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We just can't let these things happen

Report from the Women and Health – Maternity Service Provision Policy Group

Women Shaping Policy
2005

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Summary

- Poverty and other forms of social deprivation have a huge impact on how and whether women access maternity services.
- Poverty and other forms of social deprivation affect women differently from men.
- There is a lack of understanding about the barriers that prevent women from accessing maternity and other health services.
- Social and economic disadvantage should be an underpinning feature in the design and delivery of maternity and other health services.
- Services need to be designed to meet the needs of women from all groups in society, particularly the socially excluded.
- Issues to do with social disadvantage crosscut rural issues and there is scant evidence of interventions that address the complexities of women's lives in rural areas.
- Models of care in rural areas should reflect the realities of women's lives. They should take full account of the social, economic, transport and community infrastructure in an area.
- There needs to be more emphasis on multi-agency working and a more joined up approach to providing health services.
- There are models of using a joined up approach work with the most vulnerable women. These should be replicated across Scotland.
- Women should be represented on decision-making boards to ensure women's voices are heard and their concerns taken into account as new services are developed.

Introduction

The Scottish Women's Convention (SWC) is an independent body funded by the Scottish Executive until 2007. It aims to provide a systematic way for women and organisations working with women to come together to discuss specific issues that are of interest or concern to them. The SWC provides a strategic input into policy development by taking the views of women on issues such as health to the policy makers and others.

Since its first meetings in December 2003, the SWC has formed policy groups on women and health, women and poverty, women and the criminal justice system and violence against women. These policy groups allow women's voices and concerns to be heard, discussed, debated and then channelled into the government consultation process.

The Women and Health Policy Group was set up by the SWC as there was considerable interest and concern about rural maternity services. There was intense media pressure at the time surrounding the increasing centralisation of maternity services such as the threat to consultant-led maternity services in Caithness and Sutherland and the proposal to close the Queen Mother's Maternity Hospital in Glasgow. There was great frustration at the seeming lack of consultation with and consideration for women and their families. Consequently, the group decided to focus its attention on rural issues and maternity service provision; to explore the issues in more depth; and bring forward recommendations for future action. After discussion, the resulting Maternity Service Provision Policy Group (MSPPG) agreed to extend its focus to include socio-economic development issues and maternity services.

This report describes the work of the MSPPG. It sets this within the women and health agenda and highlights examples of the kinds of activities group members have been involved in to improve women's lives. While these are important initiatives in their own right, they are a good exposition of the main issues and information which the MSPPG considered when discussing reproductive health, poverty and exclusion. The report goes on to review the policy context and concludes by giving the group's main findings and recommendations. The report does not attempt to explore issues in depth but to highlight concerns for future action.

The SWC plans to use this report to highlight key issues, to generate further debate and to raise the key themes which have emerged with the Scottish Executive and the Scottish Parliament.

Maternity Service Provision Policy Group

Membership

The first meeting of the maternity service provision policy group took place in June 2004. The group met until June 2005 as a study group. Its membership was diverse, representing a wide range of interests. A core group of ten attended its monthly meetings. Others were kept up to date and informed through regular briefings and bulletins. Debbie King from the Scottish Women's Convention helped develop and service the group.

Core group

Molly Baikie	Member	North Action Group Caithness
Dr Elizabeth Boyd	Member	Glasgow Association of Women Graduates
Jo Harknett	Member/Volunteer	Birth Resource Centre, Edinburgh
Dr Mary Hepburn	Consultant Obstetric and Gynaecologist	Princess Royal Maternity Hospital, Glasgow
Anne Kelly	Development Worker	Greater Easterhouse Women's Aid
May MacGugan	Patient Partnership Forum	Argyll and Clyde
Joyce MacRae	Co-Chair of the policy group. Member	Scottish Women's Rural Institutes, Scottish Women's Convention Steering Group
Aelex Miller	Vice Chairman	North Action Group, Caithness
Margaret Tait	Co-Chair of the policy group. Member	British Federation of Women's Graduates Scottish Women's Convention Steering Group
Dr Dorothy Ward	Member	Medical Women's Federation/Medical Women's International Association

Other participants

Fiona Armstrong	Coordinator	Birth Resource Centre, Edinburgh
Chris Bush	Resource Worker	South Lanarkshire Domestic Abuse Partnership
Annette Ferguson	Midwife, Islay	
Evelyn Forrest	Acting Maternity Services Manager	Wishaw General Hospital
Sabera Islam	Member	Amina – The Muslim Women's Resource Centre
Huda Alarashi	Member	Amina – the Muslim Women's Resource Centre
Sadie Kelly	National Secretary	Union of Catholic Mothers, Scotland
Janet Law	National Policy Officer	Out of School Network, Glasgow
Mary McElligot Marilyn McGill		Glasgow Women's Aid
Maureen MacMillan	MSP, Highland	
Katrina Purcell		
Sandie Stevens		The Toybox Children's Centre
Jay Stewart		
Maria Wilson	Principal Midwife	Simpson Centre for Reproductive Health
Dr Janet Warren	Member	Glasgow Association of Women Graduates

Agreeing the focus

An early task for the group was to read relevant documents to set the policy context for its work. Key concerns noted in minutes of the first meeting were:

- *Rural issues, including the Highlands and especially islands*
- *Minority ethnic women*
- *Women with disabilities*
- *Central/urban areas*
- *Caithness where consultancy services were temporarily withdrawn and threatened in the longer term*
- *Hospital closures*
- *Lack of choice for women*
- *Safety concerns*

"We discussed how we could reach as many women as possible to gather their ideas, concerns and the issues which are important for them."

