**GOVERNING BODY**

<table>
<thead>
<tr>
<th>Agenda Item No.</th>
<th>07</th>
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<tr>
<td>Reference No.</td>
<td>IESCCG 19-39</td>
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<tr>
<td>Date.</td>
<td>23 July 2019</td>
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**Title**

Maternity Transformation Programme Overview

**Lead Chief Officer**

Lisa Nobes, Chief Nursing Officer, Suffolk CCG’s

**Author(s)**

Helen Bowles, Maternity Programme Manager

**Purpose**

To present an overview of the Maternity Transformation Programme

**Applicable CCG Clinical Priorities:**

1. To promote self care
2. To ensure high quality local services where possible
3. To improve the health of those most in need
4. To improve health & educational attainment for children & young people
5. To improve access to mental health services
6. To improve outcomes for patients with diabetes to above national averages
7. To improve care for frail elderly individuals
8. To allow patients to die with dignity & compassion & to choose their place of death
9. To ensure that the CCG operates within agreed budgets

**Action required by the Governing Body:**

The Governing Body is asked to note the report.
1. **Introduction**

1.1 Maternity and neonatal services were subject to a national review during 2014/15; resulting in the five year forward view for maternity services being produced (named Better Births). Further guidance related to the reducing maternal and neonatal deaths, prematurity, and birth complications was issued. Three significant documents were published:

- Better Births - Improving maternity outcomes - Five year forward view for maternity services 2016
- Saving Babies Lives care bundle 2016
- NHS Improvement Neonatal Health and Safety Collaborative Programme 2017

1.2 The targets within these documents have been brought together to formulate the **national maternity transformation programme**. The programme must be implemented at a system level, to ensure consistent levels of provision and outcomes.

1.3 It is a complex programme of work with challenging targets within now relatively short timeframes. This programme requires significant transformation input and monitoring, to ensure the Suffolk and North East Essex Local Maternity System (LMS), the ICS and NHSE are assured of delivery, in a timely and safe manner.

2. **Why? - Outcomes for our Population**

2.1 The transformation programme has a number of intended outcomes for our population:

2.2 The predicted clinical outcomes of implementing the national programme are significant, with a likely:

- **50% reduction** in stillbirths, neonatal deaths, maternal death, and babies born with brain injuries;
- **16% reduction** in pregnancy loss, and **24% reduction** in pre-term birth.

2.3 Less invasive and intensive interventions during births are also expected to increase because of the transformation. So women will be less likely to require local analgesia/epidural (**15% reduction**) or an episiotomy (**16% reduction**), both of which can delay women from returning to normal activities.

2.4 **Women will be more likely** to have a home birth or midwife led care.
2.5 Most importantly, it should **improve the care experience** for women during pregnancy and birth, and the health outcomes for the child and mother postnatally.

2.6 Locally, the care pathways currently being developed are also aimed at achieving:

- Higher breastfeeding rates
- Improved smoking cessation
- Improved diabetes prevention
- Improved communication about safeguarding concerns and issues
- Improved emotional wellbeing and support networks

2.7 These outcomes could provide meaningful changes to the people living within our system. The **possible** societal impact of these outcomes could include:

- less children who require SEND and continuing care input
- healthy and supported parents
- less emotional and physical stress on families due to positive pregnancies and birth outcomes
- parents who can return to work instead of needing to stay at home to care for a child with long term conditions/complex disabilities,
- improved educational attendance and attainment due to less children with long term illnesses or brain injury, and
- ultimately, more children who can develop into healthy adults, who can access employment, support their community and bring families of their own into the world.

2.8 There will be potential monetary savings through less extensive interventions during the baby’s birth.

The costs of individual interventions are as follows:

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Cost per woman 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epidural</td>
<td>£1200</td>
</tr>
<tr>
<td>neonatal stay per 24 hours (for pre-term birth)</td>
<td>£284</td>
</tr>
<tr>
<td>normal hospital delivery without epidural</td>
<td>£4321</td>
</tr>
<tr>
<td>normal home delivery without epidural</td>
<td>£2514 (financial saving of £1807)</td>
</tr>
</tbody>
</table>

2.9 To put this into perspective in 2018/19 we had 8674 births (excluding One to One births) within the ICS population, with the following breakdown of birth locations:
2.10 A 5% increase in home births would offer a potential £783,696 saving as well as enabling women to birth in a natural, familiar and relaxing environment.


