EQUALITY IMPACT ASSESSMENT RECORD

Title of policy/ practice/ strategy/ legislation etc.	Implementation of *The Best Start: A Five-Year Forward Plan for Maternity and Neonatal Care In Scotland*	
Minister	Cabinet Secretary for Health and Sport, Jeane Freeman MSP	
Lead official	[redacted], Maternal and Infant Health	
Officials involved in the EQIA	**Name**	**Team**
	[redacted]	Maternal and Infant Health
Directorate: Division: Team	Directorate for Children and Families Improving Health and Wellbeing Division Maternal and Infant Health Team	
Is this new policy or revision to an existing policy?	Implementation of *The Best Start*, published in 2017, following the Strategic Review of Maternity and Neonatal Services in Scotland in early 2015.	

Screening

Policy Aim

Background

The Minister for Public Health announced the Strategic Review of Maternity and Neonatal Services in Scotland in early 2015. This Review focused on creating a refreshed model of care and approach to maternity and neonatal services and to examine choice, quality and the safety of those services in light of current evidence and best practice, in consultation with service users, the workforce and NHS Boards. A Review team was convened and tasked with making recommendations for a Scottish model of care that contributed to the Scottish Government's overall aim of delivering person-centred, safe and effective care. The Review team was comprised of representatives from key professional groups involved in managing and delivery maternity and neonatal services, representatives from Scottish Government, staff-side organisations, third sector representatives and academics working in maternal and infant health research

This Review was grounded in a strong evidence base, led by an Evidence and Data Sub-Group. Eight efficient evidence reviews were produced by the Sub-Group and provided the evidence base for the Review. The outcomes of these efficient evidence reviews is published online: https://blogs.gov.scot/child-maternal-health/2019/03/18/best-start-evidence/.

The Best Start: A Five-Year Forward Plan for Maternity and Neonatal Care in Scotland

Following this, In January 2017 the Scottish Government published *The Best Start: A Five-Year Forward Plan for Maternity and Neonatal Care in Scotland*. The report contains 76 recommendations which focus on putting families at the centre of maternity care so that all women, babies and their families get the highest quality of care according to their needs. This is intended to ensure that mothers, babies and families are at the centre of service planning and delivery and that mum and baby are kept together as much as possible.

Implementation of *The Best Start* will contribute to the delivery of the Scottish Government's National Outcomes 5, 6, 7 and 16.

- Our children have the best start in life and are ready to succeed.
- We live longer, healthier lives.
- We have tackled the significant inequalities in Scottish society.
- We have improved the life chances for children, young people and families at risk.
- Our public services are high quality, continually improving, efficient and responsive to local people's needs.

Implementation of the recommendations contained within *The Best Start* is fundamental in ensuring that all children and their families have the best possible start in life.

Recommendations

The main recommendations and themes of *The Best Start* are:

- **Continuity of Carer**: all women will have continuity of carer from a primary midwife, and midwives and obstetric teams will be aligned with a caseload of women and co-located for the provision of community and hospital based services. Early adopter boards (EABs) will be identified to lead change.

- **Mother and baby at the centre of care:** Maternity and Neonatal care should be co-designed with women and families from the outset, and put mother and baby together at the centre of service planning and delivery as one entity.

- **Multi-professional working:** Improved and seamless multi-professional working.

- **Safe, high quality, accessible care**, including local delivery of services, availability of choice, high quality postnatal care, colocation of specialist maternity and neonatal care, services for vulnerable women and perinatal mental health services.

- **Neonatal Services:** proposes a move to 3-5 neonatal intensive care services in Scotland in the short term, progressing to 3 within 5 years. Note: report does not recommend closing any neonatal services, but reducing the number who care for the very smallest and sickest babies (currently managed in 8 units across Scotland).

- **Supporting the service changes**: Report also includes a number of recommendations about transport services, remote and rural care,

telehealth and telemedicine, workforce, education and training, quality improvement and data and IT.

Implementation

An Implementation Programme Board chaired by Jane Grant, Chief Executive of NHS Greater Glasgow and Clyde was established with representation from across the maternity and neonatal community in Scotland, as well as service user representation via the NCT and Bliss.

The 76 recommendations were split into those suitable for local implementation and those requiring national implementation. A Local lead was appointed in each of the 14 NHS Boards and they are currently progressing 23 recommendations.

Four sub groups were established to drive forward many of the nationally led recommendations. The sub groups are Continuity of Carer and Local Delivery of Care, Perinatal Services, Evidence and Data and Workforce and Education. The remaining nationally led recommendations sit with the Scottish Government for implementation.

Who will it affect?

Implementation of *The Best Start* targets pregnant women, babies and their families It will also have an impact on service delivery, and so on the maternity and neonatal workforce including midwives, obstetricians, neonatologists, neonatal nurses and healthcare support staff. This means that it has the potential to impact on anyone who interacts with maternity and neonatal services in either a personal or professional capacity.

Equality legislation covers the protected characteristics of: age, disability, gender reassignment, gender including pregnancy and maternity, race, religion and belief, and sexual orientation. As implementation of *The Best Start* has the potential to affect women, their babies and their families so the scope of this equality impact assessment (EQIA) is extended beyond the list of protected characteristics to include wider socio-economic considerations; including people living in low income households and people living in remote rural areas.

What might prevent the desired outcomes being achieved?

Achievement of the desired outcomes will be dependent on a number of factors. The implementation landscape is complex and there are various opportunities and risks across workstreams towards implementation of the recommendations. Close working with service providers, including multidisciplinary health professionals, third sector and service users, is critical.

- Workforce considerations: movement to the new models of maternity and neonatal care is a departure from previous models of care, with potential implications for health professionals across a variety of settings, from primary to tertiary care.

- Infrastructure considerations: including development of community hubs and facilities to allow health professionals to deliver care closer to home, development of transitional care facilities; provision of full range of places of birth, as well as provision of space for partners to stay nearby and provision of emergency overnight accommodation for parents with babies in neonatal care.
- Education: for both workforce and prospective parents.
- Cross-cutting policy work, including work being delivered by other policy teams (e.g. Perinatal Mental Health).

Stage 1: Framing

Results of framing exercise

As noted above, the recommendations in *The Best Start* are predicated on research and best practice evidence. Broad consideration of the protected characteristics under the Equality Act 2010 is recorded below.

Protected Characteristic	Potential Impact
Age	• *The Best Start* addresses concerns for babies and pregnant women, their babies and families as its primary focus. Impact on wider families may be incidental to this but is not the primary focus. • Young parents are not addressed specifically within the recommendations but the focus on person-centred care mitigates against this, as the focus is on individualised care for each person, rather than standardised care stratified by needs profile. Recommendation 35 makes specific reference to vulnerabilities. Continuity of carer (Recommendation 1) is intended to enable the development of a closer relationship between a woman and her midwife across her pregnancy journey, which may be of particular importance for younger and older mothers, particularly, in the case of the latter, in terms of age-related risks in pregnancy. • No recommendations within the *Best Start* should adversely impact the workforce directly because of age. There is the chance of an indirect impact as the age demographic of the workforce may include people with caring responsibilities.
Disability	• The ethos of *Best Start* is that care is individualised around each woman and any clinical, social, physical and psychological needs. • Continuity of carer (Recommendation 1) is intended to enable the development of a closer relationship between a woman and her midwife across her pregnancy journey, which may be of particular importance for those living with a disability. • *Best Start* aims to deliver care closer to home wherever possible, including the use of technology where appropriate.

	• It is not expected that any recommendations within the *Best Start* should adversely impact the workforce because of disability. Any adjustments that are required currently to enable a member of the workforce to carry out their job would also be expected to be made for any change to how that job is carried out in the future.
Sex	• As implementation of *The Best Start* concerns the provision of maternity and neonatal services, there are inherent differences in how men and women will be affected. • The recommendations and the overarching ethos of *The Best Start* focus on establishing family-centred care, ensuring that partners feel included at all stages. • No recommendations within the *Best Start* should adversely impact the workforce because of sex.
Gender Reassignment	• Where clinical care is the key consideration, reference is made to the 'woman'. This language recognises that biological women can achieve a pregnancy and is not intended to exclude trans men. • No recommendations within the *Best Start* should adversely impact the workforce because of gender reassignment.
Sexual Orientation	• *The Best Start* references partners and is intended to be inclusive of all sexual orientations and genders. • Noted that HFEA confidentiality requirements preclude disclosure of pregnancies resulting from IVF/ assisted conception treatment between health professionals. • No recommendations within the *Best Start* should adversely impact the workforce because of sexual orientation.
Race	• The ethos of *Best Start* is that care is individualised around each woman, taking account of any additional requirements. • No recommendations within the *Best Start* should adversely impact the workforce because of race.

Religion/ Belief	• The ethos of *Best Start* is that care is individualised around each woman which would include any religious or cultural need. • No recommendations within the *Best Start* should adversely impact the workforce because of religion or belief.

