Best Start in Lothian

Maternity and Neonatal Strategy

2018 - 2023
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Foreword

Welcome to NHS Lothian’s five year strategy for Maternity and Neonatal services across Lothian. This strategy sets the direction for the modernisation of our model of care in line with the Scottish five year strategy ‘The Best Start: A Five Year Forward Plan for Maternity and Neonatal Care’ (Scottish Government January 2017).

Within Lothian, we care for between 9,000 and 10,000 births per year, caring throughout the antenatal period, labour and after each birth. We have a strong and proud tradition of being a leader in care and our centres provide regional and national expertise in obstetric and neonatal care.

In addition to caring for women, babies and their families within Lothian, we receive and care for women and babies from other health board areas who need intensive or specialised care.

Having a baby is the most special of periods in any family’s life and we recognise that our care is very important, not only to ensure high quality and safe care but also to provide trusted relationships between families and health professionals to ensure our care is person-centred and supportive of people’s individual needs.

The ‘Best Start in Lothian – Maternity and Neonatal Strategy 2018 – 2023’ mirrors the national strategy for Scotland within the context of Lothian.

We look forward to a five year period of significant focus, transformation and a new model of care which aims to place all our mothers and babies at the heart of service design.

Professor Alex McMahon
Executive Director Nursing, Midwifery and Allied Healthcare Professionals
Section 1
Setting the Scene
1. Setting the Scene

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

On 20th of January 2017, the Scottish Government released the new five year strategy for Scotland The Best Start: A Five Year Forward Plan for Maternity and Neonatal Care, which sets out a vision for the future planning, design and safe delivery of high quality maternity and neonatal services in Scotland. It puts the family at the centre of decisions so that all women, babies and their families get the highest quality of care according to their needs. Jane Grant, Chief Executive, NHS Greater Glasgow and Clyde was appointed on 21 February 2017 to lead the implementation of the recommendations. The Minister for Public Health and Sport (Aileen Campbell) responded to the review in a statement to Parliament on 21 February and outlined her priorities for implementation.

Extract from Ms Campbell's speech

‘Every day, our maternity services deliver an excellent service to families across Scotland. In our maternity care experience survey, women reported over 90 percent satisfaction with the care that they had received. We also continue to reduce rates of maternal mortality, stillbirth and neonatal mortality in Scotland to record low levels. The number of neonatal deaths has reduced by 40% since 2007, which means that, in 2015, 76 more babies’ lives were saved by the high-quality care that was provided by staff in neonatal units across Scotland. It also means that there were 76 fewer bereaved families. That improvement is a testament to the hard work of the staff who look after sick babies in Scotland. Our maternity system secures high satisfaction ratings among women and continues to improve care and outcomes for the sickest babies. We are in a position of strength, but we are not complacent and know that there is much that we can do to make further improvements. That desire to improve and transform in part inspired the review. The report is a landmark publication that represents a major opportunity to improve services even further, and its recommendations will transform service delivery in Scotland.

For example, some women currently experience no continuity of maternity care and can see numerous different midwives and obstetricians throughout their care journey. That is not what women or staff want, and evidence tells us that it is not good for care. To give women and staff what they tell us they want – which the report describes as family-centred care – will require a radical shift in how we deliver care. There is no doubt that such a change will be challenging to deliver and, for many of our midwives and obstetricians, will represent a significant change in ways of working, but it will ensure better care.’
1. Setting the Scene

The Best Start Vision:

All mothers and babies are offered a truly family-centred, safe and compassionate approach to their care, recognising their own unique circumstances and preferences.

Fathers, partners and other family members are actively encouraged and supported to become an integral part of all aspects of maternal and newborn care.

Women experience real continuity of care and carer, across the whole maternity journey, with vulnerable families being offered any additional tailored support they may require.

Services are redesigned using the best available evidence, to ensure optimal outcomes and sustainability, and maximise the opportunity to support normal birth processes and avoid unnecessary complications.

Staff are empathetic, skilled and well supported to deliver high quality safe services, every time.

Multi-professional team working is the norm with an open and honest team culture, with everyone’s contribution being equally valued.
1. Setting the Scene

Main recommendations of Best Start:

- **Continuity of carer**
  - From primary midwife and obstetrician through prenatal, intrapartum and postnatal care
  - Care co-located for the provision of community and hospital-based services
- **Person-centred maternity and neonatal care**
  - Relationship-based, personalised care
  - Aiming to keeping mums, babies and families together
  - Safe and family-centred neonatal care
- **Multidisciplinary team care**
  - Women receive the level of care they need
  - Clear referral pathways
- **Safe, high quality and accessible care**
  - Development of community hubs
  - Postnatal neonatal care
  - Specialist maternity and neonatal care co-located
  - Support for vulnerable women and improved perinatal mental health services
- **Neonatal care**
  - Three to five neonatal intensive care units should be the immediate model for Scotland, moving to three within five years
  - Development of a national model for 7 day neonatal community services
- **Transport**
  - Recommendations focused on safe and prompt transfer of neonates, and clear cot identification
- **Remote and Rural care**
  - Formalising support for additional skills and competencies in relation to remote and rural working
- **Workforce**
  - Workforce planning, and planning for training and education
- **IT and Quality improvement**
  - Development of quality improvement dashboards
  - Single maternity care system and electronic maternity record.
1. Setting the Scene

National Implementation Programme Board and Implementation Plan

An Implementation Programme Board has been established and met for the first time on 9 June 2017, chaired by Jane Grant, Chief Executive of NHS Greater Glasgow and Clyde, with representation from across Scotland. The group have agreed which of the 76 recommendations require national, regional or local delivery. 23 of these 76 are deemed within the gift of local health boards to deliver via their own redesign and modernisation processes.

In addition, the Scottish Government wrote to Health Boards (17/8/17) asking for expressions of interest in becoming an Early Adopter Board (EAB). NHS Lothian expressed an interest and after submission of supplementary information (see additional document) the Scottish Government formally offered NHS Lothian a position as one of the 5 Early Adopter Boards (25/9/17).

Early Adopter Boards were asked to demonstrate:

- Senior leadership support to ensure local leadership and governance
- Ability to undertake workforce planning to underpin the new models and ways of working
- Ability to support staff development and training as part of the change management process

- A willingness and ability to share learning throughout the process, and use this to support wider NHS implementation
- A willingness and ability to report data on a range of nationally agreed outcomes
- An organisational culture that can support and implement change, with planning anticipated towards the end of 2017 and implementation from the first half of 2018.

It is anticipated that Early Adopter Boards across Scotland, would lead the way in implementing:

- Midwifery continuity of carer model for all women, including vulnerable women and families
- A new model for hospital-based maternity services, including postnatal neonatal care, and the associated core workforce
- Aligned and co-located midwifery and obstetric teams
- Enhanced roles for support workers in the community and in community hubs
- Community Hubs for the delivery of maternity care and, in time, neonatal outreach.
1. Setting the Scene

The policy landscape shaping Best Start strategy and implementation:

Within Scotland, the themes of Early Years and Supporting Children, Young People and Families are fundamental. The maternity and neonatal periods are the building blocks to make Scotland the best place to grow up.

