Integrated Impact Assessment

Interim report		Final report	x

1. Best Start in Lothian: Maternity and Neonatal Strategy 2018-2023

2. What will change as a result of this proposal?

Women will experience real continuity of care and carer, across the whole maternity journey. Vulnerable families will be offered additional support.

This will result in a better relationship between mother and midwife, better outcomes and increased support for normal birth processes. It will also result in a significant workforce realignment and workforce planning for our midwifery, obstetric and neonatal workforce with an emphasis on an open and honest team culture with everyone's contribution being equally valued.

There will be three neonatal units in Scotland designated as neonatal intensive care units. It is anticipated that the Neonatal Unit at the Royal Infirmary of Edinburgh (RIE) is likely to be one of the three units. The resulting increase in intensive care activity will impact on neonatal workforce planning as well as impacting on families from out with Lothian whose babies are transferred to the RIE to receive intensive care.

3. Briefly describe public involvement in this proposal to date and planned

The Scottish Government commissioned a large scale survey of mothers in Scotland ('Having a Baby in Scotland – Listening to Mothers'). This consisted of 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. For Lothian, the questionnaire was sent to 690 women chosen at random, 298 responded (a 43% response rate). The areas of improvement which were identified at a national level formed the foundations of the national 'Best Start' strategy. Our local Best Start mirrors the Scottish Government strategy.

The Scottish Government Maternal and Infant Nutrition Survey 2017 results which were published in February 2018 will inform the implementation of the Best Start policy. The Lothian Maternity Services Liaison Committee represents service users and MLSC have been fully involved in the development of the strategy for Lothian and implementation delivery.

4. Date of IIA

19 March 2018

5. Who was present at the IIA? Identify facilitator, Lead Officer, report writer and any partnership representative present and main stakeholder (e.g. NHS, Council)

Name	Job Title	Email
Karen Grieve	**Strategic Programme Manager, Maternal and Child Health, NHS Lothian (Lead Officer)**	**Karen.Grieve@nhslothian.scot.nhs.uk**
Jessica Miller	**Assistant Strategic Programme Manager, Maternal and Child Health, NHS Lothian (Report writer)**	**Jessica.miller@nhslothian.scot.nhs.uk**
Rhona McInness	**Consultant Midwife, Napier University & NHS Lothian**	**R.McInnes@napier.ac.uk**
Yvonne Freer	**Clinical Reader, Neonatal Unit, Simpson Centre for Reproductive Health**	**Yvonne.Freer@nhslothian.scot.nhs.uk**
Mathilde Peace	**Chair, Maternity Services Liaison Committee**	**mathilde.peace@nhs.net**
Kate Vesey	**Midwife, Simpson Centre for Reproductive Health**	**Kate.Vesey@nhslothian.scot.nhs.uk**
Claire Glen	**Senior Health Promotion Specialist (Co-facilitator)**	**Claire.Glen@nhslothian.scot.nhs.uk**
Sarah Archibald	**Senior Health Promotion Specialist (Co-facilitator)**	**Sarah.Archibald@nhslothian.scot.nhs.uk**
Katy Ruggeri	**Clinical Midwifery Manager, Simpson Centre for Reproductive Health**	**katy.ruggeri@nhslothian.scot.nhs.uk**
Lynne Kerr	**Clinical Nurse Manager, Neonatal Services**	Lynne.kerr@nhslothian.scot.nhs.uk Not present at meeting but reviewed document and perspective

