

Greater Glasgow NHS Board

Board Meeting

Tuesday, 7 October, 2003

Board Paper No. 03/61



Chief Executive

Future of Maternity Services in Greater Glasgow

Recommendation:

The NHS Board is asked to receive the Reports and presentations from the Midwifery Workshop, the Maternity Services Users Network, and the Maternity Working Group.

Background:

In May 2003 the NHS Board approved a process to inform formal public consultation on how to provide modern, safe and sustainable maternity delivery services. The paper which set out the approved arrangements is attached at Appendix I.

The aim of the process was to ensure that, before the NHS Board developed its proposals for formal public consultation, all of the critical issues were carefully and transparently considered in a major pre-consultation process which enabled strong public and professional engagement.

Included with this paper are three Reports:

- Report of Midwifery Workshop: Mary McGinley, Head of Midwifery at the Princess Royal Maternity Hospital will speak to this (Appendix 2).
- Report of MATNET, the maternity services consultation network: Christine Caldwell, who facilitates MATNET, will speak to this (Appendix 3).
- Report of Maternity Working Group: Margaret Reid, Chair of the Working Group, will speak to this (Appendix.4).

The presentation and discussion of these three reports is intended to enable the production of a formal consultation paper for consideration by the NHS Board at its 21st October 2003 meeting. This would be followed by three months of consultation which would include a range of further opportunities for professional and public comment before the NHS Board makes a final decision and recommendation to the Minister for Health and Community Care.

That consultation process will include:

- meetings at which the consultative proposals will be presented and the public will be able to ask questions and express their views;
- engagement with staff interests;
- further engagement with other NHS Boards.

The consultation document will be circulated to those on the NHS Board's standard consultation list and made available on the website.

The NHS Board is asked to receive the Reports of presentations from the Midwifery Workshop, the Maternity Services Users Network, and the Maternity Working Group.

Greater Glasgow NHS Board

Board Meeting

Tuesday 20th May 2003

Board Paper No. 2003/32

**DIRECTOR OF PLANNING
AND COMMUNITY CARE**

IMPROVING MATERNITY SERVICES – THE NEXT STEPS

Recommendation:

The Board approve:-

- A) the proposed process to establish a Working Group with the remit to:-**
- **comprehensively review and provide advice how to provide modern, safe and sustainable maternity delivery services for our population as the final stage of implementing of the Maternity Services Strategy.**
 - **carrying out its work in a fully engaging, transparent and accessible way.**
- B) the establishment of a comprehensive effort, through the Maternity Services Liason Committee's (MSLC's) consultation network, to engage consumer interests in maternity services to further inform its decisions.**

1 Purpose

- 1.1 The purpose of this paper is to set out a process of public, patient and professional engagement to enable the Board to reach a decision on the disposition and development of maternity delivery units, to ensure we have a pattern of services which offers the highest quality and safest service for women and their babies.

This is the final strand implementing the Maternity Services Strategy, which was developed in partnership with women, and has already achieved a number of the priorities they set for services. These include, strengthened community services, innovative maternity centres, improved relationships with primary care and better information and support for pregnant women.

- 1.2 This is an important decision about a core part of our Maternity Services but it is important to restate that for the vast majority of women, almost all of their care, during the normal process of pregnancy and birth, is provided by midwifery, medical and primary care staff working in community settings.

2 Background

- 2.1 It is important to set this current decision in a wider context. A review of the Maternity Services Strategy was conducted under the auspices of the Maternity Services Liaison Committee (MSLC) in 1999. The MSLC brings together clinical, professional and consumer interests to advise the Board on Maternity policy. The MSLC recommendations, endorsed by the Board for consultation, included the advice that, due to the reducing number of deliveries and pressures on clinical services, particularly obstetric and anaesthetic rotas, the only sustainable pattern of services for the future should be two delivery units in Glasgow rather than the present three.
- 2.2 Expanding the basis for that advice, the MSLC highlighted:-
- births in 1998/99 were already below the level projected for 2001 with an anticipated maximum of 11,400 in Glasgow and the new Princess Royal Maternity Hospital (PRMH) with a capacity to deliver of at least 6000.
 - delivery units below 3000 may not be able to retain neonatal intensive care facilities.
 - obstetric and neonatal staffing is not sustainable across the 3 sites as a result of changes to doctors working hours and training.
 - the Royal College of Obstetricians and Gynaecologists recommendations in “Toward Safer Childbirth” could not be met on 3 sites.
 - the extent to which the vast majority of women can receive almost all of their care in community settings with the delivery experience limited to a single, short episode, reflecting the development of community services and reducing lengths of stay.
- 2.3 Following through the MSLC report, the Board undertook a major consultation exercise in Autumn 1999 and in reviewing the outcome of consultation in November of that year approved a Maternity Strategy with a series of recommendations, including a reduction in delivery units from 3 to 2 – seeking further advice from MSLC on how that decision should be implemented and the implications for current services.

- 2.4. Following approval of the Maternity Strategy, a MSLC sub group was established in late 1999 to advise the Board on the process and key issues to reach a decision on which delivery site should close, to enable the development of the new pattern of services. The sub group report was approved by MSLC in May 2000 and submitted to the Health Board with the recommendation that the Board establish an extensive programme of public engagement around the maternity strategy and full consultation to debate the options for the future shape of delivery services.
- 2.5 In parallel to this process the critical phase of consultation on the Acute Services Review raised the question of the future siting of paediatric services – it was concluded that a combined process for paediatrics and maternity services should be a core component of the further development of the Acute Services Strategy and further process on delivery unit changes was held pending that process. By late 2001, that further development and consultation had concluded that decisions on the siting of paediatric and the delivery component of maternity services should not form part of the overall Acute Services Review, which was finally approved in August 2002.
- 2.6 The rest of this paper proposes the way in which the Board should arrive at a fully informed view on the future pattern of delivery units in advance of formal public consultation. Key aims of the process are to enable all of the clinical, professional and women’s interests to have their say in this important decision and to ensure that the Board is fully advised on all aspects of this matter prior to reaching conclusions. The paper also describes the policy context, regional planning dimensions and the key clinical, service and financial issues.

3. Current Position and Key Issues for Decision Making

- 3.1 Glasgow currently has three maternity units providing consultant deliveries. The Princess Royal Maternity Hospital (PRMH), opened in 2001, at present it delivers around 4,800 babies against a probable capacity of 6500 and, therefore, has significant unused facilities in our most modern maternity unit. The Queen Mother’s (QMH) and the Southern General(SGH) deliver respectively, 3400 and 3000 women each year operating at around 60% of their potential capacity. Both have ageing facilities which need capital investment to provide a modern standard of accommodation.
- 3.2 The QMH and PRMH each provide a range of services for the West of Scotland including neonatal intensive care and foetal medicine, and in the case of the QMH, an obstetric and neonatal medical service co-located with the neonatal surgical and tertiary paediatric specialties within the Royal Hospital for Sick Children.
- 3.3 The earlier work of the Maternity Services Liaison Committee, fully consulted on by the Board, established that in order to provide the best clinical care in modern facilities, supported by further capital investment, we need to decide

whether the Southern General or Queen Mother's Hospital Units should be the focus for future delivery services and development in partnership with the PRMH.

- 3.4 There are a number of important issues which need to be considered in determining the future pattern of delivery services.

Our primary concern must be to achieve the highest standard of care and safety for women and their babies. That means we need to consider carefully the relationship between maternity services, and the needs of women and babies who experience complications or problems during delivery, recognising that, for the vast majority of patients, this is an uncomplicated and happy event. We also need to make sure that we are providing care in modern facilities, properly used, that those services are accessible to women and their families and fully linked to community services, before and after delivery, where almost all maternity care is provided.

We also need to consider the future development of services – particularly as we are currently making capital investment decisions for the long term – a significant issue here is the judgement on whether, in the longer term, there would be major benefits to co-locating adult and paediatric services, redeveloping the Children's hospital on a new site.

- 3.5 In addition to the clinical case for change a further significant factor is the opportunity cost for other child and maternal health services of maintaining facilities which are not being fully utilised. This is especially so as we have a whole range of priorities, particularly around developing community services and support for vulnerable families, which require investment.
- 3.6 The next section outlines a way in which we could establish a process to consider these issues and provide the best possible and informed advice to the Board.

4 Proposed Process

- 4.1 As the previous section outlines – the question of which delivery unit should be developed as Glasgow's second centre for the future, is a complex one, with a number of clinical, patient and financial factors which need careful evaluation. The process outlined below is intended to ensure that before the Board develops its proposals for formal public consultation all of the critical issues are carefully and transparently considered in a way which enables strong public and professional engagement.

- 4.2 We propose the establishment of a small Working Group which will consider all of the available evidence and information. This will include a number of sessions, open to the public, where key interests will have the opportunity to set out their views for discussion and debate.

In addition, the group will be able to invite relevant professional and patient interests to attend in order to obtain their views on the key issues.

- 4.3 **The working group will be independently chaired and will include 4 non executive Board members. Its purpose will be to thoroughly consider all of the relevant clinical, service and financial issues and offer a report to the full Board on the preferred option for which delivery service should be developed as Glasgow's second centre to best meet the needs of women and babies. This will enable the Board to reach propositions for full and formal public consultation.**

- 4.4 Support to the group will be provided by dedicated administrative capacity and a range of inputs from the Board's child and maternal, women's health and planning teams. The group may also seek external clinical advice, sourced through the relevant Royal Colleges and other professional bodies. Extensive input from our communications team will ensure an appropriate profile for the group's work and to ensure the widest possible opportunity for engagement.

- 4.5 In addition to the Working Group we will, through the MSLC, identify the consumer interests and networks around maternity services and establish a process to brief those interests and networks on the key issues. This will enable a range of patient views to be fully included in the Board's evaluation. The paper at attachment one provides further detail on this approach. Given that midwives are the largest professional group involved in the provision of these services, we will also reconvene the cross Glasgow midwifery forum which helped us to formulate other aspects of the Maternity Strategy.

- 4.6 Our proposal is that these two important strands of work should be completed by the middle of August 2003 to enable the Board formulate propositions and to embark on formal, public consultation in October 2003.

This two stage process enables a wide range of engagement before proposals are finalised but with a further opportunity for involvement during the public consultation process.

5 Policy Framework

- 5.1 Decisions on maternity services need to be made within the framework of a number of recent policy statements. In Scotland, the deputy Minister for Health led an Expert Group on Acute Maternity services,(EGAMS), which reported earlier this year. This work followed up the Framework for Maternity Services in Scotland, published by the then Minister for Health in 2000.
- 5.2 In addition, the regular, UK wide enquiries into maternal deaths and recent English Department of Health work on a National Service Framework for children and young people, provide further policy direction, including detailed work on neonatal intensive care.
- 5.3 There is also a range of guidance available from professional organisations, including the Royal College of Obstetrics and Gynaecology, the British Association of Paediatric Surgeons and the British Association of Perinatal Medicine.
- 5.4 This various policy guidance would provide important material for the working group to apply to our situation in Greater Glasgow.

