

# Inequalities Sensitive Practice Initiative

Maternity Unit Report – 2008

Princess Royal Maternity Hospital



## Acknowledgment

I would like to take this opportunity to thank the staff from the maternity services in NHS Greater Glasgow and Clyde who supported me with information gathering by participating in group or one-to-one sessions. I would also like to thank colleagues in partner agencies who contributed their thoughts and reflections. Thanks also to Barbara Boyd of NHS GG&C Information Services for her support with information retrieval and Yvonne Johnstone, ISPI, for administration support.

Anne Bryce  
Project Lead - Maternity  
Inequalities Sensitive Practice Initiative

## 1. Introduction

This report forms part of an information gathering exercise undertaken through the Inequalities Sensitive Practice Initiative to provide baseline data on the care currently provided to pregnant women, assessed as having additional needs in NHS Greater Glasgow and Clyde. It forms one of a series of reports that together provides an overview of care provision in NHS Greater Glasgow and Clyde.

The purpose of this report is to provide an overview of the provision of care to pregnant women who have multiple, complex or additional needs, through the Princess Royal Maternity unit. Information has been gathered from a number of sources: NHSGG&C Information Services and service reports and through discussions with individuals and groups of workers from the maternity service and its partner agencies. The report offers an insight into current practice and approach, multidisciplinary and interagency working and stakeholder reflections on the provision of inequalities sensitive services.

### 1.1. Demography

The area served by the Princess Royal Maternity Hospital spans two of the most densely populated and deprived areas of Glasgow, North Glasgow and East Glasgow with a combined population of approximately 225,000. It also serves two less deprived, more mixed communities that sit outside the Glasgow City boundary, East Dunbartonshire with a population of approximately 108,000 and South Lanarkshire with a population of approximately 56,500. Women from other Glasgow CHCP areas also opt to have their babies in the Princess Royal Maternity Hospital.

Although it is difficult to obtain accurate figures it is estimated from GP registration figures that there are 10,000 asylum seekers and refugees living in Glasgow. North Glasgow, specifically Springburn and Barmulloch, has the highest numbers of asylum seekers and refugees with over 2,000 accommodated through dispersal within Glasgow. While East Glasgow has a lower proportion of black and minority ethnic residents (1.5%) than Glasgow as a whole (5.5%), in recent years small groups of asylum seekers and refugees have moved into the area, as have also a number of East European nationals.

## 1.2. Inequalities

Of all the CHCPs in Glasgow, the North and the East CHCPs have the highest proportion of people living in deprivation. According to the Scottish Index of Multiple Deprivation over 140,000 residents of these communities are living in areas which are considered to be the most deprived in Scotland, (SIMD most deprived 15%). In North Glasgow 49.9 % of the population, and in East Glasgow over 35% of the population, a combined total of over 91,000 people, live in neighbourhoods that are extremely deprived i.e. in the 5% most deprived areas in Scotland.

A number of indices illustrate the impact of social disadvantage on community health and well being in these areas:

- North Glasgow has 33% above the Scottish average deaths from cancer and 45% above the Scottish average for deaths from coronary heart disease
- Life expectancy is considerably lower for both men and women compared to the general population in Scotland, around 66% for men and 74% for women.
- There are high levels of unemployment. More than half the working age population is not in work and only a limited number are moving into sustainable employment.
- There are high levels of long term limiting illness, e.g. 29% of all households in East CHCP.
- Both communities have higher rates than the Glasgow average for disability

Further indices illustrate the impact of social disadvantage on child health and wellbeing:

- A higher percentage of low birth weight babies ( 8.8% in North Glasgow and 8.5 % in East Glasgow compared to 7.1% in the NHS Greater Glasgow area)
- Higher rates of smoking in pregnancy ( between 35 – 39.5 % compared to the average in NHS Greater Glasgow area of 23.5%)
- Higher rates of infant deaths in some areas e.g. 10.1 infant deaths per 1000 live births in Bridgeton and Dalmarnock compared to a rate of 5.3 in Scotland

