

NHS Greater Glasgow and Clyde	Paper No. 24/155
Meeting:	NHSGGC Board
Meeting Date:	17 December 2024
Title:	Maternity and Neonatal draft strategy
Sponsoring Director/Manager	Mr Jamie Redfern Director of Women and Children's Services Prof Angela Wallace Nurse Director
Report Author:	Dr Mary Ross-Davie, Director of Midwifery, Dr Colin Peters, Clinical Director, Neonates

1. Purpose

The purpose of the attached paper is to: introduce the newly developed NHSGGC Maternity and Neonatal Five year strategy and seek support and approval from the Board for the strategy for publication.

2. Executive Summary

The paper can be summarised as follows:

- A new draft maternity and neonatal strategy has been developed with a range of stakeholders and in consultation with staff and the community that we serv.
- The strategy seeks to build on the work of the Best Start review recommendations and continue to implement and embed some of the key Best Start recommendations.
- The strategy sets out eight key areas of strategic intent: personalised care; safe high quality specialist care; reducing inequalities; using resources wisely; developing our team; positive stakeholder engagement; public protection and clinical governance.

3. Recommendations

The NHS Board is asked to consider the following recommendations:

- That NHSGGC adopts the Maternity and Neonatal strategy as the blueprint and strategic direction for the development of our services over the next five years

4. Response Required

This paper is presented for approval

5. Impact Assessment

The impact of this paper on NHSGGC's corporate aims, approach to equality and diversity and environmental impact are assessed as follows: (Provide a high-level assessment of whether the paper increases the likelihood of these being achieved.)

- Better Health Positive impact
- Better Care Positive impact
- Better Value Positive impact
- Better Workplace Positive impact
- Equality & Diversity Positive impact
- Environment Positive impact

6. Engagement & Communications

The issues addressed in this paper were subject to the following engagement and communications activity: online surveys with women and families; engagement sessions with staff; consultation with partnership and a range of stakeholders.

7. Governance Route

This paper has been previously considered by the following groups as part of its development: Women and Children's Directorate Management Team; Strategic Management team; Women and Children's, Acute and Area partnership forums; Maternity, women and children's and acute governance groups; Board Clinical and Care Governance committee.

8. Date Prepared & Issued

06.12.24
10.12.24

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Meeting:	NHSGGC Board
Meeting Date:	17 December 2024
Title:	New Maternity and Neonatal Five-Year Strategy
Sponsoring Director/Manager:	Mr Jamie Redfern Director of Women and Children's Services Prof Angela Wallace Nurse Director
Report Author:	Dr Mary Ross-Davie, Director of Midwifery, Dr Jane Richmond, CD Obstetrics and Dr Colin Peters, CD Neonatology

1. Introduction

The Women and Children's Directorate leadership team, with support from the Nursing and Midwifery Board Nurse Director, planning, public health, public protection, human resources and the public engagement and public involvement teams, have developed a comprehensive five year strategy for maternity and neonatal services for NHSGGC. This strategy sets out the vision and a clear direction for the development of these services for 2024-2029.

2. Background

The Scottish Government's Best Start maternity and neonatal review report was published in January 2017. This has been the guiding policy document for our services since that time and set the national direction for these services for the next five years. As a result of the impact of the pandemic, the timelines for implementation of the review's recommendations were extended by two years for most recommendations, until end March 2024. Three key areas: the implementation of the national bereavement care pathways, the new national Neonatal intensive care model and continuity of carer, had extended timelines for implementation of 2025 and 2026 respectively.

As the national Best Start implementation programme comes to an end, and with no new national maternity and neonatal policy in development, it was identified that maternity and neonatal services across GGC would benefit from the continued focus and drive provided by a coherent strategy.

The development of the strategy was started in 2021, but was necessarily delayed by the delayed announcement of the final Scottish Government plans for the national neonatal model of care. This announcement, in July 2023, identified that the RHC

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neonatal unit at the QEUH would become one of the three units defined as Neonatal Intensive Care Units (NICU), along with Edinburgh and Aberdeen providing care for the smallest and sickest babies. Neonatal units at Princess Royal Maternity, University Hospital Wishaw, and Ninewells will be redesignated as Local Neonatal Units (LNU) which will continue to provide intensive care for many patients.

The development of the strategy document presented today has been a process of collaborative work across sectors and teams, with consultation and engagement with staff, partnership and women and families.

3. Assessment

The maternity and neonatal leadership teams are proud of the significant progress we have been able to make in relation to Best Start implementation since 2022. In maternity, this has included the establishment of alongside midwife units in all maternity units, the roll out of antenatal and postnatal community based continuity of carer models across all parts of our service and the implementation of the national bereavement care pathways. There is still further work to do to continue to fully implement and embed key recommendations of the Best Start review, and this strategy supports the continued focus on these areas.

The final strategy document presented today has been co-designed and produced with all key professional groups and specialities. This has included engagement and input with GGC wide teams and experts including our Nursing Directors, equalities team, public health consultants, public protection team, clinical governance and effectiveness leads, allied health professional and human resources colleagues. All of the core maternity and neonatal professional and managerial leaders and partnership colleagues have been engaged in its development and been given the opportunity to comment on and shape the document.

Aims and Vision

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

Key areas of strategic intent set out in the strategy

1. Personalised family centred responsive care
2. High quality, safe care for all, including high quality specialist care when it is needed
3. Reducing inequalities
4. Redesigning the way we provide services to give the highest quality care for the best value for money
5. Developing our team to ensure safe staffing, with high levels of retention and job satisfaction

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6. Engaging with key stakeholders, in particular with women and families to help shape service improvement
7. Robust clinical governance and effectiveness
8. Effective public protection.

Engagement and Consultation with staff

A series of Teams meetings were undertaken in Autumn 2022 and repeated in Summer 2024 to consult with all maternity staff about the priorities for our new strategy. Levels of engagement with these sessions was good, with representation from all different professional groups. Where there had been less engagement from one profession or team, the draft document was sent to specific leads to seek feedback and comment during summer 2024. Positive feedback and amendments were received and incorporated in the final document.

This process confirmed that staff felt the key areas of strategic intent proposed were appropriate. Staff were encouraged to identify any gaps and propose any changes, which were incorporated into this final version.

Through the Autumn of 2024, there have been regular staff engagement and information sessions about the new neonatal model of care.

The draft strategy has been formally shared with the Women and Children's and Acute Partnership forums.

Engagement with women and families

We have been active in developing our approaches to ensure that we are systematically asking women about their experience of care with us and to engage them in service developments.

We have established a new Maternity Voices Partnership and also a Third Sector Organisations network in the summer of 2024. These evolving groups enable women, who have given birth with us in the last two years and those organisations that support them, to be offered regular opportunities to engage with us to help us shape our service developments. We are working to ensure that these groups are representative of the diverse populations that we serve and that we reach out actively to lesser heard groups, including global majority women, refugee and asylum seeking women and those living with deprivation and social complexity. The key strategic intent areas of the strategy have been shared with these groups and positive responses were received.

We have undertaken a series of online surveys with women over the last 18 months, with responses from nearly 5000 women. These surveys have sought their views on

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our strategic priorities and confirmed the importance that women place on relationship based continuity of carer during their maternity journey, adequate time at antenatal appointments to fully explore their choices and make informed decisions and easy access to antenatal education and information.

There have been three pieces of public engagement work, led by the Public Engagement and Public involvement team, linked to the strategy at a number of stages.

- The first in March 2023 looked at strategy high level aims, women's experiences of care and helped inform early thinking.
- The second in late 2023 looked at continuity of carer a key best start outcome and foundation to the strategy
- The most recent in Mid 2024 looked at more general maternity experiences, also touching on travel, appointment time and location while also assessing changes in continuity overtime.

The reports of the results of these surveys are attached with this paper as appendix two.

The Scottish Government undertook a consultation exercise with the public about the new neonatal model during summer 2024 and the neonatal service continues to engage regularly with families with current and recent experience of neonatal care.

Strategy document design

The draft strategy document shared with this committee has been designed professionally, with input from our Board communications team. The document meets our 'clear for all' guidelines and is in line with corporate colour and design guidelines.

The photographs used throughout the document are up to date, featuring current staff and recent service users, with their consent. We have ensured that these pictures are as reflective as possible of our diverse populations.

Our aim is to have some hard copy copies of the strategy available for staff and key stakeholders. The document will also be hosted on our website. The document will be accompanied by:

- A references and useful links document that enables the reader to engage with the resources, websites and policy documents that are referenced in the document. This is attached with this paper as appendix three.
- A short summary document and poster to share the key messages with all staff and the public. This will also include translated versions for our key community languages.

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- A range of marketing and information resources to share information about the strategy and implementation progress, including a podcast format, short films etc

Implementation plans

While far reaching and aspirational, it is vital that the strategy is realistic and has clear timelines and systems to support implementation of the stated aims.

The current Best Start implementation structures within the Women and Children's Directorate, including an Executive oversight group, operational oversight group and a range of working groups, will evolve to focus on implementation of the strategy. The Maternity leadership team has begun to develop a planning process to establish priorities, timelines and the establishment of the appropriate governance and implementation structures.

Alignment with other Board priorities and strategies and national priorities

In the development of this strategy, we have been mindful of the need for this strategy to align with and support a range of other NHSGGC strategies, including the public protection, quality, nursing and midwifery and workforce planning strategies and the Moving Forward together programme.

We are aware that Healthcare Improvement Scotland is in the process of instigating an inspection programme for maternity and neonatal services during 2025 and new maternity care standards to be published later in 2025. These developments will further inform and shape the ongoing implementation of this strategy across NHSGGC.

4. Conclusions

We have been able to make significant progress in relation to implementing the Best Start maternity and neonatal recommendations over the last two years.

We acknowledge that there is continued work to be done to further embed some of the key Best Start recommendations.

Our new maternity and neonatal strategy ensures that our Board has a clear vision and sense of direction for these crucial services for the next five years.

The strategy, which has been coproduced with all key relevant stakeholders not only continues the work set out in Best Start, but also identifies key areas for development and focus for our services over the next five years. This includes a reduction in health inequalities, a focus on the needs of the most vulnerable who are

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most likely to have poor outcomes from their maternity and neonatal care; robust public protection, strong clinical governance systems, the continued evolution of the use of digital technology and new ways of working to ensure we provide a modern and efficient service. The strategy also sets out a clear vision for the development of our maternity and neonatal teams.

5. Recommendations

We ask the NHSGGC Board to consider the strategy document for approval and implementation, with assurance of scrutiny at the following committees:

- Board Clinical Governance Forum
- Clinical and Care Governance Committee

6. Implementation

We continue to focus as a senior maternity and neonatal team on implementation of the Best Start review recommendations. We will develop our Best Start implementation systems and processes to enable planning, leadership and implementation of the maternity and neonatal strategy.

Implementation will include ongoing and regular engagement with women and families, other key stakeholders, partnership and staff.

The implementation of this far reaching strategy will require support from NHSGGC Board, with clear focus, appropriate workforce and necessary investment to become embedded and sustainable.

7. Evaluation

We will continue to use a range of approaches to evaluate the impact of Best Start recommendation implementation and the strategy implementation. This will include engagement with staff through in person meetings to discuss impact as well as online surveys to assess staff views; engagement with women and families to hear their views and responses to changes and audit of processes and outcomes of our care.

8. Appendices

Appendix one: The draft maternity and neonatal strategy

Appendix two: The three public engagement surveys reports undertaken

 [20230322 Maternity Engagement Report Strategy Engagement v1.docx](#)

 [20240115 Continuity of Carer Engagement Report v1.docx](#)

 [20240912 Understanding Maternity Experiences Survey Biannual Report 2024a.docx](#)

Appendix three: Useful links and bibliography – page to sit beside strategy on website

These appear below in the order that they appear in the strategy:

- The Best Start review: Scottish Government five-year forward plan for the improvement of maternity and neonatal services in Scotland, 2017, [The best start: five-year plan for maternity and neonatal care - gov.scot \(www.gov.scot\)](#)
- The Scottish Government's Women's Health plan, 2021-2024, [Supporting documents - Women's health plan - gov.scot \(www.gov.scot\)](#) The Women's health plan: progress report, 2023, [Women's health plan: progress report - gov.scot \(www.gov.scot\)](#)
- NHSGGC Moving Forward together, [Moving Forward together - NHSGGC](#)
- NHSGGC Digital Health and Care Strategy, 2023-2028 [Digital Health & Care Strategy - Digital On Demand 2023-2028 - NHSGGC](#)
- NHSGGC Public Protection Strategy, 2023-2026 [Public Protection Strategy 2023-2026 - NHSGGC](#)
- MBRRACE-UK Perinatal and Maternal morbidity and mortality reviews [MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK | MBRRACE-UK | NPEU \(ox.ac.uk\)](#)

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- NHSGGC Maternity services [Maternity Services - NHSGGC](#)
- NHSGGC Neonatal services [RHCG - About us \(nhsggc.org.uk\)](#)
- The UNICEF UK Baby Friendly initiative [The Unicef UK Baby Friendly Initiative](#)
- Bliss baby Charter Accreditation [Bliss Baby Charter | Bliss](#)
- Milk Bank Scotland [Milk Bank Scotland - NHSGGC](#)
- Scottish Government Perinatal and Infant Mental health Programme [Perinatal and Infant Mental Health Programme Board - gov.scot \(www.gov.scot\)](#)
- Scottish Patient Safety Programme Perinatal Programme [SPSP Perinatal programme | Healthcare Improvement Scotland - SPSP Perinatal Programme \(ihub.scot\)](#)
- Guideline for screening and treatment of retinopathy of prematurity, Royal College of Ophthalmologists [2008-SCI-021-Guidelines-Retinopathy-of-Prematurity.pdf \(rcophth.ac.uk\)](#)
- Badgernet maternity and neonatal digital records, [Maternity & Neonatal | Healthcare | Our Solutions \(systemc.com\)](#)
- NHSGGC Investors in People [Investors in People \(IiP\) - NHSGGC](#)
- NHSGGC iMatter [iMatter - NHSGGC](#)
- Civility saves lives [Home | Civility Saves Lives](#)
- NHS Scotland Healthy working lives [Healthy Working Lives - Public Health Scotland](#)
- Parents' experiences of communication in neonatal care, PEC, Picker Institute [Parents' Experiences of Communication in Neonatal Care - Picker](#)
- Perinatal Mortality Review Tool (PMRT) [Perinatal Mortality Review Tool | PMRT | NPEU \(ox.ac.uk\)](#)
- Perinatal SAER (Serious adverse event review) [Maternity and neonatal \(perinatal\) adverse event review process: guidance - gov.scot \(www.gov.scot\)](#)
- Healthcare Improvement Scotland Quality Management System [Quality Management System | Healthcare Improvement Scotland - Quality Management System \(ihub.scot\)](#)
- National Neonatal Audit Programme (NNAP) [National Neonatal Audit Programme \(NNAP\) | RCPCH](#)
- National Maternity and Perinatal Audit (NMPA) [Homepage \(maternityaudit.org.uk\)](#)

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- Scottish Government Getting it right for every child (GIRFEC) [Getting it right for every child \(GIRFEC\) - gov.scot \(www.gov.scot\)](#)
- UN Convention of the Rights of the child [UN Convention on Rights of a Child \(UNCRC\) - UNICEF UK](#)

NHSGGC Maternity and Neonatal Strategy 2024 - 2029

A Five-Year Plan for NHS Greater Glasgow and Clyde



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

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

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

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

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

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

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



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

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



Background

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

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

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

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

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



Current Services

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

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

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

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



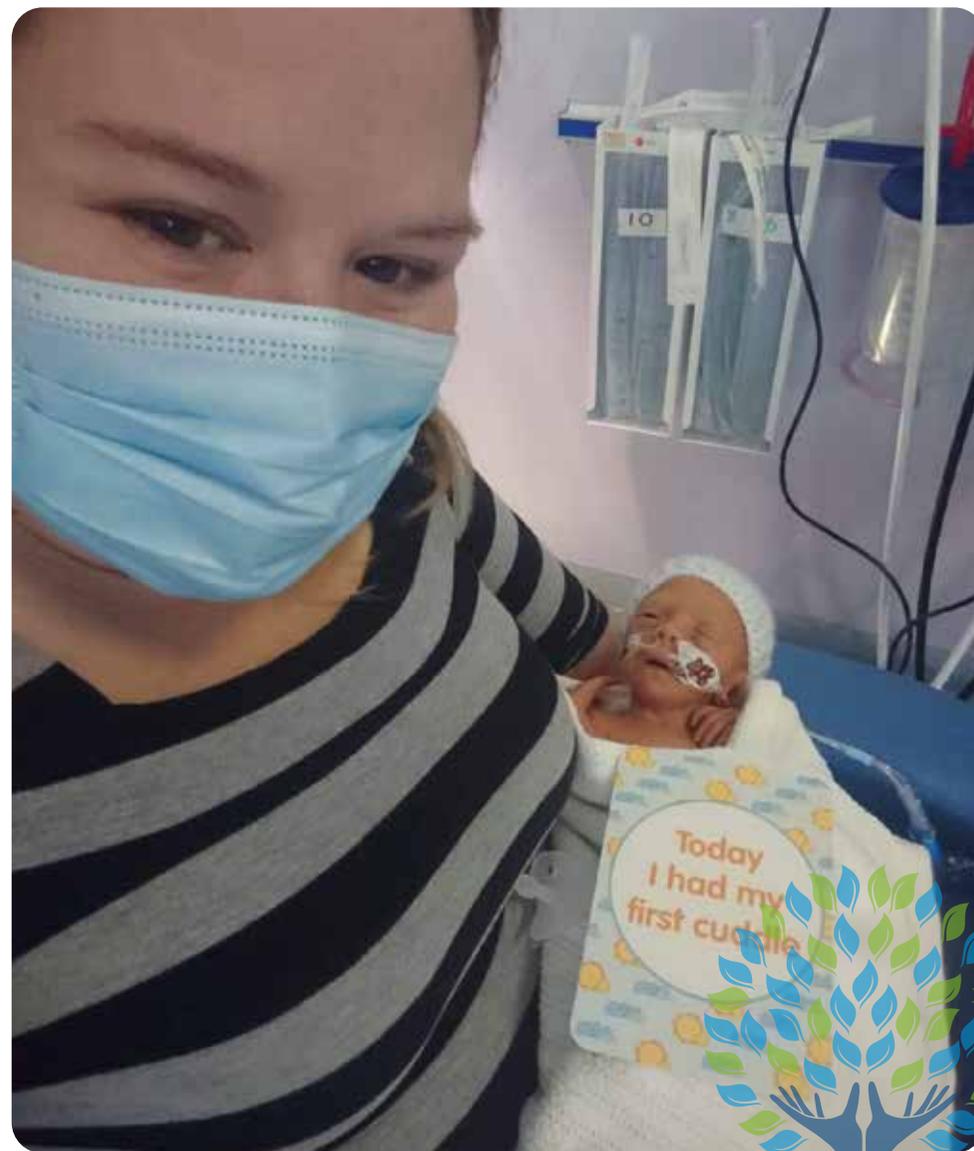
Current Services

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

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

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

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



Current Services

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

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

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

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

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

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





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

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

The PRMH neonatal unit is a level three neonatal unit and provides all forms of intensive support except for those infants who require neonatal surgery and/or ECMO. The neonatal unit provides four intensive care cots, six high dependence cots and 18 special care cots.

The RAH neonatal Unit in Paisley provides level two neonatal services with three intensive care, three high dependence and 10 special care cots. Short term intensive care is supported, however all births at less than 28 weeks' gestation, or those where the need for neonatal intensive care is anticipated, are preferentially transferred to level three units for the duration of their intensive care.

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

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



Aims and Vision

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

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



1. Personalised family centred, responsive care

2. High quality, safe care for all, including high quality specialist care when it is needed

3. Reducing inequalities

4. Redesigning the way we provide services to give the highest quality care for the best value for money

5. Developing our team to ensure safe staffing, with high levels of retention and job satisfaction

6. Engaging with key stakeholders, in particular with women and families to help shape service improvement

7. Robust clinical governance and effectiveness

8. Effective public protection



Mission and Values

Our mission statement for NHS Greater Glasgow and Clyde is:

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

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

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

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

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



What we know about where we are now:



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

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

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



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



Strategic Intent 1: Delivering personalised, family centred, responsive care through the maternity and neonatal journey

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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



What we know about where we are now:



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

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

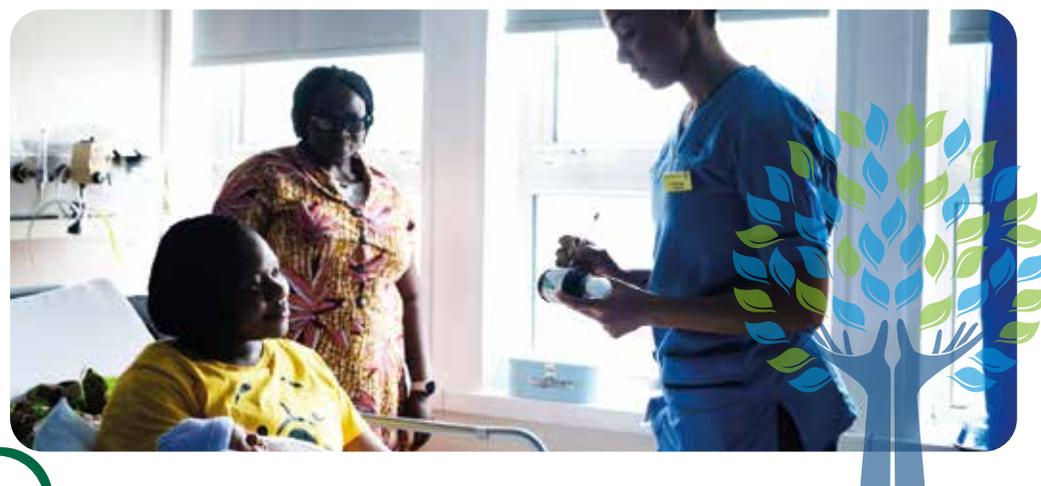
We have a neonatal liaison team who are helping to support earlier discharge to home reducing the days of stay in hospital for our babies.

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

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

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

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



What we know about where we are now:



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

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

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

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

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

We have an internationally recognised Fetal Medicine service.

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

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



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

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

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

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

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

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

Further development of the fetal medicine services.

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

We will provide a range of specialist antenatal clinic services for women with complex pregnancies.

These services will be supported by our commitment to multi-disciplinary working.

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

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



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

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

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

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

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

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

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



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

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

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

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

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

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

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



What we know about where we are now:

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

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



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

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

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

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



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

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

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

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

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

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

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

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

More global majority women will describe their experiences of maternity care positively and fewer will have cause to complain.



Strategic Intent 3: Reducing inequalities

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

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

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

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

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

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

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

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

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

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



What we know about where we are now: Estate

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

We have three neonatal units.

