Modernising Maternity Services - The Next Steps

Recommendation:

- the Board endorses:
  - the proposals in this paper, derived from the recently concluded preconsultation process, as the basis for formal public consultation on Modernising Maternity Services;
  - the proposed approach to consultation including the development of accessible public material;

- the Board notes:
  - the strong clinical advice about the colocation of adult, maternity and children’s hospital services emerging from the preconsultation process and considers its response.

A. BACKGROUND AND PURPOSE

1.1 The Board’s Maternity Services Strategy, approved in 1999 following an intensive process of public and professional debate, included the decision to reduce the number of delivery units in Glasgow from three to two. This conclusion was reached with and retains, strong clinical support, for a number of important reasons:

- the birthrate is falling and is below the level needed to sustain three delivery services;
- the brand new Princess Royal Maternity Hospital has significant spare capacity in first class facilities;
- we cannot meet the highest standards of modern clinical practice in three units and medical staff spread across three sites is not sustainable;
- most women have most of their care in community settings and it is important that resources for maternity services are focused in the community, achieving maximum benefit, not underused hospital buildings.
1.2 Deciding on which hospital should be developed as our second delivery unit was always going to be difficult. Glasgow has been well served by its maternity hospitals over the years when the birthrate was higher. It is important to see this final strand of implementing the Maternity Services Strategy in the context that, while this is a key decision about a core part of our maternity services, 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. This paper reflects that reality and therefore includes important questions about the development of community and midwifery services. It is essential that the basis for the future pattern of provision is firmly evidence based and fully explained to the public. Our objective is to provide high quality and safe hospital care and focus resources on community services.

1.3 In May 2003, recognising the difficulty of charting the way forward, and with full commitment to public involvement, the Board established a major preconsultation exercise. This has ensured that, before developing these proposals for formal consultation, all of the critical issues have been considered in a way which has enabled strong public and professional engagement. The preconsultation process had three strands:

- A Working Group, independently chaired, but including three non Executive Board members, with the remit to:
  - comprehensively review and provide advice on how to provide modern, safe and sustainable maternity delivery services for our population as the final stage of implementing the Maternity Services Strategy;
  - carrying out its work in a fully engaging, transparent and accessible way.
  
  The Working Group report - produced from a detailed review of policy guidance, external clinical guidance, visits to the hospital sites, written evidence and a number of public sessions to enable clinical and other staff to offer their views, is attachment 1.

- A workshop for midwifery staff from all thee services offering the opportunity for practitioners to give their perspective on the future organisation of services. The report of the workshop is attachment 2.

- The development of a report by the Maternity Service User Network (MATNET) which was established by the Maternity Services Liaison Committee in May 2003 to develop and support user involvement in the planning, management and delivery of maternity services. The full MATNET report is attachment 3.

1.4 It is important that the Board consider the recommendations of all three reports in moving to formal consultation and the proposals for consultation in this paper are directly drawn from the issues raised in the preconsultation processes.
1.5 The remainder of this paper is in four sections:

B. Proposed consultation process;

C. Issues for consultation including a summary of the recommendations and themes arising from the:
   - maternity services working group;
   - midwifery workshop;
   - report of MATNET.

D. Supporting staff and managing change.

E. Short commentary on financial issues.

1.6 Planning future services in Glasgow must take account of developments in other NHS Boards. Over the last five years we have worked closely with Lanarkshire and Argyll and Clyde NHS Boards as they have developed and implemented proposals to change maternity services to ensure a co-ordinated approach.

1.7 A small number of women, from outside the West of Scotland, access services at the QMH, including fetal medicine, and we have, therefore, kept all NHS Boards and the National Services Division of the Scottish Executive Health Department in touch with the preconsultation process. Section B outlines a proposed approach to ensure their appropriate engagement in this further phase of consultation.

B. PROPOSED CONSULTATION PROCESS

2.1 It is important to acknowledge the substantial level of interests who have already been engaged in the process so far, but we also need to ensure that this phase of formal consultation, on specific proposals, enables all interested parties to express their views before final decisions are reached.

2.2 It is proposed that the consultation is firmly rooted in the outcome of the three strands of the preconsultation process. The next section of this paper draws these into a series of themes and includes clear proposals, based on those reports, on which it is suggested we consult. We have also developed specific consultation questions which will be included in the material outlined below. The purpose of these questions is to seek public and professional input to ensure our final modernisation plan for maternity services is comprehensive. The Board will wish to test final proposals for decision against the points raised in the consultation.