Extent/Level of EQIA required

As a result of the framing exercise, a full EQIA was carried out, covering the implementation of *The Best Start* as a whole thematically, as some of the individual recommendations are more complex and multi-faceted than others. In this way, implementation of each of the 76 recommendations is considered in a proportionate manner.

- Continuity of carer.
- Person-centred maternity and neonatal care.
- Multi-professional working.
- Safe, high quality and accessible care.
- Re-designing neonatal care and services.
- Supporting the changes.
- Wider implications.

It should also be noted that, for the implementation of recommendations which are being led locally, it is expected that Health Boards will undertake their own Impact Assessments to satisfy their local requirements. This EqIA therefore takes national implementation as its primary focus.

Stage 2: Data and evidence gathering, involvement and consultation

Include here the results of your evidence gathering (including framing exercise), including qualitative and quantitative data and the source of that information, whether national statistics, surveys or consultations with relevant equality groups.

Characteristic[1]	Evidence gathered and Strength/quality of evidence	Source	Data gaps identified and action taken
AGE	In relation to age, we know from ISD statistics that women are now giving birth later in life. Often this can bring an additional element of complexity to a pregnancy therefore care needs to be based around each woman and her individual needs.	https://www.isdscotland.org/Health-Topics/Maternity-and-Births/Publications/2019-11-26/2019-11-26-Births-Report.pdf https://blogs.gov.scot/child-maternal-health/2019/03/18/best-start-evidence/	• Choice of place of birth location currently contains guidelines on age. A literature review has been undertaken to establish if these restrictions are the most up to date evidence. • Research into the rising Caesarean section rate will consider if age is a factor.
DISABILITY	In 2012, 28 per cent of men and 35 per cent of women in Scotland reported a limiting long-term condition or disability. In 2011, the proportion of people in Scotland with a long- term activity-limiting health problem or disability was 20 per cent (1,040,000 people), the same proportion as reported in 2001 (1,027,872 people).	Scottish Health Survey 2012 2011 Census https://blogs.gov.scot/child-maternal-health/2019/03/18/best-start-evidence/	• The ethos of *Best Start* is that care is individualised around each woman and any clinical, social, physical and psychological needs. • Care should be delivered closer to home wherever possible, including the

[1] Refer to Definitions of Protected Characteristics document for information on the characteristics

			use of technology where appropriate.
SEX	The large majority of lone parent households are headed by women and these households tend to experience high poverty rates: 34% were in poverty in 2014/15, compared with 26% of single working age women without children. For comparison, 16% of couples with dependent children were in poverty in 2014/15. These statistics have implications for child poverty, as women tend to be the main carers of children.	Sourced from the Equality Impact Assessment for the Child Poverty (Scotland) Bill. https://blogs.gov.scot/child-maternal-health/2019/03/18/best-start-evidence/	• Redesigning neonatal care may have an impact on the ability of women and their partners to be able to visit and bond with their baby. Creation of the Neonatal Expenses Fund should mitigate this by reimbursing travel costs. However, this would affect a very small number of families whose baby would require highly specialised care. • This is also balanced with the overall redesign of neonatal care which will see an increased role for families in caring for their baby in neonatal care and an increase in facilities for families to stay, for example in Neonatal Transitional Care. • An increase in partners to stay in maternity units should be consistent across

			Scotland to ensure equity of access and improve support for mothers and increased bonding.
PREGNANCY AND MATERNITY		https://blogs.gov.scot/child-maternal-health/2019/03/18/best-start-evidence/	N/A
GENDER REASSIGNMENT		https://blogs.gov.scot/child-maternal-health/2019/03/18/best-start-evidence/	N/A
SEXUAL ORIENTATION		https://blogs.gov.scot/child-maternal-health/2019/03/18/best-start-evidence/	N/A
RACE	Black women still have more than five times the risk of dying in pregnancy or up to six weeks postpartum compared with white women, women of mixed ethnicity three times the risk and Asian women almost twice the risk.	https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202019%20-%20WEB%20VERSION.pdf https://blogs.gov.scot/child-maternal-health/2019/03/18/best-start-evidence/	• Outcomes for BAME women and their babies are poorer. Introducing continuity of carer should help mitigate this • Individualised care planning should identify clinical, social, physical and psychological needs including risks associated with women from BAME background. Best Start recommendation 29: Women who present out with a maternity setting or have a pre-existing condition should receive timely medical advice in

			relation to their pregnancy.
RELIGION OR BELIEF		https://blogs.gov.scot/child-maternal-health/2019/03/18/best-start-evidence/	N/A
MARRIAGE AND CIVIL PARTNERSHIP (the Scottish Government does not require assessment against this protected characteristic unless the policy or practice relates to work, for example HR policies and practices - refer to Definitions of Protected Characteristics document for details)		https://blogs.gov.scot/child-maternal-health/2019/03/18/best-start-evidence/	N/A

Stage 3: Assessing the impacts and identifying opportunities to promote equality

Having considered the data and evidence you have gathered, this section requires you to consider the potential impacts – negative and positive – that your policy might have on each of the protected characteristics. It is important to remember the duty is also a positive one – that we must explore whether the policy offers the opportunity to promote equality and/or foster good relations.

Do you think that the policy impacts on people because of their age?

Age	Positive	Negative	None	Reasons for your decision
Eliminating unlawful discrimination, harassment and victimisation			X	
Advancing equality of opportunity	X	X		• Continuity of midwifery carer will be offered to all women, regardless of characteristic. Where a woman requires input from a Consultant Obstetrician she should expect to receive continuity of obstetric carer in addition. • Evidence for choice in place of birth will be reviewed to ensure policies are up to date with the best available evidence and clinical opinion. • There is the chance of both a positive and a negative indirect impact as the age demographic of the workforce may include people with caring responsibilities. Continuity of carer may require a different working pattern for staff which may affect staff with caring responsibilities. However, evidence indicates increased autonomy and flexibility in setting working hours that comes with this policy should allow staff the flexibility to work around these caring responsibilities.

Promoting good relations among and between different age groups			X	

Do you think that the policy impacts disabled people?

Disability	Positive	Negative	None	Reasons for your decision
Eliminating unlawful discrimination, harassment and victimisation			X	
Advancing equality of opportunity	X	X		• Continuity of midwifery carer will be offered to all women, regardless of characteristic?. Where a woman requires input from a Consultant Obstetrician she should expect to receive continuity of obstetric carer in addition. • Increased use of technology in maternity and neonatal care could have a positive impact on disabled people if it meant more care could be delivered virtually and decrease travel needed. However, care would have to be taken to ensure that there were no negative impacts on a disabled person if they were unable to use technology and that they could still receive the same level of care without technology. • No recommendations within the *Best Start* should adversely impact the workforce directly because of disability. For continuity of carer, it is expected that more midwives would work in a community based setting. Necessary adjustments may have to be made as they would have been in the current work setting. Increased use of technology, working flexibly and bringing care closer to home may have a positive impact on a disabled member of the workforce.

Promoting good relations among and between disabled and non-disabled people			X	

Do you think that the policy impacts on men and women in different ways?

Sex	Positive	Negative	None	Reasons for your decision
Eliminating unlawful discrimination			X	
Advancing equality of opportunity	X			• Partners to stay should allow more partners to be involved in the care of their baby. • The Neonatal Expenses Fund will provide equal access for both men and women to visit their baby in neonatal care. • Parents will be encouraged to take an active part in the care of their baby in neonatal care.
Promoting good relations between men and women	X			• Bringing care closer to home allows partners to be involved in all aspects of pregnancy care. Providing facilities for partners to stay, either on the postnatal ward or in Neonatal Transitional Care promotes family bonding.

Do you think that the policy impacts on women because of pregnancy and maternity?

Pregnancy and Maternity	Positive	Negative	None	Reasons for your decision
Eliminating unlawful discrimination			X	

Advancing equality of opportunity	X			• The aim of *Best* Start is that all women will be offered an equitable service across Scotland based around their individual needs and circumstances.
Promoting good relations	X			• Women should feel part of the decision making process around all aspects of her pregnancy care including personalised care planning, relationship based care, choice of place of birth and receive continuity of midwifery carer and obstetric carer where applicable.

Do you think your policy impacts on transgender people?

Gender reassignment	Positive	Negative	None	Reasons for your decision
Eliminating unlawful discrimination			X	
Advancing equality of opportunity			X	
Promoting good relations			X	

Do you think that the policy impacts on people because of their sexual orientation?

Sexual orientation	Positive	Negative	None	Reasons for your decision
Eliminating unlawful discrimination			X	
Advancing equality of opportunity			X	
Promoting good relations			X	

Do you think the policy impacts on people on the grounds of their race?

