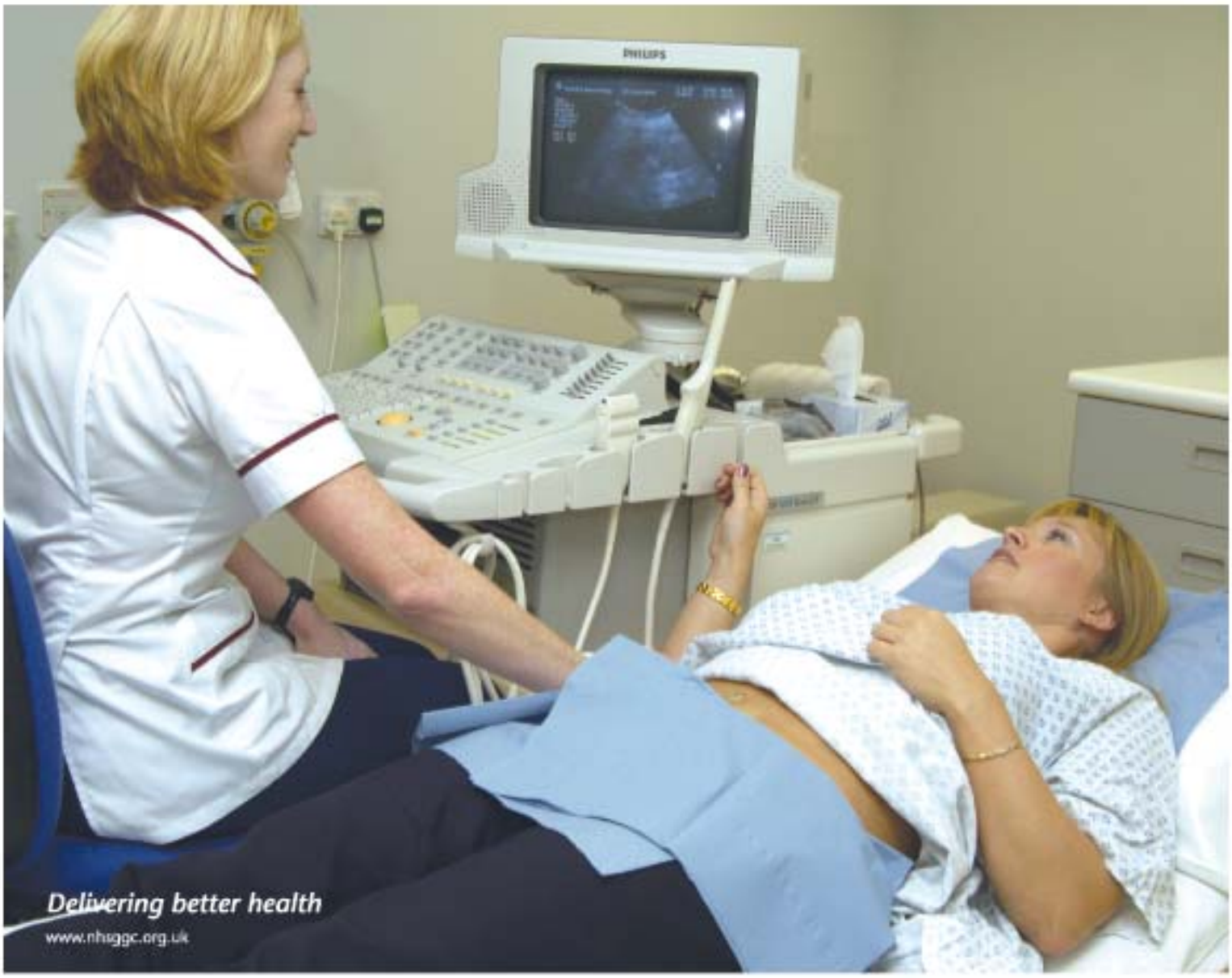
NHS
Greater Glasgow and Clyde

Consultation on proposed changes to maternity services in Clyde



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MATERNITY SERVICES REVIEW

1. INTRODUCTION AND PURPOSE

During the past 18 months, NHS Greater Glasgow and Clyde has been working on a range of service strategies within the Clyde area. Among these has been a review of maternity services.

The review that has been undertaken has involved detailed consideration of a range of options for the provision of services at the Community Maternity Units (CMUs) at Inverclyde Royal Hospital (IRH) and the Vale of Leven Hospital.

The purpose of this paper is to give all interested stakeholders the opportunity to offer their views on the detailed information which it contains. The paper sets out why, after detailed review and appraisal of the four main options which are described, NHS Greater Glasgow and Clyde's preferred option is to close the delivery service components of the IRH and Vale CMUs and move to a single midwifery-led birthing unit at the Royal Alexandra Hospital in Paisley. In this proposal, all antenatal and postnatal services currently provided at the CMUs at Inverclyde Royal and Vale of Leven Hospitals will be retained.

The Vale of Leven and Inverclyde Royal CMUs would **remain open** and continue to provide essential local maternity services which account for the vast majority of current activity. Our proposal would affect around 150 women each year who currently give birth in the CMUs. Over 34,000 episodes of post and antenatal care would continue to be provided locally.

However, the paper recognises that there are alternative options and seeks views on these as well as on our preferred option.

The paper also provides the conclusions of the Independent Scrutiny Panel (ISP) in relation to maternity services and outlines the Board's response.

The consultation period will run for 12 weeks from the 27th March 2008 to the 19th June 2008. All feedback received during consultation will be considered by the Board of NHSGGC before any recommendation is made to the Cabinet Secretary for Health and Wellbeing. The Cabinet Secretary will make the final decision about any major service change.

To help in the submission of responses, we are offering some suggested questions which anyone responding to the consultation can use, if they wish. The questions invite comments on the Board's analysis and provide opportunity to challenge our proposal. They also ask for views on the full range of options which we have considered, and which are set out in this paper, and invite feedback on any other options that have not been considered.

The suggested questions which it may be helpful to consider are:

- Do you agree with our proposal that there should be a single midwifery birthing suite for Clyde based at the RAH?
- If you do not agree with our proposal, why is the case?
- Do you think the other options that we have examined would be a better alternative?
- For what reasons do you think this?
- What reasons or issues do you think the Board should consider that would strengthen the case for the option you prefer?

- Are there any other options you can suggest that have not previously been considered?

The paper includes the following sections:-

2. OVERVIEW OF COMMUNITY MATERNITY SERVICE

2. 1 Introduction

NHS Greater Glasgow and Clyde has initiated a number of service reviews since taking responsibility for the health of the population of the Clyde area, as the successor to NHS Argyll and Clyde Health Board.

As part of these service reviews it undertook a review of maternity services in the Clyde area. The review focussed on two main issues:

- The impact of changes which are planned to maternity services in Greater Glasgow on services in Clyde;
- The utilisation of the community maternity units in Clyde.

Within the former Greater Glasgow, maternity services are provided across three main patient sites, Princess Royal Maternity, Queen Mothers Hospital and Southern General Hospital. Princess Royal Maternity and Queen Mothers Hospital both provide tertiary services. In 2005/06 there were 12,000 births across Glasgow.