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

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

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

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



Strategic Intent 4: Using our estates and resources to provide the best care and value for money

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

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

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

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

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

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

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

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

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

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



What we know about where we are now: Digital

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

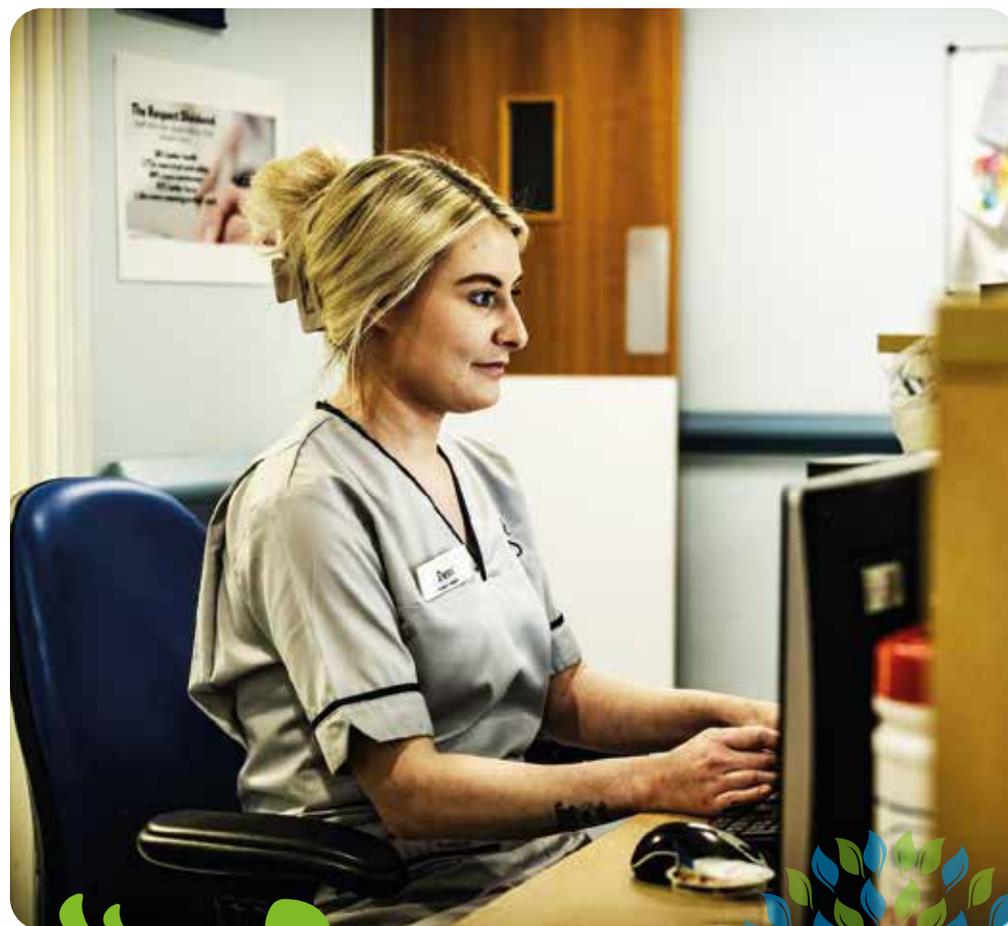
There are opportunities to further develop our use of technology to provide modern high quality services for women and families; there are some approaches to care that could be updated including clinic provision, communication methods with families and women.

Sometimes our data are difficult to access and review.

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

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

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



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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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



Strategic Intent 5: Developing our team

What we know about where we are now:

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

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

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

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



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

Strategic Intent 5: Developing our team

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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



Strategic Intent 5: Developing our team

Where we want to get to in the next five years: We will have a continued focus on staff wellbeing, including

A continued commitment to Peer Support.

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

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

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

Continued commitment to iMatter and Investor in People accreditation.

We will further embed programmes such as Civility Saves Lives.

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



Strategic Intent 5: Developing our team

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

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

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

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

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

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

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

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



What we know about where we are now:

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

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

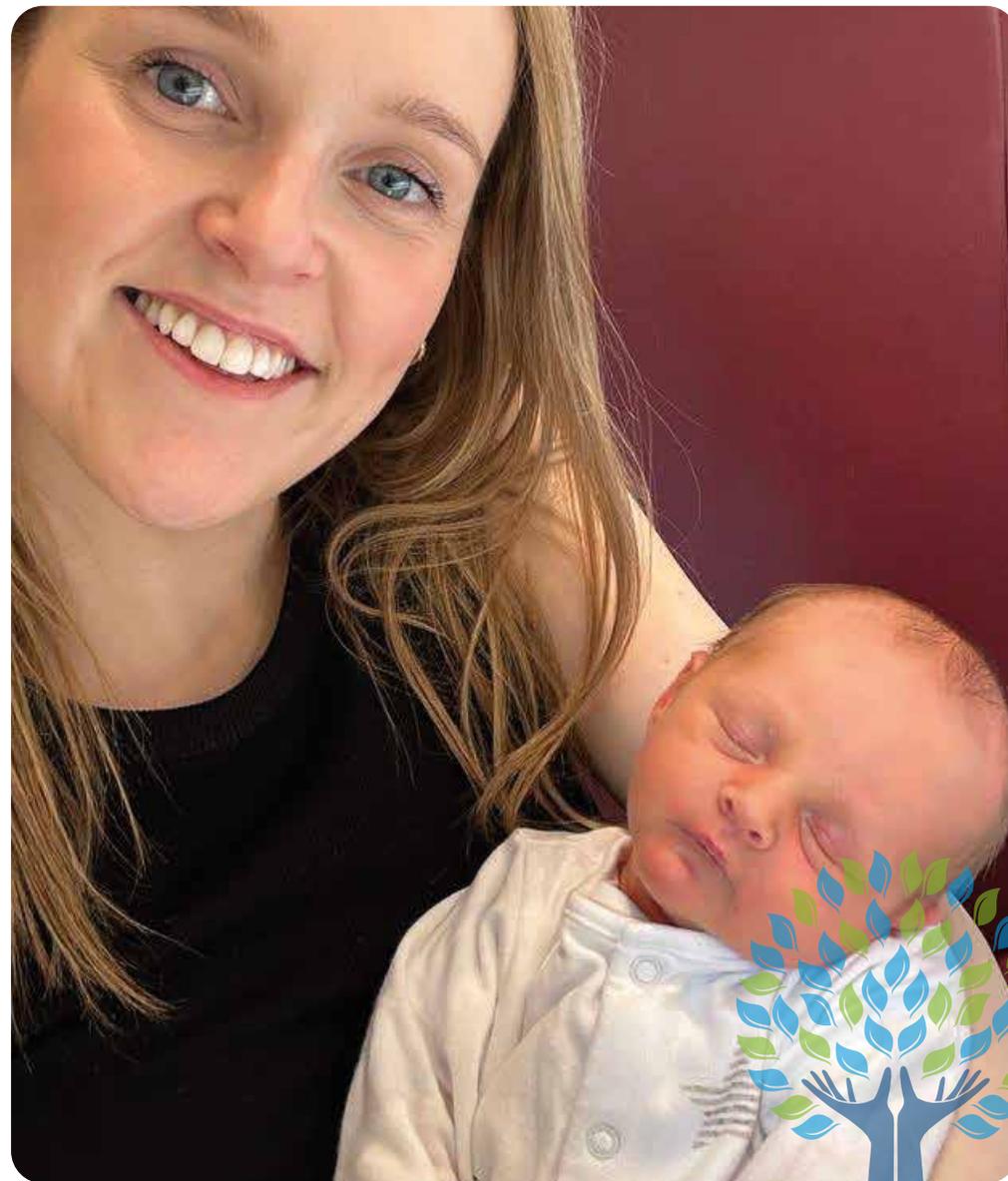
We have informal regular networking between service providers and third sector organisations, such as the National Childbirth Trust (NCT), HomeStart, British Red Cross and Amma Birth companions, and have recently established a new maternity third sector liaison network.

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

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

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

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



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

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

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

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

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

We will have active staff wellbeing activities in all areas.

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

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

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

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

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



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

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

This will include:

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

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

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

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

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



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

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

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

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

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

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

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



Outcomes and where we aim to be:

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

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

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

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

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



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



Outputs over the five-year period will include:

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

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

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

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

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

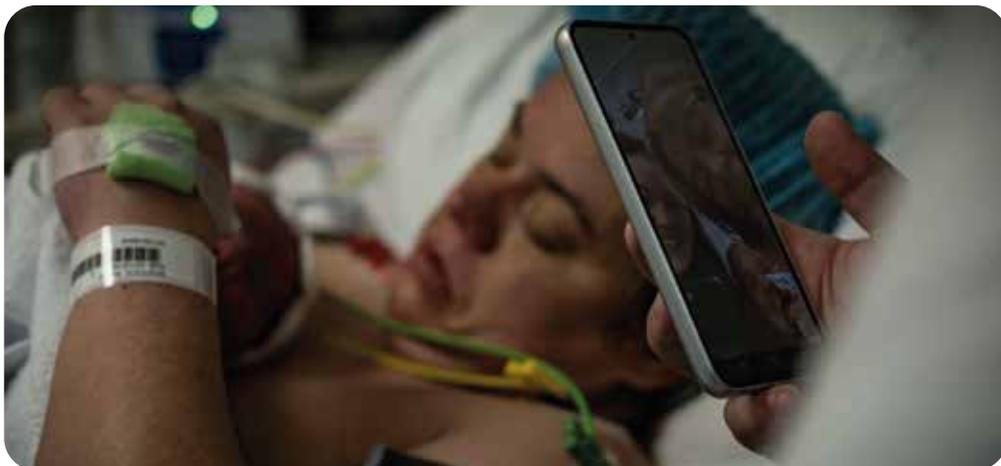
We will continue to review external reports into maternal deaths, stillbirths and complexities in newborns. We will continue to benchmark our services against report recommendations, disseminating learning and focusing on implementation of recommendations for improvement.

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

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



What we know about where we are now:



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

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

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

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

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

NHSGGC Public Protection Strategy.

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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



Maternity and Neonatal Services

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

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

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



Conclusion: Our vision for the next five years

In this strategy, we have set out a direction of travel for our maternity and neonatal services in Greater Glasgow and Clyde. To make the positive changes we wish to see, we will need the right processes, systems, staffing and leadership structures.

To do this, we know that we must change what we do within finite resources. We will need to ensure that we are working in the most efficient way. We believe that positive changes can be made through developing innovative approaches to care, harnessing technology and developing our team.

We also understand that by changing the way we do things, we should be able to reduce demands on the service, reduce duplication and ensure that all interventions are necessary and beneficial.

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

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

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

Robust financial controls will be a standard part of all associated approval and reporting processes used moving forward.



Understanding Maternity Experiences

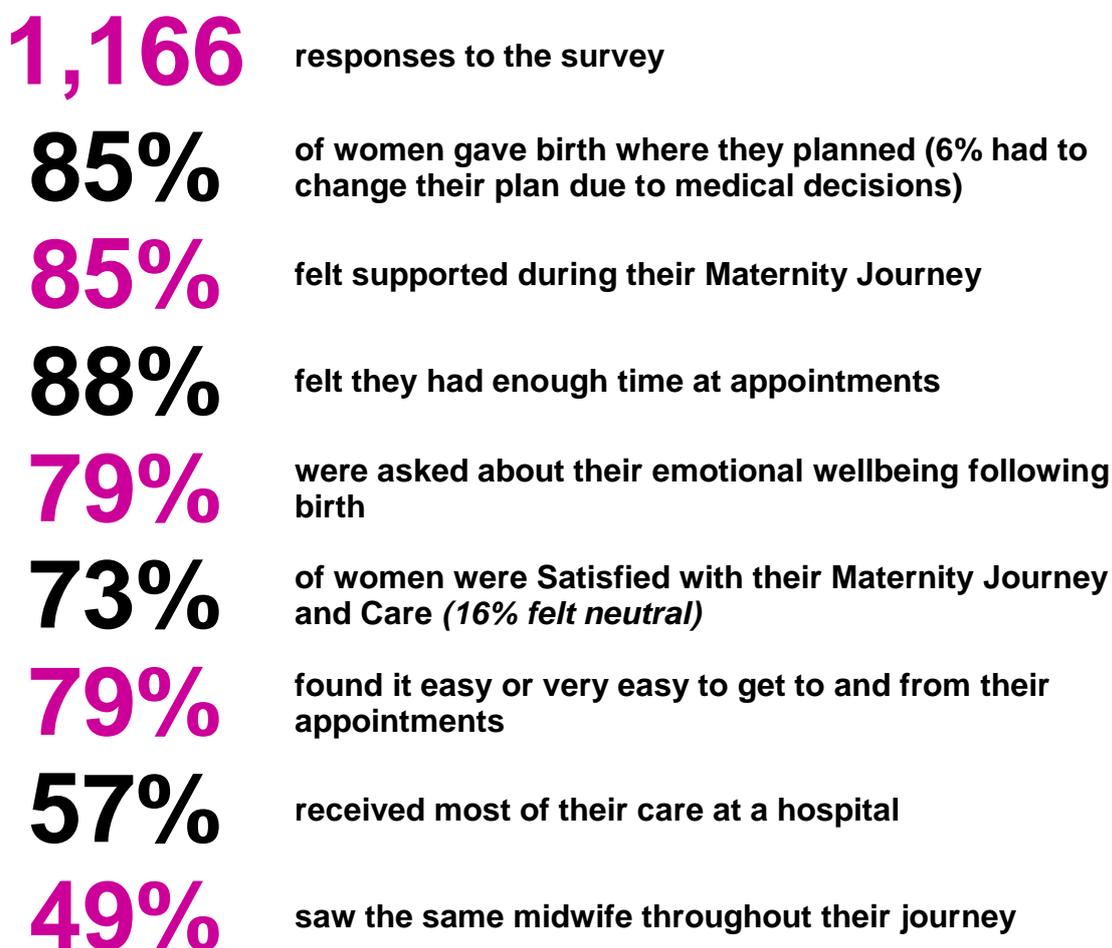


Introduction and Background

This report provides insights into the experiences of women who gave birth in NHSGGC, gathered through a survey conducted in July and August 2024. The survey was sent via text message to 6,101 women who had given birth since the start of 2024, receiving 1,166 responses.

This round of survey work builds on the success of the initial engagement round in 2022-23, aiming to enhance our understanding of maternity experiences, specifically location of care, appointment times and continuity of carer to help the board begin measuring the impact of changes made to maternity care through 2023/24 as a result of feedback from women.

Infographic insights

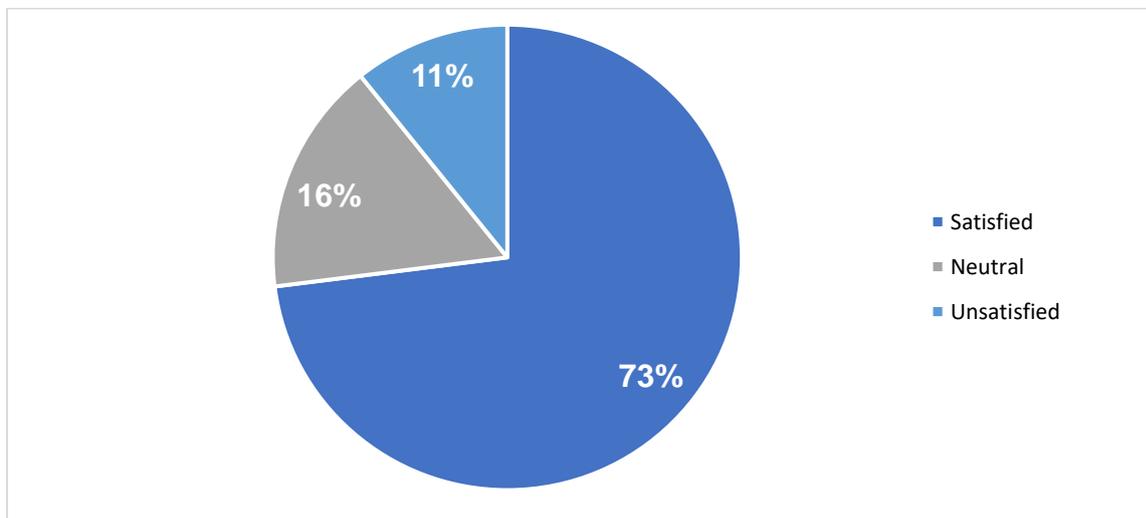


Engagement Summary

This section supports the ongoing work aligned with the NHSGGC Maternity Best Start Strategy. It focuses on understanding women's experiences across various aspects of maternity care, including general care experiences, appointments, continuity of carer, and travel to and from appointments. The insights provided here aim to establish a baseline for tracking changes over time as NHSGGC implements resources to educate both staff and women on maternity care options and the importance of continuity of carer.

Satisfaction with their entire Maternity Journey and Care

The below chart shows the general satisfaction shared by women about their entire maternity journey, with 73% of mothers sharing they were satisfied with their maternity journey, 16% felt neutral, and 11% were dissatisfied. This generally positive reception highlights the effectiveness of maternity care services. It is important to note that this was the first time we asked about overall satisfaction with a woman's maternity journey, making cross-comparison challenging.



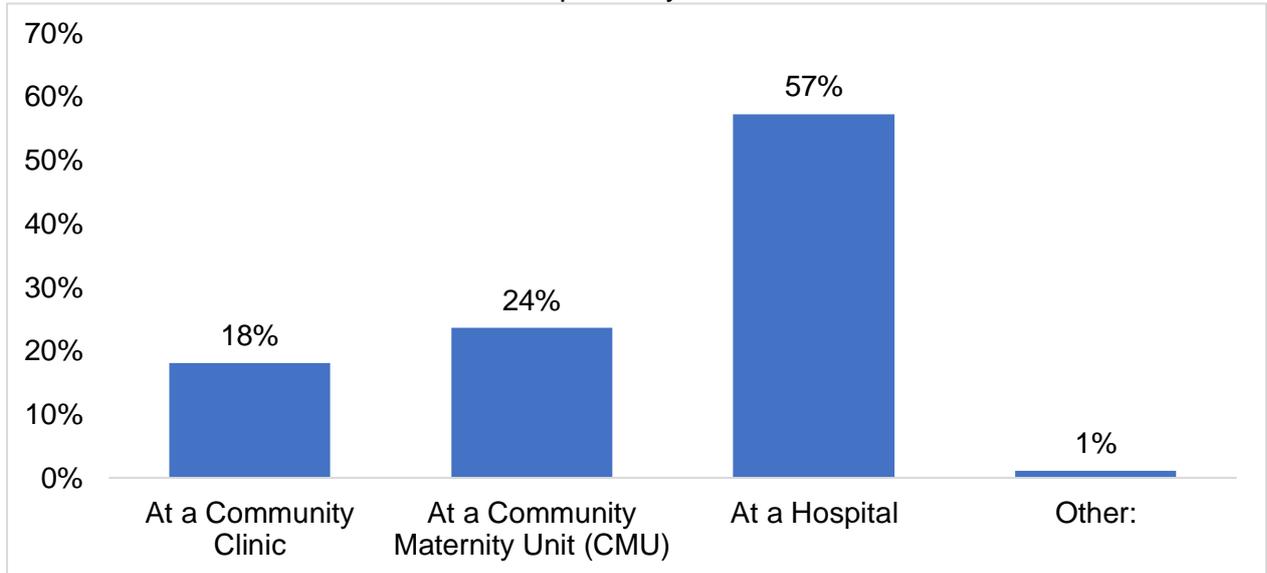
In future surveys we will look to align this with national maternity survey approaches to provide more accurate cross comparison.

Care location during pregnancy

The following section provides insights into maternity care location, before exploring travel experiences to appointments for women.

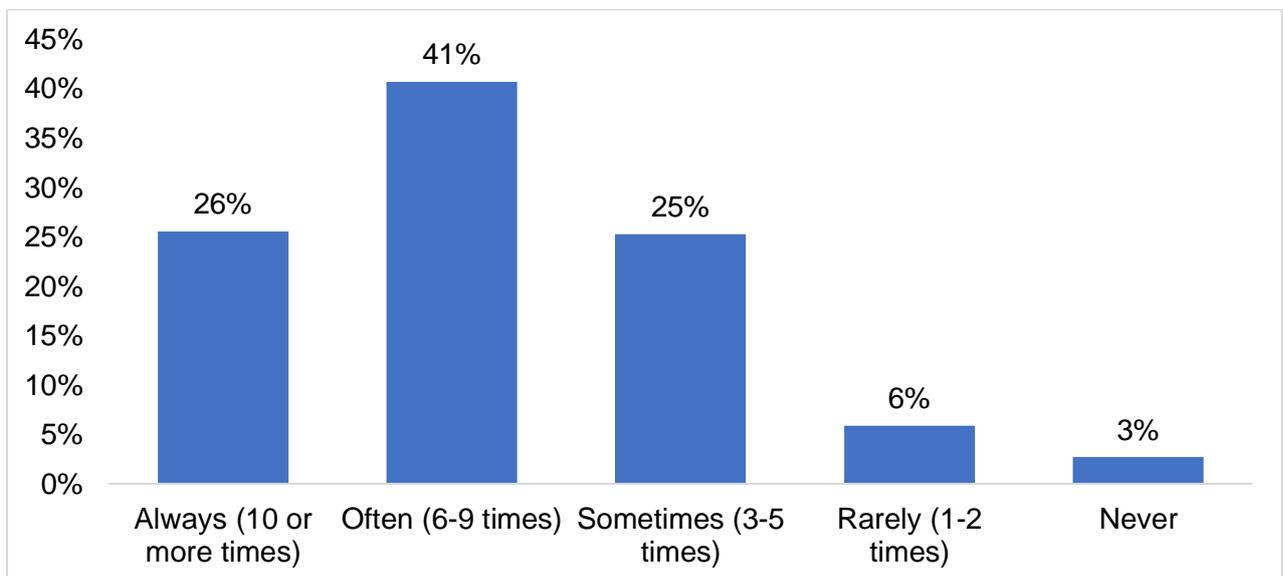
Where did you receive most of your maternity care?

The chart indicates that the majority of women received hospital-based care (57%), followed by community maternity units (24%), and community clinic settings (18%). A small number of women received care primarily at home.

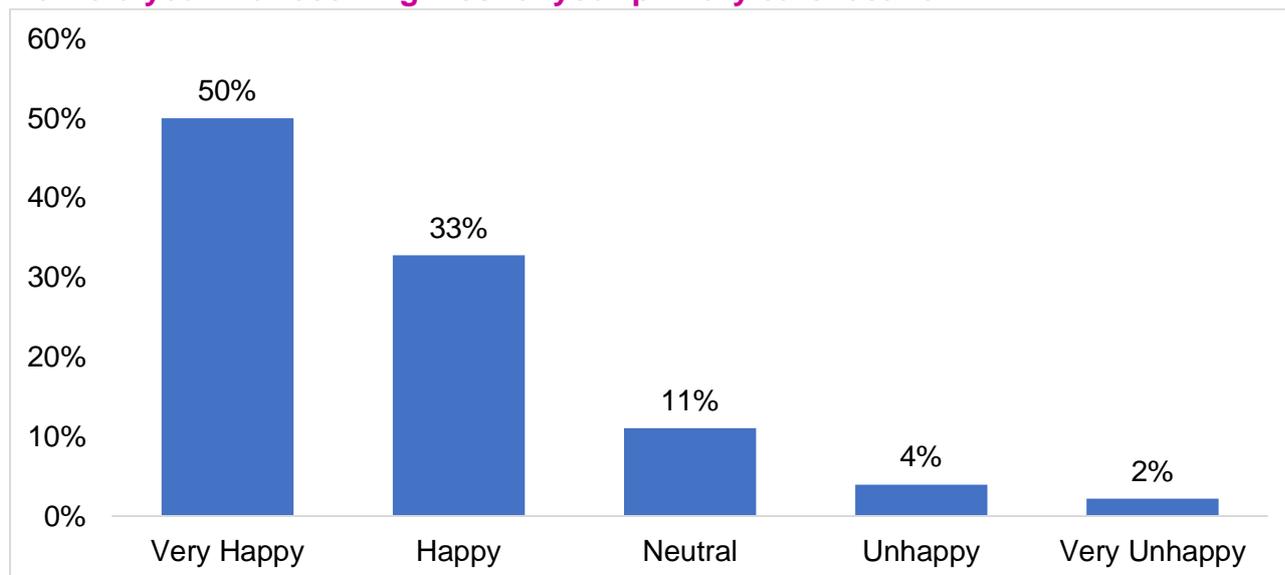


How often did you visit this site during pregnancy?

