

<b>NHS Greater Glasgow and Clyde</b>	<b>Paper No. 25/18</b>
<b>Meeting:</b>	<b>NHSGGC Board Meeting</b>
<b>Meeting Date:</b>	<b>25 February 2025</b>
<b>Title:</b>	<b>Maternity and Neonatal Strategy</b>
<b>Sponsoring Director:</b>	<b>Angela Wallace, Board Nurse Director</b>
<b>Report Author:</b>	<b>Dr Mary Ross-Davie, Director of Midwifery Jamie Redfern Women and Children's Director Jane Richmond, Clinical Director Obstetrics Colin Peters, Clinical Director Neonatology</b>

## 1. Purpose

**The purpose of the attached paper is to:**

The Strategy was presented to the Board for approval on 17 December 2024. The presenting team were asked to make some minor amendments to the document, to undertake a meeting with a Non-Executive Board member to respond to a query and to undertake and present a formal EQIA (Equality impact assessment).

**The requested amendments have been made, the meeting has been undertaken and the EQIA is attached with the final amended strategy document.**

## 2. Executive Summary

**The paper can be summarised as follows:** Please find attached the revised Strategy document.

This includes several small changes that were requested by the Board at the meeting on 17 December:

- strengthened mention of perinatal mental health, the MNPI team and the mother and baby unit (p4 & p15)
- Strengthened mention of neonatal surgery (p18)
- Removal of the words 'cause to complain' in reference to global majority women's experience (p20).

## BOARD OFFICIAL

- As a clinical team we discussed the need for figures as requested by one of the Board non Exec directors - particularly in relation to maternal and neonatal mortality for Global majority women. We will ensure specific numerical target figures for any service improvement, where appropriate, realistic and evidence based, will be in the detailed implementation plan. The document as a whole does not set numerical targets for any service improvements and these will be included in the implementation plan.
- The final query was from a colleague from Inverclyde asking about consultation with women in that area. This is not referenced in the strategy document. The Director of Midwifery, Board Nurse Director and Director of Women and Children's met with the Non-Exec Director from Inverclyde. We talked through the consultation we had undertaken and continue to undertake with women from all parts of the Board, including Inverclyde. We also talked about maternity services in Inverclyde more generally. There were no further concerns about the strategy in relation to Inverclyde that were raised.

Also find attached the formal EQIA completed by the Women and Children's and Equalities team, as requested. Any individual service change will also have a detailed specific EQIA completed prior to commencement of a project, as has been done with the Best Start continuity and AMU projects.

### 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:**

- **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 clinical governance groups; Board Clinical and Care Governance Committee

**8. Date Prepared & Issued**

**Paper prepared on: 11.02.25**

**Paper issued on: 17.02.25**

# 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, the Perinatal and Infant Mental Health Framework and the Women's Health Plan over the coming five years.

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

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



## 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.



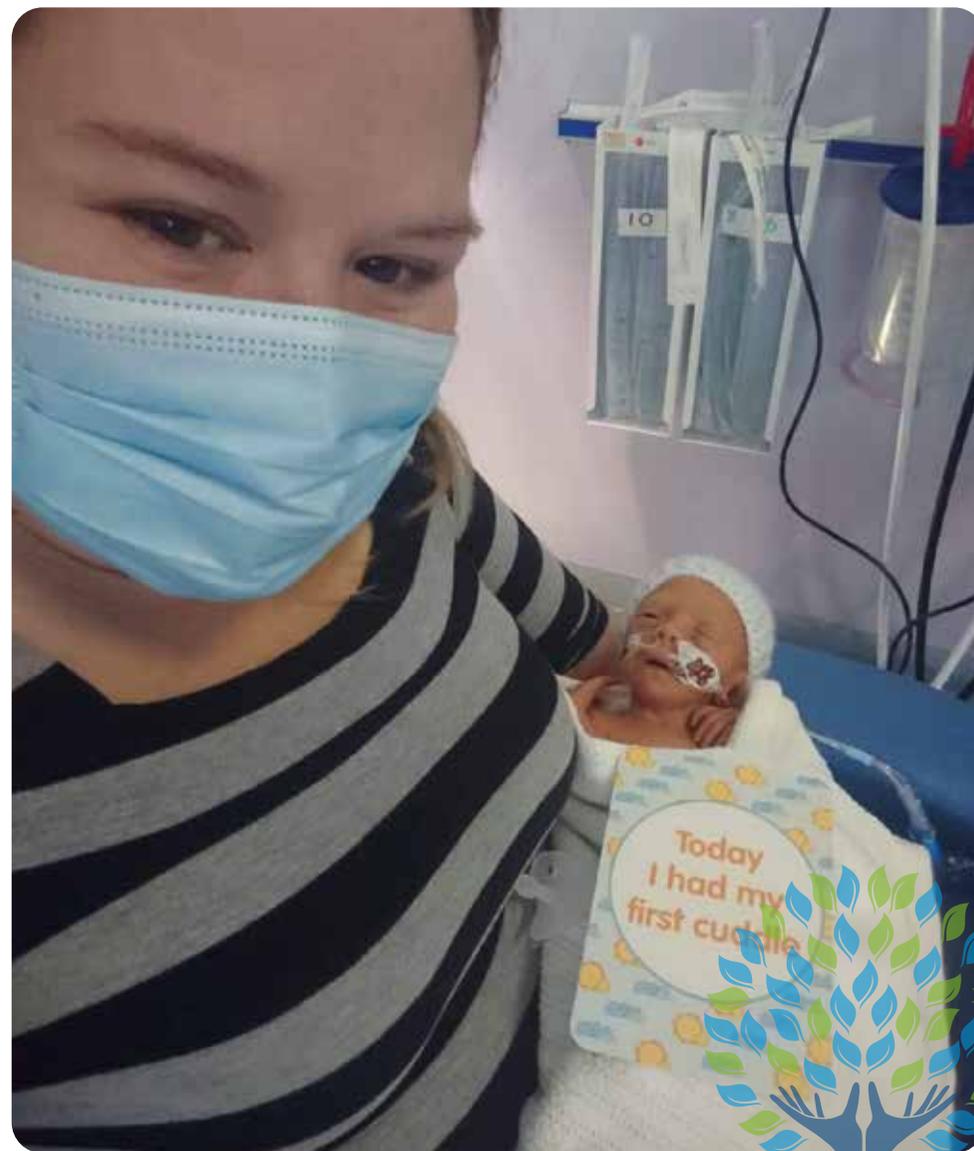
## Current Services

**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.

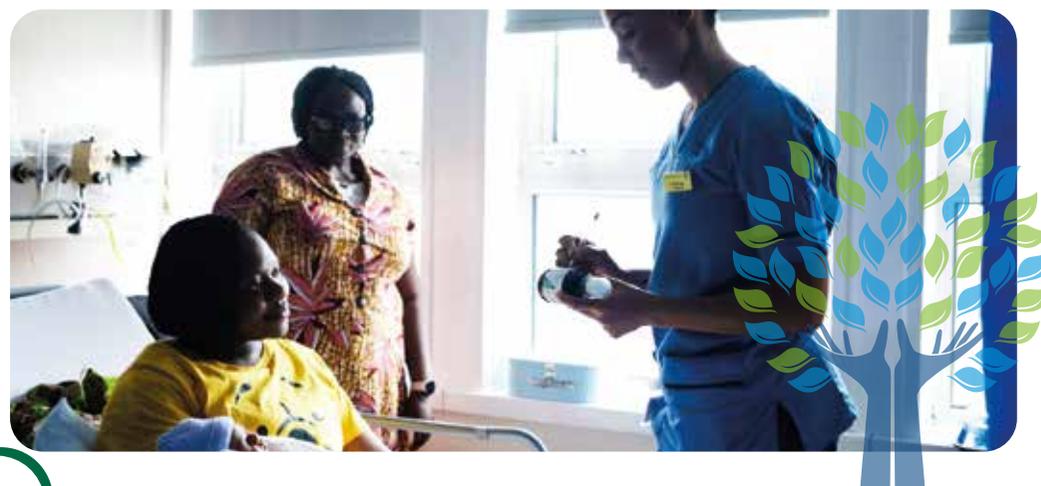
We have a neonatal liaison team who are helping to support earlier discharge to home reducing the days of stay in hospital for our babies.