Race	Positive	Negative	None	Reasons for your decision
Eliminating unlawful discrimination			X	

Advancing equality of opportunity	X			• Continuity of carer will be offered to all women, regardless of race and will be tailored around individual needs and circumstances. Where a woman requires input from a Consultant Obstetrician she should expect to receive continuity of obstetric carer in addition. All women will receive equity of access to midwifery and obstetric services, with the target of carrying out the initial booking appointment before 12 weeks applicable to all women, regardless of race.
Promoting good race relations			X	

Do you think the policy impacts on people because of their religion or belief?

Religion or belief	Positive	Negative	None	Reasons for your decision
Eliminating unlawful discrimination			X	
Advancing equality of opportunity	X			• Continuity of carer will be offered to all women, regardless of religion and belief and will be tailored around individual needs and circumstances. Where a woman requires input from a Consultant Obstetrician she should expect to receive continuity of obstetric carer in addition
Promoting good relations			X	

Do you think the policy impacts on people because of their marriage or civil partnership?

Marriage and	Positive	Negative	None	Reasons for your decision

Civil Partnership[2]				
Eliminating unlawful discrimination			X	

[2] In respect of this protected characteristic, a body subject to the Public Sector Equality Duty (which includes Scottish Government) only needs to comply with the first need of the duty (to eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010) and only in relation to work. This is because the parts of the Act covering services and public functions, premises, education etc. do not apply to that protected characteristic. Equality impact assessment within the Scottish Government does not require assessment against the protected characteristic of Marriage and Civil Partnership unless the policy or practice relates to work, for example HR policies and practices.

Stage 4: Decision making and monitoring

Identifying and establishing any required mitigating action

If, following the impact analysis, you think you have identified any unlawful discrimination – direct or indirect - you must consider and set out what action will be undertaken to mitigate the negative impact. You will need to consult your legal team in SGLD at this point if you have not already done so.

Have positive or negative impacts been identified for any of the equality groups?	Yes
Is the policy directly or indirectly discriminatory under the Equality Act 2010[3]?	No
If the policy is indirectly discriminatory, how is it justified under the relevant legislation?	
If not justified, what mitigating action will be undertaken?	

Describing how Equality Impact analysis has shaped the policy making process

The ethos of the Best Start is to individualise care around the needs of women, their individual circumstances and their family circumstances. By being aware of the key characteristics within the Equality Impact analysis, we are clear on the benefits that can be gained by tailoring care to women.

Monitoring and Review

The Best Start Implementation Programme Board will take cognisance of the Equality Impact analysis and review to ensure that there are no unintended consequences during policy implementation.

Stage 5 - Authorisation of EQIA

Please confirm that:

[3] See EQIA – Setting the Scene for further information on the legislation.

♦ This Equality Impact Assessment has informed the development of this policy:

Yes ☒ No ☐

♦ Opportunities to promote equality in respect of age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation have been considered, i.e.:

- Eliminating unlawful discrimination, harassment, victimisation;
- Removing or minimising any barriers and/or disadvantages;
- Taking steps which assist with promoting equality and meeting people's different needs;
- Encouraging participation (e.g. in public life)
- Fostering good relations, tackling prejudice and promoting understanding.

Yes ☒ No ☐

♦ If the Marriage and Civil Partnership protected characteristic applies to this policy, the Equality Impact Assessment has also assessed against the duty to eliminate unlawful discrimination, harassment and victimisation in respect of this protected characteristic:

Yes ☐ No ☐ Not applicable ☒

Declaration

I am satisfied with the equality impact assessment that has been undertaken for *The Best Start: A Five Year Forward Plan for Maternity and Neonatal Care in Scotland* and give my authorisation for the results of this assessment to be published on the Scottish Government's website.

Name: [redacted]
Position: Deputy Director, Head of Improving Health and Wellbeing Division
Authorisation date:

The Best Start – New Model of Neonatal Care

NHS Lothian Early Implementers Evaluation Report – January 2020

Introduction

The early implementation started on September 2nd 2019. This report highlights key activity and outcome measures of the short term evaluation criteria.

Short term outcomes/measures

Quantitative Measures

	Outcome		Measure	Definition	Measurement system	Who?	13th January Position
1	**New Model of Neonatal Intensive Care: Appropriate and timely transfers**	1.1	Number of NHS Lothian /Fife/A&A babies meeting agreed new model of care criteria	Number of babies meeting criteria	Badgernet neonatal /maternity / TRAK	Fife	Nil
		1.2.1	Number of in utero transfers for NICU care		In-utero coordination service	Fife	[redacted]
		1.2.2	Number of in utero transfers for NICU care who don't deliver			Fife	[redacted] ([redacted] had 2 IUT and on each occasion did not result in a delivery at RIE and was discharged back to

							Fife)
		1.3.1	Number ex utero transfers of babies meeting NICU criteria		Badgernet neonatal		0
		1.3.2	Length of babies stay in LNU before transfer to QEUH/ERI		Badgernet neonatal		n/a
2	**Mother and baby kept together**	2.1	Accommodation available for parents on or near neonatal unit	Was accommodation available and offered to parents?	NNU data		[redacted] deliveries [redacted] [redacted] [redacted] [redacted]). Accommodation on the unit was available and offerred
3	**Parents were informed about what was happening**	3.1	Information leaflet available for parents	Information leaflet available that describes new model of care	Yes/no	All	Verbal explanation and discussion about transfer and repatriation given. Leaflet ? not given in Edinburgh ? given in Fife
4.	**Parents were involved in babies care**	4.1	Parents involved in ward rounds	As per NNAP measure	Badgernet	RIE	parents of the[redacted] babies had early communication with senior staff and parents attended ward rounds.
		4.2	Unit working towards Bliss Baby Charter accreditation	Unit has signed up to the Bliss Baby Charter accreditation process	Yes / no	RIE	Yes unit is working towards this

				and is working towards achieving accreditation.			

Qualitative measures

	Outcome		Qualitative Measure	Measurement	13th January Position
5.	**Operation of new model of neonatal intensive care**	5.1	Safe and effective in utero transfer	? need to agree this with local units and have an agreed network approach going forward	Currently there is a weekly video conference with Fife in place. If this has not been needed then there is an email between the units to confirm any activity.
		5.2	Timely and appropriate repatriation of babies back to nearest Local Neonatal Unit	As above	[redacted] in utero transfers that delivered [redacted] babies have been repatriated 1. [redacted] delivered 2 days post IUT and repatriated 7 days post delivery. Uncomplicated 2. [redacted] delivered on same day of IUT and repatriated 8 days post delivery. Uncomplicated There were no delays or issues with cot availability, Scotstar for

					repatriations. Regular communication about repatriation with Fife
		5.3	Ability of NICUs to remain open to referrals at all times	Exception reporting	No issues reported.
		5.4	Effective communications	As above	As above 5.1 Regular communications and updates between the units about all the transfers
		5.5	Transfer process	As above, but with ScotSTAR/SAS input	Not aware of issues from Scotstar. All transfers appear to have been smooth.
	Mother and baby kept together	5.6	Did parents feel they had every opportunity to be with their baby	Parental questionnaire	Parental questionnaires have not been completed yet
6.	**Parents were informed about what was happening**	6.1	Did parents understand why their baby was being transferred	As above	Parental questionnaires have not been completed yet
		6.2	Was the transfer process explained to parents	As above	Yes
		6.3	Did parents understand the repatriation process	As above	Parental questionnaires have not been completed yet.
7.	**Parents were involved in babies care**	7.1	Did parents feel informed and part of decision making process in relation to their babies care	As above -	Parental questionnaires have not been completed yet.

Forward View Towards Medium/Long Term Outcomes

Summary of improvement work to support Keeping mothers and babies together

1. **Extending transitional care and keeping babies together with mothers on the wards**

- 4x transitional care beds already established on the neonatal unit RIE.

- Transitional care on the postnatal wards was not in place and is being established. To date 62 babies (late preterm and term) have been cared for on the wards. In order to achieve this for all eligible babies, an additional nursery nurse is required on each shift. This will need an additional 5.4 nursery nurses. All have been appointed and Xx have been recruited and are expected to start working by Feb 2020.

2. **Keeping mothers and babies together once discharged home**
    a. Promoting care of well term breast fed babies with 10-12% weight loss in the community setting
        i. 40 babies were able to have ongoing care at home community midwives without needing review by neonatal staff. Prior to this improvement model these babies would have had to attend the neonatal unit for review and management
        ii. The model has been rolled out to 7 of the 10 community midwifery teams and on track for full roll out by March 2020

7-Day Neonatal Community service to support discharge and ongoing care

- Neonatal community team fully established from September 2019. This is a 7 day service with daily 12 hour shifts
- A neonatal consultant lead for the community team has been established from August 2019
- Joint working group with RHSC children community nursing team has been established to develop shared governance, guidelines and pathways
    - Since October 2019 the community team are now managing babies needing NG feeding at home. There have been 1-2 babies a month discharged home earlier with this service. Approximately Length of stay reduced by 5 days/baby.

