NHS GREATER GLASGOW & CLYDE

MATERNITY STRATEGY

2006 – 2011

Date of Approval: 2008
Date of Review: 2012

TABLE OF CONTENTS

1 EXECUTIVE SUMMARY

NHS Greater Glasgow & Clyde is committed to improving the health of women and children and to tackling inequality in health by developing and improving its maternity services, its care pathways, and the facilities where maternity services are provided. Maternity services play a key role in improving the health of mothers and their babies, i.e. from and during the antenatal period to birth, and thereafter in the postnatal care period.

The aims of this strategy are to ensure that we provide services and facilities that are fit for purpose and that will support the best possible outcomes for women and their babies. This strategy takes cognisance of Equalities Legislation, and operational delivery service implementation plans reflect this in order to ensure that equality and diversity are mainstreamed within NHS Greater Glasgow & Clyde's Maternity Services.

This strategic document provides a summary of the history and background to the development and implementation of NHS Greater Glasgow & Clyde's strategic plan for modernisation of its maternity services and maternity facilities. The document is set out in sections, which include the national strategic context, the public health agenda, where we are now, where we want to be, and the actions we are taking to implement the strategy.

While separate strategic plans for maternity services were developed prior to April 2006 by the NHS Greater Glasgow and the NHS Argyll & Clyde organisations, both strategic plans were developed in a context of demonstrating adherence to the underpinning principles and goals set out in ***A Framework for Maternity Services in Scotland*** *(Scottish Executive, February 2001), and the* ***Expert Working Group on Acute Maternity Services (EGAMS 2002)***. This document combines both of the strategies, and specifically takes into account the recommendations of the Calder Group Report, chaired by Professor Andrew Calder, published in March 2006.

In 2006, NHS Greater Glasgow & Clyde established a Maternity Strategy Implementation Steering Group (MSISG) to oversee the strategic direction for maternity services. Thereafter, in July 2008, the MSISG reconvened as a Maternity Strategy Executive Group (MSEG), to reflect the implementation phase of the strategy; in particular the implementation of the successful £28m Full Business Case, approved in May 2008, to modernise maternity facilities and to build a new extension to the existing maternity unit at the Southern General Hospital, Glasgow.

2 HISTORY AND BACKGROUND TO THE DEVELOPMENT OF THE STRATEGY

Two strategic plans for maternity services were developed separately prior to April 2006, i.e. the Greater Glasgow Maternity Strategy (developed by NHS Greater Glasgow) and the Argyll & Clyde Maternity Strategy (developed by NHS Argyll & Clyde). Although the strategic plans were developed separately, both demonstrated the underpinning principles and goals set out in ***A Framework for Maternity Services in Scotland,*** *published in February 2001*, and **the *Expert Working Group on Acute Maternity Services*** *(EGAMS 2002*). From April 2006, the newly formed NHS Greater Glasgow & Clyde organisation embarked upon a process to bring the strategies together into a single strategic document for maternity services.

- **Greater Glasgow**

NHS Greater Glasgow's (NHSGG) Acute Services Review planning processes have been ongoing since the 1990s to deliver an agreed, affordable, city-wide plan for the major redevelopment of acute hospitals, including maternity services, essential to the provision of 21st century healthcare.

In 1999, following widespread consultation with women's groups and medical professionals, it was agreed that two maternity units should serve Glasgow. Pressures on midwifery, obstetric, neonatal and anaesthetist workforces were such that change was essential. There had been a strong clinical consensus about the need to move from three to two maternity delivery units in Glasgow. The operation of three units was inefficient, the level of medical cover required to sustain three units could not be maintained long term, and moving to two maternity units could meet future requirements for deliveries in a more sufficient, sustainable way, providing high quality service arrangements.

In 2003 the Board of NHSGG returned to consideration of its strategy and launched a fresh consultation exercise. As part of its pre-consultation process, the Board established the Maternity Services Modernisation Working Group. This Group sat for five months and took evidence from a broad range of stakeholders, which included nine clinical experts nominated by the Royal Colleges. The Group's report was submitted to the NHS Board at a Special Board meeting in October 2003, and midwives and representatives from the Maternity Services Users Network (MatNet) also submitted reports. Thereafter, the NHS Board agreed to consult with the public on the Working Group's Report, which recommended the closure of the Queen Mother's Hospital in Glasgow. The consultation commenced in November 2003 for 3 months.

In 2004 the NHSGG Board considered the outcomes of the formal consultation and three reports supporting proposals for the modernisation of maternity services. It was agreed that maternity services should be provided from two sites, i.e. from the maternity unit at the Southern General Hospital and from the Princess Royal Maternity. The Queen Mother's Hospital would therefore close. In September of that year, the then Minister for Health and Community Care accepted the rationale for moving to two maternity units and in addition accepted the NHSGG Board's recommendation that the Queen Mother's Hospital should close.

The Minister also took account of the views expressed by several consultees that the "gold standard" in delivering care in the future would be achieved by providing adult acute services, maternity services and specialist children's services together on a single site. As part of that decision on maternity services, the Minister announced the provision of a New Children's Hospital for Glasgow and a commitment to make available £100 million of Treasury capital funding to support the building of a new children's hospital. The Minister also announced that an Expert Advisory Group would be established.

In 2005, an Expert Advisory Group was established as a Clinical Advisory Group on Glasgow Children's and Maternity Services to advise the Minister for Health and Community Care and the NHSGG Board about the implementation of the decision to provide a new children's hospital in the city, and co-location with adult and acute maternity services. Professor Andrew Calder chaired the Group, known as the Calder Group.

In the second half of 2005/06, NHSGG launched a process of option appraisal and thereafter consultation in order to determine the location of the new children's hospital. The Calder Group reported to the Minister in March 2006, and recommended that the New Children's Hospital should be based on the Southern General Hospital campus. The Calder Group was tasked with "advising NHS Greater Glasgow on maximising the quality of care at the Queen Mother's Hospital until the New Children's Hospital is commissioned". In response, the three main recommendations proposed by the Calder Group were as follows:

- *"The site for the new children's hospital in Glasgow should be on the Southern General campus adjacent to the, soon to be constructed South Glasgow Hospital and the existing Maternity (and Gynaecological) unit.*

- *The planned programme of refurbishment and upgrading of the existing facilities at the Southern General Hospital maternity (including new neonatal and labour ward provision) should be examined in the light of the adjacent construction of the children's hospital. Specifically, the opportunity should be explored of constructing an interface that would ultimately link the maternity and children's hospital and house the most acute critical facilities of operating theatres, intensive care for neonates and older children, and a new state of the art labour ward all functionally integrated.*

- *During the interim period until the full triple co-location of services is achieved, the arrangements whereby maternity services move towards reconfiguration from three units to two should be carefully planned on a city wide, single-system basis, led by the respective lead clinicians in obstetrics, paediatrics, neonatalogy and anaesthetics. The advantage of the current adjacency of the Queen Mother's Hospital maternity service to the RHSC (Royal Hospital for Sick Children) should be preserved as long as it is appropriate and feasible but ultimately it must be seen as subordinate to critical issues of maternal safety. We expect that the move to 2 sites will have to take place between 2007 and 2009".*

The Calder Group's Report also recommended, *"that for however long the Queen Mother's Hospital continues to function during the interim period to the commissioning of the new Children's Hospital, where there are clear fetal issues requiring specialist neonatal care, these mothers should continue to deliver in the Queen Mother's Hospital. Mothers at risk of major obstetric haemorrhage, severe pre-eclampsia or with significant medical co-morbidity should deliver at a site where specialist medical, surgical and intensive therapy facilities are provided as recommended by the NHS QIS Maternity Standards (2005)".*

- **Clyde**

In 2003, the former NHS Argyll and Clyde health organisation undertook a major review of the provision of its maternity services, with the objective of ensuring safe and sustainable maternity service for the residents of NHS Argyll and Clyde. From April 2006 Clyde's maternity services fell within the management and administration of the NHS Greater Glasgow & Clyde (NHSGGC) organisation. During 2006/07, NHSGGC initiated a number of service reviews for the Clyde area, including a review Clyde's maternity services.

The review focused on two main issues; the impact of changes that were planned to maternity services in Greater Glasgow on services in Clyde, and the utilisation of Clyde's Community Midwife Units (CMUs). Affordability was also a consideration in the overall review of Clyde's acute services because of an inherited financial deficit from Clyde. Solutions therefore had to be identified that would not compromise patient care, whilst allowing financial balance to be regained by March 2009; offering value for money and equity of service provision across the Board's area.

CMUs within Clyde offer a valuable comprehensive maternity service to their local population. While recognising that the CMUs were busy in their delivery of antenatal and postnatal services, it was clear that the Vale of Leven and Inverclyde CMUs were significantly under utilised within their birthing suites. Clyde's CMUs had been developed to provide midwife led maternity care to low risk, healthy women, using previously agreed EGAMs eligibility criteria to assess risk and clearly identify women suitable for low intervention midwifery led care.

Due to health related reasons a number of women move from a low risk category to high risk category and transfer from midwifery led care in the antenatal stages of their pregnancy to hospital led care. Of the 73 parliamentary constituencies for which the Scottish Index for Mortality and Deprivation captured information in 2006, Dumbarton and Greenock are both in the 25 most deprived constituencies (by share of the 20% most deprived zones figures). This impacts significantly on the number of women who are eligible to deliver within a CMU.

However the converse of this is that, while women are insufficiently healthy to be eligible to deliver within the CMUs, their health needs are such that local provision of the full range of antenatal and postnatal services, including the Special Needs in Pregnancy Service (SNIPS), are essential. The provision of high quality antenatal and postnatal care is of particular importance to women living in deprived communities.

A working group, set up in December 2006, consisting of staff members, staff side representatives, finance and management representatives, was tasked to look at alternative models of care for the CMUs, within the principles of providing a value for money service across Clyde, whilst maintaining local access to maternity care. Of four options considered, the preferred option at that time was to have one CMU birthing unit located at the Royal Alexandra Hospital in Paisley. That option retained essential local community midwife-led services. In June 2007 the NHSGGC Board considered and approved the proposals, while awaiting the outcome of an Expert Independent Scrutiny Exercise, established by the Scottish Government in August 2007.

In 2008, on the recommendation of the Scottish Government, and based on the outcome of the Expert Independent Scrutiny Panel, NHSGGC undertook a formal public consultation to obtain the views of the local communities about the NHS Board's proposed changes to the CMU services in Dumbarton and Inverclyde. The consultation concluded in June 2008.

During 2008/09, and following the formal public consultation, the NHS Board's decision to retain CMUs at both Inverclyde and Vale of Leven Hospitals is being actively supported by an extensive marketing campaign. The campaign will not only publicise the breadth of services available from the community midwifery led service in the local communities, it is aimed at encouraging more women to use the birthing facilities provided at the units, where this is clinically appropriate, as well as continuing to use the range of antenatal and postnatal services provided at the units

3 KEY DRIVERS FOR CHANGE

3.1 National Policy

- **A Framework for Maternity Services in Scotland**

In February 2001, the Scottish Executive launched ***A Framework for Maternity Services in Scotland*****.** The framework was developed based on consultation with maternity services' professionals and users and set out the vision and principles and practice for modern, responsive and effective service, reflecting the views and wishes of the women and their families who use the service. The Framework took into consideration Scotland's mix of urban and remote communities, with some areas of concentrated poverty and disadvantage in Scotland's cities.

The Deputy Health Minister set up a short-life working group, the Expert Working Group on Acute Maternity Services (EGAMS), to examine how the principles set out in the Framework could be applied. In 2002, the EGAMS group published its findings in ***Implementing A Framework for Maternity Services in Scotland*** (Scottish Executive 2002). The Group concluded "*The present provision and shape of acute maternity services is no longer sustainable in the light of changes in the number and locations of births in Scotland (demographic changes), training and workforce pressures, and the need to ensure clinically safe and cost-effective practice".* In particular, developing the full potential of midwifery services would be a priority. NHS Greater Glasgow & Clyde has embraced the vision and principles set out in these two significant reports; in developing its local services, through regional and national planning processes, and through its wider stakeholder engagement processes, including its Maternity Services Liaison Committee.

Equally Well, the Scottish Government's Report of the Ministerial Task Force on Health Inequalities (Scottish Government 2008), highlights that while Scotland's health is improving rapidly, it is not improving fast enough for the poorest sections of Scotland's society, and that health inequalities remain a major challenge. Improving health and addressing inequalities in health has been influential in the planning of the delivery of the organisation's strategic direction for maternity services, including shaping its services, pathways of care, service redesign programmes, workforce planning, and in its capital building and design programmes.

3.2 Workforce Drivers

A number of workforce drivers have the potential to impact change both individually and collectively across the NHSGGC Women & Children's Directorate. These are briefly described below:

The closure of the Queen Mother's Hospital will lead to relocation of the Maternity Services workforce within NHS Greater Glasgow and Clyde. A workforce plan for Maternity Services, Midwifery in the West of Scotland was published in 2005, and is currently being updated. A medical staff workforce plan is also being developed, and will take account of the Scottish Government's ***A Force for Improvement*** – ***The Workforce Response to Better Health Better Care*** *(final draft November 2008).* The main source documents outlining service planning within NHSGGC's Acute Services include the Acute Services Plan and the associated Clinical Strategy for Acute Services.

In addition, plans specific to women and children's services include Local Delivery Plans, the Calder Report, the Maternity Strategy as well as the Full Business Case for the capital development of the new build extension and refurbishment of maternity facilities at the existing maternity unit on the Southern General Hospital (SGH) site. These underpin the future of a range of services that fall under the umbrella of the NHSGGC Women and Children's Directorate.

NHSGGC's workforce is likely to undergo significant change in the future, characterised by a shift of workforce resources from indirect to direct care, including the re-profiling of the workforce skill mix and the creation of new roles, offering career advancement for professionally qualified as well as other disciplines of staff. The principles of *A Force for Improvement* are reflected in the Women & Children's Directorate approach to its workforce; recognising the value and importance of equality and diversity in its workforce, both for service delivery in order to provide responsive care, and of its importance for the recruitment and retention of staff.

- **Improved Productivity**

Delivering improved workforce performance and effectiveness is increasingly important to improve service delivery, and efficiencies and savings will be re-invested into the workplace, where appropriate. Two priority target areas for improved efficiency are to reduce staff absence levels across NHS Scotland, and to increase Consultant productivity.

- **Modernising Medical Careers**

The new system of training for doctors saw recruitment to the specialist registrar grade cease in December 2006 as well as the Senior House Officer grade at July 2007 with speciality training commencing in August 2007. By the time the new acute hospitals open, doctors will be emerging from specialty training with less experience than existing consultants. The intention is that the service will be provided largely by doctors who have completed specialty training with a reduction in the service contribution from those in training. Crucially, this will lead to a phased reduction in the number of middle grade doctors to the number required to replace trained doctors as they retire.

- **Pay Modernisation**

This major piece of reform has been conducted throughout the UK and within acute services covers the new Consultant Contract and Agenda for Change. While the new reform packages are designed to improve recruitment and retention, they also act as a strong lever for change and to facilitate new ways of working. Pay modernisation will impact on current workforce capacity though harmonization of hours and terms and conditions, e.g. annual leave entitlements. The pay modernisation agenda also acts as a lever for improving workforce efficiency and effectiveness through opportunities for improving workforce redesign and improved teamwork. The pay modernisation agenda provides the opportunity to manage issues of workload as well as ensure compliance with the Working Time Regulations by acting as a lever for the introduction of new working patterns.

