Appendix 1

NHS
North East London

NEL maternity and neonatal demand & capacity

Summary document

This document is a summary of the work that has been carried out as part of the maternity and neonatal demand and capacity programme

This piece of work is the starting point for exploring **how maternity and neonatal services in North East London can meet the changing needs of women and babies** and will inform how services in NEL in the future will meet the needs of local people through provision that is safe, high quality and accessible.

The first stage of this work has involved **understanding the current state**. This is through **collating and analysing data** to understand current activity and look at future demand projections, as well as **synthesis of existing work** done to date in NEL and national guidance, and **stakeholder engagement**. These findings have been brought together into a **case for change which identifies opportunities for the future**.

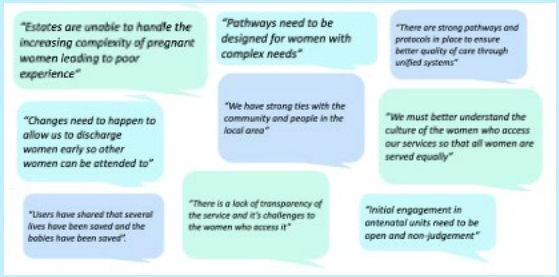
The second stage of the work was to **co-design best practice care models** for maternity and neonatal services, considering the opportunities identified in the case for change, national guidance and best practice examples. These care models were **developed with clinicians and wider stakeholders and** are intended as a starting point for future work

The high-level care models set out areas for further, data driven, exploration to develop more detailed care models that are deliverable, sustainable, make the best use of system assets, and deliver on the opportunities identified in the case for change.

The case for change themes were developed through the engagement with stakeholders, desktop review and analysis and modelling

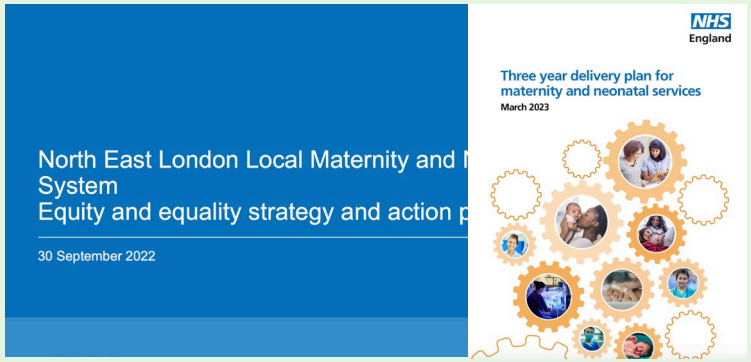
Stakeholder engagement

- Conducted 1:1 or small group interviews with over 50 stakeholders from across the system including service user representatives, Trusts, ICB, LMNS, ODN, LAS and Local authority colleagues
- Gathered views on current strengths of services, challenges and opportunities for the future



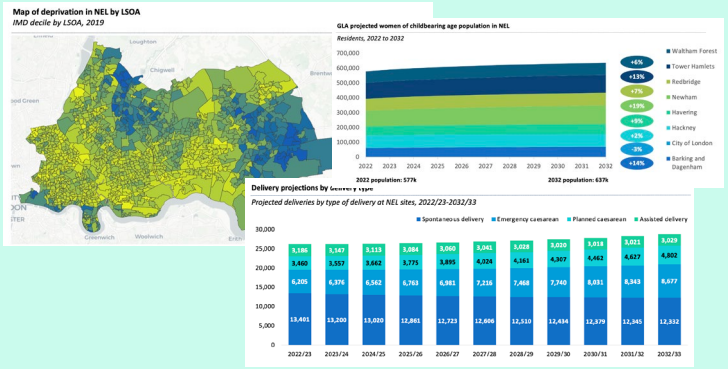
Desktop review

- Reviewed local NEL strategy, planning and work completed to date around maternity and neonatal services
- Reviewed service user feedback including from Healthwatch and CQC
- Reviewed national guidance and best practice documentation



Analysis and modelling

- Developed demand and capacity modelling to understand the projected future position in a 'do nothing' scenario
- Conducted further analysis including workforce, activity in and outflows and activity profiles by site



There is an opportunity to ensure maternity demand and capacity are matched across NEL, and to strengthen pathways and models of care to remove unwarranted variation

Matching demand and capacity across the system

- **Population growth** in NEL will outweigh a declining birth rate, which means that the NHS will need to support **more births** over the next 10 years
- Pregnancies and births are also **increasingly complex**, meaning **more resources are required for each birth**
- There is a need to **ensure capacity is matched to the needs of birthing people** in NEL

Strengthening antenatal and postnatal care pathways

- A high proportion of pregnant people in NEL have **other health conditions and may experience complex social factors** which mean their pregnancies are not low risk
- There are opportunities to **improve early booking** and **ensure effective communication**
- In addition to strengthening antenatal pathways, improving **pre-conception healthcare and prevention** is key
- **Postnatal care pathways** are a key element to contribute to improving health and care outcomes for families

Addressing variation in quality, access and experience

- **Service offer, pathways and processes are not consistent,** meaning pregnant people with similar needs have a different experience depending on where they choose to give birth
- There are opportunities to **ensure best practice is followed** (eg. around induction of labour)
- Service users report opportunities to improve access and their experience of care

Reducing health inequalities

- There are **stark and persistent inequalities in outcomes** for people from different population groups, for example, babies born to Black and Asian women are more likely to have a **low birth weight** and these women are **more likely to have a stillbirth** than White women
- Women in NEL are **more likely to book pregnancies later**, **particularly pregnant people from global majority communities**, which has implications for antenatal care and outcomes

There are opportunities for neonatal services to ensure care is delivered in the most appropriate setting, which will improve quality and safety

Delivering neonatal care in the appropriate setting

- It is important that neonatal care is provided in the most appropriate setting to ensure the highest possible quality of care is provided to each baby
- High occupancy levels in neonatal units increases quality and safety risks for babies; repatriating babies to LNUs from NICUs can free up vital capacity to care for the sickest babies
- Currently, **NEL neonatal units are experiencing high occupancy levels,** particularly at Royal London, and particularly in intensive care and high dependency
- There are opportunities both to **facilitate in-utero transfers** so babies are born in the appropriate care setting for their needs, as well as to ensure **repatriation of babies to their local unit** when they are well enough

Enhancing transitional care and care at home for neonatal services

- There is an **opportunity to improve transitional care across all neonatal units in NEL** to support improved discharge processes whilst maintaining contact between mother and baby, avoiding separation
- Transitional care supports the bond between the baby and their mother whilst maintaining support from midwives and neonatal nurses, which facilitates mothers being able to pick up issues more readily post discharge
- Developing the **neonatal outreach service** in NEL provides an opportunity to readily discharge babies and their families that require support which could be provided at home
- **Strong transitional care and outreach teams provide a better experience** for babies and their families whilst contributing to freeing up capacity on the neonatal unit at NEL hospitals

Stakeholders have described significant opportunities to ensure workforce models optimise the use of resources and prioritise staff wellbeing

Making the most effective use of staff resource

- There are **significant pressures on staff** across the system in both maternity and neonatal services with high **vacancy rates** and staff shortages being the cause of most escalations
- Alongside vacancies, **increasing acuity puts additional pressure on staff**, but the workforce model and model of care have not changed
- There is an opportunity to **optimise the future workforce model** to make best use of staff resources, ensuring **resourcing is aligned with case mix** and enabling staff to operate at the top of their skills and competencies
- There is also a need for **innovative approaches** to support recruitment in these areas

Improving staff wellbeing

- Stakeholders praise staff working in maternity and neonatal services as **hard-working, resilient and working together to provide safe care** in a challenging environment
- However, staff are feeling the pressure of the situation, increasing the **risk of burnout**
- NHS staff surveys show **reductions in staff morale and sense of wellbeing** in staff, particularly for midwives in NEL trusts
- Focusing on staff wellbeing is important for **their experience**, the ability to **retain and recruit** staff, as well as improving the **quality of care and experience for their patients**

The care models were developed based on a combination of national guidance, best practice and stakeholder engagement

- The case for change identified opportunities for improvement in maternity and neonatal services
- These opportunities provided a basis to understand what the future provision of maternity and neonatal services should be min NEL to best meet the needs of the population that they serve
- Considering the opportunities identified, initial drafts of future clinical models for maternity and neonatal services in NEL were developed based on best practice examples and national guidance including Better Births, Ockenden Report, the Neonatal Critical care review and BAPM Standards
- The care models were then shared and co-designed with clinicians and stakeholders in a workshop setting
- The current care models require further iteration with stakeholders in the next phase of work, so they can act as the basis for determining how services should be organized in the future and address all aspects of the case for change, including improving staff wellbeing

Maternity care pathway summary

This is a draft best practice model of care and represents how care could be delivered in the future and does not reflect the current care pathway

DRAFT WORK IN PROGRESS

Pre-conception | Access to care | Antenatal care | Birth and treatment | Postnatal care

Pre-conception

Pre-conception support

- General advice
- Specialist advice
- Perinatal mental health support

Access to care

Woman or person confirms pregnancy:

- Self-referral (online)
- Primary care referral
- Institutional referral
- Hospital referral

If needed

Central booking system for preference selection*

**Helpline available*

Booking appointment

- Risk stratification of all pregnant women including women being induced
- Personalised care plan
- Options to book interpreters for all appointments
- Social support advice
- Mental health support

Antenatal care

Choice of Site and birth plan

- Home birth
- Standalone Midwife led unit
- Obstetric led unit
- Alongside Midwife led unit

Routine care

- Advice and education (obesity, smoking, alcohol)
- Routine appointments, investigations & scanning
- Immunisation hub
- Health visitor
- Antenatal education & classes
- Diabetes support and care

Additional services if required

- Community / peer support / VCSE
- Antenatal screening +/- referral to fetal medicine
- Mental health support

Additional care / specialist input

- Maternal medicine pathway
- Fetal medicine pathway (incl. counselling and other specialist clinics)
- Diabetes/ other condition support & care
- Placenta accrete network

Social prescribing is provided throughout

Birth and treatment

Care may be transferred to an alternative unit (patient choice or clinical indication) during the antenatal or birthing period or can be performed in-utero

Birthing

Triage of birthing location can occur earlier for a planned c-section

Triage to reassess suitability of birthing location and birthing plan:

- Induction of labour
- Booked C-section
- Home birth
- *Transfer if needed*
- Midwife led unit
- *Transfer if needed*
- Obstetric led unit
- Spontaneous delivery
- Emergency operative or assisted delivery

If needed

Complications

Pregnant woman or person

- Maternity HDU
- Adult ICU

Baby – enhanced ward-based care

- Transitional care

Baby – neonatal care

- Neonatal outreach
- Neonatal unit (LNU / NICU) co-located with an obstetric led unit

Access to mental health support / risk assessment if needed

Postnatal care

Parent and baby

- Postnatal ward / readmissions
- Transitional care
- Specialist neonatal referral
- Feeding support
- Home visits
- Health visitor
- Neonatal community outreach
- Repatriation to local unit
- Social care support
- Long-term education for a healthy lifestyle

Post partum woman or person specific

- Primary care support
- Mental health support
- Physiotherapy
- Community midwife
- Family planning
- Bereavement support (across whole maternity pathway)
- Postnatal education
- Referral to other healthcare services incl. pre-conception
- Care for complex woman and people

The maternity care model is split into four key phases with details around each to be iterated further (1/2)

Pre-conception and access to care

- Personalised pre-conception care for women or people considering pregnancy is key to support people to be in the best health before a pregnancy and increases the chances of conception, reduces the risks associated with a pregnancy, for example reducing the chances of a miscarriage or stillbirth, and optimise outcomes for the mother and the baby.
- These services should be community-based and delivered through proactive outreach, public health, social prescribing and the VCSE.
- Identification of people who should be signposted to pre-conception support services should be informed by risk stratification including demographic to target support to those who are most at risk of poor outcomes.
- Once someone identifies that they are pregnant, they can either self-refer to maternity services, or access maternity care via their primary care practitioner.
- There is an opportunity to provide a more streamlined approach to accessing care through a centralised booking system, providing a single point of access to book a first midwife appointment.

Antenatal care

- It is important that during the antenatal phase, care focuses on checking the health of the baby and pregnant woman or person, providing accessible information to support a healthy pregnancy and discussing the options and choices for care.
- It is important that previous birth experiences and baby loss are considered and targeted support provided as required. Additionally safeguarding and advocacy must be a core part of antenatal care pathways, as well as interpreting services for those who need them.
- The risk profile of pregnant women and people is increasing because of increasing complexity so access to specialist care and support must be optimised so that capacity matches demand.
- Multi professional working is key in understanding the right unit for a pregnant woman or person to book into for their delivery, particularly for those with co-morbidities.
- There must also be collaborative working across organisations including with public health, the VCSE and primary care, so that there is additional support for vulnerable women.

The maternity care model is split into four key phases with details around each to be iterated further (2/2)

Birth and treatment

- A pregnant women and people will be supported to make an informed choice as to where and how to give birth through the antenatal phase and this could be at home, in a midwifery led unit, or in an obstetric led unit.
- The profile of births in NEL has changed with the projected case-mix suggesting a greater share of more complex deliveries through planned and emergency caesarean deliveries and shift away from spontaneous, lower risk deliveries.
- Pregnant women and people need to be able to choose a place of birth that is best suited to their individual needs
- To provide the full range of choice, NEL would like to provide a standalone midwifery led unit as an option if feasible, but it is important that these units are sustainable and have sufficient staff to deliver high quality, safe care
- There is an opportunity to leverage learning from other hospital care pathways, such as inpatient elective care to optimise efficiency and use of resources for planned procedures. There is an appetite for further exploration of a hub for planned caesarean sections, for those whose medical needs are not highly complex.

Postnatal care

- High-quality postnatal care ensures that the mother and baby are recovering well and can have a significant impact on the life chances and wellbeing of the women or person, baby and family.
- Postnatal care can be provided to both the parent and baby or care that is specific to the post-partum woman or person and can range from routine care received following all births through to specialised care for the most complex women.
- Primary and community-based care will play a key role in providing equitable, high quality postnatal care for parents and their babies.
- Having postnatal pathways and services locally available to all residents makes it easier to navigate following delivery NEL sites and ensures that all women receive care in a fair and equitable manner.
- Currently it is mainly proactive women from affluent communities that make use of postnatal services so it is crucial that all women and people are made aware of the information and services that are available to them following their birth.

Neonatal care pathway summary

This is a draft best practice model of care and represents how care could be delivered in the future and does not reflect the current care pathway

DRAFT WORK IN PROGRESS

Labour | **Decision to admit** | **Inpatient stay** | **Onward care**

Triage to an appropriate site based on need

Choice of site can be made at any point up until the onset of labour

In-utero transfer to an alternative birth setting if anticipated level of neonatal care exceeds local availability with receiving units doing everything possible to take the transfer

Driven by BAPM standards

Delivery out of hospital with midwifery care

Transferred to nearest neonatal unit in the ICB

Presentation in labour at an Emergency Department

Delivery at an alongside midwifery-led unit

Admission to neonatal unit on site

Delivery at an obstetric-led unit

Transitional care can occur immediately after delivery if admission to neonatal unit is not required

Neonatal unit on admission (co-located with an obstetric unit)

Type of unit on admission depends on local availability:

NICU (level 3)

LNU (level 2)

Type of care provided:

Intensive care

Step down in care

High dependency care

Step up in care

Special care

If needed

2 Transfer between hospitals in the ICB

If specialist input is required

NICU *Repatriation* / *Uplift* **LNU**

3 Transfer to alternative NICU if specialist treatment is required

Transfer to Royal London Hospital if specialised surgery is required

If needed

4 Transfers to an appropriate level unit outside of the ICB

Repatriation back to local hospital from specialist unit or unit outside of ICB

Transitional care on labour, neonatal and postnatal wards incl. feeding support

Mental health support for parents incl. wellbeing support

Community neonatal outreach

Outreach from the specialist hospital

Postnatal midwifery review and support for maternal health

Baby specific

- Repatriation to LNU closer to home
- Follow-up appointments (neonatal or paediatrics)
- Multidisciplinary team follow up
- Specific neurodevelopmental follow up for high-risk infants
- Primary care follow up
- Hospital at home services
- Feeding support
- Referral to social/palliative care
- Neonatal community outreach

Pregnant woman or person specific

- Onward referral
- Postnatal education
- Mental health support
- Primary care input
- Community midwife
- Physiotherapy
- Family planning advice
- Bereavement support
- Community support groups and networks
- Social care
- Referral to other healthcare services inc. pre-conception

The neonatal care model has three phases and will be subject to iteration in the next phase of work (1/2)

Labour and decision to admit

- To ensure care is delivered in the most appropriate setting, pregnant women and people would be advised to deliver at a unit where the level of neonatal support available is in line with their baby's anticipated needs.
- Babies that are expected to be at the highest risk of needing support from intensive care will deliver in an obstetric unit with a co-located NICU (level 3), aligned to the BAPM standards.
- Babies can be transferred in-utero transfer to an appropriate birth setting would ideally be undertaken to prevent mother and baby separation when there are unexpected complications which require an uplift in care
- Coordination across units in NEL could include establishing neonatal units as a single bed base for neonatal care which would be centrally managed and would enable collaboration between sites to manage flow
- Neonatal transfer and transport services with sufficient capacity to meet demands are critical to support this

Inpatient stay

- All neonatal inpatient care in NEL would continue to be delivered at either an LNU or a NICU; inpatient capacity at both levels needs to be aligned to demand
- The future care model should clearly define the catchment population for NEL and aim for all babies within that catchment area to be able to receive care within the system
- Capacity also needs to be sufficient to meet the needs of babies from other systems needing NICU care
- If a baby requires an uplift in care, they may require a transfer to another unit within or outside the ICS, or to a specialist hospital. A transfer for an uplift in care would typically result in a move from an LNU to a NICU.
- If a baby has been transferred for an uplift in neonatal care, they will be repatriated back to their closest LNU at the earliest opportunity where it is safe to do so. Enhancing repatriation processes ensures that the baby and parents can be as close to their family and support network as possible.
- The proposed care model would have a set of objective criteria for repatriating babies back to their local neonatal unit from the NICUs in NEL, utilising the neonatal ODN repatriation guidelines.