The above chart shows how many visits women felt they had to their primary care site during their pregnancy, with most women sharing they visited between 6 to 9 times (41%).



How did you find receiving most of your primary care location?



The above chart provides insight into how women felt receiving the majority of their care where they did, with the majority being Very Happy or Happy with their care location (50% and 33% respectively).

Why did women answer this way about their primary care location?

As a follow up to this question, we also asked women why they were happy to unhappy with their care location. They shared a range of topics, with some key themes emerging relating to the below, the majority of comments were positive in nature.

Positive Themes

- Many respondents expressed overall satisfaction with their care, mentioning that they felt well looked after and supported.
- Midwives and staff were frequently described as friendly, helpful, and knowledgeable.
- Respondents highlighted specific instances where the care they received was exceptional, such as being sent for a scan that saved their baby's life or being supported by a specialist midwife team.

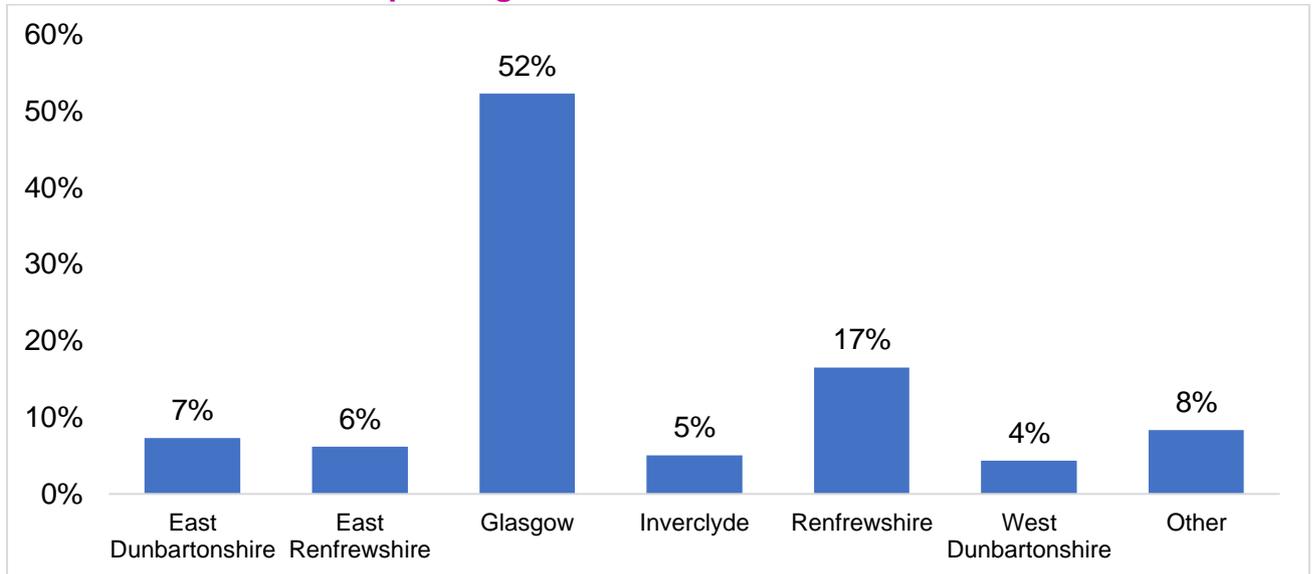
Negative Themes

- Some respondents reported negative experiences, including rushed appointments, lack of consistency in care, and poor communication.
- Issues with staff attitudes and treatment were also mentioned, with some patients feeling neglected or treated unkindly.
- There were mentions of long wait times and seeing different midwives at each appointment, leading to inconsistent information.

Travel

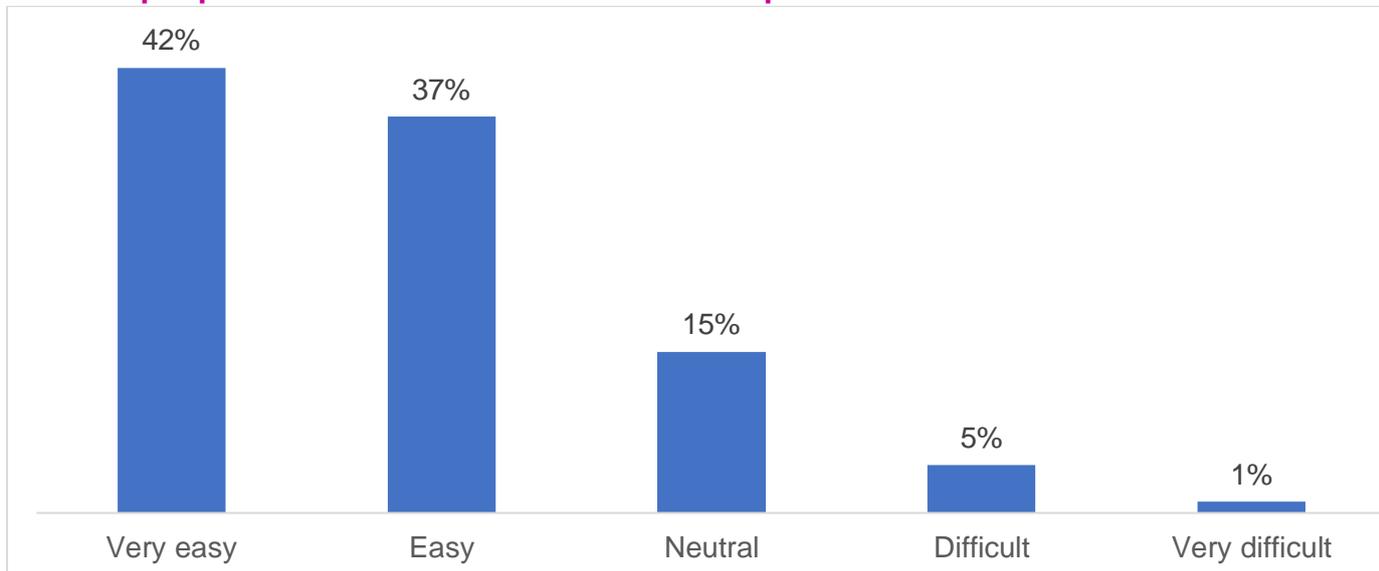
The following section looks at where women and the travel aspects related to maternity care. It focuses on the geographic distribution of the respondents and the accessibility of maternity services from their places of residence.

Where do the women responding live?



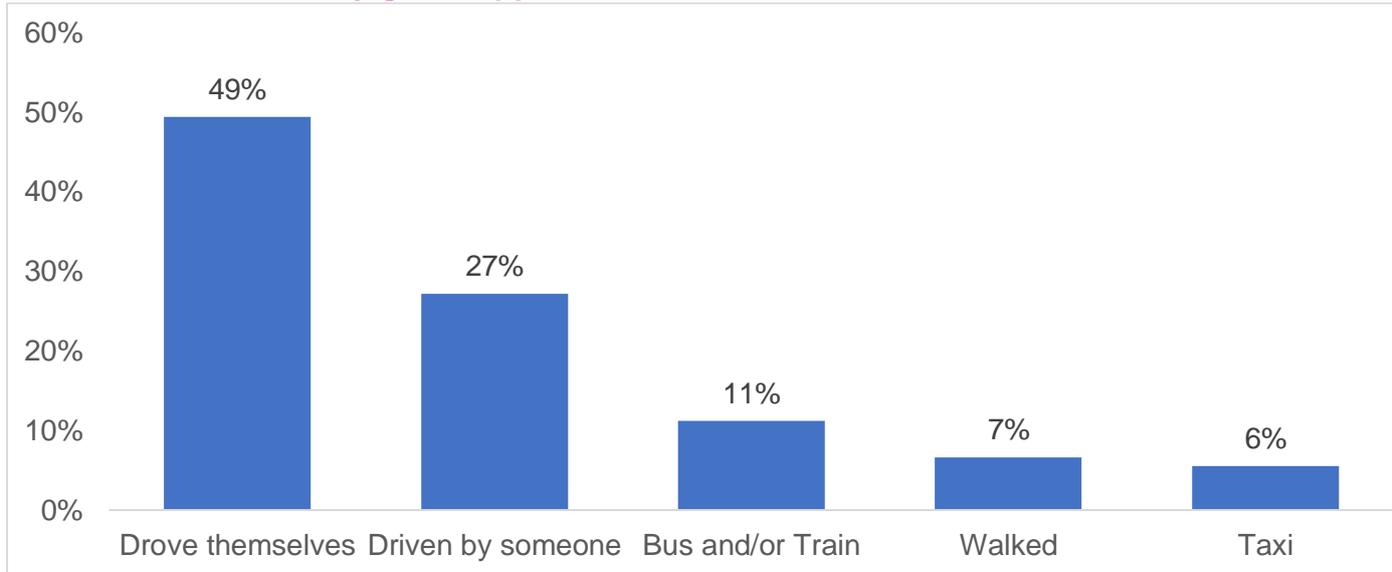
The above chart provides insight into the geographic location of women responding to this survey. We saw the largest response from Glasgow at 52%. When looking at the recorded areas of residence for the women sent this survey we see broadly similar layout as we do in self-reported residence area.

How did people find travel to and from their main place of care?



While the majority of respondents found travel Very Easy or Easy, we say 6% find travel Difficult or Very difficult (5% and 1% respectively). This may require further engagement to understand specific travel challenges and how we can help support women to access maternity care.

How did women usually get to appointments?

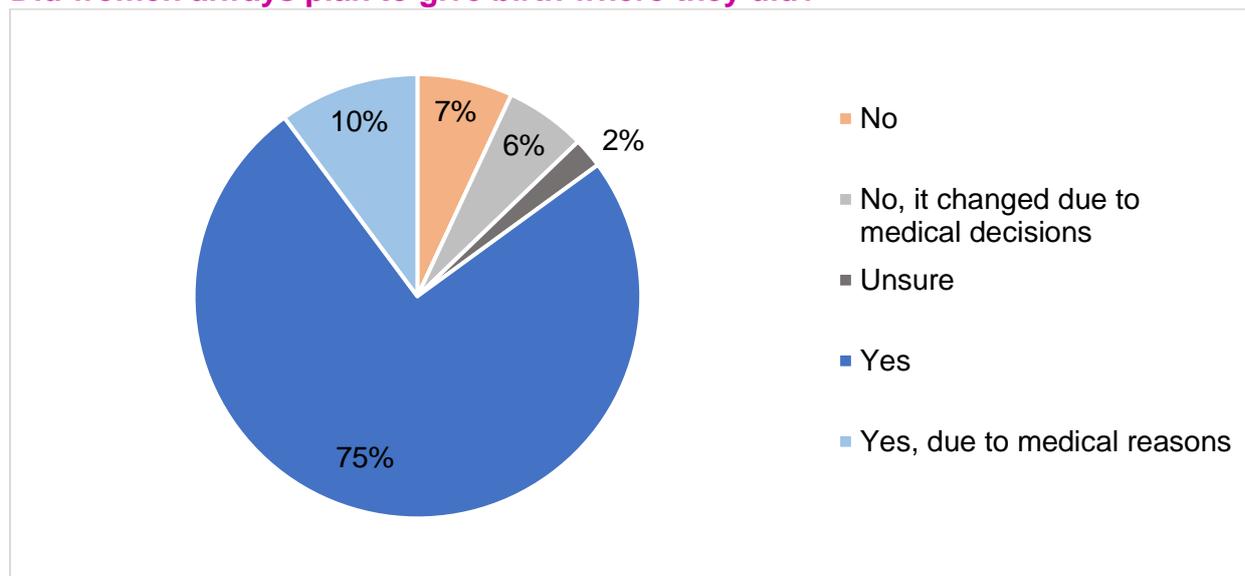


The above chart shows majority of women, representing 76% of respondents, relied on private vehicles (either driving themselves or being driven by someone) to reach their appointments. A smaller portion of the respondents used public transportation or taxis to get to appointments, possibly pointing to opportunity to engage specifically with this subset of women to understand why they chose to travel in the way they did.

Birth Planning & Care

The following section provides insight into the decisions, preferences, and experiences related to where and how women planned and received their maternity care. Aligning with the NHS Scotland Best Start strategy, this section underscores the importance of individualised care planning and the availability of choices that respect women's preferences and circumstances. Through exploring where women planned to give birth versus their actual birthing locations, the survey captures insights into the flexibility and responsiveness of maternity services in accommodating the evolving needs during pregnancy.

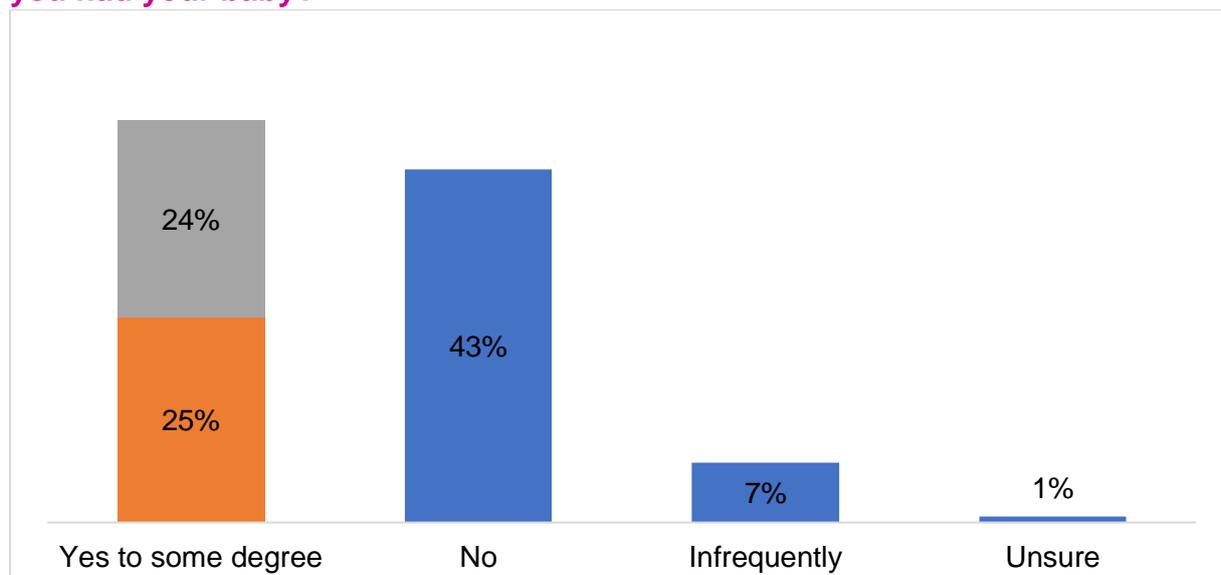
Did women always plan to give birth where they did?



The above chart shows the majority of women were able to give birth at their planned locations (85%), reflecting a strong alignment between antenatal care plans and actual care received, which is a key goal of the Best Start strategy.

We also saw a small proportion (6%) of plans were altered due to medical reasons, illustrating the dynamic nature of maternity care where adjustments are often necessary to ensure the safety and health of both mother and child.

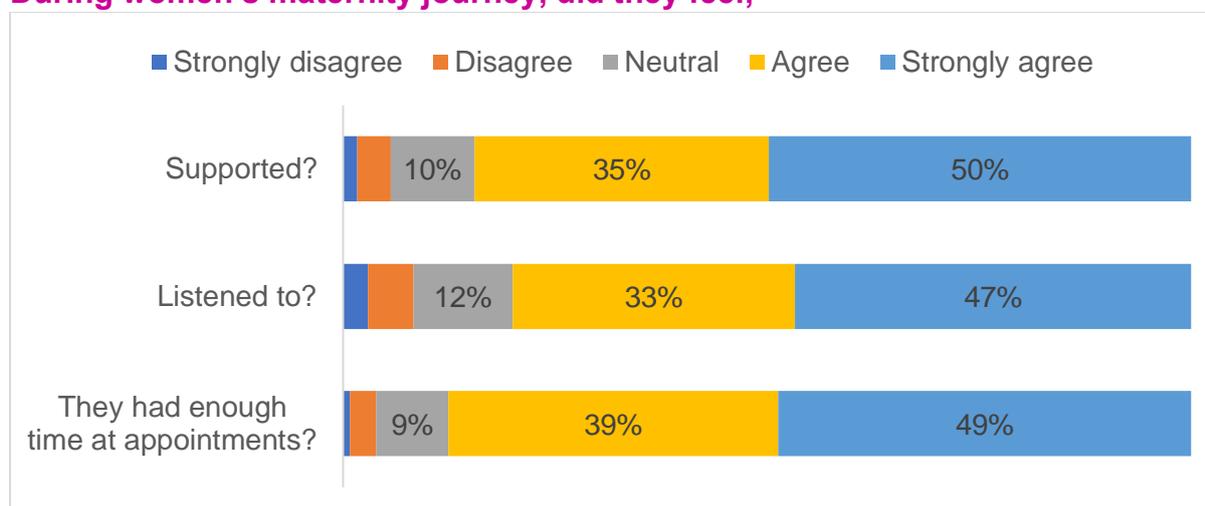
Did you see the same midwife during your pregnancy, at home visits and after you had your baby?



The nearly even split highlights an area for improvement in achieving the Best Start's goal of continuity of carer. We saw **49%** of respondents see the same midwife consistently, with **51%** seeing different midwives or infrequently seeing the same one.

We have seen a **10%** increase in women seeing the same midwife since our initial survey and the introduction of case load holding models in maternity services. We have also seen a **5%** reduction in women sharing no when asked this question.

During women's maternity journey, did they feel;



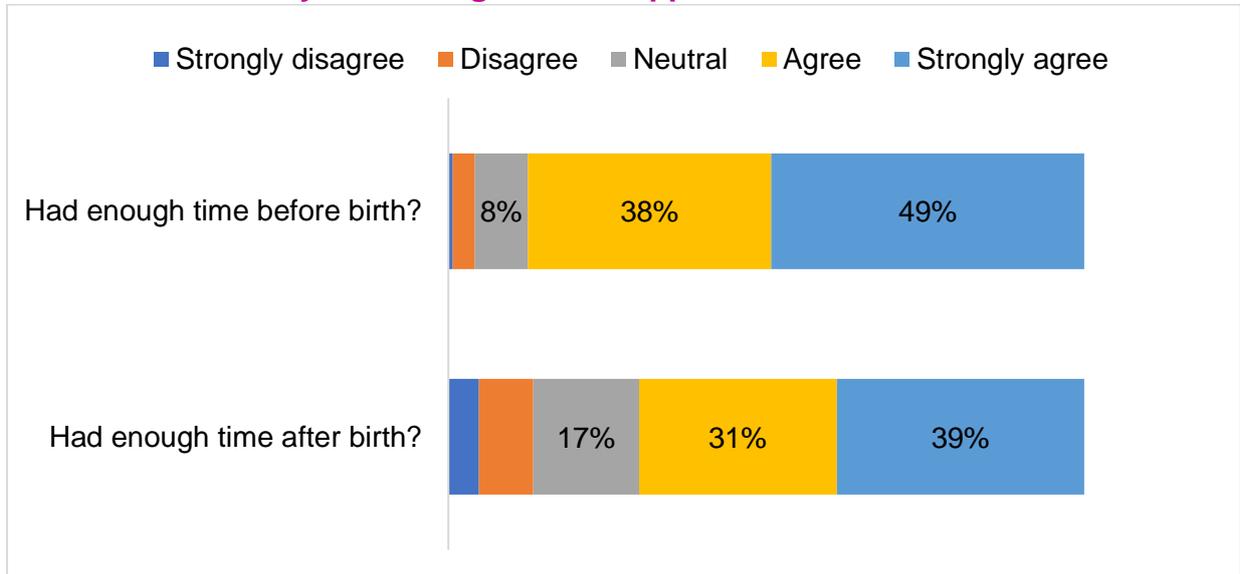
The majority of women felt supported, listened to, and believed they had enough time during their appointments, indicating positive aspects of the maternity care provided.

When compared to previous engagement activity we have seen an improvement in regard to how listened to women felt. During our first engagement asking this question we saw **72%** of women agree they were supported in some manner, with us seeing **85%** in the most recent group.

Time at appointments

The following section provides insight into appointment time in maternity care through two lenses: overall satisfaction with appointment durations pre and post birth while also sense checking if any more time could have been helpful to women.

Did women feel they had enough time at appointments?

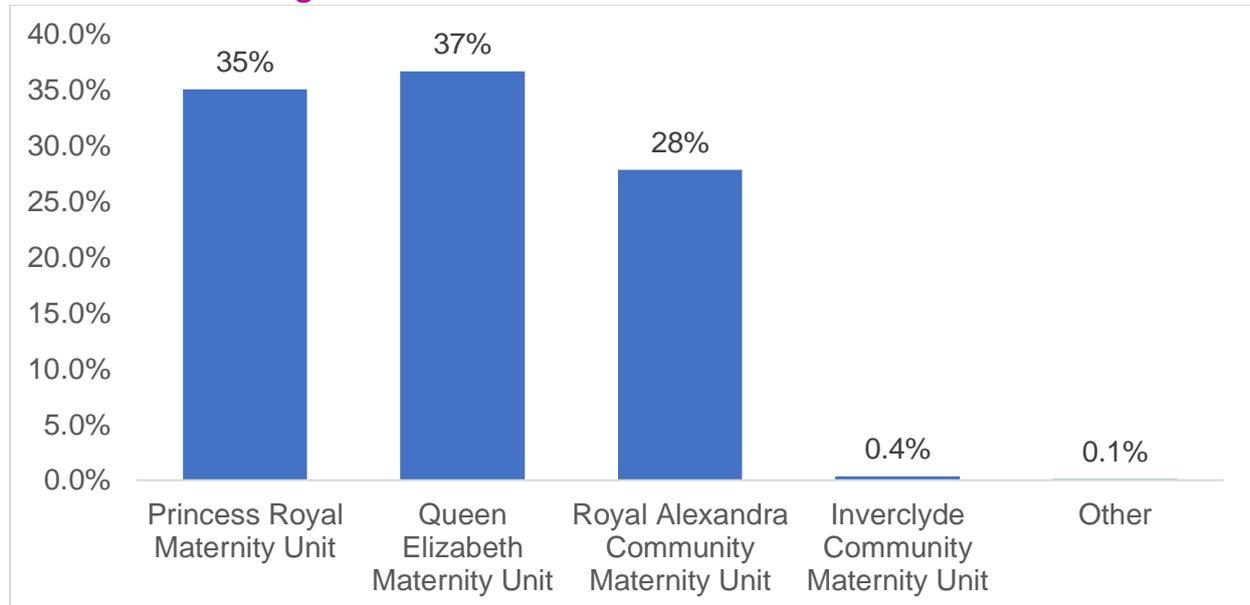


This question was added to our survey following patient feedback received during our first large scale survey in 2023. As a result of that initial feedback NHSGGC has increased appointment time for women across the board and we wanted to better track the impact of these longer appointments overtime. The data shows that a significant majority (87%) felt that they had sufficient time during their appointments, which we are hopeful will continue to increase across future surveys.

Birth experience

This section of the report examines the settings and circumstances surrounding where women gave birth, aligning with NHS Scotland's Best Start strategy that emphasises accessible, personalised maternity care. Understanding the environments in which women choose to give birth helps in evaluating the adequacy of options available and tailoring services to meet diverse needs and preferences.

Where did women give birth?



We saw the majority of responders share that they gave birth at the Queen Elizabeth site, followed by Princess Royal and the Royal Alexandra. When compared to previous engagement work we see a more even distribution of responses between these services, previously the QEUH site accounted for 43% of response, PRM 29% and RAH 22%. We have unfortunately seen a reduction in responses from women giving birth at the Vale of Leven and Inverclyde Royal sites, and future engagement will look at how we can capture voices from women giving birth in these locations.