6. Evidence available at the time of the IIA

Evidence	Available?	Comments: what does the evidence tell you?
Data on populations in need	There are 9,000-10,000 births in Lothian each year. The overall birth rate trend reflects the national trend which is decreasing. In 2017, there were 9,057 births compared to 9, 424 in 2016. In 2016, more births (59%) in Lothian were to women over 30 years compared to Scotland (52%).	Although there is a national trend for a decreasing birth rate, the overall population in Lothian is increasing and this is reflected in projections for working age service users and children. We also have large scale house building occurring in Midlothian, which will be attractive to people of child-bearing age. These elements suggest that the demand for our maternity services will rise in the life span of the Best Start in Lothian strategy. The percentage of mothers giving birth over 30 years of age suggests a future need for further interventions and complications.
Data on service uptake/access	Births in Midwife Unit: 2015 1235 (13%) 2016 1164 (12%);Consultant Units 2015: 7192 (85%);2016 (86%); Home Birth 2015: 88 (0.95%) 2016 89 (0.95%) 10% of all live births at Simpson Centre for Reproductive Health are admitted to the Neonatal Unit (NNU)	Use of our midwife led unit (birth centre at SCRH) may increase with changes to the criteria for admission to the birth centre which are scheduled to undergo review. The birth centre affords a more tailor-made birth experience such as more choice of pain control method and is in keeping with the aims promoting choice and decreasing interventions which underpin Best Start. Families of babies admitted to the NNU are no more likely to be from the most deprived areas than the least deprived areas.
Data on equality outcomes	Within Lothian, there is significant variation in breastfeeding rates across council areas. The highest rates are in Edinburgh City	The rates of breastfeeding in Lothian are highest in our most affluent areas (Edinburgh City) and lowest in areas of deprivation (West Lothian). One of the effects of continuity of carer will be to

Evidence	Available?	Comments: what does the evidence tell you?
	(74% for any breastfeeding at first health visitor appointment versus West Lothian (49% for any breastfeeding). Lothian has surpassed the HEAT target for antenatal booking (80% by 12 weeks gestation). <u>Neonatal feeding outcomes at discharge (2016):</u> Neonatal Unit (SCRH): Exclusive breast milk: 32% Mixed feeding: 40% Exclusive formula: 28%	provide more consistent support with breastfeeding. In 2015, Lothian had a lower teen birth rate 16.3/1,000 child bearing age women compared to 18.9/1,000 for Scotland. The percentage of all maternities booked by 12 weeks gestation in areas of deprivation all surpass the national HEAT target of 80% and this high standard is maintained across all socioeconomic groups. Early antenatal booking is widely acknowledged to be associated with improved pregnancy outcomes. According to the most recent available breastfeeding data, there has been very little change in the percentage of women exclusively breastfeeding at first visit (around day 10 of birth) except for those in SIMD1 quintile where there has been a slight increase. At 6-8 weeks there is a slight increase in women continuing to breastfeed. Irrespective of SIMD quintile, older and non-smoker mothers are more likely to breastfeed than younger mothers who smoke. Local NNU data on the effect of maternal age and deprivation (using SIMD 2012 quintiles) suggest: • The average age of mothers whose babies are admitted to the NNU is 31 years (3% of mothers are teens) • Mothers more likely to exclusively breastfeed/offer breast milk at discharge are those between 25-35 years of age

Evidence	Available?	Comments: what does the evidence tell you?
	SCBU (St John's Hospital) Exclusive breast milk: 43% Mixed feeding: 9% Exclusive formula: 45% Not known: 3%	• Mixed breast & formula feeding at discharge is associated with increasing maternal age other than those >39 years old where it begins to decrease • Families of babies admitted to the NNU are less likely to offer exclusive breast milk or mixed breast/formula milk feed at discharge if they are from the most deprived areas (23% & 33% respectively in SIMD1) as compared to those in the least deprived areas (40% & 40% respectively in SIMD5).
Research/literature evidence	An efficient evidence review on improving care for vulnerable population was conducted by the National Best Start Review Group. http://www.gov.scot/Publications/2017/01/7728/7 (See Chapter 4)	The efficient evidence review identified the following key aspects of high quality care for women and babies from vulnerable groups: • Continuity of carer • Promoting positive staff attitudes • Good communication and assistance if English not first language • Universal model of effective multi-agency care with women receiving extra services if needed • Highly accessible services (i.e. multiple barriers addressed) of high technical quality for all women The Best Start Scottish Government strategy states that pregnancy is a key time when women may be more receptive to modifying their lifestyle and improving their health for the wellbeing of their baby. Therefore the potential for the enacting change