3.1 The clinical outcomes mentioned above are obviously broken down into a set of deliverables (see Appendix A for detailed list), which are based on evidence based practice and learning from pioneer sites.

3.2 The transformation programme requires current pathways and working patterns to be radically changed. Co-production is essential in all areas of the transformation, co-produced with our workforce and users. There are three Maternity Voice Partnerships (MVP), one per Alliance, who represent families and users of the services. The MVP’s are proactive in their own right, but also have a seat at the LMS Board, and are actively involved in the entire transformation programme. Supporting the main work streams detailed below are task and finish groups focussed on workforce planning and development, engagement, digital, outcome evaluation framework, and estates.

3.3 The main pillars of the transformation programme are:

<table>
<thead>
<tr>
<th>Personalised Care</th>
<th>Continuity of Carer</th>
<th>Safety</th>
<th>Postnatal Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% women to have Personalised Care Plans by March 2021</td>
<td>100% women to have the same/buddy midwife throughout the pregnancy, birth and postnatal care by March 2025</td>
<td>50% reduction still, neonatal deaths, maternal deaths and brain injuries births by 2025</td>
<td>Postnatal improvement plan by October 2019</td>
</tr>
<tr>
<td>Dynamic Digital maternity record will provide unbiased information to inform care planning, and to enable women to make informed choices about their care</td>
<td>20% by 03/19</td>
<td>Implementation of the Saving Babies Lives bundle by 2020</td>
<td>Investment in perinatal mental health services</td>
</tr>
<tr>
<td></td>
<td>35% by 03/20</td>
<td></td>
<td>Postnatal care resourced appropriately, including midwife care up to 28 days post</td>
</tr>
<tr>
<td></td>
<td>50% by 03/21</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>100% by 03/25</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Each team of</td>
<td></td>
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</table>
Women to be informed about their choice of care provider and location of birth

Community hubs available to meet with midwives and other appropriate services by March 2020

midwives to have an identified obstetrician

Neonatal care transformed through the Critical Care Review recommendations

National standardised investigation process

Clinical outcome review and continuous improvement

Local Learning Systems established to review and improve practice

birth

Seamless pathways for transition to health visiting and specialist services

4. **How? – Programme Delivery and Risks**

4.1 A programme plan is in place to track delivery of all milestones. Progress is monitored monthly by the LMS Board, and reported within the programme highlight reports to STP Board.

4.2 The LMS provides bi-monthly assurance to the regional NHSE team, by assessing our achievement against the key deliverables. **SNEE is currently is on track with all deliverables.** There are however some risk to delivery:

a) **Continuity of Carer (CoC)**

Continuity of Carer requires a higher ratio of midwives:women. Whilst investment is required into the additional workforce, there will ultimately be savings to the system when the system and clinical outcomes (described above) are achieved.

NHSE has commended SNEE LMS for its innovative and sustainable approach to rolling out CoC. The LMS funded a CQC recognised workforce planning tool to enable the three maternity units to analyse their acuity of care, and subsequent workforce needs. However, the service model needed to be implemented before the planning tool could report on its recommendations. Six engagement events were therefore held across the ICS to engage with the maternity workforce, medics and service users to gain ideas of how the model could be implemented. The events recommended which services would become the early implementers, and volunteer midwives were recruited to deliver the teams. The LMSB made a decision to provide short term investment to enable the additional midwife hours to be resourced. During the period of funding, the model will be evaluated and cross referenced to the workforce planning tool, to enable the LMS to inform commissioning intentions and business planning cycles for 2020/21. The midwives from the early implementer teams (wave 1) have become champions of the model and are working with midwifery colleagues to develop the next wave of teams.

A National data collection exercise was completed in March 2019 to evidence whether the target of 20% of women receiving continuity of care for them during pregnancy, birth and postnatally had been attained. SNEE achieved 34%; however, this included a large number of women moved across onto the pathways during March 2019. If these women were extracted from the data, the overall average was 9%. This is line with the majority of LMS across the country.
The next target (articulated in the NHS Long Term Plan), is to achieve 35% of women by March 2020. The LMS are developing plans for the wave 2 teams to enable sufficient increase in women receiving CoC care, from 9% to 35% by March 2020. This is a huge challenge. Again, the LMS has agreed to fund backfill for all three maternity sites to assist in achieving this steep increase during 2019/20. However, substantive money will need to be found to fund these additional staff members.