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

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

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

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

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

We have an internationally recognised Fetal Medicine service.

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

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



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

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

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

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

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

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

### Further development of the fetal medicine services.

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

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

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

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

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



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

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

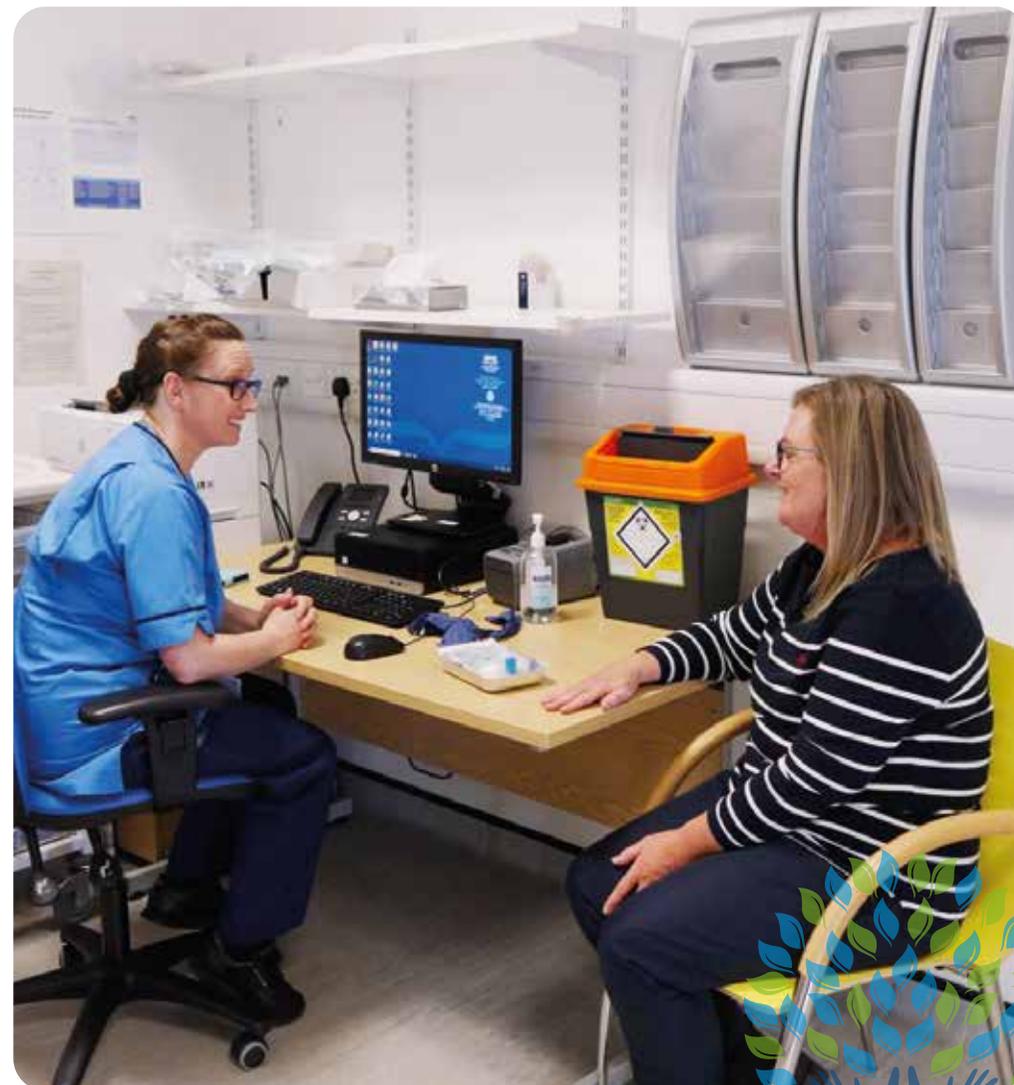
We will develop the provision of innovative community based maternity care, including greater access to virtual appointments when these are suitable.

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

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

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

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



## Strategic Intent 2: Safe, high quality care for all, including high quality specialist care when it is needed

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

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

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

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

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

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

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

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

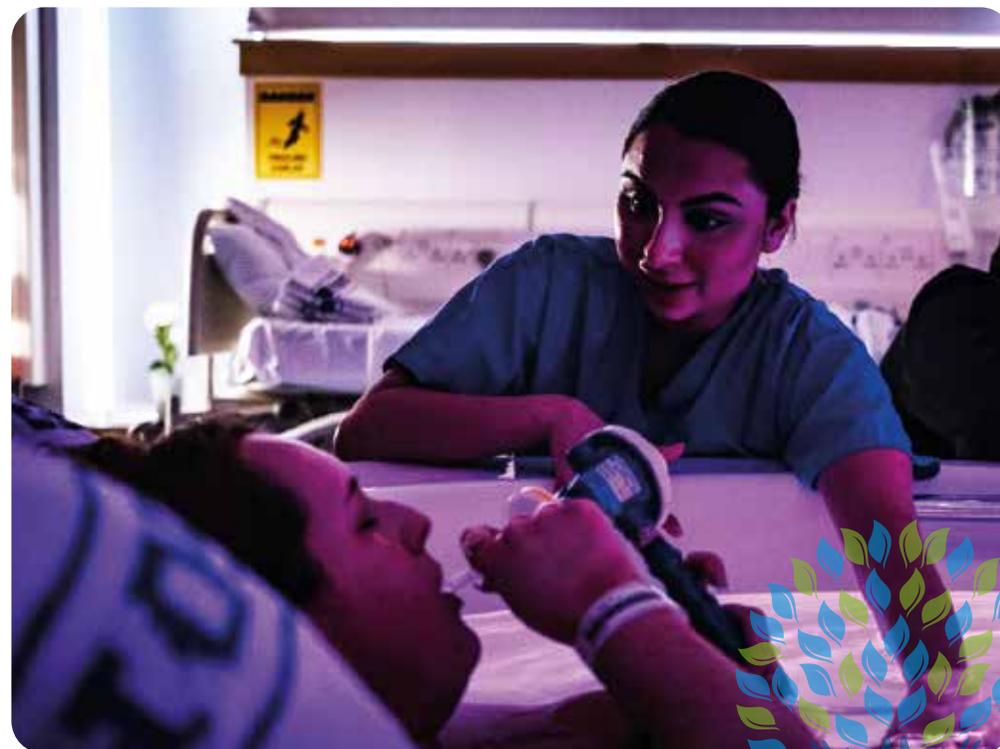
**All maternity and neonatal teams will be provided with opportunities to improve their care of families with protected characteristics or living in deprivation.**

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.



