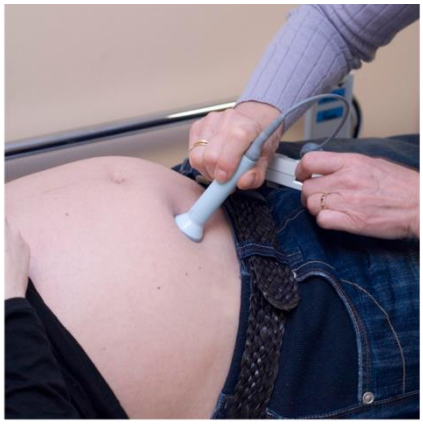
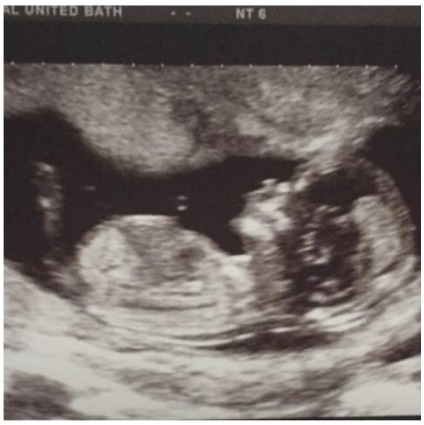









Our Local Maternity Transformation Plan

BATH AND NORTH EAST SOMERSET, SWINDON AND WILTSHIRE LOCAL MATERNITY SYSTEM (LMS)

October 2017

Foreword

Our ambitious goal is that every woman in our region will have an equally positive experience regardless of her personal circumstance, whether she is a lone parent, a young parent supported by Family Nurse Partnership, a woman in a same sex relationship and any other pregnant woman in our community.

Birth is a special experience for all, from the women and their babies, to their partners and families through to the midwives and other birth attendants who have the privilege of being with women during this miracle of new life. This is the birth of a family too, who need to be supported so that all new parents have the confidence to take care of themselves and their new baby.

This letter reflects the care and support that we want every new mother to have. It is the unique experience of one woman, her baby and her partner.

A letter to a my baby

As I watch you sleep deeply and safely, I reflect on the love I have for you and the joy you have brought me and your father.

You have had the best start in life and your dad and I have been fully supported to bring you into the world safely. We feel confident that we will be the best parents you could wish for. We thank all our carers for their support.

The health visitors continue to support us and give us information that is consistent with what we learned from our team of midwives to ensure you are developing and thriving. In partnership with my GP they also help me take care of my emotional wellbeing and knowing they are close at hand helps me feel protected, safe and confident to care for you.

Health professionals have been skilled at supporting me to nurture and sustain you by bringing you to the breast and continuing to breastfeed. Their partners in the community, such as children centres and others, are also available for us if we need extra support on our journey as new parents and to ensure we have a positive experience during this transition in our lives.

I chose your place of birth to be the safest and most relaxing place for us. During your birth, midwives enabled me to feel empowered and to be guided by my own instinct. The encouragement of family, friends and health professionals on the day gave your dad the confidence to be an amazing birth partner. Your birth felt private, safe and secure and I felt cared for, listened to and treated respectfully. I was able to follow my body's cues and make informed decisions about our care in labour and if I needed additional support, obstetricians and paediatricians were on hand.

There was much preparation leading up to your birth. I was confident in my decision about where to birth following open and informed discussion with my midwife. There were also opportunities for your dad to be involved in this. During my pregnancy with you I felt your movement, we talked about it at my antenatal checks, and my team of midwives measured and prodded me to check you were developing properly. I felt cared for, and as parents to be, contact with our midwifery team and antenatal classes prepared us for your birth and parenthood. We also built a social network along the way meeting other new parents.

When your dad and I felt ready for new beginnings, we prepared ourselves for conception, ensuring we were as healthy as possible and able to give you the best start in life.

Those nine months of us being together as one were an unforgettable journey as you developed from an egg to an infant. I look forward to our life as a family and feel blessed that we have received the best care possible.

Forever Yours

A New Mother

This is an exciting time for our maternity services and for women and families in B&NES, Wiltshire and Swindon. Service user representatives have been centrally involved in developing our local transformation plan, working alongside key stakeholders, sharing information, considering needs, identifying gaps and shaping services that have women and their families at the centre.

We begin this transformation from a strong base with well-established relationships across the local maternity system (LMS); good engagement from all parties; and a shared passion and commitment from all stakeholders to change our services for the better. It is now time to put our well thought out plans into action and drive forward our vision for “all women to have a safe and positive birth and maternity experience and to be prepared to approach parenting with confidence.”

Trudi Webber (MSLC Vice Chair) on behalf of service users

1. Introduction

Bath and North East Somerset, Swindon and Wiltshire (BSW) maternity services have increasingly been working together to improve services for women. Strong relationships have developed between the three hospital Trusts and commissioners. We welcome the publication of "Better Births, Improving outcomes of Maternity Services in England" as it provides a vision and framework for us to progress. The national blueprint for maternity as described in the Five Year Forward View has also been used to form this plan.

The providers and commissioners within BSW are active participants in the South West Maternity Clinical Network, which benchmarks providers and facilitates quality improvement initiatives. We are well placed to build on the success of this established network to transform our local maternity services through clinical leadership.

We will proactively engage with women, fathers, families and communities to ensure safe births, positive experiences and equity for all women. As organisational boundaries blur, staff and services will be enabled to improve communication and continuity of care. We will work together with partner agencies to develop seamless pathways that enable women and their families to access services to further enhance their physical, emotional and mental health in pregnancy and support the transition to parenthood ensuring the best possible start for babies.

We recognise that the commitment and ideas from staff provide the foundation of any transformation and we will ensure that their feedback informs and shapes our plan as it develops. Through embedding a continuous quality improvement approach, we will further develop the existing safety culture that is evidenced by transparent reporting and sharing of learning from serious incidents. We are committed to sharing and learning from each other when things go wrong as well celebrating success.

The current national pilot projects underway will provide additional learning and guidance which we are keen to adapt for our Local Maternity System as the evidence becomes available. This is an exciting time for maternity services in England, and we are looking forward to not only implementing our local plan but also being part of the country wide transformation that aims to make maternity care amongst the best in the world.

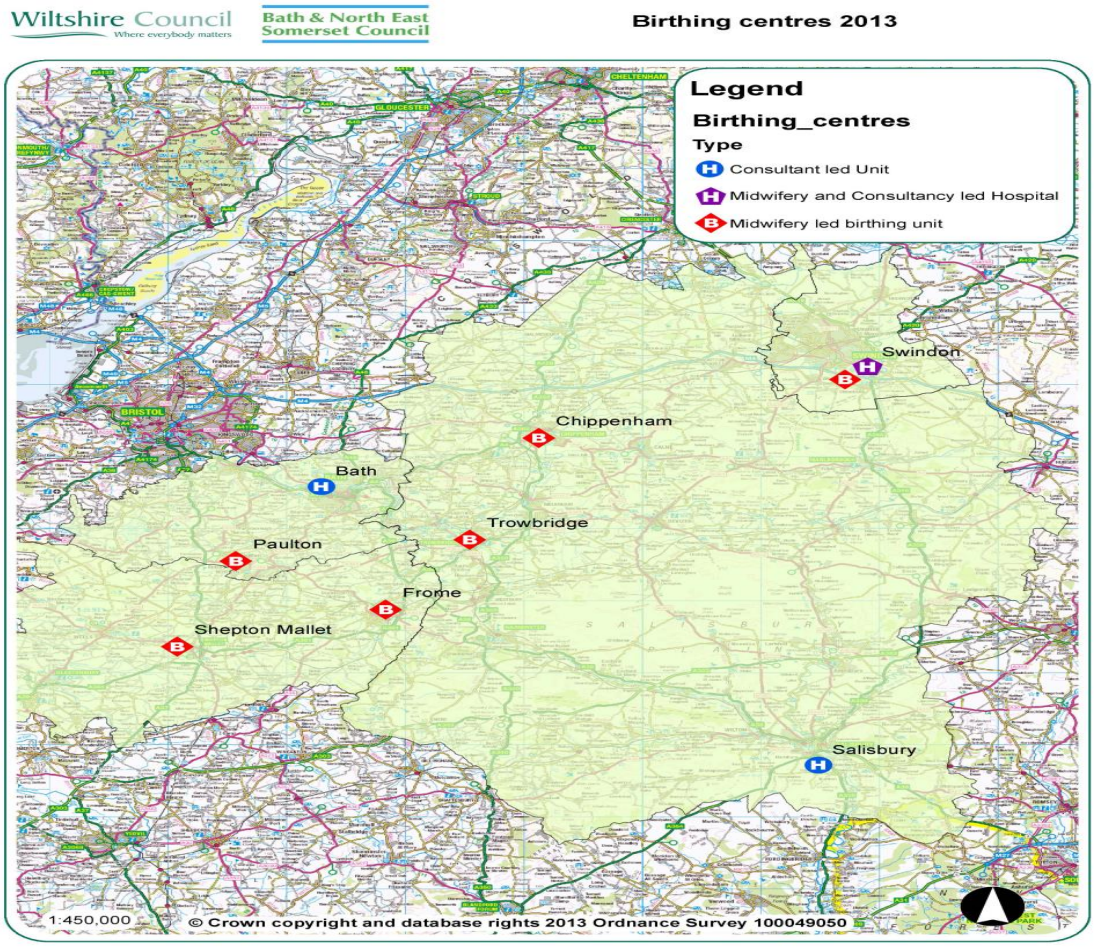
2. Our Local Maternity System

A Local Maternity System (LMS) has been created across the Bath and North East Somerset, Swindon and Wiltshire (BSW) Strategic Transformation Partnership (STP) footprint. The LMS is hosted by Wiltshire Clinical Commissioning Group (CCG) and includes service users and all providers and commissioners across the maternity pathway.

Our LMS has an extremely varied demographic structure and geography, which poses challenges to the delivery of maternity services. It features large rural areas (particularly the mid-Wiltshire Salisbury plain area) as well as urban centres. The main acute providers and larger towns are located on the periphery of the STP footprint. The footprint incorporates a largely affluent population but there are pockets of deprivation (6.4% of the population falls within the most deprived quintile).