Evidence	Available?	Comments: what does the evidence tell you?
		through a supportive, consistent therapeutic relationship is enhanced
Public/patient /client experience information	The national Best Start review process engaged with 14 NHS Territorial Boards, 600 frontline staff (in 41 sessions with maternity and neonatal staff). Engagement with service users was through face to face sessions (65 focus groups were conducted), and the 'Having a Baby in Scotland (2015') survey of women who had used maternity and neonatal services over the last six years. (2000 women completed survey)	For Lothian, 89% of women gave positive responses about antenatal care (3% worse than national average), 92% gave positive responses rating care during labour and birth (same as national average), 87% gave positive responses of care in hospital and after birth (2% better than national average), and 90% gave positive ratings for care received at home after birth (1% worse than national average).
Evidence of inclusive engagement of service users and involvement findings	As part of the national review, five bespoke services user events were arranged to reach service users in remote and rural areas, vulnerable groups and mother and toddler groups. For these bespoke events, over 600 women and partners participated. One of the principles that guided the national review was reducing the impact of inequalities. In particular, the review recognised the importance of every mother and baby being supported to access they services they need and the importance of recognising and proactively addressing the needs of vulnerable families.	

Evidence	Available?	Comments: what does the evidence tell you?
Evidence of unmet need	In general the quality of maternity care in Scotland was rated very highly by services uses. Areas that could be improved upon helped form the foundations for the national Best Start strategy which our Lothian strategy mirrors. Some of the areas for improvement which were identified were: For service users: - Women whose first language was not English raised the importance of translator support and the need for information to provided in their own language - Women want access to high quality up-to-date information on pregnancy, birth options , caring for their baby and neonatal care. - More information and choice - Better emotional support - More access to services locally and support for parents of babies in neonatal units to stay with their babies - Better breastfeeding support	- We must consider how language accessible our information is for our main languages spoken in Lothian - We must consider if we have sufficient information available electronically to our mothers and if it is clearly presented and easy to locate - We must consider if we are providing good support to our mothers s with mental health problems, developmental and other disabilities, additional health needs. - How will staff be affected by their changing roles,

Evidence	Available?	Comments: what does the evidence tell you?
	Staff highlighted: - Issues with the availability of good quality information for parents - Pressures on the availiabity of neonatal cots and issues with transfers - Increased workload and impact on contact time with women, related to the expansion of the midwifery role - Recruitment and in a number of staff groups (this will apply to difficulties in recruiting to posts at St John's Hospital)	
Good practice guidelines	National Institute for Health and Care Excellence (NICE) Safe Staffing Guideline NG4 for 2015 Royal College of Midwifery (RCM) Guidance on implementing the NICE safe staffing guideline on midwifery staffing in maternity settings Neonatal Care in Scotland: A Quality Framework British Association of Perinatal Medicine Service Standards for Hospitals Providing Neonatal Care (3rd edition) (2010)	The RCM guidelines on implementing the NICE Staffing guidelines make recommendations on continuity of care and the importance of mutual respect in effective working relationships. Both of these principles are reflected in Best Start. Both neonatal documents set standards for the provision of neonatal care. The Scottish document sets these standards under the headings of 'person-centred, safe, efficient, effective, equitable and timely'. These principles support the implementation of the Best Start recommendations for both the workforce and the families.

Evidence	Available?	Comments: what does the evidence tell you?
Environmental data	The national Best Start Strategy calls for a decrease in the number of neonatal intensive care units to three national units within five years.	It is anticipated that Lothian will be one of the three national neonatal units and as a consequence there will be increased travel from locations outside of Lothian. There will also likely be an increase in bed capacity and accommodation for families to stay with their babies. This will result in building works and the increased energy use involved in building and increasing bed capacity.
Risk from cumulative impacts		
Other (please specify)		
Additional evidence required		