Getting it right for the children of Scotland is the best prevention we can make within public life, as healthy, happy and achieving children grow up to be productive, healthy, happy adults.

Getting it Right for Every Child (GIRFEC) and Children and Young People (Scotland) Act 2014

Getting it right for every child is vital, and this starts from preconception onwards. In Scotland, Getting It Right for Every Child (GIRFEC) has been a national approach to children and young people services for 10 years, and moved into law under the Children and Young People (Scotland) Act 2014.

The Best Start: A Five Year Forward Plan for Maternity and Neonatal Care starts the journey to Getting it Right for Every Child in Scotland. Midwives will link with health visitors in the antenatal period using the GIRFEC model and in preparation for handover to the health visitor in the postnatal period.

The new Universal Pre-Birth to Preschool Pathway for all of Scotland’s children (delivered by health visitors and family nurses) commenced in Lothian from October 2016. This supports a holistic and person-centred model, where levels of support are tailored to each family’s needs. Therefore the changes to the model of care under Best Start will dovetail into the Universal Pathway bringing supportive models of care from pre-birth through preschool.
1. Setting the Scene

Royal College of Midwives: ‘Getting the Midwifery Workforce Right’

In 2016, the Royal College of Midwives launched ‘Getting the Midwifery Workforce Right’. Their report is reflected in the Best Start recommendations from Scottish Government relating to continuity of midwifery care.

NICE Safe Midwifery Staffing for Maternity Settings Guidelines NG4 2015

In February 2015, The National Institute for Health and Care Excellence (NICE) published NICE Safe Midwifery Staffing for Maternity Settings Guidelines NG4 2015 which set out recommendations for safe staffing in maternity settings. The report was published following high profile reports on failings in maternity care including the ‘The Report of the Morecambe Bay Investigation’. In response to the NICE report, the Royal College of Midwives (RCM) published ‘RCM Guidance on Implementing the NICE Safe Staffing Guidelines on Maternity Staffing in Maternity Settings’ which emphasises the importance of having the right number of staff available to care for mothers and babies and makes recommendations on clinical governance, transparency and continuity of care. The importance of a culture of mutual respect was highlighted as important to sustain effective working relationships.

Health and Social Care Delivery Plan (December 2016)

This plan sets out the programme to further enhance health and social care services, which are systems that:

- Are integrated
- Focus on prevention, anticipation and supported self management
- Take forward the recommendations from the 2015 Maternity and Neonatal Review
- Will make day-case treatment the norm, where hospital treatment is required and cannot be provided in a community setting
- Focuses on care being provided to the highest standards of quality and safety, wherever the setting, with the person at the centre of all decisions
- Ensures people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

The plan focuses on three areas, referred to as the ‘triple aim’:

Better Care – Better Health – Better Value

GP Contract and Scottish Government Primary Care Visions and Outcomes

The role of the GP is transforming to become an ‘Expert Medical Generalist’ in the community, focusing on complex care; undifferentiated illness; and outcomes, quality and leadership – the way to make best use of GP skills. Other roles in primary care are evolving, such as advanced nurse practitioners, the role of pharmacists, paramedics, etc.
1. Setting the Scene

The role of the GP in maternity and neonatal care has reduced with past policy, with the clear role of midwives in community and linked geographical obstetricians. The GP role in complex care will continue for women who have long term conditions and ongoing medical needs throughout their pregnancy and beyond. The role of the health visitor as a primary care member will also support the joint working between maternity care and primary care.

The World Health Organisation report on stillbirths and neonatal deaths (WHO 2016) highlighted the importance of examining individual cases to identify underlying reasons for the deaths and provide opportunities to learn what is needed to prevent similar deaths. A full review is completed for every baby who dies in Lothian. A retrospective audit of a random selection of 16 stillbirth case reviews from 2015-2017 across RIE and St John’s maternity services was conducted in 2017 to ensure that the appropriate review process had taken place. In each case, the reviewers considered: whether multidisciplinary team review took place, whether the appropriate method was used, whether a significant adverse event review was done if needed, and the date at which the significant adverse event review took place. The reviewers concluded that there is a reliable and appropriate review process for significant adverse events and stillbirths within NHS Lothian Maternity Services.

The AFFIRM Study

The AFFIRM study aims to reduce stillbirth by implementing and testing a package a care to recognise, assess and manage reduced fetal movement. It was launched in 2014 and has been rolled out across the UK at different time periods. Lothian was in the first cluster in early 2014.

For more information on stillbirths, see the birth outcomes section of the Additional Document: What do we know about Lothian (ADD LINK)
Improvement Work in Lothian

Being Open Improvement Work

A model of clinical communication training that enables staff to have effective, supportive discussions with families about adverse events and to involve families in the review process has been developed and tested in Lothian in response to the Lancet Executive Report (Heazall, 2016) that “Empathic behaviour in all encounters between bereaved parents and care providers can minimise additional emotional and psychological costs, both immediately after the stillbirth of a baby and in the longer term”.

The Being Open work is based on the National Patient Safety Agency (NPSA) framework – ‘Being Open, saying sorry when things go wrong’ (2009). It will also help meet most of the requirements for the Duty of Candour Act (2006) which will begin reporting in 2018. This process is now reliably embedded within Maternity Services and is being spread to other areas in a bid to implement it across all acute services.
Section 2


This section reports on our progress in the ‘NHS Lothian Maternity Plan 2009-2015’

In the period following the previous plan, we delivered many service improvements in care and facilities. We modernised the labour ward at St John’s Hospital (SJH), and neonatal units at SJH and the Royal Infirmary of Edinburgh’s Simpson Centre for Reproductive Health (SCRH). We opened the Birth Centre at SCRH. We also worked to improve the health of mothers and babies across Lothian and reduce inequalities.

Although there has been a period between the end of the last strategy and the beginning of our current strategy, work has continued in Lothian to achieve the strategic vision of the NHS Lothian Maternity Plan 2009-2015 while awaiting the Scottish Government’s ‘Best Start’ strategy.

To evaluate whether we have delivered what we planned in the NHS Lothian Maternity Plan 2009-2015, we look at how well we met some of the key objectives in Maternity Services Action Plan 2009-2015. For each objective listed below, we evaluate whether we achieved it and describe key achievements which helped deliver our aims.

![Interior View of Birth Centre at Simpson's Centre for Reproductive Health](image)

Did we deliver on improving the health of mothers and babies in Lothian?