The neonatal care model has three phases and will be subject to iteration in the next phase of work (2/2)

Onward care

- An enhanced, properly funded Neonatal Transitional Care service will facilitate the smooth transition of care from a hospital setting back into the home setting following discharge.
- Transitional care will allow mothers and babies to be cared for together away from the neonatal unit, freeing up crucial capacity to allow for babies to be cared for in the most appropriate setting.
- Following discharge, babies and their families would have access to a range of onward care support services.
- A key aspect of the onward care will be the neonatal outreach service which will be operational 7 days a week and will provide care for these service users in the community setting and at home.
- Stakeholders expressed a desire to explore the opportunity to expand hospital at home services to include neonatal care to provide care away from the hospital setting where feasible.
- The future care model will have clear guidance on the step from neonatal to paediatric care across NEL to ensure that high quality, safe care continues for service users.

There are key enablers for the effectiveness of the proposed care models (1/2)

Culture of collaboration	• Developing a culture of collaboration across the ICS is a key condition for the future success as the draft care models are reliant on organisations in NEL working together to provide care that is centred around the service user. • It is crucial that all stakeholders deliver maternity and neonatal care as **one system** with individual organisations working as collaborative parts within the overall system, and service users experience a seamless set of services
Communications and engagement	• Clear and consistent communication across NEL is key to developing trusted relationships between organisations. • Engaging with other hospitals breaks down existing siloes and creates teams that want to work together which positively contributes to the development of a culture of collaboration. • It is important that communication is enhanced across all parts of the maternity and neonatal pathway
Digital and information systems	• Currently not all units are linked together, with some units still using paper records which limits the effectiveness of the care model. • An interoperable connected system would improve the way in which the organisations within NEL can work together by accessing data in a readily manner whilst facilitating transfers and network working.
Technology	• Enhancing the provision of technology across services in NEL is crucial in ensuring that care can be delivered effectively and productively in a capacity constrained system where demand is projected to increase. • The population has changed since these services were first designed and technology is key in making best use of the current configuration of space within the units in NEL.

There are key enablers for the effectiveness of the proposed care models (2/2)

Workforce strategy

- Developing a workforce strategy in NEL is crucial to the future success of the proposed care model to ensure that staff resource is being most effectively whilst considering their overall well-being.
- Looking after the workforce in maternity and neonatal services is key for the future success of the care model as will encourage staff buy in whilst improving retention and recruitment.
- Staff should feel heard regarding their ways of working preferences with consideration of their preferred work-life balance where possible through flexible working patterns with careful consideration.

Estates and resources

- The proposed draft care models require estates and resources to be aligned to the pathways that have been developed to ensure the success of the care model in the future.
- This may require a degree of flexibility within how estates are configured to ensure that there is sufficient space and resources available to meet the proposed pathway changes.
- The current estates were not built for the world that we have now and as such it is important to map the future requirements of the proposed care model to what the estates are currently to understand any gaps in consideration of potential capital constraints.

The next phase of work will include engaging on the case for change and further iterating the draft care models

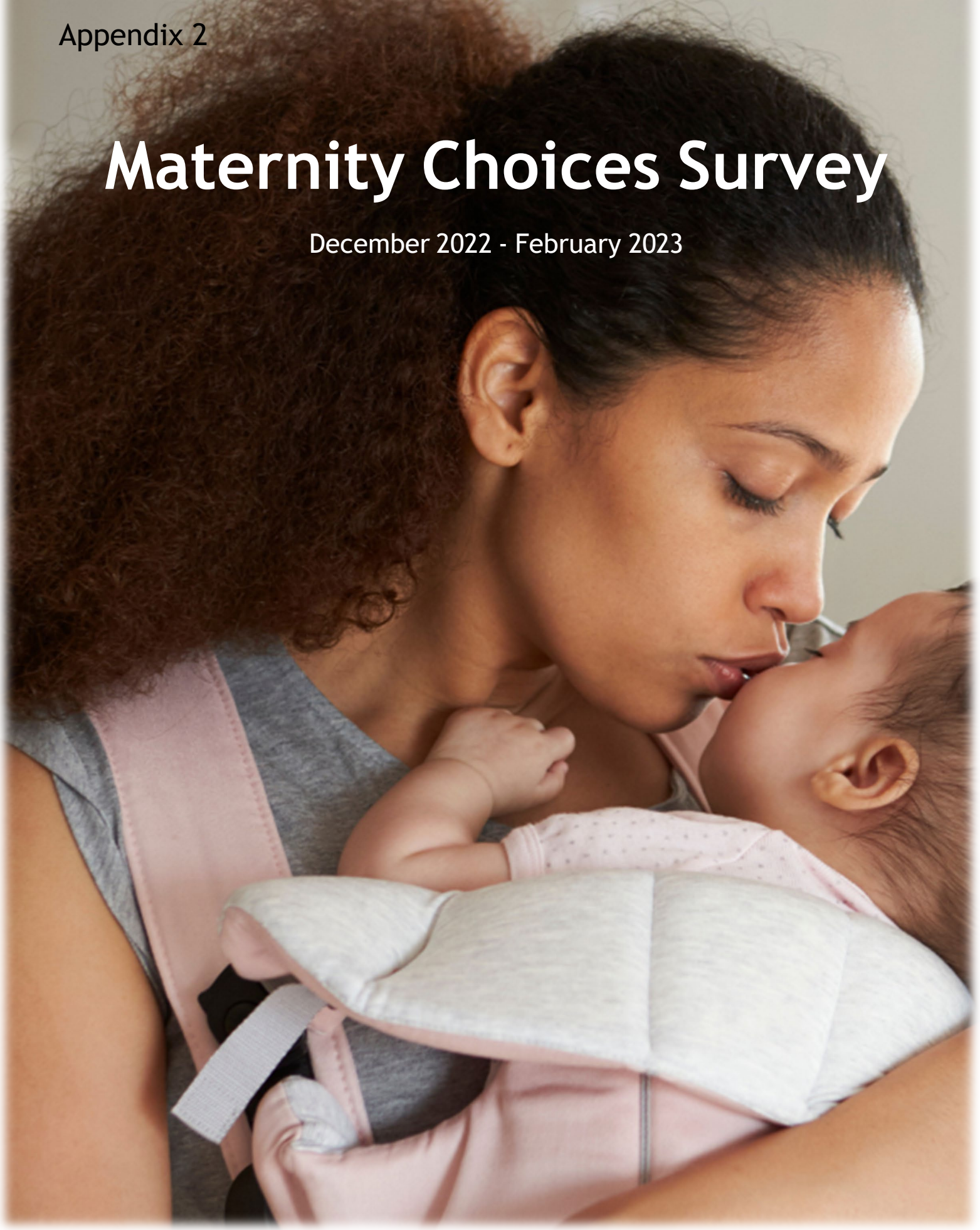
Next steps

- Broader engagement on the case for change is now required with services users, patients, clinical staff working at all stages of the care pathway and partner organisations
- This engagement will refine the work and ensure it describes a future for maternity and neonatal services that aligns with the needs and wants of all stakeholders.
- Development of the more detailed care models will run in parallel with the engagement to develop a detailed description of what care will look like in the future, and what services are then required and where to deliver this. The work will be clinically led with multi-professional input and engagement, and take a data driven approach to develop deliverable, sustainable service models.
- Once this has taken place each partner organisation will need to align behind the care model, and commit to developing the plans for its delivery, recognising some aspects of this will rest with single organisations and some will require broader collaboration

Appendix 2

Maternity Choices Survey

December 2022 - February 2023



local healthwatch working together

North East London Healthwatch

(Redbridge (Lead), Barking & Dagenham, Newham, Havering, Hackney & City, Tower Hamlets & Waltham Forest)

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Executive Summary

This project was additionally commissioned by North East London Local Maternity and Neonatal Service following the development of the Maternity Equity and Equality Action plan 2022. Themes developed from this extensive engagement had a focus on global majority community views and led to a request for insight from NEL Healthwatch into:

- the demand for and nature of culturally sensitive Maternity care provision within NEL
- the reasons for choice of Maternity Unit to evidence any contributing factors

Methodology

We heard from 403 Maternity service users across North East London through a live survey link between December 2022 and February 2023. Additionally, a one-week snapshot engagement across Maternity Units and community antenatal clinics took place in February 2023 where teams of researchers and volunteers were able to engage with Maternity service users directly.

Findings

We are still seeing an ongoing division in maternity experience relating to health inequality. Due to sensitive questioning, we can deliver a closer identification of particular communities facing intersectional disadvantage:

- referral by GP seems to lead to a lower level of choice and co-production experienced by Maternity service users than self-referral mechanisms
- Service users from Black African, Turkish, Pakistani and Eastern European communities are less likely to experience choice of maternity unit
- Fluency in English is a well-known marker of inequality, and we see this here.
- Being a single parent, although now less stigmatised, remains a marker of inequality
- Respondents of Black ethnicities experience a double barrier to maternity care because they are more likely to value cultural symmetry but less likely to experience this.
- Polish and Pakistani respondents were less likely to report having access to professionals who speak their language.
- Antenatal classes have suffered a pandemic impact. They are no longer widely available free at the point of access, and this might negatively impact service users facing inequality.
- Antenatal provision is at times perceived to be rushed and lacking engagement from Maternity Health professionals.

Recommendations

- Creating greater awareness of the nature of health inequality across North East London.
- Further research into GP referral structures
- Further research into self-referral choice mechanisms.
- Management of capacity issues within antenatal provision.
- Clear information about antenatal waiting times and the impact of delayed arrival.

- Training for staff in engagement and empathy (and trauma informed care, particularly for previous baby loss as with the previous equity and equality recommendations)
- Cultural sensitivity training for Maternity staff caring for service users from Black, Polish and Pakistani communities
- Interpreting services for any service user with less than conversational English
- Improved parking facilities where a car is the main mode of transport.

The Maternity Report 2022-23, with analysis by Borough and Maternity Unit, give further information on these findings.

Introduction

The North East London Local Maternity and Neonatal System (NEL LMNS) is a partnership of organisations, women and their families working together to deliver improvements in maternity services in north east London. NEL LMNS is part of the North East London Health and Care Partnership, the Integrated Care System (ICS) for north east London[1].

Healthwatch organisations are the health and social care champions for people living and working in local communities. We listen to the experiences of people who use GPs and hospitals, dentists, pharmacies, care homes or other support services. As an independent statutory body, we have the power to make sure NHS leaders and other decision makers listen to local feedback and improve standards of care.

Background

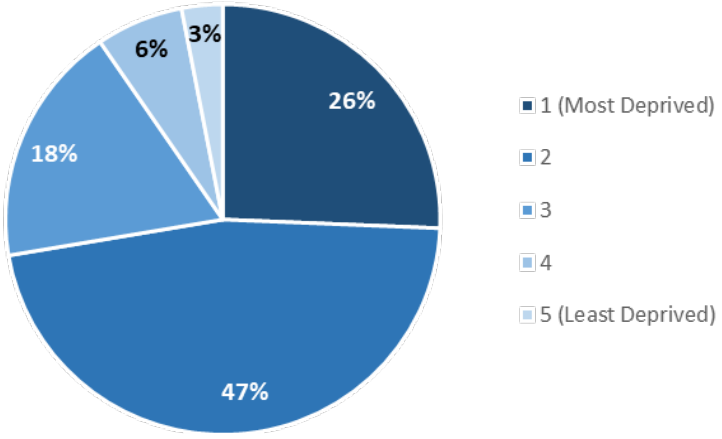
Last year, Healthwatch from north east London supported NEL LMNS to engage with pregnant people mainly from global majority[2] communities to support the development of an equity and equality strategy[3], aimed at ensuring all babies born and cared for in any north east London maternity unit has the best possible start in life.

The project aims were driven by the context of maternity experience in north east London. The boroughs involved were Hackney, Tower Hamlets, Newham, Waltham Forest, Redbridge, Barking and Dagenham and Havering.

North East London has the highest birth rate in the UK and a prediction of growth in population to 270,000 in the next 20 years. As the most diverse ICS in the country, with 53% of the population identifying as Black, Asian or from a global majority, compared to 11% across England overall.

73% of babies born in NEL in 2020/21 are from two of the most deprived quintiles:

[1] https://www.northeastlondonhcp.nhs.uk/aboutus/north-east-london-integrated-care-system.htm
[2] https://dictionary.cambridge.org/dictionary/english/global-majority
[3] North East London Local Maternity and Neonatal System Equity and Equality Strategy and Action Plan Summary Report 9th December 2022



In response to the initial report's findings, a new project was commissioned to understand what influences an individual's choice to use specific maternity services.

To reflect the NEL landscape, the Healthwatch Equity and Equality 2022 project delivered insight from Maternity service users' experience over the previous four years, with a particular focus on ethnic minority community views. The key themes led to action plans which can be viewed in the Equity and Equality strategy.

Following the publication of the strategy, the LMNS further requested insight from NEL Healthwatch into:

- the demand for and nature of culturally sensitive Maternity care provision within NEL
- the reasons for choice of Maternity Unit to evidence any dominant drivers

Research objectives

To gather the experiences of people who are currently receiving pre-natal support across north east London, and those immediately after birth (within the last month).

Methodology

The survey was live from December 2022 until February 2023 and received 403 completed submissions. The focus was on antenatal experience and one-month post-birth, to enable access to service users' recent reflections on choice of maternity unit and issues of cultural sensitivity.

The survey was disseminated widely using national platforms such as Mumsnet and the Baby Buddy app, local community networks from each Healthwatch and Hospital communications teams. An appendix of sharing sites is contained in this report.

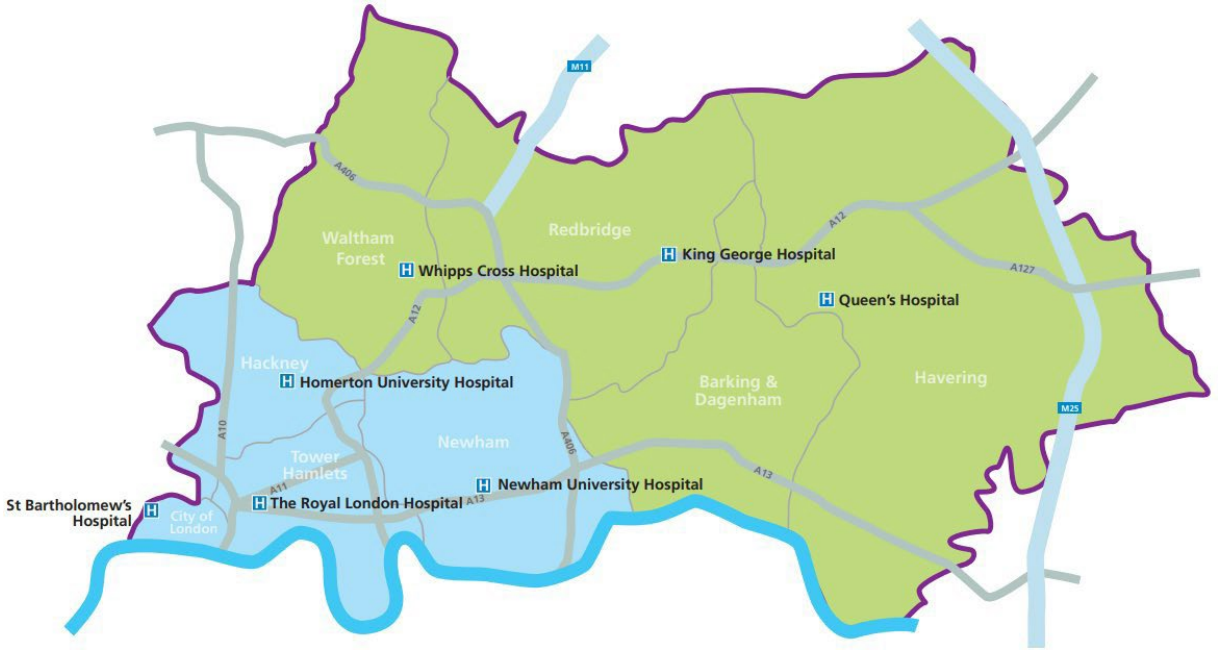
In-person engagement and surveys were completed in the week of 6-10 February with

visits conducted at each NEL maternity unit, along with antenatal clinics either within hospitals or in a variety of community locations such as children's centres. The in-person sites are also listed in the appendix.