The group decided that the spread of issues, often overlapping, meant that more would be achieved overall if it were to focus on services/barriers to:

1. Women experiencing social and/or economic deprivation
2. Women in rural areas
3. Asylum seekers

Finite resources meant that the first two topics came to be the prime focus of the year's activities but it was agreed that any reports produced should indicate that future work could concentrate on the needs of minority ethnic women and particularly refugees and asylum seekers. As discussions developed it was clear to all that the barriers women face through social and economic deprivation or rurality are not mutually exclusive but that socio-economic issues cross cut the agenda.

Taking action

Our main tasks over the year included:

Database: staff contacted a wide range of individuals and organisations informing them about the work and asking them to contribute.

Mapping exercise: staff undertook a mapping exercise of the organisations involved in maternity services preliminary to further consultation.

Study: the group read and discussed various policy and research documents.

Sub groups: the group formed two sub-groups to consider rural and socio-economic deprivation issues and barriers to services.

Information gathering: the group gathered information and disseminated this widely through its networks.

Consultation: those attending meetings represented a range of women and networks. This was particularly important as there was no budget to run focus groups across Scotland.

Lobbying: the group wrote to Malcolm Chisholm, MSP, then Health Minister to ask what progress had been made in implementing the changes recommended in previous policy documents. The group also met with the Scottish Executive Women and Children's Unit to discuss concerns.

National Maternity Services Workforce Planning Group: the group was represented at a meeting of the National Planning Group.

Workshop: the group led a very successful workshop at an International Women's Day Event in Edinburgh in March 2005. Feedback was gathered from a wide range of women and the group was reassured that it was concentrating on the relevant issues facing women in Scotland.

Comments from members

Those taking part in the group found the experience both helpful and challenging. They made the following comments:

"It struck me that we were talking about issues of life and death."

"I feel very much better informed about the problems faced by pregnant women and those looking after them, both family and staff, in rural areas and also about the considerable problems of providing adequate ante-natal care to women on drugs. I feel I now have a better understanding of these problems which I will convey to the members of my organisation."

"I felt very well received here and felt able to discuss issues."

"I was appalled at my ignorance. If we needed to learn these things, then what about others?"

"It's been a pleasure getting to know people and hear what they do and what the other problems are."

Women and Health

This section briefly illustrates the fact that women have special health needs. When looking at issues to do with health and social and economic exclusion women tend to experience disadvantage differently to men. This disadvantage is often aggravated by the additional and different responsibilities they carry.

While it is widely recognised that women have special health needs because of their reproductive functions, it is becoming clearer that there are other variations between men and women that affect their health, the illnesses they suffer, longevity and so on. These differences are not simply biological. There are gender differences to do with the way men and women lead their lives. Domestic responsibilities, usually associated with female gender can have a negative impact on both physical and mental health. This is especially true for women raising families in poverty (1). Gender violence is a major health hazard for women worldwide (2).

The Westminster government has created a Public Sector Duty to promote Gender Equality which requires the NHS in England to ensure that services are made more accessible to women and men and that their respective healthcare needs are distinguished by gender. The Public Sector Duty will also applies in Scotland.

In Scotland, there has recently been substantial interest in gender differences in health. For example Glasgow University has an extensive research programme exploring the gendered dimensions of the experience of a range of illnesses, links between gender, work-life balance and health, and the relationship between gendered constructions of identity and health (see www.msoc-mrc.gla.ac.uk/CurrentResearch/Gender/gender.html).

The NHS in Glasgow has led the way in promoting understanding about how inequality in society affects women's health. The Glasgow Women's Health Policy (3), aims to ensure that important issues identified by women – emotional and mental health, health effects of poverty, safety in the home, community and workplace, sex differences in the presentation of various diseases – are given priority. A women's unit within the board has responsibility for progressing the policy which is part of an ongoing programme of women's health activity in the city.

Considerable work has been done to tackle domestic abuse in health settings in Glasgow and elsewhere in Scotland. The Scottish Executive guidance for health care staff in NHS Scotland (4) has encouraged particular focus on domestic abuse, including the role of midwifery and other maternity staff, given that pregnancy and recent childbirth is a common trigger for domestic abuse. Currently a Scottish Executive expert group is considering the introduction of routine questioning by midwives to encourage disclosure of domestic abuse.

Despite these initiatives, there are few other examples of a strategic attempt to address women's health issues from a gender perspective. While tackling inequalities in health is central to the Scottish Executive's strategic policy direction because of the likely health improvement gains, gender perspectives on inequalities have so far been lacking. Yet, research in the UK and in Scotland shows that women are at greater risk of poverty than men and are likely to remain in poverty for a longer period of time. A comprehensive literature review undertaken for the Scottish Executive Equal Opportunities Committee by the Centre for Research on Families and Relationships (5) examined research into gender inequality across a range of issues. The report highlighted gender differences in how women experience poverty and exclusion as well as rural poverty and disadvantage. Whilst the report did not explore health inequalities directly it did consider violence and abuse, prostitution, homelessness and access to services.

NHS Scotland has commissioned a report into gender and health. This report is due to be published in 2005. The Scottish Women's Convention hopes that this report will provide the necessary leverage to bring a gender perspective into the provision of health services.

The next section focuses on a couple of exemplars of ways of tackling these important issues.

Taking Action on Social and Economic Deprivation

Women's Reproductive Health Service

*"You don't treat us like sh*** here."*

The Women's Reproductive Health Service (WRHS) is a citywide multi-disciplinary service based at the Princess Royal Maternity Hospital in Glasgow. Providing reproductive health care for women with social problems, the clinic has been running for 15 years providing total maternity care for vulnerable women and babies in the community for up to 12 weeks postnatally as well general reproductive health care for non-pregnant women.