- High numbers of dependent children in lone parent families
- High rates of dependent children in households where no adults are employed (41% in North Glasgow compared to Glasgow average of 36.3%)
- High numbers of children as social work service users (almost one in 10 in North Glasgow)

There were 4,282 deliveries of residents of Greater Glasgow and Clyde in the Princess Royal Maternity in 2007. While there were deliveries of residents from all GG&C areas, the majority of the deliveries were of residents of the East CHCP (31%), the North CHCP (18%), East Dunbartonshire CHCP (13%) and South Lanarkshire CHCP (13%).

See Table 1 below.

| CHCP of residence   | All deliveries | Percentage of Total |
|---------------------|----------------|---------------------|
| East Dunbartonshire | 540            | 13%                 |
| East Renfrewshire   | 74             | 2%                  |
| East                | 1316           | 31%                 |
| Inverclyde          | 14             | 0.3%                |
| North Lanarkshire   | 238            | 5%                  |
| North               | 776            | 18%                 |
| Renfrewshire        | 13             | 0.3%                |
| South East          | 435            | 10%                 |
| South Lanarkshire   | 576            | 13%                 |
| South West          | 106            | 2.5%                |
| West Dunbarton      | 26             | 0.6%                |
| West                | 168            | 4%                  |
| <b>Total</b>        | <b>4,282</b>   | <b>100%</b>         |

Source = NHS GG&C Information Services / GRO birth registrations

### 1.3. Service provision

Greater Glasgow maternity services have developed a three-tier model of care provision:

- A baseline service for all women provided through the three maternity units, Queen Mother's Hospital, Princess Royal Maternity and the Southern General Hospital, that includes a mainstream public health assessment process

- Enhanced services for women with additional needs who are also a) experiencing homelessness, b) asylum seekers and refugees and c) pregnant teenagers, provided through a Link Midwife system. Enhanced services are not required by all women in these categories. Women who have good family and/or community based support are cared for through mainstream services. However women assessed as requiring more support can be jointly managed by the team midwife and the Link Midwife together or where there are more complex needs managed by the Link Midwife alone.
- A specialist Glasgow wide service, the Women's Reproductive Health Service (WRHS) based in the Princess Royal Maternity, that provides multi-disciplinary and multi-agency, inpatient and community based care, for women with multiple and complex needs, particularly women with drug and/or alcohol problems. This service aims to provide wrap around care working in partnership with the woman, her family and social care and addictions services, to secure the best health and social care outcomes for mother and infant.
- To supplement and support the public health dimensions of midwifery care, services have been developed to offer training, consultation and advice on gender based violence and child protection to practitioners within the Women and Children's Directorate. A smoking cessation service is also available

## 2. Princess Royal Maternity

The Princess Royal Maternity is situated within the Royal Infirmary hospital site and serves the aforementioned communities of North and East Glasgow, East Dunbartonshire and the communities of Cambuslang and Rutherglen in South Lanarkshire. It also provides a number of board wide specialist services including the Women's Reproductive Health Service (WRHS), an inpatient and community based service for women with the most complex health and social care needs.

## 2.1. Deliveries in 2007

There was a total of 5,504 deliveries in the PRM in 2007. Of these 1,222 births (22%) were of non Greater Glasgow & Clyde (GG&C) residents. Of the 4,282 deliveries from within GG&C area, 2,363, (55%) were born of residents living in the 20% most deprived neighbourhoods in Scotland (Scottish Index of Multiple Deprivation Quintile 1 areas). Of these births 976 (41%) were of residents of the East CHCP, 646 (27%) from residents of the North CHCP, 275 (12%) from the South-East CHCP and 213 (9%) from South Lanarkshire CHCP.