- **Working Time Regulations**

These Regulations are the basis of the Government's objective to create a flexible labour market underpinned by minimum standards of working time. The Regulations protect the most vulnerable workers against working excessive hours and give them a right to rest breaks, rest periods away from work and paid annual leave. The Working Time Regulations provide for minimum daily and weekly rest periods, annual paid holidays, and a limit on the working week to an average of 48 hours and restrictions on night work. More specifically this will impact on junior doctors in 2009 and in ensuring rotas are compliant.

- **NHS Careers Framework**

The NHS Careers Framework was formally launched in Scotland in October 2006. It supports NHS Boards and regions to articulate the future workforce development needs through alignment with workforce planning and modelling, the implications of service redesign as well as to support robust succession planning. The NHS Careers Framework is also linked to the Knowledge and Skills Framework (KSF) and to the use of national occupational standards in producing development plans for new as well as existing roles. With the support of the Scottish

Government and NHS Education for Scotland, we are beginning to use the Careers Framework to plan the competences required in our future workforce. The future workforce will feature a set of new roles to deliver re-designed services.

- **Service Redesign and New Roles**

Issues of service re-design must be linked to improved standards and quality of care. New role development is therefore crucial in supporting service redesign and the vision for NHS Scotland set out in the Scottish Government's Report *Better Health, Better Care;* shifting activity from acute to primary care. *Better Health, Better Care* identifies evolving models of care integrated with the patient as the partner while also supporting the development of new roles. Five core workforce challenges have been identified that run through the *Better Health, Better Care action plan*. These are:

- Tackling health inequalities
- Supporting a real shift in the balance of care
- Continuing the development of a high quality workforce
- Ensuring best value – e.g. delivery of HEAT and efficiency targets
- Mainstreaming of workforce – moving towards integration of workforce planning with service delivery

Because services rely on integral working with many other specialities, we will continue to work in partnership with other services to address workforce developments and across service dependencies.

- **Maternity Services**

Implementation of the NHSGGC Maternity Strategy puts in place consolidation of in-patient activity on three sites; at the maternity unit on the Royal Alexandra Hospital site in Paisley, the transfer of services from the Queen Mother's Hospital (QMH) to the Southern General Hospital maternity unit, and the Princess Royal Maternity based at the Glasgow Royal Infirmary site. In particular, services aligned to the transfer of services from the QMH are likely to see significant changes in which the current staffing resource is allocated and provided. In taking this proposal forward engagement is already underway with a number of key stakeholders, including professional leads and staff representatives, in determining potential changes to current staffing levels. Workforce planning is also taking forward work to identify any impacts of additional workload from neighbouring NHS Boards, and the impact on the service from an increasing immigrant population. In addition, work is underway to evaluate how the development of new roles, e.g. Care Assistants (MCAs), can lead to a more efficient and productive workforce.

- **Clyde Integration**

The integration of Clyde's services for women and children into the Women and Children's Directorate was completed in 2008.

In 2008, following formal public consultation, the NHS Board's decision to retain CMUs at both Inverclyde and Vale of Leven Hospitals is being actively supported by an extensive marketing campaign. The campaign will not only publicise the breadth of services available from the community midwifery led service in the local communities; it is aimed at encouraging more women to use the birthing facilities, where clinically appropriate, as well as the antenatal and post natal services provided from the units. The outputs from the campaign will be monitored for any workforce impacts to the way services are currently provided.

- **National Planning – Development of Maternity Care Assistants (MCAs)**

The national programme to develop Maternity Care Assistant roles (MCAs) has been welcomed in its initial phase to support skill mix changes, and more specifically an increase in the number of Career Framework level 4 posts. Currently there is one education provider nationally (Robert Gordon University, Aberdeen) and it is likely therefore to take some time to produce significant change. There are 25 places nationally, and the lead-in times for training are challenging. However, further work is being led by NHS Education for Scotland (NES) to identify more local education providers.

Over the next 5 years it is anticipated that NHSGGC will see an increased demand for such a resource which will pose certain questions about the supply routes, given the options for direct entry and through the development of current staff. This issue remains critical in understanding the ability to support a step change in the local configuration of the workforce, and on a national workforce basis.

- **Nursing and Midwifery Council (NMC) Registration**

The NMC has indicated that Midwives can maintain their registration by working in neonatal units but only under very specific conditions. Midwives currently operating solely in neonatal units in the UK are required to demonstrate that they have practised as a midwife for a minimum of 450 hours every three years in order to retain their registration. However, the guidance in Scotland is that any emerging vacancies within neonatal units should not be filled through direct entry midwives. NHSGGC will therefore continue its active policy to recruit children's Registered Nurses (RN) and adult RNs into neonatal units. This is likely to have a bearing on national commissioning and supply levels.

- **Medical Staff Annual Job Planning/ Extra Programmed Activities (EPAs)**

The aim is to deliver a reduction in EPAs, and in doing so there may be a requirement for additional non-medical resources to be sourced, such as Advanced Neonatal Nurse Practitioner roles (ANNPs). However, these roles can be difficult to recruit. Therefore, in order to support this objective, additional medical resource, either at Consultant or Staff Grade level in the short term may be required.

- **Modernising Medical Careers (MMC)**

The Modernisation of Medical Careers should see a reduction to a future projected gap in the consultant workforce. Though not specific to obstetrics and gynaecology, gaps elsewhere are filled through fixed term Senior (medical) Trainees (STs). However, this will no longer be possible in the future and likely to leave gaps at junior and middle grade levels. This, in turn, is likely to impact on other staff groups, both in terms of numbers and levels of competence. For example, any demand for increasing numbers of Advanced Nurse Practitioner (ANP) roles may result in certain areas losing an experienced cohort of staff as these individuals look to move into these new posts

- **Work/ Life Balance**

The organisation actively promotes a range of flexible and family friendly policies. These can impact on the service, with pressures on the system to maintain staffing levels and backfilling of posts. However, the organisation fully supports a work life balance approach, recognising that this type of approach has the potential to improve recruitment and retention rates overall.

- **Working Time Regulations**

As indicated earlier, from August 2009, junior doctor time will be reduced to an average of 48 hours. This reduction in available resource will impact on current rotas, and will place additional pressure on ensuring these rotas are compliant, as well as the level of banding payments.

As the opt out clause of the Working Time Regulations is going through a negotiating process in Europe, the UK law remains unchanged on this point and workers are still able to opt-out of the weekly working time limits. However, removal of the 48 hour waiver could hamper available resource, particularly those available through Nurse Banks.

4 THE PUBLIC HEALTH AGENDA OF MATERNITY SERVICES

All of our maternity staff have a key role to play in promoting health and wellbeing and to address inequalities in health. By working with colleagues in Community Health Care Partnerships (CHCPs), partner organisations and agencies, we will continue to develop our services in a framework of improving health. There is also a management twinning arrangement with the East Glasgow CHCP, through which we will develop care pathways that take account of and link with the improving health agenda, focussing on women, children and families.

4.1 Equality Scheme 2006-2009

NHSGGC is fully committed to promoting equality and diversity. Tackling inequalities is a key transformational theme of the organisation, and the organisation has identified equality as part of its core business. The organisation's planning priorities reflect the explicit identification of how equality will be integrated in relation to a set of overarching corporate themes that aim to:

- **Improve Resource Utilisation:** making better use of our financial, staff and other resources
- **Shift the Balance of Care:** delivering more care in and close to people's homes
- **Focus Resources on Greatest Need:** ensure that the more vulnerable sectors of our population has the greatest access to services and resources that meet their needs
- **Improve Access:** ensure service organisation, delivery and location enable easy access
- **Modernise Services:** provide our services in ways and in facilities which are as up to date as possible
- **Improve Individual Health Status:** change key factors and behaviours which impact on health
- **Create an Effective Organisation:** be credible, well led and organised and meet our statutory duties

To support delivery of the Equality Agenda, the organisation has a Single Equality Scheme and each operating Directorate has an Equality Implementation Plan. Equality Impact Assessments have also been undertaken across a variety of services, including maternity services, in an effort to identify existing good practice and to address areas for improvement.

As equality affects women's health, and specifically in relation to the maternity strategy, the work of the Pregnancy Pathway Redesign Group was critical to redesigning and enhancing the midwife led services across NHS Greater Glasgow & Clyde and for responsiveness in addressing equality in the care of pregnant women.

Of note, a first phase of the redesign supporting the pregnancy pathway was implemented in 2008, with a roll out of the redesigned service in 2009. This work was supported by an Inequalities Sensitive Practice Initiative.

The Inequalities Sensitive Practice Initiative (ISPI) project was undertaken to support the development of maternity care pathways; ensuring that the care pathways developed were sensitive to the needs of women, their partners, and their families to address multiple disadvantage and inequality in the origins and implications of poor health and social status. The outcomes of the ISPI work have been influential in developing equality and diversity responsive care pathways and practice descriptors.

In addition, the principles of Spiritual Care, as set out in the Scottish Government Health Directorate's circular, CEL(2008)49, are embedded in service delivery and are supported by the NHS Board's Spiritual Care Policy.

4.2 Public Health Screening Unit

The NHSGGC Public Health Screening Unit is responsible for managing, co-ordinating and monitoring the screening programmes across NHS Greater Glasgow and Clyde, as well the Argyll and Bute areas that are part of the NHS Highland organisation.

Getting it Right for Scotland's Children (Scottish Executive, 2005) included guidance on the implementation of Hall 4 (the Fourth Edition of *Health For All Children* - Edited by David M B Hall and David Elliman**,** 2003), which examined the evidence for existing child health surveillance and screening activity, including the purpose, content and timing of interventions, and takes into account the impact of social, economic and environmental factors on children's health. The recommendations in Hall 4 also reflect the advice of the National Screening Committee, which considers all screening programmes at a national level.

The guidance recognised that it is important to empower and support children and adolescents themselves to take responsibility for their own health needs. Hall 4 also recommended that enhanced health promotion work to inform and educate parents about their children's development and needs, so that they can seek the right advice and help when they need it. The Public Health Unit also therefore plays a significant role in education and training of staff, parents, children and young people and the public in general.

Since April 2006, a key area of the Public Health Screening Unit's ongoing work has been the integration of systems and processes for screening programmes as a single organisation; involving the bringing together of NHSGGC's screening programmes, and ensuring that consistency of service and compliance with national standards across Greater Glasgow and Clyde are in place. The information management and handling carried out by the Unit also play a key role in mapping health issues, trends and needs across the organisation's geographic area of responsibility.

Screening Programmes – Screening programmes specific to the health of women, before during and after pregnancy and for the new born are essential to maintaining healthy mothers and babies and in identifying health and wellbeing issues requiring care, support and services provided in our hospitals and community health care services. Screening programmes currently operating in NHSGGC, including future national developments, are:

- Breast Screening
- Cervical Screening
- Pregnancy Screening
- Communicable Diseases in Pregnancy
- Newborn Bloodspot Screening
- Universal Newborn Hearing Screening
- Pre-school Vision Screening
- Bowel Screening
- Scottish Cervical Call/Recall System

There are separate multidisciplinary Screening Steering Groups for each programme, and the remit of each group includes developing and implementing programmes set within standards for services developed and monitored by NHS Quality Improvement Scotland. Public engagement and feedback is captured through direct input to the work programmes, where possible, by open days and user surveys.

For example, the remit of the Pregnancy Screening Programme Steering Group is to provide an area-wide forum to co-ordinate and monitor all aspects of the screening programme offered to NHSGGC residents and to Argyll residents who are part of NHS Highland.

The group's remit includes pregnancy screening programmes for:

- Down's syndrome and neural tube defects
- Communicable diseases (HIV, Hep B, syphilis, rubella).
- Formal advice to NHS Greater Glasgow and Clyde (and NHS Highland) for the pregnancy screening programmes
- Ensuring screening programmes are provided to the best possible standard, and to meet national pregnancy and newborn screening clinical standards set by NHS QIS (October 2005).
- Developing pregnancy screening programmes in accordance with national guidance
- Contributing to local programme annual reports

4.3 Priority Areas of Public Health

Public health areas of priority include:

- Social Inequality
- Poverty
- Nutrition
- Smoking
- Exercise
- Postnatal Depression/Mental Health
- Teenage Pregnancy
- Substance Misuse
- Domestic Violence
- Baby Friendly Initiatives - Infant Feeding, including Breast Feeding*
- Parenting Skills
- Sexual Health
- Dental Health
- Accident Prevention
- Services for Refugees/Asylum Seekers
- Social and emotional support for parents
- Screening Programmes

****NHS Greater Glasgow and Clyde's infant Feeding Strategy was launched in 2008***

4.4 HEAT Targets

Improving breast feeding rates is a HEAT target HEAT targets are set down by the Scottish Government's performance division for Health Boards, and the NHSGGC Infant Feeding Strategy will support NHSGGC' s staff and services to deliver the breast feeding target.

HEAT stands for:

- **Health Improvement** for the people of Scotland - improving life expectancy and healthy life expectancy;
- **Efficiency** and Governance Improvements - continually improve the efficiency and effectiveness of the NHS;

- **Access** to Services - recognising patients' need for quicker and easier use of NHS services; and
- **Treatment** Appropriate to Individuals - ensure patients receive high quality services that meet their needs.

NHSGGC's **Infant Feeding Strategy** was launched in 2008. Increasing the breastfeeding rates is one of the key priorities of the Infant Feeding Strategy. Breastfeeding can make a major contribution to an infant's long-term health and development, reducing the incidence of conditions such as gastroenteritis, eczema and asthma. It is also linked to better health outcomes for the mother, including cutting down the risks of breast and ovarian cancer, osteoporosis and obesity.

The strategy is aimed at promoting and supporting the best nutritional choices for all babies and infants from 0-2 years. Over the next four years health care staff will also be working to establish lifelong healthy eating habits, increase the use of appropriate vitamin supplements, and reduce health inequalities. The three key strands of the strategy look at providing more staff training to provide support for mums and babies, closer monitoring of standards of care and raising public awareness and acceptability of breastfeeding.

Action has also been taken to improve professional communication including a new handover of care document which is being made available at all six maternity units throughout NHSGGC. These documents will provide health visitors with information on a child's feeding from birth. Public consultation has influenced the new approach via focus groups and individual responses.

5 WHERE ARE WE NOW?

5.1 Demographics

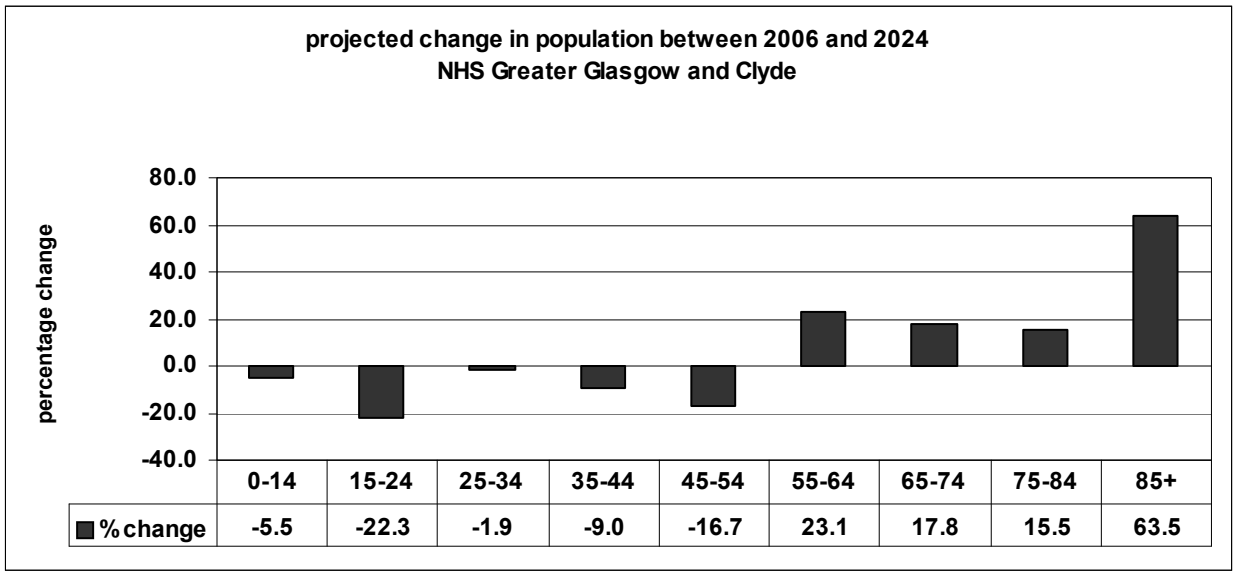
- ***Population***

The combined mid-year estimated population of the NHS Greater Glasgow and Clyde area at 30th June 2007, provided by the General Registrar Office for Scotland (GROS) , was 1,192,419, of which 47.9 % are male (570,953) and 52.1 % female (621,466). The population for Scotland (GRO mid-year estimate for 2007) is 5,144,200.

