Contents

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 scrum 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

Algerian Women's Group

Aymara

Bengali Women's Group

Black Parent's Forum

LOVO

Parent Action

Pecan Women's Group

SIDA

Southwark Traveller Action Group

Southwark Disability Forum

Rockingham Pre-school

Rockingham Nursery

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

Marcina Brown

Elizabeth Crook

Clara Fiti

Layla Glover

Paula Hill

Ginette Hogan

Arthur Holmes

Florence Igbokwe

Rahala Khalida

David Lee

Jessica Leech

Catherine Simonds

Zoe Silverthorne

Virginia Wynn-Jones

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

Lisa Colledge

Bruce Kidd

Tom Seery

Rebecca Sinnott

Alexandra Quinn-Savory

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.

Maternity Commission key themes and priorities

The Commission consisted of six public meetings running from January to September 2024, each with a different theme and set of priorities:

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	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. The Motherhood Group have a team of researchers and staff with lived experience who carry out community engagement projects. 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.
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 1st Place Childrens and Family Centre, which is a group session run

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

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, 2023[1]
- Better Births, 2016[2]
- The Black Maternity Experience report, 2022[3]
- 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, 2023[6]
- MBRRACE-UK Perinatal Mortality Surveillance for 2022, 2023[7]
- Listen to Mums: Ending the Postcode Lottery on Perinatal Care, 2024[8]

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 pregnancy[6], a figure relatively in line with other high-income countries[9].

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 2023[6] and 2024[7] 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.

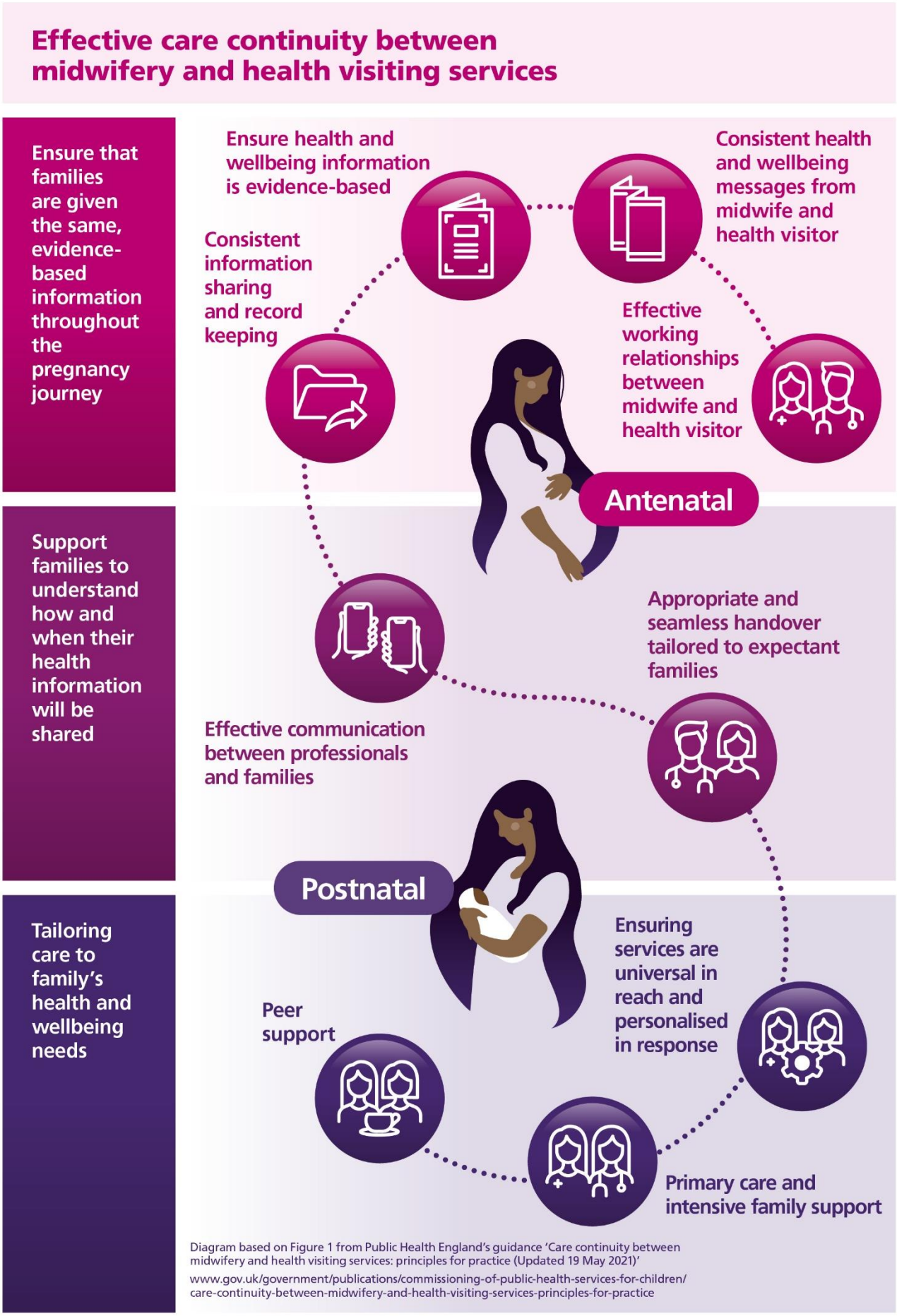


Figure 1. Diagram based on Figure 1 from Public Health England's guidance 'Care continuity between midwifery and health visiting services: principles for practice (Updated 19 May 2021)

The NHS Long Term Plan[10], 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 Plan[11] 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 Scheme[12] 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 wholescale 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 it[13].

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 Review[14] and the Commons Health and Social Care Committee's inquiry into the safety of maternity services in England[15], have underscored the persistent and severe staffing shortages in maternity care[16]. 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 review[14], the Birth Trauma Inquiry[8] 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 areas[18].

