Maternity and Paediatric Services at Dr Gray's Hospital, Elgin

Chief Medical Officer's Advisory Group Report

November 2018

Scottish Government
Riaghaltas na h-Alba
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Dr Gray's maternity and paediatric services
Report of the CMO Advisory Group

Remit

1. The Chief Medical Officer requested that this small expert group provide insight and guidance on the measures proposed by NHS Grampian to maximise the maternity care which can be provided in Dr Gray's Hospital (DGH) following the change in service to a Community Midwifery Unit (CMU) in August 2018. The full Terms of Reference for the group can be found at Annex 1. The CMO asked the Group to look at NHS Grampian's Phase One plan for the improvement of existing provision of Maternity and Paediatric Services at Dr Gray's Hospital and the future plans for the return of obstetric services.

2. As part of our work, the team worked with NHS Grampian Management team and engaged with local clinicians, Maternity Services Liaison Committee (MSLC) and the KeepMUM campaign group to gain a range of views on the existing service and the proposals provided by NHS Grampian. We also spoke with clinicians at NHS Highland (Raigmore).

3. The Chief Medical Officer requested that a short report be provided to include:

    1. Exploration of the development areas set out by NHS Grampian and agreed with the Cabinet Secretary. Including the feasibility and likely success of these additional measures and any advice which can be given to ensure success and/or improve upon the plans.
    2. Further recommendations to improve the care provided locally for women in DGH in the CMU setting including obstetric emergency triage, antenatal and postnatal care.
    3. Review of clinical pathways for the CMU, for transfer (both emergency and elective), and for antenatal care, and comparison with national/professional body standards and experience in other parts of Scotland.
    4. Engagement with local clinical staff to allow inclusion of local solutions to break down barriers to different ways of working and to build on communication with NHSG staff in Aberdeen.
    5. Engagement with and feedback to NHSG management
    6. Exploration of NHS Highland capacity and referral pathways to increase number of women able to travel to Raigmore for antenatal care or birth if this is a shorter journey for them.

Group Members:
Dr Rennie Urquhart – retired Obstetrician, NHS Fife
Justine Craig – Chief midwife, NHS Tayside
Una McFadyen – retired Paediatrician, NHS Forth Valley
Margaret McGuire – Executive Director of nursing NHS Greater Glasgow and Clyde*

*Provided senior input into development of report, but not involved in visits or discussions with staff.

Introduction

4. This paper considers the provision of maternity and paediatric services in the short and medium term at Dr Gray's Hospital, Elgin (DGH) and is prepared to the terms of reference provided by the Scottish Government . The Cabinet Secretary for Health and Wellbeing has instructed NHS Grampian to develop a plan as to how they will return an obstetric led service to DGH as soon as possible.

5. The Cabinet Secretary has agreed several priority actions for Dr Grays Hospital, Elgin (DGH) with NHS Grampian:
   I. Reinstating elective caesarean sections
   II. Increasing number booked for delivery at CMU to 35% of total bookings (currently 25%)
   III. Reducing unnecessary transfers to AMH by reviewing reasons for maternal transfer.
   IV. Increasing antenatal care delivered at DGH by reviewing what specialist antenatal/postnatal services currently provided in Aberdeen Maternity Hospital (AMH) can be delivered locally.
   V. Working with NHS Highland to increase capacity in Raigmore to allow more women from Moray to receive care there in addition to the emergency transfers which have already been agreed.
   VI. Working to improve historically poor experience of trainees in O&G/Paeds at DGH.

6. The current service provision has been predicated on the unavailability of paediatric cover and this is the primary reason for the temporary service change.

7. It should be acknowledged that the group had a limited timetable for completing the work and therefore were not able to follow up some suggestions to gain a deeper insight into particular options. In particular there was not sufficient time to discuss current experience and views on future plans with clinicians in the Aberdeen Royal Infirmary.

8. Before the priority actions are considered, below, the group would like to thank all the NHS Grampian and NHS Highland staff and service users with whom the advisory group engaged for their time and their honesty in discussing a wide range of aspects of the current situation; this was wholly appreciated by the advisory group. Our group listened to and considered all the views expressed and there were many similar themes emerged. These are outlined below.