The maps below detail birthing locations across the LMS.

Map 1: Birthing locations as per 2013*



**Note: Shepton Mallet now provides antenatal and postnatal care only.*

Map 2: Better Births Initiatives Mapping – Live birth density:

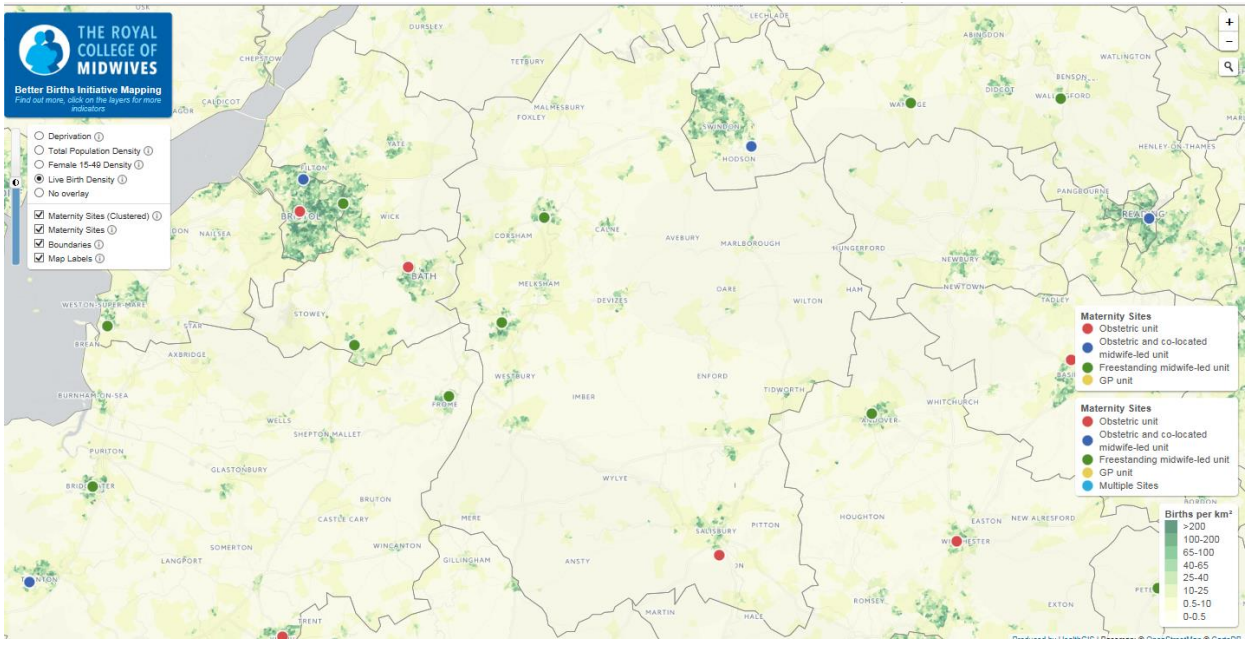
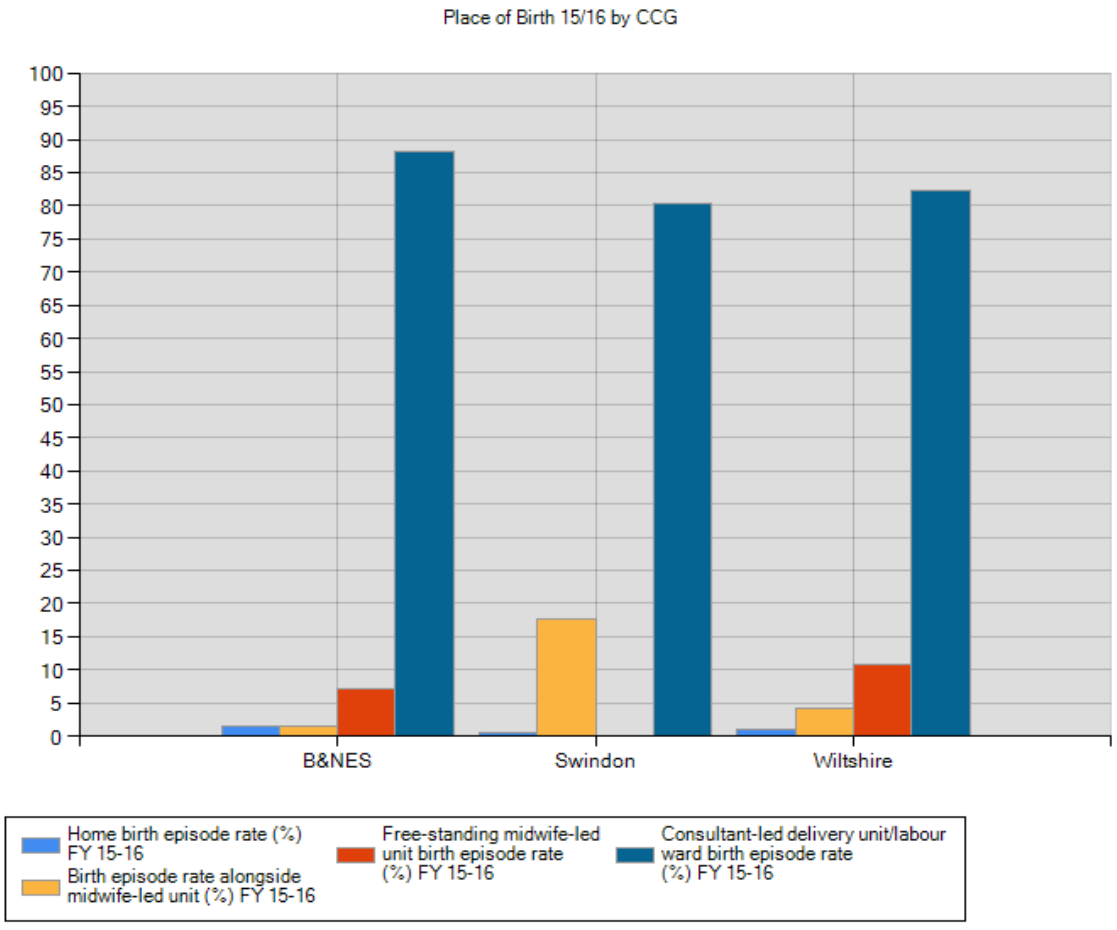


Table 1: Current maternity provision across the STP footprint:

Organisation	Maternity care and birth provision				
	Antenatal and postnatal care	Hospital based consultant care	Home birth	Standalone birth centre	Co-located birth centre
Royal United Hospitals Bath NHS Foundation Trust	√	√	√	Trowbridge Chippenham Frome Paulton	
Great Western Hospitals NHS Foundation Trust	√	√	√		√
Salisbury Hospitals NHS Foundation Trust	√	√	√		

The maternity provision naturally affects the choices women make around where they birth. Figure 1 below illustrates this variation across the LMS.

Figure 1: Place of Birth 15/16 by Clinical Commissioning Group

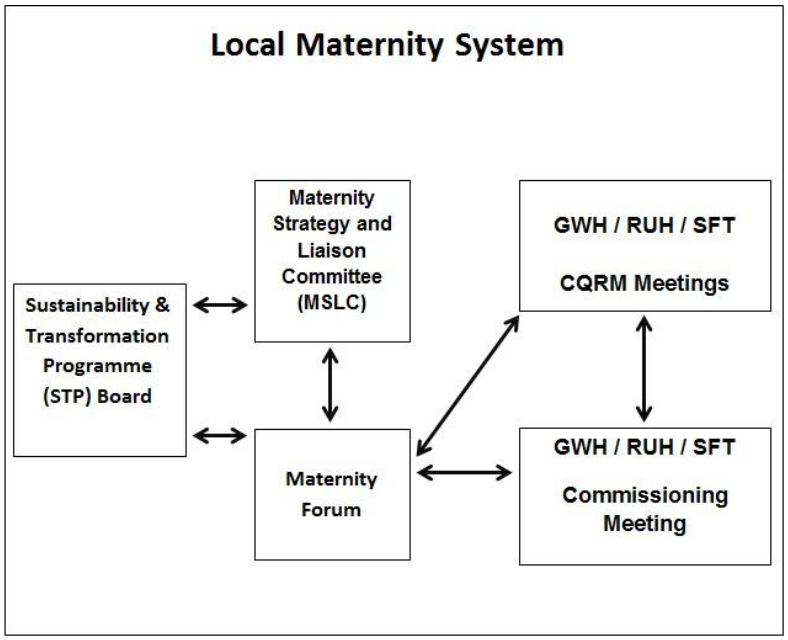


Source: SWSCN

2.1 Governance

The Local Maternity System consists of the Maternity Strategy Liaison Committee and the Maternity Forum. The Maternity Strategy Liaison Committee (MSLC) is the multi-disciplinary strategic arm of the LMS that drives the strategic direction for services across the maternal care pathway. It is informed by national policy and local agendas. Its work includes reviewing national policy, such as the Better Birth Recommendations and responding to local needs and agendas. It is chaired by Public Health and is attended by a range of stakeholders including service users (See Appendix 1 for core membership). Ensuring providers and commissioners take account of the views and experiences of women and their families who use maternity services is a key function of the group. The Maternity Forum, which is maternity service specific, is the operational arm of the LMS, focusing on clinical review of performance data and delivering the strategic objectives. Maternity services are commissioned by B&NES, Swindon and Wiltshire CCGS and quality and safety assurance is provided through CCG Contract Quality Review meetings and processes. Maternity measures are included in the CCG Internal Assurance Framework (IAF). This data is reviewed at the Maternity Forum.

Fig 2: The LMS Governance framework



The development of a local Maternity Voices Partnership is being discussed with current service user representatives at the MSLC. The above framework will be amended to reflect developments in this area in due course.

2.2 The LMS and Accountable Care Organisations

Accountable care is about bringing organisations in an defined area together to work towards a common goal of helping the local population to live healthy, independent lives in which the right health and social care is available when needed.

Providers and commissioners are being encouraged to join forces in a way that will enable woman and their families to access, and staff to provide, care that is more integrated and free from the organisational barriers that can often cause delay, confusion and frustration to many. The organisations will include local councils, health care providers and social services.

