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.

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WRITTEN EVIDENCE SUBMISSION:
Guy's & St Thomas NHS Foundation Trust

Submitted: 9 January 2024

INTRODUCTION

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- 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

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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?

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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.