NHSGGC
Maternity and Neonatal Strategy 2024 - 2029

NHS Greater Glasgow and Clyde

A Five-Year Plan for NHS Greater Glasgow and Clyde

A Message from Professor Angela Wallace, NHS Board Executive Director of Nursing and Midwifery

As the Director of Nursing and Midwifery for NHS Greater Glasgow and Clyde (NHSGGC) and the Executive lead for Best Start implementation, it gives me great pleasure to introduce the five-year maternity and neonatal strategy.

Maternity and neonatal services play a vital role in the long-term health of our population and are a key priority for NHSGGC. This is reflected in the journey we plan to take with you over the next five years, as outlined in this strategy. In it we set out our aims and vision. We also clearly illustrate what our core mission and values are.

As in all the services we successfully deliver, the focus will be on providing the highest quality, personalised, family centred, responsive care. It is important to me that you feel a part of all this, with effective stakeholder engagement essential, both in setting out and then delivering the strategy.

Effective use of the significant resources we have allocated to maternity and neonatal care is a key objective. This covers workforce, estate, technology and finance.

We are motivated to continue to reduce inequalities in experience and outcomes extending across all protected characteristics, including ethnicity, sexuality, disability and gender, and inequalities related to deprivation. To do this, we will embed accessibility and an individualised approach to our service in everything we do. We will also provide tailored support that recognises the wider challenges and needs of our families, and works with them to achieve the best outcomes for both family and child.

So, enjoy the read and please take every opportunity to comment on what matters to you. Celebrate in our successes with us but also continue to engage with us when you feel things could be better.

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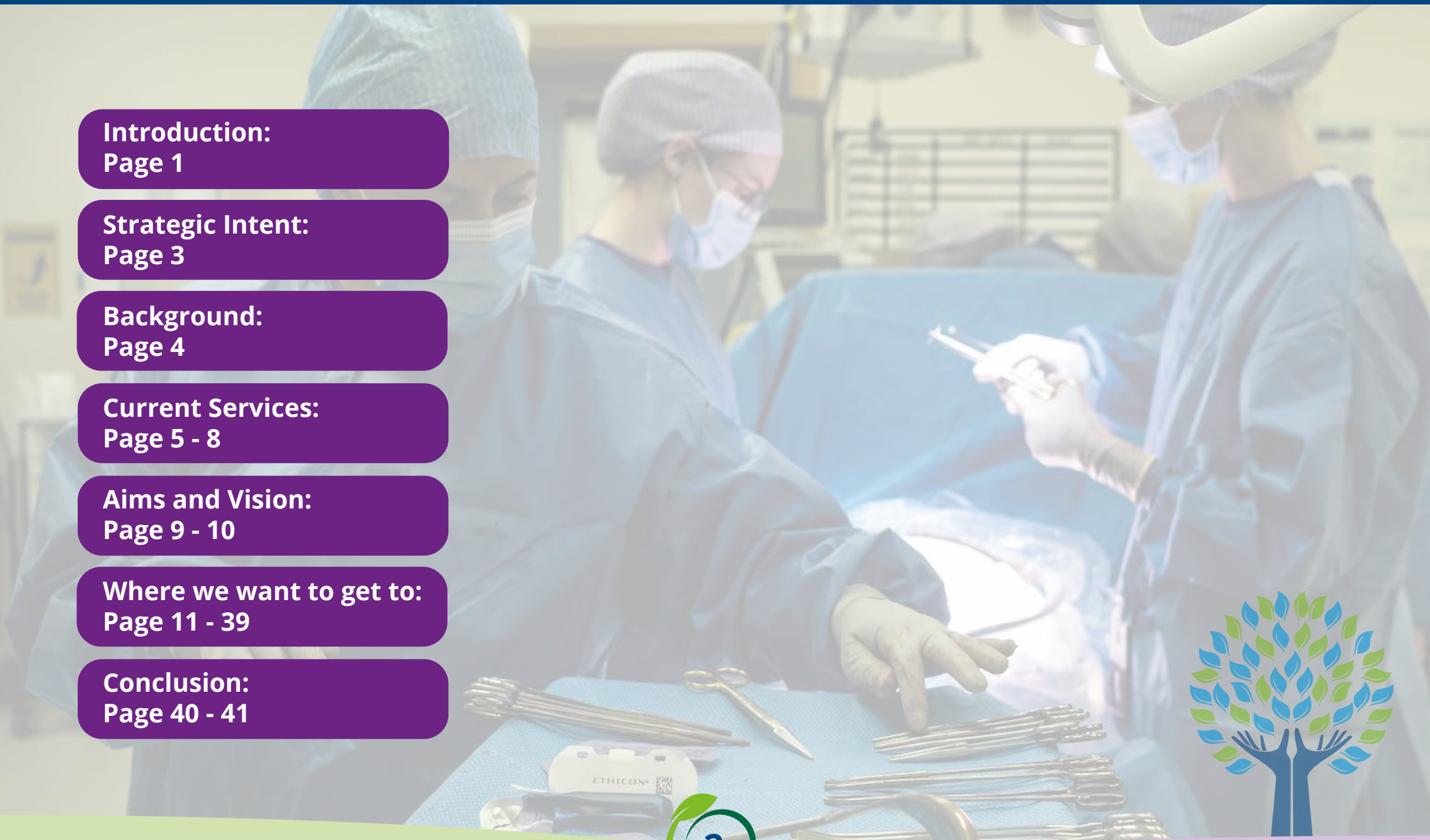


This strategy sets out eight key areas of strategic intent for our maternity and neonatal services over the next five years

1. Personalised family centred, responsive care
2. High quality, safe care for all, including high quality specialist care when it is needed
3. Reducing inequalities
4. Redesigning the way we provide services to give the highest quality care for the best value for money
5. Developing our team to ensure safe staffing, with high levels of retention and job satisfaction
6. Engaging with key stakeholders, in particular with women and families to help shape service improvement
7. Robust clinical governance and effectiveness
8. Effective public protection

Creating a place where children can flourish in their early years is a national Public Health priority for Scotland.

This journey begins pre-conception and continues during pregnancy into the early days of life. Since 2017, the Scottish Government has set a strategic direction for maternity and neonatal services across the country with the Best Start five-year review plan. Within NHS Greater Glasgow and Clyde, our maternity and neonatal services continue to evolve, guided by the Best Start principles.

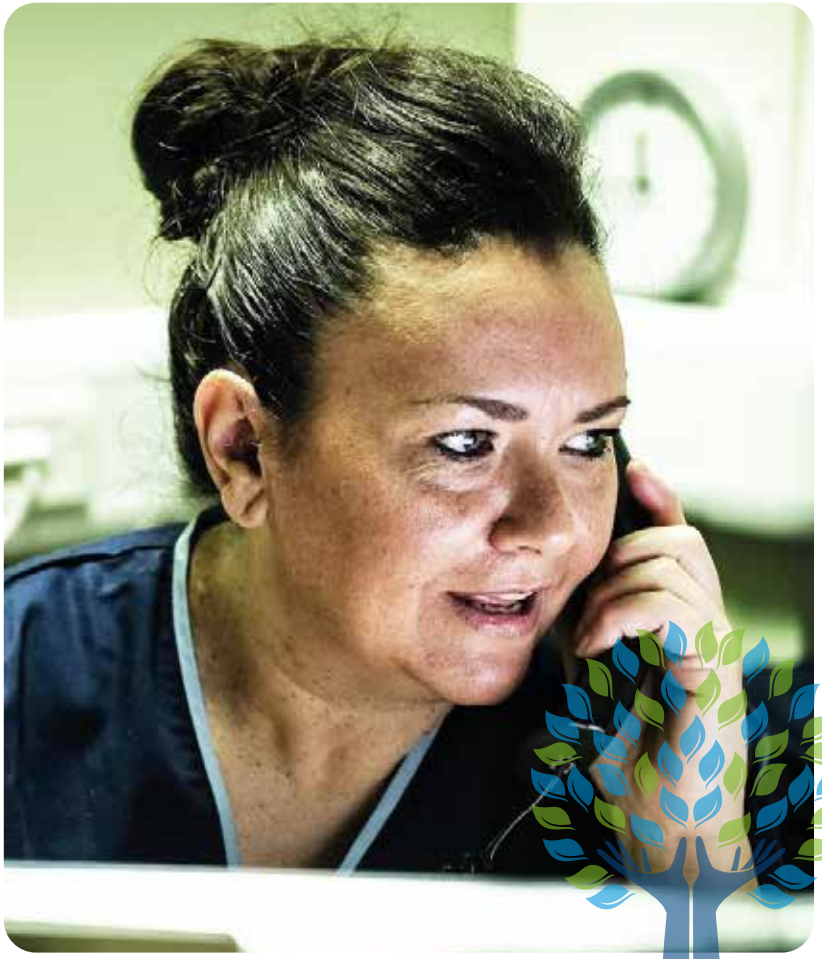
We have made significant progress over the last seven years to effectively implement many of the key recommendations set out in the Best Start review. We are committed to embed and develop further the implementation of the key recommendations and principles of Best Start, the Perinatal and Infant Mental Health Framework and the Women's Health Plan over the coming five years.

