Inequalities with Maternity Care – HSC Scrutiny

The objective of this paper is to answer and provide assurance to the HSC Scrutiny for the questions submitted with regards to maternity and heath visitor provisions at Croydon University Hospital

Q1) The UK generally compares poorly with other developed economies on maternal and neonate outcomes. What is being done at a national level to address this?

The Maternity and Neonatal Safety Improvement Programme was renamed following the launch of the NHS Patient Safety Strategy in 2019, which was updated in February 2021. It was previously known as the Maternal and Neonatal Health Safety Collaborative. The Maternity and Neonatal Safety Improvement Programme is one of the National Patient Safety Improvement Programmes in place to help deliver better care for patients.

The programme aims to:

- Improve the safety and outcomes of maternal and neonatal care by reducing unwarranted variation and provide a high-quality healthcare experience for all women, babies and families across maternity and neonatal care settings in England.
- Contribute to the national ambition, set out the NHS Long Term Plan to reduce the rates of maternal and neonatal deaths, stillbirths, and brain injuries that occur during or soon after birth by 50% by 2025.
- Contribute to the national ambition, set out in Safer maternity care: progress and next steps to reduce the national rate of preterm births from 8% to 6%.

The Maternity and Neonatal Safety Improvement Programme is led by the National Patient Safety Improvement Programme team and covers all maternity and neonatal services across England. It continues to be supported by 15 regionally based Patient Safety Collaboratives, hosted by the Health Innovation Network.

In 2023 Ruth May provided an update on the programme prior to the launch of the Maternity and Neonatal Three Year Delivery Plan (TYDP)

"The NHS is continuing to prioritise making maternity and neonatal care safer, more personalised, and more equitable for women, babies, and families, we are delivering on commitments made in the NHS Long Term Plan and since to improve experience and outcomes, including specific actions to reduce known inequalities"

"To strengthen our approach we are expanding the leadership by appointing a neonatal National Clinical Director and we have announced the appointment of ICB Chief Executive Officer, Sam Allen, as Chair of the Maternity and Neonatal Programme Board. The Chair will work alongside the NHS England maternity and neonatal programme to represent the programme at the most senior levels of the NHS, wider health sector and with key stakeholders. They will also provide additional advice,

scrutiny and challenge to drive the delivery of the maternity and neonatal programme. We are also developing the data and tools available to enable Trusts to identify issues earlier and take action, and we have increased staffing numbers across the maternity and neonatal workforce".

In March 2023, the NHS England Board agreed the Three-Year Delivery Plan for Maternity and Neonatal Services. The plan brings together existing national commitments alongside action in response to independent reports on services in East Kent and Shrewsbury and Telford. This paper sets out progress against the four themes of the plan:

- Listening to and working with women and families with compassion
- Growing, retaining, and supporting our workforce
- Developing a culture of safety, learning and support
- Standards and structures that underpin safer, more personalised, and more equitable care.

Outcomes:

The NHS is making progress on the National Maternity Safety Ambitions to halve the rates of stillbirths, neonatal death, maternal death and brain injury in babies between 2010 and 2025, and to reduce the national rate of pre-term births. We exceeded the interim target of a 20% reduction in stillbirth and neonatal mortality by 2020. publication of the MBRRACE-UK perinatal mortality surveillance report for births in 2022 was released on the 11th of July 2024, The report focused on births from 24 completed weeks' gestational age, with the exception of the section on mortality rates by gestational age, which also includes information on births at 22 to 23 completed weeks' gestational age. The key messages from the report were:

- Extended perinatal mortality rates decreased across the UK in 2022 (UK extended perinatal mortality rate: 5.04 per 1,000 total births) after a rise in 2021, although rates remain higher than both 2019 and 2020.

- Compared with rates in 2021, stillbirth rates per 1,000 total births in 2022 were lower across all the devolved nations except Scotland, where there was a small increase: 3.35 (UK); 3.33 (England); 3.31 (Scotland); 3.63 (Wales); and 3.49 (Northern Ireland).

- There were increases in the neonatal mortality rate per 1,000 live births in England and Wales compared with 2021: 1.69 (UK); 1.67 (England); 1.59 (Scotland); 1.91 (Wales); and 2.29 (Northern Ireland).

Listening to women and families:

An ambition has been set that women always experience care that is kind and compassionate, that they are listened to, and have equitable access to specialist care. Services are being transformed to provide the care that women need including consistent access to pelvic health services, maternal medicine networks and perinatal mental health services. National data from May 2023 show that an additional 16,000

women per year accessed specialist community perinatal mental health services and maternal mental health services (for women experiencing loss or trauma arising from pregnancy or birth, or fear of birth) compared to two years previously.