Development of skills and rotation for staff in smaller units within catchment for NICU

- No specific discussion with fife about how to develop skills and rotation of staff with Fife. Planning to meet with local units to discuss how to develop this.
- NHS Lothian has identified time in new neonatal consultant workforce model to increase availability to support local units. NHS lothian currently attends BGH 1x month for an education and training session.

Developing Parent/Family Involvement

A Family integrated improvement programme has been established with 2 neonatal consultant leads. The team has visited and been working with the GG&C Fi care team to learn from their experience. These are examples of improvements [redacted]

Enhance education and promote innovation:

- Introduction of cue based feeding package:
  - This package involves both staff education and parental education package.
  - It includes details on passing a nasogastric tube, testing the
  - It aims to increase confidence of staff as teachers, and of families as primary care-givers and to ultimately facilitate earlier discharge with the support of the community team
- Learning from FiCare good practice:
  - Attendance of a core group at national FiCare conference (Glasgow 2019):
    - To enhance and develop exisiting relationships and to form new collaborative working and development opportunities
    - Presentation of local FiCare work at FiCare conference in Leeds (2019)
  - Visit to Aberdeen to observe their FiCare work and learn from their successes
- Bespoke design and introduction of baby milestone cards
- **Moderate preterm follow up clinic**
  - Pilot of a specialised clinic for moderate preterm infants
    - Involving families in follow up in a unique and innovative format
    - Small group of families with weekly clinic mornings for 5 consecutive weeks
    - Provides peer support as well as intensive post discharge medical support and education
    - Highly valued by parents and families

Improvement in parental facilities aiming for an improved family experience:

High dependency and special care

- New armchairs, which are now placed permanently at each cot space in high dependency,
    - These provide a comfortable and welcoming environment for families, encouraging them to spend time with their babies, and in particular, promoting skin to skin time.
- White boards at each cot space
    - This method of communication has enhanced communication and family satisfaction.
    - The boards are used by families to communicate to staff, and vice-versa

Neonatal unit refurbishment

- Involvement of FiCare group in the upcoming neonatal unit development, including the parental lounge area with kitchen and facilities.

Listening to our families:

- **Feedback from the re-designed discharge questionnaire:**
    - The neonatal unit discharge questionnaire has been refreshed and re-launched. This obtains valuable family feedback on unit performance, parental experience and family information. It has be re-designed in collaboration with families, including the ideal format (paper, electronic) and timing of receiving the questionnaire, as well as the entire content being reviewed and updated. This will allow continued improvement upon regular receipt of these questionnaires.

Support for families with an aim to improve family experience and reduce parental psychological burden:

- Initiation of new psycho-social weekly ward rounds (from 14/1/20). These ward rounds are multidisciplinary, involving medical staff, nursing staff, the community team, family support team and chaplaincy teams, psychology and follow up team. They will form a regular, standardised method for identifying families on the neonatal unit who may benefit from enhanced support and coordinating offered supports.
- Implementation of antenatal and neonatal anticipatory care planning
- Introduction of an admission package to support parenting and attachment:
    a. Including hand and footprint packs for families to have early mementos
    b. Books to promote reading and interaction with their baby, focussing early on language nutrition
    c. A photograph of their baby

The Best Start – New Model of Neonatal Care

NHS GGC & NHS Ayrshire & Arran Early Implementers Evaluation Report – January 2020

Introduction

As of the 19th of August, the neonatal unit in Crosshouse Hospital, Ayrshire changed its level of function and no longer manages babies of 25+6 weeks gestation and under. Those babies instead will be managed at the Royal Hospital for Children, Glasgow (or the Royal Infirmary Edinburgh, where there is no capacity in the RHCG).

As of Monday 4th November the criteria to consider in utero transfer of women to Queen Elizabeth University Hospital, Glasgow also included;

1. All women likely to deliver at gestation 26+6 weeks or less (no change to current process)
2. All multiple pregnancies likely to deliver at gestation 27+6 weeks or less (extension of one week to current process)
3. All women likely to deliver a baby of less than 800gm as estimated on ultrasound scan (new criterion).

To date there have been no infants < 26+ 6 weeks gestation transferred to The Royal Hospital for Children from Cross House Hospital and only 4 In-utero transfers, 3 of which were repatriated prior to delivery, the 4th was still in the QEUH at time of writing.

Short term outcomes/measures

Quantitative Measures

	Outcome		Measure	Definition	Measurement system	Who?	13th January Position
1	**New Model of Neonatal Intensive Care:**	1.1	Number of NHS A&A/Fife babies meeting NICU criteria	Number of babies meeting criteria for	Badgernet neonatal	A&A/ Fife	Nil

	Appropriate and timely transfers			complex and/or prolonged NICU care			
		1.2.1	Number of in utero transfers for NICU care		In-utero coordination service	A&A/ Fife	[redacted]
		1.2.2	Number of in utero transfers for NICU care who don't deliver	No of mothers and length of antenatal stay			[redacted] x 2 days [redacted] x 3 days [redacted] (+3 days, not discharged at time of writing)
		1.3.1	Number ex utero transfers of babies meeting NICU criteria		Badgernet neonatal	A&A/ Fife	Nil
		1.3.2	Length of babies stay in LNU before transfer to QEUH/ERI		Badgernet neonatal	A&A/ Fife	n/a
2	**Mother and baby kept together**	2.1	Accommodation available for parents on or near neonatal unit	Was accommodation available and offered to parents?	Locally collected	QUEH/ ERI	QEUH has facilities (Both IP & Ronald MacDonald House)
3	**Parents were informed about what was happening**	3.1	Information leaflet available for parents	Information leaflet available that describes new model of care	Yes/no	All	Yes
4.	**Parents were involved in babies care**	4.1	Parents involved in ward rounds	As per NNAP measure	Badgernet	QUEH/ ERI	n/a (no births to date but is standard practice)
		4.2	Unit working towards Bliss Baby Charter accreditation	Unit has signed up to the Bliss Baby Charter accreditation process and is working	Yes / no	QUEH/ ERI	Yes, RHC & Cross House both signed up.

				towards achieving accreditation.			

Qualitative measures

	Outcome		Qualitative Measure	Measurement	13th January Position
5.	**Operation of new model of neonatal intensive care**	5.1	Safe and effective in utero transfer	Monthly case conference review of discharged babies to discuss – including neonatal and maternity input from both sites to discuss systems and processes for transfer, to cover cases where in utero transfer did not occur and joint decision making around these cases.	Daily call in place.
		5.2	Timely and appropriate repatriation of babies back to nearest Local Neonatal Unit	As above	No babies to date. There have been [redacted] in-utero transfers who were subsequently discharged home undelivered with follow up care continued from NHS Ayrshire & Arran. One woman going on to deliver within the agreed criteria for Ayrshire and Arran.
		5.3	Ability of NICUs to remain open to referrals at all times	Exception reporting	No issues reported.

		5.4	Effective communications	As above	A daily Neonatal Consultant phone call between Ayrshire and Arran and RHC to discuss any possible in- utero transfers or infants of concern has been implemented successfully and is now well embedded. A clinical mailbox was set up for written correspondence on any in-utero transfers between Glasgow and Ayrshire; Of the [redacted] women discharged from Glasgow, [redacted] did not receive the appropriate follow up appointment. Steps have been put in place to ensure there are no gaps in communication preventing appropriate follow up being implemented timeously.
		5.5	Transfer process	As above, but with ScotSTAR/SAS input	All have gone smoothly from an In Utero Coordination Service perspective, other than one that was erroneously referred to the PRMH rather than RHCG. On review of this call, this was in part because the referrer asked for either the RHCG or

					the PRM rather than the agreed pathway, and the dispatcher managing the call did not recall that this was not the agreed process. The error was noted by the PRM consultant and the referral correctly directed to the RHCG/QEUH instead. A reminder has been sent out to all SSD staff managing ICS calls, however this will remain a latent risk for as long as there are these specific arrangements in place affecting a small proportion of the overall workload of the service.
	Mother and baby kept together	5.6	Did parents feel they had every opportunity to be with their baby	Parental questionnaire	1 questionnaire completed, no issues reported
6.	**Parents were informed about what was happening**	6.1	Did parents understand why their baby was being transferred	As above	n/a
		6.2	Was the transfer process explained to parents	As above	Yes
		6.3	Did parents understand the repatriation process	As above	1 questionnaire completed, no issues reported.
7.	**Parents were involved in babies care**	7.1	Did parents feel informed and part of decision making process in relation to their babies care	As above -	1 questionnaire completed, no issues reported.

Forward View Towards Medium/Long Term Outcomes

Transitional Care

Transitional Care in place at Cross House since December 2018 (62 infants transferred)
RHC/QEUH due to open immanently.

Developing Parent/Family Involvement

The RHC Neonatal Unit is committed to ensuring that parents and families are partners in the care of their baby/babies. The unit has a well established family integrated care group "HUGG", who have presented their achievements locally, nationally and internationally.