6 Regional Planning

- 6.1 In reaching conclusions about the pattern of maternity units for Glasgow it will be important to take cognisance of the plans of adjacent Boards, both in terms of any changes to flows of women into Glasgow delivery units but also reflecting the tertiary services provided by Glasgow hospitals for other parts of the West of Scotland .
- 6.2 Lanarkshire Health Board have a stable pattern of provision with a modern single delivery unit at Wishaw hospital. Argyll and Clyde are currently consulting on options to change the pattern of their maternity services. That process is due to conclude by the end of July 2003 which will enable our decisions to be made in the context of a clear, final strategy for Argyll and Clyde residents. Our planning to date has assumed Argyll and Clyde continues to have a substantial consultant maternity unit, meeting the delivery requirement of the majority of its own population, which presently has the following pattern of deliveries (2000/01 figures).

| | |
|-------------------------------------|-----------|
| Royal Alexandria Hospital, Paisley | 2047 |
| Inverclyde Royal Hospital, Greenock | 984 |
| Vale of Leven Hospital, Alexandria | 862 |
| Midwifery units | <u>88</u> |
| | 3891 |

Flows into Glasgow from other West of Scotland Boards are relatively marginal and there is no indication these will change.

7. Conclusion

This is an important, long term decision about the shape of core component of Maternity Services and the aim of the process this paper recommends to the Board is to ensure that our decision making is based on a full assessment of the issues allowing the key interests to be comprehensively engaged in advance of formal public consultation.

REPORT OF MIDWIFERY WORKSHOP

1. Background

The Board agreed that one strand of the pre consultation on Maternity Services should be a workshop for midwives from the three Greater Glasgow Services. The Workshop was run on 25th August 2003. Fifteen midwives from each unit, representing a cross section of service areas were invited and 44 attended.

Heads of Midwifery agreed that Mary McGinley from PRMH, would attend the Board Meeting to speak to this Workshop Report.

This short covering report summarises the outcome of the Workshop.

2. Key Themes

Attachment one to this paper is a more detailed summary of the points made in the Workshop. This section draws those individual points into a number of key themes.

2.1 Which unit should close?

As one would expect there was a clear divergence of views around the issue of which unit should close. Participants recognised that all of the services had things to commend them. The debate focused on the benefits of co location with Adult Services, versus co location with specialist paediatric services. There was some discussion on whether three units should or could be retained.

The discussion quickly moved on to map out the points which midwives felt were important in managing a change from three delivery units to two. The overriding theme was that change to delivery units should be a reduction in sites not care provision and that the opportunity to look more widely at the whole midwifery service should be taken. The rest of this section covers the contents of those discussions.

2.2 Midwifery roles

Much of the dialogue focussed on the potential to significantly change the midwifery role.

- Greater emphasis on midwifery led care in normal pregnancy with direct access
- Different relationships between midwives and GP's including more geographic service structures.
- Creating the opportunity to extend the public health impact of the midwife – there was real enthusiasm for this issues raised included the potential for a renewed focus on access, prioritising excluded women and tackling inequality were central themes.
- The EGAM's report needs to be implemented and consistent practise agreed across greater Glasgow.

2.3 **Hospital Issues**

There was much discussion about the impact of larger delivery units and a number of important messages:

- large units are not necessarily problematic if one to one and personal care is provided in high quality facilities. This requires adequate staffing levels;
- providing good facilities for the mothers of sick babies is important;
- outreach from hospital sites should be maximised to reduce hospital attendances and transfers;
- there should be choices of models of care within delivery units - including domino, midwifery led and homebirths is a fundamental requirement;
- continuing to develop high quality critical care for mothers at risk is important;
- high quality and effective neonatal transport is critical;
- re provision of specialist clinics needs to be properly organised.

2.4 **Community services**

There is a strong consensus that community services are the most important area for development:

- We need to achieve local access for the majority of care and the majority of women;
- targeting more assertively and with more resources those who have not traditionally accessed services is an important, developing midwifery role;
- facilities in the community are highly constrained and need to be addressed;
- the potential of technology, for example, telemedicine, needs to be worked through;
- the Community Health Partnership provides an organisational form for much stronger relationships in primary care – a team approach to the care of women, children and families.

2.5 **Staff issues**

A series of priorities about staffing emerged from the discussion:

- a number of the midwives present had already been through the closure of a unit - one on three occasions. We need to learn from previous closures;
- midwives highlighted the positive impact of previous changes in developing different ways of working;
- people want the closure to be managed with full staff involvement and choices for individuals about their future workplace and pattern. Although there should be consistent service models there should also be the potential for different way of working within those;
- all midwives agreed there needs to be more practitioner involvement in decision making to raise morale and retain staff;
- a number of issues about infrastructure, including transport policy and information technology need attention to manage the closure well;
- staff feel under pressure, seeing increasingly different and more diverse communities, often with higher expectation and levels of need..

3. **Conclusion**

This workshop gave midwives the opportunity to have an intensive and open discussion about a wide range of issues and implications of change to delivery units. This material will inform the development of the formal consultation paper and most importantly will strongly inform the implementation of change.

ATTACHMENT ONE.

A. DELIVERY UNITS - KEY POINTS FROM DISCUSSION

1. Access and Choice

- Access is an issue.
- Socio-economic conditions and transport.
- Concern regarding closure:
 - health of women in Glasgow?
 - health of women in Scotland?
- Do we need to close - resources should be retained in maternity.
- Community - local access - very important South and North.
- Three excellent units - two reduces choice for women.
- Feedback women don't really highly value the delivery unit as a key issue.

2. Adult and Paediatric Co location

- Sick children - QMH
- Sick women - SGH
- Framework for maternity services:
 - within an acute hospital;
 - EGAMS - same site as adult services;
 - blood bank available
 - adult - would need to debate and reassure patients.

3. Implications of a Closure

- Not an issue for PRMH or most other units - local.
- Stabilise infants - we now have transport services.
- Neonatal ICU - may require transfer.
- QMH have a midwife on site to support mothers transferred with ill and sick babies.
- Community Midwives to provide support:
 - need for facilities at RHSC for mothers – bath/beds;
 - number of sites should not matter:
 - Community Care - Public Health;
 - Peripheral clinics – Drumchapel, WRHS - women choose - stigma.
- The future lies in the community.
- Need for higher quality service.
- If you close one - more women going through a bigger labour ward.
- Production line - how to ensure that resources are there to provide “personal care”
- Avoid conveyor belt - for staff and patients.
- Midwives - homebirth and domino.
- Re-invest savings into maternity services.
- **Important** - midwife led intrapartums and one to one care in labour.
- Less than 1% currently homebirths will more women choose this?
- Homebirth will increase if conveyor belt.
- Care currently is good.
- Identify booking midwife.

- Continuity of care.
- Place of delivery should not be an issue, guarantee a high quality service.
- Link with Yorkhill vs psychiatric mother and baby neurological sciences.
- How can we be reassured that the community facilities will be available.
- Skills and training – education for midwives.
- Closure of Rutherglen - we achieved this.
- Need to give services close to home.
- Women should not feel compelled to choose home birth rather than have conveyor belt birth.
- Education can provide expertise.

4. Rutherglen Experience

- Homebirths did not increase.
 - Community services – women tend to:
 - Millbrae - high satisfaction:
 - Ultrasound
 - Parenthood
 - Antenatal
 - Postnatal
- \ local to the women
 same team throughout
 / women's health/social
- Asylum seekers find and use it well.
 - A lot of women who have foetal problems and maternal don't separate out neatly.
 - Practice then and practice now.
 - We have evolved so much in the past 16 years what will future be - public health.
 - Role of the midwife.
 - Short stay in hospital:
 - Consultant and Surgeon;
 - mother and baby should not be separated.
 - Paramount avoid separations of mother and baby - cardiac/surgeons can walk across and talk to mother.
 - Concern - where and how will this happen.
 - Not a concern in other big cities.
 - Optimum care currently given MSLC - women were asked previously we need to make women aware and seek their views - How can we do this?

5. Issues for Neonates

- Need to ensure there is no separation
- Care for mother alongside babies
- Can this be built in
- Routine detailed ultrasound many more will be identified antenatal
- Genetics/cardiac/surgeons all at RHSC

6. Risk

- What is the balance?
- Children's hospital on an adult site - RHSC has a very good environment - not a capital priority.

Current Services:

PRMH:

- Developing detailed scanning interpreted at RHSC Telemedicine.
- Minor operations done within the Neonatal Unit - minimise the transfer of babies.

QMH:

- Mothers facilities at QM's/Yorkhill.
- Mum's delivery service for seriously sick babies?
- Mother with first day section should get good midwifery care alongside baby at RHSC.
- PKU:
 - Metabolic service – outpatients
 - Follow up – options to move midwife or PKU
 - Specialists – Metabolic care at RHSC

SGH:

- 24/52 - 6 transfers in six weeks.
- 3 return journeys.
- Consider costs.
- Mothers – view baby comes first.
- Medical clinic on any site – diabetic/hypertensives.
- ITU there may not be a bed but if you have an Adult ICU you get the clinical team.

Maternity Services- from West End:

- Maternal - WIG closure ASR plans.
- Not fair that they are both close together and both North of the river. Not equitable.

RHSC:

- Would not ventilate a woman at QMH.
- Could RHSC provide ITU adult care? They care for adolescents.
- Asylum seekers - projection for birth rates but 10,000 more women to achieve 500 births.

7. Car Parking

- Access for staff vs patients – green transport policy as an issue for us.

B. DISCUSSION ON WHAT ARE MOST IMPORTANT TO GET RIGHT

8. Staff Issues

- a. Midwives in urban areas have a huge caseload
- b. Education
- c. Staffing levels
- d. Stress management
- e. Involvement in decision making
- f. Model –if it works for women and midwives “one size does not fit”
- g. Remuneration – adequate reward
- h. Pay structure – Agenda for Change

E Grade – higher than G and H with shift payments

Retention - of expertise in the service

Facilities for staff within the service, crèche, sports, etc

9. Recruitment

- HDU
- Critical Care – (Nursing Skills)
- Investment in staff education
- Conferences/study day
- Adequate staffing to allow study time
- Turnover lower

Allowing staff to work in ways that they want to work

10. Service Models

- Midwife led care
- Direct access to midwives
- GP Contract – makes GP gate keeper – should not be the model
- Direct referral to midwives
- Remove need for consultant visit
- High risk – consultant only
- Ability to assess – risk – education.
- Midwife prescribing.
- Medical complications not always highlighted in the referral need for GP’s to inform.
- Screening/information.
- Midwife – as an integral part of PCT every GP should access midwife.
- Critical mass – not small numbers as GP surgery but central midwifery session.
- Need to look at hours of service.
- Out of hours.
- Access to midwives.
- Replicate what has worked before comprehensive service linked to LHCC – Millbrae/Rutherglen.
- Need to ensure all women have access to a midwife, some GP’s can’t provide space.

- Women who want advice out of hours – need to take pressure off delivery units.
- Outwith clinic hours – women attending calling/breast feeding “advice and clinics should be available”.
- Opportunity in new CHP.
- Improve CHP – with involvement of midwives.