- ***Projected Population in Scotland and NHSGG&C***

Based on GROS projections, the Scottish population is expected to stay at around the 5 million mark for the next 18 years, only slightly increasing to 5.1 million by 2019 until a decrease is forecast for after 2036. The NHSGGC population is expected to reduce overall by 2.1% by 2024 since base year (2006), although this reduction will be particularly marked for specific age groups with implications for the planning of new services in Glasgow. For example, it is expected that there will be 5.5% fewer children aged 0-14 years in the NHSGGC area by 2024. On the other hand, there will be considerably more in the older age groups, with implications for the planning of services (Figure 1).

Figure 1: Projected change in population in NHSGGC between 2006 and 2024.



This so-called "demographic shift"' (ageing of the population) that has been occurring for the past 30 years since deaths exceeded births for the first time in 1976, is more extreme in the NHSGGC area than in Scotland as a whole and will continue for the next few decades (Table 1 provides the net percentage changes by forecasted year and by age group and Figure 1 demonstrates the demographic shift graphically).

More importantly for planning maternity services, planners need to consider the projected numbers of women in the reproductive age ranges by 2026 (Table 1) and what their plans are for family size (reflected by fertility rates). According to Table 1, there will be considerably fewer people aged 15-24 years and aged 35-44 years in the future but there will be *more* people aged 25-34 years until 2021, which incorporates the peak age for having children (see row highlighted in yellow). However, by 2026, even this most reproductively active age group will be in decline (highlighted in pink in Table 1).

Table 1: Projected change in population from base year by age group, NHSGGC

Age Group	Base Year 2006	2011	2016	2021	2026
0-14	**196,962**	-2.8	-2.6	-2.9	-7.8
15-24	**169,943**	-6.1	-15.6	-22.0	-21.0
25-34	**161,381**	9.4	11.9	3.7	-6.2
35-44	**184,263**	-13.0	-19.5	-12.6	-10.4
45-54	**163,744**	8.4	5.0	-9.6	-16.6
55-64	**129,713**	6.2	13.9	23.8	19.9
65-74	**100,645**	-2.6	5.3	13.4	23.6
75-84	**64,164**	2.5	4.7	6.9	19.1
85+	**20,769**	9.1	25.2	48.2	70.8
All Ages	**1,191,584**	-0.2	-0.7	-1.4	-2.6

The ageing of the population within NHSGG&C is not uniform across the area however in that it varies to some extent by council area. Furthermore, the decline in the number of women in the reproductive age group of 25-45 becomes more extreme in the longer term so it is important to examine the projected change between 2006 and 2024 (Figure 2) as well as between 2006 and 2031 (Figure 3). Figures 2 and 3 also demonstrate that the smallest decline in the number of women in the reproductive age group is within our largest council area Glasgow City. Much larger declines are expected in Inverclyde and East Dunbartonshire.

Figure 2: Projected change in female population aged 25-45 years in NHSGGC by council between 2006 and 2024.

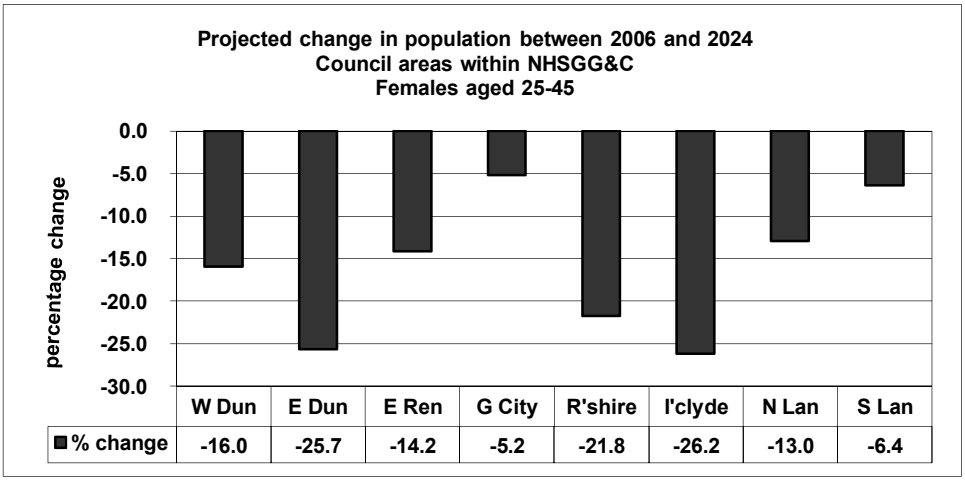
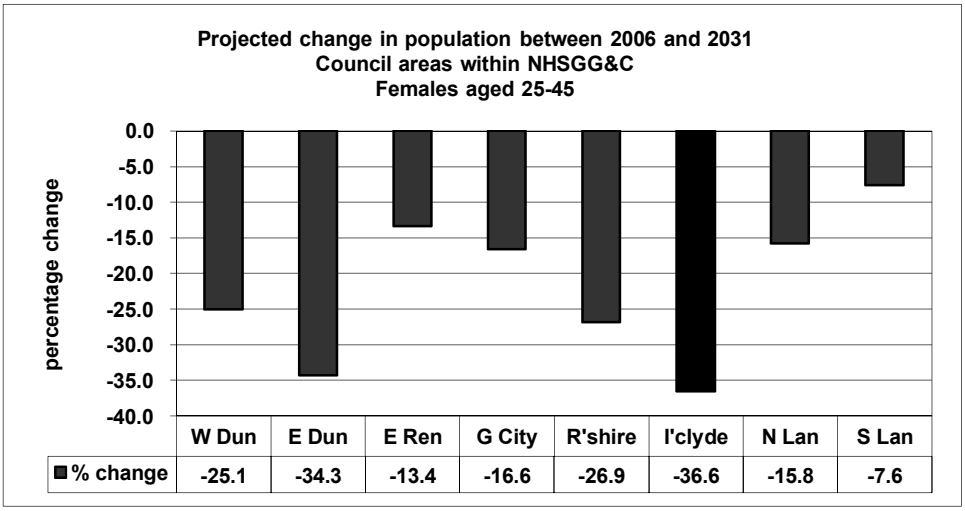


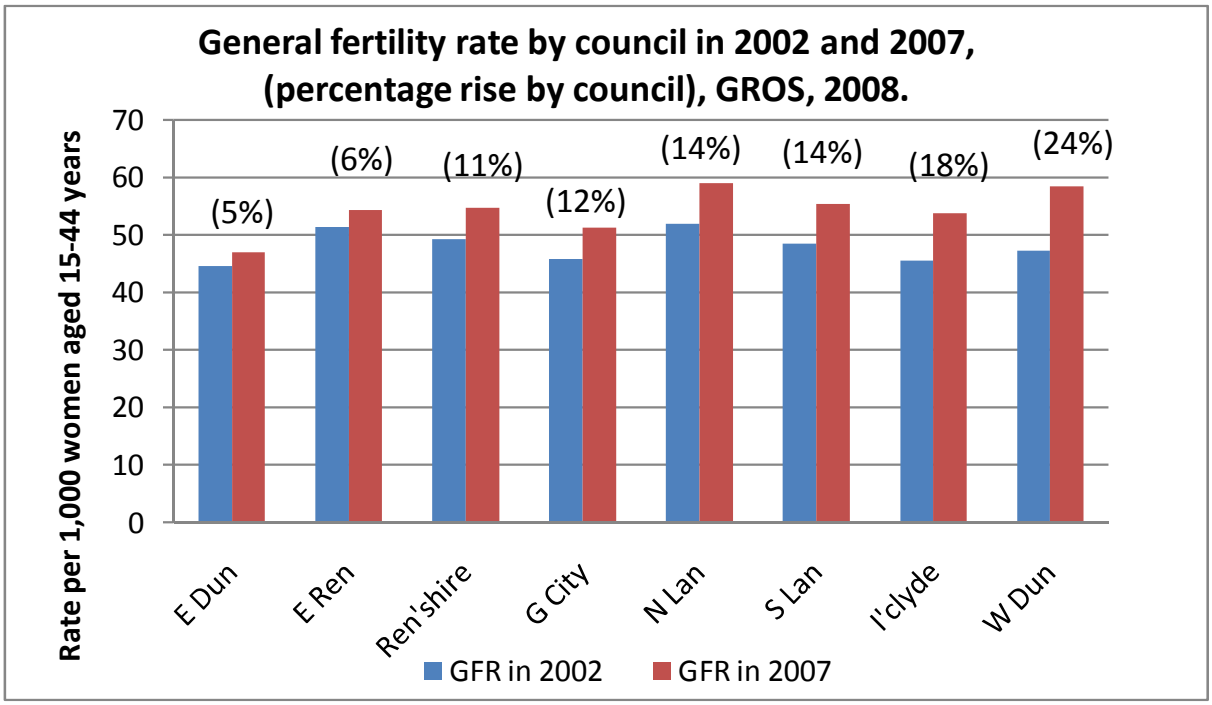
Figure 3: Projected change in female population aged 25-45 years in NHSGGC by council between 2006 and 2031.



Overall, this changing demography suggests we will not need higher capacity maternity services in the long-term future, particularly serving the Clyde councils of West Dunbartonshire, Inverclyde and Renfrewshire as well as East Dunbartonshire. Nevertheless, demographic projections can be unreliable and the GROS have repeatedly amended their birth rate predictions in recent years. Maternity services healthcare planners will continue to monitor these projections carefully, and build in a sufficient margin of error to their planning assumptions to take account of future uncertainty.

Furthermore, births are a function of both the number of women of reproductive age and the fertility rate of those women. The general fertility rate (GFR), which is the number of live births per 1000 women between the ages of 15 and 44 years, has increased between 2002 and 2007 for most council areas in Scotland (Figure 4). This increase in the fertility rate was unexpected. The percentage rise has been highest in West Dunbartonshire (24%) and Inverclyde (18%).

Figure 4: General fertility rate by council in the NHSGG&C area in 2002 and 2007, as well as the percentage rise between the two years (shown in brackets).



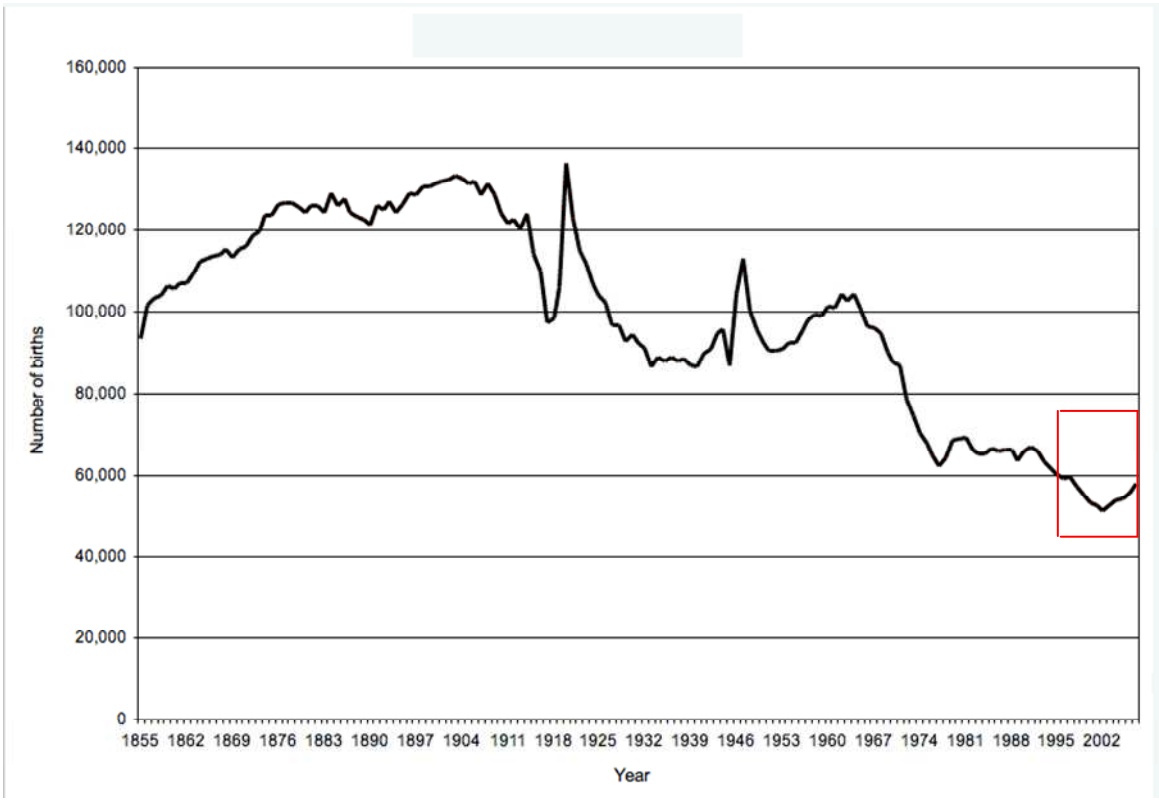
- ***Births in Scotland***

Despite the unexpected recent rise in fertility in all Greater Glasgow and Clyde councils (and indeed in all Scottish councils), the long-term trend for the number of births in Scotland has broadly been one of dramatic decline since the turn of the last century (circa 1903) punctuated by a few significant, though temporary and usually short-lived periods of increasing rates (Figure 5). In recent years, Scotland has been experiencing another one of those periods of increasing births, the numbers having risen by more than 12% between 2002 (51,270) and 2007 to reach 57,581.

However, it is important to appreciate that these numbers are still well below those seen in the early 1960s when they peaked at over 100,000 p.a. and are still below numbers seen in the mid 1970s and early 1990s where they reached 65-70,000 p.a. The relatively small rise that we are currently experiencing is well within the scope of the previous temporary rises.

It is important to note that some of the recent increase in births in NHSGGC has been due to immigration from the EU27 countries plus asylum seekers. Some of these births may be complicated by the factors related to recent immigration of vulnerable ethnic minorities. Future migration patterns are difficult to predict with certainty particularly during periods of global economic difficulty. Although there is no routine mechanism for identifying the extent of this client group's contribution to overall birth numbers from this source, the Women & Children's maternity services recognise that this group may have special needs and are sensitive to those needs.

Figure 5: Live births in Scotland showing the dramatic decline since 1903 and the half dozen temporary rises that result from the fluctuation. The box in red marks the period highlighted for GG&C statistics below.