---

[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 death[19].

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
• The average age of Southwark mothers in 2022 was around 33 years[23], compared to 30.9 years in England and Wales[24]. • Mothers over the age of 35 are at increased risk of complications during pregnancy and childbirth e.g., pre-eclampsia, miscarriage, gestational diabetes, maternal mortality [25]. • Babies of older mothers face higher risks of high or low birth weight, stillbirth, preterm birth and chromosomal abnormalities [26].	• Southwark has high levels of deprivation across the north and centre of the borough[27]. • 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 wards[29].

[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 England[29].
- 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 countries[29].

Asylum Seeker and Refugee status

- There is no data on how many pregnant women are seeking asylum and housed in initial accommodation centres[30] (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 midwives[31].

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 nationally[28].
- 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 background[32].
- 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 England[33].
- An estimated 10% of Southwark women who had their booking appointment[34] 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 English[35].

[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 England[36]. 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.

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

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.

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 midwifery[39] 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*

background[41]. 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-morbidities[42]). 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 2018[44]. 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 period[46].

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) inspections[41].

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 adaptions 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 increasing[28]. 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 1938[24]. 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 England[24].

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 UK[29]. 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 Midwives[48]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 is 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 career[49].

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 Survey[50] 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 repercussions[52].

"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 report[6] 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% nationally[53]. The largest group other than White is 'Black, Black British, Caribbean or African', with 25% of Southwark resident reporting this as their ethnicity[53]. 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).

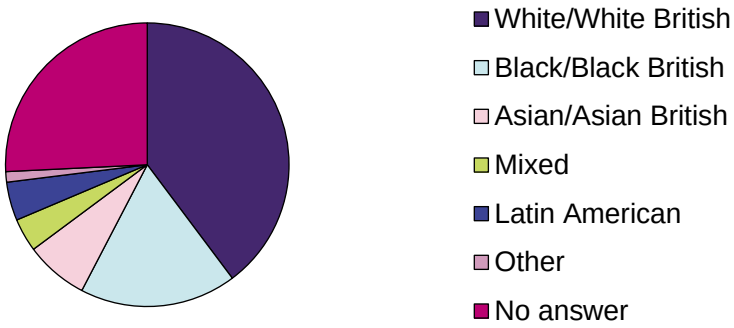


Figure 3. Survey respondents by ethnicity (%).

- 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%).

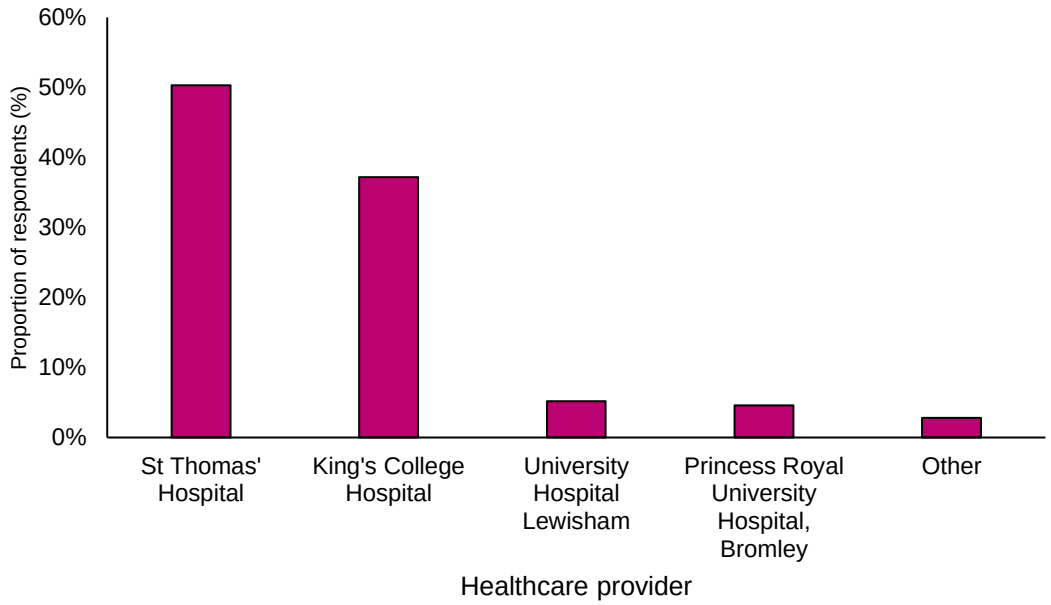


Figure 4. Proportion of respondents by provider of maternity care.

- 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

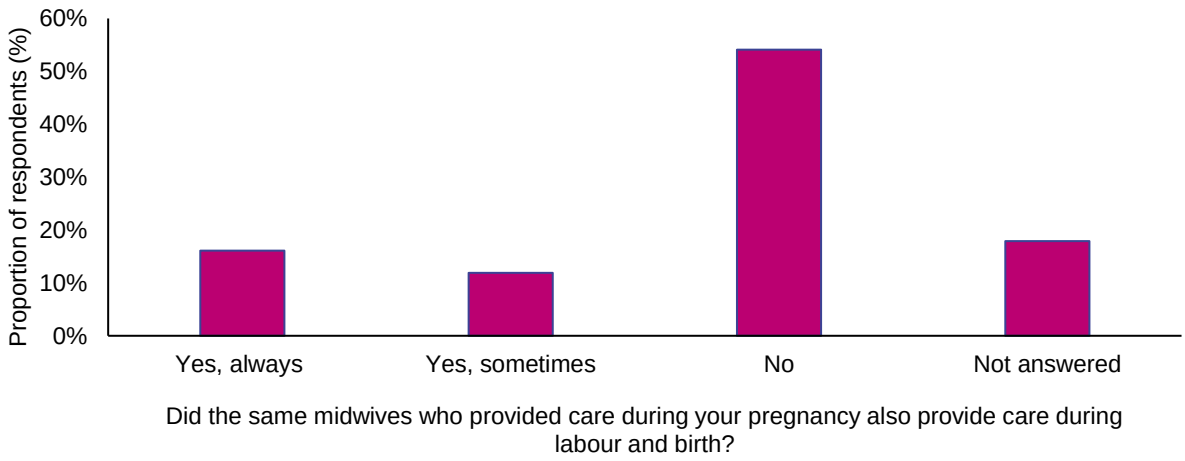


Figure 6. Proportion of respondents by continuity of maternity care.