Why did you give birth here?

When asked to tell us more about why they chose to give birth where they did women share a range of themes. These themes highlighted a range of factors that

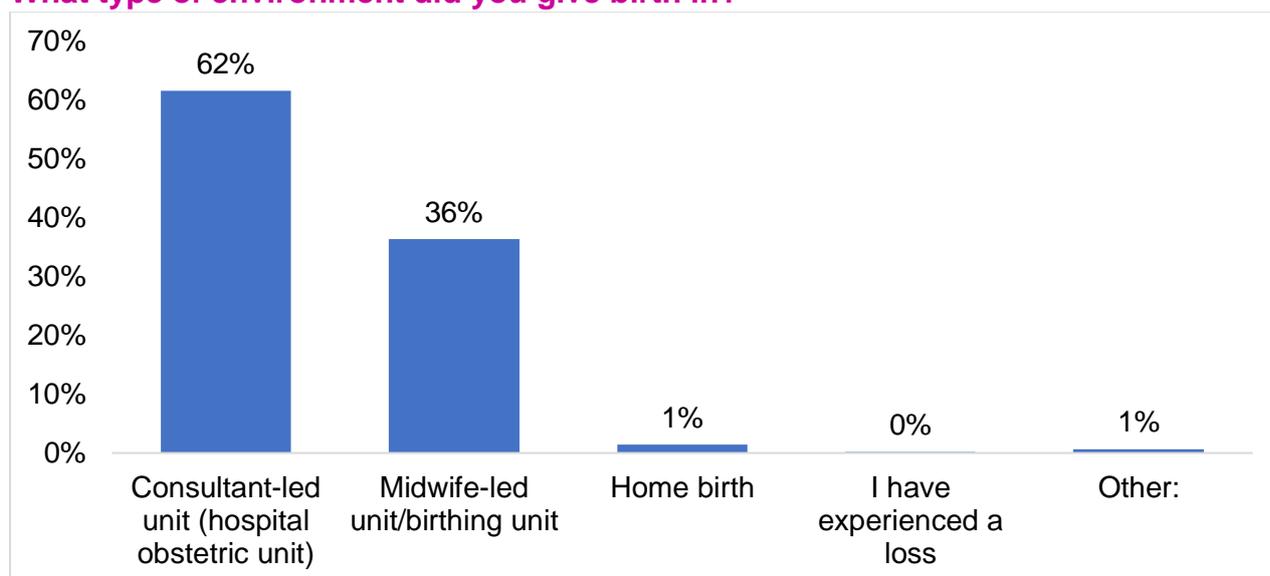
influenced women's choices for their birthing locations, ranging from medical reasons to personal preferences and previous positive experiences.

Key themes were:

- **Medical Reasons and Safety:** High-risk pregnancies, medical conditions, or the need for specialised care led some women to choose specific hospitals. The presence of neonatal units or the availability of medical interventions was also a factor.
- **Personal Preferences and Comfort:** Some women preferred a hospital setting for the reassurance of having doctors and consultants on hand. Others chose based on the availability of specific birthing options, such as water births.
- **Previous Positive Experience:** Women who had previously given birth at a particular hospital and had a positive experience often chose to return to the same hospital.
- **Proximity and Convenience:** Some women chose to give birth at a location that was closest to their home. Convenience in terms of travel and parking was also a factor.
- **Recommendations and Reputation:** Recommendations from friends, family, or medical professionals influenced some women's choices. The reputation of the hospital or the care received by others also played a role.

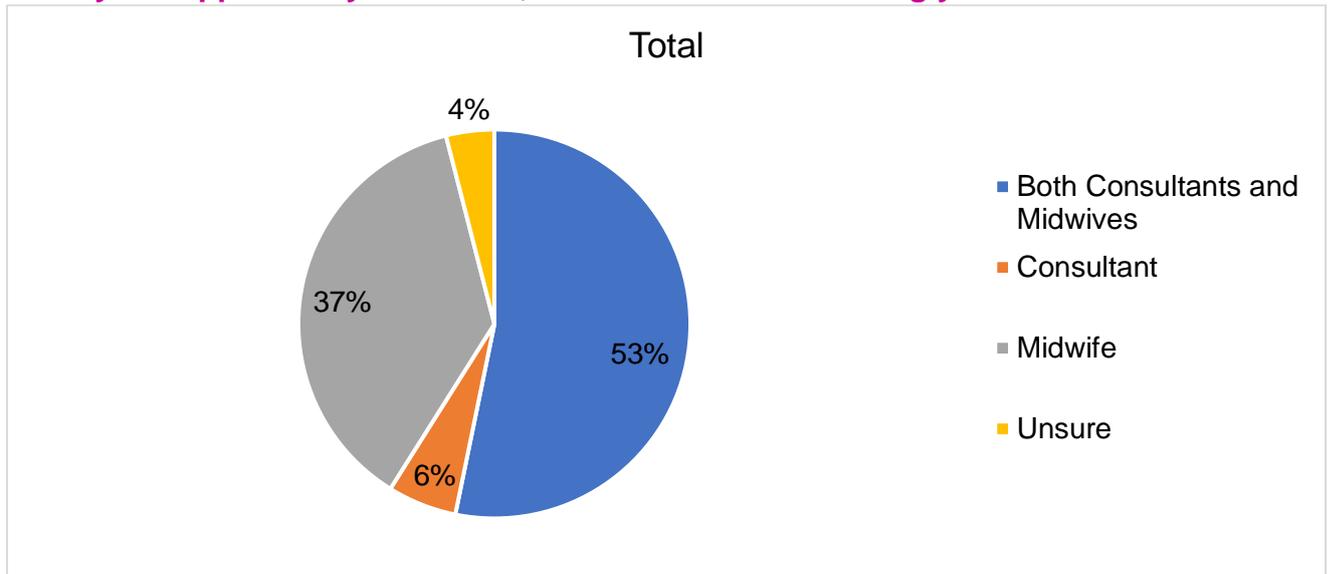
In our review of maternal choices and support systems during childbirth, the data reveals a diverse range of birthing environments and support types, reflecting the varied preferences and needs of expectant mothers. This diversity underscores the importance of offering tailored birthing options and support mechanisms, a principle championed by the Best Start Scotland initiative.

What type of environment did you give birth in?



Looking at the responses of women asked about the environment they gave birth in we saw a significant number (62%) of mothers sharing they gave birth in a hospital consultant-led setting. However, the data also shows a meaningful selection of midwife-led units and home births.

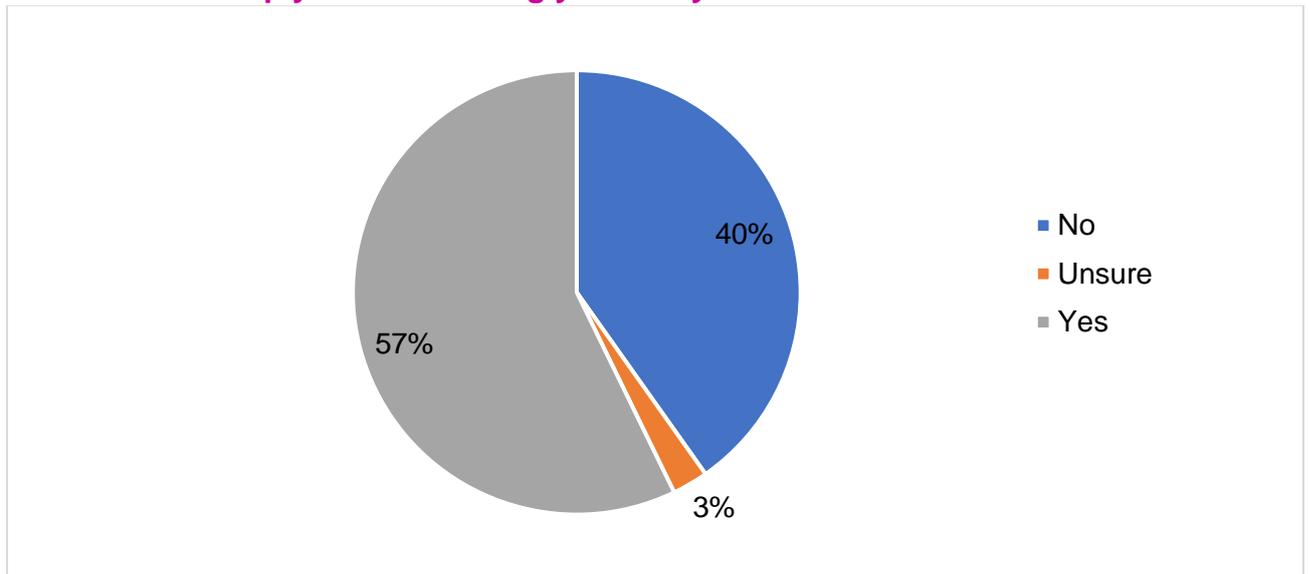
Were you supported by a midwife, consultant or both during your birth?



The support received during birth varied, with many mothers stating they received combined care involving both midwives and consultants (53%).

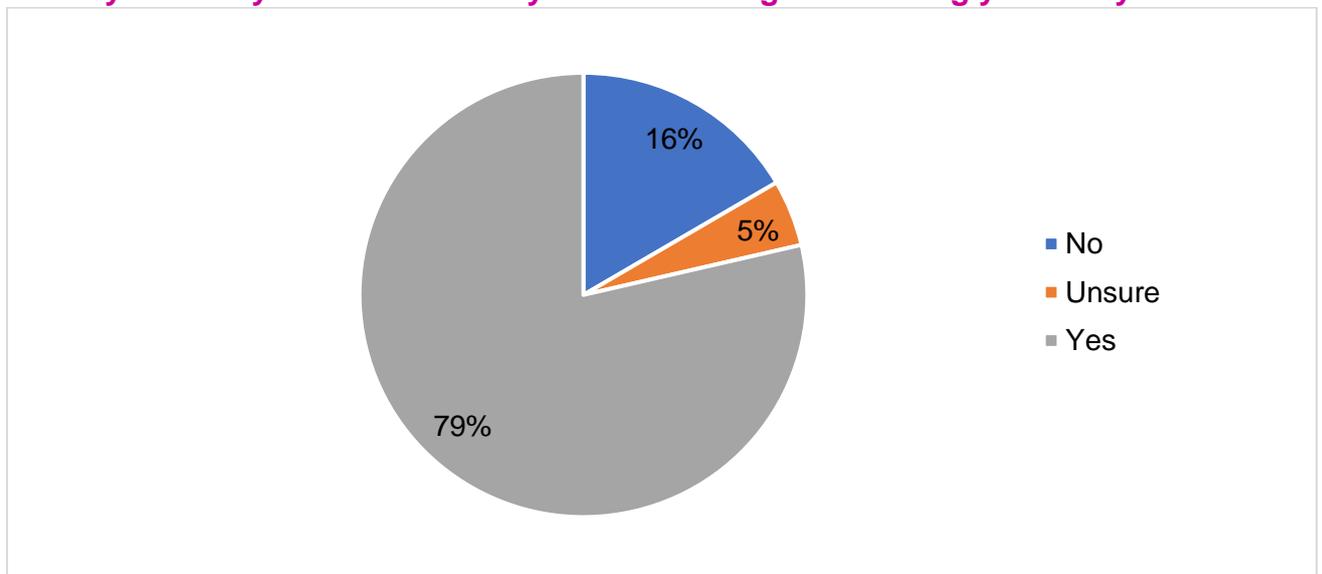
Post Birth Support

Did someone help you with feeding your baby?



The responses to the question "Did someone help you with feeding your baby?" revealed that 57% of women received assistance, highlighting the critical role of postnatal support in establishing feeding routines. However, 40% of respondents indicated they did not receive help, and 3% were unsure, pointing to potential gaps in the post-birth support system.

Did anyone ask you the emotions you were feeling after having your baby?



A significant majority, 79%, shared that they were indeed asked about their emotions, reflecting NHSGGC maternity service desire to better recognise and support mental and emotional health in postpartum care. This proactive approach by healthcare providers helps ensure that new mothers receive the necessary support to navigate the complex emotional landscape following childbirth.

Support Provided

The survey provided women the opportunity to share additional comments on particularly good aspects of care, what they felt could have been better or different and any advice they think would help future mothers. The following section provides insights into the main themes identified.

What care or support stood out to you as good, and something you want to see more of?

Answers to this question helped highlight several key areas where the quality of care has not only met but surpassed expectations, showcasing practices that could serve as benchmarks for future improvements. Comments received have been shared with maternity colleagues across NHSGGC, with the below section providing high level themes based on these comments.

Themes Identified:

Supportive and Professional Staff:

- Many comments highlighted the professionalism, knowledge, and supportive nature of the staff, including midwives, consultants, and health

Consistent and Continuous Care:

- Comments appreciated the continuity of care, seeing the same midwife or health visitor regularly, which helped build trust and comfort. The importance of consistent staff in daycare and home visits was also highlighted.

Emotional and Mental Health Support:

- Several comments mentioned the importance of emotional support, empathy, and understanding from the staff, especially during challenging times. Mental health support was noted as a crucial aspect of care.

Breastfeeding and Postnatal Support:

- Postnatal support, including home visits and aftercare, was highly valued. Many comments emphasised the importance of breastfeeding support and the positive impact of knowledgeable and supportive staff.

Personalised and Respectful Care:

- The importance of personalised care, listening to patients' wishes, and respecting their decisions was frequently mentioned. Comments appreciated staff who took the time to understand and address individual needs and preferences.

What care or support stands out as something you would change or like to see provided differently?

While most comments reflected positive experiences and satisfaction with the care received, women did share some areas where they felt they would like to see improvements that could enhance the overall quality of service.

Communication and Listening

- We heard from some women about how they felt communication could be better, and that staff could be better at listening to and addressing concerns during their pregnancy. Additionally, there were comments shared expressing a desire to see better cross department communications alongside better pre appointment note checking by staff.

Support and Aftercare

- Some individuals highlighted that they felt follow-up care post birth could be better, particularly when they sought help with breastfeeding after challenging births. Better communication about pain relief and next steps during labour, as well as increased support for mothers experiencing postpartum depression, were also suggested by women.

Staff Attitude

- While the majority of comment shared around staff were very positive, we did receive some negative experiences were about staff being less considerate and understanding during appointments. Examples shared were around ultrasound appointments and interactions during labour.

Facilities and Environment

- Comments about facilities and the environment generally related to waiting times, improvements to privacy, and noisy wards. One person suggested the need for a separate room after a Caesarean birth to improve their recovery experience.

Consistency and Continuity of Care

- The need for more consistent care was a recurring theme. Some individuals mentioned seeing different midwives at each appointment, while others highlighted the lack of continuity in care from consultants, and how seeing the same midwife improved the appointment quality

Is there any advice or help you would have liked to see mothers receive in the future?

Here are the themes from the comments in the document for the question: "Is there any advice or help you would have liked to see mothers receive in the future?"

Support and Continuity of Care

- Many women expressed the desire for more support, especially when separated from their babies. They also emphasised the importance of regular checks from midwives and health visitors, even if the baby is not at home¹. Consistent advice from midwives, doctors, consultants, and health visitors was also highlighted as crucial.

Breastfeeding Support

- Breastfeeding support was a significant theme. Women mentioned the need for better resources, such as NHS lactation consultants, and more comprehensive breastfeeding classes that address challenges and alternatives³. Some women felt that the current breastfeeding support was insufficient and had not improved over the years.

Antenatal and Postnatal Care

- Women suggested improvements in antenatal classes, specifically on how to breathe and push during labour. They also mentioned the need for more checks on mothers themselves, not just the babies, and better aftercare. Including fathers more in birth plan discussions was also recommended.

Communication and Information

- Clear and consistent communication was another common theme. Women wanted more advice on the pros and cons of being induced, face-to-face discussions rather than just receiving leaflets. They also emphasised the importance of being well-informed about what to expect during labour and postnatal care.

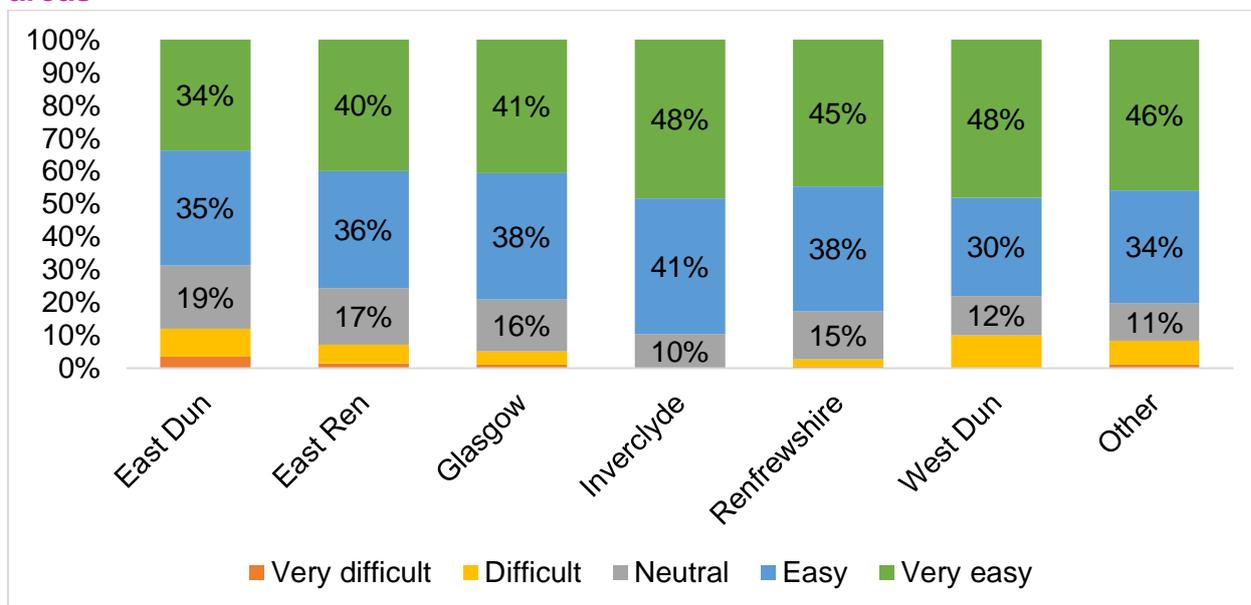
Emotional and Practical Support

- Some women highlighted the need for emotional support and practical advice, such as the importance of snacks after labour, advice on activities to do with newborns outside the house, and ensuring that feeding is well-established before leaving the hospital.

Cross Comparison of experiences by Local Authority area

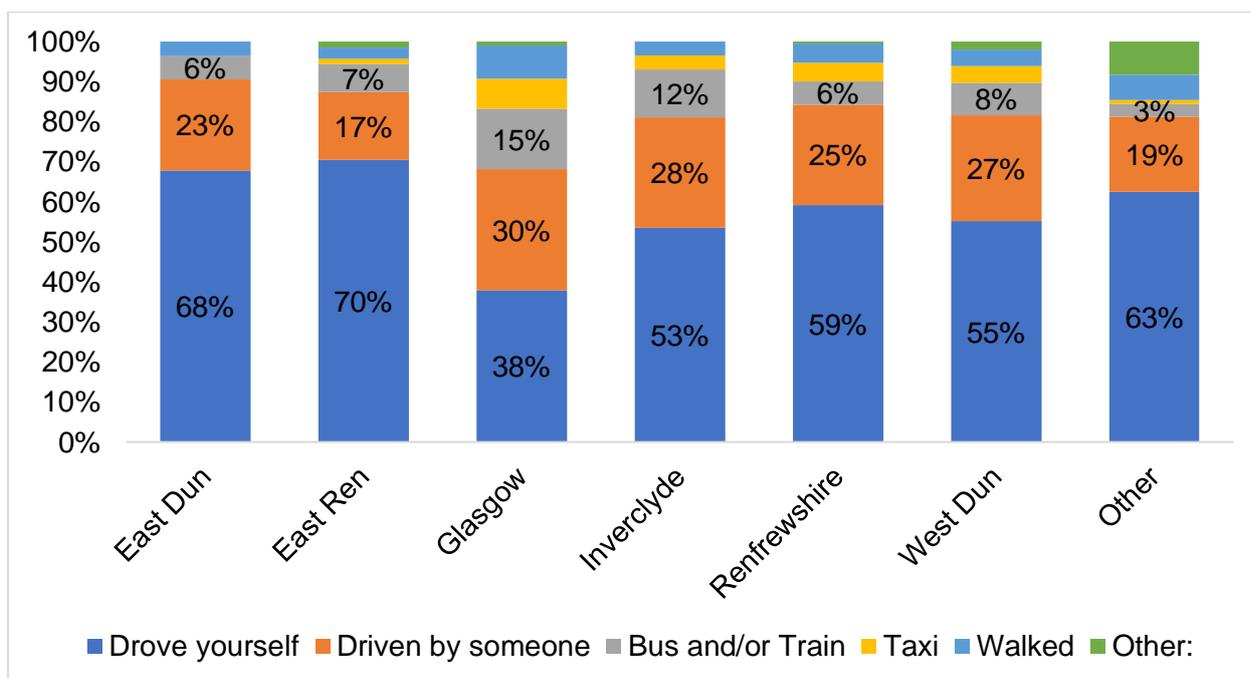
NHSGGC were interested in exploring how women's experiences with maternity services vary depending on their locality. This section provides a brief cross comparison of these experiences across different Local Authority areas, offering insights into various aspects such as travel to appointments, satisfaction with continuity of care, and overall service quality.

How did women find travelling to appointments from different Local Authority areas



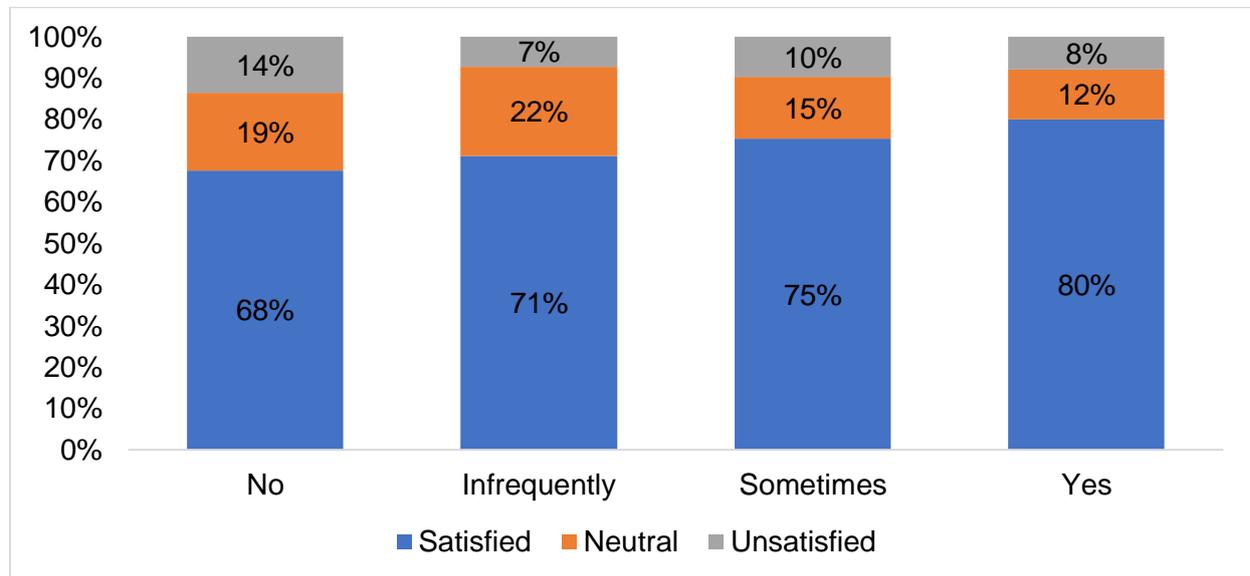
How did women get to appointments across different Local Authority areas

We saw the largest deviation in method of travel to appointments in Glasgow City, which saw a lower volume of women drive themselves, and a greater incidence of women being driven by someone, getting a taxi or walking.