1. **What did we set out to do:** Implement agreed, evidence Based parenting frameworks

**Did we achieve it?** We are making progress across the Region and our key achievements are:

- **Bump Start Pregnancy Cafes**
  This work is done in partnership with the City of Edinburgh Council and uses the principles of the Baby Friendly Initiative to promote breastfeeding and attachment

- **Solihull Training**
  Support parents/children to promote healthy attachment

- **Sling Library with West Lothian Council**
  Using a sling or “baby wearing” promotes bonding and attachment between babies and parents

- **Training/Support of Sure Start**
  Promoting breastfeeding and weaning training, peer support

- **Triple P, Incredible Years, and Dads2b parenting programmes**

2. What we set out to do: Establish Direct Booking Service to improve antenatal care

Did we achieve it? In 2010, NHS Lothian set up the Direct Booking Service for pregnant women so that mothers can phone up and book appointments with midwives directly without having to go through their GP.

Key achievements: Direct Booking Service

Our booking rates have improved each year since 2011. The Government target (HEAT target) is that 80% of women in each socio-economic group (SIMD quintile) will book for pregnancy care by the end of the 12th week of pregnancy.

Antenatal Booking by Lothian HSCP 2011 - 2017

<table>
<thead>
<tr>
<th></th>
<th>Edinburgh CHP</th>
<th>Midlothian CHP</th>
<th>West Lothian CHP</th>
<th>East Lothian CHP</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>86.80%</td>
<td>88.99%</td>
<td>86.79%</td>
<td>86.78%</td>
<td>87.04%</td>
</tr>
<tr>
<td>2012</td>
<td>90.02%</td>
<td>91.88%</td>
<td>88.96%</td>
<td>91.31%</td>
<td>90.12%</td>
</tr>
<tr>
<td>2013</td>
<td>90.32%</td>
<td>92.35%</td>
<td>90.97%</td>
<td>91.14%</td>
<td>90.73%</td>
</tr>
<tr>
<td>2014</td>
<td>90.72%</td>
<td>92.60%</td>
<td>90.22%</td>
<td>91.22%</td>
<td>90.87%</td>
</tr>
<tr>
<td>2015</td>
<td>90.86%</td>
<td>93.34%</td>
<td>90.79%</td>
<td>94.19%</td>
<td>91.48%</td>
</tr>
<tr>
<td>2016</td>
<td>90.62%</td>
<td>94.48%</td>
<td>91.00%</td>
<td>92.98%</td>
<td>91.35%</td>
</tr>
<tr>
<td>2017</td>
<td>91.63%</td>
<td>96.08%</td>
<td>93.67%</td>
<td>93.89%</td>
<td>92.73%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>89.97%</td>
<td>92.43%</td>
<td>89.95%</td>
<td>91.32%</td>
<td>90.36%</td>
</tr>
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**ANTENATAL BOOKING**

*We have surpassed the HEAT target of 80% across all areas in Lothian since 2011.*

3. What we set out to do: Achieve 44% of all women breastfeeding at 6 weeks by 2011.

Did we achieve it? Yes, in 2011/12, 49.1% of infants were breastfeeding at 6-8 weeks, in 2015/16, 52% of infants were breastfeeding at 6-8 weeks.

4. What we set out to do: To reduce the percentage of women who smoke during pregnancy from 29% >20%.

Did we achieve it? Yes, we achieved our goal and maintained this since 2011 for women in Edinburgh and East Lothian, and since 2015 for women in Midlothian and West Lothian.

5. What we set out to do: ‘Stop for Life’ campaign for pregnant women to be rolled out across Lothian.

Did we achieve it? ‘Smokefree Lothian’ (previously ‘Stop for Life’) provide smoking cessation and second hand smoke exposure advice to pregnant women across Lothian following CO reading at the booking visit. All acute sites are able to provide support to in patients as part of the Smoking Cessation Acute Services.

NHS Lothian is a UNICEF Baby Friendly Initiative accredited health board. The Baby Friendly Initiative is a quality improvement programme that is designed to provide parents with the best possible care to build close and loving relationships with their baby and to feed their baby in ways which will support optimum health and development.

- The Simpson Centre for Reproductive Health (SCRH) and St John’s Hospital are fully accredited Baby Friendly hospitals.

In the community, NHS Lothian achieved stage 2 accreditation in November 2016. This means that UNICEF has audited our community staff and has determined that they have been effectively trained in breastfeeding and relationship building. Lothian underwent stage 3 assessment in November 2016 and await formal notification of the result.

In recent years, there has been momentum to expand the Baby Friendly Standards to neonatal and special care baby units.

- The Neonatal Unit at SCRH and the Special Care Baby Unit at St John’s have recently undergone their stage 1 assessment with UNICEF.

Did we deliver on addressing Inequalities in Birth Outcomes?

6. What we set out to do:

**Reduce Inequalities** to achieve the same outcomes for all mothers and babies, no matter where they come from, what their income is, what their age is and to develop partnerships with other statutory and voluntary services for vulnerable and disadvantaged families.

Did we achieve it? We have some positive achievements in this very complex area.

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**Key achievements: Reducing Inequalities**

- We reached the Scottish Government target of 80% antenatal booking across socio-economic groups **Scottish Index of Multiple Deprivation (SIMD)** quintiles.
  - We saved families £1,000s of pounds through the Pregnancy and Intervention Money Advice Project.
- We were the first test site in Scotland for the **Family Nurse Partnership (FNP)**, and Scottish Government continues to roll this out across Scotland.
- We worked in partnership to **deliver positive parenting programmes**. According to the UCL Institute for Health Equity report ‘**Local action on Health inequalities: Good Quality Parenting Programmes**’; ‘the quality of parenting affects children’s long-term physical, emotional, social and educational outcomes and therefore differences in parenting between social groups have implications for health inequalities.'

Reducing Health Inequalities: The PIMAP project (Pregnancy and Intervention Money Advice Project)
PIMAP was launched in West Lothian three years ago.
- It is a partnership project between Citizens Advice Bureau (CAB) Livingston and NHS Lothian.
The aim of the project is to offer advice on a range of financial services to pregnant women, their families and those families with children under a year old. Topics include debt, benefits, housing issues, etc.
The success of the project very quickly became apparent, saving families £1,000s of pounds. To date, the project has reached hundreds of families and their recruitment has expanded to the whole of West Lothian, the maternity ward at St John’s Hospital and the dads2b group.

Reducing Health Inequalities: Family Nurse Partnership (FNP)
- The FNP is a programme for first time young mums, aged 19 years or under.
- FNP has successfully been rolled out across our health board. FNP started in 2010 in Edinburgh city and was expanded to West Lothian in 2013, Midlothian in 2014 and East Lothian in 2016.
- 81% of our FNP clients in Lothian come from the two most deprived SIMD quintiles.

Did we deliver our improvements in services for Black and Ethnic Minority Women (BME)?