NHS Greater Glasgow undertook a detailed maternity review and has developed a strategy for service provision. Future service will be provided from two sites, Southern General Hospital (5,200 births) and Princess Royal Maternity (6,800 births) both supporting tertiary referrals. Each site will provide low risk birthing rooms and Early Pregnancy Assessment Units. All appropriate antenatal services will be provided locally with only the highest risk pregnancies having to be seen in the centre.

2.2 Background

NHS Argyll and Clyde undertook a major review of maternity services in 2003, which resulted in a redevelopment and reconfiguration of services across the Board area. This redesign of services resulted in the current configuration of consultant and midwifery led units at the Royal Alexandra Hospital (RAH) and Community Maternity Units (CMUs) at Inverclyde Royal Hospital (IRH) and the Vale of Leven Hospital (VoL). Women from the Inverclyde and West Dunbartonshire areas retained the choice to access delivery services in Greater Glasgow hospitals.

The reconfigured service was underpinned by the principles of individualised care, promoting women's choice, providing the opportunity to give birth in natural surroundings, offering a less 'medicalised' birth and providing locally accessible midwifery care. Predictions of activity levels were estimated and were considered to be sufficient to support sustainable and affordable service delivery.

2.3 Activity

The CMUs within Clyde offer a valuable comprehensive maternity service to their local population. While recognising that the CMUs are busy in their delivery of antenatal and post natal services, it is clear that they are significantly under utilised within their birthing suites. Within Inverclyde and Vale of Leven around 30% (27% at VoL, 32% IRH) of pregnant women are choosing to book with their local CMU. Of the 30% of women who choose the CMU, around 30% (36% VoL, 25% IRH) actually deliver within the unit. This equates to 9% of the total caseload, therefore 91% of women from Inverclyde and the Vale of Leven catchment areas are currently delivering in maternity units distant from their local CMU.

In 2006 IRH and VoL had 73 and 74 deliveries respectively, averaging 1.4 births each week. As the birthing suite element of the service is staffed 24 hours / 7 days a week by two midwives at each site, there is a disproportionate amount of resource attached to this service. 40% of the midwifery staffing resource at the CMUs at the Vale and IRH is used to staff the birthing suite. However, only 12% of the expectant mothers from these areas labour within the CMUs (and only 9% deliver). The cost per birth at IRH and VoL is £5,696 and £5,753 respectively. The comparable cost for the midwife led service at the RAH is £1,836 per birth.

A number of women are transferred from midwifery led care in the antenatal stages of their pregnancy due to health related reasons that move them from a low risk category to higher risk, whilst around 30% (29% from VoL and 32% from IRH) are transferred during labour, most of which incur an ambulance journey of 25-30 minutes. The Audit of Care Provided and Outcomes Achieved by Community Maternity Units in Scotland 2005 undertaken by the Scottish Programme for Clinical Effectiveness in Reproductive Health demonstrated that the Scottish average (%) of transfers to a consultant led unit in labour or within one hour of labour was 17% (2005). The transfer rates from the Vale of Leven and the IRH are significantly above that average.

2.4 Demographics

The CMUs have been developed to provide midwife led maternity care to low risk, healthy women. Eligibility criteria are used to assess risk and clearly identify women suitable for low intervention midwifery led care. Of the 73 parliamentary constituencies for which the Scottish Index for Mortality and Deprivation captured information in 2006, Dumbarton and Greenock are both in the 25 most deprived constituencies. This is determined by their share of the 20% most deprived zones across the country. This impacts significantly on the number of women who are eligible to deliver within a CMU. However the converse of this, is while women are insufficiently healthy to be eligible to deliver within the CMUs, their health needs are such that local provision of the full range of antenatal and post natal services including Special Needs in Pregnancy (SNIPS) and Early Pregnancy Assessment Unit (EPAU) is essential. The provision of high quality antenatal and postnatal care is of particular importance to women living in deprived communities.

2.5 Options for Service Delivery

A “working group” consisting of staff members, staff side representatives, finance and management representatives was tasked to look at alternative models of care for the CMUs, within the principles of providing a value for money service across Clyde, whilst maintaining local access to maternity care.

The group began by establishing requirements for essential local service provision, a comprehensive suite of antenatal and postnatal services deemed necessary to meet the health needs of the local population. The working group progressed a long list of options to a short-list of four.

The four short listed options were:

Option 1: Status Quo

Option 2: Retain local births at all units through on-call shift pattern at VoL and IRH

Option 3: Retain local births at all units through Caseload Management at VoL and IRH

Option 4; Single midwife-led delivery service for Clyde, sited at RAH

All four options retained current levels of local antenatal and postnatal services and the choice for women to access delivery services in Glasgow hospitals.

2.6 Selection of Preferred Option

The four options were evaluated in terms of their relative benefits and associated risks by a working group including staff and users. This evaluation is described in **Appendix 1.**

Option 4, a single CMU birthing unit for Clyde, located at the RAH was appraised and scored as the preferred option for service delivery. This option:

1. Retains all essential local services at the IRH and VoL:

    - Antenatal Care by Midwives - Antenatal Care in the community, GP surgeries, CMU and women's homes;
    - High risk antenatal care by consultant obstetrician in the CMU;
    - Full programme of parent education;
    - Ultrasonography service x 5 days with midwife scanners for routine booking scans;
    - Ultrasound service supported by high-risk sessions and anomaly scans undertaken by medical and specialist midwifery ultrasonographers;
    - Community based post natal care;
    - Triage drop-in service;
    - Special Needs in Pregnancy (SNIPS);
    - Special Needs Liaison;
    - Complementary Therapy;
    - Smoking Cessation;
    - Home Births.

2. Retains the choice of low intervention births for women in Clyde, either at the RAH, Paisley or within Glasgow.

3. Delivers substantial savings towards reducing the financial deficit.

Our preferred option for consultation is therefore the closure of the delivery elements of the Community Maternity Units at Inverclyde Royal and the Vale of Leven hospitals with women from those areas retaining the choice to access consultant or midwife led services at the RAH or the maternity units in Glasgow. However, we are also seeking view on the alternative options.

During the consultation period we will also be conducting an audit to ensure that we fully understand the choices that expectant mother's make. This was recommended by the Independent Scrutiny Panel and will be presented to the Board of NHSGGC along with the consultation feedback.

2.7 Impact of the Proposal

The impact on local services at IRH and VoL is only on delivery services. The tables below illustrate the proposed change.

Impact - VoL	**2006**	**Proposed Service**
Routine antenatal visit	5818	5818
Antenatal day care	571	571
Scans (midwife and Consultant)	1599	1599
Early Pregnancy Assessment	1039	1039
Parent Education	1579	1579
Community postnatal checks	3677	3677
Births	74	0
Total	**14,357**	**14,283**

Impact - IRH	**2006**	**Proposed Service**
Routine antenatal visit	6849	6849
Antenatal day care	948	948
Scans (midwife and Consultant)	4531	4531
Early Pregnancy Assessment	881	881
Parent Education	2051	2051
Community postnatal checks	5081	5081
Births	73	0
Total	**20,414**	**20,341**

2.8 Access

Access to high quality antenatal and postnatal services are critical for women living in deprived communities. These proposals preserve the status quo in respect of the full range of antenatal and postnatal care. The only change in terms of access is that around 150 women will make a single additional journey to the centre of their choice in either the RAH or in Glasgow, to give birth to their babies.