Satisfaction changes between reported continuity of carer

There was a clear link in responses between a higher level of continuity of carer reported and the satisfaction with care. Overall satisfaction dropped to 68% when no continuity was reported and this rose to 80% where the woman mainly saw the same midwife through her appointments.



Conclusion

The findings from the 2024 Maternity Survey provide valuable insights into the experiences of women who gave birth in NHSGGC. The majority of respondents reported positive experiences, with high levels of satisfaction regarding the location of care, appointment times, and continuity of carer. The data highlights the importance of continuous care provided by the same midwife, which significantly impacts maternal satisfaction levels.

While the overall feedback is encouraging, there are still areas for improvement. Addressing these in partnership with women will be crucial in enhancing the quality of maternity services and ensuring that all women receive the support they need throughout their maternity journey.

Future evaluation and engagement work will continue to assess women's experiences, driving service improvements across NHSGGC. By maintaining an open feedback mechanism and regularly engaging with mothers, NHSGGC can ensure that maternity services evolve to meet the needs and expectations of women and their families.

Continuity of Care Experience Report

January 2024



Report By:	NHSGGC Patient Experience Public Involvement Team. Contact: Paul Hayes, PEPI Manager: paul.hayes2@ggc.scot.nhs.uk
Date:	31/10/2023
Purpose of Paper:	To inform strategy and service development

Purpose of Report

This report provides insight into the experiences of Continuity of Care in NHSGGC Maternity services shared by women via digital survey. Surveys were shared with people through text message, with all women who had accessed the BadgerNet app over a 12-month period receiving a text. Alongside presenting findings this report highlights emerging themes for further consideration by NHSGGC.

Background

The survey was developed by NHSGGC's Patient Experience Public Involvement (PEPI) team in partnership with the Continuity of Carer Project Midwife. Its purpose was to gain a deeper understanding of Continuity of Carer experiences from women who had given birth between January 2022 and March 2023. This work will be used to drive improvements around Continuity of Carer and influence the development of NHSGGC Maternity and Neonatal Strategy.

A mixture of closed and open questions were used and the survey was translated into the four most commonly used languages by BadgerNet users in NHSGGC. These languages were Arabic, Polish, Romanian and Urdu. The survey was sent to over **13,000** women, in June 2023 with NHSGGC receiving **2,889** responses.

This was a response rate of **21%** with the survey reaching a wide range of communities across NHSGGC, with responses collated and analysed by the PEPI team.

At a Glance



Summary of Responses by Question

The following section provides insight into the responses received by all women completing the continuity of care survey, where appropriate further analysis is provided to



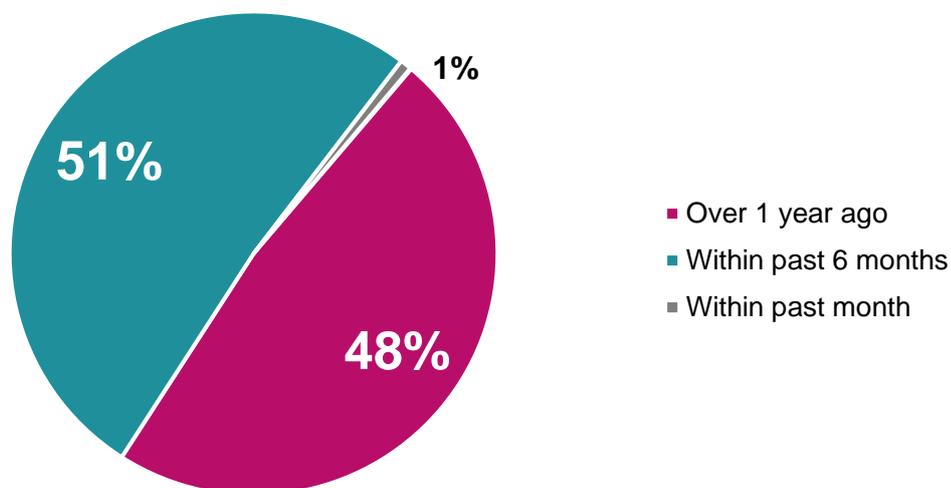
highlight notable data points. Following this section will be a thematic analysis of improvement themes as identified by the PEPI team from free text comments.

What stage of your pregnancy were responders at?

The majority of those completing this survey had given birth (**97%**) with the remaining responders at a range of stages of pregnancy. This is to be expected with the data being from 2022 and early 2023. It is anticipated that future work will explore how to more effectively capture the views of women during pregnancy, building on the work carried out as part of the [NHSGGC Understanding Maternity Experiences Survey Report](#).

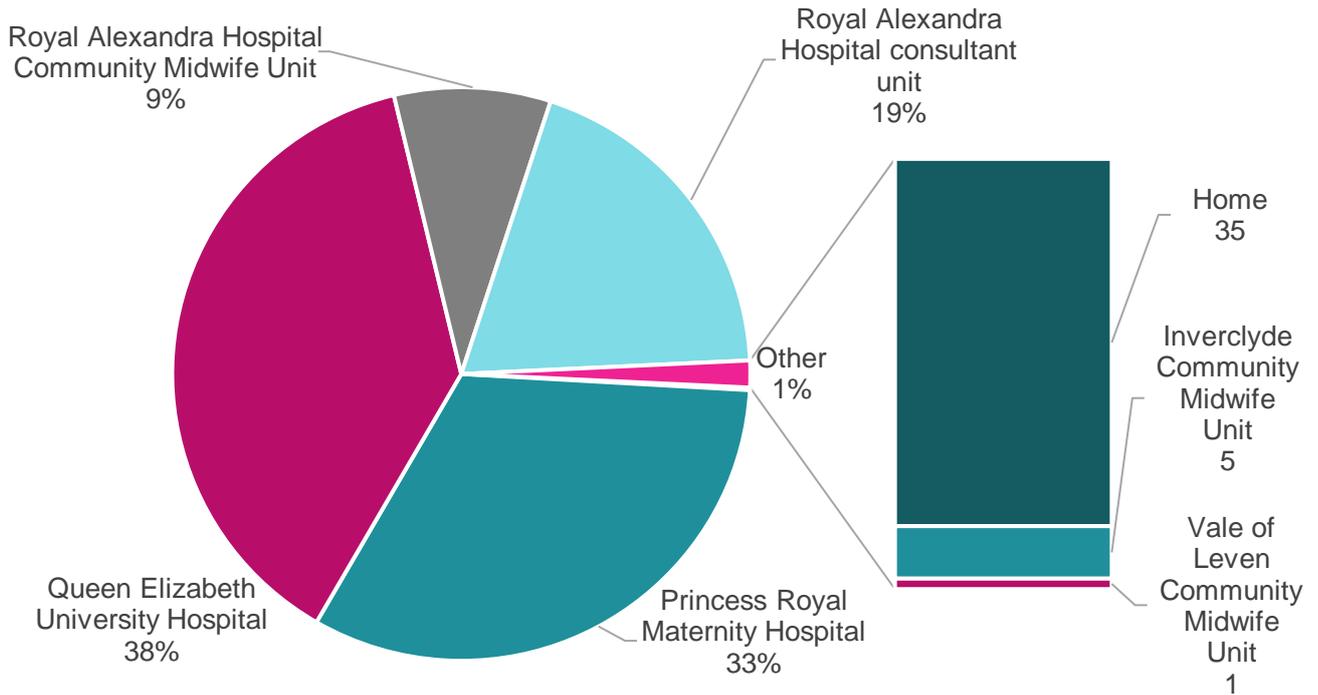
Section 1: Giving Birth and Midwife contact.

When did women give birth



The majority of women sharing their experiences had given birth in the last 6 months (**51%**) with **48%** giving birth over a year ago and only **1%** having given birth within the last 6 months.

Where did women give birth?

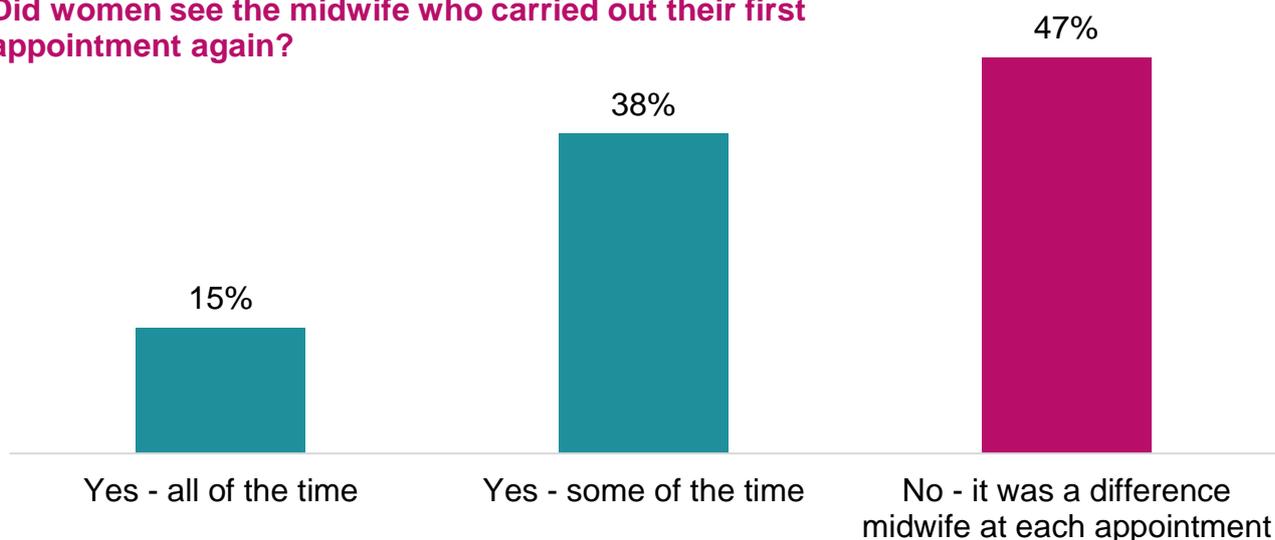


We saw the majority of women that had given birth did so at the Queen Elizabeth University Hospital (**38%**), followed by the Princes Royal Maternity Hospital (**33%**). We saw fewer responses from the stand alone Community Midwife Units, with the Vale of Leven, and Inverclyde Community Midwife units making up less that **1%** of responders.

The above figures are broadly in line with the birth location data of the women offered the opportunity to share feedback as can be seen in the below table.

Birth Site used by those text a survey	Percentage of Total
Glasgow Princess Royal Maternity	34.45%
Inverclyde Royal Hospital Maternity	0.32%
Queen Elizabeth University Hospital	39.08%
Royal Alexandra Maternity Hospital	25.89%
Vale of Leven Maternity	0.26%

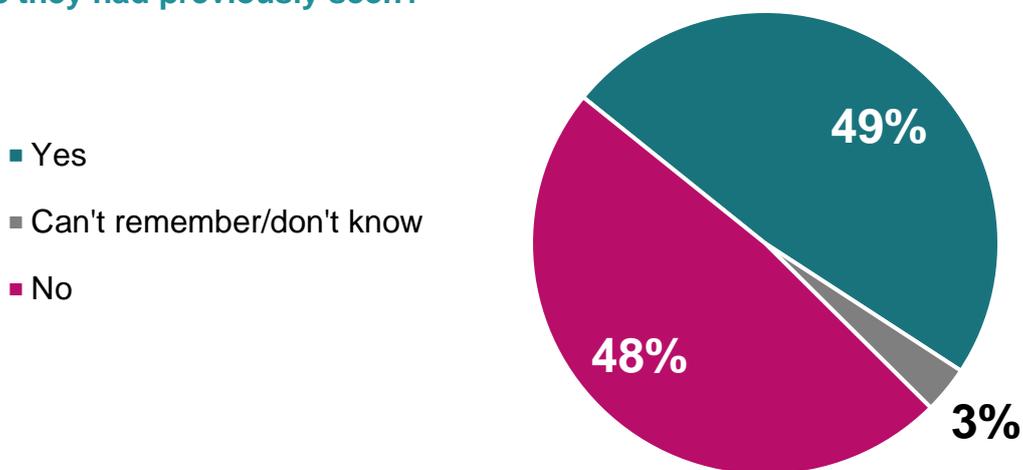
Did women see the midwife who carried out their first appointment again?



When looking at the data we saw 53% of women saw the same midwife again following their first appointment at least some of the time, though only 15% reported consistent meetings with the same midwife.

When looking at this question through the lenses of ethnicity other than white we see 15% of women receive continuity of carer all the time. We do see a change of +4% in women seeing a different midwife at each appointment, 51% rather than 47% for the full responder group.

After they had their baby, did women receive a home visit from a midwife they had previously seen?

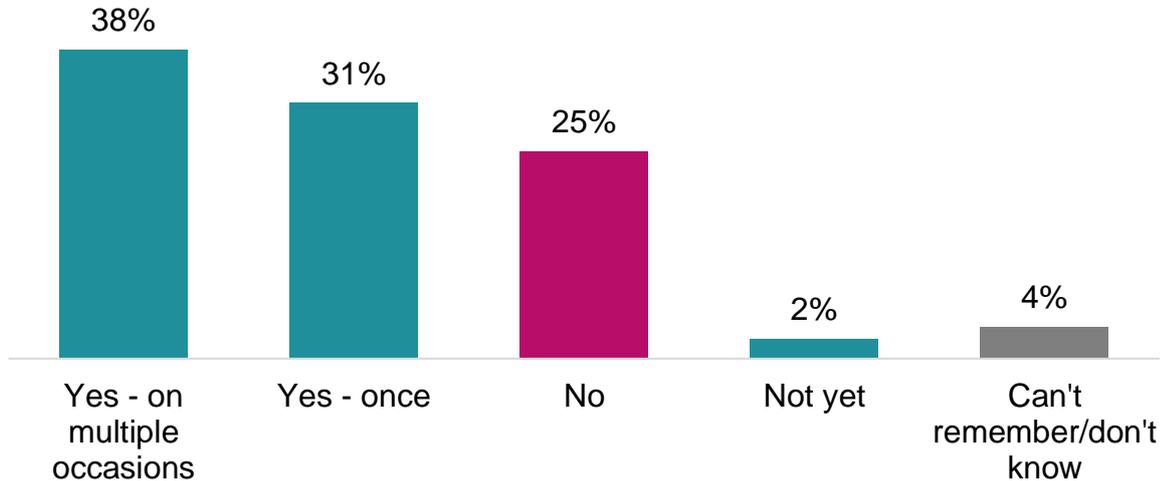


We saw 49% of women share that they had received a home visit following birth from a midwife they had previously met with at an appointment, with 48% stating they had not and 3% being unable to remember. This reinforces the direction of improvement identified from earlier engagement that improvements to continuity of carer is key to improving maternity experiences for women across NHSGGC.

Section 2: Birth Planning

We asked women to tell us about their experience of birth planning, specifically if they had the chance to discuss their plan during pregnancy, if their birth plan was made and if it was met.

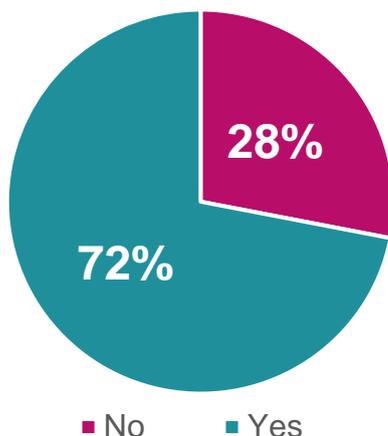
Did women have the opportunity to discuss their birth plan during pregnancy?



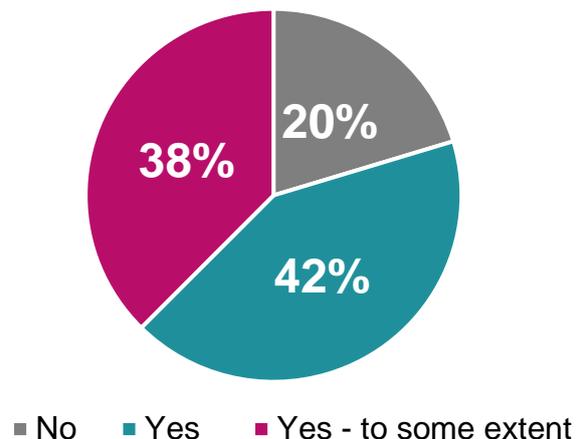
The majority (70%) of women sharing feedback stated they had conversations with NHSGGC staff about their birth plan. We saw 39% of respondents share that they had multiple conversations, with 31% having at least one. We did see 26% state no such discussion took place, pointing to opportunity to learn and improve how NHSGGC ensures birth plan conversations are undertaken.

Analysis of ethnicity data in relation to birth planning amongst ethnicities other than white show similar results to the full responder group, with 69% having conversations about birth planning with NHSGGC.

Was a Birth plan Made?



Was your birth plan met

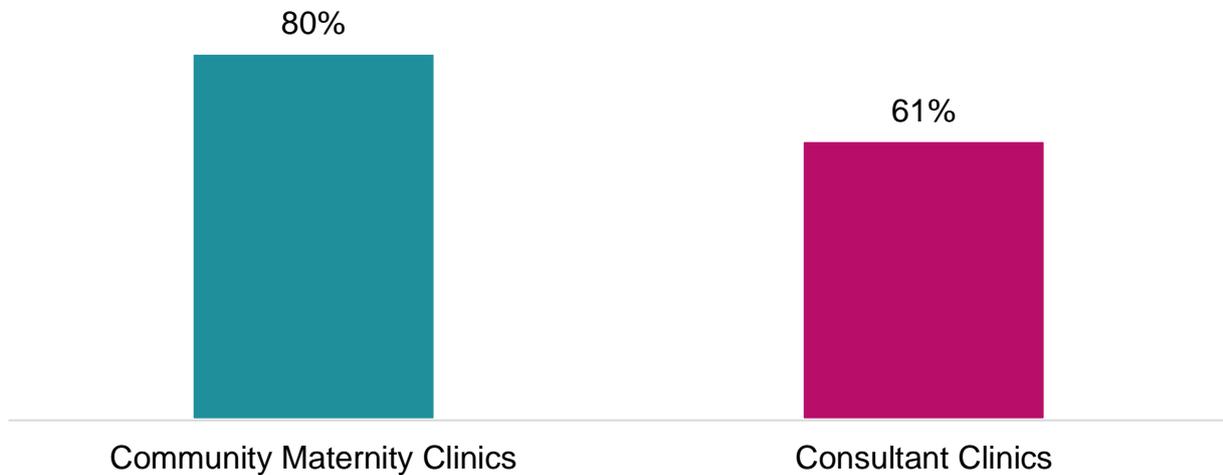


Seventy two percent of respondents shared that they had a birth plan made, with 80% of these responders sharing it was met to at least some extent.

Section 3: Clinics Visited

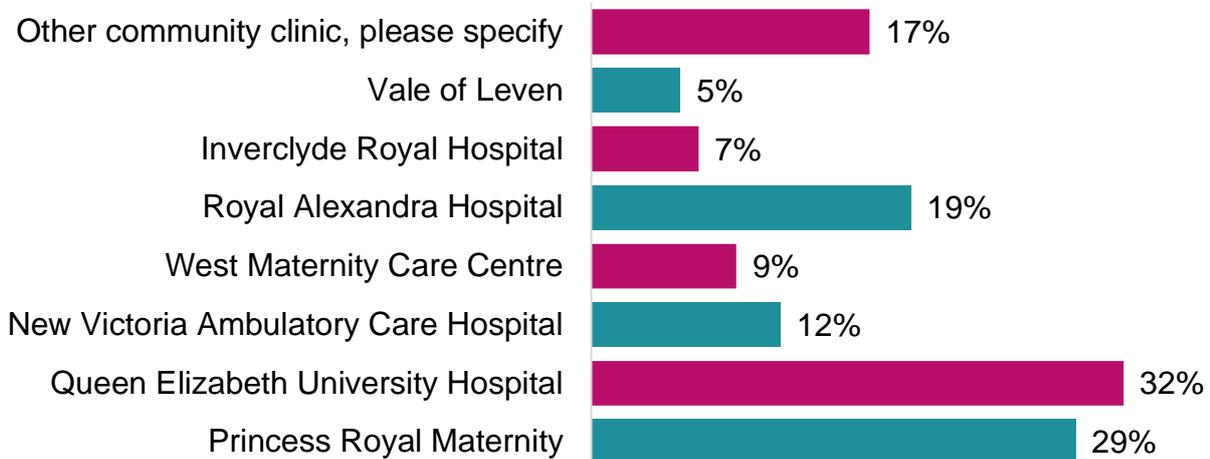
Women shared their experiences of attending clinics during their pregnancy, with a focus on understanding the types of clinics attended, the location of said clinics and the staff they interacted with. This final area of questioning aimed to help us better understand Continuity of Carer interactions across clinics and locations.

What clinics did women attend?



Women were invited to tell us about the clinics they visited, with them able to select multiple answers. We saw a greater number of Community Maternity Clinic appointments selected. All appointments took place at a range of sites across NHSGGC as detailed below.

Where did women visit for their clinic appointments?



When looking at the above graph we see 17% of the results flagged as “other”, when digging deeper into the additional information provided by women we saw a range of locations visited. The majority of these locations were Health and Social Care facilities, with a smaller number of sites referenced from other health boards, such as Lanarkshire and the Western Isles.

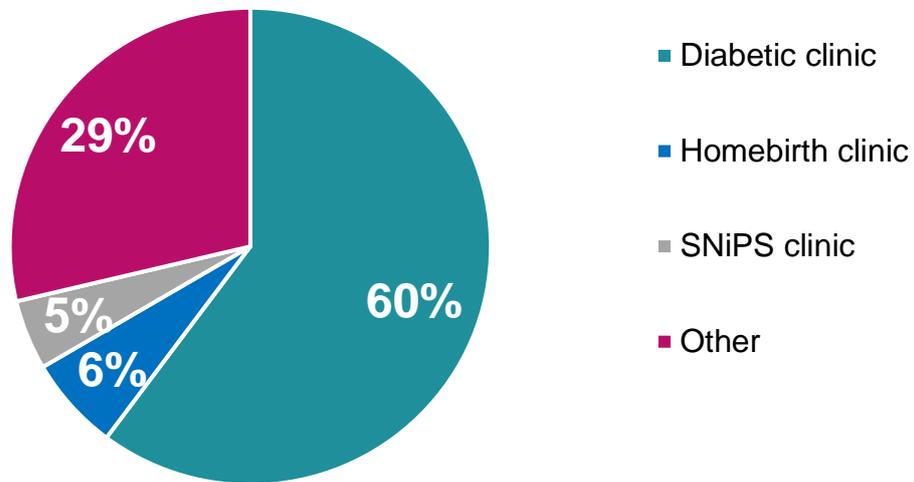
Did women see the same staff at their appointments?

This question saw an unusually low response in comparison to other questions, with only 505 women sharing their response about midwife continuity and 1518 sharing their experience of consultant continuity. Of those who did respond **64%** stated they did not see the same midwife across appointments, with **61%** stating the same in relation to consultants.

The PEPI team have looked into this anomaly and can not find a functional reason in the survey for the lower response rate, but will be carefully monitoring this question type if included in future surveys.