ACAD or other non hospital health
Model all can be done is community except ultrasound

- Scanner/Consultant and M/W could be in the community

11. **Medical Complications at Hospital Clinic**

EGAMS - needs to be applied
 - risk assessment
 - criteria for midwifery/consultant care

- Need to persuade Consultants to allow EGAMS midwifery models
- What works or local community and team geographical focus rather than GP
- Encourage Consultant link for each community area
- Building trust – geographic team
- EWTD – consultant contract
 - Need for change
 - Consultants can't do it all
 - Midwives need to manage their caseload

12. **Named Consultant**

- Midwife is main carer
- Ultrasound scanning – midwives
- Radiographers

Consultant – high risk – with midwives.
 Midwife – healthy women.

13. **Rutherglen Closure - Lessons**

- Being involved in discussions about the future
- Stress – anxiety
- Where they will be transferred to
- Grades – recruitment problems

Need for community bases to be established before closure

14. **Car Parking**

- Green/parking policy
- Ways of working – community bases
- Public transport policy
- Community HP/locality bases

- Geographical teams
- IT & accommodation
- Timetable – 1 year capital build programme
- Positive benefits of taking ideas to the other unit. It is not always a negative thing. QM's midwife – remembers things benefiting from the influx of Stobhill midwives to the unit.
- Positive change
- Whatever the outcome the quality of service for women should be the same or better.
- Views from team at RHSC. What would need to change at Yorkhill if QM's was to close?
- Babies currently being cared for QM's in RHSC post closure – what will happen?

Shape of service focused on community

Midwife managed beds within both units

Women delivering in large units should not be denied delivery in a midwives unit. Midwives should be able to deliver range of care.

- We will have some additional capacity – choice for women requires this opportunity
- Service re-design
- Moving midwifery forward
- Learn from Rutherglen and Stobhill closure

Greater Glasgow's Maternity Services: A Users Perspective on the Proposed Changes

Paper for the Greater Glasgow NHS Board Meeting to Discuss the Future of Maternity Services in Greater Glasgow

**Paper by MatNet, the Maternity Services Consultation Network
7th October 2003**

1. Background

The Greater Glasgow NHS Board Maternity Services Liaison Committee established MatNet, the Maternity Services Consultation Network, in May 2003 in order to develop and support user involvement in the planning, management and delivery of maternity services. The purpose of the network is to ensure that the needs and concerns of users and the wider community systematically inform the development of maternity services. MatNet is still a new group but it hopes to develop as a place where plans for maternity can be discussed with an informed group of potential, recent and past users.

MatNet links into the considerable work on maternity and childrearing issues that currently takes place in the community. This work ranges from fairly traditional approaches e.g. breastfeeding support, parenting support and development; home visiting schemes and parents drop in groups, to specific work on the maternity experience. While it is recognised that MatNet still has work to do in terms of its representativeness of the wide range of groups, interests and communities in the city the MatNet model is seen as being a strong model of community representation, potentially providing a voice and viewpoint for a cross section of Glasgow's users of maternity services.

The current members of the network, who have been involved in the development of this report, are: -

- ❖ National Childbirth Trust, West Glasgow Branch
- ❖ Maryhill Mother's Group
- ❖ Starting Well Health Support Workers
- ❖ Breastfeeding Initiative Volunteers
- ❖ East End Health Action
- ❖ Maryhill Community Health Project
- ❖ Father's Support Group, Ruchazie

As well as the above groups a number of individuals also contributed to this paper. One further member, Budhill Family Learning Centre, was unfortunately not able to take part in the preparation of this report.

2. Consultation on Maternity Developments

In order to prepare this report MatNet has consulted widely within the network. Information on the proposed changes was sent to all members and briefing meetings followed with each group. A MatNet meeting was held to bring together the different groups. Catriona Renfrew, Director of Planning, GGNHSB, attended this meeting and provided information and support during the discussion of the proposed changes. This meeting was also attended by the Modernising Maternity Services Working Group, which is gathering evidence before making a recommendation on hospital closure to GGNHSB. Three members of this Working Group attended MatNet as observers.

This report was prepared by MatNet in order to bring forward the experience and expertise of those who use services to the future plans for maternity. It is hoped that this will make a meaningful contribution to the consultation on the modernising agenda for maternity services.

3. A Tough Choice to Make

MatNet recognises that there is a difficult decision to be made about the future of Glasgow's maternity hospitals – that is the reduction of hospitals from 3 to 2. The network agreed that such a decision was necessary and that one hospital site should be closed. However, MatNet had no view on which site this should be. MatNet feels that it would be more appropriate for it to comment on how maternity services could be developed to meet the needs of users.

4. Developing Glasgow's Maternity Services

The network agreed that hospital closure could offer an opportunity to identify and implement changes in services that would benefit women and their families across the city. The following developments are proposed for **all women** in Glasgow and not just as compensatory measures for those who may lose their local hospital.

4.1 Developing Community Based Provision

The most important issue agreed by MatNet was the need to increase maternity services within local communities. Regardless of which hospital is to close there is a need to provide community services that give women access to as wide a range of local maternity services as possible. The model of community services adopted in Rutherglen following the closure of the maternity unit there was highly recommended as a model for the city.

In addition to providing traditional services MatNet felt that ante-natal services could be expanded to include a range of other information for women such as welfare rights. There was general, but not overwhelming, support for a 'public health' role for midwives but the network repeatedly stressed that midwives would need training and support if they were to take on this role. This was especially true where the issues being raised with women were sensitive or embarrassing.

Over the course of its meetings ante-natal classes emerged as a key factor for MatNet. It was felt that access to ante-natal classes would be greatly improved if they were provided in local venues such as health centres, leisure centres or other community facilities. A multi-disciplinary group looking at maternity services in the east end currently runs ante-natal classes at the Eastbank Health Promotion Centre in

Shettleston and this venue has proved very popular with women. This initiative was also recommended as a model for the city.

It was felt that ante-natal classes had great value for women and their partners as they created friendships, relationships and networks that could provide invaluable support once the baby was born and the family was adjusting to life with a new baby. By running the class in a local community there was a greater chance of creating a supportive network that could maintain outside the class and so help new parents.

However, the location of ante-natal classes was not the only factor discussed. The timing of classes was also felt to be an issue. It was felt that more and more women were working late into their pregnancy and so were not available to attend classes run during the day. There was a great deal of support for increased flexibility in timings with evening classes proposed to help women attend with their partners.

Access to and take up of ante-natal classes by fathers was also raised. The Father's Support Group felt that ante-natal classes offered an opportunity to involve and include fathers that was often overlooked. They also pointed to a lack of information and support for new dads, which could be helped by providing information either in leaflets or at ante-natal classes.

It was felt that greater community-based services could help with access to ante-natal services but more than that it could help to encourage other models of midwifery including home and domino births.

4.2 Supporting Women to Attend Hospital Based Services

Despite its strong commitment to and support for expanded community-based services MatNet also recognises that there are times when women may have to attend hospital. This may be for a one-off visit or, should either the baby or the mother's health need to be monitored, regular clinic attendance. In such cases MatNet would like the Board to consider how it can support women to attend hospital services. Pregnant women, often with other young children, attending hospital are faced with a number of difficulties that may well be manageable under normal circumstances but which are huge problems when pregnant, unwell and anxious.

The health board needs to consider public transport, car parking, rest facilities, childcare and access to water, tea/coffee or meals.

A particular issue is transport. There was a very strong feeling that all developments need to consider transport as this can often present very real difficulties for both pregnant women and those caring for or visiting them. The location of services, poor access by public transport and the enormous difficulties in parking were repeatedly raised as problems. When planning the closure of one hospital MatNet feels that travel to the remaining two must be given a high priority.

4.3 Midwifery & Service Developments

MatNet has already raised the issue of training for midwives in order to support them in taking on a public health role. There were, however, a number of other issues raised in relation to midwives. Consistency of carer was considered very important. Pregnancy and childbirth were greatly helped by developing a relationship with a

midwife. This was often not possible and the lack of such a relationship was keenly felt. Staffing was also an issue with many women believing that hospitals were understaffed. This was particularly true of labour ward.

The role of midwives in future service developments was an important issue. Some groups felt that the systems and hierarchies midwives worked in hampered more innovative midwifery models such as domino or home births. Similarly, midwife referral was viewed very positively by the network but thought difficult to achieve within the existing systems.

One issue that emerged strongly from the network was the lack of awareness of the choices available to women in maternity care. One choice in particular was the choice of hospital for delivery. Many women appeared to be unaware of their various options and MatNet would like to see better information to ensure that they can participate fully in such basic decisions.

4.4 Post-Natal Support for Women

A strong message from all the MatNet groups was the need for better post-natal services for women. The network felt that the vast majority of women spent very little time in hospital and that in comparison there were very few post-natal services. Many women spoke about their feelings of anxiety, fear and of being overwhelmed when they went home from hospital and for the need to ensure that service developments tried to help with this difficult time.

Many groups said that a greater level of support was needed post-natally and that such support should be flexible. In many cases the type of support required was emotional. In these cases it may not be a midwife or a Health Visitor that is needed. The idea of a Douala – a woman who supports another woman during pregnancy - was raised. However, maternity services would need to be responsible for ensuring that a bridge was established between hospital services and the woman's home. There was considerable support for the Starting Well project and, in particular, for the model of needs-led support it offers.

Peer groups were recommended as a means of supporting new mothers and new fathers but it was also noted that a health professional such as a Health Visitor is needed to facilitate groups. New mothers could not set up and organise a group, although they may well be able to keep it going if it proved beneficial.

Finally, the location of post-natal services was questioned with a strong recommendation that these also be located within local communities and not only in hospital sites. There was a strong feeling that the families who needed post-natal services would find it difficult to access them unless they were local and easily reached. MatNet felt that in many cases the women who were able to access hospital sites were not those most in need of services.

4.5 Maternity Facilities

MatNet felt that there were several factors that should be considered when the programme of renovation is being planned for the remaining hospital. The link between women's well being in delivery and the physical condition of maternity facilities was discussed and the following identified as being important. Facilities

should be well decorated and well ventilated with windows rather than closed-in. Women asked that the facilities currently available at the Tower Suite in the Queen Mother's Hospital be used as a model for the future.

Facilities should also recognise that sometimes partners needed to stay at the hospital and so accommodation should be provided for them. Similarly, it should be possible to accommodate mothers for a short time if their baby's discharge is delayed. This would assist mothers to spend time with their child, establish breast-feeding and reduce the stress of separation. The network also requested that mothers and partners be given a short additional time together in the delivery room after the delivery and before transfer to the ward. This would allow time for reflection and recuperation before moving back to a possibly busy ward setting.

The move to community-based services would also have implications for facilities. MatNet felt that some services such as ante-natal classes could be provided in a range of community venues but that local health centres would probably need to absorb much of the demand for local clinics. It was felt that additional space would be required as women quite often felt 'squeezed in' to health centres and that the current arrangements were not flexible enough to accommodate drop-in or emergency access.

MatNet would like to continue to be involved in commenting on and influencing building and renovation plans.

5. Conclusion

MatNet welcomes the opportunity to present its views in this way and hopes that, though its membership of the MSLC, it will be able to continue to contribute to the plans for Glasgow's maternity services.

The network accepts that one of the three existing maternity hospitals will close but feels that that whatever site it is then community-based services must be developed to ensure that women continue to have good access to maternity services. Furthermore, it is not enough to develop community services in any one area of Glasgow – these developments should be city-wide.