From its base in the centre of Glasgow, the service runs five outreach clinics in health centres in Easterhouse, Pollock, Drumchapel, Possilpark and Rutherglen, all areas of deprivation falling within Glasgow's social inclusion partnerships. The clinics are targeted at pregnant women with social problems that could affect the health of the woman and/or her baby, or compromise parenting e.g. drug dependency, child protection concerns. Midwives provide core services at clinics but they work as a team alongside staff from other disciplines including addiction services, social workers and Women's Aid.

Mary Hepburn, consultant obstetrician, who set up the initiative and Anne Kelly, Support and Development Worker at Greater Easterhouse Women's Aid, give their perspectives. They are tackling at first hand some of the issues identified in the Why Mothers Die Report (1) which found that many women who died maternally, particularly the vulnerable and socially excluded, had found it difficult to access or maintain access with services.

Mary Hepburn, consultant obstetrician, WRHS says:

"Poverty makes the biggest difference to maternal health and access to care. There is a major problem with the way maternity services are provided. The sickest mothers with the sickest babies have the greatest need for healthcare but they don't get it. That's because services are designed more for middle class women. There is still a view within the profession that poor people are responsible for their own misfortunes. But if you provide the services flexibly, in ways that take account of what is going on in the lives of women, for example with addiction problems, they do turn up. They may be half an hour late but they do come.

For women living in poverty or with disadvantage there are huge issues. Far more of them die, and far more of their babies die. There is a much higher risk of babies being born immature and with low birth weight. These babies grow into sick adults with less good reproductive health. So the knock on effects are felt through the generations and are a huge drain on health services, never mind the human cost to women and their families.

The WRHS provides care for women with severe social problems. These include women with drug or alcohol problems, psychiatric illness, learning disability, a history of themselves or their children having been in care; also women with a history of having experienced abuse, homelessness, financial difficulties, young age or failure to attend standard services. Sometimes it is the partner or another member of the family who has the problem. Drug use affects more than half the women who come.

An evaluation of the service showed that women come to our clinics because our staff do not judge them. They rated understanding staff more highly than the quality of medical care. Most of the women we see want you to understand what they are going through. They already think they are inadequate and worthless and have low self-esteem and they don't want to go anywhere that they think will make them feel worse.

We try to remove some of the other barriers that women face. Traditionally access to maternity and other services is through the GP. But if you don't have a GP because you are mobile, a drug user, homeless, disruptive or for some other reason you may never get into the maternity system. Even if you get an appointment, you might not make it. It's not that the appointment is not important. It's that there are other pressures, whether it's picking up a methadone prescription, not having the bus fare, or some other reason. The answer is to bring all the services to the one place so that women don't need to go to different places for healthcare. Anyone can refer a woman to WRHS including the woman herself.

The work we are doing is vitally important. Glasgow has levels of poverty, which are second to none, and the effects are immense. Women coming to our clinics get a good experience and the chance to be with professionals who understand the issues. We don't collude and we don't avoid the problems. We look to see what can be done. We offer respect and good quality care based on need – medically and socially – and women are more likely to find pregnancy rewarding. Ultimately, some women won't be able to take their babies home, but by coming here they increase their chances of keeping their child and also of being effective parents.

Our figures speak for themselves. At first we had a handful of referrals and now we are up to more than 400 a year. However, the future remains uncertain and

while the WRHS receives mainstream funding, there is constant scrutiny with the push to have maternity care for many groups of women and reproductive healthcare for most non-pregnant women provided by mainstream services. This disrupts continuity in reproductive healthcare while making the specialist service itself more comparable to mainstream services. But given that poverty affects health, women coming though this clinic have potentially high-risk pregnancies and should not only be dealt with in the same way as other 'high-risk' maternity cases but should receive continuity of reproductive healthcare.

There's no doubt that poverty affects health. A significant proportion of the women I looked after in the 80s have since died."

Anne Kelly, development worker, Greater Easterhouse Women's Aid says:

"Our involvement began in August 2004 when it was acknowledged that a high percentage of women needing intensive support after giving birth were experiencing domestic abuse. We took part in the WRHS satellite clinic at Easterhouse Health Centre along with staff from social work and addiction services. We go along to the clinic every Monday and are on hand for any women who want to speak to us. Women are all asked by the midwife about their experiences at home so domestic violence is routinely picked up.

For lots of women, addiction, severe anxiety and depression are a direct result of domestic violence or child sexual abuse. This clinic gives them a route into discussing the issues and means we can offer a high level of contact and one-to-one support throughout their pregnancy and afterwards.

One woman I saw was referred to the clinic because of her excessive use of diazepam and extreme behaviour. But when she got the chance to sit down and talk about what was going on she told me about how she had been abused as a child. She came onto the ward for detox and she also went through counselling. Chances are that anywhere else, she would just have been seen as someone who was violent and with a serious drug problem. No one had got to the core of it before.

What we are doing is making sure that women who face extreme difficulties get a chance to get the correct services. For many women it may make the difference as to whether they can ultimately keep their baby. If we are involved early enough, we can work with her throughout her pregnancy and get the support she needs in place. If she's had the chance to work on what is happening at 12-14 weeks, by the time of the pre-birth case conference at 32 weeks, the chances are the baby will go home with her with a package of support. It's a great example of multi-agency working and a way of providing almost instant access to all services as well as first hand early intervention.

Women like coming to these clinics because they know that we won't stigmatise them. We are not identified as a different sort of clinic, women feel safe and comfortable about coming along. The service is close to where they stay and it's flexible so if they can't get along for a set appointment time they can still see us. Often vulnerable women, for example women who are homeless or drug users see themselves as invisible in the system. They have low self-esteem. But if you are going to run a service then you need to meet the needs of all women."

"You have much more time because all your supports are together in the one place and less worry about being on time for appointments."

"It helped me keep my baby, because had I not attended she would be in care."