## 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.

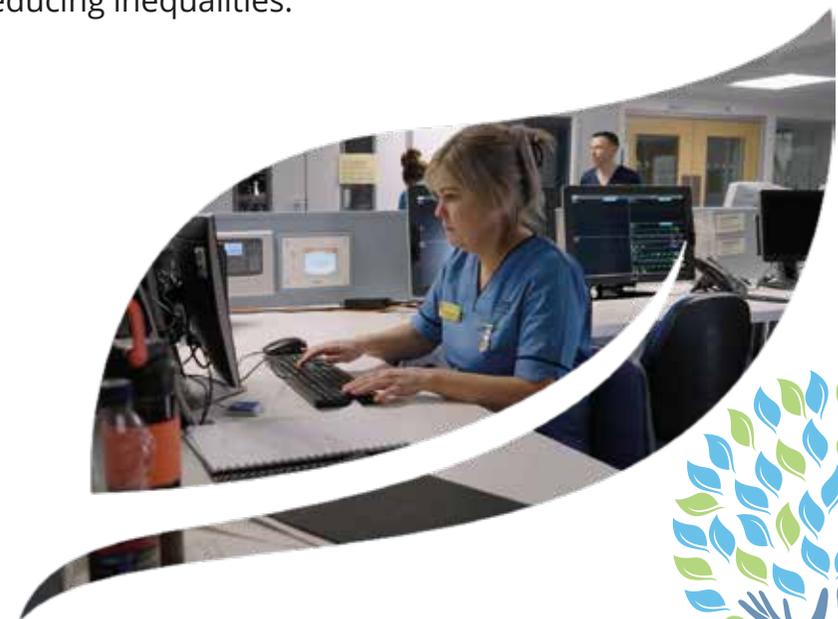
We will have developed more tailored antenatal education and information suitable for all of the women and people in our care.

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.

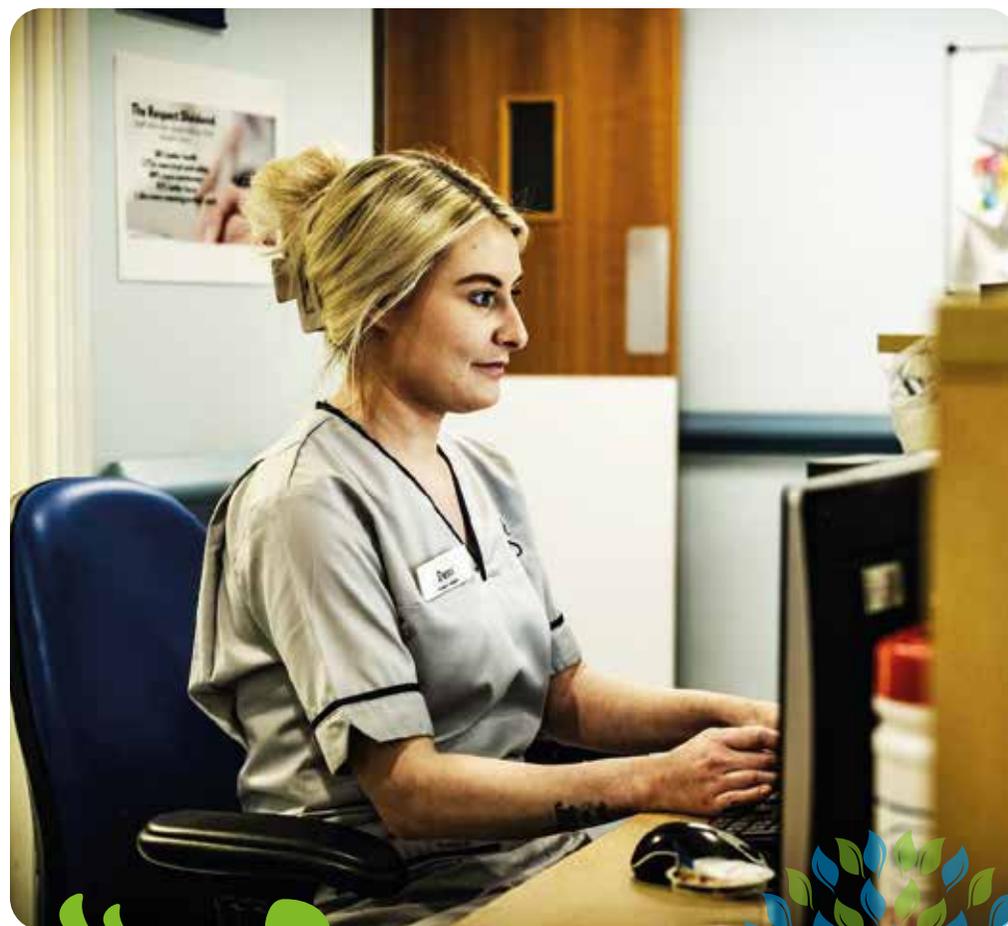
There are opportunities to further develop our use of technology to provide modern high quality services for women and families; there are some approaches to care that could be updated including clinic provision, communication methods with families and women.

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.



### 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).

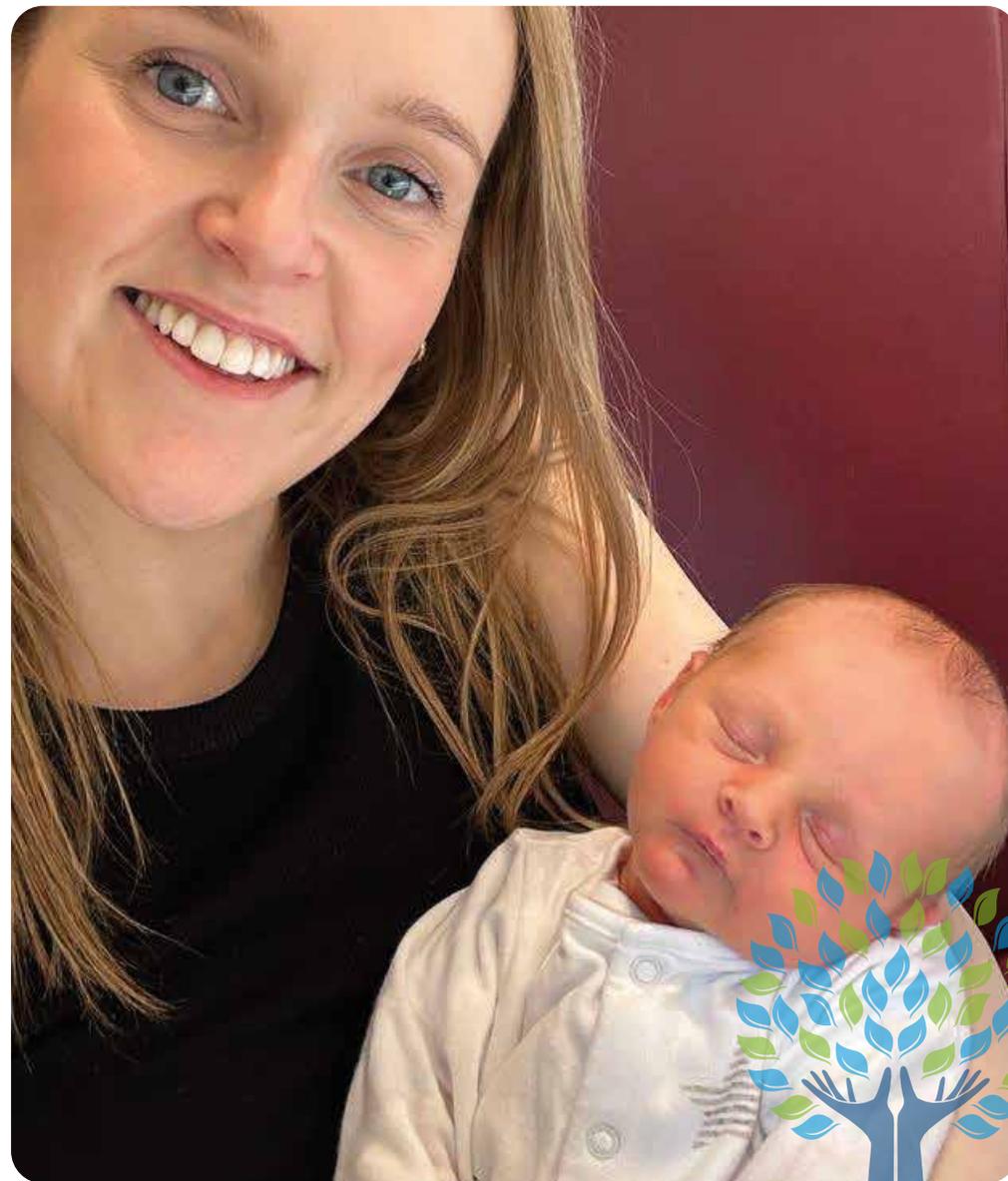
We have informal regular networking between service providers and third sector organisations, such as the National Childbirth Trust (NCT), HomeStart, British Red Cross and Amma Birth companions, and have recently established a new maternity third sector liaison network.