Women did go onto share free text comments in much larger numbers which provided valuable insight into continuity, and their views on improving antenatal appointments. These are detailed further into the report.

Had women attended any other clinics?



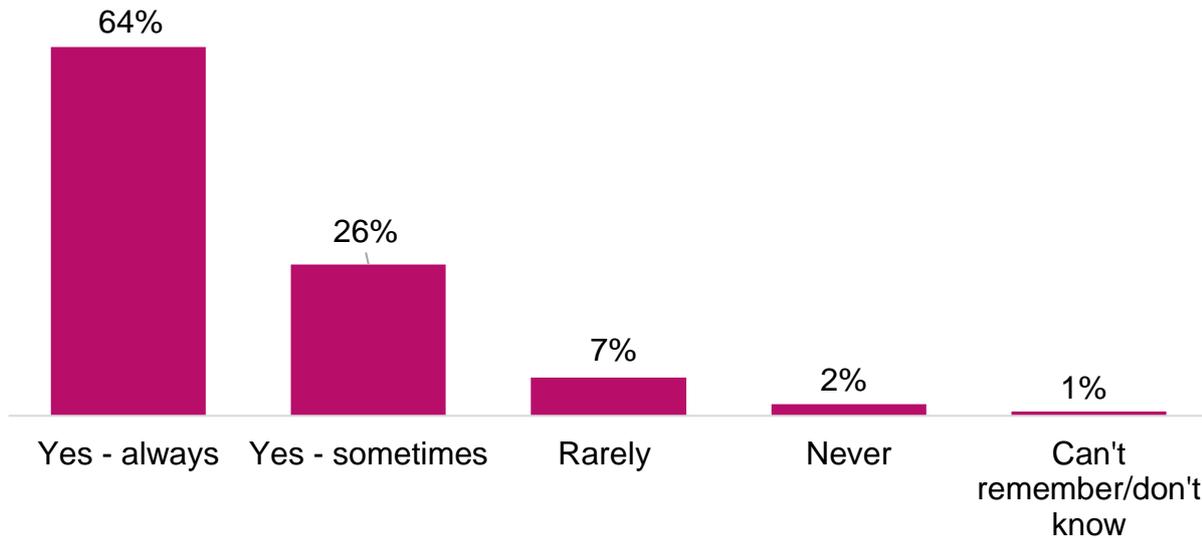
When looking at other clinics attended women shared information on a variety of spaces where they had received care. The most commonly shared were local General Medical Practices and Health Centres, such as those in Bridgeton, Barrhead and the Gorbals. They also shared information about ambulatory care hospital support they received from Stobhill, the Victoria and West Glasgow Ambulatory Care Hospitals.

We also saw a number of women share they had attended Cardiac clinics, Physiotherapy Support and Pregnancy Assessment Centres as well as Mental Health Support clinics.

Section 4: Antenatal Appointments

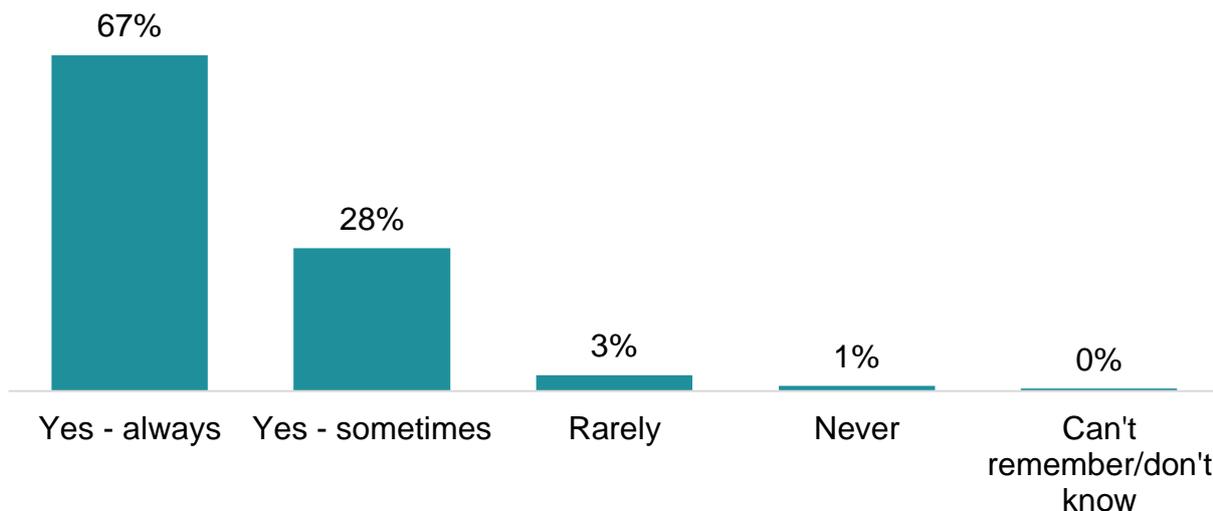
The survey provided the opportunity for women to share their insights into antenatal appointments. The questions focused on understanding peoples thoughts on the time provided for antenatal appointments, the information provided and where they felt improvements could be made.

Did women feel they were given enough time to ask questions or discuss their pregnancy with a midwife?



The majority of women (64%) shared that they felt the time given at appointments for questions and discussions on pregnancy was always enough, with 26% of women sharing it was sometimes enough. Seven percent shared they rarely felt there was enough time and 2% never had enough time.

Did women feel the information they were given during antenatal appointments was easy to understand?

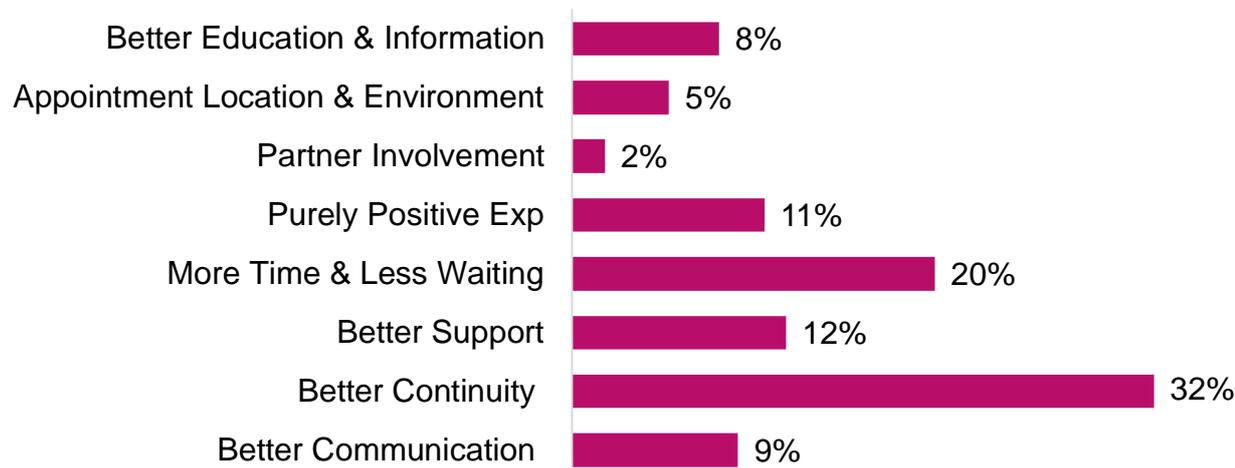


Sixty seven percent of women answering this question shared the felt the information provided at appointments was always easy to understand. We saw 28% stating it was sometimes easy to understand, with 3% sharing it rarely was. This points to opportunity to review and better understand how to increase information quality.

Themes identified from free text comments.

We asked women to provide insights into where they felt we could improve antenatal appointments, with 1098 women providing additional comments around possible improvements. These comments were analysed by the PEPI team and Project Midwife to identify common themes and areas for improvement. These are outlined in the chart below, with “Better Continuity” being the most commonly identified theme followed by “More Time & Less Waiting” when attending our sites.

How did women feel we could improve antenatal appointments?



In-depth view of themes

The following section will focus on each theme and provide additional insight into the comments shared by women. All comments will influence the work of maternity services in NHSGGC and reflect the most commonly held positions and views shared by women completing the survey.

Better Continuity

We saw a number of comments shared about continuity of carer, with the majority of comments referencing this as important. Comments ranged from specific calls for greater continuity to comments highlighting the value women placed on being able to build a more in-depth relationship with their midwife.

Key benefits cited by women were around the better management of health conditions that could be exacerbated by pregnancy. They also felt it would help them feel more comfortable in asking questions and addressing any emerging complications or risks as the pregnancy progressed while importantly avoiding repetition and wasting appointment time bringing staff up to speed on their care needs.

Comments

Continuity of midwife staff throughout pregnancy.

Allow patients with low risk conditions to be managed by community midwife team and re referred to consultant management if change/deterioration.

More consistency with midwives, more time to discuss options, more time and care given when making birth plan, more care over/less dismissive of possible complications that could be helped by other departments i.e physio

seeing the same midwife and/or consultant would really help build a relationship and make it easier to discuss difficult topics

Because I had some challenges with my mental health I have been lucky to have an assigned midwife at some point during my pregnancy. It was a very difficult time and she was absolutely MARVELLOUS. I can't thank her enough. Having a "dedicated" midwife

makes all the difference. Because sometimes you see the same staff but they don't remember you while MY midwife she knew me and my surroundings. She was just perfect and it alleviated a lot of the stress/ and anxiety.

I would like to see Dr during the pregnancy more often and the same midwife not all the time different one. Every appointment I had to repeat the same information (due to new person) instead of focusing on current pregnancy

More Time and Less Waiting

When identifying themes around time we saw women predominantly share the desire to see more time be available to discuss their care, their care plan and questions about their pregnancy. Women also shared that they would like to see appointments run closer to the advertised time, with appointment delay being a major cause of stress and frustration when visiting one of our sites.

It was felt that addressing these aspects of care would lead to more meaningful conversations with staff, and clearer outcomes for women when attending clinics.

Comments

My first midwife appointment was phone consultant then each appointment was with someone else. I felt rushed a lot and sometimes was given different information. So would be good if appointments would be made with this same midwife and mum's could txt or call her with concerns as hospitals are very busy. I felt like I had no support and no-one to discuss my fear and concerns.

Time keeping was really bad. Would often be waiting for an hour and often longer. One day I waited for close to two hours. I asked at the desk but they always said they were running late.

More intentional time to speak about birth / birth plan.

More time to ask questions, it was so fast I often thought of them after the appointment. Discuss the leaflets together rather than give them to me to read at home, so I can ask questions on the spot and avoid worrying later

I know the NHS is understaffed but I waited over an hour for some appointments, the waiting room was very warm and sitting for long periods uncomfortable, maybe have birthing balls available?

Better Education & Information

Women shared a range of suggestions for information improvement, these suggestions were often linked to the development of more robust patient education systems alongside staff development and empowerment. Closely linked to better information were

suggestions to ensure all staff took a person-centred approach to birth, working with parents to clearly explain health risks of various choices in a way that didn't come across as scare mongering.

Comments

Really clear information provided on things that mum may not know about. Eg. additional growth scans. I left my appointment worried about my baby's growth as I was told I was measuring small but wasn't given any other information.

I understand that no one wants to scare first-time mums but I think there's not enough focus on what can go wrong during labour.

So when I was told I would have to have an emergency section I felt really shocked and unprepared.

Giving information on attachment and development of your baby especially the brain development. All mums should learn about their baby connections with them not just the physical development but emotional and neurological attachment.

When seeing the dr through the consultant clinic information was used to encourage/scaremonger into induction at 39 weeks. The dr told me my risk of still birth was double after age of 40 and increasing each week after 37 weeks but the real risk was still very small. The dr didn't know the real risk per 1000 births but used information to coerce.

Appointment Location & Environment

When providing feedback about antenatal appointments, we saw a number of suggestions relating to the environment our appointments take place in alongside comments on location of appointments, with a desire to see more community appointments offered. We also saw women share a desire to see better temperature control where possible, particularly in summer months as waiting any sort of time for appointments could be very uncomfortable.

Comments

I had bloods taken to rule out Obstetric Cholestasis and was informed I would be contacted directly by a midwife if there were any concerns. After no contact from 2 weeks, a chance telephone appointment with my own GP, I was informed my bloods were very abnormal and that I had to attend the hospital that day as a matter of urgency. Communication of bloods results is very important.

I will say you should try to give those in their last trimester, close appointment with their ultrasound appointment because it was difficult for me during my last trimester going for two different appointments in a week at the hospital.

Have air-con as the department is very hot during the hotter months, which is uncomfortable when pregnant

Appointment to discuss a birth plan. I was fobbed off every time I mentioned it

Provide antenatal classes again. I was seen in community in Lanarkshire but hospital was Glasgow. I had to pay for private antenatal classes, which were previously provided on the NHS for free before COVID.

Partner Involvement

While continuity and general support were the primary comments shared by women, we did see a number of references to better support for partners to get involved in pregnancy. Women wanted to see their partners encouraged to attend, and for consistent messaging on when others could come to appointments with them. It should be noted that feedback relating to partner restrictions related to COVID restrictions which have been lifted. These comments still provide valuable insight into how valuable women find the inclusion of their partners and the importance of ensuring partners are aware they can attend.

Comments

Take more time with the mothers and allow partners into appointments!!! So stressful that my husband was not allowed into the appointments with me

Be more inclusive, at antenatal classes. I opted out of these classes as they were geared towards pregnant women only and did not include the father. Father's need to be more included in this aspect to help prepare them for birth and post birth.

Partners being allowed to each midwife visit if we needed although I appreciate appointments may have changed since COVID times.

I was told a lot of important information about having a larger baby however I was on my own and was very upset about the things I was told, I think partners should be allowed to every appointment as letters would state to come on your own.

Purely Positive Experiences

Alongside improvement focused responses we heard from a number of women who shared purely positive experiences and interactions with our Maternity services and staff. These comments primarily focused on the professionalism of our staff, and how supportive they were to women during their pregnancy. These comments will be shared with service leads at relevant sites. Some comments highlight patient perceptions of how busy our staff are, praising the care they delivered while expressing a desire to see staff support increased where possible.

Comments

The departments were clearly busy, and I suspect understaffed. But I can honestly say I was treated with respect, kindness and professionalism throughout. I felt the midwives and doctors were a team working on my behalf.

They are all amazing midwives and doctors at the Princess Royal maternity hospital and continue being your fantastic selves you are all doing an excellent job

I think they were all fabulous, I only seen several midwives due to being diabetic. I was up weekly towards the end and there was only 1 not so pleasant experience but she could have been having a bad day!

I felt I was personally well cared for, and the midwives and doctors all very professional. However, it was obvious that there is additional strain/pressure on the midwives in-particular as they often seemed stressed and pushed for time.

I couldn't fault any part of the pregnancy journey. Every midwife/consultant always put my baby and my feeling first. I had a great experience given I had a lot of anxiety throughout and they always put my mind at ease

Better Support

When sharing feedback on how we could improve antenatal classes women provided valuable insight into how we could improve overall support to them. Much of this feedback focused on greater clarity of communications and improvements to active listening. Women would also like to see more regular contact with staff, and the option to talk through concerns to ensure they had shared understanding with the staff supporting them. This theme was heavily linked to continuity and the desire to see the same midwife team over time, providing further context for how women would like to be supported.

Comments

I felt that they just wanted you in and out and was given more anxiety at each appointment. I had told them on numerous occasions that I had anxiety and was really worried and nobody had put it into my notes until I had broke down crying. The midwife spoke me into getting tests for edwards syndrome yet when I had my scans I told them I wanted the test they didn't do it then told me it was too late after I had waited for 5 weeks on the results. I really feel for girls who are on their first pregnancy. I have had 2 older kids and sailed through it. This time has made me never want to do it again.

Some midwives dismissed my anxieties. One was very abrupt on my first ever appointment setting a bad tone but thankfully follow up ones and Kered was amazing at west care hospital in west end. She was so understanding and gave me lots of time to chat through my questions.

Midwife's are great dr me Murphy was great but one consultant didn't listen be was over talking me and didn't listen

Midwives could have been more understanding and support relevant to the choices I was making. I have support after my baby was born, but heavily dismissed when pregnant.

As a first time mum, I felt that there was minimal contact in my first trimester. Given that this is the period where most of the worry begins and most of the questions would start, it would have been good to have had some more appointments there. I also felt the length of time between midwife appointments (once they started) seemed long during second trimester.

Better Communication

Across multiple themes we saw communication stand out as an area where women would like to see improvement, this ranged from written to spoken communication and generally focused on how we could ensure mothers were better informed about how the service worked.

Comments

I think a bit more explanation on things would be good. My personal example is Gtt testing I've not had this in 3 different pregnancies and not once been told what my limits for fasting and 2 hourly bloods should be for the test. Which had caused confusion as I have been given inaccurate information this time around.

Inform us better on the letter for appointment of what we are attending for. So we dont need to guess by department we have to attend. I didnt know what to expect from any appointment except the ultrasound scans.

I would have liked to choose the RAH from the start. I had my first midwife appointment at the QEUH, where they weren't sure if I could transfer - which turned out not to be an issue.

Make it a little bit more simple. It was in begining confusing to go first to Vale of Lavern, then local appointment in helensbrugh, then 2h by train during my labour to get to paisley - Royal alexandria hospital. Then postnatal visits - regularly different midwife.

I still believe that all midwives were amazing! Felt supported, just in the last weeks of my pregnancy there was a lot of travelling an stress.

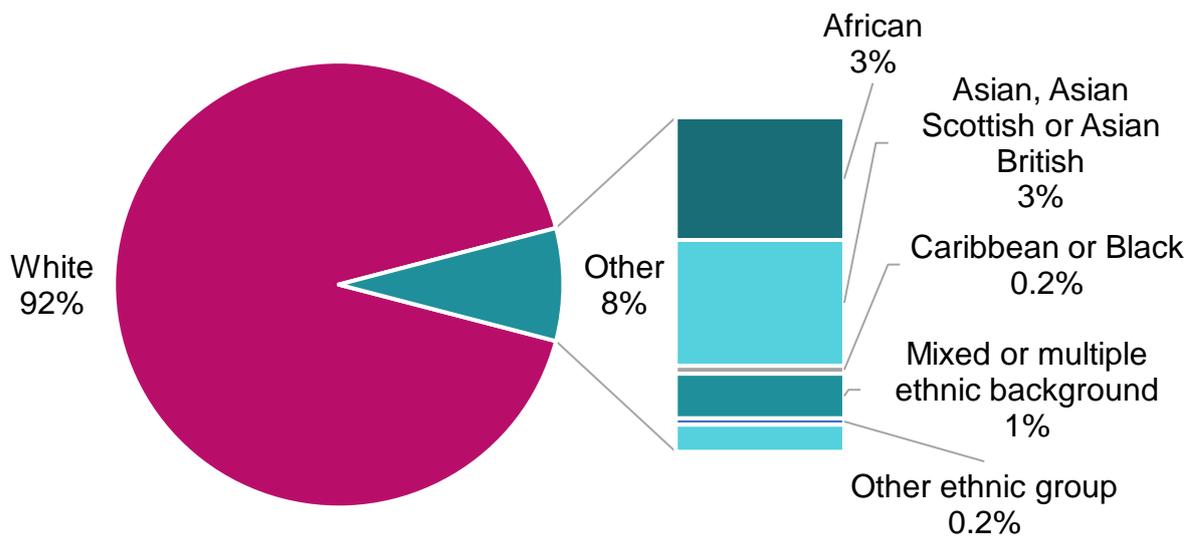
The diabetes was never really explained until hospital appointments. Having a point of contact would have put my mind at rest for a lot of things, once I got told I had diabetes my local midwife called to say she would see me after the baby arrived. I did feel a bit lost with no one to contact and never did hear from that midwife again.

Section 5: Accessibility and Equalities Information

Alongside questions aimed at developing greater understanding of womens experience of care we also captured equalities monitoring information. This allowed us to better understand the demographic make up of those responding to our survey.

What is your ethnicity?

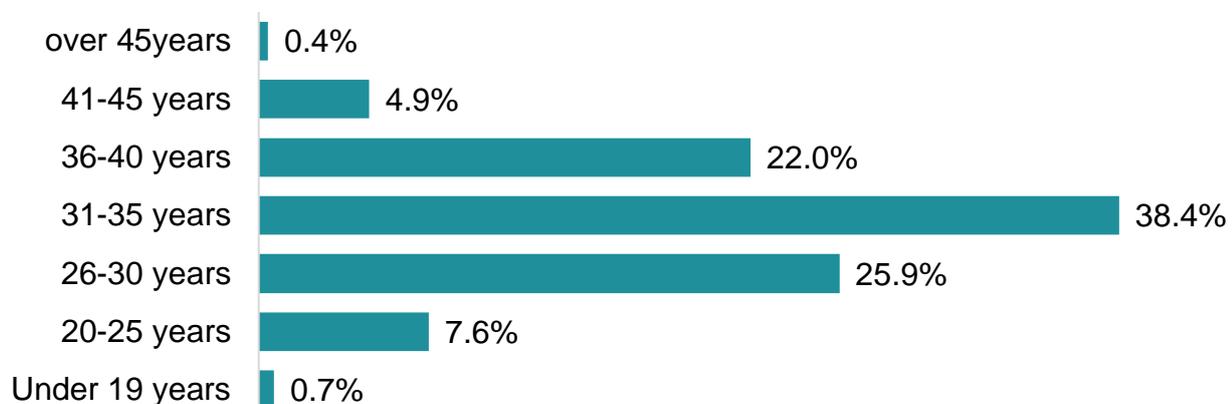
We saw 89% of responders share additional information on their ethnicity. This helps us better understand who we are reaching without messaging and where we may need to carry out further engagement activity to capture experiences from all our communities.



As can be seen in the above chart, 92% of respondents identified as white, with 8% sharing that they identified as other ethnicities, this is broadly in line with the population make up of NHSGGC. It should be noted that this make up may change based on new census information as it is released to organisations and the public.

Age range of respondents.

We also asked women to share their age range, with 91% of people sharing information on their age range. The majority of respondents were aged between 31-35 followed by 26-30. This is broadly in line with usage rates for maternity services, though cannot be directly compared due to different measures being used between data sets. This will be corrected in future surveys.



Response rates between language groups

When analysing responses we were able to extract responses received in each language. Across all languages other than English we saw a 11.1% response rate to the survey, with 30 people responding in English when offered other languages.

We saw the largest response rate amongst the Urdu and Polish speaking population (9.7%) with the lowest response rate being seen amongst the Romanian speaking population (4.7%). Arabic speakers showed a 6.7% response rate.

Language data was obtained from the Badgernet app, it should be noted that 30 people did complete the survey in English when offered the option of another language. There is no way to tell which language these women had selected as preferred on Badgernet.

Future surveys will look to expand our language offer, working with equalities colleagues to effectively reach our communities.

Potential Next Steps Consideration

This piece of engagement work resulted in 2889 women sharing their current and past experiences of maternity care. Key themes and learning identified from the experiences shared are outlined below alongside impacts and actions being taken forward by maternity services;

- Opportunity to further develop engagement through use of social media and text messages utilising our Equalities team to assist with translation.
- It was identified there is an opportunity to improve how NHSGGC captures maternity experiences on an ongoing basis, building off the learning from this engagement activity to develop a recurring feedback survey to be sent 6 monthly to women capturing experiences at different stages of their maternity experiences, not just on continuity of carer.
- Utilise future surveys as a recruitment and promotion method for the NHSGGC Maternity Voices Partnership

Continuity of Carer project actions influenced by findings from this engagement activity and ongoing staff engagement.