"I had more time to talk about my problems other than having a baby, someone listened to me."

These comments came from a 21-year-old woman whose four-year-old daughter is presently in care. For the first five months of her pregnancy she had no antenatal care, placing her new born baby at risk of being placed in the care of the social work department like her older sister.

However, after many meetings the reality of the situation became evident to the woman and she kept her first appointment at the clinic. As a direct result of this, observations could be recorded and forwarded to her involved Social Worker. Things were turning around, her use of benzodiazepines ceased (this was evidenced by urine testing within the clinic), her reactive behaviour towards workers changed and her self-esteem improved.

She gave birth to a healthy baby girl weighing 8lb 3oz. A post-birth meeting took place within the maternity unit, actively including all involved agencies. As the woman's lifestyle had changed, the baby could go home with her mum with an intensive package of support.

Her social worker visits daily, she meets with addiction services weekly, and weekly support sessions are provided by Women's Aid to address past issues.

Six weeks on, things are still going well and this family unit has remained together. Her goal at the moment is to have her older daughter home. This is now achievable as contact has been increased and unsupervised one-day-a-week contact now takes place.

This is a clear example of the benefits which a multi-agency approach brings to vulnerable women, who might otherwise slip through the net.

North Action Group

"Many local women are saying that should the unit be downgraded, they will take the decision not to have any more children as having a baby in a midwife-led unit, with no consultant experience close by is too risky. This is very sad for the area as a whole and will have a negative economic effect."

"...expectant mothers were removed from their families five days prior to their expected delivery date, families experienced financial hardship to the extent that two fathers that I know of ended up sleeping in their cars in the middle of this; two mothers gave birth so quickly that there was no time to transfer them to Inverness..."

The North Action Group (NAG) formed in March 2004 to campaign to maintain full maternity services in Caithness and Sutherland in the face of the NHS Highland proposal, based on a report by Professor Calder,[1] to downgrade the consultant-led unit in the 116-bed Caithness General Hospital to a midwife-led unit. This proposal would mean that all first-time mothers and those not expecting straightforward deliveries would need to travel the 105 miles to Raigmore Hospital in Inverness to deliver their babies.

Several members of NAG have been active in the SWC maternity services provision group. **Molly Baikie** describes why she got involved in NAG and what it has achieved.

"I got involved as a concerned member of the Caithness community. I also worked as a manager in the hospital before retirement."

"When the unit opened in 1986 it was one of the best-run units in Scotland, a centre of excellence with fully functioning staffing. Twenty years ago, women here gave birth in far better circumstances."

"High risk mums have always had to go to Inverness. However, what NHS Highland proposed in 2004 was centralising services to such an extent that they would be completely undermined. Driven by alleged staffing instability, the response seemed to be to cut services entirely rather than find workable solutions which had the interests of women, their babies and the community at heart. Recently, there were two emergencies here and if there had been no consultant and the women had had to go to Inverness either they or the babies would have died. The board says it is about safety and not money. We dispute that. We were fed up that women's voices were not being listened to and that a perfectly good service was under threat."

Molly adds that there are many reasons against closing the consultant-led unit, *"It's 105 miles from Wick to Inverness and the road gets blocked every winter with snow. If there's a car accident, it also gets blocked. And when that happens, there's no alternative as there is only one main road out of Caithness. In addition, depending on when it is blocked, it could entail a detour of several miles to rejoin it. There's also a shortage of ambulances and there is no guarantee of an air alternative."*

"It's not just expectant mothers who have to travel but also health staff, partners and their families. There was a well-publicised case recently where a midwife had to drive all the way to Inverness in her own car following the ambulance because otherwise she would have had no transport home to Wick again. Partners tell us that it is difficult for them to make the journey especially if there are other children in the family. Plus it's expensive, not just in travel but finding somewhere to stay and there's not much accommodation in the hospital and what little there is, is poor."

"We know that there's a higher risk of postnatal depression in women who have to go to Raigmore in Inverness. Having a baby away from home, worrying about how your other children are doing, not having family and friends to visit is a bleak prospect for prospective mothers. And it's far better for other children in the family to be able to see their mums and the new baby and get settled down quickly again. It's just not a good situation for the mother, the baby or her family."

"We also faced the prospect of losing much more if our consultants were to go. No maternity consultants would mean no gynaecological services, and this would have reduced the number of anaesthetists required. Less anaesthetists would have had a knock-on effect on the surgical unit, the nursing staff and the on call staff. So, what we were facing would have been a catastrophe both for Caithness General and the local community."

NAG mounted a high profile campaign starting with a massive public rally on Mothers' Day 2004. Molly says, *"Over 2,000 people turned up to the rally in Caithness – a huge number for the area (this would be equivalent to 120,000 taking to the streets of Edinburgh) – and this really showed the strength of feeling. We also had the full support of our MP and all MSPs. Local businesses also threw their weight behind the campaign and helped us raise funds for banners and other publicity."*

1 Maternity Services in Caithness and Sutherland, an independent review conducted on behalf of Highland Acute Hospitals Trust, March 2004

In June 2004 NAG took its protest to Edinburgh and met with MSPs. Subsequent activity led to a series of parliamentary questions on the proposals, and in September 2004 many MSPs signed a parliamentary motion calling on a moratorium on the centralisation of NHS services in Scotland until a national strategy was formed.