MatNet recognises that there will be significant staffing, resource and organisational implications arising from the developments it is proposing but feels that there are currently unparalleled opportunities for re-thinking the ways in which maternity services are delivered. We urge GGNHSB to take this opportunity to include in its development programme the needs and experiences of those who use services and to continue to find ways of informing, including and involving women, their partners and other carers.

MODERNISING MATERNITY SERVICES IN GLASGOW

**Working Group Report
a pre-consultation process carried out for the
Greater Glasgow NHS Board**

Working group Membership

| | |
|---------------------------------|---|
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October 2003

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Introduction

Greater Glasgow NHS Board has been committed for several years to a process for reshaping its maternity services. After wide consultation, the decision was reached in 1999 by the (then) Greater Glasgow Health Board to reduce the number of maternity hospitals in the city from 3 to 2. There were three maternity hospitals in Glasgow, Glasgow Royal Maternity Hospital, the Queen Mother's Hospital (QMH) and Southern General Maternity Unit (SGH). In 2001 Glasgow Royal Maternity Hospital ('Rottenrow') closed and a new maternity hospital, the Princess Royal Maternity Hospital (PRMH), was opened, co-located with Glasgow Royal Infirmary.

Since 1999 data from Scottish Executive have shown that the birth rate within Scotland has continued to fall – in 2001 the number of births in Scotland were at their lowest number ever recorded, at 51,642 births, 1500 fewer than in 2000 – with births in Glasgow city being equally reduced (see Table 1).

Table 1. Births in Greater Glasgow H/B by year (ISD data)

| <i>Year</i> | <i>Babies born</i> |
|-------------|--------------------|
| 99/00 | 11491 |
| 00/01 | 11084 |
| 01/02 | 11024 |
| 02/03 | 11300* |

(*includes deliveries from Vale of Leven Hospital, Argyll and Clyde NHS Board, following its closure)

A number of rooms at PRMH remained unopened, while bed occupancy fell from 73% and 78% for QMH and SGH in 1993 to 59% and 63% respectively in 2002; bed occupancy at PRMH rose from 67% to 74%¹. Staffing difficulties in the maternity services in Scotland were considerable, with shortages in neonatology, and trainee shortages in anaesthesia, obstetrics and neonatal paediatrics. Additional constraints were imposed by the New Deal for Junior Hospital Doctors hours, and by changes in consultant job plans deriving from the new EU Directive on Working Hours. The need to consider the future of the Greater Glasgow maternity services thus became urgent and a decision required as to which maternity hospital should close. One commentator summarised the situation by writing "Resources relevant to the quality of care are spread too thinly over 3 maternity units".

Options

The two options available to the Board are as follows:

- The closure of the Southern General Hospital Delivery Unit and expansion of facilities at the Queen Mother's Hospital to deal with additional deliveries
- The closure of the Queen Mother's Hospital and expansion of facilities at the Southern General Hospital Delivery Unit to deal with additional deliveries

¹ These figures are for overall adult bed occupancy and include pre- and postnatal beds. The rise at PRMH is partly explained by the closure of Rutherglen maternity hospital during that time period plus a change of other policies which affected bed occupancy.

The Pre-consultation process

This report is part of a consultation process which follows the guidelines on consultation and public involvement issued by the Scottish Executive in May 2002. The current guidance requires a pre-consultation stage to any major service change proposal to gain the views of key interest groups on a range of options. A pre-consultation Working Group was established in May 2003, the *Modernising Maternity Services Working Group*, to consider both options available to the Board. The remit of the Group is as follows:

- *Comprehensively review and provide advice how to provide a modern, safe and sustainable maternity delivery services for our population as the final stage of implementing of the Maternity Services Strategy*
- *Carrying out its work in a fully engaging, transparent and accessible way*
(Minutes, GGNHS Board Meeting 20th May 2003)

The report which derives from the pre-consultation process described below concludes with a number of recommendations which will be presented to Greater Glasgow NHS Board in October 2003. At that meeting reports will also be presented by MATNET (a city-wide umbrella group representing a range of voluntary maternity groups) and by an informal group of senior midwives from the 3 Units, following a seminar at which their views were reported. These reports will inform the Board which will then reach a decision, subject to a formal 3 month consultation period.

The Working Group has, during the pre-consultation stage, gathered information on this complex issue in a number of ways;

- 1 The Working Group visited the 3 maternity delivery units in Greater Glasgow and met with staff on-site.
- 2 Leaflets were sent to a wide range of professional and other groups on the Greater Glasgow NHS Board mailing list to inform them of the process and invite individuals and groups to give evidence in August on the topic of the maternity hospitals and the experiences of staff working in the hospitals. The Working Group held eleven “evidence” sessions for clinical and non-clinical staff (Appendix 1). Evidence was heard from 85 individuals, including representatives from professional organisations, staff from clinical, midwifery and nursing backgrounds, Support Groups, representatives from the Local Health Council, MSPs and others. Advance notice of these sessions was advertised through the media to invite members of the public to attend.

More than 55 written submissions were received from many sources within United Kingdom. (Appendix 2).

- 3 External clinical advisors were consulted at the beginning and end of the pre-consultation stage. Nine individuals were nominated by their professional bodies; expertise covered obstetrics, anaesthesia (both paediatric and adult), neonatology, neonatal surgery and midwifery (see Appendix 3). The majority of expert advisors visited Glasgow twice and were given a tour of the hospitals prior to meeting the Working Group. The concluding session had 8 of the 9 present; all were asked to indicate their recommendation about which hospital to close, whilst one expert sent his comments in writing with a recommendation contained with the submission.
- 4 The Working Group had access to relevant documents which are referenced in this report.

- 5 The Working Group attended a meeting of MATNET as observers, when the various options were discussed.

The process outlined above proved invaluable to the Working Group, allowing them to identify and focus on the key issues. The Group was particularly impressed by the commitment, enthusiasm and indeed, passion of those health professionals and others who presented evidence to the Group.

'Givens'

In the process of consultation the Working Group took certain issues as agreed. It did not consider further, for example, the earlier debate about '3 to 2', ie the reduction in the number of maternity hospitals in Glasgow. It was understood that the choice of closure of a maternity hospital would not include consideration of the recently-opened PRMH.

It understood that, in keeping with its 'modernising' remit, the Working Group would consider long term solutions to the maternity services and indeed embrace this opportunity to offer recommendations to develop services.

The Group were aware of the decisions stemming from the Acute Services Review and the ultimate reconfiguration of adult hospitals within Glasgow which would result in in-patient services being split between three sites, Gartnavel General Hospital, the Southern General Hospital and Glasgow Royal Infirmary².

It was known that from April 1st 2004 the reorganisation of the National Health Service in Scotland would strengthen unified working and that recommendations to the maternity services should fit into, and also ideally benefit from, opportunities arising from the new structure.

It was recognised that Glasgow maternity services did not routinely scan women at 20 weeks with an anomaly scan. Routine scanning is currently under review by NHS Quality Improvement Scotland. One possible outcome of the review would be that in future a 20 week anomaly scan would be routinely carried out in Glasgow with greater possibilities to diagnose fetal anomalies.

Finally, but importantly, the Working Group understood from professional documents that the process of childbirth cannot be without risk. Thus maternity services should be set up with a view to *minimising the risk to mother and infant*.

Findings from Pre-consultation

The Glasgow population

The context within which maternity services are provided in Glasgow is important to remember. The *Confidential Enquiries into Maternal Mortality in the United Kingdom*, an influential triennial review published on behalf of the joint Departments of Health for the 4 UK countries (CEMD 2001) reported in their 2001 publication that women from deprived areas were more likely to have poor maternal-fetal outcomes and greater morbidity associated with childbirth. More women in Glasgow fall into this category than anywhere else in Scotland, with 48.4% of women at PRMH falling into the 5th (most deprived) quintile, 44.3%

² Ambulatory Care and Diagnostic Centres will be located at Stobhill Hospital site and the Victoria Infirmary Hospital site.

and 47.2% from QMH and SGH (*Expert Group on Acute Maternity Services Reference Report*, EGAMS 2002)³.

As well as deprivation factors, figures show that the age of first pregnancy across Scotland has risen with the mean age of first pregnancy being 26. Approximately 17% of Glasgow women giving birth were aged 35 and over, with PRMH having the lowest percentage (15%), SGH, 17% and QMH the highest with 20% (EGAMS 2002). Additionally, it was reported at the evidence sessions that there was an increasing number of women giving birth who had existing medical conditions (for example eg diabetes, heart problems), who were having multiple births, and an increasing number of women with assisted conceptions (and resultant multiple births). Finally comment was made about obese women giving birth, a risk factor for thrombo-embolism. These are all factors which would lead to the categorisation of the mother as 'high risk' (CEMD 2001).

Maternity Hospitals

PRMH is a new build located on the site of Glasgow Royal Infirmary. The hospital has 2 theatres with a recovery area and an area suitable for the care of critically ill women, 4 high dependency beds⁴, 123 obstetric beds catering for different risk groups, a midwives birthing unit, prenatal assessment unit, early pregnancy unit, daycare, ultrasound, an antenatal clinic and a neonatal intensive care unit (NICU). In 2002 4,719 women were delivered at the hospital (ISD data) although the hospital has capacity to deliver 6,000-6,500 women per year. Data reported in EGAMS (2002) show that 6.4% of women had a parity of 3+ while the hospital had a Caesarian section rate of 21%. Plans are under way to move in-patient gynaecology services into the PRMH.

QMH is co-located on the Yorkhill site with the Royal Hospital for Sick Children (RHSC). QMH has 70 obstetric beds, 4 early pregnancy assessment beds; 14 delivery rooms including 4 beds in the Tower suite (low risk) and 1 high dependency bed. It has 2 obstetric theatres and a daycare unit with 12 places. QMH contains prenatal/fetal medicine services, with specialist skills required for intrauterine therapy and a NICU. Data show that in 2002 the QMH delivered 3,232 women (ISD data). Data reported in EGAMS (2002) show that 7% of women had a parity of 3+ while the hospital had a Caesarian section rate of 26.3%. The RHSC is a paediatric hospital which serves the West of Scotland, and is the Scottish Centre for neonatal cardiac surgery. The Yorkhill site hosts a number of additional clinical and support services which are shared by the two hospitals.

The SGH, an adult hospital with a range of services, has a maternity hospital within its complex and a NICU. It has 52 obstetric beds, 10 delivery rooms, 1 obstetric theatre and 5 high dependency beds. Currently refurbishment work is underway to provide in- and outpatients gynaecology services and daycare. On-site are other adult departments including medicine, surgery, the Institute of Neurological Sciences and the Queen Elizabeth National Spinal Injuries Unit for Scotland which provides services to the whole of Scotland. Data for 2002 show that SGH delivered 2,714 women (ISD data). Data reported in EGAMS (2002) show that 8.3% of women had a parity of 3+ while the hospital had a Caesarian section rate of 21.4%.

³ EGAMS – The Expert Group on Acute Maternity Services produced two reports, one an overview and one a reference report. In a letter dated 25th September 2003, M.McGuire notes “The position of both reports is clear, both reports were agreed by the EGAMS membership, are integral components of EGAMS and complement each other. Neither report takes precedence over the other, the reference document being in greater detail and outlining the available evidence and consensus opinion while the overview report is a summary”.