Titled 'Maternity Choices Week', this engagement was created and supported by all NEL Healthwatch, and benefitted from strong and wide co-operation with our NHS Midwifery colleagues, from Patient Experience teams, clinicians, and directors of Maternity Units. We were also assisted by Maternity Voices Partnerships with interpreting help.

Additional context was gained from a focus group of researchers who undertook the engagement in a debrief setting immediately post Maternity Choices week. These themes are summarised in the following high-level findings and are also used throughout to add a broader frame of reference.

Following the high-level summary, data is presented (within a separate appendices) by borough and by maternity unit to reflect the current LMNS area:

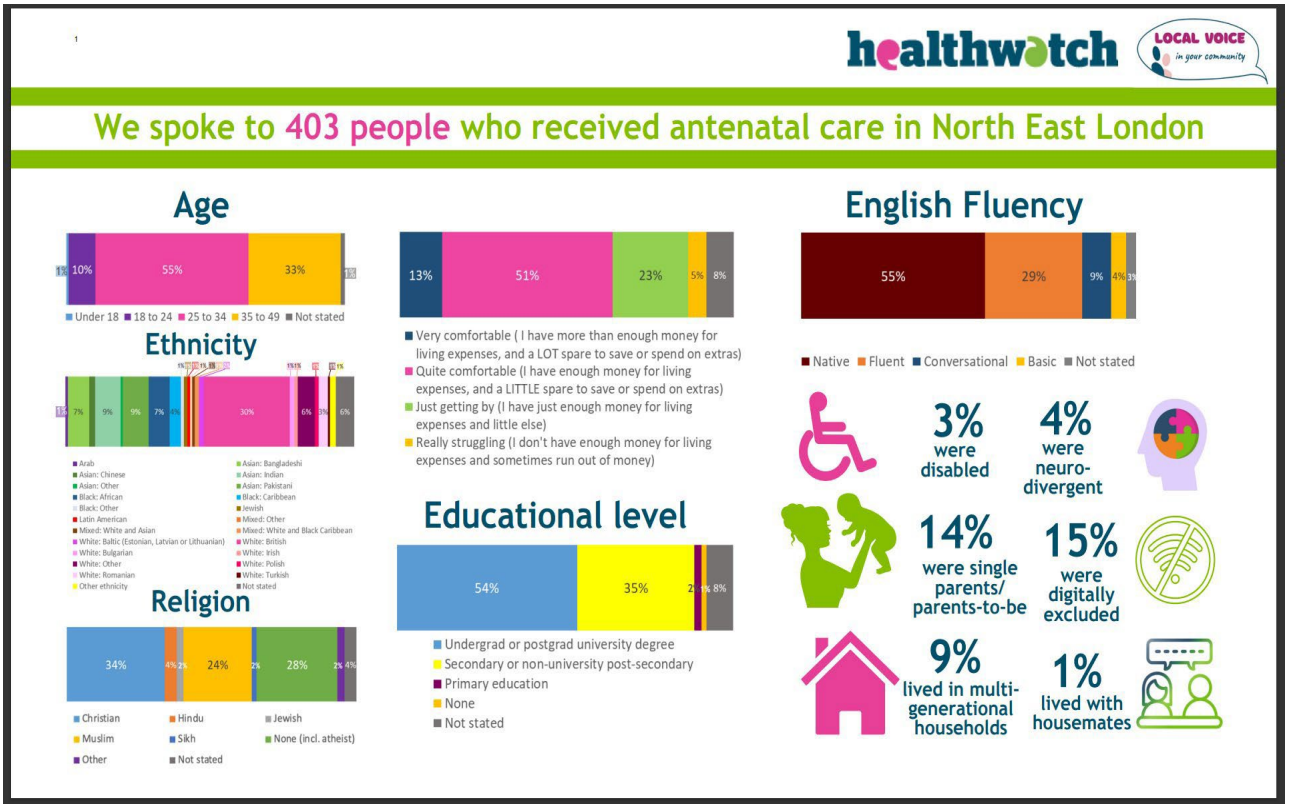


The survey was analysed by our Healthwatch data insights team, with the benefit of the Community Insights System[4]. This resource was developed to gather searchable, interactive, and current service user feedback from health and social care across NEL with the benefit of historical context.

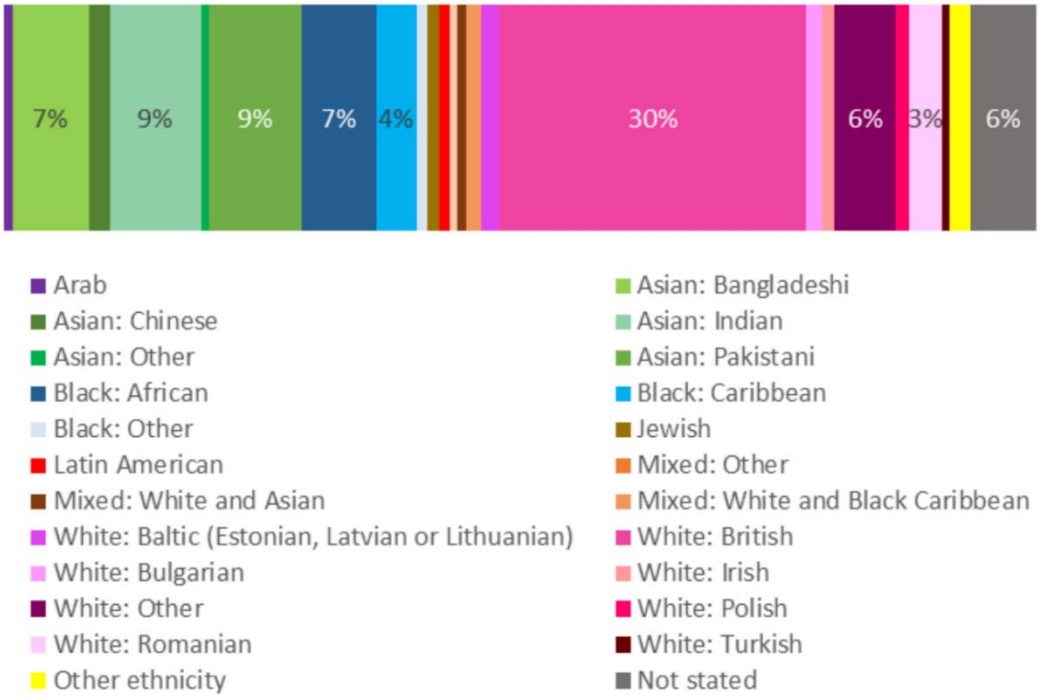
[4] https://intranet.northeastlondon.icb.nhs.uk/news/community-insights-system-helping-us-understand-local-peoples-experience-of-health-and-care-services/

Focused findings

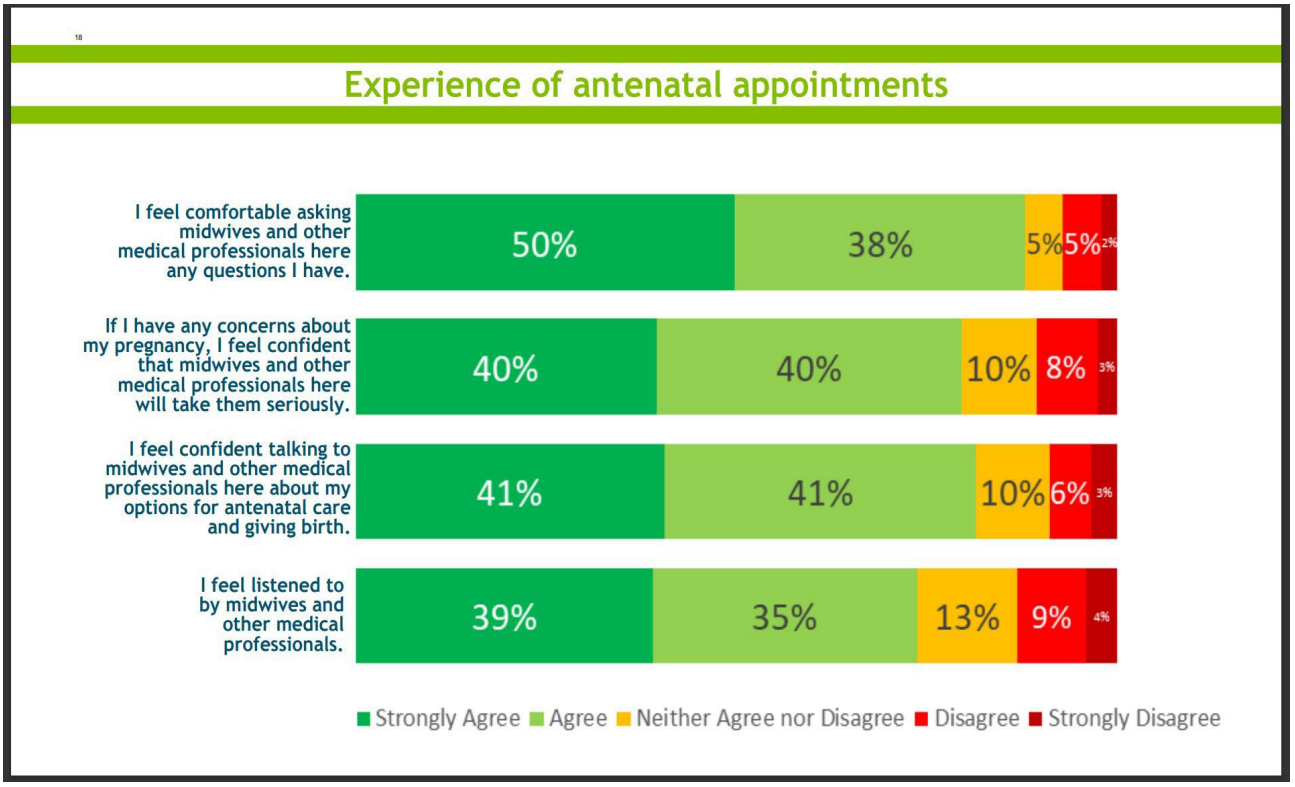
Our survey reflects the multiple diversities of North East London, which is useful for being able to interpret and make recommendations from the data. For example, our survey respondents were diverse in ethnicity, with 30% being White British and evenly distributed across religious affiliation. Financially we had a slightly higher than expected range of respondents who were 'quite comfortable.' A similarly high proportion of respondents at 54% were educated to undergraduate level or above:

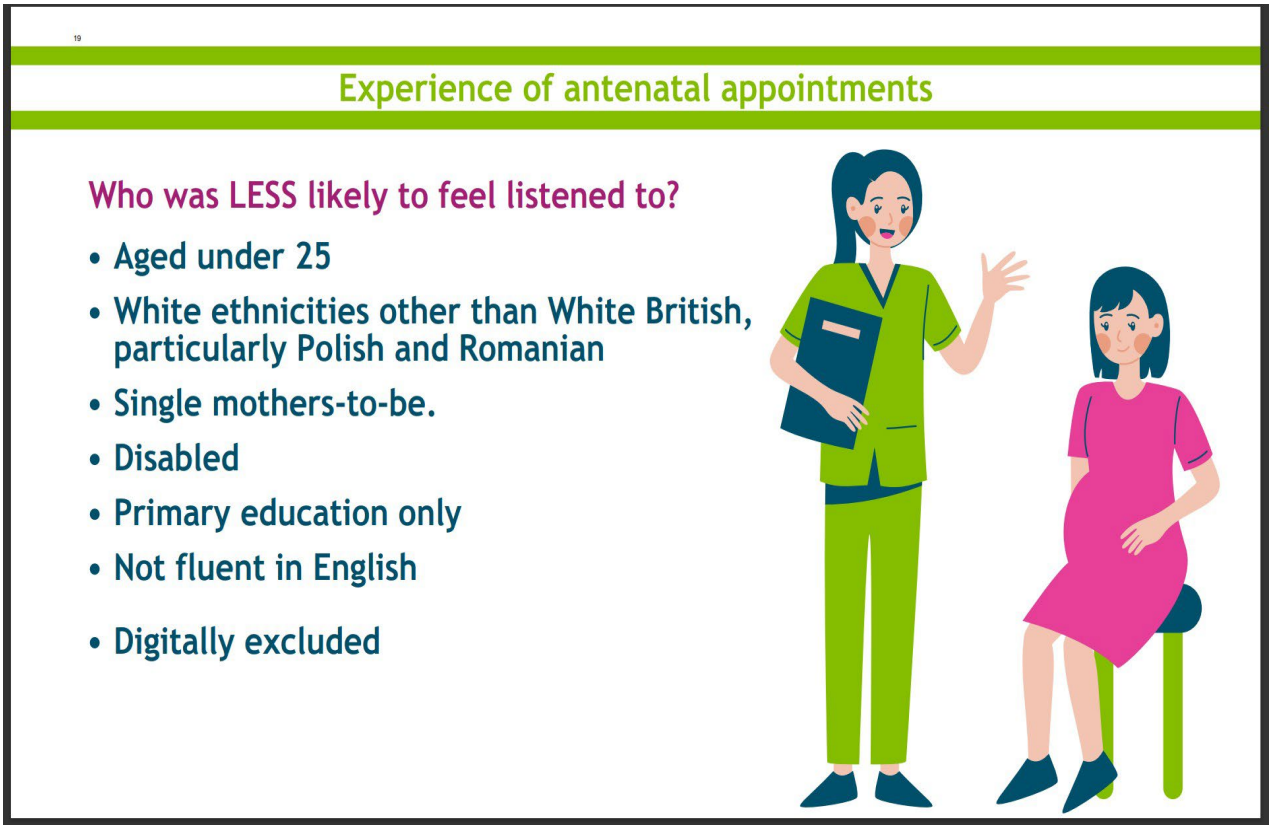


A deeper dive into the ethnicity of survey respondents shows more of the diversity and richness of the data set:



Most respondents had positive feedback on their antenatal experience and felt listened to by midwives; however, inequalities correlating with ethnicity, social class and disability may be affecting a small but distinct population of NEL Maternity service users:

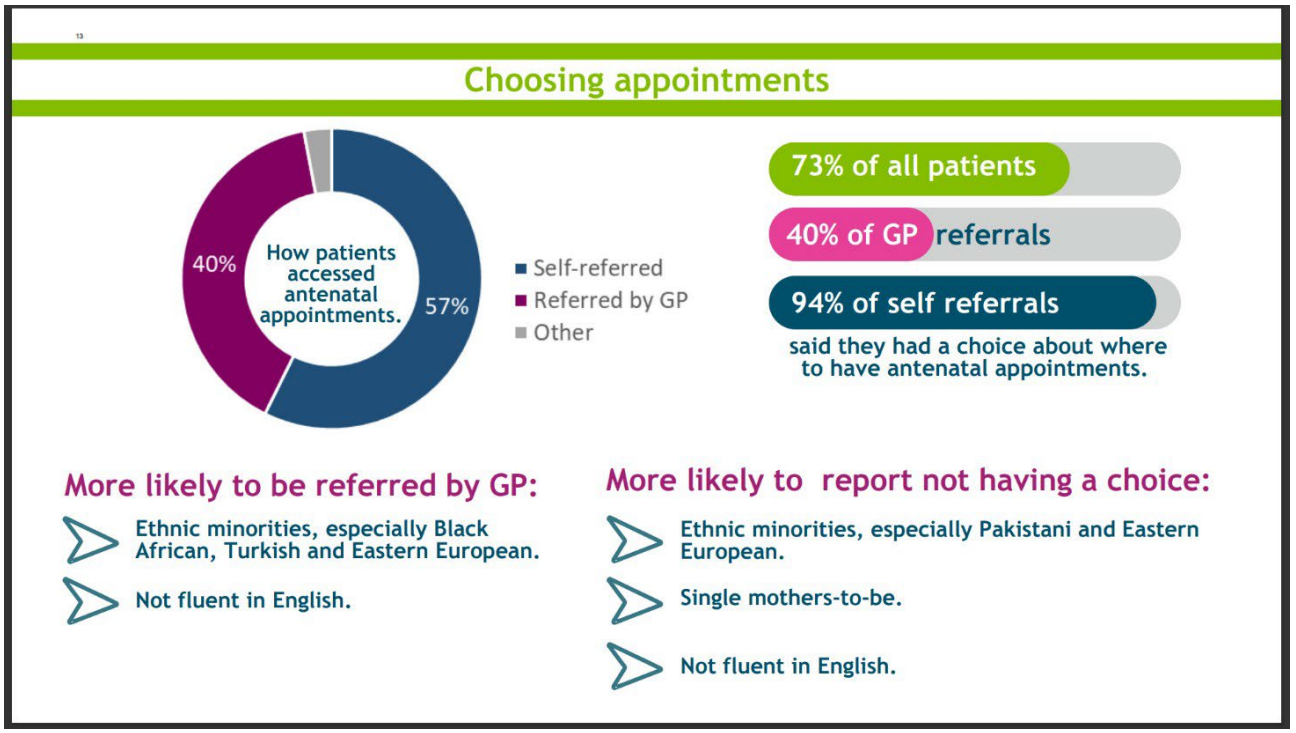




Although a large majority of service users were fluent in English, 9% identified with conversational English and 4% as basic. A notable 15% were digitally excluded, which given the following findings on referral pathways, might be extremely relevant when identifying access barriers to choice in maternity care.