In A&A, the neonatal unit this year presented its own local Family Integrated Care Conference and from this has established a Family integrated care working group with new members joining regularly to strengthen our ethos of parents as partners in care. There is a Twitter and Facebook page promoting the good work that is going on within the unit.

The RHC Neonatal Unit was among the first in Scotland to achieve Stage 3 UNICEF Neonatal Baby Friendly Accreditation in 2018. Following a final stage 3 audit this month, the A&A Neonatal unit is presently awaiting to hear if they have been successful in achieving the UNICEF Neonatal Baby Friendly Accreditation.

7-Day Neonatal Community service to support discharge and ongoing care.

In A&A, there is a working group presently being established to look at how we can support early discharge and on-going care over a seven-day service.

GG&C have limited staff to provide 7 day service and working on a plan.

Development of skills and rotation for staff in smaller units within catchment for NICU.

In A&A, to ensure staff maintain their skills and ICU competencies, the NNU is presenting its own 3 monthly Neonatal Education Day to staff.

Within GGC there is a robust Education plan to staff support by 3 Neonatal Educators and Neonatal Infant Feeding Advisor. Nursing staff undertaking the neonatal qualification in speciality or Advanced Practice course who are based in the GGC Level 2 Unit are given the opportunity to work within the Level 3 unit for a period of time to gain experience in intensive care. Though there is at present no planned rotation of staff across the 3 units they are moved on a regular basis to support activity as required.

GGC neonatal teams have been actively involved in the National Discharge Planning Group.

[redacted]

[redacted]

[redacted]

From: [redacted]@nhslothian.scot.nhs.uk>
Sent: Tuesday, June 29, 2021 1:15 PM
To: [redacted]@gov.scot>; [redacted]
[redacted]@gov.scot>
Subject: RE: Neonatal Early Implementers - Capturing Data and Sharing Learning

Hi [redacted],

Apologies again for the delayed response to the below request for information.

Please find attached a summary of Best Start transfers into NHS Lothian covering Q1 2020 – Q1 2021 inclusive.

Please let me know if you require any further information.

Bw,
[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

The Best Start – Neonatal Early Adopters Report

NHS Lothian

June 2021

Purpose

The purpose of this report is to provide a high-level overview of activity in relation to Mothers and Babies transferred into NHS Lothian's care as part of the early adoption of transfer and repatriation criteria.

In-utero transfer activity

RIE accepted the following numbers of in-utero transfers (IUT) per quarter

Period	Total IUT	Best start RVHK (<27W)	Other centres (<27w)	Other RVHK
Q1 2020	10	[redacted]	[redacted]	0
Q2 2020	11	[redacted]	[redacted]	0
Q3 2020	[redacted]	[redacted]	[redacted]	0
Q4 2020	[redacted]	[redacted]	0	0
Q1 2021	13	[redacted]	[redacted]	0
Total	46	10	10	0

During the same time period there were no IUT <27w out of Fife to any other centre.

During the same time period there was [redacted] <27weeks gestation born in Fife, who could not be transferred out in-utero because of lack of time before delivery. This baby was transferred to RIE the morning after delivery.

RIE provided care to all mothers who were booked in Fife who met the criteria agreed for inclusion in the initial phase of Best Start and all of their babies when they delivered in association with the IUT. Edinburgh also accepted a similar number of mothers from other centres for IUT at <27 weeks gestation during the same time period

During the same time period there were no in-utero transfers out of Edinburgh.

Best start babies whose mothers booked in Fife but delivered in Edinburgh after IUT 1.1.20-31.3.21:

Gestation	Days in RIE (first admission)	Other days RIE	Outcome
23+1 weeks	28		Died
25+1 weeks	32	5	Survived
26+0 weeks	22	23	Survived
26+1	13		Survived
26+6	9	18	Survived
27+0	17		Survived
27+1	15		Survived

Other days in RIE represents care days when the babies were transferred back to RIE for various reasons after initial re-patriation (eg ROP treatment, NEC needing surgical care).

One baby born in Fife and transferred to Edinburgh under Best Start

Gestation	Days in RIE (first admission)	Other days RIE	Outcome
25+1	25	9	Survived

Total in-patient days in RIE NNU for these best start babies =216

There have been some other babies transferred from RVHK outwith the best start criteria

Gestation	Days in RIE (first admission)	Other days RIE	Outcome
29+6	75		in-patient
38+6	5		survived
27+3	1		died

Overall there is approximately 1 intensive care cot in the Royal Infirmary of Edinburgh occupied by a baby from Fife per day.

When a best start baby is born we refer them to the team in Fife on Badgernet so that they have access to the full electronic record. We have a weekly VC with Fife to discuss these babies, including planning of their transfers back to Fife.

[redacted]

From: [redacted]@nhslothian.scot.nhs.uk>
Sent: Tuesday, November 22, 2022 3:57 PM
To: [redacted]@gov.scot>; [redacted]
[redacted]
Cc: [redacted]
[redacted]
[redacted]
Subject: RE: Neonatal Meeting Follow Up

Hi [redacted],

Please see attached report as requested.

Please let us know if there is anything further we can support with.

Kind regards,
[redacted]

[redacted]
[redacted]
[redacted]
[redacted]
[redacted]
[redacted]

[redacted]

[redacted]

[redacted]
[redacted]

[redacted]
[redacted]

The Best Start – New Model of Neonatal Care

NHS Lothian Early Implementers Evaluation Report – November 2022

Contributors

[redacted] – Consultant Neonatologist
[redacted] – Consultant Neonatologist (leading on KMBT workstream)
[redacted] – Consultant Neonatologist (leading on innovation workstreams)
[redacted] – Clinical Nurse Manager (Neonatal Services)
[redacted] – Charge Nurse (Neonatal Community Team)
[redacted] and [redacted] – Data Managers
[redacted] and [redacted] – Clinical Psychologists, MNPI team
[redacted] – Specialist Physiotherapist
[redacted] – Assistant Service Manager (Maternity and Neonatal)

Introduction

The early implementation started on 2nd September 2019, with Fife referring ITU work through to NHS Lothian. Despite delays caused by the Covid-19 pandemic, several key outcomes have been achieved, and work is ongoing to further develop our neonatal services in line with the Best Start strategy.

This report highlights key activity and outcome measures of the short-term evaluation criteria, spanning the period 1st January 2020 and 31st October 2022.

Quantitative Measures

	Outcome		Measure	Definition	Measurement system	Who?	November 2022 Position
1	**New Model of Neonatal Intensive Care: Appropriate and timely transfers**	1.1	Number of NHS Lothian / Fife babies meeting agreed new model of care criteria	Number of babies meeting criteria	Badgernet (neonatal) /maternity TRAK	Fife	15 babies at <28 weeks gestation.
		1.2.1	Number of in utero transfers for NICU care		In-utero coordination service	Fife	In total, 15 women were transferred from Fife to RIE at <28 weeks gestation. 2020: 6 2021: 7 2022: 2 Ten of these women went on to give birth at RIE and their baby was admitted to NNU.
		1.2.2	Number of in utero transfers for NICU care who don't deliver			Fife	Due to limitations in the collection of data from the TRAK and Badgernet electronic patient records we are able

							to formulate the following response: Between 1st January 2020 and 31st October 2022 there were five in utero transfers from Fife who did not deliver at RIE, or their baby was not admitted to the RIE NICU.
		1.3.1	Number ex utero transfers of babies meeting NICU criteria		Badgernet (neonatal)		Between 1st January 2020 and 31st October 2022 there were five ex utero transfers: 2020: 2 2021: 1 2022 (to 31/10/22): 2
		1.3.2	Length of babies stay in local neonatal unit before transfer to RIE		Badgernet (neonatal)		[redacted] babies came directly to the Simpson, all were at the dispatching hospital < 14 hours. [redacted] babies came from Fife via other hospitals. These

							babies were later admitted to RIE after 7 and 4 days respectively.
2	**Mother and baby kept together**	2.1	Accommodation available for parents on or near neonatal unit	Was accommodation available and offered to parents?	NNU data		Accommodation is available within the unit (2x double rooms) and on the floor above (2x doubles and 2x singles).
3	**Parents were informed about what was happening**	3.1	Information leaflet available for parents	Information leaflet available that describes new model of care		All	These are given by the referring hospital. We currently have a workstream in progress to develop a neonatal services website for parents to access also.
4.	**Parents were involved in babies care**	4.1	Parents involved in ward rounds	As per NNAP measure	Badgernet (neonatal)	RIE	Parents are actively involved in face to face ward rounds, they are welcome to stay and be involved with all conversations. There is an option in Badgernet to

							record whether a parent has attended.
		4.2	Unit working towards Bliss Baby Charter accreditation	Unit has signed up to the Bliss Baby Charter accreditation process and is working towards achieving accreditation.		RIE	We have recently attained our Pledge of Improvement certificate (November 2022). Work is ongoing to gain our Bliss Baby Charter accreditation. This accreditation is dependent upon completion of works to improve parent & family facilities on the unit.