Public relations and communication

9. We repeatedly heard from a variety of sources that communication with both staff and public has been poor and women remain confused and lacking confidence in NHS Grampian and the safety of the service provided, for example women were particularly concerned about the risk of delivering at the roadside on a dangerous road during a transfer to AMH. There was a sense that communication is improving but is still not sufficient. It was appreciated that this is a rapidly changing landscape, but immediate communication about any issues to expectant mothers and frontline staff need to be improved.

10. Communication with women could be improved by making sure that there are clear, regularly updated instructions about how to, and when to contact services, and where to go. All staff including community staff and GPs **must** be included and updated about changes in the plan so that consistent clear messages and information are being sent out to women. There are many ways to do this including Facebook, web pages, midwife phone calls and routine visits, text message and potentially through the electronic handheld notes. A variety of routes should be used to ensure all women are kept informed. The information must be accurate, reliable and consistent and accessible 7 days a week around the clock, e.g. through a communication hub.

11. An action time line is required immediately to share with staff and services users. It must be acknowledged that this will be subject to change, this would be a critical tool in engaging and communicating with the local community and would reduce anxiety at many levels. If there are specific issues, such as unsuccessful recruitment efforts, then explaining what can be done to overcome barriers would help engage the representatives of the public in supporting NHS Grampian, and would show progress is being made. Greater inclusion of members of the MSLC is required in working groups and discussions. Long periods of no communication and communication only in response to questions is creating a lack of trust. A proactive, inclusive and open strategy is required.

12. Fathers and families seem to be excluded in the temporary process with their needs appearing to be unrecognised, for example in relation to accommodation in Aberdeen. Concerns were raised by women and midwives that care is not individualised to women and families circumstances.

13. Aberdeen Maternity Hospital Clinicians were perceived by members of the MSLC to have an inflexible mind set and to have not been visible at public and staff meetings. The public remain concerned that there is not a commitment to reopening full services and that the temporary situation will become permanent.

Travel, safety, cost and choice

14. In the short and medium term there are very real and understandable concerns regarding these issues. The temporary change has fallen over the critical winter months creating additional anxiety across all stakeholder groups. Concern about travelling long distances to Aberdeen in bad weather is significant and this must be considered as part of the overall safety picture.

15. We understand that NHSG and NHSH have agreed that women labouring in DGH who require emergency transfer will be taken to Raigmore. However we were told of two occasions where this was declined at the time of transfer and the women diverted to AMH. The extended travel time in emergency cases places women and babies at increased risk.

16. Prior to the change women could opt for care at Raigmore from early in pregnancy, this option has now been discontinued in order to build capacity for emergency transfers during labour from DGH. Removing this choice is a contradiction to the ethos of the Best Start and Realistic Medicine in enabling

cross boundary working, choice of place of birth, keeping families together, and enabling and facilitating care as close to home and the local community as possible.

17. For many women in the north-west of the region, transferring their planned care to Raigmore would be beneficial in terms of travel, safety and cost. However it is acknowledged that NHS Highland has capacity issues. Enabling DGH midwives to provide continuity of carer and accompany women who are in their care to Raigmore should be explored using the Memorandum of Understanding between NHSH and NHSG and as an extension of the Best Start 'Early Adopter' scheme.

18. The cost of travel to Aberdeen we were told by both midwives and women was, for some, prohibitive. Staff, service users and DGH management provided differing accounts of the provision of support for transport. It is essential that this is clarified so that staff, including community midwives and GP's, and service users know what support is available and how to access this.

19. We were told by staff that two types of training in neonatal resuscitation are in place, this risks staff confusion and needs to be addressed urgently.

Staff morale, inclusion, training and communication.

20. We were impressed with the new management and leadership structure that is now in place in DGH. We think this is very positive and a good step forward, and were encouraged by the proactive attitude demonstrated and the good grasp of what was needed locally.

21. It is our perception, from our discussions with medical, midwifery and paediatric staff at DGH that morale is low. Staff also told us that communication has been poor and that the current crisis is not unexpected and that plans should have been in place at a much earlier juncture. Some staff feel patronised and told us that they felt that the issues they have raised were not being treated seriously.

22. Staff also told us that they want to see a firm clear plan with a timescales for the restoration of obstetric and paediatric services. They are concerned that they will become deskilled and worry about the security of their jobs under the current arrangements.