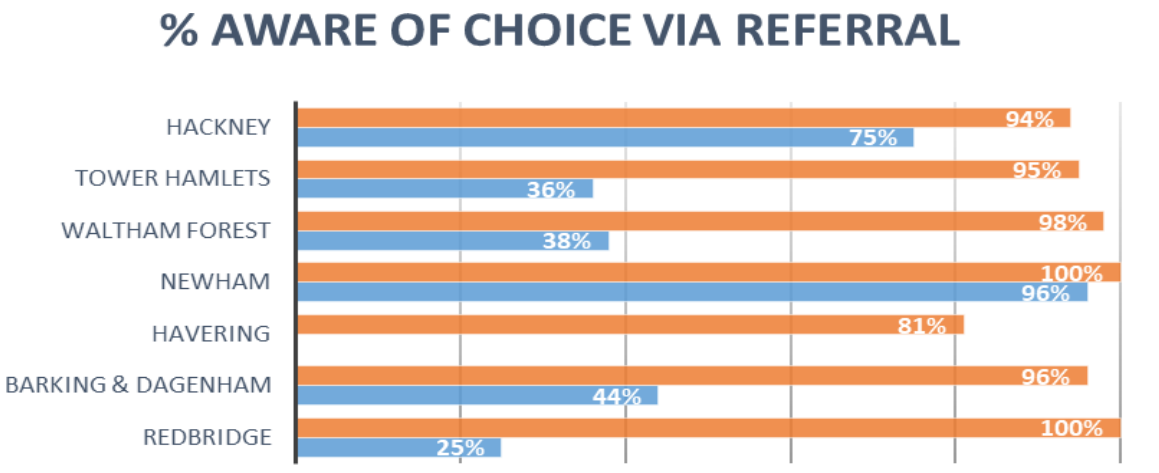
Choice of Maternity Unit

There was a polemic in the data between those referred to a Maternity Unit for antenatal appointments by their GP and those by self-referral pathways. A further insight into health inequality is gained from studying these pathways:



Whilst many service users self-referred to antenatal appointments (57%), those referred by their GP (43%), experienced less choice. The level of choice differed by a wide margin, with 40% of those referred by a GP identifying the availability of choice, compared to 94% of service users who self-referred.

This polarization appears to reflect issues of inequality, due to linked data showing the ethnicity and social background of service users more likely to be referred by a GP. A lack of fluency in English, belonging to a global majority community and being a single parent were also strong determinants of the availability of choice. It is worth noting that there was some difference in findings across the Boroughs for this finding:



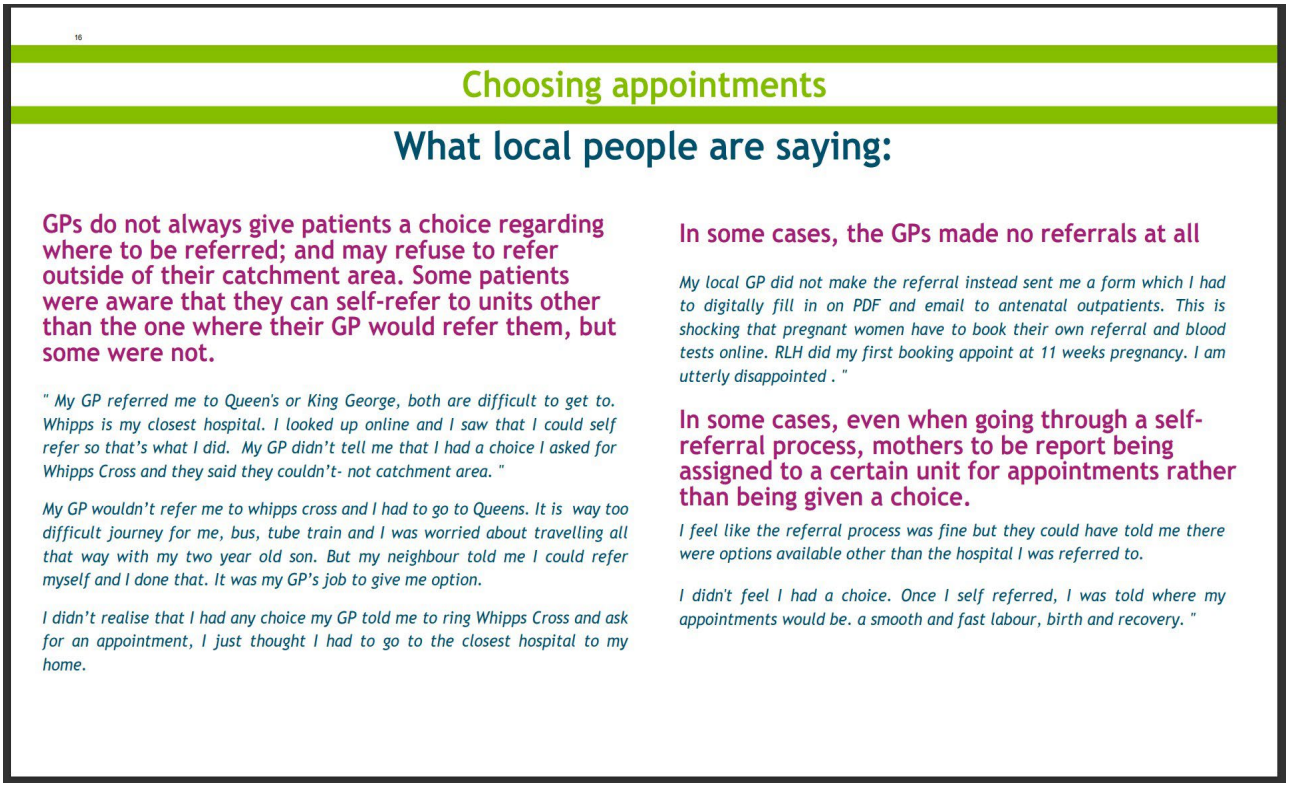
	REDBRIDGE	BARKING & DAGENHAM	HAVERING	NEWHAM	WALTHAM FOREST	TOWER HAMLETS	HACKNEY
SELF	100%	96%	81%	100%	98%	95%	94%
GP	25%	44%	0%	96%	38%	36%	75%

It may be possible to interpret that service users who require greater assistance in navigating access to maternity services then face an additional barrier to co-production in the early weeks of their Maternity journey.

Newham had a very high level of choice identified by service users referred by their GP, whereas in Redbridge and Havering these figures were much lower. The reasons for these variations across NEL in primary care practice could be worthy of further exploration.

The following data extracts show service users encountered barriers to choice when accessing maternity care through their GP. Additionally, and not visible from the survey data, was a theme of service user experience of the self-referral process itself being variable.

A feature of this is not hearing back from the referral process and needing to chase the referral. In some instances, the self-referral process also limits choice and gives a direct referral.
Service users who felt they did not have much choice were more likely to have additional health needs, such as high-risk pregnancies or long-term conditions. Those who lived a long way from antenatal facilities and those who may struggle to access information were also more likely to feel they did not have a choice:



17

Choosing appointments

What local people are saying:

Experience of the self-referral process is variable.

"Simple process, fill in the form and get an appointment."

Referral process wasn't clear. I initially contacted my GP but my GP told me to self-refer. I self-referred to Royal London but haven't heard back so had to chase the referral. "

I initially referred myself to Royal London Hospital (my local service) but I didn't even receive an acknowledgement of the referral. When I phoned to check my referral had been received, the person on the phone was quite abrupt with me. That and comparing CQC ratings made me decide to go for Homerton instead. I received an acknowledgment of my referral and a reference number from Homerton immediately, which was reassuring.

Some patients felt that, in practice, they didn't have much choice. This is particularly the case for those with additional health needs, such as high-risk pregnancies or long-term conditions, those living too far away from most antenatal facilities and those who may struggle to access information.

I didn't have any choice as soon as I had gestational diabetes I was part of the team at Queen's. They were fantastic, to be fair, however I was quite sad to not be seen my local midwife anymore since she knew me better. I was concerned about something a few weeks before I gave birth and in the end contacted the local midwife. I wish I'd have contacted her sooner as it would have saved a few months of worry. The diabetic team were amazing but it would have been nice to have the choice to see both if possible.

Would have been good to see where all of the centres were - there were some much easier to get to "

I would have gone to another hospital if I was given the choice. I hear so many negative comments about Whipps Cross maternity, but I have no real choice but to come here as I live close by and have 3 other children at home. "

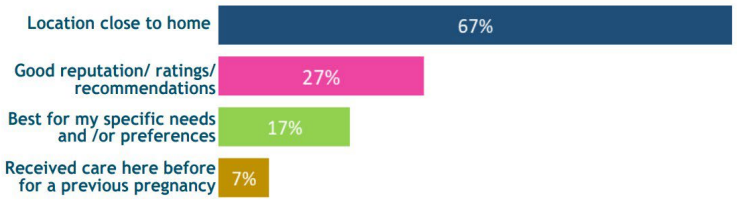
"It was my local centre and I wasn't aware that I could choose to have the appointments elsewhere "

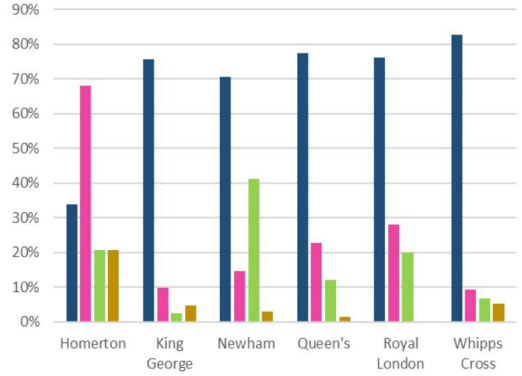
For most service users who self-referred to antenatal care, the predominant reason for choice of respondents was a location close to home (67%).
A good reputation for the maternity unit was the next most common driver of choice for just over a quarter of respondents, followed by a specific needs reason (17%) and previous experience (7%). Respondents could make multiple choices for this question:

15

Choosing appointments

Reasons for choosing this location for antenatal appointments
(patients who DID have a choice)

