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When Digital Ambition Meets the Reality of Maternity Care

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Digital transformation has the potential to make maternity care safer and more responsive, but technology only succeeds when it fits the physical environment, clinical pathways and the needs of the people using it.

When someone asks for help, can they explain what they need? Does the request reach the right member of staff? Can an urgent need be escalated without adding unnecessary noise and distress? **These questions connect the technology to the experience of mothers, babies, families and staff.**

They have come into sharper focus for me through discussions with healthcare professionals from across the UK on an advisory board convened by SSG. Colleagues from different specialities described how digital tools can support care, but also how easily their value is lost when the building, workflow and patient need are considered separately.

This has changed how I think about nurse call as one part of a wider digital maternity environment.

When digital ambition meets the physical ward

I believe that one of the biggest gaps in digital transformation is **assumed readiness**. Digital tools may offer better communication, more timely alerts and useful information about care. Yet these capabilities depend on reliable connectivity, adequate power, space for equipment and workflows that staff can use. Older hospital buildings were not designed for today's digital pressures or for patients who need closer monitoring.

When those conditions are overlooked, staff may face signal loss, missing information or delays in escalation. In an older maternity building, **these risks can be difficult to spot** from a system specification alone. Walking through real ward scenarios with estates, IT and clinical staff before infrastructure and hardware decisions are finalised can reveal where a proposed system may struggle in practice.

That exercise does not have to lead to major building work. It may show which spaces already work well, where connectivity or equipment placement needs attention, and how a request moves from bedside to response. These findings can guide improvements within the existing estate and help the system deliver its intended benefits while supporting quality and safety across maternity services.

A quieter ward must still be a responsive ward

The ward environment is another part of that picture. The early days between mother and baby should allow time for rest, recovery and family bonding, even when hospital care is needed. Women may also have complex clinical needs or spend longer on the ward. **Avoidable noise and interruptions affect families** and can **make it harder for staff to concentrate** on the most important tasks.

A quieter ward must still feel safe and responsive. Nurse call raises practical choices about which alerts need to sound at the bedside, which could reach the appropriate staff member directly, and how families know a request has been received. A mother holding her baby or recovering from a caesarean section may find a patient hand unit difficult to use or reach, perhaps speech could offer another way to ask for help. **These possibilities need to be explored** with clinical teams and families, alongside clear escalation routes and input from estates and digital colleagues.

The people who use a system should shape it

These choices need input from the **people who will use the system**. During a visit to SSG's Tech Centre, the advisory board worked through patient scenarios with colleagues from different trusts and specialities. The scenarios reflected challenges we encounter in daily care, including alarm fatigue, task prioritisation and accessibility. Seeing how newer nurse call capabilities could address them opened my eyes to possibilities I had not known existed. **How can staff ask for a solution when they do not know it is possible?**

Those conversations also showed that many of these challenges are shared across specialities, whether or not colleagues have a digital role. Yet the people who experience the problems may not be involved when project requirements are set. In maternity digital projects, estates may be consulted after workflows have been designed. In nurse call projects, frontline staff and patients may be brought in after infrastructure decisions. **When teams are unaware** of what a system could offer, **opportunities to improve care can be missed** before the design is even fixed.

Bringing those experiences into the same conversation early should become standard practice. **Projects are more likely to succeed when clinical, digital, estates and patients shape the requirements from the outset.** Clinicians and patients can explain what they need, while estates and IT teams can test whether the space and infrastructure will support it. Procurement and digital teams can then assess capabilities against a shared understanding of the care they are intended to improve. This matters even more when budgets and clinical urgency pull teams in different directions.

Data that helps us learn

The Tech Centre visit raised another question for me: what could we learn from information a connected nurse call system might provide? We have not traditionally had access to this data. Patterns in calls and alerts could help teams understand when requests increase, where interruptions recur and whether alert-routing processes support timely responses.

This approach to data is familiar in maternity care. Services already use electronic patient record data to compare care with national baselines. In our region, we use discrepancies as a starting point for shared learning rather than blame. **Nurse call information should be treated in the same way:** to understand patient needs and improve workflows, not to judge an individual member of staff by a response time taken out of context.

Keeping every family in mind

Data can show how a system is used, but it cannot tell us everything about the people who struggle to use it. That matters across maternity care, not only at the bedside. Digital exclusion can mean someone cannot access online information, contact a service easily or receive an appointment message in a form they can use. The consequences may include a missed appointment or a delay in seeking help. **Making a route digital does not mean every family can use it.**

Patients and clinical teams therefore need to help shape how services communicate and how someone asks for help on the ward. **Their input can reveal barriers that a technical specification might miss** and help teams plan accessible alternatives.

Making digital investment count

Digital transformation in maternity should **begin with people, not technology**. As healthcare organisations continue to invest in digital transformation, the question should not be what a system can do, but whether the people who use it every day have helped shape how it works.

Maternity teams understand where care pathways create challenges in day-to-day practices. Women and families understand where communication, accessibility or support can fall short. **Those insights need to meet the knowledge of estates and digital teams from the outset** so that organisations can make investments that deliver meaningful change.

When digital ambition, clinical practice and patient experience come together, technology becomes a genuine enabler of safer, more responsive maternity care.

The goal is simple: a ward where a mother can ask for help in a way that works for her, staff receive the information they need without unnecessary noise, and the environment supports a safe and timely response.

Success should be measured not by the capabilities a system offers, but by whether those everyday moments of care work better for the people who depend on them.

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