23. We got a strong sense that staff are willing to adapt and explore options, however they feel discouraged and disempowered. Midwives told us that they are keen to accompany women who are transferred to Raigmore and continue to look after them there. However they perceive existing red tape is making this difficult and they don't feel encouraged to do so due to uncertainty about their role, their contracts and differing NHS Board procedures.

24. We heard some innovative ideas about the future of paediatrics and maternity services at DGH from staff. The ideas proposed included changing models of care and training opportunities, increased use of telemedicine, and introduction of a Service Level Agreement to allow NHSG midwives to continue care into NHS Highland.

25. There is a perception by staff that NHS Grampian sees DGH as an ‘add-on’ to the main service in AMH with concerns raised about the level of commitment from NHSG management to restoration of the service at DGH. Staff were also of the view that the priority for staffing is focussed on AMH, and posts in DGH are a secondary and lesser concern for recruitment. There was also a perception that AMH would not be willing to share or rotate staffing because of impact on AMH capacity.

26. Paediatric staff feel that too much of the shift and focus was on restoring the maternity and obstetric service with little consideration given to paediatric staff or services in DGH

Feasibility and comments regarding the 6 priorities for service

1. Reinstating elective caesarean sections (ELCS)

27. Reinstating elective caesarean sections (ELCS) would provide a more accessible service for women and their families. Service users would appear to welcome this as would staff members across all specialities. However it is unclear whether women and their families fully understand the implications of providing this service.

28. Our opinion is that ELCS can be provided safely at DGH with the right infrastructure, risk management and emergency process in place and assuming all staff are appropriately skilled and maintain competencies. In our view this service could resume as soon as paediatric cover is in place, and our understanding is that this cover is in hand and will be in place in the immediate short term, although questions remain about the nursing capacity to reopen a SCBU or operate transitional care beds. Once Paediatric support is in place ELCS provision could be returned within weeks. This is based on the assumption that appropriate and competent anaesthetic, obstetric and midwifery staffing is in place to deliver services. The details of the planned onsite and on call paediatric cover for neonates should be clarified with clear agreed clinical guidelines and pathways for assessment, immediate life support, stabilisation and post resuscitation care.

29. There is a need for some local discussion between the specialties to ensure cover. For example, in replacement for the GP trainee the A&E junior doctor could provide medical cover (rarely required) out of hours with back up from the obstetrician at home. In the very rare event of an ELCS requiring a return to theatre, the obstetrician has surgical assistance via a local arrangement in place. We are therefore satisfied that with the competency and risk management caveats and appropriate escalation processes in place, a safe level of staffing could be provided consistent with current acceptable standards of care.

30. There are risks to placing an ELCS service in what purports to be a CMU. There is a risk that obstetricians feel compelled to act in emergency and urgent situations when women are in labour because they are on site, rather than

following the agreed model of transferring those emergency cases to Raigmore. This may then lead to unsafe situations and uncertainty. At present Obstetric staff remain on call for 'life and limb' emergencies as per the paediatric model in place and described by local staff. This creates a difficult model to describe to women, so that they can make an informed choice of place of birth. The model does not follow a generally recognised definition of CMU/ Freestanding Midwifery Unit, and is not consistent with NHSG's guidelines for midwife care. There is therefore a need, at the point at which the new model is introduced, that this is accompanied by clear guidelines for staff on when a woman should be transferred and when local obstetric provision should be used.

31. There is also a concern that women would choose ELCS to avoid travel to Aberdeen Maternity Hospital (AMH). All groups discussed this and felt that this may emerge. Maternal request for primary C/S is increasingly common throughout the country however clinicians should continue to provide full information of risks and benefits applicable to the women's individual situation in providing advice in relation to C/S. This would need to monitored.

32. From the figures provided, returning a ELCS service to DGH would see 50-80 additional babies per year born at DGH rather than AMH. The obstetric staff are keen to resume this service and they believe that to restart ELCS at DGH is safe. They fear losing skills if unable to operate regularly, reduced job satisfaction and potential problems with senior staff retention /recruitment. The midwifery opinion is that the risk is as outlined previously, difficulty in communicating informed choice and introducing a level of risk not normally found in a traditionally operating CMU.