2.3 To ensure the formal consultation is fully engaging and accessible we propose that user friendly information leaflets will be developed on each key recommendation, based on the material in this paper, backed up by access to more detailed information for those who want it. We know there are complex issues which need to be clearly explained. We will also make available all of the written material submitted as evidence to the Maternity Services Working Group.

2.4 It is proposed that the formal consultation includes:
2.5 The Board will welcome further suggestions on how the consultation should be as open as possible.

2.6 Section A of this paper recognised the importance of continuing to engage other NHS Boards. It is proposed that we offer detailed briefing to other Boards and the National Services Division (NSD) to ensure they can respond to this consultation if they wish to do so. Small numbers of women from most parts of Scotland are delivered at the Queen Mothers and some of the services provided there have wider national dimensions. NSD also directly commission a number of services from the RHSC and will have an interest in ensuring these services are sustained if there is no maternity hospital on site.

2.7 The proposed timescale for the consultation is from the beginning of November until the end of January, enabling a full report and recommendations to be made to the February Board meeting.

C. ISSUES FOR CONSULTATION

This Section draws together the recommendations of the three preconsultation reports and proposes a series of questions on each issue. Understandably, following the Board discussion on 7th October the immediate focus of campaign and media attention has been on the delivery unit location and the wrong perception of an immediate threat to the Children’s Hospital. It is important to emphasise that the outcome of the preconsultation exercise covers much wider ground, reflecting the fact that for most women, in normal pregnancies, maternity care is a community based service. We need to emphasise that we are considering issues affecting the whole pattern of maternity care, across Greater Glasgow.

3. Location of Delivery Services

Proposal: delivery services should be located in the new facilities at the PRMH and high quality provision at the Southern General.

3.1 The Working Group recommended the development of the Southern General as the preferred site for the second delivery unit. Their detailed report sets out the basis for that recommendation, with ambitious objectives for the quality of services on that second site: The recommendations are:

- a detailed assessment of the balance of risks to women and babies recognising services must provide safe and high quality for both;
- reference to national policy guidance;
- it is important that following the formal consultation process and once agreement has been reached about the shape and form of the future services,
EMBARGOED UNTIL MEETING

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 intensive care for babies (NICU) at the SGH 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.

3.2 The Midwifery Workshop did not offer a conclusion on the location of the second service but their report included a number of related points:

- high quality and effective neonatal transport is critical;
- the reprovision of specialist services needs to be carefully planned in developing a final strategy;

3.3 MATNET accepted the case for a move to two delivery services but did not offer a view as to which service should close. They also commented that hospital closure could offer an opportunity to implement service changes which would benefit women and their families. Their detailed thinking is reflected in the later in this section.

3.4 Questions on Location of Second Service

1. Are there any factors which have not been fully reflecting in the Working Group’s report and do you have any views on their assessment of the key issues and risks?

2. All three reports have commented on the needs to have a coherent and co-ordinated approach to implementing change when a decision is reached. Do you have any thoughts about how this should be organised?

3. The Working Group made a number of comments on neonatal intensive care and transport arrangements. Organising these services properly will be key to safe care for babies. Are there any other issues in relation to this which we should consider

4. Future Organisation of Maternity Services in Greater Glasgow

Proposal: there should be greater consistency and co-ordination in the organisation of maternity services with a Glasgow wide approach to service delivery.

4.1 All three reports offer important recommendations about the organisation of maternity services and we are committed to considering the full range of those recommendations in reaching final decisions about services across Greater Glasgow.

4.2 The Working Group recommended:

- 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.

4.3 The Midwifery Report highlighted:

- the need for a consistent service model across Greater Glasgow;
- the opportunity of change to look more widely at the organisation of the whole maternity service and the potential of change to facilitate new ways of working.

4.4 MATNET was also keen to see a Glasgow wide approach to services, with the focus on all areas not just the one affected by change.

4.5 Questions on the Organisation of Maternity Services

1. How can an integrated system of working be developed?
2. How can clinical leadership be strengthened and drive forward change management?
3. How can patient and family interests be engaged in a Glasgow wide change programme?

5. Sustaining the Quality of Services

Proposal: the important quality of service issues outlined below need to be fully reflected in our final reorganisation of services.

5.1 All three groups highlighted a range of points about the need to sustain and enhance the quality of services.

5.2 The Working Group recommended:

- 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.
5.3 The Midwifery Report highlighted a number of points which should be addressed:

- ensuring staff are skilled in providing critical care where required;
- avoiding separation of mothers and babies;
- managing the impact of larger units to ensure that personal aspects of care are not compromised and that one to one care in labour is achieved;
- provision of good facilities for the mothers of sick babies is important;
- managing outreach from hospitals to reduce hospital attendances and transfers;
- offering choice in models of care within delivery units including midwife managed and domino as well as home birth.

