariably along busy roads in the borough, however, levels of Nitrogen Dioxide have improved over the last decade and more so in the past year since the extension of the Ultra Low Emission Zone (ULEZ) in London. The highest concentration of Nitrogen Dioxide was recorded at the Tower Bridge Road monitoring site (SDT18), with an annual mean concentration of 41.6 µg/m³. Except for the Tower Bridge site, the national objectives for NO₂ were generally met (40µg/m³). However, the more ambitious World Health Organisation (WHO) guideline of 10 µg/m³ was exceeded at many monitoring locations across Southwark.
12. It is a similar position with concentrations of Particulate Matter (PM). Measurements at all (six continuous monitoring) sites complied with the national air quality objective of 40 µg/m³ for large particulate matter (PM₁₀) in 2023. However, most of these sites exceeded the WHO guideline of 15 µg/m³ annual average.
13. Regarding smaller particulate matter (PM_{2.5}) the levels have remained stable over the monitoring period. The annual average levels monitored at

all six locations in Southwark complied with the national air quality objective of 20 µg/m³ in 2023 and the London's target of 10 µg/m³. It should be noted that the London target of 10 µg/m³ is the target level to be achieved by 2030. Southwark is therefore well ahead of expectation in this area. However, all sites exceeded the WHO guideline of 5 µg/m³ for annual average of small particulate matter. The highest average recording over the year was at the Vicarage Grove site and the second highest was the Old Kent Road site.

14. Although not a regulated pollutant, Ozone (O₃) has adverse effects on health therefore, it is included in the national Air Quality Strategy with a limit of 100 mg/m³ not to be exceeded more than 10 times a year for the average recordings over an 8 hourly running period. Ozone levels have been monitored at the Elephant and Castle monitoring site and there has been a notable increase in concentrations in the recent years. In 2023, monitoring records show the acceptable level was exceeded on 19 occasions.

KEY ISSUES FOR CONSIDERATION

15. The levels of Nitrogen Dioxide (NO₂) are gradually falling across the borough as shown in the results for the automatic monitoring stations and at the diffusion tube locations. This trend is mirrored by a slow downwards trend in measurements from across London. Exceedance of the national air quality objective for NO₂ is still commonly found on busy road corridors in Southwark.
16. In Southwark, the levels of PM₁₀ are well below the national air quality objective and are gradually falling across the borough as shown in the results for the automatic monitoring stations. Long-term trend is decreasing, whilst the short-term trend for the last three years remains unclear for some roadside sites, including Old Kent Road (SK5), Lower Road (SKA), and Vicarage Grove (SKB) where the levels appear to have remained stable. This trend is mirrored by a slow downwards trend in measurements from across London.
17. Southwark commenced monitoring PM_{2.5} for the first time in 2020. This is a small fraction of particle known to adversely impact health. The national Air Objective for PM_{2.5} is a target of 15% reduction in concentrations at urban backgrounds to be achieved between 2010 and 2020 and to be maintained thereafter. This target reduction has been achieved at the Elephant and Castle monitoring site. The London local target for the level of small particulate matter is an annual limit of 10 mg/m³ which is the same as the World Health Organisation (WHO) recommended guideline. Southwark Air Quality Strategy will monitor compliance with the local and WHO recommended guideline. All monitoring sites showed that measurements for this pollutant were generally below 10mg/m³, although compliance at one site, Vicarage Grove was marginal, with a result of 9.9mg/m³.

18. Southwark does not monitor for Sulphur Dioxide (SO₂) but modelling and measured levels from elsewhere in the capital indicate that levels in Southwark are well below the national air quality objectives.
19. The majority of actions due in 2023 were delivered on target. Key actions met in 2023 include:
 - Adopted Southwark's 2023-2027 Air Quality Action Plan.
 - Expanded the monitoring network with new sensor sites.
 - Continued working with the Climate Change Team to link the local air quality with the Borough's Climate Carbon Reduction programme.
 - Continued working with the authority's Highways Service to monitor air quality in the Low Traffic Neighbourhoods that were introduced during the Covid-19 lockdown to facilitate walking and cycling.
 - Completed a further discovery research on the airText project to increase the uptake of the airText app amongst vulnerable persons and those from black and minority ethnic communities. Engagement with the community then commenced earlier this year.
 - Expanded the "OurBike" scheme to four cargo bikes available to local businesses and residents to hire. There were previously two bikes available for hire.
 - A substantial increase in Electric Vehicle Charging Points in the Borough.
20. Outside of Regulatory Services there has been good liaison with other service areas with the responsibility for delivery of AQAP actions. In particular, Public Health, Parking, Highways and Transport Planning have all increased their active involvement in delivery of the AQAP actions.
21. Some actions are not yet achieved. They include:
 - Decision on civil enforcement of idling vehicles. A London-wide joint working group is seeking a clarification on enforcement approach.
 - Civil enforcement of the Smoke Control Area.
 - Development of an air quality monitoring data dashboard.
 - Air quality action plan dashboard and tracker.
22. For the purposes of air quality monitoring and assessment of compliance with national-level objectives, the UK is divided into 43 zones. In 2023 the UK met the limit value for the hourly mean Nitrogen Dioxide (NO₂) in all zones. 34 zones met the limit value for annual mean NO₂, with nine zones exceeding. The exceeding zones include Greater London, which is expected to be the last region to meet the current air quality objectives. Overall, there has been a significant reduction of NO₂ levels in Southwark recorded over the recent years, but the recommendation remains to achieve all the actions in the AQAP to ensure all areas become and remain compliant with the annual air quality objective for NO₂.

23. Progress on delivery of the current AQAP is good. Many actions are being delivered on target, with only a few complex actions delayed in their delivery e.g., those involving planning policy and district heating. The intention to deliver these actions in the future remains.

Policy implications

24. The AQAP was devised to be a living document, updated each year by the outcomes of the air quality annual status reviews (ASRs). This ensures the AQAP remains relevant and up to date over its 5-year lifespan by ensuring:
- All actions of significance are captured, including actions undertaken that were not originally in the action plan.
 - As actions are achieved or become outdated, their targets can be revised.
 - If Southwark becomes aware of new ideas, knowledge or initiatives they can be considered for incorporation.

Community impact statement

25. All sectors of the community are affected by local air quality. A report by the Environment Agency found that areas of poor air quality significantly correlate with areas of deprivation. There are a number of deprived wards within Southwark that are areas of deprivation, as defined by the Government. (Source - Official National Statistics).
26. PM_{2.5} levels are used to calculate an indicator in the Public Health Outcomes Framework (PHOF) – Fraction of Mortality Attributable to Particulate Matter Pollution. This indicator is calculated for each local authority in England, and it intended to enable Directors of Public Health to prioritise action on air quality in their local area. The estimated fraction of mortality attributable to long-term exposure to current (2022) levels of anthropogenic PM_{2.5} is higher in Southwark than the average for London or England, accounting for 7.6% of all deaths in 2022¹. The London Value is 7.1% and England the value is 5.8%
27. In 2023 – 2024, 16,314 Southwark patients (over 6 years old) have an asthma diagnosis and 4,570 patients (all ages) have a diagnosis of chronic obstructive pulmonary disorder². There is evidence that exposure to air pollution exacerbates long term health conditions among health vulnerable people.

¹ Public Health England website:

<https://fingertips.phe.org.uk/search/fraction%20of%20mortality%20due%20to%20particulate%20air%20pollution#page/1/gid/1/ati/501/iid/30101/age/230/sex/4/cat/-1/ctp/-1/yr/1/cid/4/tbm/1>

² [https://fingertips.phe.org.uk/respiratory-](https://fingertips.phe.org.uk/respiratory-disease#page/1/gid/8000003/pat/6/ati/501/are/E09000028/iid/93963/age/1/sex/4/cat/-1/ctp/-1/yr/3/cid/4/tbm/1)

[disease#page/1/gid/8000003/pat/6/ati/501/are/E09000028/iid/93963/age/1/sex/4/cat/-1/ctp/-1/yr/3/cid/4/tbm/1](https://fingertips.phe.org.uk/respiratory-disease#page/1/gid/8000003/pat/6/ati/501/are/E09000028/iid/93963/age/1/sex/4/cat/-1/ctp/-1/yr/3/cid/4/tbm/1)

Consultation

28. The 2023 Annual Summary Report (ASR) was compiled with information from all departments and service areas responsible for the delivery of actions, and from Southwark's air quality monitoring data, with further supporting data from the London Air Quality Network.
29. Data from the Annual Status Report on air quality inform the development and review of the Air Quality Action Plan which involves the input of colleagues from a number of different services across the council.

SUPPLEMENTARY ADVICE FROM OTHER OFFICERS**Assistant Chief Executive, Governance and Assurance**

30. None sought

Strategic Director of Resources

31. None sought

Other officers

32. This report is for noting, and no advice has been sought from other officers.

APPENDICES

No.	Title
Appendix 1	Air Quality Annual Status Report 2023
Appendix 2	GLA comments on ASR 2023

AUDIT TRAIL

Lead Officer	Head of Regulatory Services	
Report Author	Paul Newman, Environmental Protection Team Leader	
Version	Final	
Dated	29/10/2024	
Key Decision?	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	Comments Sought	Comments Included
Assistant Chief Executive, Governance and Assurance	No	No
Strategic Director of Resources	No	No
Cabinet Member	No	No
Date final report sent to Constitutional Team	31 October 2024	

London Borough of Southwark Air Quality Annual Status Report for 2023

Date of publication: October 2024



This report provides a detailed overview of air quality in Southwark during 2023. It has been produced to meet the requirements of the London Local Air Quality Management (LLAQM) statutory process¹.

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The following amendments to this report were made following an appraisal from Defra and GLA

Page	Table Reference	
17	Table E	Correction of a typo
23	Table G	Insertion of 2021 and 2022 Breathe London NO ₂ Data
28	New Figure	Figure 3 added, showing trend for diffusion tube sites located within Focus Areas
47	Table M	Insertion of 2021 and 2022 Breathe London PM _{2.5} Data
105	Figure 17 Figure 18 Figure 19	Numbering updated to account for new Figure 3 Addition of scale bars and north arrows

¹ LLAQM Policy and Technical Guidance 2019 (LLAQM.TG(19))

Contents

Abbreviations	7
1. Air Quality Monitoring.....	9
1.1 Locations.....	9
1.2 Comparison of Monitoring Results with AQOs	21
1.2.1 Nitrogen Dioxide (NO ₂)	21
Discussion of trends in annual mean NO ₂ at continuous monitors	26
Discussion of trends in annual mean NO ₂ at diffusion tube sites.....	31
Discussion of trends in hourly mean NO ₂	37
1.2.2 Particulate Matter (PM ₁₀)	38
Discussion of Trends in annual mean PM ₁₀	41
Discussion of trends for hourly and 24-hour mean PM ₁₀	45
1.2.3 Particulate Matter (PM _{2.5}).....	46
Discussion of Trends in PM _{2.5} concentrations.....	52
1.2.4 Ozone (O ₃).....	53
Discussion of Trends in O ₃ concentrations	57
2. Action to Improve Air Quality.....	58
3. Planning Update and Other New Sources of Emissions	90
4. Additional Activities to Improve Air Quality.....	94
Appendix A Details of Monitoring Site Quality QA/QC	97
A.1 Automatic Monitoring Sites.....	97
A.2 Diffusion Tubes	97
A.3 Breathe London Sensors.....	99
A.4 Adjustments to the Ratified Monitoring Data	103
Appendix B Full Monthly Diffusion Tube Results for 2023	105
Appendix C Map(s) of Monitoring Locations and AQMAs.....	109
Figure 17 - Map of Southwark's Automatic Monitoring Sites	109
Figure 18 - Map of NO ₂ Diffusion Tubes in Southwark in 2023 showing annual mean NO ₂ concentrations, µg/m ³	110
Figure 19 - Map of Breathe London Sensors in Southwark in 2023 showing annual mean NO ₂ concentrations, µg/m ³	111

Tables

Table A - Summary of National Air Quality Standards and Objectives	7
Table B - Summary of World Health Organisation global air quality guidelines published in 2021	8
Table C - Details of Automatic Monitoring Sites for 2023	10
Table D - Details of Non-Automatic Monitoring Sites for 2023	11
Table E - Details of Selected Breathe London Sensor Monitoring Sites for 2023.....	18
Table F - Annual Mean NO ₂ Ratified Monitoring Results from Automatic Monitoring sites.....	21
Table G - Annual Mean NO ₂ Monitoring Results from Breathe London Sensor Sites	24
Table H - Annual Mean NO ₂ Ratified and Bias-adjusted Monitoring Results from Diffusion Tube Sites	27
Table I - NO ₂ Automatic Monitoring Results: Comparison with 1-hour Mean Objective, Number of 1-Hour Means > 200µg.m ⁻³	33
Table J - Annual Mean PM ₁₀ Automatic Monitoring Results (µg.m ⁻³).....	38
Table K - PM ₁₀ Automatic Monitoring Results: Comparison with 24-Hour Mean Objective, Number of PM ₁₀ 24-Hour Means > 50 µg.m ⁻³	42
Table L - Annual Mean PM _{2.5} Automatic Monitoring Results (µg.m ⁻³).....	46
Table M - Annual Mean PM _{2.5} Monitoring Results from Breathe London Sensor Sites	50
Table N - O ₃ Automatic Monitoring Results: Comparison with Objective, Daily maximum 8-hour running mean > 100 µg.m ⁻³	53
Table O - Declared Air Quality Management Areas	59
Table P - Delivery of Air Quality Action Plan Measures	61
Table Q - Planning requirements met by planning applications Southwark Council in 2023	90
Table R - Factors from Local Co-location Studies	100
Table S - Bias Adjustment Factor	102
Table T - Short-Term to Long-Term Monitoring Data Adjustment of Southwark Nitrogen Dioxide Diffusion Data	104
Table U - Short-Term to Long-Term Monitoring Data Adjustment of Southwark Continuous Monitoring data – PM10.....	104
Table V - NO ₂ Fall off With Distance Calculations	104
Table W - NO ₂ 2023 Diffusion Tube Results (µg.m ⁻³).....	105

Figures

Figure 1 - Trend in Annual Mean NO ₂ Concentrations at Southwark's Existing Air Quality Monitoring Stations, 2017 – 2023	22
Figure 2 - Trend in annual mean NO ₂ concentrations at Southwark's existing and past continuous air quality monitoring stations, 2000 - 2023	23
Figure 3 - Trend in annual mean NO ₂ concentrations at Southwark's diffusion tube sites within Air Quality Focus Areas, 2017 - 2023.....	31
Figure 4 - Hourly NO ₂ Concentrations at Southwark's Continuous Air Quality Monitoring Stations: Comparison with 1-Hour Mean Objective	34
Figure 5 - Time-varied NO ₂ Concentrations at Southwark's Continuous Air Quality Monitoring Stations in 2023.....	35
Figure 6 – 1-hour NO ₂ Concentrations at Breathe London Sensor Sites in 2023	36
Figure 7 - Trend in Annual Mean PM ₁₀ Concentrations at Southwark's Existing Air Quality Monitoring Stations, 2017 – 2023	39
Figure 8 - Trend in Annual Mean PM ₁₀ Concentrations at Southwark's Existing and Past Air Quality Monitoring Stations, 2000 – 2023	40
Figure 9 – 24-hour PM ₁₀ Concentrations at Southwark's Continuous Air Quality Monitoring Stations: Comparison with 24-Hour Mean Objective	43
Figure 10 - Time-varied PM ₁₀ Concentrations at Southwark's Continuous Air Quality Monitoring Stations in 2023.....	44
Figure 11 - Trend in Annual Mean PM _{2.5} concentrations at Southwark's Existing Air Quality Monitoring Stations, 2017 – 2023	47
Figure 12 – 1-Hour PM _{2.5} Concentrations at Southwark's Continuous Air Quality Monitoring Stations.....	48
Figure 13 - Time-varied PM _{2.5} Concentrations at Southwark's Continuous Air Quality Monitoring Stations.....	49
Figure 14 – 1-Hour PM _{2.5} Concentrations at Breathe London Sensor Sites in 2023.....	51
Figure 15 - Trend in Annual Mean O ₃ Concentrations at Southwark's Existing Air Quality Monitoring Station, 2017 – 2023.....	54
Figure 16 - Trend in Annual Mean O ₃ Concentrations at Southwark's Existing And Past Air Quality Monitoring Stations, 2000 – 2023	55
Figure 17 – Daily Maximum 8-Hour Running Mean O ₃ Concentrations at Southwark's Continuous Air Quality Monitoring Station in 2023	56
Figure 18 - Map of Southwark's Automatic Monitoring Sites.....	109

Figure 19 - Map of NO ₂ Diffusion Tubes in Southwark in 2023 showing annual mean NO ₂ concentrations, µg/m ³	110
Figure 20 - Map of Breathe London Sensors in Southwark in 2023 showing annual mean NO ₂ concentrations, µg/m ³	111

Abbreviations

Abbreviation	Description
AQAP	Air Quality Action Plan
AQMA	Air Quality Management Area
AQMS	Air Quality Monitoring Station
AQO	Air Quality Objective
BEB	Buildings Emission Benchmark
BL	Breathe London
CAB	Cleaner Air Borough
CO _{2e}	Carbon Dioxide Equivalent
EPT	Environmental Protection Team
EV	Electric Vehicle
FA	(Air Quality) Focus Area
GLA	Greater London Authority
LAEI	London Atmospheric Emissions Inventory
LAQM	Local Air Quality Management
LBS	London Borough of Southwark
LLAQM	London Local Air Quality Management
NRMM	Non-Road Mobile Machinery
PM ₁₀	Particulate matter less than 10 micron in diameter
PM _{2.5}	Particulate matter less than 2.5 micron in diameter
TEB	Transport Emissions Benchmark
TfL	Transport for London

Table A - Summary of National Air Quality Standards and Objectives

Pollutant	Standard / Objective (UK)	Averaging Period	Date ⁽¹⁾
Nitrogen dioxide (NO ₂)	200 µg.m ⁻³ not to be exceeded more than 18 times a year	1-hour mean	31 Dec 2005
Nitrogen dioxide (NO ₂)	40 µg.m ⁻³	Annual mean	31 Dec 2005
Particles (PM ₁₀)	50 µg.m ⁻³ not to be exceeded more than 35 times a year	24-hour mean	31 Dec 2004
Particles (PM ₁₀)	40 µg.m ⁻³	Annual mean	31 Dec 2004

Pollutant	Standard / Objective (UK)	Averaging Period	Date ⁽¹⁾
Particles (PM _{2.5})	20 µg.m ⁻³	Annual mean	2020
Particles (PM _{2.5})	Target of 15% reduction in concentration at urban background locations	3-year mean	Between 2010 and 2021
Sulphur dioxide (SO ₂)	266 µg.m ⁻³ not to be exceeded more than 35 times a year	15-minute mean	31 Dec 2005
Sulphur dioxide (SO ₂)	350 µg.m ⁻³ not to be exceeded more than 24 times a year	1-hour mean	31 Dec 2004
Sulphur dioxide (SO ₂)	125 µg.m ⁻³ not to be exceeded more than 3 times a year	24-hour mean	31 Dec 2004

Notes:

(1) Date by which to be achieved by and maintained thereafter.

Table B - Summary of World Health Organisation global air quality guidelines published in 2021².

Pollutant	Standard / Objective (UK)	Averaging Period
Nitrogen dioxide (NO ₂)	200 µg.m ⁻³	1-hour
Nitrogen dioxide (NO ₂)	10 µg.m ⁻³	Annual
Particles (PM ₁₀)	45 µg.m ⁻³	24-hour
Particles (PM ₁₀)	15 µg.m ⁻³	Annual
Particles (PM _{2.5})	5 µg.m ⁻³	Annual
Particles (PM _{2.5})	15 µg.m ⁻³	24-hour
Sulphur dioxide (SO ₂)	40 µg.m ⁻³	24-hour

Note:

The Guideline values in **Table B** are currently not mandatory and are not required to be achieved in order to comply with UK legislation. The values identified in **Table B** are based on extensive research into the health effects of poor air quality.

² World Health Organization (2021). WHO global air quality guidelines: particulate matter (PM_{2.5} and PM₁₀), ozone, nitrogen dioxide, sulphur dioxide and carbon monoxide. World Health Organization. <https://apps.who.int/iris/handle/10665/345329>. License: CC BY-NC-SA 3.0 IGO

1. Air Quality Monitoring

1.1 Locations

In 2023, Southwark had six automatic air quality monitoring stations. Further details of these stations are provided in **Table C**. Two of the automatic monitoring stations are located in air quality Focus Areas; the location of the stations are shown in **Figure 17** in **Appendix C**. Southwark also has an extensive network of diffusion tubes monitoring NO₂. Spread throughout the borough there are 89 diffusion tubes at 85 sites across Southwark³. **Table D** provides the location information of Southwark Council's diffusion tube network.

Figure 18 in **Appendix C** shows the locations of the NO₂ diffusion tubes. As the Southwark's Air Quality Management Area (AQMA) has been extended to cover the whole borough, all the monitoring sites are within the AQMA. In 2023 one site was removed from the survey – it was SDT 162 at East Dulwich Primary School – the site was replaced by a Breathe London monitor.

This report also presents data from a network of Breathe London sensors, for those sites which achieved data capture of above 70%. Locations of the monitors are shown in **Table E and Figure 19**. These monitors provide indicative results only, and cannot be used to evaluate compliance with air quality objectives.

³ Two AQMS sites have three co-located NO₂ tubes: Elephant & Castle, and Old Kent Road. The remaining diffusion tube is used as a 'travel blank' necessary for accurate analysis.

Table C - Details of Automatic Monitoring Sites for 2023

Site ID	Site Name	Site Type	X (m)	Y (m)	Pollutants monitored	In Southwark AQMA?	Monitoring technique	Distance to Relevant Exposure (m) ⁽¹⁾	Distance to kerb of nearest road (m) ⁽²⁾	Inlet height (m)
SK5	Old Kent Road	Roadside	534844	177515	NO _x , NO ₂ , PM ₁₀	Yes	Chemiluminescence and BAM	1	5	2.0
SK6	Elephant & Castle	Urban Background	531884	178835	NO _x , NO ₂ , O ₃ , PM ₁₀ & PM _{2.5}	Yes	Chemiluminescence, UV Absorption & FIDAS	10	35	3.5
SK8	Tower Bridge Road	Roadside	533488	179804	NO _x , NO ₂ , PM ₁₀ & PM _{2.5}	Yes	Chemiluminescence & FIDAS	7	4	1.7
SK9	Old Kent Road	Roadside	534844	177515	PM ₁₀ , & PM _{2.5}	Yes	FIDAS	1	5	2.0
SKA	Lower Road	Roadside	535272	179331	NO _x , NO ₂ , PM ₁₀ & PM _{2.5}	Yes	Chemiluminescence & FIDAS	7	4	1.7
SKB	Vicarage Grove	Roadside	532904	176694	NO _x , NO ₂ , PM ₁₀ & PM _{2.5}	Yes	Chemiluminescence & FIDAS	0	3	4
SKC	South Circular Road	Roadside	533698	173268	NO _x , NO ₂ , PM ₁₀ & PM _{2.5}	Yes	Chemiluminescence & FIDAS	17	3	4

Notes:

(1) 0m if the monitoring site is at a location of exposure (e.g. installed on the façade of a residential property).

(2) N/A if not applicable

Table D - Details of Non-Automatic Monitoring Sites for 2023

Diffusion Tube ID	Site Name	Site Type	X OS Grid Ref (Easting)	Y OS Grid Ref (Northing)	Pollutants Monitored	In AQMA? Which AQMA?	Distance to Relevant Exposure (m)	Distance to Kerb of Nearest Road (m)	Tube Co-located with a Continuous Analyser	Height (m)
SDT 1, SDT 2, SDT 3	Co - location Tube at Roadside Air Quality Monitoring Site Old Kent Road - Tube 3	Roadside	534849	177512	NO2	Southwark AQMA	1.0	5.0	Yes	2.5
SDT 4	Lamppost (141-02) Rotherhithe Old Road SE16	Kerbside	535675	178796	NO2	Southwark AQMA	2.0	0.5	No	2.5
SDT 5	Lamppost (180 - 31) Drummond Road SE16	Kerbside	534640	179336	NO2	Southwark AQMA	6.0	0.5	No	2.5
SDT 6	Lamppost (2330 - 37) adjacent to 168 Queens Road	Kerbside	535253	176679	NO2	Southwark AQMA	14.0	0.5	No	2.5
SDT 7	Lamppost (Unmarked) adjacent to 167A Rye Lane SE5	Kerbside	534333	176155	NO2	Southwark AQMA	2.0	0.5	No	2.5
SDT 8	Lamppost (2051 - 11) Dunstons Road adjacent to 215 Underhill Road	Kerbside	534553	174263	NO2	Southwark AQMA	8.0	0.5	No	2.5
SDT 9	Lamppost 05-35 Dulwich Common adjacent to 23 Hambledon Place	Kerbside	533470	173204	NO2	Southwark AQMA	3.0	0.5	No	2.5
SDT 10	Lamppost (2076 - L02) adjacent to 2 Village Way	Kerbside	532940	174392	NO2	Southwark AQMA	13.0	0.5	No	2.5
SDT 11	Post adjacent to 11 Camberwell Church Street	Kerbside	532663	176740	NO2	Southwark AQMA	2.0	0.5	No	2.5
SDT 12, SDT 13, SDT 14	Co - location Tube at Background Air Quality Monitoring Site Elephant & Castle - Tube 3	Urban Centre	531884	178836	NO2	Southwark AQMA	10.0	35.0	Yes	2.5
SDT 15	Lamppost (1390 - 58) Blackfriars Road	Kerbside	531641	180290	NO2	Southwark AQMA	3.0	0.5	No	2.5

Diffusion Tube ID	Site Name	Site Type	X OS Grid Ref (Easting)	Y OS Grid Ref (Northing)	Pollutants Monitored	In AQMA? Which AQMA?	Distance to Relevant Exposure (m)	Distance to Kerb of Nearest Road (m)	Tube Co-located with a Continuous Analyser	Height (m)
SDT 18	Tower Bridge Lamppost No1 East side	Roadside	533599	180062	NO2	Southwark AQMA	3.0	0.5	No	2.5
SDT 20	Tower Bridge school fence Tower Bridge Road East side	Kerbside	533520	179849	NO2	Southwark AQMA	0.5	2.5	No	2.5
SDT 24	Opposite Papa Johns west side - Lamppost 40	Kerbside	533444	179620	NO2	Southwark AQMA	3.0	0.5	No	2.5
SDT 29	Opposite Haddon Hall, west side	Kerbside	533105	179117	NO2	Southwark AQMA	2.0	0.5	No	2.5
SDT 31	Bricklayers Arms Roundabout - by St Olave's School, west side	Kerbside	532937	179043	NO2	Southwark AQMA	10.0	0.5	No	2.5
SDT 37	Wansey Street Lamppost	Kerbside	532340	178711	NO2	Southwark AQMA	10.0	0.5	No	2.5
SDT 38	Walworth Road opposite junction to Elephant Road - west side	Kerbside	532074	178825	NO2	Southwark AQMA	2.0	0.5	No	2.5
SDT 39	New Kent Road Lamppost 3 North Side (Metro Centre)	Kerbside	532053	179070	NO2	Southwark AQMA	10.0	0.5	No	2.5
SDT 41	New Kent Road Lamppost 29 Northside (Rodney Place)	Kerbside	532390	178974	NO2	Southwark AQMA	20.0	0.5	No	2.5
SDT 42	Peters Hills with St Mary's and St Paul's C of E Primary School - Salter Road	Kerbside	536037	180341	NO2	Southwark AQMA	10.0	0.5	No	2.5
SDT 48	Adjacent to Beechwood Court, 3 Crystal Palace Parade	Kerbside	533912	171366	NO2	Southwark AQMA	20.0	0.5	No	2.5
SDT 49	Lamppost 129-08 Lynton Road (west)	Kerbside	533873	178592	NO2	Southwark AQMA	10.0	0.5	No	2.5

Diffusion Tube ID	Site Name	Site Type	X OS Grid Ref (Easting)	Y OS Grid Ref (Northing)	Pollutants Monitored	In AQMA? Which AQMA?	Distance to Relevant Exposure (m)	Distance to Kerb of Nearest Road (m)	Tube Co-located with a Continuous Analyser	Height (m)
SDT 52	Kingsdale Foundation School Alleyn Park SE22	Kerbside	533150	172123	NO2	Southwark AQMA	10.0	0.5	No	2.5
SDT 53	Lamppost (2074 - 25) adjacent to Edward Alleyn Club, Burbage Road	Kerbside	532668	173998	NO2	Southwark AQMA	10.0	0.5	No	2.5
SDT 54	Lamppost 11 Camberwell Grove	Kerbside	532951	176417	NO2	Southwark AQMA	10.0	0.5	No	2.5
SDT 55	Lamppost 11A St Georges Way (South Side)	Kerbside	533350	177603	NO2	Southwark AQMA	3.0	0.5	No	2.5
SDT 57	Notre Dame RC School	Kerbside	531531	179256	NO2	Southwark AQMA	5.0	0.5	No	2.5
SDT 61	Junction of Brunel Road and Rupack Street	Kerbside	535176	179665	NO2	Southwark AQMA	3.0	0.5	No	2.5
SDT 66	Adjacent to Prince of Orange Lower Road	Kerbside	535384	179161	NO2	Southwark AQMA	3.0	0.5	No	2.5
SDT 77	Adjacent to steps to Park Street on Southwark Bridge Road	Kerbside	532294	180406	NO2	Southwark AQMA	10.0	0.5	No	2.5
SDT 81	Lamppost No 02 Borough High Street	Kerbside	532690	180212	NO2	Southwark AQMA	3.0	0.5	No	2.5
SDT 82	Lamppost no 01 Adjacent to 125 Borough High Street	Kerbside	532572	180029	NO2	Southwark AQMA	3.0	0.5	No	2.5
SDT 84	Little Dorritt Park Entrance Lamppost No 8	Kerbside	532487	179850	NO2	Southwark AQMA	5.0	0.5	No	2.5
SDT 87	Lamppost 0139-43 188A Lower Road	Kerbside	535795	178828	NO2	Southwark AQMA	3.0	0.5	No	2.5
SDT 88	Lamppost (52) Jamaica Road	Kerbside	534457	179454	NO2	Southwark AQMA	5.0	0.5	No	2.5