33. The reinstatement of elective caesarean sections at DGH requires:

- Confirmation the paediatric cover is in place
- Agreement with staff in A&E that their resident doctor will provide medical cover for post C/S patients out of hours.
- Clear pathways for who is being referred for emergencies and when local obstetricians are to be called on.
- Clear protocols and guidelines on emergency transfer.

2. Increasing number booked for birth at CMU to 35% of total bookings (currently 25%).

34. The criteria for CMU intrapartum care are consistent across NHS Grampian and are similar to CMU guidelines throughout the country. We would caution and advise against any alteration to these. If alteration is unavoidable, this should be undertaken only after an assessment of risk and risk mitigation. NHSG are hoping to achieve a rate of 35% of women delivering in the CMU, however this is an ambitious and possibly unrealistic target based on rates in other CMU's across Scotland. It also must be acknowledged that there will be a high percentage of transfers for primigravids, (36 % - Birthplace Study 2014).

35. Setting such a target may have unintended consequences and may lead to 'overselling', or a lack of objectivity in place of birth discussions. A fine balance is

required when this type of target is in place, there may be perception from staff they have to achieve the target and managers may find they are focusing on the target not holistic care, maternal choice and safety.

36. Attention should also be given to ensuring options for home birth are in place, as indicated in The Best Start. The Birthplace study points to home birth as the optimum place for birth for low risk parous women.

37. Bookings should be audited regularly to ensure that all women who are eligible to receive intrapartum care at DGH have all of their options explained to them, bearing in mind that some women who are eligible for birth at DGH may choose to birth in Aberdeen and this choice must be respected.

38. The fact that DGH is in the unique situation of having a CMU service with obstetricians available during the day and on call overnight (for gynaecology and "life and limb" obstetric emergencies) should not allow entry (or exit/transfer) criteria for the CMU to be relaxed. It should be made clear to women who book for birth in the CMU that in most cases, if complication arise during labour, transfer to Raigmore will be arranged. Development of emergency antenatal complications will trigger referral to AMH.

39. Information about benefits and risks of all births setting should be clearly communicated to women at booking so they can make an informed choice about place of birth. This should include information on risk of transfer for both primigravidae and mutigravidae from CMU to AMH or Raigmore,

3. **Reducing unnecessary transfers to Aberdeen Maternity Hospital (AMH) by reviewing reasons for maternal transfer.**

40. Reasons for transfer and referral to and booking at AMH will need regular review and audit to ensure that women are not having to travel to Aberdeen unnecessarily.

41. Transfers should be reviewed by the multidisciplinary team in a non-judgemental and learning environment. This should become routine for all cases of CMU transfer. However it may undermine the clinicians if transfers are termed unnecessary in retrospect. The decision of the clinician at the time has to be respected the right environment needs to be created and an appropriate balance found to avoid a culture of fear of transferring and adverse outcomes.

42. This new service represents a big change for midwives in building safety and confidence in a new CMU service a high transfer rate would initially be expected, this is normal, until staff and women start to trust processes and their judgement.

43. The blurred lines of potential obstetric presence also need to be considered in terms of transfers or non transfers as has already been highlighted above.

4. Increasing antenatal care delivered at DGH by reviewing what specialist antenatal/postnatal services currently provided in Aberdeen Maternity Hospital (AMH) can be delivered locally.

44. Triage hours at DGH are currently 9am – 5pm weekdays only. Women are required to phone DGH for triage during these hours and phone AMH out of hours. This has caused confusion amongst some women and needs to be clarified with both staff and service users. Out of hours there is no medical cover at DGH, so if a pregnant women turns up at DGH out of hours and her care cannot be managed by a midwife, she must be transferred to AMH.

45. Telemedicine options were suggested by some clinicians however others thought that this would not be possible due to the availability of staff at AMH. It is important that DGH and AMH explore use of telehealth technology (e.g. attend anywhere) to reduce further the requirement to transfer to AMH for assessment.

46. Extending triage, day assessment and antenatal assessment clinics until 10pm was widely discussed across all groups, this would reduce the number of women going to AMH for triage especially in the early evening and be a good use of obstetric skills. There is a risk that if an emergency occurs, practitioners may be obliged to act as previously outlined, this risk exists in the current configuration. Extending the hours for triage would reduce unnecessary transfers to AMH, it would also provide women additional reassurance that if they do need to transfer it is safe and appropriate to do so.