5.4 MATNET reported extensively on the quality issues they felt were important, these included:

- stronger post natal care;
- staffing levels and consistency of care;
- the physical quality of facilities;

5.5 Questions on Sustaining the Quality of Services

Clearly many of these points will need to be dealt with in great detail as part of the process of implementing change. We know there will be particular challenges to ensure that:

- specialist services, for example, fetal transfusion and care for patients with metabolic disorders are maintained within the proposed new pattern of maternity services;
- arrangements are in place to ensure that there continue strong and effective clinical relationships between maternity and specialist paediatric services, which would no longer be collocated.

1. Are there any important quality issues not identified in the work of the three groups?
2. On the particular issue of avoiding separation of mothers and their babies, what would be the best way to achieve this if the QMH and RHSC were not on the same site?

6. Accessible Antenatal and Day Care

Proposal: developing and improving community services will be a core part of our proposals for service change.

6.1 One of the strongest, most consistent themes from the three groups related to access to services.

6.2 The Working Group recommended:

- 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.

6.3 The Midwifery Report highlighted a number of points of importance:

- local access for the majority of care for the majority of women including midwifery choices;
- improved access for disadvantaged groups;
- accommodation and facilities to provide maternity care in the community need to be expanded;
- use of technology including telemedicine could enhance services;
- Community Health Partnerships offer a new way for midwives to engage with primary care;
- consultant medical staff should be linked to geographical area;
- Millbrae and Rutherglen Maternity Centres offers a model of excellence.

6.4 MATNET had a number of significant comments:

- community services should be increased and the model in Rutherglen was particularly recommended;
- community services should be provided in a wider range of services, including leisure centres and other non NHS facilities;
- services need to be more flexible including opening times.

6.5 Questions on Accessible Antenatal and Day Care

The feedback from the preconsultation highlights the importance of the provision and development of community services from the point of view of women and frontline staff.

1. What would be the priorities for changes to community maternity services?
2. How should we decide on the siting of new services? For example, should the focus be on the most deprived areas, those with the lowest uptake or those closest to the delivery unit which will close?
3. How can we enhance further midwifery links with primary care?

7. The Development of Midwifery Services

Proposal: our final reorganisation of services will include specific proposals to develop midwifery services which are central to the provision of high quality maternity care. We want to ensure best practice and consistent care are provided across Greater Glasgow

7.1 This is another area which emerged as of major significance during the preconsultation process.
7.2 The Working Group recommended:

- 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.

7.3 The midwifery report highlighted a wide range of issues relating to midwifery including:

- need to ensure adequate staffing levels and manageable midwifery caseloads;
- education and training for new roles;
- involving staff in decision-making;
- consistent service models but flexibility in ways of working;
- greater emphasis on midwife managed care for women experiencing a normal pregnancy - direct access to a midwife;
- strengthen relationships with GPs, with local geographic service structures;
- extend the public health role of the midwife.

7.4 MATNET comments on midwifery services focused on community services but also:

- the potential of a stronger public health role for midwives;
- issues about choice, both of community services and of direct access to midwives not through a GP or consultant.

7.5 Questions on the Development of Midwifery Services

1. Is this a comprehensive overview of what is required to develop midwifery services?
2. What is the best way to tackle these issues and given resources are not unlimited what are the priorities for change?

8. Future Arrangements for Fetal Medicine

Proposal: fetal medicine services currently provided at QMH will be transferred to the PRMH providing a single consolidated service for the West of Scotland and including current national services provided at the QMH.

8.1 The fetal medicine service at the QMH is an important centre providing local, regional and national services ensuring it is sustained and developed is critical. A significant issue arising from the closure of the QMH is the best future arrangements for fetal medicine.

8.2 The Working Group recommended that:

- 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.

8.2 Neither MATNET or the Midwifery Report offered specific views on this issue.

8.3 Questions on the Future Arrangements for Fetal Medicine

1. Does the proposed consolidation of this service at the PRMH represent the best way of sustaining and developing Glasgow as a centre for excellence?
2. If not what are the alternatives and the reasoning which underpins them?

9. Access and Transport

Proposal: our final modernisation proposals should clearly take account of access and transport issues, mainly by delivering as much service as possible in community settings.

