St George's, Epsom and St Helier University Hospitals and Health Group

Epsom Hospital
Dorking Road
Epsom
Surrey, KT18 7EG
www.epsom-sthelier.nhs.uk
Tel: 01372 735 735

Re: Healthwatch Maternity Experience work 2025

28 August 2025

Private and Confidential

Sent via email: pete@healthwatchsutton.org.uk

Dear Pete,

I am responding to the Healthwatch report you shared on 31 July 2025 outlining the experience of residents of the London Borough of Sutton in relation to maternity services at St Helier Hospital.

Thank you to you and your team for your time and engagement undertaking this work and for sharing your findings with us. Please accept this letter as our formal response to the report received.

Background

ESTH were first approached by Healthwatch in December 2024 to explore, via qualitative research, the experiences of maternity service users within Sutton. Sam London (Communications and Engagement Officer, Healthwatch Sutton) met with Annabelle Keegan (Director of Midwifery, ESTH) on a number of occasions. An initial briefing was discussed and the suggested topics for focus groups are outlined below:

- Being left alone while at St Helier maternity unit or birth centre
- Being listened to
- Communication and understanding, particularly of medical tests needed before discharge from hospital
- Discussions after labour, including a chance to ask questions
- Being given information on baby vaccinations
- Unsympathetic/unempathetic treatment by staff

After discussion, it was agreed to explore the 5 themes that came through the CQC Patient Survey 2025 as needing some improvement work. These themes are listed below:

- What do you wish you had known or been informed about before you went into labour.
- What was your experience in labour?
- When did you receive information about pain relief?
- What do you wish you had known/been told before you had your baby/went into labour?
- Postnatal – up to 6 weeks after labour:
    - What support and information were you given in the 6 weeks after you had given birth. Who gave you this information?
    - Did you receive any advice/support on feeding your baby?
    - Did you receive any advice/support on any mental health concerns?

I think it is important to recognise that Epsom and St Helier University Hospitals NHS Trust (ESTH) have received the highest positive feedback across all maternity services in the region for two consecutive years however, the Trust's Maternity senior leadership team recognise it is vital to learn from the themes identified as areas for improvement. Further detail is included in the next section in relation to the Trust actions underway.

Recommendations and Next Steps

The report is welcomed and the recommendations are acknowledged. Whilst it is worth noting that these findings represent a very small sample of the individuals who access maternity services at ESTH, work continues to address the recommendations and areas of improvement identified.

The report outlines 5 recommendations:

1. Being left alone
2. Not being listened to
3. Not being given a choice
4. Conflicting advice from midwives and consultants
5. Understanding of tests on baby (including Tongue-tied.)

The report also outlines 5 potential areas of improvement:

1. Unsympathetic/lacking empathy
2. Discussion after birth
3. Aftercare, including care of stitches
4. Finding support after leaving hospital, including feeding support
5. Information on vaccinations.

In order to address the above points and to progress ongoing improvement, in line with the objectives in the 3 Year Delivery Plan, the ESTH Maternity team continues to work collaboratively with Maternity and Neonatal Voice Partners (MNVP), the Integrated Care Board (ICB) and Local Maternity and Neonatal System (LMNS.)

Furthermore, the Maternity leadership team (which comprises of a Director of Midwifery, Head of Midwifery, four Clinical Matrons, three Consultant Midwives, and Specialist

Midwifery roles) support safe staffing, safety, and quality on a daily basis. Additionally, the service receives support from obstetric, medical and operational colleagues.

Key areas of work include:

- **Personalised Care:** the effective use of personalised care plans continues to be reviewed. These care plans are built into Badgernet (the electronic system used in Maternity) to ensure the provision of holistic and individualised care. The teams continue to strengthen their personalised care planning, including providing care outside of guidance, to ensure women are supported to make an informed choice.
- **Global Majority Service User Support & engagement:** the Maternity Transformation lead continues to facilitate focus groups for ethnic minority groups and improvement has been seen over time. Output from these groups feeds into guideline and policy review work in Maternity. Work is also progressing to implement the Capital Midwife anti racism framework and the Trust website is currently under review to strengthen access to information in different languages and formats.
- **Patient Survey Action Plan:** ongoing collaboration continues between the maternity team and the Maternity and Neonatal Voices Partnership (MNVP) to co-produce an action plan focusing on the areas of the patient survey which scored the lowest. This includes improving information shared surrounding place of birth, induction of labour and maternal mental health.
- **Advice and Information:** work is ongoing to improve the maternity website as well as explore other media platforms. Many women have said they prefer written information over digital/links and therefore the team are also considering whether it would be feasible/affordable to provide a resource such as the NHS Pregnancy Book.
- **Safe Staffing:** the maintenance of the 100% target of one-to-one midwifery care in labour is a key safety metric. A twice daily internal SitRep monitors the provision of this and there is a clear escalation process within maternity to ensure women receive one-to-one care in established labour. The service also now has dedicated theatre nurses in post who can care for women in recovery post caesarean section; this is freeing up our midwifery workforce to focus on care in labour.
- **Care Quality Commission (CQC) Action Plan:** the CQC action plan included 8 Must Do actions which have all now been marked as complete. To note: work to our estates remains ongoing.

To ensure complete oversight of all actions within maternity a unified plan with tracker has been developed to form the basis of review from ward to board. I hope this information has provided a helpful overview of the work underway which aims to address the recommendations/areas of improvement outlined in your report.

Working with Healthwatch provided our Maternity team with the opportunity to understand the themes identified in more depth. We would welcome your support, as offered, with relevant upcoming initiatives.

Yours sincerely,

Alex Shaw

Chief Operating Officer - ESTH

on behalf of

James Blythe

Managing Director - ESTH