⁴ These rooms are used for women when it may be beneficial for them to be more closely monitored than normal or where there is an extreme and life-threatening situation such as a severe haemorrhage or severe pre-eclampsia/eclampsia

Clinical Issues

Pre- and early pregnancy Care

All three hospitals provide pre- and early pregnancy care. The value of these services was stressed and it was seen as important that they should be made easily accessible for women.

Antenatal Care

Women receive most of their maternity care in the community and spend only a few days during and after delivery in hospital (in 2002 30% of mothers were discharged by or on the second day postnatally at QMH and SGH, with nearly 40% of mothers at PRMH discharged at that time). Organisation of antenatal services is therefore very important.

Different models of antenatal care operate across the city. The PRMH midwives work within small teams which cover a set geographical area and link to a named consultant and groups of GPs. These midwives also provide intrapartum care in the midwives birthing unit where they provide care for women experiencing normal labour and delivery. The QMH operate a system of midwife-led outreach clinics within health centres and general practices. The SGH reported consultant-led antenatal care with midwifery teams seeing patients in general practices.

Daycare facilities are offered by all three hospitals across the city. Midwives from PRMH reported on the Rutherglen Maternity Care Centre (MMC), opened to ensure good antenatal services were provided locally after the closure of Rutherglen Maternity Hospital. The Centre offers community midwifery, scanning and day care services with consultant clinics for women who require that input. A comparative evaluation of this MMC with one at Millbrae (attached to the SGH) reports that while they are well received by women they are both currently under-utilised (see Shields *et al*, nd).

In the evidence sessions midwives reported concern that with closure of one maternity unit women from deprived areas would have greater difficulty in accessing the antenatal services. 'Women from social deprived areas need local services'. The issue of transport was raised, both in terms of lack of available car parking for visitors and public transport.

Midwifery-led care within the hospital setting

Whilst planning for maternity services rightly focuses upon the availability and response of services where mother and baby are potentially at risk, the majority of women will experience an uneventful delivery. Many women in every city, including Glasgow, will have been identified as at 'low risk' and will have an uneventful childbirth. Earlier policy documents (for example, "*Changing Childbirth*," Department of Health 1993 and Scottish Office Home and Health Department [1993]) recommended that for these women services should become midwife-led, and that midwifery units should be developed in maternity hospitals, a point re-emphasised in EGAMS (2002). It is important that services are configured to respond to their needs.

All three hospitals had 'low tech' rooms available for low risk childbirth. Experts encouraged us to emphasise the value of the midwifery delivery beds in the Glasgow hospitals and to use this opportunity to develop further the concept of midwifery-led care for low risk women.

QMH and SGH have both received UNICEF baby friendly awards for promoting breastfeeding, QMH among the first in the UK to receive the award.

High risk births

Although the United Kingdom is now fortunate to have a very low incidence of maternal mortality from childbirth, nevertheless a foundation stone of the services are that they are organised to ensure maternal safety. The Confidential Enquiry notes that “Women at known higher risk of complications should not be delivered in maternity services separate from acute hospital facilities (p14)” and that “tertiary centres accepting the care of women with medical complications in pregnancy must be staffed at consultant level by physicians with relevant specialised medical experience and knowledge of obstetrics” (p19, CEMD 2001).

The emergency situation

Few women will require access to an Intensive Therapy Unit (ITU) during childbirth (CEMD 2001). There is, however, wide recognition that rapid access to ITU is an essential component of well-organised maternity services, CEMD (2001) states that “in over 31% of deaths in this report there was a recorded need for intensive care”. Statistics vary but CEMD (2001) quotes 1 women in 1000 being admitted to ITU and Scottish data confirm this figure. In Scotland 40 obstetric cases were admitted to Scottish ITUs in 1999, 50 in 2000 and 59 in 2001. The two main SICS (Scottish Intensive Care Society) diagnoses were post-partum haemorrhage and toxæmia/PIH/eclampsia/pre-eclampsia (Scottish Intensive Care Society Audit Group). Hospitals such as QMH and SGH would expect to transfer no more than 5 women per year to ITU. In NHS Greater Glasgow there were 9 admissions in 1999, 12 in 2000 and 11 in 2001, with one death in 1999.

All three maternity hospitals have access to ITU, the PRMH and SGH with ITU on-site, with the QMH off-site. EGAMS (2002) notes that Level III centres (i.e. consultant-led specialist maternal-fetal units with more than 3,000 births)⁵ should have “on-site adult intensive care”(p55). Since the availability of emergency care was presented as a critical issue for the services considerable time was spent in the evidence sessions on the protocols and procedural responses of the three hospitals to emergency situations.

High Dependency Unit

At the evidence sessions midwives from the three maternity units explained the risk assessment procedure used in their units to decide if a woman requires high dependency care. Generally the risk assessment approach was the same in the three units.

Models differ with respect to staffing the labour ward, and to providing cover for the high dependency unit.

- At the PRMH the staffing model was described as a core team of midwives dedicated to the labour ward. Their midwifery birthing unit is staffed by community midwives who come into the unit on a rota basis.
- The QMH staffing model was described as a core staff of midwives dedicated to the labour ward, complemented by midwives who are part of the hospital rotation scheme, i.e. they spent time in all areas, antenatal, intrapartum, and postnatal care. Additionally, community midwives spend 1 week per year in the labour suite as part of their personal development plan. QMH also employ operating department

⁵ There are two Level III centres in Glasgow, PRMH and QMH; with SGH designated as Level IIc, delivering 1000-3,000 births per year (EGAMS 2002).

practitioners (ODPs) who are trained in critical care procedures; currently of the five, two have a nursing background.

- The SGH has a core team of midwives supported by a rota of midwives from the community, who split their time 50/50 between intrapartum care and community midwifery.

At each hospital midwives working in the labour wards had completed appropriate training (e.g. the advanced life support obstetrics [ALSO] courses).

In addition to midwife cover, in all three maternity units obstetricians and obstetric anaesthetists provide care to women requiring high dependency care. At present only the PRMH fulfils the requirements laid down in EGAMS (2002) for full obstetric anaesthetic consultant cover on a 24 hour basis. Anaesthetic rotas are an area of concern for GGNHS service planning although it was suggested during the evidence gathering that a separate obstetric anaesthetic consultant rota would be possible on the second site when services were reorganised.

Emergency responses

It was emphasised during the evidence sessions that on many occasions a maternal emergency cannot be predicted. Thus while in all three hospitals women were stabilised on-site, the importance of rapid access to adult back-up services (for example interventional radiology) to carry out life-saving procedures was said to be paramount. Staff from PRMH and SGH described how staff from on-site adult ITU would come to the labour ward high dependency area to provide additional expertise in emergency situations and contribute to the decision of transfer of the mother to an adult ITU. Staff from PRMH reported a demonstrable benefit of the current situation following the move from Glasgow Royal Maternity Hospital (Rottenrow), which was a stand-alone maternity hospital. The Expert Advisors noted that the availability of on-site gynaecology staff (particularly those with an interest in gynaecological oncology) with experience of dealing with major maternal haemorrhage, was an additional advantage of obstetric and gynaecology services being co-located. Whilst QMH does not have direct access to this immediate level of specialist assistance it does have access to an “obstetric crash team”⁶ the composition and speciality of which is the same as the HDU team.

Staff would access the ITU Bed Bureau to check availability, and if transfer off-site was required the “Shock Team”⁷ would be notified and with the necessary expertise the patient then be transferred. This would occur when an ITU bed was not available at the PRMH and SGH on-site, or in the case of QMH, because there is no ITU facility on-site. At the PRMH and SGH transfer of a patient to an available ITU bed on-site would be carried out by the obstetric HDU and on-site ITU teams and the “Shock Team” would not be utilised.

As well as the availability of the unit obstetric anaesthetist, PRMH and SGH can call for consultant anaesthetic assistance from the hospital ITU where there would also be another trainee on-call. This flexibility was confirmed by the expert advisors to be important since at the time of an emergency the on-site anaesthetist may be unable to respond with help (for example engaged in theatre with another birth).

⁶ “Crash team,” a team with the necessary clinical expertise who are called to an emergency on-site, eg cardiac arrest, major haemorrhage.

⁷ Shock team, a team with the necessary clinical expertise to transfer critically ill patients between sites, based at Glasgow Western Infirmary

At QMH a call for additional expertise would be taken at the Western Infirmary for adult intensivists to attend QMH. The mother would be stabilised and transferred to an ITU bed (at the Western or another available bed in the city) for interventional procedures. Staff at QMH noted that they had radiology on-site in the form of a paediatric radiologist and additional anaesthetic expertise. It was felt by the expert advisors that whilst this would be an appropriate response in an emergency, it was not a basis on which to plan future services and would leave clinicians and Greater Glasgow NHS Board exposed and potentially open to criticism. It was agreed that in an emergency situation it was essential that staff with experience of dealing with maternal haemorrhage were immediately available and that paediatric-trained staff were unlikely to have the same level of experience.

During the evidence sessions some commented that in all three hospitals transport of a mother in a critical condition to ITU was by ambulance. It has been confirmed that at the PRMH there is direct access to the ITU and other medical and surgical specialties via internal lifts and corridors within the hospital. At SGH transfer is across site by a dedicated ambulance. Oral evidence led us to understand that transferring a woman in an obstetric emergency situation was difficult and time-critical. Women were reported not to respond well to transfer, a statement supported by research (e.g. Durairaj *et al* 2003) and the CEMD (2001). However written evidence, confirmed by the expert advisors, noted that the critical timescale is not in the transfer of the mother to the ITU but in bringing ITU clinical expertise to the critically ill women in the HDU.

Access to Blood and Lab facilities

There was concern expressed in the evidence sessions that all hospitals did not have speedy access to high quality blood and blood products and laboratory services. This was pursued in the sessions and the Working Group are satisfied that all three hospitals have appropriate access to blood products and laboratory services.

Gynaecology services in Glasgow

All three hospitals offered gynaecology services. Although the general view was that the location of gynaecology in relation to maternity hospitals should not be a deciding factor, it was agreed that co-locating obstetrics and gynaecology on the same site was of value, particularly to staff in training since junior hospital doctors benefited from the ready exposure to both specialities.

Maternal-Fetal Medicine in Glasgow

In Glasgow there are two units which practice the sub-speciality of maternal-fetal medicine, at the PRMH and the QMH, although staff at PRMH preferred the term 'maternal-fetal medicine' and QMH, Fetal medicine. Both units are of international standing and with a strong research profile which bring credit to the Glasgow health services. It was suggested by some staff that the research in the PRMH was more oriented towards maternal conditions and at QMH, fetal problems. At QMH research on fetal surgery was an important development and one which clearly derived benefit from the co-location with RHSC. Both units have a substantial training role.

Neonatal Care

All three maternity units in Glasgow have an on-site NICU and therefore access to neonatal services including intensive care and special care. In addition to normal post-natal care, all three provide neonatal medical care to very sick neonates.

In the PRMH NICU there are currently 10 Intensive care cots and 23 special care cots which if working at full capacity these could be increased to 12 and 32, respectively. The QMH has a NICU with 10 intensive care cots and 18 special care cots. On-site is the Regional Genetic Medicine Services and infants at QMH also benefit from other services available at RHSC, including ECMO (see below). In addition the QMH is able to provide neonatal intensive care for surgical cases treated at RHSC, and intensive care for neonates with complex metabolic, autoimmune and cardiac disorders. The NICU at SGH is smaller than the other two with 4 intensive care cots and 17 special care cots.