The strategy will link to many other programmes and initiatives, particularly the NHSGGC Moving Forward Together programme, the NHSGGC Nursing and Midwifery Strategy, Digital, Mental health and the Public Protection and Quality Strategies. The implementation of this strategy will take place in the context of other local work and the development of new national Scottish Government maternity and neonatal policy direction in the coming years.

This document will set the vision for maternity and neonatal services in Greater Glasgow and Clyde from 2024 to 2029.

Greater Glasgow and Clyde supports approximately 13,000 women through their maternity journey every year. The birth rate in Greater Glasgow and Clyde had been falling, in line with national trends, since 2012. There have been signs in the last year that our birth rate across Greater Glasgow and Clyde is now beginning to rise again. This is likely to further increase with the changes to the national neonatal unit model. At the same time, pregnant women* are on average older, and obesity and gestational diabetes is increasing, with associated complications. Mental health concerns are also noted to be increasing amongst the women in our care.

***Throughout this document we will refer to 'women' using maternity services. We do this in recognition that the great majority of people accessing maternity care define themselves as female; however, we also support some people who do not define as women. We would always provide individualised care and use their preferred pronouns and preferred terms, for example, pregnant or birthing person.**



Greater Glasgow and Clyde has high levels of deprivation among the population, including the pregnant population. Deprivation is linked to higher rates of obesity, smoking, substance misuse, medical complexity, and mental health problems during pregnancy. These can negatively impact outcomes for both the mother and the developing child, with deprivation linked to higher rates of poor outcomes including stillbirths, small for gestational age infants, preterm births, and neonatal deaths.

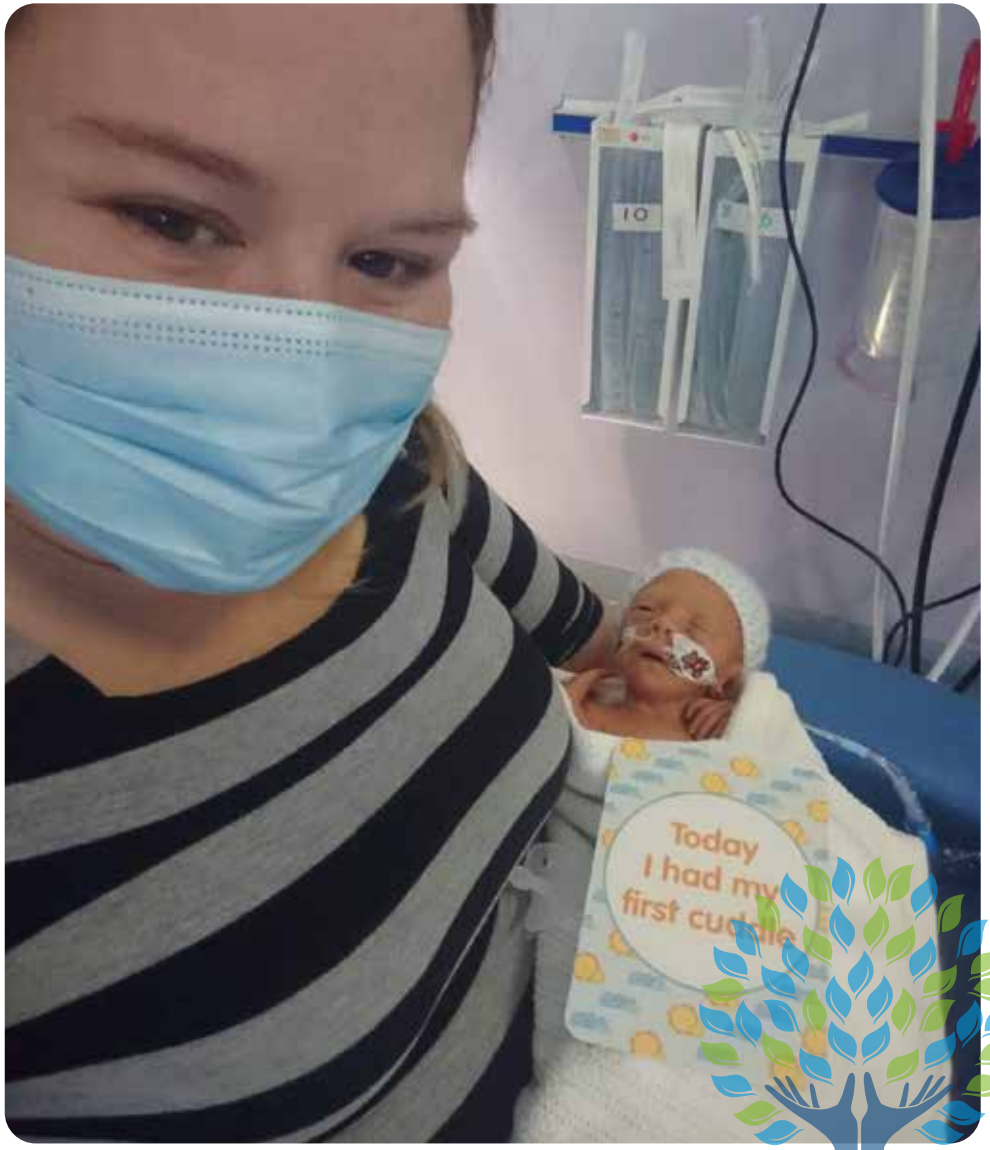
Providing the necessary support requires longer appointments, more observation and assessment, and more referrals to specialist services. Glasgow has a higher number of Black women, Asian women and women from other ethnic minorities (also described as global majority women in this strategy) than other parts of Scotland. In the UK, work such as the Maternal, Newborn, and Infant Clinical Outcome Review programme (MBRRACE) reports into perinatal and maternal mortality, have shown that Black, Asian and other ethnic minority women are also more likely to experience worse pregnancy outcomes than their white British counterparts. The causes of this are likely to include factors such as discrimination, access to services and poverty.

Maternity and neonatal services in Greater Glasgow and Clyde are provided across three large maternity units, three community midwifery units, three neonatal units and six community midwifery teams.

Care is delivered by a large multi-disciplinary team of over 1000 professionals, including midwives, medical professionals, and Allied Health Professionals. We work closely with colleagues from public health, primary, and social care, to ensure that there is a joined-up approach to supporting new families.

Maternity services are provided through universal community midwifery care during the antenatal period. Antenatal appointments and education take place in a range of settings, including in our large maternity units, but also at women's homes and in HSCP centres and GP's surgeries.

All women receive between eight and twelve antenatal appointments, with the aim to start care from eight to ten weeks of pregnancy. Women and newborns are then visited at home after the birth for at least ten days, with most care provided by the named primary community midwife, before being transferred to the care of health visitors.



Women with more complex needs in pregnancy will also receive antenatal care from their named obstetrician in one of the five maternity units. Ultrasound scans, additional psychological interventions and other multidisciplinary care, including dietetics and physiotherapy are also available across all sites.

