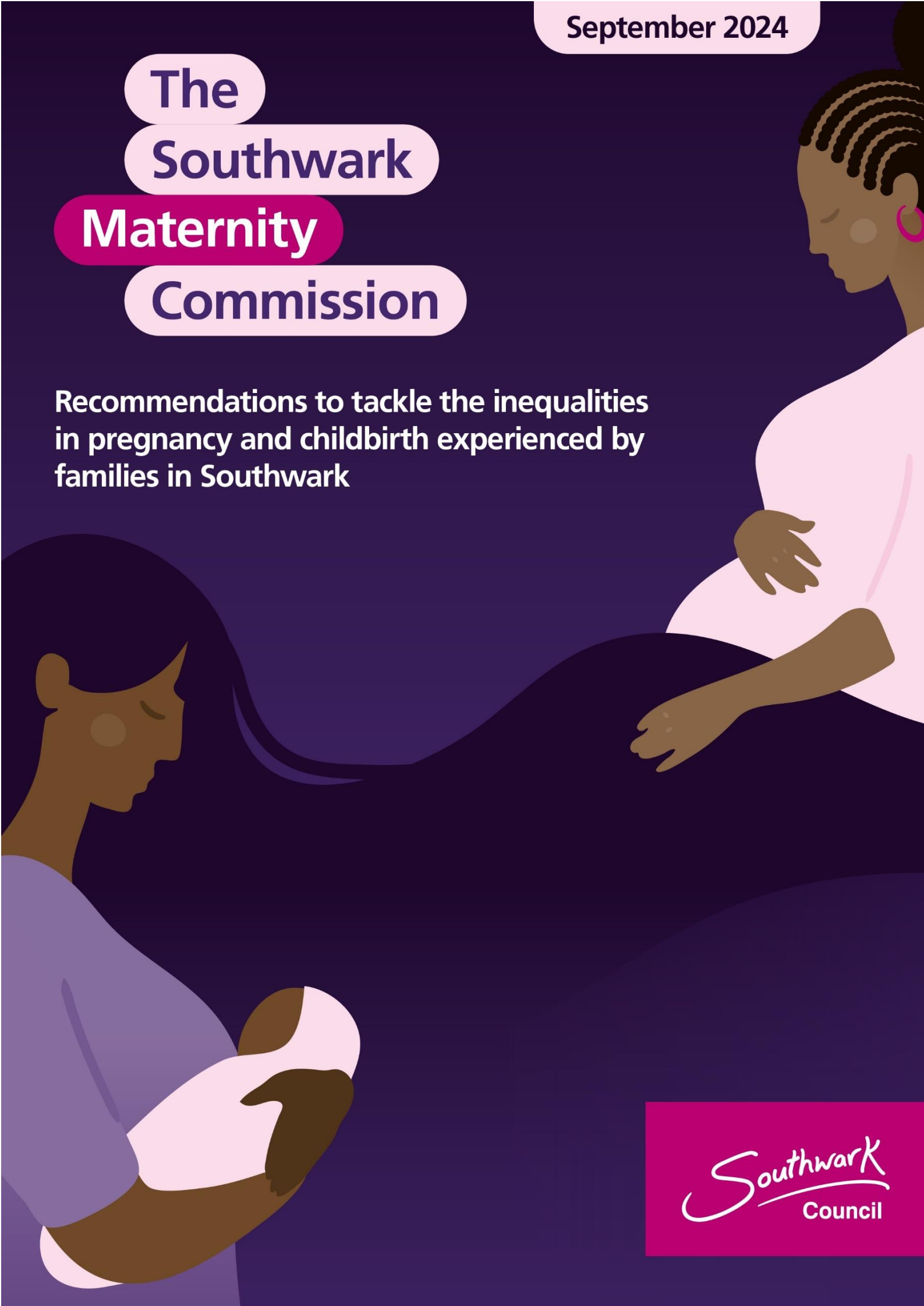
September 2024

The Southwark Maternity Commission

Recommendations to tackle the inequalities in pregnancy and childbirth experienced by families in Southwark



Southwark Council

Contents

Inclusivity statement

All means all

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

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

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

A message from the Southwark Maternity Commission Panel

Councillor Evelyn Akoto

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

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

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

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

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

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

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

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

Dame Professor Donna Kinnair

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

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

About the Southwark Maternity Commission Panel

Dr Benedicta Agbagwara-Osuji

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

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

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

Omar Campbell

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

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

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

Sandra Igwe

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

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

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

Becca Jones

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

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

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

Jacqui Kempen

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

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

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

Michele Misgalla

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

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

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

Cheryl Rhodes

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

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

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

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

Acknowledgements

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

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

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

Aainna Women's Group

Algerian Women's Group

Aymara

Bengali Women's Group

Black Parent's Forum

LOVO

Parent Action

Pecan Women's Group

SIDA

Southwark Traveller Action Group

Southwark Disability Forum

Rockingham Pre-school

Rockingham Nursery

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

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

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

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

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

Gargie Ahmad

Marcina Brown

Elizabeth Crook

Clara Fiti

Layla Glover

Paula Hill

Ginette Hogan

Arthur Holmes

Florence Igbokwe

Rahala Khalida

David Lee

Jessica Leech

Catherine Simonds

Zoe Silverthorne

Virginia Wynn-Jones

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

Lisa Colledge

Bruce Kidd

Tom Seery

Rebecca Sinnott

Alexandra Quinn-Savory

Report authors: Megan Velzian and Clodagh Cox

Chapter One: An introduction to the Southwark Maternity Commission

Southwark Maternity Commission

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

Councillor Evelyn Akoto, Founder of the Southwark Maternity Commission

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

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

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

The Commission aimed to:

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

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

In undertaking its work, the Commission listened to:

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

Engagement

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

Engagement with residents

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

Engagement with professionals

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

Key outputs

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

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

Use of literature and best practice

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

- LMNS Equity and Equality Strategy, 2023[1]
- Better Births, 2016[2]
- The Black Maternity Experience report, 2022[3]
- MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) Perinatal Confidential Enquiry, 2023[4,5]
- MBRRACE-UK Saving Lives, Improving Mothers' Care, 2023[6]
- MBRRACE-UK Perinatal Mortality Surveillance for 2022, 2023[7]
- Listen to Mums: Ending the Postcode Lottery on Perinatal Care, 2024[8]

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

[1] South East London Maternity & Neonatal System (2023) *Equity and Equality Strategy*
[2] National Maternity Review (2016) *Better Births: Improving outcomes of maternity services in England*
[3] Five X More (2022) *The Black Maternity Experiences Survey: A Nationwide Study of Black Women's Experiences of Maternity Services in the United Kingdom*
[4] MBRRACE-UK (2023) *Perinatal Confidential Enquiry: A comparison of the care of Asian and White women who have experienced a stillbirth or neonatal death*
[5] MBRRACE-UK (2023) *Perinatal Confidential Enquiry: A comparison of the care of Black and White women who have experienced a stillbirth or neonatal death*
[6] MBRRACE-UK (2023) *Saving Lives Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2019-21*
[7] MBRRACE-UK (2024) Perinatal Mortality Surveillance: *Report for births in 2022*
[8] The All-Party Parliamentary Group on Birth Trauma (2024) *Listen to Mums: Ending the Postcode Lottery on Perinatal Care*

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

National context

By global standards, giving birth in the UK is very safe. In 2019-2021, 241 out of 2,066,997 women giving birth in the UK died during or up to six weeks after pregnancy[6], a figure relatively in line with other high-income countries[9].

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

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

Inequalities remain a significant problem when it comes to maternal outcomes, particularly those highlighted by the 2023[6] and 2024[7] MBRRACE reports:

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

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

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

Health policy

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

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

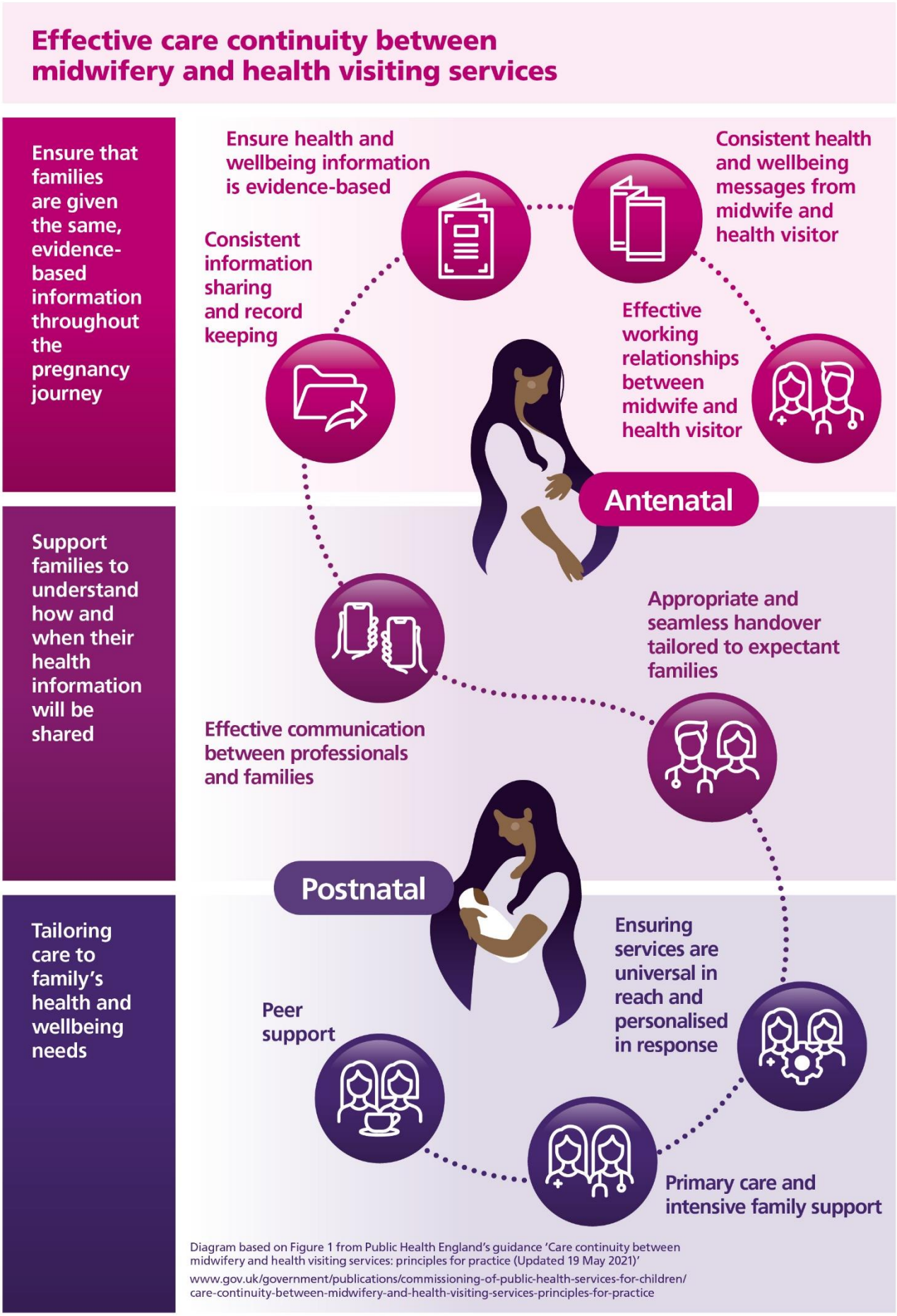


Figure 1. Diagram based on Figure 1 from Public Health England's guidance 'Care continuity between midwifery and health visiting services: principles for practice (Updated 19 May 2021)

The NHS Long Term Plan[10], which was NHS England's response to changes in society and health needs, includes commitments based on measures set out in Better Births. These included ensuring continuity of carer for 75% of women from Black, Asian and minority ethnic communities and those from the most deprived groups by March 2024, and halving the rates of stillbirth and neonatal and maternal deaths by 2025. Initiatives to tackle health inequalities include prioritising continuity of carer for women from ethnic minority groups and other vulnerable groups. Other aims include increasing access to perinatal mental health services and increased support for breastfeeding and smoking cessation advice. It also commits to the digital transformation of maternity services to make it easier to share information.

The Three-Year Delivery Plan[11] for maternity and neonatal services outlines how the NHS will enhance care, making it safer, more personalised, and more equitable for women, babies, and families. Following several national plans and reports, the plan brings together the key objectives that that services are asked to deliver against over the next three years. In line with the Maternity Commission, this plan was informed by input from those who have used maternity services, the workforce, service leaders, regional stakeholders, and national stakeholders. There are numerous similarities between findings at a local level in Southwark and nationally. The objectives of the Three-Year Delivery Plan include:

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

The NHS Resolution's Maternity Incentive Scheme[12] is now in its sixth year of operation and continues to support safer maternity and perinatal care by driving compliance with ten safety actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025. The Maternity Incentive Scheme applies to all acute Trusts that deliver maternity services and are members of the Clinical Negligence Scheme for Trusts.

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

[10] NHS (2019) *The NHS Long Term Plan*
[11] NHS England (2023) *Three-year delivery plan for maternity and neonatal services*
[12] NHS Resolution (2024) *Maternity (and perinatal) Incentive Scheme, Year Six*

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

The COVID-19 pandemic caused wholescale disruption of health and care including maternity care services. There was at least partial, and in some cases, whole suspension of progress towards various objectives set out in Better Births. In line with Better Births, the NHS Long Term Plan committed to 35% of women being placed on a continuity of carer pathway by March 2020. However, in September 2022, NHS England announced that there would no longer be a target date for maternity services to deliver against this target of 35% until maternity services in England could demonstrate sufficient staff levels to be able deliver it[13].

Staff recruitment and retention is a challenge in maternity services, particularly after the NHS Bursary Scheme in England was discontinued in 2017. Although student bursaries have since been reinstated in part, the effects of the temporary discontinuation are likely to have implications for future staffing levels. Recent reports, including the Ockenden Review[14] and the Commons Health and Social Care Committee's inquiry into the safety of maternity services in England[15], have underscored the persistent and severe staffing shortages in maternity care[16]. Midwives, maternity support workers, and other staff report struggling to find the time to adequately support women and families, provide timely information, and compensate for the lack of senior and experienced colleagues. The situation is particularly critical in England, where the shortage of midwives is currently estimated at 2,500.[17]

Midwives have also been a role under scrutiny over recent years, with the Ockenden review[14], the Birth Trauma Inquiry[8] and the case of the neonatal nurse found guilty of the murder of babies in her care making headline news. As a result, staff we engaged with reported feeling “demonised” by the media.

Where safe staffing is in place, NHS England continues to encourage rollout of midwifery continuity of carer, prioritising Black, Asian and Mixed ethnicity women, as well as those from the most deprived areas[18].

---

[13] NHS England (2022) *Midwifery continuity of carer*
[14] Ockenden Report (2022) *Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust*
[15] Department of Health and Social Care (2021) *The government's response to the Health and Social Care Committee report: safety of maternity services in England*
[16] All Party Parliamentary Groups (2022) *Safe Staffing: The impact of staffing shortages on maternal and neonatal care*
[17] RCM (2024) *How to fix the midwifery staffing crisis.*
[18] NHS England (2022) *Priorities and operational planning guidance*

Wider socio-economic context

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

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

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

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

The local picture

Headline figures in Southwark

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

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

Demographics and wider determinants of health

Age	Deprivation
• The average age of Southwark mothers in 2022 was around 33 years[23], compared to 30.9 years in England and Wales[24]. • Mothers over the age of 35 are at increased risk of complications during pregnancy and childbirth e.g., pre-eclampsia, miscarriage, gestational diabetes, maternal mortality [25]. • Babies of older mothers face higher risks of high or low birth weight, stillbirth, preterm birth and chromosomal abnormalities [26].	• Southwark has high levels of deprivation across the north and centre of the borough[27]. • In 2022/23, 18.6% of under 16-year-olds in Southwark were in relative low-income families, a higher percentage than London (15.8%) but lower than England (19.8%)[28]. • Between 2018-2021, 30% of all stillbirths occurred in the five most deprived wards, over twice as many as to those in the five least deprived wards[29].

[20] NHS Digital (2018-21) *Birth registrations*
[21] **Live births:** a baby that is born alive at any time, regardless of the length of the gestation period
[22] Note: This data source only refers to deaths wherein a pregnancy-related cause is listed on the death certificate and coded as the underlying cause and so may not reflect the true picture of maternal mortality in Southwark
[23] JSNA Annual Report (2023) *Southwark's Joint Strategic Needs Assessment*
[24] Office for National Statistics (2024) *Birth characteristics in England and Wales: 2022*
[25] Correa-de-Araujo & Yoon (2021) *Clinical Outcomes in High-Risk Pregnancies Due to Advanced Maternal Age*
[26] Glick, Kadish & Rottenstreich (2021) *Management of Pregnancy in Women of Advanced Maternal Age: Improving Outcomes for Mother and Baby*
[27] Department for Levelling Up, Housing and Communities (2021) *English Indices of Deprivation 2019*
[28] Office for Health Improvement and Disparities (2024) *Child and Maternal Health*
[29] Southwark Council (2024) *Health Needs Assessment: The First 1,001 Days*

Country of birth

- Over half of all births in Southwark are to mothers born outside of England[29].
- Between 2018-2021, mothers' main non-UK countries of birth, were Nigeria, Sierra Leone, Ghana and the US.
- Local data reveals that stillbirth disproportionately affects women born in African countries[29].

Asylum Seeker and Refugee status

- There is no data on how many pregnant women are seeking asylum and housed in initial accommodation centres[30] (IACs) such as hotels in Southwark.
- National evidence suggests that pregnant people living in initial accommodation face a range of challenges, including poor nutrition, increased risk of mental health conditions, poor housing conditions, and being moved between IACs during pregnancy, often resulting in a need to change maternity services and midwives[31].

Wider social determinants of health

- As of 2022/23, 22 per 1,000 (2.2%) of households including one or more dependent children in Southwark are owed a prevention or relief duty under the Homelessness Reduction Act. Local authorities owe prevention duties to help stop households at risk of homelessness losing their accommodation. This rate is substantially higher than that of London and nationally[28].
- Southwark Stands Together is Southwark Council's response to the inequalities exposed by COVID-19 and the events of 2020, as articulated by the Black Lives Matter protests. Engagement with residents through Southwark Stands Together highlighted one-third of residents from an ethnic minority background had experienced racial discrimination in health and care services, increasing to 41% among those from a Black ethnic background[32].
- Of 2,600 children in need in Southwark at the end of March 2023, 5% had a primary need of parent's disability or illness, compared to 2% in England[33].
- An estimated 10% of Southwark women who had their booking appointment[34] in 2021/22 were deemed to be subject to complex social factors, such as poverty, substance misuse, asylum seeker and refugee status, age under 20, domestic abuse, difficulty speaking and/or understanding English[35].