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.

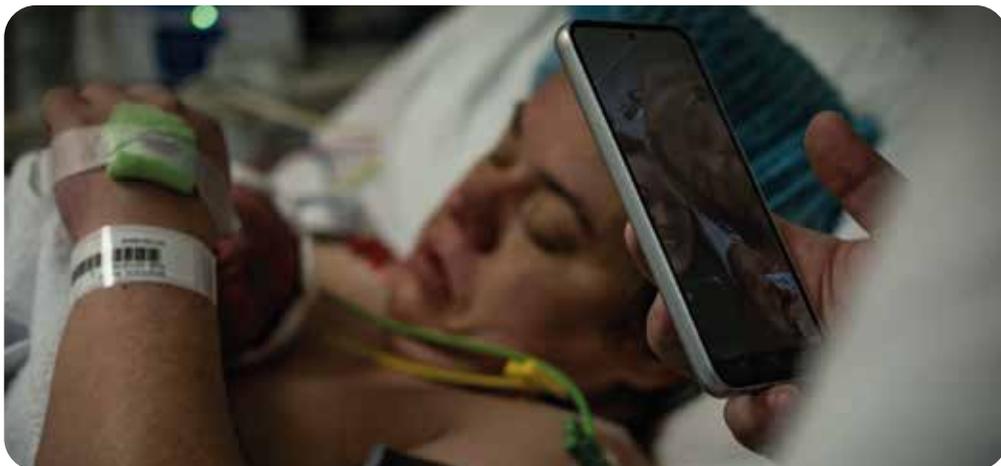
We will continue to review external reports into maternal deaths, stillbirths and complexities in newborns. We will continue to benchmark our services against report recommendations, disseminating learning and focusing on implementation of recommendations for improvement.

### 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.





## NHS Greater Glasgow and Clyde Equality Impact Assessment Tool

Equality Impact Assessment is a legal requirement as set out in the Equality Act 2010 (Specific Duties)(Scotland) regulations 2012 and may be used as evidence for cases referred for further investigation for compliance issues. Evidence returned should also align to Specific Outcomes as stated in your local Equality Outcomes Report. Please note that prior to starting an EQIA all Lead Reviewers are required to attend a Lead Reviewer training session or arrange to meet with a member of the Equality and Human Rights Team to discuss the process. Please contact Equality@ggc.scot.nhs.uk for further details or call 0141 2014560.

Name of Policy/Service Review/Service Development/Service Redesign/New Service:

The Maternity and Neonatal Five year strategy -

Is this a: Current Service x  Service Development x  Service Redesign x  New Service  New Policy x   
Policy Review

Description of the service & rationale for selection for EQIA: (Please state if this is part of a Board-wide service or is locally driven).

The purpose of the Maternity and Neonatal Strategy is to set out the vision and aims for the Board-wide maternity and neonatal services across NHSGGC over the next five years. This strategy builds on the work undertaken to implement the key recommendations of the Scottish Government's Best Start maternity and neonatal review report, which 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.

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The development of the strategy was started in 2021, but was necessarily suspended 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 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 re-designated as Local Neonatal Units (LNU) which will continue to provide intensive care for many patients.

### 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
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.

The strategy sets out, in each key area of intent, a summary of where the service is now and then where we want to be in the next five years. This includes a range of changes and outcomes. Some of these are aiming to further implement and embed key recommendations of the Best Start strategy, including further increases in continuity of carer in the antenatal and postnatal periods; implementation of the National bereavement care pathways and the new national NICU model. Some of these focus on further developing, along with colleagues from outside maternity and neonatal services, our specialist service provision, our public protection management and our clinical governance systems and processes. The strategy document also sets out a range of actions to tackle health inequalities in the maternity and neonatal

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journey, develop our teams and redesign services.

The services and activities directly impacted by this strategy are the maternity and neonatal services; the women, babies and families who are cared for by these services and the staff who work within them, across NHSGGC. However, any change in these services has an impact on and needs to be developed in conjunction with a range of other services, both within NHSGGC and beyond. These include primary care, third sector organisations, social work, specialist services, and colleagues working in other directorates in GGC including the public protection team, public health colleagues, the public engagement and public involvement team and the equalities team and neighbouring maternity and neonatal services. All new strategy documents require an EQIA to be undertaken prior to Board approval.

**Who is the lead reviewer and when did they attend Lead reviewer Training? (Please note the lead reviewer must be someone in a position to authorise any actions identified as a result of the EQIA)**

**Name:**

Dr Mary Ross-Davie, Director of Midwifery

**Date of Lead Reviewer Training:**

**Please list the staff involved in carrying out this EQIA**

**(Where non-NHS staff are involved e.g. third sector reps or patients, please record their organisation or reason for inclusion):**

Dr Mary Ross-Davie  
Dr Colin Peters  
Dr Jane Richmond  
Jamie Redfern  
Dr Noreen Shields

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	<i>Example</i>	<b>Service Evidence Provided</b>	<b>Possible negative impact and Additional Mitigating Action Required</b>
<p>1. <b>What equalities information is routinely collected from people currently using the service or affected by the policy? If this is a new service proposal what data do you have on proposed service user groups. Please note any barriers to collecting this data in your submitted evidence and an explanation for any protected characteristic data omitted.</b></p>	<p><b><i>Age, Sex, Race, Sexual Orientation, Disability, Gender Reassignment, Faith, Socio-economic status data collected on service users. Can be used to analyse DNAs, access issues etc. Maternity and Neonatal services routinely collect a range of equalities information for national reporting purposes and to monitor the demographics of our pregnant and newborn population.</i></b></p>	<p>Age, Sex, Race, Sexual Orientation, Disability, Faith are all collected from BadgerNet documentation. The Maternity booking appointment, using the System C Badgernet electronic patient record, records the following information about women/pregnant people at the start of their pregnancy journey:  <b>Sex/Gender</b> – although all people receiving pregnancy care will be biologically female, we recognise that some pregnant people do not define as female; We recognise that some pregnant people will define their gender as male or non-binary. We ask all people booking for pregnancy care for their preferred pronouns. We will provide personalised care, respecting the person’s preferences for language relating to their pregnancy and maternity journey.  <b>Sexual orientation</b> – we ask all of those booking for pregnancy care about their social and family network, including their partner. We discuss the route to becoming pregnant, in terms of fertility treatment and donor eggs or sperm. We also care for women who are acting</p>	<p>Reliance on fields being correctly populated on BadgerNet</p>