Qualitative measures

	Outcome		Qualitative Measure	Measurement	November 2022 Position
5.	**Operation of new model of neonatal intensive care**	5.1	Safe and effective in utero transfer	Agreed network approach	Currently there is a weekly video conference with Fife in place. If this has not been needed then there is an email between the units to confirm any activity. The Fife team have also attended our NNU educational meetings programme.
		5.2	Timely and appropriate repatriation of babies back to nearest Local Neonatal Unit	As above	A daily conference call is held between all the neonatal units in Scotland where we identify opportunities for babies to be transferred back to their local neonatal units/referral centres. Where capacity allows we aim to facilitate this at the earliest safe time to transfer the babies. We also proactively discuss repatriation plans with our colleagues in Fife at our weekly conference.
		5.3	Ability of NICUs to remain open to referrals at all times	Exception reporting	The NHS Lothian NNU is declared open at all times. Referrals are considered and risk assessed on an individual basis and babies are accommodated wherever possible. Despite very high activity in the Unit and staffing

					challenges, no ongoing issues have been reported with capacity.
		5.4	Effective communications	As above	As above (5.1 and 5.2).
		5.5	Transfer process	As above, with ScotSTAR/SAS input	We are not aware of any issues arising from ScotSTAR. All transfers appear to have been smooth with no issues reported.
	Mother and baby kept together	5.6	Did parents feel they had every opportunity to be with their baby?		Parents are welcome in the unit at all times. All parents are offered an opportunity to provide feedback on the care they receive. Where possible, parents are offered the opportunity to accompany their baby when they are repatriated by ScotSTAR.
6.	**Parents were informed about what was happening**	6.1	Did parents understand why their baby was being transferred	As above	Parental questionnaires have not been developed, however parents have the opportunity to provide feedback and no issues related to this have been identified.
		6.2	Was the transfer process explained to parents	As above	Yes.
		6.3	Did parents understand the repatriation process	As above	Parental questionnaires have not been developed, however parents have the opportunity to provide feedback and no issues related to this have been identified.
7.	**Parents were involved in babies care**	7.1	Did parents feel informed and part of decision making process	Neonatal unit feedback / parental questionnaire	We receive excellent verbal and written feedback from parents. An

			in relation to their babies care		online questionnaire has been developed but is not well utilised.

Summary of improvement work to support Keeping Mothers and Babies Together

1. Extending transitional care and keeping babies together with mothers on the wards

Transitional care on the postnatal wards is now well established at the RIE. To date 243 babies (late preterm and term) have been cared for on the maternity wards. The introduction of criteria-led discharge has allowed babies to be discharged from the NNU to the postnatal ward at the earliest opportunity has significantly reduced length of stay and minimised separation of mother and baby.

In order to provide transitional care for all eligible babies, an additional nursery nurse is required on each shift. To achieve this an additional 5.4 WTE nursery nurses are required. These additional posts were funded and filled in February 2020 using Best Start funding allocated by Scottish Government, however funding for these posts ceased in February 2022 and further funding has yet to be confirmed. As some nursery nurses have since left or reduced their working hours, there are now only 1.23 WTE additional staff in post. We have been unable to fill the vacancies due to lack of ongoing funding.

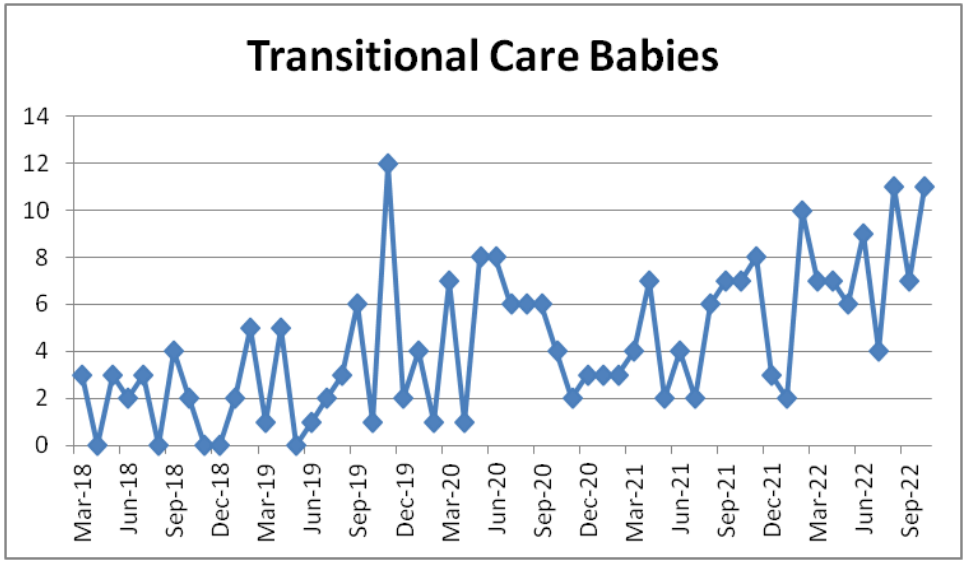

Fig. 1. Demonstrating increase in babies cared for in transitional care over time.

2. Keeping mothers and babies together once discharged home

Promoting care of well, term, breastfed babies with 10-13% weight loss in the community setting: Following an update of guidelines and ongoing support from a neonatal consultant offered to the community midwifery teams when assessing babies, we have been able to offer extended care at home from the community midwives without needing review by neonatal staff. Prior to this improvement model these babies would have had to attend the neonatal unit for review and management.

Home phototherapy: Home phototherapy was introduced in April 2020 at the Edinburgh site, and in June 2022 at the St John's site, thus avoiding separation of mother and baby as well as the need for readmission to hospital. In 2022, the following babies received home phototherapy:

Phototherapy in the community			
Month	RIE	SJH	Total
January	[redacted]	N/A	[redacted]
February	[redacted]	N/A	[redacted]
March	[redacted]	N/A	[redacted]
April	[redacted]	N/A	[redacted]
May	[redacted]	N/A	[redacted]
June	[redacted]	[redacted]	[redacted]
July	[redacted]	[redacted]	[redacted]
August	12	[redacted]	19
September	[redacted]	[redacted]	[redacted]
October	12	[redacted]	13

3. 7-Day Neonatal Community service to support discharge and ongoing care

The neonatal community team has been fully established since June 2020. This includes appointment to the new post of Community Team Lead. This new Band 7 post was funded for 1 year and while the Team Lead remains in post, ongoing funding has not been confirmed by Scottish Government. The community team provide a 7-day service across NHS Lothian with staff working 12.5-hour shifts.

Since October 2019 the community team have been supporting families to feed their babies by nasogastric tube in the home setting. Numbers of babies have been steadily increasing, with approximately 5-6 babies offered this service at home each month. This service has reduced the length of stay by approximately 5 days per baby.

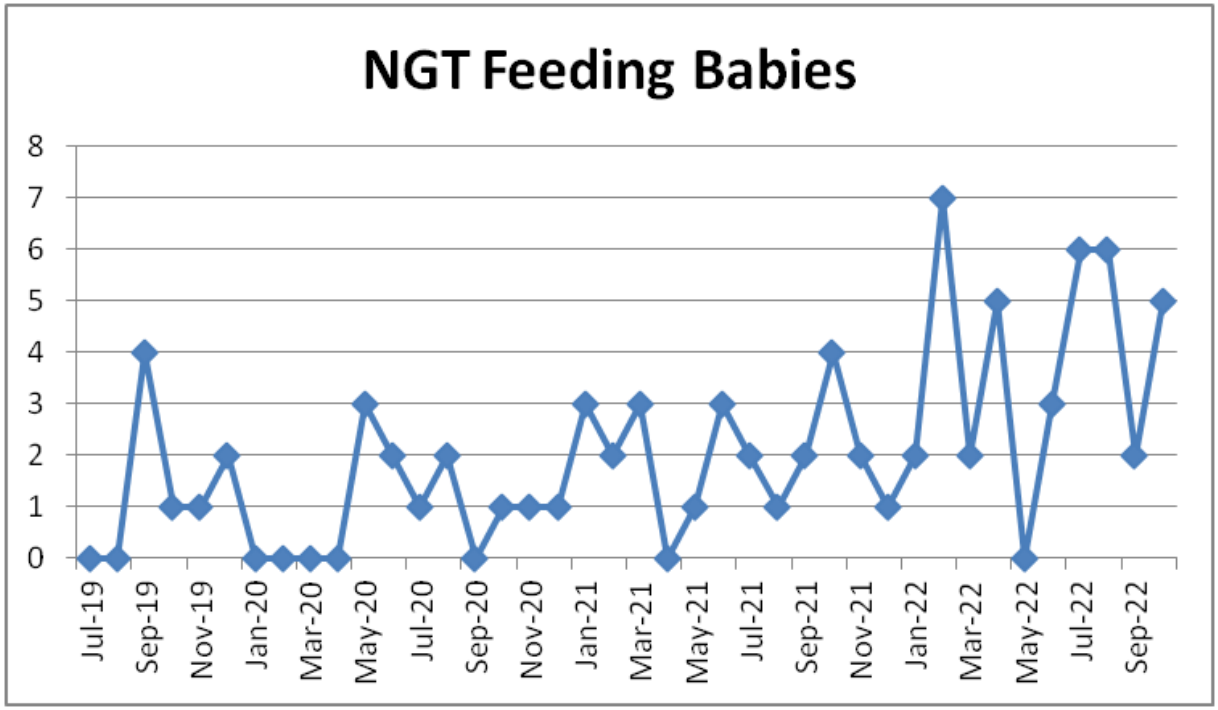

Fig. 2. Number of babies discharged home with NGT feeding has been steadily increasing.