[30] **Initial Accommodation Centres (IACs):** Lodgings for people who are awaiting the outcome of their claim for asylum. Some asylum seekers who have been granted support from the Home Office may remain in IACs until there is space in longer-term, temporary accommodation.
[31] Maternity Action (2022) *Maternal Health: exploring the lived experiences of pregnant women seeking asylum*
[32] Southwark Council (2021) *Southwark Stands Together – Findings from listening events, roundtables and online survey*
[33] Department for Education (2022) *Characteristics of Children in Need 2021/22*
[34] **Booking appointment: Refers** to the first midwife appointment, which should take place before ten weeks of pregnancy
[35] NHS Digital (2022) *Maternity Services Data Set*

- Southwark has a high number of women and girls found to have experienced female genital mutilation (FGM), with 160 Southwark resident women and girls recorded as having FGM, more than twice the rate for London and five times the rate for England[36]. It is worth noting that the actual figure in Southwark is likely to be higher as many cases go unrecorded. FGM has long term physical and psychological health problems and can affect maternal and neonatal health including postpartum bleeding, increased risk of caesarean section and neonatal death.[37, 37, 38]

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

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

Summary of local maternity services

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

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

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

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

---

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

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

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

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

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

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

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

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

Chapter Three: Maternity care in Southwark

Overview

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

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

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

Meeting One: Hearing from providers of maternity care in Southwark

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

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

Hearing from: Local Maternity and Neonatal Systems (LMNS)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

While the trust did not provide data in their submission, they offered case studies of how data is used to improve service provision. When asked for an example of where the service has analysed their data to pinpoint root causes for disparities in service uptake, representatives detailed a case where caseload midwifery[39] was used in an area with low service uptake and high infant mortality rates, leading to significantly reduced infant mortality rates in that area.

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

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

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

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

Direct quote from Meeting One:

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

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

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

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

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

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

background[41]. GSTT described the building up of a trusting relationship across the whole of the maternity journey. They also described how continuity of carer is easier to provide during pregnancy due to preplanning, whereas during labour, childbirth and postnatal care it can be harder to guarantee.

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

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

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

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

The King's College Hospital (KCH) has maternity services at both Denmark Hill and Princess Royal University Hospital sites. Denmark Hill is a Level 3 Neonatal Intensive Care Unit with a tertiary unit taking referrals for women with specific health conditions relating to pregnancy that require specialist care (such as foetal medicine, those with abnormally invasive placenta, hypertension, liver disease, renal disease and other co-morbidities[42]). The trust is also a teaching centre for both medical and midwifery students.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Patient and Carer Race Equality Framework (PCREF)[43] was a key recommendation produced by the Independent Review of the Mental Health Act 2018[44]. The PCREF is the first anti-racism framework launched by NHS England and forms a core part of the Advancing Mental Health Equalities strategy.[45] SLaM was selected as a PCREF pilot site for this anti-racism framework, which exists to eliminate the unacceptable disparity in the access, experience and outcomes that Black communities face and to significantly improve their trust in mental health services.

SLaM have reviewed service data which shows that people from Black African, Black Caribbean, Black Mixed and Black Other census categories are likely to have the poorest access, experiences and outcomes of mental health and have selected to focus attention on these groups. These inequalities are not limited to mental health services and are also evident in perinatal mental health services. Women from Black and Asian ethnic groups were less likely to be asked about their mental health, to be offered treatment or to receive support in the postnatal period[46].

This mandatory framework will support trusts and providers on their journeys to becoming actively anti-racist organisations, by ensuring that they are responsible for co-producing and implementing concrete actions to reduce racial inequalities within their services. It will become part of Care Quality Commission (CQC) inspections[41].

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

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

[43] NHS England (2023) *Patient and Carer Race Equality Framework*
[44] Department of Health and Social Care (Use of Force Act) 2018: statutory guidance for NHS organisation in England and police forces in England and Wales
[45] NHS (2023) Advancing mental health equalities - Patient and carer race equality framework
[46] Redshaw & Henderson (2016) *Who is actually asked about their mental health in pregnancy and the postnatal period? Findings from a national survey*

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

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

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

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

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

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

Common themes and actions

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

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

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

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

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

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

Actions completed by Southwark Council taking place following the meeting:

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

Chapter Four: Hearing from the workforce

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

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

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

The Commission invited workforce feedback from four main sources:

- A public meeting was held in March 2024 focusing on the workforce, which captured an open discussion in a safe space for attendees. The meeting was facilitated by Cllr. Akoto and the Commission panel, it was recorded but not live streamed, allowing participants to recall any information they did not want to be shared and there was an allocated space for participants outside the meeting room, should participants feel overwhelmed by the subject topic.

- Southwark Council ran an online session consultation for professionals.

- The Motherhood Group facilitated a workforce engagement session which provided an opportunity for staff to share experiences, challenges and successes in delivering maternity care in the borough.

- Informal written or verbal contributions were left on the Commission's dedicated email and voicemail facility.

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

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

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

Emerging themes

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

Staffing and staff retention

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

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

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

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

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

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

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

Workplace culture and safety concerns

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

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

Stigma around vulnerability

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

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

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

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

Meeting the complex needs of residents

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

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

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

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

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

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

Across the UK, while overall birth rates are declining, the complexity of births is increasing[28]. This rise in complexity is driven by various factors, including maternal age, number of previous pregnancies, existing health conditions, communicable and non-communicable diseases and social factors affecting health.

A significant contributor to this complexity is that women are choosing to have children later in life. The standardised mean age of mothers who gave birth in 2021 was 30.9 years – the highest on record since data collection began in 1938[24]. In Southwark, the trends largely reflect those seen at the national level with the total number of babies born in Southwark decreasing year on year over the past decade, a total decrease of 35%. Despite the decline in birth rates, the average age of mothers giving birth in Southwark continues to rise. This reflects the broader trend of delayed parenthood, which contributes to the increasing complexity of pregnancies.

This decline in general fertility rate is observed across all age groups but is particularly pronounced among younger women with the average age of mothers having their first child in Southwark is 32.8 years, compared to 30.9 years in England[24].

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

Southwark is also characterised by its diverse population. New mothers in the borough come from a wide range of backgrounds, with 55% being born outside the UK[29]. The most common non-UK countries of birth for mothers are Nigeria, Sierra Leone, Ghana, Poland, and Somalia. This diversity adds another layer of complexity to maternity care, as different cultural, linguistic, and social needs must be addressed.

Harnessing community supports and organisations

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

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

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

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

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

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

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

Mental health of the workforce

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

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

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

Staff reported experiencing stress, burnout, depression, anxiety, panic attacks and PTSD due to work related stress; 54% of participants who completed the workforce survey reported they had experienced poor mental health because of their job. Staff reported feeling left alone to deal with problems as senior colleagues and management are also overworked and unable to support junior staff. Similar research carried out by the Royal College of Midwives[48]across the UK, found that 64% of midwives and maternity support workers said they felt burned out or exhausted at the end of most or all their working shifts.

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

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

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

Challenges to workforce retention in maternity services

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

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

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

"There's not enough incentives. I don't think the work we do is appreciated"

Although the average number of midwifery students enrolled per university has increased over the past decade, the number of graduates does not match this rise in student enrolment. In 2021/22, there was only an average of 45.7 students graduating as midwives per institution with the most common reason for permanently leaving being a change of mind about the course and career[49].

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

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

Institutional racism

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

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

Racism experienced by midwives, maternity support workers, and NHS staff in England is well-documented. The 2020 NHS Staff Survey[50] revealed that discrimination based on ethnicity remains the most common issue, with 42% of midwives who faced discrimination citing this reason. The

[49] RCM (2023) *State of Midwifery Education*
[50] NHS England (2021) *2020 NHS Staff Survey*

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

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

The Panel was informed that, although the NHS should support staff in freely expressing their concerns, the reality is starkly different. The entrenched fear of backlash and institutional racism creates significant barriers for Black and ethnic minority staff to speak out, ultimately impeding improvements in both patient care and staff well-being. Given that Black and ethnic minority staff are almost 20% more likely to enter the formal disciplinary process compared to their White counterparts, it is unsurprising that they fear potential repercussions[52].

"Adopting racist actions from an institutionally racist structure"

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

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

Conclusion

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

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

[51] NHS England (2024) *NHS Workforce Race Equality Standard – 2023 Analysis Report for NHS Trusts*
[52] RCM (2021) *Racism in the workplace – Position Statement*

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

Chapter Five: Hearing from women

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

The MBRRACE report[6] revealed an almost four-fold difference in maternal mortality rates amongst women from Black ethnic backgrounds and an almost two-fold difference amongst women from Asian ethnic backgrounds compared to White women. These disparities remain unchanged since 2018, indicating a lack of progress in reducing maternal health inequalities.

Southwark is one of the most diverse boroughs in the country. Data from the 2021 Census shows that just under half of Southwark residents (49%) have a minority ethnic background, compared to 19% nationally[53]. The largest group other than White is 'Black, Black British, Caribbean or African', with 25% of Southwark resident reporting this as their ethnicity[53]. This means that inequalities linked to ethnicity have a direct impact on a large proportion of residents.