## 2.2. Mainstream Provisions

The Princess Royal Maternity offers continuity of care to women in the community with midwives providing a number of services in the community setting, for example, maternity clinics based in GP practices, parentcraft classes and breast-feeding workshops. Community midwives routinely provide intrapartum care through the Midwifery Birthing Unit (MBU) and the labour suite, and postnatal care in the Midwifery Birthing Unit and in the community.

Given the demographic profile of the key communities served by PRM, mainstream maternity staff are routinely required to support women and families that experience a wide range of inequalities, for example, women and families who are asylum seekers or refugees, families experiencing poverty and unemployment, women and families where there is long term limiting illness or disability, women who are single parents and women who are survivors of gender based violence. Women identified as having more complex needs such as women who have a drug misuse problem or women with severe and enduring mental health problems, are referred to the Women's Reproductive Health Service.

## 2.3. Community Midwives Perspectives

Meetings were held with midwives working from the Princess Royal Maternity and from Rutherglen Maternity Care Centre. Generally midwives were satisfied with the support they received in caring for women with additional needs. The hospital social work service was highly regarded by staff in the PRM as a resource for advice and support in managing women with additional needs. Most women with multiple or complex needs were referred to or re-directed into the WRHS and had little or no contact with mainstream services. Community midwives valued the service provided by the WRHS.

Community staff who were not based in the PRM, or who were working outwith Glasgow City Council jurisdiction, were not as satisfied with the available support to them in caring for women with additional needs. A number of issues were raised:

- Contact and partnership working with social work. Reciprocal working was described as poor, particularly around information sharing. Midwives reported sharing information with social workers but that social workers failed to share important information with them. An example was given where a midwife involved in a woman's care had not been told that the woman's partner was a sex offender. It was reported that social workers cite client confidentiality as the main reason for not passing on information.
- A midwife working in East Dunbartonshire reported that it was more difficult to get social work support for her clients. The hospital service at the PRM is primarily concerned with residents of Glasgow City Council and often unable to provide her with information pertinent to her local area of work.
- Midwives appreciated that social workers carried a weight of accountability around child protection and that this now had resonance for their own profession. Midwives reported 'fear of getting it wrong' and this anxiety often informed their actions. Midwives expressed a need for more clarity around roles and responsibilities in relation to child protection.
- Midwives' role and relationship with health visitors was reported as good. The view was expressed that health visitors' enhanced role in child protection surveillance had changed how they were now viewed by service users in the community. Midwives felt that health visitors were distanced and stigmatised in similar ways to social workers in relation to their role in child protection. Midwives reported that they were not regarded in this way and were keen that this should continue to be the case.
- Midwives expressed a concern about the lack of opportunity to attend training such as child protection. Pressures of work, late cancellation of training and training not being mandatory were reported as causal factors.
- Midwives reported that the way services were currently structured mediated against

continuity of care and a community focus. Staff could be pulled out of community based work to shore up staff shortages in hospital services. It was felt that this demonstrated a lack of value placed on community based maternity care.

- Midwives reported that shared care practices had resulted in decreased client contact. Community midwives reported that they could have a total of 4 contacts with a woman during her pregnancy– booking and 3 antenatal appointments. This, along with the reduced opportunity for a home visit, meant there were fewer opportunities for assessment and information gathering. It was acknowledged that there were no longer the resources available to provide such a service but staff felt that should resources become available then services should be designed to include home visits.
- Midwives expressed awareness of social exclusion as a key issue in many of the communities in which they were worked. Material deprivation was thought to be less of an issue in some areas.
- Midwives asserted that, while women from deprived communities had additional needs, so too did many service users from more advantaged backgrounds. Assumptions should not be made that they had fewer issues or that they required less input. The example of domestic violence was given.
- Midwives raised concerns about early years strategies where resources were focused on the most deprived. Midwives felt there were risks in dispensing with universal services to children as some health issues could be missed.