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-cisheterosexual[54] 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 inequalities[55].

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 disadvantage[56], 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 health[57].

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 well[58]. 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 Lambeth[59] 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 UK[60], 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 Redshaw[61] 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 care[62]. 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 factors[35]. 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 outcomes[28]. 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 England[35]. 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 populations[64]. 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 LGBT+ 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 people[65].

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 tans and nonbinary people. A cisheteronormative[66] 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 people[67].

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 are[68]:

> **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 of 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 women[69]. 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 review[70] 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 populations[72].

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-today 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 tokophobia[74]. 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 let 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 morbidity[75]

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 2018-19[76] reporting that 25% of women had an episiotomy[77], 12% an assisted vaginal birth[78], 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 delay[80] 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%).

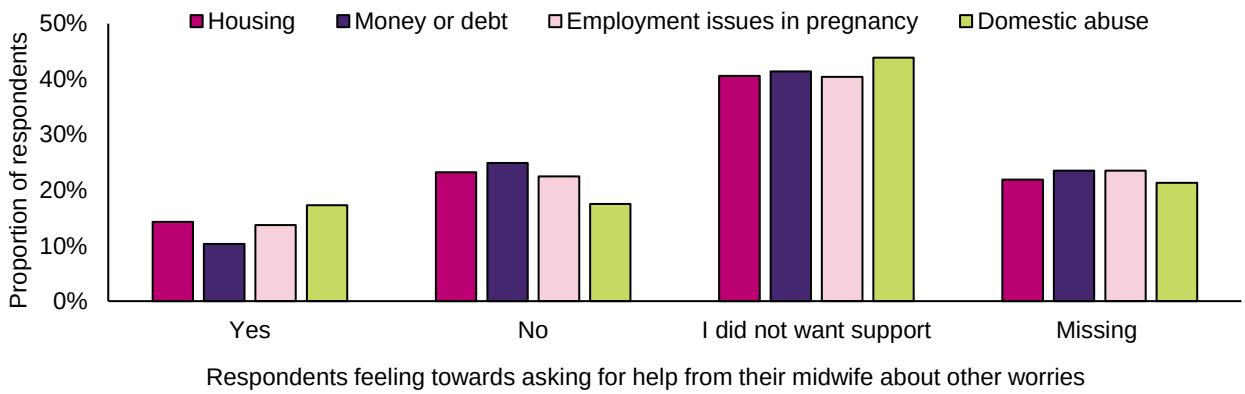


Figure 7. Respondents feeling towards asking for help from their midwife about worries related to housing, money or debt, employment issues in pregnancy, and domestic abuse.

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.

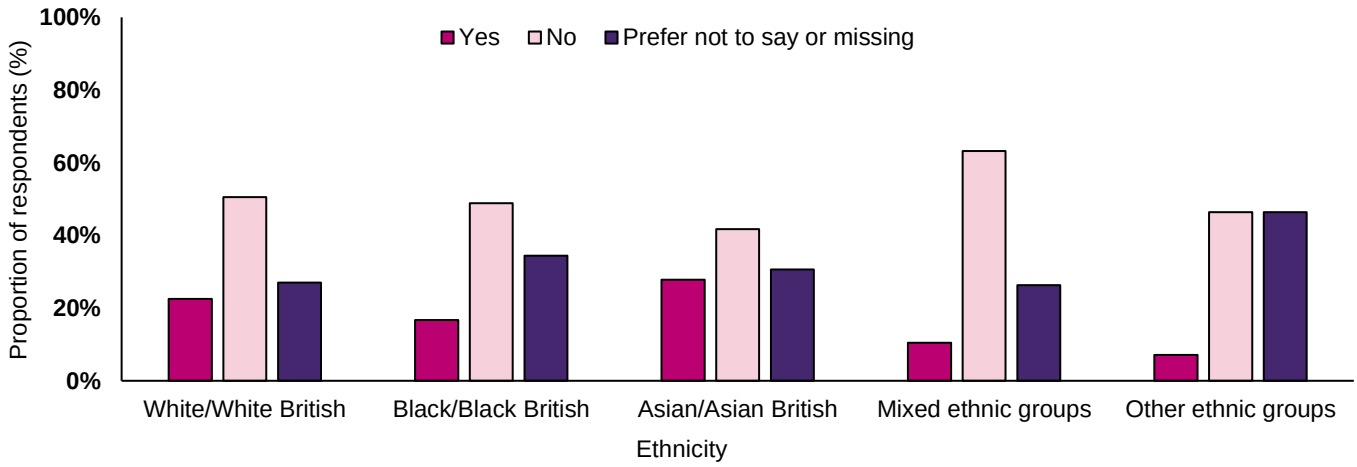


Figure 9. Proportion of respondents experiencing poor prenatal mental health by ethnicity.