In September 2004 NHS Highland convened a series of public meetings to discuss the future of maternity services in Caithness. To coincide with this, NAG organised a postcard campaign to feed in the views of the public to the consultation process. Almost 5000 postcards were received. Molly says, *"There was absolutely no support for the board at these meetings but we got the impression that they weren't really listening but were determined to press ahead."*

In February 2005, NHS Highland set up a Caithness and Sutherland Maternity Action Team to look at a way forward for maternity services at Caithness General Hospital. The first meeting set up several sub groups to which NAG provided representatives. Molly comments, *"The groups to date have made very little progress because the chair had one objective only – to close the consultant-led unit. He did not appear interested in finding other solutions. However, the chair has now changed. We anticipate that the action team will report in the autumn."*

NAG continues to campaign for local services to be preserved. Molly is hopeful that the status quo will prevail and that the consultant-led unit will be maintained. She says, *"The board has come out of this whole thing very badly. It tried to walk over people and not listen to us. They have spent all this money on consultants and I think they will end up with the status quo – they can't afford to make any more mistakes. There are recruitment and retention issues here and the NHS has to look at how to make this area more attractive so that staff will want to come and work here. We could continue functioning with three consultants. But if we had four, that would be ideal as then there could be more outreach work with clinics in Golspie for example. We have recently heard that all three locum consultants in the maternity department have contracts until the end of September."*

"If we had not set up NAG the unit would have been shut down."

The Policy Context

The previous sections have illustrated the issues. This section gives the policy context and shows that the issues addressed by the Scottish Women's Convention are consistent with the policy framework.

Improving access to services and healthcare for women who are socially excluded and disadvantaged and for rural women is consistent with the national policy framework. Over the past few years, there has been a major focus on how health services should be provided to reflect the Scottish Executive's social justice agenda. Within maternity services, this sits alongside a major modernisation programme undertaken by NHS boards in response to factors including the falling birth rate and the EU limits on doctors' hours.

Our National Health

In *Our National Health, A plan for action, a plan for change* (6), the Scottish Executive sets out the direction and priorities for investment and reform in NHS Scotland and states 'core aims' to improve the health of people in Scotland to tackle the inequalities in health between the rich and poor. This is consistent with the Scottish Executive's broader policy of tackling social inclusion and bringing about social justice (see also *Closing the Opportunity Gap* (7) in which the Executive described its anti-poverty programme and *Building a Better Scotland* (8), the 2004 spending review which aimed to reduce health inequalities by increasing rate of improvement across a range of indicators including teenage pregnancy).

Our National Health states that (inter alia) *'we need an NHS which:*

- *Is focused on health improvement and the particular health needs of local communities and excluded groups*
- *Works in partnership with other organisations to achieve joint objectives*
- *Listens and responds to individuals and communities*
- *Is patient-centred, with different parts of the community connecting up properly'*

Key action points for maternity provision are to prepare for healthy pregnancies, support parents and encourage health in early life. It mentions the need to give sensitive support and advice to women experiencing domestic abuse. It also states the intention to publish a national Maternity Services Framework which *'will ensure choices for women and their families while recognising the need for clinical safety and assist decision-taking on the design of maternity services across Scotland.'*

A Framework for Maternity Services in Scotland

A Framework for Maternity Services in Scotland (9) states how the principles in *Our National Health* will be applied to maternity services. It recognises that the framework will have implications for workforce planning. Subsequently, the Scottish Integrated Workforce Planning Group was tasked with considering workforce options.

The framework challenged the NHS to provide a community-based midwife-managed service with easy access to specialist services when required and addresses maternal health as a way of improving paediatric health. It set out 27 principles for maternity care and highlighted the impact of social inequalities:

'Social influences before, during and after pregnancy have a significant and far-reaching impact on child and maternal health

Social investment in the next generation is the key to healthy families and healthy people, and will help to make a healthier future for everyone

Government cross-cutting policies are targeting resources to the 30% of Scottish children born into relative poverty in key areas such as childcare, education, employment, health, housing and welfare benefits'

Principles enshrined in the framework included:

'Maternity services should be tailored to the needs of the individual woman.

Maternity care should be organised to provide a flexible, appropriate, clinically effective and accessible service in response to the needs of women.

Women have the right to choose how and where they give birth.'

Implementing the Framework

In 2002 the Scottish Executive published *Implementing a Framework for Maternity Services in Scotland, Overview Report of the Expert Group on Acute Maternity Services* (10). This report from short life working group (EGAMS) dealt with how to apply the principles set out in the framework. The report concluded that the current configuration of acute maternity services was no longer sustainable taking into account the falling birth rate and workforce pressures. It recommended that the principles in the framework were all 'robust'. It indicated particular challenges: *Scotland's mix of urban and very remote communities, with some areas of concentrated poverty and disadvantage in our cities and a very dispersed population in some rural areas, presents real challenges to the delivery of maternity services.*

But while there was some mention of rural issues, the principles of reducing inequalities had no prominence.

The EGAMS report has been used as the template for reviewing and developing maternity services.

Following on from the report, A National Maternity Services Workforce Planning Group was established in 2004 to:

- *Review workforce profile, to scope current and future service provision, to review workforce demand in the short, medium and longer term, and review the capacity of the various supply mechanisms to meet that demand*
- *To advise on the supply of relevant professional and other staff*
- *To establish working relationships with and offer support to regional workforce networks and workforce co-ordinators*
- *To monitor and review training competencies in line with the changing needs and demands of the workforce*
- *To examine and address immediate workforce issues.*

This multi-disciplinary group is chaired by Professor Calder and is due to report.

Regional maternity services co-ordinators were appointed to help implement the framework EGAMS report and to ensure that boards worked across boundaries to ensure delivery of effective, joined-up services.

The Scottish Multi-professional Maternity Development Unit was set up to develop and deliver multi-professional training on key areas identified in the EGAMS report.

The Scottish Executive also set up a Scottish maternity website for clinicians and service users.