Source: GROS registration data

Birth rate projections until the period 2030-2031 from the General Registrar Office **(GRO)** for Scotland indicate that birth rates were expected to fall further to reach 50,260 p.a. (see figure 7 below).

Within Scotland, birth rates vary dramatically. The highest standardised rates in 2007 were observed in rural and semi-rural council areas such as Moray (14.3 per 1,000 pop'n) and East Lothian (13.7 per 1,000) while the lowest standardised rates were observed in large urban areas such as Edinburgh (8.1 per 1,000) and Glasgow (9.7 per 1,000). None of the Scottish council areas with high birth rates are within the area served by NHSGGC.

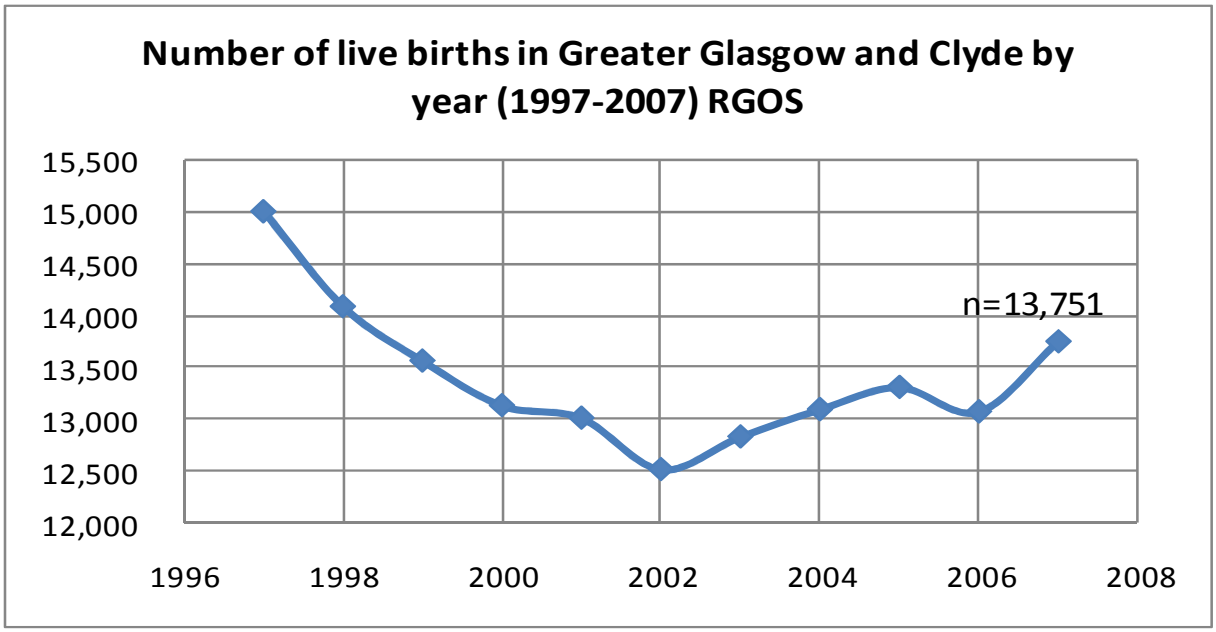
- ***Historical planning assumptions for the Greater Glasgow portion of NHSGGC***

In 2004, NHS Greater Glasgow's planning assumptions proposed that a redesigned Greater Glasgow service should plan for just over 11,000 births; planning for 5,000 births at the maternity unit at the Southern General Hospital (SGH), and 6,250 births at the Princess Royal Maternity (PRM). In 2006, NHS Greater Glasgow reviewed these figures, and based on 2005 activity levels, it was agreed that the plan should be adjusted to 12,000 births per annum, with an expected flow of 6,800 births to the PRM and 5,200 births to the SGH. In April 2006, the NHSGGC organisation was created by incorporating the Clyde portion of Argyll and Clyde NHS Board into the existing NHS Greater Glasgow area.

- ***Actual and projected live births in Greater Glasgow and Clyde***

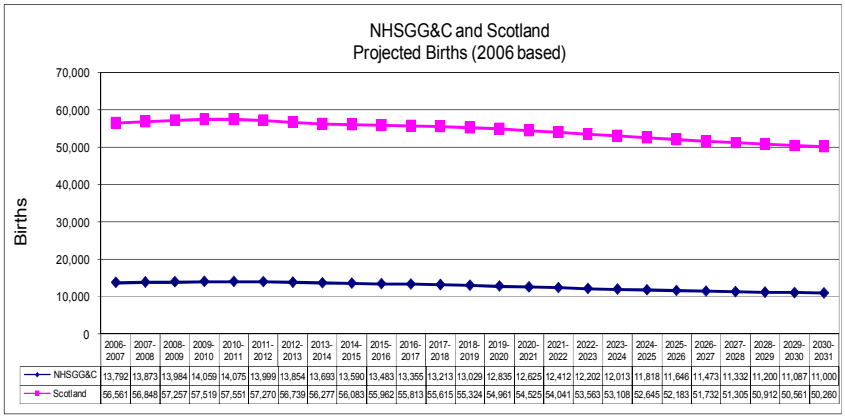
The number of births in Greater Glasgow and Clyde (GGC) reflects broadly the trend in Scotland shown in **Figure 5 above**. The recent trend in births for Greater Glasgow for the period from 1996 to 2007 is depicted in **Figure 6 below**, which is for the period highlighted in the red box in Figure 5. This demonstrates that the recent rise in Scotland is reflected in a similar rise in GGC residents. Since 2002, the number of live births has increased in GGC by 9.9% (from 12,515 to 13,751) slightly less than 12.3% rise seen across Scotland. Currently, services are planned on the basis that Glasgow's maternity units will have 12,500 births and approximately 3,500 in Clyde's services. However, the expectation is that the rise in births will be short-lived in keeping with previous increases and the Scottish trend over the past 150 years. **Figure 6** which shows Glasgow births, acts as a useful reminder that these increases are regarded as temporary.

Figure 6: Actual number of live births for Greater Glasgow by year from 1997 to 2007, Register General Office for Scotland – <u>Glasgow Residents</u>



The projected number of births for both Greater Glasgow and Clyde and for Scotland is shown in **Figure 7 (see over)**. According to the Register General Office for Scotland, the number of births is predicted to gradually decline to 11,000 in 2030-2031. This reassures health service planners that it is appropriate to build maternity services commensurate with that expected reduction in live births. The projected number of births for the individual council areas within NHSGGC area are shown in **Figures 8 and 9 (see over)**.

Figure 7: Projected live births in NHSGG&C from 2006 to 2031 based on 2006 census data, supplied by the Register General Office for Scotland.



	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	2024-2025	2025-2026	2026-2027	2027-2028	2028-2029	2029-2030	2030-2031
NHSGG&C	13,792	13,873	13,984	14,059	14,075	13,999	13,854	13,693	13,590	13,483	13,355	13,213	13,029	12,835	12,625	12,412	12,202	12,013	11,818	11,646	11,473	11,332	11,200	11,087	11,000
Scotland	56,561	56,848	57,257	57,519	57,551	57,270	56,739	56,277	56,083	55,962	55,813	55,615	55,324	54,961	54,525	54,041	53,563	53,108	52,645	52,183	51,732	51,305	50,912	50,561	50,260

Figure 8: Projected live births in Glasgow City from 2006 to 2031 based on 2006 census data, supplied by the Register General Office for Scotland.

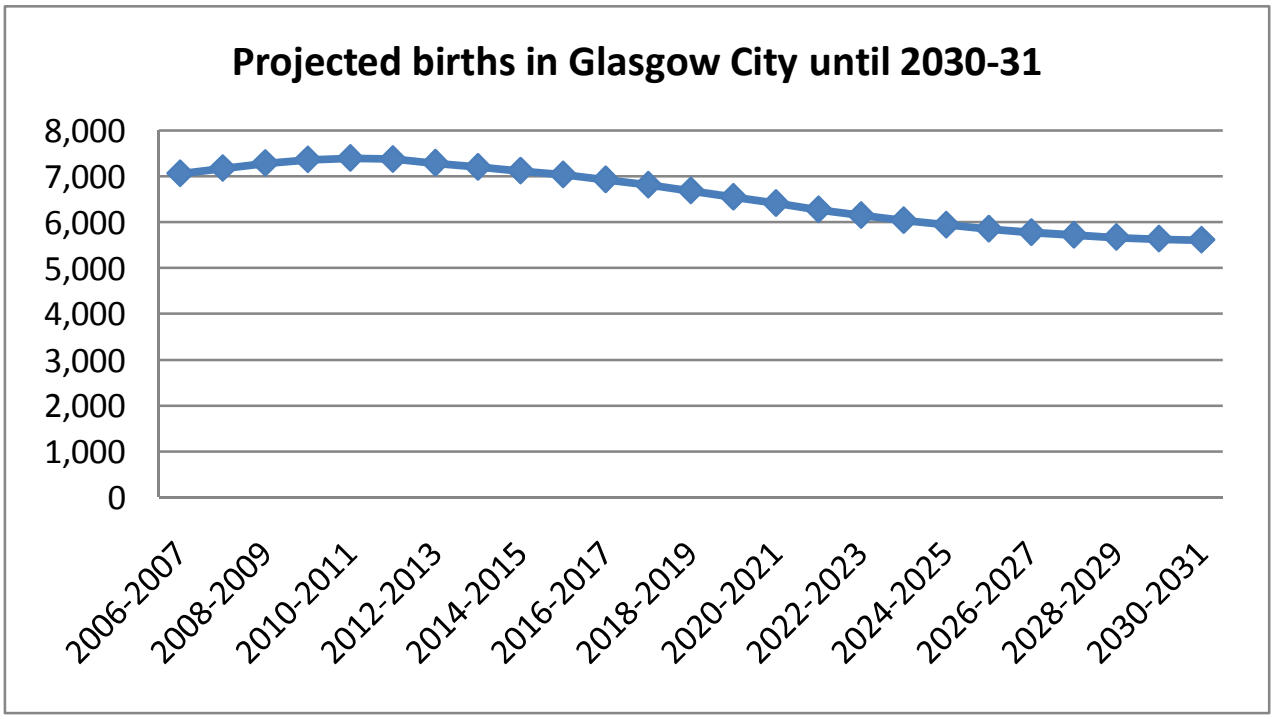
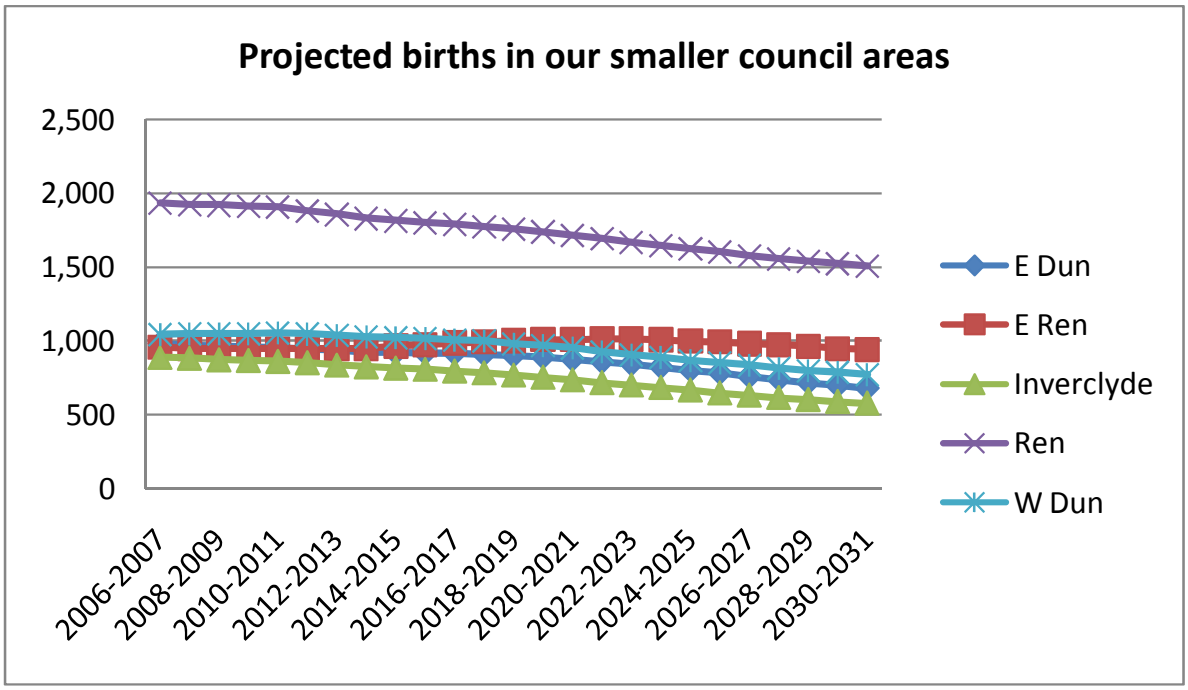
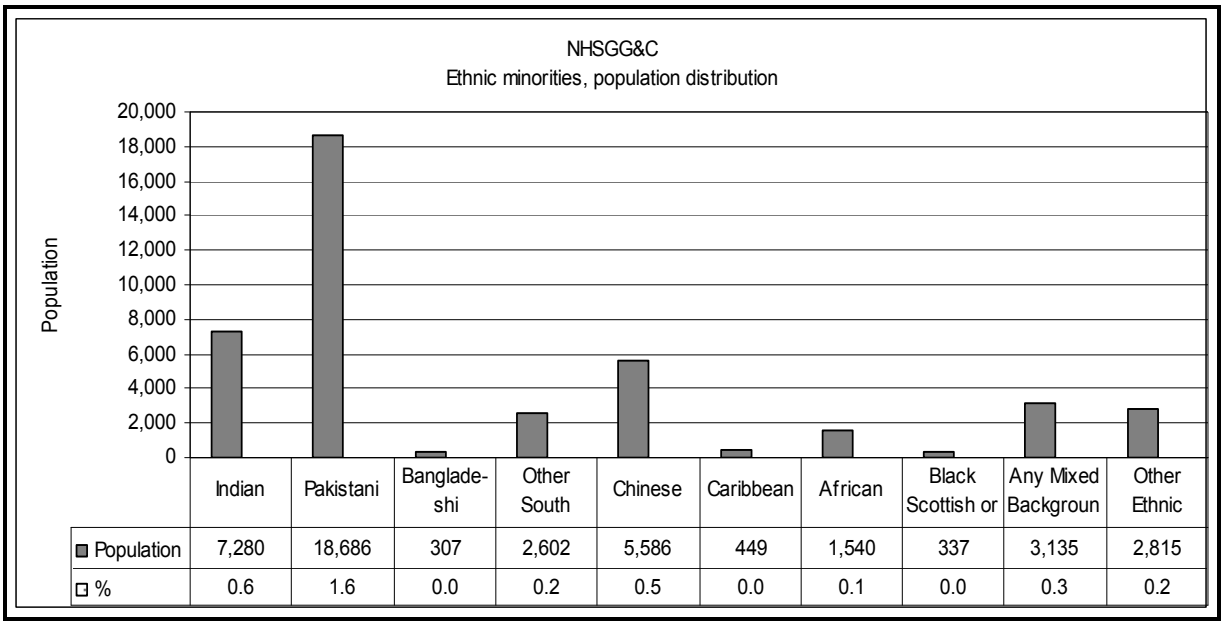


Figure 9: Projected live births in the smaller councils served by NHSGG&C from 2006 to 2031 based on 2006 census data, supplied by the Register General Office for Scotland.