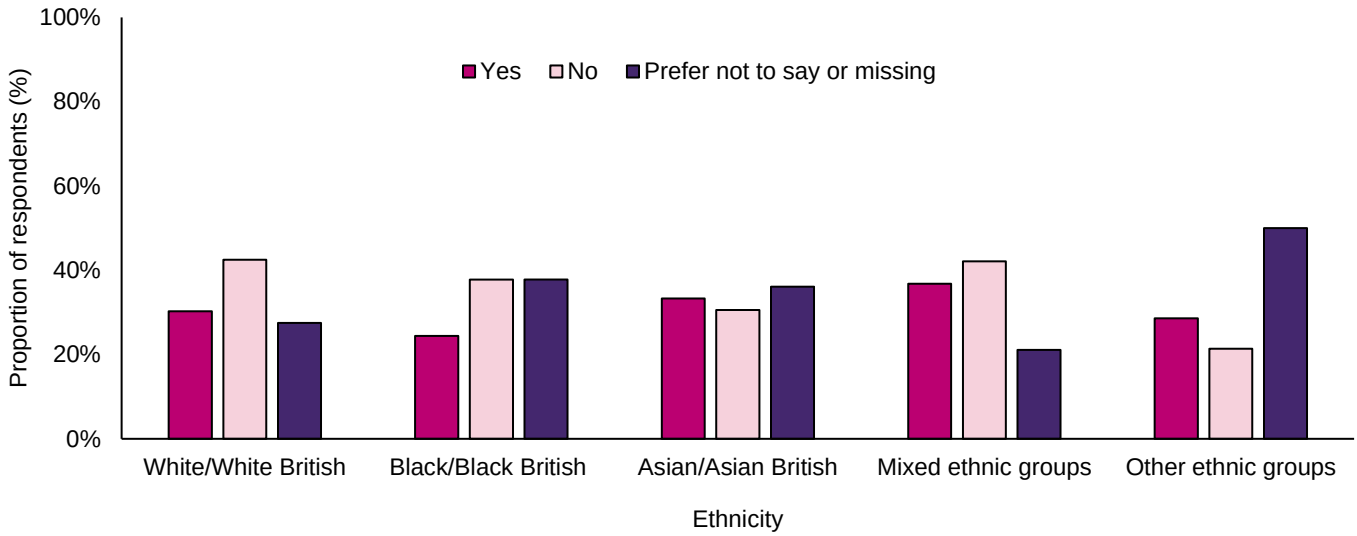


Figure 10. Proportion of respondents experiencing poor postnatal mental health by ethnicity.

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 gravidarum[84] (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 needs[29]. Certain groups are as 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 adaptions 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 Europe[88] 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 primiparous[89] 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 baby[91]. 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 Code[92] and to practise within the law of the United Kingdom (UK) by upholding human rights in the care that they offer and provide[93]. 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 report[94] 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.

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 Southwark 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 Southwark Council, Primary Care partners and the VCFSE sector organisations, a more holistic approach can be taken to improving maternity care and outcomes in Southwark.

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	**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.	Central Government LMNS, GSTT, KCH, SLaM
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.	Central Government
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.	Central Government, LMNS, GSTT, KCH, SLaM

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.	LMNS, GSTT, KCH, SLaM, GPs, Southwark Council, VCFSE organisations
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.	LMNS, GSTT, KCH, SLaM, Southwark Council, VCFSE organisations
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).	LMNS, GSTT, KCH, SLaM, GPs, Southwark Council, VCFSE organisations
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	LMNS, GSTT, KCH, SLaM, GPs, Southwark Council, VCFSE organisations
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	LMNS, GSTT, KCH, SLaM, GPs, Southwark Council, VCFSE organisations

	enhance and provide consistent services across borough borders.	
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.	Southwark Council
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.	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

August 2024

Contents

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.

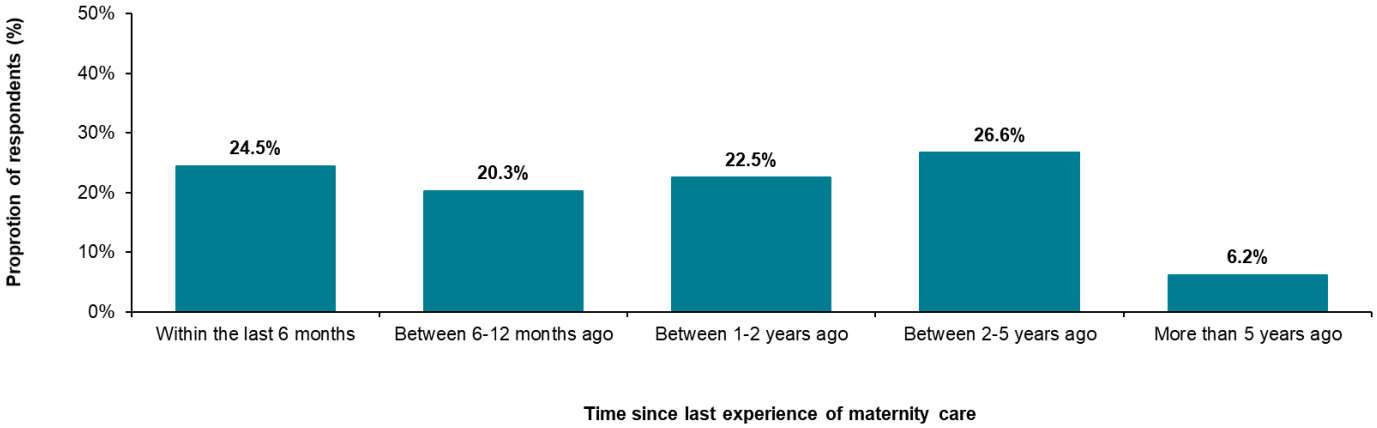
Communication Medium	Number	%
Email from council	126	25.0%
Facebook	40	8.0%
Conversation with friend/neighbour/family	36	7.2%
Twitter	32	6.4%
Southwark Council website	28	5.6%
Instagram	26	5.2%
WhatsApp message	21	4.2%
Conversation with council officer/councillor	20	4.0%
Media coverage (Southwark News, 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%).