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			<p>as surrogates for others.</p> <p><b>Race and Ethnicity</b> – We ask all women and people booking for pregnancy care about their racial and ethnic background. This enables appropriate screening to be offered, for example for sickle cell anaemia and thalassaemia for at risk populations, and for targeted gestational diabetes screening for those at higher risk. We also ask about the need for interpreters and seek to provide appropriate interpreting and translation support to enable full understanding and informed decision making throughout the maternity journey.</p> <p><b>Disability</b> – we ask all women and people booking for pregnancy care about any physical or learning disabilities or difficulties, in order for us to identify their support and care needs. We also ask about mental health current or previous problems.</p>	
		<i>Example</i>	<b>Service Evidence Provided</b>	Possible negative impact and Additional Mitigating Action Required
2.	<b>Please provide details of how data captured has been/will be used to inform policy</b>	<i>Internal audits and national evidence have identified that Global majority women are more</i>	Colleagues from the Public Health team liaise with focus groups for African women, Chinese women, South Asian women, Gypsy Travellers and Roma community, as these groups have	During 2025 we wish to expand our engagement to LGBTQI+

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	<p><b>content or service design.</b></p> <p>Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).</p> <p>1) Remove discrimination, harassment and victimisation <input checked="" type="checkbox"/></p> <p>2) Promote equality opportunity <input checked="" type="checkbox"/></p> <p>3) Foster good relations between protected characteristics. <input checked="" type="checkbox"/></p> <p>4) Not applicable <input type="checkbox"/></p>	<p><i>likely to experience poorer outcomes from maternity care. Local feedback, including the Amma Birth companions Experience and outcomes report, identified that their client group and experienced discriminatory behaviours.</i></p>	<p>been found to book later than the HEAT target for antenatal booking.</p> <p>Quarterly meetings are in place with third party sector organisations, to hear feedback and areas for improvement in care.</p> <p>Equalities information on ethnicity and primary language is collected, in June 2023 this led to the development of a continuity of carer maternity survey which offered women the opportunity to read and respond in their own language. This piece of work is informing the creation of ongoing maternity engagement surveys, the complaints process and focus group work. This has led to the development of an ongoing maternity survey that will be translated into the top 5-10 languages used in our service. The service will monitor referrals to financial inclusion services, we will work to ensure all women who would benefit are able to access the service.</p> <p>We have an Action plan following the Amma Birth companions Experience and Outcomes report March 2024, to seek to improve the experience and outcomes of refugee and asylum seeking women, this has included seeking additional anti racist training for maternity staff; audit and improvements of interpreting services; training about use of</p>	<p>organisations and groups, as well as a range of disabilities support organisations.</p>
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			<p>interpreting services and increased monitoring of experience and outcomes for global majority women.</p> <p>In summer 2024 we established a new Third Sector organisations partnership network with maternity care providers, which provides an open forum for discussions, building of positive working relationships between agencies and with maternity services.</p>	
		<i>Example</i>	<b>Service Evidence Provided</b>	<b>Possible negative impact and Additional Mitigating Action Required</b>
3.	<p><b>How have you applied learning from research evidence about the experience of equality groups to the service or Policy?</b></p> <p><b>Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).</b></p>	<p><b><i>There has been recent Scottish national work about approaches for positive engagement with service users from a range of backgrounds – There is a wealth of evidence from the rest of the UK where Maternity Voices Partnerships are a well embedded part of maternity services. There is evidence from the MBRRACE UK wide</i></b></p>	<p>We have established a new MVP (Maternity Voices Partnership) which includes outreach to a range of groups representing lesser heard voices and global majority women. Our Third Sector network group, also established in summer 2024, is a group that will meet regularly, with membership of a range of organisations that support women from different backgrounds. Developing good working relationships with these organisations increases our reach to women served by these organisations, for example Amma Birth Companions, African Women’s network etc. We will seek views through a variety of means</p>	

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	<p>1) Remove discrimination, harassment and victimisation <input checked="" type="checkbox"/></p> <p>2) Promote equality of opportunity <input checked="" type="checkbox"/></p> <p>3) Foster good relations between protected characteristics <input checked="" type="checkbox"/></p> <p>4) Not applicable <input type="checkbox"/></p>	<p><i>research reports into perinatal and maternal mortality that highlight the increased risk of poor outcomes from global majority women, women who don't have English as a first language, women with chronic conditions including mental illnesses and women living with deprivation.</i></p>	<p>including surveys and focus groups for any significant service change. We routinely translate our surveys with recent maternity service users into the top ten community languages to increase engagement from women for whom English is an additional language.</p> <p>Where people experience prejudice as a result of their protected characteristic, the provision of continuity of carer can be very beneficial. People who are accessing maternity care will be more likely to attend, share openly about any problems and concerns etc, if they are able to build a trusting relationship with a limited number of professionals. This means that they do not have to repeat their story and explain their life to a large number of professionals.</p>	
	<p><i>Example</i></p>	<p><b>Service Evidence Provided</b></p>	<p><b>Possible negative impact and Additional Mitigating Action Required</b></p>	
<p>4.</p>	<p><b>Can you give details of how you have engaged with equality groups</b></p>	<p>In 2023, accessible patient surveys were conducted to inform the antenatal and</p>	<p>Our local patient engagement work in 2022, 2023 and 2024 (via surveys and patient focus groups with those in poverty, disability and</p>	

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<p><b>with regard to the service review or policy development? What did this engagement tell you about user experience and how was this information used? The Patient Experience and Public Involvement team (PEPI) support NMSGC to listen and understand what matters to people and can offer support.</b></p> <p><b>Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).</b></p> <p><b>1) Remove discrimination, harassment and victimisation <input checked="" type="checkbox"/></b></p> <p><b>2) Promote equality of opportunity <input checked="" type="checkbox"/></b></p>	<p>postnatal care redesign, birth planning, parent education and intrapartum care pathways. This led to the development of further engagement work in July 2024. Feedback was received from 1166 women focusing on the post birth population, and capturing their experiences of birth planning, appointments and travel to and from said appointments. Surveys are created using easy read language, we will continue to work with the PEPI (Patient Engagement and Public Involvement) team to reduce and remove barriers to engagement.</p>	<p>from BAME communities) is informing an ongoing system of patient feedback which is accessible to all, with, for example, surveys in community languages.</p>	
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	<p>3) Foster good relations between protected characteristics <input checked="" type="checkbox"/></p> <p>4) Not applicable <input type="checkbox"/></p>			
	<p><i>Example</i></p>	<p><b>Service Evidence Provided</b></p>	<p><b>Possible negative impact and Additional Mitigating Action Required</b></p>	
<p>5.</p>	<p><b>Is your service physically accessible to everyone? If this is a policy that impacts on movement of service users through areas are there potential barriers that need to be addressed?</b></p> <p><b>Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).</b></p> <p><b>1) Remove</b></p>	<p><i>An access audit of an outpatient physiotherapy department found that users were required to negotiate 2 sets of heavy manual pull doors to access the service. A request was placed to have the doors retained by magnets that could deactivate in the event of a fire. (Due regard to remove discrimination, harassment and victimisation).</i></p> <p><i>An outpatient clinic has</i></p>	<p>15% of NHSGGC's inpatient population have a physical disability. Health centres and hospitals where community midwifery care is conducted are wheelchair accessible, lifts are available where services are not on ground level. From engagement work, 85% of women were able to give birth in their preferred location, while 6 % had to change their plans due to medical reasons. This evaluation has provided valuable insights into the factors influencing birth planning and with findings helping to shape how NHSGGC works to improve the support provided to women in making informed choices about their place of birth. The Inverclyde Royal Hospital is 16 miles, a 30-40 minute drive from the RAH. The Vale of Leven is 18 miles, 30-40 minute drive from the RAH. This proposed change reduces the availability of unit based</p>	