### 3. The Women's Reproductive Health Service (WRHS)

Since 1990 the Glasgow Women's Reproductive Health Service has provided a citywide service for women with complex social problems. The stated aim of the WRHS is:

"To provide an integrated approach and effective care for pregnant women with a range of social problems likely to affect the health of the woman and her children or to affect her ability to care for her child".

The WRHS developed out of an identified need for increased support to pregnant women with special needs, particularly women who failed to attend standard services such as women with problematic drug or alcohol use, severe psychiatric illness, learning disability or other complex need. The service has been developed over a number of years under the direction of Dr Mary Hepburn and has grown from a local initiative to a city-wide service specialising in the provision of care to women with multiple and complex needs. WRHS is now regarded worldwide as a model of good practice.

#### 3.1. Key Features of the WRHS

Staff working in the WRHS have developed inequalities sensitive ways of working in order to identify and meet the needs of vulnerable women, their infants and their families. Key features of the service include accessibility, non-judgmental approaches, holistic assessment, client inclusion and partnership working.

##### Accessibility of Services

Staff from the WRHS became aware early into the development of the service that maternity provision needed to be designed around the diverse needs of the women it served. Services needed to be accessible in terms of geographical location and pathways into maternity care and to offer a range of health and social care support services

Ease of access to the WRHS service is facilitated through 6 community clinics located respectively in Possilpark, Castlemilk, Drumchapel, Pollok, Easterhouse and the city centre. Attendance at clinics is maximised through joint care arrangements with Community Addictions Teams, which includes substitute prescribing. Co-ordinated care and support is provided through close partnership working with social services and addictions services in particular, through Community Health and Care Partnership (CHCP) based liaison meetings.

##### Non Judgemental approaches

The attitude and approach of staff is felt to be fundamental to the success of the service. Women who have substance misuse problems often feel guilty about their behaviour and may be anxious that they will be judged by service providers as bad people or unfit parents, (Hepburn, 1997) A non-judgmental, supportive approach therefore underpins service intervention. A qualitative study, undertaken in 2002, reported that service users felt they had developed

trusting relationships with practitioners which had both enabled them to be honest about their personal situations and lifestyle behaviours, and had supported them to take more control over their lives (Cosgrove et al, 2002)

### Holistic Assessment and Client Inclusion

Staff working within the WRHS report feeling comfortable working with this client group and report high levels of job satisfaction. A comprehensive social history, taken at the first visit, provides the opportunity to raise and discuss sensitive issues with clients and supports the identification of additional health and social care needs. Practitioners provide an unhurried space in order to help clients find their voice, articulate needs and concerns and actively contribute to decisions about their care. This approach recognises and validates clients lived experience and provides a respectful, open and honest platform from which to negotiate and agree a mutually acceptable plan of care. Practitioners are skilled in developing trusting, working relationships, assessing need and managing risk in relation to both the mother and the unborn child and working practically with partner organisations to meet the material, social, emotional and psychological needs of the women and their families. While practitioners undertake a thorough assessment at the outset, assessment is also an ongoing process with practitioners sensitive to changes in personal circumstances and flexible in care responses throughout the maternity pathway.

### Partnership Working

Partnership working has been a key aspect of the service with close working relationships developed between WRHS, the Glasgow Addictions Service and PRM social work services. Fortnightly liaison meetings provide an opportunity for information sharing, case discussion and care planning. An addictions worker from the East Community Addictions Team provides on site support to clients attending the WRHS clinic in the city centre clinic in the PRM and undertakes a liaison service with the geographical teams. A similar role is undertaken by the social work department based in the PRM.

Partner agencies, along with WRHS staff, take responsibility for reporting to the liaison meeting, sharing relevant information with regard to clients' circumstances and the progress of the pregnancy and participating in decisions about the woman's care. Women, and partners where appropriate, are informed

of, and involved, in care decisions. This multi-agency way of working was reported as being highly valued by service users. Women reported appreciating the interest taken in the wider context of their lives and the support they received with clinical and non-clinical issues. (Cosgrove et al, 2002).