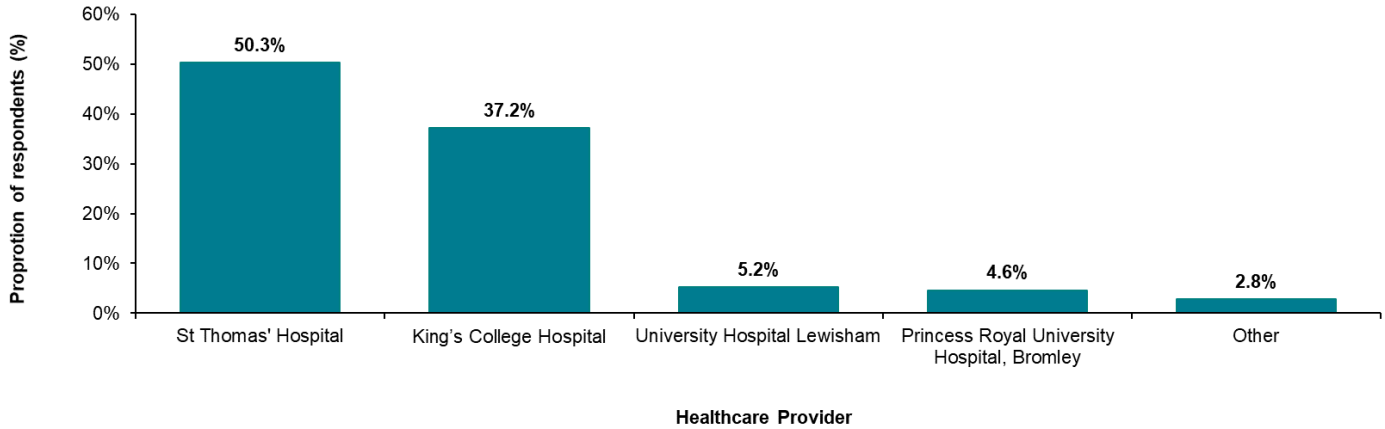
Healthcare Provision

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.

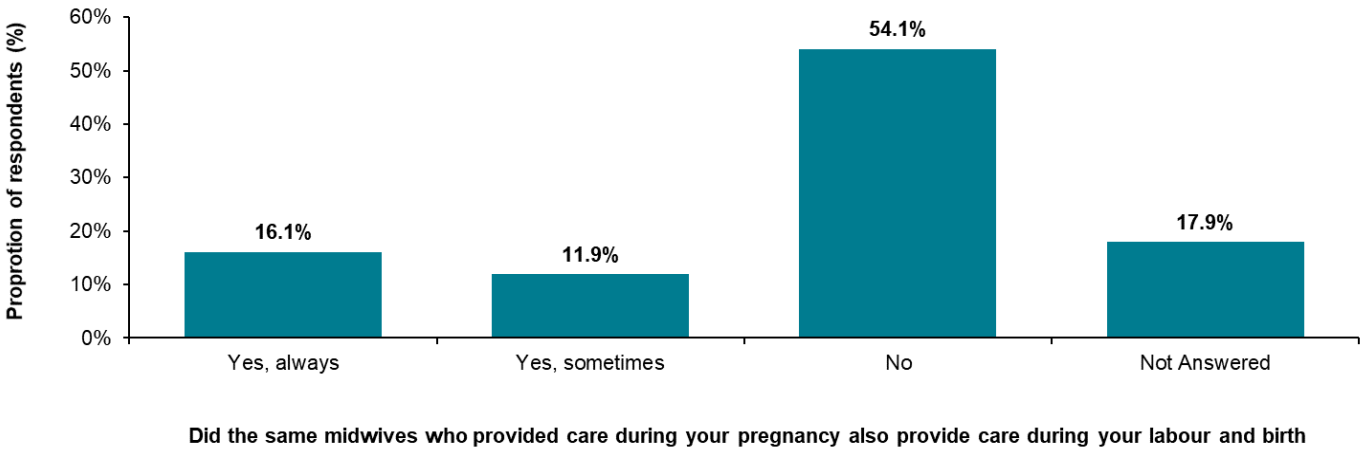


Supplementary Figure 2. Proportion of respondents by provider of maternity care.

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%).



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).

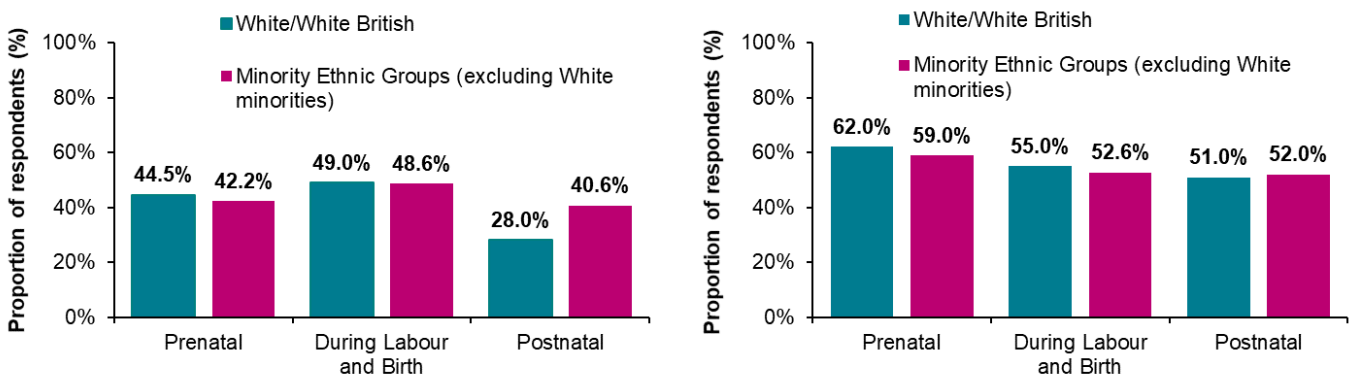
Supplementary Table 3. Proportion of respondents able to get help from their midwife or doctor when they needed it across the care pathway.