Maternity and Neonatal Voices Partnerships (MNVPs) have been established in every system to work with families to improve care. Lessons from independent reports highlight the need to go further. Through the three-year delivery plan clear expectations have been set for trusts and ICBs about the involvement of MNVPs and that they should be well supported with a fully funded workplan.

Health inequalities remain a priority commitment; every Local Maternity and Neonatal System is implementing an equity and equality action plan with evidence-based interventions which reflect the needs of the local population. We are implementing enhanced midwifery continuity of carer (MCoC) to ensure safe, consistent, and personalised care in the areas of highest need. Nationally trusts are not expected to deliver against a target level of MCoC, and this will remain in place until maternity services in England can demonstrate sufficient staffing levels to do so. In the meantime, providers must ensure that safe staffing is in place before the rollout of further MCoC teams.

Standards and structures

To deliver the national ambitions to improve care, maternity and neonatal teams need to be supported by robust standards and structures – including best practice, timely access to data, and appropriate digital and estates infrastructure.

In May 2023, NHSE published an updated version of the Saving Babies' Lives Care Bundle. This sets out best-practice clinical guidance to reduce perinatal mortality and pre-term births and is accompanied by tools to support implementation and track progress. Trusts were expected to implement the care bundle by March 2024.

Since March, the CQC has published inspection reports for 53 provider units as part of the targeted inspections of maternity services announced by the government in July 2022. 19 units have seen their overall rating go down, and 5 went up. Across the 53 units, three are now rated as outstanding overall, with a further two achieving the highest rating for the 'well-led' domain. Corydon university hospital maternity was rated as GOOD. 31 units were rated as 'requires improvement' or 'inadequate' in the well led or safe domains. Key emerging themes identified by the CQC are leadership and staffing, culture, personalised care and triage. The majority of these are addressed through work streams of the programme. The increased demand for triage is requiring a multi-organisational approach including good practice guidance being produced by RCOG.

Croydon in engaged and involved with all aspects as outline above, we have set ambitions and targets alongside the TYDP in conjunction with SWL. We have embedded the asks for Saving Babies Lives care bundle (V3) including quarterly review supported by the LMNS. We have an engaged MNVP team and are currently recruiting into a neonatal

lead to support the work of listening to our neonatal families to ensure equity and alignment with maternity. We are developing our perinatal mental health services and working with SLAM we have recruited a senior midwife to lead on the pathways of mental health support for those who have suffered pregnancy loss (HELIX). We have also maintained 3 key MCoC teams two of which focus on our postcodes with areas of highest deprivation and include asylum seekers and migrants housed through the home office (more detail below).

Q2) How does Croydon compare against other London boroughs and the wider national statistics? What are the differences and commonalities? What are the causes of the differences? What are we doing about it?

Q3) Surveys show variations in outcomes with deprivation and ethnicity variations being apparent. What are the root causes of this, and what are we doing about it? A recent study in the Lancet is available here. Please cover impacts on both maternal and baby outcomes.

MBRRACE-UK is a national collaborative programme of work involving the surveillance and investigation of maternal deaths, stillbirths and infant deaths. It is a national audit programme and is commissioned by all UK governments to collect information about all late fetal losses, stillbirths, neonatal deaths and maternal deaths across the UK. The programme tracks information about where and why babies and mothers die every year.

MBBRACE Saving Lives Improving Mothers' Care 2024 report findings showed: 275 women died during pregnancy or up to six weeks after pregnancy in 2020-2022 13.56 women per 100,000 died during pregnancy or up to six weeks after pregnancy

The below data is the position of CUH in relation to the national picture for key indicators and outcomes that relate to increased risk of maternal or neonatal death and/or maternal or neonatal poor outcomes.

Deprivation data

Key surveillance finding from MBRRACE: Women living in the most deprived areas had a maternal mortality rate twice that of women living in the least deprived areas, emphasising the need for a continued focus on action to address these disparities

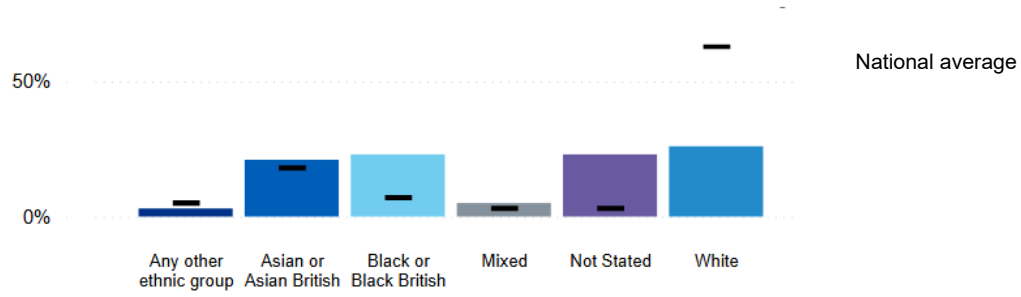
Data shows (see table below) that for December 2024 80% of the women booked for care with Croydon maternity department live within the 1-5 deciles of deprivation, this is not only above the national average of 59% but when compared to our south west London colleagues such as Kingston (21%), highlights that the Croydon population are at an increased risk of poorer outcomes.