- Implement caseload holding model across GGC to facilitate CoC from the first booking appointment throughout pregnancy and the postnatal period.
- Providing midwives with their own clinic templates which reflect longer appointment times (1.5hr booking appointment, x9 30 minute return appointments) this will provide more time during appointments to discuss birth preferences or answer questions women may have.
- Review of midwives and obstetricians aligned to postcodes to enhance CoC by reducing caseload sizes to more manageable numbers.

ENDS



Report:	Understanding Maternity Experiences Surveys
Report By:	NHSGGC Patient Experience Public Involvement Team. Contact: Paul Hayes, PEPI Manager: paul.hayes2@ggc.scot.nhs.uk
Date:	22/03/2023
Purpose of Paper:	To inform strategy and service development
Classification:	N/a
Sponsoring Director:	

Understanding Maternity Experiences Survey and Clinic Interviews

Purpose of Report

This report provides insight into the experiences of maternity services shared by women via digital survey and clinic interview. These surveys were shared with people shared through Social Media, Badgernet and community networks alongside feedback with clinic interviews carried out at each of the NHS Greater Glasgow and Clyde (NHSGGC) Maternity sites. Alongside presenting findings this report highlights emerging themes for further consideration and action by NHSGGC.

Background

The survey was developed by NHSGGC's Patient Experience Public Involvement (PEPI) team in discussion with the Director of Midwifery and service leads. Its purpose was to gain deeper understanding of recent Maternity experiences across NHSGGC and inform the development of the new Maternity and Neonatal Strategy. The engagement was driven by a desire to listen and learn from the recent lived experience of women and to understand what is working well with maternity services and what people would like to see from the service in the future.

A mixture of closed and open questions were posed during both the survey and the clinic interviews. This captured the views and feedback of **447** people with a range of experiences. We saw **381** people share their experiences and awareness via the digital survey, with **66** people taking part in the clinic interview survey across each of our maternity sites.

The survey was shared with the public via NHSGGC's Social Media accounts, through community networks and via the Badgernet maternity app with responses collated and analysed by the PEPI team.

Report structure

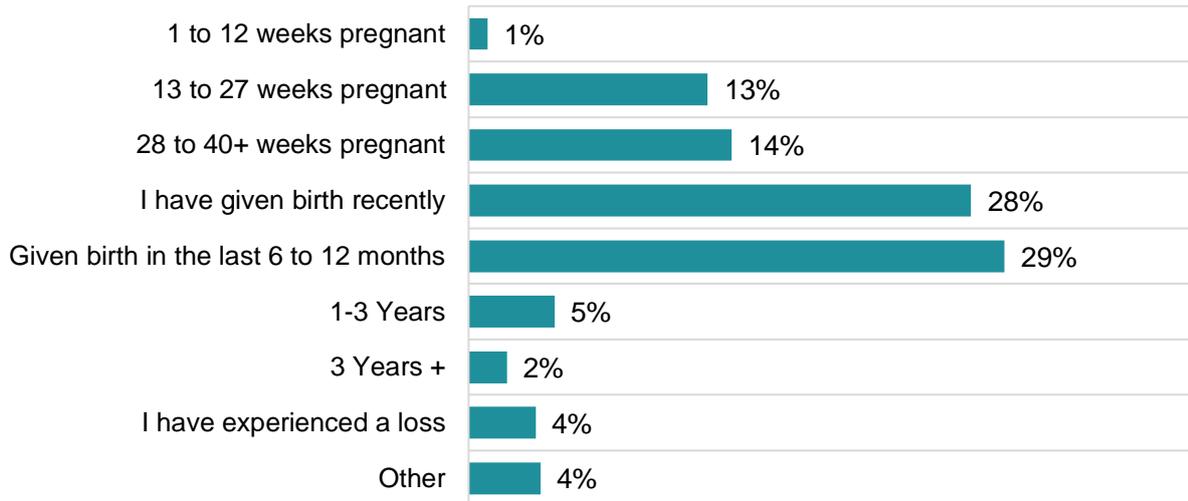
Due to the mixed methods used to capture the experiences of women using NHSGGC Maternity services this report is split into the following sections;

- Summary of Social Media and Badgernet Survey
- Summary of Maternity Clinic Interview Surveys
- Emerging themes and findings from across both surveys, highlighting similarities and any differences between data sets.

Summary of Social Media and Badgernet Survey Responses by Question (including a cross-section of comments)

To compliment the conversations had with women in a clinic setting and ensure we reached the wider population the PEPI team facilitated the sharing of a digital survey through community networks, the Badgernet maternity app and over Social Media. We received **381** responses to this survey, with the following providing a summary of these responses. All comments have been shared with maternity leads for more in-depth analysis and learning.

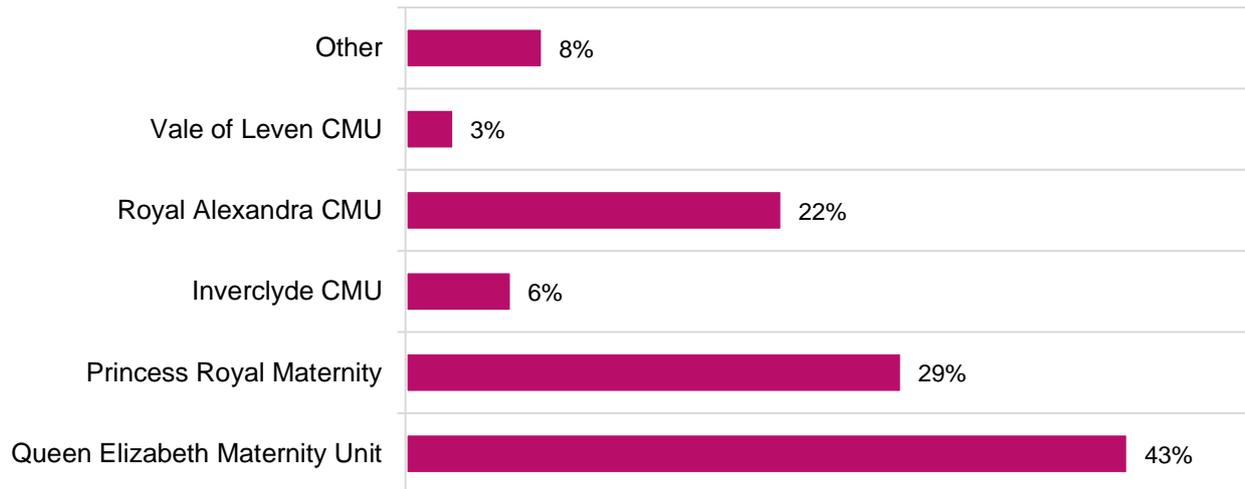
What stage of your pregnancy were responders at?



The majority of those completing this survey had given birth recently or in the last 12 months (**57%**), with the next largest group of responders currently being pregnant (**28%**).

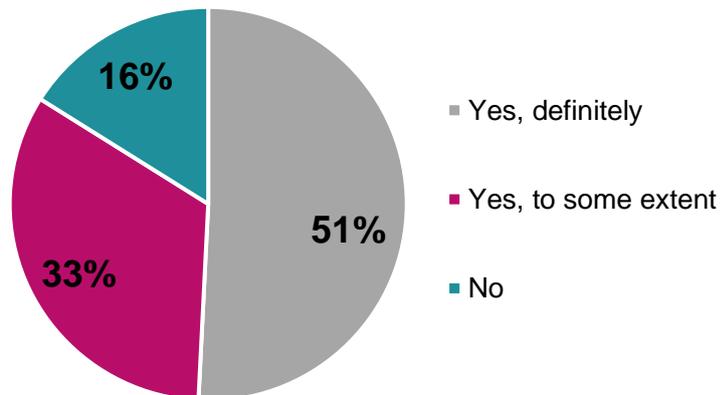
14 people that have experienced a loss completed the survey sharing insights into their experiences of loss and how we could improve the support we provide to mothers experiencing this. They were asked an additional question about the bereavement support they received, with 11 women providing additional information. Eight shared that they did not receive bereavement support, with some comments shared suggesting further training of staff could be helpful. We heard from 3 women that stated they did receive support, but two felt it came too late or only consisted of bereavement counselling.

What maternity services did women visit most often?



We saw the majority of women completing this survey share that they most often visited the Queen Elizabeth site, followed by the Princes Royal. Other sites commonly visited were outside the NHSGGC area by women living in Lanarkshire area, or women who had visited the West Glasgow Ambulatory Care Hospital for support.

At the start of their pregnancy care, did women feel they were given enough information?



We asked women what additional information they would have liked to receive?

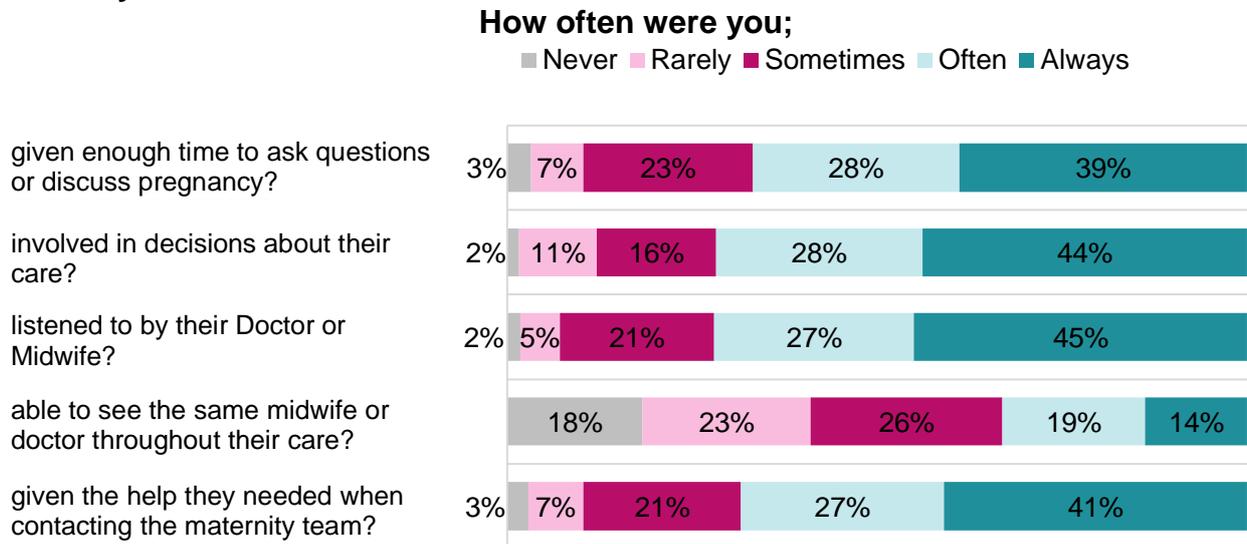
The majority of answers focused on the need for greater clarity around appointment times, locations of clinics and what to expect when attending a maternity unit. Greater knowledge of birthing options and the different options available to women earlier in their pregnancy was also raised as important along with a desire to see more information shared about how pregnancy impacts the mother's health and wellbeing.

Example Comments:

- Information on what appointments would be scheduled and how/ when I'd find out about them
- Antenatal classes that included basics like changing nappies etc
- Information about birthing choices without bias to allow an informed decision
- More information on risks of a caesarean and that a baby might end in neonatal. This wasn't shared until after the birth which was not helpful getting this info at that stage

- Information on home birth, information on hypnobirthing and information on each intervention and the reason it may be offered and the risks attached
- There should have been thorough counselling about what would happen during labour and delivery. The clinic was oversubscribed and too busy so doctors didn't have time to do proper counselling
- Options about my care, e.g. which hospital, birth plan etc
- Info on postpartum visits and what to expect at hospitals. Differences between sites and types of birth etc
- Clear information on appointments well ahead of time, when they are expected to be and whether I can bring my partner.
- Choice in days of appointments too, I can only attend the consultant in one half day and my other child isn't meant to come - difficult when I have no other childcare options on that day
- Honest support about breast feeding and how if difficulties arise, maternal shame and guilt acknowledged and supported rather than encouraged to persist when distressed
- Would have been good to see someone when I first found out I was pregnant to discuss the dos and do nots then I would have worried less. Also to confirm the pregnancy.

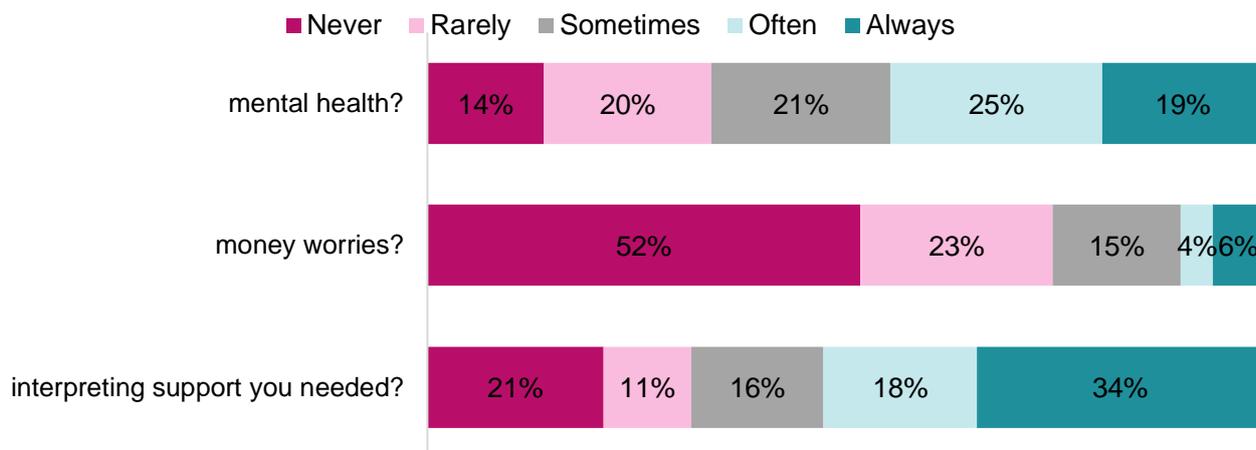
Women were asked how often they felt they experienced the following during their maternity care



Women generally shared they experienced the above always or often, with their ability to see the same midwife or doctor throughout their care seeing the largest deviation from the norm. When looking at this question we saw only **14%** of women share they always saw the same staff member, with this also presenting the highest number of respondents indicating 'never' or 'rarely' (**41%**).

We would like to know if you received any additional support during your appointments.

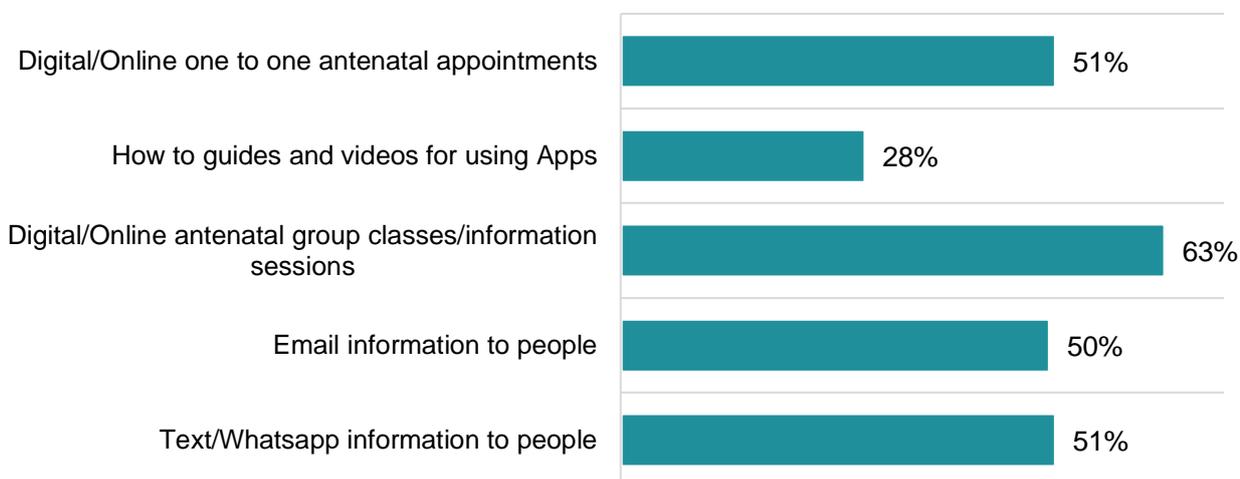
How often were you asked about;



When looking at equalities outcome in maternity services we broadly even split amongst those asked about their mental health, with over **65%** sharing it had been discussed sometimes, often or always. With regards to money worries we saw **52%** of women share they had not been asked about money worries, only **6%** shared they had always been asked about these.

We also asked women about interpreting support needs with **38** women sharing their insights into interpreting support. We saw over **50%** indicated they often or always had the support they needed, with over **30%** of respondents stating they never or rarely had support needed.

Would you find it helpful if NHSGGC providing the following digital options to access advice and support?



Alongside gaining a greater understanding of women’s experiences of maternity services we also asked about how women would like to receive advice and support digitally. This question was asked to help inform future service delivery and understand what would be most useful to women. We saw **63%** of people show interest in digital antenatal groups or information sessions, with **51%** of women interested in one to one antenatal appointments.

Women also expressed interest in the use of email and text messaging to access advice and support alongside digital groups and more traditional methods. How to guides and videos shared via apps were selected the least often at **28%**.

Were there any parts of your maternity journey that were particularly good and that you think should be seen more often?

Answers to this question generally focused on the caring compassionate nature of our staff and the importance of listening caring approach to those going through pregnancy. We also saw women call out examples of particularly excellent care, such as antenatal services, text messages from midwife teams and being given the time to raise concerns.

Example Comments:

- Maternity triage was excellent when I had to attend a number of times between 20 and 30 weeks
- Midwives were all lovely and supportive. Majority of appointments had plenty of time to ask questions. Sonographers very friendly and knowledgeable.
- The midwives on the pre natal, postnatal and labour wards have each time been exceptional. Midwives at maternity assessment are majority of the time lovely but ridiculously busy and spread thin.
- As an older mother and with IVF I found that the RAH listened to my concerns and didn't pressurise me into any decisions I wasn't comfortable with. The RAH provides a very calm, thorough, and respectful service.
- My experience in the 3 times I attended maternity assessment/triage at the QEUH was excellent, I felt listened to and not fobbed off like I had been in another part of the maternity care at the Victoria. Also, the actions the midwife and doctor team took when my little boy was in distress at the end of my labour was amazing and I'll forever be grateful they got him out safely.
- I had a fabulous experience of the perinatal mental health team who gave me invaluable support during my pregnancy and afterwards.
- The midwives and doctors in the QEUH recovery wards are amazing, I was there for a week and the care was excellent however it was obvious to me they were at times understaffed and under resourced and so under pressure as staff.
- I asked to see the same midwife that helped a lot with anxiety around my pregnancy. I elected to have a c section and this wasn't questioned
- The new introduction of health visitor during pregnancy is very beneficial.

Are there any parts of your maternity journey that could have been better, or that you would like to see changed?

When analysing comments relating to what could have been better, we saw a number of women sharing a desire for more information at the start of pregnancy, though it needs to be delivered in a digestible way and not given all at once. We also saw a desire for a change in how women contact the early pregnancy assessment service, with the current telephone and answer machine system feeling frustrating to access. There was also a desire to see more connected services, easier cross referral to support and easier access to a person's information and test results through Badgernet.

Example Comments:

- I'd like to see test results uploaded to badger app faster. It can increase anxiety not knowing if everything is okay.
- slow down, advise on how and what to read, help to navigate and get right information at correct time
- Not given correct info regarding how the clinics are run by receptionist (obstetrics dept) at QEUH. I wish it would be made clear at the beginning how the clinics are run.
- My badger app was not regularly updated.
- As a second time mum it was presumed that I knew what I was doing which in general was true however I didn't know about the differences between first and second time. In particular I didn't know that the labour could be much quicker second time and I ended up having an unplanned delivery at home. I would have liked to have had more conversations about this as part of my birth plan
- I think being given more Awareness to things that can go wrong, and their symptoms. Like HELLP syndrome, I had a lot of symptoms but never heard of this so dismissed signs, such as swelling, nausea, heartburn as common side effects. I ended up going to triage at 3am, thinking I had bad heartburn but was seriously ill
- Knowing what to expect at the appointment following a scan to confirm loss of baby. I would have been able to better mentally prepare if I knew what sort of things would be discussed.
- Lack of support with gestational diabetes. The advice given from Dietician and diabetic nurse on diet could have been better. More training needed with that. Got better help from online resource
- I would like to see the antenatal care changed, to make the woman more empowered and involved in decision making process. In addition more information / support in preparation for the birth.

Summary of Clinic Interview Surveys

Staff from the PEPI team worked with Maternity service leads across NHSGGC to arrange clinic visits at the; Queen Elizabeth Maternity Unit, Princes Royal Maternity, Royal Alexandria Maternity Unit, Inverclyde Community Maternity Unit, Royal Alexandra Community Maternity Unit and the Vale of Leven Maternity Unit.

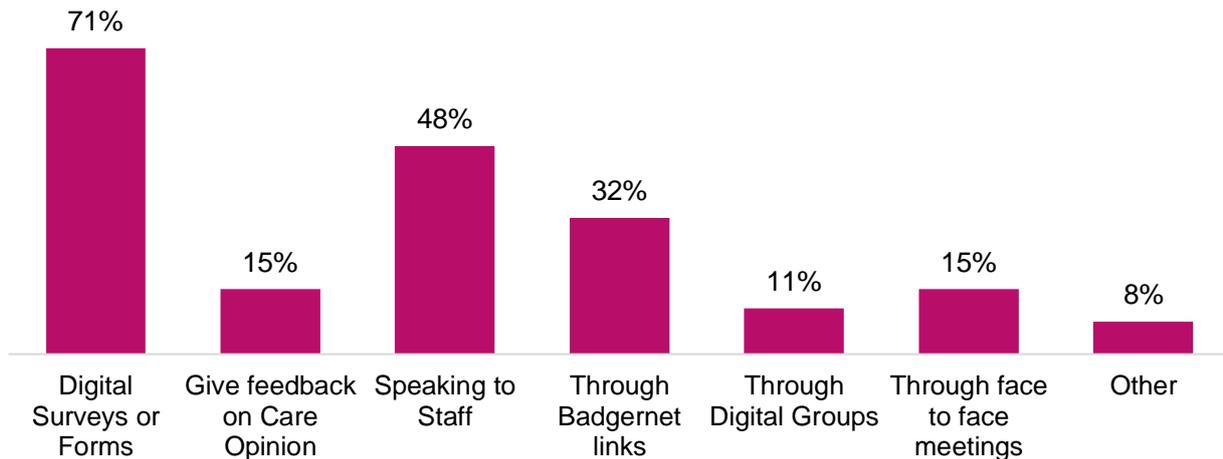
Questions asked during these visits were developed to better understand the needs of women, their experiences of current services and their hopes for future maternity service developments.

Sixty Six Women provided feedback on the questions listed below with summary findings provided in the order that women were asked the questions.

What matters most to you during your pregnancy?