Given the relatively small numbers of births affected by the proposal we do not anticipate any significant impact on the consultant led units at either the RAH or in Glasgow. As described in section 3.6, there are currently approximately 64 intrapartum transfers from the Vale and Inverclyde to the RAH each year. These are predominantly undertaken by ambulance and will not require to be undertaken in future. Therefore we do not anticipate that there will be significantly increased workload for the Scottish Ambulance Service as a result of these changes.

3. DETAILED INFORMATION

3.1 Review Process

The review:

- Examined the maternity service configuration within Glasgow and took account of any implications for services within Clyde;
- Detailed the current service and associated resources and sought to understand the reasons why the service is under utilised and provide alternative options for service provision.

To undertake the review a structure of operational and planning teams was put in place, responsible for ensuring engagement and involvement of key stakeholders in the review and development of detailed options for the service. This included:

- a reference group;
- community engagement and staff meetings;
- an option appraisal event.

3.2 Facilities

The CMUs developed within Clyde provide local antenatal and postnatal care for all women within their catchment area, including high-risk women through a model of shared care with Obstetricians and General Practitioners. Women who have been assessed as low risk can choose to give birth within their local CMU.

The Community Maternity Unit at the VoL is a purpose built unit within the Vale of Leven Hospital. It comprises accommodation for out-patient antenatal obstetric and midwife clinics, a day care unit and a parent education facility, which is also used as a drop-in service for women. There is a separate access to facilities for women experiencing early pregnancy problems (EPAU) and together with the antenatal care service there is access to a dedicated obstetric ultrasound department.

Accommodation for the birthing suite comprises four birthing/postnatal rooms one of which incorporates a birthing pool.

The Community Maternity Unit at Inverclyde Hospital is situated on level F of the acute hospital. The CMU was adapted from existing in-patient facilities and now comprises accommodation for antenatal clinics, two dedicated ultrasound rooms, a Special Needs in Pregnancy (SNIPs) room and a parent-education facility.

Accommodation for the birthing suite comprises two adapted birthing/postnatal rooms with a temporary birthing pool facility in one.

Resources were invested in each unit based on anticipated activity rates relating to caseload size and number of births. Each CMU is open and staffed 24 hours a day/ 7 days a week.

3.3 Staffing Resource 2006/07

Midwifery	VoL CMU:	IRH CMU:	RAH CMU:
WTE Trained	23.14 trained	27.87 trained	41.19 trained
WTE Untrained	4.51 untrained	3.99 untrained	4.42 untrained

3.4 Rollover Budget 2006/07

	Pays	Non-pays
VoL CMU	£1,026,300	£62,000
IRH CMU	£1,185,400	£56,000

3.5 Analysis of caseload and births

Vale of Leven Hospital-

It was anticipated that Vale of Leven CMU would have between **179 and 210** births based on a caseload of **844**, i.e 21-25% of caseload would result in CMU birth.

Actual Activity				
Year	**Bookings**	**Births**	**Caseload**	**%Births:caseload**
2004	140	61	758	8%
2005	162	64	735	9%
2006	204	74	744	10%

Based on 2006 information, Vale of Leven CMU is delivering between 35% and 41% of predicted births or 8-10% of caseload.

Inverclyde Royal Hospital-

It was anticipated that Inverclyde CMU would have between **204 and 240** births based on a caseload of **960,** i.e 21-25% of caseload would result in CMU birth**.**

Actual Activity				
Year	**Bookings**	**Births**	**Caseload**	**%Births:caseload**
2004	180	91	911	10%
2005	316	115	841	14%
2006	287	73	892	8%

Based on 2006 information, Inverclyde CMU is delivering between 30% and 36% of predicted births or 8-13% of caseload.

3.6 Transfers in Labour

Each of the CMUs have eligibility criteria, based on risk factors for a CMU birth. These are based on the national criteria published in the Overview Report of the Expert Group on Acute Maternity Services (EGAMS) 2002. An important issue in relation to delivery services is the extent to which women need to be transferred when already in labour.

Intrapartum Transfers to a Consultant Led Unit

Vale of Leven	Women admitted in labour	Transfers to a consultant-led unit in labour or within one hour of delivery		Transfers to a consultant-led unit in the 2nd stage of labour	
	No	No	%	No	%
2004	77	17	22	0	0
2005	78	26	33	4	5
2006	102	30	29	2	2

Inverclyde Royal	Women admitted in labour	Transfers to a consultant-led unit in labour or within one hour of delivery		Transfers to a consultant-led unit in the 2nd stage of labour	
	No	No	%	No	%
2004	101	18	18	0	0
2005	154	45	29	3	2
2006	107	34	32	0	0

The Audit of Care Provided and Outcomes Achieved by Community Maternity Units in Scotland 2005 undertaken by the Scottish Programme for Clinical Effectiveness in Reproductive Health demonstrated that the Scottish average (%) of transfers to a consultant led unit in labour or within one hour of labour was 17%. Clearly the IRH and VoL centres are substantially above that level. It is not a desirable model of service to ambulance transfer women in labour - where that can be avoided.

4. OPTIONS FOR SERVICE DELIVERY

4.1 A 'working group' consisting of staff members, staff side representatives, finance and management were tasked to look at alternative models of care for the CMUs, adhering to the principles of providing a value for money service across Clyde, whilst maintaining local access to maternity care.

4.2 The group began by establishing and defining those services which are regarded as essential to the provision of a local service. They termed this 'Essential Local Service Provision' (ELSP). They then 'brainstormed' a long list of potential options, which would deliver these requirements. This information was shared with operational staff and following this no further options or changes to essential service provision were added.

4.3 Essential Local Service Provision

- Antenatal Care by Midwives- Antenatal Care in the community, GP surgeries, CMU and women's homes
- High risk antenatal care by consultant obstetrician in the CMU
- Full programme of parent education.
- Ultrasonography service x 5 days with midwife scanners for routine booking scans
- Ultrasound service supported by high risk sessions and anomaly scans undertaken by medical and specialist midwifery ultrasonographers.
- Community based post natal care
- Triage drop-in service
- Special Needs in Pregnancy (SNIPS)
- Special Needs Liaison
- Complementary Therapy
- Smoking Cessation
- Home Births

4.4 The working group progressed from the long list of options to a short-list of four. The four short listed options were:

1. Status Quo.
2. Retain local births at all units through on-call shift pattern at VoL and IRH
3. Retain local births at all units through Caseload Management at VoL and IRH
4. Single midwifery-led unit in Clyde, sited at RAH

Appendix 1 of this paper describes the service models associated with each of these options in detail. All four options retain all essential local service provision. These options were then subject to a detailed option appraisal exercise. The option appraisal process and its conclusions are also outlined in Appendix 1 of this paper.