7. What we set out to do: Improve services for Black and Ethnic Minority Women (BME)

Did we achieve it? We have made improvements in how widely available information is to women who do not have English as their first language. The Maternity Services Liaison Committee (MSLC) has been working with Health Scotland to make translated material more widely available and free to all health boards through the web2print service. This has allowed us to make overall progress to better serve the black and ethnic minority women of Lothian.

Key Achievements: Improving services for Black and Ethnic Minority Women (BME):

In June 2017, NHS Lothian launched our own in-house translation service. We are recruiting our own cohort of full-time interpreters and bank interpreters and will have access to an agency framework to cover the excess demand. NHS Lothian has a contract with thebigword, a telephone interpreting service which is available 24/7 365 days a year with an average answering time of 40 seconds in Lothian in 2016.

Our Centralised Booking Service is using ‘The Big Word’ to give ethnic minority mothers the choice to make their first appointment with the midwife.

NHS Health Scotland resources are available in 9 different languages and formats and since February 2018 are available through web2print. This includes key publications such as ‘You’re Pregnant! – scans and tests’, ‘Your Baby- newborn tests’, ‘Childhood Immunisations’, ‘Off to a good start, Fun first foods’.

Our Black and Ethnic Minority (BME) representatives in Lothian are working on ‘Redesigning Health Information for Parents’ with Health Scotland. This project has involved 4 ethnic minority focus groups with phase 1 completed.

The MSLC are working with the NHS Inform website to decrease barriers to information for mothers who do not have English as their first language.

Did we deliver our staffing and capital investment outcomes?

8. **What did we set out to do:** Build midwife-led Birth Centre for up to 1,000 births at the SCRH site

**Did we achieve it?** The Birth Centre opened in 2010 and was designed to promote natural childbirth and encourage more beds to be open at SCRH. More than 1,000 babies have been delivered at the birthing centre each year since it opened.

9. **What we set out to do:**
   Strengthen neonatal services at St John’s with neonatal nurse practitioners.

**Did we achieve it?**
Yes, we have an advanced practitioner working in our St John’s unit.
10. **What did we set out to do:** Improve the accommodation for maternity services at St John’s.

**Did we achieve it?** The complete upgrade of the St John’s Labour Ward was finished in 2014, along with a complete reconfiguration and upgrade of the Special Care Baby Unit (SCBU) at St John’s.

**The labour and SCBU units at St John’s Hospital:**
- Underwent a multi-million pound upgrade to ensure they can meet demand and complexity of cases
- The Labour Ward now has 9 self-contained delivery suites with en-suite bathrooms
- Each room in the labour ward was fitted with a TV, bigger windows, birth balls and mats to help mums and dads stay comfortable
- The new Special Care Baby Unit (SCBU) provides 10 cots with modern clinical facilities for babies who require specialist care
- The design focuses on the provision of family-centred care with the inclusion of two bedrooms with en-suite facilities to allow parents to room in with their babies, a family room for use by parents and siblings with a small kitchen area and a counselling room allowing privacy
11. What did we set out to do?
Increase the participation of service users in plans and decisions about the future development of the service.

Did we achieve it?
We collaborated with the Maternity Services Liaison Committee (MSLC) to increase the participation of mothers.

The MSLC is a committee which advises Lothian NHS Board on the care they provide to pregnant women and their partners and the parents of new babies and ensures that NHS Lothian takes into account the views of women and families using the service.

Membership of the MSLC includes: Service users, Operational Service Leads, Public Health, Primary Care, Local CPP representative, local university colleagues.

Key Achievements:

 ✓ Mothers’ comments and suggestions for improvement for the postnatal wards in SCRH were reviewed and implemented through an MSLC working group.

 ✓ The MSLC relayed service user feedback about triage and helped make some changes to improve women’s experience.

 ✓ The MSLC is currently working on the issue of consent and how to obtain meaningful consent.
Section 3

What do we know about?

3.1 Births in Lothian
3.2 Service User Views
3.3 Our Workforce
3.1. What do we know about births in Lothian?

Birth Numbers
Number of births in Lothian each year – local data 2010-2017
There have been around 9,500 births (range 9057-9909) each year in Lothian over the past 8 years.

<table>
<thead>
<tr>
<th>Year</th>
<th>Births</th>
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<tbody>
<tr>
<td>2010</td>
<td>9909</td>
</tr>
<tr>
<td>2011</td>
<td>9829</td>
</tr>
<tr>
<td>2012</td>
<td>9770</td>
</tr>
<tr>
<td>2013</td>
<td>9582</td>
</tr>
<tr>
<td>2014</td>
<td>9575</td>
</tr>
<tr>
<td>2015</td>
<td>9320</td>
</tr>
<tr>
<td>2016</td>
<td>9424</td>
</tr>
<tr>
<td>2017</td>
<td>9057</td>
</tr>
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Source: NHS Lothian TRAK System

The number of births (the number of women giving birth rather than the number of babies born) in 2017 shown above from local data is lower than in previous years. This reflects the national birth rate trend which is seen as decreasing in the Birth Trends (ISD) chart below. The 2017 local data on number of births is not yet published nationally and so is not included in the ISD Birth Trends chart.

Birth Trends (ISD) – 2009-2016

Note:
This data from ISD relates to the birth rate per 1,000 women of childbearing age (age 15-44) in Lothian.


The majority of pregnancies in Lothian are singleton (one baby) with around 2.5% being twins or multiples in 2016, which is comparable to the Scottish rate of 2.8%.
3.1. What do we know about births in Lothian?

Birth trend comparisons between Lothian and Scotland

Birth rates (live and all) are lower in Lothian than in Scotland but birth trends from 2009-2014 followed a similar pattern.

After a fall in births between 2012 and 2015, births have again increased to the current rate of 49.1/1000 women


Population and Birth Trends Projections for Scotland and Lothian

Current Scottish population projections from National Records Scotland (NRS) provide an indication of the future size and age structure of Scotland’s population based on a set of assumptions about future fertility, mortality and migration. The total population of Scotland is anticipated to rise from 5.40 million in 2016 to 5.69 million in 2041. The rise in population is driven by projected migration into Scotland both from the rest of the UK and from overseas, while the number of deaths is projected to exceed the number of births every year.

In the population projections, fertility is taken to mean the total number of children a woman would have, on average, at the end of her child bearing years. It is sometimes expressed as completed family size. The long term total fertility rate for Scotland is assumed to be 1.65. The number of births in Scotland is expected to decrease initially from its 2015-16 level of 55,300 to 53,400 in 2016-17 before increasing to a peak of 56,800 in 2022-23 before falling again to 55,000 by 2040-41.
3.1. What do we know about births in Lothian?