Ethnicity - There is wide range of ethnic groups residing in the NHSGGC area (Figure 10), although almost 90% are Scottish Caucasian (white). Other countries of origin include the Indian subcontinent (7,280), Pakistan (18,686) and other Asian countries such as China (5,586). There is no clear and simple relationship between ethnicity, socio-economic status and maternal health in Scotland. Some clusters of people of ethnic minority origin live in the most privileged parts of GGC and some live in the most socially deprived.

Figure 10: The numbers of people, and the percentages they make up, in the various ethnic minority groups in NHSGGC in 2006.



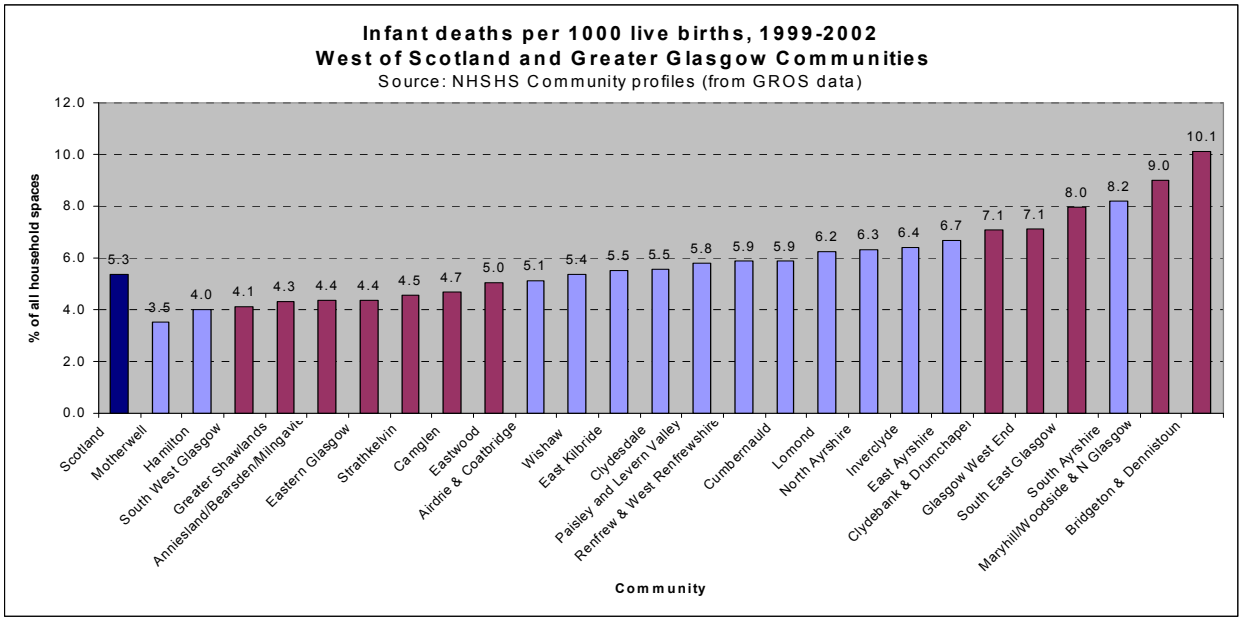
	Indian	Pakistani	Banglade-shi	Other South	Chinese	Caribbean	African	Black Scottish or	Any Mixed Backgroun	Other Ethnic
Population	7,280	18,686	307	2,602	5,586	449	1,540	337	3,135	2,815
%	0.6	1.6	0.0	0.2	0.5	0.0	0.1	0.0	0.3	0.2

- ***Health Indices***

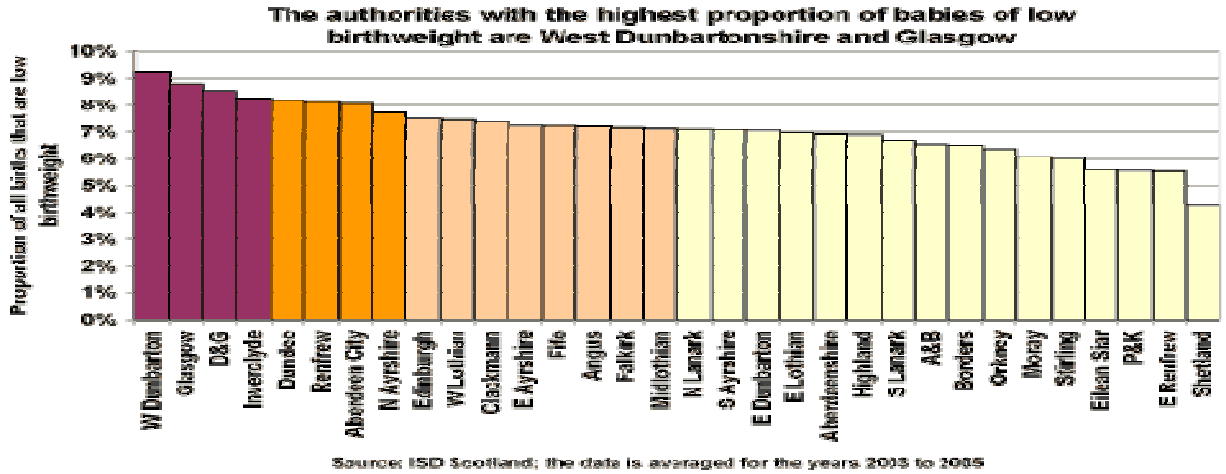
The birth weight of babies, with a focus on low birth weight and very low birth weight, born full term, and babies born prematurely is a key aspect of service planning, because it provides an indication of the immediate care needs and future health prospects for a particular child, the health and socio-economic status of the mother and the antenatal care received by the mother, amongst other factors. Important determinants of birth weight include the degree of prematurity, whether multiple births are involved, and the socio-economic status of the mother; the latter reflecting key risk factors such as poor diet, alcohol intake and smoking both before and during pregnancy.

Infant Deaths and Inequalities – An example of the impact of inequalities on infant mortality is illustrated below. It shows that the risk of death is almost 2.5 times greater if you live in a disadvantaged area, such as Bridgeton, as compared to say Greater Shawlands. Slide 1 below:

Slide 1



Low birth weight – Low birth weight is regarded nationally as an indicator for tackling inequalities. In the illustration below, Slide 2, NHSGGC has within its geographic boundaries 2 local authorities with the lowest birth weights in Scotland, these are West Dunbartonshire (9.2%) and Glasgow City (8.7%), this compares to East Renfrewshire with around (4%). Birth weight of less than 2.5 Kg is associated with poor child health and delayed physical and intellectual development.



Recent trend data (Table 2 below) suggests that the percentage of all births in NHSGGC that were born prematurely has remained remarkably static over the past 30 years at approximately 6.5%. This trend data also suggests that the percentage of those premature babies born with low or very low birth weight has fluctuated to some extent the past 30 years in NHSGGC, with an unwelcome peak in 1994 and a slight deterioration in recent years where the percentage of premature babies born with either low or very low birth weight has exceeded 60% in contrast to that combined figure during the mid 1970s when it was 54-56% of premature babies. It should be noted that between the 1970s and early 1990s the age of viability changed from 28 to 24 weeks.

In contrast, the percentage of babies born full term that were born with a low birth weight has broadly declined over the past 30 years - from an average of 3.6% for the period from 1976-1980 to an average of 3.0% for the period from 2003-2007.

In summary, the percentage of babies born prematurely has not changed significantly over the past 3 decades, and their birth weights have actually deteriorated in recent years. The birth weights of those born at full term has improved modestly over that same time period. It is important to bear in mind that even if birth rates decline in the future, social inequalities in adverse birth outcomes may get worse and the need for specialist maternity services will require to be maintained or even increased.

Birth weight distributions within a population tend to remain fairly stable over time and this is the pattern in NHSGGC. Birth weight is the outcome of a complex interplay of biological, social and clinical factors, rendering any attempt to interpret changing patterns highly problematic.

Recent advances in antenatal care may have both reduced the risk of prematurity/low birth weigh (LBW), while at the same time increasing the proportion of VLBW survivors (rather than incidence) with a consequent increase in morbidity. The increase in maternal age and the proportion of multiple births resulting from the increasing use of technology, such as IVF, are both likely to have resulted in a higher risk of LBW.

Changing registration practices may also have had an impact, e.g. some extremely low birth weight stillbirths may have previously been recorded as miscarriages. Epidemiological indicators of maternity services include maternal, perinatal and to a lesser extent, infant mortality. When numbers are small, there is much random fluctuation of these rates and, therefore, interpretation is therefore difficult.

Table 2: Birth related information by year for the period from 1976 to 2007, provided by ISD via SMR02, downloaded in October 2008.

All Births [1,2] for NHSGG&C[3], by term and birthweight

Year ending 31 March by year from 1999 to 2007

		Premature (born before 37 weeks gestation)				Full Term (born at or after 37 weeks gest.)			
			Percentage				*Percentage*		
	Total	**All Prem**	**VLBW (under 1500g)**	**LBW (1500 - 2499g)**	**Normal (2500g +)**	**All Full Term**	**VLBW (under 1500g)**	**LBW (1500 - 2499g)**	**Normal (2500g +)**
1976	13539	832	*13.5*	*40.9*	*43.9*	12707	*0.1*	*3.6*	*96.0*
1977	12092	679	*14.7*	*40.1*	*42.4*	11413	*0.1*	*3.7*	*95.9*
1978	12167	711	*13.4*	*42.9*	*42.6*	11456	*0.1*	*3.6*	*96.2*
1979	12219	673	*15.6*	*41.9*	*41.5*	11546	*0.1*	*3.6*	*96.2*
1980	12543	682	*11.0*	*46.5*	*41.8*	11861	*0.1*	*3.5*	*96.2*
1981	13157	823	*13.0*	*46.5*	*39.7*	12334	*0.0*	*3.1*	*96.7*
1982	12920	780	*15.8*	*45.6*	*37.6*	12140	*0.0*	*3.0*	*96.9*
1983	12392	719	*13.6*	*47.7*	*38.0*	11673	*0.0*	*3.2*	*96.8*
1984	12295	753	*13.7*	*47.0*	*39.0*	11542	*0.0*	*2.8*	*97.2*
1985	12491	827	*13.5*	*46.7*	*39.1*	11664	*0.0*	*2.9*	*97.1*
1986	12713	800	*14.0*	*47.3*	*38.4*	11913	*0.0*	*3.2*	*96.7*
1987	12690	804	*13.9*	*45.5*	*40.3*	11886	*0.0*	*3.3*	*96.7*
1988	12838	814	*14.4*	*47.3*	*38.3*	12024	*0.0*	*3.1*	*96.8*
1989	12320	788	*15.6*	*45.7*	*38.5*	11532	*0.0*	*2.9*	*97.1*
1990	12071	774	*15.6*	*43.3*	*40.7*	11297	*0.0*	*3.0*	*96.9*
1991	11743	748	*15.6*	*43.9*	*40.2*	10995	*0.0*	*2.8*	*97.1*
1992	12493	767	*15.4*	*46.0*	*38.3*	11726	*0.0*	*3.2*	*96.7*
1993	11667	794	*15.2*	*43.5*	*41.2*	10873	*-*	*3.1*	*96.9*
1994	11385	692	*21.2*	*38.4*	*40.3*	10693	*0.0*	*2.8*	*97.2*
1995	10947	714	*17.8*	*46.6*	*35.3*	10233	*-*	*3.4*	*96.6*
1996	10642	697	*15.4*	*43.8*	*40.8*	9945	*0.0*	*3.5*	*96.5*
1997	10367	692	*16.9*	*46.7*	*36.4*	9675	*-*	*3.0*	*97.0*
1998	14341	942	*15.4*	*46.2*	*38.3*	13399	*0.0*	*2.9*	*97.1*
1999	13423	918	*16.2*	*46.4*	*37.0*	12505	*0.0*	*3.1*	*96.9*
2000	12847	916	*15.6*	*44.2*	*39.9*	11931	*0.0*	*2.9*	*97.1*
2001	12568	872	*18.4*	*43.6*	*38.0*	11696	*0.0*	*2.9*	*97.1*
2002	12031	819	*14.4*	*46.0*	*39.4*	11212	*0.0*	*3.2*	*96.8*
2003 [r]	12081	804	*15.7*	*46.0*	*37.4*	11277	*0.0*	*3.1*	*96.8*
2004 [r]	12489	934	*16.5*	*46.6*	*36.5*	11555	*0.1*	*3.1*	*96.8*
2005 [r]	12778	923	*16.3*	*41.8*	*41.5*	11855	*0.1*	*2.9*	*97.0*
2006 [p]	12516	890	*15.3*	*43.9*	*40.3*	11626	*0.1*	*3.2*	*96.5*
2007 [p]	12716	810	*15.1*	*41.4*	*43.3*	11906	*0.0*	*2.7*	*97.2*

1 - Excludes home births and births at non-NHS hospitals.

2 - Where four or more babies are involved in a pregnancy, birth details are recorded only for the first three babies delivered.

3 - Scotland data includes births where NHS board of residence is unknown or outside Scotland.

r - Revised.

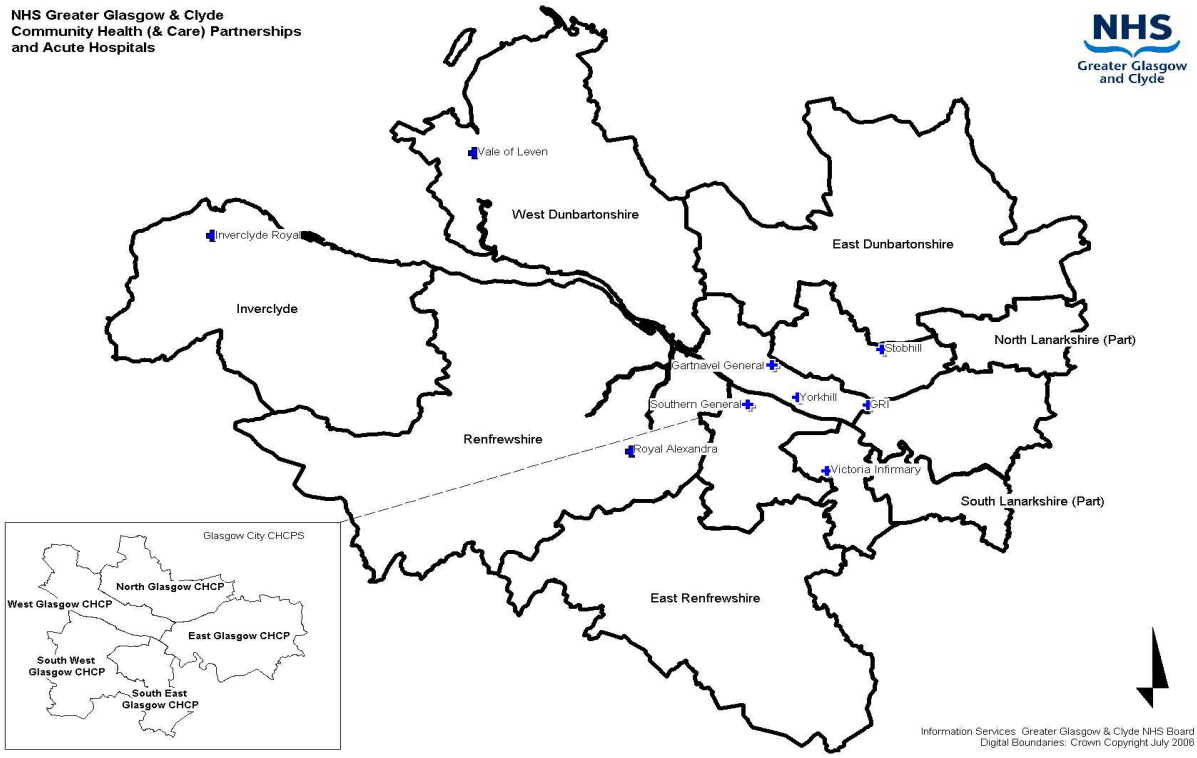
p - Provisional.