The preferred option was concluded as a single midwifery led delivery service at the RAH with women from Inverclyde and West Dunbartonshire retaining the choice to access the three midwifery-led delivery services in Glasgow. This model:

- retains all essential local services;
- continues to offer a range of delivery choices;
- offers an economic service contributing an estimated £500K in savings to the reduction of the Clyde financial deficit.

5. STAFF ISSUES

5.1 If a final decision is made to implement the proposal outlined in this document there will be an impact on our staff. Our commitment is to ensure that all affected staff would have redeployment opportunities which could meet their aspirations and best utilise their skills.

5.2 Throughout any implementation of the proposed change work will continue with staff and their representatives to manage the impact of the change. This would be done within the context of the national and local organisational change policies.

5.3 Staff directly affected by the changes proposed, in addition to meetings with the trade unions, would have one to one meetings / individual redeployment interviews. NHS Greater Glasgow and Clyde has a successful track record in redeploying staff taking into account each individual's skills and personal circumstances. Redeployment would be the first consideration with the aim of securing alternative employment for displaced staff as a result of service change.

5.4 Deployment could potentially be to a post at a lower grade and in these circumstances protection of earnings will apply. Any redeployment would also be supported by a training and development plan, which would include induction and orientation programmes, and retraining and skills updating where necessary.

6. PUBLIC ENGAGEMENT

6.1 Four public events were held in order to facilitate the inclusion of the user perspective in the review. The first event was a public meeting, held at the David Lloyd Centre in Paisley. It agreed a strategy for community engagement that would focus on meeting with current and recent users of maternity services in Clyde, meeting in venues and at times that would be convenient for women with young children and that would aim to provide an opportunity for women to discuss the review with key health professionals.

6.2 Following this strategy a further three community engagement events were held.

6.3 All the women who came to the meetings were recent and/or current users of maternity services in Clyde. Some were accompanied by friends or partners and some by family members. The events were supported by members of the Maternity Services Review Reference Group and Midwives from the local services.

6.4 There was extensive publicity for the meetings. They had been promoted by the CMUs and all were well publicised with the help of Inverclyde Community Care Forum, West Dunbartonshire Community Health Partnership, GP practices, chemists, baby shops, post offices and local community venues. In addition a school bag drop to nursery and primary school pupils was undertaken in Inverclyde.

6.5 The purpose of the meetings was to try to build an explanatory account of women's decision-making in maternity care, particularly the reasons why they chose or did not choose to use the CMUs. The discussions are summarised below.

6.6 What do women like about care at the CMU?

- a wide range of services used and valued at the CMU including phone line for advice, day care/drop in support on demand, alternative therapies, early pregnancy service, pre-conception advice, breast feeding classes and support, physiotherapy;
- having continuity of a small midwifery team and the subsequent personalised attention was important to women;
- the model of care in the CMU was valued and women felt empowered as a result;
- the CMU approach builds trust and good relationships with midwives;
- the local CMU facilitates the involvement of partners and the extended family
- local services are less stressful as don't have to worry about travel – either to appointments or when go into labour;
- the intensive one to one experience of care in the CMU was valued;
- women welcomed the opportunity for a natural birth;
- the knowledge and skills of the midwifery staff were acknowledged and women felt safe in their care and know that if transfer to a CLU was required this would be undertaken.

6.7 Why do they not use the CMU?

- lack of knowledge of what was available at the CMU;
- a feeling that GPs inappropriately steered women to the CLU, especially for a first baby;
- women's lack of information on their options and the perception that they don't have a choice;
- fear of the unknown and presumptions of pain;
- fears of risks so want a doctor present —"just in case";
- impression of 'strict' criteria for the CMUs;
- lack of knowledge of direct access to midwife;
- pressure from others – family, friends, colleagues – to use the CLU;
- the local perception of the VoL hospital as 'troubled'.

6.8 A number of other issues were raised that appeared relevant to the review. These were:

- geography and lack of public transport make access to Paisley and Glasgow difficult;
- women wanted consistent information on services from health care professionals;
- lack of information available to the public about low intervention birth;
- decision on where to deliver can't be made quickly – need time to learn about options before making a choice;
- need to educate local women and health professionals on the benefits of, services available and good outcomes at the CMUs;
- it was expressed by some women that there might be too much emphasis on what could not be done at the CMU and more emphasis should be made of what is possible. A fine balance needs to be achieved to ensure informed choice is made.

7. REVIEW BY THE INDEPENDENT SCRUTINY PANEL

7.1 The Independent Scrutiny process ran from September 2007 to November 2007. The full report of the Independent Scrutiny Panel (ISP) is available as part of the suite of consultation documents on the NHSGGC website. The process of Independent Scrutiny was established by the Cabinet Secretary for Health and Wellbeing. The aim is to improve public confidence in, and the transparency of, the decision making of NHS Boards. The ISP report describes the role of the panel as: "Effectively the role of the Panel was to test the processes behind NHS Greater Glasgow and Clyde's proposals for major service change, challenge the quality of the thinking and of the development process behind the Board's proposals, and to come forward with a series of comments intended to help ensure that the eventual public consultation is based on openness, thoroughness and inclusiveness."

7.2 This section of the consultation document is a full extract of the section of the Independent Scrutiny Panel report that related to the provision maternity services.

7.3 *Maternity Services*

In 2003, NHS Argyll and Clyde replaced Consultant-led delivery services at both Inverclyde Royal Hospital (IRH) and the VoL Hospital (VoL) with new midwife-led community maternity units (CMU), and co-located a third CMU with the existing Consultant-led units (CLUs) at the RAH (RAH). All of these units offer a wide range of local maternity services, antenatal and postnatal care, including a 24-hour midwife led birthing suite for "low-risk" births (expectant mothers who are healthy and meet the criteria for a midwife-assisted birth as distinct from a Consultant-led one). For a period of eighteen months, following the loss of the consultant-led units, and prior to the opening of the CMUs at both hospitals, neither hospital provided birthing facilities for local mothers.

In April 2006, when Clyde services were amalgamated with those of Greater Glasgow, NHS Greater Glasgow and Clyde initiated a review of maternity services across Clyde. Later that year, the Clyde Maternity Services Review Reference Group was established, one aim of which was to identify a contribution to the large budgetary deficit inherited from the former NHS Argyll and Clyde. The birthing suites at the CMUs at VoL and IRH were being significantly under-utilised, resulting in costs per birth at VoL and IRH close to three times the cost of a birth at RAH (IRH £5,696 per birth, VoL £5,753 and RAH £1,836).

Suggestions for service change were aired at public engagement events in Greenock and Alexandria at which there were 10 and 40 attendees respectively.

Following an initial option appraisal exercise, there were further public engagement events, when four possible options for maternity facilities at VoL and IRH were discussed. Attendance at the events was poor, with a total of three women attending two events held on 30th May 2007 in Alexandria and "around 20" women attending at Inverclyde. From an initial long-list of 12 options originally considered by Health Board staff, the four short-listed options were as follows:

1. Status Quo
2. Retain local births at all units through on-call shift pattern at VoL and IRH
3. Retain local births at all units through Caseload Management at VoL and IRH
4. Single midwife-led delivery service for Clyde, sited at RAH.