While these units vary in capacity and staffing levels there was less discussion about the neonatal services in the evidence sessions, the view being that they were adequate. On the site visits, repeated comments were made in all three units about the difficulties of recruiting and staffing the NICUs with appropriately trained staff, especially neonatal nursing staff, which any reorganised service should help ameliorate. Such staff shortages are nationally recognised (BAPM 2001). The focus of concern in the evidence sessions related to the location of QMH adjacent to the RHSC, and the latter's role and services as an important paediatric hospital in Scotland.

Neonatal surgery

EGAMS notes that maternity units should have “neonatal intensive care and neonatal surgery either on-site or close-by” (EGAMS 2002, p55). Likewise, the British Association of Paediatric Surgeons recommends that surgical neonates are managed within a paediatric surgical unit which should be closely linked to a neonatal intensive care unit (BAPS 1999). RHSC is the Scottish referral centre for neonatal and paediatric cardiac surgery in Scotland but also carries out a wide range of surgical procedures.

We were advised of the difficulties associated with closing the QMH NICU for post-surgical neonates. It was felt that these neonates would require NICU-based care which would not be available. Others, including the expert advisors, have suggested that elsewhere neonates are either transported back to their host NICU on the same day, if the surgery was minor, or would be cared for in the PICU until they were sufficiently stable to be transported.

It is widely agreed that the close integration of maternity and neonatal services provides a high quality of care for the sick neonate requiring medical or post surgical intensive care. We received evidence from staff across Scotland vouching for the excellence of the existing service. Staff emphasised the concern and anxiety of parents that resulted from their infant undergoing surgery. The Working Group would not disagree, but figures in Table 2 show that the numbers of the very young neonatal surgical cases of RHSC were small, and of those very young neonates admitted for surgery, the majority were transported from other hospitals. Accommodation for parents would already be an important aspect of service delivery which had been managed successfully.

Table 2. All neonatal admissions to RHSC under 28 days of age (ISD data)

| <i>Provider</i> | <i>Yorkhill site</i> | | <i>Transported to RHSC from elsewhere</i> | |
|--------------------------------------|----------------------|-------------|---|-------------|
| | <i>2001</i> | <i>2002</i> | <i>2001</i> | <i>2002</i> |
| No of surgical episodes ⁸ | 81 | 80 | 192 | 213 |
| No admitted at 0 to 1 day old | 26 | 29 | 38 | 37 |
| No operated on at less than 24hrs | 7 | 8 | 1 | 4 |

⁸ The reasons for surgery/major investigation were mainly cardiac, abdominal and digestive.

In the evidence sessions concern was expressed about transporting infants, especially in relation to the neonatal surgical cases. Neonatologists would probably agree with the statement that the best transport system is the mother herself, *in utero*, but the expert advisors noted that across the UK neonates are being transferred across the services on a daily basis. The BAPS ‘*Paediatric Surgery: Standards of Care*’ (BAPS nd) states that “Retrieval of ill infants and children by a team from the specialist centre is well established practice. Premature infants with respiratory distress and infants with severe cardiac disease are regularly transferred to specialist units. Equally, infants and children requiring specialist paediatric surgical management can be transported safely to a regional centre after initial stabilisation” (BAPS, nd,p17).

Within Glasgow neonatal transport services have improved considerably in recent times. Funding received at the beginning of 2003 has contributed significantly to the establishment of a dedicated infant transport ambulance, the new system (the National Newborn Transport Services (NeTS) Western Service) now being in place. It is a one phone call system with a co-ordinator with out-of-hours medical and (increasingly) nursing cover. The system anticipates between 400-500 annual transfers and since it was set up in March 10th 2003, has recorded no deaths and no major morbidity due to transfer. As with the NICUs, there is reported staffing difficulties which have not been completely resolved; transport fellows are reported to be in place, assistants have still to be trained but this is in progress.

Research and Teaching

Research is carried out at PRMH and QMH, the latter with links to RHSC. As noted above, both units have an international profile. There are University of Glasgow staff at PRMH (Obstetrics and Gynaecology) and honorary University staff at QMH, with University staff being based in RHSC, notably in Medical Genetics, Child Health (including the PEACH Unit) and Child and Adolescent Psychiatry. Most of the academic groupings fall within the new academic Division of Developmental Medicine at Glasgow University⁹, which is split across the two sites. There are no academics in the SGH maternity services.

Research in both PRMH and QMH is associated with the Maternal-Fetal medicine. In the evidence sessions we were told that the ‘Yorkhill’ site is highly research active and has good collaborative research links between QMH and RHSC. There was concern expressed in both the oral and written evidence that relocation of the maternity hospital would reduce these research links and the productivity of the teams. It was agreed by the Working Group that proximity can facilitate informal research discussion and it acknowledged that good collaborative working links were well-established within the Yorkhill site. However, many collaborative research projects are successful with teams located geographically distant and staff on both sites have run research projects which have had national and international collaborators.

We heard from all three hospitals about the importance of training and the value of the different arrangements for training junior staff. Difficulties were described to the Working Group of providing optimum training to junior staff if QMH were to close, with junior medical and nursing staff losing the opportunity to experience the ‘natural’ linkage between maternity and paediatric care. The Working Group would hope that with the reorganised services training should be arranged so that all junior staff in specialty training across Glasgow should be exposed to such valuable lessons.

⁹ Child and Adolescent Psychiatry is part of the Division of Community Based Sciences

Other Services

During the course of the evidence sessions the Working Group heard evidence from a wide range of staff working in services associated with maternity care. Services were located in one hospital but some were offered with a city-wide, West of Scotland or a national remit. Some at QHM operated in conjunction with RHSC. There was considerable concern that closure of a hospital would have a 'domino' effect and would result in closure of the linked services.

We comment below only on those services drawn to our attention in the evidence sessions and any view should be qualified by an awareness that we have only heard from some services and staff and that we have not carried out any external evaluations. There were a number of services which appeared to the Working Group to represent 'best practice'. It may be appropriate to consider whether they should be made available to women across the city.

- Clinical services include the national PKU services based on the Yorkhill site, with laboratory services and clinical expertise available. The service offers advice, treatment and support for individuals who have PKU and their families and has been operating for a number of years.
- Additionally, we heard of the access of QMH patients to specialised paediatric visual electrophysiology, audiology and foetal, neonatal and paediatric MRI imaging services, renal services and clinical psychology. Other clinics to which mothers at QMH have access – and which we heard about - are a diabetic pregnancy service and a medical-obstetric clinic. Others yet are noted on information received about the QMH.
- SGH have a planned specialist in-patient Mother and Baby Unit for Perinatal Illness to be opened early in 2004; the hospital also has an on-site ophthalmologist who consults in the maternity unit, one of whom is a joint adult/paediatric ophthalmologist. Information about the hospital lists further clinics provided on-site.
- PRMH offers a range of clinical services. One mentioned on a number of occasions was the Women's Reproductive Health Service based in PRMH and serving disadvantaged women with medical and social problems in pregnancy. The Unit delivers local services across the city and liaises with other services such as social work.

Each hospital also offers a range of support services, not all replicated elsewhere. All, however, offer bereavement services. All hospitals have rooms where families with terminally ill babies may spend time and stay overnight; QMH and SGH have support from voluntary organisations for bereaved women and families. We heard from two Chaplains of the value of their services.

All hospitals have some provision for women and their partner to stay overnight (for example, if they have a sick infant in the NICU). The family approach was reported as well developed at the QMH which has access to the Ronald Macdonald House, which is a registered charity and which provides accommodation for parents who have a sick infant on the Yorkhill site (annually for over 500 families from all over Scotland).

The Yorkhill site contains several family support services including the Family Information and Support Services, a Child Protection Advisor and Domestic Abuse Midwife and a Young People's service including a youth worker. These services are based on-site, shared between the two hospitals, RHSC and QMH and funded by Yorkhill Trust. The Family Information

and Support Services offers families whose child was in RHSC or mother in QMH access to the Internet as well as practical and emotional support. A crèche was introduced in 2003.

Staff from two voluntary organisations (SANDS, Miscarriage Association) who offer their services in the maternity hospitals presented evidence. Neither group offered a view about preferred location. Both groups were anxious that changes to the services would result in difficulties in continuing the services; “we’re keen that the service is maintained; we just need a place to meet”.

Qualitative issues

A significant feature of the evidence sessions was the importance of the qualitative aspects of the service which staff feared would be lost in a relocation. Staff from all hospitals commented on the value of having colleagues on-site to whom they could ask ready advice about a patient, or who when contacted, could attend an on-going consultation. Each had clearly built up their own supportive professional networks which varied depending upon the group and the hospital.

Staff also reported anxieties around professional/patient consultations in a reorganised service. On the other hand, the Working Group also heard of a reported lack of equity with existing professional contacts, with staff noting difficulties in obtaining professional advice from other clinicians not on-site.

The Working Group recognises that changes to the services will foster some working relationships while others would require more effort to be maintained. While access to colleagues may not be so easy it is hoped that new communication patterns will be established. Although we were told that “decision-making across sites is more difficult”, many staff already work across sites and the reported main frustrations tended to be practical, the time-consuming nature of travel, finding car-parking and so on. Mention was made to existing working links between hospitals for professional practice and research.

Location, estates and transport

Location

A brief description of the location of the hospitals appears in the introduction to the report. EGAMS listed 20 maternity hospitals in Scotland, with 17 being located on the same site as an adult hospital with ITU services. More recent information from the Scottish Executive¹⁰ noted that 19 hospitals were either co-located or to become co-located with adult hospitals.

Estates

Estate issues are described at the end of this report as they were not a priority during the pre-consultation process. For that process we concentrated upon clinical and related issues. Nevertheless, the structure of the respective buildings and their maintenance are central to the maternity services. Costs relating to estate matters will contribute significantly to the final decision by the Board, and have contributed to our final decision.

Our advice on estate issues derives from a report of Keppie Design Ltd and Currie and Brown, commissioned by the Board to provide an appraisal of relative capital costs between the two options and building on an earlier report from WS Atkins 1997. The report is available from NHS Greater Glasgow. Since our remit was to consider recommendations

¹⁰ Letter from M.M.McGuire dated 16.09.2003

which look to the future, we have focused not upon a short term option (Option 1) but on Option 2, 5-10 years.

The Keppie Report summarises the options and costs, which are indicative, and notes “We believe that to allow the QMH to continue to operate, without risk of potential building failure, the backlog of upgrade work must be completed, at worst, within a 5-10 year period. Furthermore, the work, which is required to satisfy the statutory requirements, should be considered as urgent and be carried out within the same timescale. It has not been possible within the timescale of our study to consider in detail the disruption that will be created by these works. We agree with the WS Atkins report that it may not be possible to carry out these works whilst the QMH remains operational.”

Detailed costs for Option 2 to the SGH total £7.1M; to QMH, £19.5M.

