AIMS For a better birth...

Bigger is not always better!

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Sarah Davies and Heather Rawlinson discuss the experience of centralisation of maternity services in Greater Manchester

We write this article as midwives and mothers who were part of an eight-year campaign against the maternity unit closures and centralisation in Greater Manchester. Centralisation, also known as 'reconfiguration', is currently very popular in today's resource-starved NHS. Reconfiguration means the closure of units - which of course makes the remaining ones larger. These larger hospitals are then feted as 'Centres of Excellence' which provide supposedly better care and more choice for childbearing women. Six months after the last maternity unit closure, the centralisation of maternity services in Greater Manchester is being cited by the head of the Royal College of Obstetricians and Gynaecologists, and the head of the Royal College of Physicians, as a model to be emulated throughout the country[1,2] But are the changes an improvement, and what do they mean for our maternity services?

Manchester's reconfiguration, dubbed 'Making it Better', is to date the largest in the UK. We now have eight consultant obstetric units instead of thirteen. The smaller consultant units which have been closed over the past four years are Trafford General maternity (January 2010; approximately 2,800 births per year); Rochdale maternity (June 2011; 3,000); Salford maternity and neonatal (November 2011; 3,500); and Bury maternity and neonatal (March 2012; 2;500). There are now larger maternity units at Wigan, Tameside, North Manchester, Oldham, Bolton, Wythenshawe, Stockport and Central Manchester. Central Manchester and Bolton will become amongst the largest hospitals in the country, with Central Manchester on track for 8,500 births a year. Although freestanding units were recommended as part of the plans, Manchester Primary Care Trusts (PCTs) showed no appetite for them and so none of the proposed birth centres at Trafford, Bury and Rochdale have gone ahead. Salford was able to retain a freestanding birth centre due to sustained local political pressure, but the service will be up for review in a year's time.

In the reconfiguration, staff have been uprooted from units where they have given many years of service, leaving friends and colleagues and moving to new posts. Many experienced staff have retired rather than face the upheaval; others have left the area. This has meant the loss of an important pool of experience and brings concerns about skill mix, as well as the amount of support available for newly qualified midwives. Change has affected all midwives, whether they transferred to a new unit or stayed in an existing one. Levels of midwifery autonomy differ from unit to unit, and everyone has had to develop new working practices and form new team relationships.

During our campaign against the closures we voiced concerns about capacity, safety and intervention rates. When the reconfiguration plans were first published, they were based on a far smaller number of births than we currently have and the new units have already had to be expanded well beyond what was anticipated. The birth rate has since continued to rise, faster than the rest of the country, and the units are extremely busy. Contrary to the 'spin' about poorer units warranting closure,2 Salford Royal, which served one of the most deprived districts in the UK, was amongst the best-performing and was closed nonetheless.

We are concerned about the increased travel distances in a congested urban area which inevitably mean it takes longer to access services in labour or in an emergency. This of course has implications for both home and hospital births. Anecdotally it is reported that the number of babies born before they are attended by a midwife (BBA) has increased, as has the number of births occurring in Accident and Emergency units, although no official figures are available yet. We have concerns about safety in the community, due to the fragmentation of services. For example, Salford community has been divided between four different trusts and no longer exists as an entity for maternity care. This means four different policies for everything from safeguarding children to home birth.

From the monthly figures of local trusts, we know that intervention rates have risen. Salford Royal had the lowest caesarean section rate in Greater Manchester (17.6%) and now current rates are well over 20% in all trusts apart from Central Manchester. In Bolton the caesarean section rate in August 2012 was nearly 30%.

There is a medicalised culture in some of the larger units that was not there in the smaller ones (for example doctors doing 'labour ward rounds', when previously they would wait to be invited into the rooms). Many more women seem to be being diagnosed with risk factors. This phenomenon was also found in the recent Birthplace study, where almost 20% of women in the obstetric unit group had at least one complicating condition noted at the start of care in labour, compared with less than 7% in the other settings.3 The increased intervention rates in the hospitals are likely to be a result of the reduced autonomy of midwives that is often seen in more medicalised units - for example midwives not feeling free to exercise their clinical judgement and being expected to adhere strictly to medical guidelines. Also the time pressures in busy units inevitably lead to a culture of intervention rather than 'watchful waiting'. One positive element is that labour ward staffing has improved, so that most labouring women receive one-to-one care from a midwife. However, the large postnatal wards have become exceedingly busy and women are discharged home early. In addition, most Trusts are now contracted to provide only three postnatal visits which raises concerns about ongoing postnatal support and recognition of problems.

But the picture is not all doom and gloom. Midwives are amazingly resourceful, and women continue to have babies! Bolton, St Mary's, Wythenshawe and Stockport all have 'co-located' birth centres which offer midwife-led care. Salford freestanding birth centre had 170 births in the first 10 months after opening and bookings are increasing rapidly. At North Manchester, the new co- located midwifery-led-unit (MLU) is proving to be very popular with both women and midwives. It opened in September 2011,

became fully operational in December and had over 500 births in the first year. It is staffed by core staff and community midwives who are on call for the unit twice a month and also come in with 'their' women. Community midwives who already follow their women are exploring the feasibility of caseloading. In Stockport, a lead midwife has succeeded in leading change to make the co-located birth centre the 'default' option for women. Bolton has recently recruited a Consultant Midwife, which will help to address the issue of rising intervention in that Trust. (When the reconfiguration plans were first approved, a consultant midwife was promised for each Trust.)