The great majority of women give birth in one of the three large maternity units:
the Princess Royal Maternity Hospital (PRMH) in the North of the city, the Queen Elizabeth University Hospital (QEUH) in the South and the Royal Alexandra Hospital (RAH) in Paisley. Midwife-led intrapartum care is available in the new alongside midwife-led units within the labour suites at the PRMH and QEUH and in our long established three Clyde community maternity units at the RAH, Inverclyde and the Vale of Leven. Homebirth is also available for women who choose this option.

We provide both planned and emergency caesarean births at all three large maternity units. The three large maternity units provide 24/7 triage services, early pregnancy and day assessment services, as well as inpatient antenatal and postnatal wards. The anaesthetic teams on each site can offer pain relief options such as epidural or remifentanil patient-controlled analgesia.

The maternity services across GGC are managed as one service, with a GGC-wide leadership team and local maternity unit leads. There are unified structures and processes for guidelines and policies, clinical risk, practice development, staffing and continuing professional development.

The service is well respected offering a practice learning environment in maternity care for medical students, paramedic and AHP students and midwifery students.

Maternity services are provided for women coming from other health boards, based on their preference or medical need.

Some babies are born requiring additional care and support through our neonatal services. The neonatal unit at Royal Hospital for Children (RHC) is the lead perinatal centre for the West of Scotland.

The RHC is the location for the neonatal elements of the Scottish ECMO (Extra Corporeal Membrane Oxygenation) service, the national cardiac service, and national airway reconstruction service. The unit currently has 30 intensive care/high care cots and 20 special care cots. The neonatal service works in partnership with an extensive range of tertiary paediatric services including surgery, ENT, neurosurgery, endocrinology, respiratory, plastic surgery, ophthalmology, gastroenterology, genetics, neurology, infectious diseases, orthopaedics, and radiology. The QEUH hosts the Ian Donald Fetal Medicine Unit, a specialist regional and national unit which cares for families with complex pregnancies and undertakes fetal interventional procedures. This leads to a high proportion of congenital anomalies and other high-risk pregnancies delivering on the QEUH/RHC site.

The PRMH neonatal unit is a level three neonatal unit and provides all forms of intensive support except for those infants who require neonatal surgery and/or ECMO. The neonatal unit provides four intensive care cots, six high dependence cots and 18 special care cots.
The RAH neonatal Unit in Paisley provides level two neonatal services with three intensive care, three high dependence and 10 special care cots. Short term intensive care is supported, however all births at less than 28 weeks' gestation, or those where the need for neonatal intensive care is anticipated, are preferentially transferred to level three units for the duration of their intensive care.

All neonatal units have a family-centred approach to providing care to patients and parents. Care is planned with families to meet individual need. The aim to keep mothers and babies together is at the forefront of decision making.

The neonatal consultant group in Glasgow operate as a single team across the city whilst retaining strong links to an individual site, ensuring the maintenance of robust clinical teamwork. All three units operate as part of the Scottish Perinatal Network with staff taking a lead on key aspects of its delivery, including clinical leadership, guideline development, benchmarking, and discharge planning.

To provide the safest, highest quality maternity and neonatal services to the people of Greater Glasgow and Clyde and, when needed, beyond.

This strategy provides the route map to ensure that over the next five years, maternity and neonatology services are committed to further developing through eight key strategic commitments:

1. Personalised family centred, responsive care
2. High quality, safe care for all, including high quality specialist care when it is needed
3. Reducing inequalities
4. Redesigning the way we provide services to give the highest quality care for the best value for money
5. Developing our team to ensure safe staffing, with high levels of retention and job satisfaction
6. Engaging with key stakeholders, in particular with women and families to help shape service improvement
7. Robust clinical governance and effectiveness
8. Effective public protection

Our mission statement for NHS Greater Glasgow and Clyde is:

"To deliver effective and high-quality health services, to act to improve the health of our population, and to do everything we can to address the wider social determinants of health which cause health inequalities."

Care and compassion: Our patients come first. We dedicate our time and resources to bring the best possible care and comfort we can to the children and families we look after.

Dignity and respect: Your values matter to us. We explore your priorities and concerns, respect your opinions and treat you with dignity.

Openness and honesty: Integrity is at the heart of what we do. We keep you informed and are always open and honest with you.

Quality and teamwork: We strive to deliver the highest quality care through a process of continual improvement, guided by local and national expertise. We are responsive to the changing world around us. Our team works in partnership with families to improve the health of women and babies, both now and in the future.

What we know about where we are now:

We are proud of the high quality care we provide across NHSGGC maternity and neonatal services. We know there are always improvements to be made to ensure that our care is consistently personalised and responsive for every family, every time.

All three neonatal units are UNICEF Baby Friendly 'Fully Accredited'. The PRMH and RHC, in 2023, became the first two level three neonatal units to be accredited as achieving sustainability. Recognising the complexity of the babies cared for in both units, the assessors identified these units as examples of excellence. The RHC and PRMH neonatal units have also been awarded the Bliss Baby Charter Accreditation for delivering against the seven principles of family integrated care.

We receive lots of positive feedback from women and families about the care we provide, but we also hear about how we can improve our service. In line with Safe Staffing legislation, we regularly use current workforce tools and national guidance to assess our staffing levels.

Feedback about maternity care at RAH:
My experience right from my first booking appointment to taking my baby home has been a pleasure and a joy. Every staff member I encountered was kind, professional, caring and made me feel at ease.

Where we want to get to in the next five years:

Most women will receive continuity of carer in the antenatal and postnatal period from their named midwife and obstetrician.

More women will have met the midwife who cares for them during labour and birth.

Women and parents will consistently describe feeling fully informed about all aspects of their pregnancy, birth and postnatal journey and report that they felt able to make their own informed decisions about their care.

Women suitable for midwife-led intrapartum care will be able to access a homebirth or midwifery unit birth if this is their choice.

Women who make choices that fall outside normal practice or guidance, will be provided with sensitive and professional care that respects their rights to make informed choices.

Women and their partners will describe feeling well prepared for labour, birth and early parenting, with easy access to the right antenatal and parenting education for them.

Women will receive one-to-one high quality midwifery support during active labour in a calm environment in line with their preferences and needs.

New parents will consistently describe feeling prepared, educated and supported with their choice of infant feeding.

Parents of babies requiring neonatal care will consistently recognise themselves as partners in the care of their newborns.

Where we want to get to in the next five years:

Safe maternity and neonatal services have as their bedrock safe levels of staffing at all times. We are working proactively to implement and meet Scottish Government Safe Staffing legislation.

More women will be able to have the support person of their choice stay with them during any inpatient stay; more parents will be supported to stay in the neonatal unit with their babies; more new babies who are suitable for transitional care will be cared for alongside their mother in a postnatal transitional care area.

We will continue to develop our neonatal community service to deliver care in the home, keeping mothers and babies together and preventing readmission to hospital. This service will be implemented across all of Greater Glasgow and Clyde.

We will continue to support neonatal units across Scotland with education and training that facilitates earlier repatriation to units closer to home, where families tell us they wish their care to be based.

With innovation and workforce support we will shift the balance of care to the home, to deliver care in the right place for the needs of the baby and family.

What we know about where we are now:

We provide a large range of specialist neonatal services. This includes national neonatal cardiology and Extra Corporeal Life Support services.

Our neonatal service has strong links with the Royal Hospital for Children, seeing a range of babies regionally and nationally referred for specialist neonatal surgery and / or paediatric physician joint care.

We have a neonatal liaison team who are helping to support earlier discharge to home reducing the days of stay in hospital for our babies.

We have a neonatal liaison team who work with neonatal units across the west of Scotland to support earlier repatriation to local units. They host weekly repatriation meetings and support neonatal units with education and training to support earlier repatriation.

We have a Donor Milk Bank which procures human breast milk from across Scotland, and is the hub for safe processing of this milk for onward distribution to neonatal and maternity units across Scotland.

We have a programme of memory milk donation which supports mothers donating their milk following loss of their baby. The QEUH host a memory tree recognising donations.

We are at the start of our implementation of the Best Start neonatal review recommendations - moving towards a revised model, with one neonatal intensive care unit at the QUEH and two local neonatal units, at the PRMH and RAH.

What we know about where we are now:

We have a well-developed multi-disciplinary service for women living with the highest levels of social complexity, the Blossom team.