A joint working group with the NHS Lothian Children's Community Nursing Team has been established to develop shared governance, guidelines and pathways. Work is ongoing to develop electronic patient records which link babies' maternity and neonatal notes for easy communication between neonatal and midwifery teams.

To ensure an equitable service across NHS Lothian, all KMBT initiatives are now being rolled out at St John's Hospital by staff in the Special Care Baby Unit. They are now able to offer at-home phototherapy and at-home NG feeding.

4. Development of skills and rotation for staff in smaller units within catchment for NICU

This work stalled somewhat during the Covid pandemic but is now being revisited. There is no specific plan in place with Fife about how to maintain skills and rotation of staff with Fife, however discussions around how to develop and sustain this rotation have commenced.

NHS Lothian has identified time within the new neonatal consultant workforce model to increase availability to support local units. NHS Lothian currently attends the Borders General Hospital once month for an education and training session.

5. Developing Parent/Family Involvement

A Family Integrated Care (FiCare) Improvement Programme has been established with two neonatal consultant leads. The team has visited and been working with the GG&C FiCare team to learn from their experience. Examples of improvement initiatives include:

- **Roll out of vCreate** (secure video messaging service that helps NNU team stay connected with families throughout their care journey): This encourages parental engagement and empowerment. NHS Lothian has successfully launched this and has been featured in a BAPM webinar and also on Scotland radio.
- **Parental admission pack**: Promotes bonding, initiates principles of developmental care, benefits of reading to baby.
- **Parental 24/7 access**: No exclusion during ward rounds. This encourages parents to be partners in care and be present for shared decision making.
- **Cue based feeding package**: Led by senior nursing team to support parents to learn baby cues.
- **Home NGT feeding package**: Led by HDU/neonatal community team and Dr Angela Davidson, promotes earlier discharge.
- **Re-instatement of quiet hour**: Promotes skin-to-skin or kangaroo care.
- **Sibling packs:** Help families talk with older siblings about preterm birth.
- **PEP talks - Parental Empowerment Programme:** Knowledge is power. Pilot of parental education sessions interrupted by Covid and not yet returned.
- **Parental co-design:** Developing a new communication tool around neurological imaging and consequences of preterm birth.

- **New electronic patient questionnaire**: Designed to use feedback data in real time to drive parent-focused change. Main points relate to RIE facilities and some suggestions for improvement in continuity of communication.

- **Keeping Mothers and Babies Together workstream:** Reducing term admission, prompt discharge with criteria-led discharge programme, keeping babies at home where possible - all important work but perhaps not necessarily ways to involve families)
- **Coming up in 2023:**
    - Pilot of parents joining ward round virtually
    - Pilot of parent-led ward rounds
    - Parental focus group on improving parental experience: Volunteers found following Simpson's Special Care Baby charity drive

6. Enhance education and promote innovation:

- Introduction of cue-based feeding package:
    - This package involves both a staff education and a parental education package.
    - It includes details on passing a nasogastric tube, testing the pH of aspirate, and offering an NG feed.
    - It aims to increase confidence of staff as teachers, and of families as primary care-givers and to ultimately facilitate earlier discharge with the support of the community team.
- Bespoke design and introduction of baby milestone cards.
- Pilot of parent education sessions for providing ongoing care at home, looking to focus on: Monitoring baby's temperature at home; Resuscitation; Going home / going out; Baby-led feeding; Safe sleeping; Identifying a sick baby.
- Development of innovative, responsively designed neonatal services website to support families.

7. Moderate preterm follow up clinic

Our specialised, multidisciplinary (MDT) clinic for moderate preterm infants works to:

- Give MDT expert support in an efficient manner for infants who would normally only see a consultant and only virtually for the last 2 and a half years.
- Give parents more confidence in looking after their babies: This includes all areas of development as well as knowing where to seek help should they require it.
- Offer peer support for families who attend during the sessions and the families in the group have kept in touch after the group has finished. This was highly valued by families in the questionnaire post clinic.

- Offer a highly specialist physiotherapist review. We have managed to identify four babies, at three months corrected gestation, who were at increased risk of poor developmental outcomes, allowing the earliest possible intervention and therefore the best outcomes. These babies had been reviewed in the consultant clinic with no problems seen at this age.

8. Improvement in parental facilities aiming for an improved family experience:

High dependency and special care

Reclining chairs are now available to parents in all nurseries. These provide a comfortable and welcoming environment for families, encouraging them to spend time with their babies and in particular, promoting skin to skin time.

Whiteboards are available at each cot space. The boards are used by families to communicate to staff, and vice-versa. This method of communication has enhanced communication and family satisfaction.

Neonatal unit refurbishment

Involvement of FiCare group in the planned neonatal unit refurbishment that includes improved parents' overnight accommodation and the establishment of a parental lounge area with kitchen facilities. Unfortunately the refurbishment has been severely delayed due to problems resolving financial agreements between NHS Lothian and the building freeholder. These are outwith the Unit's control and no date has been confirmed to start the programme of works. The Neonatal Unit charity, Simpson's Special Care Babies, is financially supporting the refurbishment.

Listening to our families

The neonatal unit discharge questionnaire has been refreshed and re-launched. This obtains valuable family feedback on unit performance, parental experience and family information. It has been re-designed in collaboration with families, including the ideal format (QR code) and timing of receiving the questionnaire, as well as the entire content being reviewed and updated. This will allow continued improvement upon regular receipt of these questionnaires.

9. Support for families with an aim to improve family experience and reduce parental psychological burden

The Maternity and Neonatal Psychological Intervention (MNPI) team works closely with families to provide psychological and emotional support. In 2020, 1.2 WTE Clinical Psychologists were appointed to develop and deliver the service that had been scoped for the NNU. Alongside this, the Scottish Government released the Delivering Effective Services report to outline the nature of anticipated Maternity & Neonatal Psychological Interventions services across Scotland. NHS Lothian submitted a bid for MNPI funding which was partially awarded. Since then, the NNU service has been maintained, delivering support for families and for staff. The aims of the service are inherently linked with improving family experience and reducing parental psychological burden. MNPI support for neonatal families includes:

- **Antenatally, where a high likelihood of neonatal care is indicated**
    - Information for parents about MNPI supports and consultation for neonatal team;
- **During baby's inpatient care episode**
    - Access to the service for all NNU families, with assessment and signposting where needed.
    - Staff consultation and liaison
    - Responsive support for acute stress response and coping
    - Collaboration with partner agencies to provide peer and befriending support: Neonatal Dads Online – DadsRock; Aberlour (East Lothian)
- **Following a neonatal care episode (up to 1 year post baby's discharge)**
    - Access to trauma focussed and/or parent-infant interventions
    - Link to perinatal trauma pathway
    - Link to bereavement pathway
- **During a subsequent pregnancy**
    - Link to tokophobia/complex adjustment pathways
    - In development: Access to adapted group service (online)
    - Linking in with partner agencies
- **Support for staff & staff training**
    - Responsive group supports; signposting; supervision of peer supporters
- **Service development**
    - Ongoing contribution and consultation for neonatal unit service development e.g. public facing website, family feedback questionnaire/process

Concurrent to NNU service development, scoping was undertaken for maternity services and additional roles including Clinical Psychology, Clinical Associate of Applied Psychology and Specialist Midwife have been approved and recruited to, with the full MNPI team launched in May 2022. Current full MNPI service delivery in addition to the neonatal service includes:

- Evidence based 1:1 psychological interventions & group work
- Maternity inpatients responsive support service
- Birth Reflections Service in conjunction with midwifery colleagues

From: [redacted]
To: [redacted]
Cc: [redacted]
Subject: Re: Neonatal Early Implementers - Capturing Data and Sharing Learning
Date: 25 November 2022 16:09:15
Attachments: 20221122.Neonatal.EarlyImplementer.Report.docx

Hi [redacted], I've put some data in this document. If you can add A&A data/comment, that would be great.
[redacted]

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From: [redacted]@aapct.scot.nhs.uk>
Sent: Friday, November 25, 2022 4:03:58 PM
To: [redacted]@ggc.scot.nhs.uk>; [redacted]
[redacted]@aapct.scot.nhs.uk>; [redacted]@gov.scot>
Cc: [redacted]
Subject: Re: Neonatal Early Implementers - Capturing Data and Sharing Learning

[redacted],

Do you want me to fill in the right-hand column (currently labelled '13th January Position') with Ayrshire data for the time period 19/08/19 to 04/11/22?