7. In summary, what impacts were identified and which groups will they affect?

Positive Effects	Affected populations
1. Broad impact on child health in terms of improved nutrition during pregnancy, improved breastfeeding and other factors which will be promoted by the improved continuity of care and this will have broadly better health outcomes for children and young people.	1. Young people and children
2. Keeping mothers and babies together as much as possible has immediate benefits on breastfeeding and relationship building	2. Mothers and babies
3. Since the new model proposed by the strategy involves continuity of carer, it will not be necessary for the patient and family to tell their story multiple times as their	3. Men (including trans men), Women (including trans women), same sex couples and non-binary people

care provider(s) will develop familiarity with their particular needs and circumstances due to consistent contact and be able to provide them with care which is sensitive to their needs.	
4. Positive impacts for example for those with autism who will find it less stressful to see their midwife in more accessible, less stressful environments. This will apply to a wide range of disabilities. For long term medical conditions, the caregiver will develop a deeper understanding of the client's medical condition and this will benefit the client by enabling the caregiver to provide care which is very specific to the individual needs of the client.	4. Disabled people
5. Gypsy travellers do not tend to be registered with a GP and having a named midwife who will move around the city with them will result in less disruption to care.	5. Minority Ethnic People
6. The midwife will become familiar with the roles, polite way to refer to partners etc... so as to minimise any interpersonal conflict between the client and the midwife.	6. LGBT
7. There may be issues related to money and finance which are easier to raise with the relationship between families and midwife is more developed	7. Those vulnerable to falling into poverty
8. The continuity of carer may have a positive impact as the established relationship between midwife and client will increase the chance of the midwife observing the signs of domestic abuse	8. Those experiencing domestic abuse
9 . When these women move into temporary accommodation, their midwife will continue to care for them, regardless of where in Lothian they live. This will provide increased continuity of care and associated outcome benefits.	9. Homeless
10. As continuity of carer will lead to the midwife having a greater understanding of the particular situation of each family she is working with, the midwife will be more likely to observe that a partner is incarcerated. In the case of an incarcerated mother, the mothers are normally released to NHS Lothian for delivery and this will not	10. Those in criminal justice system/at risk for criminal justice system (mothers and partners)

change. However, the mother, like all mothers under the new care pathway, will have increased contact with her midwife and benefit from the therapeutic relationship. This may be particularly beneficial for this vulnerable group of incarcerated mothers who will have the opportunity to develop an enhanced relationship with her midwife which will support her during the pregnancy to make positive changes. We know that women are more likely to make positive wellbeing and health changes during pregnancy.	
11. There is potential for improvement in the numbers of mothers who do not attend appointments due to the benefits of care being provided in the community (and resulting decrease in travel time) and the positive impact of an enhanced therapeutic relationship.	11. Those living in deprived communities
12. Community hubs will differ. Some will have birthing facilities, scanning facilities. It is hoped that in a five or ten year time frame there will be an increase in the number of birth rooms which are available in more remote locations to allow for births closer to home or increased opportunities to give birth at home.	12. Those living in rural/semiurban locations
13 Decreasing inequalities is one of the main aims of the Scottish Government Best Start strategy. The Lothian Best Start strategy mirrors the Scottish Government strategy. This will be accomplished by providing extra support to those who need it.	13. Families who require extra support
14. Promote participation, inclusion: The one to one relationships which will be developed between midwife and service users are likely to promote participation as a result of the improvement in the therapeutic relationship which will encourage service users to engage with their care.	14. All mothers
15. Build family support networks, resilience and community capacity: The strategy will support community capacity through the development of community hubs.	15. Communities
16. Reduce crime and fear of crime including hate crime: Evidence from the Family Nurse Partnership shows improved outcomes for fathers with regard to	16. Families

incarceration rates. An aspirational long term goal of this strategy would similarly be to decrease incarceration rates within families by supporting them to make positive lifestyle choices.	
17. Protect vulnerable children and adults: The Best Start strategy aims to provide extra support to improve outcomes.	17. Vulnerable children and adults
18. Promote healthier lifestyles: For service users, the enhanced therapeutic relationship aims to promote healthier lifestyles.	18. Mothers and Families
19. New set of IT equipment will be required due to community based aspect of care delivery. For some staff groups, this will be seen as positive, for some this will be seen as negative.	19. Staff
20. Initially, there may be some negative impact around anxiety about the unknown and the multiple changes which will happen during the realignment of working patterns. Mitigating actions will be to keep staff briefed through various channels of our communications and also by giving staff a forum to voice their concerns. All workforce changes will be done with partnership input	20. Staff
21. As a result of improvements in the therapeutic relationship with the mother and family, staff will experience increased job satisfaction	21. Staff
22. For neonatal services, centralisation of care of very sick/at risk babies has the potential to improve their outcomes	22. High risk babies admitted to NNU
Equality and Human Rights	
Positive Effects	
1. **Eliminate discrimination and harassment:** The new Best Start way of working has the possibility of breaking down some of the silos between different types of	1. Staff