Pregnant women with multiple and complex needs may, for a number of reasons, find it difficult to look after their own health and wellbeing and consequently the health and well being of the unborn child. Two key agencies offer tailored social care support.

- The Parent Support Team based in the social work department in the PRM offers increased health and social care support to women who are socially deprived, who are substance dependent or who have mental health needs, during pregnancy and for the first few months after childbirth. Clients are referred around 28 weeks gestation, primarily through WRHS midwives, Social Work, Addictions services, health visitors or GPs. Workers provide support to clients to build resilience, manage finances and home circumstances and prepare for parenthood. Parent support workers work closely with individuals and with other helping agencies and link to, and inform the liaison team and pre and post-birth conferences of their work and progress made. The Parent Support Team establish good communication links with all the health and social care agencies involved, including ward medical staff, neonatal staff and health visitors.
- The Parent and Children Together teams based in the Community Health and Care Partnerships offer early intervention support to families identified as in need, or potentially in need, of social support. The teams undertake a comprehensive assessment of need and institute tailored packages of care to support families through critical episodes in their lives and to establish alternative sources of ongoing support. PACT Team leaders chair local liaison meetings and support the co-ordination of care to vulnerable pregnant women.

### 3.2. The Women’s Reproductive Health Service (WRHS)

To aid appropriate referrals into the specialist service criteria for referral were developed and circulated to all maternity units. Criteria included:

- Current or past drug or alcohol issues
- Previous children not living at home
- Combination of social factors with the potential to affect the care of the child e.g. Homelessness, Domestic Abuse

This has been used in conjunction with the Integrated Care Pathway for Substance use, Child Protection or Complex Social Issues in Pregnancy, to guide staff in making appropriate care decisions for women with multiple and/or complex needs.

The Out-Patient manager at the PRM undertakes a risk assessment process with all referrals for maternity care to identify women assessed as having multiple and/or complex needs. Women identified in this way are re-directed in to the WRHS. Women receiving mainstream care, who are subsequently found to have complex needs can also be re-routed to WRHS care, preferably within the first 2 trimesters of pregnancy.

In the past 5 years the number of total births through the Women’s Reproductive Health Service has remained relatively constant with an average, in that period, of around 279 births per annum. (See table below). Last year there were 267 births recorded. The majority of women have been referred in to the service because of support needs in relation to drug and/or alcohol dependency and receive multi-agency assessment, monitoring and care planning through the area based CHCP multi-agency liaison groups and the WRHS city centre clinic.

#### Profile of Bed Usage in Ward 71 (WRHS) from 2003-04 to 2007-08

| WRHS                          | 03-04 | 04-05 | 05-06        | 06-07 | 07-08 |
|-------------------------------|-------|-------|--------------|-------|-------|
| Staffed beds                  | 8     | 8     | 8            | 8     | 8     |
| Total births                  | 274   | 310   | 251          | 296   | 267   |
| Average length of stay (days) | 4.2   | 3.4   | 4.0          | 4.75  | 3.2   |
| Average bed occupancy         | 73.6% | 58%   | missing data | 60%   | 57%   |

This user group tends to stay longer in hospital, an average of 4 days over the 5 year period, compared to 2.4 days for mainstream wards over the same period. This reflects the level of need of mother and infant in the early postnatal period where infants may, for example, be of low birth weight, experiencing withdrawal symptoms and be generally less robust, and mothers who due to their own life circumstances, require extra support in developing parenting skills and routines and establishing attached and attuned relationships with their infant.

The average percentage bed occupancy over 4 years (data from 2005-06 missing) for the WRHS ward is 62% compared to 67% for mainstream wards in the Princess Royal Maternity over the same period. It is clear that there is some under usage of the beds in Ward 71 compared to mainstream care. However the pattern and usage indicate that demand for WRHS care is relatively constant and consistent.