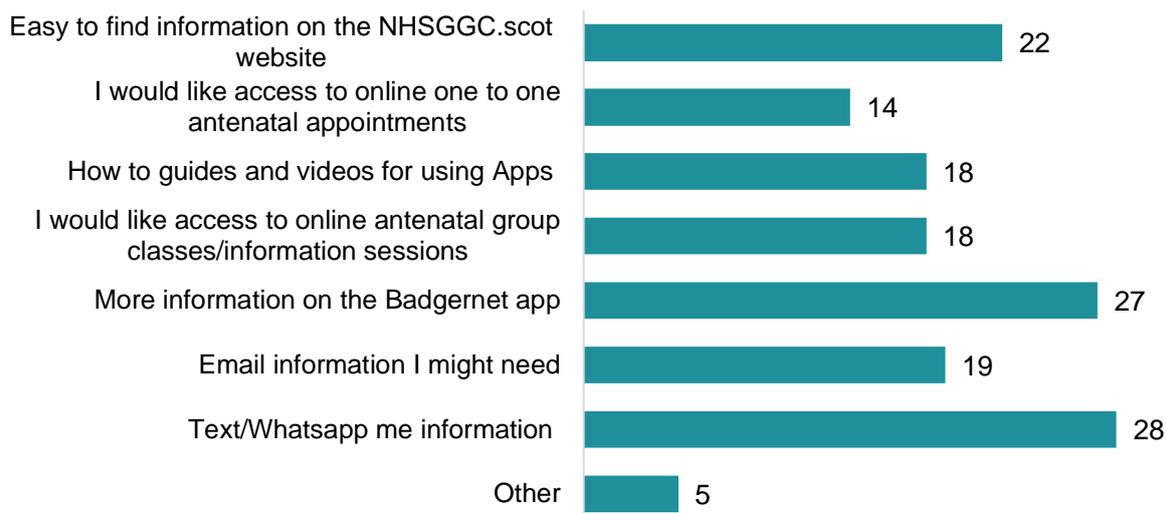
We asked women what mattered most to them during their pregnancy, the majority of women shared that a safe birth and healthy baby were most important to them. We also saw a number of women share how they valued reassurance from staff alongside easy to access information, and the involvement of their partner in their maternity journey.

How would you like to give feedback or get involved in maternity services in the future?



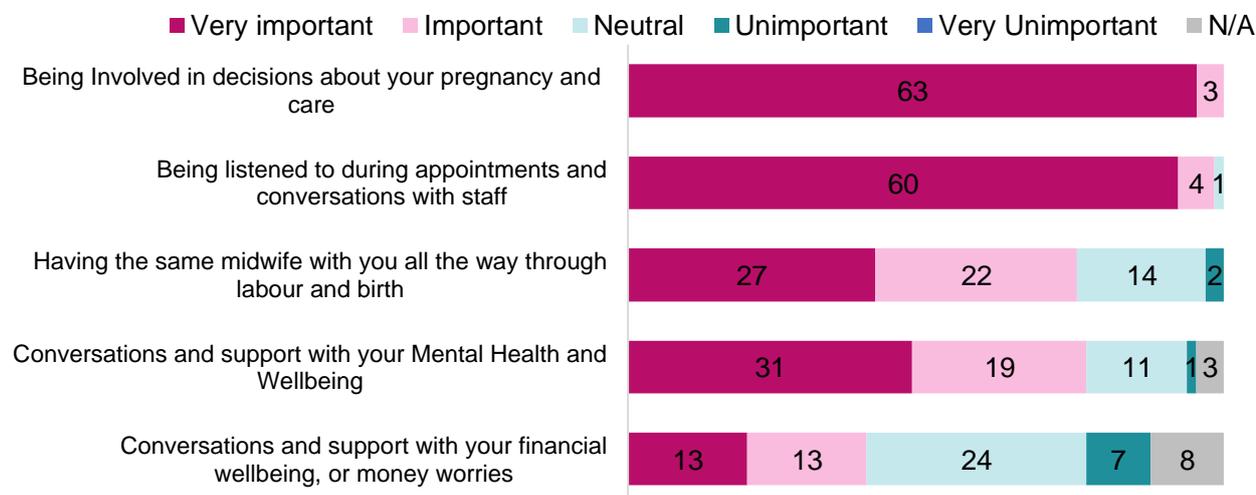
We asked how women would like to feedback about their care over time, and how they might like to get involved in services. Women could provide multiple answers to this and we saw the majority indicated the use of Digital Surveys, with staff conversations being the next most common method. Other methods suggested were focused on the use of comment cards and boxes in clinic spaces that could be filled out and returned to staff.

How could we make it easier for people to access digital maternity services?



When asked about their digital access to maternity services we saw a spread of interest across all suggested areas, with the provision of more information on Whatsapp or text services being the most popular option selected alongside increased information being available on Badgernet. Again other options shared focused on women sharing the importance of all of these options and a desire to see improved access across all the areas listed above.

How important do you feel the following support is to make sure you have a positive pregnancy?



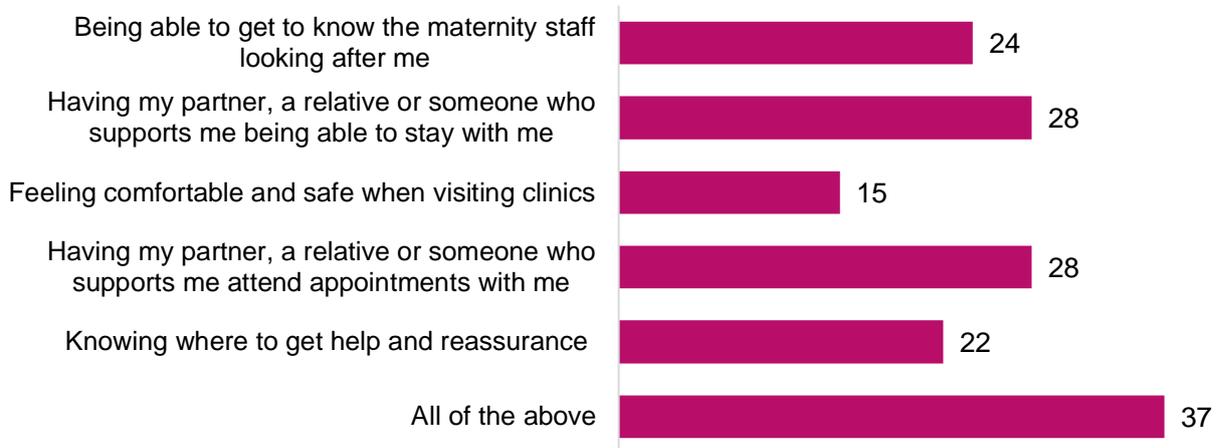
A key part of the clinic interview process was to better understand what was important to women during their maternity journey. We saw being involved in decision making and being listened to by staff during appointments as generally very important to women.

When asking about the importance of having the same midwife through labour and birth, 49 out of 65 respondents (75%) indicated they felt this was important.

When looking at the importance of conversations about mental health and wellbeing, 50 out of 65 respondents (77%) found this to be important to some degree.

In relation to conversations on financial issues or money worries 26 out of 65 respondents (40%) found this to be of importance with 24 out of 65 (37%) providing a neutral response to this.

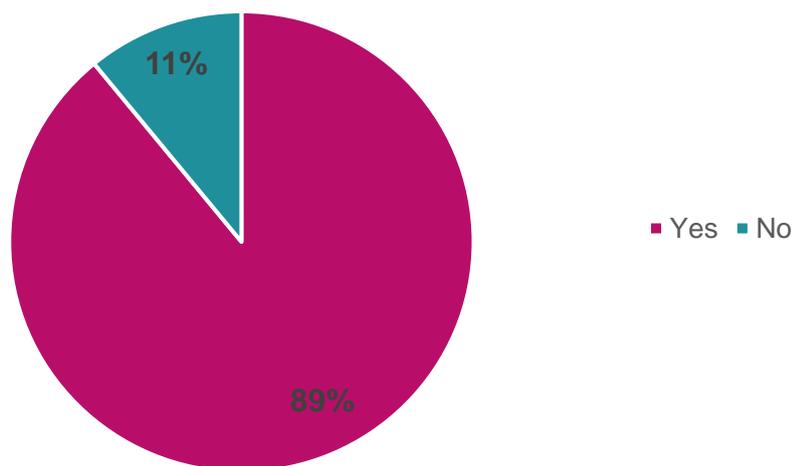
Thinking of the future, what do you feel would be important in ensuring a positive pregnancy experience?



To help understand what a positive pregnancy looks like we asked women to share which of the above statement they felt was most important to them. The majority sharing they felt all of the options were equally important. This was followed by having their partner able to be more involved in their maternity journey, attending appointments and staying with women following birth.

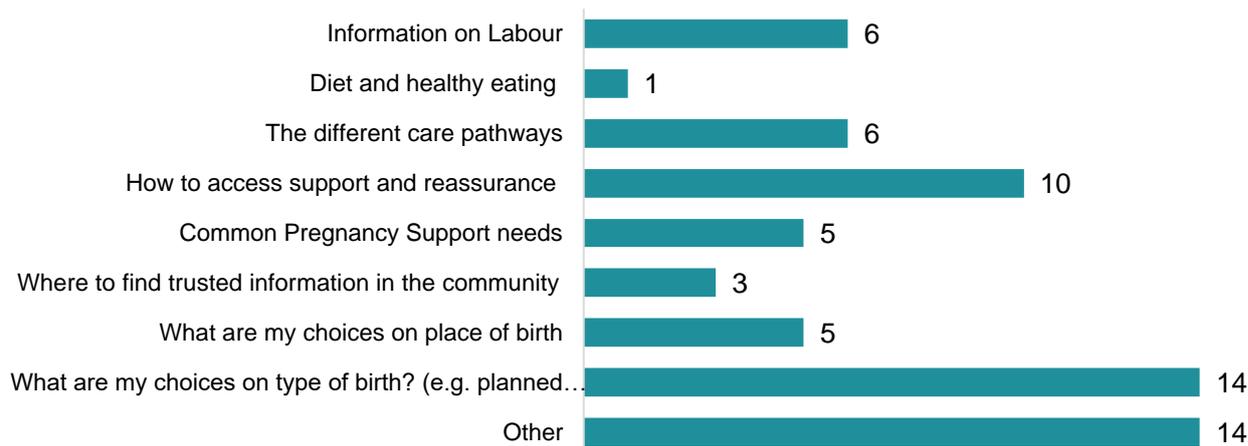
We also saw a desire to get to know the maternity staff looking after them, with women also keen to have more knowledge about where to get help and reassurance with pregnancy related issues and questions.

Are you aware you may be assisted by a doctor during birth in addition to a midwife if things are more complicated?



While the majority of women were aware that a doctor may assist their birth (89%) we did see 11% share a lack of awareness of this possibility.

What type of information is most important to you during your pregnancy?



We asked women to focus in on the singular piece of information they felt was most important to them. When answering this question we saw a number of women select the “other” option and share that they felt all of these information types were important to them and something they would like to see more of.

Choice of birth type and how to access support and reassurance were the next most common answers, with diet, and healthy eating support being the least shared answer, followed by where to find information in the community.

What does a positive birth environment look like to you?

We asked women about a positive birth environment, and received a number of responses, a selection of which have been extracted below. The majority focused on having a safe comfortable environment with people that they knew around them, be that staff, partners or relatives.

Example Comments:

- Hospital environment preferred, same staff throughout my pregnancy would also be preferred and having my partner with me all the way.
- Visiting times should be longer to allow relatives to stay and help with the baby, especially after having a c-section.
- Somewhere I can have my husband with me that’s private and comfortable
- A place where support and care is available when needed.
- My husband being there, along with familiar faces and a friendly environment.
- Open and warm staff throughout for reassurance and confidence empathetic care ready to provide any advice needed.
- Comfortable, and as calming as possible. Somewhere for my partner to rest while nearby.
- Being listened to when I need pain relief and not dismissing my pain during birth.
- Happy to be in hospital environment as long as partner can be involved.
- Calming space caring down to earth staff, with all the information I need shared and ready to hand
- Quiet and calm environment. Helpful and knowledgeable staff/care providers. Being informed on what is going on and what stage of labour I'm at, and how long it may take.
- Midwife led units where I can choose to dim lights and have easy access to a birth ball and pool.

What support would you like to see NHSGGC provide to help women and their partners adapt to parenthood in the first weeks after the birth?

When asking what support women would like to see for themselves and partners in the first weeks after birth we saw a desire for localised information and strong links with their community midwife. Mental health support and easier access to advice and reassurance lines via text or phone-call were also raised as important. We also saw suggestions for partner focused check-ins to make sure they have the information they need.

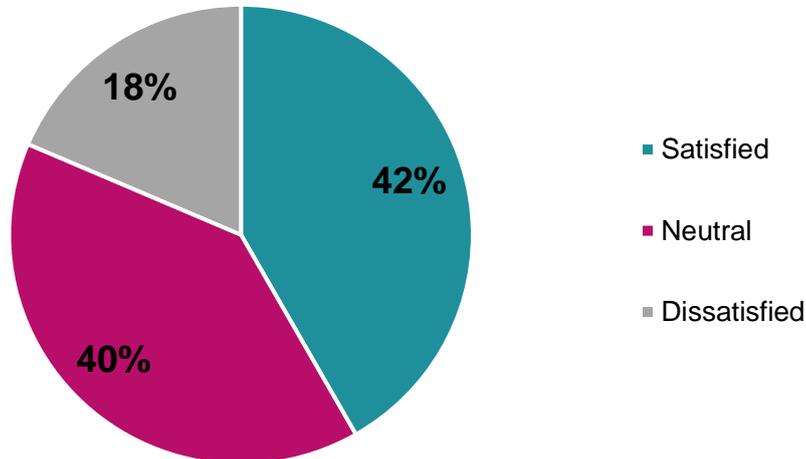
Example Comments:

- Feeling comfortable to link with midwife and health visiting if I need advice. Maybe a check in for partners, how they are coping, and siblings if not the first child.
- Health visiting and midwife follow up is important, also breastfeeding advice if needed.
- Guides, and support groups to help figure things out.
- Any advice and support at all is helpful, not making assumptions about peoples knowledge and covering the very basics can be important
- It would be helpful to offer some structured support visits around the early weeks after birth
- Being able to call for advice from the same team who know you and know your history
- More emphasis on healing/ symptoms after labour and birth for mum
- A 24 hour service where I could have questions answered. Either digitally or through phoning.
- realistic expectations on what to expect in the early days after getting home
- All home visits with an appointment instead of a 'time window'
- Advice in the hospital prior to being discharged, e.g. breastfeeding support or what to do when the baby is ill, how best to wash them and dress them etc
- Mental health support if complicated birth or when having an extended stay in hospital post birth

Badgernet Related Feedback

The following section provides a summary of questions asked about the Badgernet app, and women's experiences using the platform. All women answering both the digital survey and face to face clinic conversations were offered this question with the majority offering answers.

How satisfied were women with the Badgernet app and information contained within it?



When looking at satisfaction with the Badgernet app we can see a large number of women sharing their experiences through the social media and Badgernet survey share neutral satisfaction, pointing to opportunity to improve their experience and shift more experiences toward satisfaction.

Do you use the Badgernet app?

Of those spoken to during clinic visits, fifty-seven (86%) of the women answered this question, sharing that they had made use of Badgernet. The remainder sharing they did not make use of it. When asked how they would rate the app on a one to five scale the average response returned was a relatively neutral figure of 3.21.

How could we make it easier to use or access the Badgernet app?:

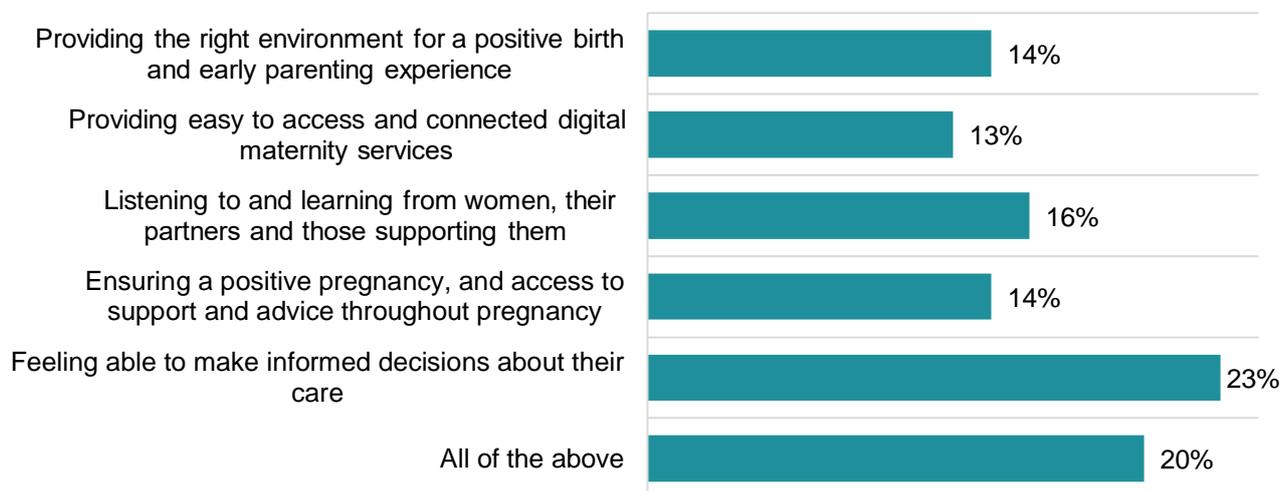
When asked how we could improve the Badgernet app 39 women shared the following insights and issues they would like to see addressed:

- We saw a number of women raise issues with the apps speed, particularly loading times when trying to navigate it or find information that led to a frustrating experience.
- We also heard from a number of women that they found it difficult to find the section they needed, and that they felt information was missing or hard to find when they navigated there. Examples:
 - “blood results aren’t published to view so therefore unable to view results”
 - “to check the results of an ultrasound you have to scroll through all the ultrasounds ever taken.”
- Women also shared issues with appointment information either not being available or disappearing from the app causing them to use it less and rely on other ways to track or follow up appointments.

How can we Improve Maternity Services across NHSGGC?

Alongside questions aimed at understanding current service provision we also asked women about areas where they would like to see NHSGGC make the most improvement in over the coming years. The following section outlines the answers provided first by those reached when attending a clinic, followed by those who completed the digital survey.

Clinic attendees were asked which of the following areas they would like to see NHSGGC make the most improvement in.



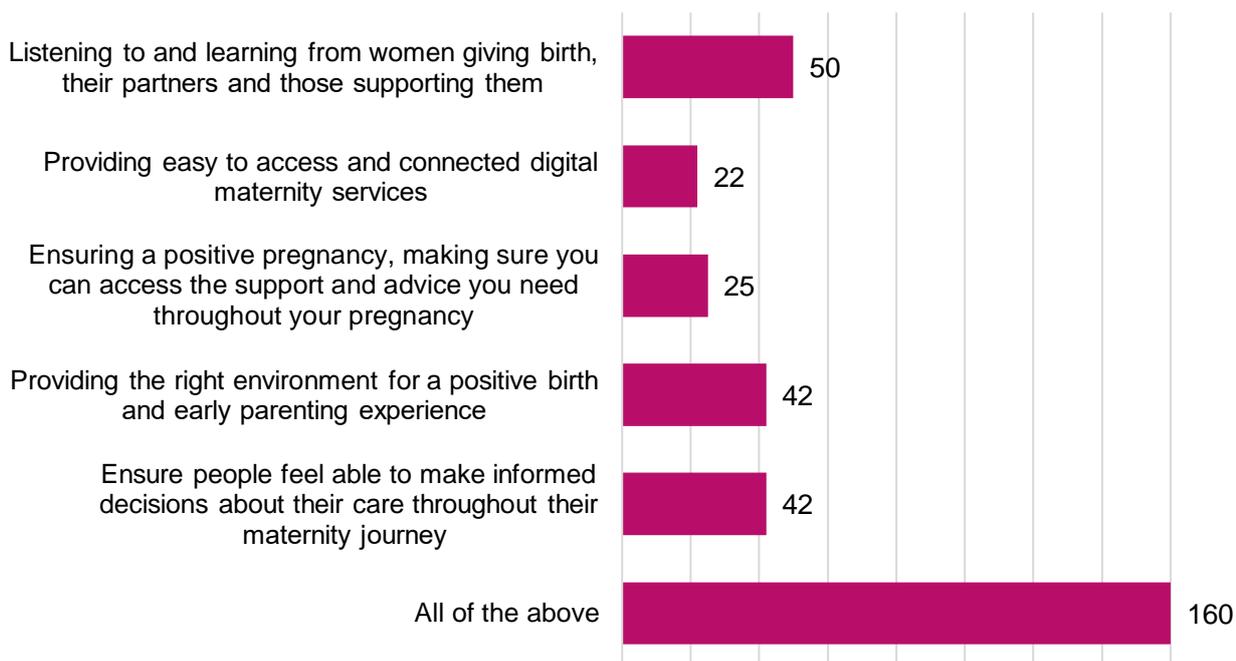
During conversation with women on this topic anecdotal feedback provided around this question was generally positive in relation to the maternity service. We saw a desire for improvement across each of the options presented to women, with feeling able to make informed decisions the most commonly selected option, followed by a desire to see improvement in all of these areas.

We also offered women the opportunity to tell us about anything they felt was missing from the above. Twenty three women shared thoughts on areas for further improvement that we could explore.

Other areas to improve on:

- How we care for first time parents, and offer extra reassurance and guidance where necessary alongside support for new mothers with a focus on what to expect through pregnancy and post birth.
- Waiting times at clinic appointments was raised by several people, with them sharing a desire for more transparency on expected wait and what to expect at an appointment.
- Better communication and information sharing on post birth issues, particularly breastfeeding challenges, how to find information, help and reassurance.
- Badgernet was specifically mentioned as an area for improvement, with the in app appointment information not always being correct when checked with a service.

Those answering the digital survey were asked which of the following areas would you like to see NHSGGC make the most improvement in?



Mirroring the question asked to women attending clinics with NHSGGC we asked women to share what they felt were the areas they would like to see NHSGGC make the most improvement in. The majority (**160**) felt all of these areas were important to see improvement in, followed by listening and learning from women giving birth, their partners and those supporting. It was also important that we provide a positive birth environment to women and to ensure that women feel able to make informed decisions about their maternity journey.

We also offered women the opportunity to tell us about anything they felt was missing from the above. Two hundred and one women shared thoughts on areas for further improvement that we could explore.

Other areas to improve on:

- A focus on the person, and treating each pregnancy as individual rather than grouping them and treating them the same. Tailor the care and information to what is needed by each women by listening to their questions and needs.
- Women shared a desire to see more staff on wards, and around clinic areas. This was linked at times to a desire to see more clarity on realistic wait times when attending clinics.
- Peer linkages with other mothers, a chance to speak to and reflect with others who have recently given birth to identify what could be changed and improved.
- Similar to the clinic based conversations we saw better communication and information sharing on post birth issues, particularly breastfeeding challenges, how to find information, help and reassurance raised by women.
- We saw a desire to move away from a more medical birth, and empower staff to talk about alternative, alongside mental health and other support topics to provide a more holistic maternity experience to women.
- Greater information sharing between community midwives and health visitors, especially if they are spread across a geographical area.

Emerging Themes for Consideration

Across each of the engagement approaches we heard from **447** women about their current and past experiences of maternity care. Across both approaches we saw general agreement that the following areas were ones for NHSGGC Maternity to focus on improving in the coming years;

- Listening to and learning from women giving birth, their partners and those supporting them
- Providing easy to access and connected digital maternity services
- Ensuring a positive pregnancy, making sure you can access the support and advice you need throughout your pregnancy
- Providing the right environment for a positive birth and early parenting experience
- Ensure people feel able to make informed decisions about their care throughout their maternity journey

Alongside these areas of improvement we saw additional themes emerging that while linked to those outlined above are still distinct. The main focus of these themes were around the use of technology, and how we could improve access to tests, appointments and other information through Badgernet .

We also saw women praise the human element and how they appreciated the time spent with them by maternity staff, the compassion they were shown and care given. From this we saw women share that they would like the opportunity to spend more time speaking with midwives about their pregnancy journey without feeling as time pressured.

Another important topic shared was the chance to learn from other women's experiences of maternity through their stories and from speaking with them. This was focused mainly on new mothers learning from past experiences, but we also heard from women interested in more peer learning/support models that could help them navigate being new parent.

ENDS