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

The Best Start – New Model of Neonatal Care

NHS GGC & NHS Ayrshire & Arran Early Implementers Evaluation Report – Update November 2022

Prepared by [redacted], Clinical Director, NHS GGC Neonatal Services

Introduction

On 19th of August 2019, the neonatal unit in Crosshouse Hospital, Ayrshire changed its level of function and aimed to deliver babies of 25+6 weeks gestation and under at the Queen Elizabeth University Hospital / Royal Hospital for Children, Glasgow (or the Royal Infirmary Edinburgh, where there is no capacity in the RHCG).

From Monday 4th November 2019 the criteria to consider in utero transfer of women to Queen Elizabeth University Hospital, Glasgow was extended to include;

1. All women likely to deliver at gestation 26+6 weeks or less (no change to current process)
2. All multiple pregnancies likely to deliver at gestation 27+6 weeks or less (extension of one week to current process)
3. All women likely to deliver a baby of less than 800gm as estimated on ultrasound scan (new criterion).

The following data are from the period 19/8/2019 until 4/11/22 and represent the care delivered in RHC – it does not reflect data for babies who did not follow the established pathway. In some cases where babies were born in Ayrshire close the to the upper thresholds indicated, joint assessments have been undertaken and RHC consultants have provided remote support. (data obtained from Badgernet neonatal)

Criteria 1

14 babies born at **<27+0** weeks, booked in Ayrshire & Arran, cared for in RHC

Born	22	23	24	25	26	Total
Ayrshire	[redacted]			[redacted]	[redacted]	[redacted]
QEUH		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Days of Care: 241 Intensive Care, 175 High Care, Zero Special Care days

Criteria 2

No multiples of 27+0 to 27+6 were cared for in RHC

Criteria 3

[redacted]babies with a birth weight <800g and born at ≥ 27+0 were cared for in RHC – [redacted]born in QEUH & [redacted]in Ayrshire

Additional Care

94 babies born at **≥ 27+0** weeks, booked in Ayrshire & Arran, cared for in RHC

68 born in Ayrshire, 26 born in QEUH

Days of Care: 585 Intensive Care, 443 High Care, 274 Special Care (includes those meeting Criteria 3)

Short term outcomes/measures

Quantitative Measures

	Outcome		Measure	Definition	Measurement system	Who?	4th November 2022 Position
1	**New Model of Neonatal Intensive Care:**	1.1	Number of NHS A&A babies meeting NICU criteria	Number of babies meeting criteria for	Badgernet neonatal	A&A	See above for known data regarding babies

	Appropriate and timely transfers			complex and/or prolonged NICU care			following pathway to QUEH/RHC
		1.2.1	Number of in utero transfers for NICU care		In-utero coordination service	A&A	
		1.2.2	Number of in utero transfers for NICU care who don't deliver	No of mothers and length of antenatal stay			
		1.3.1	Number ex utero transfers of babies meeting NICU criteria		Badgernet neonatal	A&A	See above for known data regarding babies following pathway to QUEH/RHC
		1.3.2	Length of babies stay in LNU before transfer to QEUH/ERI		Badgernet neonatal	A&A	n/a
2	**Mother and baby kept together**	2.1	Accommodation available for parents on or near neonatal unit	Was accommodation available and offered to parents?	Locally collected	RHC	QEUH has facilities (Both IP & Ronald McDonald House or local hotel accommodation at short notice)
3	**Parents were informed about what was happening**	3.1	Information leaflet available for parents	Information leaflet available that describes new model of care	Yes/no	All	Yes - in RHC patients receive information about the unit on arrival.

4.	**Parents were involved in babies care**	4.1	Parents involved in ward rounds	As per NNAP measure	Badgernet	RHC	Yes - Parents invited to all Ward Rounds. Family Integrated Care at the heart of model of care. 88% of all parents attended at least one ward round in RHC in 2021. For babies admitted for >7days this is 95%. *(NNAP reports for England and Wales a figure of 86% for all parents – Scotland not in this analysis.)*
		4.2	Unit working towards Bliss Baby Charter accreditation	Unit has signed up to the Bliss Baby Charter accreditation process and is working towards achieving accreditation.	Yes / no	RHC	Yes - RHC achieved Bliss Baby Charter Gold Award in 2022

Qualitative measures

	Outcome		Qualitative Measure	Measurement	4th November 2022 Position
5.	**Operation of new model of neonatal intensive care**	5.1	Safe and effective in utero transfer	Monthly case conference review of discharged babies to discuss – including neonatal and maternity input from both sites to discuss systems and processes for transfer, to cover cases where in utero transfer did not occur and joint decision making around these cases.	Daily call in place to determine need for transfer and discuss repatriation. Weekly repatriation calls to update LNU team on babies in RHC and follow up on babies repatriated. Yearly network led review of <27wks not born in maternity with NICU.
		5.2	Timely and appropriate repatriation of babies back to nearest Local Neonatal Unit	As above	Weekly discussion between units facilitates repatriation when both teams content. No currently defined measurement of "timely and appropriate"
		5.3	Ability of NICUs to remain open to referrals at all times	Exception reporting	Daily calls between all Scottish units to determine capacity to accept referrals. RHC will only exceptionally be closed i.e. national service for cardiac/ECLS etc. SPN have data on transfers not following early implementer pathway. RHC capacity to accept transfer is limited mostly by staffing. Nursing establishment is in turn limited by

					identified workload. Should greater workload be created through announcement of 3-5 NICUs, staffing should increase with appropriate reallocation of funding.
		5.4	Effective communications	As above	The previously instituted daily Neonatal Consultant phone call between Ayrshire and Arran and RHC has been replaced by weekly calls with agreement of both organisations Comprehensive discharge letters are completed and shared at the time of transfer.
		5.5	Transfer process	As above, but with ScotSTAR/SAS input	Acute transfers are arranged via ScotSTAR conference calls. The RHC consultant is available to participate 24/7. Elective repatriations are identified in advance and communicated to ScotSTAR neonatal by a customised electronic tool.
	Mother and baby kept together	5.6	Did parents feel they had every opportunity to be with their baby	Parental questionnaire	No questionnaire since process became business as usual.

6.	**Parents were informed about what was happening**	6.1	Did parents understand why their baby was being transferred	As above	n/a
		6.2	Was the transfer process explained to parents	As above	n/a
		6.3	Did parents understand the repatriation process	As above	n/a
7.	**Parents were involved in babies care**	7.1	Did parents feel informed and part of decision making process in relation to their babies care	As above -	Parental partnership in care is fundamental to the Bliss Baby Charter. Assessment. Successful audit of parents required that they describe positive involvement in decision making.

Forward View Towards Medium/Long Term Outcomes

Transitional Care

Transitional Care in place at Cross House since December 2018
GGC developing TC firstly in PRM before developing in QEUH.

Developing Parent/Family Involvement

The RHC Neonatal Unit is committed to ensuring that parents and families are partners in the care of their baby/babies. The unit has a well-established family integrated care group "HUG", who have presented their achievements locally, nationally and internationally.

The RHC Neonatal Unit was among the first in Scotland to achieve Stage 3 UNICEF Neonatal Baby Friendly Accreditation in 2018 and the first to achieve Bliss Charter Gold Standard.

7-Day Neonatal Community service to support discharge and ongoing care.

GG&C have expanded their liaison staffing. They are close to providing a 7-day service in PRM and working toward further expansion in RHC. Outreach surgical liaison supports repatriation to LNUs with ongoing surgical conditions, e.g. stoma care.

Development of skills and rotation for staff in smaller units within catchment for NICU.

Within GGC there is a robust Education plan to staff, supported by 3 Neonatal Educators and Neonatal Infant Feeding Advisor. Nursing staff undertaking the neonatal Qualification in Speciality or Advanced Practice course who are based in the GGC Level 2 Unit are given the opportunity to work within the Level 3 units for a period to gain experience in intensive care. Though there is at present no planned rotation of staff across the 3 units they are moved on a regular basis to support activity as required. QiS availability and cost is a current and future concern for all neonatal units in Scotland

GGC neonatal teams have been actively involved in the National Discharge Planning Group.

Strategy

GGC is developing the latest version of its Maternity and Neonatal Strategy. In many ways the neonatal strategy requires a clear Scottish Government announcement to allow staff and public engagement, and open and transparent discussion around capacity, staffing , service redesign, funding, education, and much more.