While the WRHS is a city-wide service, an audit report undertaken in 2003 indicated that a number of women, who met the criteria for referral to WRHS, did not access the service. More recently, an overview of service provision at the Southern General hospital, reported that in 2007 increased numbers of local women with multiple and complex needs, had opted to attend the SGH maternity unit. It is not known whether this trend will continue or the reasons why the women, who met the criteria for WRHS, chose to attend the SGH maternity service. Poor assessment processes and follow through by staff, along with client preference for the local maternity unit, were postulated as reasons for low uptake of the service in the 2003 audit.

### 3.3. Staffing of WRHS

There are a total of 10.3 whole time equivalent (WTE) midwives working in the WRHS. Of these 4.8 WTE midwives work in the community setting, staffing the joint maternity/addictions clinics, undertaking home visits and attending local liaison meetings. Midwives working in the WRHS have a higher staff-client ratio compared to mainstream community midwives in recognition of the time required to undertake a comprehensive social history and needs assessment, to provide and co-ordinate support, to monitor the effectiveness of the care plan and to contribute to partnership working arrangements.

At the time of writing the inpatient unit of the WRHS has been transferred to accommodation within an adjacent ward. The future model of specialist care provision is currently under consideration as part of the overall obstetric re-design initiative. The Inpatient unit has 8 beds and was staffed by 5.5 WTE midwives. The higher staff-client ratio reflects the diverse and complex needs of the clients and the necessity to both monitor and support parenting competence and infant wellbeing. Women in the ward are given opportunities to learn infant care skills, to be supervised in the care of their infants, to be supported to become more aware of and attuned to their babies' needs, and to be supported to identify and get support for, their own health and social care needs. Women value the open, honest, supportive relationships developed with staff and opportunities to discuss personal and social issues in relation to personal health and life circumstances such as mental health, domestic abuse or drug and/or alcohol use. (User Engagement Survey, 2007)

### 3.4. Stakeholder Perspectives on the Special Needs in Pregnancy Service

The Women's Reproductive Health Service has provided an inpatient and outpatient based support and liaison service to meet the particular needs of the most vulnerable women booked for maternity care in the NHS Greater Glasgow area. The service has robust and efficient communication networks for the timely sharing of information within and between the maternity services and health and social care agencies in both the statutory and voluntary sectors. The service is valued by health professionals in the maternity service and by partner agencies within the hospital and community that work closely with the WRHS team. The service is felt to be efficient and effective in supporting the care needs of vulnerable women and their families while undertaking a key role in early intervention and child protection.

Social service partners described a number of important features of the WRHS service:

- Good communication systems that support partnership working
- Good levels of attendance at and contribution to liaison, pre-birth and post-birth meetings
- Provision of good clinical overview of substitute prescribing

- Continuity of care supported through increased frequency of appointments where appropriate and joint clinics with addictions services

It was reported that, some services that were no longer offered through WRHS inpatient provision were missed, e.g. respite care, detoxification service and stabilisation of drug treatments. Such inpatient services were felt by partner agencies to be of great benefit to women experiencing multiple disadvantage. It was also reported that the learning and practice developments associated with the Vulnerable Infant Project had not been followed up.

## 4. Inequalities Sensitive Practice

Drugs workers based in the East Community Addictions Teams were invited to consider best practice in the care of pregnant drug users. All participants commended the service provided by the WRHS.