Health in Scotland

The annual report of the Chief Medical Officer, *Health in Scotland 2004* (11), describes challenges to health and healthcare in Scotland over the past year. The report states that the gap between the rich and poor in Scotland has increased and that health inequalities within Scotland appear to be widening. It also states that people in Scotland are less healthy than their English counterparts. The report says that the NHS has a vital role to play in respect of its own services. *'There are inequalities in both access and uptake of heathcare service. People in deprived communities are less likely to use services and often present later and have worse outcomes. There is a need for evidence about what is effective in promoting access and uptake for deprived and excluded populations.'*

National Framework for Service Change

In May 2005, the Executive published *Building a Health Service Fit for the Future: National Framework for Service Change in the NHS in Scotland by Professor David Kerr* (12). This 20-year plan for the NHS stresses the importance of local services. Launching the report Professor Kerr said, "We need to focus on getting the right services out in the community rather than the bricks and mortar of hospital buildings."

The report was commissioned amid local protests against the downgrading and closure of accident and emergency and maternity units across the country and took evidence from doctors, patients and communities during November 2004. This consultation strongly indicated that communities wanted local services.

Key messages include:

- Ensuring sustainable and safe local services
- Viewing the NHS as a service delivered predominantly in local communities rather than in hospitals
- Preventative, anticipatory care
- Fully integrating the NHS (including social care providers, GPs and patients and so on)
- Developing new skills
- Developing options for change ***with*** people, not ***for*** them.

Proposals of particular relevance to the SWC include:

- Targeted action in deprived areas to prevent future ill-health and help reduce health inequality
- Developing networks of rural hospitals to support remote communities
- Giving the public and patients a voice in changing how health services are provided
- Integrating key parts of the health service.

For maternity services, the report endorses updates on developments since the publication of the Expert Group on Acute Maternity Services. It goes on to make specific recommendations about future configuration of maternity services and states that these should continue to be delivered as locally as possible:

- *High quality maternity care should be based on the available evidence about clinically safe and effective practice, and must be woman and baby centred.*
- *A strong multi-professional team approach is integral for the delivery of an appropriate seamless maternity services (sic).*
- *The principles in A Framework for Maternity Services in Scotland, especially the tiered and incremental framework for antenatal, intrapartum, postnatal and neonatal care, should be fully implemented.*
- *The concept of risk assessment and management should be developed at all levels of maternity service provision.*
- *The role of the midwife as the lead professional in low risk pregnancy, childbirth and peurpeum (sic) should be promoted and supported.*
- *One-to-one maternity care should be the norm in childbirth.*
- *Community Maternity Units, where deliveries are midwife-led, should be developed, either standalone or coterminous with a Consultant-led Unit.*
- *All healthcare maternity professionals should have the appropriate skills and competencies to deliver the appropriate service at each level of care, supported by appropriate communication and explicit referral networks for required incremental care.*
- *The rates of caesarean section and instrumental vaginal delivery should be regularly audited and reviewed locally and nationally.*

The report makes further recommendations about the planning and delivery of maternity and neonatal services and highlights the importance of consultation. *'Service Users, Voluntary Groups and Communities should all be encouraged to be involved in developing and monitoring maternity services. Locally this is vital as maternity services do not only impact upon the patient (i.e. mother / child) but the wider family.'* The report recommends that:

- *The Scottish Executive and NHS Boards should put in place systems to encourage and support user involvement in service development.*
- *Maternity Service Liaison Committees should be developed and maintained within NHS Boards.*
- *Women must be informed about risk with unbiased evidence-based information to help them decide where to receive care and give birth. Professionals should balance maternal choice, demand and need against assessment of risk and the availability of services.*

Conclusions

Improving access to maternity services for women who are excluded and disadvantaged whether through poverty, geography or some other issue is consistent with the general policy framework. So too is the principle that planning and provision of services should take full account of the views of those who have to use them. Making this meaningful to women is the challenge.

Main Findings of the Maternity Services Provision Group

There was a general consensus within the group that women's voices are not properly taken into account in planning services. This is the key theme to take forward.

There are many barriers which make it difficult for women to access services and there is evidence of a one size fits all approach and increasing centralisation which simply does not work.

Main barriers to women in accessing maternity services are poverty and other forms of social exclusion and geography. These are not mutually exclusive.

Socio-economic deprivation and social exclusion

How do poverty, social exclusion, drug taking, prostitution, domestic abuse and other issues affect how women access maternity services? How are women's different needs taken into account as new models of service develop? These are the questions the group grappled with over the year.

There are significant inequalities between population groups in Scotland, particularly between the most and least affluent. These are increasing rather than reducing. Poor life circumstances are concentrated in the least affluent and most excluded communities which, in turn, experience the poorest health (13).

A recent report from the Joseph Rowntree Foundation (14) indicates that Scotland has the highest rates of premature death of any part of Great Britain. It also indicates that there are substantial inequalities between groups of the population. Babies born in the most deprived areas have lower birth-weights than those born in less deprived areas. The report uses the new Scottish Index of Multiple Deprivation (SIMD) to show the geographical distribution/ deprivation across Scotland. Although Glasgow, Edinburgh and Dundee have high concentrations of low-income families, many people of low incomes live outwith these areas.

Poverty and other forms of social disadvantage affect how and whether women access maternity services. But our experience is that services do not take account of the realities of women's lives and services are not provided appropriately. Often contact with such women is provided when there is an emergency, rather than through a planned and systematic approach.

Poverty does not cause social problems such as domestic abuse. But if a woman is experiencing domestic abuse or is an asylum seeker or in some other way disadvantaged, then poverty exacerbates the problems and increases the barriers.