47. Staff fed back that the higher numbers of women attending AMH for triage and assessment was creating additional pressure on staff at AMH who have, on occasion, felt required to admit women unnecessarily rather than discharging them in the early hours of the morning due to their long journey time.

48. There seems to be confusion on where pre-assessment for caesarean sections should take place. Some (all?) Women are being required to travel to AMH for assessment. Concerns were also expressed over these assessments in AMH due to long wait times, calls to be seen during the night and in some cases, and no pre-assessment being received prior to caesarean section due to capacity issues at AMH. These pre-assessments should be carried out at DGH working to NHS Grampian wide protocols and with easy communication between the professionals in AMH and DGH to avoid unnecessary travel.

49. In line with NICE guidelines women should be offered induction of labour between 41+0 and 42+0 weeks to avoid the risks of prolonged pregnancy. Concerns were raised by both women and community midwives regarding long inpatient waits for induction at AMH and frequent rescheduling of induction dates (one example was given of a women who was told to call back three days in a row then told that she should wait by the phone for AMH to phone her). Capacity issues were cited as the reason for this. It is important that when women who are traveling to AMH for induction, clinicians give consideration to the practicalities of distances travelled and communicate clearly with women of possible delays, where that can be anticipated to avoid premature travel. It would not however be safe at this time to return inductions to DGH.

50. Keep MUM and the Maternity Services Liaison Committee raised some concerns about early transfer home post-birth from AMH, quoting the 6 hour discharge as having a negative effect on breastfeeding rates. Whilst DGH has high rates of

breastfeeding due to longer postnatal stay with midwifery support, early discharge is now the norm throughout Scotland with the focus on community midwifery support for establishing breastfeeding, support services appear to be in place from community midwives to do so, and this service can continue to be enhanced. There is potential for community services to increase support given they are now called in less frequently to cover DGH

Paediatric Support

51. It was concerning to hear that a number of jaundiced babies are having to be referred back to Aberdeen. We would recommend that the numbers of these babies are being audited and if this is the result of early discharge then there needs to be a review of postnatal guidelines that includes paediatric review in DGH and provision of local phototherapy, NG feeding if required, and breast feeding support. We suggest this is developed as Transitional Care rather than SCBU so that any elective section mothers and babies can stay together with the additional nursing support of the trained midwives.

52. We suggest that there is a nominated link neonatal paediatrician from Abderdeen who has responsibility for the DGH neonatal service and supports their education needs, QI tests of change with review for safety and outcome audits.

53. To cover the needs of babies in a maternity unit there is a need for resources that are substantially well developed in DGH with appropriately trained midwives already in post and keen to maintain their skills e.g:

- An appropriate environment for safe birth
- 'Warm bundle' or equivalent,
- Staff trained in assessment at birth and effective intervention if indicated – Neonatal Resuscitation skills
- Baby Friendly postnatal care – support for establishing feeding and early attachment
- First steps for parenting skills
- Examination of the newborn
- Recognition of the sick infant
- Stabilisation of the sick infant for ongoing care on site or for transfer
- Assessment and guideline led management of common perinatal problems including moderate jaundice requiring phototherapy, hypoglycaemia
- Preparation for home – car seat, safe sleeping, GP registration
- Post discharge support

54. Taking the Best Start and Scottish Patient Safety Programmes as national initiatives some of these requirements could be adapted to help re-establish the maternity service at DGH that is suitable for the population of Moray. There is also a need for neonatal assessment and stabilisation competencies in all the current settings possibly including Primary Care and Ambulance staff while at risk transfers in labour may be delayed or prolonged.

5. Working with NHS Highland to increase capacity in Raigmore to allow more women from Moray to receive care there in addition to the emergency transfers which have already been agreed.

55. The group agree this is a significant area for exploration and although we were unable to schedule further meetings with NHS Highland, further feasibility work is needed in this area.