9.1 In any service change access and transport emerge as important issues. It is important to emphasise that it is not proposed that all women who presently deliver at the QMH would need to access services at the SGH. Of the 3200 women who presently deliver at the QMH we would expect around half to access services at the PRMH.

9.2 The Working Group recommended:

• 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.

9.3 The Midwifery Report focused on access to services, particularly in the community rather than physical access and transport. Although the access issue was highlighted and needs to be addressed in relation to staff.

9.4 MATNET focus on access was strongly on the development of community services but also on barriers to access, for example, for women from ethnic minorities. However, they also highlighted specific measures we could take to improve access to hospital services.

9.5 Questions on Access and Transport

1. Although we know that for the majority of women attendance at a hospital service is on limited occasions and only for relatively short periods it is clear there are concerns about access which must be addressed. The key question is the extent to which these can be tackled by the approach to community maternity services and ensuring that the out-patient services at the QMH are reprovided as locally as possible?
2. Central to the things we would need to do as part of the detailed implementation of change is to agree the catchment areas which would be served by community maternity services linked to the units at the Southern
General and the PRMH. Our approach to this would be to look at access issues and seek the views of women, local primary care services and community midwives. Is that the right approach?

3. Are there other specific access and transport issues we should address if we close delivery and inpatient services at the QMH?

10. Services at the RHSC

Proposal: consider what is an appropriate, separate, further process to decide what long-term decisions are required on the future of Children’s Hospital services.

10.1 The Working Group were not specifically asked to consider children’s services but have, quite properly reported that a strong and consistent theme on the optimal service model for women and babies emerged from local and external clinical evidence.

10.2 The Working Group recommended:

- 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.

10.3 It is proposed that the Board does not need to seek comment on this recommendation at this stage but concludes that a future, separate process should be considered to advise on the pattern of hospital services for children. There is no suggestion of relocation of the RHSC in the short or medium term (fifteen years). Throughout this process the Board has been clearly, publicly committed to that position.

D. SUPPORTING STAFF AND MANAGING CHANGE

11.1 There are two important dimensions to how this decision will impact on staff. Firstly, we recognise the emotional impact of these proposals for change. We know staff are highly committed and dedicated to the services they provide. Our aim is to manage change as well as possible. Secondly at an individual level, there will be real concern and uncertainty. To address these two dimensions we believe a number of principles are important and we will establish detailed proposals to ensure the changes are managed in a way which:

- maintains morale and commitment during this consultation process and while change is implemented;
- retains the key clinical staff whose expertise and commitment achieve excellence in care by ensuring people have job security;
- builds on the experience learned from previous closure and ensure it informs the additional work with staff to agree their personal future;
- ensures communication is always fast and clear.
11.2 Many staff have had the opportunity to participate in the preconsultation exercise but we also regard it as critical that we enable staff to express their views through this consultation process. NHS staff should not feel they are placed in a position of “campaigning” against the NHS Board if we create opportunities for their engagement in what we know is a difficult decision.

11.3 There are nearly 300 staff directly involved in providing maternity services at the Queen Mothers Hospital. If the conclusion, following this consultation exercise, is that the Queen Mothers should close we would redeploy those staff into the expanded services at the PRMH and Southern General. The detailed arrangements for this cannot be put in place until a final decision is reached and dialogue can begin with individual members of staff.

E. SHORT COMMENTARY ON FINANCIAL ISSUES

12.1 This review was not driven by a financial agenda - the focus has been on clinical sustainability and safety but this section provides a short summary of the underlying financial issues.

12.2 At a headline level, the capital cost of the consequential short-term expansion and improvement at the Southern General is around £5million. The initial element of that capital is containable within the existing capital programme.

12.3 Our working assumption has been that consolidation from three services to two should not require additional resources and will reduce capital charge and estate costs. The only challenge to that has been around the possible requirement for a significant Neonatal Intensive Care Unit at the RHSC. The Working Group’s analysis suggests this is not necessary. The Board will be able to consider that point further when it has responses to consultation on this and other clinical issues.

12.4 It is necessary that financial modelling reflecting the proposals and questions raised in this paper is undertaken during the consultation process to ensure the Board’s final recommendations includes appropriate analysis of the financial issues. Heads of Midwifery have already agreed to undertake a detailed workforce planning exercise which will provide information planning for future midwifery staffing. We know from the experience of the Rutherglen closure that changes to hospital based services do offer opportunities to strengthen community services without increasing overall service costs.
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)

<table>
<thead>
<tr>
<th>Year</th>
<th>Babies born</th>
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<tbody>
<tr>
<td>99/00</td>
<td>11491</td>
</tr>
<tr>
<td>00/01</td>
<td>11084</td>
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(*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 Rutherfurglen 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 Infirmary.