The appraisal of the four options selected by Board staff as being potentially viable was conducted broadly according to best practice, with weighting and scoring against a set of explicit criteria.

The preferred option contained in the strategic paper put to the NHS Greater Glasgow and Clyde Board on 26th June 2007 was for the closure of the delivery elements of the CMUs at IRH and VoL with women from these areas retaining the choice to access Consultant or midwife led services at the RAH or the maternity units in Glasgow.

A strong financial case has been made for this preferred option. The cost of the Clyde wide maternity service would be reduced from just over £4 million per annum to approximately £3.5 million per annum by closure of these two CMUs.

A further justification for closure could be made on the basis that women preferred to have their babies in units with ready access to a Consultant, rather than use the CMUs. At VoL, it was anticipated that between 179 and 210 births would take place at the CMU, based on a caseload of 844 i.e. between 21 and 25%. However, in 2006, there were only 74 births, representing less than 10% of the original caseload. The picture is similar at IRH. There is a huge loss of potential CMU births at the point of risk assessment, with only between 30 and 40% of pregnant women being judged to be sufficiently free of risk factors to have the CMU birth. Despite the need to satisfy safety criteria before being booked at a CMU, in 2006 some 30% of women had to be transferred by ambulance to a Consultant-led unit in labour, or within 1 hour of delivery.

This contrasts with a Scottish rate of 17% in 2005.

91% of local women whose pregnancy is judged to be clinically safe exercise their choice to use facilities other than the birthing suites at VoL and IRH.

The Expert Group on Acute Maternity Services (EGAMS) selection criteria appear to be applied slightly differently in each Clyde CMU. In IRH, they are interpreted rigidly, justified by concerns over transfer distance. RAH shows greater flexibility due to the proximity to the CLU and anaesthetic cover. At VoL, there is an opinion that the EGAMS criteria require review, such as that relating to Strep.B positive mothers. The VoL CMU puts much more emphasis on the approach and philosophy of the intra-partum care being given, of which the midwives are very proud. There has been significant public concern over the prospect of the closure of the birthing suites in the CMUs at VoL and IRH, most notably in West Dunbartonshire where there have been large, well organised public demonstrations. At the public meetings held by the Panel in Greenock and Dumbarton, concerns were expressed by members of the public and by local practicing midwives. These included: criticism of the loss of choice to have a baby within one's local community; the difficulties for family and friends to visit a mother in Paisley

(especially for Dumbarton residents who would have to cross the Erskine Bridge); the possibly over-stringent safety criteria for CMU bookings; and the view that the CMUs had never been positively promoted by the Health Board, nor given adequate time in which to earn the confidence of local mothers.

Neither of the stand-alone CMUs accepts post-natal transfers back from Paisley or Glasgow after operative or assisted vaginal deliveries. Such a model would allow women to be cared for closer to home, but does raise many issues regarding transfer and possible pressure on the ambulance service. It is noted that in both Tayside and Grampian, CMUs accept post-natal women.

It has been put to the Panel that the current rate of births at the free-standing CMUs creates the risk of midwives becoming de-skilled through lack of practise. It should not be beyond the capacity of NHS Greater Glasgow and Clyde to find ways of managing that risk.

It appears to the Panel that the case is essentially economic, with the current cost per birth at the peripheral CMUs being considerably greater than those at Paisley, created as a direct consequence of having staff and facilities unused much of the time. The extent of the underutilisation of the CMUs in Greenock and VoL provoked much discussion within the Panel. We originally wondered whether mothers were being put off the midwife units by comments they heard during the referral process, possibly from their general practitioner. Enquiries did not support this suspicion; all mothers being referred from within the catchment area are initially seen by a midwife. There is no clear evidence as to why 91% of mothers who are eligible for a CMU birth choose to go elsewhere. At a public meeting in 2007, NHS Greater Glasgow and Clyde undertook to investigate the situation and determine the reasons for the low uptake of CMU birthing.

The Panel saw no evidence of this investigation, and suggested to the Board that a targeted, anonymous, questionnaire survey should be carried out in order to understand mothers' attitudes. During the course of the Panel's deliberations, the Board conducted a snapshot survey, over 8 days, of the reasons mothers chose not to give birth in a local CMU. The Panel feels that such a survey should be carried out over a much longer period of two or three years.

The midwife-led CMUs were created some four years ago and it appears to the Panel that little has been done either by NHS Argyll and Clyde or NHS Greater Glasgow and Clyde to publicise the benefits of such units, and specifically to get the message across to expectant mothers.

The Health Board accepts that when the CMUs were being designed in 2002/2003, it was acknowledged that an appreciable period would be required before the new model became embedded in the local cultures and until anything approaching the projected CMU birth rates would be achieved. This was estimated at between 5-10 years. The Panel was concerned that this prediction does not appear to have been contained in any papers presented to the Health Board, nor is it apparent in the paper describing the basis for consultation.

It is the experience of CMUs elsewhere, for example in Perth and Kinross, that it takes several years, at least five, for confidence to be felt in the prospect of

having a baby without ready access to a Consultant. It seems to the Panel that it is possible that, given high profile, positive, publicity the very slowly increasing usage of the CMUs could be accelerated. Greater usage would reduce the cost per birth and would diminish the economic argument against sustaining the units.

The report commissioned by NHS Quality Improvement Scotland, published in February 2007 "Audit of Care Providers and Outcomes Achieved by Community Maternity Units in Scotland, 2005" recommended that national and local eligibility criteria for interpartum care within CMUs should be reviewed and simplified. A powerful factor which diverts women away from midwife-led CMUs is the stringency of the assessment process for risk. The Panel understands that there is an intention to review and possibly amend the EGAMS scale, and obviously any review of the criteria with a full, unbiased, explanation to mothers, might result in an increase in CMU bookings and deliveries.

The review and working groups responsible for generating and evaluating the options are to be commended for conducting a structured, quantified option appraisal. However, it was not clear to the Panel the extent to which the views of mothers, and of the general public, influenced the weighting and scoring, especially of benefit factors such as maximising choice for mothers, accessibility for families, and continuity of pre-, intra-, and post-natal care. The Panel also felt unclear as to whether the costs of increasing the maternity service at RAH had been fully and clearly accounted for in the preferred option.

The Panel heard strong views that the closure of the midwife-led birthing suites at the CMUs in VoL and Greenock would represent a cost-saving exercise necessitated by the pressure for the repayment of the debt inherited from NHS Argyll and Clyde. Powerful and coherent arguments were put forward by local practising midwives, and from the general public, to the effect that the loss of these facilities could not be justified simply on cost alone. Interestingly, midwives at the CMU at RAH said they considered it would take 5-10 years to change the local culture of birthing, and also that they considered the closure of the birthing units at IRH and VoL as "a disaster"

It was put to the Panel at one of its site visits that local practising midwives had not been consulted on the options being developed. Specifically, there had been no opportunity or midwives to argue for the inclusion of a post-natal care role for CMUs in IRH and VOL.