midwifery practice as we move toward a generic job description. Further, the focus on open and respectful multidisciplinary staff aims to break down barriers between staff groups	
2. **Reduce differences of status**: The emphasis on open and respectful relationships between the multidisciplinary team aims to remove the hierarchical structure so that everyone's input is equally valued.	2. Staff
3. **Increased control over social/work environment:** Staff will have more control as they will be managing their own diary. However, they may experience an initial sense of loss of control as they are having a new way of working imposed upon them.	3. Midwifery Staff
4. **Promote healthier lifestyles:** In the long term, the aim is for increased job satisfaction among staff which would result in decreased sickness. Staff may experience a decrease in physical activity due to increased travel time in cars.	4. Midwifery Staff
Negative effects 1. ○ Travellers may not benefit as much as other groups as they may move out of the region during the relevant period and therefore not benefit from continuity of carer in the way that other populations groups will. ○ Learning Disabilities: The strategy will be web-based and there are no versions planned for those wil learning disabilities ○ Non-English speakers: In order not to disadvantage non-English speakers, the web-based strategy must be translated into other languages ACTION: ensure the strategy is available in other languages	1. Minority ethnic people
2. People misusing substances: Our current model of care includes care by the multi-agency PREPARE team for our mothers with substance misuse issues. Since the Best Start strategy recommends some limitations on	2. People misusing substances

specialist support. We are undecided about how this group will be impacted and pilot results will provide more information on this.	
3. There will be fewer hospital staff required. These changes will be required to go through partnership consultation and organisational change and may meet with resistance from currently hospital-based staff.	3. Hospital-based staff
4. With the centralisation of care of high risk/very sick babies, there will be additional stress placed on neonatal staff due to managing more very sick babies.	4. Neonatal staff
5. Changes to shift patterns: Full time roles will involve longer shifts and fewer work days.	5. Midwifery staff
6. Staff who do not own a car or do not have a driving license: These staff will be impacted as staff will be working out in the community which will require a car in some areas. Staff will be exposed to potential dangers of travelling to unfamiliar places. Staff who do not have a driver's license would likely remain part of the core hospital team. All new midwives may be required to have a driver's license.	6. Midwifery staff who do not own a car or have a driving license
7. It may become necessary to require midwives to live within a certain perimeter so that the midwife can access the mother in a certain time frame. This would limit choice.	7. Staff who wish to live a longer distance form mothers they care for
8. Midwives who are single parents may be disadvantaged as they will be required to be on call and may need to leave their home at short notice to care for women. All of these changes will be tightly monitored by organisational change and partnership.	8. Midwives who are single parents
9. Families from out with NHS Lothian whose babies are born within or transferred to the RIE for the provision of intensive care may incur additional personal costs. Although a scheme is in place to reclaim some expenses, the scheme does not cover the cost of accommodation should this be required. For these families, there are additional issues related to managing the home, time away from other children, and	9. Families from out with Lothian whose babies receive intensive care at RIE

separation from partners. Parents will also be separated from their local social network which provides practical and emotional support. This is especially important for those in marginalised communities. Mothers who are transferred into Lothian for specialist care will not be managed by their named midwife and this will result in loss of continuity within an established relationship Where mothers/carers are from NHS Lothian and staying in to provide 'transitional' care to their babies who will be discharged from neonatal services, their needs in terms of education, support, privacy and recreation may need to be considered. Partners may also be expected to be available in the absence of the mother and this needs to be factored in when designing accommodation/services.	