Month	Trust	National	Indicator	Trust
December 2024				
Value outside reporting parameters	2%	0%	Index of deprivation of mother at booking	Croydon Health Services NHS Trust
1st Decile (Most)	3%	14%	Index of deprivation of mother at booking	Croydon Health Services NHS Trust
2nd Decile	23%	12%	Index of deprivation of mother at booking	Croydon Health Services NHS Trust
3rd Decile	18%	12%	Index of deprivation of mother at booking	Croydon Health Services NHS Trust
4th Decile	27%	11%	Index of deprivation of mother at booking	Croydon Health Services NHS Trust
5th Decile	9%	10%	Index of deprivation of mother at booking	Croydon Health Services NHS Trust
6th Decile	6%	9%	Index of deprivation of mother at booking	Croydon Health Services NHS Trust
7th Decile	3%	9%	Index of deprivation of mother at booking	Croydon Health Services NHS Trust
8th Decile	5%	8%	Index of deprivation of mother at booking	Croydon Health Services NHS Trust
9th Decile	2%	8%	Index of deprivation of mother at booking	Croydon Health Services NHS Trust
10th Decile (Least)	2%	7%	Index of deprivation of mother at booking	Croydon Health Services NHS Trust
Pseudo postcode	2%	0%	Index of deprivation of mother at booking	Croydon Health Services NHS Trust

Ethnicity Data:

Key finding from MBRRACE; there was a nearly three-fold difference in maternal mortality rates amongst women from Black ethnic backgrounds and an almost two-fold difference amongst women from Asian ethnic backgrounds compared to White women.

December 2024 data showed that of the 330 women booked for care at CUH 26% identified as White, 23% as Black or black British, 21% as Asian or Asian British and 3% as Ethnic other, unfortunately 23% of women and pregnant people did not state their ethnicity. Compared to our SWL colleagues CUH book a larger proportion of BAME services users. Of the services users booked for care at Kingston 2% identified as Black or Black British whilst at St George 12% of their service users identified at Black or Black British



Complex Social Factors:

Key finding from MBRRACE; 9% of maternal deaths in 2020-2022 have multiple disadvantages identified.

Examples of complex social factors in pregnancy include: poverty; homelessness; substance misuse; recent arrival as a migrant; asylum seeker or refugee status; difficulty speaking or understanding English; age under 20; domestic abuse. Of the service users

booked in December 20% fell into this category, for our neighbouring partners this number ranged between 0% and 13%

Month	Trust	National	Indicator	Trust
December 2024				
Yes	20%	11%	Complex Social Factors	Croydon Health Services NHS Trust
No	80%	83%	Complex Social Factors	Croydon Health Services NHS Trust

For many of the known factors impacting maternal outcomes Croydon has a population that is above the national average for women and pregnant people identified as having a disparity in their outcomes. Despite this outcomes for Women, pregnant people and babies in Croydon remain good.

Mode of birth:

For most women and birthing people, a vaginal birth is the option recommended by their healthcare professional because there is:

- More choice over where to give birth
- More choice about who is in the room during labour and birth
- A shorter recovery time and shorter stay in hospital
- Lower chance of wound or womb infection
- Less chance of serious complications in this birth and future pregnancies
- No chance of abdominal scar tissue (adhesions) which can cause internal pain and problems with operations later in life
- Hormones are released during labour which support breastfeeding
- A higher chance of uninterrupted skin to skin contact after birth, which helps initiate breastfeeding

However Caesarean section (CS) rates are increasing nationally and a pregnant person right to choose their mode of birth along with recommendations to induce births to support positive neonatal outcomes mean that the national average for CS births in England is approx. 45%

At CUH the CS rate has is in line with the national average, the breakdown below shows that the elective rate is 20% whilst the rate of emergency CS births is 27%. The population and demographic within CUH as outlined above mean that risk factors for co-morbidities such as gestational diabetes and hypertension may dictate discussions and advice regarding time of birth and increase interventions such as induction of labour. Whilst these are areas we monitor and observe the national landscape is