It is also unknown whether there are sufficient numbers of trained midwives available within the economy to increase the workforce by the required amount. The Midwifery Support Worker role is being expanded to facilitate the model, but the specialist nature of the care is predominantly dependent on qualified midwives coming into post. The LMS is supporting the Heads of Midwifery to develop workforce development plans to establish how (as a system) we can attract sufficient midwives to our area.

b) Saving Babies Lives audit

Saving Babies Lives is focussed on delivering services in a manner that can reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries. It concentrates on:

- reducing smoking in pregnancy,
- risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction
- raising awareness of reduced fetal movement,
- effective fetal monitoring during labour.
- reducing preterm birth (new requirement added in March 2019)

Process and outcome indicators accompany all five elements. The LMS was required to submit a clinical audit to NHSE/I in March 2019. The feedback indicated that the LMS was considered to require “support” to achieve a consistent provision across the LMS. An LMS action group is under development to respond to the audit feedback, and to address the additional Saving Babies Lives requirement of reducing preterm birth. All LMS’ must be compliant with the entire care bundle by March 2020. It is unknown whether investment is required into this area of practice. For example, WSFT have not been able to provide the additional level of scanning resource required to deliver the new pathway. To enable compliance and improving outcomes investment may be required in both capital and revenue resource. Resource requirements will be scoped within the action planning process.

c) Digital Maturity

Better Births states that a digital maternity tool should be in place to implement the following:

- Digital access to unbiased information to enable the service user to make informed decisions
- A dynamic electronic care plan, kept up to date as pregnancy progresses
- Service user access to their own maternity record, and ability to update it
- Information on local services
- Data collection on quality, outcomes and performance
- Enable smooth transition and sharing of information between midwife, obstetric and neonatal care, and ongoing care in the community from their GP and health visitor.
The digital tool will underpin the personalised care and choice agenda, with the ultimate aim of providing patient centred care, and increasing the number of women giving birth in a midwife led setting. It is therefore a critical tool to enable the transformation programme to be realised.

Currently within the LMS, there are varying levels of technology used within the maternity services:

- Colchester Hospital site have Medway electronic record,
- Ipswich Hospital use paper records and have hand held notes,
- West Suffolk Hospital use paper records and have hand held notes, but have plans to roll-out e-Care within 2019/20, and
- One to One have a bespoke electronic record insitu.

The LMS procured an impartial assessment of our digital readiness to achieve these milestones. It recommended that:

- Ipswich Hospital site to adopt Medway electronic notes system in line with its sister site and introduce an archiving system for CTG/scans
- Investment is made into IT equipment to enable midwives to be delivering the required models of care in the community
- ICS digital developments are progressing, but are not quite ready to provide the required platforms to enable the digital maternity needs to be met. An APP will therefore be used for three years to enable progress be made on personalised care planning.

The APP (and 3 year maintenance plan) has been purchased by the LMS. The remaining actions are the responsibility of the provider trusts. The Director of Midwifery is undertaking internal discussions to establish whether funding can be assigned to these essential tools.

5. How? – Resources and Assurance Frameworks

5.1 Financial Plan for 2019/20 (See appendix C for Full Plan)

The financial plan has been focused on trying to achieving the higher priorities/mandatory targets and highlighted risks within the four pillars:

<table>
<thead>
<tr>
<th>Area of Spend</th>
<th>Amount</th>
<th>Pillar</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuity of Carer</td>
<td>£602,000</td>
<td>Continuity of Care</td>
<td>Extension of the original ESNEFT wave 1 teams from six to 12 months (8wte) Wave 2 teams at ESNEFT and WSFT (7wte) (Oct 19 – Mar 20).</td>
</tr>
<tr>
<td>Mum and Baby App</td>
<td>£54,500</td>
<td>Personalisation</td>
<td>To achieve two national deliverables, and immediate start to introducing the choice agenda for women within SNEE.</td>
</tr>
<tr>
<td>Co-Production</td>
<td>£33,000</td>
<td>All Pillars</td>
<td>Support the three Maternity Voice Partnerships to actively engage with families, and to take a lead role in service transformation.</td>
</tr>
<tr>
<td>Whose Shoes</td>
<td>£15,000</td>
<td>All Pillars</td>
<td>Continuous improvement tool, an essential element of the maternity programme</td>
</tr>
<tr>
<td>Engagement</td>
<td>£4500</td>
<td>All Pillars</td>
<td>To engage with women &amp; families to promote the changes made, to promote healthy pregnancy messages, and promote the choice agenda</td>
</tr>
<tr>
<td>Programme Leadership</td>
<td>£157,000</td>
<td>All Pillars</td>
<td>Clinical lead posts (see below), programme manager, and an admin post (to be recruited summer 2019).</td>
</tr>
<tr>
<td>Alliance Project Leadership</td>
<td>£50,000</td>
<td>All Pillars</td>
<td>Part-time project management within the Alliances to ensure localised implementation of the programme, to co-ordinate Alliance maternity forums, and address localised performance.</td>
</tr>
<tr>
<td>Total</td>
<td>916,000</td>
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</table>
5.2 Maternity transformation would like to work with ICS partners to establish whether the following critical areas of transformation could be funded. There was insufficient funding from NHSE to cover these areas, but they are seen as key to achieving the ambition of providing the best start in life for our population.

<table>
<thead>
<tr>
<th>Area</th>
<th>Funding</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal Care</td>
<td>£15,000</td>
<td>Safety Clinical lead for one day a week to interpret new national guidance and inform action planning.</td>
</tr>
<tr>
<td>Postnatal Care</td>
<td>£6000</td>
<td>Postnatal Care To purchase equipment, training or for a deep dive exercise to be completed.</td>
</tr>
<tr>
<td>CoC Related equipment</td>
<td>£100,000</td>
<td>Continuity of Care Clinical and IT equipment necessary to deliver the service</td>
</tr>
<tr>
<td>Saving Babies Lives</td>
<td>TBC</td>
<td>Safety TBC following gap analysis</td>
</tr>
<tr>
<td>Healthy pregnancy schemes</td>
<td>TBC</td>
<td>Safety Multi-agency working to promote healthy living during pregnancy and reduce negative outcomes i.e. weight management, smoking cessation, wellbeing</td>
</tr>
<tr>
<td>Post Birth contraception</td>
<td>TBC</td>
<td>Safety To support women vulnerable of becoming pregnant shortly after birth by offering early contraception advice and implants</td>
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</table>

5.3 **Strategic and Clinical Leadership**

The Local Maternity System Board (LMSB) was established in 2017. It is the strategic vehicle for maternity transformation and quality improvement, with key stakeholders represented. It seeks assurance that the national transformation programme is delivered locally, and to the quality standard that is required for our residents. The LMSB oversees the programme but will also gain its assurance from the Alliances to ensure service developments are implemented, and embedded within local services. Each Alliance has an executive lead and senior responsible officer for the programme.

The programme is clinically led. The Chief Nurse (Suffolk) is SRO. A full time senior midwife and obstetrician (1 day per week) were appointed in October 2018. They are responsible for moving the transformation agenda forward, setting the ambitions for maternity services, and assisting the system learning and development. A part-time programme manager (0.6 wte) supports the clinical leads and SRO to manage the transformation programme, and provide assurance of accountable organisations.

The three Alliances will have maternity forums, where local performance, learning, and transformation delivery will be addressed for the population served. The LMS Board will set the vision and overarching transformation programme. The Alliances will implement and embed the programme, and need a forum to resolve local issues, and ensure the correct allocation of resources according to their population’s needs. The Alliances will therefore develop local maternity delivery plans, providing assurance of delivery to the LMSB, and to their individual Alliance governance frameworks.

This work has begun through the creation of a ‘Healthy Pregnancy Plan for Suffolk and North East Essex’ with the support of Public Health Suffolk. The plan’s priorities are to:

- Support good maternal and paternal health
- Promote best start in life for babies
- Increase safe deliveries and good birth weight
- Prevent adverse health factors in pregnancy
5.4 **Quality and Continuous Improvement Leadership**

In line with the national neonatal Health and Safety Collaborative programme a Local Learning System (LLS) forum has been developed. The group reviews maternity and neonatal care, enabling learning to be shared across the system, and quality improvements to be made.