Diffusion Tube ID	Site Name	Site Type	X OS Grid Ref (Easting)	Y OS Grid Ref (Northing)	Pollutants Monitored	In AQMA? Which AQMA?	Distance to Relevant Exposure (m)	Distance to Kerb of Nearest Road (m)	Tube Co-located with a Continuous Analyser	Height (m)
SDT 89	School Fence St James' CoE Primary School Jamaica Road	Roadside	534241	179435	NO2	Southwark AQMA	0.5	2.0	No	2.5
SDT 90	Lamppost adjacent to 375 Old Kent Road	Kerbside	533800	178220	NO2	Southwark AQMA	5.0	0.5	No	2.5
SDT 91	Lampost adjacent to 221 Old Kent Road	Kerbside	533379	178556	NO2	Southwark AQMA	3.0	0.5	No	2.5
SDT 92	School Fence Ilderton Road SE16	Roadside	535222	178032	NO2	Southwark AQMA	0.5	2.0	No	2.5
SDT 93	Lamppost No 9 adjacent to 14 Hanover Park	Roadside	534243	176558	NO2	Southwark AQMA	2.0	0.5	No	2.5
SDT 95	Junction of Eynella Road & Court Lane Lamppost 2591 - 09	Kerbside	533700	173892	NO2	Southwark AQMA	2.0	0.5	No	2.5
SDT 97	Barry Road	Kerbside	533940	173998	NO2	Southwark AQMA	5.0	0.5	No	2.5
SDT 98	South Circular Road Junction with Underhill Road	Kerbside	534503	173251	NO2	Southwark AQMA	9.0	0.5	No	2.5
SDT 100	Post adjacent to 1d Calton Avenue	Kerbside	533159	174191	NO2	Southwark AQMA	2.0	0.5	No	2.5
SDT 101	Lampost 307 - 19 adjacent to 91 Herne Hill	Kerbside	532303	174756	NO2	Southwark AQMA	5.0	0.5	No	2.5
SDT 102	Lamppost (No1) De Crespigny Park	Kerbside	532599	176277	NO2	Southwark AQMA	5.0	0.5	No	2.5
SDT 103	Lamppost (369 - L07) Coldharbour Lane	Kerbside	532471	176388	NO2	Southwark AQMA	15.0	0.5	No	2.5
SDT 104	Lamppost (8) Newington Butts	Kerbside	531835	178686	NO2	Southwark AQMA	15.0	0.5	No	2.5

Diffusion Tube ID	Site Name	Site Type	X OS Grid Ref (Easting)	Y OS Grid Ref (Northing)	Pollutants Monitored	In AQMA? Which AQMA?	Distance to Relevant Exposure (m)	Distance to Kerb of Nearest Road (m)	Tube Co-located with a Continuous Analyser	Height (m)
SDT 105	Lamppost (2229 - L41) adjacent to Oliver Goldsmith School Southampton Way	Kerbside	533592	176851	NO2	Southwark AQMA	0.5	0.5	No	2.5
SDT 106	Post adjacent to 80 Camberwell Road	Kerbside	532409	177597	NO2	Southwark AQMA	18.0	0.5	No	2.5
SDT 107	Lamppost (1065 - L45) adjacent to 351 Walworth Road	Kerbside	532426	178051	NO2	Southwark AQMA	10.0	0.5	No	2.5
SDT 111	Lamppost 31A - 239 Walworth Road	Kerbside	532294	178354	NO2	Southwark AQMA	5.0	0.5	No	2.5
SDT 112	Adjacent to 3 West Square on Parking Sign	Kerbside	531621	179112	NO2	Southwark AQMA	3.0	0.5	No	2.5
SDT 113	Lamppost adjacent to 43 Westminster Bridge Road	Kerbside	531481	179421	NO2	Southwark AQMA	7.0	0.5	No	2.5
SDT 114	Lamppost No 1 Goose Green / East Dulwich Road	Kerbside	533799	175324	NO2	Southwark AQMA	10.0	0.5	No	2.5
SDT 132	Lamppost 2732 - 01 adjacent to 117 - 125 Rye Lane	Kerbside	534237	176363	NO2	Southwark AQMA	5.0	0.5	No	2.5
SDT 136	Lamppost (2160 - L12) adjacent to Dog Kennel Hill School	Kerbside	533232	175775	NO2	Southwark AQMA	10.0	0.5	No	2.5
SDT 137	Lamppost (2136 - L18) at the t-junction adjacent to Champion Hill	Kerbside	532988	175570	NO2	Southwark AQMA	10.0	0.5	No	2.5
SDT 138	Lamppost (2127 - L11) Pytchley Road	Kerbside	533364	175561	NO2	Southwark AQMA	8.0	0.5	No	2.5
SDT 139	Lamppost (2139 - L29) Grove Lane	Kerbside	533030	176022	NO2	Southwark AQMA	4.5	0.5	No	2.5

Diffusion Tube ID	Site Name	Site Type	X OS Grid Ref (Easting)	Y OS Grid Ref (Northing)	Pollutants Monitored	In AQMA? Which AQMA?	Distance to Relevant Exposure (m)	Distance to Kerb of Nearest Road (m)	Tube Co-located with a Continuous Analyser	Height (m)
SDT 140	Post near the Dog Kennel Hill school entrance on Dog Kennel Hill	Kerbside	533221	175715	NO2	Southwark AQMA	3.0	0.5	No	2.5
SDT 142	Lamppost 2640L05 Cheltenham Road	Kerbside	535321	175023	NO2	Southwark AQMA	11.0	0.5	No	2.5
SDT 143	Lamppost 005 adjacent to 34A Sydenham Hill	Kerbside	534540	172387	NO2	Southwark AQMA	26.0	0.5	No	2.5
SDT 144	Lamppost 2087L04 Dulwich Wood Park	Kerbside	533328	171601	NO2	Southwark AQMA	27.0	0.5	No	2.5
SDT 145	Lamppost 2544L08 Croxted Road	Kerbside	532768	172732	NO2	Southwark AQMA	16.0	0.5	No	2.5
SDT 146	Lamppost 423-23 Croxted Road	Kerbside	532486	173535	NO2	Southwark AQMA	5.5	0.5	No	2.5
SDT 147	Lamppost (1515 - L13) John Ruskin Street	Kerbside	532230	177756	NO2	Southwark AQMA	7.0	0.5	No	2.5
SDT 148	Lamppost (1515 - L38) John Ruskin Street	Kerbside	532002	177578	NO2	Southwark AQMA	21.0	0.5	No	2.5
SDT 149	Lamppost 1436L03 Kennington Park Place	Kerbside	531479	177990	NO2	Southwark AQMA	21.5	0.5	No	2.5
SDT 150	Lamppost 2302L14 Albany Road	Kerbside	533522	178187	NO2	Southwark AQMA	36.0	0.5	No	2.5
SDT 151	Junction of Townley Road & Lordship Lane Lamppost (2300 - 01)	Kerbside	533660	174480	NO2	Southwark AQMA	5.0	0.5	No	2.5
SDT 152	Lamppost (2300 - L19) Townley Road	Kerbside	533245	174655	NO2	Southwark AQMA	14.0	0.5	No	2.5
SDT 153	Lamppost (2292 - 27) Dulwich Village	Kerbside	533123	173780	NO2	Southwark AQMA	2.8	0.5	No	2.5

Diffusion Tube ID	Site Name	Site Type	X OS Grid Ref (Easting)	Y OS Grid Ref (Northing)	Pollutants Monitored	In AQMA? Which AQMA?	Distance to Relevant Exposure (m)	Distance to Kerb of Nearest Road (m)	Tube Co-located with a Continuous Analyser	Height (m)
SDT 154	Lamppost (1125 - L37) Portland Street	Kerbside	532836	177844	NO2	Southwark AQMA	5.0	0.5	No	2.5
SDT 155	Junction of East Street / Portland Street	Kerbside	532597	178433	NO2	Southwark AQMA	7.5	0.5	No	2.5
SDT 156	Junction of Stead Street / Flint Street	Kerbside	532643	178677	NO2	Southwark AQMA	5.0	0.5	No	2.5
SDT 157	Lamppost (1027 - L03) adjacent to Braganza Street	Kerbside	531648	178257	NO2	Southwark AQMA	3.0	0.5	No	2.5
SDT 158	Lamp Conduit Adjacent to Arch 12 Angel Lane	Kerbside	532195	178276	NO2	Southwark AQMA	3.0	0.1	No	2.5
SDT 159	Lamp Conduit Adjacent to Arch 4 Angel Lane	Kerbside	532167	178336	NO2	Southwark AQMA	3.0	0.1	No	2.5
SDT 160	Lamppost 423-44 Croxted Road	Kerbside	532202	173907	NO2	Southwark AQMA	4.0	0.5	No	2.5
SDT 161	Lamppost 2120-02 adjacent to 8 East Dulwich Grove	Kerbside	533771	175173	NO2	Southwark AQMA	3.0	0.5	No	2.5
SDT 162	On the southern downpipe at Harris East Dulwich Primary School, Lordship Lane	Kerbside	533737	174679	NO2	Southwark AQMA	0.0	5.5	No	2.5
SDT 163	Camberwell New Road	Kerbside	532025	177057	NO2	Southwark AQMA	6.0	0.5	No	2.5
SDT 164	Wyndham Road	Kerbside	532087	177193	NO2	Southwark AQMA	6.5	0.5	No	2.5

Table E - Details of Selected Breathe London Sensor Monitoring Sites for 2023

Site ID	Site Name	Site Type	X (m)	Y (m)	Pollutants monitored	In Southwark AQMA?	Distance to Relevant Exposure (m) ⁽¹⁾	Distance to kerb of nearest road (m) ⁽²⁾	Inlet height (m)	Site Description
CLDP0037	Charlotte Sharman Primary School	Urban Background	531602	179165	NO ₂ & PM _{2.5}	Yes	0	29	2.7	Elephant and Castle area.
CLDP0022	Elephant & Castle (reference co-location)	Urban Background	531884	178835	NO ₂ & PM _{2.5}	Yes	N/A	43	2.5	Co-located with AQMS analysers.
CLDP0323	Elm Lodge Surgery	Roadside	532384	174290	NO ₂ & PM _{2.5}	Yes	N/A	5	4.2	The node is near the entrance of the surgery to assess the exposure of patients and staff visiting the surgery.
CLDP0080	Guy's Hospital	Roadside	532820	179990	NO ₂ & PM _{2.5}	Yes	0	2	3.5	A hospital site.
CLDP0448	Harris Primary Academy, East Dulwich	Roadside	533740	174682	NO ₂ & PM _{2.5}	Yes	0	5	3.0	A school site.
CLDP0384	Imperial War Museum	Urban Background	531357	179067	NO ₂ & PM _{2.5}	Yes	0	60	Tbc	This sensor unit is installed on the southern perimeter of the Imperial War Museum. It is part of the Breathe London Cultural Network sponsored by Bloomberg Philanthropies.

473

18

Site ID	Site Name	Site Type	X (m)	Y (m)	Pollutants monitored	In Southwark AQMA?	Distance to Relevant Exposure (m) ⁽¹⁾	Distance to kerb of nearest road (m) ⁽²⁾	Inlet height (m)	Site Description
CLDP0175	London Wildlife Trust Centre For Wildlife Gardening	Urban Background	533799	175517	NO ₂ & PM _{2.5}	Yes	N/A	40	3.2	This is one of nine Nodes deployed at locations which are expected to have low pollution levels, but which are representative of large areas around them.
CLDP0357	Maudsley Hospital	Roadside	532618	176191	NO ₂ & PM _{2.5}	Yes	8	2	3	Maudsley monitor is 2m away from main road and near outpatients main entrance
CLDP0078	Oliver Goldsmith Primary School	Urban Background	533572	176787	NO ₂ & PM _{2.5}	Yes	0	11	2.4	Located between Peckham and Camberwell
CLDP0108	SWK-BL1 : Croxted Road / Guernsey Grove	Roadside	532183	173962	NO ₂ & PM _{2.5}	Yes	10	0.5	2.5	This Node is located in a residential area to monitor the air quality on a boundary road of L.B. Southwark and L.B. Lambeth Low Traffic Neighbourhood opposite Guernsey Grove

Site ID	Site Name	Site Type	X (m)	Y (m)	Pollutants monitored	In Southwark AQMA?	Distance to Relevant Exposure (m) ⁽¹⁾	Distance to kerb of nearest road (m) ⁽²⁾	Inlet height (m)	Site Description
CLDP0107	SWK-BL2 : Croxted Road/Dalkeith Road	Roadside	532473	173581	NO ₂ & PM _{2.5}	Yes	6	0.5	2.5	This Node is located in a residential area to monitor the air quality on a boundary road of L.B. Southwark and L.B. Lambeth Low Traffic Neighbourhood opposite Dalkeith Road
CLDP0042	Tower Bridge Primary School	Roadside	533531	179864	NO ₂ & PM _{2.5}	Yes	0	3.4	2.3	It is located next to Tower Bridge.

1.2 Comparison of Monitoring Results with AQOs

1.2.1 Nitrogen Dioxide (NO₂)

Table F - Annual Mean NO₂ Ratified Monitoring Results from Automatic Monitoring sites

Site ID	Site type	Valid data capture for monitoring period % ^(a)	Valid data capture 2023 % ^(b)	2017	2018	2019	2020	2021	2022	2023
SK5	Automatic	97.4	97.4	42.4	40.6	38.0	25 ^a	28.5	26.2	24.2
SK6	Automatic	78.9	78.9	34.1	32.0	30.4	21.2	22.8	21.9	20.0
SK8	Automatic	99.4	99.4	-	-	-	29.9	31 ^a	29.9	29.1
SKA	Automatic	90.7	90.7	-	-	-	-	27.9	26 ^a	26.6
SKB	Automatic	96.3	96.3					40.4	32.4	30.8
SKC	Automatic	95.0	95.0					28 ^a	25.8	25.9

Notes:

The annual mean concentrations are presented as µg m⁻³.

Exceedances of the NO₂ annual mean AQO of 40 µg m⁻³ are shown in **bold**.

NO₂ annual means in excess of 60 µg m⁻³, indicating a potential exceedance of the NO₂ hourly mean AQS objective are shown in **bold and underlined**.

Means for diffusion tubes have been corrected for bias.

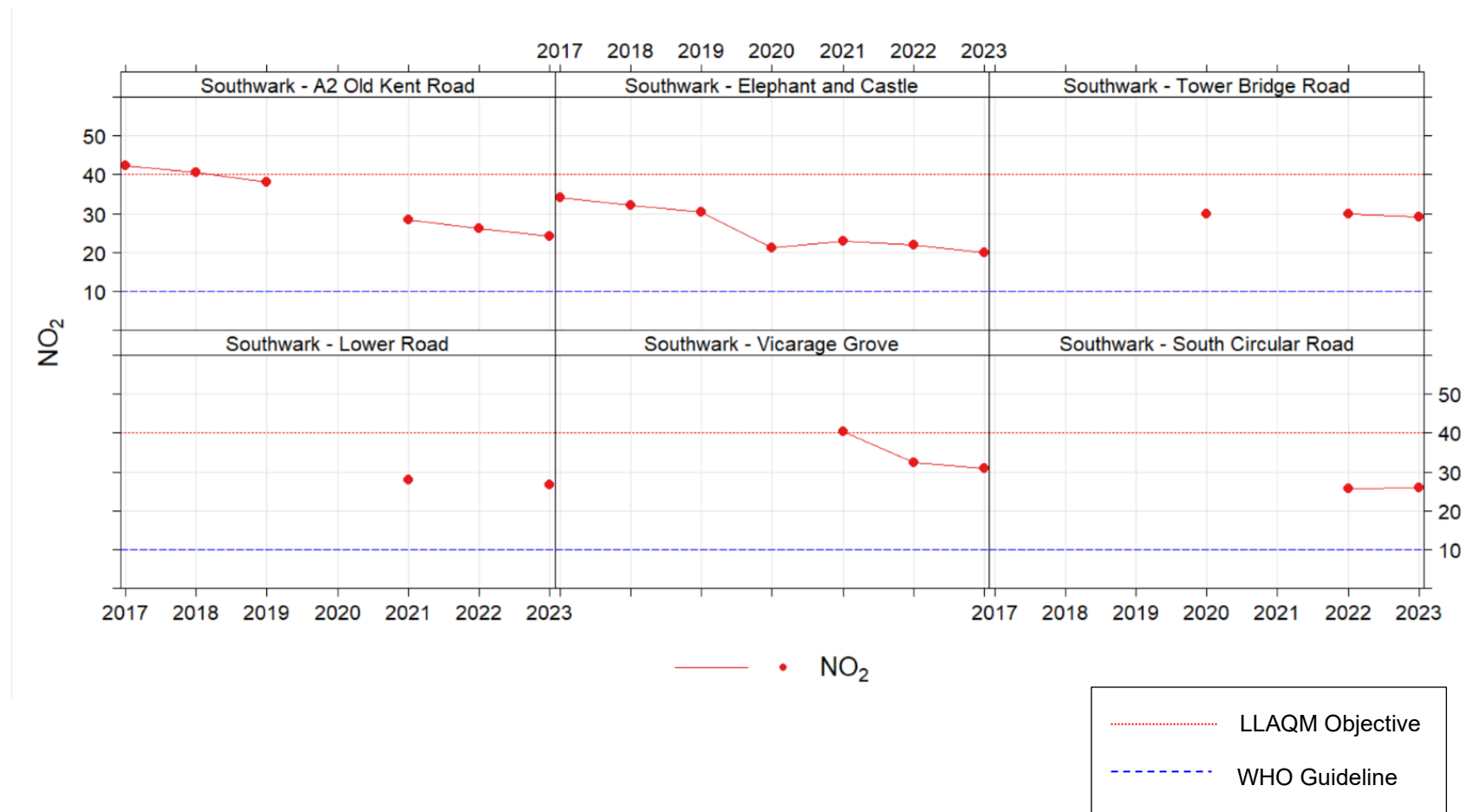
^a All means have been “annualised” in accordance with LLAQM Technical Guidance if valid data capture for the calendar year is less than 75% and greater than 25%. See **Appendix A** for details.

Concentrations are those at the location of monitoring and not those following any fall-off with distance adjustment.

(a) Data capture for the monitoring period, in cases where monitoring was only carried out for part of the year.

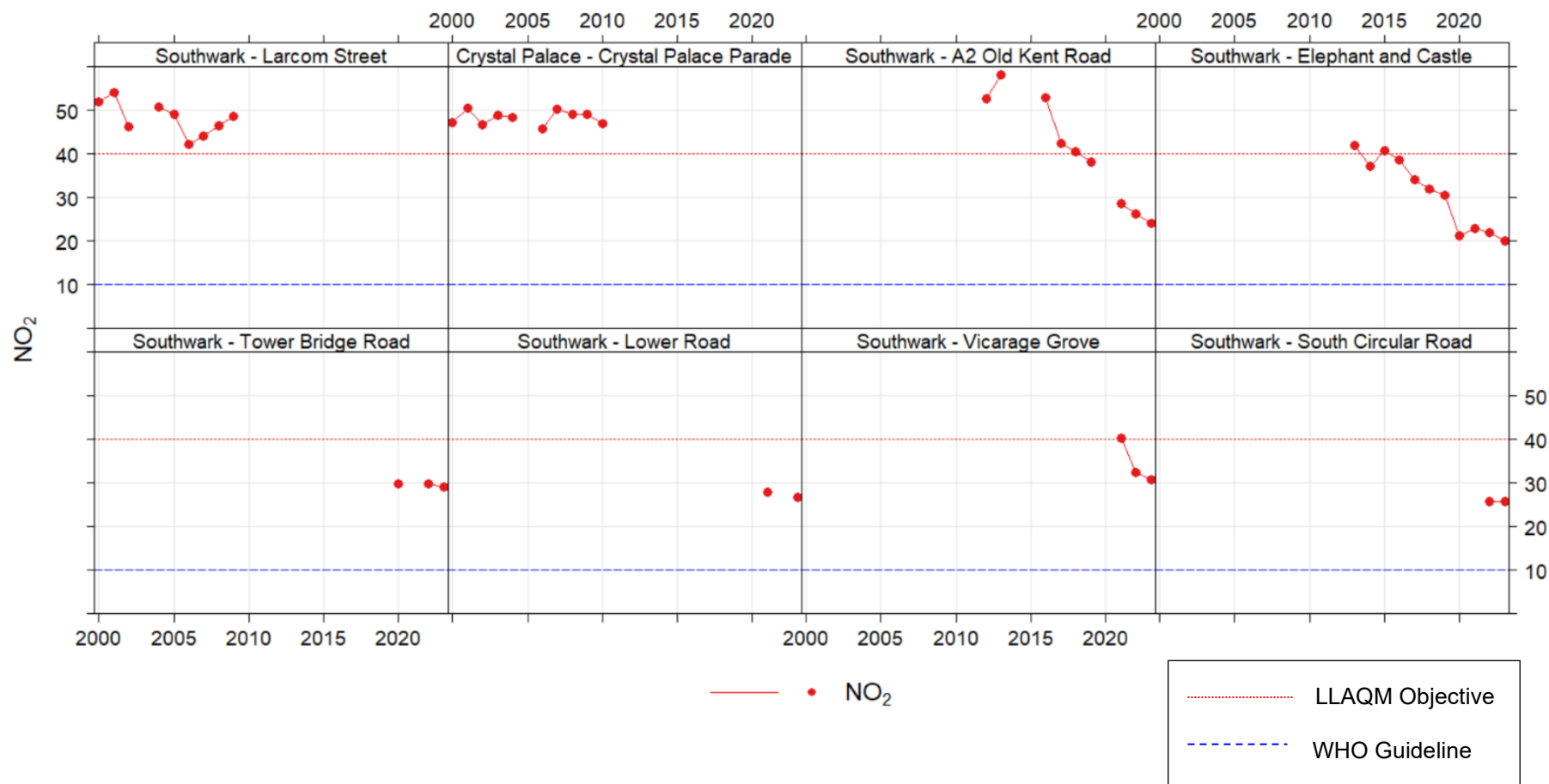
(b) Data capture for the full calendar year (e.g. if monitoring was carried out for six months the maximum data capture for the full calendar year would be 50%).

Figure 1 - Trend in Annual Mean NO₂ Concentrations at Southwark's Existing Air Quality Monitoring Stations, 2017 – 2023



Note: Means below 75% data capture for the calendar year have been excluded from graph.

Figure 2 - Trend in annual mean NO₂ concentrations at Southwark's existing and past continuous air quality monitoring stations, 2000 - 2023



Note: Means below 75% data capture for the calendar year have been excluded from graph.

Table G - Annual Mean NO₂ Monitoring Results from Breathe London Sensor Sites

Site ID	Site Name	Site type	Monitoring Method	Valid data capture 2023 % ^(a)	2021	2022	2023
CLDP0037	Charlotte Sharman Primary School	Urban Background	Sensor	99	25.9	25.6	23.0
CLDP0022	Elephant & Castle (reference co-location)	Urban Background	Sensor	95	21.7	20.9	19.1
CLDP0323	Elm Lodge Surgery	Roadside	Sensor	98		25.7	24.0
CLDP0080	Guy's Hospital	Roadside	Sensor	99	25.5 (73%)	26.4	23.6
CLDP0448	Harris Primary Academy, East Dulwich	Roadside	Sensor	73			23.4
CLDP0384	Imperial War Museum	Urban Background	Sensor	97		29 (4%)	32.3
CLDP0175	London Wildlife Trust Centre For Wildlife Gardening	Urban Background	Sensor	98	22.3 (51%)	22.4	19.9
CLDP0357	Maudsley Hospital	Roadside	Sensor	95		35.3 (27%)	30.5
CLDP0078	Oliver Goldsmith Primary School	Urban Background	Sensor	97	27.0	26.7	23.6
CLDP0108	SWK-BL1 : Croxted Road / Guernsey Grove	Roadside	Sensor	98	26.0 (66%)	26.7	24.4
CLDP0107	SWK-BL2 : Croxted Road/Dalkeith Road	Roadside	Sensor	99	25.9 (42%)	27.3	28.4
CLDP0042	Tower Bridge Primary School	Roadside	Sensor	98	32.4	34.3	30.1

Notes:

These results are indicative only.

The annual mean concentrations are presented as µg m⁻³. Means are yearly averages and have not been “annualised”.

Concentrations are those at the location of monitoring and not those following any fall-off with distance adjustment.

Exceedances of the NO₂ annual mean AQO of 40 µg m⁻³ are shown in **bold**.

NO₂ annual means in excess of 60 µg m⁻³, indicating a potential exceedance of the NO₂ hourly mean AQS objective are shown in **bold and underlined**.

If the data capture for the year is less than 75% in 2021 or 2022, the data capture is shown in the brackets adjacent to the annual mean.

(a) Data capture for the full calendar year (e.g. if monitoring was carried out for six months the maximum data capture for the full calendar year would be 50%).

Discussion of trends in annual mean NO₂ at continuous monitors

The Council monitored NO₂ continuously at six locations during 2023. **Table F** compares the ratified and adjusted monitored NO₂ annual mean concentrations for the years 2017-2023 with the air quality objective of 40µg.m⁻³. Data capture was good (above 75%) during 2023 at all six sites and, as such, no annualisation has been required.

All six continuous monitoring sites met the national objective for annual mean NO₂ in 2023. **Figures 1 and 2** demonstrate a general downward trend in NO₂ concentrations over the monitoring period at the six sites; the reduction from 2021 is particularly noticeable at the Vicarage Grove site. Although the overall trend is downward, most sites have shown relatively stable concentrations in the last four years. Decreasing concentrations at roadside monitoring locations are in agreement with the national trend for roadside NO₂.

Sensors are an indicative method of monitoring. **Table G** shows that the sensor units at the Imperial War Museum, Maudsley Hospital and Tower Bridge School measured highest annual mean NO₂ levels in 2023 when compared to other BL sensor sites.

Table H - Annual Mean NO₂ Ratified and Bias-adjusted Monitoring Results from Diffusion Tube Sites

Site ID	X OS Grid Ref (Easting)	Y OS Grid Ref (Northing)	Site Type	Valid Data Capture for Monitoring Period (%) ⁽¹⁾	Valid Data Capture 2023 (%) ⁽²⁾	2017	2018	2019	2020	2021	2022	2023
SDT 1- 3	534849	177512	Roadside	100.0	100.0	41.9	42.4	35.9	24.5	29.2	27.5	25.2
SDT 4	535675	178796	Kerbside	100.0	100.0	54.7	42.9	39.8	30.7	34.9	33.6	29.9
SDT 5	534640	179336	Kerbside	100.0	100.0	32.2	30.4	31.1	-	23.0	21.9	19.2
SDT 6	535253	176679	Kerbside	92.3	92.3	63.1	38.0	36.1	35.0	28.4	35.1	28.6
SDT 7	534333	176155	Kerbside	100.0	100.0	46.4	34.9	31.6	20.7	21.0	26.8	23.0
SDT 8	534553	174263	Kerbside	100.0	100.0	32.4	27.4	28.1	18.8	21.4	19.8	17.5
SDT 9	533470	173204	Kerbside	100.0	100.0	50.7	36.8	34.5	29.5	35.1	31.8	27.0
SDT 10	532940	174392	Kerbside	100.0	100.0	32.3	29.6	28.9	19.6	23.4	20.8	18.7
SDT 11	532663	176740	Kerbside	100.0	100.0	63.1	50.2	45.4	34.2	39.7	38.0	34.3
SDT 12- 14	531884	178836	Urban Centre	100.0	100.0	41.9	35.3	32.8	19.9	22.7	23.7	21.8
SDT 15	531641	180290	Kerbside	100.0	100.0	51.9	46.2	42.1	31.6	31.4	32.5	29.7
SDT 18	533599	180062	Roadside	100.0	100.0	60.6	54.2	54.6	35.6	37.5	37.0	41.6
SDT 20	533520	179849	Kerbside	100.0	100.0	60.0	52.3	48.6	32.9	36.1	35.1	31.2
SDT 24	533444	179620	Kerbside	92.3	92.3	68.3	53.6	51.1	38.8	40.3	39.1	38.8
SDT 29	533105	179117	Kerbside	90.4	90.4	73.9	57.0	50.5	37.5	39.0	38.7	37.2
SDT 31	532937	179043	Kerbside	100.0	100.0	46.5	41.4	38.6	27.5	31.9	31.7	28.0
SDT 37	532340	178711	Kerbside	90.4	90.4	32.5	31.1	27.4	19.2	22.6	21.9	21.2
SDT 38	532074	178825	Kerbside	100.0	100.0	63.6	44.9	40.1	30.4	34.5	34.8	32.5
SDT 39	532053	179070	Kerbside	100.0	100.0	46.2	40.0	35.6	25.1	30.1	32.2	26.6
SDT 41	532390	178974	Kerbside	100.0	100.0	46.0	39.8	37.6	35.1	30.7	35.3	31.3
SDT 42	536037	180341	Kerbside	100.0	100.0	36.2	34.9	35.6	24.0	28.1	27.7	26.8
SDT 48	533912	171366	Kerbside	100.0	100.0	32.2	29.3	28.0	29.5	32.8	31.3	27.8
SDT 49	533873	178592	Kerbside	92.3	92.3	33.0	29.0	27.5	19.2	22.1	20.8	19.2
SDT 52	533150	172123	Kerbside	100.0	100.0	33.7	26.1	26.0	18.1	19.7	18.2	15.4
SDT 53	532668	173998	Kerbside	100.0	100.0	28.1	25.3	23.8	16.6	18.0	16.6	14.7
SDT 54	532951	176417	Kerbside	100.0	100.0	32.4	29.4	28.3	19.1	23.4	21.5	19.1
SDT 55	533350	177603	Kerbside	92.3	92.3	35.0	34.1	31.4	19.8	22.7	19.5	15.5
SDT 57	531531	179256	Kerbside	100.0	100.0	44.0	39.8	34.8	24.8	27.4	26.3	23.8
SDT 61	535176	179665	Kerbside	100.0	100.0	35.9	34.3	32.9	23.0	25.8	25.8	23.4
SDT 66	535384	179161	Kerbside	100.0	100.0	33.3	33.8	30.4	21.9	25.6	23.7	21.5

Site ID	X OS Grid Ref (Easting)	Y OS Grid Ref (Northing)	Site Type	Valid Data Capture for Monitoring Period (%) ⁽¹⁾	Valid Data Capture 2023 (%) ⁽²⁾	2017	2018	2019	2020	2021	2022	2023
SDT 77	532294	180406	Kerbside	90.4	90.4	49.0	45.2	41.0	26.8	27.2	31.3	27.8
SDT 81	532690	180212	Kerbside	100.0	100.0	68.4	59.0	52.7	39.6	39.4	34.7	39.1
SDT 82	532572	180029	Kerbside	92.3	92.3	61.2	50.4	45.2	30.9	32.2	34.0	31.8
SDT 84	532487	179850	Kerbside	100.0	100.0	50.2	40.9	39.1	29.3	29.7	29.4	27.5
SDT 87	535795	178828	Kerbside	92.3	92.3	57.0	46.5	46.2	34.7	35.0	36.0	37.4
SDT 88	534457	179454	Kerbside	100.0	100.0	52.3	45.5	42.7	34.4	32.4	35.6	32.5
SDT 89	534241	179435	Roadside	92.3	92.3	42.0	40.8	35.8	25.2	29.4	28.6	25.3
SDT 90	533800	178220	Kerbside	100.0	100.0	50.8	52.0	43.7	34.3	34.6	34.8	33.4
SDT 91	533379	178556	Kerbside	90.4	90.4	55.5	51.1	46.2	34.8	35.3	34.4	32.0
SDT 92	535222	178032	Roadside	100.0	100.0	57.6	48.7	45.2	27.0	32.1	28.6	26.8
SDT 93	534243	176558	Roadside	100.0	100.0	58.4	53.3	37.8	30.7	33.1	32.6	33.2
SDT 95	533700	173892	Kerbside	100.0	100.0	24.8	26.9	26.1	16.8	18.1	15.9	14.0
SDT 97	533940	173998	Kerbside	100.0	100.0	37.5	37.3	32.5	24.3	26.8	24.4	23.0
SDT 98	534503	173251	Kerbside	100.0	100.0	43.1	36.8	36.5	34.4	28.1	34.3	29.8
SDT 100	533159	174191	Kerbside	100.0	100.0	35.8	34.7	34.1	17.4	18.8	16.4	14.3
SDT 101	532303	174756	Kerbside	100.0	100.0	34.2	31.9	34.6	23.6	26.2	24.5	21.4
SDT 102	532599	176277	Kerbside	100.0	100.0	38.2	34.4	32.7	23.3	27.5	25.3	22.1
SDT 103	532471	176388	Kerbside	90.4	90.4	38.7	35.0	31.4	27.0	30.2	28.2	24.9
SDT 104	531835	178686	Kerbside	100.0	100.0	48.9	46.8	38.9	32.1	33.8	32.9	36.4
SDT 105	533592	176851	Kerbside	100.0	100.0	44.2	39.8	35.6	24.7	29.9	27.3	24.4
SDT 106	532409	177597	Kerbside	100.0	100.0	48.0	40.9	34.8	34.1	30.4	35.5	33.5
SDT 107	532426	178051	Kerbside	100.0	100.0	38.5	35.5	35.7	23.4	25.7	26.7	23.7
SDT 111	532294	178354	Kerbside	100.0	100.0	46.6	42.3	36.4	27.5	30.1	29.7	28.1
SDT 112	531621	179112	Kerbside	100.0	100.0	31.3	27.6	25.0	18.1	20.6	19.6	17.4
SDT 113	531481	179421	Kerbside	92.3	92.3	74.0	58.5	46.0	37.5	37.5	34.2	36.4
SDT 114	533799	175324	Kerbside	100.0	100.0	37.4	31.6	33.0	22.6	25.2	25.0	21.8
SDT 132	534237	176363	Kerbside	100.0	100.0	-	-	33.0	21.5	23.9	28.6	25.8
SDT 136	533232	175775	Kerbside	100.0	100.0	-	-	33.8	20.2	23.9	22.3	20.1
SDT 137	532988	175570	Kerbside	100.0	100.0	-	-	25.2	16.4	19.5	17.7	15.6
SDT 138	533364	175561	Kerbside	100.0	100.0	-	-	31.1	24.7	27.4	25.9	23.4
SDT 139	533030	176022	Kerbside	90.4	90.4	-	-	33.2	24.1	27.5		18.6
SDT 140	533221	175715	Kerbside	100.0	100.0	-	-	31.3	22.9	24.7	23.8	20.6
SDT 142	535321	175023	Kerbside	100.0	100.0	-	-	29.0	20.5	20.6	18.3	16.0