Sustainability and Transformation Partnerships (STP) will need to co-ordinate with the Accountable Care Organisations within their area to influence the agenda.

Co–design approach to identifying key streams and priorities including engagement events with staff and service users will set priorities for areas of focus relevant to the needs of the population that the Accountable Care Organisation covers.

The LMS will liaise closely with neighbouring Accountable Care Organisations and STPs to ensure that priorities are shared and discussed to ensure the maternity agenda has influence and a voice.

3. An understanding of the local population and its needs for maternity services

It has not been feasible within the time limitations to conduct a full maternal health needs assessment across the LMS to inform this plan. Nevertheless, all available data has been reviewed from a range of sources including Public Health England, the South West Clinical Network Maternity Dashboard and RightCare and some conclusions drawn.

3.1 Geography and population

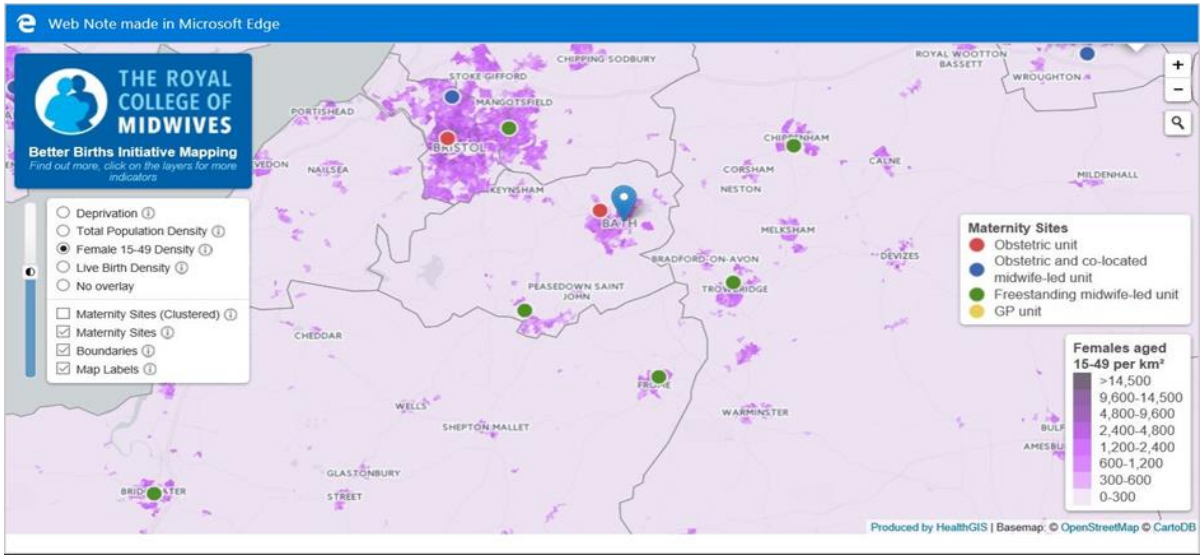
Wiltshire, Swindon and B&NES span a large geographical area of 3,875 km^2 with a total population of 894,065 based on ONS 2016 mid-year estimates. Each area has distinctively different geographies and demographics which are important to consider when transforming maternity services locally.

Wiltshire is a predominantly rural area covering an area of 3,485 km^2 and population density averages 140 people per km^2. It is largely white-British population with few people from ethnic minorities. Access to maternity services varies considerably for women living in different parts of Wiltshire.

Swindon is a large town covering an area of only 40 km^2 and the average population density is 5,447 people per km^2. The 2011 Census showed population growth to be faster in Swindon than the England average and the population from minority ethnic groups nearly doubled in ten years. B&NES area contrasts greatly in terms of density and diversity of population. The City of Bath accounts for approximately half the population and is 12 times more densely populated that the remainder of North East Somerset. About 10% of the population are non-white-British. In terms of deprivation B&NES is one of the least deprived authorities in the country, ranking 247 out of 326.

The density of female population aged 15 to 49 is reflected in map 3 overleaf. The LMS will undertake further work to analyse the data that informs the map and consider the implications.

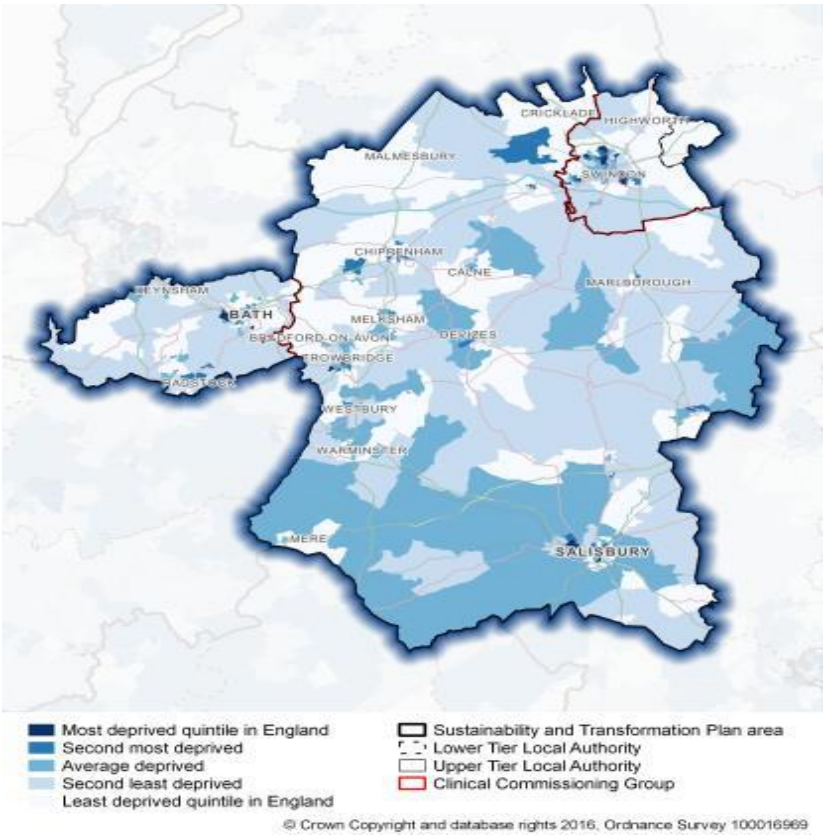
Map 3: Better Births Initiative Mapping – Female 15-49 Density



3.2 Deprivation

The Index of Multiple Deprivation (IMD) ranks the 32,844 Lower Super Output Areas (LSOAs) in England in terms of deprivation. LSOAs contain about 1,500 people. Wiltshire and B&NES are considered to be generally prosperous areas; however, there are hidden pockets of deprivation as illustrated in Map 4. Based on 2015 IMD data, 12 LSOAs in Wiltshire are within the 20% most deprived LSOAs in England and five in B&NES. Deprivation is more evident in Swindon with 19 LSOAs within the 20% most deprived nationally and eight of those are in the 10% most deprived.

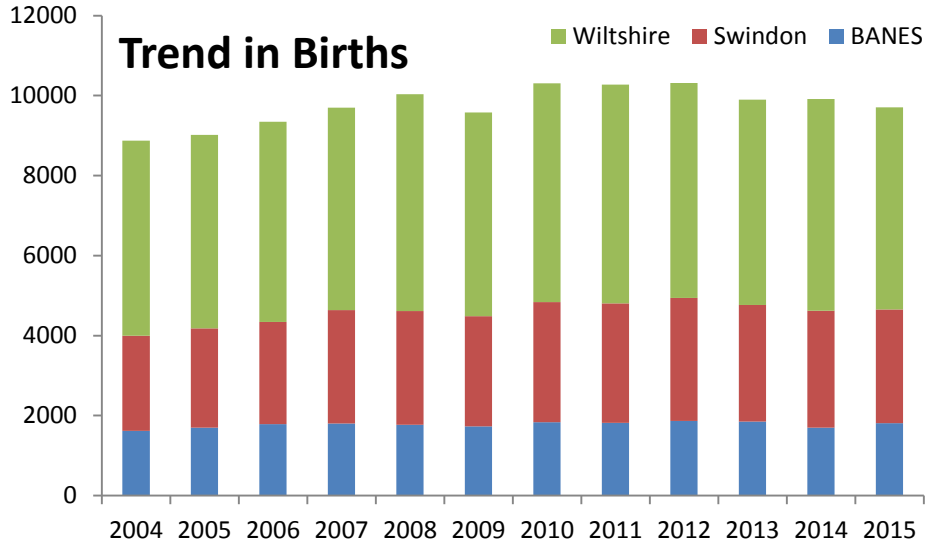
Map 4: Deprivation quintile map 2016



3.3 Number of live births

Over the last 12 years there has been some variation in the overall number of births with a low of just under 9,000 in 2004 to a high of over 10,300 in 2012. There has been little variation, however, in the proportion of births in each of the three areas during the same period (Figure 3). Most recently (2015), just over half the births were to women who lived in Wiltshire (53%), just under a fifth were to women who lived in B&NES (18%), and just under a third were to women who lived in Swindon (29%).