Challenges with exploring racism

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

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

Sources of information and their limitations

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

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

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

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

Survey responses overview

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

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

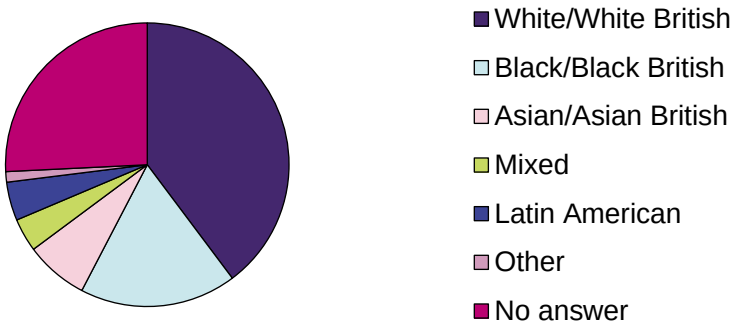


Figure 3. Survey respondents by ethnicity (%).

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

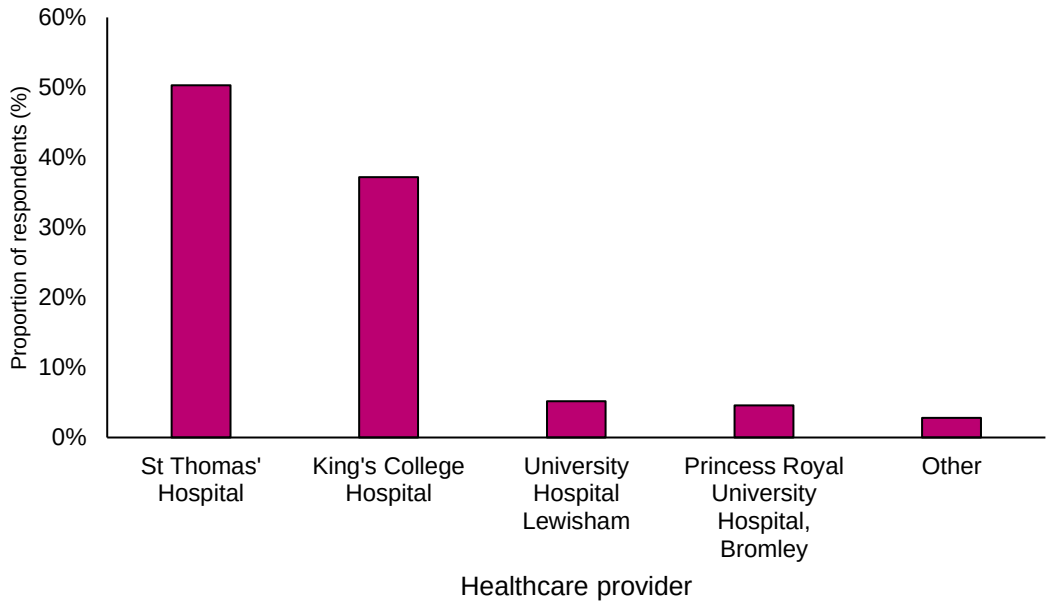


Figure 4. Proportion of respondents by provider of maternity care.

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

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

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

Emerging themes

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

Access to the right information

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

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

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

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

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

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

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

Effective communication

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

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

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

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

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

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

"I shouldn't have to concentrate on my pain and advocate for myself at the same time"

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

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

Dismissal of (women's) concerns by healthcare staff

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

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

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

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

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

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

Benefits of continuity of carer

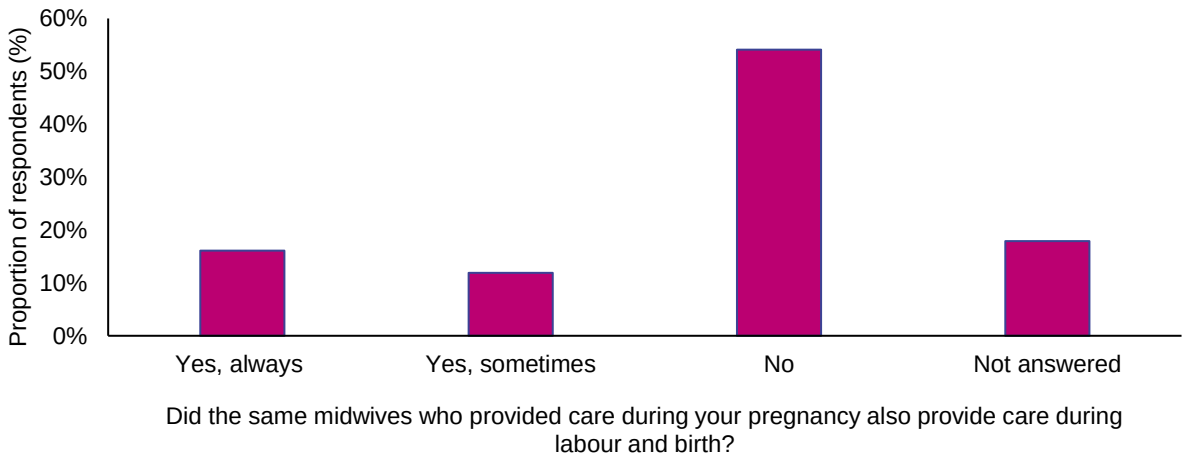


Figure 6. Proportion of respondents by continuity of maternity care.

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

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

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

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

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

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

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

Discrimination and intersectionality

A recurrent theme throughout the Commission was that of discrimination. This included discrimination around age, marital/relationship status, race, and language. Other forms of discrimination should also be considered within the context of this work, including discrimination against non-cisheterosexual[54] gender identity and/or sexual orientation, disability and long-term conditions, and asylum seeker or refugee status. Although accounts from individuals identifying with these groups were limited, this is likely attributable to stigmatisation of these identities and not because they do not exist within the birthing population in Southwark.

The intersectionality of these characteristics is also important to consider. Intersectionality refers to how race, class, gender and other characteristics "intersect" with one another to exacerbate inequalities[55].

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

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

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

importance of providing care that works for the most vulnerable with severe and multiple disadvantage[56], including women:

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

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

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

Age

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

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

Marital/relationship status

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

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

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

Refugees, migrant and asylum seekers

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

Despite government guidelines, hospital charging practices often neglect the welfare of migrants, with those unable to pay being pursued by third-party debt collectors. This deters women from accessing maternity care, as reflected in 4.6% of respondents to the Commission survey stating that they avoided seeking maternity care due to worries in relation to the need to pay for care. Late access to care can negatively affect physical and mental health[57].

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

In addition, Southwark-based engagement work by the Latin American Women’s Rights Service (LAWRS) and the Indoamerican Refugee and Migration Organization (IRMO) heard from Latin American women who were not offered interpreters for their appointments, leaving individuals without reassurance that everything was well[58]. In line with The Equality Act 2010, the NHS and wider public sector should have provisions in place for interpretation and translation services. It is the right of every patient to have a professional interpreter help them at every stage of care, and it is the responsibility of the provider to arrange this.

Work by Healthwatch Lambeth[59] similarly found that among Spanish and Portuguese speakers, not being able to express themselves left women feeling powerless, and some were unaware of the opportunities for interpreters. This same piece of work uncovered concerns around misinformation among maternity care professionals about migrant’s rights to access care. Women found it difficult to challenge or correct this misinformation which resulted in feelings of stress and fear.

---

[57] Feldman (2020) *NHS charging for maternity care in England: Its impact on migrant women*
[58] Latin American Women’s Rights Service and IRMO (2023) *The right to healthcare: A community-led approach to better health outcomes for the Latin American community*
[59] Healthwatch Lambeth (2024) *Exploring experiences of maternity care in women from Black, Asian and Minority Ethnic communities and women with a learning disability*

In a report on inequalities in maternity care experienced by migrant people and babies from Doctors of the World UK[60], key findings included that:

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

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

Disabilities and long-term conditions

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

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

Research on women with physical disabilities by Malouf, Henderson and Redshaw[61] found that emotional wellbeing and support, during and beyond pregnancy, is an area in need of improvement, although access to care was generally satisfactory for disabled women. Other research identified infant feeding and better communication in the context of individualised care as

[60] Doctors of the World UK (2022) *Inequalities in maternity care experienced by migrant pregnant women and babies*
[61] Malouf, Henderson & Redshaw (2017) *Access and quality of maternity care for disabled women during pregnancy, birth and the postnatal period in England: data from a national survey*

areas of improvement, however there was evidence of specific groups appropriately receiving more care[62]. This mirrors some of the themes identified in the survey responses; among respondents, those with a recorded disability were 1.6 times more likely to either always or sometimes receive continuity of carer than those without, and those with a disability were more likely to know how to contact their local maternity service.

Complex social factors

An estimated 10% of Southwark women who had their booking appointment in 2021/22 were deemed to be subject to complex social factors[35]. Complex social factors can impact pregnancy outcomes in different ways. For example, domestic abuse increases the risk of miscarriage, infection, preterm birth and injury or death to the foetus. It can also cause emotional and mental health problems for the mother, such as stress and anxiety, which can affect the development of the baby.[63]

Timely access to maternity care is frequently inhibited by complex social factors. Pregnant women with complex social factors book later on average, and late booking is associated with poor obstetric and neonatal outcomes[28]. Facilitating early booking is more important for these groups than the general population; however, in 2021/22 43% of women in Southwark had their booking appointment late, a rate similar to England[35]. This illustrates the need for additional work to ensure timely access to early pregnancy care, particularly for vulnerable social groups.