Opinions expressed to the Panel from the National Childbirth Trust and the Royal College of Midwives are strongly in favour of birthing at CMUs. The Royal College observes that "it has already been established that the review (of Clyde maternity services) is on the basis of Clyde's financial saving plan and not about service delivery or safety". The College also refers to the current review of the eligibility criteria for CMU admission, some of which will be taken forward under the Keeping Childbirth Natural and Dynamic Project (KCNDP). In addition to expressing positive views about CMUs in general, the National Childbirth Trust feels that the information offered in the Health Board's summary of proposals is not comprehensive enough upon which to base a decision.

The QIS report referred to above acknowledges the enormous contribution to maternity care in Scotland by CMUs. A recommendation is that the contribution could be increased by further extending the core skills of midwives to include greater involvement in ultrasound scanning, prescribing, and routine examination of the newborn.

Tele-health technology should be used to support midwives in these extended areas.

KEY POINTS

The crucial question of why mothers choose not to use the CMUs in Alexandria and Greenock remains unanswered. The Panel suggests that a prospective postal questionnaire of mothers should be undertaken over a longer period to clarify the reasons for failure to choose a CMU rather than a Consultant-led unit.

The Panel feels that an additional option should be developed by the Board and presented for consultation. This would be to run the CMUs for, say, a further three year period, accompanied by a positive community education programme informed by a survey of women's attitudes.

The possible further option of using the stand-alone CMUs for post-natal inpatient care should also be developed, with the involvement of local midwives, and presented for consultation.

In addition to positive publicity, a review of risk criteria might increase usage and reduce the costs per case.

While it was good to see a conventional, quantified, option appraisal of the CMU proposals, the Panel felt that the Board should demonstrate the extent to which the public were involved in determining the options for appraisal and how their views influenced the weighting and scoring, particularly on factors such as choice, accessibility, and continuity of care.

If intra-partum care is to be withdrawn from the stand-alone CMUs, a review of the workforce and possible associated costs should be conducted, and this information should be fed into the option appraisal.

Options to consider for consultation are:
1. Status Quo
2. The status quo accompanied by positive publicity and monitoring of birth suite activity
3. Use of stand-alone CMUs for post-natal in-patient care, linked to, or independent of, Option 2
4. Transfer of birthing to RAH

End of Independent Scrutiny Report

8. NHS GREATER GLASGOW AND CLYDE'S RESPONSE TO THE INDEPENDENT SCRUTINY PANEL REPORT.

In a number of respects the Panel endorsed the process which has developed our proposal to cease the delivery services within the CMUs, notably:

- the strength of the financial case for our preferred option;
- the quality of the option appraisal;
- the under-utilisation of staff and facilities.

8.1 However the panel also comment on our public engagement process, recommend that we consult on an option to retain the delivery services for a number of years, revise the risk criteria for CMU delivery and suggest that we consider providing post natal care within the CMUs.

8.2 The response of NHSGGC to these aspects of the Panel's conclusions is described below.

Public Engagement

The Panel suggests that more could have been done to increase the level of public engagement and involvement in the option appraisal process. Substantial efforts were made to achieve public engagement in this process and to ensure a patient perspective influenced the option appraisal. The rest of this section outlines the detail of those processes.

A total of seven community engagement meetings were held for the Clyde Maternity Review. These facilitated user involvement in all stages of the review.

The first event, a public meeting held at the David Lloyd Centre in Paisley on 9th January 2007, was attended by a number of individual users and representatives of voluntary organisations that acted for women's interests. This group met to discuss and agree a strategy for the further community engagement with users. It agreed that community engagement would focus on meeting with current and recent users of maternity services in Clyde, meeting in venues and at times that would be convenient for women with young children and would aim to provide an opportunity for women to discuss the review with key health professionals. NHSGGC made a commitment to provide childcare, expenses for travel etc and child-friendly venues.

A second public meeting was held with the then Provost of Inverclyde, an Inverclyde councillor and a representative of the Scottish Health Council that evening at the David Lloyd Centre. This meeting endorsed the community engagement strategy.

Following agreement of the community engagement strategy 3 meetings were held. These were:

- Fun World, Greenock, Wednesday 28th February, 9.30 am - 12.30 pm;
- Kidzworld, Alexandria, Wednesday 7th March, 11.00 am - 3.00 pm;
- Community Maternity Unit, Alexandria, Tuesday 13th March 2007, 7.00 pm.

There was extensive publicity for the meetings. The CMUs, West Dunbartonshire Community Health Partnership and the Inverclyde Community Care Forum all promoted the events. Colourful posters were placed in GP surgeries, chemists, baby shops, post offices and local community venues. In Inverclyde 100 posters were distributed. In addition a school bag drop to nursery and primary school pupils was undertaken in Inverclyde. This sent out 7,000 notices for the meetings.

Despite this the numbers attending were low. In total, 10 women attended the Greenock event, 30 the daytime event in Alexandria and 8 the evening session. All were recent and/or current users of maternity services. Some were accompanied by friends, partners and some by their mothers. One woman went on to join the Review Steering Group and continued to provide user input into the review process.

At the conclusion of the three meetings the findings were written up and this report was integrated with the other sources of data used in the review.

A summary of the feedback from women was produced in a newsletter. This newsletter was distributed via the West Dunbartonshire Community Health Partnership and the Inverclyde Community Care Forum. The newsletter contained an invitation to those who had not yet participated in the review to get in touch and either write to or meet with a representative of the Board.

There were two ways in which users were engaged in the option appraisal.

First, two individual users participated in the option appraisal alongside staff, staff side representatives, finance and senior managers. In addition a Community Engagement Manager attended the option appraisal with a remit to represent the views expressed during the engagement meetings in the process.

Second, three public meetings were held to discuss the four options under consideration with maternity users. These were:

- Community Maternity Unit, Alexandria: Wednesday 30th May 2007, 4.00 pm;
- Community Maternity Unit, Alexandria: Wednesday 30th May 2007, 7.00 pm;
- Inverclyde Community Care Forum, Thursday 31st May, 11.00 am.

Invitations to these meetings were sent to all the participants in the first round of meetings and the CMUs also promoted them among their users. The numbers attending were again low. Two women attended the Alexandria meeting while around 20 came to Inverclyde.

Again the findings were produced in a report and this was considered by the Review Steering Group. The findings from the community engagement events were included in the final report and recommendations.

<u>Continuing the Current Service</u>

The Panel concludes that the question of why mothers choose not to deliver in the CMUs is largely unanswered and that we should revise our risk criteria and formally consult on an option to run the delivery facility for a further three

years. There are a number of points that is important to make in relation to this:

- The EGAMS risk criteria were established by a group of national experts and we do not consider them to be over stringent. We also do not consider it appropriate that these should be relaxed in order to offer the potential to increase numbers delivering in the CMUs. The two CMUs delivery services already have excessively high levels of transfers in labour. This would indicate that risk criteria should be tightened rather than relaxed;

- there are two clear answers to the question of women's decisions on the CMU delivery service usage;

    - a large number of women in both areas require to be delivered in a consultant unit for clinical safety with deprivation a major driver of contra-indications to CMU delivery;

    - many women choose to access a midwifery led service at the RAH with the advantage of access to full consultant led obstetric and anaesthetic care if they require it.