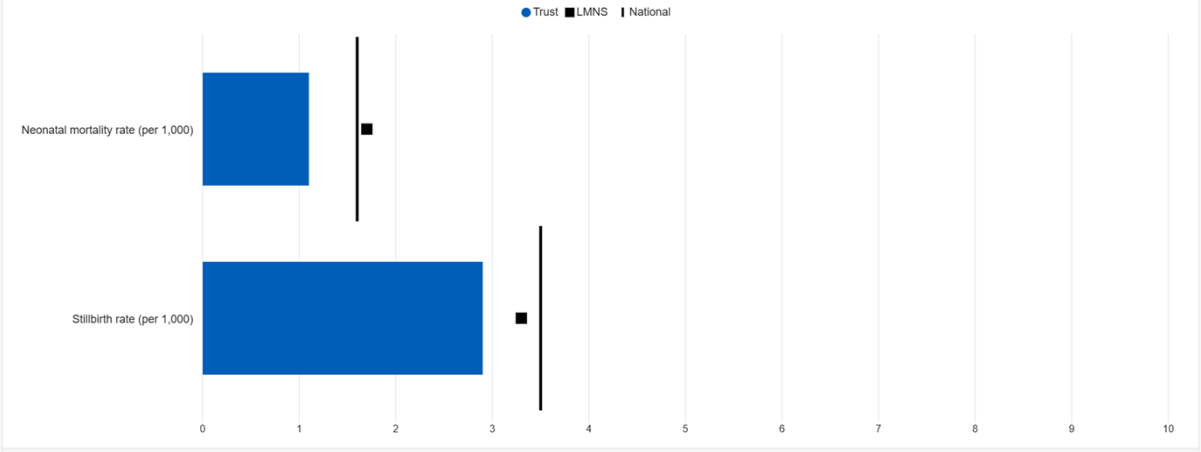
focused on choice for the service user and so ambitions to lower caesarean section rates do not exist

Month	Trust	National	Indicator	Trust
December 2024				
Elective c-section	20%	20%	Method of delivery	Croydon Health Services NHS Trust
Emergency c-section	27%	25%	Method of delivery	Croydon Health Services NHS Trust
Instrumental	7%	10%	Method of delivery	Croydon Health Services NHS Trust
Spontaneous	43%	44%	Method of delivery	Croydon Health Services NHS Trust

Whilst we do not focus on the mode of birth in order for service users to make fully informed choices and understand the impact of birth on their own health both now and in future pregnancy's it is of vital importance that education is mainstay in our work. In the last 4 months with the financial support of family hubs we have been able to reintroduce parent education classes, something that we have not had since the pandemic due to the significant staffing challenges we were facing. The sessions are varied and cover an introduction the hospital and our offer of care, as well as classes specifically for fathers, classes discussing birth and what to expect and sessions focussed on infant feeding and postnatal care. The classes are well attended and we are building the bank of information and education we provide to include specialist sessions on multiple births, hypertension and gestational diabetes as well as looking at ways to have the classes in multiple languages and across multiple platforms.

Alongside our modes of birth being aligned with national averages our neonatal outcomes also are within the expected range. The month of December highlighted that our neonatal mortality rate and stillbirth rate per 1,000 were both lower than not only our SWL colleagues but also the national average (as seen in the table below) Whilst this data peaks and troughs, any month where an increase is noted a deep dive is actioned looking into all of the cases and deriving immediate learning and identifying if any changes in practice need to occur, this is carried out by our maternity and neonatal teams to ensure high quality safe care is always achieved.

Neonatal outcomes



Whilst we sit in a challenged position with some population factors that cannot be changed we have a multitude of provisions to support good outcomes for mothers and babies and align with the national agendas for SBLV3 and TYDP.

MNVP

The MNVP serves the needs of local women and birthing people and their families and the Local Maternity System, including all acute and community services and community hubs. It links with clinical network(s), to contribute towards and follow regional strategic direction, and links with other MNVPs within the LMS to share good practice.

The MNVP will listen to and act upon women and birthing people, family and carer feedback at all stages of the commissioning cycle – from needs assessment to contract management. All members are committed to working in partnership and to implementing woman and birthing person-centred care. Woman and birthing person-centred care offers women and birth people information, choice and care based on best available evidence, always respecting their choices and human rights.