Fig 3: Trend in Live Births



Source: ONS

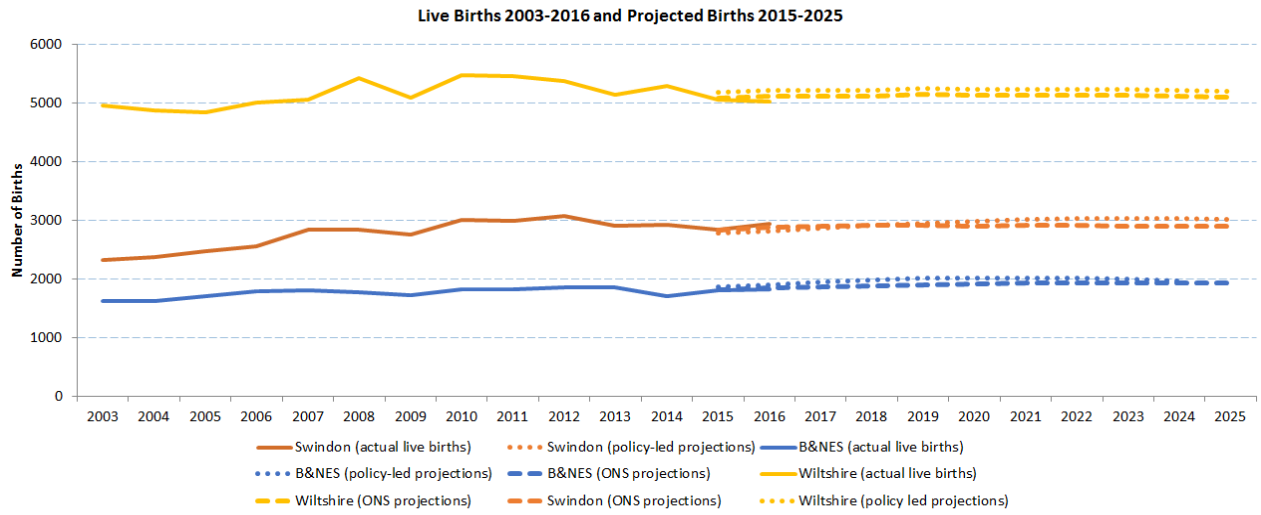
Although the number of births in each area has fallen slightly recently (Table 2), the latest ONS projections forecast a gradual increase in the number of births for each area. Local policy-led projections sometimes present a different picture (Figure 4). Swindon Borough Council's policy-led projection forecast a slightly bigger rise in Swindon births. In Wiltshire plans to increase housing, as set out in the Core Strategy, and the army rebasing programme are expected to impact on birth numbers. An initial crude estimate suggests this could result in over 700 additional births across Wiltshire.

Table 2: Number of live births by local authority

	Swindon	B&NES	Wiltshire
2012	3,073	1,867	5,378
2013	2,911	1,854	5,133
2014	2,923	1,702	5,290
2015	2,847	1,808	5,050

Source: ONS

Figure 4: Projected number of births



Source: ONS, BANES, Wiltshire and Swindon Borough Councils

3.4 Early booking

It is recommended that women have access to maternity services for a full health needs assessment ideally by 10 weeks of pregnancy (NICE, 2008). Late booking and late access to antenatal care is a known risk factor. In B&NES, Swindon Wiltshire ≥90% of women book early in pregnancy in line with the South West median is 92%.

3.5 Flu vaccination in pregnancy

The Public Health England influenza immunisation programme aims to offer protection to those who are most at risk of serious illness or death should they develop influenza. Preventing flu in pregnancy plays an important part in preventing maternal deaths (MBRRACE, 2014).

Table 3 provides data on flu vaccination uptake in pregnancy and shows a small increase across the LMS in 2016/17 compared with 2015/16. Increasing the uptake flu vaccinations in pregnant women is a priority for the LMS and flu clinics were introduced in some maternity services across the footprint in 2016/17 as a pilot approach. All maternity services are keen to follow suit ready for the 2017/18 flu season and planning is underway in readiness. Improved access for pregnant woman at scheduled screening appointments commenced in October 2017.

Table 3: Provisional cumulative uptake data for England for vaccinations in pregnancy given from 1 September 2016 to 31 January 2017

	Pregnant women	
Area	**2015/16**	**2016/17**
B&NES	44.0%	45.7%
Swindon	46.7%	46.9%
Wiltshire	42.9%	43.9%
Gloucestershire	43.9%	46.7%
BGSW	44.2%	45.8%
England	42.3%	44.8%

Source: ImmForm website, registered patient GP practice data (PHE)

The national expectation is to deliver flu vaccinations to 75% of the pregnant population therefore further work is required to achieve this.

3.6 Complex needs

The following risk factors are known to increase a mother and baby's vulnerability to adverse events: booking late in pregnancy (early booking data is routinely collected to monitor this); maternal age where risks are higher for younger women and older women; language barriers; smoking in pregnancy; obesity in pregnancy; maternal mental health; multiple births. Data related to these risk factors is presented in Table 4 with the exception of maternal mental health for which robust data is not yet available.

Table 4: Women with complex needs in pregnancy by CCG area (2015-16)

	Swindon	B&NES	Wiltshire	South West median
Early booking in pregnancy rate (1)	86.4%	91.9%	90.0%	90.0%
Birth rate from under 18 conceptions	4.0%	1.2%	2.4%	1.4%
Birth rate in women aged 40 or over (1)	1.4%	1.3%	2.4%	2.4%
% of babies born to mothers born in the Middle East and Asia (2014) (2)	10.5%	3.2%	2.7%	3.25%
Smoking at birth rate (1)	10.9%	7.4%	9.8%	10.9%
Obesity –BMI 30+ (1)	20.2%	17.2%	21.2%	21.0%
Multiple births (per 1000) (2015) (2)	20.4	14.5	14.2	14.9

Source: (1) South West Clinical Network Maternity Dashboard / (2) PHE Public Health profiles

Wiltshire has a higher percentage of women over 40 years birthing than in the other areas, but not exceptionally high for the South West. The difference in ethnicity of mothers is very apparent in Swindon with over 10% of babies born to mothers from the Middle East and Asia, reflecting the greater ethnic diversity in Swindon. Smoking rates are highest in Swindon and lowest in B&NES which may be related to levels of deprivation in the respective areas. Maternal obesity is lowest in B&NES and similar to the South West median in both Wiltshire and Swindon. Swindon has a notably higher rate of multiple births than B&NES and Wiltshire.

RightCare Maternity and Early Years data comparing Wiltshire, Swindon and B&NES each with their 10 most demographically similar CCGs also highlights smoking in pregnancy as an area of 'opportunity' for improvement. Overweight and obesity rates in children aged 4-5 are also notably high compared with demographically similar CCGs suggesting there is opportunity for improvement. Babies born to obese mothers are at greater risk of becoming obese children which highlights the importance of working to ensure women adopt healthy lifestyles before and during pregnancy and to support and enable more women to breastfeed. The RightCare data for all CCGs within the LMS was presented and discussed at the Maternity Forum on Thursday 25 May 2017 and the above priorities identified.

3.7 Perinatal mental health

Perinatal mental illness refers to a range of mental health problems of varying severity that can affect women during pregnancy and in the year after birth including anxiety, depression and postnatal psychotic disorders. Such problems affect up to 20% of women at some point during pregnancy and for the first year after birth and can have a significant negative impact on the mother, family and her developing child. Mental illness is one of the leading causes of maternal death in the UK and the number of new mothers committing suicide has not fallen over the past decade. Babies born to mothers experiencing perinatal mental health illness are at increased risk of prematurity, low birth weight, infant mortality, suboptimal growth, illnesses, neurodevelopmental problems and long-term cognitive outcomes.

Table 5 provides an estimate of perinatal mental illness across the LMS broken down by area and shows the potentially large numbers of women to suffer from mild to moderate mental illness during the perinatal period. Research indicates that there will also be a proportion of fathers who develop mental health difficulties during this period.

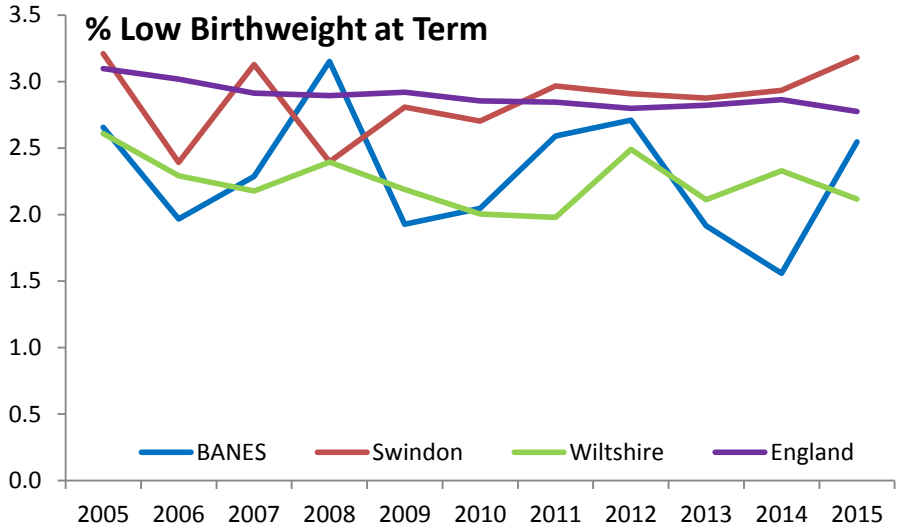
Table 5: Perinatal Mental Health Projections taken from the Chi Mat tool

Perinatal Mental Health Projections	NHS Wiltshire	NHS B&NES	NHS Swindon
Estimated number of women with postpartum psychosis (2013/14)	10	5	10
Estimated number of women with chronic SMI (2013/14)	10	5	10
Estimated number of women with severe depressive illness (2013/14)	140	55	90
Estimated number of women with mild-moderate depressive illness and anxiety (lower estimate) (2013/14)	460	180	290
Estimated number of women with mild-moderate depressive illness and anxiety (upper estimate) (2013/14)	685	270	435
Estimated number of women with PTSD (2013/14)	140	55	90
Estimated number of women with adjustment disorders and distress (lower estimate) (2013/14)	685	270	435
Estimated number of women with adjustment disorders and distress (upper estimate) (2013/14)	1,370	540	865

3.8 Low birthweight babies

Low birth weight (babies born weighing less than 2.5kg) is a major determinant of mortality, morbidity and disability in infancy and childhood and also has a long-term impact on health outcomes in childhood and adult life. Low birthweight of full term babies is obviously of most concern and routinely monitored. Figure 5 shows the trend across the LMS and compares with England.

Figure 5: Trend in percentage of low birthweight at term babies



Source: ChiMat

The average percentage of low birth weight babies at term has been falling in England as has the percentage in both Wiltshire and B&NES. In Swindon the percentage has been rising and is now higher than the England average.

3.9 Caesarean births

Unnecessary caesarean (not medically indicated) births carry additional risk of complication to both the mother and baby as well as increased health care costs. The latest data available locally (Table 6) shows the percentage of caesarean births broken down by NHS Trust and by CCG area in 2016-17. The data ranges from 22.9% at the Royal United Hospital NHS Foundation Trust, significantly lower than the South West median of 24.9%, to 27.6% at the Great Western Hospital NHS Foundation Trust, significantly higher than the South West median.