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	<p><b>discrimination, harassment and victimisation</b></p> <p><b>2) Promote equality of opportunity</b> <input type="checkbox"/></p> <p><b>3) Foster good relations between protected characteristics</b> <input type="checkbox"/></p> <p><b>4) Not applicable</b> <input type="checkbox"/></p>	<p><i>installed loop systems and trained staff on their use. In addition, a review of signage has been undertaken with clearer directional information now provided.</i></p>	<p>labour and birth care in IRH and VOL. This is an option that is chosen by an average of 20 women each year in each unit – a very small proportion of the local pregnant population &lt;2%. Currently the majority of women from these areas choose to birth at RAH.</p>	
	<p><b>Example</b></p>	<p><b>Service Evidence Provided</b></p>	<p><b>Possible negative impact and Additional Mitigating Action Required</b></p>	
<p><b>6.</b></p>	<p><b>How will the service change or policy development ensure it does not discriminate in the way it communicates with service users and staff?</b></p>	<p><b><i>Following a service review, an information video to explain new procedures was hosted on the organisation's YouTube site. This was accompanied by a BSL signer to explain service changes to Deaf service</i></b></p>	<p>All midwives have access to face to face and telephone interpreters with staff being directed to the NHSGGC Interpreting Policy. Key information (i.e. NHSGGC Rights to Maternity Care – Step by Explore effectiveness of new accessible information approach by engagement with women.</p> <p>Briefed all staff on NHSGGC's Interpreting</p>	

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<p>Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).</p> <p>1) Remove discrimination, harassment and victimisation <input checked="" type="checkbox"/></p> <p>2) Promote equality of opportunity <input checked="" type="checkbox"/></p> <p>3) Foster good relations between protected characteristics <input checked="" type="checkbox"/></p> <p>4) Not applicable <input type="checkbox"/></p> <p>The British Sign Language (Scotland) Act 2017 aims to raise awareness of British Sign Language and improve access to services for those using the language. Specific attention</p>	<p><i>users.</i></p> <p><i>Written materials were offered in other languages and formats.</i></p> <p><i>(Due regard to remove discrimination, harassment and victimisation and promote equality of opportunity).</i></p>	<p>Protocol. Step Guide) will be available in all 40 community languages, easy read and British Sign Language. There is a standard message on the BadgerNet app in English and community languages regarding requesting written information in accessible formats and a review of accessibility of information is taking place. Part of the service redesign is to continue to provide local community based antenatal care with a focus on personalised care which has seen the introduction of longer antenatal appointment times. This implementation will maintain local access to schedule universal antenatal care by facilitating continuity of carer which reduces barriers to communication as women build a trusting relationship with their midwife.</p>	
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	should be paid in your evidence to show how the service review or policy has taken note of this.			
7	<b>Protected Characteristic</b>	<b>Service Evidence Provided</b>	<b>Possible negative impact and Additional Mitigating Action Required</b>	
(a )	<p><b>Age</b></p> <p><b>Could the service design or policy content have a disproportionate impact on people due to differences in age? (Consider any age cut-offs that exist in the service design or policy content. You will need to objectively justify in the evidence section any segregation on the grounds of age promoted by the policy or included in the service design).</b></p> <p><b>If this decision is likely to impact on children and young people (below the age of 18) you will need to evidence how you have considered the General Principles of the United Nations Convention on the Rights of the Child. Please include this in Section 10 of the form.</b></p>	<p>Demographic information collected from BadgerNet documentation.</p> <p>We provide tailored additional support services to young pregnant women under the age of 20 years, through the Family Nurse partnership programme. This programme provides long term continuity of carer through the Family nurse, who stays supporting the family until the baby is two years old.</p> <p>We also identify those women, over the age of 40 years, who are at higher risk of adverse outcomes in pregnancy and so they received additional assessments and screening, with obstetric medical oversight.</p>	<p>Reliance on fields being correctly populated on BadgerNet.</p>	

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	<p>Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).</p> <p>1) Remove discrimination, harassment and victimisation <input checked="" type="checkbox"/></p> <p>2) Promote equality of opportunity <input checked="" type="checkbox"/></p> <p>3) Foster good relations between protected characteristics. <input checked="" type="checkbox"/></p> <p>4) Not applicable <input type="checkbox"/></p>		
(b )	<p><b>Disability</b></p> <p>Could the service design or policy content have a disproportionate impact on people due to the protected characteristic of disability?</p> <p>Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).</p> <p>1) Remove discrimination, harassment and victimisation <input checked="" type="checkbox"/></p> <p>2) Promote equality of opportunity <input checked="" type="checkbox"/></p> <p>3) Foster good relations between protected <input checked="" type="checkbox"/></p>	<p>In NHSGGC, for inpatients 15% have a physical disability, 16% Deaf/Hearing impaired, 6% blind visually impaired and 1% have a learning disability. Disability is captured in the Communication and mobility tab within demographics on BadgerNet. Interpreting Services - NHSGGC Information on booking BSL interpreter. All sites are physically accessible.</p>	

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	<p>characteristics.</p> <p>4) Not applicable <input type="checkbox"/></p>		
	<p><b>Protected Characteristic</b></p>	<p><b>Service Evidence Provided</b></p>	<p><b>Possible negative impact and Additional Mitigating Action Required</b></p>
<p>(c )</p>	<p><b>Gender Reassignment</b></p> <p><b>Could the service change or policy have a disproportionate impact on people with the protected characteristic of Gender Reassignment?</b></p> <p><b>Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).</b></p> <p>1) Remove discrimination, harassment and victimisation <input checked="" type="checkbox"/></p> <p>2) Promote equality of opportunity <input checked="" type="checkbox"/></p> <p>3) Foster good relations between protected characteristics <input checked="" type="checkbox"/></p> <p>4) Not applicable <input type="checkbox"/></p>	<p>6% of NHSGGC’s inpatient population are LGBTQI+. Maternity staff use guidance from the Scottish Trans Alliance website on the use of pronouns as best practice in working with Trans men who access maternity care. This is further supported by use of NHGGC Gender Reassignment Policy and the EHRC’s Single/Separate Sex Service Guidance.</p>	

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	<b>Protected Characteristic</b>	<b>Service Evidence Provided</b>	<b>Possible negative impact and Additional Mitigating Action Required</b>
(d)	<p><b>Marriage and Civil Partnership</b></p> <p><b>Could the service change or policy have a disproportionate impact on the people with the protected characteristics of Marriage and Civil Partnership?</b></p> <p><b>Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).</b></p> <p><b>1) Remove discrimination, harassment and victimisation</b> <input type="checkbox"/></p> <p><b>2) Promote equality of opportunity</b> <input type="checkbox"/></p> <p><b>3) Foster good relations between protected characteristics</b> <input type="checkbox"/></p>	<p>We ask all women about their partner, sexual orientation, fertility journey and family support during their pregnancy.</p> <p>Our teams have significant experience of caring for a range of different families and seeks to provide personalised care.</p> <p>All maternity staff have mandatory training on equality and diversity.</p> <p>The maternity service team has committed, through a co-produced behaviours charter, not to tolerate any forms of prejudice and discrimination including racism, sexism and homophobia.</p>	

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	<p>4) Not applicable <input checked="" type="checkbox"/></p>		
(e)	<p><b>Pregnancy and Maternity</b></p> <p><b>Could the service change or policy have a disproportionate impact on the people with the protected characteristics of Pregnancy and Maternity?</b></p> <p><b>Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).</b></p> <p>1) Remove discrimination, harassment and victimisation <input checked="" type="checkbox"/></p> <p>2) Promote equality of opportunity <input checked="" type="checkbox"/></p> <p>3) Foster good relations between protected characteristics. <input checked="" type="checkbox"/></p> <p>4) Not applicable <input type="checkbox"/></p>	<p>This is our core business. Our commitment to identify and remove any barriers to receiving optimum care on the grounds of pregnancy and maternity runs through all mainstream aspects of care. Our work understands and responds to the intersectional relationship between different characteristics and discrimination. We know pregnancy and maternity experiences may differ significantly across different groups and use research and engagement to ensure we are constantly reviewing and adapting practice.</p>	
	<p><b>Protected Characteristic</b></p>	<p><b>Service Evidence Provided</b></p>	<p><b>Possible negative</b></p>