Throughout 2024 the MNVP have strengthened their engagement with our service users, carrying out 15 steps through all areas of maternity and providing feedback on areas of improvement and good practice to support the service users journey. In April 2024 supported by the ICBs a Whose Shoes event focusing on the voices of the neonatal familes, was held to understand the barriers and areas for further development within the neonatal debarment, as with much of or service user feedback estate and the lack of space to provide BAPM compliant care was raised along with noise levels, since the event we have implements new noise monitors and created quite time within the nurseries to support the neonates developmental journey.

Parent education

In November 2024 a new role was developed alongside the family hubs to support with parent education and communication internally and externally.

The specialist midwifery role has developed AN education packages for birthing people and their partners to enable them to have information pertaining to the pregnancy and birth journey in a setting that enabled them to build community support and ask questions without time barriers.

The current courses are;

Labour and Birth Online Session 1	
Welcome to Croydon	
Baby Steps Postnatal Care	
Labour and Birth Online Session 2	
Bump and Baby Group	Midwife Q&A
Happy Baby Community	Midwife Q&A

Each session can hold 20- 25 couples with uptake ranging from 10% - 50% the aim in the new financial year is to secure further funding to enable the growth of the sessions and upskilling of the wider workforce to support parent education, informed choice and personalised care.

Midwifery Continuity of care (CoC)

The midwifery continuity of carer model should be the foundation of maternity care, in which women receive seamless care from a primary known midwife for the majority of their care. A midwifery continuity model works within and alongside the multi-disciplinary maternity team. Some women will need care from a range of professionals in addition to their primary midwife. The opportunity for women to build relationships with their key maternity care providers should be built in to the design of maternity systems.

At CUH we have maintained 3 COC teams Lucina is a low intervention team comprised predominantly of women who wish to birth in our birth centre.

Leander and Rainbow are CoC teams based on geography focusing on postcodes with the highest proportion of BAME and vulnerable service users, predominantly the north of the borough. The two teams also capture our migrant and asylum seeking populations. Averages from October-December 2024 are demonstrated in the Tables below for all

aspects of care. The trust overall team continuity score for antenatal care remained over 70% during this time. For the same quarter team continuity for postnatal care had dropped below 70%, this is due to increased sickness within the teams. Named midwife postnatal continuity remains below the 70% target, this is mainly due to the working patterns of the teams.

Table 1.

ANTENATAL CARE	Leander	Lucina	Rainbow	CUH Average
Team Continuity	100%	94%	88%	94%
Named midwife continuity	84%	72%	62%	73%

Table 2.

POSTNATAL CARE	Leander	Lucina	Rainbow	CUH Average
Team Continuity	88%	51%	66%	68%
Named midwife continuity	28%	32%	32%	31%

Intrapartum Continuity

At the moment we have suspended reporting on intrapartum care as our teams continue to face multiple challenges as a direct result of our current staffing skill mix. At present a significant amount of continuity of care midwives are redeployed to work within non-intrapartum wards. As our MCoC teams are largely comprise of experienced band 6 midwives and redeployment of the skilled workforce is vital for overall safety.

Overall Delivery of Continuity of Carer

We have recently had a large influx of Band 5 midwives. This does follow our yearly trend as recruitment largely garners Band 5 midwives hoping to undertake their preceptorship programme rather than Band 6 midwives ready to join continuity of care teams.

As the trust is now in a better position regarding recruitment, the MCoC teams are fully recruited. The Public Health and Maternity Transformation Matron is creating an action plan regarding improving the overall delivery of Continuity of Carer.

Working with our community partners;

Working with both family hubs and the Asian resource centres ARRC CUH maternity team are participating in and supporting programmes that support women and their families in the PN period with specific focused on Black and Asian families due to the disparities in outcomes and access to health services as outlined above.

Meeting our community where they are at and with support from people that speak their language or looks like them will support engagement, uptake of the service and having feedback from all members of our population allowing us to truly have a service that is fit for the purpose of all.

Q4) In 2019 Healthwatch Croydon reported on mental health services and maternity. The report identified a number of issues. Please show us how those issues have been addressed.

The recommendations from the 2019 report are listed below and the subsequent actions taken by CUH to date.

• *Increased signposting and information on offer to potential new parents: This should be implemented through a variety of mediums including, healthcare and allied professionals, community groups, websites, emails, social, media and text messages, and active distribution of pamphlets and leaflets*.

Within CUH we have relaunched our Instagram social media page as an opportunity to signpost and reach out to potential parents and pregnant people. The introduction of a Public health matron is strengthening ties with our primary care colleagues to enable us to share information and updates through a variety of channels, work is still ongoing to further strengthen this through the relaunch or our HEARD programme.

• *Increased continuity of care, more collaboration between the various services along the maternity pathway: Implementation of a maternity intranet or private internal network*.