Transport

Although the majority of submissions focused upon clinical issues, the topic of transport to the respective hospitals was a recurrent theme in the pre-consultation process, and one stressed in written evidence from (primarily) users of the services and family. Transport issues in relation to the services are undergoing a review by the Greater Glasgow NHS Board and it is worthwhile here only to note that they form an important consideration in any future plans.

The preferred long-term solution

A view expressed in the evidence sessions by staff from all three hospitals was that the preferred long-term solution, acceptable to all, was that the maternity and paediatric hospital should be located on an adult site. This point was expressed repeatedly, and echoed by the expert advisors. They acknowledged that many cities have not yet achieved this solution. The Working Group was not given a brief which explicitly encompassed consideration of the RHSC but feel that it would misrepresent the evidence, both oral and written, to ignore this important statement about the future organisation of the maternity services in Glasgow.

In summary; key issues

The Working Group received a substantial volume of evidence, both written and oral, about the services. The Group also met with expert advisors with whom they discussed critical issues to be considered when planning the future services. The report and the recommendations derive from these sources, as well as from national sources of professional guidance.

Maternal safety: Although maternal mortality from childbirth is now very low, nevertheless the services are organised to ensure minimum risk to the mother giving birth. National and professional documents support the decision of locating a maternity hospital on-site with a hospital with adult ITU services.

The trend of maternity hospitals in Scotland has been towards relocation to an adult hospital with on-site adult ITU facilities with 19/20 hospitals now moved to, or moving to, a site co-located with adult services. QMH will remain as the only maternity hospital without adult ITU on-site.

Expert advice as well as research evidence suggests that transfer of mothers in an emergency condition is time-critical and that mothers do not transport well. Locating maternity services (for low and high risk mothers) with on-site ITU facilities allows a rapid transfer of the woman if there are complications during labour or delivery.

As well as stressing the importance of transfers, many acknowledged the importance of providing access of expertise from an on-site adult ITU to the mother in an emergency situation; QMH does not have rapid access to adult health services which is seen as a vital component when planning maternity services for the future.

Maternal emergencies were seen as less predictable than neonatal emergencies. This would increasingly be the case if the Glasgow maternity hospitals adopted a 20 week routine anomaly scan which would provide greater likelihood of predicting the need for neonatal surgery.

Very small numbers of critically ill women will be transferred from any hospital in one year. Experience of junior medical (obstetric and anaesthetic staff and midwives) of managing life-threatening emergency situations in the mother is therefore likely to be very limited. Staff on an adult site (notably medical, anaesthetic, and gynaecological specialties) have more routine exposure to adult emergencies and hence more experience.

National guidance for women who might be categorised as 'high risk', (eg from areas of deprivation, older mothers, multiple pregnancies and/or who have existing medical conditions) is that they should give birth to a hospital with on-site ITU facilities. Statistics relating to Glasgow women suggest that a significant proportion will fall into a high risk category.

Neonatal safety: It was generally agreed that although staffing of the NICUs in Glasgow was part of a national shortage, the NICUs were thought of as appropriate in their standard of care.

Neonatal transport within Glasgow is now organised to offer an appropriate standard to provide safe transport to neonates who require transporting across the city.

Neonates can be safely transported to and from RHSC before and after surgery from other hospitals; it was stressed that such transport takes place elsewhere in the UK on a daily basis.

Service organisation: It was noted that the units worked to different protocols and practices. Services across the three units were not equitable. Experts stressed the importance of the development of midwife-led care where appropriate.

Research: It is clear that research in this broad area is strong and that any changes to the service should ensure that research strengths are maintained.

Estates: The study undertaken by Keppie Design and Currie and Brown into the capital costs associated with the various options at both QMH and SGH offered substantially different costs associated with refurbishment. The report concluded that in the medium term the QMH might not be able to provide maternity services while substantial refurbishments were being made to the building.

Transport: Transport issues were seen to affect both patients and staff. We were asked to make strong recommendations to ensure good transport provision in any future services.

Recommendations for modernising the maternity services in Glasgow

Recommendation 1

Transfer maternity services from Queen Mother's Hospital to the Southern General Hospital site, with the exception of the QMH Fetal Medicine Unit.

- It is important that following the formal consultation process and once agreement has been reached about the shape and form of the future services, implementation should be carried out quickly, with a Steering Group established to oversee the process.
- Closure of the QMH would result in additional neonatal transfers to RHSC; the Working Group strongly suggests that the service requirements of the transfer services are considered as a priority.
- the proposed changes would mean that the SGH NICU would require additional resourcing in terms of staffing and equipment. The rationalisation of the services should facilitate this process.
- While it is not evident that the RHSC would require a substantial NICU on-site, the staffing complement should be considered to ensure that there is sufficient staff with NICU experience.
- The decision to transfer maternity services to SGH site was supported by the majority of the expert advisors.

Recommendation 2

Maternity services should be organised as single integrated system across Greater Glasgow using agreed protocols and an agreed model of care for the two delivery units and community services.

- Establishment of a single integrated system for maternity services would facilitate cross hospital working, integrate rotas for junior hospital doctors and unify models of care.
- Visible clinical leadership would be essential to drive forward the change management process needed to achieve an integrated maternity service, which has the ultimate aim of improving services for patients and their families and improving the working environment and conditions for staff.
- The reorganisation should include a city-wide workforce plan which would incorporate training and development.
- We received a proposal for a Maternal and Child Operating Division in Greater Glasgow, responsible for developing a single integrated system addressing issues of equitable provision of care, funding and enhanced community services. The Working Group saw merit in this proposal if consistent with the other recommendations within this report.

Recommendation 3

Existing quality services as provided are sustained and be made available across Greater Glasgow

- It is important that changes maintain the excellence of Glasgow maternity services; this includes the many examples of good practice which are evident in the existing clinical services in one hospital/location but which at present are not always available on a city-wide basis. The implementation team should treat this as a priority.
- The examples of good support services should be equally sustained and made available on a city-wide basis where appropriate.

Recommendation 4

Accessible antenatal and daycare services for the population of Glasgow should be enhanced.

- Accessible antenatal and daycare facilities should be provided for all women within Glasgow and care is required to ensure that the closure of QMH does not reduce women's access to services. Women in socially deprived areas and women from ethnic backgrounds, in particular, need every opportunity to ensure easy access to care.
- The Working Group believes that a Maternity Care Centre facility should be considered for mothers in the West End.
- There were examples of good practice where midwives were expanding their role and offering broader range of support to women and this should be enhanced by developing the public health role of midwives.

Recommendation 5

Existing midwifery service within the PRMH is encouraged and that midwifery delivery beds within SGH are developed, along with the relevant 'ethos' of a midwifery based unit.

- Midwifery Unit at PRMH is utilized fully, and that midwifery delivery beds are developed at the SGH, staffed by appropriately trained midwives. Such a service should be aimed at low risk women, and should facilitate a midwifery ethos to birthing.

Recommendation 6

The Fetal Medicine Unit should be transferred to PRMH

- The Fetal Medicine Unit is recognised to be of international excellence and the Board, in bringing about changes to the service, should do their utmost to ensure that excellence in this area is built upon and developed.
- Staff should be offered every support for their research and the opportunity to build on their research strengths should be given high priority.

Recommendation 7

That Greater Glasgow NHS Board, in its deliberations over transport issues as a result of the Acute Services review, should include a consideration of the impact on public/patients as a consequence of the proposed transfer of services from QMH to SGH.

- The Working Group is aware of on-going work by an NHS Greater Glasgow sub-committee on transport issues. We ask that this committee consider this proposed service change as part of its remit.

Recommendation 8

In coming to a decision about the future location of maternity services, Greater Glasgow NHS Board should also consider the long-term relocation of RHSC to the SGH site, taking into account the regional and national role of services provided by the RHSC.

- It is acknowledged that any decision relating to RHSC would require appropriate consultation and be commensurate with the Board's overall strategic and financial plan.

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Appendix 1. Evidence Sessions

Danny Crawford, Local Health Council
Moirra Ravey, Local Health Council
Patricia Bryson, Local Health Council
Caroline McCalman, Local Health Council
Louise Wheeler, Local Health Council

Alistair Bull, Chaplain, Yorkhill NHS Trust
Geraldine Dodd, Family Support and Information Co-ordinator, Yorkhill NHS Trust
Sheila Smith, Cardiac Liaison Team Leader, Yorkhill NHS Trust

Blair Robertson, Chaplaincy Co-ordinator, South Glasgow University Hospitals NHS Trust

Sandra White MSP

Julie and Jim Riley (parents)

Sue Forsyth, Chair of Partnership Forum, Yorkhill NHS Trust
Tom Holmes, Secretary of Staffside of Partnership Forum, Yorkhill NHS Trust

Dr Alison Wood, R&D Development Manager, Yorkhill NHS Trust

James Cassidy, Chair, Greater Glasgow Area Nursing and Midwifery Committee

Dr Peter Robinson, Consultant Paediatrician in Metabolic Diseases, Yorkhill NHS Trust
Dr Heather Maxwell, Consultant in Renal Medicine, Yorkhill NHS Trust
Dr Peter Galloway, Consultant in Biochemistry, Yorkhill NHS Trust
Dr Andrew Watt, Clinical Director: Diagnostic Imaging, Yorkhill NHS Trust
Dr Neil Geddes, ENT Consultant, Yorkhill NHS Trust

Dr Alison Robertson, Clinical Psychologist, Yorkhill NHS Trust
Dr Joyce Reid, Consultant in Anaesthesia, QMH/WI
Dr Michael Bradnam, Head of Clinical Physics, Yorkhill NHS Trust

Dr Alan Cameron, Consultant obstetrician, Yorkhill NHS Trust
Dr Lena Macara, Consultant obstetrician, Yorkhill NHS Trust
Dr Kevin Henretty, Consultant obstetrician, Yorkhill NHS Trust
Dr Christine Taggart, Consultant obstetrician, Yorkhill NHS Trust
Dr Janet Roberts, Consultant obstetrician, Yorkhill NHS Trust
Dr William Chatfield, Consultant obstetrician, Yorkhill NHS Trust

Helena McLaren, Glasgow Support Volunteer, Miscarriage Association
Mana Hazlek, Glasgow Support Volunteer, Miscarriage Association

Dr Brian Cowan, Medical Director, South Glasgow University Hospitals NHS Trust

Lyn Wojciechowska, Head of Midwifery, South Glasgow University Hospitals NHS Trust
Irene Woods, Senior Midwife, South Glasgow University Hospitals NHS Trust
Anne Glenn, Senior Midwife, South Glasgow University Hospitals NHS Trust
Sam Donovan, Senior Midwife, South Glasgow University Hospitals NHS Trust

Dr Fiona MacKenzie, Consultant Obstetrician, PRMH
Dr Burnett Lunan, Consultant Obstetrician, PRMH
Dr Alan Mathers, Clinical Director, PRMH

Dr Peter Raine, Consultant in Surgical Paediatrics, Yorkhill NHS Trust
Dr Carl Davis, Consultant in Surgical Paediatrics, Yorkhill NHS Trust
Dr Robert Carachi, Consultant in Surgical Paediatrics, Yorkhill NHS Trust

Eleanor Stenhouse, Head of Midwifery, Yorkhill NHS Trust
Claire Gonella, Supervisor of Midwives, Yorkhill NHS Trust
Diane Paterson, Senior Midwife - Community/Outpatients, Yorkhill NHS Trust
Jessie Scott, Senior Midwife - Neonatal Unit, Yorkhill NHS Trust