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			<b>impact and Additional Mitigating Action Required</b>
<b>(f)</b>	<p><b>Race</b></p> <p><b>Could the service change or policy have a disproportionate impact on people with the protected characteristics of Race?</b></p> <p><b>Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).</b></p> <p><b>1) Remove discrimination, harassment and victimisation</b> <input checked="" type="checkbox"/></p> <p><b>2) Promote equality of opportunity</b> <input checked="" type="checkbox"/></p> <p><b>3) Foster good relations between protected characteristics</b> <input checked="" type="checkbox"/></p> <p><b>4) Not applicable</b> <input type="checkbox"/></p>	<p>10% of NHSSGC women using maternity services are from the BAME community (of this cohort 55% non-English speakers, 65% do not read or write English), whereas in NHSGGC 5% of the population are from the BAME community. In terms of access, maternity staff can request information leaflets to be translated into other languages on request. There are links on the NHSGGC maternity website to the interpreting service for women to access. Interpreting Services - NHSGGC information for midwives to book an interpreter, each site has their own access code. Demographic information collected from BadgerNet documentation. The Maternity BAME group, with joint membership from the Equalities, public health, PEPI and maternity teams, is working on a range of areas of service improvement to improve the care, experience and outcomes of global majority women.</p>	
<b>(g)</b>	<p><b>Religion and Belief</b></p> <p><b>Could the service change or policy have a disproportionate impact on the people with the protected characteristic of Religion and Belief?</b></p>	<p>77% of NHSGGC's inpatient population have a religious belief. Religion is captured within BadgerNet demographics. Maternity Staff have access to NHSGGC's Spiritual Care Manual. We provide memory making boxes specifically</p>	

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	<p><b>Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).</b></p> <p>1) Remove discrimination, harassment and victimisation <input checked="" type="checkbox"/></p> <p>2) Promote equality of opportunity <input checked="" type="checkbox"/></p> <p>3) Foster good relations between protected characteristics. <input checked="" type="checkbox"/></p> <p>4) Not applicable <input type="checkbox"/></p>	<p>designed by and for Muslim women when experiencing a pregnancy or baby loss, that are culturally appropriate.</p>	
	<p><b>Protected Characteristic</b></p>	<p><b>Service Evidence Provided</b></p>	<p><b>Possible negative impact and Additional Mitigating Action Required</b></p>
<p>(h )</p>	<p><b>Sex</b></p> <p><b>Could the service change or policy have a disproportionate impact on the people with the protected characteristic of Sex?</b></p> <p><b>Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).</b></p>	<p>The strategy places women at the centre of care planning and delivery. Adopting a person-centred approach informed by an understanding of societal discrimination on the grounds of sex creates a pregnancy pathway that should empower women to make the right choices at the right time. Our commitment to challenging gender based violence remains a constant and all staff are</p>	

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	<p><b>1) Remove discrimination, harassment and victimisation</b></p> <p><b>2) Promote equality of opportunity</b></p> <p><b>3) Foster good relations between protected characteristics.</b></p> <p><b>4) Not applicable</b></p>	<p><input checked="" type="checkbox"/> ined to sensitively enquire and respond appropriately to disclosures of GBV. This extends to ensuring all women have protected</p> <p><input checked="" type="checkbox"/> vate time where any concerns can be raised.</p> <p><input checked="" type="checkbox"/></p> <p><input type="checkbox"/></p>	
(i)	<p><b>Sexual Orientation</b></p> <p><b>Could the service change or policy have a disproportionate impact on the people with the protected characteristic of Sexual Orientation?</b></p> <p><b>Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).</b></p> <p><b>1) Remove discrimination, harassment and victimisation</b></p> <p><b>2) Promote equality of opportunity</b></p> <p><b>3) Foster good relations between protected characteristics.</b></p> <p><b>4) Not applicable</b></p>	<p>Experiences in NHSGGC Maternity services reflect the broader organisational commitment to challenge heteronormative assumptions in care provision.</p> <p>Maternity colleagues deliver inclusive and sensitive care to lesbian women, a commitment that is visible through adoption of the NHS Scotland Pride Pledge programme.</p> <p><input checked="" type="checkbox"/></p> <p><input checked="" type="checkbox"/></p> <p><input checked="" type="checkbox"/></p> <p><input type="checkbox"/></p>	

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	<b>Protected Characteristic</b>	<b>Service Evidence Provided</b>	<b>Possible negative impact and Additional Mitigating Action Required</b>
(j)	<p><b>Socio – Economic Status &amp; Social Class</b></p> <p><b>Could the proposed service change or policy have a disproportionate impact on people because of their social class or experience of poverty and what mitigating action have you taken/planned?</b></p> <p><b>In addition to the above, if this constitutes a ‘strategic decision’ you should evidence due regard to meeting the requirements of the Fairer Scotland Duty (2018). Public bodies in Scotland must actively consider how they can reduce inequalities of outcome caused by socioeconomic disadvantage when making <u>strategic</u> decisions and complete a separate assessment. Additional information available here: <a href="http://www.gov.scot/publications/fairer-scotland-duty-guidance-for-public-bodies/pages/introduction.aspx">Fairer Scotland Duty: guidance for public bodies - gov.scot (www.gov.scot)</a></b></p>	<p>The strategy will be adopted against a challenging financial context for many women. The intersectional impact of poverty and maternity is stark and is further compounded when considered against other protected characteristics like Race and Disability.</p> <p>NHSGGC engage with the Healthier, Wealthier children programme and midwives are able to refer women and families for financial inclusion advice and support.</p>	
(k)	<p><b>Other marginalised groups</b></p> <p><b>How have you considered the specific impact on other groups including homeless people, prisoners and ex-offenders, ex-service personnel, people with addictions, people involved in</b></p>	<p>In NHSGGC the Blossom team (previously known as the SNIPS team), is a dedicated team of specialist midwives who provide care for vulnerable women and their families across the healthboard. This team has a focus on midwifery and consultant continuity of carer</p>	

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	<p><b>prostitution, asylum seekers &amp; refugees and travellers?</b></p>	<p>also. We work in line with the principles of GIRFEC and work in collaboration with colleagues in primary and social care, public protection and health visiting colleagues. All community midwives are offered level 3 child protection training. Midwives working the Blossom team receive supervision from the public protection team and are supported to undertake more advance public protection education through a university module.</p>	
<p><b>8.</b></p>	<p><b>Does the service change or policy development include an element of cost savings? How have you managed this in a way that will not disproportionately impact on protected characteristic groups?</b></p> <p><b>Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).</b></p> <p><b>1) Remove discrimination, harassment and victimisation</b></p> <p><b>2) Promote equality of opportunity</b></p> <p><b>3) Foster good relations between protected characteristics.</b></p> <p><b>4) Not applicable</b></p>	<p>We have committed in this strategy to consider how services can be changed to be as efficient as possible, harnessing new technologies and new approaches to care that may lead to cost savings. On occasion, a service development will require an increase in investment and resources.</p> <p>Any significant service change, for example our recent projects developing continuity of carer and the Alongside midwife units are proceeded by an EQIA and this would be the case for any future development.</p> <p>We would use our new forums for consultation, including the Third Sector network, MVP and online engagement in a range of languages prior to any major service change to gather views and understand impact on those affected.</p>	

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		Service Evidence Provided	Possible negative impact and Additional Mitigating Action Required
9.	<p><b>What investment in learning has been made to prevent discrimination, promote equality of opportunity and foster good relations between protected characteristic groups? As a minimum include recorded completion rates of statutory and mandatory learning programmes (or local equivalent) covering equality, diversity and human rights.</b></p>	<p>We are in line to receive additional Endowment funding to support anti-racist training for all maternity staff during 2025. All maternity staff have mandatory online training on Equality and Diversity.</p>	