We have specialist services for women with significant mental health issues, including the MNPI (Maternal and Neonatal Psychological interventions) MDT team and the Mother and Baby inpatient unit and community outreach team.

We will continue to invest in the development of collaborative, multi-disciplinary and multi-agency care for women living with social complexity, deprivation and mental health problems.

We have higher rates of induction of labour and caesarean birth than the national Scottish or UK average.

We have higher rates of preterm birth than the national Scottish or UK average.

Our adjusted and stabilised perinatal death rates are around the national average for similar services.

We have an internationally recognised Fetal Medicine service.

Women with the most complex pregnancies do not currently consistently receive high levels of continuity of carer from the most appropriate professionals.

We have some specialist obstetric clinics for women with medically complex pregnancies including women with cardiac conditions, diabetic women, women with multiple pregnancies and women with social complexity, including substance use. We have recent examples of successful multi-disciplinary care for some women by specialist midwives.

Where we want to get to in the next five years:

Where there is a pregnancy loss, stillbirth or neonatal death, parents will be cared for in an appropriate private environment and receive sensitive care at the time of diagnosis of the loss and throughout their journey afterwards.

We will provide the highest quality early pregnancy advice service for any woman with a suspected or threatened loss.

They will be supported with decision making, memory making and offered ongoing bereavement care.

We will continue to develop our already established pathways of care and continuity of carer for women and families who have experienced a pregnancy loss or stillbirth, including high quality bereavement care. We will take maximum opportunity in these important areas of health care and develop links with specialist third sector organisations.

We will continue to grow the internal links between our maternity and neonatal services and paediatric services delivered from the RHC.

Further development of the fetal medicine services.
Recognised as an international centre of excellence, it is essential we provide the correct clinical environment, and the team have access to the most modern state of the art equipment and technology. We will continue to encourage promotion of this service both locally and across the UK / internationally.

We will provide a range of specialist antenatal clinic services for women with complex pregnancies.
These services will be supported by our commitment to multi-disciplinary working.

Women who are at risk of the poorest outcomes in maternity care, including those living with social complexity and drug use, global majority women, diabetic women and women living with obesity, will receive continuity of carer across their maternity journey and be enabled to access care easily and as early as possible in pregnancy.

We will provide appropriate specialist support for women who have expressed fear of childbirth, women preparing for birth after a previous caesarean, or previous birth trauma.

Where we want to get to in the next five years:

We will develop our use of home-based monitoring for women with need for frequent monitoring and assessment during pregnancy.

We will develop the provision of innovative community based maternity care, including greater access to virtual appointments when these are suitable.

We will provide specialised care and assessment to continue to reduce preterm birth and pregnancy loss.

We will focus on perinatal optimisation – implementing the Scottish Patient Safety Perinatal Programme bundle of interventions to improve outcomes for babies born prematurely.

We will invest in new evidence-based investigations, screening, immunisation and care packages, including the SPSP Perinatal programme work packages to improve outcomes in maternity care for women and neonates.

We will be delivering high quality neonatal care for babies from Greater Glasgow and Clyde and across Scotland in a neonatal intensive care unit and local neonatal units in line with Best Start recommendations.

Where we want to get to in the next five years:

We will continue to develop our neonatal community service to deliver care in the home and prevent readmission of mother and baby to hospital. This service will be implemented across all of Greater Glasgow and Clyde.

We will continue to build on our well established regional and national networks which support specialist services including neonatal surgery.

We will continue to strengthen the links between neonatology and medical and surgical specialities in the Royal Hospital for Children.

We will continue to develop our outreach service to support other neonatal units to facilitate care closer to home when it is safe to do so, in line with established pathways of care.

We will provide high quality outpatient follow-up aligned to national recommendations for babies and women requiring this.

We will develop a four year follow-up clinic for babies we have cared for in the neonatal units.

We will ensure a robust process is in place for retinopathy of prematurity screening, in line with the Royal College of Ophthamologists' guidance.

In collaboration with other boards, we will review the financial and environmental sustainability of the milk-bank service.

What we know about where we are now:

We receive lots of positive feedback from those who use our maternity and neonatal services for the care we provide. Like the rest of the UK, we know that global majority (Black, Asian and other ethnic minority) women and women living with deprivation are more likely to have poor experiences of, and poorer outcomes from, maternity care. Women in these groups are less likely to contact maternity services early in pregnancy, and may need more support to improve outcomes.

Whilst our teams are skilled in patient-centred care and communication we know that not all women who require an interpreter receive professional interpreting of high quality at every point of contact, impacting on patient experience and increasing clinical risk.

We also know that our information, education and services need to be more accessible to all women.

We do not know whether women with a range of other protected characteristics including disabilities and LGBTQI+ people accessing our services have less positive experiences of care.

Whilst we have the Blossom team to care for many women living with social complexity, including drug and alcohol use, and gender-based violence; we know there is a much wider group of women who require additional support and care to have the healthiest outcomes. This includes women who smoke, have mental health challenges or who are living with financial or housing insecurity. We know there is even more that could be done through developing pathways of care and multi-agency collaboration beyond obstetric and midwifery care.

We know that breast feeding plays a crucial role in narrowing health inequalities between rich and poor. Breast feeding for three months reduces the risk of obesity in adulthood by 13%. Data from NHSGGC shows lower rates of breast feeding among young women and with global majority women. We also know that women from low income families are more likely to have a premature or sick infant and are less likely to breast feed.

Where we want to get to in the next five years:

We will have improved outcomes for women and newborns from ethnic minorities and from deprived communities.

Global majority women and women who don't have English as their first language and women living with deprivation and social complexity will book earlier in pregnancy.

There will be consistent use of high quality translation and interpreting services whenever needed during antenatal, intrapartum and postnatal care, and for any neonatal care needed.

All maternity and neonatal teams will be provided with opportunities to improve their care of families with protected characteristics or living in deprivation.

This will include training in reducing inequalities, motivational interviewing, identifying and challenging racism and unconscious bias; supporting the needs of women with disabilities and LGBTQI+ people and families accessing our services.

We will consistently gather the appropriate data around protected characteristics and monitor the experience and outcomes for those who are more likely to have poor outcomes of maternity and neonatal care.

More women living with deprivation and global majority women will receive greater continuity of carer, antenatally and postnatally. More of these women will also receive full pathway continuity of carer.

More global majority women will describe their experiences of maternity care positively.

Where we want to get to in the next five years:

Women will be consistently and sensitively asked about risk factors including gender based violence, financial stress, smoking, alcohol and drugs, increasing detection of these issues amongst women in maternity services so as to allow appropriate support.

More women in need will receive targeted additional support in response to these factors including funded transport to antenatal care, pathways of care agreed with partners in statutory services, access to appropriate third sector support, smoking cessation support and financial advice. We will see improved engagement of families that need social work input, smoking cessation, mental health, substance abuse and financial inclusion support.

Outcomes of maternity and neonatal care will be more equal than currently in relation to key clinical risk outcomes.

We will have increased the support for women living with deprivation who wish to breastfeed their babies.

We will have developed more tailored antenatal education and information suitable for all of the women and people in our care.

We will have increased the proportion of our nursing and midwifery trained and untrained workforce from global majority backgrounds, to ensure that we better reflect the community we care for.

We will have members of the maternity and neonatal team with roles focused on improving cultural safety.

Through our implementation of evidence based care packages we will hope to see a reduction in preterm birth, small for gestational age babies and number of babies who never receive breastmilk.

We have an infant feeding support service across all of our maternity and neonatal service. This team will be developed to provide the right support, in the right place when it is needed. We will develop the infant feeding team with a key focus on reducing inequalities.

What we know about where we are now: Estate

We have five maternity units; three consultant led and two community maternity units.

We have three neonatal units.

Our buildings were configured and established before the changes of recent years, which have seen a significant shift in the demographics and needs of the population we serve. We have seen a significant increase in rates of caesarean birth and the number of inductions, and a reduction in the number of women wishing to give birth in our community maternity units.

We have challenges with availability of appropriate space for developing neonatal transitional care, alongside midwife units, planned caesarean birth capacity, induction of labour, enabling all partners to stay postnatally, bereavement and counselling facilities.