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 minimizing 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 Deaths 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%

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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 woman 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 toxaemia/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) 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

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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).

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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>
<thead>
<tr>
<th>Provider</th>
<th>Yorkhill site</th>
<th>Transported to RHSC from elsewhere</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year</td>
<td>2001</td>
<td>2002</td>
</tr>
<tr>
<td>No of surgical episodes(^8)</td>
<td>81</td>
<td>80</td>
</tr>
<tr>
<td>No admitted at 0 to 1 day old</td>
<td>26</td>
<td>29</td>
</tr>
<tr>
<td>No operated on at less than 24hrs</td>
<td>7</td>
<td>8</td>
</tr>
</tbody>
</table>

\(^8\) 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 University, 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.

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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 Executive 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

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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 safety 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 reported 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.
References


British Association of Paediatric Surgeons (nd). *Paediatric Surgery: standards of care.*

British Association of Paediatric Surgeons (1999). *Surgical services for the Newborn.*


Royal College of Obstetricians and Gynaecologists and Royal College of Midwives (1999). *Towards safer childbirth; minimum standards for the organisation of labour wards.*


Appendix 1. Evidence Sessions

Danny Crawford, Local Health Council
Moira 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
## Appendix 2. Written Submissions

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<tr>
<td>26&lt;sup&gt;th&lt;/sup&gt; September 2003</td>
<td>Laura Gibson</td>
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<td>22&lt;sup&gt;nd&lt;/sup&gt; September 2003</td>
<td>Dr Matt J Carty, Consultant Obstetrician and Gynaecologist, Southern General University Hospitals NHS Trust</td>
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<td>21&lt;sup&gt;st&lt;/sup&gt; September 2003</td>
<td>Dr Paul Galea, Chairman, Area Paediatric Sub Committee</td>
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<td>Dr Ian Bone, Consultant Neurologist, South Glasgow University Hospitals NHS Trust</td>
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<td>Michael Duffy</td>
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<td>Brian M Simmers, Chairman, Yorkhill Childrens Foundation</td>
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<td>UNISON Scotland</td>
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<td>Professor Ian Greer, Regius Professor of Obstetrics and Gynaecology, University of Glasgow</td>
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<tr>
<td>10&lt;sup&gt;th&lt;/sup&gt; September 2003</td>
<td>Alison J MacLeod, Consultant Obstetrician and Gynaecologist, St Johns Hospital Livingston</td>
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<td>10&lt;sup&gt;th&lt;/sup&gt; September 2003</td>
<td>Area Nursing and Midwifery Committee</td>
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<td>9&lt;sup&gt;th&lt;/sup&gt; September 2003</td>
<td>Sally Kuenssberg, Chair, Yorkhill NHS Trust</td>
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<td>Dr J P McClure, Deputy Medical Director, Ayrshire and Arran Acute Hospitals NHS Trust</td>
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<td>8&lt;sup&gt;th&lt;/sup&gt; September 2003</td>
<td>Dr Norman C Smith, Consultant Obstetrician, Grampian University Hospitals NHS Trust</td>
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<td>Anna F Dominiczak, British Heart Foundation Professor of Cardiovascular Medicine, BHF Glasgow Cardiovascular Research Centre</td>
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<td>Dr Robert D H Monie, Consultant Physician, Southern General University Hospitals NHS Trust</td>
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<td>Mr Jonathan Best, Chief Executive, Yorkhill NHS Trust</td>
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<td>4&lt;sup&gt;th&lt;/sup&gt; September 2003</td>
<td>Professor M Connor, Division of Developmental Medicine, University of Glasgow</td>
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<td>Dr N J Kenyon, Consultant Obstetrician and Gynaecologists, Vale of Leven District General Hospital</td>
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<td>4&lt;sup&gt;th&lt;/sup&gt; September 2003</td>
<td>Dr T L Turner, Consultant Paediatrician, Dr A Cameron, Consultant Obstetrician and Ms Eleanor Stenhouse, General Manager/Head of Midwifery, Yorkhill NHS Trust</td>
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<td>3&lt;sup&gt;rd&lt;/sup&gt; September 2003</td>
<td>Dr H Gordon Dobbie, Consultant Obstetrician and Dr S M Prigg, Consultant Obstetrician, Ayrshire and Arran Acute Hospitals NHS Trust</td>
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<td>Dr Roch Cantwell, Consultant Perinatal Psychiatrist, Glasgow Perinatal Mental Health Service</td>
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<td>Mary Grant</td>
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<td>Dr M Small, Consultant Physician, North Glasgow University Hospitals NHS Trust</td>
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<td>Jennifer Welch, Consultant Paeditician, Yorkhill NHS Trust</td>