Source: SMR02, ISD Scotland

- ***NHS Greater Glasgow & Clyde Geographic Boundaries***

On 1st April 2006, the former NHS Argyll and Clyde was dissolved. Responsibility for its population was divided between NHS Greater Glasgow and NHS Highland. The new organisation, now called NHS Greater Glasgow and Clyde, covers almost a quarter of the entire Scottish population and encompasses the following local authority areas:

- East Dunbartonshire
- East Renfrewshire
- Glasgow City
- Inverclyde
- Renfrewshire
- West Dunbartonshire
- Part of North Lanarkshire
- Part of South Lanarkshire



The map also identifies hospital maternity services across NHS Greater Glasgow & Clyde's geographic boundaries as outlined in this strategy, i.e.

- Maternity Unit, Royal Alexandra Hospital, Paisley
- Maternity Unit, Southern General Hospital, Glasgow
- Princess Royal Maternity, Glasgow Royal Infirmary

5.2 Current Service Models

- **In the Greater Glasgow area**

Current obstetric services in Glasgow are provided from 3 main inpatient sites:

- Princess Royal Maternity (PRM) in the North
- Queen Mother's Hospital (QMH) in the West
- Southern General Hospital (SGH) in the South.

Both the PRM and QMH provide a tertiary service and specialised services, such as fetal medicine.

Princess Royal Maternity (PRM): The PRM is co-located on the Glasgow Royal Infirmary site and its current capacity would enable 5600 births per year. The PRM offers all models of care, dependent on risk assessment. Referral is from GP practices to consultant obstetricians, with booking histories and risk assessment being undertaken by midwives at antenatal clinics within the hospital or at antenatal clinics that are held in a number of localities throughout North Glasgow in Health Centres and GP practices. Midwives run the outreach antenatal clinics, with consultant obstetricians in attendance on a sessional basis, to review those women assessed as high risk.

There is a Midwives Birthing Unit at PRM that is used by women who wish to give birth in a more 'normal', less clinical environment. Community midwives run this unit. Women who use this facility are deemed to be low risk and require minimal intervention. A birthing pool is available in this area. The Women's Reproductive Health Service (WRHS), which will be renamed the Special Needs in Pregnancy Service (SNIPS) is based on site at the PRM. This service caters for women who have significant social or addiction problems and who require a more complex package of care to support them during pregnancy and following birth. This service is being rolled out to enhance equity of access to this specialist service throughout Greater Glasgow.

Queen Mother's Hospital (QMH): The QMH is co-located on the same site as the Royal Hospital for Sick Children (RHSC) and delivers approximately 3400 births per year. The QMH offers all models of care, dependent on risk assessment. Referrals are made from GP practices to consultant obstetricians. Antenatal care is provided in the hospital setting and West Glasgow in Health Centres and GP Practices. Midwives predominantly deliver antenatal and postnatal care, with consultant sessional input for higher risk mothers.

Midwives currently located in the 'tower suite' of the hospital, provide low risk intrapartum care. This provides women with more 'normal surroundings' within the hospital setting. The philosophy is to enable less medical clinical intervention during the birth process. A diagnostic fetal medicine service is provided from PRM & QMH and an interventional fetal medicine service at QMH.

Southern General Hospital Maternity Unit (SGH): The SGH maternity unit is located on the main Southern General Hospital site and provides for 3400 births per year. SGH offers all models of care, dependent on risk assessment. Referral is from GP practice to consultant obstetricians. Most antenatal care is provided at an antenatal care centre at Millbrae or in GP practices or Health Centres in South Glasgow. SGH also provides antenatal care from the main hospital site. The SGH does not currently provide a 'low risk' midwives birthing unit. However, the model of care is promoted throughout the labour suite. A birthing pool is available.

Early Pregnancy, Day Case and Triage: All three sites provide Early Pregnancy Advisory Services (EPAS) and day care. Rutherglen and Millbrae Centres also provide day care. The QMH have developed a triage area with planned roll out of the triage system across all sites.

- **Neonatal Services/Interventional Fetal Medicine**

The neonatal service is currently provided across three inpatient sites in Glasgow, the Princess Royal Maternity (PRM), the Queen Mothers' Hospital (QMH) & the Southern General Hospital (SGH).

PRM - The Neonatal Unit at PRM is co-located on the Glasgow Royal Infirmary site. There are currently a total of 33 cots, 10 intensive care cots and 23 cots for infants requiring high dependency or special care. The Neonatal Unit at PRM is a tertiary referral centre for the West of Scotland and provides both acute and regional referral services. Outpatient services are provided within the PRM.

QMH - The Neonatal Unit at QMH is co-located on the same site as the Royal Hospital for Sick Children (RHSC). There are currently a total of 28 cots, 10 intensive care cots and 18 cots for infants requiring high dependency or special care. The Neonatal Unit at QMH, in conjunction with RHSC, is a tertiary referral centre for the West of Scotland and provides both acute and regional referral services. Both units also provide a national service for extremely ill infants, both term and preterm, who have rare conditions/illnesses that require treatment for congenital heart disease and major airway problems amongst others. Outpatient services are provided within QMH.

SGH - The Neonatal Unit at SGH maternity unit is located on the main Southern General Hospital site. There are currently a total of 21 cots, 3 intensive care cots, 1 high dependency cot and 17 special care cots. Outpatient services are provided within SGH.

Antenatal Services - Antenatal services are provided locally at Millbrae, Rutherglen, Drumchapel and Clydebank. In advance of the planned closure of the Queen Mother's Hospital, antenatal services currently provided from the hospital are to be provided in the West of Glasgow, and an alternative accommodation option is being sought, with the aim of relocating the service during 2007/08.

- **In the Clyde Area**

Royal Alexandra Hospital (RAH) - There is one consultant led obstetric unit based at the Royal Alexandra Hospital in Paisley (3100) births, with a co-located community maternity unit delivering approximately 400 births.

Vale of Leven and Inverclyde Royal Hospital (VOL and IRH) - Currently, the community maternity units (CMUs) at the VOL and IRH are expected to each deliver approximately 100 births in 2008/09.

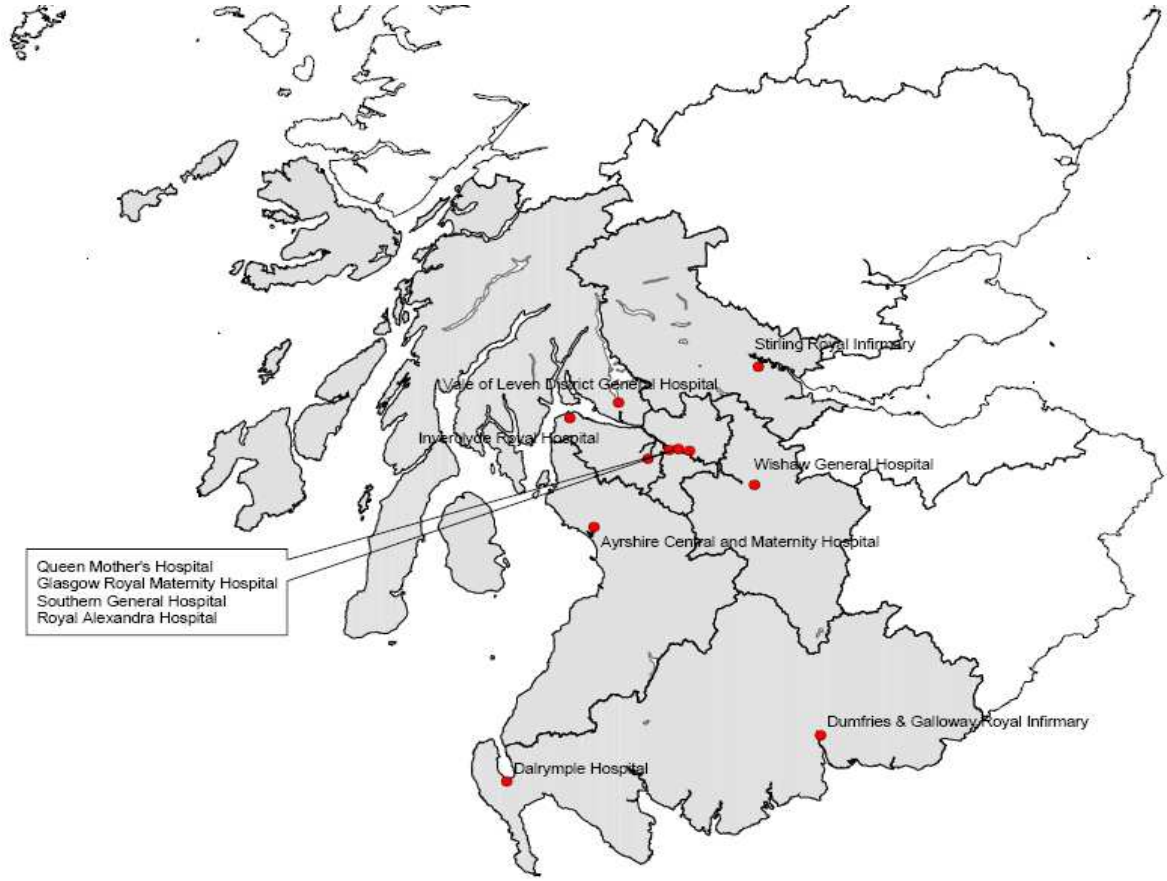
CMUs - CMUs provide facilities for water-birth and also provide a full range of out-patient based services including a day-care and early pregnancy service.

Neonatal Services - The neonatal unit at the RAH is co-located with the consultant–led unit and has 4 Intensive Care Cots and 16 Special Care Cots. A national review of the number of neonatal cots required for the West of Scotland has been undertaken and a report of the outcome is expected early in 2009. The outcome of that review may impact on local ITU cot services, and therefore work is currently in progress to review local cot provision across the Greater Glasgow and Clyde area.

5.3 National and Regional Planning Agenda

West of Scotland Boards agreed to form a regional planning group for maternity services in early 2005. The regional group, initially called the West of Scotland EGAMS Implementation Group (now called the West of Scotland Regional Maternity Services Group) focussed on an assessment of the region against the EGAMS recommendations and progressed to a broader focus on planning maternity services for the region.

The following map shows the geographic area covered by the regional planning group (shaded area) – and highlights the current hospitals providing maternity services in the West of Scotland region:



The current maternity regional planning work programme includes the following areas:

- High Risk Care
- Neonatal Services
- Consultant Workforce Planning
- Workforce Planning for Other Medical Staff Groups

High Risk Care: - Work undertaken to map existing referral patterns for high risk care across the West of Scotland and make recommendations for concentrating referrals over the PRM and QMH sites has led to the establishment of regional referral guidelines and criteria; to the PRM when the risk is attributed to the past medical history of the mother, and to the QMH, where the risk is in relation to the fetus in the present pregnancy and requires interventional fetal medicine. The criteria and guidance are based on current service configuration and will be reviewed when there is greater clarity about medical workforce numbers.

Neonatal Staffing - A preliminary piece of work on medical staffing projections in relation to neonatology/paediatrics and obstetrics has been undertaken. This work will be linked into the outcome of work being undertaken by an Obstetrics Group of a Regional Medical Workforce project, and National Transitional Board work.

Neonatology - Regional guidance has been developed and implemented for identifying cot availability and also guidelines for transferring mothers and babies. The guidelines consolidate the number of current centres for neonatology referrals. Work to explore options for potential further consolidation of neonatology services across the West of Scotland has been identified, and would be undertaken alongside work by the Ministerial Action Group's sub-group on neonatology.

Medical Workforce- Work has commenced to understand the detail of the medical staffing projections for staffing services, and the impact of these on the level of service, which can be delivered. In addition, the outcome of work currently being undertaken to develop a maternity competency framework, and the impact on overall competencies, and therefore workforce numbers, training and development needs would be factored into the regional planning agenda for maternity services.

Training and Education: Additional resources have been identified though the NHS Education for Scotland organisation (NES) to increase the provision of maternity training courses.

6 WHERE DO WE WANT TO BE?

6.1 Planned Service Models

The new service model located in the Greater Glasgow area will provide a triage system in both maternity facilities, i.e. at the maternity unit of the Southern General Hospital and at the Princess Royal Maternity; thereby streamlining the number of patients requiring admission to inpatient beds. This will enable a reduction in the overall number of antenatal and postnatal beds from the 2004 planning assumption of 196 beds, to 179 beds, increasing the throughput of beds to 65-70 births per bed.

Interventional Fetal Medicine will be closely aligned to neonatal critical care facilities based at the SGH. Diagnostic fetal medicine services will continue to be provided from both PRM and SGH.

In light of the physical adjacency with the New Children's Hospital, the SGH neonatal unit will also become the receiving centre for children requiring treatment under national contracts. Both the PRM and SGH will provide secondary and tertiary neonatal services

The Medical Neonatal Unit has been integrated with the Surgical Intensive Care unit (currently located within the Royal Hospital for Sick Children, Glasgow (RHSC). This provides an integrated intensive care facility which will in future link directly into the paediatric intensive care unit facilities within the New Children's Hospital. There are 44 physical cot spaces already available at the PRM, and a further 37 will be provided at the SGH

The Hospital Maternity Services Model for the Greater Glasgow Area

NHS Greater Glasgow April 2004	Planned for late 2009 (Post Calder March 2006)
• three maternity sites: QMH, SGH and PRM	• two maternity sites: SGH and PRM
• 11,250 births across Glasgow	• **12,000 births across Glasgow***
• (5,000 SGH/ 6,250 PRM)	• (5,200 SGH/ 6,800 PRM)
• 196 obstetric beds	• 179 obstetric beds
• 55-60 deliveries per bed (57)	• 65-70 deliveries per bed (67)
• 81 neonatal cots	• 81 neonatal cots (plus 12 additional RHSC SICU cots which will be integrated into the SGH maternity unit)
• interventional fetal medicine at PRM	• interventional fetal medicine at SGH

**The service recognised that since the 2006 plans for maternity services were developed, there had been an increase in births across Greater Glasgow, and expected births in 2008/09 are likely to be in the region of 12,700. There is physical capacity within the system to manage this increase. See also Section 4.2 Demographics for more information relating to birth trends.*

The service model for the Clyde area includes the consultant led obsetric facility at the Royal Alexandra Hospital in Paisley and three Community Midwife-led Units, one at the Royal Alexandra Hospital, one at the Inverclyde Royal Hospital and one at the Vale of Leven Hospital in Alexandria. In addition, local services provided from the CMUs include:

- Antenatal Care by Midwives- Antenatal Care in the community, GP surgeries, CMU and women's homes;
- High risk antenatal out-patient care by consultant obstetrician in the CMU;
- Full programme of parent education;
- Ultrasonography service x 5 days with midwife scanners for routine booking scans;
- Ultrasound service supported by high-risk sessions and anomaly scans undertaken by medical and specialist midwifery ultrasonographers;
- Community based post natal care;
- Triage drop-in service;
- Special Needs in Pregnancy (SNIPS);
- Special Needs Liaison;
- Complimentary Therapy;
- Smoking Cessation;
- Home Births.