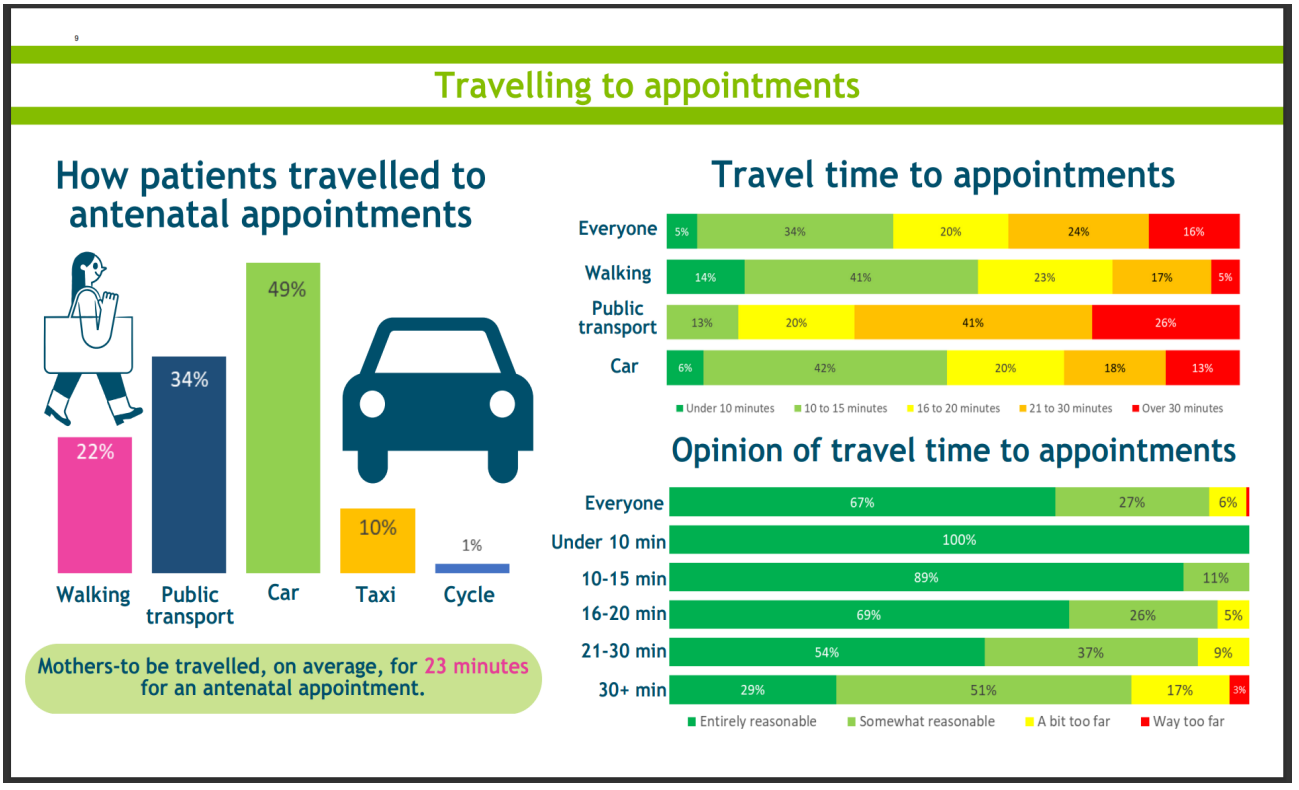


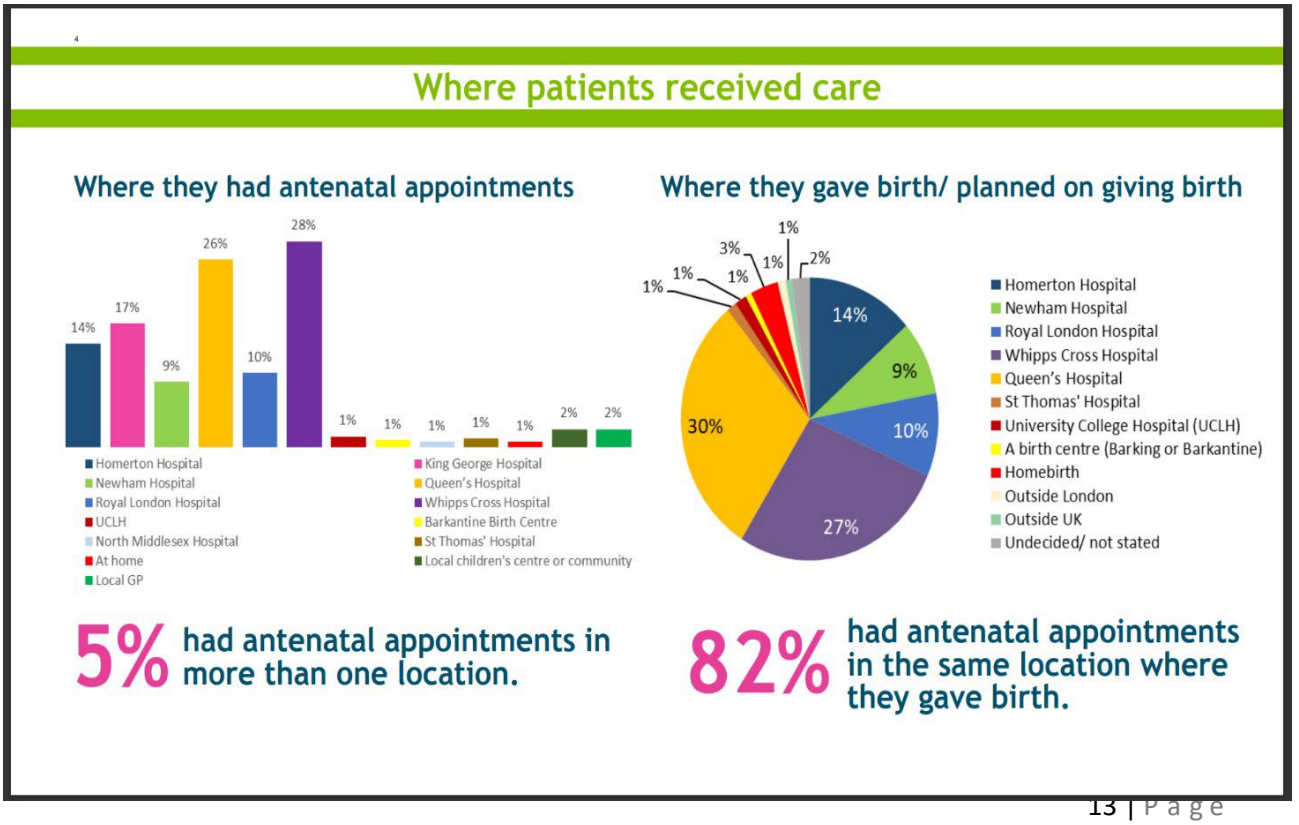


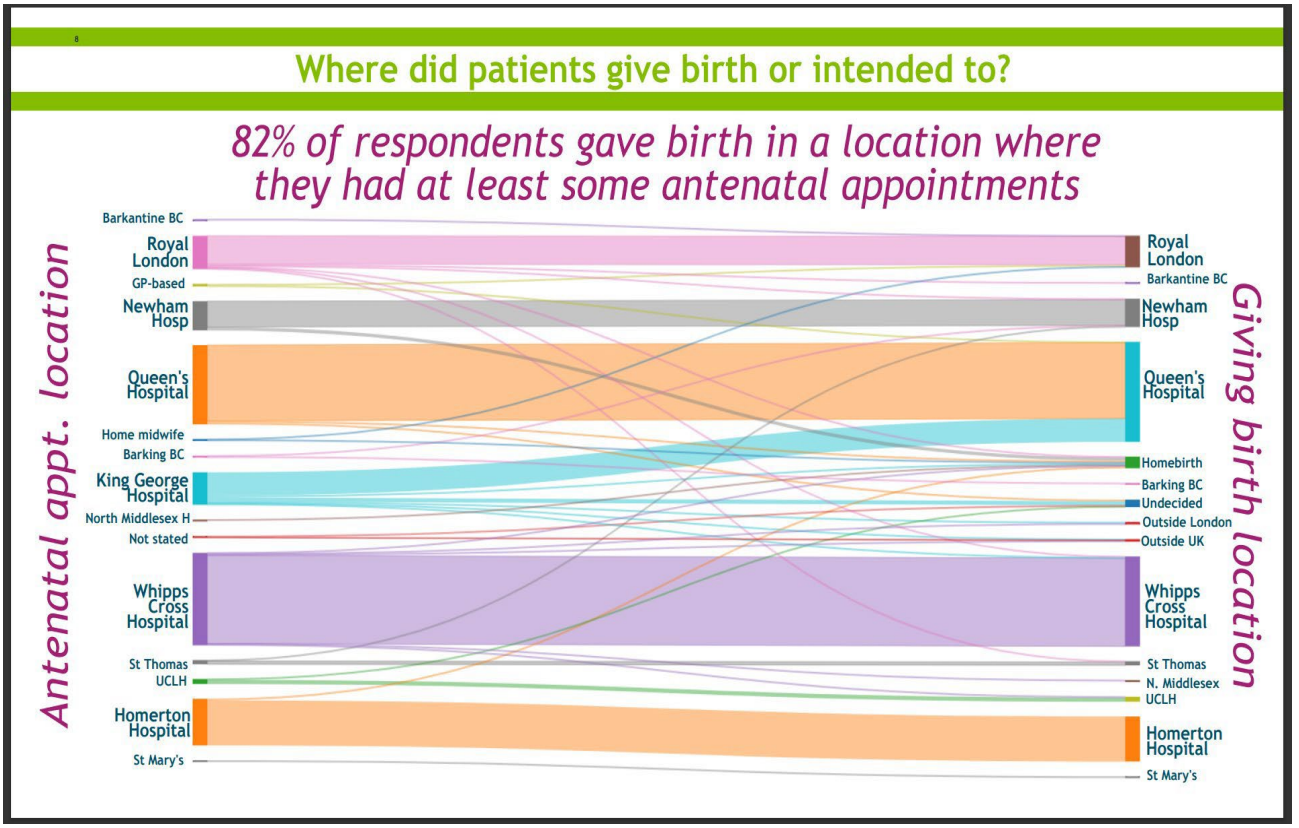
Travelling to appointments

The related findings about travel to appointments reveal a picture of uniformly accessible Maternity care with most travel times under 30 minutes and the average being 23 minutes.

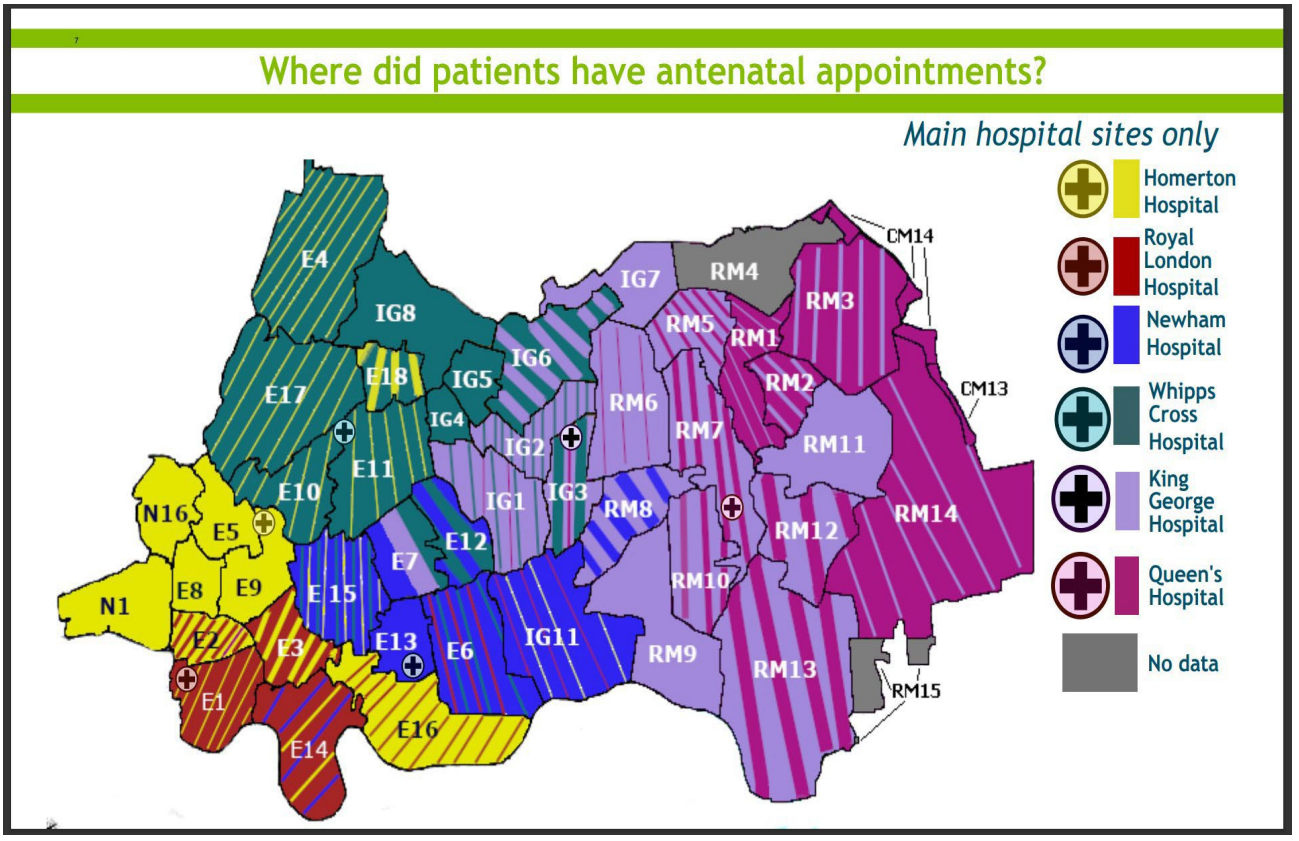
Most respondents had antenatal appointments in a hospital-based location with over 80% being in the hospital where they gave or intended to give birth:

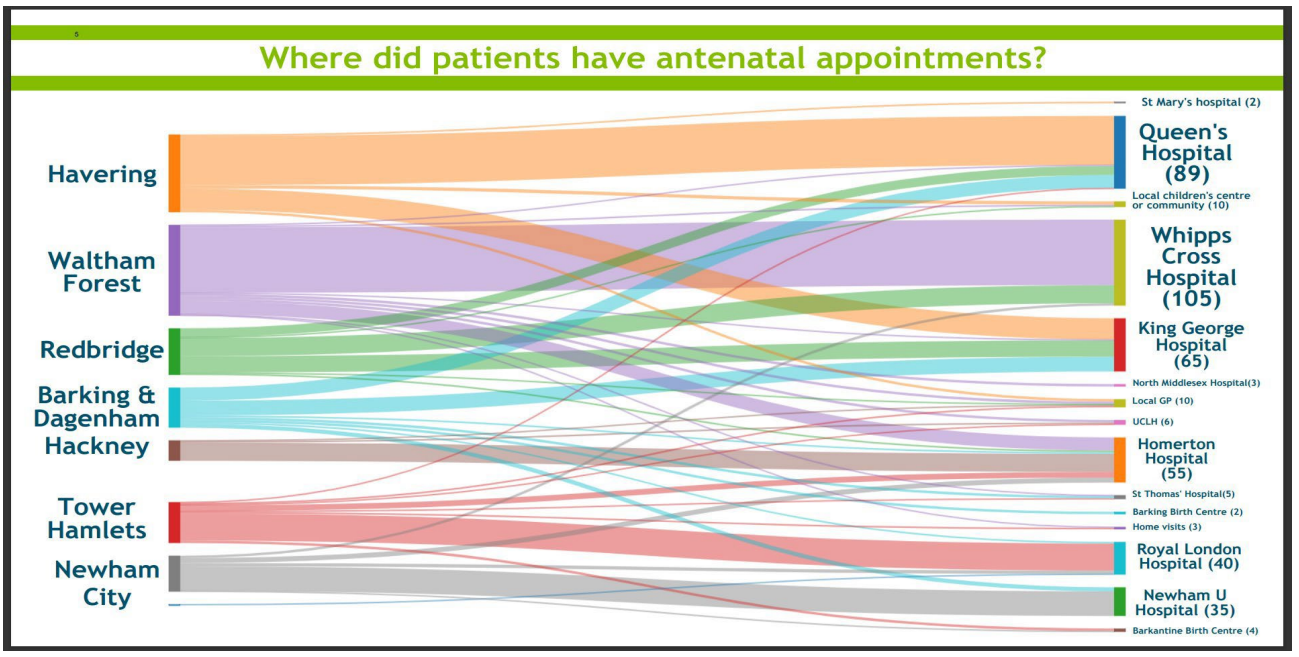






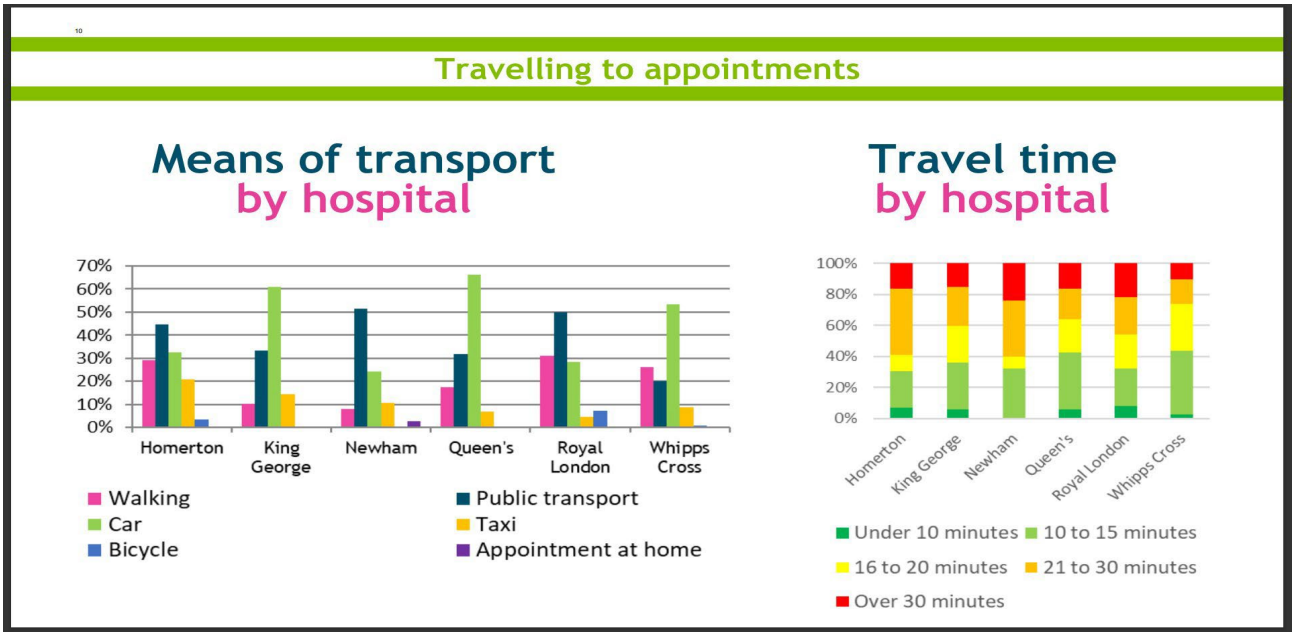
The issue of travel did not therefore appear to be a barrier to accessing Maternity care. The following data display shows where patients had antenatal appointments according to Borough. It is noticeable that Queen's Hospital has a much larger referral area than other Maternity Units:





Many service users (49%) travelled to appointments by car, although data from our researchers' focus group indicated a strong complexity arising from parking difficulties. This also fed into concerns about missing appointments when a late margin was exceeded, and service users were turned away. Clinics have different policies about acceptable delay and our recommendation would be that this should be made clearly visible in appointment information.

Other methods of travel stated were public transport (34%), walking (22%), and using a taxi (10%). People accessing King George Hospital, Queens Hospital and Whipps Cross had the highest car use. Focus group feedback expressed a clear difficulty identified with parking particularly at Queen's Hospital. Our recommendation would be that this is an access barrier for Maternity service users, particularly those who might be in the last trimester of pregnancy and possibly accompanied by other children:



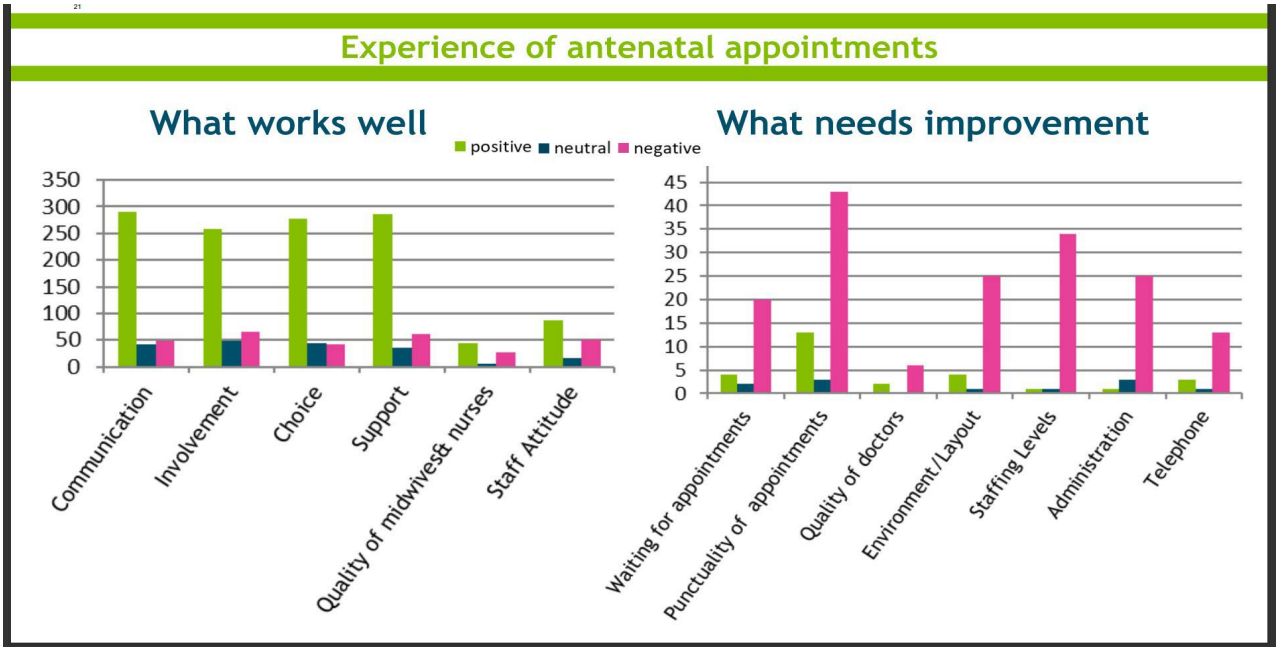
Public transport appeared to be more effective in the inner London boroughs and might raise the possibility of exploring dedicated bus routes in the outer London Boroughs in future planning.