Site ID	X OS Grid Ref (Easting)	Y OS Grid Ref (Northing)	Site Type	Valid Data Capture for Monitoring Period (%) ⁽¹⁾	Valid Data Capture 2023 (%) ⁽²⁾	2017	2018	2019	2020	2021	2022	2023
SDT 143	534540	172387	Kerbside	100.0	100.0	-	-	25.7	18.5	20.2	18.6	16.7
SDT 144	533328	171601	Kerbside	100.0	100.0	-	-	33.5	23.4	24.8	22.0	19.5
SDT 145	532768	172732	Kerbside	100.0	100.0	-	-	25.0	19.5	21.4	19.7	17.4
SDT 146	532486	173535	Kerbside	100.0	100.0	-	-	29.5	20.6	23.2	21.6	18.6
SDT 147	532230	177756	Kerbside	100.0	100.0	-	-	35.4	22.6	26.6	24.0	20.9
SDT 148	532002	177578	Kerbside	100.0	100.0	-	-	31.6	22.4	27.0	24.2	21.2
SDT 149	531479	177990	Kerbside	100.0	100.0	-	-	33.5	22.1	23.4	22.3	19.8
SDT 150	533522	178187	Kerbside	100.0	100.0	-	-	31.7	28.3	31.1	28.9	25.7
SDT 151	533660	174480	Kerbside	100.0	100.0	-	-	28.6	18.6	22.0	20.1	17.0
SDT 152	533245	174655	Kerbside	92.3	92.3	-	-	31.5	19.4	22.8	21.1	18.5
SDT 153	533123	173780	Kerbside	92.3	92.3	-	-	27.2	17.1	20.2	18.8	16.5
SDT 154	532836	177844	Kerbside	90.4	90.4	-	-	34.7	23.3	25.6	24.0	20.5
SDT 155	532597	178433	Kerbside	100.0	100.0	-	-	31.3	20.1	22.0	20.8	18.5
SDT 156	532643	178677	Kerbside	100.0	100.0	-	-	36.0	25.4	26.3	24.6	22.8
SDT 157	531648	178257	Kerbside	100.0	100.0	-	-	33.1	19.4	24.1	20.9	18.9
SDT 158	532195	178276	Kerbside	100.0	100.0	-	-	-	18.2	20.4	20.9	17.4
SDT 159	532167	178336	Kerbside	100.0	100.0	-	-	-	16.0	19.4	20.9	16.9
SDT160	532202	173907	Kerbside	100.0	100.0	-	-	-	-	23.1	22.5	20.5
SDT161	533771	175173	Kerbside	84.6	84.6	-	-	-	-	-	29.2	25.3
SDT 162	533737	174679	Kerbside	100.0	25.0	-	-	-	-	-	23.0	22.1 ^a
SDT 163	532025	177057	Kerbside	75.0	75.0	-	-	-	-	-	26.2	25.2
SDT164	532087	177193	Kerbside	75.0	75.0	-	-	-	-	-	23.4	19.9

^a Annualisation has been conducted where data capture is <75% and >25% in line with LLAQM.TG19

Diffusion tube data has been bias adjusted

Reported concentrations are those at the location of the monitoring site (bias adjusted and annualised, as required), i.e. prior to any fall-off with distance correction

Notes:

The annual mean concentrations are presented as $\mu\text{g.m}^{-3}$.

Exceedances of the NO_2 annual mean objective of $40 \mu\text{g.m}^{-3}$ are shown in **bold**.

NO_2 annual means exceeding $60\mu\text{g.m}^{-3}$ indicating a potential exceedance of the NO_2 1-hour mean objective are shown in **bold and underlined**.

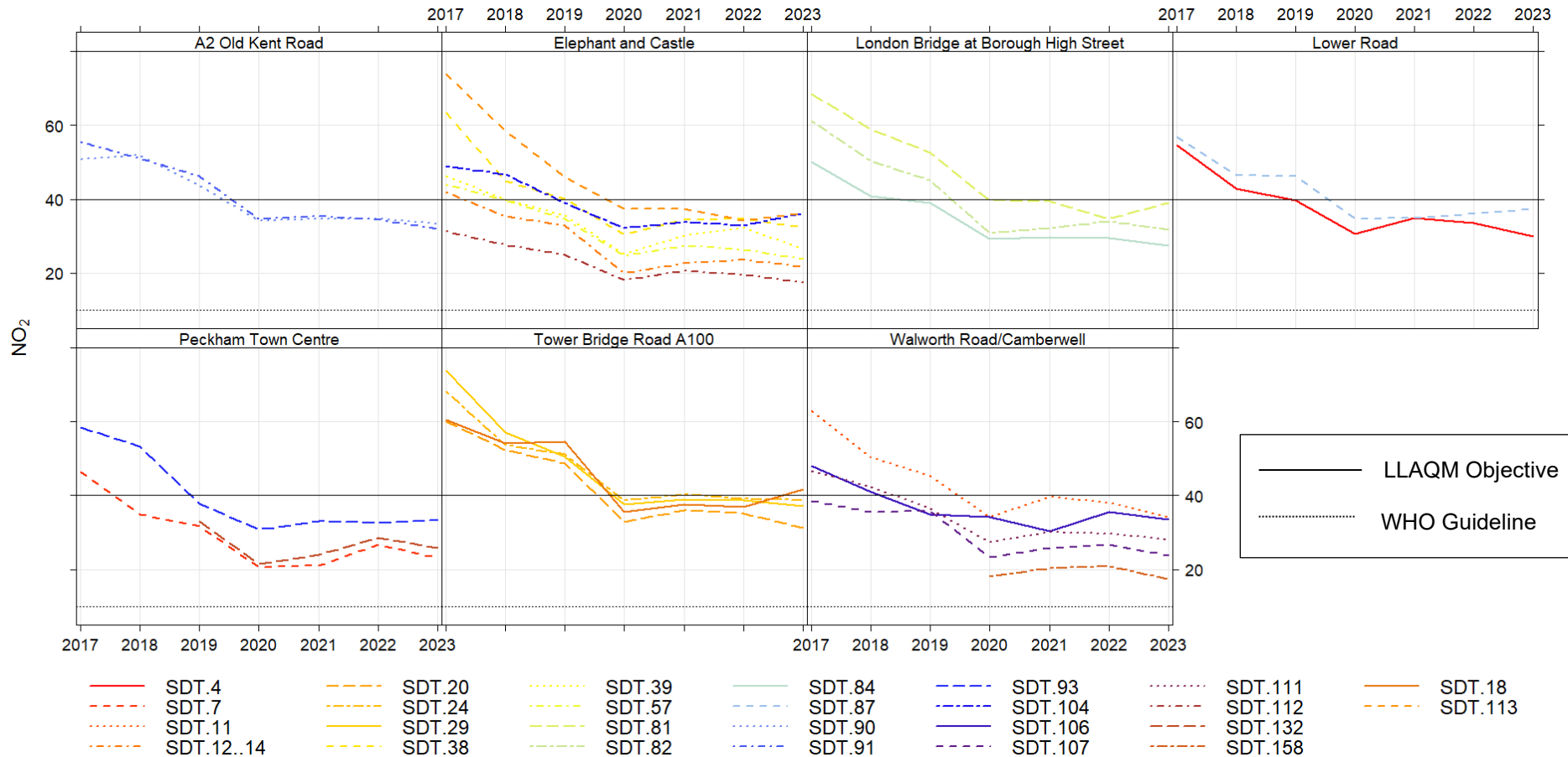
Means for diffusion tubes have been corrected for bias. All means have been “annualised” in accordance with LLAQM Technical Guidance if valid data capture for the calendar year is less than 75% and greater than 25%.

Concentrations are those at the location of monitoring and not those following any fall-off with distance adjustment.

(1) Data capture for the monitoring period, in cases where monitoring was only carried out for part of the year.

(2) Data capture for the full calendar year (e.g. if monitoring was carried out for 6 months, the maximum data capture for the full calendar year is 50%).

Figure 3 - Trend in annual mean NO₂ concentrations at Southwark's diffusion tube sites within Air Quality Focus Areas, 2017 - 2023



Note: The graph includes sites SDT 18 (adjacent to the Tower Bridge FA), and SDT 113 (adjacent to the Elephant and Castle FA).

Discussion of trends in annual mean NO₂ at diffusion tube sites

All diffusion tube sites but one showed compliance with the annual objective of 40µg.m⁻³ in 2023 (**Table H**). The site SDT18 at Tower Bridge Road exceeded the objective with a result of 41.6µg.m⁻³. However, the site was compliant when the result was corrected to the nearest residential exposure (see **Table V**).

Overall there has been a reduction of NO₂ levels in Southwark recorded by diffusion tubes in 2023. **Figure 3** confirms a decreasing trend for the sites located within the Air Quality Focus Areas (FAs).

Table I - NO₂ Automatic Monitoring Results: Comparison with 1-hour Mean Objective, Number of 1-Hour Means > 200µg/m³

Site ID	Valid data capture for monitoring period % ^(a)	Valid data capture 2023 % ^(b)	2017	2018	2019	2020	2021	2022	2023
SK5 Old Kent Road	97.4	97.4	0	0	0	0	0	0	0
SK6 Elephant & Castle	78.9	78.9	0	0	0	0	0	0	0 (91.6)
SK8 Tower Bridge	99.4	99.4	-	-	-	0	0	0	0
SKA Lower Road	90.7	90.7	-	-	-	-	0	0	0
SKB Vicarage Grove	96.3	96.3	-	-	-	-	0	0	0
SKC South Circular Road	95.0	95.0	-	-	-	-	0	0	0

Notes

Results are presented as the number of 1-hour periods where concentrations greater than 200µg m⁻³ have been recorded.

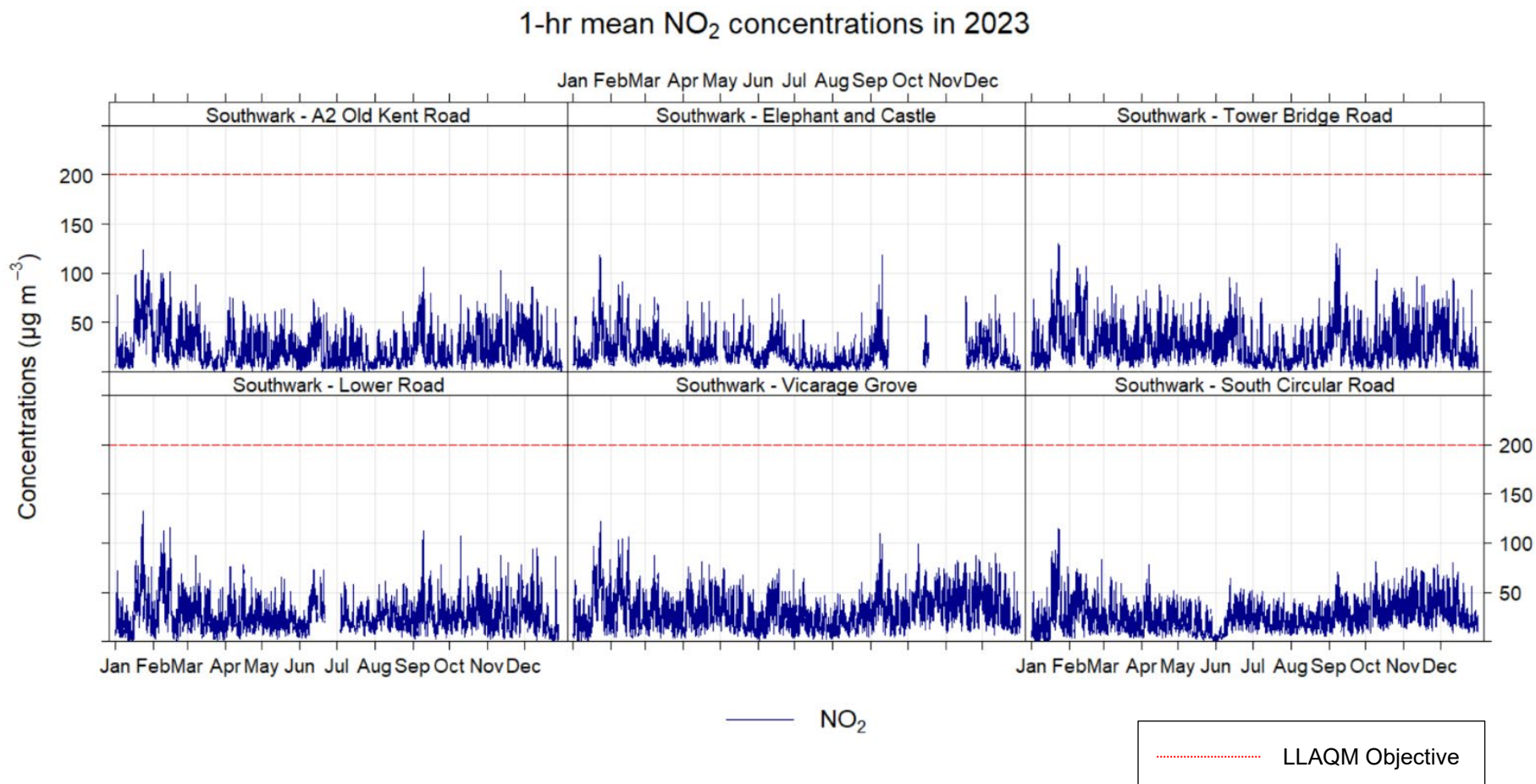
Exceedance of the NO₂ short term AQO of 200µg m⁻³ over the permitted 18 hours per year are shown in **bold**.

If the period of valid data is less than 85%, the 99.8th percentile of 1-hour means is provided in brackets.

(a) Data capture for the monitoring period, in cases where monitoring was only carried out for part of the year

(b) Data capture for the full calendar year (e.g. if monitoring was carried out for six months the maximum data capture for the full calendar year would be 50%)

Figure 4 - Hourly NO₂ Concentrations at Southwark's Continuous Air Quality Monitoring Stations: Comparison with 1-Hour Mean Objective



489

Figure 5 - Time-varied NO₂ Concentrations at Southwark's Continuous Air Quality Monitoring Stations in 2023

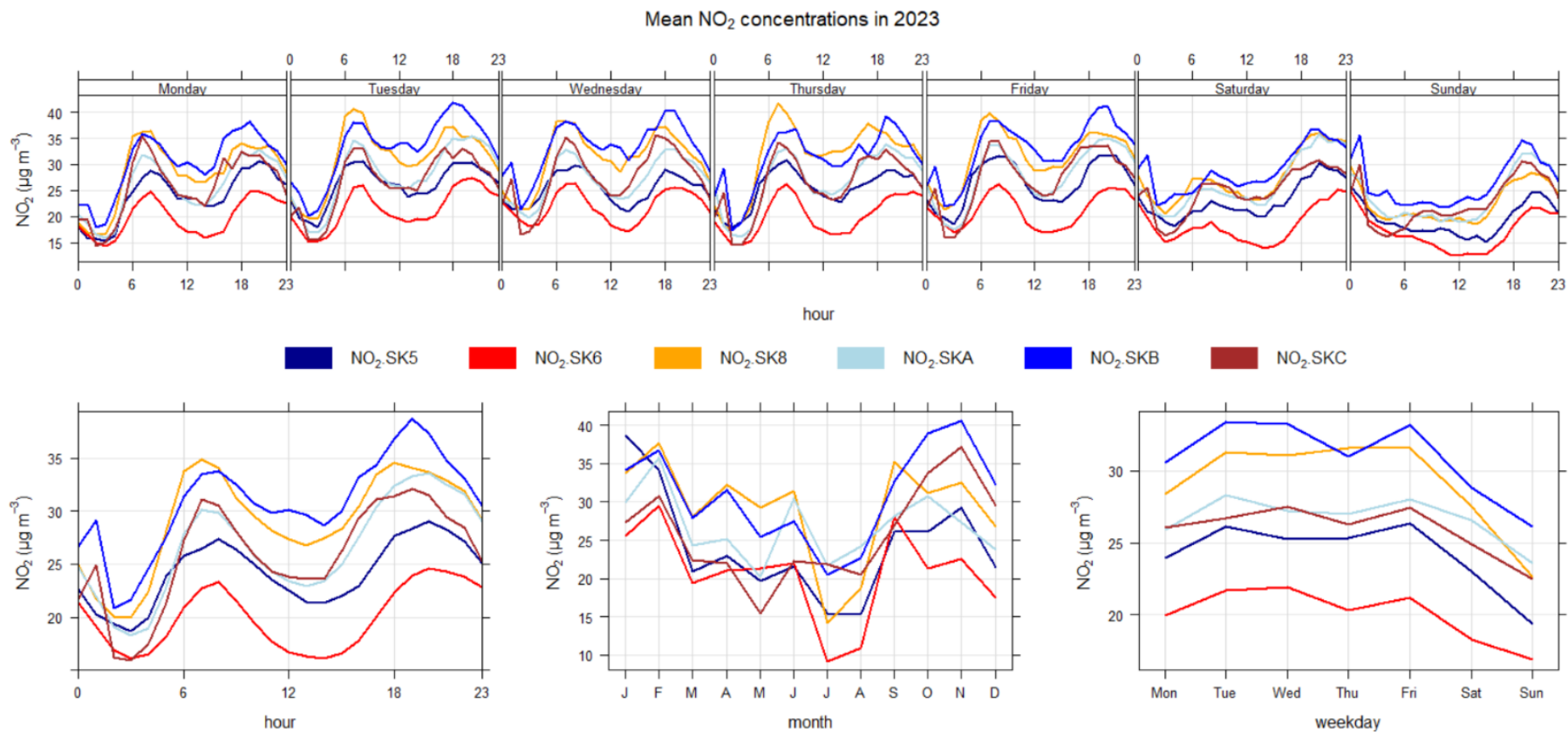
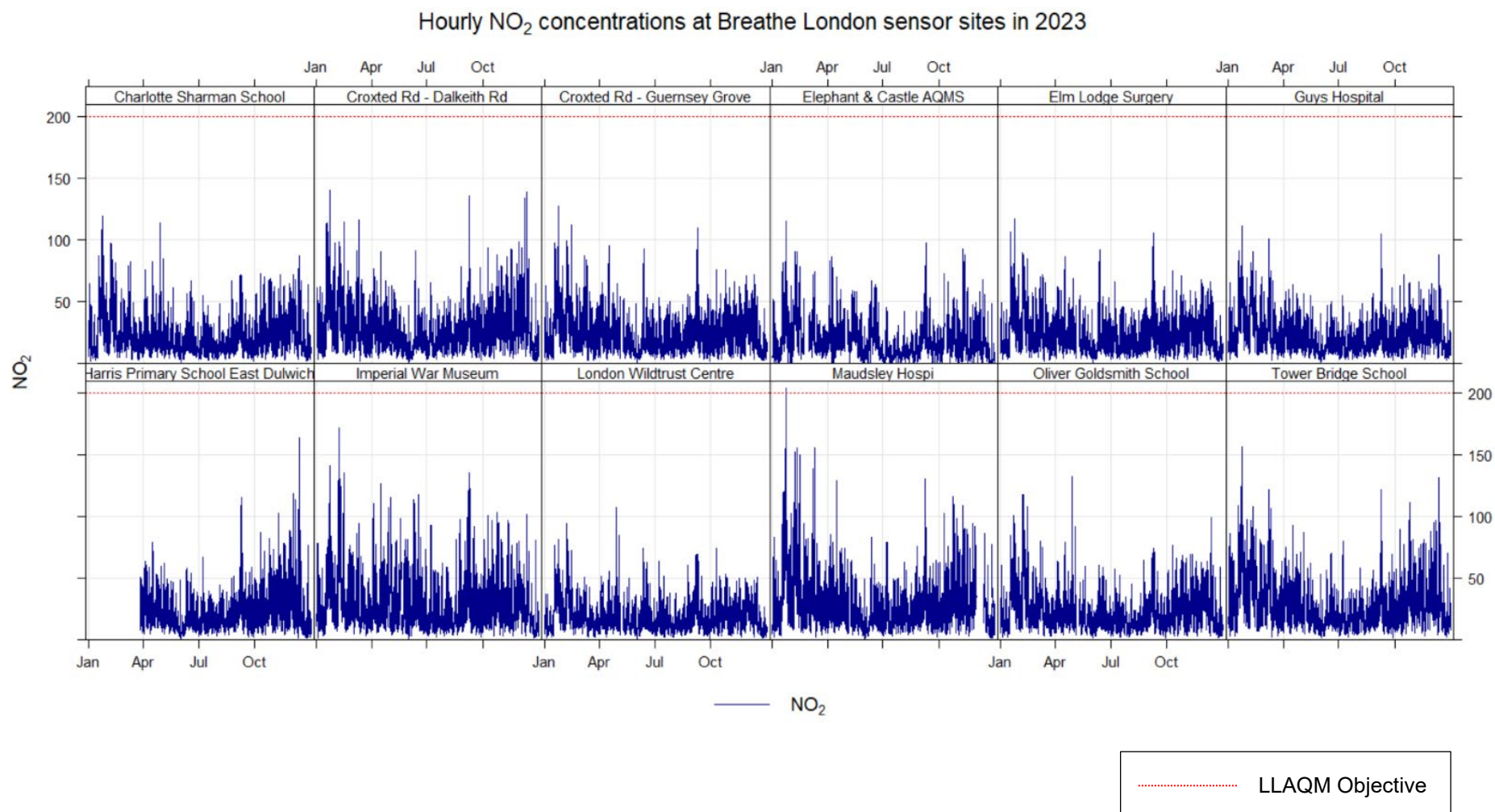


Figure 6 – 1-hour NO₂ Concentrations at Breathe London Sensor Sites in 2023



NB: Sensor results are indicative only.

Discussion of trends in hourly mean NO₂

The 7-year trend in short term NO₂ concentrations shows that all existing sites were compliant with the 200 µg.m⁻³.1-hour objective in 2023 and previous years (see **Table I** and **Figure 4**).

The variation in NO₂ levels for time of the day and month of the year is shown in **Figure 5**. The highest month-averaged concentrations in the year were generally recorded over the autumn and winter months, and the lowest over July and August. The analysis of hourly mean concentrations by day of the week indicates that the highest concentrations were recorded during afternoon traffic peaks throughout the working week from Monday to Friday. Weekend levels showed an evening peak after 6pm. The lowest levels for time of the day NO₂ were observed at the background site SK6 at Elephant ad Castle, whilst the site SKB at Vicarage Grove generally showed the highest levels in time-varied NO₂.

Indicative results from sensor units shown in **Figure 6** suggest that all the locations were below the 1-hour NO₂ objective in 2023.

1.2.2 Particulate Matter (PM₁₀)

Table J - Annual Mean PM₁₀ Automatic Monitoring Results (µg.m⁻³)

Site ID	Valid data capture for monitoring period % ^(a)	Valid data capture 2023 % ^(b)	2017	2018	2019	2020	2021	2022	2023
SK5 Old Kent Road (BAM)	72.3	72.3	21.5	22.4	23.6	22.2	20.5	21.1	22.3 ^a
SK6 Elephant & Castle	90.3	90.3	19.2	19.8	16.7	15.9	14.4	16.1	12.8
SK8 Tower Bridge	99.2	99.2	-	-	-	-	17.6	16.4	15.2
SK9 Old Kent Road (FIDAS)	96.9	96.9	-	-	-	-	16.6	17.8	16.8
SKA Lower Road	98.2	98.2	-	-	-	-	15.3	17.2	15.0
SKB Vicarage Grove	88.6	88.6	-	-	-	-	16.1	17.3	16.9
SKC South Circular Road	96.0	96.0	-	-	-	-	13 ^a	14.6	12.3

Notes

The annual mean concentrations are presented as µg.m⁻³.

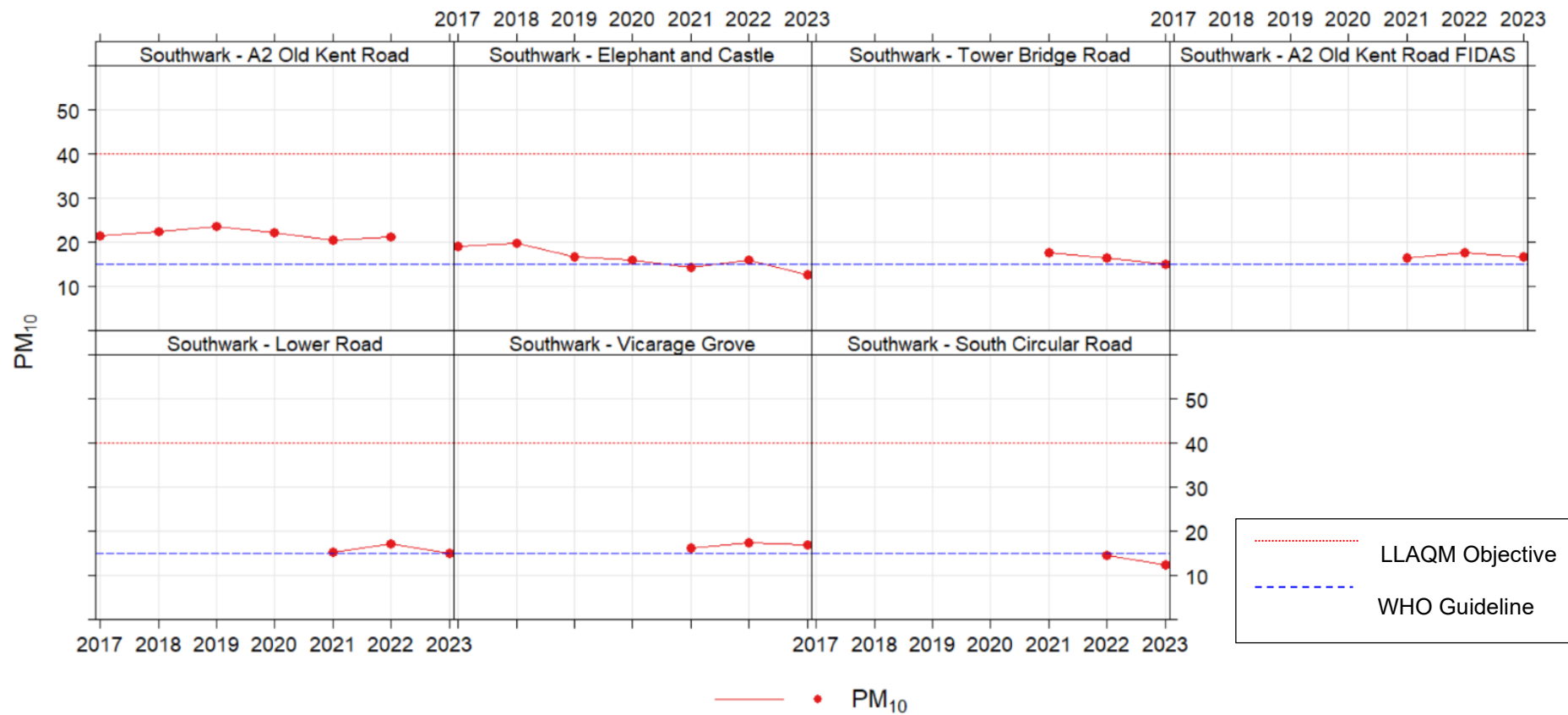
Exceedances of the PM₁₀ annual mean AQO of 40 µg.m⁻³ are shown in **bold**.

^a All mean averages have been “annualised” in accordance with LLAQM Technical Guidance, if valid data capture is less than 75% and more than 25%.

(a) Data capture for the monitoring period, in cases where monitoring was only carried out for part of the year.

(b) Data capture for the full calendar year (e.g. if monitoring was carried out for six months the maximum data capture for the full calendar year would be 50%).

Figure 7 - Trend in Annual Mean PM₁₀ Concentrations at Southwark's Existing Air Quality Monitoring Stations, 2017 – 2023



Note: Means below 75% data capture for the calendar year have been excluded from graph.

Figure 8 - Trend in Annual Mean PM₁₀ Concentrations at Southwark's Existing and Past Air Quality Monitoring Stations, 2000 – 2023



Note: Means below 75% data capture for the calendar year have been excluded from graph.

Discussion of Trends in annual mean PM₁₀

The Council monitored PM₁₀ continuously at six locations during 2023; it is worth noting that the site SK5 at Old Kent Road monitors PM₁₀ with two different monitoring methods – a BAM and a Fidas analyser. **Table J** compares the ratified and adjusted monitored PM₁₀ annual mean concentrations for the years 2017-2023 with the air quality objective of 40µg.m⁻³. Data capture was good (above 75%) during 2023 at all sites but one. Short-term to long-term data adjustment (annualisation) has been carried out for results from the BAM analyser in Old Kent Road (site SK5). Details of the annualisation can be found in **Appendix A**.

Automatic monitoring of PM₁₀ at the monitoring sites indicated that the annual mean was complied with in 2023 and all previous years (**Table J**). However, most sites have remained above the WHO guidelines. **Figures 7** and **8** show that the long-term trend for PM₁₀ is decreasing, whilst the short-term trend for the last three years remain unclear for some roadside sites, including SK5 Old Kent Road, SKA Lower Road, and SKB Vicarage Grove.