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.

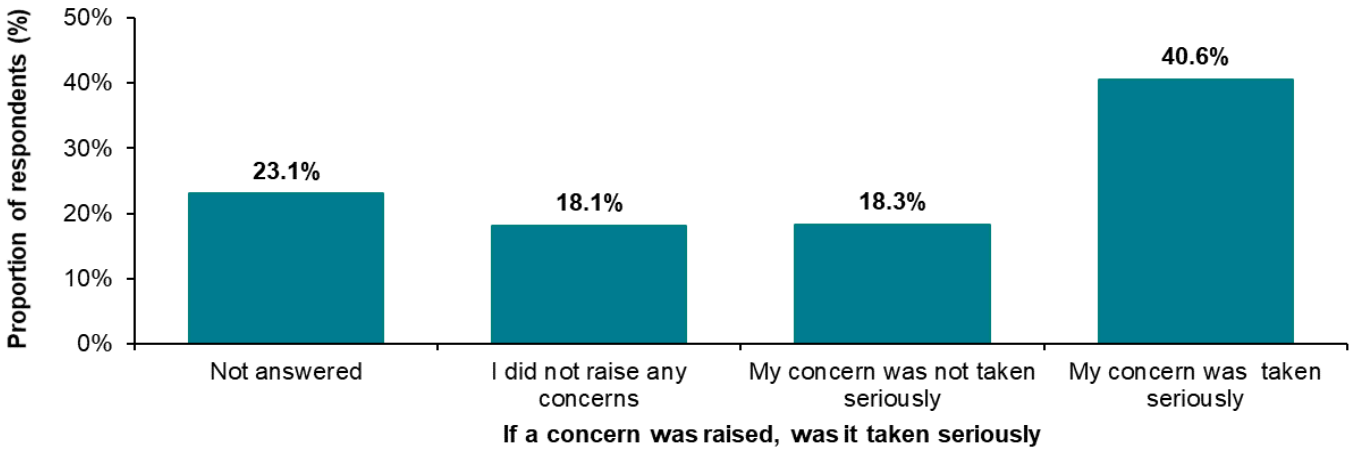
Nearly two thirds (64.0%) of respondents felt that they were able to ask all the questions they wanted to about their care (no: 14.3%; missing: 21.7%); proportions were lower among respondents of ethnic minority groups (66.5%; excluding White minorities) compared to those of a White ethnicity (71.7%). 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%).

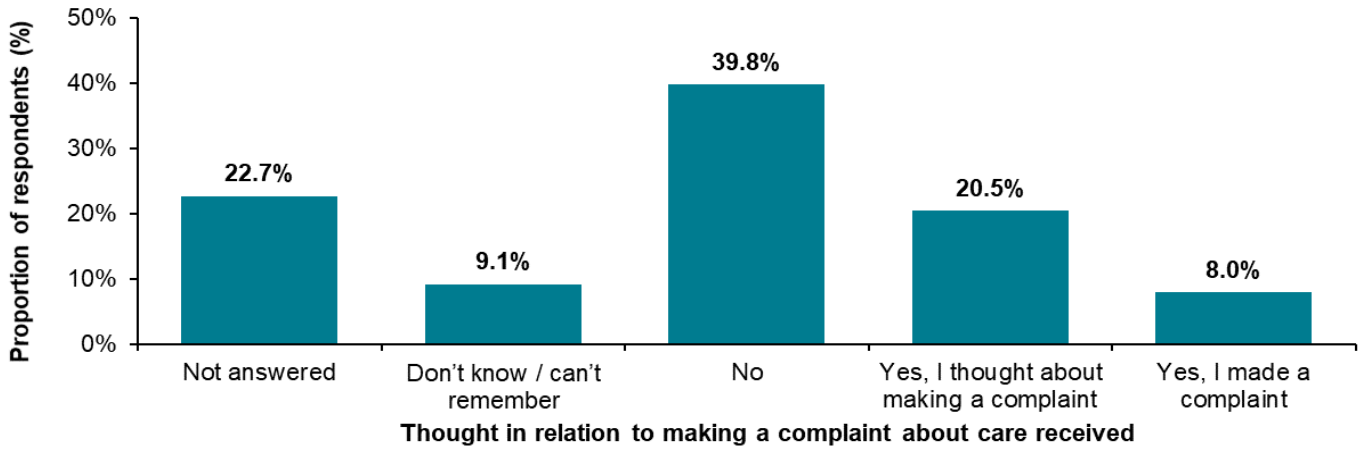
Less than one third of respondents (28.5%) either thought about making a complaint or made a complaint (Supplementary Figure 6). Respondents of a White ethnicity were 1.3 times more likely to either think about, or make a complaint compared to those of an ethnic minority group (37.0% vs 28.9% of respondents, 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.