As outlines above we have maintained CoC for our vulnerable service users we have also created a team whose focus is severe mental health concerns (Lotus team) they do not provide intrapartum continuity but ae able to maintain a caseload of our most at risk

mental health service users and work alongside our perinatal mental health specialist obstetrician to care plan and support these women and pregnant people through their pregnancy and postnatal journey. We have a specialist band 7 midwife who manages the team and also caseloads a selection of the women. The Band 7 also provides education to the wider midwifery team through monthly mandatory training and attends safety huddles to provide updates for specific cases to the wider team. This roe is integral to support the wider service whilst ensuring high levels of care provision within the specialist team. We have also recruited in to the HELIX role, the post is a collaborative post with SLAM providing specialist midwifery care for women who have suffered bereavement and have mental health concerns. The midwife works with a specialist MDT team in the SLAM to provide education support and care for this caseload of service users.

We are yet to set up a maternity intranet but with support from our digital midwife we will look to create a plan around how this can be set up ensuring co-production and the appropriate stakeholder engagement. We are however active within the perinatal network and partake in the regular meetings with feedback and updates as requested.

• *Facilitate mental health education amongst the pathway for expectant parents: This can be done through antenatal classes, seminars or wellbeing workshops within children's centres or NCT groups*.

Addressed above with the inception of parent education, our specialist perinatal mental health midwives will also work with our parent education lead to develop bespoke education packages both for women with MH concerns but also for the wider population with regards to signposting, what to look out for and where to seek advice or further support, this is an ambition set by our public health matron for the 25/26 financial year

• *Scope out a new pathway for service users who identify themselves as having mental health challenges, prioritise their referral: Service users who identify as having mental health challenges should have prioritised pathways*.

Having the specialist mental health team means these service users are prioritised we have also redeveloped or self-referral form to ensure that at the point of referral all service users with additional needs or medical conditions are allocated to the correct teams for early intervention and support as required. The self-referral has been redeveloped at the end of 2024 and we continue to observe this and monitor feedback about ease of use and correct placement or service users in to appropriate community teams

• *Recruitment of staff into the borough, to ensure services are not overstretched: Consideration can then be given to the emotional wellness of service users, emotional wellbeing is being side-lined due to the pressure running the service*.

Due to a robust recruitment and retention strategy CH is proud to announce that we have our lowest vacancy rate of the last 5 years. We currently have a vacancy of less than 5WTE midwives with a pipeline to fill this with our currently employed internationally educated midwives. Not only ha our recruitment plan been robust and seen significant positive impacts our retention has also been well supported and engaged the workforce appropriately. We are now in the difficult position of not having job to offer our current cohort of student midwives, we are however working with our SWL colleagues to look for a local plan to address this and also proactively recruiting against maternity leave and retirement to avoid gaps and offer opportunities as soon as possible. Having a well-established substantive team means that all mandatory training and standards as set by ourselves are maintained, monitored and when not actioned managed versus working with a transient temporary workforce where these standards are harder to monitor and manage

• *Increased support networks like the local children's centres*

Over the past 12 months with the support of SW core connectors, our public health matron and the MNVP we have increased our presence in children centres and our working in partnership with our health visitor colleagues and other community partners. We have well attended infant feeding sessions within our children centres and our midwifery teams are available to screen for signs of postnatal depression or answer questions concerning mental health. These relationships can continue to be strengthened and our MNVP and midwifery teams will look at the appropriate ways to strengthen these relationships

• *Find a solution to variance in service: Additional training and benchmarking against exemplar services that have proven quality and patient satisfaction*.

Developing robust mandatory training packages is helping to support all teams with the levels of care and information they provide, being reactive to both service user and staff feedback through you said we did forums of MNVP meetings means we are able to try and rive the service in the direction that supports and compliments both. We need to improve our forums for formal feedback and so utilising Friend and Family (FFT) feedback is an area of focus for us in the next financial year.