56. NHSG and NHSH have agreed, via a "memorandum of understanding" that women who experience complications in labour will be transferred from DGH to Raigmore for obstetric care. However on two occasions the transfers were not accepted by Raigmore (capacity/staffing issues being cited by NHS Highland) leaving the staff at DGH feeling vulnerable and requiring women in an emergency situation to transfer to AMH. Transfer in these emergency situations should be direct and automatic and not dependant on the situation at the time in Raigmore as it would be for transfers from any NHS Highland CMU. This needs to be clearly communicated across all levels of staffing at Raigmore.

57. Staff at Raigmore reported that their capacity had also been influenced by the change in service at Caithness and so the needs of both their north and east communities are needing to be accommodated.

58. Strong consideration **must** be given to directing higher risk women to Raigmore for planned antenatal and postnatal care, and to allowing women to choose to birth there. It is unacceptable that women from North West Grampian have to travel to AMH and are expressly 'forbidden' from attending Raigmore. Over 1/3 of the DGH catchment area (43,000) live in Elgin, Forres and Lossiemouth (EFL) less than 35 miles from Inverness. Previously some of these woman could elect to deliver at Raigmore. This option was removed from their choices (by NHS Highland) in order to facilitate the intake of emergencies from DGH. There are many areas across Scotland which achieves this cross border working, for example in Tayside women from North East Fife have care in Ninewells and women from Lanarkshire may travel to Glasgow.

59. Capacity issues at Raigmore need to be further investigated and the development of the alongside unit should not preclude higher risk women from neighbouring areas choosing to have their care there. Consideration should be given to seeking and considering data from NHSH on length of stay, occupancy rates and birth rates in Raigmore.

60. During this interim period until services are restored to DGH, staffing resources from DGH should be diverted to Raigmore to support women from the Moray area to opt for birth at Raigmore. The barriers that prevent NHS Grampian staff from working in NHS Highland (and vice versa) must be removed:

    Midwifery: DGH midwives work on the Raigmore Bank so it must be possible to redeploy underused staff in DGH to Raigmore. All Scottish midwives should be trained to the same standard and be able to work anywhere in the country across different Health Boards.

Medical Staff: Locums are quicker to appoint than substantive posts and could be advertised immediately. Joint NHSH/NHSG substantive consultant posts should be funded. These doctors could work in Inverness in the short/medium term with redeployment to DGH when the junior/resident doctor issues are resolved. There are many examples of consultant posts in Scotland that are funded jointly (e.g. recent Fife/Lothian consultant gynae-oncologist)

Capacity: Precedents are set in all Scottish hospitals , Winter bed crises happen every year. Acute surgical wards are taken over for medical emergencies. Obstetric beds could be increased at the expense of another "cold" speciality. Obstetrics is a core service and MUST take priority. The acceleration of the opening of the AMU at Raigmore also has the capacity to free up more space within the obstetric unit and needs to be accelerated. It is essential that safe local care for mothers and babies is prioritised even at the risk of an impact on elective non urgent surgery waiting times/ targets

61. Previously approx. 1000 women per year delivered at the obstetric unit in DGH. We estimate based on current uptake that this will drop to about 250 deliveries per year in the CMU (although NHSG are hoping that the figure will be higher). The remainder (about 750 women per year) will have to travel to AMH under the current arrangements

62. Our estimates are that if women from the Elgin, Forres and Lossiemouth (EFL) area were able to book to deliver at Raigmore this, combined with resuming ELCS would reduce this number to nearer 400.

CMU deliveries at DGH (based on current 25%)	250women/year
Restarting ELCS at DGH	70women/year
Elgin, Forres and Lossiemouth 'high risk' to Raigmore	250women/year
Total "Local" Deliveries	570women/year

This leaves about 400-450 women who will still need to travel to Aberdeen Maternity Hospital.

63. There is some anxiety within DGH and Moray that this move would jeopardise the reopening of Dr Gray's as an obstetric led unit. KeepMUM and the MSLC welcome the return of the option to deliver at Raigmore in the short /medium term but are concerned that this option may quietly become long term and that plans for the return of full obstetric services at DGH will be shelved. It therefore must be communicated clearly to service users and staff that it is a **temporary** short to medium solution and that the only acceptable long term solution is the return of obstetric services at DGH.