We require greater access to community clinic spaces to provide caseload community based care.

We will need to develop our physical environment, including maternity beds and neonatal cots, to accommodate the changes from the Best Start neonatal review implementation.

Where we want to get to in the next five years: Estate

We will have reviewed our use of space and configured services that provide the high quality care we aspire to, within available resources.

As a result of the national changes to neonatal service provision, we will be providing more maternity care to women from outside our Board area.

We will improve, update and refurbish those spaces that are no longer fit for purpose.

We will have functioning neonatal transitional care areas in our maternity units.

We will have one neonatal intensive care unit and two local neonatal units. The neonatal intensive care unit will have the capacity and facilities to provide care for the most premature and sickest babies.

More of our universal antenatal and postnatal care will be provided in community spaces and in women's homes.

We will have an appropriate system to support transfer of women and babies to the most suitable unit for their care across Greater Glasgow and Clyde.

We will have high quality, well resourced homebirth and midwife-led intrapartum care provision.

Feedback from a father about antenatal education classes: Each class were worthwhile and educational. As a couple we are not from Scotland originally, and we are pregnant with our first child so it was the first time we heard a lot of this information unique to parenting and to this country. I genuinely did not know a lot to do with basic labour and childcare but feel a lot more informed of what to look out for, and how to support my wife, and what will hopefully be the best for our child.

What we know about where we are now: Digital

Most women in our care use our Badgernet app and have ready access to digital technology.

There are opportunities to further develop our use of technology to provide modern high quality services for women and families; there are some approaches to care that could be updated including clinic provision, communication methods with families and women.

Sometimes our data are difficult to access and review.

Some of our systems do not communicate well with each other. Health professionals currently need to access multiple applications when caring for one woman or patient and our digital records are not able to be shared between services.

We have a Greater Glasgow and Clyde- wide digital strategy.

The neonatal service does not have a full electronic patient record, we are currently using the summary version of the Badgernet system.

Where we want to get to in the next five years: Digital

Our service will be at the forefront of digital developments in maternity and neonatal care.

Our service will be fully engaged with the wider Greater Glasgow and Clyde digital strategy and developments.

We will have high quality fit for purpose full digital maternity and neonatal records, which are able to interface with other key services.

We will have involved service users in all of these developments.

Where clinical care can safely be provided digitally, we will develop digital and hybrid approaches to care, with equivalent alternatives in place for families with digital poverty and access limitations. This is likely to include greater use of online consultations and education, increased support for home monitoring and self-care.

We will provide modern, effective online antenatal education in a range of formats and available in all key local community languages.

We will have options to involve women, patients and families in their care using digital solutions, to ensure individuals and their carers feel informed, empowered and enabled to support their own health.

We will ensure that all staff working in maternity and neonatal services have access to the up-to-date technology and digital support, with the right training and support to utilise them effectively.

We will have access to good quality data to understand our service, the needs of women and families and our outcomes. We will have instituted a full and comprehensive neonatal electronic patient record.

Where we want to get to in the next five years: Equipment

Ensure ongoing investment in the maintenance and upgrading of relevant equipment.

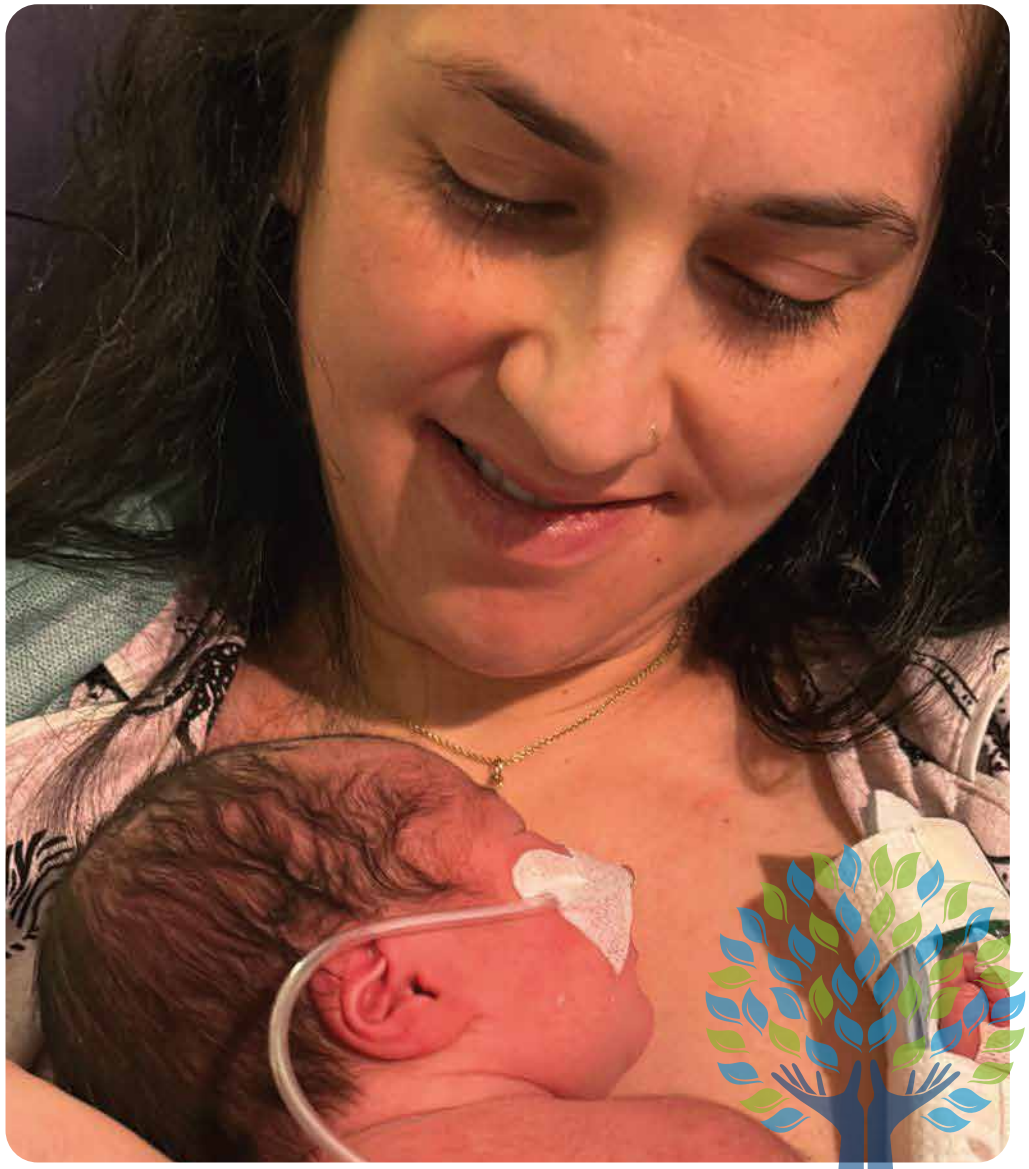
Continue to invest in our highly specialist services, neonatal surgery, cardiology, complex airways, fetal medicine and our ECLS (Extra corporeal life support) programme.

Develop opportunities for ongoing innovation within maternity and neonatal services with the introduction of new technologies to provide enhanced patient care and user experience.

Prepare a detailed Board-wide capital equipment inventory to be updated and routinely reviewed. This will provide services with the ability to anticipate spending and support service planning.

Identify equipment with existing lifespan of less than 10 years and consider for replacement using a transparent and robust risk assessment process.

Ensure that any required capital equipment will be provided through standard Board capital planning and procurement processes. Purchasing processes will align with NHS sustainable purchasing practice.



What we know about where we are now:

There are approximately 1357 staff directly employed within maternity and neonatal services in NHSGGC.

Our team includes nurses, midwives, obstetricians, anaesthetists, neonatologists, maternity care assistants, neonatal care assistants, support workers, operating department practitioners, general and service managers and a range of administrators and other vital support staff.

These individuals interact with a range of additional services in hospitals and the community, culminating in a substantial workforce who are dedicated to improving the life and wellbeing of pregnant women, their children and families across NHSGGC.