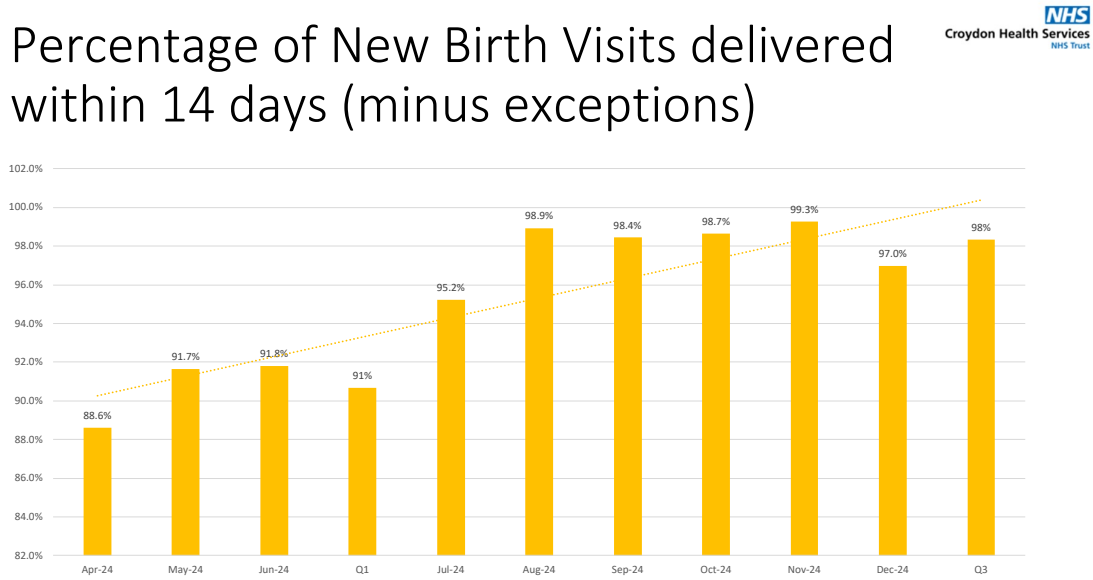
• *Communicate effectively the mental health challenges that can be faced by new parents: A high proportion of new parents in the borough have identified as having mental health challenges, but a proportion did not recognise symptoms. Ensure*

residents understand what symptoms look like for some of the more frequent mental health conditions to reassure them

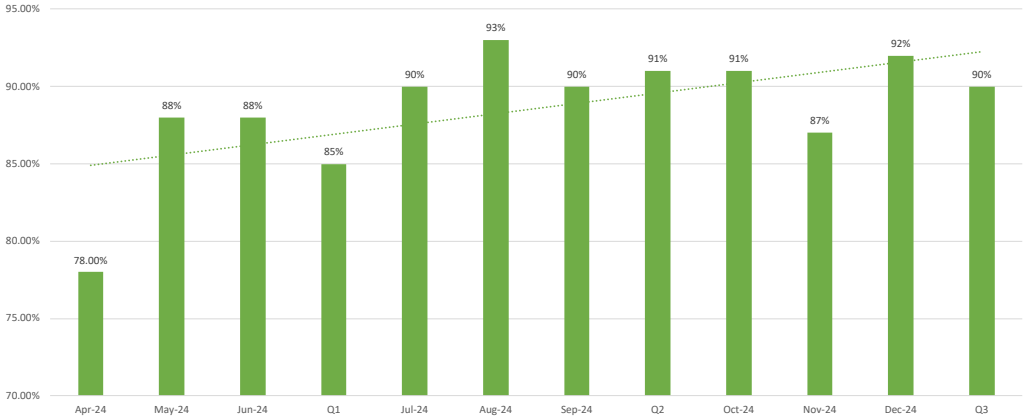
Asides for what is outline above stronger working relationships with or primary care partners will be required to drive the recognition and support of symptoms. Our public health matron has begun attending GP forums and with the focus of these actions will discuss ways that we can collaboratively support improvements in this area. Feedback on progress will be provided through internal process and via our quarterly reports.

Q5) Croydon's health visiting performance has been amongst the poorest in London for some considerable time. What are the current statistics and what are we doing about it?

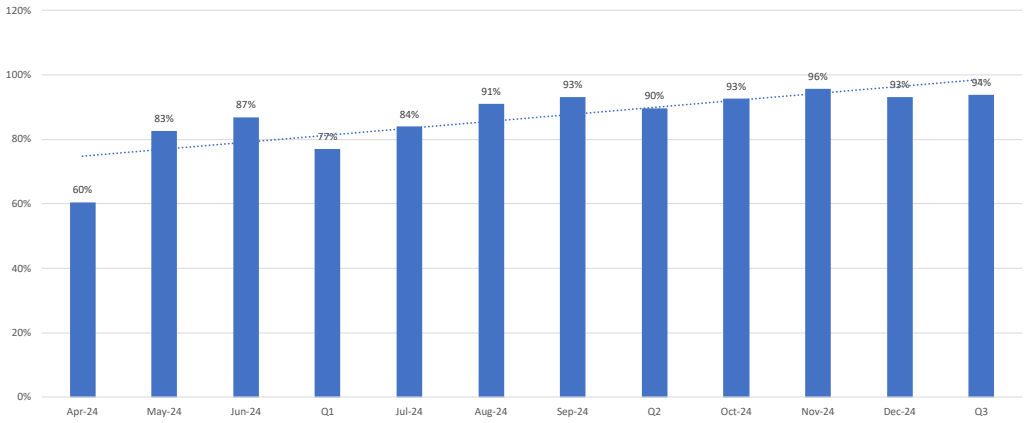
Croydon's Health visiting service has shown huge improvements on mandated contact KPI performance in the past 5 months. Seen below are the outcomes for the last 11 months which show an upward trend on performance. Croydon is now achieving similar outcomes for performance to many other less populous London boroughs.