64. Urgent discussions are needed at Board level with strong support from Scottish Government to ensure that discussions between NHS Grampian and NHS Highland are progressed to reduce barriers in this area as a matter of urgency. Agreements must also be communicated clearly with staff in Raigmore and DGH.

6. Working to improve historically poor experience of trainees in O&G/Paeds at DGH.

65. We have not spoken with the Post Graduate Dean but trainee recruitment will continue to be a recurring problem every few months unless changes are made, making it difficult to run a sustainable service. The Post Graduate Dean has responsibility for training not service. Trainees should be supernumerary and can't be relied upon for service work. Therefore the service needs to consider other options for staffing a safe obstetric service without the inclusion of trainees.

66. With regards to paediatrics, there is evidence that ANNPs can provide safe alternative model of service to junior doctors. ANNPs are in short supply but they might be attracted to posts in Elgin and are likely to cost less than medical locums. Similarly APNPs should also be considered for the paediatric ward. Both ANNP's and APNPs can be trained in non-medical prescribing. Physician Assistants have a variable set of skills and specialties and should also be considered.

Recommendations

Following all our discussions and observations we have developed the following recommendations:

Communication:

- NHS Grampian urgently need to produce a comprehensive strategy with a clear timeline for the restoration to obstetric services. Service users including fathers and families should be involved in discussions from an early stage. This should be shared with staff and the public.

- NHS Grampian should provide clear information to women on who to contact, where they should go for triage and other essential information. This should be provided though a number of different channels and communicated to frontline staff. Daily bulletin updates could be created and widely publicised.

- All women should be given an informed choice about their options of place of birth. Women should be offered, homebirth, DGH, AMH and Raigmore as real options and their personal risk factors as well as the general risks and benefits of each type of units including, for example, information about rates of transfer (for both primigravidae and mutigravidae) from the CMU to Aberdeen and Raigmore should be clearly communicated to women at booking so they can make an informed choice about place of birth. The current leaflet is not up to date and needs urgent revision.

- NHS Grampian should provide clarity around cost of travel, accommodation and easy access to support for women travelling to AMH.

- Relations between NHS Grampian management and staff at DGH need to improve as the staff at DGH percieve a “them and us” situation. They need reassurance that they are valued and their opinions and concerns meaningfully considered. This attitude is embedded over many years and will take time, effort and a willingness to improve on both sides.

DGH Services short/medium term:

- DGH should restart elective caesarean sections only once appropriate paediatric cover is in place. A full risk assessment of this must be undertaken. We would expect this could be in place by the end of the year. Monitoring for increase in ELCS is needed once an ELCS service returns. Obstetric referral and interventions should be monitored closely if ELCS services recommences.

- DGH must maintain strict adherence to CMU entry criteria guidelines and not relax these as a result of obstetric presence until such a time as this can be relied upon for full service. However we recognise that once a women is in labour in the CMU, due to the presence of obstetricians, extreme emergency situations may be dealt with differently than in a normal CMU and we recommend that there is complete clarity for staff on professional responsibilities in these situations.

- DGH should review each transfer/referral to ensure women who wish to book for DGH are not being sent to Aberdeen unnecessarily. AMH and Raigmore should provide feedback on the cases to DGH staff in a constructive manner.

- DGH should, with caution, expand triage and day assessment hours – this would not be a CMU model though and clarity is required round roles in emergencies including ventouse practitioners.

- DGH should not consider introducing induction of labour as next step up until a round the clock obstetric service is restored.

- NHS Grampian should not implement targets for birth and bookings at DGH, this is a risky strategy and we need to learn from the findings of the Morecambe Bay report.

- NHS Grampian should audit postnatal readmissions of mothers and babies and consideration given to whether postnatal readmissions can be managed at DGH as part of a transitional care service.

- NHS Grampian must ensure all current staff have the same updated training in basic neonatal resuscitation and recognising the sick infant – Scottish Maternity/NES courses offer NLS with additional advanced skills training in line with national guidelines.

NHS Grampian/ Highland relationship:

- NHS Grampian should confirm with NHS Highland that Raigmore will take emergency transfer cases as if they were Highland women and that these can be referred straight to Raigmore without the need for negotiation. This should be communicated clearly to all staff on the Labour wards at both DGH and Raigmore.