All programmes of work have a continuous improvement methodology incorporated. MVP groups are championing the review of initiatives, and working their respective Alliance colleagues to address any changes that are required.

A Serious Incident/near miss group has also been established, led by the Obstetrics clinical lead. All providers discuss Serious Incident/near misses, and share the learning and actions they have taken as a result. This will enable good practice to be adopted across the whole LMS, and enable consistent care and quality levels to be achieved.

**Maternity Transformation Programme Assurance Framework**

- Family & Friends testing
- Complaints and Serious Incidents
- Number of babies requiring therapeutic cooling
- Smoking rates in mothers
- % normal vaginal deliveries vs % c-sections
- No. of stillbirths
- No. of neonatal and maternal deaths

The clinical leads and public health will develop the current evaluation framework to ensure it is robust, and provides sufficient information to support the continuous improvement of services, as well as the overarching maternity transformation programme. The local evaluation framework will directly link into the regional reporting framework to NHS England.

6. **Conclusion**

6.1 Robust clinical leadership and programme governance arrangements are in place, work streams are embedded and delivering, and the financial plan has been submitted for approval from NHSE. However, extensive work is still required to deliver the remaining milestones/service developments. This will require investment from the entire system and is therefore a significant risk.
Maternity Transformation programme overview
In Suffolk & NEE:
A baby is stillborn every 10 days, and
A newborn baby dies every month.
Nationally, in 2014-16 9.8 women per 100,000 died during pregnancy or up to six weeks after childbirth in the UK.
Better Births and the Maternity Transformation programme aims to improve health outcomes for babies and women
What do we want to achieve?

50% reduction in stillbirth, neonatal death, maternal death and babies born with birth related brain injuries by 2025

16% reduction in pregnancy loss and 19% reduction in women losing their baby before 24 weeks

24% reduction in pre term birth

15% reduction in women requiring regional analgesia

16% reduction of episiotomies
Programme Outcomes

• Informed and empowered women
• Community focused care
• Healthy pregnancies
• Less birth complications
• Healthy start for babies and children
• Co-produced and continuously improved services
• Reduce inequalities
Population Outcomes

- Better outcomes for children giving them the best start in life.
- Healthy and supported parents
- Less emotional and physical stress on families due to positive pregnancies and birth outcomes
- Improved personal financial positions for families.
- Improved educational attendance and attainment for children and young people allowing them to reach their potential
- Ultimately, more children who can develop into healthy adults, who can access employment, support their community and reach their potential.
National cost of maternity claims

Total value of clinical claims received £4,370.3m

50% Obstetrics
16% Miscellaneous
8% Paediatrics
8% Casualty/A&E
3% Orthopaedic surgery
3% Neurosurgery
2% General surgery
2% General medicine
2% Radiology
5% Gynaecology
2% Ambulance
8% Other (aggregated specialties)
Addressing the population needs within Suffolk and North East Essex

The population’s demographics and health profiles directly impact on pregnancy outcomes. The majority of these are avoidable:

• 11% of pregnant women in our STP (nearly 1000), smoked during their pregnancy and at the time of delivery in 2018/19.

• Nearly half (48.6%) of pregnant women have a BMI over 25 (overweight) or 30 (obese) at the time of their first maternity appointment.

• 5 in every 100 expectant women develop gestational diabetes, who did not have diabetes before their pregnancy.

• Over half (52.6%) of women giving birth are aged 30 or over; with the proportion of women having their first baby after the age of 40 being higher than the proportion having their first baby before they were 18.

• Up to 20% of women develop a mental health problem during pregnancy or within a year of giving birth.
Impact of diabetes

- 32% of babies of diabetic mothers admitted to NNU
- 18% Ipswich
- 27% W Suffolk (2014-2016 data)

Recurrence rates for gestational diabetes vary between 30% and 84% after the index pregnancy, and the recurrence rate is about 75% in women with a history of insulin- treated gestational diabetes (NICE Section 4)

- epidemiological data showed that the incidence of type 2 diabetes increased most rapidly in the first 5 years after pregnancy.
What is the future model of maternity care?