Birth trends for the lifespan of this strategy should see an increase of 6.4% from 2016/17 to 2022/23 numbers based on Scottish predictions, but then stabilise and fall slightly again towards 2040. However, using the national trend data may not fully capture the unique needs of Lothian. Consideration is required to the following population trends:

<table>
<thead>
<tr>
<th>% Change in Population between 2014 and 2039</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midlothian</td>
</tr>
<tr>
<td>East Lothian</td>
</tr>
<tr>
<td>Edinburgh City</td>
</tr>
<tr>
<td>West Lothian</td>
</tr>
<tr>
<td>NHS Lothian</td>
</tr>
</tbody>
</table>


We know, therefore, that overall the population of Lothian is going up, and this is reflected in the working age and children, suggestive of families in the fertile range who may be users of maternity and neonatal services. In addition, we know of major house building in areas such as Midlothian which are attractive to young families. These elements suggest that the demand for our maternity services will rise in the life span of this strategy period from the population within Lothian.

However, we are seeing a much lower population rise in all ages in West Lothian, and especially in working age and children. Recent trends of through flow at St John’s maternity unit mirror this trend. Following the Royal College of Obstetrics and Gynaecology peer review visit in 2015, a rezoning exercise was piloted to encourage women from the west corridor of Edinburgh to use the SJH facility to reduce demand on the SCRH units, but thus far this has not affected the usage across the 2 sites.

In addition, we anticipate higher usage from women and babies outwith Lothian who are transferred for specialised care at SCRH (see page 31).

Therefore, robust bed modeling and geographical care will be a key focus of the action plan for this strategy to ensure that the demand across Lothian is met in the new model of care.
3.1. What do we know about births in Lothian?

Births Trends in Lothian by Council area (ISD)

The City of Edinburgh birth rate has varied from 1991 to 2015 with a low of 4,477 in 2002 and a high of 5,671 in 1991. The number of births in Edinburgh has been more variable than other council areas over this time frame.
3.1. What do we know about births in Lothian?

Births (Number of mothers giving birth) in Lothian from women who live outside of Lothian (Main other regions who regularly use the services) (Local Data)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>South Lanarkshire CHP</td>
<td>29</td>
<td>46</td>
<td>47</td>
<td>122</td>
<td>0.44%</td>
</tr>
<tr>
<td>Scottish Borders CHP</td>
<td>25</td>
<td>33</td>
<td>33</td>
<td>91</td>
<td>0.33%</td>
</tr>
<tr>
<td>Falkirk CHP</td>
<td>26</td>
<td>30</td>
<td>30</td>
<td>86</td>
<td>0.31%</td>
</tr>
<tr>
<td>North Lanarkshire CHP</td>
<td>19</td>
<td>13</td>
<td>20</td>
<td>52</td>
<td>0.19%</td>
</tr>
<tr>
<td>Dunfermline and West Fife CHP</td>
<td>19</td>
<td>12</td>
<td>12</td>
<td>43</td>
<td>0.15%</td>
</tr>
<tr>
<td>Kirkcaldy and Levenmouth CHP</td>
<td>9</td>
<td>3</td>
<td>4</td>
<td>16</td>
<td>0.06%</td>
</tr>
<tr>
<td>Other CHP</td>
<td>13</td>
<td>13</td>
<td>28</td>
<td>54</td>
<td>0.19%</td>
</tr>
<tr>
<td>Errors, Blanks, Unrecognised Postcodes</td>
<td>25</td>
<td>23</td>
<td>17</td>
<td>65</td>
<td>0.23%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>140</td>
<td>150</td>
<td>174</td>
<td>529</td>
<td>1.67%</td>
</tr>
</tbody>
</table>

Source: NHS Lothian Trak System

This data provides us with a baseline of the areas in Scotland where women are transferred to Lothian as a specialist centre. Under the National Best Start vision and implementation plans, this number is anticipated to rise as intensive neonatal care providers are reduced to 5 units, then 3 units for Scotland. This will require increased intra-uterine transfers of mothers and care of these mothers and babies at birth and in neonatal intensive care areas.
3.1 What do we know about births in Lothian?

**Birth locations: consultant unit, birth centre, at home**
The majority of births in NHS Lothian are in a consultant unit: 87.6% of the 75,570 births from 2009-2016. The NHS Lothian Maternity Plan 2009-2015 recommended a midwife-led Birth Centre for up to 1,000 births to be established at Simpson Centre for Reproductive Health (SCRH). The birthing centre opened in November 2010 and was designed to promote natural childbirth and encourage more beds to be open at SCRH. Since being fully opened, there have been more than 1,000 births in the centre each year, with 1,164 babies (12.4%) born there in 2016. The criteria for using the birth centre will be reviewed, during the lifespan of Best Start in Lothian 2018-2023 to be more inclusive, and to increase choice and numbers of mothers using the birth centre.

The home birth rate in Lothian (0.94% in 2015 and 2016) is in line with the Scottish average of 1%. Unplanned birth (BBAs – either unplanned at home or elsewhere) account for less than 1% of Lothian births.

<table>
<thead>
<tr>
<th>DOD Year</th>
<th>BBA</th>
<th>Consultant Unit</th>
<th>Homebirth</th>
<th>Midwife Birth Centre</th>
<th>Not known</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>77</td>
<td>9552</td>
<td>172</td>
<td>105</td>
<td>3</td>
</tr>
<tr>
<td>2011</td>
<td>77</td>
<td>8589</td>
<td>136</td>
<td>1023</td>
<td>4</td>
</tr>
<tr>
<td>2012</td>
<td>47</td>
<td>8030</td>
<td>116</td>
<td>1556</td>
<td>21</td>
</tr>
<tr>
<td>2013</td>
<td>81</td>
<td>8061</td>
<td>106</td>
<td>1312</td>
<td>22</td>
</tr>
<tr>
<td>2014</td>
<td>69</td>
<td>8128</td>
<td>90</td>
<td>1265</td>
<td>23</td>
</tr>
<tr>
<td>2015</td>
<td>67</td>
<td>7912</td>
<td>88</td>
<td>1235</td>
<td>18</td>
</tr>
<tr>
<td>2016</td>
<td>61</td>
<td>8077</td>
<td>89</td>
<td>1164</td>
<td>33</td>
</tr>
<tr>
<td>2017</td>
<td>73</td>
<td>7793</td>
<td>71</td>
<td>1100</td>
<td>20</td>
</tr>
</tbody>
</table>

**Assisted Conception Trends:**
Data from the NHS Lothian Assisted Conception Unit Website indicates that 188 pregnancies were from in vitro fertilisation (IVF) or intracytoplasmic sperm injection (ICSI) resulting in 142 live births in 2015 (see [http://www.nhslothian.scot.nhs.uk/Services/A-Z/EdinburghAssistedConceptionProgramme/Pages/Success-Rates.aspx](http://www.nhslothian.scot.nhs.uk/Services/A-Z/EdinburghAssistedConceptionProgramme/Pages/Success-Rates.aspx)). There is no information on trends or how many women using the service are from NHS Lothian.