Table K - PM₁₀ Automatic Monitoring Results: Comparison with 24-Hour Mean Objective, Number of PM₁₀ 24-Hour Means > 50 µg.m⁻³

Site ID	Valid data capture for monitoring period % ^(a)	Valid data capture 2023 % ^(b)	2016	2017	2018	2019	2020	2021	2022	2023
SK5 Old Kent Road (BAM)	72.3	72.3	18	19	8	2	11	8	7	2 (32.9)
SK6 Elephant & Castle	90.3	90.3	21	1	2	14	3	2	4	0
SK8 Tower Bridge	99.2	99.2	-	-	-	-	2	6	6	1
SK9 Old Kent Road (FIDAS)	96.9	96.9	-	-	-	-	5	7	6	3
SKA Lower Road	98.2	98.2	-	-	-	-	-	2	5	1
SKB Vicarage Grove	88.6	88.6	-	-	-	-	-	2	6	5
SKC South Circular Road	96.0	96.0	-	-	-	-	-	0	2	0

Notes

Exceedances of the PM₁₀ 24-hour mean objective (50 µg.m⁻³ over the permitted 35 days per year) are shown in **bold**.

Where the period of valid data is less than 85% of a full year, the 90.4th percentile is provided in brackets.

(a) Data capture for the monitoring period, in cases where monitoring was only carried out for part of the year

(b) Data capture for the full calendar year (e.g. if monitoring was carried out for six months the maximum data capture for the full calendar year would be 50%).

Figure 9 – 24-hour PM₁₀ Concentrations at Southwark’s Continuous Air Quality Monitoring Stations: Comparison with 24-Hour Mean Objective

24-hr mean PM₁₀ concentrations in 2023

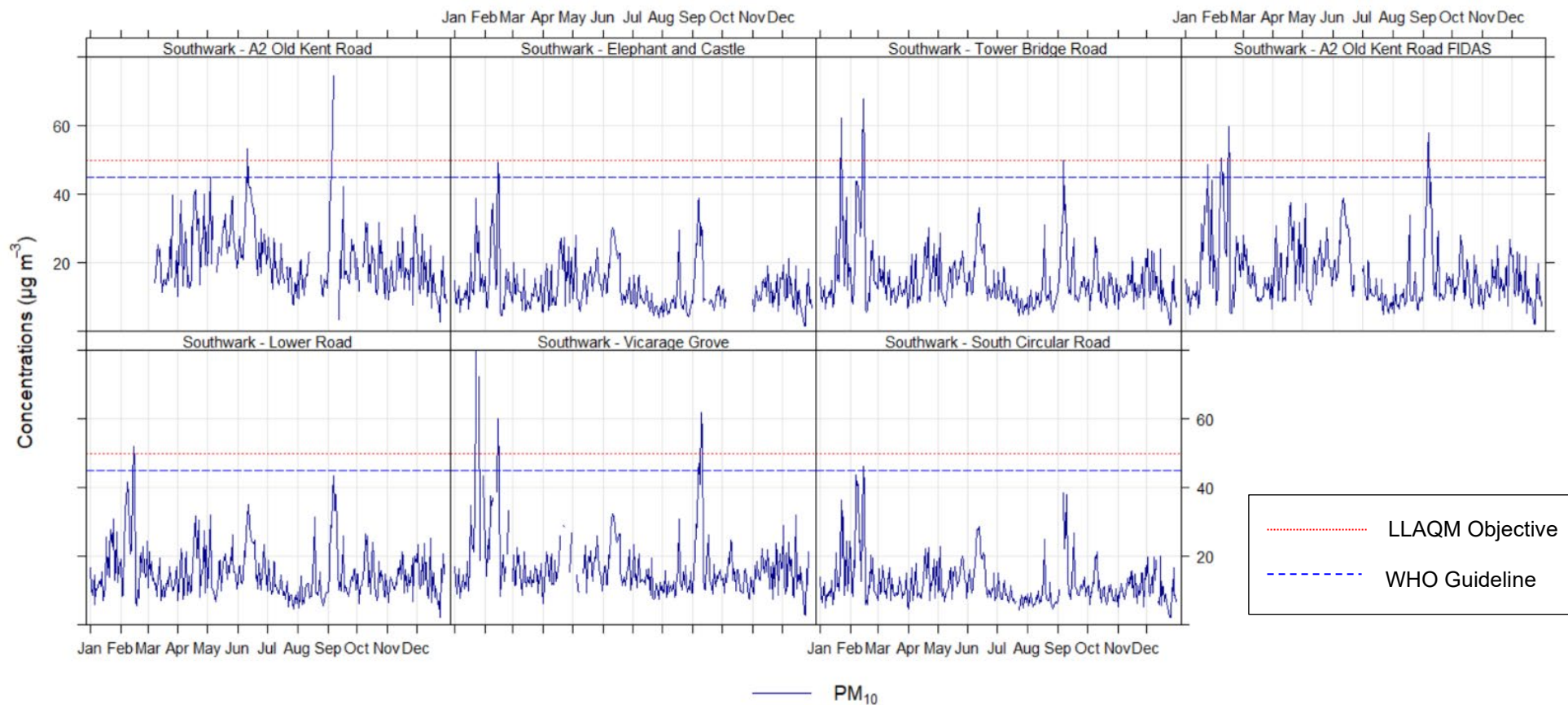
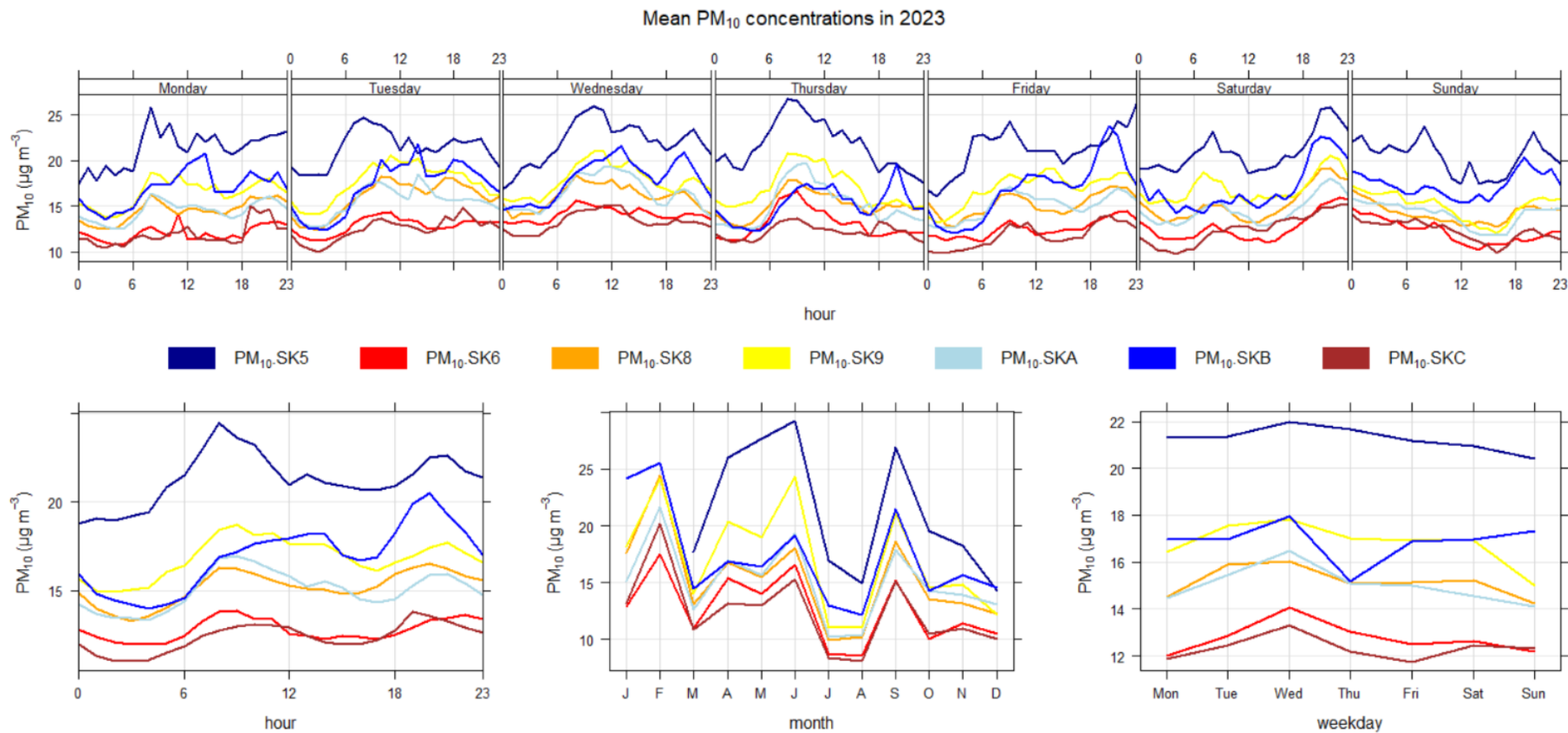


Figure 10 - Time-varied PM₁₀ Concentrations at Southwark's Continuous Air Quality Monitoring Stations in 2023



Discussion of trends for hourly and 24-hour mean PM₁₀

The 7-year trend in short term PM₁₀ concentrations shows that all existing sites were compliant with the 50µg.m⁻³.24-hour objective in 2023 and previous years (see **Table K**).

Peaks in concentrations of PM₁₀ at the monitoring sites were observed during regional episodes in January and February. The levels also peaked at most sites in September (**Figure 9**).

From the analysis of diurnal variation in hourly mean concentrations it is found that generally the morning and afternoon peaks were less pronounced than those for NO₂, and average concentrations measured on the weekends were not much lower when compared to weekdays (**Figure 10**).

1.2.3 Particulate Matter (PM_{2.5})

Table L - Annual Mean PM_{2.5} Automatic Monitoring Results (µg.m⁻³)

Site ID	Valid data capture for monitoring period % ^(a)	Valid data capture 2023 % ^(b)	2017	2018	2019	2020	2021	2022	2023
SK6 Elephant & Castle	89.0	89.0	-	-	-	9 ^a	9.1	9.4	7.7
SK8 Tower Bridge Road	99.2	99.2	-	-	-	8 ^a	10.4	9.3	8.4
SK9 Old Kent Road (FIDAS)	96.9	96.9	-	-	-	9 ^a	9.5	9.9	9.0
SKA Lower Road	98.2	98.2	-	-	-	-	9.3	9.7	8.3
SKB Vicarage Grove	88.6	88.6	-	-	-	-	9.9	10.1	9.9
SKC South Circular Road	96.0	96.0	-	-	-	-	7 ^a	8.5	7.1

Notes

The annual mean concentrations are presented as µg.m⁻³.

Exceedances of the PM_{2.5} annual mean AQO of 20 µg.m⁻³ are shown in **bold**.

^a All means have been “annualised” in accordance with LLAQM Technical Guidance, if valid data capture is less than 75% and more than 25%.

(a) Data capture for the monitoring period, in cases where monitoring was only carried out for part of the year.

(b) Data capture for the full calendar year (e.g. if monitoring was carried out for six months the maximum data capture for the full calendar year would be 50%).

Figure 11 - Trend in Annual Mean PM_{2.5} concentrations at Southwark's Existing Air Quality Monitoring Stations, 2017 – 2023

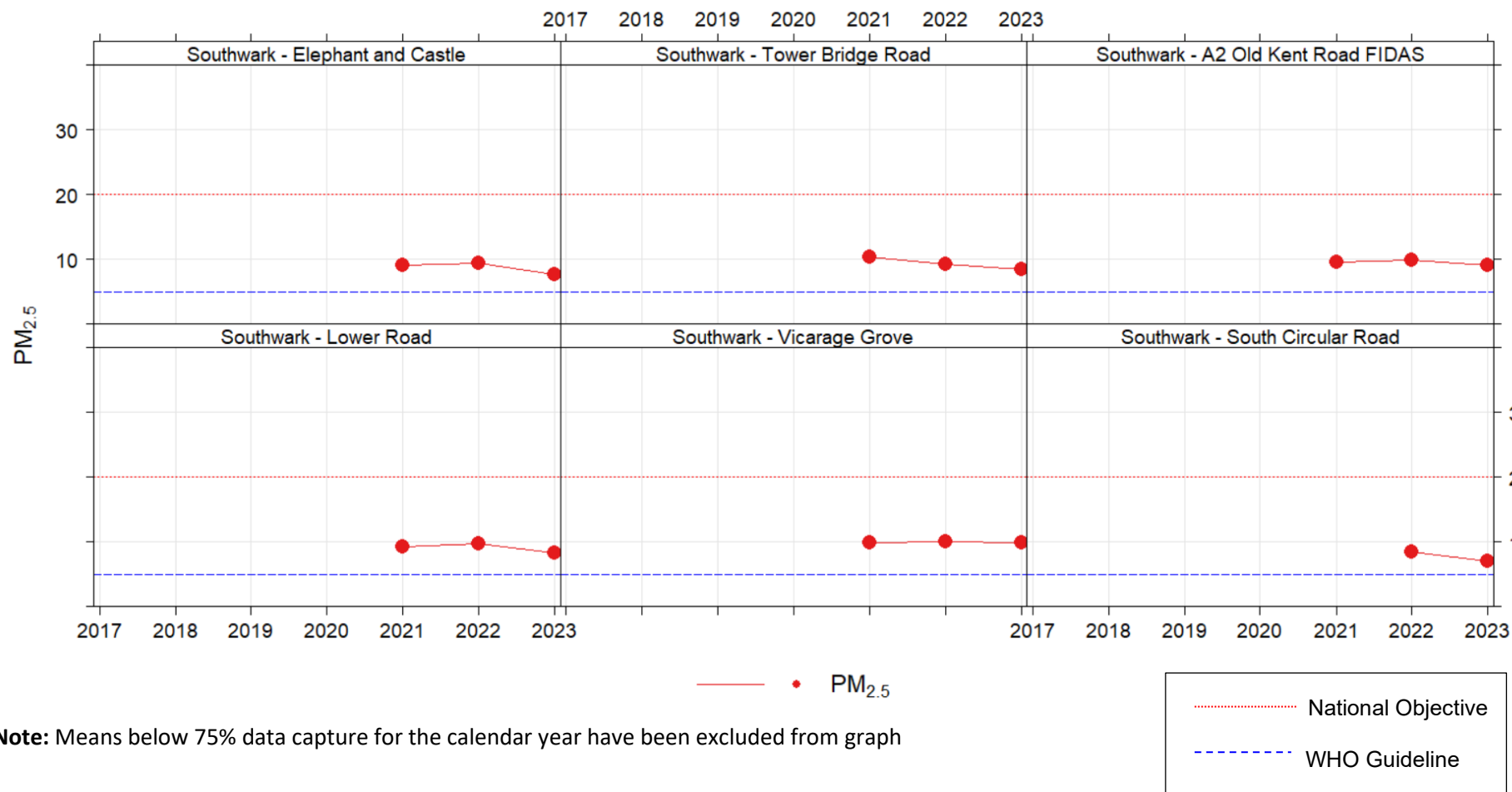
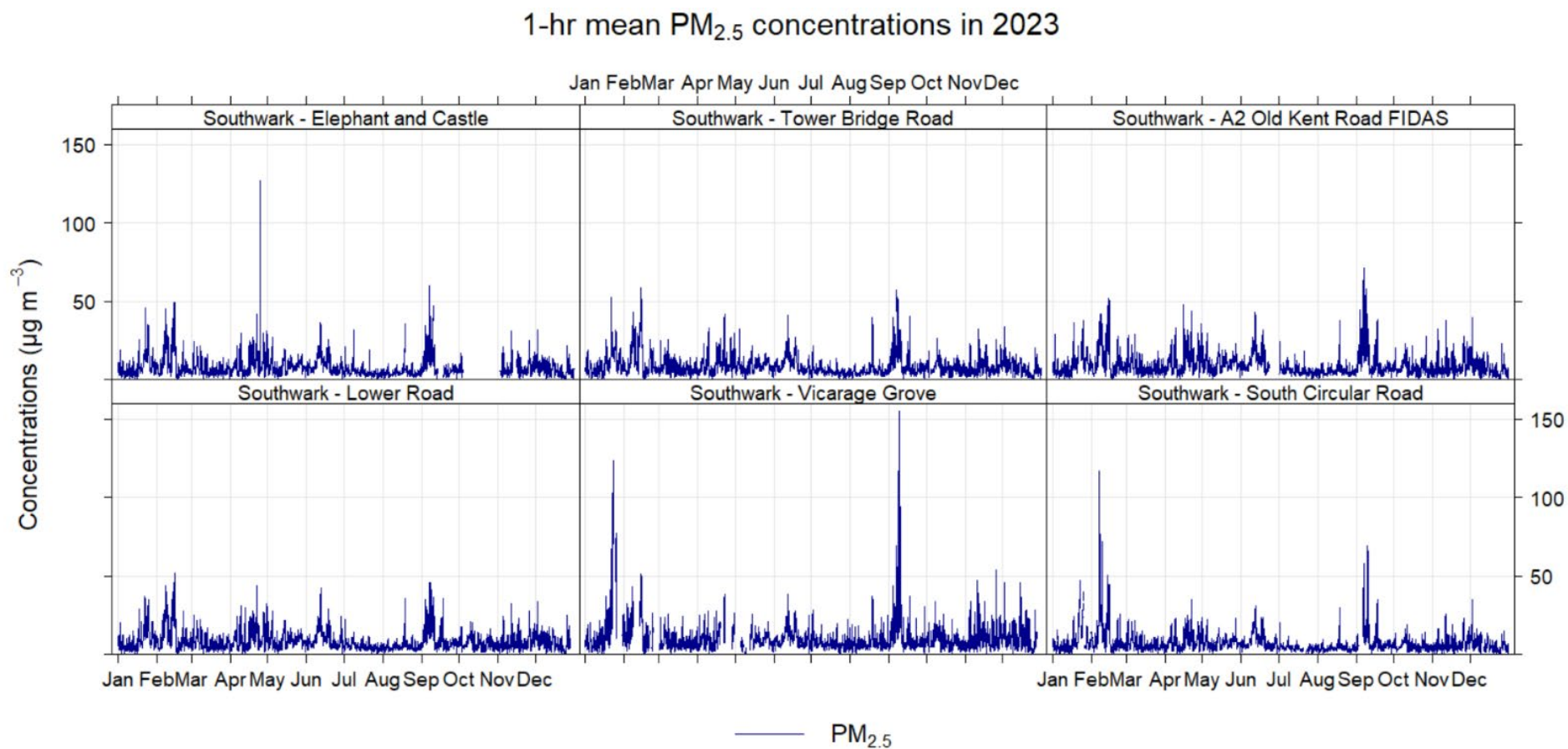


Figure 12 – 1-Hour PM_{2.5} Concentrations at Southwark’s Continuous Air Quality Monitoring Stations



503

Figure 13 - Time-varied PM_{2.5} Concentrations at Southwark's Continuous Air Quality Monitoring Stations

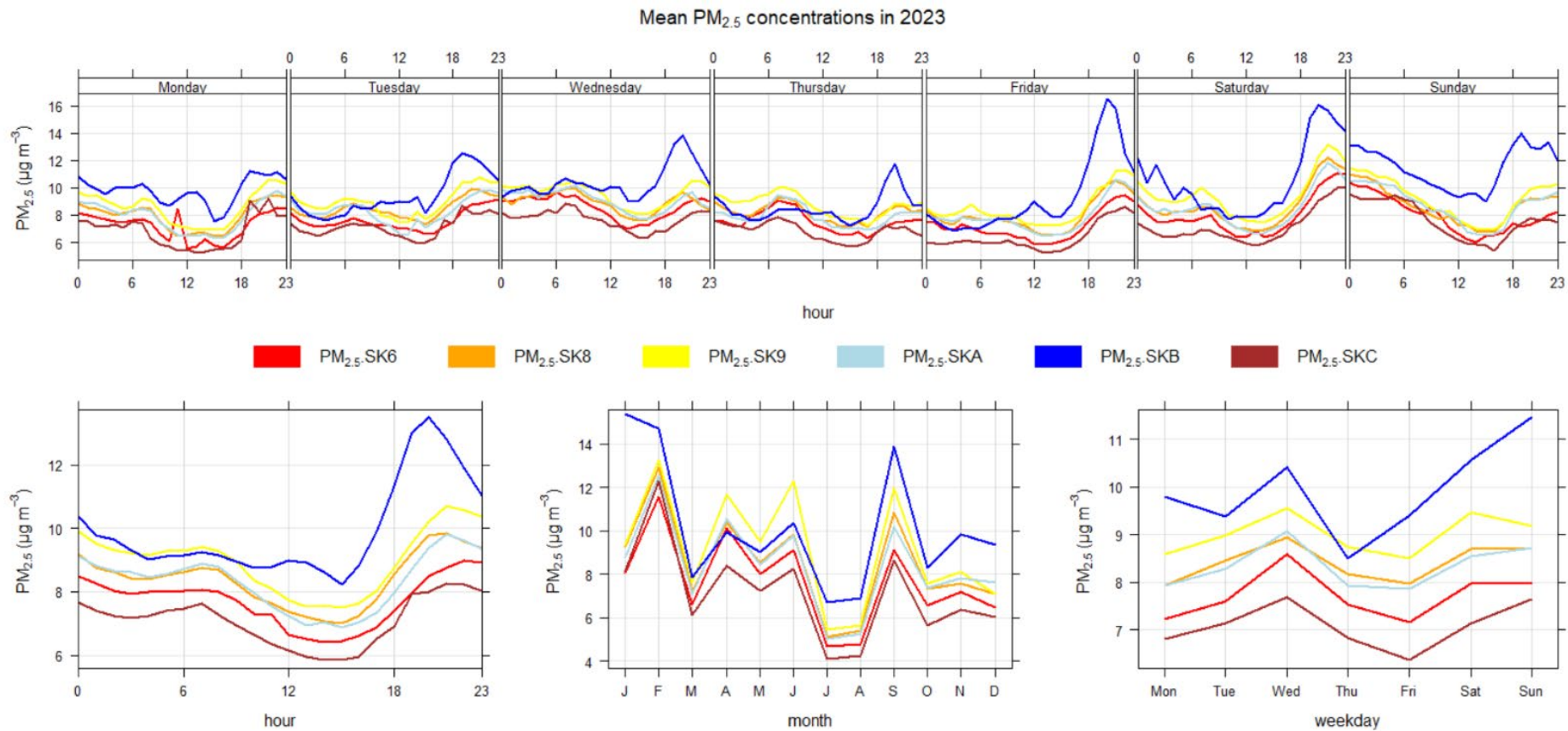


Table M - Annual Mean PM_{2.5} Monitoring Results from Breathe London Sensor Sites

Site ID	Site Name	Site type	Monitoring Method	Valid data capture 2023 % ^(a)	2021	2022	2023
CLDP0037	Charlotte Sharman Primary School	Urban Background	Sensor	99	8.6	8.8	8.1
CLDP0022	Elephant & Castle (reference co-location)	Urban Background	Sensor	97	9.1	9.0	7.9
CLDP0323	Elm Lodge Surgery	Roadside	Sensor	98		7.5 (55%)	7.2
CLDP0080	Guy's Hospital	Roadside	Sensor	99	10.4 (51%)	10.2	8.3
CLDP0448	Harris Primary Academy, East Dulwich	Roadside	Sensor	73			8.2
CLDP0384	Imperial War Museum	Urban Background	Sensor	97		7.6(4%)	7.5
CLDP0175	London Wildlife Trust Centre For Wildlife Gardening	Urban Background	Sensor	98	8.5 (58%)	8.4	7.6
CLDP0357	Maudsley Hospital	Roadside	Sensor	95		9.1 (27%)	7.9
CLDP0078	Oliver Goldsmith Primary School	Urban Background	Sensor	97	8.8	9.1	8.2
CLDP0108	SWK-BL1 : Croxted Road / Guernsey Grove	Roadside	Sensor	98	10.0 (71%)	10.0	7.9
CLDP0107	SWK-BL2 : Croxted Road/Dalkeith Road	Roadside	Sensor	99	9.6(42%)	9.7	8.7
CLDP0042	Tower Bridge Primary School	Roadside	Sensor	98	10.9	10.6	8.5

Notes:

These results are indicative only.

The annual mean concentrations are presented as $\mu\text{g m}^{-3}$. Means are yearly averages and have not been “annualised”.

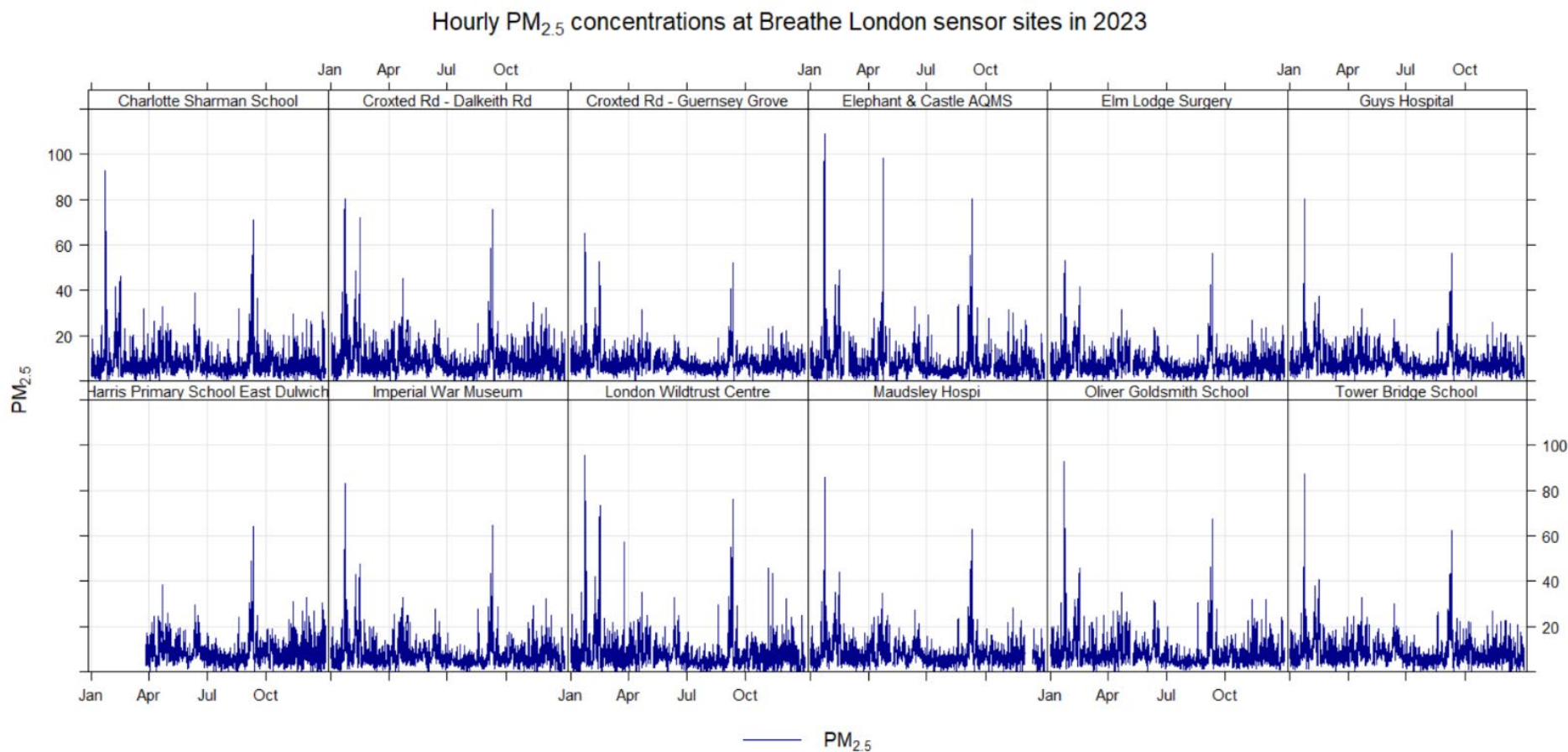
Concentrations are those at the location of monitoring and not those following any fall-off with distance adjustment.

If the data capture for the year is less than 75% in 2021 or 2022, the data capture is shown in the brackets adjacent to the annual mean.

Exceedances of the PM_{2.5} annual mean AQO of $20 \mu\text{g m}^{-3}$ are shown in **bold**.

(a) Data capture for the full calendar year (e.g. if monitoring was carried out for six months the maximum data capture for the full calendar year would be 50%).

Figure 14 – 1-Hour PM_{2.5} Concentrations at Breathe London Sensor Sites in 2023



NB: Sensor results are indicative only.

Discussion of Trends in PM_{2.5} concentrations

PM_{2.5} objectives have been set out in the UK Air Quality Regulations. Results from the monitoring sites indicate that concentrations have remained well below the limit value of 20µg.m⁻³ in 2023 and all the years of monitoring (**Table L, Table M** and **Figure 11**). All sites were technically below the earlier WHO guideline value of 10µg.m⁻³ adopted in the London Plan, although compliance at SKB Vicarage Grove was marginal with a result of 9.9µg.m⁻³ (**Table L** and **Figure 11**). The latest WHO guideline of 5µg.m⁻³ has been exceeded at all sites.

The levels of PM_{2.5} have remained stable for the monitoring period.

Figure 12 shows peaks in PM_{2.5} levels in January (SK9 Old Kent Road, SKB Vicarage Grove, SKC South Circular Rd) – which corresponds with a particulate matter episode, February (SKC South Circular Rd), and September (SK8 Tower Bridge Rd, SK9 Old Kent Road, SKB Vicarage Grove, SKC South Circular Rd). The results from sensor sites presented in **Figure 14** indicate the concentrations peaking in January, February, April and September.

The analysis of average hourly concentrations by day of the week indicates that the levels peaked during evening hours throughout the week, with the highest peaks recorded on Fridays and Saturdays. The site which recorded the highest time-averaged levels was SKB Vicarage Grove (**Figure 13**).