Brenda Townsend, Director of Nursing, Yorkhill NHS Trust

Diane Anderson, Supervisor of Midwives, Yorkhill NHS Trust
Lorna Pender, Supervisor of Midwives, Yorkhill NHS Trust
Ann Ovens, Supervisor of Midwives, Yorkhill NHS Trust

Professor Forrester Cockburn (paediatrics)
Professor Dan Young (paediatric surgery)
Professor John Stephenson (paediatric neurology)
Dr Krishna Goel (chief paediatrician)
Dr Robert Logan (biochemistry)
Professor Charles Whitfield (midwifery)

Pauline McNeill MSP

Dr Tom Turner, Consultant Neonatologist, Yorkhill NHS Trust
Dr Jonathan Coutts, Consultant Neonatologist, Yorkhill NHS Trust
Dr Peter Macdonald, Consultant Paediatrician, Yorkhill/SGH
Dr Leila Al Roomi, Consultant Neonatologist, Yorkhill NHS Trust

Dr Regina O'Connor, Obstetric Anaesthetist, SGH NHS Trust
Dr Stewart Pringle, LW Consultant, SGH NHS Trust

Dr Gibson, Obstetrician, QMH, Yorkhill NHS Trust
Sister Karen McIntosh, Midwife, QMH, Yorkhill NHS Trust
Sister Sandra Whitelaw, Midwife, QMH, Yorkhill NHS Trust

Morgan Jamieson, Medical Director, Yorkhill NHS Trust

Dr Andrew Powls, Consultant Paediatrician, PRMH

Dr Alex Macleod, Consultant Anaesthetist, NGUT

Professor Laurence Weaver, Yorkhill NHS Trust

Dr Cameron Howie, Consultant Anaesthetist, South Glasgow University Hospitals NHS Trust
Dr Garrioch, Consultant Anaesthetist, South Glasgow University Hospitals NHS Trust
Dr Marco Gaudoin, Consultant Obstetrician, South Glasgow University Hospitals NHS Trust
Dr Ian Ramsay, Consultant Obstetrician, South Glasgow University Hospitals NHS Trust

Liz Terrace, Midwife, North Glasgow University Hospitals NHS Trust
Liz Callander, Midwife, North Glasgow University Hospitals NHS Trust
Sharon Smith, Midwife, North Glasgow University Hospitals NHS Trust

SANDS (Stillbirth and Neonatal Death Society)

Dr Alan Houston, Consultant Cardiologist, Yorkhill NHS Trust

Grant Urquhart, Consultant Radiologist, South Glasgow University Hospitals NHS Trust

Anne Byrne, Midwife, Yorkhill NHS Trust
Cindy Horan, Midwife, Yorkhill NHS Trust
Barbara Cochrane, Dietician, Yorkhill NHS Trust

Appendix 2. Written Submissions

| Date | From |
|---------------------------------|--|
| 26 th September 2003 | Laura Gibson |
| 22 nd September 2003 | Dr Matt J Carty, Consultant Obstetrician and Gynaecologist, Southern General University Hospitals NHS Trust |
| 21 st September 2003 | Dr Paul Galea, Chairman, Area Paediatric Sub Committee |
| 17 th September 2003 | Dr Ian Bone, Consultant Neurologist, South Glasgow University Hospitals NHS Trust |
| 14 th September 2003 | Michael Duffy |
| 12 th September 2003 | Brian M Simmers, Chairman, Yorkhill Childrens Foundation |
| 11 th September 2003 | UNISON Scotland |
| 10 th September 2003 | Professor Ian Greer, Regius Professor of Obstetrics and Gynaecology, University of Glasgow |
| 10 th September 2003 | Alison J MacLeod, Consultant Obstetrician and Gynaecologist, St Johns Hospital Livingston |
| 10 th September 2003 | Area Nursing and Midwifery Committee |
| 9 th September 2003 | Sally Kuenssberg, Chair, Yorkhill NHS Trust |
| 9 th September 2003 | Dr J P McClure, Deputy Medical Director, Ayrshire and Arran Acute Hospitals NHS Trust |
| 8 th September 2003 | Dr Norman C Smith, Consultant Obstetrician, Grampian University Hospitals NHS Trust |
| 8 th September 2003 | Anna F Dominiczak, British Heart Foundation Professor of Cardiovascular Medicine, BHF Glasgow Cardiovascular Research Centre |
| 8 th September 2003 | Dr Robert D H Monie, Consultant Physician, Southern General University Hospitals NHS Trust |
| 5 th September 2003 | Mr Jonathan Best, Chief Executive, Yorkhill NHS Trust |
| 4 th September 2003 | Professor M Connor, Division of Developmental Medicine, University of Glasgow |
| 4 th September 2003 | Dr N J Kenyon, Consultant Obstetrician and Gynaecologists, Vale of Leven District General Hospital |
| 4 th September 2003 | Dr T L Turner, Consultant Paediatrician, Dr A Cameron, Consultant Obstetrician and Ms Eleanor Stenhouse, General Manager/Head of Midwifery, Yorkhill NHS Trust |
| 3 rd September 2003 | Dr H Gordon Dobbie, Consultant Obstetrician and Dr S M Prigg, Consultant Obstetrician, Ayrshire and Arran Acute Hospitals NHS Trust |
| 3 rd September 2003 | Dr Roch Cantwell, Consultant Perinatal Psychiatrist, Glasgow Perinatal Mental Health Service |
| 3 rd September 2003 | Mary Grant |
| 2 nd September 2003 | Dr M Small, Consultant Physician, North Glasgow University Hospitals NHS Trust |

| Date | From |
|------------------------------|--|
| | Hospitals NHS Trust |
| 31 st August 2003 | Jennifer Welch |
| 28 th August 2003 | Dr T L Turner, Consultant Paeditrician, Yorkhill NHS Trust |
| 28 th August 2003 | Lorna McLellan |
| 28 th August 2003 | Alan Houston, Consultant Paediatric Cardiologist, Yorkhill |
| 28 th August 2003 | Dr S J Wisdom, Consultant Obstetrician and Gynaecologists, Dumfries and Galloway Royal Infirmary |
| 27 th August 2003 | Professor C R Whitfield et al |
| 27 th August 2003 | Dr Michael Morton, Consultant Child Psychiatrist and Dr Alice McGrath, Senior Registrar in Child and Adolescent Psychiatry |
| 26 th August 2003 | Graham Tydeman and Rennie Urquhart, Consultant Obstetricians, Forth Park Hospital |
| 26 th August 2003 | Dr Rhona G Hughes, Lead Clinician/Obstetrics, Lothian University Hospitals NHS Trust |
| 26 th August 2003 | Area Medical Committee |
| 26 th August 2003 | Professor James C Dornan, Director of Fetal Medicine, Royal Jubilee Maternity Service, Belfast |
| 25 th August 2003 | David McVicar, Chairman, Ronald McDonald House |
| 25 th August 2003 | Dr T J Beattie, Consultant Paediatrician and Nephrologist, Yorkhill NHS Trust |
| 22 nd August 2003 | Dr Ian Laing, Consultant Neonatologist, Simpson Centre for Reproductive Health |
| 22 nd August 2003 | Professor H L Halliday, Consultant Neonatologist, Royal Maternity Hospital, Belfast |
| 21 st August 2001 | Dr Peter Fowlie, Consultant Paediatrician, Tayside University Hospitals Trust |
| 21 st August 2003 | Dr Fiona Crichton, Consultant Obstetrician/Gynaecologist, Falkirk and District Royal Infirmary |
| 19 th August 2003 | Dr Janet Brennand, Consultant in Fetal and Maternal Medicine, Yorkhill NHS Trust |
| 19 th August 2003 | Dr Judith Simpson and Dr Chris Tomlinson |
| 19 th August 2003 | Dr B E Gibson, Consultant Haematologist, Yorkhill NHS Trust |
| 18 th August 2003 | Dr Colin G Semple, Consultant Physician, Southern General University Hospitals NHS Trust |
| 18 th August 2003 | Grant D K Urquhart, Consultant Interventional Radiologist, South Glasgow University Hospitals NHS Trust |
| 18 th August 2003 | Una McFadyen, Consultant Paediatrician, Forth Valley Acute Hospitals NHS Trust |
| 15 th August 2003 | Dr Paul Galea, Consultant Paediatrician, Yorkhill NHS Trust |
| 5 th August 2003 | Duncan McNeill MSP (Greenock and Inverclyde) |

| Date | From |
|-----------------------------|---|
| 5 th August 2003 | Pauline McNeill MSP (Glasgow Kelvin) |
| August 2003 | Dr T E Lavy, Consultant Ophthalmologists, Yorkhill |
| August 2003 | David Stone, Professor of Paediatric Epidemiology, Yorkhill |
| August 2003 | Dr Valerie D Hood, Consultant Obstetrician and Gynaecologist, |
| August 2003 | Jessie Scott, Neonatal Clinical Manager, Yorkhill NHS Trust |
| August 2003 | Mr Andrew Radford, UNICEF |
| 24 th July 2003 | Diana Clark, Practice Development Midwife, South Glasgow University Hospitals NHS Trust |
| 24 th July 2003 | Dr William Anderson, Medical Director, North Glasgow University Hospitals NHS Trust |
| 23 rd July 2003 | Roderick Duncan, Consultant Orthopaedic Surgeon/Honorary Clinical Senior Lecturer, Yorkhill NHS Trust |
| 14 th July 2003 | Graham Vahey, Consultant Psychotherapist |
| 11 th July 2003 | Marie Davie, National Officer, Royal College of Midwives Board for Scotland |
| 10 th July 2003 | Mary Curtis |
| 8 th July 2003 | Margaret Walker |
| 7 th July 2003 | Jacki McIlraith |
| 7 th July 2003 | Ruth Aitken, Secretary, Cathcart and District Community Council |
| 17 th June 2003 | John Morrison, Leader of the Council, East Dunbartonshire Council |

Appendix 3. Expert Advisors

Obstetricians:

Professor Peter Soothill, Department of Obstetrics and Gynaecology, St Michael's Hospital, Bristol

Professor David James, Professor of Feto-maternal Medicine, School of Human Development, Queen's Medical Centre, Nottingham

Professor Charles Rodeck, Clinical Sciences, Department of Obstetrics and Gynaecology, Royal Free and University College Medical School, London

Neonatologist/Neonatal Surgeon:

Mr Anthony JB Emmerson, Consultant Neonatologist, Clinical Director of Neonatal Services, St Mary's Hospital, Manchester

Mrs Leela Kapila, Willoughby on the Wolds, Leicestershire

Anaesthetists;

Dr Ian Barker, Department of Anaesthetics, Sheffield Children's Hospital, Sheffield

Dr William Frame, Chair, Anaesthetic Sub-Committee, North Glasgow University Hospitals NHS Trust, Glasgow Royal Infirmary, Glasgow

Dr Griselda Cooper, 6 Lord Austin Drive, Marlbrook, Bromsgrove, Worcestershire.

Midwife

:

Ms Cathy Warwick, General Manager Women and Children's Services, Kings College Hospital, Denmark Hill, London