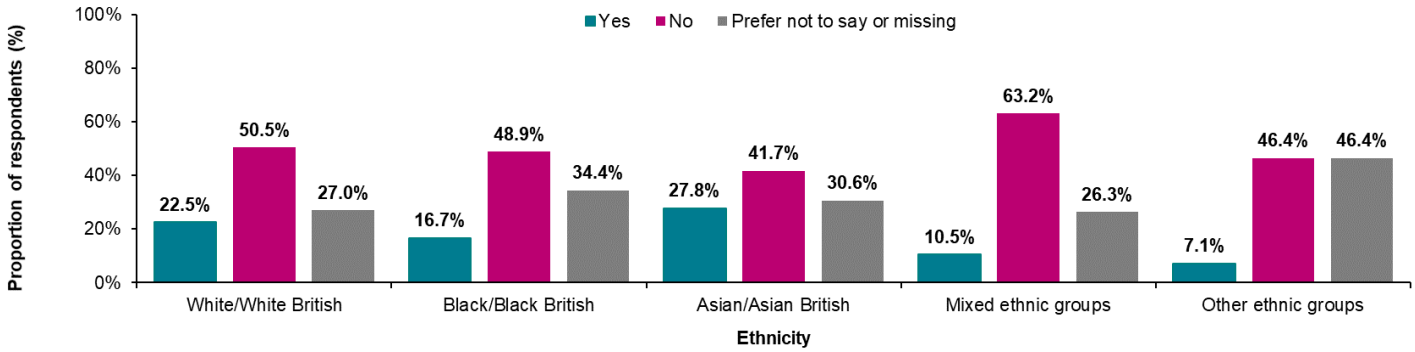
Mental Health

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.

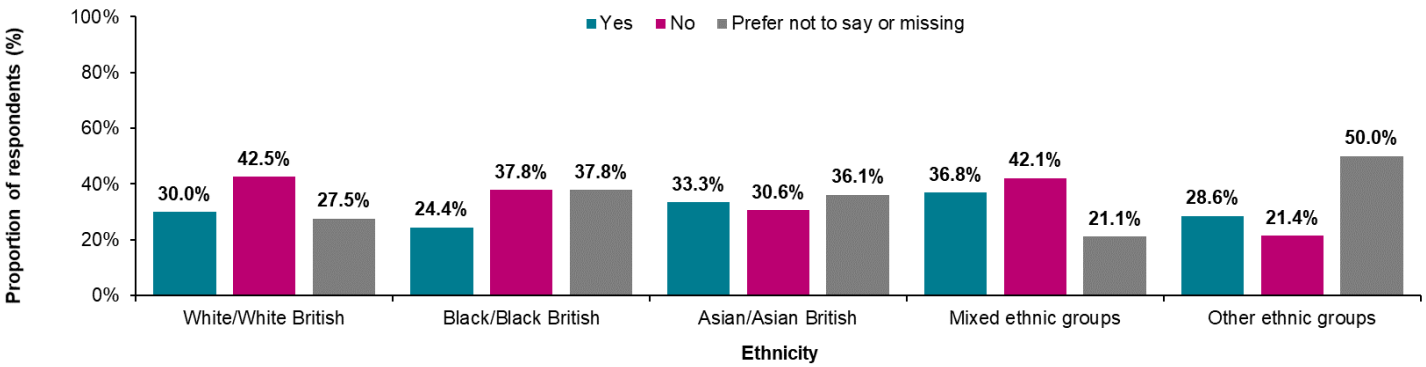
Supplementary Table 6. Proportion of respondents experiencing poor mental health, during their pregnancy, and after their baby was born, respectively.

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

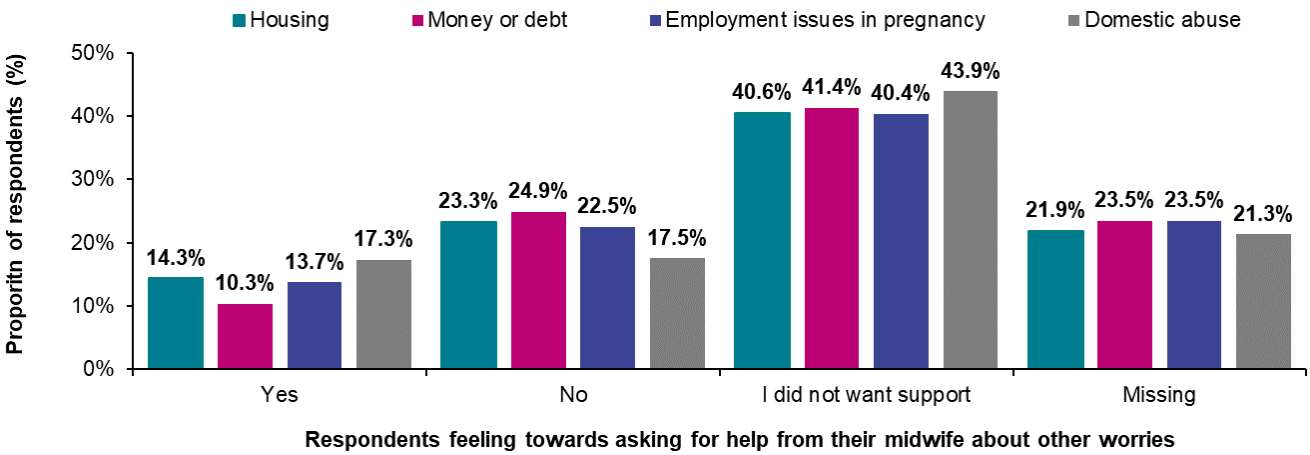
White minorities) compared to those of a White ethnicity (73.5%), but lower among respondents aged 35 years old and over (68.6%) compared to those aged 34 years old and under (77.6%). Respondents with a disability were more likely to know how to contact their local maternity service compared to those 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.