1.2.4 Ozone (O₃)

Table N - O₃ Automatic Monitoring Results: Comparison with Objective, Daily Maximum 8-hour Running Mean > 100 µg.m⁻³

Site ID	Valid data capture for monitoring period % ^(a)	Valid data capture 2023 % ^(b)	2017	2018	2019	2020	2021	2022	2023
SK6 - Elephant & Castle	93.1	93.1	1	9	8	16	14	20	19

Notes

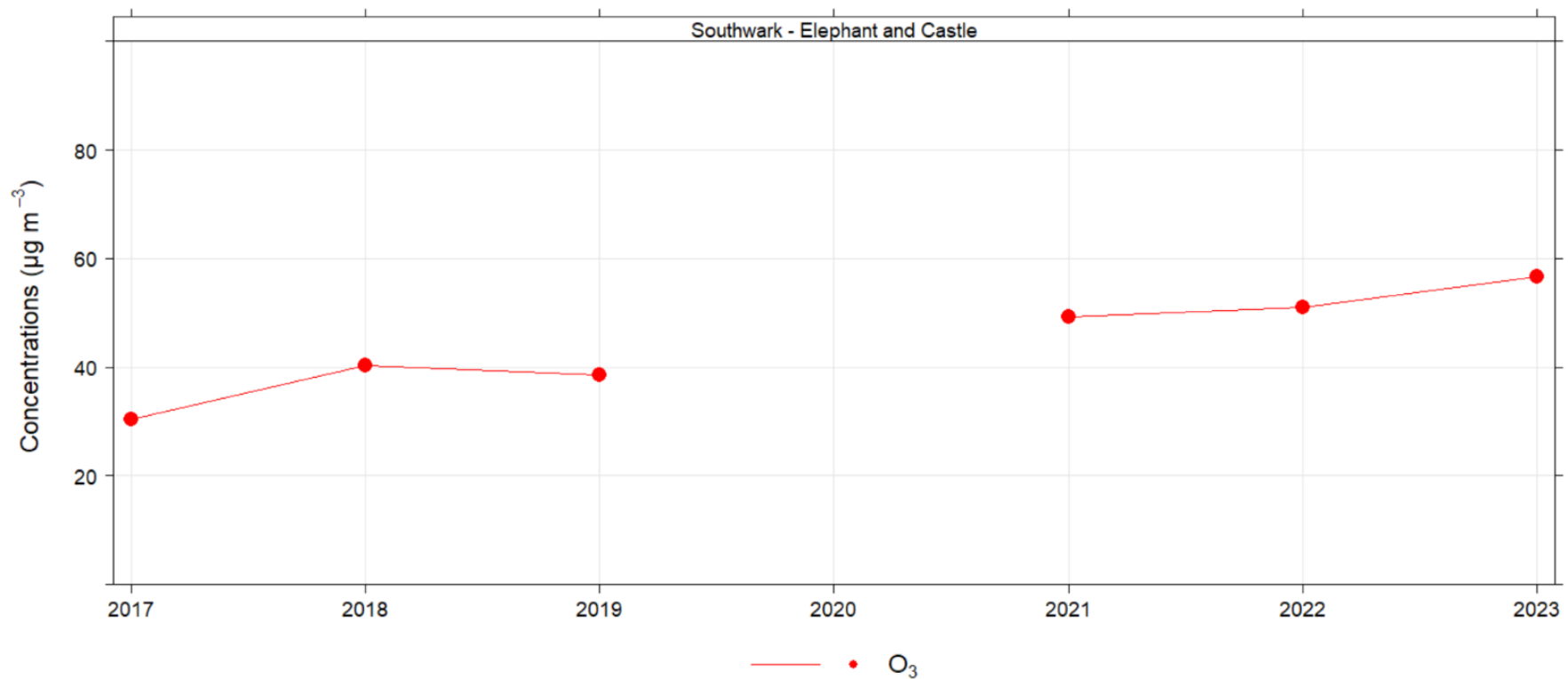
Exceedances of the O₃ 8 hourly running mean objective (100 µg.m⁻³ not to be exceeded more than 10 times a year) are shown in **bold**.

(a) Data capture for the monitoring period, in cases where monitoring was only carried out for part of the year

(b) Data capture for the full calendar year (e.g. if monitoring was carried out for six months the maximum data capture for the full calendar year would be 50%).

Figure 15 - Trend in Annual Mean O₃ Concentrations at Southwark's Existing Air Quality Monitoring Station, 2017 – 2023

Annual mean O₃ concentrations at Elephant & Castle



Note: Means below 75% data capture for the calendar year have been excluded from graph.

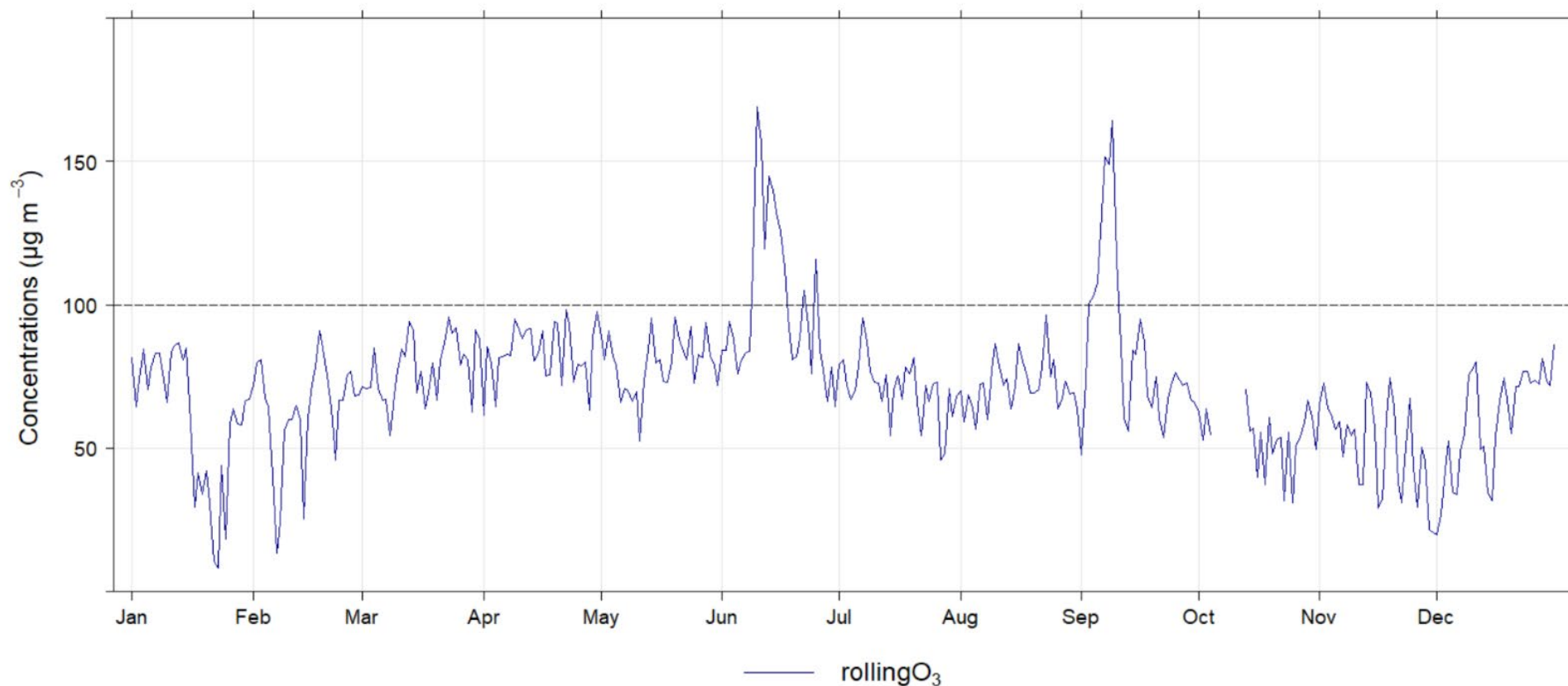
Figure 16 - Trend in Annual Mean O₃ Concentrations at Southwark's Existing And Past Air Quality Monitoring Stations, 2000 – 2023



Note: Means below 75% data capture for the calendar year have been excluded from graph.

Figure 17 – Daily Maximum 8-Hour Running Mean O₃ Concentrations at Southwark’s Continuous Air Quality Monitoring Station in 2023

Daily maximum 8-hour rolling mean O₃ concentrations at Elephant & Castle



Discussion of Trends in O₃ concentrations

Continuous monitoring of O₃ is undertaken at the Elephant and Castle background monitoring site. O₃ is a transboundary pollutant; the sources of O₃ are frequently spatially distant from the measured site of the concentrations. This pollutant does not have a prescribed air quality objective for LLAQM purposes; however, it has been reported as recommended by the GLA.

There has been a notable increase in O₃ concentrations in the recent years (**Table N** and **Figures 15 and 16**). There is no LLAQM standards for O₃, however, the national Air Quality Strategy standards establish a limit of 100 µg.m⁻³ not to be exceeded more than 10 times a year for the 8 hourly running mean. This limit has been consistently exceeded at the Elephant and Castle site since 2020 (**Table N**). **Figure 17** shows that two periods of elevated O₃ concentrations recorded in 2023 took place in June and September.

2. Action to Improve Air Quality

2.1 Air Quality Management Areas

Air Quality Management Areas (AQMAs) are declared when there is an exceedance or likely exceedance of an air quality objective. After declaration, the authority should prepare an Air Quality Action Plan (AQAP) within 12 months. The AQAP should specify how air quality targets will be achieved and maintained, and provide dates by which measures will be carried out.

A summary of AQMAs declared by London Borough of Southwark can be found in **Table O**. The table presents a description of the AQMA that is currently designated within the Southwark Borough. Appendix C provides a map of the AQMA and also the air quality monitoring locations in relation to the AQMA. The air quality objectives pertinent to the current AQMA designation are as follows:

- NO₂ annual mean
- PM₁₀ 24-hour mean

Pollutant concentrations may vary significantly from one year to the next, due to the influence of meteorological conditions. Before considering revocation of the AQMA on the basis of measured pollutant concentrations, Southwark needs certainty that any future exceedances (that might occur in more adverse meteorological conditions) are unlikely. Southwark will not consider revocation of the Air Quality Management Area until measurements carried out over several years, national trends in emissions, local emissions factors and national monitoring information, all indicate that the AQMA should be revoked. **Tables H, J, K, L and O** indicate that these conditions have not yet been met. Furthermore, in order to avoid revocation of the Air Quality Management Area followed soon after by the need for re-declaration, Southwark will also consider the potential for air quality standards to be more strict in future, and for this purpose will consider changes in international guidance issued by the World Health Authority, alongside the UK national air quality standards and objectives.

Table O - Declared Air Quality Management Areas

AQMA Name	Date of Declaration	Pollutants and Air Quality Objectives	One Line Description	Is air quality in the AQMA influenced by roads controlled by Highways England?	Level of Exceedance: Declaration	Level of Exceedance: Current Year	Number of Years Compliant with Air Quality Objective	Name and Date of AQAP Publication	Web Link to AQAP
Southwark AQMA	Declared 01/06/2003, Amended 08/06/2023	NO ₂ – Annual Mean	Whole Borough	NO – LBS & TfL	43.0µg.m ⁻³ . (Southwark 1) 68.8µg.m ⁻³ . (Southwark 2)	41.6µg.m ⁻³ . (SDT 18) 39.1µg.m ⁻³ . (SDT 81) 38.8µg.m ⁻³ . (SDT 24) 37.4µg.m ⁻³ . (SDT 87) 37.2µg.m ⁻³ . (SDT 29) 36.4µg.m ⁻³ . (SDT 104) 36.4µg.m ⁻³ . (SDT 113)	Historical sites Southwark 1 and Southwark 2 were located in the north area of the district. Although those sites had been closed down, more recent monitoring continues to show that some locations remain above or close to the objective level. Compliance has been achieved in the south part of the district.	LBS AQAP 2022-2027, January 2023	LBS AQAP 2022-2027
Southwark AQMA	Declared 01/06/2003, Amended 08/06/2023	PM ₁₀ – 24-Hour Mean	Whole Borough	NO – LBS & TfL	32* (Southwark 1) 39* (Southwark 2)	5* (SKB Vicarage Grove) 3* (SK9 Old Kent Road) 1*	Monitoring has shown legal compliance with PM ₁₀ objectives, however WHO standards for particulate matter have not been met at some monitoring sites.	LBS AQAP 2022-2027, January 2023	LBS AQAP 2022-2027

AQMA Name	Date of Declaration	Pollutants and Air Quality Objectives	One Line Description	Is air quality in the AQMA influenced by roads controlled by Highways England?	Level of Exceedance: Declaration	Level of Exceedance: Current Year	Number of Years Compliant with Air Quality Objective	Name and Date of AQAP Publication	Web Link to AQAP
						(SK8 Tower Bridge; SKA Lower Rd)			

* Number of exceedances of the 24-hour mean objective of 50 µg.m⁻³

- London Borough of Southwark confirm the information on UK-Air regarding their AQMA(s) is up to date
- London Borough of Southwark confirm that all current AQAPs have been submitted to GLA

2.2 Air Quality Action Plan Progress

Table P provides a brief summary of Southwark Council progress against the Air Quality Action Plan, showing progress made this year. New projects which commenced in 2023 are shown at the bottom of the table.

Table P - Delivery of Air Quality Action Plan Measures

LLAQM Action Matrix Theme - Monitoring and other core statutory duties

Action ID	Action	Outputs, Targets and KPIs	Progress <ul style="list-style-type: none"> • Emissions/Concentration data <ul style="list-style-type: none"> • Benefits • Negative impacts / Complaints
1.1	Maintain the Authority's automatic air quality monitoring stations in the Borough	All monitors maintained and over 90% data capture annually	<ul style="list-style-type: none"> • All stations were maintained, serviced and calibrated to current guidance. • No emissions / concentrations benefits but critical in terms of understanding emissions.
1.2	Maintain the Authority's Nitrogen Dioxide Diffusion Tube Survey in the Borough in accordance with current guidance	All diffusion tube results to be published within 5 weeks of collection on the website	<ul style="list-style-type: none"> • The diffusion tube network was maintained at 2022 level, and the in accordance with current guidance. • Data Analyst resource provided to progress creation of air quality dashboard. • No emissions / concentrations benefits but critical in terms of understanding emissions.
1.3	Work with the GLA Breathe London Project	Southwark has several sites in Borough, details to be reported annually.	<ul style="list-style-type: none"> • All sensor networks including Breathe London were maintained in accordance with current guidance. <ul style="list-style-type: none"> • Data can be accessed at https://www.breathelondon.org/

Action ID	Action	Outputs, Targets and KPIs	<p style="text-align: center;">Progress</p> <ul style="list-style-type: none"> • Emissions/Concentration data <ul style="list-style-type: none"> • Benefits • Negative impacts / Complaints
			<ul style="list-style-type: none"> • Data Analyst resource provided to progress creation of air quality dashboard. • No emissions / concentrations benefits but critical in terms of understanding emissions.
1.4	Prepare and produce all London Local Air Quality Management Framework reports as required.	<p style="text-align: center;">Submission of the Annual Status Report to the GLA</p> <p style="text-align: center;">KPI – Report submitted by the 31st May each year</p>	<ul style="list-style-type: none"> • All reports required by the London Local Air Quality Management Framework were produced and submitted. This report to be submitted by the new London-wide extended deadline of 31st July 2024. • No direct emissions / concentrations benefits but critical in terms of air quality work.
1.5	New publicly consulted Air Quality Action Plan every 5 years	<p style="text-align: center;">The next full revised Air Quality Action Plan is due 2028</p> <p style="text-align: center;">KPI – Report submitted by the 31st May each year</p>	<ul style="list-style-type: none"> • A final version of AQAP 2023-2027 was published in August 2022. • Reduction in emissions of Particulate Matter and Nitrogen Dioxide depending on the nature of the measures.
1.6	Review the Authority's Air Quality Management Area and air quality action plan annually	<p style="text-align: center;">Review every year when preparing the Annual Status Report</p> <p style="text-align: center;">ASR will have an annual progress note published within it</p>	<ul style="list-style-type: none"> • The AQMA designation for annual mean NO₂ was reviewed and approved by Cabinet in 2022, AQMA boundary amended on UK-Air website in June 2023. • The AQAP 2023–2027 is reviewed: a) quarterly through internal processes, and b) annually through the ASR reporting process. • No emissions / concentrations benefits but critical in terms of understanding emissions.
1.7	Respond to all appropriate air quality consultations	<p style="text-align: center;">Consultation to be responded within consultation timetable</p>	<ul style="list-style-type: none"> • The Environment Protection Team received and responded to all air quality related consultations during the year.

Action ID	Action	Outputs, Targets and KPIs	<p style="text-align: center;">Progress</p> <ul style="list-style-type: none"> • Emissions/Concentration data <ul style="list-style-type: none"> • Benefits • Negative impacts / Complaints
			<ul style="list-style-type: none"> • Possible reduction in emissions of Particulate Matter and Nitrogen Dioxide depending on the nature and outcome of the consultation.
1.8	Support the introduction of a new or revised Clean Air Act that improves public protection from atmospheric pollution	To lobby Government for the introduction of the Clean Air Act and / or GLA to introduce new Clean Air provisions within a London Local Authority Act	Measure complete. LBS was in support of changes to the smoke control area regime, which were implemented in the Environment Act 2021.
1.9	Respond to Defra's Environment Act 2021 consultation in setting a PM _{2.5} target to improve public protection from Particulate Matter (PM _{2.5}) atmospheric pollution	To lobby Government for the inclusion of WHO PM _{2.5} guidelines into the Environment Act 2021 regulations	Measure complete.
1.10	Promote delivery of information on pollen	AirTEXT distributes information on pollen, which is available through a daily text	<ul style="list-style-type: none"> • Pollen alerts are shared with the public through the AirText service. • No emissions / concentrations benefits.
1.11	To adopt the World Health Organization air quality guidelines	<p>L.B. Southwark to adopt the guidelines as part of Air Quality Action Plan and work with the Mayor of London towards meeting the standard by 2030</p> <p style="text-align: center;">KPI – Report annually</p>	<ul style="list-style-type: none"> • Guidelines were adopted in the new AQAP. • LBS is committed to achieving World Health Organisation targets for Particulate Matter in accordance with the targets in the London Plan and the Environment Strategy. • Medium to High reduction in emissions of Particulate Matter and Nitrogen Dioxide.
1.12	Review best practice and technical guidance on the use of Low Cost Sensors	QA and QC report on performance of low cost sensors will be published in the ASR	<ul style="list-style-type: none"> • The EPT team has taken part in surveys on the use of low-cost air quality sensors. • The team has supported and welcomed the publication of a Code of Practice for the selection, deployment, and quality control of low-cost air quality sensor systems in outdoor ambient air -

Action ID	Action	Outputs, Targets and KPIs	<p style="text-align: center;">Progress</p> <ul style="list-style-type: none"> • Emissions/Concentration data <ul style="list-style-type: none"> • Benefits • Negative impacts / Complaints
			<p style="text-align: center;">Low Cost AQ Sensor Code of Practice: PAS 4023:2023.</p> <ul style="list-style-type: none"> • No emissions / concentrations benefits but critical in terms of understanding emissions.
1.13	Embed air quality considerations in all new Council policies.	Report annually in the ASR	<ul style="list-style-type: none"> • When relevant policies are due to be updated, the policy is reviewed to ensure that air quality improvements are included in the revised document. • Small to High reduction in emissions of Particulate Matter and Nitrogen Dioxide.
1.14	Maintain the Authority's sensor network in the Borough in accordance with current guidance	All monitors maintained and data published on website	<ul style="list-style-type: none"> • A sensor monitoring survey was in operation throughout 2023. LBS have been investigating budget options for the QA/QC work. • Data Analyst resource provided to progress creation of air quality dashboard. • No emissions / concentrations benefits but critical in terms of understanding emissions.

LLAQM Action Matrix Theme - Emissions from developments and buildings

Action ID	Action	Outputs, Targets and KPIs	Progress <ul style="list-style-type: none"> • Emissions/Concentration data <ul style="list-style-type: none"> • Benefits • Negative impacts / Complaints
2.1	Ensuring emissions from construction are minimised by developers fully complying with Southwark's Technical Guidance for Demolition and Construction	All major sites to submit an Air Quality Assessment in accordance the current version of the GLA's guidance "The Control of Dust and Emissions during Construction and Demolition Supplementary Planning Guidance". Review Highways standard contract terms in 2025-2026 to address idling at road works and generator types. KPI - All applications met the requirements of the technical guide.	<ul style="list-style-type: none"> • EPT officers work plans ensure that the requirements are practically met. <ul style="list-style-type: none"> • All development must comply with Southwark's Technical Guidance for Demolition and Construction: https://www.southwark.gov.uk/assets/attach/3011/Technical-Guidance-for-Demolition-Construction.pdf • Medium to High reduction in emissions of Particulate Matter and Nitrogen Dioxide.
2.2	All Major development sites to submit a demolition management (DEMP) and / or Construction Management Plan (CEMP)	Annual reporting of number of Demolition Management Plans and Construction Management Plans that have been reviewed KPI - Number of reviews of Demolition Management Plans and Construction Management Plans	<ul style="list-style-type: none"> • This was required of all Major⁴ development. • 13 planning applications were approved in 2023 with a CEMP. • Medium to High reduction in emissions of Particulate Matter and Nitrogen Dioxide.
2.3	Ensuring all medium and high risk sites have real – time PM monitoring on site and that the information from this monitoring is easily accessible to the public	Annual reporting of number of sites that are reporting site monitoring KPI - Number of construction sites with site monitoring	<ul style="list-style-type: none"> • This was required of all Major⁵ development. • Medium to High reduction in emissions of Particulate Matter and Nitrogen Dioxide.

⁴ A MAJOR development is defined by Town and Country Planning (Development Management Procedure) Order (England) 2015: <https://www.legislation.gov.uk/uksi/2015/595/article/2/made>

⁵ As above

Action ID	Action	Outputs, Targets and KPIs	<p style="text-align: center;">Progress</p> <ul style="list-style-type: none"> • Emissions/Concentration data <ul style="list-style-type: none"> • Benefits • Negative impacts / Complaints
		KPI - Review technical guide to ensure appropriate mitigation and dust management responses	
2.4	Ensuring emissions from construction are minimised by developers by submitting a transport logistics assessment in accordance with Transport for London's (TfL) Construction Logistics guidance	<p>All major sites to submit a Transport Logistics in accordance the current version of the TfL guidance</p> <p>Control of construction vehicles delivery times to reduce impact on local communities congestion and air quality</p> <p>KPI - 100% of all major sites</p>	<ul style="list-style-type: none"> • New requirement has been implemented for all development to have a Construction Logistics Plan. • Medium to High reduction in emissions of Particulate Matter and Nitrogen Dioxide.
2.5	Produce a construction code of practice for minor sites to be used as informative	<p>Information to be secured by either planning conditions or s106 agreements</p> <p>KPI - Annual reporting of informatives issued</p>	<ul style="list-style-type: none"> • The GLA's "The Control of Dust and Emissions during Construction and Demolition Supplementary planning guidance can be found at https://www.london.gov.uk/programmes-strategies/planning/implementing-london-plan/london-plan-guidance-and-spgs/control-dust-and#:~:text=The%20aim%20of%20this%20supplementary,for%20non%2Droad%20mobile%20machinery • LBS has scheduled this work stream for 2024. • Medium to High reduction in emissions of Particulate Matter and Nitrogen Dioxide.
2.6	Minimise emissions from construction by ensuring all construction site Non-Road Mobile Machinery (NRMM) comply with the	<p>All relevant Planning applications to include the appropriate NRMM condition</p> <p>KPI - 100% of all relevant applications</p>	<ul style="list-style-type: none"> • London Borough of Merton are contracted to undertake construction site NRMM inspection visits as part of a pan London project.

Action ID	Action	Outputs, Targets and KPIs	<p style="text-align: center;">Progress</p> <ul style="list-style-type: none"> • Emissions/Concentration data <ul style="list-style-type: none"> • Benefits • Negative impacts / Complaints
	London Environment Strategy Policy 4.2.3a	<p>Southwark to maintain an updated list of construction sites on a quarterly basis KPI - Four lists each year</p> <p>Southwark to subscribe to the Mayor's Air Quality Fund South London NRMM Enforcement Project KPI - Annual subscription paid</p> <p>Mayor's Air Quality Fund South London NRMM Enforcement Project to submit regular reports to Southwark KPI - Four reports each year</p> <p>Southwark's Environment Protection Team to investigate all non-compliant sites as reported by the NRMM Lead Authority KPI - All non – compliant sites investigated</p>	<ul style="list-style-type: none"> • Annual subscription to the pan-London project was paid. • LBS maintained a list of construction sites in 2023 and all sites found non-compliant were investigated. • Low to High reduction in emissions of Particulate Matter and Nitrogen Dioxide.
2.7	Ensuring emissions from construction and demolition sites are minimised by developers to comply with the London Environment Strategy Policy 4.2.3	<p>All major sites to submit an Air Quality Assessment in accordance the current version of the GLA's The Control of dust and emissions during Construction and Demolition Supplementary Planning Guidance"</p> <p>KPI - 100% of all relevant applications</p> <p>KPI - Annual reporting of the number of NRMM conditions / s106 interventions</p>	<ul style="list-style-type: none"> • LBS secured funding for a Construction Monitoring Officer, whose role will be look to progress and report on all measures aimed at tackling emissions from construction sites and events. • EPT officers work plans ensure that the requirements are practically met. • Medium to High reduction in emissions of Particulate Matter and Nitrogen Dioxide.

Action ID	Action	Outputs, Targets and KPIs	<p style="text-align: center;">Progress</p> <ul style="list-style-type: none"> • Emissions/Concentration data <ul style="list-style-type: none"> • Benefits • Negative impacts / Complaints
2.8	Continue to control emissions from permitted processes via inspection and enforcement	<p>Annual reporting of number of inspections in accordance with LAPPC risk regime and number of enforcement notices.</p> <p>KPI - Report to be submitted to Defra by the due date</p>	<ul style="list-style-type: none"> • LBS complied with the inspection schedule. • The report will be submitted in 2024. • Low reduction in emissions of Particulate Matter and Nitrogen Dioxide.
2.9	Enforce Air Quality Neutral Policy and Air Quality Positive Policy	KPI - All Planning applications with boilers or other heat sources to be given a standard planning condition which requires pre-occupation information or testing reports to be submitted to Planning.	<ul style="list-style-type: none"> • This measure was agreed in principle with Planning in 2023. • LBS received one air quality positive application in 2023 and it was accepted (see application ref. 23/AP/1854). • All planning applications that were granted permission in 2023 met the air quality neutral requirements. • Low to High reduction in emissions of Particulate Matter and Nitrogen Dioxide.
2.10	Master planning and redevelopment areas aligned with the Air Quality Positive and Healthy Streets approach	<p>KPI - Complete review of Southwark Plan in the context of air quality</p> <p>KPI - Respond to the Sustainable Transport Plan consultation to include improvements to air quality in 2022 – 2023</p>	<ul style="list-style-type: none"> • Planners have programmed the review in late 2024. • EH team responded to the Sustainable Transport Plan consultation. • See Southwark Plan Policy 65 and Climate Change Action Plan A.1.iii ⁶

⁶ <https://www.southwark.gov.uk/assets/attach/128550/Climate-Change-Action-Plan-Accessible.pdf>

Action ID	Action	Outputs, Targets and KPIs	Progress
			<ul style="list-style-type: none"> • Emissions/Concentration data <ul style="list-style-type: none"> • Benefits • Negative impacts / Complaints
2.11	Promoting and delivering energy efficiency and energy supply retrofitting projects in all buildings through Energy for Londoners (EfL) retrofit programmes such as RE:FIT, RE;NEW, DEEP and through Borough carbon offset funds.	<p>KPI - Implement improvements to Council Medium Combustion Plant (MCP) to reduce emissions and improve monitoring by 2025</p> <p>KPI - Retrofit to improve energy efficiency at five libraries and three children centres by 2024</p>	<ul style="list-style-type: none"> • Low to High reduction in emissions of Particulate Matter and Nitrogen Dioxide. • All MCP boilers underwent emission tests in 2023. • Retrofit work for the libraries and children centres commenced in 2023 and is in progress. • See Climate Change Action Plan D.1.iii, D.1.iv, D.1.vii, D.2.ix, & E.2 ⁷ • Low to High reduction in emissions of Particulate Matter and Nitrogen Dioxide.
2.12	Southwark's Smoke Control Area (SCA) is fully promoted and enforced (GLA mandatory action)	<p>Enforce the requirements of the Clean Air Act in the Borough</p> <p>KPI - 100% of service requests investigated</p> <p>Enforce the requirements of the Environment Act in the Borough to control the sale of unauthorised solid fuels.</p> <p>KPI - At least one campaign per year.</p> <p>KPI - When appropriate formal action to be taken in 100% of cases.</p> <p>Publicise on a regular basis that whole of Southwark is a Smoke Control Zone</p> <p>KPI - At least one campaign per year.</p>	<ul style="list-style-type: none"> • Southwark's Smoke Control Area can be found at https://www.southwark.gov.uk/assets/attach/1468/smoke-control-order-2009.pdf • A grant application was submitted to Defra in July 2023 and was approved in principle in November 2023 to extend the SCA to inland waterways. • Full attendance of the GLA Wood Burning Group meetings and participation in the pan-London campaigns. • Smoke enforcement action was taken for all relevant cases and appropriate notices served. • Low to High reduction in emissions of Particulate Matter and Nitrogen Dioxide.

⁷ <https://www.southwark.gov.uk/assets/attach/128550/Climate-Change-Action-Plan-Accessible.pdf>

Action ID	Action	Outputs, Targets and KPIs	<p style="text-align: center;">Progress</p> <ul style="list-style-type: none"> • Emissions/Concentration data <ul style="list-style-type: none"> • Benefits • Negative impacts / Complaints
		Attend the GLA Wood Burning Working Group and contribute to the outcomes of the group.	
2.13	Ensuring adequate, appropriate and well located green space and infrastructure is included in new and existing developments	<p>KPI - The number of new green infrastructure granted through the planning process in the year</p> <p>KPI - The number of new green infrastructure implemented in the year</p>	<ul style="list-style-type: none"> • This KPI needs changing as the data is not collected in this way. Green infrastructure projects has not been defined. Figures that are available include a Net Gain in the Number of Trees, and Biodiversity Net Gain (not commenced in 2023). • Low to High reduction in emissions of Particulate Matter and Nitrogen Dioxide.
2.14	Reducing emissions from all Combustion Plant	<p>All developments to comply with the London Plan heating hierarchy and that air quality and carbon emissions are fully assessed in planning applications</p> <p>KPI - 100% of all relevant applications</p> <p>KPI - Annual reporting of the number of conditions / s106 interventions</p> <p>KPI - Number of ultra-low NOX boilers / heat pumps installed in the year</p>	<ul style="list-style-type: none"> • The work plan of the Development Control Officers contains requirement to ensure that London Plan heating hierarchy is met and assessed. • There were no S106 deeds signed in 2023 which contain a specific air quality contribution. • Conditions relating to “combustion plant” or 'heating networks' were attached to two planning approvals – see ref. 22/AP/1063 and ref. 23/AP/0768 • Low to High reduction in emissions of Particulate Matter and Nitrogen Dioxide.
2.15	To reduce emissions of Particulate Matter from commercial kitchens especially PM _{2.5}	Devise and complete a pilot project to produce technical guidance for kitchen operators to reduce emissions of PM _{2.5} .	<ul style="list-style-type: none"> • LBS explored options for a pilot project to produce technical guidance for kitchen operators to reduce emissions of PM_{2.5}. Not progressed due to resources at present. • LBS to contact any catering chains with a Southwark Home Authority agreement, to discover whether they

Action ID	Action	Outputs, Targets and KPIs	<p style="text-align: center;">Progress</p> <ul style="list-style-type: none"> • Emissions/Concentration data <ul style="list-style-type: none"> • Benefits • Negative impacts / Complaints
			<p>may have any interest in participating in a project to validate the current air quality modelling due to commercial catering in the London Atmospheric Emissions Inventory. See comment above.</p> <ul style="list-style-type: none"> • Low to Medium reduction in emissions of Particulate Matter and Nitrogen Dioxide.
2.16	Embed air quality in designs of estates	<p>KPI - Number of Design Briefs produced that include air quality principles</p> <p>KPI - Number of Air Quality Positive Estates built in the year</p>	<ul style="list-style-type: none"> • No design briefs produced in 2023. • No Air Quality Positive Estates were proposed during 2023, however one air quality positive development was proposed in 2023: ref. 23/AP/1854. • Highways and regeneration teams would have included air quality in project design. • Low to High reduction in emissions of Particulate Matter and Nitrogen Dioxide.
2.17	Reducing emissions from Combustion Plant in heating networks	<p>Officers to regularly update the borough – level energy masterplan and identify opportunities for new heat networks as well as extending or inter-connecting existing networks to support cleaner, lower carbon heat supply.</p> <p>Installation of heat pumps on site in three locations - Consort, Newington & Wyndham</p> <p>KPI: Confirmation of the completion of all 3 sites</p> <p>KPI: Annual reporting of the number of conditions / s106 interventions</p>	<ul style="list-style-type: none"> • Three sites completed for the installation of ASHP: Consort, Newington & Wyndham. • An Energy Use review has been carried for operational buildings, it planned to repeat the review for state schools and the housing estate. • Regular meetings were held with s106 Compliance Manager.