Table 6: Caesarean births rates by NHS Trust and CCG area (2016-17)

	Caesarean birth (1)
NHS Trust	
Royal United Hospitals Bath NHS Foundation Trust	22.9%
Great Western Hospitals NHS Foundation Trust	27.6%
Salisbury Hospitals NHS Foundation Trust	23.1%
CCG	
B&NES	Data not available
Swindon	27.6%
Wiltshire	23.6%
South West median	24.9%

Source: (1) South West Clinical Network Maternity Dashboard

Work has commenced across the LMS to explore caesarean birth rates. This includes a dedicated research project at GWH being supported by the University of West of England.

3.10 Breastfeeding

Breastfeeding reduces the risk of infant infection and mortality and confers protection for the mother from breast cancer. There is also some evidence that breastfed babies have lower incidence of Sudden Infant Death Syndrome (SIDS), are less likely to be obese as children and have a higher IQ. Table 8 shows the latest annual data and a more up to date snapshot from the regional maternity dashboard.

Table 7: Breastfeeding initiation by area

Breastfeeding initiation by area	Breastfeeding initiation		
	1415 (1)	**1516 (2)**	**1617 (2)**
Swindon	84.1%	84.4%	79.2%
B&NES	76.3%	84.4%	no data
Wiltshire	80.1%	76.3%*	74.4%*
South West	79%	77.4% (median)	77.9% (median)
England	74.3%	n/a	n/a

*Source: (1) Department of Health Statistical releases / (2) South West Clinical Network Maternity Dashboard / *affected by data quality issues*

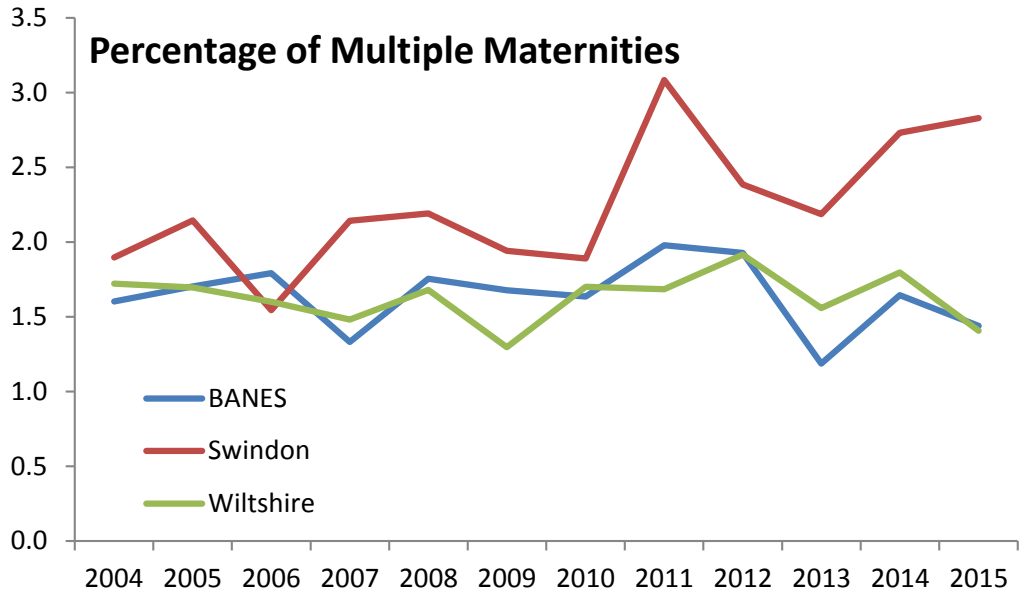
Breastfeeding initiation rates in Swindon, B&NES and Wiltshire have been higher than the national and regional averages for many years. This continues to be the case although data quality issues have affected the ability to monitor progress accurately over the last 12 months.

However, a closer look at the data reveals variation in relation to age and deprivation. Breastfeeding initiation rates are lower in more deprived areas and breastfeeding initiation among young mothers (under 25 years of age) is statistically significantly lower than any other age group.

Despite a high percentage of women initiating breastfeeding, historic data suggests that many women cease breastfeeding in the early weeks. Due to changes in the way 6-8 week breastfeeding data is collected recent data quality is variable across the LMS and, therefore, not included. As data quality improves breastfeeding drop-off rates will be monitored and analysed to ensure women are being supported to sustain breastfeeding.

3.11 Multiple births

Figure 6: Trend in multiple births which carry risks for both the mother and baby



Source: ONS Vital Statistics

The trend for both B&NES and Wiltshire is generally consistent and the same. The trend in Swindon is increasing and is now higher than both B&NES and Wiltshire.

3.12 Infant mortality and stillbirth

Wiltshire, Swindon and B&NES MSLC maintains regular oversight and scrutiny of infant mortality and stillbirth data to enable it to fulfil its key function of ensuring maternity care is of the highest quality. Infant mortality is well recognised as an indicator of population health; the wellbeing of infants, children and pregnant women; and of progress towards addressing inequalities. Most infant deaths occur in the first 27 days of life and stillbirths and infant deaths are associated with a number of complex risk factors, including obesity, smoking, maternal age and inequalities.

It is well recognised that many of the risk factors that impact on low birth weight, infant mortality and stillbirth are disproportionately represented in the most deprived communities. Local data supports this.

The Wiltshire, Swindon and B&NES Stillbirth and Infant Mortality Report (2017) looked in detail at births, stillbirths, perinatal and infant mortality across the LMS and associated risk factors over the last ten years. In summary:

- **Infant mortality rates** in B&NES and Swindon are reducing while in Wiltshire the trend is relatively flat.
- The **stillbirth rates** are broadly similar in all areas although the trends vary. There is an upward trend in B&NES, a downward trend in Swindon and a fairly consistent trend in Wiltshire.

Perinatal mortality rates are similar for all areas. The trend in Swindon is reducing; for B&NES and Wiltshire the trend is flat.

3.13 Key Challenges

Based on the factors set out in this section, the key challenges facing the LMS are as follows:

- Improve maternal nutrition and reduce maternal obesity levels.
- Reduce smoking in pregnancy to 6% by 2022.
- Increase the uptake of the flu in pregnancy vaccination to better protect women.
- Increase breastfeeding rates with a particular focus on young mothers and those from more deprived communities.
- Maintain implementation of the NHSE *Saving Babies' Lives* care bundle and monitor progress.
- Improve the care pathway for women with maternal mental health difficulties, including those with chronic low-level problems.
- Developing continuity of care and appropriate staffing levels in the context of a rising birth rate and increasing complexity within existing resources.
- Managing the expectations of staff, service users, their families and communities.
- Ensure equity of maternity provision across the LMS whilst ensuring services are able to respond to demographic variations and the differing needs of the population.
- Ensure we have sustainable workforce across our system with robust planning.
- Ensure we continue to consult and co-create our vision and future delivery of our services with our population.
- Ensure we balance improving the overall health of the maternal population with targeting interventions effectively to address the health inequalities that exist.

4.0 The views of women

In April 2017 Public Health professionals worked together with service user representatives from the MSLC to develop and implement an online Place of Birth Survey. The survey focussed on what and/or who informs women's decision about where to birth their baby and was targeted at women who were currently pregnant and those who had given birth within the last year. The week long survey received 850 responses.

The respondents were from a fairly representative sample in terms of deprivation and there was a 50:50 split between those pregnant and those who had given birth in the last 12 months. The data was analysed, themes drawn out and the following recommendations made:

- Develop ways of engaging with partners and ensuring they have access to unbiased information to inform decision making around place of birth.

- Ensure unbiased information and discussion that includes the risks and benefits of all birthing options is offered to all expectant parents consistently across the Local Maternity System. To include identifying and agreeing use of an online tool, e.g. Which Choices.

- Actively promote positive birth stories and experiences to expectant parents and the wider community to promote positive birthing generally and to help break down misconceptions about certain birthing choices, such as birthing in the community.

- Engage with service users to gain a more detailed and deeper understanding of what aspects of birth environment affect their decision about where to birth.

- Adopt a similar methodology in the future to gather feedback from a representative sample of service users on issues related to maternal health and care.

Maternity services have a variety of tools to gather patient experience and feedback including Friends and Family Test (FFT), CQC Maternity Picker Survey, Birth Reflections, Compliments and Complaints. This information is regularly triangulated to gather themes, both positive and areas for improvement, to ensure priorities align with what our women and their families are telling us.

Local themes include:

- Quality of care – kindness, compassion, listening.
- Continuity of Care – antenatal and postnatal.
- Better communication between teams / other health professionals.
- Emotional wellbeing and support in the post-natal period.

There are clear similarities to the national picture and the priorities of Better Births: Safer Care, Personalised Care, and Continuity of Carer, Working across boundaries, Multi-professional working and Better Postnatal and Perinatal Mental Healthcare (Better Births).

All maternity services have facilitated or are planning to run 'In Your Shoes' workshops. The word cloud below features an example from one of our Trust's.

5.0 Better Births Gap Analysis

All maternity providers completed a self-assessment against the Better Births recommendations. These assessments were reviewed at the MSLC and common themes drawn together to help shape the priorities of this transformation plan.

Themes from the 'Better Births' analysis from 2016

There are seven areas that each provider within the B&NES, Swindon and Wiltshire LMS measured themselves against. This self-assessment was formulated as a GAP analysis.

Red – unlikely to achieve this recommendation without significant investment or service transformation, which has not yet been agreed.
Amber – have a good possibility of achieving this recommendation within the national time-frame.
Green – already meet this recommendation or can realistically achieve it by March 2017.