*For more information, see Best Start in Lothian: What we know about our population [https://www.nhslothian.scot.nhs.uk/OurOrganisation/Strategies/Pages/default.aspx](https://www.nhslothian.scot.nhs.uk/OurOrganisation/Strategies/Pages/default.aspx)*
3.2. What do we know about service user views?

What Our Service Users Tell Us?

‘Having a Baby in Scotland 2015: Listening to Mothers’ – as part of the Strategic Review of Maternity and Neonatal Services in Scotland (2015) the Scottish Government commissioned a large scale survey. This was led by the Scottish Health Council who delivered a programme of public and service user engagement, across all NHS territorial Board areas and gathered views from people who had used maternity and neonatal services in the last five years.

3.2. What do we know about service user views?

‘Having a Baby in Scotland 2015: Listening to Mothers: Results for NHS Lothian
The following table lists the survey questions that had a high percentage of positive responses from mothers in Lothian. The questionnaire was sent to 690 women chosen at random, 298 responded, a 43% response rate. The number in column 3 indicates how Lothian compares with the rest of Scotland. (+ indicates better than Scottish average, - indicates lower than Scottish average)

For the full report, please see http://www.gov.scot/Resource/0049/00490649.pdf

<table>
<thead>
<tr>
<th>Mothers’ views about care...</th>
<th>Positive Scores</th>
<th>Compared to Scottish Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal care...</td>
<td>89%</td>
<td>-3</td>
</tr>
<tr>
<td>During labour and birth...</td>
<td>92%</td>
<td>0</td>
</tr>
<tr>
<td>In hospital and after the birth...</td>
<td>87%</td>
<td>+2</td>
</tr>
<tr>
<td>At home after the birth...</td>
<td>90%</td>
<td>-1</td>
</tr>
</tbody>
</table>

In general, the quality of maternity care in Scotland is rated very highly by service users. Areas that could be improved were identified however and these helped form the foundations of the ‘The Best Start: A Five-Year Forward Plan for Maternity and Neonatal Care in Scotland’.
What areas for improvement were identified from the ‘Having a Baby in Scotland’ survey which formed the foundations of ‘The Best Start’

In the national survey, service users said they wanted:

- **Continuity of care and carer** – building relationships with staff and seeing the same person or team throughout their care, breastfeeding support, the opportunity for more partner support for bonding with their babies, and minimizing separation
- **More information and choice** – and better communication and consistent advice including the use of digital technology
- **Better emotional support** – for families with babies in neonatal care, and care for bereaved parents
- **More access** – to services locally, and support for parents of babies in neonatal units to stay with their babies

For more information, see Best Start in Lothian: What do we know about our population?
https://www.nhslothian.scot.nhs.uk/OurOrganisation/Strategies/Pages/default.aspx
3.3 What do we know about our workforce?

**Midwifery and Nursing Workforce:**

We have 446 midwives (360.4wte) working in maternity services in Lothian. 33% of these midwives are 50 years and over age range, with 11.5% of these over 55 years.

In Community Midwifery we have 127 midwives (97.46 whole time equivalents/wte) and 45% of these midwives are over 50 years of age.

In addition, there are 107 non registered staff (81.51 wte midwifery care assistants, healthcare support workers etc) and of these staff 46% are over 50 years of age.

The table below shows the age of our midwifery workforce. Most of our midwifery staff are in the 50-54 years age group and will soon be eligible for retirement. As a result, there is to be a Scotland-wide increase in 2016/17 to 191 midwifery students, up 4.9% from 2015/16.
3.3 What do we know about our workforce?

Neonatal Nursing

‘Neonatal Care in Scotland: A Quality Framework’ (The Quality Framework) was published in 2013 by the Scottish Government, and sets out the range of services required to ensure high-quality care is provided to babies born premature or sick, and their families.

The Quality Framework sets out the nurse-to-baby ratios which should be provided for babies receiving different levels of neonatal care. The recommendations are:

- 1 nurse available for every 4 babies requiring special care
- 1 nurse available for every 2 babies requiring high dependency care
- 1 nurse for every baby requiring intensive care

All of these ratios are the minimum required to provide high quality care. Due to the individual care needs of each baby, some will need a higher nurse-to-baby ratio. Babies requiring intensive or high dependency care should be cared for by nurses who have completed accredited training in specialised neonatal care or who are undertaking this training and working under the supervision of a registered nurse who is qualified in specialty (QIS).

The Quality Framework sets out that a minimum of 70% of the registered nursing workforce establishment should hold an accredited post-registration qualification in specialised neonatal care. This standard is vitally important to ensure that a high proportion of the nurse workforce in each unit has proven competence in providing complex care to vulnerable babies.

Training a nurse to be qualified in a specialty takes about five years in total. This consists of a nursing degree (generally three years), and then a minimum of six months experience working in a neonatal unit to be eligible for the QIS training course. This post registration qualification then takes a further year to complete.

There are two neonatal units in NHS Lothian, one intensive care unit at the Royal Infirmary of Edinburgh and one local neonatal unit at St John’s Hospital in Livingston. The funded nursing establishments in both units have been calculated according to the staffing
Levels defined in the Quality Framework. However, maintaining nurse staffing levels and the appropriate skill mix for the caseload of babies is a challenge due to staff maternity leave, retirement and normal staff turnover rates. As a result, a rolling recruitment programme is in place to address this.

There are challenges around recruitment as there is a lack of neonatal nurses who are already ‘qualified in specialty’ to recruit to senior vacancies. This is a national issue and is not exclusive to NHS Lothian. Nursing staff are therefore supported ‘in-house’ to undertake training to become ‘qualified in specialty’ and approximately 8 staff are supported annually to complete the course.

At present, 73% of registered nursing staff in post at the RIE and 81% at St John's Hospital are qualified in specialty; this is above the recommended minimum of 70%. A further 4 staff at the RIE are due to complete training and a further 7 have recently commenced the course.

The Neonatal Unit at the RIE has a Community Outreach Service providing 6 day cover for follow up care in the community.

An Education Practitioner post has been developed for the Neonatal Service across Lothian to support the education and continuing professional development needs of the nursing team.

There is a well established team of 8 Advanced Neonatal Nurse Practitioners (ANNPs) who work across both sites on the junior and middle tier medical rotas. The long term vision is to have a team of 14 ANNPs to support the service.

In Lothian, 24% of the registered nursing staff in neonatal services are 50 years and over (11% of these being 55 and over). In special care, 25% are over 50 years (21% over 55) In the neonatal transport team, 38% are over 50 years (14% over 55 yrs)
3.3 What do we know about our workforce?

Age Profile of NHS Lothian Neonatal and Obstetric Medical Workforce:

At the Simpson Centre for Reproductive Health (SCRH), 41% of our medical staff are over 50 years (18% over 55 years) and at St John’s Hospital, 35% of our medical staff are over 50 years (6% over 55 years).

At SCRH, 57% of our neonatal staff are over 50 years (14% over 55 years).