A number of features of inequalities sensitive practice derived from the discussion:

- It was acknowledged that raising issues of ongoing drug use could be challenging for staff, especially if the primary focus was on maintaining a friendly relationship with clients. However all workers have a professional responsibility to challenge clients about their substance use behaviour, or suspected behaviour, and record appropriately. This record can provide evidence in relation to child care and protection hearings at a later date. It was acknowledged that midwives required good back-up systems and structures to undertake this kind of intervention.
- Workers suggested that the maternity services complaints procedures should be more visible and accessible to clients. It was felt that clients with multiple and complex needs may feel less able to report experiences of poor maternity care. All users should be made aware at booking, of expected standards of care and the complaints procedure.
- Parenting classes. Workers felt that many clients would benefit from better support in preparing for the responsibility that pregnancy brought, such as, managing routine, managing money, child care and protection and parenting. As most of their clients did not want to attend mainstream classes it was suggested that special classes could be developed to meet their particular needs. It was

suggested that attendance could be enhanced by linking in to pre-birth meetings and the Parent Support Team and by offering incentives.

- Partnership styles of working with clients were felt to be key to successful interventions. It was important not to talk down to clients but to work in non-prescriptive ways - explaining things and making sure clients felt part of the decision making process.
- Values based training that supports workers to undertake inequalities sensitive practice and to challenge colleagues who are discriminatory.

## 5. Conclusion

There is evidence of a great deal of high quality provision of care to women who have additional needs attending the Princess Royal Maternity. Most community midwives felt they were served well by the current structures and systems such as links to hospital social work services. However some difficulties were reported in gaining access to social care support and partnership working with agencies based in local authority areas that lie outwith Glasgow City Council.

The WRHS is regarded as a model of good practice providing a much needed and valued specialist service for pregnant women with multiple and complex needs. The approach of its skilled workforce enables and empowers women, living in difficult circumstances, to articulate their needs and access appropriate support. Women with multiple and complex needs who had used the service in the past 3 years, responded positively to the care they received, acknowledging the benefits that had been accrued from the holistic approach and integrated ways of working:

*"she (midwife) really, really looked after me well....had a bit of depression while I was pregnant so made sure she kept in touch...gave me her number to phone if I needed help.... said to others at the hospital about my depression to see everything was okay...saw psychiatrist. With a past history of depression the midwife wanted to make sure I was set up in case"*

Drug User (User Engagement survey, 2007).

Partner agencies such as social work and addictions services reported a high standard of care provided by the WRHS and commended the integrated care provision made possible through good partnership working.

Services provided through community midwives in the Princess Royal Maternity, the WRHS community midwives and the WRHS inpatient unit were well regarded by internal and external agencies and practitioners as providing appropriate, efficient and effective care to women with additional needs and their families.

It is clear from the demographic profile of the North and East CHCPs that the population served by the PRM is one of the most deprived in Scotland and indeed in Europe. It has high levels of poverty along with the acute health and social problems associated with such disadvantage. Over half of the women who delivered in the PRM in 2007 were living in the Scottish Index of Multiple Deprivation (SIMD) quintile 1 areas, i.e. the 20% most deprived neighbourhoods in Scotland. This in itself has implications for family health and wellbeing.

Maternity services in the Princess Royal Maternity have a key role in addressing health inequalities through the continued development of inequalities sensitive practice in both mainstream and specialist provision. Women accessing mainstream care are likely to have a range of additional needs related to poverty, gender, disability and ethnicity including communication difficulties, gender based violence, housing and finance problems and mental health issues. Meeting these needs has implications for service design, partnership working structures and practice, practitioner training and staff support. Women with multiple and complex needs require co-ordinated, empathetic, specialist support that works in partnership to improve maternal health and wellbeing, build client resilience, and support parenting capacities. At the same time all services require to be aware of their responsibilities in relation to the care of vulnerable children and be active in assessing and securing the safety and wellbeing of the newborn infant and other children in the family home.

## 6. References

- North Glasgow Community Health & Care Partnership (2007), Development Plan 2007-10.  
 East Glasgow Community Health & Care Plan (2007), Development Plan 2007- 10.  
 Inequalities Sensitive Practice Initiative, NHSGGC (2008) Maternity Services User Engagement Survey Report.  
 Cosgrove, K. and Shields, N. (2002) Social Issues and Maternity Care: experiences from the WRHS, NHSGGC.