- Continuity of care
- Personalised care
- Safety
- Postnatal care
- Proactive & innovative care
LMS MVP involvement
Why is continuity important?

Would you choose to see a different dentist every time?

Would you choose to see a different hairdresser every time?
How are we improving safety?

• Continuity of carer
• Targeted smoking cessation support to reduce smoking in pregnancy
• Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR)
• Raising awareness of reduced fetal movement (RFM)
• Effective fetal monitoring during labour
• Reducing preterm birth
Innovation for health improvement

Joint development of ‘Healthy Pregnancy Plan for Suffolk and North East Essex’ with the support of Public Health Suffolk

• Smoking cessation
• Weight management
• Exercise programmes
• Wellbeing services
• Counselling for previous loss or trauma
• APP based information
• Pre-conception advice
• Contraception
• The need for preconception care: 45% of pregnancies are unplanned or associated with feelings of ambivalence
• Planning pregnancy, promoting healthy behaviours and reducing risk factors are important for improving pregnancy outcomes
• Early contraception for vulnerable women
Our business is birth

We aim to offer true choice for all women across the LMS

Women want information  Reputation counts

#CanDoHealthandCare
How are we delivering this change in practice?

- Multi-agency approach
- Co-production with service users and workforce
- Delivering innovative models of care
- Workforce planning
- Financial support
- Quality and continuous improvement leadership
- Humanistic framework
- Sustainability at the forefront of change
Feedback and evaluation
Anna’s story

Two and a half years ago I had a traumatic assisted delivery at CHUFT which left me with a beautiful healthy baby boy, but a grade 4 tear and significant post partum haemorrhage. It took me months to recover. We were told then that any future children would need to be delivered by caesarean section.

I became pregnant again late last year. When I arrived in triage for my pre-op I was incredibly nervous to even be in the building again. I can not convey to you enough how wonderful Denise (midwife) and the whole team were on that day, putting us at ease and explaining everything.

On the day of our caesarean section Denise and the whole team were wonderful and made our section and daughters birth so special, we felt safe and cared for throughout. The continuity of having one main person care for us was the main factor in this, we completely trusted her and she was wonderful!

I was home within 24hrs after the lovely Zelia and the obstetrician had check us over. A few days later we had a follow up call from Denise to check I was fine and recovering well.

Working for the NHS myself, I am fully aware on the constraints placed on services, and I would therefore like to congratulate you on achieving what felt like gold standard care within what I am sure are very limited resources.

We will be forever grateful to Denise and the Venus team for giving us a wonderful birth experience.

Changing an operation to a birth experience
What families say

“polite, kind and professional”

“Excellent communication”

“I actually got to meet the people looking after me which made me feel much more confident about the whole procedure”

“Having the continuity and knowing they were there throughout was great”

“Knowing on the morning of my birth that I was going to be met by the same midwife I’d met the day before took away all my nerves”

“five star service”

“I felt heard”

“I have had three sections and this was my best by far due to the care I had with these fabulous ladies”

“You will never know how much you turned an extremely scary time, in to a time we felt very well supported - Thank You”

“I felt fully updated throughout”

“What a wonderful new service”

“I felt relaxed and in control and much less stressed with this amazing new team”

“...always have a smile on their faces”

“Everyone was extremely helpful and friendly”

“Brilliant care”

“Hope the team continues to be there for others, so they can have the same experience as I have”

“highly recommended”

“Everyone was so nice and helpful”

“All staff have been amazing”

“Glad I had my baby with this wonderful new service”

“made to feel at home”

“Very efficient and well organised”

“I had my baby the first week Venus Team commenced, Although scared I was looked after so well by the team”

#CanDoHealthandCare
Challenges we face & support needed

• Data to know how we are doing.
• Digital maturity i.e. personalisation, workforce efficiency, and evidencing care delivery and change
• Organisations to consider increased funding for workforce ratios
• Estate e.g. maternity hubs, increased scanning capacity, off site counselling
• Population’s health e.g. prevalence of smoking, obesity, deprivation
• Traditional approach of seeing maternity services as supporting an “event” rather then the start of impacting on a child’s life.
• Cultural change to Alliance maternity boards leading the work for their localities with LMS oversight.