Neonatal Medical Workforce:

‘The British Association of Perinatal Medicine (BAPM) Service Standards’ set out guidelines for the minimum number of medical staff needed at each level of seniority. Medical staffing rotas should have a minimum of eight tier one (junior) staff members such as doctors new to the specialty and advanced neonatal nurse practitioners, eight tier two (middle grade) staff members such as specialty doctors and more experienced advanced neonatal nurse practitioners, and seven tier three (expert) staff members who are medical consultants.

The Quality Framework provides additional detail on how medical staffing rotas should be configured between each level of unit:

<table>
<thead>
<tr>
<th>Level one</th>
<th>These units need 24 hour availability of a consultant pediatrician and out of hours cover is provided as part of a general paediatric service.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level two</td>
<td>These units need 24 hour availability of a consultant pediatrician who has experience of and training in neonatal care. Out of hours cover can be provided by the general paediatric service. There should be 24 hour cover of resident experienced support with the ability to respond immediately to neonatal emergencies and 24 hour cover for provision of direct care with sole responsibility for the neonatal service. This can be a member of medical staff, an ANNP or a QIS nurse who has undertaken extended training.</td>
</tr>
<tr>
<td>Level three</td>
<td>These units must have 24 hour availability of a consultant neonatologist whose duties, including out of hours cover, are solely on the neonatal unit. There should be 24 hour cover of resident experienced support for sole cover of the neonatal service and associated emergencies, and 24 hour cover for provision of direct care with sole responsibility for the neonatal service; delivered by either a tier one doctor or ANNP.</td>
</tr>
</tbody>
</table>
3.3 What do we know about our workforce?

**Neonatal Allied Health Professional workforce:**
The Neonatal Quality Framework sets out comprehensive guidelines for involving a range of allied health professionals in the neonatal team. There should be a dietitian, physiotherapist and/or occupational therapist, speech and language therapist and a clinical psychologist within the neonatal team. Level three units should also have access to a specialist neonatal pharmacist whose job plan contains identified and protected time for providing advice and support in neonatal pharmacy.

Both NHS Lothian units have access to a specialist neonatal pharmacist on site. The Unit at the Royal Infirmary of Edinburgh (RIE) has a dedicated neonatal physiotherapist. The service at St John’s has access to a paediatric physiotherapist on site. Neither unit has a clinical psychologist, dietitian or speech and language therapist within the neonatal team, however both teams do have access to a dietitian and a speech and language therapist at the Royal Hospital for Sick Children (RHSC).

Both units have access to a Diana Children’s Nurse to support palliative and end of life care. A Family Support Worker is based in the unit at the RIE one day a week to provide additional emotional support to families. Both posts are through partnership working with the Children’s Hospice Association Scotland (CHAS).
Section 4

Our Implementation Plan
4. Our Implementation Plan

In this next section, we will outline our broad long term aims for implementing Best Start in Lothian against the main recommendations of Best Start.

Our Best Start in Lothian Baseline on the 23 recommendations that Scottish Government Best Start team believe can be implemented within local health boards without regional or national leadership or co-ordination is available at https://www.nhslothian.scot.nhs.uk/OurOrganisation/Strategies/Pages/default.aspx


A longer term action plan will be developed to work towards 2023, once the learning from the five Early Adopter Boards is analysed and recommendations for next steps made locally and nationally.

What are we aiming for?

1. Continuity of Carer
   We will work as an early adopter pilot site from December 2017 to March 2019, testing the primary midwife caseload model in a community team within NHS Lothian. The learning from this will inform NHS Lothian’s roll out of this model and inform the national implementation team to enhance national roll out.

2. Person-centred care
   Our aims will be to keep mums, babies and families together using a relationship based, personalised care model. This will include a safe and family-centred neonatal care model. As an early adopter board, we will test a model of transitional care to keep more babies together with their mums on postnatal wards. Moving forward, we will work in a regional and national model to review cot and bed numbers to ensure that we keep families with complex care needs together, e.g. to manage intrauterine transfers and care packages.

3. Multi-disciplinary team care
   We will work towards a model of community hub maternity care ensuring that midwives and obstetricians work within this geographical model. For women with increased medical needs, we will ensure that their hospital-based care still follows a relationship-based personalised model. We will work with national colleagues on the criteria for the “red” and “green” pathways and have clear Lothian care pathways for all women.
4. Our Implementation Plan

4. Safe, high quality and accessible care
We will continue to work to ensure a safe, high quality and accessible care model. This will include developments such as community hubs, specialist maternity and neonatal care co-location, support for vulnerable women, and improved perinatal mental health services. NHS Lothian hosts the East Scotland Mother and Baby Unit at St John’s Hospital. In addition, NHS Lothian has a community perinatal mental health team who support Lothian women with known mental health conditions, co-ordinating care in pregnancy.

5. Neonatal Care
NHS Lothian, as a provider of national and regional neonatal intensive care, will work with the national implementation team on the plan to move to five intensive care units initially, with a further reduction to three.

6. Transport
We will work with the Scottish Ambulance Service to ensure that Best Start recommendations on transport support the needs of women and babies in Lothian.

7. Remote and Rural Care
NHS Lothian, as a tertiary expert provider of obstetric and neonatal care, will work with the national implementation team and neighbouring health boards with remote and rural needs.

8. Workforce
Analysis of workforce needs will be tested in the pilots within the early adopter board workstreams. This will include detailed analysis of the current workforce - whole time equivalent (wte) age, skills and competencies, contractual needs, and a strategic plan to develop the workforce required to deliver the full model of Best Start within the five year period.

To enable this to happen, we will deliver this closely with staff themselves, partnership forums, Trade Unions and Human Resources. The size of this service change for the workforce is significant and as such will require a step change and measured process. Partnership and Union representation from the Royal College of Midwives are present on both the project leadership teams and programme board, and will guide and assist the organisational change processes required.
4. Our Implementation Plan

9. Quality Improvement

NHS Lothian will work with the national implementation group on the development of the national dashboards and single maternity care system and electronic maternity record. NHS Lothian will continue to strive for service improvement using Maternity and Children Quality Improvement Collaborative (MCQIC) methodology and local quality improvement team action plans. MCCQIC is part of the wider NHS Scotland Patient Safety Programme.

NHS Lothian Maternity Services have recently re-launched their quality improvement programme and are setting their priorities for 2017- 2018 in line with Health Improvement Scotland (HIS) requirements. The aims of this programme are to reduce avoidable harm in women and babies through reducing stillbirths and neonatal mortality.