Accessing traditional antenatal and postnatal services is difficult for many women experiencing disadvantage. For example, a woman with drug dependency may find it difficult (for all sorts of reasons) to attend a traditional 'booking in' appointment at a main maternity hospital. But pregnant women with significant drug misuse problems may have other social problems and their care should reflect this. In *Getting our Priorities Right* (15), the Scottish Executive sets out its guidelines for working with children and families affected by substance misuse. These recognise the impact of drug and alcohol use and their associated social problems on the health and social outcomes of pregnancy and emphasise the importance of multi-agency working to tackle this.

We also found during our discussions that services are not 'joined up' and so do not meet the needs of women. For women leading chaotic lives due to multiple problems a holistic care package would be more suitable where the care provided is tailored to suit the women's needs, in one clinic. For example, reproductive health care is fragmented and maternity services rarely provide contraceptive services. So, women requiring contraceptive services have to go somewhere else for these after delivery (16) (17).

A UK Parliamentary Health Select Committee Report *Inequalities in Access to Maternity Services* (18) found that women from a range of backgrounds, including those on a low income, those who are homeless and women from black and ethnic minority groups are unlikely either to demand or receive the attention they need to see them though pregnancy, labour and postnatally. It also found that that there were barriers to accessing maternity services including prejudice in relation to class, race or disability, lack of advocacy and interpreting services, lack of continuity of care for homeless women and dispersed asylum seekers; there was also a lack of consultation.

Such barriers are major and have a significant and long term effect not only on individual families but on our society as a whole.

The latest report of the Confidential Enquiry into maternal and child health in the United Kingdom (1) provides ample evidence of inequalities in healthcare and maternity provision. This report into maternal deaths found that women suffering social disadvantage were up to 20 times more likely to die than women from less disadvantaged groups. Maternal deaths had increased since the previous report. The report defined those experiencing disadvantage as 'those living in extreme poverty and those with multiple social problems, women from some minority ethnic groups and those who did not speak English, homeless or

travelling women and refugees and asylum seekers.' Also defined as experiencing disadvantage were 'those with stigmatising conditions such as previous mental illness, being under age or HIV positive, or who misused drugs, alcohol or other substances, and those who experienced domestic violence.'

Risk factors for maternal death included social disadvantage, poverty, being a member of a minority ethnic group, late booking or poor attendance, obesity, domestic abuse and substance abuse, many factors of which are crosscutting. Psychiatric illness was the largest cause of maternal deaths overall. This included suicide drug misuse.

Ethnic minority women are twice as likely to die during pregnancy or immediately after the birth of a child as white women (19). Given that there is a sizeable ethnic minority population in Scotland, particularly in Glasgow as a result of the government's asylum seeker dispersal programme, this is a vital concern.

Poverty and social disadvantage also affect infant mortality rates and contribute to low birth weight. There are correlations between diet, low maternal weight, ethnicity, smoking, low income and low birth weight (20).

Poverty and disadvantage can have an impact on the likelihood of postnatal depression. A study of 480 new mothers found the two key risk factors for PND were lack of a confidante and low income and that women who both lived in poverty and lacked a confiding relationship were 19 times more likely than other mothers to develop PND (21).

A report into teenage pregnancy (22) found that the conception rate increases with deprivation with a 4-5 fold difference in the rate between those living in deprivation category 1 compared with deprivation category 7. Outcome of pregnancy also varies by area of deprivation, with the highest percentage of births occurring in the most deprived areas.

Conclusions on Socio-economic deprivation and social exclusion

From its discussions the Maternity Service Provision Policy Group concluded that:

- Poverty and other forms of social deprivation have a huge impact on how and whether women access maternity services.
- Poverty and other forms of social deprivation affect women differently from men.
- There is a lack of understanding about the barriers that prevent women from accessing maternity and other health services.
- Social and economic disadvantage should be an underpinning feature in the design and delivery of maternity and other health services.
- Services need to be designed to meet the needs of women from all groups in society, particularly the socially excluded.
- There needs to be more emphasis on multi-agency working and a more joined up approach to providing health services.
- The model demonstrated by the Women's Reproductive Health Service in Glasgow is to be applauded.
- The lack of joined up services increases costs to the NHS and other agencies with women requiring long-term support from health, child protection and other social services.

Socio-economic deprivation and social exclusion in Rural Areas

Falling birth rates, workforce capacity issues and the centralisation of acute services have meant that maternity service provision in rural areas is under intense scrutiny. During 2004, proposals to centralise maternity services in Caithness and in Argyll and Clyde caused huge concern for women and their families, and there are similar concerns and issues across the country. There are current concerns about developments in Perthshire where maternity services have been centralised in Dundee, Borders and Dumfries and Galloway.

Increasing centralisation and consequent downgrading consultant-led units (CLU) to midwife-led units (MLU) are likely to mean that more women need to travel significant distances particularly first-time mothers and those expecting high-risk births.

The 2004 proposals resulted in a storm of protest, not simply because of the obvious 'inconvenience' to women living in rural areas, but because of the risks to maternal and foetal health; the likelihood of increasing numbers of elective caesareans; the knock-on effects both socially and economically on communities; the apparent lack of consultation; and the flouting of the sentiments and fundamental principles of the Scottish Executive's own policies.

The current situation in Argyll highlights the issues. Argyll is a scattered island community where access to consultants is via Paisley, some 80 miles from Lochgilphead and 113 miles from Oban. This creates problems for staff and pregnant women at the maternity unit in Oban, which covers a very scattered rural area and ten islands. These problems are exacerbated by the fact that GPs have more or less opted out of midwifery care. The Oban midwives report feeling 'undermined' and, at the time of writing, are in the 90-day period before the proposed changes come into place. One of these is to have no midwife on duty in the hospital at night but instead 'on call' at home.

Currently, Oban ambulances are available for transfers but under the proposed ambulance changes all paediatric and midwifery services emergencies will operate from Paisley. In common with other rural districts, distance/transport is a big problem since there are no direct transport links with Paisley and all transport is to Glasgow.