Table 8: Themes from the 'Better Births' analysis from 2016

Work stream	Positives	Challenges	Overall RAG rating
Personalised care and choice	All 3 providers currently looking at ways of giving unbiased information	• 2 providers have 3 out of 4 birth place choices. • Personalised plans not fully implemented.	Red
Continuity of Carer	In some areas there is evidence of continuity of in the antenatal period	• All providers have a high number of midwives that have chosen to work part time. • None of the 3 maternity services have continuity within the Obstetric workforces.	Red
Better Postnatal and perinatal mental healthcare	Perinatal infant mental health pathway is being developed across the LMS footprint and all providers are engaged with this development	• Post natal care provision is patchy and there is little consistency in the post natal offer. • There is a variation in availability of community mental health services.	Amber
Working across boundaries	All providers are involved with local systems- MSLC and planned maternity forum	• There are no shared policies and pathways between the providers. • Digital systems are not compatible between providers. • Community hubs are not yet a	Amber

		consideration.	
Safer care	**All providers site a culture of learning and continuous improvement Duty of Candour in place in all organisations All providers are signing up to the National Maternity and Neonatal Health safety Collaborative**	**The rapid redress scheme is an expectation but this has not been outlined nationally**	**Green**
Multiprofessional working	**All providers have teams that train and learn together**	• **Peer reviews not yet in place** • **No systems in place to learn across the region**	**Amber**
Payment System		**National system not yet in test**	**Red**

6.0 Financial Case for Change

The Local Maternity System has not identified any financial savings as part of its development of this transformation plan. This has been acknowledged by the STP leadership group. However, this plan aims to deliver safe and efficient services which reduce duplication and explore transformation opportunities.

As the early adopters' feedback on progress with personal budgets, the LMS will review its position and agree next steps and timeframes.

7. Local Maternity System Vision for 2021

Our co-created LMS vision is that:

"All women to have a safe and positive birth and maternity experience, and be prepared to approach parenting with confidence."

Our work plan is underpinned by four core commitments:

a. Women and their chosen support networks will be partners in care

Women will receive unbiased, timely information to enable them to participate fully in personalised care planning, and they will be encouraged to explore and question available options. Services will reflect on the language they use, focusing on the women's experience. Above all women will be listened to.

b. Maternity services and organisational partners within the LMS will work collaboratively

Woman will receive a service that is seamless and joined up irrespective of where they access their care. Women will receive personalised care and staff will be enabled to provide continuity.

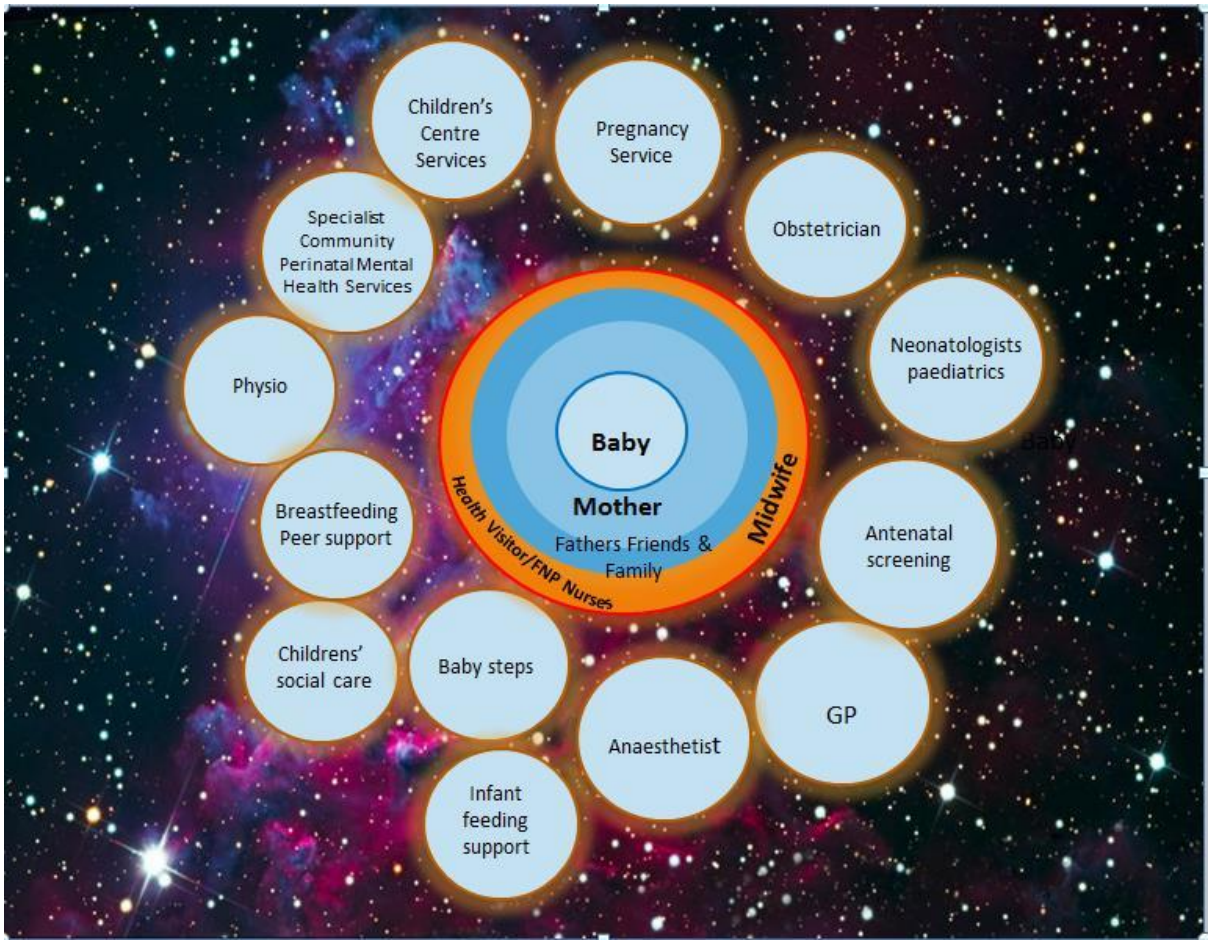
c. We will enhance safety through assisting all women to experience the best birth possible for their personal circumstances.

Woman will be supported to make informed decisions, ensuring risks and benefits are assessed, discussed and managed proportionality. We will adopt an approach that works with the physiology of labour and optimises physical and mental good health. Learning will be shared across organisations and multidisciplinary teams will learn together.

d. Woman, partners and their families will be supported and enabled to optimise their health in preparation for pregnancy, birth and parenthood.

Ensuring staff have the skills and confidence to deliver consistent and effective public health interventions that positively impact on outcomes for women and children.

The diagram below illustrates the range of services that are available for woman and families during their maternity journey dependent on their level of need.



7.1 Implementing the vision

The action plan below was informed by a series of stakeholder workshops and is working document that identifies the direction of travel. This action plan will be developed further by our LMS and will be flexible to meet agreed objectives.

Table 9: Actions, current position and next steps

	Action	Current Position	Next Steps (including who, what, where and how)
1	**Personalised care and choice**		
1.1	Share local policies and agree common language and protocols around maternity care. Align/standardise policies as much as possible.	LMS planning workshops have included discussions on common language. Non standardised language at present but each Provider already working with staff to discuss language used. Policies and protocols similar as based on national guidance but require review to identify differences that could be discussed as LMS.	• Set up LMS Policy Group- requires lead Consultant and Midwife from each clinical area within eight weeks from launch of strategy. • Potential for each Consultant/Midwife to review identified protocols guidance for the three clinical areas. • Consider drop box or other method of sharing guidelines. Each clinical lead to liaise with Informatics team. • Heads of Midwifery Services (HOMs) to lead standardised language workstream. • Place of birth Choice leaflet to be agreed across LMS area by Providers, Maternity Forum and MSLC.
1.2	Standardise maternity notes across LMS including personalised care plans	RUH and GWH use same notes. SFT have different notes. Aim for all areas to use the same notes.	• HOM Salisbury to discuss with Clinical Governance and agree standardised records. • To obtain and implement revised notes for Salisbury (until such time as digital records can be shared across LMS (or

			nationally).
1.3	Identify common digital platform for professionals and women, partners and families	No common digital platform- Each Maternity Service uses a different electronic records system which do not communicate. No one source of information for service users	• Project lead to co-ordinate bid from STP for this platform. • Learn from other areas that may have progressed this action. • Use digital platform to promote a wide range of positive birth stories to expectant parents and the wider community
1.4	Provide welcoming, consistent, unbiased, informed, timely information to women and their partners regarding their maternity care	Standardised information for women tailored to individual clinical areas available within each Trust but not in a central location for LMS.	• Project lead to procure webpage for LMS. • To consider facility for booking care and appointments online across LMS. • Draw on findings from local Place of Birth user survey to ensure women and their partners are consistently informed about the risks and benefits of all birth options in a way that is meaningful to them.
1.5	Implement LMS triage system	No standard triage system at present. Background work being undertaken by midwifery representative from each Acute Trust. Expressions of interest submitted to SW Hub project.	• Working group led by Project lead to be set up by December 2018. • Share Wessex Unscheduled care pathways to use as basis for discussion of protocols. • Working group to evaluate potential use of SW Hub as LMS triage for all LMS Providers of Maternity Care with standardised triage tools.
1.6	Standardise antenatal and postnatal pathways	Most pathways similar but require review to	• LMS and Safeguarding Specialist Midwives

	for all women, especially pathways for vulnerable women	identify inconsistencies across LMS	to agree Cross boundary policy about how vulnerable women will be identified and alerted across LMS area. • Consider central Safeguarding email address. • Policy group MSLC to review antenatal and post natal care pathways across LMS.
1.7	Standardise birth reflections and VBAC (Vaginal Birth after Caesarean) services across the STP	All areas provide Birth reflections services. No current sharing of trend analysis from Birth reflections across LMS. VBAC support services require mapping for each provider	• Each Provider to identify VBAC /positive birth champions (Midwife and Obstetrician). • To set up quarterly meeting for champions for positive birth reflections and VBAC services. • Map Positive Birth reflections services for LMS by Project lead. • Map VBAC services across LMS by project lead.
1.8	Consider adopting elements of the Stepping up to Public Health (PH) resources to empower women and to enable staff to personalise maternal public health	No current mapping of provision of Stepping up to PH resources. Women do not routinely complete their own notes. Women not routinely asked to identify "what is important to you or what do you want to know about or ask".	• Better Births Project Led to review evidence and identify pilot sites for agreed elements of Stepping up to PH resources. • Project lead to formulate proposal and present at MSLC.