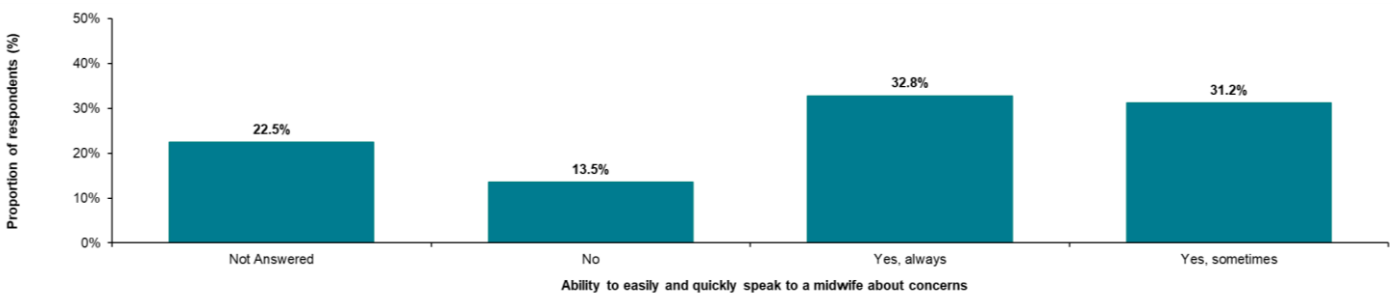
Over one-tenth (12.9%) of respondents would have preferred to receive information in another language, with Spanish and Chinese most frequently listed, respectively.

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.

2024

The Motherhood Group: Southwark Maternity Commission Engagement Report

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

THE MOTHERHOOD GROUP

Contents

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 🌍

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.

Approximately[1] 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-seven[2].

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 founded 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 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.

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 responsible 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.

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 Reponses Table

Where did you receive maternity care?	When was your last experience of maternity care?	How was your experience of ante-natal 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

Appendix 2

The Motherhood Group - STAG 'Mums Connect' online sharing session

External Inbox ×

Faylisha Scott <faylisha@themotherhoodgroup.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@themotherhoodgroup.com

The Motherhood Group, Tripod, Lambeth Town Hall,
1 Brixton Hill, London SW2 1RW
www.themotherhoodgroup.org

Coordinators of:

New Message

Appendix 3

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 🌍

THE MOTHERHOOD GROUP

https://themotherhoodgroup.org/newsletters/

HOME ABOUT CAMPAIGNS PROJECTS SERVICES NEWS/EVENTS DONATE

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

THE MOTHERHOOD GROUP

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). T*he 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.. 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)

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.
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.
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.

How does the LMNS share data on demographics and local need with other partners? *(e.g. local authorities, partner organisations)* (max 250 words)

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.

Health inequalities

How does the LMNS use local data to identify health inequalities? (max 250 words)

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.
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.
We also use feedback from women and birthing people, this feedback is incorporated into appropriate actions plans.

What steps do the LMNS take to reduce identified health inequalities? (max 250 words)

Some examples of what we have implemented to reduce inequalities as an LMS are;

- 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? *(e.g. ensuring all receive the same opportunities to grow professionally)* (max 250 words)
ICB
What efforts are your organisation making to diversify your workforce? *(e.g. what hiring and retention policies exist?)* (max 250 words)
ICB
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)
ICB
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)

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 delevers 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 recomemndations 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. Multidiscipinary 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 depravation 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, Kings'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)

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.
Where do you find you are encountering difficulties? (max 250 words)
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. 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.
What could help you to achieve this more effectively? (max 250 words)
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.

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)
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. 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.
Where do you find you are encountering difficulties? (max 250 words)
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.

What could help you to achieve this more effectively? (max 250 words)
Ring fenced funding for midwifery models to increase continuity of carer from central funds. Improved access to community based space to increase numbers of clinics and health promotion activities in multi-agency hubs. 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.
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)
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. 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. 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.
Where do you find you are encountering difficulties? (max 250 words)
Personalised care is generally being met, but improved multi-agency liaison would improve this further.
What could help you to achieve this more effectively? (max 250 words)
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.

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)
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. 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.
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)*
How successfully is your organisation achieving this? (max 250 words)
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.
Where do you find you are encountering difficulties? (max 250 words)
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.
What could help you to achieve this more effectively? (max 250 words)
Improved collaboration between national policy changes and local providers to reduce the impact of unintended consequences. 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.
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)*
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 attendes 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)
- 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) – 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 Doulas 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 Portugese.
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
Acccess 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-aligment 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 there 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. *(NHS Long Term Plan, 2019)*
How successfully is your organisation achieving this? (max 250 words)
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: · Implementation of 70% of interventions across all 6 elements overall · Implementation of at least 50% of interventions in each individual element 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 An action plan is included in the Board Declaration Form and will be a priority to deliver compliance over the coming months.
Where do you find you are encountering difficulties? (max 250 words)
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. 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. We have lead obstetricians across both sited that lead fetal monitoring alongside a midwifery colleague. The job specifications and dedicated time is being reviewed within the Trust.

What could help you to achieve this more effectively? (max 250 words)
We have created a new senior head of midwifery role for compliance who will oversee the ongoing action plans and evidence collection. A dedicated audit and guideline midwife who will improve compliance to data collection and evidence to assure compliance to the care bundle.
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)*
How successfully is your organisation achieving this? (max 250 words)
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. **Maternity Safety Champions** - 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)
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.
What could help you to achieve this more effectively? (max 250 words)
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.
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)*
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)
• 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)
We take all recommendations relevant to perinatal mental health and consider what amendments or implementations to service delivery are required. Any significant service change will be discussed through relevant leadership, governance and quality meetings within the trust, PMOA directorate and specialist perinatal pathways.
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)
• 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)
• 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 Partership (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)
Seeking consent from index patient to contact fathers/partners and significant others to have a conversation. 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? Time – additional responsibility on clinicians and workforce challenges.
What could help you to achieve this more effectively? (max 250 words)
Assistant Psychologist recruited to lead and support workstream and Senior Leadership Team (fixed term for 12 months) EQUIP – able to plan a session on fathers mental health last year and there is a plan to arrange another one for this year Family event to be planned by the service for include fathers, partners and significant others. Staffing with specific interests

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 *(NHS Long Term Plan, 2019).*
How successfully is your organisation achieving this? (max 250 words)
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. 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. We are offering teaching and training to student midwives and other professionals regarding perinatal loss and trauma-informed care. 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.
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 adaptions 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.

_____