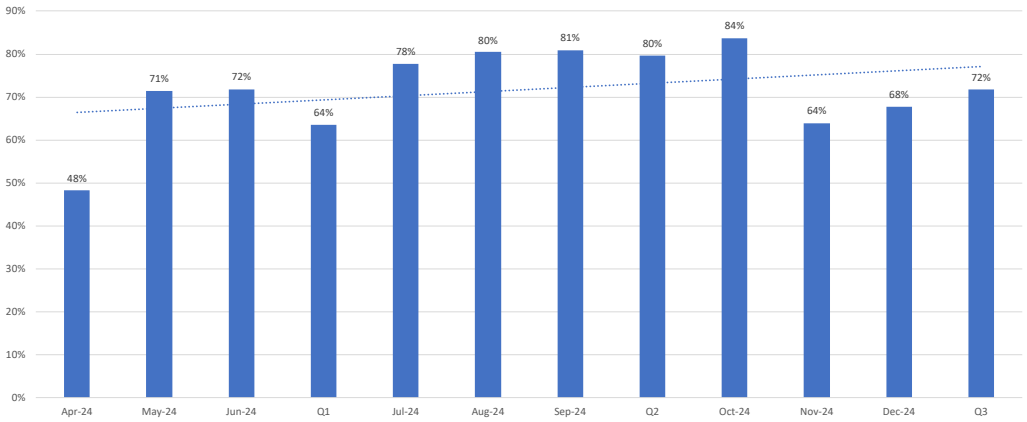
Percentage of children who received a 6-8 week review by 8 weeks (minus exceptions)



Percentage of children turning 15 months who have received a 1 year developmental review

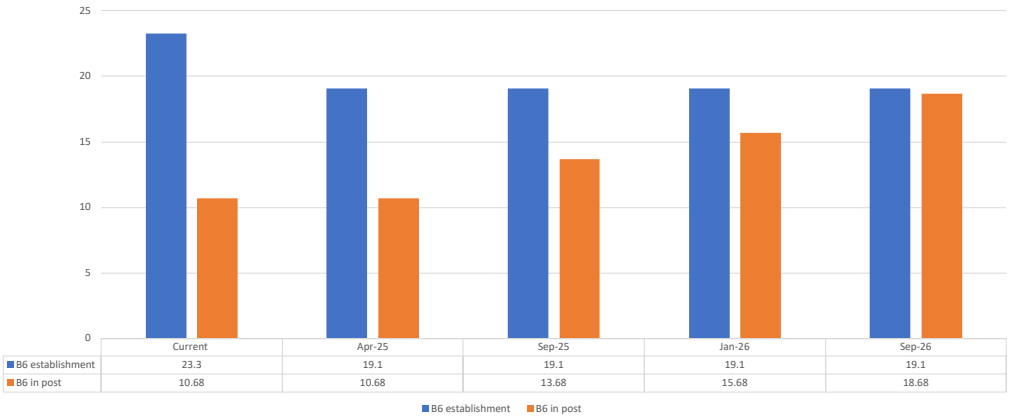


Percentage of children who received a 2 year developmental review by 30 months



Health visitor growth within the service is being developed and longstanding vacant Health visitor posts are being repurposing to create band 5 development posts with an in-house training programme and competency framework. The trajectory for this is shown below.

Health Visitor Recruitment Trajectory



	Current	Apr-25	Sep-25	Jan-26	Sep-26
B6 establishment	23.3	19.1	19.1	19.1	19.1
B6 in post	10.68	10.68	13.68	15.68	18.68

The service is working on efficient and practical ways to make the service more accessible to all families and to offer a tailored, more intensive approach to the families who need it most. This will be delivered through an enhanced pathway which will be in place of the Family Nurse Partnership programme which has been decommissioned.

Conclusion:

In summary a significant amount of work had gone into ensuring optimised care and outcomes for women and children receiving care within Croydon, trends remain upwards with plans in place to further embed and develop services, Ongoing internal and external scrutiny and assurance ensures delivery of key objectives and KPIs