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

LGBTQ+ identity

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

There is a clear body of evidence that demonstrates that lesbian, gay, bisexual and trans people experience significant health inequalities in terms of outcomes, service provision and health risk factors in comparison to cisheterosexual populations[64]. Research suggests that the mental health

---

[62] Redshaw et al. (2013) *Women with disability: the experience of maternity care during pregnancy, labour and birth and the postnatal period*
[63] NHS (2021) *Domestic abuse in pregnancy*
[64] McDermott, Nelson & Weeks (2021) *The Politics of LGBT+ Health Inequality: Conclusions from a UK Scoping Review*

of lesbian, gay and bisexual people is worse than that of the general population, and there is very little high-quality evidence on the physical health of LGBT people[65].

Research into the experiences and educational needs of professionals delivering maternity services suggested that staff witness transphobia among colleagues and can be apprehensive about providing care to childbearing tans and nonbinary people. A cisheteronormative[66] model of care which lacks awareness of trans and nonbinary issues was reported, and educational needs included information about practicalities of childbearing, use of inclusive language, and creating policies and processes for supporting childbearing trans and nonbinary people[67].

Racism including lack of cultural sensitivity

Racism was explored in further detail at Meeting Four, however the theme of racism within the maternity care system emerged throughout all meetings and engagement work. Racism can take many forms; often the examples that come to mind are overt forms of racism such as slurs and hate crimes. However, racism is likely to be experienced in a less obvious way within the context of maternity care. Four key types of racism are[68]:

> **Intrapersonal racism:** when a person accepts stereotypes about themselves and those who share the same racial identities, while believing that members of other racial groups are superior.
>
> **Interpersonal racism:** when a person's conscious or subconscious racial bias influences their interactions and perceptions of other people.
>
> **Institutionalised racism:** the implicit of explicit practices and policies within an organisation that establish barriers for racial and ethnic minorities.
>
> **Structural racism:** the way laws, policies, or practices are structured to advantage the group in power and disadvantage ethnic minorities, restricting access to services, opportunities, and resources.

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

---

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

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

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

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

Black, Asian and minority ethnic women

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

One systematic review highlighted how the technocratic birthing system and discriminatory practices in NHS maternity services fail ethnic minority women[69]. It outlined how in the context of persistent understaffing and heavy workloads there is more of a focus on measurements and procedures as opposed to provision of kind, patient-centred care. Overall, the review argues that ethnic minority women are being left in the dark about what to expect, their right and their choices throughout their pregnancy and postnatally.

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

Another review[70] similarly identified themes of poor communication, lack of respect for the culture and lack of support, and found that Black, Asian and minority ethnic women's experiences were generally more negative and engagement with maternity services was poor.

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

Black and Mixed-Black Participants

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

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

[69] MacLellan et al. (2022) *Black, Asian and minority ethnic women's experiences of maternity services in the UK: A qualitative evidence synthesis*
[70] Drake et al. (2022) *The Experiences of Black, Asian and Minority Ethnic Women of Maternity Services in the UK*

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

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

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

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

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

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

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

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

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

Asian participants

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

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

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

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

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

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

Gypsy, Traveller and Roma participants

Engagement with the Gypsy, Traveller and Roma (GRT) community was limited, and there appears to be a gap in the literature surrounding the experiences and outcomes of pregnant people within these ethnic groups in the UK. However, a systematic review into the perinatal maternal and infant health outcome of GRT women in European countries provided evidence that GRT women and children experience more negative outcomes than general populations[72].

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

[71] MacLellan et al. (2022) *Black, Asian and minority ethnic women's experiences of maternity services in the UK: A qualitative evidence synthesis*
[72] Ekezie et al. (2024) *Perinatal health outcomes of women from Gypsy, Roma and Traveller communities: A systematic review*

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

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

Latin American

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

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

Compassionate care

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

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

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

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

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

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

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

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

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

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

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

Birth plans and personalised care

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

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

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

One woman who contributed at the public meeting described her experience of maternity care having been diagnosed with severe tokophobia[74]. As a result of this and other complex social factors, she was assigned to a multi-disciplinary team with a single point of access to support. Her experience of care was described as “incredible”, and she thanked the team of professionals who supported her, particularly those from SLaM. This is an example of where birth plans and personalised care works and leads to positive outcomes for mother and baby. However, her experience was not the case for several other women.

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

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

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

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

[74] **Tokophobia:** Pathological fear of pregnancy

Maternal and infant morbidity[75]

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

These are comparatively common complications, with the National Maternity and Perinatal Audit report on births between 2018-19[76] reporting that 25% of women had an episiotomy[77], 12% an assisted vaginal birth[78], and 3% third and fourth-degree tears. However, any complication carries significant risk and can, in some cases, be prevented with higher standards of care.

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

Several survey responses mention that their baby's head was injured during delivery, usually as a result of an instrumental delivery. Another survey response reported that her son had a severe hypoxic-ischaemic encephalopathy (HIE)[79] brain injury, causing hearing loss and global developmental delay[80] as a direct result of poor maternity care.

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

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

[75] **Morbidity:** ill-health and injury
[76] National Maternity and Perinatal Audit, 2022. *Clinical Report*
[77] **Episiotomy**: A cut in the area between the vagina and anus (perineum) during childbirth
[78] **Assisted vaginal birth:** Birth helped by use of a ventouse (vacuum cup) or forceps or both
[79] **HIE injury:** Hypoxic-ischaemic encephalopathy is a type of brain damage caused by a lack of oxygen to the brain before or shortly after birth. HIE is graded as mild (stage 1), moderate (stage 2) or severe (stage 3).
[80] **Global developmental delay:** a diagnosis given when a child has not reach two or more of their developmental milestones at an expected age
[81] Chhabra (2014) *Maternal Near Miss: An Indicator for Maternal Health and Maternal Care*

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

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

In-patient environment

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

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

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

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

Wider support

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

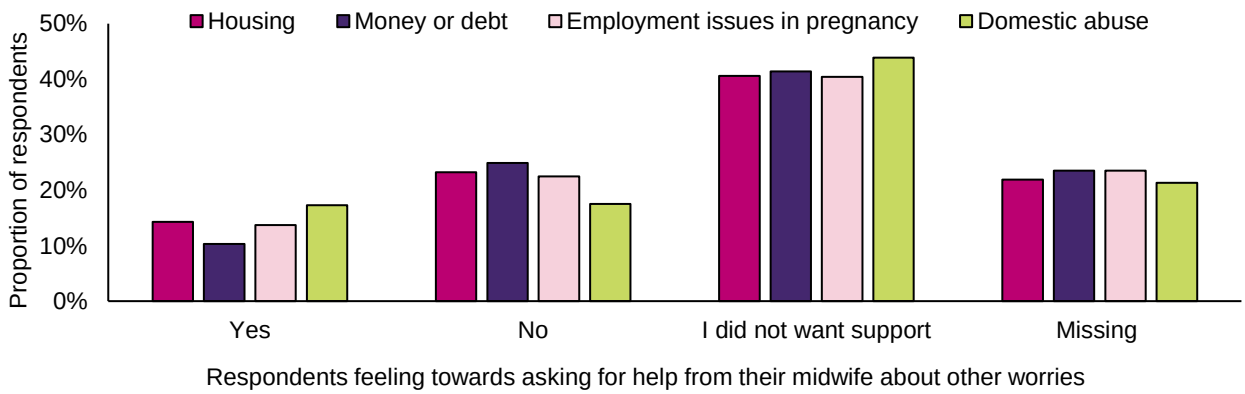


Figure 7. Respondents feeling towards asking for help from their midwife about worries related to housing, money or debt, employment issues in pregnancy, and domestic abuse.

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

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

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

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

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

Community care and support systems

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mental healthcare

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

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

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

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

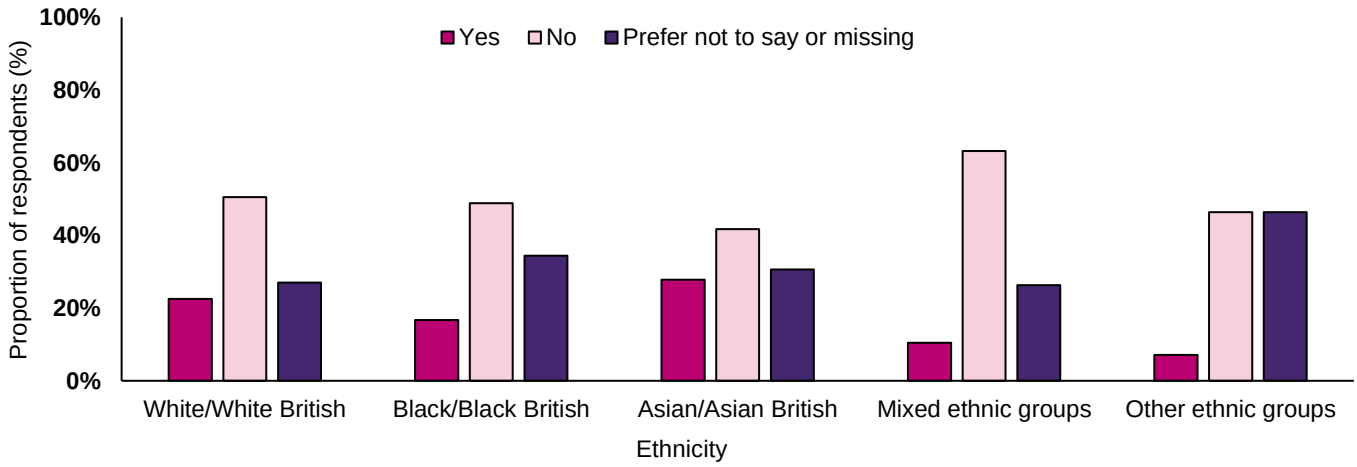


Figure 9. Proportion of respondents experiencing poor prenatal mental health by ethnicity.