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**10. In addition to understanding and responding to legal responsibilities set out in Equality Act (2010), services must pay due regard to ensure a person's human rights are protected in all aspects of health and social care provision. This may be more obvious in some areas than others. For instance, mental health inpatient care or older people's residential care may be considered higher risk in terms of potential human rights breach due to potential removal of liberty, seclusion or application of restraint. However risk may also involve fundamental gaps like not providing access to communication support, not involving patients/service users in decisions relating to their care, making decisions that infringe the rights of carers to participate in society or not respecting someone's right to dignity or privacy.**

**The Human Rights Act sets out rights in a series of articles – right to Life, right to freedom from torture and inhumane and degrading treatment, freedom from slavery and forced labour, right to liberty and security, right to a fair trial, no punishment without law, right to respect for private and family life, right to freedom of thought, belief and religion, right to freedom of expression, right to freedom of assembly and association, right to marry, right to protection from discrimination.**

**Please explain in the field below if any risks in relation to the service design or policy were identified which could impact on the human rights of patients, service users or staff.**

None identified

**Please explain in the field below any human rights based approaches undertaken to better understand rights and responsibilities resulting from the service or policy development and what measures have been taken as a result e.g. applying the PANEL Principles to maximise Participation, Accountability, Non-discrimination and Equality, Empowerment and Legality or FAIR\* .**

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We are instigating an MDT approach to engagement with a range of stakeholders to ensure full consideration of all service users' needs during any change process.

\*

- **Facts:** What is the experience of the individuals involved and what are the important facts to understand?
- **Analyse rights:** Develop an analysis of the human rights at stake
- **Identify responsibilities:** Identify what needs to be done and who is responsible for doing it
- **Review actions:** Make recommendations for action and later recall and evaluate what has happened as a result.

### **United Nations Convention on the Rights of the Child**

**The United Nations Convention on the Rights of the Child (Incorporation) (Scotland) Act 2024 came into force on the 16<sup>th</sup> July 2024. All public bodies may choose to evidence consideration of the possible impact of decisions on the rights of children (up to the age of 18). Evidence should be included below in relation to the General Principles of the Act. The full list of articles to be considered is available [here](#) for information.**

**No Discrimination: Where the decision may have an impact, explain how the EQIA has considered discrimination on the grounds of protected characteristics for children. You may have considered children in each of the EQIA sections and returned relevant evidence.**

As a service we are carefully monitoring the outcomes of our care by key characteristics such as race and ethnicity, to identify where improvements can be made. This may require additional training for staff in the recognition of conditions that may be less visible in patients with darker skins, such as jaundice.

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**Best Interests of the child: Where the decision may have an impact, explain how the EQIA has evaluated possible negative, positive or neutral impacts on children. You may find that any options considered need to be reframed against the best possible outcome for children.**

All service change and developments in maternity and neonatal care need to place the needs of women, their newborns and their families at their heart.

In particular in postnatal and neonatal care, the needs of the infant are paramount. We design services to maximise the ability of mothers and babies to stay together, being cared for as one 'dyadic' unit rather than two separate individuals, where this is appropriate. We wish therefore, as set out in this strategy, to increase our ability to do this by expanding our provision of newborn transitional care units, where babies requiring some additional support can be cared for alongside their mothers; we have also set out an approach to providing more community neonatal outreach, to enable more babies to be cared for at home with their families rather than in hospital. This includes the provision of home phototherapy services and infant feeding support in the home.

**Life, survival and development: Where the decision may have an impact, explain how the EQIA has considered a child's right to health and more holistic development opportunities.**

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The strategy sets out how we wish to create services that are both personalised for each individual family, while also providing specialist care for those that need it. The strategy sets out ambitions in terms of updating environments to provide the most homely care environment, while also being in line with infection prevention and control best practice.

**Respect of children's views: Where the decision may have an impact, explain how the views of children have been sought and responded to. You need to consider what steps were taken in Q4 in relation to this.**

The children in our direct care are generally pre verbal and we are not able to consult. However, we are committed to fully consulting parents of newborns about their care and supporting informed decision making. Where we have a child who is pregnant and requiring maternity care, we ensure that we put the right safeguards and additional supports in place.

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Having completed the EQIA template, please tick which option you (Lead Reviewer) perceive best reflects the findings of the assessment. This can be cross-checked via the Quality Assurance process:

- Option 1: No major change (where no impact or potential for improvement is found, no action is required)
- Option 2: Adjust (where a potential or actual negative impact or potential for a more positive impact is found, make changes to mitigate risks or make improvements)
- Option 3: Continue (where a potential or actual negative impact or potential for a more positive impact is found but a decision not to make a change can be objectively justified, continue without making changes)
- Option 4: Full mitigation of identified risk not made, decision to continue without objective justification (Lead Reviewer to provide explanatory note here):
- Option 5: Stop and remove (where a serious risk of negative impact is found, the plans, policies etc. being assessed should be halted until these issues can be addressed)

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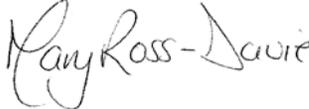
11. If you believe your service is doing something that ‘stands out’ as an example of good practice - for instance you are routinely collecting patient data on sexual orientation, faith etc. - please use the box below to describe the activity and the benefits this has brought to the service. This information will help others consider opportunities for developments in their own services.

Actions – from the additional mitigating action requirements boxes completed above, please summarise the actions this service will be taking forward.	Date for completion	Who is responsible?(initials)
No actions identified		

Ongoing 6 Monthly Review      please write your 6 monthly EQIA review date:

Lead Reviewer:  
EQIA Sign Off:

Name Dr Mary Ross-Davie  
Job Title      Director of Midwifery

Signature   
Date      31.12.24

Quality Assurance Sign Off:  
(NHSGGC Assessments)

Name      Alastair Low  
Job Title      Planning Manager  
Signature      A Low

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**Date 31/12/24**

**Where unmitigated risk has been identified in this assessment, responsibility for appropriate follow-up actions sits with the Lead Reviewer and the associated delivery partner.**

**NHS GREATER GLASGOW AND CLYDE EQUALITY IMPACT ASSESSMENT TOOL  
MEETING THE NEEDS OF DIVERSE COMMUNITIES  
6 MONTHLY REVIEW SHEET**

**Name of Policy/Current Service/Service Development/Service Redesign:**

--

**Please detail activity undertaken with regard to actions highlighted in the original EQIA for this Service/Policy**

		Completed	
		Date	Initials
<b>Action:</b>			
<b>Status:</b>			
<b>Action:</b>			
<b>Status:</b>			
<b>Action:</b>			
<b>Status:</b>			
<b>Action:</b>			
<b>Status:</b>			

**Please detail any outstanding activity with regard to required actions highlighted in the original EQIA process for this Service/Policy and reason for non-completion**

		To be Completed by	
		Date	Initials
<b>Action:</b>			
<b>Reason:</b>			
<b>Action:</b>			
<b>Reason:</b>			

BOARD OFFICIAL

Please detail any new actions required since completing the original EQIA and reasons:

		To be completed by	
		Date	Initials
Action:			
Reason:			
Action:			
Reason:			

Please detail any discontinued actions that were originally planned and reasons:

Action:	
Reason:	
Action:	
Reason:	

Please write your next 6-month review date

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Name of completing officer:

Date submitted:

If you would like to have your 6 month report reviewed by a Quality Assuror please e-mail to:

[alastair.low@ggc.scot.nhs.uk](mailto:alastair.low@ggc.scot.nhs.uk)