Process measures to indicate improvements that affect this outcome are:

- Reducing severe postpartum haemorrhage (PPH)
- Increased cardiotocograph (CTG) education, escalation policy and its reliable implementation, documentation, stickers and "buddy reviews"
- Recognising the deteriorating mother with the use of the Maternity Early Warning Score (MEWS) and appropriate escalation
- Sepsis management and treatment using NHS Lothian's maternity criteria
- Improvements in VTE (venous thromboembolism) risk assessment on booking
- A focus on smoking cessation and a tailored package of care
- Percentage of women with a documented discussion about fetal movement
- Increasing the percentage of normothermic babies at transfer from Labour ward
- A positive and pro-active safety culture with daily ward safety briefings, cross-site maternity capacity meetings (focus on safety), significant events debriefs (e.g. all PPHs > 2.5 litres, eclampsia), and structured handovers to aid effective communication
- Increase the percentage of women satisfied with their experience of maternity care. Maternity services are part of the NHS Lothian Programme of Executive Leadership Walk Rounds.
4. Our Implementation Plan

10. Effective Use of Financial Resources

When Scottish Government launched the national Best Start Strategy, the vision was that the new models of care would be cost neutral to health boards in the long term, as money would move within the system to create the changes required. An example of this might be savings realised from reduced medical interventions in deliveries (e.g. induction of labour or caesarian section rates) which can be used to increase midwifery costs to enable the smaller caseloads required for the primary midwife model.

However, the existing model of care must run in tandem with the testing of the new model in various stages and therefore new costs are envisaged in the transitional period. The financial elements are part of the testing within the 5 Early Adopter Boards. The NHS Lothian Best Start project leadership team, Women’s Clinical Management Team and the Best Start Programme Board will assess the steps required to achieve the expectations of delivering as an early adopter area against the current financial envelope. The two year action plan has financial planning within it and will explore what is deliverable within existing resources within NHS Lothian and in conjunction with any additional project funds that can be sourced from Scottish Government.

In the current model, hospital-based care accounts for £24.7 million and community based care (100% of community midwifery) is £5.3 million. In addition, women’s support services, (administration, management etc) covers all areas of care and accounts for £0.7 million. The total budget for pregnancy, birth, postnatal and neonatal care for Lothian is £30.7 Million.

In the future model, hospital-based costs will partially transfer to a community-based model, and similar to the acute care/primary care transformation for all healthcare, the balance should shift. Core staffing in hospital intrapartum care will reduce as community midwifery teams take on primary midwife roles and care for more women in birth (either at home, in midwifery-led units and labour wards). For instance, community midwives currently have 100-120 women each at any time under their care. In the new model, the primary midwife will have 35 women on their caseload at any time (42 per annum), therefore we would need to increase our community midwife establishment threefold (as minimum) to meet the new caseload sizes. The resource is to come from hospital maternity care, by reducing the core establishment in areas such as intrapartum care (as you will need fewer midwives in labour ward, as community midwives will deliver babies in whatever setting is chosen/appropriate for the women in their caseload). As part of the 2 year action plan and piloting, we will assess these costs in detail and NHS Lothian will only be able to provide what is safe, effective and affordable within available resources.
4. Our Implementation Plan

The current financial spend within Women’s Services (Maternity and Neonatal) is displayed below:

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pan Lothian Community Midwifery</td>
<td>£5.3m</td>
</tr>
<tr>
<td>RIE Wards 119 (Antenatal &amp; Postnatal) &amp; 211 (Postnatal) Inpatient Care</td>
<td>£4.0m</td>
</tr>
<tr>
<td>RIE Labour Suite</td>
<td>£4.0m</td>
</tr>
<tr>
<td>RIE Obstetrics Services Support &amp; Running Costs</td>
<td>£0.6m</td>
</tr>
<tr>
<td>RIE Medical Obstetric Staff</td>
<td>£1.9m</td>
</tr>
<tr>
<td>Neonatal Unit</td>
<td>£5.4m</td>
</tr>
<tr>
<td>RIE Neonatal Medical Staff</td>
<td>£1.0m</td>
</tr>
<tr>
<td>RIE Pregnancy Support Centre</td>
<td>£0.2m</td>
</tr>
<tr>
<td>SJH Labour Suite</td>
<td>£2.1m</td>
</tr>
<tr>
<td>SJH Ward 11 (Antenatal &amp; Inpatient Care)</td>
<td>£1.7m</td>
</tr>
<tr>
<td>SJH Outpatient Clinic</td>
<td>£0.3m</td>
</tr>
<tr>
<td>SJH Ward 10 Day Assessment</td>
<td>£0.3m</td>
</tr>
<tr>
<td>SJH Obstetrics Services Support &amp; Running Costs</td>
<td>£0.1m</td>
</tr>
<tr>
<td>SJH Pregnancy Support Unit</td>
<td>£0.1m</td>
</tr>
<tr>
<td>SJH SCBU</td>
<td>£1.0m</td>
</tr>
<tr>
<td>SJH Medical Obstetric Staff</td>
<td>£0.7m</td>
</tr>
<tr>
<td>Lothian Birth Centre</td>
<td>£1.2m</td>
</tr>
<tr>
<td>RIE Outpatient Department</td>
<td>£0.4m</td>
</tr>
<tr>
<td>RIE Day Assessment</td>
<td>£0.3m</td>
</tr>
<tr>
<td>RIE Fatal Medicine</td>
<td>£0.1m</td>
</tr>
</tbody>
</table>
4. Our Implementation Plan

Our Governance, Leadership and Delivery of this Strategy:

**Abbreviations:**
- **SPT** = Maternal & Child Health Planning, Policy & Performance Team
- **BSPB** = NHS Lothian ‘Best Start’ Programme Board
- **EABPT** = Early Adopter Board Project Team

**NHS Lothian ‘Best Start’**

- Scottish Government ‘Best Start’ Team
- **5 x EAB Learning Network**
- NHS Lothian Early Adopter Board Project Team
- **‘Best Start’ Programme Board**
- NHS Lothian SPC
- Corporate MT

**NHS Lothian Acute Division**

Women’s CMT

**Responsible for:**
- Operational Care for Maternity & Neonatal
- Quality Improvement

**Responsibilities:**
- Planning and agreeing the best pilots
- Setting pilots up
- Doing baseline & follow up impact data
- Staff communication re pilots
- Workforce planning specific to pilots
- Finances specific to pilots
- HR specific to pilots

**Actions (who is responsible for delivery):**

1. Writing new NHSL Strategy (SPT)
2. Consultation & Publication & Communication plan for strategy
3. Starting to implement the 23/76 best start recommendations
4. Medium to longer term workforce planning (with learning from pilot & national group)
5. Financial Planning (BSPB and Women’s CMT)
6. Continuity of Care (BSPB)
7. Transition care (EABPT)

**17/18 resource £50k**

**18/19 £50k**
For more information:

If you wish to find out more about this strategy or the partner documents, please visit our NHS Lothian website:
https://www.nhslothian.scot.nhs.uk/OurOrganisation/Strategies/Pages/default.aspx

For Further Details from the National Team:

The National Report:
http://www.gov.scot/Publications/2017/01/7728

The Scottish Government Website for Best Start work:

The Scottish Government Best Start on Twitter:
@SGChildMaternal