In order to provide safe, efficient and effective services, our workforce priority is to support and invest in our employees at every point in their career journey.

Feedback about maternity care: I was wonderfully taken care of throughout my pregnancy. This included staff at a local clinic, who were so kindly in their manner, knowledgeable, empowering & understanding. Staff were super supportive of anything we wanted to explore or understand; thorough and totally professional, but in a warm and genuine way.

Where we want to get to in the next five years:
We will develop our team through

Providing a consistent and proactive approach to enabling all of our teams: obstetricians, anaesthetists, neonatologists, midwives, nurses and non-registered staff, general managers, service managers and administrators, to access continuing professional development that supports them to practice safely and effectively, to develop themselves and the care they give and to provide an effective service.

Offering excellent ring-fenced continuing professional development, including a variety of multi-disciplinary team learning.

Continue to encourage and support our teams to access Quality Improvement learning and skills development in order to apply these approaches in practice to bring about positive change in service provision.

Regular staff engagement and consultation to ensure everyone is involved in improving services.

Identifying appropriate support to ensure we have the right number of neonatal nurses who are qualified in specialty.

Developing advanced nursing and midwifery roles to provide the highest quality evidence-based care, including development of consultant midwife roles and a continuous programme of Advanced Neonatal Nurse Practitioner training.

Working to develop our non-registered workforce to provide a well-developed skill mix across all services.

We will continue to develop specialist midwifery and nursing roles to enhance care provision, including infant feeding, high dependency care, perinatal mental health, bereavement, diabetes and nurses qualified in speciality.

Where we want to get to in the next five years:

We will ensure that our midwives are supported to train, qualify and maintain their skills in detailed examination of the newborn.

We will support nurses and midwives to become non-medical prescribers.

We will have developed our leadership structures, roles and people.

We will have an appropriate highly skilled administrative team to support our general management and clinical teams to work effectively.

We will offer flexible, person-centred approaches to working.

Working in partnership with our staff-side colleagues to ensure the needs of staff are considered in all service development.

Ensure staffing is in line with the Scottish Government Safe Staffing legislation, through the use of all appropriate tools and systems.

The staffing establishment across the current three sites will undergo continuous workforce planning reviews against national recommendations.

We will continue to be engaged in national and international multicentre research. We will deliver high quality local research and develop a research strategy which offers families participation in appropriate studies.

Where we want to get to in the next five years:

We will have a continued focus on staff wellbeing, including

A continued commitment to Peer Support.

A focus on understanding and reducing the risk of stress in the workplace.

The strongest possible commitment to a safe clinical environment with close links to health and safety.

Innovative and well established delivery of programmes like Schwartz Rounds. (Schwartz rounds are a forum that provide a structured, regular opportunity where all staff come together to discuss the emotional and social aspects of working in healthcare.)

Continued commitment to iMatter and Investor in People accreditation.

We will further embed programmes such as Civility Saves Lives.

Functioning Healthy Working Lives Initiatives across all parts of the service.

Where we want to get to in the next five years:
These changes should lead to

Reduction in sickness levels and numbers of the team leaving before retirement.

An increase in the number of high quality candidates for posts.

Higher levels of engagement in CPD, higher and further education.

Greater levels of clinician, midwife and nurse-led research and Quality Improvement taking place across maternity and neonatal services.

A robust management and leadership structure that reflects best practice and is an exemplar for Scotland.

A reduction in the number of unfilled vacancies and the use of bank and agency staff.

Feedback about QEUH: Our newborn was admitted to NICU and subsequently SCBU. We were impressed by the professionalism and care given to our son by all members of staff. Our son also required donor milk from the Milk Bank - we were so impressed with this service and all the staff and volunteers which make this happen. Thank you!

What we know about where we are now:

We actively use Care Opinion across our services, with good levels of use from women and families.

We do not currently have an MSLC (Maternity Services Liaison Committee) or MVP (Maternity Voices Partnership).

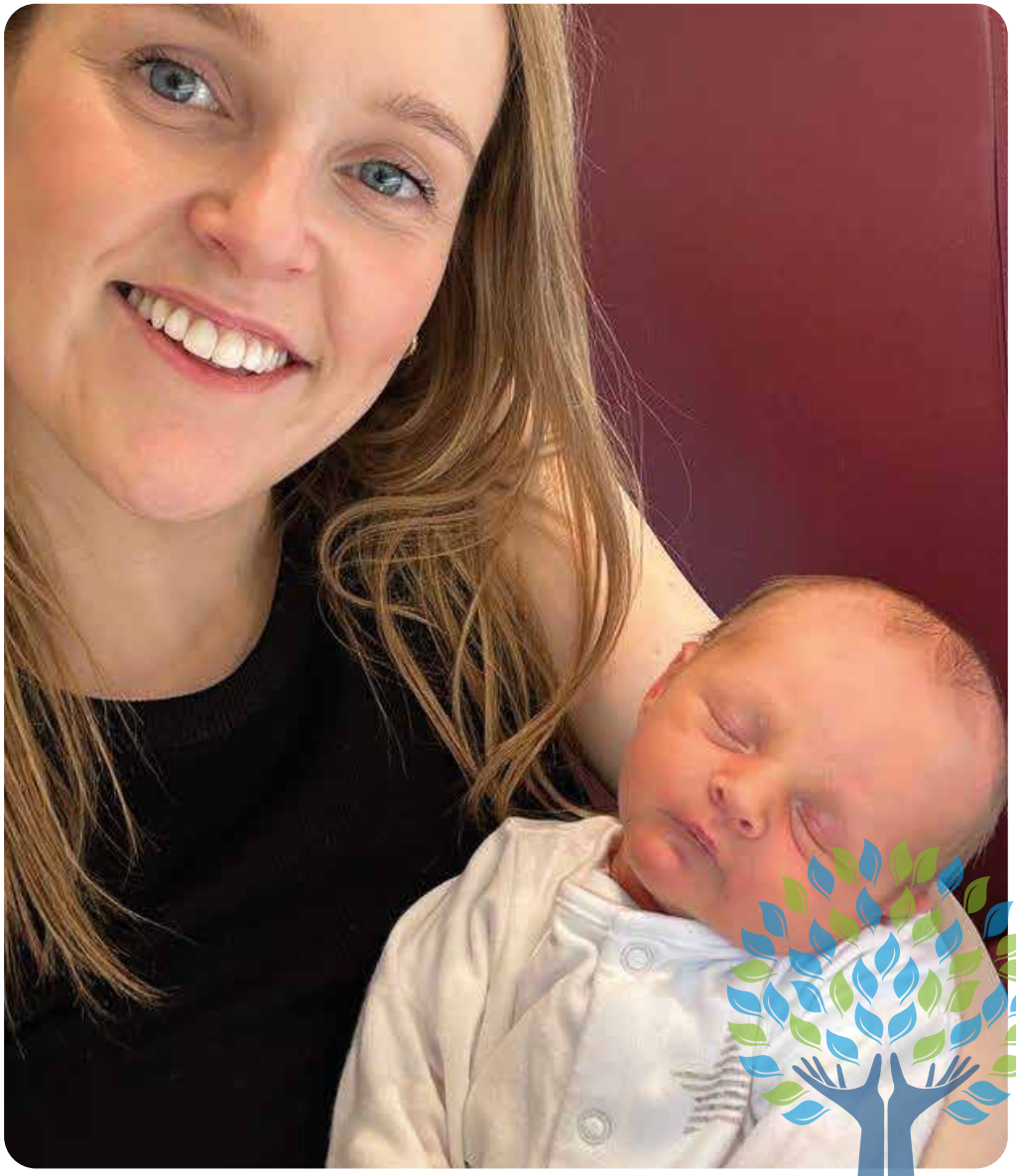
We have informal regular networking between service providers and third sector organisations, such as the National Childbirth Trust (NCT), HomeStart, British Red Cross and Amma Birth companions, and have recently established a new maternity third sector liaison network.

We have developed our use of online surveys to women and families to increase engagement.

There is active social media for the Royal Hospital for Children, but not one for maternity services.

We have positive approaches to staff engagement, including regular senior team walkabouts, effective partnership working, along with working groups to develop service changes in a collaborative way.