Emergency caesarean sections have been performed in Oban where there is a gynaecologist living in the area. However, her part-time contract does not cover the midwifery unit, and her supervision of caesarean sections has been through 'grace and favour' rather than any commitment from the health board.

Although Lochgilphead midwifery unit is currently operating under the proposed changes, its area of responsibility is less rural, has a smaller population and fewer tourists.

Our discussions focused on the following key issues:

Travel

In rural areas women may have to travel long distances by road in an emergency. There are increased risks associated with bad weather, poor roads and heavy traffic. Air alternatives are under-resourced, for example there are plans to reduce the number of helicopters servicing Orkney, Caithness and Inverness, and these may not be suitable in poor weather.

There are also transport issues for health staff who may have to travel long distances with women but who are without return transport; and ambulance crews are unhappy at the prospect of delivering babies or dealing with other complications en route, when births are planned to take place in hospitals.

Similarly, partners and other family have to travel long distances to be with the woman and baby.

Cost

The high cost of transport and accommodation may mean that women may have to have their babies with no family members around at the birth or to visit once the baby is born.

Accommodation

There is a lack of adequate and inexpensive accommodation near to the hospital for partners and other family members.

Medical services

The loss of consultant services can result in cuts to other services such as gynaecology, anaesthetics and surgery. This has a knock–on and detrimental effect on the community as a whole.

Effect on women

There are concerns about risk to women and babies through road or air transfer, particularly in an emergency. Separation from family and friends may be a factor in causing postnatal depression (21).

Economic

There is a domino effect of loss of income to rural communities when vital services are centralised (23). This includes relocation of staff, migration of the population to live beside key services with a knock-on effect on rural schools, retail, transport and other services.

Skills

Staff may not be geared up to deal with the inevitable demands on different skill-sets. A study of sustainable maternity service provision in remote and rural areas of Scotland found that there was scant evidence about quality and remote and rural maternity services or about professional competencies (24).

Conclusions on rural issues

From its discussions the Maternity Service Provision Policy Group concluded that:

- Models of care in rural areas should reflect the realities of women's lives. They should take full account of the social, economic, transport and community infrastructure in an area.
- Issues to do with social disadvantage crosscut rural issues and there is scant evidence of interventions that address the complexities of women's lives in rural areas.
- Women should be represented on decisions making boards to ensure women's voices are heard and their concerns taken into account as new services are developed.

Recommendations

The Maternity Service Provision Policy Group recommends that:

General

Women should have informed choice about where and how and in what circumstances they have their babies. This choice should be available to all women in Scotland, regardless of where they live.

A 'one size fits all' approach should not be applied to the provision of maternity services as women have different needs according to their location, their economic background, family circumstances and so on.

Agencies must work together to ensure that services meet the needs of all women including those from disadvantaged groups.

Consultation

The SWC maternity service provision policy group would welcome further dialogue about maternity service provision for all women.

The SWC should be invited to be involved in developing and monitoring maternity services as described in the Kerr report (12).

The SWC should be invited to participate in any consultation and action following on from the publication of the NHS Gender and Health report.

Funding

Funding is crucial to the provision of services which meet all women's needs. The group re-emphasises the importance of services such as the outreach clinics which should have continued mainstreamed funding at an appropriate level.

Socio-economic issues

Social and economic disadvantage should be an underpinning feature in the design and delivery of maternity and other health services.

Services need to be designed to meet the needs of women from all groups in society, particularly the socially excluded.

There needs to be more emphasis on multi-agency working and a more joined-up approach to providing health services.

Services should be provided on a multi-agency basis to ensure women receiving maternity services are linked into other forms of support.

Care, services and information should be provided for women before pregnancy, throughout pregnancy and after the birth.

Such services should be of high quality and properly funded.

There are excellent models working successfully with the most vulnerable women and these should be continued and replicated across Scotland.

Training for midwives, maternity consultants and other relevant healthcare staff should place more emphasis on issues relating to socio-economic deprivation (pre- and post-qualification and continuous professional development).

Parliamentary questions should be tabled to enable a full discussion of the impact of socio-economic deprivation on access to maternity services.

Rural areas

Models of care in rural areas should reflect the realities of women's lives. They should take full account of the social, economic, transport and community infrastructure in an area.

Issues to do with social disadvantage crosscut rural issues and there is scant evidence of interventions that address the complexities of women's lives in rural areas.

There should be adequate transport, e.g. air and road to ensure that women receive services promptly.

Accommodation of a reasonable standard should be provided for partners/close family for women who have to travel to hospital away from their home area.

Travel costs should be quickly and fully reimbursed.

Research

More research is required on these issues. This includes investigation into the needs of women in rural areas, for example in Perthshire where maternity services have recently been centralised in Dundee and in Inverclyde where services have been centralised in Paisley.

The needs of asylum seekers and other women facing cultural barriers should be researched and addressed.

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Appendix

Key themes which emerged from the group's work

General

Key decisions on services often take no notice of women's views

Strategies/policies do not translate to services for women and babies

Management issues in delivering services

Services designed which do not meet basic case needs

Fear of infection

Health Boards are not elected

No diversity in the membership

Women's voices perhaps listened to but not acted on

Rural issues

Transport – air, ambulance, boat

Accommodation

Safety

Knock on effect in other services if maternity services are lost

No choice for women

Distance – affect on developing postnatal depression

Socio-economic issues

Some women can't access services but need ante and post natal care

Such women do not have a voice

Need joined up local services

Importance of multi-agency approach

Ongoing care for baby and mother should be provided

Women are slipping through the net – postnatal depression

Themes not addressed by the group due to capacity issues

Asylum seekers

Ethnic minority women

Aftercare

Parenting