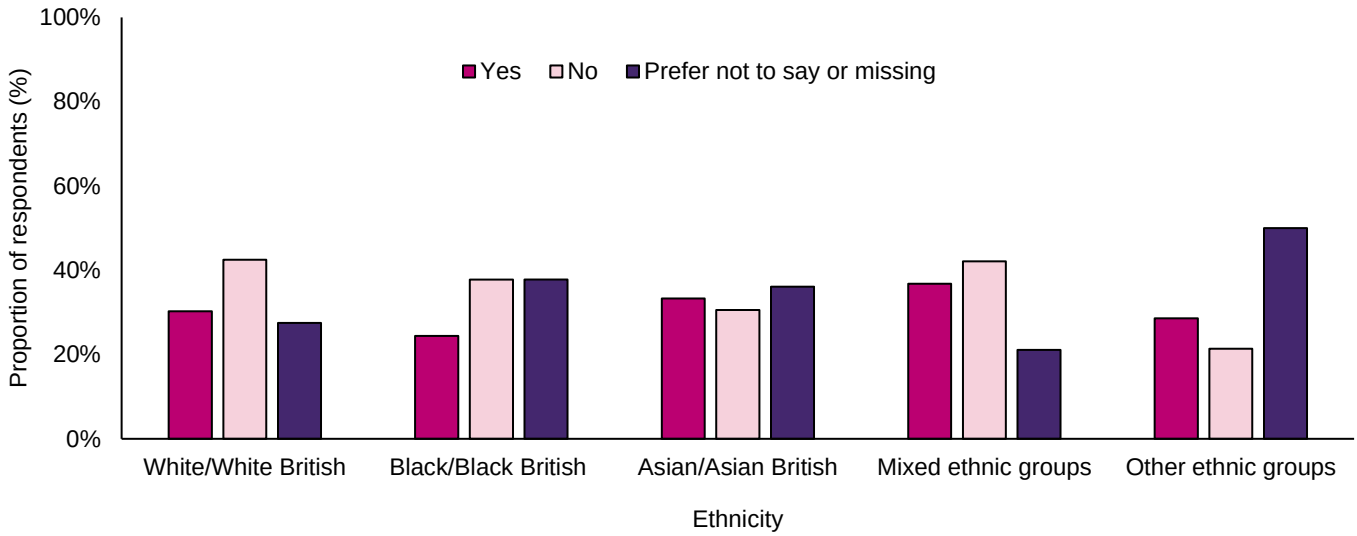


Figure 10. Proportion of respondents experiencing poor postnatal mental health by ethnicity.

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

Others describe having their symptoms missed, and feeling left alone to cope with anxiety, depression and PTSD for years after their pregnancy. Some struggled with their mental health because of physical health complications from their birth, such as bladder issues and third- and fourth-degree tears, while some struggled during their pregnancy due to debilitating hyperemesis gravidarum[84] (morning sickness).

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

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

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

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

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

It is estimated that 3,000 people in Southwark who are pregnant or have a child under the age of 2 have perinatal mental health needs[29]. Certain groups are as greater risk of psychiatric conditions during this period, with socioeconomic deprivation intersecting with ethnicity to magnify negative health outcomes for ethnic minority groups and those living in socioeconomic deprivation.[85]

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

Impact of COVID-19

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

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

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

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

[85] Womersley, K., Ripullone, K. & Hirst, JE. (2021) *Tackling inequality in maternal health: Beyond the postpartum*
[86] Platt & Warwick (2020) *COVID-19 and Ethnic Inequalities in England and Wales*

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

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

Recognising staffing difficulties

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

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

Conclusion

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

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

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

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

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

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

Chapter Six: Capturing the voices of fathers and male carers

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

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

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

Emerging themes

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

Lack of awareness of available support

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

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

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

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

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

"There were no posters in any of the classes for me"

Feeling excluded from decision-making

There is an increasing body of research which highlights the role of fathers in maternal health and child development. A World Health Organization report on fatherhood and health outcomes in Europe[88] outlined that increased involvement of father during pregnancy and delivery results in better outcomes for women, babies and fathers and birthing partners.

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

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

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

This experience is supported by the literature; evidence from a national survey demonstrates that paternal engagement is highest in partners of primiparous[89] White women, those living in less deprived areas, and in those whose pregnancy is planned. The study demonstrated the considerable sociodemographic variation in partner support and engagement, and highlighted the importance of health professionals recognising that women in some sociodemographic groups may be less supported by their partner and more reliant on staff.[90]

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

[88] World Health Organization (2007) *Fatherhood and Health outcomes and Europe: a summary report.*
[89] **Primiparous**: A woman who has given birth once is primiparous
[90] Redshaw & Henderson (2013) *Fathers' engagement in pregnancy and childbirth: evidence from a national survey.*

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

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

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

Support from local community services

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

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

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

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

Mental health needs and the support available

The focus group strongly supported the notion that postnatal depression in men is often overlooked. Participants mentioned frequently hearing about postnatal depression in women but felt it did not apply to them, despite it being a prevalent issue that often goes undiagnosed in both groups, with up to 1 in 10 new fathers become depressed after having a baby[91]. As a result of not

[91] NHS (2022) *Overview - Postnatal depression*

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

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

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

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

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

Informed consent

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

Midwives have a professional duty to uphold the NMC's Code[92] and to practise within the law of the United Kingdom (UK) by upholding human rights in the care that they offer and provide[93]. Midwives must provide women with the information and support that they need to make decisions about their care and must respect the decisions that women make. With the general principle that if a patient is unable to make their wishes known, treatment can be given without their consent in order to save their life or prevent serious deterioration in the patient's condition. If there is time, the patient's next-of-kin should be involved in decisions about their care.

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

[92] Nursing and Midwifery Council (2018) *Professional standards of practice and behaviour for nurses, midwives and nursing associates*
[93] British Institute of Human Rights (2016) *Midwifery and human rights: a practitioner's guide*

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

Ethnicity and racism

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

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

Over the course of the Commission, the panel heard several cases of local Black women not being listened to, believed or concerns taken seriously. These issues have been identified on a national level also in Birthrights report[94] where the theme that echoed the inquiry's general findings was not being listened to – dismissal, lack of compassion and power dynamics in relation to a White partner being taken more seriously than the Black pregnant person.

Conclusion

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

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

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

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

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

Chapter Seven: Recommendations

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

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

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

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

Figure 11. The Commission's five overarching themes

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

Strengths and limitations

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

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

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

Five key themes

1) Tackling discrimination and better supporting women with specific needs

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

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

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

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

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

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

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

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

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

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

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

Ten recommendations

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

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

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

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

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

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

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

Outcome 1: Reduced infant mortality

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

Outcome 2: Reduced maternal morbidity

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

Outcome 3: Increased positive experience of maternity care

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

Outcome 4: Increased staff satisfaction

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

Outcome 5: Closing the health inequality gaps

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

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

Chapter Eight: Next steps

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

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

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

Commitment from Health and Wellbeing Board

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

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

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

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

Strategic steering group

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

Sub-groups for recommendation areas

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

Expectations around timelines

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

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

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

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

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

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

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

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

Conclusion

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

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

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

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

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

Glossary

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

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

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

Appendices

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

Appendix 2: The Motherhood Group x Southwark Maternity Commission

Appendix 3: Meeting One evidence submissions

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

Appendix 4: Resident survey

Appendix 5: Workforce survey

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

Public Health Intelligence Team

August 2024

Contents

Summary

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

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

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

Background

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

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

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

Limitations

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

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

Demographics

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

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

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

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

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

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

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

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

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

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

Survey Access

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

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

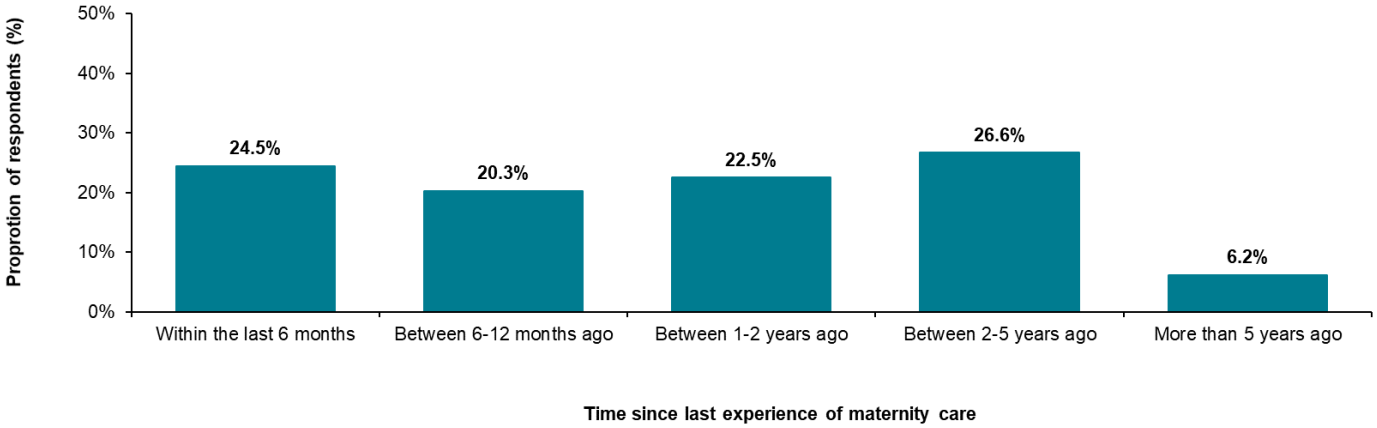
Communication Medium	Number	%
Email from council	126	25.0%
Facebook	40	8.0%
Conversation with friend/neighbour/family	36	7.2%
Twitter	32	6.4%
Southwark Council website	28	5.6%
Instagram	26	5.2%
WhatsApp message	21	4.2%
Conversation with council officer/councillor	20	4.0%
Media coverage (Southwark News,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