Promoting the Service

After considering the potential for increased promotion of the service leading to more women choosing to give birth in the CMU facilities we do not think there is anything we can do to significantly improve this. The reason for this is that all local women are currently booked by midwives in the CMUs and the vast majority receive all of their antenatal care in the Units. Women are exercising a clear choice to book births at the RAH during discussions with local CMU staff. We therefore do not consider that it is a lack of awareness of the facility that is the decisive factor.

Postnatal Inpatient Care in CMUs

The Panel suggested that we should put to public consultation an option to provide postnatal care in the CMUs. Having considered this suggestion in detail we do not believe that this would represent a viable option. There are a number of reasons for this conclusion. Firstly, the overwhelming majority of women have very short lengths of stay following delivery which means it would not enhance the service they receive to transfer them between hospitals. Another reason is that, as described by the Panel, this suggestion raises a number of issues regarding transfer and possible pressures on ambulance services. We had considered this model when we were developing the short list of options for appraisal and our further consideration reinforced our initial conclusion, i.e. that postnatal transfer is not an appropriate proposition. The Units used by the panel as examples both provide delivery services rather than stand-alone post natal care.

Our review of the ISP report did not lead us to change our preferred option because:

- There is no persuasive evidence that a further three years of delivery services in CMUs will impact significantly on throughput and reduce the unit cost to an acceptable level.

- There is no basis, therefore, to forego the potential to secure £1.5 million savings over that three-year period.

- Asking 150 patients per annum to make a single journey to the RAH for a hospital stay of less than 48 hours is not a significant service change - nor in the context of the vast majority of activity remaining in the CMUs - a centralisation of service.

However, we are consulting on the range of alternative options as described elsewhere in this paper.

Audit of Parental Choice

The Panel also suggested that we undertake further public testing of the choices made by mothers.

We agree with the Panel that an audit of mothers choices would offer value and we will undertake such a study during the consultation period. This will be reported to the Board with the outcome of consultation. Because the Board paper is a publicly available document the outcomes of the further testing on choice will be publicly available.

9. THE CONSULTATION PROCESS

9.1 The section describes our approach to formal consultation. This builds on the extensive programme of public and community engagement, which has shaped this review.

9.2 The consultation period runs from 27th March 2008 and will last until 19th June 2008 – a total of twelve weeks. We will carefully consider all the feedback we receive during the consultation period. Summaries will be presented to members of the NHS Board. The comments received will inform Board Members as decide on a final set of proposals. These proposals will then be forwarded to the Cabinet Secretary for Health and Wellbeing for a final decision.

9.4 This consultation document, coupled with the other material available as part of the consultation process, provides detailed information describing why we believe that the option to close the birthing suites at Inverclyde Royal and Vale of Leven Hospitals and have a single midwifery-led birthing suite for Clyde, situated at RAH is a sound option based on best use of valuable resources. This information, combined with the engagement events and meetings, is intended to ensure that by the end of the public consultation process stakeholders have a clear understanding of why this proposal is being put forward, the opportunity to challenge it, and to comment on other options.

9.5 A consultation summary leaflet will be produced which will take full advantage of design format and language to ensure it is accessible and as clear as possible. This will be widely distributed via the Involving People and CHP databases and to local facilities including GP Surgeries.

9.6 Alternative Languages and Formats

The consultation leaflet will carry references in other languages to highlight that the information is available in different languages and formats including large-print and audio cassette

9.7 Any view that is put forward during consultation will be taken account of and reported in the analysis of responses. However, we believe it would be useful if you could address the following key issues:

- **Do you agree with our proposal that there should be a single midwifery birthing suite for Clyde based at the RAH?**
- **If you do not agree with our proposal, why is the case?**
- **Do you think the other options that we have examined would be a better alternative?**
- **For what reasons do you think this?**
- **What reasons or issues do you think the Board should consider that would strengthen the case for the option you prefer?**

- **Are there any other options you can suggest that have not previously been considered?**

9.8 There will be a number of ways you can make your views known:

9.9 One-to-one Meetings and Briefings for Individual Stakeholders will be held as required and will include key groups and elected representatives. During the public consultation period local staff will organise a number of events and drop-in sessions across Clyde specifically aimed at service users. These will be held in the CMUs and at facilities used by women who may be affected by the proposed change. These will be publicised locally and women who attended previous community engagement events will also be invited to participate.

Staff meetings and briefings will also be organised and staff will be notified of these directly.

If you wish to attend a public meeting based on workshop discussions about these proposals, please let us know by calling 0800 027 7246. We are flexible as to the date, time and format of such an event and will base the arrangements according to the level of demand and type of requests we receive.

9.10 All material will be made available on the NHSGGC website and specific consultation response pages will be created.

9.11 You can also **post your consultation submission** to us care of:

John Hamilton
Head of Board Administration
NHS Greater Glasgow and Clyde
350 St Vincent Street
Glasgow
G3 8YZ

Or you can email your submissions to

clydematernity@nhsggc.org.uk

All submissions must reach us no later than 19th June 2008.

9.12 We will ensure that copies of our **summary leaflet** are distributed widely in the Inverclyde and Vale of Leven catchment areas, including GP surgeries and hospital waiting areas. Press releases will be tailored to suit local media requirements.

9.13 What happens after consultation

We will carefully consider all the feedback we receive during the consultation period. Summaries will be presented to members of the NHS Board. The comments received will inform Board Members as they decide on a final set of proposals. These proposals will then be forwarded to the Cabinet Secretary for Health and Wellbeing for a final decision.

Appendix 1

OPTION APPRAISAL

An option appraisal process was carried out on 23rd May 2007, with 24 members of the steering group and working group, including staff, service users, staff side representatives, finance and managers.

BENEFIT CRITERIA

The four options were evaluated in terms of their relative benefits. Each benefit criterion was scored by the group giving it a weighting, then each option was scored against how well it met the criterion. The benefit criteria were as follows:

1.	Maximises acceptability to staff (e.g. in relation to working patterns and health and safety)
2.	Maximises acceptability to women (e.g. minimises need to wait for midwife to open CMU unit or requirement to go home within 6 hours after birth)
3.	Maximises accessibility for women (e.g. maximises local access, including for special needs services, and minimises travel time and cost for families)
4.	Meets service standards (e.g. relating to choice, one-to-one care in labour and continuity of care)
5.	Maximises choice in type of birth for women
6.	Maximises accessibility to members of the multi-disciplinary team in emergency situations
7.	Maximises the number of women eligible for and likely to take up the option of CMU birth
8.	Minimises the number of ambulance call-outs
9.	Maximises alignment to NHS Greater Glasgow and Clyde strategy
10.	Maximises perceived best use of resources

RISK CRITERIA

Each member of the group allocated each risk factor a score in terms of its likely impact, then scored these against each of the options.

1.	Inability to recruit and retain staff
2.	Inability to meet working time directives
3.	Inability to comply with family friendly and work-life balance policies
4.	Reduces health and safety for staff (e.g. due to lone working or increased stress)
5.	Reduces health and safety for women and babies (e.g. due to discharge within 6 hours following birth)

OPTION APPRAISAL SCORING

The results of the benefits and risk scoring was calculated by a Health Economist in the planning department. The cost of each option, ranked from highest to lowest in cost saving terms were incorporated into the overall result.