1.9	Align to public health strategies and be mutually supportive	Variations in public health strategies that support maternity and neonatal services.	• Project lead and MSLC to map variation across LMS. • Baby steps evaluations to be shared across LMS. • Consider alignment of public health initiatives that impact on Maternity services across LMS area to avoid inconsistencies in care provision.
2	**Postnatal care and perinatal mental health**		
2.1	Implement local PIMH plans and ensure synergies across LMS where appropriate (links to MSLC priority 1.3)	There are many similarities in the pathways in each area, e.g. a well-being plan is given at all bookings, but also variations e.g. the midwives screening tool questions vary. There are named MH support MWs at each acute hospital but they are not MH specialists. The adult MH provider (AWP) is the same across the STP but, there are local variations in referrals to, and provision from, Improving Access to Psychological Therapies (IAPT) and Primary Care Liaison Services (PCLS). There is a lack of specialist community	• The recently appointed STP PIMH development lead is currently reviewing PIMH strategies/pathways in the 3 CCGs. To avoid confusion for maternity services, we aim to develop and launch one PIMH strategy across the STP area. • An STP bid for 2018/19 'pump priming' for a new specialist community PIMH service is being prepared ready for submission to NHS England in late 2017.

		perinatal MH services across the STP.	
2.2	Infant feeding leads and breastfeeding strategy leads to work together to contribute to Joint Strategy Needs Assessments (JSNAs) and ensure consistency of provision and messages across LMS	There are specialist infant feeding leads in all maternity and health visiting services as well as commissioning leads in each CCG. But there are differences in breast feeding policies which need to become more aligned. Although all services are Breastfeeding Friendly Initiative (BFI) accredited, women can still receive inconsistent messages from different professionals, including neonatal feeding guidance.	• Infant feeding leads currently meet quarterly and are becoming more aligned due to the SWSCN work. • Ensure governance of BFI accreditation is linked to Early Help Boards as well as contract management of services. • Work together across STP to ensure consistency in data collection and recording. • GPs and Paediatricians also need to provide consistent messages - Health visitors best placed to influence.
2.3	Standardise transitional care pathways across the LMS, with a focus on keeping mothers and babies together, smooth transitions and effective communication between services at all times and appropriate on-going care in the community	There is variation between and across maternity services in how care is provided to new babies who need additional monitoring and/or interventions. Acute Trusts are working collaboratively towards a transitional care model Communication between maternity, Paediatrics, SCBU/NICU, GPs and health visitors, infant feeding specialists is not always consistent.	• Acute trusts evaluating pilots. • All units to participate in the ATAIN programme to keep mothers and babies together. • Commissioners raising payment issues around transitional care at regional and national levels. • Need to develop and adopt a procedural pathway to ensure all relevant communication (including finance) and discharge summaries are completed in a timely manner.
2.4	Adopt a consistent approach to routinely	Each maternity provider offers the	• The services will expand to offer each

	offering all women the opportunity to reflect on their birth experience, particularly in the early postnatal period (link to 1.7 above)	opportunity for mothers to reflect on their birth experience with a midwife and/or obstetrician. Nevertheless the opportunity is not currently promoted/ provided routinely.	woman the opportunity to talk about the birth – not just those with a negative experience. Pathways to be formalised between IAPT and maternity services to ensure women are receiving the right support at the right time.
2.5	To ensure women and their partners are empowered and confident making the transition to parenthood and preparing for any subsequent pregnancies, actively promote preparation for parenthood and support positive parenting throughout the maternal care pathway (MSLC priority).	Delivery of antenatal education and transition to parenthood varies across the LMS (health visiting and maternity services) both in terms of content and reach. This applies to both universal provision and targeted programmes, such as Baby Steps. Access to self-funded and voluntary sector provision is also varied. IAPT group based programmes are also inconsistently provided across the area.	• Review and collate current provision in each area including support for parents who have very premature babies. • Review learning outcomes/ take up (including fathers/ partners) and evaluate user feedback. • Continue to align midwifery and health visitor universal antenatal education offering and ensure sessions are accessible to and meet the needs of those vulnerable families who need them most. • Raise awareness of other providers for those who can self-fund. • Consider business proposal for Baby Steps in B&NES.
3	**Workforce transformation**		
3.1	Ensure our workforce is designed to meet the needs of the MTP		• Identify and work with workforce modelling experts to progress.
3.2	Identify and respond to staff training needs and enable effective public health promotion	Staff training around public health promotion and brief interventions is patchy	• Maternity services to undertake a training needs assessment across the LMS.

	and support for women and their families	and often topic focussed e.g. smoking. Possible areas for development previously identified include motivational interviewing.	• Work with public health colleagues to identify training/ learning opportunities to respond to need e.g. raising the issue of weight, making every contact count.
4	**Continuity of carer**		
4.1	Define what continuity of carer is for our LMS		• Review impact of continuity of carer at a local level to develop an LMS model that meets the needs of women, babies, families and staff.
4.2	Draw on lessons learnt from early adopter sites to model continuity of carer locally		
4.3	Link with workforce transformation workstream to develop model for achieving continuity of carer through the maternity journey in response to women's local needs		
5	**Working across boundaries / multi-agency working**		
5.1	Develop and implement memorandum of understanding between providers to prevent the need for unnecessary repeat ANNB screening	Not in place	• Establish current position / blocks. • Liaise with NHSE –advice and guidance. • Maternity Heads of Service to raise requirement on internal governance forums by end of November 2017 – check internal processes required. • Wilts Maternity forum to agree next steps December 2017.
5.2	Standardise information sharing and ensure	Information sharing across wider early years	• Ensure strategic and operational

	all providers and staff have a shared understanding about being part of a wider team supporting women through their maternity journey - link to 1.1	services is inconsistent. Interfaces between maternity and other early year's services are problematic due to information governance, organisational boundaries. This hampers practitioners working better together and operating more as a wider early year's workforce.	partnership approach to the early years.
5.3	Implement routinely monitored team inboxes within all maternal care providers across the LMS, including maternity, health visiting, community mental health etc.	Not in place in all trusts – e.g. needed for birth notes, discharge summaries and the wider system – maternity /HV/ CCs/ early years In place for Health Visitors already? Share learning	• Need to agree local structures and processes to enable this & need to determine how to achieve this for all professional groups, maternity, health visiting, community mental health and identify if any others are required by end of November 2017. • Identify issues / blocks / IT challenges. • All professional groups to communicate new in-box email addresses. • To be implemented by end of January 2018.
5.4	Ensure consistent public health messaging, use of online resources and signposting for information across LMS	Local currently – with variation	• Public health to be an agenda item at Wilts Maternity Forum – link to national programme. • Consultation with service users re needs / approach. • Review BANES Early Help App – consider adopting this across LMS with local

			information. • Flu jabs first messages required. • Project plan campaigns with a timeline including identification of resources available / media type.
5.5	Invite appropriate early years(0-5 year) partners to discharge planning meetings and formalise MW-CC link role	Obstetricians not fully aware	• Each Trust to identify lead liaison role. • Identify Children's centre contacts. • Raise awareness of CC services across wider maternity services & locally. • Identify what meetings they are required to attend - all/ selected by invitation? • To be in place by February 2018.
5.6	Establish mechanisms to enable midwives to work across organisational boundaries	Not in place – required to aid recruitment & staffing shortfalls and spread shared practices	• Dialogue with university training schools of nursing required. Consider rotational posts. • Consult existing staff in each Trust to seek expressions of interest / suggestions on way forward. • Share learning from new LMS / SWAST Midwife role – set up (October 2017) and implementation/practice (2017/18).
5.7	Develop a collective vision for community hubs across services involved in the maternal care pathway to ensure families across the STP receive a service that is as seamless and joined up as possible (MSLC priority) links to	Not in place	• Share learning from Swindon Accountable Care model to be implemented 2018/19 (Team Swindon) model). • Identify what services are required in the hub to support maternity services?

	5.5		• Identify the expected benefits of community hub & outcome success measures?
5.8	Ensure Early Help /Early Intervention strategies are linked to ensure a whole system approach across the STP. Links to 6.7	Each CCG / Local Authority area has different arrangements for delivering the early years agenda and varying degrees of sign up from agencies.	• To review strategic early years arrangements and working processes across the STP.
6	**Safer Care**	**Current Position**	**Next Steps**
6.1	Deliver against Safety Collaborative priorities	Great Western Hospital is in Wave 2 and Salisbury and Royal United Bath are in Wave 3 of the Maternal and Neonatal Health Safety Collaborative, a three year programme to support improvement in the quality and safety of maternity and neonatal units across England.	• Each organisation will receive a wide-ranging support package over the life of the programme. This includes tailored resources and networks, in the meantime learning from Wave 1 organisations will take place via clinical networks.
6.2	In conjunction with the SWCN develop a joint safety improvement plan across the LMS	Individual Trusts have benchmarked against Better Births and have locally agreed priorities for Maternity Safety Improvement Plan (MSIP).	• To collaborate across the LMS to develop joint MSIP.
6.3	Review implementation of maternity based clinics to increase uptake of vaccination in pregnancy (MSLC priority)	Each Trust in LMS has developed its own local plan for delivering vaccination in pregnancy.	• Review 2016/17 data and update at maternity forum on uptake of vaccinations to date and agree strategies to promote including supporting across LMS.