Nature of antenatal clinic provision

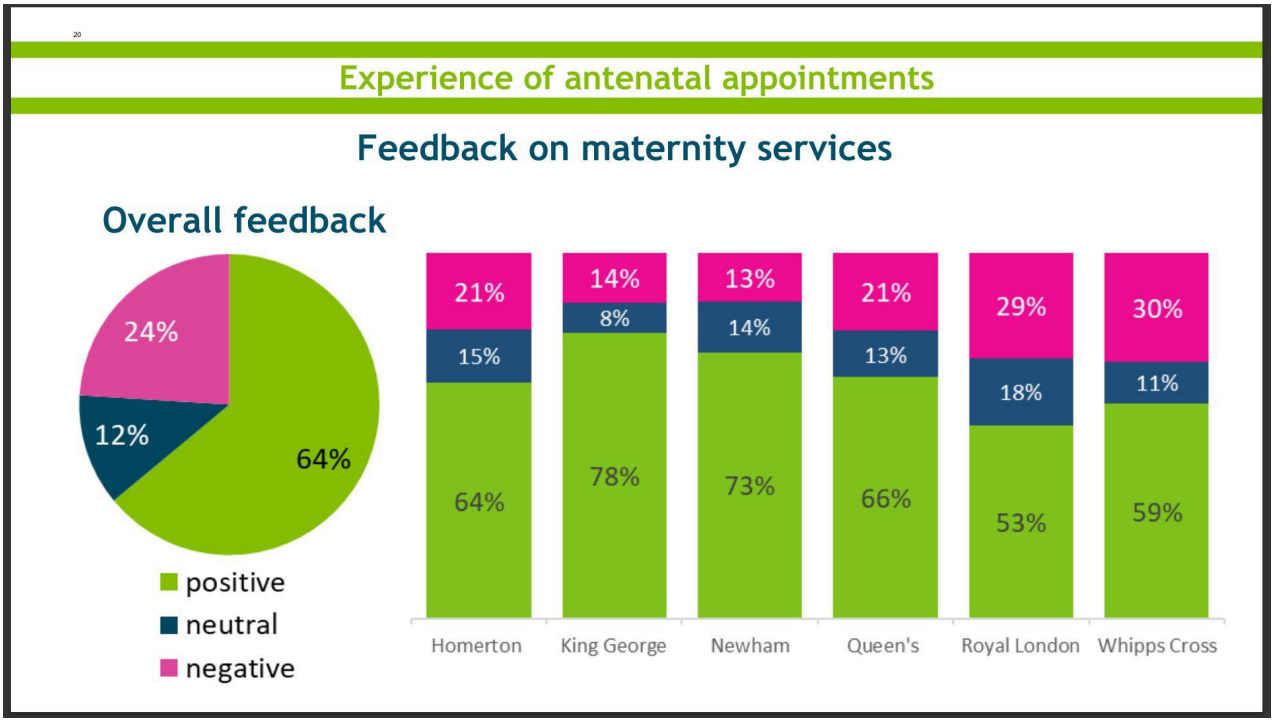
There was a noticeable theme about antenatal clinics that differed to maternity unit feedback, with service users expressing concern that maternity staff did not have the time to engage with their questions and requests.

Antenatal appointments were consistently identified as running late with service users spending a long time in waiting rooms. A small number of service users reported that the waiting rooms were uncomfortable and unfriendly.

Additionally, administrative staff were reported to occasionally be unresponsive to the concerns of service users.



There were some differences between Hospitals on this finding, with King George Hospital having the highest level of positive feedback and the Royal London at the lowest:

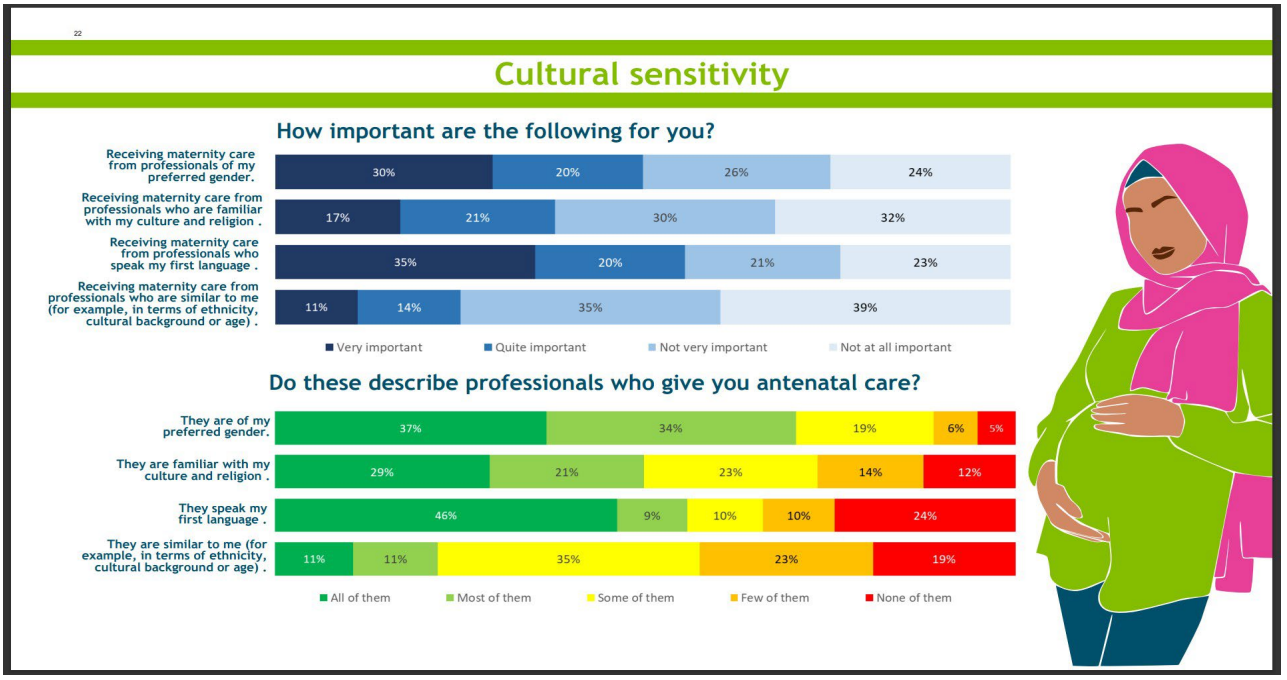

20
Experience of antenatal appointments
Feedback on maternity services
Overall feedback
24%
12%
64%
positive
neutral
negative
21%
15%
64%
14%
8%
78%
13%
14%
73%
21%
13%
66%
29%
18%
53%
30%
11%
59%
Homerton
King George
Newham
Queen's
Royal London
Whipps Cross

Our focus group of researchers identified the way in which antenatal clinic provision operates as a first port of call particularly for complex pregnancies and for those with unresolved grief from previous baby loss.

A lack of engagement at this point would therefore be an access barrier to Maternity service users, particularly those from our identified communities who already encounter a lack of choice and difficulty in negotiating the structures of care provision.

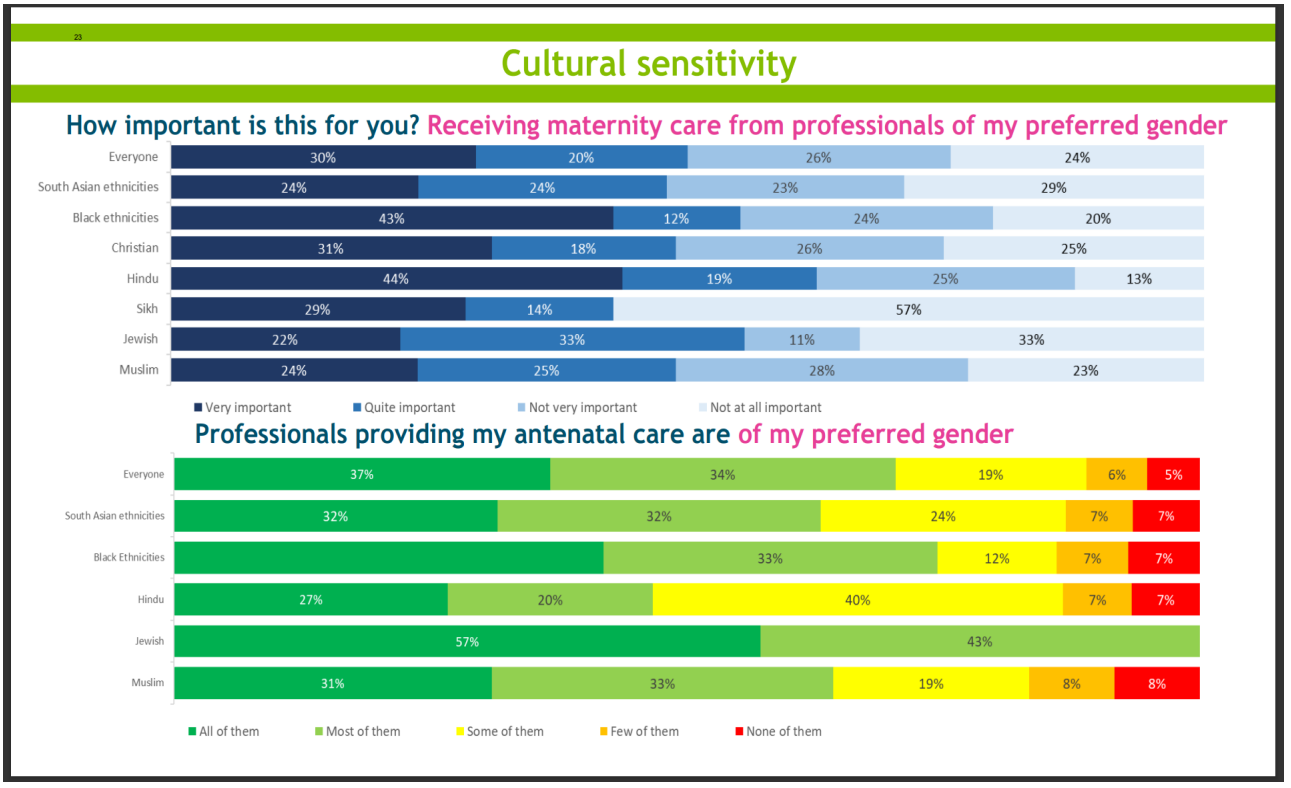
Cultural Sensitivity

There was another polemic in the data we gathered relating to cultural sensitivity. For some communities, the gender of their Maternity Health Professional and provision of culturally sensitive maternity care was very important. For other communities, this was less important.

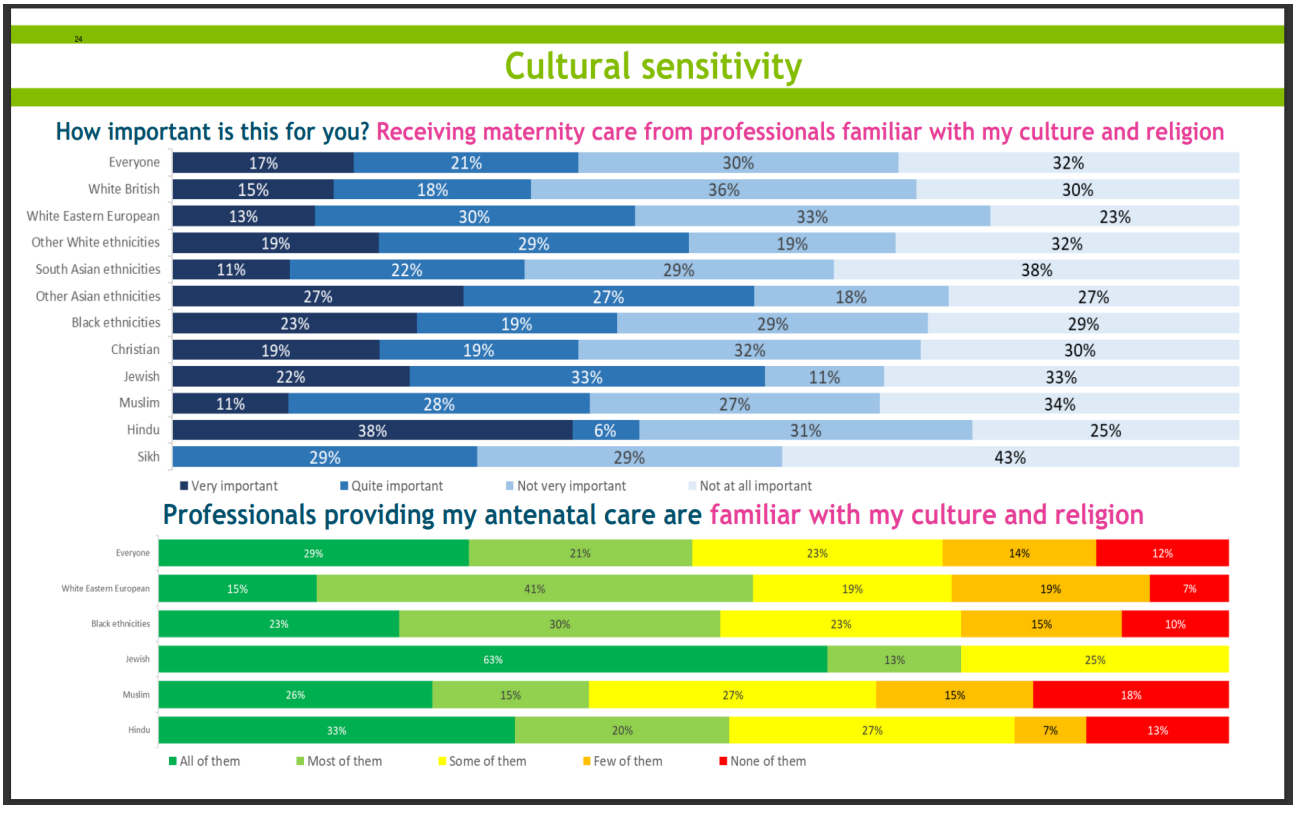


English fluency was a strong source of difference in the importance of access to healthcare professionals who speak the service users' own language.

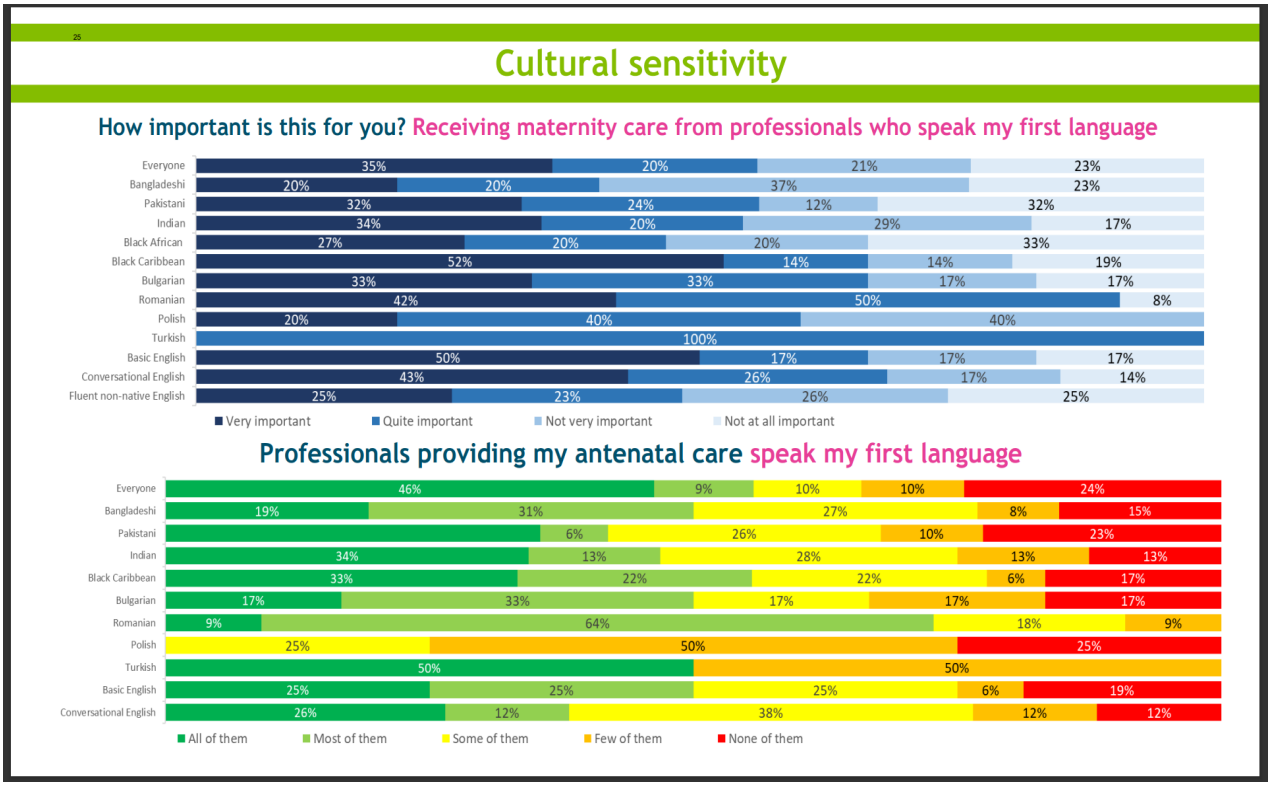
This data allows us to draw careful inferences about the maternity care needs of particular communities who would otherwise face a significant barrier to engagement and co-production.