	Option 1 Status Quo	**Option 2 On-call**	**Option 3 Caseload**	**Option 4 RAH Midwifery-led Delivery Service**
Risk Score Lowest score=lowest risk	5.96	16.95	17.71	6.92
Weighted Benefit Score	527	412	388	508
Cost	£4,106,800	£3,568,175	£3,634,934	£3,550,763
Cost Benefit Weighted benefit score divided by cost	129	115	107	143
Ranking	2	3	4	1

Option 1: Status Quo

Service Description

This option retains the current service of:

- Dedicated on-duty midwifery staff Monday - Friday for early pregnancy, day-care, Special Needs In Pregnancy service, parent education at RAH, VoL and IRH.
- Antenatal high risk obstetric clinics and ultrasound sessions at RAH, VoL and IRH.
- Two dedicated midwives available on-duty 24/7 for birthing suite and telephone advice/drop-in at RAH, VoL and IRH.
- Seven day daytime community midwifery service for antenatal and postnatal care.

Benefits

- Women have access to local birthing unit.
- No change to staff working practice and rotas.

Risks

- Retains three units working under capacity in Clyde.
- This option does not address maximising use of NHS resource to deliver a 'value for money' service.
- This option does not release financial benefits that would support reduction of Clyde's deficit.

Option 2: Retain Local Births at All Units through On-call System at IRH and VoL

Service Description

- RAH services remain as described in option 1.
- All essential local service provision remains at VoL and IRH.
- Dedicated on-duty midwifery staff Monday-Friday to cover early pregnancy, Special Needs In Pregnancy service and ultrasound sessions at VoL and IRH.
- Midwifery staff on-duty to cover day-care, clinics and community will also provide cover for the birthing suite Monday-Friday 9-5pm as required, VoL and IRH.
- Out of hours cover for birthing suite provided by two on call midwives from Monday-Friday from 5pm -9am, VoL and IRH.
- At weekends birthing suite covered by one of two midwives on-duty for community midwifery service 9-5pm supported by one on-call midwife from 9am-5pm, VoL and IRH.
- Out of hours cover for birthing suite at weekends provided by two on-call midwives from 5pm-9am.
- Total of ten on-call periods from 5pm to 9am, Monday-Friday (five nights with two midwives per night).
- Total of six on-call periods at weekend - one each day to support community midwife and four to provide two on-call staff per night.

Benefits

- Women have access to local birthing unit.
- Flexible workforce, enabling financial savings to be made.
- Remaining staff continue to work at their local site.
- Midwives able to practice using full range of midwifery skills.

Risks

- Requires **all** staff at both VoL and IRH to participate in on call rota.
- Lead in time for Midwives to arrive to open birthing suite out of hours (u to 1 hour).
- Health and Safety - staff required to open up birthing suite out of hours, both units isolated. VoL isolated building, IRH isolated floor within main building.
- Health and Safety - women arrive at unopened unit prior to midwife. No A&E service at VoL.
- Potential disruption on daytime services following on-call.
- Pressure on women to be discharged home soon after birth for community based postnatal care, as unit not staffed. Potential impact on breast feeding support.
- Potential to breach EWTD in times of high activity and staff absence.
- Occupational stress associated with on-call commitments.
- Financial savings will be released incrementally in line with staff turnover and organisational change policy process.

Option 3: Retain Local Births at all Units through Caseload Management at IRH and VoL

Service Description

- Based on 'Albany practice model' (London). Provision of a dedicated midwife throughout pregnancy and birth for a caseload of low risk women.
- Two hundred low-risk women at VoL and IRH would receive total maternity care episode from a team of 5 midwives on each site including the provision of intra-partum care at home or at CMU of choice in Clyde.
- Each midwife has a total primary caseload of 40 women and is named secondary midwife with commitment to provide care for an additional 40 women.
- Midwives provide on-calls as necessary and do not receive enhanced or on-call payments but receive 3 months leave each year.
- Remaining women receive high-risk care as per status quo.
- All other local services remain same as status quo.
- Birthing suite at RAH remains staffed 24/7.

Benefits

- Women have access to local birthing unit and have continuity of care for women from a named midwife.
- Flexible workforce, enabling financial savings to be made.
- Remaining staff continue to work at their local site.

- WTE staff who carry a caseload are able to practice using their full range of midwifery skills.

Risks

- Impact on work/life balance for midwifery staff.
- Sustainability - very high burnout rate reported at other centres which have introduced caseload management.
- Lead in time for Midwives to arrive to open birthing suite out of hours (up to 1 hour).
- Health and Safety - staff required to open up birthing suite out of hours, both units isolated. VoL isolated building, IRH isolated floor within main building.
- Health and Safety - women may arrive at unopened unit prior to midwife. No A&E service at VoL.
- Staff not carrying a caseload are unable practice using their full range of midwifery skills.
- Financial savings will be released incrementally in line with staff turnover and organisational change policy process.

Option 4 Single Midwifery-led Delivery Service for Clyde, sited at RAH

Service Description

- All essential local service provision remain at VoL and IRH.
- Additional one midwife per shift at birthing suite would be required at RAH, rotated from VoL and IRH to enable midwives to practice full range of skills.
- 1.94 WTE additional auxiliary support at RAH.
- Women can access RAH or Glasgow services.

Benefits

- Maximises use of available capacity and resource.
- Flexible workforce, enabling financial savings to be made.
- Negates need for intrapartum transfers from IRH and VoL CMUs.
- Extended criteria used at RAH, expands eligibility for more women to have CMU birth.

Risks

- No local access to birthing suite at IRH and VoL.
- Potential impact on CLU and Glasgow services if women chose non CMU birthing option.
- Potential increase in ambulance requests from home to birthing unit of choice.
- Financial savings will be released incrementally in line with staff turnover and organisational change policy process.

If you would like this document in Braille or audio-tape format, please contact:

If you would like this document in another language, please contact:

Ma tha sibh ag iarraidh an fhiosrachaidh seo ann an cànan eile, cuiribh fios gu:

如果您需要该信息的其它语言版本，请联系：

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إذا رغبت في الحصول على هذه المعلومات بلغة أخرى، الرجاء الاتصال بـ:

ਜੇਕਰ ਤੁਹਾਨੂੰ ਇਹ ਜਾਣਕਾਰੀ ਕਿਸੇ ਦੂਜੀ ਭਾਸ਼ਾ ਵਿਚ ਚਾਹੀਦੀ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਸੰਪਰਕ ਕਰੋ:

اگر آپ یہ معلومات کسی اور زبان میں حاصل کرنا چاہتے ہیں تو براہ مہربانی رابطہ کریں:

Eğer bu bilgiyi bir başka dilde istiyorsanız lütfen bağlantı kurunuz:

Jeśli chcesz uzyskać te informacje w innym języku skontaktuj się z:

0141 201 4915
perl@ggc.scot.nhs.uk