Action ID	Action	Outputs, Targets and KPIs	<p style="text-align: center;">Progress</p> <ul style="list-style-type: none"> • Emissions/Concentration data <ul style="list-style-type: none"> • Benefits • Negative impacts / Complaints
		<p>Regular meetings held throughout the year with the s106 compliance manager</p> <p>Complete feasibility studies (with input from residents) which will allow every estate in the borough to design plans to move away from gas as an energy source</p> <p>KPI: Procurement of ten detailed feasibility studies to set the scope for upcoming major decarbonisation works at high priority estates. Southwark will be consulting with residents as part of the works process.</p> <p>Identifying combustion sources where cost effective carbon reduction with substantial air quality benefits</p> <p>KPI: Annual reporting of energy use in Council owned buildings.</p>	<ul style="list-style-type: none"> • The total carbon emissions from LBS operational buildings for 2021/22 were estimated at 5,997 tCO_{2e}⁸. • See Climate Change Action Plan E.2.ii and E.2.iii ⁹ • Low to High reduction in emissions of Particulate Matter and Nitrogen Dioxide.

⁸ Draft *Operational Buildings Decarbonisation Strategy 2024*, London Borough of Southwark, 2024.

⁹ <https://www.southwark.gov.uk/assets/attach/128550/Climate-Change-Action-Plan-Accessible.pdf>

LLAQM Action Matrix Theme - Public health and awareness raising

Action ID	Action	Outputs, Targets and KPIs	<p style="text-align: center;">Progress</p> <ul style="list-style-type: none"> • Emissions/Concentration data <ul style="list-style-type: none"> • Benefits • Negative impacts / Complaints
3.1	Public Health having shared responsibility for borough air quality issues	<p>Director of Public Health to chair Air Quality Steering Group KPI - Annual progress report</p> <p>The Public Health - Place & Health Improvement Team actively involved with Air Quality Projects KPI- Annual progress report</p> <p>Biennial review of Southwark's Joint Strategic Needs Assessment (Air Quality) ('Air Quality JSNA'). KPI - Annual progress report</p> <p>Air Quality is a Health and Wellbeing Board priority KPI - Annual report to the Health and Wellbeing Board</p>	<ul style="list-style-type: none"> • The Director of Public Health chairs the Air Quality Steering Group. Public Health have been involved with air quality work across the council, including with EPT, Construction, Housing, and schools. EH have supported Public Health's air quality work, including the Annual Public Health Report 2023 which focuses on air quality. Projects include co-developing training to support construction compliance officers to comply with air quality regulations, offering schools and care homes funding to install air filter units, supporting the redesign of the airTEXT service, and improving air quality through school Superzones. • The air quality JSNA was published in 2022. It was reviewed in 2023 when it fed into the Annual Public Health Report about air quality. • The Health and Wellbeing Board were updated on air quality action at a board meeting in 2023. The Annual Public Health Report was presented to board members, focusing on indoor and outside air quality along with recommendations for stakeholders working on air quality. • Low reduction in emissions of Particulate Matter and Nitrogen Dioxide.
3.2	Work with the Public Health Team to strengthen engagement with Southwark Clinical Commissioning Group and GP surgeries	To promote the Airtext service through the GP's and other health providers KPI - Report annually on the progress	<ul style="list-style-type: none"> • The Public Health team is part of the air quality alerts cascade system in the council. Public Health is also an active member of the airTEXT review project which will be used to promote airTEXT through health services.

Action ID	Action	Outputs, Targets and KPIs	<p style="text-align: center;">Progress</p> <ul style="list-style-type: none"> • Emissions/Concentration data <ul style="list-style-type: none"> • Benefits • Negative impacts / Complaints
			<ul style="list-style-type: none"> • Reduction in emissions of Particulate Matter and Nitrogen Dioxide by undertaking the measures in this Action Plan.
3.3	Engagement on air quality issues with Business through the Borough's Business Improvement Districts.	KPI - Number of businesses actively engaged on air quality KPI - Number of businesses acting to reduce emissions	<ul style="list-style-type: none"> • Launch of Thriving High Streets Fund (THSF) in Q1 2023/24. Developed to support thriving town centres and high streets in Southwark. Grants of up to £25k available with a focus on a greener Southwark and healthy and safe high streets as cross cutting themes. In total, 50 applications were received in Round 1 and grants awarded to 11 projects across the borough. Round 2 of THSF to launch in Q4 2023/24. • Low reduction in emissions of Particulate Matter and Nitrogen Dioxide.
3.4	Southwark supports Airtext and promotes and shares the GLA high pollution alert services (GLA mandatory action)	Southwark annual subscription to the Airtext service operated by Cambridge Environmental Research Consultants (CERC) To promote the Airtext service through the GP's and other health providers KPI - Number of Airtext subscribers in the Borough To cascade the London Mayor's High and very High pollution alerts KPI - 100% High and Very High alerts cascaded	<ul style="list-style-type: none"> • At the end of 2023, Southwark had 431 subscribers receiving air quality alerts by SMS text message (289 subscribers), email (118 subscribers) and voicemail (24 subscribers). • This represents an increase of 37 (9.4%) compared with the end of 2022, when there were 394 Southwark airTEXT subscribers (269 text, 101 email and 24 voicemail). • All four of the High and Very High alerts in 2023 were cascaded to the schools and the public. • No emissions / concentrations benefits but helps avoid or mitigate the effects of high exposure.
3.5	Improve the uptake of Air Quality information to	Implementation of recommendations in the Air Alert Discovery project	<ul style="list-style-type: none"> • Further Discovery took place in 2023, and engagement with the community for the airTEXT Alerts project commenced in 2024.

Action ID	Action	Outputs, Targets and KPIs	<p style="text-align: center;">Progress</p> <ul style="list-style-type: none"> • Emissions/Concentration data <ul style="list-style-type: none"> • Benefits • Negative impacts / Complaints
	vulnerable persons in the Borough	KPI - Annual Communication Plan and campaign of relevant air quality improvement topics	<ul style="list-style-type: none"> • No measurable emissions / concentrations benefits but helps avoid or mitigate the effects of high exposure.
3.6	Provide air quality information leaflets at health care facilities, libraries, pharmacies and other frequently used facilities	KPI - Annual progress reports	<ul style="list-style-type: none"> • A set of ten 'top tips' to help people protect themselves from air pollution was developed. These are published on the council's website as part of the Annual Public Health Report 2023 and was circulate to a number of local stakeholders. Air quality information will also be circulated to libraries and GP surgeries, who have confirmed they are happy to do so. In addition, a pilot was running throughout 2023 to offer schools and care homes air filter units to improve air quality. As part of the evaluation, settings will receive information on air quality related to air filter units. • No measurable emissions / concentrations benefits but helps avoid or mitigate the effects of high exposure.
3.7	Promote School Air Quality Audits to all schools in the Borough (GLA mandatory action)	<p>To promote the London Mayor's School Pollution Helpdesk and GAP's online 'school air quality audit' and other promotion materials to all schools.</p> <p>A school audit evaluation report will be produced</p>	<ul style="list-style-type: none"> • A Final report for the Southwark School Air Quality Audit Programme 2020-2022 was published in April 2023. • Low reduction in emissions of Particulate Matter and Nitrogen Dioxide.
3.8	Reducing pollution in and around schools (GLA mandatory action)	<p>Implementation of recommendations from the Southwark Schools' Air Quality Audits</p> <p>At least one recommendation from each air quality audit is implemented annually</p> <p>Idling signage will be offered to all schools</p>	<ul style="list-style-type: none"> • A list for new school streets has been prepared. This has now been complete and has formed the basis for 24/25 programme. • A list of schools that would benefit from green screens was completed and will be shared with the air quality team to assess before contact made with Schools.

Action ID	Action	Outputs, Targets and KPIs	Progress
		<p>Develop priority list for new schools streets to be put in place</p> <p>Develop a list of schools that would benefit from green screens</p> <p>KPI - Implement 9 new school streets before 2026</p>	<ul style="list-style-type: none"> • Emissions/Concentration data <ul style="list-style-type: none"> • Benefits • Negative impacts / Complaints <ul style="list-style-type: none"> • Six new timed closures for school streets were implemented in 2023/24; these are: <ul style="list-style-type: none"> • St John's & St Clements, Goodrich Primary School, Dulwich Wood Primary School, James Allen Girls School (JAGS), Lyndhurst Primary School and Surrey Square Primary School. • Low to High reduction in emissions of Particulate Matter and Nitrogen Dioxide.
3.9	Encourage schools to join the TfL STARS accredited travel planning programmes	<p>Proportion of schools in Southwark with STARS Bronze, Accreditation each year</p> <p>Proportion of schools in Southwark with STARS Silver Accreditation each year</p> <p>Proportion of schools in Southwark with STARS Gold Accreditation each year</p>	<ul style="list-style-type: none"> • The total number of schools in Southwark is 94. At present we have: <ul style="list-style-type: none"> - 36 Gold accredited schools - 4 Silver accredited schools - 12 Bronze accredited schools • The work is ongoing. • Low reduction in emissions of Particulate Matter and Nitrogen Dioxide.
3.10	Assess the feasibility of Street Space measures around educational and health premises	<p>KPI - Annual progress report</p> <p>Implement additional 3 school streets every year.</p> <p>Review of all schools to determine any potential measures to reduce traffic near schools to be undertaken completed before 2024.</p>	<ul style="list-style-type: none"> • Six School Streets implemented in 2023. • Upgrade of streetspace outside Comber Grove Primary School complete. Plans in place to improve streetspace outside a number of other schools where timed closures are not feasible. • Review of all schools to determine any potential measures to reduce traffic near schools has been carried out and forms the basis of 2024/25 Highways Programme.

Action ID	Action	Outputs, Targets and KPIs	<p style="text-align: center;">Progress</p> <ul style="list-style-type: none"> • Emissions/Concentration data <ul style="list-style-type: none"> • Benefits • Negative impacts / Complaints
			<ul style="list-style-type: none"> • See Climate Change Action Plan G.4.iv ¹⁰ • Medium reduction in emissions of Particulate Matter and Nitrogen Dioxide.
3.11	To create school super zones in the Borough	<p style="text-align: center;">Annual progress report</p> <p style="text-align: center;">KPI – Number of School Super zones in the Borough</p>	<ul style="list-style-type: none"> • LBS has three superzones: Ark Walworth (created in 2022), St Francis (created in 2022) and Surrey Square (created in 2024). • Public Health has plans to create three more; these will be Bacons College, Keyworth and one more (to be decided). • Low to Medium reduction in emissions of Particulate Matter and Nitrogen Dioxide.
3.12	To create school walking maps for all schools in the Borough	<p style="text-align: center;">Annual progress report</p> <p style="text-align: center;">KPI - Number of School Walking Maps in the Borough</p>	<ul style="list-style-type: none"> • All Walking Maps are located here: www.southwark.gov.uk/school-walking-map • The maps are in alphabetical order per school. We have 50 maps in total, 25 maps produced in 22/23 and 25 maps in 23/24, this year. Further 25 maps will be made in 24/25. • The maps are offered to primary, SEN and nursery schools. The Highways team targets those in the high obesity/deprivation area first; then offer to those taking part in the timed school street closure programme and/or working towards their travel plan accreditation.

¹⁰ <https://www.southwark.gov.uk/assets/attach/128550/Climate-Change-Action-Plan-Accessible.pdf>

Action ID	Action	Outputs, Targets and KPIs	<p style="text-align: center;">Progress</p> <ul style="list-style-type: none"> • Emissions/Concentration data <ul style="list-style-type: none"> • Benefits • Negative impacts / Complaints
			<ul style="list-style-type: none"> • Low to Medium reduction in emissions of Particulate Matter and Nitrogen Dioxide.
3.13	Raising awareness about indoor air quality	<p style="text-align: center;">To produce a toolkit on domestic and commercial indoor air pollution and how to reduce personal exposure</p> <p style="text-align: center;">KPI - Indoor Air Quality toolkit produced</p>	<ul style="list-style-type: none"> • Joint applications for funding by the Central London Cluster Air Quality Group were unsuccessful so the project is waiting for funding. • Low to Medium reduction in emissions of Particulate Matter and Nitrogen Dioxide.
3.14	<p>Review the progress of recommendation 13 of the Chief Medical Officers report 2017</p> <p>a) Southwark Clinical Commissioning Group (CCG) Groups should analyse local air quality monitoring data for breaches of air pollution standards, and publish these alongside the local hospital data for impacts on admissions for respiratory and cardiovascular disease and</p> <p>b) Public Health England should aggregate and analyse progress</p>	<p style="text-align: center;">KPI - Annual progress report</p> <p>Work with NHS to develop a method to analyse air quality and correlation with admission and outpatient presentation data for air pollution related conditions</p>	<ul style="list-style-type: none"> • Meeting held with ICS colleague working on climate change to discuss areas to collaborate. Actions to date include further introductions to NHS colleagues working on air pollution and climate change, and sharing relevant networks or pieces of work. • No emissions / concentrations benefits but critical in terms of understanding impacts of air pollution.

Action ID	Action	Outputs, Targets and KPIs	Progress <ul style="list-style-type: none"> • Emissions/Concentration data <ul style="list-style-type: none"> • Benefits • Negative impacts / Complaints
	annually for a national public report to NHS England		

LLAQM Action Matrix Theme - Delivery servicing and freight

Action ID	Action	Outputs, Targets and KPIs	<p style="text-align: center;">Progress</p> <ul style="list-style-type: none"> • Emissions/Concentration data <ul style="list-style-type: none"> • Benefits • Negative impacts / Complaints
4.1	Develop guidance to support procurements and contracts that impact air quality.	<p>Council approach to consider impacts of air quality in Southwark when procuring goods and services</p> <p>Develop guidance for all departments to consider the impact of their procurement on air quality in Southwark</p> <p>Air quality considerations included within the specification or terms of procurement or contracts as most appropriate</p> <p>Develop a robust monitoring process to review effectiveness of air quality guidance on the procurement process KPI - Guidance developed</p> <p>Report on the number of contracts with air quality criteria as a specification of the contract on an annual basis</p> <p>Review TfL report findings into fleet vehicle speed limiters and consider inclusion in Fleet procurement policy</p>	<ul style="list-style-type: none"> • The procurement guide is under development. • Low to High reduction in emissions of Particulate Matter and Nitrogen Dioxide.
4.2	Installing bookable permit only loading bays at pilot projects.	<p>Annual progress reporting</p> <p>KPI – Number of bookable permit holder only Loading Bays in the Borough</p>	<ul style="list-style-type: none"> • Trial in Bankside (Kerb dock) - involving two virtual loading bays to be booked by local operators with a potential to link up with river freight- ended in 2023. However, the bays have remained in place and bookable. An evaluation report, signed off by Impact On Urban Health. An executive summary with action plan based on the consultation of workshops was produced. Project page and links to the documents: https://gridsmartercities.com/kerb-dock-project/

Action ID	Action	Outputs, Targets and KPIs	<p style="text-align: center;">Progress</p> <ul style="list-style-type: none"> • Emissions/Concentration data <ul style="list-style-type: none"> • Benefits • Negative impacts / Complaints
			<ul style="list-style-type: none"> • Grid Smarter Cities have continued working with the Swan pub and operators in the area to see them use the bays at Bankside. <ul style="list-style-type: none"> • Project page and the links to the documents: https://gridsmartercities.com/kerbdock/ • Trial in Walworth LEN – five bookable loading bays and one associated virtual bay - started in January 2024. • Low to High reduction in emissions of Particulate Matter and Nitrogen Dioxide.
4.3	Explore with the Port of London Authority (PLA) the methods of control of shipping emissions and use of shipping to mitigate land based emissions	<p style="text-align: center;">Annual progress reporting</p> <p style="text-align: center;">KPI: Reduction in NO_x, PM₁₀ & PM_{2.5} emissions</p> <p>Review riverside hotspot indicated by LAEI and consider further actions</p> <p>Submit consultation response on any future revision of PLA Air Quality Strategy</p>	<ul style="list-style-type: none"> • The PLA published its first Air Quality Strategy (AQS) in 2018, later updated in 2020. It contains a 5-year action plan to reduce emissions across the PLA's jurisdiction. An action from the AQS is the monitoring of emissions on the Thames. An AQMesh sensor with two NO₂ diffusion tubes has been collecting data at Tower Pier. • Specific classes of vessel must be fitted with Thames AIS (Automatic Identification System). The data, collected by the PLA, can be used for boat emission estimation. Emissions are also tracked through PLA's Maritime Emissions Portal (MEP). <ul style="list-style-type: none"> • EPT awaiting a revised AQAP from the PLA. • Medium to High reduction in emissions of Particulate Matter and Nitrogen Dioxide.
4.4	Support and engagement with river and rail movement projects.	Participation in three projects associated with river freight	<ul style="list-style-type: none"> • LBS supported Cross River Partnership in their river freight trial at Bankside Pier, and have worked with them in applying the lessons of this trial and supporting the development of freight traffic on the Thames.

Action ID	Action	Outputs, Targets and KPIs	<p style="text-align: center;">Progress</p> <ul style="list-style-type: none"> • Emissions/Concentration data <ul style="list-style-type: none"> • Benefits • Negative impacts / Complaints
			<ul style="list-style-type: none"> • See Climate Change Action Plan I.2.ii ¹¹ • Medium to High reduction in emissions of Particulate Matter and Nitrogen Dioxide.
4.5	Reducing emissions from delivering to local businesses and residents	<p>Percentage increase in Ultra Low emission Vehicles in Southwark</p> <p>Monitor survey information from cargo bikes e.g. bikes from bikes for business. Support click and collect projects</p> <p>Use connections to businesses and markets to facilitate shorter supply and distribution chains KPI - Work with the Business Improvement Districts to understand best practice in supporting local supply chains and how this can be rolled out to other areas of the borough</p> <p>Develop and deliver a Sustainable Freight and Last Mile Delivery Hubs Plan by 2026 that prioritises areas of greatest need and potential Support businesses to switch to zero pollution delivery vehicles, working with them to shift more local deliveries to electric cargo bikes Support and engage in all available projects that increase the use of cargo bikes and e-cargo vehicles KPI - Number of projects that supported</p>	<ul style="list-style-type: none"> • Internal working group convened to progress cargo bike funding in Southwark. • Streets for People included the support for the increase use of low- and ultra low emission vehicles in freight and servicing. These are being developed as part of the forthcoming Freight Plan. • Monthly monitoring data from the four cargo bikes in Southwark were received and are available on request. • See Climate Change Action Plan S.3.i, S.3.ii, S.3.iii ¹² • Low to High reduction in emissions of Particulate Matter and Nitrogen Dioxide.

¹¹ <https://www.southwark.gov.uk/assets/attach/128550/Climate-Change-Action-Plan-Accessible.pdf>

¹² As above

LLAQM Action Matrix Theme - Borough fleet

Action ID	Action	Outputs, Targets and KPIs	<p>Progress</p> <ul style="list-style-type: none"> Emissions/Concentration data <ul style="list-style-type: none"> Benefits Negative impacts / Complaints
5.1	Reducing emissions from Council Fleets (GLA mandatory action)	<p>Smarter Driver training for all fleet drivers KPI - All new drivers to receive training within six months of starting in Southwark</p> <p>Monitor the mileage and fuel use reports passed to Business Unit Managers KPI - Reduce the fossil fuel usage by 10% per year</p> <p>Every commercial vehicle procured to undergo full sustainability evaluation Climate Change Action Plan K.3.i KPI - Reduction of fossil fuel combustion vehicles in accordance with targets in the fleet strategy</p> <p>KPI - Proportion of vehicles within the Fleet that are electric, hydrogen, or hybrid.</p> <p>Fleet Strategy to promote sustainable travel KPI - Monitor and report on the EVCP at Tooley Street and Queens Road monthly</p> <p>Review of services to determine if activities can be replaced with e-bike or cargo bike.</p> <p>Identify new locations as part of EV strategy Design and implement a strategic plan to trial low emissions vehicles into the LGV/HGV fleet (including waste and highways)</p>	<ul style="list-style-type: none"> Fleet services started meetings with Business unit managers regarding the next procurement of fleet whilst going through mileage reports/ major repairs reports and seeing where possible to reduce fleet or change to EV. Fleet Services held meetings with all Business unit managers to discuss requirements and also explain the need for reduction of emissions within the next Fleet vehicles. EVCPs at Queens Road and Tooley Street are monitored for usage data. See Climate Change Action Plan K.3.i, K.3.ii, K.3.iii ¹³ Medium to High reduction in emissions of Particulate Matter and Nitrogen Dioxide.

¹³ <https://www.southwark.gov.uk/assets/attach/128550/Climate-Change-Action-Plan-Accessible.pdf>

LLAQM Action Matrix Theme - Localised solutions

Action ID	Action	Outputs, Targets and KPIs	Progress <ul style="list-style-type: none"> • Emissions/Concentration data • Benefits • Negative impacts / Complaints
6.1	Green infrastructure	<p>Monitoring and reporting of the impact of Green Infrastructure projects. KPI - Number of Green Infrastructure projects implemented by Southwark during the year</p> <p>Identify potential green corridors between key green spaces/Sites of Importance for Nature Conservation</p> <p>KPI - Review definition of green corridors within the early review of New Southwark Plan and consult on including within formal planning policy</p>	<ul style="list-style-type: none"> • This information has been requested and is pending. • A Diversity Net Gain is a new target that LBS can start reporting on under the Green Infrastructure KPI. <ul style="list-style-type: none"> • See Climate Change Action Plan V.2.i ¹⁴ • Low reduction in emissions of Particulate Matter and Nitrogen Dioxide.
6.2	Street Space Measures	<p>Complete the MAQF Low Emission Neighbourhood scheme in the Walworth Area</p> <p>Explore the opportunities to introduce further Streetspace Measures in Southwark when funding is available</p> <p>KPI - Review the 10 Streetspace Measures over the next 18 months</p>	<ul style="list-style-type: none"> • Low Emission Neighbourhood scheme in Walworth has been completed. <ul style="list-style-type: none"> • Based on community input, LBS adopted a comprehensive “Streets for People” strategy to improve street space measures. • See Climate Change Action Plan F.1.iv ¹⁵ • Low to High reduction in emissions of Particulate Matter and Nitrogen Dioxide.
6.3	Explore the feasibility with the Environment Agency to stop issuing D7 waste exemption:	KPI - Annual Reporting on progress	<ul style="list-style-type: none"> • The action has been achieved. The EP team will report the findings to the AQAP Steering Group.

¹⁴ <https://www.southwark.gov.uk/assets/attach/128550/Climate-Change-Action-Plan-Accessible.pdf>

¹⁵ As above

Action ID	Action	Outputs, Targets and KPIs	Progress <ul style="list-style-type: none"> • Emissions/Concentration data <ul style="list-style-type: none"> • Benefits • Negative impacts / Complaints
	burning waste in the open registration.		<ul style="list-style-type: none"> • Low reduction in emissions of Particulate Matter and Nitrogen Dioxide.
6.4	To lobby the Central Government and the GLA for policy changes to improve air quality in Southwark	KPI - Annual Reporting on progress Create evidence base for case to TfL for reducing emissions from buses. To include mapping all major traffic derived pollution areas including bus stops/interchanges.	<ul style="list-style-type: none"> • A study was commissioned by EPT and Highways to assess the contribution of bus emissions to total pollutant concentrations in Southwark. At locations where the modelled annual average NO₂ objective is exceeded, buses may contribute to less than 10% of the total NO_x, as seen along Old Kent Road. In contrast, at Elephant Square and St. George's Circus, buses can be responsible for over 40% of total NO_x. This highlights key areas where improving bus infrastructure would result in tangible improvements to air quality. • See Climate Change Action Plan H.1.i and H.1.iv ¹⁶ • Low to High reduction in emissions of Particulate Matter and Nitrogen Dioxide.
6.5	Apply for Mayor's Air Quality Funds and Defra Air Quality Grant to deliver air quality projects in Southwark	KPI - Annual Reporting on progress and project reports.	<ul style="list-style-type: none"> • Defra withdrew the Air Quality grant 2023/24. • When the application window opened for MAQF bids in November 2023 LBS prepared and submitted an application for a school project involving air quality monitoring and engagement for students suffering from asthma. The bid was successful, and the project will commence in 2024. • Low reduction in emissions of Particulate Matter and Nitrogen Dioxide.

¹⁶ <https://www.southwark.gov.uk/assets/attach/128550/Climate-Change-Action-Plan-Accessible.pdf>

Action ID	Action	Outputs, Targets and KPIs	Progress <ul style="list-style-type: none"> • Emissions/Concentration data <ul style="list-style-type: none"> • Benefits • Negative impacts / Complaints
6.6	To align the measures in Southwark's Climate Strategy and this action plan	KPI - Alignment of Councils strategies and Plans	<ul style="list-style-type: none"> • A number of actions in the Climate Change and Air Quality Plans were aligned and plans are under way to ensure updates to both plan take place concurrently. • Strategies (Streets for People, Walking Plan and Cycling Plan) were aligned. • Low to High reduction in emissions of Particulate Matter and Nitrogen Dioxide.

LLAQM Action Matrix Theme - Cleaner transport

Action ID	Action	Outputs, Targets and KPIs	<p style="text-align: center;">Progress</p> <ul style="list-style-type: none"> • Emissions/Concentration data <ul style="list-style-type: none"> • Benefits • Negative impacts / Complaints
7.1	Transport and air quality policies and projects are integrated	<p>KPI - The number of Healthy Streets projects delivered during the year</p> <p>KPI - The number of walking and cycling infrastructure projects delivered during the year</p>	<ul style="list-style-type: none"> • The number of Healthy Streets implemented is four: Cycleway 4 (Lower Road), Sydenham Hill 20mph, Southwark Spine (P4) and Browning Street. • All Highways schemes are set up to improve walking or cycling or both. Highways implemented 24 projects aimed at improving walking/cycling. • Low to High reduction in emissions of Particulate Matter and Nitrogen Dioxide.
7.2	Discouraging unnecessary idling by taxis and other vehicles	<p>KPI - Percentage of drivers complying with requests from Civil Enforcements Officers to switch the vehicle's engine off</p> <p>KPI - Respond to consultations on Public Carriage Vehicles</p> <p>KPI - Lobby Government on strengthening idling legislation</p>	<ul style="list-style-type: none"> • Civil enforcement ceased in 2023 due to concerns about legality of anti-idling signage. • Low reduction in emissions of Particulate Matter and Nitrogen Dioxide.
7.3	Regular temporary car free days and pedestrianisation schemes in line with proposal 4.2.1a of the London Environment Strategy	<p>KPI - Undertake 8 car free events.</p> <p>KPI - Number of new controlled pedestrian crossings (annual target) – 5 per year</p> <p>KPI - Number of level access/dropped kerb uncontrolled pedestrian crossings installed (annual target)</p>	<ul style="list-style-type: none"> • Car free events organised in 2023 were: Mums for Lungs Carnival of Clean Air; Comber Grove school event; Ewer Street Event; St Barnabas Church Christmas procession. Car free events will continue into 2024. • Highways installed 7 controlled pedestrian crossings during the 23/24. • Information on the number of uncontrolled pedestrian crossings was requested and is pending.

Action ID	Action	Outputs, Targets and KPIs	Progress <ul style="list-style-type: none"> • Emissions/Concentration data <ul style="list-style-type: none"> • Benefits • Negative impacts / Complaints
			<ul style="list-style-type: none"> • Low reduction in emissions of Particulate Matter and Nitrogen Dioxide.
7.4	Support the London Mayor to extend the Ultra-Low Emission Zone to the current LEZ boundary	KPI - Support implementation of ULEZ extension KPI - Respond to consultations on road charging.	<ul style="list-style-type: none"> • LBS was in support of the ULEZ expansion beyond the South Circular; the ULEZ was expanded on 29 August 2023. • There has been no consultation on road charging. • Low to High reduction in emissions of Particulate Matter and Nitrogen Dioxide.
7.5	Using parking policy to reduce pollution emissions	Implement borough-wide controlled Parking regime KPI - Coverage of 94% of the Borough by 2025	<ul style="list-style-type: none"> • LBS parking policy can be found in the Streets for People Policy: <ul style="list-style-type: none"> • <u>Streets for People - Southwark Council</u> • Borough-wide Controlled Parking Zones are planned for 2030 or sooner. <ul style="list-style-type: none"> • See Climate Change Action Plan G.4.iii ¹⁷ • Low to High reduction in emissions of Particulate Matter and Nitrogen Dioxide.
7.6	Installation of ultra – low emission vehicle infrastructure charging points	KPI - Percentage of electric vehicles registered in Southwark KPI - Install a further 1000 Electric Vehicle charging points in Southwark by 2026	<ul style="list-style-type: none"> • 1000 EV charge points were fully delivered in 2022/23. LBS new EV plan discusses other EV infrastructure needed to enable higher adoption rates of EV vehicles by residents.

¹⁷ <https://www.southwark.gov.uk/assets/attach/128550/Climate-Change-Action-Plan-Accessible.pdf>

Action ID	Action	Outputs, Targets and KPIs	Progress <ul style="list-style-type: none"> • Emissions/Concentration data <ul style="list-style-type: none"> • Benefits • Negative impacts / Complaints
		KPI - Implement a borough-wide strategy for EV infrastructure by 2023	<ul style="list-style-type: none"> • Low to High reduction in emissions of Particulate Matter and Nitrogen Dioxide.
7.7	Provision of infrastructure to support walking and cycling (GLA mandatory action)	<p>KPI - At least 1 kilometre of new segregated cycle lane installed every year</p> <p>KPI - Number of new cycle-hire docking stations in the Borough</p> <p>Improve access to walking in the borough and actively promote this as a zero-carbon method of transport</p> <p>Deliver the Equal Pavements Pledge, working with older people, those with disabilities and limited mobility to make sure Southwark's streets are accessible for everyone</p> <p>KPI - Number of Equal Pavement Pledge projects associated with improving walking</p> <p>Provide free cycle training for residents, including for young people, those with disabilities and cargo bike training</p>	<ul style="list-style-type: none"> • 1.3 km delivered under the Lower Road (C4) scheme. <ul style="list-style-type: none"> • No new cycle-hire docking stations has been implemented in 2023. • Cycling Plan consulted on, consultation closed 31st January 2024. Adoption planned for July 2024. • Request for more KPI statistics has been sent and the information is pending. • See Climate Change Action Plan F.1.i, F.1.ii, F.1.iv, F.1.vi ¹⁸ • Low to High reduction in emissions of Particulate Matter and Nitrogen Dioxide.
7.8	Review ability for bus lanes on borough roads to be used by non-emergency ambulances for patient transport.	KPI - Annual report of progress	<ul style="list-style-type: none"> • LBS decided not to take part in the Non-Emergency Bus Lane trial that took place as there was no sufficient evidence on the benefits of the trial to support the proposal. From an air quality perspective the concern was that the scheme would increase congestion in the bus lane. <ul style="list-style-type: none"> • Measure complete.