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

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

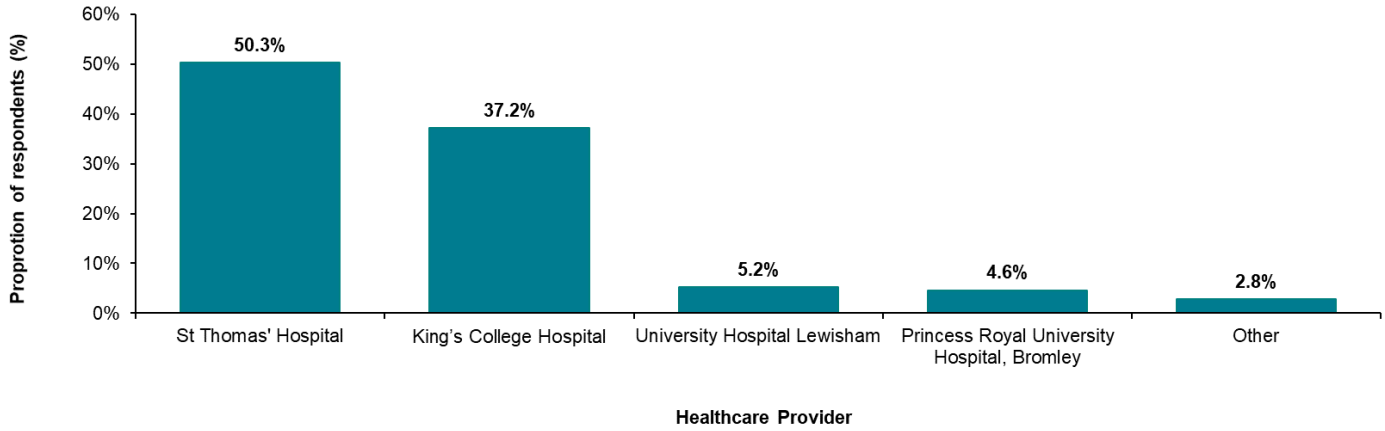
Healthcare Provision

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



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

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

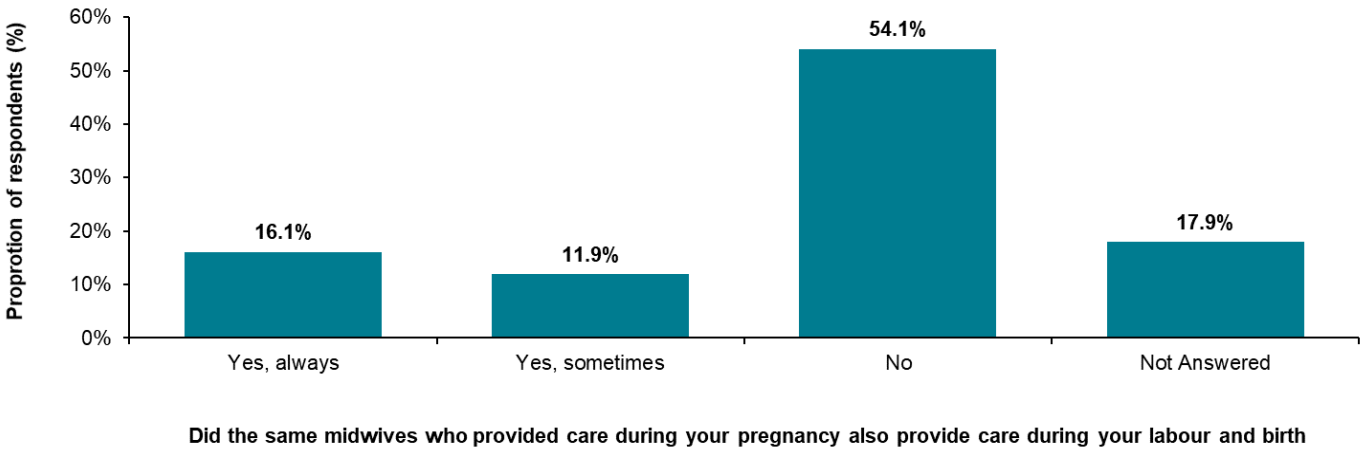


Supplementary Figure 2. Proportion of respondents by provider of maternity care.

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

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

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



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

Healthcare Access

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

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

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

Healthcare Experience

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

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

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

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

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

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

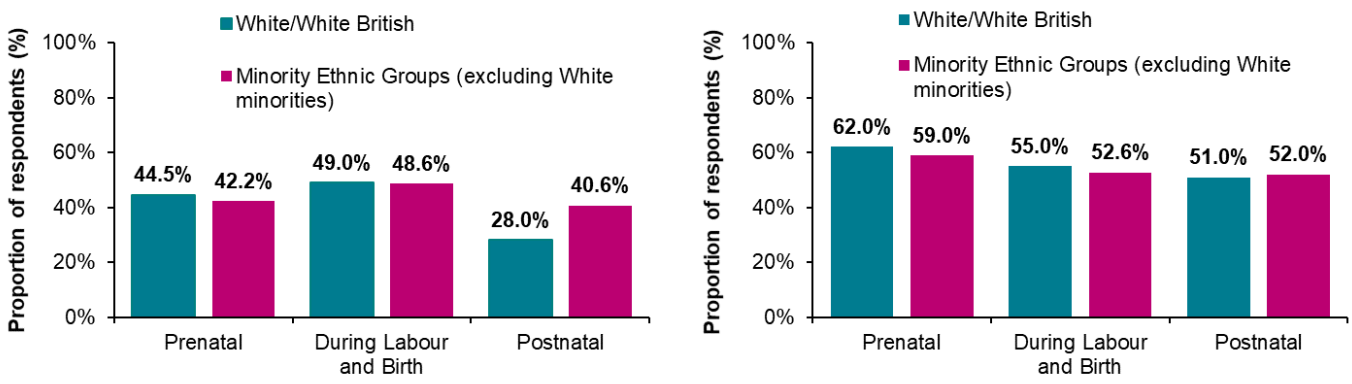
Supplementary Table 3. Proportion of respondents able to get help from their midwife or doctor when they needed it across the care pathway.

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

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

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

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



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

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

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

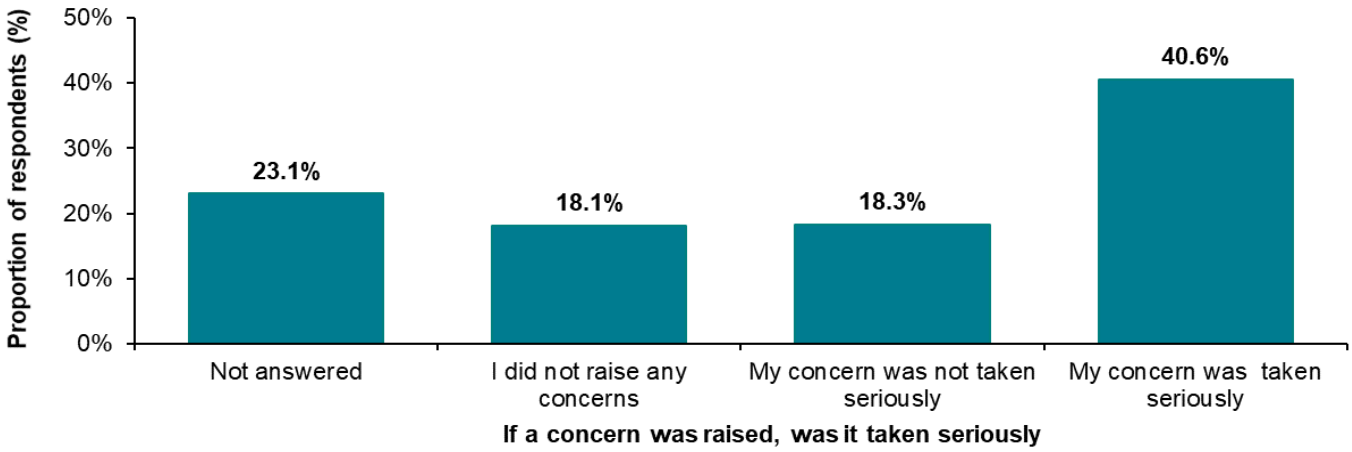
Nearly two thirds (64.0%) of respondents felt that they were able to ask all the questions they wanted to about their care (no: 14.3%; missing: 21.7%); proportions were lower among respondents of ethnic minority groups (66.5%; excluding White minorities) compared to those of a White ethnicity (71.7%).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