- **Pregnancy Pathway**

A Pregnancy Pathway Group was commissioned by the Maternity Strategy Implementation Steering Group (now MSEG) to lead implementation of redesigned multidisciplinary antenatal, intrapartum and postnatal care pathways for women, and to design service models to support the care pathways. The group's work aligned with the National Framework for Maternity Services (2001), and the EGAMS Report (2002). The group's work also incorporated the management of care pathways and services for antenatal and obstetric services including the care of high-risk mothers. The outcome of the redesign in 2008 has seen the phased implementation of the redesign, putting in place standardised midwifery services across NHS Greater Glasgow and Clyde, with midwife-led managed care service models that promote and enhance normal pregnancy and childbirth. The findings of an Inequalities Sensitive Practice initiative undertaken in maternity services was also used to influence the pregnancy pathway redesign programme, and in particular the special needs of pregnant women, which is being rolled out across Greater Glasgow's service.

6.2 Capital Programme Supporting the Maternity Strategy

During 2007 to 2011 a new build and refurbishment of accommodation in the existing maternity unit on the Southern General Hospital site will be undertaken to provide state of the art neonatal and labour suite facilities, and modern accommodation for maternity services. Capital works are also being undertaken at the Princess Royal Maternity:

- Construction of a new 3 storey facility, with 2 storeys for neonatal services, including provision for the integration of medical and surgical intensive care cots (currently in the RHSC), a new labour suite and obstetric theatres;
- A new single storey interventional fetal medicine unit;
- Refurbishment of the existing labour ward for day care, triage and early pregnancy advisory services;
- The new building will be completed by the end of 2009, enabling transfer of services from the Queen Mother's Hospital;
- A phased 4-year capital programme will complete the programme of modernisation of the SGH maternity facilities by 2011.
- A third theatre for the Princess Royal Maternity

A rolling programme of refurbishment and upgrade of facilities at Paisley's Royal Alexandra Hospital maternity unit is also being taken forward:

- Phase one of the programme, the establishment of a community maternity unit on the 3rd floor of the building was completed in November 2004. This provides parent-education facilities, 4 birthing rooms (one with a birthing pool), a six-bed postnatal area and community midwives office.

- Phase 2 has also been completed, and consists of the upgrading of in-patient facilities, providing 2 wards with a total of 49 beds including a special needs room. All in-patient facilities are now located on the 2nd floor of the building.

- In addition to the two wards, an 8-bedded transitional care area has been established, which will not be use until the full upgrade is completed in 2009, because the area is currently being used as a contingency area for services currently being upgraded.

In September 2007 planning was undertaken for the 3rd and 4th phase of the upgrading programme, including the upgrade of the neonatal unit; labour ward; obstetric theatres triage area on the first floor of the building. Followed by the ground-floor out-patient services, which include ultrasonography antenatal and gynaecology clinics colposcopy suite; day care and office accommodation. This work will be completed by December 2008.

6.3 Capital Programme - Art and Therapeutic Design

To ensure that the best design and quality concepts are embedded into plans for upgrading premises and for new building projects, in October 2006 the Scottish Executive Health Department (SEHD) issued circular HDL (2006) 58, entitled **"A Policy on Design Quality for NHS Scotland", which sets out the principles of good design: "*good design is not merely a question of visual style or personal perception but arises from the careful synthesis of many interrelated factors including architectural vision, functionality and efficiency, structural integrity and build quality, security, sustainability, lifetime costing and flexibility in use and sense of space in the community".*** The capital programme that supports the maternity strategy was developed in line with the NHS Board's Design Action Plan, and with Access to Service Legislation.

As part of the capital programme of refurbishment and new build at the SGH maternity unit, an Art and Therapeutic Design sub-group project has been commissioned by the Maternity Strategy Capital Projects Board. An Art Curator Team was appointed in September 2008 to support the sub-group's work. Endowment and charitable funding sponsorship has also been secured to fund the project. The art and therapeutic design component of the capital programme incorporates internal colour schemes, signage, way finding and the environment and space used by staff and patients in the unit. The art and therapeutic programme will be implemented in tandem with the capital programme target timescale of completion in 2009.

6.4 Service Modernisation Programme

Major service developments for the NHS Greater Glasgow & Clyde area highlighted the need for a significant focus on service design in preparation for modernisation and the delivery of future services. Two major drivers for change are the implementation of the Maternity Strategy and planning for a New Children's Hospital.

To underpin the modernisation of maternity services, including modernising the facilities that will be delivered from the new children's hospital, the Women & Children's Directorate of the Acute Services Division launched a clinician-led service design programme in February 2007. The modernisation programme involves staff, in partnership with users of services developing appropriate models of service and care pathways.

7 HOW DO WE GET THERE?

7.1 Implementing the Maternity Strategy

- **The Maternity Strategy Implementation Steering Group (convened as the Maternity Strategy Executive Group July 2008)**

In June 2006, a Maternity Strategy Implementation Steering Group (MSISG) was established to govern the implementation of the organisation's maternity strategy, including taking responsibility for the creation and delivery of an implementation plan. The MSISG's remit included governance of Clyde's maternity review and to oversee the work of the Clyde Maternity Services Review. The MSISG established Sub-Groups to take forward specific areas of its implementation programme covering service provision across NHS Greater Glasgow & Clyde. Sub-groups were established for six key areas of the implementation programme:

- Pregnancy Pathway
- Antenatal Services
- Neonatal Services
- Human Resources and Staff Communications
- Clyde Maternity Services
- Capital & Finance Project Board

One of the first tasks of the MSISG was to ensure that previously planned refurbishment of the maternity unit, based on the Southern General Hospital campus, would sufficiently address the recommendations made by the Calder Group. In that context the building and refurbishment works at the SGH maternity unit were reviewed, including:

- links into critical care in the new children's hospital, which meant that the location of the new integrated neonatal unit on the SGH site was critical and needed to be re-located within the maternity building to give better adjacencies with the new children's hospital;

- the provision of an Interventional Fetal Medicine service at SGH instead of PRM would require additional space on the SGH site;

- the recommended integration of the medical and surgical neonatal service meant that the plans to extend the existing neonatal unit would no longer be feasible as more space and better adjacencies were required; the original plans to extend the existing labour suite were no longer valid as a state of the art labour suite had been recommended, again requiring more space;

- a unit sized to undertake the additional planned increased birth activity, increased neonatal cots for the shift of surgical ITU from the children's hospital to the maternity unit and for fetal medicine.

A capital Outline Business Case was approved by the Scottish Home and Health Department's Capital Investment Group in March 2007. Thereafter, a Full Business Case for the capital development was approved by the Capital Investment Group in May 2008, achieving a £28m investment for new building and modernisation of accommodation in the maternity unit on the Southern General Hospital site, including art and therapeutic design. A capital programme of improvement works has also been carried out at the Royal Alexandra Hospital in Paisley, to improve maternity facilities on that site.

In July 2008, the MSISG reconvened as the Maternity Strategy Executive Group (MSEG), including establishing a Maternity Strategy Capital Projects Board (MS/CPB), to reflect the implementation of service strategy and the approved Full Business Case capital programme.

- **Major Capital Developments for Women and Children's Services**

Three significant areas of development are:

- the successful completion and approval of the Full Business Case in May 2008 to modernise maternity services in Greater Glasgow, achieving £28m of capital modernisation at the maternity unit including a new build facility - putting in place the co-location of gold standard maternity services with the New Children's Hospital and the new build adult hospital on one site, at the Southern General Hospital Campus, Glasgow;

- maternity services provided from the Princess Royal Maternity (PRM) were enhanced in 2006/07 by the opening of additional beds at the PRM in October 2006 and the successful transfer of services for high-risk mothers;

- the successful development and approval of the Outline Business Case for the New Children's Hospital which will be co-located with maternity and adult hospital services on the Southern General Campus, Glasgow;

- a rolling programme of refurbishment and upgrade of facilities at Paisley's Royal Alexandra Hospital maternity unit.

7.2 Service Redesign

In line with the aims of *Delivering for Health (2006)*, the Women & Children's Directorate, of the Acute Services Division, NHS Greater Glasgow & Clyde, is responsible for leading and developing modernisation of acute services for women and children across the Greater Glasgow and Clyde geographic areas.

The Directorate is "twinned" with the East Glasgow Community Health Care Partnership (CHCP), and in partnership will drive forward change, target health improvements and address inequalities in health for women and children within local communities. The Women & Children's Directorate will continue to drive forward service modernisation and health improvements and will deliver these in the context of the organisation's corporate themes:

- **Improve Services**
- **Improve Resource Utilisation**
- **Shift the Balance of Care**
- **Focus Resources on the Greatest Need**
- **Improve Access**
- **Modernise Services**
- **Improve Health**
- **An Effective Organisation**
- **Clinical Governance**

A Maternity Design Implementation Group has been established as part of the Directorate's Redesign programme, and is currently managing 7 key work streams:

- **The Hub and Spoke Model for Midwifery Led Community Care**
- **City-wide Sonography**
- **Development of the West Glasgow Maternity Care Centre**
- **Development of Triage and EPAS**
- **Community midwifery migration**
- **The transfer of antenatal services to new Ambulatory Care Hospital facilities**
- **Decommissioning of the QMH**

The initial part of the service design programme has been focussed on specific priority services, including:

- better theatre utilisation for effective utilisation
- developing improved patient centred care pathways,
- improving "front-door" services, including A&E attendances
- improving demand management
- reducing delayed discharges
- putting in place single models of care across all sites

The service design programme:

- is clinician led
- comprises working groups populated by predominantly clinicians and professional staff, with general practitioners, and staff from Community Health (and Care) Partnerships (CHCPs)
- has user and patient involvement
- is supported by a development, learning and education programme
- is being implemented with public engagement in service design work
- informs wider directorate services and key partners e.g. General practitioners, CHCP, MCNs etc
- is fully supported by a management and governance structure

7.3 Modelling Services for Vulnerable Women and Families

Midwives have a key role to play in supporting an improving health and inequalities agenda. In recognising that important role, the organisation appointed a Consultant Midwife to take a lead role in re-focussing midwifery practice to address life circumstances as part of mainstream maternity services, and to implement evidence based care to support vulnerable families. The appointment has also provided a robust link with the ongoing national agenda to improve maternity services. Specific initiatives to address the above priority areas that are being further developed include:

Services provided for vulnerable women and their families, includes women with specific needs, for example deaf awareness, and women who need language support. Specific needs are implemented in line with the NHS Board's Communication Support and Language Plan.

Inequalities Sensitive Practice Initiative (ISPI): A two year project, funded through the Scottish Executive Multiple and Complex Needs Initiative, was established in the organisation. The strategic aim of the project was to embed inequality sensitive practice in and across diverse health and social care settings. Maternity is one of four specific settings within NHSGGC that was selected because of the acknowledged good practice in the development of services to

people with multiple and complex needs. The maternity project specifically looked at the work of WRHS and to ensure that all women with special needs have equity or access to service provision across Glasgow, including practice descriptors to support women with specific needs, e.g. learning disabilities.

Asylum Seeker Support Midwife: Initial funding, secured from the Home Office Challenge provided identification of midwifery training needs related to refugees and asylum seekers and to produce an education package around care provision. This role was formalised by substantive funding in 2007/08.

Homelessness Midwife: A midwife secondment to the Homeless Families Service from November 2004 to March 2007 was established to offer support and advice to homeless pregnant women, including health education for women and their partners. Close links to the Child Protection Unit have been established, promoting improved working relationships with Social Work Area Teams and the Gender Based Violence Link Midwives. This role will be formalised by provision of recurring funding by March 2009.

Link Midwife – Pregnant Teenagers (13 – 19 years): Across NHS Greater Glasgow & Clyde a total of 1,100 pregnant teenagers deliver each year and Glasgow continues to have one of the highest teenage pregnancy rates in Scotland.

When supported, pregnant teenagers are at no greater risk of obstetric complications than the rest of the childbearing population. However, they are more likely to experience greater social and economic inequalities, which have a significant impact on their health outcomes. From July 2007, a Link Midwife approach was adopted, with notifications of all pregnant teenagers under the age of 16 years. A tiered approach to referral has been established:

- **Tier One** - Link Midwife will support Community Midwife to deliver responsive services to pregnant teenagers. Some young women may need no additional support.
- **Tier Two** - Caseload right remains with Community Midwife but additional input from the Link Midwife may be required for certain areas, e.g. education, supported accommodation, mental health – linking to the mental health pathway.
- **Tier Three** - Full caseload management by the Link Midwife for the most vulnerable young women. Maintaining close working relationships with Social Work and the Child Protection Unit, and ensuring there is a clear pathway of communication between the Link Midwife and the Health Visitor.

Gender Based Violence Midwives: A prevalence of domestic abuse has been clearly established, and it is estimated that between 1 in 3 and 1 in 5 women will have been subjected to domestic abuse at some time in their lives. Currently there are 3 Link Midwives providing professional and practical support for midwives and nurses within the Directorate. The aim is to empower vulnerable women by increasing confidence of midwives and nurses and raising awareness of domestic abuse. The midwives provide training and a rolling programme of education for multi-disciplinary staff in the Directorate. Routine enquiry is in place within all of the Maternity Units across Glasgow & Clyde. The 3 Link Midwives link closely with the Child Protection Unit, and there is a clear referral pathway for midwives to follow.

Women's Reproductive Health Service (WRHS): The Women's Reproductive Health Service (WRHS), which is delivered from the Princess Royal Maternity, provides an important service for a vulnerable group of women. The aim of the WRHS is to provide an integrated approach and effective care for pregnant women with a range of social problems likely to affect the health of the woman and her children or to affect her ability to care for her child. When a pregnant woman is linked into the service, a joint assessment of her current health, lifestyle and parenting skills is undertaken. See also SNIPS below.

Social Work Referral Form: The Social Work Referral Form, currently in use in each of the 3 Glasgow Maternity Units, is recognised by both midwives and social workers as an excellent tool for identifying risk. This form is completed by midwives, mainly during the antenatal period, in recognition of any risks requiring social work or inters agency intervention/support, e.g. previous child/children in care, alcohol misuse, mental health issues

Special Needs in Pregnancy (SNIPS): Providing services tailored to need for those identified as most vulnerable, is crucial to ensuring equality of service and reducing health inequalities. Within Glasgow, the Women's Reproductive Health Service (WRHS) has been established for almost 20 years and provides a comprehensive multi-agency approach to delivering care for women with substance misuse and some of the most complex social needs.

Recent work to implement an enhanced public health focus to midwifery care identified the following groups as also requiring enhanced services due to their case complexity; asylum seekers and refugees, teenagers, and homeless families. This work also indicated that an overarching public health assessment could be integrated within mainstream midwifery care, helping to identify those women and families requiring additional social support.

Within the Clyde area the Special Needs in Pregnancy Service (SNIPS) is an integrated social work and health service provision for pregnant women with special social or psychological needs. The aim of the service is to identify potentially vulnerable babies as early as possible in pregnancy and to provide focussed intervention. The SNIPS was recognised earlier this year with a COSLA Award for excellence in the health improvement category. It is intended to incorporate this approach across Glasgow and Clyde to further enhance care for the most vulnerable women, and to standardise the service across the organisation.

Public Health Assessment Tool: The Scottish Executive launched a Public Health Assessment Tool in Glasgow in October 2005, which the Royal College of Midwives also highly commended as a public health tool. The Assessment Tool is a record of information commenced for every woman within Glasgow at her first booking at an antenatal clinic; a copy of the information obtained being forwarded to a health visitor following postnatal transfer from midwifery care.