¹⁸ <https://www.southwark.gov.uk/assets/attach/128550/Climate-Change-Action-Plan-Accessible.pdf>

3 Planning Update and Other New Sources of Emissions

Table Q - Planning requirements met by planning applications Southwark Council in 2023

Condition	Number
Number of planning applications where an air quality impact assessment was reviewed for air quality impacts	36 (Returns records in the Planning database where an Air Quality Assessment was submitted as part of the application)
Number of planning applications required to monitor for construction dust	29 (Returns records in the Planning database where permission has been granted subject to a dust monitoring condition)
Number of CHP/Biomass boilers refused on air quality grounds	0 (Returns records in the Planning database where the proposal description contains 'CHP', 'heat', 'power' or 'biomass' and permission was refused citing air quality as a reason)
Number of CHPs/Biomass boilers subject to GLA emissions limits and/or other restrictions to reduce emissions	0 (Returns records in the Planning database where the proposal description contains 'CHP', 'heat', 'power' or 'biomass' and permission was granted subject to a condition containing the words 'reduce' and 'emission')
Number of developments required to install Ultra-Low NO _x boilers	2 (Returns records in the Planning database where the proposal description contains 'CHP', 'heat', 'power' or 'biomass' and permission was granted subject to a condition containing the words 'low', 'nox' and 'boiler')
Number of developments where an AQ Neutral building and/or transport assessments undertaken	15
Number of developments where the AQ Neutral building and/or transport assessments not meeting the benchmark and so required to include additional mitigation	1
Number of planning applications with S106 agreements including other requirements to improve air quality	There were no S106 deeds signed in 2023 which contain a specific air quality contribution. However, there were 3 schemes that had

	their S106 deed signed in the 2023 with a CEMP.
Number of planning applications with CIL payments that include a contribution to improve air quality	0
<p>NRMM: Central Activity Zone , Canary Wharf and Opportunity Areas Number of conditions related to NRMM included.</p> <p>Number of developments registered and compliant. Number of audits % of sites unregistered prior to audit Please include confirmation that you have checked that the development has been registered with the GLA through the relevant NRMM website and that all NRMM used on-site is compliant with Stage IV of the Directive and/or exemptions to the policy.</p>	<p>13 (Returns records in the Planning database where site constraints shows it to be within the CAZ and permission was granted subject to a condition containing 'NRMM')</p> <p>16 11 1 (6%) The NRMM website is used to confirm the development has been registered with the GLA.</p>
<p>NRMM: Greater London (excluding Central Activity Zone, Canary Wharf and Opportunity Areas) Number of conditions related to NRMM included.</p> <p>Number of developments registered and compliant. Number of audits % of sites unregistered prior to audit Please include confirmation that you have checked that the development has been registered at www.nrmm.london and that all NRMM used on-site is compliant with Stage IIIB of the Directive and/or exemptions to the policy.</p>	<p>32 (Returns records in the Planning database where site constraints shows it to be NOT within the CAZ and permission was granted subject to a condition containing 'NRMM')</p> <p>19 10 2 (9%) The NRMM website is used to confirm the development has been registered with the GLA</p>

The Environmental Protection Team (EPT) review planning applications for air quality implications, and comments and recommendations are communicated to planning officers. EPT queried the planning reporting systems to produce the data shown in **Table Q**. The data has been extracted from the planning systems and will undergo further review and refinement.

Southwark has engaged L.B. Merton to inspect construction sites in the Borough to check for compliance with the London Non-Road Mobile Machinery requirements. Southwark provides a list of the known construction sites in the Borough to L.B. Merton who then report to Southwark any non-compliant sites. Any non-compliances

are then addressed and or enforced by Southwark officers to ensure that all the equipment on the sites are compliant.

3.1 New or significantly changed industrial or other sources

Amended sources of significance identified in the Borough during 2023 were the following:

Amended Source	Details
<p>Veolia ES Southwark Limited Clements Road Bermondsey London SE16 4DW</p> <p>Grid Reference 534443, 179140</p>	<p>Permit number: EPR/RP3028SH To operate a medium combustion plant - Three 5.86 MWth (rated thermal input) boilers</p>
<p>Land Securities Group PLC The Forge The Phosphor Building 133 Park Street Southwark London SE1 9EA</p> <p>Grid Reference 532253, 180389</p>	<p>Permit number: EPR/AP3722SR To operate a back – up generator of 1.83 MWth (rated thermal input)</p>
<p>PricewaterhouseCoopers Services 7 More London London SE1 2RT</p> <p>Grid Reference 533266, 180158</p>	<p>Permit number: EPR/RB3399YL To operate two Combined Heat Power 0.693 MWth (rated thermal input) units</p>

4. Additional Activities to Improve Air Quality

4.1 London Borough of Southwark Fleet Replacement Strategy

Southwark has a policy of reviewing its fleet, and replacing vehicles with electric where possible. Southwark Council's Fleet Replacement Strategy is under development. This work includes the development of a robust vehicle selection process and criteria to establish the needed commercial fleet. Southwark's fleet consists of 330 vehicles, which includes 18 electric and 7 hybrid, 5% and 2% of the total respectively¹⁹. Further tranches of renewed fleet will include electric vehicles, if the appropriate vehicles are available for purchase.

4.2 NRMM Enforcement Project

Southwark continues to support the NRMM Enforcement project. The status of construction sites are reviewed by officers and any changes are noted and reported. Any non-compliances from the audits that are undertaken are actioned by the Environmental Protection Team at Southwark.

LBS have a construction condition (for a Construction Environmental Management Plan - CEMP) that goes on any major applications. That condition requires a CEMP that will include air quality / dust control measures and NRMM commitment. CEMP documents submitted to the LPA will be shared with Environmental Health for review and comments. Requirements for NRMM are also set out within the Construction guidance²⁰.

The wording of LBS CEMP condition is copied below. This condition is applied at planning application stage to go onto the decision notice. LBS also have CEMP / DEMP conditions for s106 agreements. It applies to all Major sites, and also any Minor sites where officers consider there to be a large impact from construction works and/or very sensitive receptors.

¹⁹ <https://moderngov.southwark.gov.uk/documents/s116747/Report%20GW0%20-%20Commercial%20Fleet%20Services.pdf>

²⁰ <https://www.southwark.gov.uk/environment/environmental-protection/construction>

No development shall take place, including any works of demolition, until a written CEMP has been submitted to and approved in writing by the Local Planning Authority. The CEMP shall oblige the applicant, developer and contractors to commit to current best practice with regard to construction site management and to use all best endeavours to minimise off-site impacts, and will include the following information:

- A detailed specification of demolition and construction works at each phase of development including consideration of all environmental impacts and the identified remedial measures;
- Site perimeter continuous automated noise, dust and vibration monitoring;
- Engineering measures to eliminate or mitigate identified environmental impacts e.g. hoarding height and density, acoustic screening, sound insulation, dust control measures, emission reduction measures, location of specific activities on site, etc.;
- Arrangements for a direct and responsive site management contact for nearby occupiers during demolition and/or construction (signage on hoardings, newsletters, residents liaison meetings, etc.)
- A commitment to adopt and implement of the ICE Demolition Protocol and Considerate Contractor Scheme; Site traffic – Routing of in-bound and outbound site traffic, one-way site traffic arrangements on site, location of lay off areas, etc.;
- Site waste Management – Accurate waste stream identification, separation, storage, registered waste carriers for transportation and disposal at appropriate destinations.
- A commitment that all NRMM equipment (37 kW and 560 kW) shall be registered on the NRMM register and meets the standard as stipulated by the Mayor of London

To follow current best construction practice, including the following:-

- Southwark Council's Technical Guide for Demolition & Construction at <http://www.southwark.gov.uk/construction>
- Section 61 of Control of Pollution Act 1974,
- The London Mayors Supplementary Planning Guidance 'The Control of Dust and Emissions During Construction and Demolition',
- The Institute of Air Quality Management's 'Guidance on the Assessment of Dust from Demolition and Construction' and 'Guidance on Air Quality Monitoring in the Vicinity of Demolition and Construction Sites',
- BS 5228-1:2009+A1:2014 'Code of practice for noise and vibration control on construction and open sites. Noise',
- BS 5228-2:2009+A1:2014 'Code of practice for noise and vibration control on construction and open sites. Vibration'
- BS 7385-2:1993 Evaluation and measurement for vibration in buildings. Guide to damage levels from ground-borne vibration,
- BS 6472-1:2008 'Guide to evaluation of human exposure to vibration in buildings - vibration sources other than blasting,

- Relevant Stage emission standards to comply with Non-Road Mobile Machinery (Emission of Gaseous and Particulate Pollutants) Regulations 1999 as amended & NRMM London emission standards <http://nrmm.london/>

All demolition and construction work shall be undertaken in strict accordance with the approved CEMP and other relevant codes of practice, unless otherwise agreed in writing by the Local Planning Authority.

Reason

To ensure that occupiers of neighbouring premises and the wider environment do not suffer a loss of amenity by reason of pollution and nuisance, in accordance with the Southwark Plan 2022 Policy P56 (Protection of amenity), and the National Planning Policy Framework 2021.

4.3 Air Quality Alerts

We continue to support the airTEXT notification system. Southwark has continued with a Defra Air quality fund project to improve this notification system, including better engagement with vulnerable communities.

Appendix A Details of Monitoring Site Quality QA/QC

A.1 Automatic Monitoring Sites

The Authority is a member of the London Air Quality Network. All monitoring data is ratified in accordance with Imperial College London, QA/QC procedures for the network. The Authority has out-sourced the Local Site Operator role to ESU1. They are contracted to calibrate all the pollutant monitors fortnightly.

PM₁₀ Monitoring Adjustment

Ratified data would have been corrected by the data management team at Imperial College London by dividing the data by a slope correction factor of 1.035.

A.2 Diffusion Tubes

Diffusion Tube Bias Adjustment Factors

Appendix B presents the Southwark network's raw monthly results .

A national bias adjustment factor was obtained from Defra national bias adjustment factor database (spreadsheet version number 03/24 published in March 2024) based on 23 co-location studies. The bias adjustment factor given for this methodology was 0.81, and was applied to the results presented in section 1.2 of this report.

The Authority incorporates two local co-location diffusion tube studies, by exposing triplicate tubes at two automatic air quality monitoring stations at the Elephant & Castle (Urban Background) and the Old Kent Road (Roadside). The Local Air Quality Management bias spreadsheet has been used to obtain a combined local bias adjustment factor of 0.77 derived from the two co-location studies (**Table O**). However this factor was not used to adjust the results – see the Discussion of Choice of Factor to Use section below.

QA/QC of Diffusion Tube Monitoring

The Authority has appointed Gradko International Ltd. to provide and analyse the Nitrogen Dioxide survey diffusion tubes. The laboratory supplies the Authority 20% TEA in water diffusion tubes each month. The laboratory has confirmed that it follows the procedures set out in the Practical Guidance. The Didcot Laboratory of Environmental Services Group and Gradko International submit two sets of results, whereas the other laboratories in the scheme only submit one set of results.

Laboratories participate in two QA/QC schemes. The new Air Proficiency Testing (AIR-PT) Scheme - a continuation of the Workplace Analysis Scheme for Proficiency (WASP) - is run by LGC and supported by the Health & Safety Laboratory. The other scheme is a monthly field Inter-comparison Exercise operated by the National Physics Laboratory (NPL). Defra advises that local authorities should use diffusion tubes supplied by laboratories that have demonstrated satisfactory performance under the QA/QC schemes.

The AIR-PT scheme has up 38 regular different samples and 3 different trial standards for the analytic laboratories to analyse. LGC Ltd has a programme to send out different combinations of the 41 samples in six rounds throughout the year. (The trial samples were available for one round only.) Each Sample contains 4 dynamically loaded Palmes type diffusion tubes.

Gradko International is a UKAS accredited laboratory and participates in both QA/QC schemes described above. The list of those laboratories which have performed satisfactorily in the AIR-PT scheme is provided to local authorities on the LAQM Support website²¹. In the latest available AIR-PT results Gradko has scored 100% in rounds AR055 (January to February 2023), AR056 (May to June 2023), AR058 (July to August 2023) and AR059 (September to October 2023).

²¹ https://laqm.defra.gov.uk/wp-content/uploads/2023/11/LAQM-NO2-Performance-data_Up-to-Oct-2023_V1_Final.pdf

The percentage score reflects the results deemed to be satisfactory based upon the z-score of $< \pm 2$.

Regarding the inter-comparison co-location study from Marylebone Road, it was rated as 'good' (tubes are considered to have "good" precision where the coefficient of variation of duplicate or triplicate diffusion tubes for eight or more periods during the year is less than 20%). Precision Summary Results for the laboratory for the last three years can be found on the LAQM Support website²².

A.3 Breathe London Sensors

Details of the QA/QC procedures for Breathe London sensors can be obtained from Imperial College. The website for the network states the following "Every Breathe London Node is co-located at London Air reference sites and checked by researchers at Imperial before deployment. Once deployed, the data is continually cross-checked against reference sites on the London Network in real-time to ensure the data from every sensor is as good as it can be"²³.

²² <https://laqm.defra.gov.uk/air-quality/air-quality-assessment/precision-and-accuracy/>

²³

<https://www.breathelondon.org/about#:~:text=Every%20Breathe%20London%20Node%20is%20co%2Dlocated%20at%20London%20Air,good%20as%20it%20can%20be.>

Factor from Local Co-location Studies

Southwark has two continuous monitoring sites, where co-located three Nitrogen Dioxide diffusion tubes are deployed at each site, these are at Old Kent Road, and Elephant & Castle AQMS sites. **Table R** below is an extract from the from the LAQM Diffusion Tube Data Processing Tool v4.0 accessed at [Diffusion Tube Data Processing Tool | LAQM \(defra.gov.uk\)](https://diffusion-tube-data-processing-tool.laqm.defra.gov.uk/) showing the local bias co-location studies.

Table R - Factors from Local Co-location Studies

	STEP 3a Local Bias Adjustment Input 1	STEP 3b Local Bias Adjustment Input 2	STEP 3c Local Bias Adjustment Input 3	STEP 3d Local Bias Adjustment Input 4	STEP 3e Local Bias Adjustment Input 5	STEP 3f Local Bias Adjustment Input 6	STEP 3g Local Bias Adjustment Input 7
Periods used to calculate bias	12	9					
Bias Adjustment Factor A	0.78 (0.69 - 0.89)	0.76 (0.65 - 0.91)					
Diffusion Tube Bias B	29% (13% - 45%)	32% (10% - 53%)					
Diffusion Tube Mean ($\mu\text{g}/\text{m}^3$)	31.2	25.8					
Mean CV (Precision)	3.9%	4.6%					
Automatic Mean ($\mu\text{g}/\text{m}^3$)	24.2	19.6					
Data Capture	97%	93%					
Adjusted Tube Mean ($\mu\text{g}/\text{m}^3$)	24 (22 - 28)	20 (17 - 23)					
Overall Diffusion Tube Precision	Good Overall Precision	Good Overall Precision					
Overall Continuous Monitor Data Capture	Good Overall Data Capture	Poor Overall Data Capture					
Combined Local Bias Adjustment Factor	0.77	Warning - One or more Co-location studies has Poor Overall Continuous Monitor Data Capture (i.e. <90%). Local Bias Adjustment Factor should be treated with caution.					

555

Discussion of Choice of Factor to Use

The diffusion tube data presented within the 2023 ASR have been corrected for bias using an adjustment factor (**Table S**). Bias represents the overall tendency of the diffusion tubes to under or over-read relative to the reference chemiluminescence analyser. LLAQM.TG19 provides guidance with regard to the application of a bias adjustment factor to correct diffusion tube monitoring. Triplicate co-location studies can be used to determine a local bias factor based on the comparison of diffusion tube results with data taken from NO_x/NO₂ continuous analysers. Alternatively, the national database of diffusion tube co-location surveys provides bias factors for the relevant laboratory and preparation method.

The combined local bias factor has been calculated at 0.77 using DEFRA NO₂ data processing tool. However, given that data capture for Elephant & Castle was below 90%, Southwark has used the national database co-location factor of 0.81 in this report, as it provides a higher degree of certainty. This is also a more conservative factor.

Table S - Bias Adjustment Factor

Year	Local or National	If National, Version of National Spreadsheet	Adjustment Factor
2023	National	03/24	0.81
2022	Local	N/A	0.85
2021	National	04/22	0.84
2020	National	03/21	0.81
2019	National	03/21	0.91
2018	National	03/21	0.92
2017	National	03/21	0.87
2016	National	03/21	0.92

A.4 Adjustments to the Ratified Monitoring Data

Short-term to Long-term Data Adjustment (annualisation)

Where data capture is less than 75% and greater than 25% of a full calendar year (between 3 and 9 months), the mean should be ‘annualised’ – i.e. adjusted using the methodology outlined in LLAQM.TG(19), before being compared to annual mean objectives.

The short to long term data adjustment has been undertaken for the diffusion tube monitoring site SDT162 at Harris East Dulwich Primary School, which closed down in April 2023. The calculations presented in **Table T** were carried out using the Diffusion Tube Data Processing Tool²⁴ in line with LAQM Technical Guidance LLAQM Guidance TG(19) Box 4.3.

Regarding continuous data, annualisation, in line with Box 4.2 of LLAQM TG(19), was applied to PM₁₀ results for site SK6 Elephant and Castle. Details are provided in **Table U**.

Distance Adjustment

If an exceedance was measured at a monitoring site which was not representative of public exposure, Southwark used the procedure specified in LLAQM.TG (19) to estimate the concentration at the nearest receptor.

Distance correction should be considered at any monitoring site where the annual mean concentration is greater than 36µg.m⁻³ and the monitoring site is not located at a point of relevant exposure (taking into account the limitations of the Data Processing Tool/NO₂ fall-off with distance calculator).

Southwark Diffusion tube data was distance adjusted using the Diffusion Tube Data Processing Tool²⁵. The data is provided in **Table V** below.

²⁴ [Diffusion Tube Data Processing Tool | LAQM \(defra.gov.uk\)](#)

²⁵ [Diffusion Tube Data Processing Tool | LAQM \(defra.gov.uk\)](#)

Nitrogen Dioxide

Table T - Short-Term to Long-Term Monitoring Data Adjustment of Southwark Nitrogen Dioxide Diffusion Data

Diffusion Tube ID	Annualisation Factor London Bloomsbury	Annualisation Factor London Westminster	Annualisation Factor Lewisham Deptford	Annualisation Factor Westminster Covent Garden	Average Annualisation Factor	Raw Data Simple Annual Mean ($\mu\text{g.m}^{-3}$)	Annualised Data Simple Annual Mean ($\mu\text{g.m}^{-3}$)
SDT 162	0.7537	0.7691	0.7170	0.7700	0.7525	29.4	22.1

Particulate Matter PM₁₀

Table U - Short-Term to Long-Term Monitoring Data Adjustment of Southwark Continuous Monitoring data – PM₁₀

Site ID	Annualisation Factor London Bloomsbury	Annualisation Factor London N. Kensington	Annualisation Factor London Honor Oak Park	Annualisation Factor Tower Hamlets Jubilee Park	Annualisation Factor Southwark - Elephant & Castle	Average Annualisation Factor	Raw Data Simple Annual Mean ($\mu\text{g.m}^{-3}$)	Annualised Data Simple Annual Mean ($\mu\text{g.m}^{-3}$)
SK6	1.04	1.07	1.06	1.04	1.04	1.05	21.3	22.3

Table V - NO₂ Fall off With Distance Calculations

Diffusion Tube ID	Distance (m)		NO ₂ Annual Mean Concentration ($\mu\text{g.m}^{-3}$)			Comment
	Monitoring Site to Kerb	Receptor to Kerb	Monitored Concentration (Annualised and Bias Adjusted ($\mu\text{g m}^{-3}$))	Background Concentration ($\mu\text{g m}^{-3}$)	Concentration Predicted at Receptor ($\mu\text{g m}^{-3}$)	
SDT 18	0.5	3.5	41.6	34.6	39.2	Predicted concentration at receptor within 10% of the AQS objective
SDT 24	0.5	3.5	38.8	28.2	35.2	
SDT 29	0.5	2.5	37.2	28.2	34.6	
SDT 81	0.5	3.5	39.1	34.7	37.6	Predicted concentration at receptor within 10% the AQS objective
SDT 87	0.5	3.5	37.4	22.6	32.3	
SDT 104	0.5	15.5	36.4	26.3	30.3	
SDT 113	0.5	7.5	36.4	30.0	33.4	

Appendix B Full Monthly Diffusion Tube Results for 2023

Table W - NO₂ 2023 Diffusion Tube Results (µg.m⁻³)

Site ID	X OS Grid Ref (Easting)	Y OS Grid Ref (Northing)	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Annual Mean: Raw Data	Annual Mean: Annualised and Bias Adjusted (National Bias = 0.81)	Annual Mean: Distance Corrected to Nearest Exposure	Comment
SDT 1	534849	177512	38.3	37.6	31.5	33.4	33.2	32.0	25.7	26.1	28.2	30.0	31.4	22.8	-	-		Triplicate Site with SDT 1, SDT 2 and SDT 3 - Annual data provided for SDT 3 only
SDT 2	534849	177512	40.2	40.6	29.9	33.2	34.9	33.7	25.3	27.9	29.8	30.8	32.2	21.9	-	-		Triplicate Site with SDT 1, SDT 2 and SDT 3 - Annual data provided for SDT 3 only
SDT 3	534849	177512	36.1	39.2	30.7	34.6	34.8	32.6	21.1	26.6	30.5	31.1	30.4	24.2	31.2	25.2		Triplicate Site with SDT 1, SDT 2 and SDT 3 - Annual data provided for SDT 3 only
SDT 4	535675	178796	39.9	43.1	35.0	40.8	38.0	40.2	28.6	32.5	40.1	39.4	39.1	26.1	36.9	29.9		
SDT 5	534640	179336	35.7	34.7	26.2	21.7	18.7	17.9	15.9	19.8	25.6	26.1	22.3	20.3	23.7	19.2		
SDT 6	535253	176679	38.9		36.4	38.0	36.0	33.6	28.6	30.5	39.4	39.2	38.3	28.8	35.2	28.6		
SDT 7	534333	176155	35.4	34.2	26.1	29.0	27.6	31.0	17.6	24.9	28.2	30.4	33.5	22.4	28.4	23.0		
SDT 8	534553	174263	31.6	30.5	20.9	22.3	21.0	17.9	11.6	16.9	19.7	22.5	27.0	16.9	21.6	17.5		
SDT 9	533470	173204	37.8	40.7	34.4	36.3	32.8	34.2	24.5	25.9	39.9	36.0	34.8	22.6	33.3	27.0		
SDT 10	532940	174392	32.9	29.5	22.7	23.1	23.3	23.2	14.4	19.3	21.6	21.9	26.7	18.4	23.1	18.7		
SDT 11	532663	176740	46.0	48.4	41.8	49.0	48.7	47.3	31.5	39.0	43.3	43.1	40.2	30.2	42.4	34.3		
SDT 12	531884	178836	36.6	35.4	26.3	26.2	23.2	22.8	18.0	21.7	26.8	30.5	39.6	25.8	-	-		Triplicate Site with SDT 12, SDT 13 and SDT 14 - Annual data provided for SDT 14 only
SDT 13	531884	178836	38.0	34.6	26.1	26.2	23.1	19.0	17.4	25.9	24.4	30.6	32.1	22.9	-	-		Triplicate Site with SDT 12, SDT 13 and SDT 14 - Annual data provided for SDT 14 only
SDT 14	531884	178836	36.1	35.6	26.7	25.8	21.9	20.9	16.6	21.1	24.7	28.9	33.3	23.2	26.9	21.8		Triplicate Site with SDT 12, SDT 13 and SDT 14 - Annual data provided for SDT 14 only
SDT 15	531641	180290	45.5	47.4	34.4	43.9	26.8	28.8	38.7	27.3	30.7	39.3	42.7	35.0	36.7	29.7		
SDT 18	533599	180062	51.6	56.3	52.3	51.7	51.1	55.2	47.8	48.1	57.8	55.9	49.8	38.5	51.3	41.6	39.2	
SDT 20	533520	179849	39.6	45.1	38.8	41.2	42.0	39.8	46.0	25.3	38.5	40.4	37.7	28.3	38.6	31.2		
SDT 24	533444	179620	55.0	56.9	50.6	42.0	45.0	42.5		44.1	54.5	44.9	44.3	47.2	47.9	38.8	35.2	
SDT 29	533105	179117	52.2	54.7	46.8	45.0	44.9		39.2	40.0	43.1	47.9	50.1	41.0	45.9	37.2	34.6	
SDT 31	532937	179043	34.1	42.9	34.2	35.1	31.6	30.1	26.7	32.1	38.4	41.4	39.7	28.9	34.6	28.0		
SDT 37	532340	178711	34.3	35.3		27.0	30.0	26.7	14.3	18.9	21.9	27.3	31.0	21.6	26.2	21.2		
SDT 38	532074	178825	47.1	47.6	38.7	30.2	36.6	35.8	34.1	36.7	41.6	50.0	45.6	38.0	40.2	32.5		
SDT 39	532053	179070	41.7	45.5	33.1	30.2	27.8	25.7	25.0	26.8	30.2	37.0	40.8	30.8	32.9	26.6		
SDT 41	532390	178974	43.8	46.4	42.0	43.6	30.2	36.2	30.6	35.0	38.1	42.5	44.3	31.7	38.7	31.3		
SDT 42	536037	180341	41.0	44.9	31.3	30.2	26.5	26.1	26.2	27.2	37.3	37.8	39.2	28.9	33.0	26.8		
SDT 48	533912	171366	44.7	37.4	33.2	32.8	27.9	32.8	32.5	32.5	37.6	35.7	37.0	27.6	34.3	27.8		

Site ID	X OS Grid Ref (Easting)	Y OS Grid Ref (Northing)	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Annual Mean: Raw Data	Annual Mean: Annualised and Bias Adjusted (National Bias = 0.81)	Annual Mean: Distance Corrected to Nearest Exposure	Comment
SDT 49	533873	178592	32.3	33.2	24.0	22.1	18.4	18.4		18.5	22.4	22.6	28.0	21.0	23.7	19.2		
SDT 52	533150	172123	24.0	27.8	19.1	17.0	16.0	14.2	11.7	15.7	19.6	21.2	26.1	15.3	19.0	15.4		
SDT 53	532668	173998	27.6	26.1	18.6	17.0	15.5	15.2	10.6	13.3	15.8	18.3	24.9	15.2	18.2	14.7		
SDT 54	532951	176417	33.7	33.5	25.0	21.9	17.0	17.0	15.1	19.0	23.0	25.8	30.4	21.7	23.6	19.1		
SDT 55	533350	177603	31.7		21.2	20.8	16.5	15.2	10.5	15.8	18.8	20.4	24.3	15.8	19.2	15.5		
SDT 57	531531	179256	34.1	39.3	28.2	31.3	28.4	27.6	18.9	24.5	28.7	33.8	33.2	24.8	29.4	23.8		
SDT 61	535176	179665	34.2	37.7	26.4	28.5	23.4	24.6	22.0	25.9	32.4	33.0	34.0	24.1	28.8	23.4		
SDT 66	535384	179161	31.0	35.2	27.1	29.8	26.0	25.7	15.8	22.2	28.1	27.2	29.9	20.6	26.6	21.5		
SDT 77	532294	180406	47.4	45.1		30.3	27.8	29.0	24.1	28.7	33.9	39.2	36.8	35.0	34.3	27.8		
SDT 81	532690	180212	53.3	56.5	47.5	57.8	55.5	52.7	25.0	45.8	50.2	48.7	47.6	39.3	48.3	39.1	37.6	
SDT 82	532572	180029	43.0		41.4	42.9	34.9	38.3	36.3	34.3	41.0	45.1	40.4	33.9	39.2	31.8		
SDT 84	532487	179850	44.3	43.5	35.8	32.6	28.2	32.3	30.2	27.9	34.6	36.1	35.9	26.5	34.0	27.5		
SDT 87	535795	178828	48.5	51.3	42.9	40.7	39.9	51.2	49.3	46.2		51.8	49.3	37.1	46.2	37.4	32.3	
SDT 88	534457	179454	46.1	50.4	40.0	36.9	33.9	33.4	36.2	36.5	45.0	48.3	41.9	32.8	40.1	32.5		
SDT 89	534241	179435	38.4	38.3	30.8	34.7		32.4	19.5	28.4	32.8	32.3	35.4	21.3	31.3	25.3		
SDT 90	533800	178220	47.2	28.9	43.7	46.1	47.7	46.3	29.1	38.9	45.6	45.3	46.6	29.4	41.2	33.4		
SDT 91	533379	178556	45.6	45.2	38.3	46.2	45.0	43.3	28.6	35.5	39.1	39.3		28.8	39.5	32.0		
SDT 92	535222	178032	37.8	41.8	31.9	34.4	34.3	33.2	22.0	30.1	36.1	35.6	34.9	24.9	33.1	26.8		
SDT 93	534243	176558	44.4	46.4	39.7	41.5	39.2	38.6	36.4	40.6	46.0	45.7	33.5	40.1	41.0	33.2		
SDT 95	533700	173892	26.9	26.2	16.9	16.0	14.4	13.4	9.3	13.9	15.6	18.2	22.3	14.4	17.3	14.0		
SDT 97	533940	173998	35.7	35.0	27.5	25.9	22.0	23.8	23.4	27.9	31.4	31.4	32.9	24.1	28.4	23.0		
SDT 98	534503	173251	44.5	46.3	35.0	38.3	33.9	34.2	28.4	33.8	39.8	36.5	41.1	29.5	36.8	29.8		
SDT 100	533159	174191	26.6	24.8	17.2	15.3	13.9	13.8	10.5	14.2	16.4	19.6	23.8	15.4	17.6	14.3		
SDT 101	532303	174756	34.2	31.3	25.0	25.6	22.7	24.1	18.2	22.1	30.3	29.4	31.7	22.2	26.4	21.4		
SDT 102	532599	176277	37.3	35.7	28.3	26.9	23.8	23.3	18.9	22.6	27.1	29.5	32.3	22.0	27.3	22.1		
SDT 103	532471	176388	36.7	40.9	31.9	29.0	28.8		23.2	25.1	28.5	30.3	35.7	28.0	30.7	24.9		
SDT 104	531835	178686	45.6	55.1	47.5	49.5	45.3	41.2	34.4	38.9	49.2	51.5	46.5	34.9	45.0	36.4	30.3	
SDT 105	533592	176851	37.2	36.6	27.4	26.7	26.0	25.9	24.5	25.8	35.2	36.6	33.7	26.2	30.1	24.4		
SDT 106	532409	177597	45.4	49.7	42.8	41.3	42.7	38.6	30.9	35.7	41.5	46.1	44.4	37.5	41.4	33.5		
SDT 107	532426	178051	35.9	36.6	28.1	29.8	26.0	25.2	20.1	24.8	29.3	34.5	35.0	26.6	29.3	23.7		
SDT 111	532294	178354	41.7	43.2	33.7	35.8	31.6	31.5	22.2	31.0	34.7	40.3	41.8	28.2	34.6	28.1		
SDT 112	531621	179112	31.3	31.3	21.3	21.2	17.7	17.3	12.0	17.1	19.4	24.4	27.3	18.1	21.5	17.4		
SDT 113	531481	179421	44.4	49.8	45.8	34.7	34.8	44.3		41.3	56.7	52.1	46.6	44.4	45.0	36.4	33.4	
SDT 114	533799	175324	34.1	33.9	28.0	25.0	22.0	19.9	17.3	21.4	25.5	27.7	45.0	23.5	26.9	21.8		
SDT 132	534237	176363	37.2	41.0	30.5	33.5	33.5	24.9	23.6	29.3	34.0	32.9	36.7	25.6	31.9	25.8		