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<td>Dr T L Turner, Consultant Paeditician, Yorkhill NHS Trust</td>
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<td>Lorna McLellan, Consultant Paeditician, Yorkhill NHS Trust</td>
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<td>Alan Houston, Consultant Paeditric Cardiologist, Yorkhill</td>
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<td>Dr S J Wisdom, Consultant Obstetrician and Gynaecologists,</td>
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<td>Dumfries and Galloway Royal Infirmary</td>
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<td>Professor C R Whitfield et al</td>
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<td>Dr Michael Morton, Consultant Child Psychiatrist and Dr Alice McGrath,</td>
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<td>Senior Registrar in Child and Adolescent Psychiatry</td>
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<td>Graham Tydeman and Rennie Urquhart, Consultant Obstetricians,</td>
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<td>Forth Park Hospital</td>
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<td>26th August 2003</td>
<td>Dr Rhona G Hughes, Lead Clinician/Obstetrics, Lothian University</td>
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<td>26th August 2003</td>
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<td>Professor James C Dornan, Director of Fetal Medicine, Royal</td>
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<td>Jubilee Maternity Service, Belfast</td>
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<td>David McVicar, Chairman, Ronald McDonald House</td>
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<td>Dr T J Beattie, Consultant Paeditrician and Nephrologist,</td>
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<td>Dr Ian Laing, Consultant Neonatologist, Simpson Centre for</td>
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<td>Reproductive Health</td>
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<td>Professor H L Halliday, Consultant Neonatologist, Royal</td>
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<td>Dr Peter Fowlie, Consultant Paeditrician, Tayside University</td>
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<td>Dr Fiona Crichton, Consultant Obstetrician/Gynaecologist,</td>
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<td>Dr Janet Brennand, Consultant in Fetal and Maternal Medicine,</td>
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<td>Dr Judith Simpson and Dr Chris Tomlinson</td>
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<td>Dr B E Gibson, Consultant Haematologist, Yorkhill NHS Trust</td>
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<td>Dr Colin G Semple, Consultant Physician, Southern General University</td>
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<td>Dr Paul Galea, Consultant Paeditrician, Yorkhill NHS Trust</td>
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<td>Duncan McNeill MSP (Greenock and Inverclyde)</td>
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<td>Pauline McNeill MSP (Glasgow Kelvin)</td>
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<td>Dr T E Lavy, Consultant Opthamologists, Yorkhill</td>
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<td>David Stone, Professor of Paediatric Epidemiology, Yorkhill</td>
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<td>Dr Valerie D Hood, Consultant Obstetrician an Gynaecologist,</td>
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<td>Jessie Scott, Neonatal Clinical Manager, Yorkhill NHS Trust</td>
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<td>Mr Andrew Radford, UNICEF</td>
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<td>24th July 2003</td>
<td>Diana Clark, Practice Development Midwife, South Glasgow University Hospitals NHS Trust</td>
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<td>Dr William Anderson, Medical Director, North Glasgow University Hospitals NHS Trust</td>
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<td>Roderick Duncan, Consultant Orthopaedic Surgeon/Honorary Clinical Senior Lecturer, Yorkhill NHS Trust</td>
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<td>Graham Vahey, Consultant Psychotherapist</td>
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<td>Marie Davie, National Officer, Royal College of Midwives Board for Scotland</td>
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<td>Mary Curtis</td>
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<td>Ruth Aitken, Secretary, Cathcart and District Community Council</td>
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<tr>
<td>17th June 2003</td>
<td>John Morrison, Leader of the Council, East Dunbartonshire Council</td>
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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, 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, formerly Paediatric Surgeon, Queens Medical Centre, Nottingham

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, Consultant Anaesthetist, Birmingham

Midwife:

Ms Cathy Warwick, General Manager Women and Children's Services, Kings College Hospital, Denmark Hill, London
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.
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 local to the women
    • Antenatal same team throughout
    • Postnatal 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:
  o Consultant and Surgeon;
  o 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:
  - Metabolite 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 Model

or other non hospital health
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
  o Need for change
  o Consultants can’t do it all
  o 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
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.