Environment and Sustainability	**Affected populations**
Positive 1. Decreased hospital admissions due to more intensive care in the community will lead to decreased hospital-acquired infection	1. Service users
Negative 1. Any possible climate change/environmental effects due to increased car use or investment in fleet of cars must be mitigated by investing in environmentally-friendly cars	2. General population

Economic	**Affected populations**
Positive 1. Income maximisation work with families will be enhanced by an improvement in the relationship with the midwife.	1. Service Users
2. Once pay protection is phased out, pay will be equal among midwives. The new generic job description will be subject to organisational change requirements	2. Staff
Negative 1. Midwifery Staff who have contracted shifts may have loss of earnings from change to working in the community. Staff will receive pay protection to cover this.	1. Staff

8. **Is any part of this policy/ service to be carried out wholly or partly by contractors and how will equality, human rights including children's rights , environmental and sustainability issues be addressed?**

Not applicable at this stage

9. **Consider how you will communicate information about this policy/ service change to children and young people and those affected by sensory impairment, speech impairment, low level literacy or numeracy, learning difficulties or English as a second language? Please provide a summary of the communications plan.**

See Communications Plan recommendation

10. **Does the policy concern agriculture, forestry, fisheries, energy, industry, transport, waste management, water management, telecommunications, tourism, town and country planning or land use?**

No

11. **Additional Information and Evidence Required**.

Starting in the spring of 2018, the Best Start project team will be piloting the continuity of carer and primary midwife models which will uncover issues related to the new working structure and effects on staff and service users, travel, IIT issues etc. This will yield further evidence as to how the Best Start strategy impacts staff and service users

12. **Recommendations (these should be drawn from 6 – 11 above)**

A. Communications Plan to be finalised. This report has highlighted that communication with staff and service users will help mediate any negative effects. Information about the strategy must be accessible to all groups.
B. Pilot of continuity of carer model and primary midwife model will be conducted which will inform how the strategy will impact on service users, travel, staff satisfaction and other issues.
C. There is the possibility that fleet cars will be considered and their environmental impact will need to be addressed.
D. All changes to shaft working patterns will be taken with partnership collaboration and within organisational change procedures.
E. For those travelling into Lothian from out with Lothian for specialist , accommodation and travel will need to be considered.
F. Local capacity to care for more babies requiring intensive care needs consideration – capacity includes both cot space, specialised equipment and support services to manage/maintain it, availability of skilled nursing staff in a specialty that is already understaffed according to national recommendations, increased availability of neonatologists to manage a higher acuity workload, impact of additional stress in managing more very sick babies.

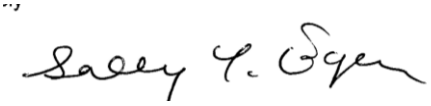
13. What actions have been, or will be, undertaken and by when?

Specific actions (as a result of the IIA which may include financial implications, mitigating actions and risks of cumulative impacts)	**Who will take them forward (name and contact details)**	**Deadline for progressing**	**Review date**
Communications Plan so that staff will be kept fully informed ○ Feedback groups ○ Staff briefing meetings ○ Newsletters ○ Website – intranet for staff and internet for service users	Frances McGuire/Karen Grieve/Katy Ruggeri	In progress	01 April 2019
Ensure that strategy is available in multiple languages	Jess Miller/MSLC	01 June 2018	01 April 2019
Pilot Best Start Midwifery team	Karen Grieve/Katy Ruggeri	01 June 2018	01 April 2019
Evaluate PREPARE and costs and benefits of continuing this Lothian service in context of national recommendations regarding specialist services in favour of individualised care	Karen Grieve/Katy Ruggeri	01 June 2019	01 April 2019
Any investment in car fleets should take into account the environmental impact of the chosen vehicles	Katy Ruggeri	Start exploring Sept 2018	April 2019
Pay protection to cover any loss of earnings for staff who have contracted shifts and for whom the new working structure will result in less earnings	Frances McGuire/Katy Ruggeri/Susan Perris	July 2018	April 2019

14. How will you monitor how this policy, plan or strategy affects different groups, including people with protected characteristics?

a. The pilot of the continuity of carer and primary midwife will yield information on effects on staff and service users. Improvement methodology will be used to mitigate negative effects.

b. Staff briefing and feedback groups are ongoing under the leadership of the chief midwife.



15. Sign off by Head of Service/ Project Lead

Name: Sally Egan

Date: 18/4/18