6.4	Sustain implementation of the Stillbirth Care Bundle to maintain reduction in stillbirths and share good practice across the STP (MSLC priority)	Each Trust within LMS has implemented the Stillbirth Care Bundle and monitors on a monthly basis: % of women identified as smokers at booking referred to a specialist stop smoking service Proportion of women having a CO test at booking Number of unexpected SGA babies born % of intrapartum CTG interpretations reviewed by a midwife / doctor hourly during labour No. of still births (>=24 weeks)	• Benchmark that there is consistency across the LMS of monitoring and reporting of Stillbirth interventions and outcome measures.
6.5	Monitor the impact of programmes to improve health in pregnancy, share learning and identify gaps in provision (MSLC priority)	Health in Pregnancy programmes are available in some Trusts (B&NES and Wiltshire) with demographic data collected to plan services and determine efficacy. Percentage of mothers recorded as smoking at time of booking Percentage of mothers recorded as smoking at time of delivery Percentage of women with BMI 30 to 34.9 at	• Need to identify current position, some Trusts are able to offer focused health improvement programmes as a result of commissioning priorities.

		booking Percentage of women with BMI 35 to 39.9 at booking Percentage of women with BMI 40 to 49.9 at booking Percentage of women with BMI 50+ at booking	
6.6	Improve understanding of the definition and prevalence of vulnerabilities in pregnancy across the STP and work to improve engagement and support for vulnerable women and their families (MSLC priority) links to 5.8	Baseline data is currently being collected across the LMS for the period 2016/17 and Q1 2017/18 which includes: Vulnerabilities: <20 years / substance misuse / perinatal mental health / homeless or housing issues / domestic abuse / recent arrival as a migrant / asylum seeker or refugee / English as a second language / concealed pregnancy Method: % of pregnant women with one of the vulnerability factors listed above (total of all pregnant women as denominator) at booking % of pregnant women with 3 or more of the	• Review the data to establish the current picture across the LMS and develop strategy in response.

		above vulnerability factors at booking % of pregnant women at booking with the 'toxic trio' at booking	
6.7	Ensure commissioners and maternity services are responding to demographic changes among women of childbearing age and considering the needs of particular vulnerable groups, including Syrian refugees, European migrants and military families (MSLC priority)	Not yet started	• Agree the data set to be collected.
6.8	Ensure effective supervisory mechanisms are in place to support midwives locally (MSLC priority)	Each individual Trust has developed a plan to support implementation of the AEQUIP Professional Midwifery Advocate role.	• To scope the opportunity of providing cross boundary cover across the LMS.
6.9	Clinicians from each provider to actively participate in the Strategic Clinical Network to drive continuous improvement	Membership already established	n/a
6.10	Work closely with neonatal network to align strategies	Already established	n/a

7.2 Co-production of the Plan

A Maternity Transformation Plan (MTP) planning event was held in June 2017 for service users, leads and staff from maternity and early years' services to reflect on the Better Births report and identify key areas for action locally. A small task and finish group came together afterwards to pull together the ideas generated on the day and formulate a draft plan. A subsequent event was organised in September 2017 to present the draft MTP to those who attended the June event to obtain feedback. The opportunity was also taken to begin work on an area for action identified in June, namely to change some of the language used during pregnancy and birth to become more user friendly and create more positive perinatal experiences for women and their partners.

7.3 MTP Co-ordination and implementation

Our LMS is developing a proposal to use assigned national ring-fenced funds to appoint a dedicated Project lead midwife and obstetrician time to help deliver the actions assure progress and support clinical engagement and ownership.

It is envisaged that each provider will identify leads for the key themes of the plan within their teams who will liaise with each other and with the MTP Project Lead to ensure actions are implemented effectively and equitably across the LMS where appropriate.

A detailed communication and engagement strategy will be developed as part of this plan. This will build on the RUH Maternity redesign programme, which commenced in December 2016 prior to the conception of the Local Maternity System. The communication and engagement strategy will be co-designed with providers and stakeholders by early November 2017.

8 The role of service users and opportunities to provide feedback

There are a range of opportunities for women accessing maternity care and those supporting them to feedback on their experience including social media, real-time feedback, 'Friends and Family', and provider surveys.

Service users have been centrally involved in the local MSLC for several years, providing the user perspective at meetings and taking forward discreet pieces of work, such as a birth environment audit and more recently, developing a place of birth user survey to which over 800 service users responded.

It is recognised there is more to be done to improve how services engage with women accessing maternity care and those supporting them and how we as an LMS listen and respond appropriately. Ideas for improvement include:

- collating service user feedback that providers and user representatives are gathering across the LMS in a way that can inform service improvement
- pro-actively seeking feedback from a representative sample of service users, not just relying on those who are confident at voicing their experiences
- ensuring we are engaging with the wider community, especially partners and families

Plans are in place to work with current MSLC user representatives and others expressing an interest to be involved in maternity service improvement to take forward this work. The development of a Maternity Voices Partnership is being discussed to build on the good work to date engaging service users.

Each provider and commissioner has a documented and advertised complaints process to support woman, families and carers when things go wrong.

9 Risks

The table details current identified risks. This will be expanded and the level of risk scored by the MOS by the end of Nov 2017.

Focus	Risk	Mitigations
Workforce	Due to the staffing models recommended by Better Births, there is a risk that they cannot be fully implemented without additional investment.	Involvement of national team to develop models of care that are deliverable and sustainable.
	Due to the shortage of skilled midwives, there is a risk that insufficient staff can be recruited / retained to implement the new models of care.	Link with HEE work, STP workforce plan etc.
	Due to proposed significant changes to working practices, there is a risk that staff availability will decline.	Ensure staff involvement and engagement with Better Births recommendations.
LMS and Accountable Care organisational development	Due to the large number of agencies involved, there is a risk that agreeing shared goals and objectives will be difficult and time consuming	Regular maternity forum and MSLC meetings with attendance by appropriate decision makers.
	Due to operational /financial issues with identifying host or new buildings, there is a risk that Community Hubs cannot be established	Primary focus is on shared care approach during transition period to National transformation of Health and Social Care.
Service Performance	Due to the proposed changes to established models of care, there is a risk of unintended consequences resulting in deteriorating performance.	Use of robust Quality Improvement methodology to inform change strategies. Continuous monitoring of outcomes with benchmarking against SW and national key performance indicators.
Service Users	Due to national developments there is a risk that women will request personal budgets for their maternity care and a decision has been made by the LMS to defer this offer.	The Maternity Transformation Plan will clearly set out what women and their families can expect.

10 Conclusion

This document sets out the initial strategy as co-created by the LMS and wider stakeholders. It is envisaged that it will inform the basis of improvements to our services for our women, babies and families. It is recognised that it will evolve in line with national maternity transformation developments.

References

South West Clinical Network Maternity Dashboard: http://maternitydashboard.swscn.org.uk/

PHE Public Health Pregnancy and Birth profile: https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-pregnancy

Universal health visiting service: mandation review:

https://www.gov.uk/government/publications/universal-health-visiting-service-mandation-review

Wiltshire, Swindon and Bath and North East Somerset Stillbirth and Infant Mortality Report (2017)

Appendix 1: Current membership of the core LMS (Maternity Forum and MSLC)

Acting Director of Acute Commissioning (Lead for Maternity STP)	Wiltshire CCG
STP lead midwife	SFT
STP lead public health representative	Wiltshire Council
Associate Director for Quality	Wiltshire CCG
Commissioning lead	B&NES CCG
Commissioning lead	Swindon CCG
Consultant Obstetrician and Gynaecologist	Royal United Hospitals Bath NHS Foundation Trust,
Clinical Midwifery Manager/Modern Matron	Royal United Hospitals Bath NHS Foundation Trust,
Head of Nursing and Midwifery, Women & Children's Division	Royal United Hospitals Bath NHS Foundation Trust,
Women and Children's Divisional Manager	Royal United Hospitals Bath NHS Foundation Trust,
Midwife	Royal United Hospitals Bath NHS Foundation Trust,
Infant Feeding Specialist	Royal United Hospitals Bath NHS Foundation Trust,
Senior Midwifery Matron	Royal United Hospitals Bath NHS Foundation Trust,
Consultant Obstetrician	Great Western Hospitals NHS Foundation Trust
Community Midwife	Great Western Hospitals NHS Foundation Trust
DAU Midwife (lead for Diabetes in DAU)	Great Western Hospitals NHS Foundation Trust
Consultant Obstetrician and Gynaecologist	Great Western Hospitals NHS Foundation Trust
Clinical Midwifery Manager	Great Western Hospitals NHS Foundation Trust
Maternity Support Worker	Great Western Hospitals NHS Foundation Trust
Consultant Paediatrician (special interest in SCBU)	Great Western Hospitals NHS Foundation Trust
Head of Midwifery	Great Western Hospitals NHS Foundation Trust
Head of Maternity and Neonatal Services	Salisbury NHS Foundation Trust
Consultant obstetrician and gynaecologist (Head of Obstetrics and Gynaecology Service.	Salisbury NHS Foundation Trust
Labour Ward Manager	Salisbury NHS Foundation Trust
Community Midwifery Manager	Salisbury NHS Foundation Trust
Safeguarding Midwife	Salisbury NHS Foundation Trust
Antenatal Services Manager	Salisbury NHS Foundation Trust
Infant Feeding Lead	Salisbury NHS Foundation Trust
Midwife	Salisbury NHS Foundation Trust
Midwife	Chippenham Birthing Centre
Head of Service, Health Visiting	Bath and North East Somerset Community Health & Care Services
Family Nursing Partnership	Bath and North East Somerset Community Health & Care Services
Infant Feeding Lead	Bath and North East Somerset Community

	Health & Care Services
GP	Wiltshire CCG
Quality Manager	Wiltshire CCG
Quality Manager	Swindon CCG
Principal Officer – Health & Wellbeing	Swindon Council
Public Health Commissioning & Development Manager, Children and Young People	B&NES Council
CAMHS and Maternity Commissioning Project Manager	B&NES CCG
Lead Commissioner	Wiltshire Council
Acting Director of Public Health	Wiltshire Council
Assistant Director for Children and Young People's Service	Wiltshire Council
Head of Service (Conception to 5 years)	Wiltshire Council
Screening & Immunisation Coordinator	NHS England
Patient Safety Programme Director	West of England Academic Health Science Network
South West Maternity and Children's Clinical Network Manager	NHS England
Quality improvement Lead, South West Clinical Network	NHS England
NCT Antenatal Teacher and NCT Doula	NCT
Service User Representatives	
Health watch representative	
Children Centre Representatives	B&NES, Swindon and Wiltshire Children Centre's Services
Health Visiting Team Leaders	B&NES, Swindon and Wiltshire Health Visiting Services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Maternity Strategy
& Liaison Committee


NHS
Wiltshire
Clinical Commissioning Group


NHS
Bath and
North East Somerset
Clinical Commissioning Group


NHS
Swindon
Clinical Commissioning Group


NHS
Royal United Hospitals Bath
NHS Foundation Trust


NHS
Great Western Hospitals
NHS Foundation Trust


NHS
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