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

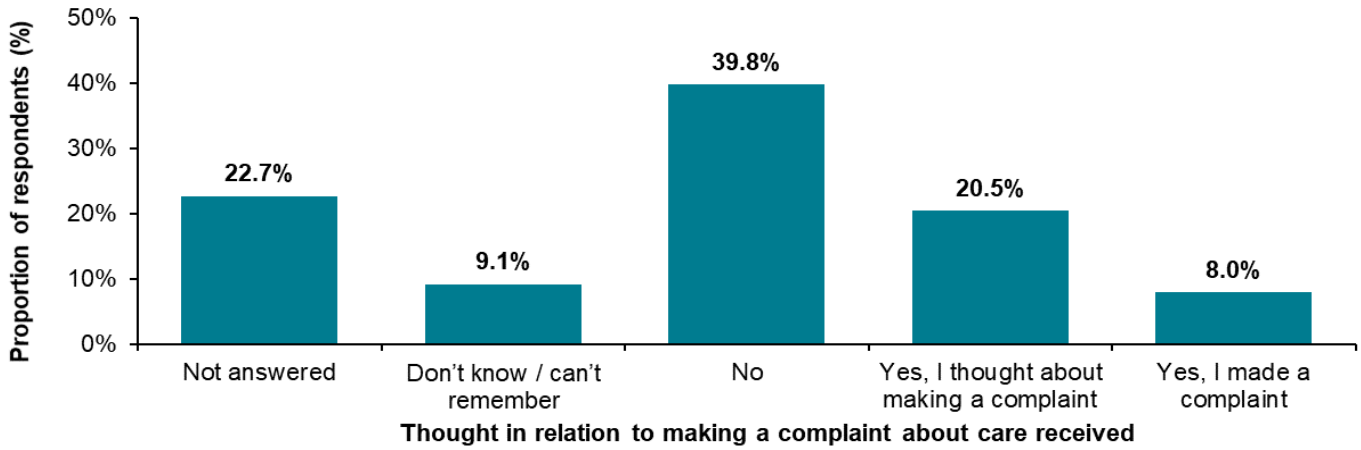
Less than one third of respondents (28.5%) either thought about making a complaint or made a complaint (Supplementary Figure 6). Respondents of a White ethnicity were 1.3 times more likely to either think about, or make a complaint compared to those of an ethnic minority group (37.0% vs 28.9% of respondents,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

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

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



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



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

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

Maternal Outcomes and Support

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

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

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

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

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

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

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

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

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

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

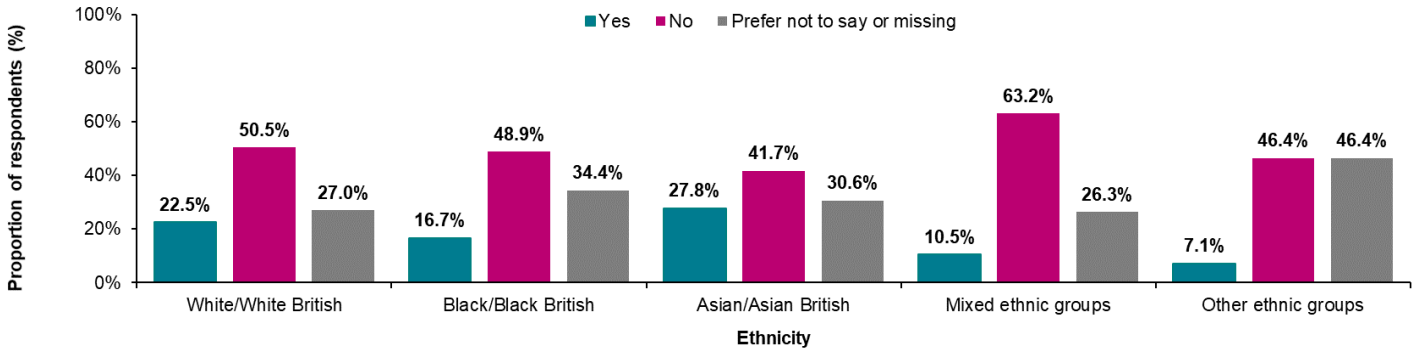
Mental Health

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

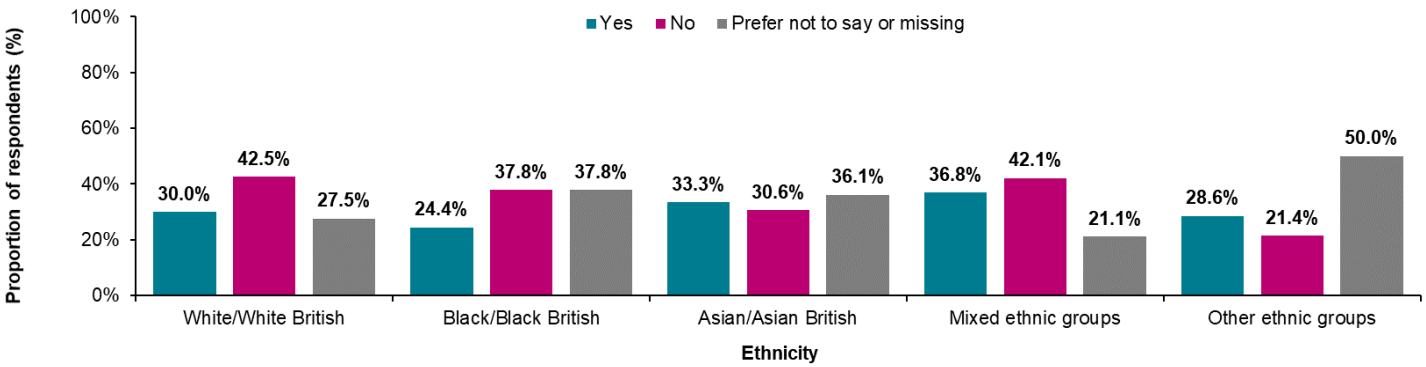
Supplementary Table 6. Proportion of respondents experiencing poor mental health, during their pregnancy, and after their baby was born, respectively.

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

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



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



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

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

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

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

Mental Health Support

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

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

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

Supporting Informed Decision-Making

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

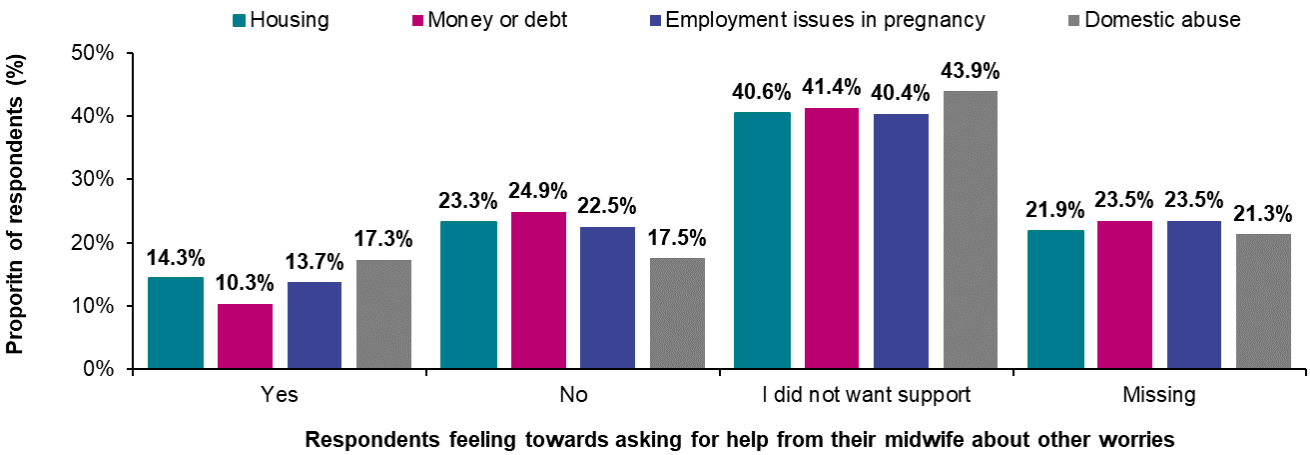
White minorities) compared to those of a White ethnicity (73.5%), but lower among respondents aged 35 years old and over (68.6%) compared to those aged 34 years old and under (77.6%). Respondents with a disability were more likely to know how to contact their local maternity service compared to those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

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

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

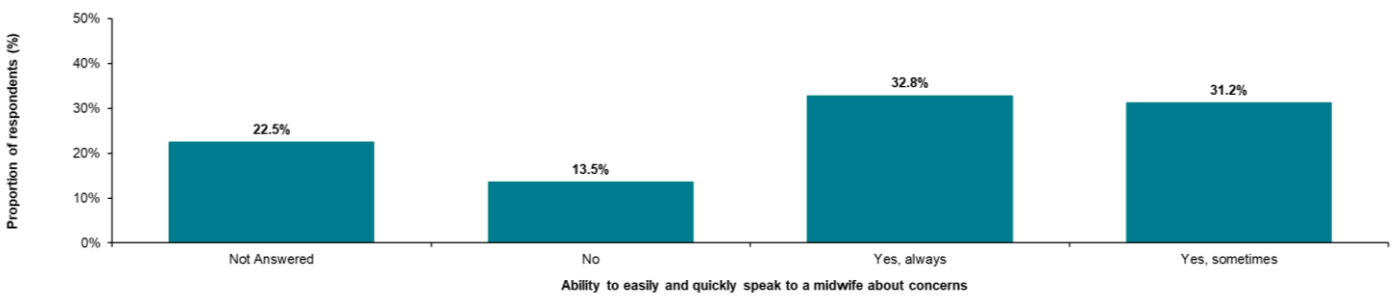
Over one-tenth (12.9%) of respondents would have preferred to receive information in another language, with Spanish and Chinese most frequently listed, respectively.

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



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

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



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