The Assessment Tool was used as a prompt to assist the midwife to identify and address key public health priorities and is clearly linked to the Mental Health Care Pathway. An audit of use of the Tool was carried out in 2007. The introduction of the Scottish Women's Hand Health Record in May 2007 supported the use of the revised tool. Of note, the Scottish Women's Hand Held Maternity Record which was launched across Scotland in May 2007, now incorporates this assessment tool within the core record.

8 HUMAN RESOURCES AND PERSONNEL ISSUES

The organisation is committed to developing an open and transparent approach to service development, recognising that staff affected by service change should be involved in the decision making processes. Therefore, consultation with Trade Unions and Staff Organisations in all matters relating to staff issues is routinely undertaken in accordance with the organisation's Policy on Managing Workforce Change. Given the proposed changes that arise from implementation of the NHSGGC Maternity Strategy, in particular the recommendations of the Calder Report, and including the changes brought about for Clyde's Maternity Strategy, it is acknowledged that partnership with staff is critical to successful delivery of the strategic plan.

Implementation of plans and service design programmes continue to be taken forward in partnership with staff, ensuring that any member of staff affected by change is appropriately involved and allowed to influence the shape of services. Staff are already engaged in the programmes of service design work being taken forward by the Women & Children's Directorate, and this involvement will continue throughout implementation of service design, including through joint working with the Area Partnership Forum of the NHS Greater Glasgow & Clyde Board. The Maternity Strategy Executive Group (formerly the MSISG) and its sub groups, in particular the Human Resources Transitions and Communications Sub-Group, operate in partnership with staff in all areas of the MSEG's work. For example, through partnership working a successful staff transfer was achieved in October 2006, when services for high-risk mothers transferred from the QMH to the PRM.

In September 2008 an HR Plan/Migration Principles Policy was developed in partnership and outlines the arrangements which will ensure that staff have full clear information on the principles which will be applied in relation to the development of services within Women and Children's Directorate and the procedures which will be used to support staff during the transition period. This is now being used to support the Community Midwifery restructuring process which commenced October 2008.

See also Section 3, Key Drivers for Change – 3.2 workforce drivers.

- **Staff Governance Standard**

A partnership working relationship to effect change has been established, and continues to be developed to ensure staff and their representatives are fully involved in the process of change. This includes, as a minimum, communication and consultation arrangements, regular open meetings for staff, access to information and MSEG meetings and organisational change policies. In taking forward redesign of services for women and children's services, staff will be fully engaged in the design processes; being encouraged to take lead roles in design projects.
The organisation's Human Resources plan takes full account of the STUC Staff Protocol and of SEHD guidance.

In June 2007 the Workforce Health Directorate of the SGHD launched the third edition of the Staff Governance Standard, which was developed and revised in partnership with staff.

Implementing the maternity strategy for NHS Greater Glasgow & Clyde staff will take full cognisance of that standard:

- Well informed,
- Appropriately trained,
- Involved in decisions that affect them,
- Treated fairly and consistently, and
- Provided with a safe and improved working environment.

9 PATIENT FOCUS PUBLIC INVOLVEMENT

NHS Greater Glasgow and Clyde is committed to ensuring that women, their families and representative groups are central to the planning and development of maternity services.

In order to ensure that all community stakeholders have an opportunity to participate in the development of the organisation's Maternity Strategy, a Patient Focus Public Involvement (PFPI) agenda was developed, to ensure geographic awareness, community ownership, user input and effective communication with stakeholders in the development and implementation of the maternity strategy. The principles of the PFPI agenda have been translated into all aspects of the development and implementation of the maternity strategy, as well as core operational service delivery.

The PFPI agenda is underpinned by four key principles:

- **Integration** – In recognising the importance of integrating the PFPI agenda into mainstream development and design of services, a PFPI specific programme of work to integrate patient and users views for maternity services has been adopted. In addition, a dedicated Community Engagement/Information Officer post was appointed to lead the PFPI agenda for the maternity strategy; working with colleagues across organisations and agencies, to ensure effective communication and involvement for new mothers, parents and community interests.

  In line with the principles of Partnership for Care, the PFPI agenda promotes that user needs are placed at the centre of service design, and by fostering effective relationships between the Women and Children's Directorate and communities, the integration of PFPI ensures that services and facilities are responsive to the needs of users and communities. The PFPI agenda is further supported by the organisation's Community Engagement Team, and by the Corporate Inequalities team for compliance with the diversity agenda.

- **Participation** - A key principle of the PFPI agenda is to ensure that community participation is representative of the women who use maternity services. Community engagement is put into practice by proactive engagement with community projects and initiatives, and has a particular focus on areas of deprivation; specifically to groups traditionally regarded as hard-to-reach, and seeking active participation of women who are less likely to engage with health service decision-making processes, because of issues such as communication or literacy difficulties, lack of confidence or a perceived lack of entitlement.

- **Engagement** - Engagement is developed as an ongoing relationship with service providers. In partnership with Community Health (and Care) Partnerships (CH(C)Ps) and local Healthy Living Projects, engagement is undertaken using nurseries, play schemes and family centres, based in local geographical housing districts.

- **Support** - Underpinning the PFPI agenda is the provision of robust arrangements to support user participation, and can include providing transport, child care facilities, or helping with understanding of agendas and papers.

This PFPI agenda has three major programmes of community engagement:

- **Effective engagement of individual women, carers and user representative groups in the implementation of the Maternity Strategy**

This programme aims to establish a network of women who directly use maternity services and link with a wider network of family and carers. Outreach work in the community provides the opportunity for women, carers and families to be informed of and contribute to the discussions around the Maternity Strategy. Engagement has also been used to identify and recruit women's input and participation into the work of the Maternity Strategy Implementation Steering Group and its sub-groups (now MSEG and MS/CPB). A member of the NHS Board's PFPI Committee is also a member of the Maternity Strategy Executive Group.

This process has also helped establish the foundations for long term and meaningful engagement structures to ensure the continued engagement of stakeholders and communities throughout the development, the build and re-design phases of the Maternity Strategy, including the art and therapeutic design dimension of the capital programme.

- **On-going participation of a range of user, carer and stakeholder interests on the Maternity Services Liaison Committee**

In recent years the Maternity Services Liaison Committee has sought to formalise the local arrangements and community based initiatives on user involvement. It established a network of user groups and consumer organisations called MatNet to bring a wide-ranging view on women's perspectives to its meetings. The purpose of MatNet is to ensure that the needs and concerns of users and the wider community systematically inform the MSLC and thus influence both local and national policies and practice that relates to maternity services. It seeks to build a network with a proactive and positive role in the development of maternity services in Glasgow.

- **Monitoring and Communications Systems**

This programme ensures that community engagement work is captured, communicated to stakeholders and fed back to users, carers, the general public, community representatives, voluntary organisations, geographic and thematic communities and partner agencies. Through an outreach programme of pro-active community briefings, seminars and communication resources, and the fostering of relationships with a range of external interests, this programme seeks to facilitate the dissemination of information on the Maternity Strategy. Furthermore, it ensures that the information gathered from users and external interests is fed into the appropriate decision-making processes of maternity services.

10 REFERENCE DOCUMENTS AND FURTHER INFORMATION

10.1 Points of Reference and Documents of Interest for Further Information

The following list of reference documents is not exhaustive but may be helpful if further background reading is required. Internet links/addresses for documents are provided, where possible. The NHS Greater Glasgow & Clyde web site can be accessed to source a wide variety of policy and strategy documents. The Scottish Government's Health Directorate web site is also a good source of information.

- NHS Greater Glasgow & Clyde internet link: **http://www.nhsggc.org.uk/content/**
- Scottish Government Health Directorates internet link: **http://www.sehd.scot.nhs.uk/**
- Scotland's Health on the Web (SHOW) internet link: **http://www.show.scot.nhs.uk/**
- NHS Quality Improvement Scotland internet link: **http://www.nhshealthquality.org/nhsqis/CCC_FirstPage.jsp**
- Scottish Executive (2006). *Children's and Maternity Services in Glasgow - Report of the Clinical Advisory Group appointed by the Minister for Health and Community Care (Calder Report).* Edinburgh: Scottish Executive. **http://www.scotland.gov.uk/Resource/Doc/1093/0023297.pdf**
- Scottish Executive (2001) *A framework for maternity services in Scotland.* Edinburgh: The Scottish Office.
- Scottish Executive (2003). *Implementing a Framework for Maternity Services in Scotland. Overview Report of the Expert Group on Acute Maternity Services.* Edinburgh: The Scottish Office.
- QIS National Overview 2007: Maternity Services and Local Reports NHSQIS website **http://www.nhshealthquality.org/nhsqis/740.html**
- NHS Scotland – NHS Quality Improvement Scotland, Sharing Good Practice in Scotland's Maternity Services – Local Initiatives by Standard
- NHSQIS (2005). *Clinical Standards – March 2005. Maternity Services.* Edinburgh: NHSQIS.
- NHSQIS (2004). *Best Practice Statement – April 2004. Maternal History taking.* Edinburgh: NHSQIS.
- NHSQIS (2004). *Best Practice Statement – April 2004. Routine Examination of the Newborn.* Edinburgh: NHSQIS.
- Audit of Care Provided and Outcomes Achieved by Community Maternity Units in Scotland 2005 (SPCERH)
- CEMACH (2004). *Why Mothers Die 2000-2002. Confidential enquiry into Maternal and Child health.* London: CEMACH.
- NMC (2005). *Midwives Rules and Standards.* London: NMC.

- RCOG and RCM (2007). Joint Statement no. 2. *Homebirths*: Page 4. London: RCOG Press
- RCOG (2002). *Advice on Planning the Service in Obstetrics and Gynaecology.* Clinical standards: Key Standard 1. London: RCOG Press
- RCOG (2006). *The management of Early Pregnancy Loss*. Guideline no.25. London: RCOG Press
- QIS (2005). *Clinical Standards – March 2005. Maternity Services. Standard Statement 2b: Early pregnancy complications.* Page 17. Edinburgh: NHSQIS
- Birthrate Plus Manpower Audit (2004-2005). Greater Glasgow Maternity Units.
- Anderson D, Powls L & Sutherland B. (2006). *6 Months Evaluation and Report.* Glasgow: Triage Unit.
- Holmes, A. & Brown, S. (2007). *Shifting the Balance of Midwifery Care: Experiences of Implementing a Public Health Midwifery Model.* Glasgow: NHSGGC.
- NHS Education for Scotland (2006). *Maternity Care Assistants in Scotland: A competency framework.* Edinburgh: NES
- Delivery for Health (2006)
- Information on Health for All Children is available **at** **http://www.health-for-all-children.co.uk**
- Getting it Right for Scotland's Children (GIR, Scottish Executive, 2005)
- NHS Greater Glasgow & Clyde Infant Feeding Strategy (2008) **http://www.nhsggc.org.uk/content/assetList.asp?aType=10&page=s775_2**
- Equally Well: Report of the Scottish Government Ministerial Task Force on Health Inequalities **http://www.scotland.gov.uk/Publications/2008/06/25104032/0**
- NHS Greater Glasgow & Clyde Acute Services Review (2007 Update)
- NHS Greater Glasgow & Clyde Clinical Strategy (2006) (Glasgow)
- NHS Greater Glasgow & Clyde - Acute Services Plan
- NHS Greater Glasgow & Clyde - Women & Children's Local Development Plan
- **NHS Greater Glasgow & Clyde Equality Scheme 2006-2009** Equality in Health **http://www.equalitiesinhealth.org/index.html**
- NHS Greater Glasgow & Clyde Public Health Unit
- Scottish Government's strategy for a healthier Scotland - **Better Health, Better Care: Action** Plan (December 2007) **http://www.scotland.gov.uk/Topics/Health/Action-Plan**
- Scottish Government's *A Force for Improvement* – The Workforce Response to Better Health Better Care *(final draft November 2008)*

10.2 Further Information

This strategy is available on request in large print and on computer disk. Other formats and languages can be supplied on request.

A copy of NHS Greater Glasgow & Clyde's Maternity Strategy can be obtained by:

- accessing the internet: **http://www.nhsggc.org.uk**
- sending an email to: **dorothy.cafferty@ggc.nhs.scot.uk**
- writing to:

  Dorothy Cafferty
  Acute Services Planning Directorate
  Management Annexe
  Southern General Hospital
  1345 Govan Road
  Glasgow G51 4TF

- telephoning: Dorothy Cafferty on 0141 201 1249

If you need any help or assistance in locating any of the documents mentioned or referenced to in this document, please use one of the contact points provided above.

10.3 Glossary of Terms

- **Child health surveillance** - used to describe routine child health checks and monitoring.

- **Child health screening** - the use of formal tests or examination procedures on a population basis to identify those who are apparently well, but who may have a disease or defect, so that they can be referred for a definitive diagnostic test.

- **Community Maternity Unit (CMU)** A maternity unit, midwife managed, occasionally with GP involvement, which may be a stand-alone unit or adjacent to a non-obstetric hospital or adjacent to a maternity unit.

- **Consultant Led Maternity Unit (CLMU)** Full maternity unit and support services for easy access to special care baby units/neo-natal intensive care and access to adult high dependency care and adult intensive care

- **Contingency Plan/Measure** A plan, drawn up as short-term measure to resolve a particular difficulty. In the case of maternity services at the Vale of Leven hospital, problems with recruitment of key medical staff has resulted in all intrapartum care being provided by the Queen Mother's Hospital in Glasgow

- **Expert Group on Acute Maternity Services (EGAMS)** This expert working group was set up in February 2002 and reported in December 2002, the purpose being to look at the implementation of the framework for maternity services in Scotland. The EGAMS report described the shape of current acute services in Scotland, the challenges and constraints and set out a service model to meet current and future needs. The full report is available on the SHOW web site.

- **European Working Time Directive (EWTD)** The working time directive provides for minimum daily and weekly rest periods, annual paid holidays, a limit on the working week of 48 hours and restrictions on night work. It excludes from its scope transport, work at sea and doctors in training.

- **Framework for Maternity Services in Scotland** This document, published in February 2001, sets out a framework for what maternity services should be offered across Scotland. The aim is to create a modern responsive 21st Century maternity service and offers a template for best practice in maternity care.

- **Demographic** Study of statistics on births, deaths and diseases.

- **Guidelines** Systematically developed statements that assist in decision-making about appropriate healthcare for specific clinical conditions.

- **Health promotion -** used to describe planned and informed interventions that are designed to improve physical or mental health or prevent disease, disability and premature death. Health in this sense is a positive holistic state

- **High Risk Birth** Women who require medical care for themselves or their baby.

- **Home Births** This is usually a planned event where the woman decides to give birth at home, with care provided by the midwife. It is normal for 2 midwives to be present for the birth. Occasionally the GP is involved in the care and is present at the birth.

- **Intrapartum Care** during the birth episode.

- **Low Risk Births** Healthy women with a normal pregnancy

- **Managed Clinical Networks (MCN)** A network of clinical staff working in a similar area that is able to work together more closely by developing a network of contacts.

- **Maternity Services Liaison Committee** A committee set up within an NHS Board area that provides a forum for the professions involved the provision of maternity care with representatives of the women who use the services to discuss issues relevant to the provision and development of maternity services in the area.

- **New Deal for Junior Doctors** *Similar to the EWTD (see above) and covers junior doctors in training*

- **SNIPS** Special Needs in Pregnancy (SNIPS)

- **Stand Alone Community Maternity Unit** An appropriately equipped midwifery unit for normal care and agreed transfer guidelines to a linked maternity unit.

- **Women Centred** The need of the individual woman provide the focus for the planning, organising and delivery of maternity services.

- **WRHS** Women's Reproductive Health Service (WRHS**)**