Site ID	X OS Grid Ref (Easting)	Y OS Grid Ref (Northing)	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Annual Mean: Raw Data	Annual Mean: Annualised and Bias Adjusted (National Bias = 0.81)	Annual Mean: Distance Corrected to Nearest Exposure	Comment
SDT 136	533232	175775	34.2	32.1	24.0	22.8	25.2	20.7	15.0	21.2	26.6	27.9	28.0	20.2	24.8	20.1		
SDT 137	532988	175570	27.8	29.0	18.4	17.2	17.0	14.5	9.8	15.5	17.7	20.0	28.6	15.6	19.3	15.6		
SDT 138	533364	175561	37.8	39.3	27.8	25.3	22.7	23.2	25.3	26.4	32.4	34.8	24.6	27.4	28.9	23.4		
SDT 139	533030	176022	33.8	30.6	23.3	23.7	21.2	19.5	13.5	20.1	22.3	24.8		19.8	23.0	18.6		
SDT 140	533221	175715	35.5	36.2	25.9	28.2	20.3	24.0	15.0	20.0	24.0	25.7	30.3	19.5	25.4	20.6		
SDT 142	535321	175023	28.0	29.1	19.8	19.6	18.0	16.8	10.7	15.3	19.2	20.0	24.9	16.2	19.8	16.0		
SDT 143	534540	172387	30.3	27.6	20.6	18.7	18.1	18.4	15.9	17.6	20.6	13.2	27.4	19.4	20.7	16.7		
SDT 144	533328	171601	31.0	31.1	22.7	25.8	27.0	25.7	16.1	21.9	23.1	22.7	26.2	15.4	24.1	19.5		
SDT 145	532768	172732	35.0	29.4	21.0	19.5	16.0	19.6	14.5	16.5	19.7	23.1	25.8	17.0	21.4	17.4		
SDT 146	532486	173535	29.3	31.2	22.8	23.2	21.8	20.9	16.4	19.7	24.6	24.9	23.4	17.8	23.0	18.6		
SDT 147	532230	177756	34.6	35.3	23.8	24.5	20.8	22.3	17.9	21.7	26.7	28.7	31.5	22.3	25.8	20.9		
SDT 148	532002	177578	33.0	35.3	26.2	25.9	23.3	22.5	18.7	20.2	26.1	31.1	30.1	21.7	26.2	21.2		
SDT 149	531479	177990	33.4	35.5	24.4	23.8	21.0	19.1	16.2	19.1	23.1	27.5	31.0	19.5	24.5	19.8		
SDT 150	533522	178187	38.6	36.2	30.5	33.7	31.9	32.9	24.3	26.9	33.8	34.0	33.9	24.5	31.8	25.7		
SDT 151	533660	174480	27.0	26.4	21.1	19.9	18.3	18.3	11.9	18.0	21.5	24.3	28.1	17.2	21.0	17.0		
SDT 152	533245	174655	33.2	29.4	21.8	19.9	20.0	19.3	14.0	18.9	22.1	25.1	27.7		22.9	18.5		
SDT 153	533123	173780		27.0	20.3	19.9	19.6	20.5	15.0	19.0	21.1	21.3	25.6	14.2	20.3	16.5		
SDT 154	532836	177844	34.9	34.6		23.5	19.9	18.5	15.9	20.4	26.8	29.6	31.7	22.0	25.3	20.5		
SDT 155	532597	178433	30.0	32.2	22.1	21.8	18.2	17.2	13.6	19.0	20.9	27.4	31.0	20.7	22.8	18.5		
SDT 156	532643	178677	36.1	40.5	27.8	27.7	22.7	21.0	17.9	21.3	27.8	32.0	36.8	26.3	28.1	22.8		
SDT 157	531648	178257	32.3	31.5	21.9	21.6	18.4	19.2	16.1	18.9	22.6	26.7	30.0	20.7	23.3	18.9		
SDT 158	532195	178276	30.0	30.9	20.3	22.1	18.6	18.5	11.6	17.9	20.1	25.2	26.7	16.7	21.5	17.4		
SDT 159	532167	178336	30.3	30.5	18.9	21.4	18.1	16.8	11.7	16.6	18.4	23.6	27.6	16.1	20.8	16.9		
SDT 160	532202	173907	33.2	32.0	24.2	24.7	22.0	21.7	18.2	19.2	26.4	28.4	31.7	21.3	25.2	20.5		
SDT 161	533771	175173	41.0	42.0	30.4	33.9	33.5	31.3	20.3	26.9			31.2	21.9	31.2	25.3		
SDT 162	533737	174679	31.7	31.7	24.9										29.4	17.9		
SDT 163	532025	177057				33.3	28.8	30.1	25.9	28.0	35.9	36.2	35.3	26.3	31.1	25.2		
SDT 164	532087	177193				24.3	22.9	21.5	17.3	21.8	28.3	32.0	31.0	22.6	24.6	19.9		

562

- All erroneous data has been removed from the NO₂ diffusion tube dataset presented in Table W
- Annualisation has been conducted where data capture is <75% and >25% in line with LAQM.TG22
- Local bias adjustment factor used
- National bias adjustment factor used
- Where applicable, data has been distance corrected for relevant exposure in the final column

☒ **London Borough of Southwark confirm that all 2023 diffusion tube data has been uploaded to the Diffusion Tube Data Entry System**

Notes:

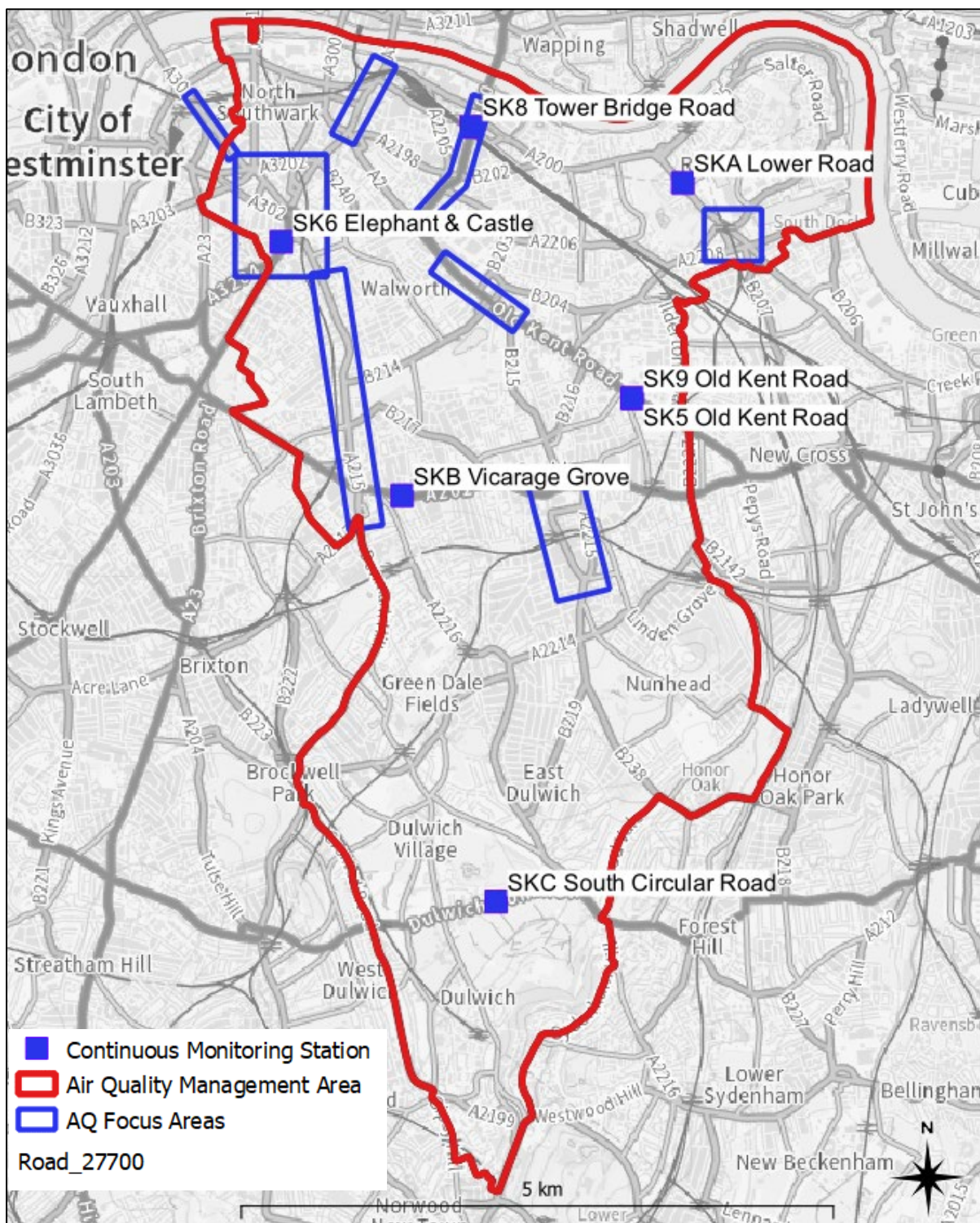
Exceedances of the NO₂ annual mean objective of 40µg.m⁻³.are shown in **bold**.

NO₂ annual means exceeding 60µg.m⁻³., indicating a potential exceedance of the NO₂ 1-hour mean objective are shown in **bold and underlined**.

See **Appendix A** for details on bias adjustment and annualisation.

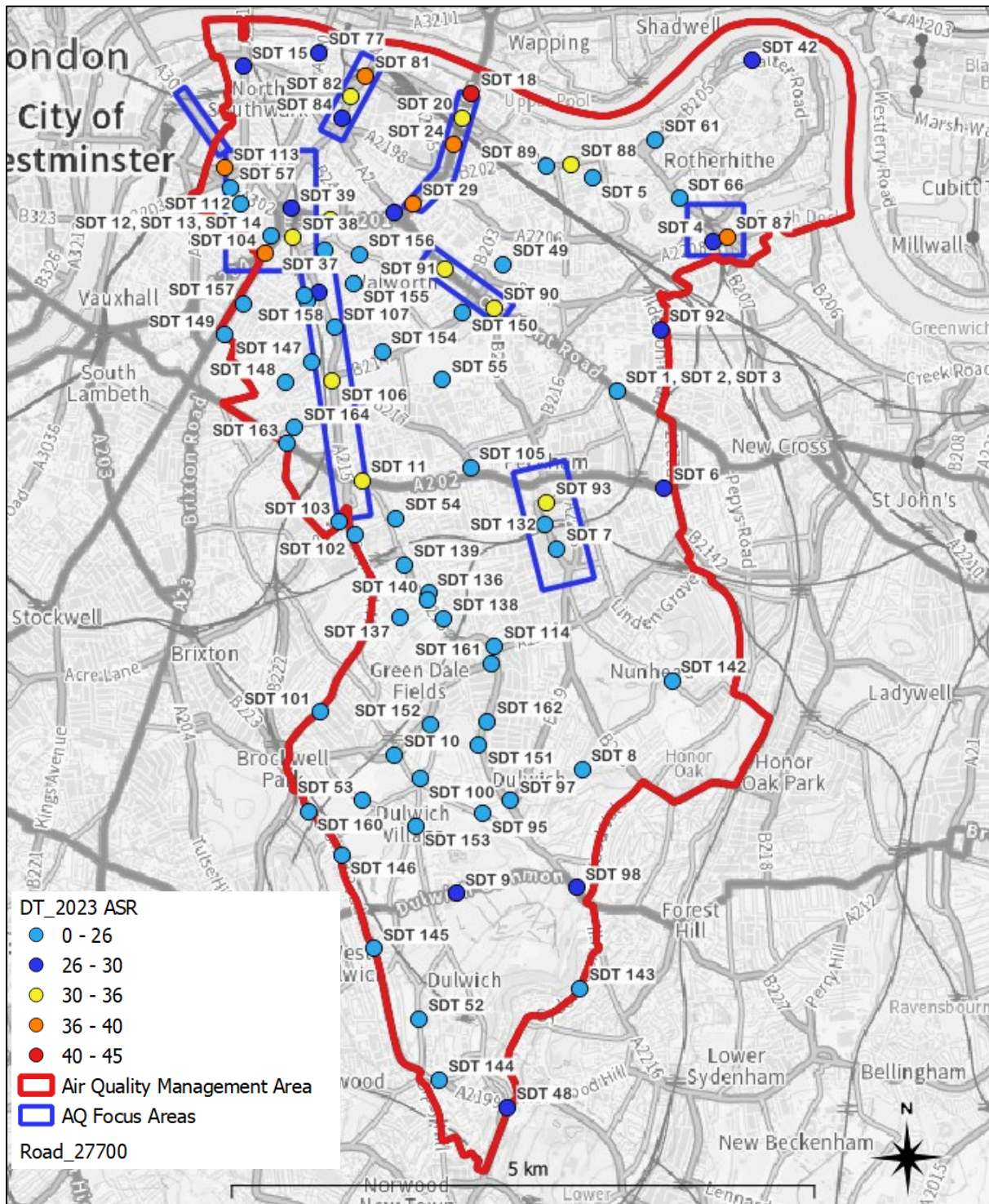
Appendix C Map(s) of Monitoring Locations and AQMAs

Figure 18 - Map of Southwark's Automatic Monitoring Sites



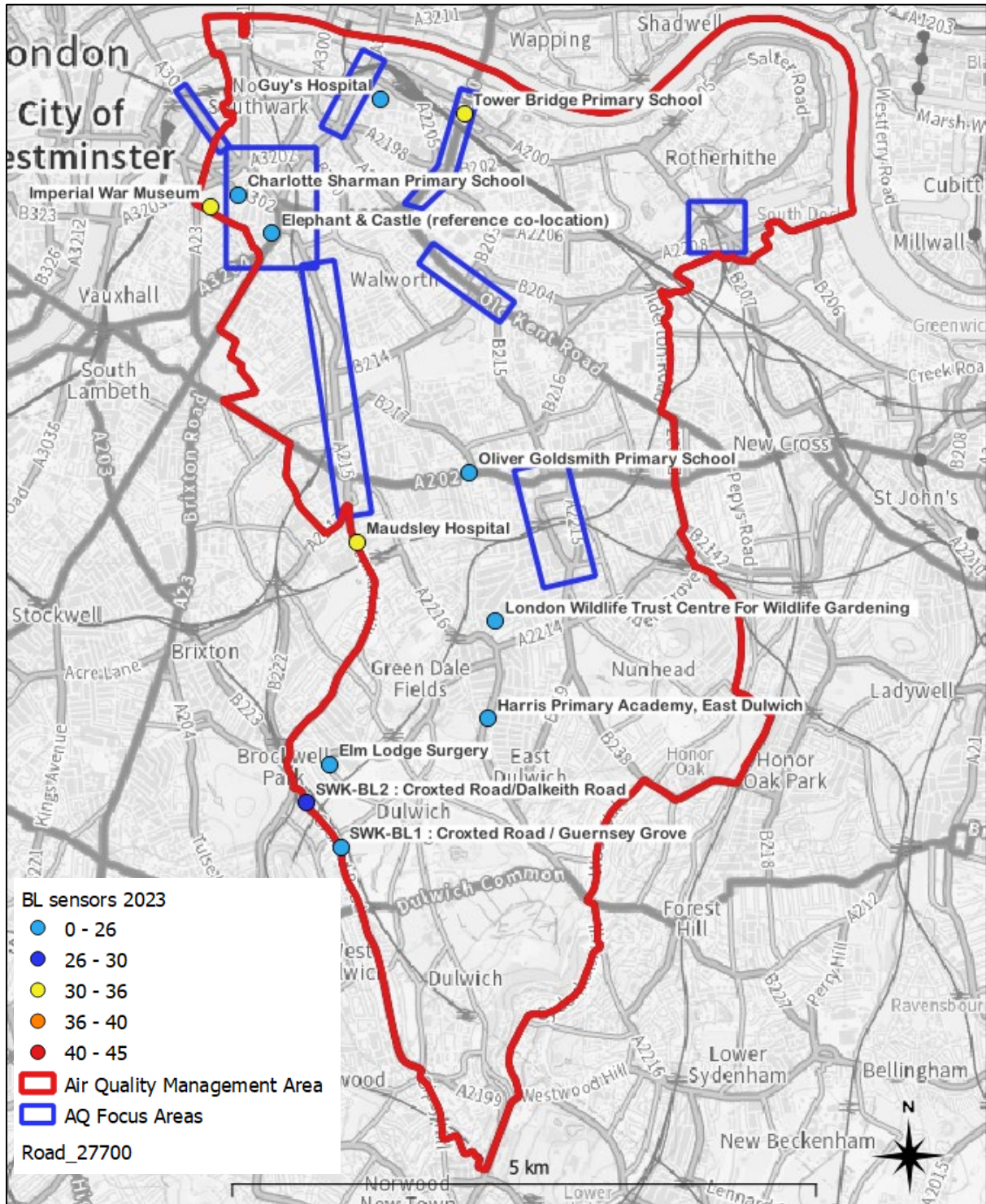
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Figure 19 - Map of NO₂ Diffusion Tubes in Southwark in 2023 showing annual mean NO₂ concentrations, µg/m³



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Figure 20 - Map of Breathe London Sensors in Southwark in 2023 showing annual mean NO₂ concentrations, µg/m³



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NB: Sensor results are indicative only.

GREATER LONDON AUTHORITY

Caroline Bruce
Strategic Director of Environment,
Neighbourhoods and Growth
Via email to: caroline.bruce@southwark.gov.uk
CC: environmental.protection@southwark.gov.uk

Department: Good Growth

Date: 22 August 2024

Dear Caroline,

Thank you for submitting your Annual Status Report (ASR) for 2023, in fulfilment of Part IV of the Environment Act 1995.

As part of the London Local Air Quality Management (LLAQM) system introduced in April 2016 and updated in 2019, the power to approve these reports sits with the Mayor of London, pursuant to Part IX of the Greater London Authority Act 1999.

Please see below for the outcome of your report assessment and some other important updates.

Assessment of your report

Based on the evidence provided by the local authority, the conclusions reached are **accepted** for all sources and pollutants **but will require amendments as described in the commentary below in bold**.

Please see the notes attached at the end of this letter for detailed comments on your report.

GLA Update

Sadiq Khan was re-elected as Mayor of London for a historic third term in May 2024. Tackling air pollution will remain a key priority for him over the next mayoral term. We can only continue to build on the successes of the last eight years through effective action in partnership with boroughs such as yours. In that spirit, there are several plans and policies I'd like to update you on:

ULEZ expansion to outer London

The Mayor expanded the ULEZ to cover all London boroughs on 29 August 2023. 95 per cent of vehicles seen driving in London on an average day are now compliant with the ULEZ standards after one month of the London-wide ULEZ operating. This

translates to 77,000 fewer of the most polluting vehicles seen driving in the zone on an average day.

Air Quality Alerts

In February 2024, the Mayor and the NHS jointly launched a new air quality alert for GPs and Emergency Departments. This alert was developed in collaboration with the [London Air Quality and Health Programme Office](#), delivering on a pledge made following the coroner's report on the death of Ella Adoo-Kissi Debrah and at the 2022 Clean Air and Health Summit.

The Mayor also updated the language in the alerts that go to schools. This will support his goal to make London the best place in the world to grow up.

I hope that you and your colleagues will continue to support the Mayor's Air Quality Alerts system and promote our messaging on days when pollution is higher than normal.

Mayor's Air Quality Fund

The Mayor was very pleased to announce Round 4 of funding for the Mayor's Air Quality Fund in March 2024. This round of funding is supporting seventeen projects to reduce particulate matter emissions, run more sustainable events and improve indoor air quality. We look forward to working with colleagues across the city as these projects progress.

Non-Road Mobile Machinery (NRMM)

The NRMM LEZ standards will get tighter with time. By 2040, all NRMM will need to be zero emission. The next stage of standards will be introduced from January 2025. For more information on the NRMM LEZ and these upcoming standards, please visit our [NRMM webpage](#).

To support the NRMM LEZ, we are continuing to work with the Cleaner Construction for London Team at London borough of Merton to deliver the pan London NRMM scheme. The GLA provide over 50% of the total necessary funds, to be match funded with £4,000 per borough per year. I'd like to thank you once again for your ongoing support for this essential scheme.

Pollution monitoring

Maintaining (and where possible enhancing) existing reference-level monitoring, supplemented by NO₂ diffusion tubes, remains as essential as ever. But to achieve higher spatial coverage of monitors, we are supporting the roll out of small sensors through our Breathe London network.

Since 2021, the Mayor has partnered with Bloomberg Philanthropies and Imperial College London to expand the Breathe London network to over 400 monitoring sites across London. All the data from the Breathe London Network is publicly available in near real time on the [Breathe London](#) website.

School filters

To further protect the health of young Londoners, the Mayor announced £2.7m of funding to deliver indoor air quality filters in all classrooms across 200 of London's most polluted schools. These filters will be installed to reduce levels of the key pollutant PM_{2.5} in classrooms.

In addition to the filters themselves, the funding will pay for school engagement, educational materials and monitoring and evaluation of the scheme which could inform further rollout of filters once this project is complete.

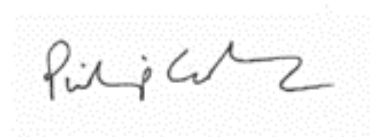
World Health Organization (WHO) Guidelines

As you know, the Mayor committed to achieving 10 µg/m³ annual mean PM_{2.5} by 2030 in London. [Projections](#) for London's air pollutant emissions and concentrations show that, without further significant action, London will not meet the WHO's health-based air quality guidelines. The projections also show that non-transport sources, such as wood burning and commercial cooking, will increase as a proportion of London's total emissions.

The GLA is undertaking research to understand what action will be needed to meet the WHO guidelines, as well as considering what additional powers would be needed. We will be engaging with London boroughs on this work in due course with a view to identifying a roadmap for achieving the WHO guidelines, and we look forward to hearing your views.

Thanks again for all your work on air quality this year.

Kind regards,



Philip Graham
Executive Director, Good Growth

Feedback on your 2023 Annual Status Report:

1. There is currently one AQMA within the borough which was declared for exceedances in the annual mean NO₂ objective and daily mean PM₁₀ objective. The Southwark AQMA covers the whole borough and was originally declared in June 2003 but amended in June 2023. The AQAP for the AQMA was published in January 2023.
2. Details regarding actions within the AQAP are included for all themes within the LLAQM matrix.
3. Across the borough, there were seven automatic monitoring stations during 2023. All of the sites measure NO_x, NO₂, PM₁₀, and six sites monitor PM_{2.5}. All but one of the sites are at roadside locations (SWK6 is situated at an urban background site).
4. Annual mean NO₂ concentrations measured at automatic monitoring sites were compliant with the objective in 2023. The maximum annual mean NO₂ concentration recorded at an automatic monitoring site was 30.8 µg/m³, recorded at SKB. Annual mean NO₂ concentrations in 2023 at all applicable monitoring sites are below pre-pandemic levels. No automatic monitoring site recorded any instance of the hourly mean NO₂ concentration exceeding 200 µg/m³.
5. There were no exceedances of the annual mean PM₁₀ objective at any automatic monitoring site in 2023. A maximum annual mean PM₁₀ concentration of 22.3 µg/m³ was recorded at SK5. There was a maximum of five instances of the daily mean PM₁₀ concentration exceeding 50 µg/m³, recorded at SKB. This is below the allowance of 35 instances. The number of instances where the daily mean PM₁₀ concentration has exceeded 50 µg/m³ has not exceeded 35 instances for at least 8 years.
6. Compliance was achieved in 2023 with regards to the annual mean PM_{2.5} objective, with a maximum concentration of 9.9 µg/m³. This is also within the Mayor's target of 10 µg/m³.
7. There are 12 indicative Breathe London monitors across the borough, which appear to monitor NO₂ and PM_{2.5}. The relevant objectives have been met at all indicative monitoring sites.
8. Passive monitoring of NO₂ was undertaken at 85 locations during 2023, including two triplicate sites co-located with automatic monitors (SWK5 and SWK6). One site was removed in 2023 (SDT162) and replaced with a Breathe London monitor.
9. There were no exceedances of the annual mean NO₂ objective at any passive monitor site following distance correction to relevant exposure. A maximum annual mean NO₂ concentration of 39.2 µg/m³ was recorded at relevant exposure (SK18). Two sites (SDT81 and SDT18) recorded concentrations above 36 µg/m³ at relevant exposure which suggests a risk of exceedance.
10. Six passive sites showed an increase in concentrations between 2022 and 2023. Concentrations across the network are largely below those recorded pre-pandemic.
11. Measured ozone concentrations at SK6 have now been included in the report following comments from the previous ASR appraisal. This is welcomed.
12. Ozone monitoring at SK6 highlights that the site has consistently exceeded the daily maximum 8-hour running mean objective since 2020.
13. QA/QC of both automatic and non-automatic monitoring data has been carried out, with sufficient evidence of all procedures. Annualisation was performed appropriately for two locations, and distance correction was applied to seven

passive monitoring sites. The Council have calculated a local co-location bias adjustment factor of 0.77 in 2023. However, a national bias adjustment factor of 0.81 has been used as this is deemed more conservative and as one co-location (SK6) has low data capture. This is welcomed.

14. An update on planning applications and new emissions sources was also provided. There were 36 planning applications which included an air quality assessment in 2023. 29 applications were required to monitor construction dust, and 15 developments had an AQ neutral undertaken.
15. Three amended industrial sources were identified by the Council, including one permit for the operation of the medium combustion plant, one permit for the operation of a back-up generator, and one permit for the operation of two combined heat power units.
- 16. It is indicated in Table E that all Breathe London monitors measure PM₁₀ and PM_{2.5} only, however results have been presented for NO₂, but have not been presented for PM₁₀. Table E should be updated with the correct pollutants.**
17. Figures have been provided to highlight the location of the monitoring sites, which are clear and easy to read. The use of a colour scheme to represent the monitored 2023 concentration is useful and should be utilised in the future. The inclusion of Air Quality Focus Areas on each figure is commended. The additional of scale bar and north arrow may be beneficial.
18. The use of several different trend graphs for automatic monitoring networks is commended and allows for clear visualisation of the trends within the borough. This is aided by the identification of both LLAQM and WHO objectives on each graph. Trend graphs would also be useful for the passive monitoring network, particularly within Air Quality Focus Areas.

Meeting Name:	Health and Wellbeing Board
Date:	14 November 2024
Report title:	Pharmaceutical Needs Assessment (PNA) Briefing
Ward(s) or groups affected:	All
Classification:	Open
Reason for lateness (if applicable):	Not applicable
From:	Sangeeta Leahy, Director of Public Health Southwark Council

RECOMMENDATION(S)

That the Health and Wellbeing Board:

1. Note the scope, process and timeline set out in this document for the refresh of the Pharmaceutical Needs Assessment (PNA).

BACKGROUND INFORMATION

1. Since 1 April 2013, every Health and Wellbeing Board (HWB) in England has held a statutory responsibility to publish and keep up to date a statement of the needs for pharmaceutical services of the population in its area, referred to as a Pharmaceutical Needs Assessment (PNA).
2. The current PNA for Southwark was published in 2021 and is due to be refreshed in 2025. This is a requirement set out by the Department of Health & Social Care.
3. As part of the process for developing the PNA, we are required to consider the current service provision and consult local stakeholders as part of the process.
4. The PNA refresh for Southwark is due for publication in October 2025 and will:
 - Identify current and expected future pharmacy needs for Southwark’s population including by reviewing population demographics and services within neighbouring areas;
 - Engage with stakeholders including health professionals and the public to identify whether unmet need is experienced;

- Review services to ensure effective allocation of resources to best meet population needs;
- Present current pharmacy provision in Southwark - including dispensing, advice on health, medicine reviews and local public health services (such as stop smoking, sexual health and support for drug users).

SCOPE

Local context

5. The PNA will be undertaken in the context of the needs of the local population. Health and wellbeing needs for the local population are described in Southwark's Joint Strategic Needs Assessment. The PNA will not duplicate these detailed descriptions of health needs and should be read in conjunction with the JSNA.
6. The Southwark profile will include demography including age/ gender (including population projections), ethnicity and deprivation; and health needs of the local population (including healthy lifestyles) compared to England average / inequalities within the borough.
7. The PNA will link into national and local strategic plans, including the local commissioning strategies and the local Joint Health and Wellbeing Strategy.

Description of pharmaceutical services

8. Providers of pharmaceutical services have an important role to play in improving the health of local people as they are easily accessible and often the first point of contact, including for those who might otherwise not access health services. Community pharmacies can contribute to the health and wellbeing of the local population by providing access to medications, support for self-care or self-limiting illnesses, information and advice, support for behaviour change, and signposting to other services.
9. Commissioners are recommended to commission services which are evidence-based, high quality, consistent, equitable, and accessible and evaluated.
10. Pharmaceutical services provided in the borough cover:
 - Essential services (distribution of pharmacies / opening hours and access / dispensing)
 - Advanced services (Medicines Use Reviews / New Medicines Service / appliance use reviews / stoma appliance customisation service)
 - Enhanced services (London Pharmacy Immunisation Service / seasonal influenza vaccination)
 - Locally commissioned services (stop smoking / sexual health / NHS Health Checks / supervised consumption / needle and syringe exchange service/ free (vitamin) D distribution)

Policy framework implications

11. There are no policy implications.

Community, equalities (including socio-economic) and health impacts**Community impact statement**

12. There are no community implications.

Equalities (including socio-economic) impact statement

13. There are no equalities implications.

Health impact statement

14. There are no health implications.

Climate change implications

15. There are no climate change implications.

Resource/Financial implications

16. The PNA will be led by the Public Health Division within Southwark Council and will require input from the Integrated Care Board and NHS England.

Legal implications

17. The refreshed PNA will be undertaken in accordance with the requirements set out in regulations 3-9 Schedule 1 of the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013.

Consultation

18. The PNA process will be overseen by a 'task & finish' group that will include members from the council (PH Team), SEL ICB, Local Pharmaceutical Committee (LPC), Community engagement team, and NHS England. The group will consult the views of a range of stakeholders (neighbouring boroughs across the South East London network, local pharmacies, etc.).

Timeline

19. The final draft Pharmaceutical Needs Assessment will be brought back to the Health & Wellbeing Board in Autumn 2025 for approval.

SUPPLEMENTARY ADVICE FROM OTHER OFFICERS**Head of Procurement**

20. None sought.

Assistant Chief Executive, Governance and Assurance

21. None sought.

Strategic Director of Resources

22. None sought.

Other officers

23. None sought.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
Southwark Pharmaceutical Needs Assessment 2022-25	Public Health / Southwark Council	Tom Seery: tom.seery@southwark.gov.uk
Southwark's Pharmaceutical Needs Assessment		

AUDIT TRAIL

Lead Officer	Chris Williamson, Assistant Director of Public Health	
Report Author	Tom Seery, Senior Programme Manager for Knowledge & Intelligence	
Version	Final	
Dated	1 November 2024	
Key Decision?	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	Comments Sought	Comments Included
Assistant Chief Executive, Governance and Assurance	No	No
Cabinet Member	No	No
Date final report sent to Constitutional Team		1 November 2024

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