The neonatal service is currently trialling a patient experience tool (PEC). PEC is the first real time survey in the UK validated for use while parents are still in the unit.



Where we want to get to in the next five years:

We will have an active and well-established Maternity Voices Partnership and third sector engagement network, developed and led in partnership between Maternity leads and key stakeholders.

Feedback capture will be embedded as standard approach across maternity and neonatal services, with a range of accessible options available that staff can suggest women and families use to share their feedback.

Engagement and feedback with staff will continue to be developed, with approaches to understand our culture and ensure staff feel part of decision making about service delivery.

We will have increased staff engagement in iMatter and Investors In People, with improved results.

We will have active staff wellbeing activities in all areas.

We will be hearing the representative views, comments and opinions from our diverse communities, ensuring that service development and design is inspired and shaped by people's lived experiences.

We will be able to provide regular updates on where and how patient experience, feedback and involvement has led to changes and improvements in service or influenced the development of new and improved ways of working.

We will carry out the implementation of this strategy in line with good practice approaches described in the NHSGGC Communications and Public Engagement strategy, alongside Planning with People Guidance and in line with National best practice.

We will create a feedback, engagement and involvement plan for maternity and neonatology services that will reinforce key messages from the maternity and neonatal strategy and aid in its implementation. This document will be developed in partnership with communities and staff and reviewed on an annual basis.

Feedback about the Royal Alexandra Hospital: My second pregnancy at the RAH and I cannot fault the standard of care each time from beginning to end.
Having a difficult second pregnancy which resulted in being cared for by staff from antenatal, daycare, triage through to postnatal and then neonatal, staff always gave the highest standard of care.

Where we want to get to in the next five years:

Patient safety and quality improvement is a top priority within Maternity and Neonatal services. Our maternity and neonatal services will deliver open, honest and transparent approaches to reviewing clinical incidents, engaging with families following adverse events and having robust Board-wide governance systems and processes overseeing maternity and neonatal care.

This will include:

Reliable and robust processes to provide assurance and ensure that learning from serious adverse events and clinical risk incidents is enacted across the whole service.

All of our care will be supported by evidence-based and up to date guidance, with the appropriate education for staff to implement.

Implementation of a full electronic patient record in neonatal services, that can communicate with the maternity record, and a fully developed, well functioning digital maternity record that includes all key elements of care.

Using technology and data to evaluate care delivery, leading to tangible improvements in patient outcomes and satisfaction.

Strengthening of existing governance to provide assurance to the Board around performance outcomes (Perinatal Mortality Review Tool - PMRT & SAER)

Where we want to get to in the next five years:

Further develop the opportunities for all members of the multi-disciplinary team, including nurses and midwives, to develop research capacity and engagement in research.

Continued engagement with the Scottish Patient Safety Programme's Perinatal Programme.

We will, in line with our NHSGGC Quality Strategy, develop our use of the Healthcare Improvement Scotland (HIS) Quality Management system, to provide a clear structure for planning, maintaining and improving quality.

Collaborative working between maternity and neonatal services will focus on improving outcomes in the preterm population and reducing avoidable separation of mother and baby.

Local Quality Improvement initiatives will be encouraged and supported, with a Quality Improvement approach being employed when considering service redesign.

Engaging in benchmarking of processes and outcomes within Scotland and the UK through engagement with the Scottish Perinatal Network, National Neonatal Audit Programme (NNAP), National Maternity and Perinatal Audit (NMPA) and MBRRACE.

Outcomes and where we aim to be:

There will be clear clinical governance processes for maternity and neonatal services that are consistently followed.

There will be regular open reporting of our care assurance and clinical outcomes, to ensure that all members of the team are aware of our performance.

There will be regular scrutiny of the safety and quality of maternity and neonatal care in Greater Glasgow and Clyde at Board level.

All evidence-based national guidance and standards will be implemented.

We will have expanded the permanent clinical risk, Quality Improvement and practice development team in maternity and neonatal services to meet the needs and size of the organisation.

Feedback about postnatal community care and feeding support: I experienced some difficulties breastfeeding my newborn baby on discharge from hospital. He was taking very little and I was highly concerned he was losing too much weight/becoming dehydrated and was going to require re-admission for feeding assistance: something I wished to avoid if at all possible.
My first visit from the community midwife proved invaluable. She quickly read my high anxiety levels and took the time to offer me expert support and reassurance. When she left, I felt supported and empowered to care for my new born baby and was more confident I could stay with my husband and toddler in the family home, something I am eternally grateful for. Thank you for your expert and empathetic care.

Outputs over the five-year period will include:

Staff will be supported to attend local and national training such as the Scottish Quality and Safety Fellowship, Scottish Improvement Leader programme and the Scottish Coaching and Leading for Improvement programme.

We will work to ensure that there is the right level of professional leadership and roles to comprehensively implement robust clinical governance across maternity and neonatal services. This will include review of the current workforce and leadership model relating to clinical risk, Quality Improvement and practice development, comparing to comparable services and ensuring Greater Glasgow and Clyde workforce matches need and workload.

The Care Assurance Standards will be fully implemented, including the Maternity Care Assurance Standards.

The Directorate will support the full implementation of the Perinatal Mortality Review Tool (PMRT) which will enhance the existing internal processes for review of neonatal deaths. Administrative, nursing, neonatal and obstetric consultant time will be allocated to ensure robust review of every case.

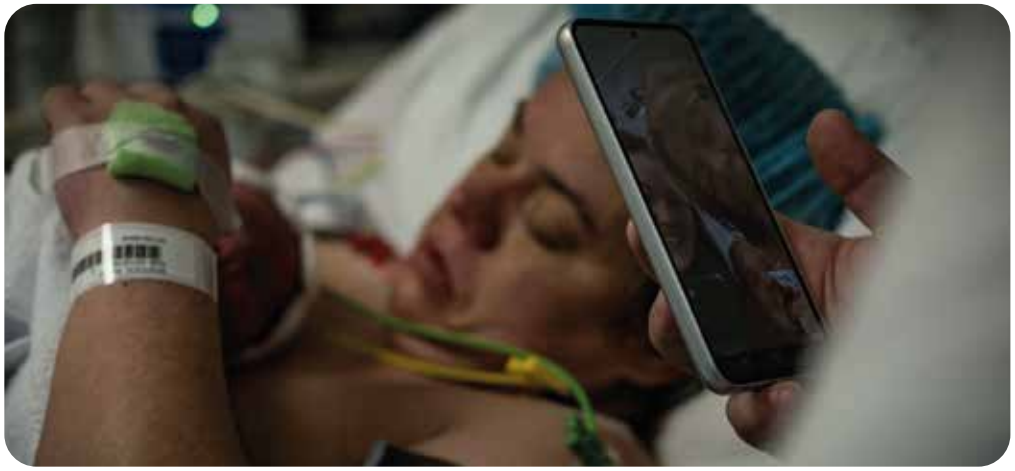
Develop our capacity to maintain up to date evidence based clinical guidelines, with accompanying education for all staff to understand what current guidance is and how to implement.

We will continue to review external reports into maternal deaths, stillbirths and complexities in newborns. We will continue to benchmark our services against report recommendations, disseminating learning and focusing on implementation of recommendations for improvement.

A consistent and transparent approach to risk assessment including monthly review of a formalised risk register will be completed across services.

We will develop a core dataset to monitor all of our key clinical performance indicators. We will use this dataset to fully understand the link between health inequalities and outcomes in our local population.

What we know about where we are now:



NHSGGC have structural and organisational responsibilities in respect of Child and Adult Protection. These include:

- The use of appropriate policies to keep children and vulnerable adults safe.
- Safe recruitment practices, staff induction and the provision of adequate training.
- Procedures for whistleblowing and complaints.
- Sound information sharing agreements.
- The promotion of a workplace culture that listens to children. young people and vulnerable adults, considering their views and wishes.

Health Boards also have corporate responsibility for ensuring that NHS staff have access to expert professional leadership and advice from their Health Board designated Public Protection leads.