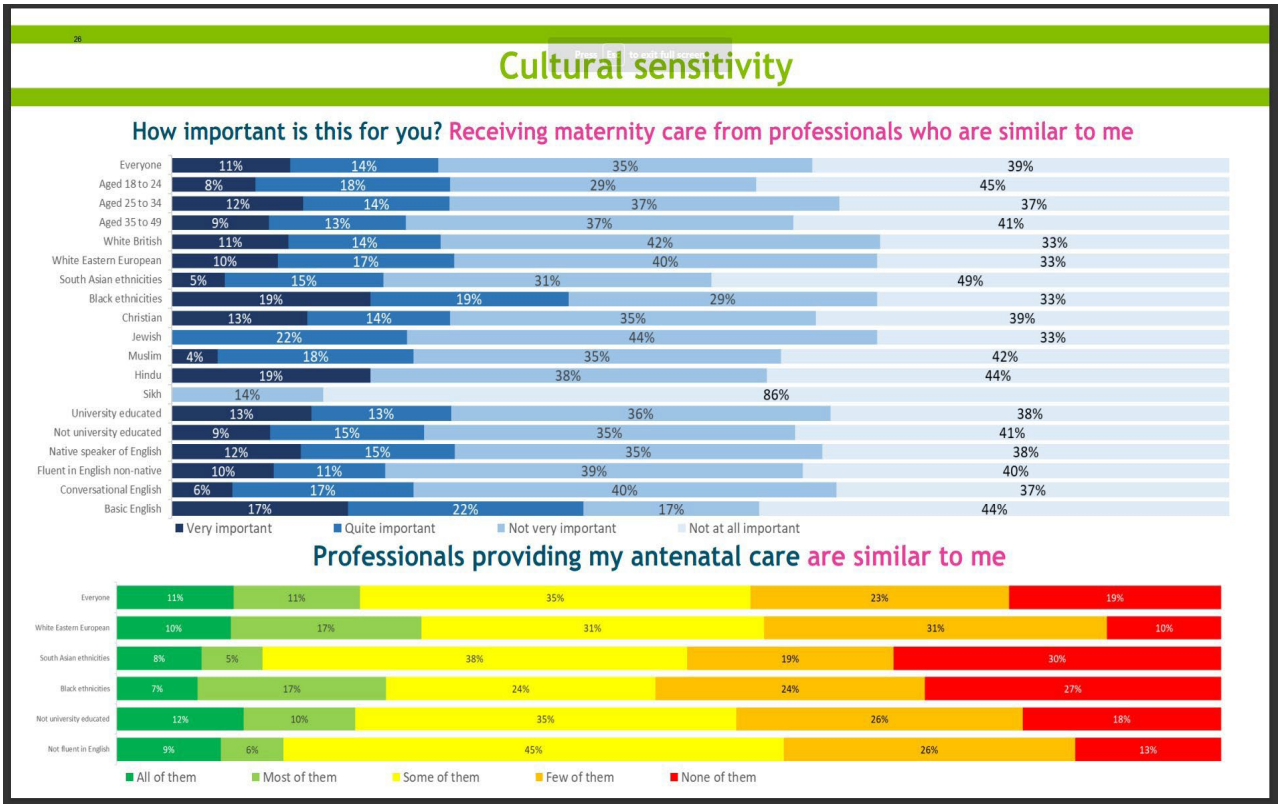
Service users from White Eastern European communities were more likely to say that it is important for them to receive antenatal care from professionals familiar with their culture. Service users from South Asian communities perceived this as less important.



Access to Maternity healthcare professionals who speak their first language was important for those with basic and conversational English, but less so for fluent non-native speakers. Polish and Pakistani respondents were less likely to report having access to professionals who speak their language.

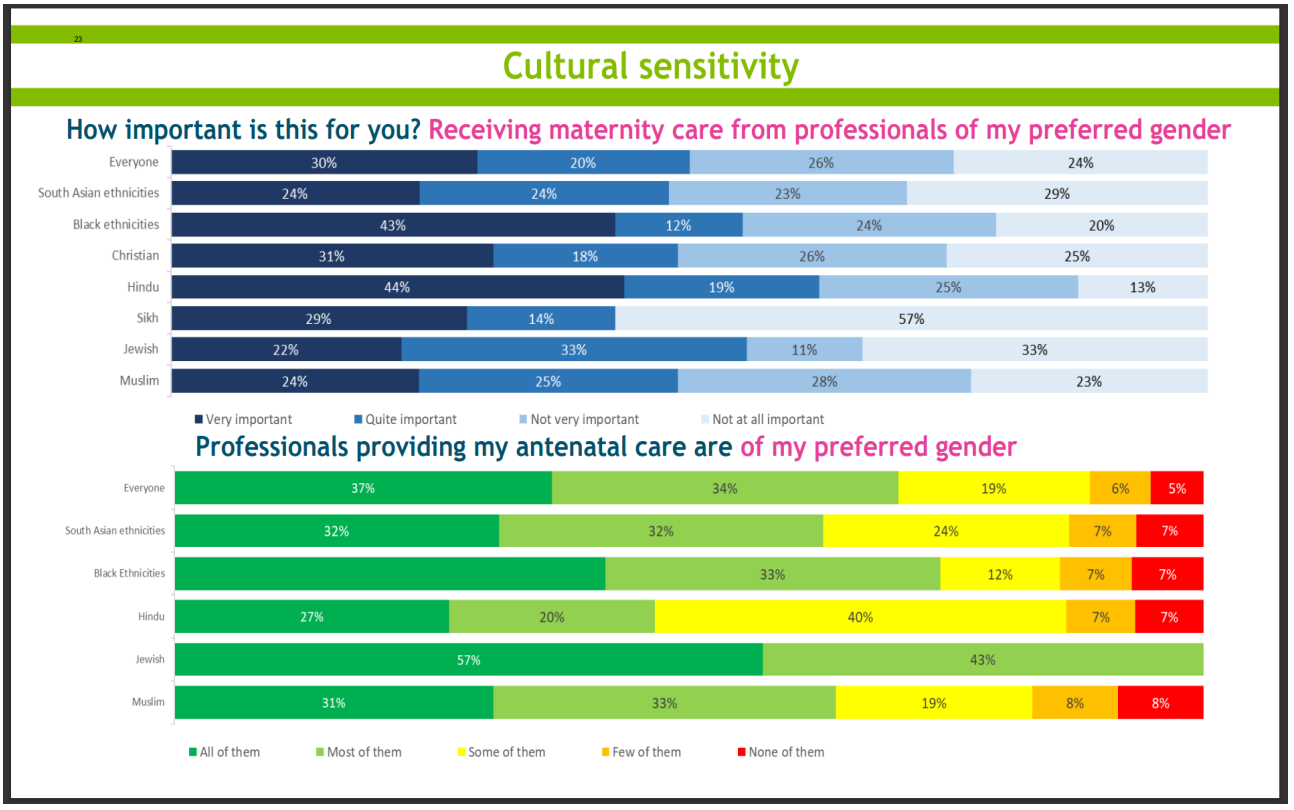


Respondents of Black ethnicities were more likely to say it is important for them to be looked after by professionals who are similar to them in terms of age and cultural background. They were also less likely to say that those currently providing them with antenatal care are similar to them.



Respondents who are Hindu were found to regard the gender of health professionals more important than other communities but were also found to be less represented.

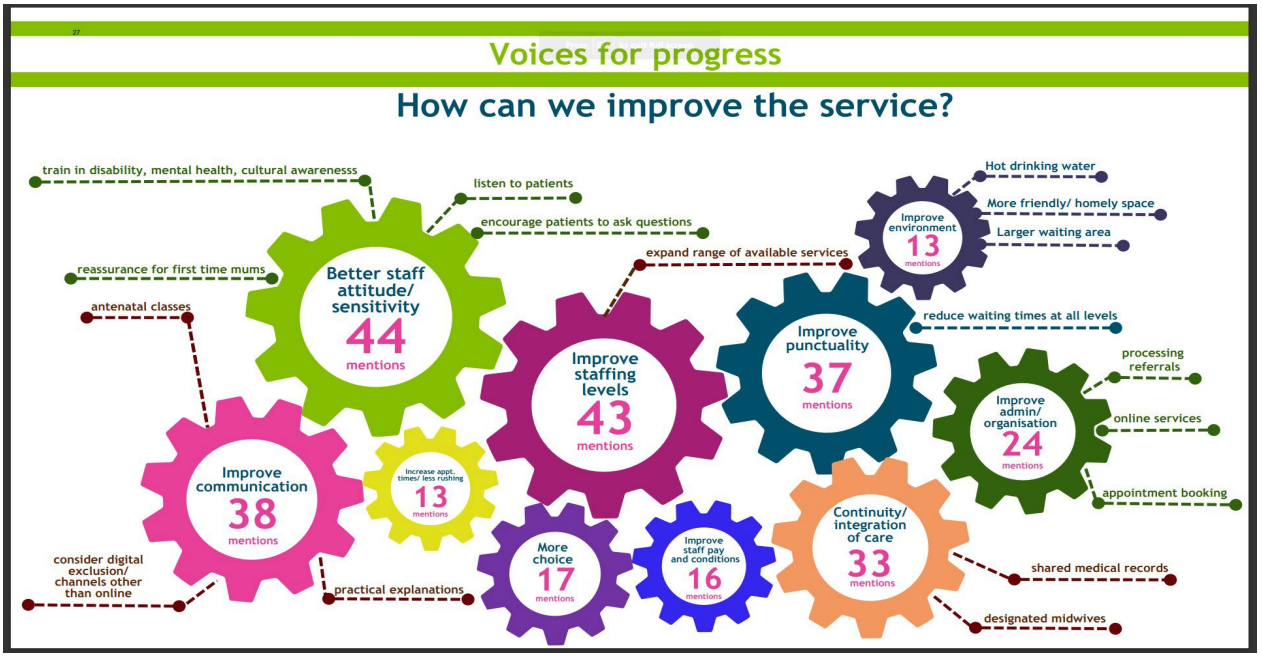
Those that identify as Sikh were the least concerned with gender, double that of other communities stating that they did not find this important at all.



Communication, staff attitude and informed care

Quotes from the free text data illustrate revealed high levels of concern about staff attitude and sensitivity, communication, and improving staffing levels and punctuality.

Care of service users who have experienced previous baby loss was a frequent point of concern, and the already established [NEL LMNS Equity and Equality strategy] for trauma informed care to be established across the Maternity Units is further underlined by this finding.



Focus group researchers' feedback

- Service users frequently unaware they had a choice of Maternity Unit
- Choices were more likely related to geographical proximity.
- Antenatal clinics are at times subject to waiting time pressure, but Maternity Units have more positive feedback.
- Free antenatal classes are not readily available across NEL.
- Available antenatal classes are too expensive for most people, costing upwards of £250.
- Absence of Antenatal classes has had a negative effect on confidence.
- Appointments need to be flexible due to traffic and parking issues.
- Cultural sensitivity responses were polarised.
- Home birthing experiences were extremely positive due to more person-centred care **(10 recorded)**
- Parking is an issue at some hospitals most notably at Queens and King George respectively.
- Several service users mentioned a care differential between the first and second/third trimesters. Complex health conditions were at times perceived to be less important when diagnosed in the first trimester. Some service users felt that they were only taken seriously when their pregnancy was considered viable. Issues of gestational diabetes and high blood pressure were mentioned in relation to this differential.

Conclusions and recommendations

We are still seeing an ongoing division in maternity experience relating to health inequality. Due to more sensitive questioning, we can deliver a closer identification of particular communities facing intersectional disadvantage.

Our findings indicate that referral by GP or self-referral correlates to the level of choice and co-production experienced by Maternity service users. Fluency in English is a well-known marker of inequality, and we see this here.

Being a single parent, although now less stigmatised, remains a marker of inequality. Service users from Black African, Turkish, Pakistani and Eastern European communities are less likely to experience choice of maternity unit.

Respondents of Black ethnicities experience a double barrier to maternity care because they are more likely to value cultural symmetry but less likely to experience this. A report published on 18th April 2023 by the House of Commons Women and Equalities Committee on Black Maternal Health highlights the continued effects of health inequalities for Black service users, with a death rate in 2022 at 3.7 times higher than that for White service users. [5]The reports also highlights the impact of severe or multiple disadvantage. Recommendations include a maternity workforce that is properly equipped to understand and recognise the significant disparities that exist, and to use that knowledge to deliver personalised, effective and respectful care.

Polish and Pakistani respondents were less likely to report having access to professionals who speak their language.

Antenatal classes have suffered a pandemic impact. They are no longer widely available free at the point of access, and this might negatively impact service users facing inequality.

Antenatal provision is at times perceived to be rushed and lacking engagement from Maternity Health professionals.

The issues of kindness and empathy were clearly resonant with our previous work on equity and equality, and current action plans are in place to address these areas. Care of service users who have experienced previous baby loss was a regular feature and the already established NEL LMNS Equity and Equality action plan for trauma informed care to be established across the Maternity Units is further underlined by this finding.

[5] https://committees.parliament.uk/publications/38989/documents/191706/default/

Recommendations

- Creating greater awareness of the nature of health inequality across North East London.
- Further research into GP referral structures.
- Further research into self-referral choice mechanisms.
- Management of capacity issues within antenatal provision.
- Clear information about antenatal waiting times and the impact of delayed arrival.
- Training for staff in engagement and empathy (and trauma informed care, particularly for previous baby loss as with the previous equity and equality recommendations).
- Cultural sensitivity training for Maternity staff caring for service users from Black, Polish and Pakistani communities.
- Interpreting services for any service user with less than conversational English.
- Improved parking facilities where a car is the main mode of transport.

Acknowledgments

We are extremely grateful for the contributions and insights made by service users who gave their time to speak to our researchers. Many identified that they wanted to contribute to improving maternity experience in North East London and to have the opportunity to thank staff teams who had cared for them well.

We also appreciate the assistance received from Maternity Units, Patient Experience Midwives, and Maternity Voices Partnerships who facilitated and supported our engagement, including support with community languages and guided our colleagues to service users who had already agreed to be part of the engagement. This was invaluable insight and provision for our research teams.

Healthwatch Redbridge was the lead research team for this project, and you would be welcome to contact us on info@healthwatchredbridge.co.uk or on 0208 553 1236

We are also indebted to our Community Insights System data team, and the Lead Officer Raluca Enescu, for analysing the datasets with multiple axes in considerable detail to allow us to make inferences for this report.

Appendix 3

NHS North East London

Maternity equity and equality

NHS North East London Local Maternity and Neonatal System

July 2022

Equity for mothers and babies

Equity means that all mothers and babies will achieve health outcomes that are as good as the groups with the best health outcomes.

For this, maternity and neonatal services need to respond to each person’s unique health and social situation – with increasing support as health inequalities increase – so that care is safe and personal for all. This will help ensure that England is the safest place to be pregnant, give birth and start parenthood.