- NHS Grampian and NHS Highland should work together to develop and implement shared clinical guidelines for Grampian, and Highland services and for both hospital and community teams will help avoid confusion and disagreement as mothers and babies are transferred between units.

- NHS Grampian and NHS Highland must work together to allow women from west of NHS Grampian area to choose to deliver there. This includes increasing capacity at Raigmore and must ensure staff can work across health board boundaries and continuity of care after discharge. These discussions may need Scottish Government facilitation and funding may also be required to facilitate this.

- Consideration should be given to seeking and considering data from NHS Highland on length of stay, occupancy rates and birth rates in Raigmore.

Long term planning for restoration of Obstetric services:

- NHS Grampian must look to engage and empower DGH staff in looking to sustainable models for the future by drawing on a variety of innovative solutions suggested by staff.

- In the longer term, the main challenge will be finding junior staff for service. The Post Graduate Deanery can't be relied upon to provide GP trainees on a regular basis. Advanced nurse/midwifery practitioners will help. The employment of salaried medical officers for general service could be considered.

- NHS Grampian should identify which staff require additional skills in Advanced Neonatal Resuscitation – NALS and update if required

- NHS Grampian should consider identifying a nominated link neonatal paediatrician from Aberdeen who has responsibility for the DGH neonatal service and supports their QI tests of change with review for safety and outcome audits.

Annex 1

CMO Advisory group – Terms of Reference

Provision of advice for maternity service at Dr Gray's Hospital Elgin and improving links with Aberdeen maternity hospital and Raigmore hospital Inverness

Membership:
Dr Rennie Urquhart – retired Obstetrician, NHS Fife
Justine Craig – Chief midwife, NHS Tayside
Una McFadyen – retired Paediatrician, NHS Forth Valley
Margaret McGuire – Executive Director of nursing NHS Greater Glasgow and Clyde

Background:
The Cabinet Secretary has agreed several priority actions for Dr Grays Hospital, Elgin (DGH) with NHS Grampian:

1. Reinstating elective caesarean sections
2. Increasing number booked for birth at CMU to 35% of total bookings (currently 25%)
3. Reducing unnecessary transfers to AMH by reviewing reasons for maternal transfer.
4. Increasing antenatal care delivered at DGH by reviewing what specialist antenatal/postnatal services currently provided in Aberdeen Maternity Hospital (AMH) can be delivered locally.
5. Working with NHS Highland to increase capacity in Raigmore to allow more women from Moray to receive care there in addition to the emergency transfers which have already been agreed.
6. Working to improve historically poor experience of trainees in O&G/Paeds at DGH.

The Ask:
This is a light touch intervention by experienced clinicians working outside NHS Grampian and NHS Highland. The group will sense check the measures proposed by NHS Grampian to maximise the maternity care which can be provided in DGH following the change in service to a Community Midwifery Unit (CMU) in August 2018.

As part of their investigations, the team should work with NHS Grampian management and local clinicians- doctors, midwives, nurses. The group should also engage with the maternity services liaison group and the KeepMUM campaign group.

<u>The CMO would expect this to include:</u>
1. Exploration of the points set out above and agreed with the Cabinet Secretary. This will include the feasibility and likely success of these additional measures and any advice which can be given to ensure success and/or improve upon the plans. Your experience with successful CMU in other HBs will be invaluable here.

2. Further recommendations to improve the care provided locally for women in DGH in the CMU setting including obstetric emergency triage, antenatal and postnatal care.
3. Review of clinical pathways for the CMU, for transfer (both emergency and elective), and for antenatal care, and comparison with national/professional body standards and experience in other parts of Scotland.
4. Engagement with local clinical staff to allow inclusion of local solutions and to break down barriers to different ways of working and to build on communication with NHSG staff in Aberdeen.
4. Engagement with and feedback to NHSG management
5. Exploration of NHS Highland capacity and referral pathways to increase number of women able to travel to Raigmore for antenatal care or birth if this is a shorter journey for them.
6. A short report covering the above points to be send to CMO by mid-October.

This publication is available at **www.gov.scot**

Any enquiries regarding this publication should be sent to us at
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St Andrew's House
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EH1 3DG

ISBN: 978-1-78781-383-0 (web only)

Published by The Scottish Government, November 2018

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS499926 (11/18)