The NHSGGC Maternity and Neonatal Strategy will align with and feed into the Public Protection Strategy, and Maternity and Neonatal services will work with colleagues to implement the Public Protection Strategy across our services over the next five years. We will continue to develop and strengthen collaborative working with the NHSGGC public protection team, in line with the new NHSGGC public protection strategy and systems.

"Public protection is the prevention of harm to unborn babies, children, young people, and adults. In Scotland, the foundations of public protection policies, guidance and legislation are held within the United Nations Convention on the Rights of the Child and the European Convention on Human Rights, and the principles and the entitlements of these Conventions must underpin health core business activities."
NHSGGC Public Protection Strategy.

Feedback about the Royal Alexandra Hospital: I felt listened to and supported in my choices as well as the absolute amazing care and support given by the Neonatal team during one of the most difficult times in our lives. I can't thank them enough.

Where we want to get to in the next five years:

Early identification of risk through assessment, with effective and appropriate support and interventions in place, placing the child at the centre of all care.

Regular training and updating for all midwives and neonatal nurses in relation to public protection and their roles and responsibilities to enable them to identify risk, devise plans of care, escalate concerns and seek help and advice from appropriate specialist services.

Multi-agency working with all partner agencies to support and implement child protection processes and procedures.

Implementation of a caseload holding model for the specialist midwifery team for complex vulnerable women.

A well developed system to provide case support and supervision from the public protection team for midwives involved in caring for families where there are public protection concerns.

Education and financial support for parents to improve their health and wellbeing.

GPs and Health Visitors integrated within the antenatal and postnatal pathways.

Robust systems to review adverse events relating to public protection and ensure learning from these events is disseminated.

Further development of the activity and engagement of the Maternity and Children's Public Protection forums, feeding up through the Public Protection and Clinical Governance structures.

Permanent establishment of a public protection midwife role to ensure implementation of appropriate pathways, build multi-agency working and provide training and support to midwives.

Implementation of The Getting it Right for Every Child (GIRFEC) approach in maternity services in NHSGGC and well-developed robust communication between community midwifery and health visiting colleagues, particularly in the antenatal period.

The provisions of the UN Convention on the Rights of a Child (UNCRC) became an Act in Scotland, with its provisions in force from July 2024. We will work to ensure that the UNCRC provisions are implemented and respected in our approach to maternity and neonatal care.

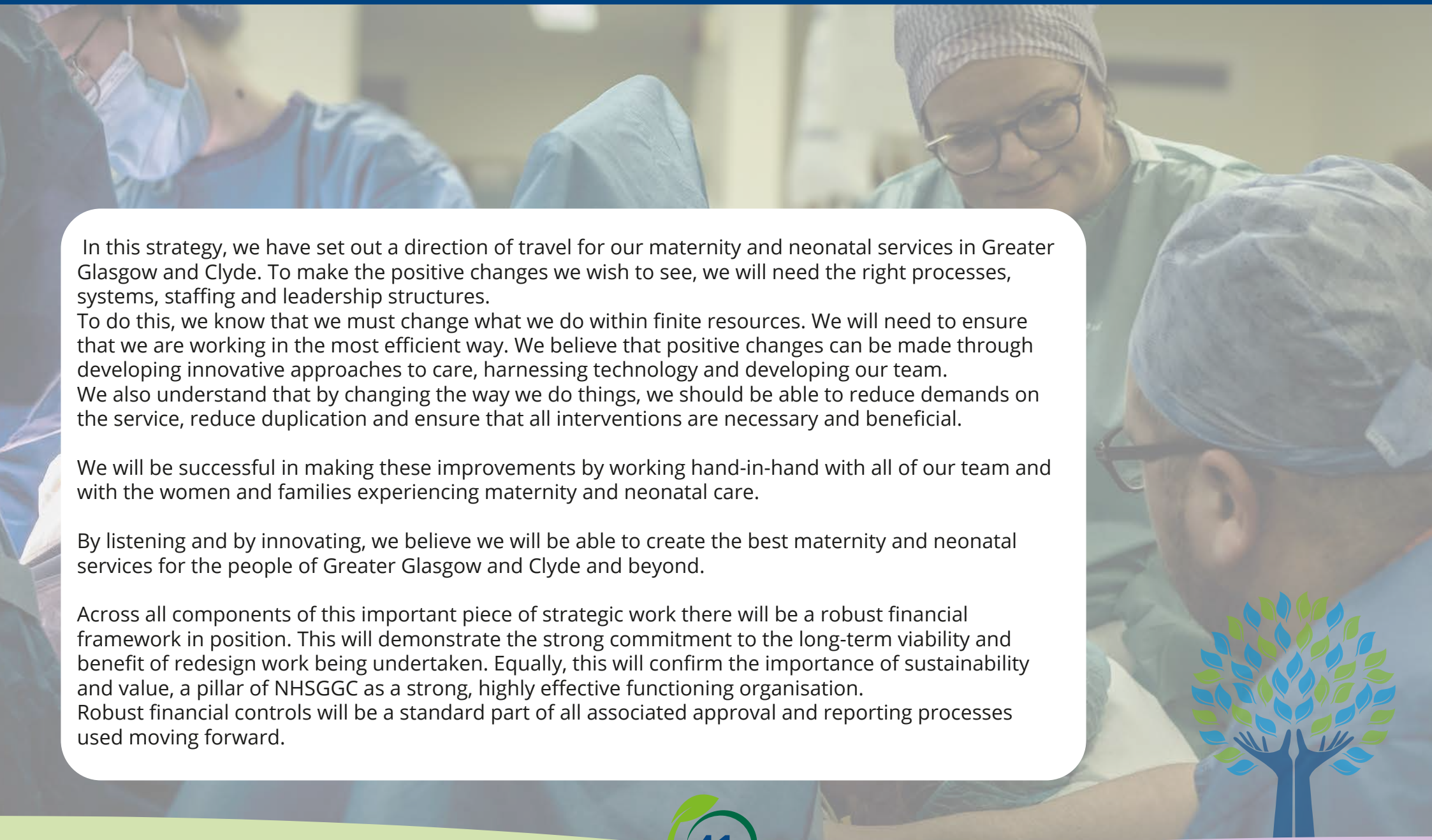
Feedback about the Royal Alexandra Hospital: Special mention to SCBU for the above and beyond support, particularly in my breastfeeding journey, meaning we got to bring our baby home sooner than expected.

Maternity and Neonatal Services

Our clear intent for the next five years is to develop services that can consistently provide the safest, highest quality maternity and neonatal services to the people of Greater Glasgow and Clyde, and when needed, beyond.

This strategy provides the route map to ensure that over the next five years, maternity and neonatology services are committed to further developing through eight key strategic commitments:

1. Personalised family centred, responsive care
2. High quality, safe care for all, including high quality specialist care when it is needed
3. Reducing inequalities
4. Redesigning the way we provide services to give the highest quality care for the best value for money
5. Developing our team to ensure safe staffing, with high levels of retention and job satisfaction
6. Engaging with key stakeholders, in particular with women and families to help shape service improvement
7. Robust clinical governance and effectiveness
8. Effective public protection



In this strategy, we have set out a direction of travel for our maternity and neonatal services in Greater Glasgow and Clyde. To make the positive changes we wish to see, we will need the right processes, systems, staffing and leadership structures.
To do this, we know that we must change what we do within finite resources. We will need to ensure that we are working in the most efficient way. We believe that positive changes can be made through developing innovative approaches to care, harnessing technology and developing our team.
We also understand that by changing the way we do things, we should be able to reduce demands on the service, reduce duplication and ensure that all interventions are necessary and beneficial.

We will be successful in making these improvements by working hand-in-hand with all of our team and with the women and families experiencing maternity and neonatal care.

By listening and by innovating, we believe we will be able to create the best maternity and neonatal services for the people of Greater Glasgow and Clyde and beyond.

Across all components of this important piece of strategic work there will be a robust financial framework in position. This will demonstrate the strong commitment to the long-term viability and benefit of redesign work being undertaken. Equally, this will confirm the importance of sustainability and value, a pillar of NHSGGC as a strong, highly effective functioning organisation.
Robust financial controls will be a standard part of all associated approval and reporting processes used moving forward.