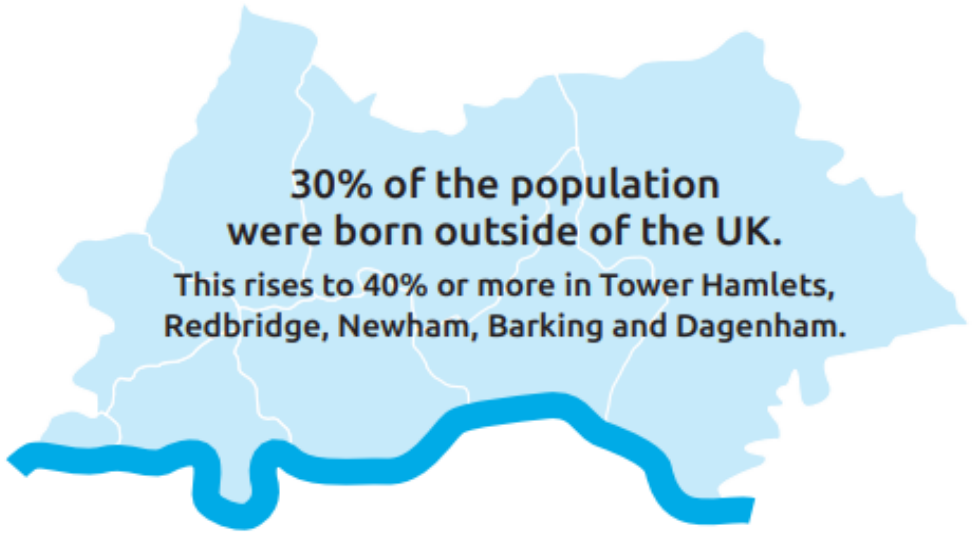
Equity and Equality Needs Assessment process

The Equity and Equality needs assessment has been conducted in direct response to the NHS 2021/22 priorities and operational planning guidance. Supplementing the Local Maternity Transformation plans developed in 2017, following a two-step process:

The two aims:	The two-step process:	Step 1 needs assessment	Step 2 action plan
• equity for mothers and babies from Black, Asian and Mixed ethnic groups and those living in the most deprived areas • race equality for staff	• Step 1 - an equity and equality assessment covering health outcomes, community assets and staff experience • Step 2 - Co-produce equity and equality action plan, ensuring it is aligned with the health inequalities work of Integrated Care Systems	• population needs analysis • outline of our community assets • summary of our staff experience data • approach to co-production	• Co-produce equity and equality action plan, ensuring it is aligned with the health inequalities work of Integrated Care Systems

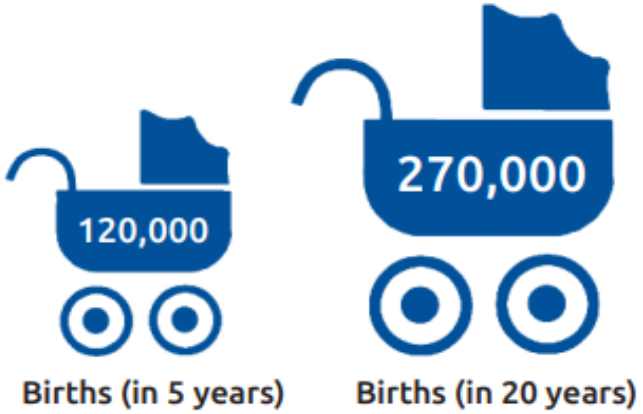
The population of north east London is 2.02 million

Our residents belong to a number of different faiths including **Christianity, Hinduism, Judaism, Islam and Sikhism**



We have the highest birth rate in the UK...

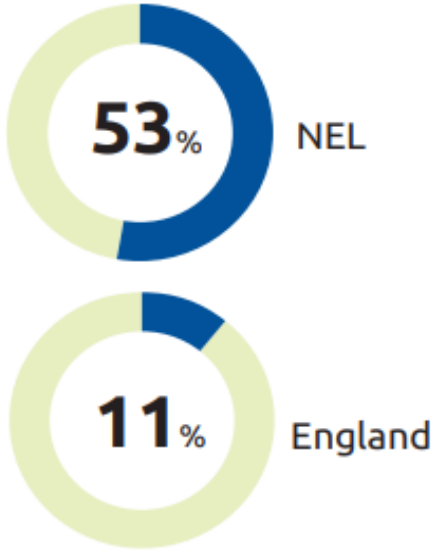
with population expected to grow by 120,000 in the next five years and by 270,000 in the next 20 years. This is equivalent to adding another place the size of Waltham Forest, Havering or Hackney.



Births (in 5 years) **Births (in 20 years)**

‘Our diversity is our strength’

We are the most diverse ICS in the country with over half (53%) of NEL's population identifying as **Black, Asian** or from an **ethnic minority** compared with 11% across England overall.



With the exception of Havering and City and Hackney, all NEL Places have predominantly non-white populations.

Newham is the most ethnically diverse locally and within England with white ethnic groups making up 25% of the population.

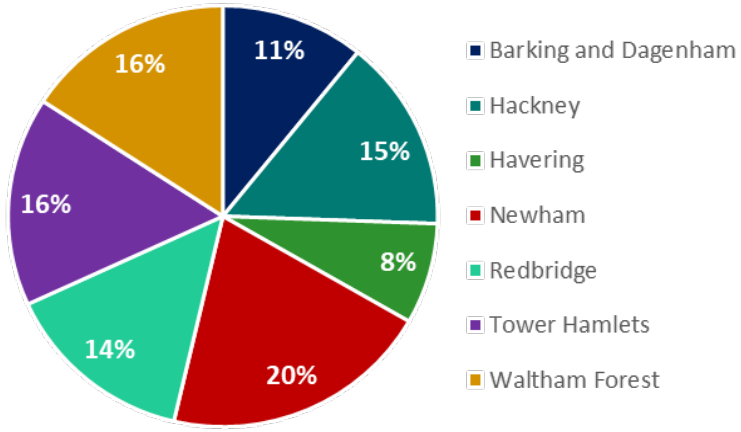
This diversity means that the effects of any inequalities are amplified as they impact more people

There were 25,950 babies born in NEL in 2020/21

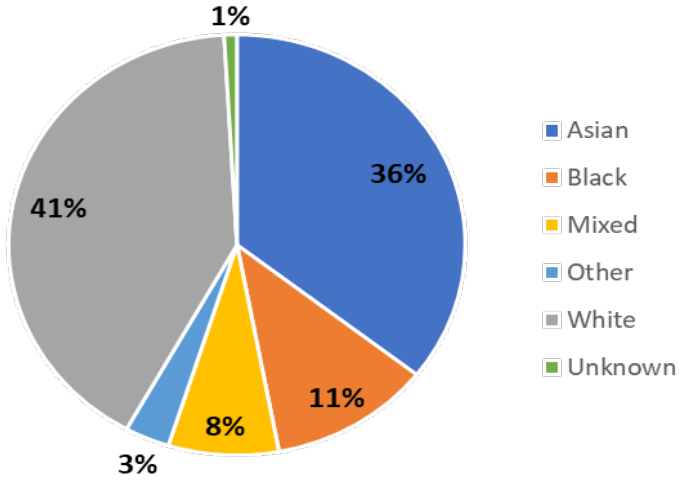
58% of those babies were born to Black, Asian, Mixed and Other ethnicity women

72% of those babies were born to women in two most deprived quintiles

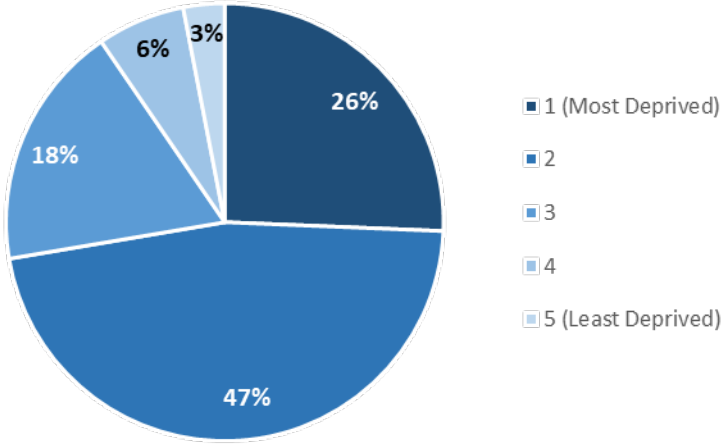
% of babies born by borough in 2020/21



% of babies born by ethnicity in NEL (2020/21)



% of babies born by deprivation quintile in NEL (2020/21)



Source: Hospital Episode Statistics (HES)

Key findings from data analysis (1)

1. The stillbirths among babies born to Black and Asian women are concentrated in 3 boroughs – Hackney, Newham and Waltham Forest - with rates markedly higher than for babies born to White women

2. Babies born to Black and Asian women are more likely to have had a neonatal admission than those born to White women

3. Babies born to Black and Asian women are also nearly twice as likely to have a low birth weight than those born to White women

4. Black women are more likely to have attended A&E during their pregnancy and within 6 months of delivery than White women

5. Women in Black, Mixed and Other groups tend to present to healthcare 2 weeks later into their pregnancy than White women

Key findings from data analysis (2)

6. Black pregnant women are almost twice as likely to be obese than White women

7. Asian pregnant women are more than 3 times - and Black women more than two times –likely to have diabetes than White women

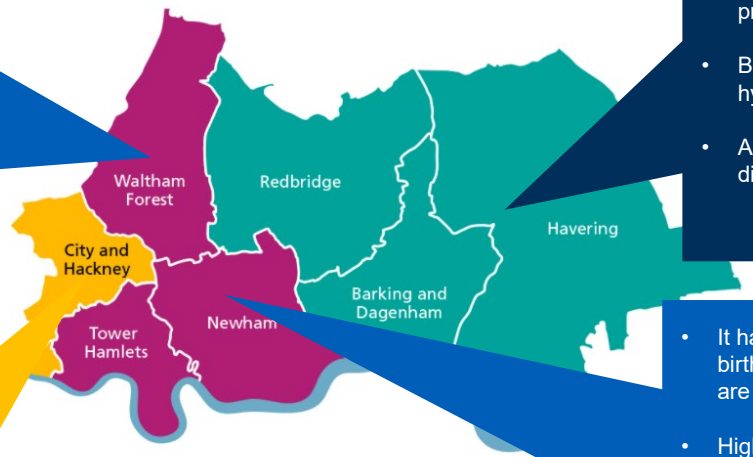
8. Black pregnant women tend to have higher rates of hypertension than White women

9. Black pregnant women are more likely to be out of employment compared with all other ethnicities

Key findings from our analysis – Borough level (1)

- Overall stillbirth rate of 3.4 in 1000 and one of the 3 boroughs in which stillbirths to Black and Asian women are concentrated
- Babies born to Asian (10%) and Black (11%) women twice as likely as babies to White women (5%) to have a low birth weight.
- Black women (16%) **twice as likely** than White women (**8%**) to have had an unplanned C-section
- Black and Mixed women tend to present to healthcare services c.4 weeks later into their pregnancy than White women.
- Black, Asian and Mixed women more likely than White women to have attended A&E or been admitted to hospital with 6 months of delivery than White women
- Black and Mixed women are two times more likely that White women to be obese and Black women twice as likely to have hypertension

- Overall still birth rate of 3 in 1000 It was one of the 3 boroughs in which stillbirths to Black and Asian women are concentrated
- Babies born to Black (14%) and Asian (15%) women nearly three times as likely than those to White women (5%) to have a low birth weight
- Babies born to Black women (20%) twice as likely to be admitted to neonatal care than those to White women (**10%)**
- More than half of women admitted to hospital during pregnancy with rates much higher among Black (65%) than White (50%) women
- Highest average rate of planned C-section across NEL (26%) with rates much higher for Black (37%) and Asian (30%) women than for White (22%)



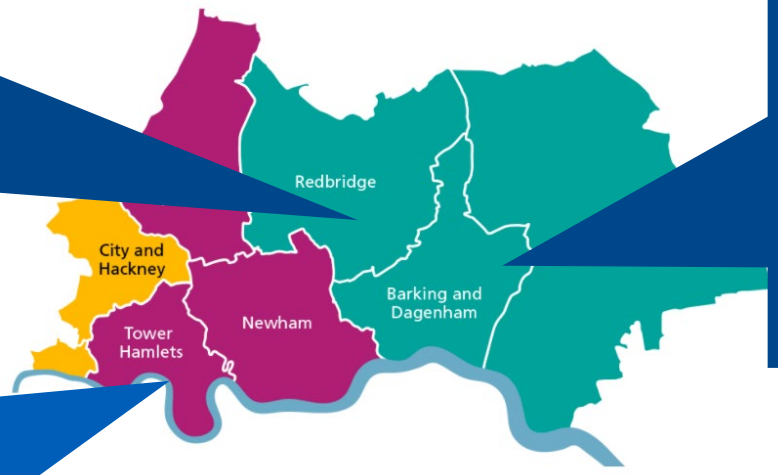
- Overall stillbirth rate of 1 in 1000 and lowest in NEL
- Has the highest average rate across NEL of women having an unplanned C-section (24%) with rates for Black (32%) and Asian (28%) women are markedly higher than for White women (22%)
- Black women tend to present to healthcare services c.4 weeks later into their pregnancy than White women.
- Black women (11%) more than twice as likely as White women (5%) to have hypertension
- Asian women (25%) more than twice as likely as White women (10%) to have diabetes

- It has one of the highest rates of stillbirths across NEL at almost 5 in every 1000 births and one of the 3 boroughs in which stillbirths to Black and Asian women are concentrated.
- Highest rates in NEL of stillbirths among Black, Asian and Other ethnicity women (**6.5 per 1000** among Asian women, **9 per 1000** among Black women, and **12.7 per 1000** among Other ethnicities)
- It has the **highest average proportion** of women giving birth to babies with **low birth weight** in NEL (c.1 in 10)
- Black and Mixed women tend to present to healthcare services more than 4 weeks later into their pregnancy than White women.
- Has among the largest disparities between Black and White women in attending A&E during pregnancy (and the largest average rate across NEL overall). Also has one of the largest disparities between Black, Asian and White women in diabetes prevalence

Key findings from our analysis – Borough level (2)

- Overall stillbirth rate of 2.5 in 1000
- Babies born to Asian (37%) and Black (34%) women much more likely those born to White women to be admitted to neonatal care (25%)
- Black women are twice as likely and Asian women are three times more likely to have diabetes than White women.
- Black women (9%) are three times more likely than White women (3%) to have hypertension
- Black women (35%) are much more likely to be obese than White women (20%)

- Highest overall stillbirth rate in NEL at 6.2 in 1000 and is based mainly by stillbirths to White women and those Unknown ethnicity – who have a very high rate at 12 per 1000 births
- Babies born to Black (12%) and Asian (11%) women are **twice as likely** to have a low birth weight than those born to White women (**5%**)
- It has one of the largest difference in rates between Black (42%) and Mixed (40%) women compared with White (26%) women attending A&E during pregnancy
- It is has the **highest** average rate across NEL of women attending A&E with 6 weeks as well as 6 months after delivery (7% and 10%)
- It has the highest average rate across NEL of diabetes prevalence (**21%) and has one of** the largest differences in rates between Asian (28%) and Black (19%) women compared with White women (**7%)**



- Overall stillbirth rate of 2.2 in 1000
- Second highest average rate across NEL of babies admitted to neonatal care (40%)
- Black women twice as likely than White women to have attended A&E and been admitted to hospital within 6 months of delivery
- Second highest average rate across NEL of women having an unplanned C-section (23%) with rates higher among Black (29%) and Mixed (29%) women compared with White women (21%)
- Mixed ethnicity women tend to present to healthcare services c.4 weeks later into their pregnancy than White women.
- Highest average prevalence rate of obesity (27%) across NEL with rates for Mixed (45%) and Black (35%) women markedly higher than among White women (25%)
- Prevalence of hypertension twice as high among Black and Mixed women compared with White women

Community asset mapping with Maternity Mates

- Mapping organisations and services that might support women during pregnancy
- Co-ordinating with organisations and key partners, e.g. social prescribers, to share resources where possible.
- Using the insights to enhance and streamline the community assets mapping:
  - Boroughs
  - Type of support provided e.g. DV, immigration, cultural/language, refuges, children's centres
  - Contact details (where possible)
- Identify gaps in borough provision of community assets and recommendations as part of the strategy

Co-production with Healthwatch

- Using existing insights and intelligence from Community Insight System, identifying support needs and staff attitude are key themes of maternal experience
- Utilise strong relationships with community and voluntary organisations, including Maternity Voices Partnership, to promote this work and reach communities that are ‘seldom heard’.
- Customise approach to engagement in order to facilitate preferred methods, to include enter and view approach, one-to-one interviews and online surveys.

Timeline

Engagement and community asset mapping	Analysis and reporting	Strategy and action plan	Submission and implementation
• Healthwatch engage with maternity stakeholders including voluntary and community groups through interviews and surveys • Maternity Mates collate and work with voluntary organisations on identifying community assets	• Healthwatch collate all data and report Borough findings to produce a NEL wide report on key themes and recommendations • Using the data collated in the needs assessment and community assets identified in mapped exercise, Maternity Mates to provide gap analysis of services	• Using the key themes, recommendations and gap analysis identified in previous step, working with senior midwives and maternity unit colleagues to plan strategy and draft 5-10 actions that can be implemented across NEL to improve outcomes and experience, with local adaptions where necessary	• Submit final strategy and action plan to NHSE by 30 September with a clear implementation plan for improvements over the next five years.
June and July	August	August and September	September