The new alongside MLUs are great; the rooms are private, calm and comfortable, pools have sparkly lights, medical equipment is discreetly hidden, there are birth couches and double beds, and partners can stay after the birth. In the consultant units, use of pools, birth balls and birth couches is far less common, with the obstetric bed still dominating the room. Midwives and students are working to change this, as they know that every woman in labour, regardless of where she has decided to birth, should be enabled to be mobile, adopt upright positions and use a birth pool or bath. When services are organised into radically different spaces ('midwifery-led, relaxed and touchy-feely' seen as different and separate from 'obstetric-led, stark and high tech'), it can add to an 'us and them' culture, as also noted in the Birthplace study.[4] This 'us' and 'them' tribalism, which is apparent in several places, is not conducive to seamless care for women.

Power issues are always at the heart of reorganisations of maternity care. The planners justify their decisions by saying that clinicians were at the heart of the changes. This is true; but it is important to ask the question: who exactly were these clinicians, and what vested interests did they have? The main power players in Manchester's reconfiguration were neonatologists, and the supposed benefits were usually couched in terms of improvements in the care of sick and premature babies. Wider public health issues were never discussed. For example Anthony Emmerson, clinical lead for the Neonatal Network, was often quoted in the press saying that centralisation would *'help to save the lives of up to 30 more babies every year'*.[5] The evidence used to underpin this statement was questionable and has been challenged, and any purported benefits certainly should have been balanced against the possible harmful effects on women in labour having to travel further. Our campaign challenged the logic of herding large numbers of healthy women into centralised hospitals (and thus putting them at higher risk) for the supposed sake of a small number of extremely small preterm babies.

There is not a great deal of research evidence evaluating NHS reconfiguration, and none for maternity; but the Nuffield Trust has suggested that reconfiguration does not benefit patients and does not reduce costs either.[6] More recently a detailed review of outcomes has concluded that hospital mergers provide no advantages other than reducing admissions. The researchers found that waiting times and travel distances both rise, and suggested that the removal of capacity may reduce patient welfare.[7] A survey of women's views and experiences in Greater Manchester has been commissioned by the Maternity Network, but the results are not yet available.

The arguments about the cost effectiveness of larger units do not add up. The overall cost of the 11 year

project in Greater Manchester has not been revealed, though according to the Children, Young People and Families' NHS Network, commissioners have already made recurrent investments of an additional £10m a year on staff and skills maintenance, and will spend £29m over the life of the project[8] We know that Greater Manchester commissioners agreed a three-year 'transitional top-up' for births of £110 for each birth, and given the greater than expected rise in the birth rate, in the current economic climate this will put further pressure on Trusts' finances. It is now clear from the Birthplace study and others[3] that midwifery-led care is less costly than obstetric-led care, but despite this there does not seem to be any plan to expand community midwifery numbers.

According to guidelines from the Royal College of Obstetricians and Gynaecologists[9] all units with 6,000 or more births a year should have at least a 60-hour consultant presence (p50). So although the majority of women giving birth in the large units are healthy and simply require midwifery care with obstetric back-up, the number of obstetric consultants has been increased. Obstetric care is, of course, essential; but it should be focused on those women who require it. The impression we are left with in Greater Manchester is that obstetric and neonatal empires have increased, while community- based care is under increasing pressure. We are concerned that the fragmentation of care will adversely affect women and families, especially the more vulnerable.[10]

In conclusion, the picture in Greater Manchester today is of an over-medicalised, over stretched, centralised service within which there are pockets of excellent midwifery-led care. Now all parties urgently need to work on ensuring that every woman is aware of her options for birth, empowered to make an informed decision about the care she wants, and able to access that service. The concepts of 'choice' (or autonomy) and control in birth are enshrined in government policy, and must be considered, not as luxuries, but as a woman's basic human right.

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Comments on Saint Mary's Birth Centre

Comments from mums

'Staff very accommodating, could not do enough! I've already recommended it to friends - a lot less clinical and more relaxed.' Estelle

'Couldn't have wished for a more enjoyable and safe birthing experience.' Jenna

'The facilities are good, staff brilliant - a great experience and very relaxing.' Vicky

'Staff were fantastic, can't thank them enough. I was really anxious about birth but my care from start to finish was outstanding.' Ashley

'Very comforting, soothing and calming, it made me feel at ease compared with my other births. Very professional staff but at the same time friendly and reassuring.' Donna

'Homely and clean, staff amazing, would definitely come again.' Angela

Comments from midwives

'Providing midwife-led care on the birth centre has given me the opportunity to develop skills in autonomous practice, and increased my confidence in my own skills and the process of normal birth.'

'I have gained real job satisfaction by providing women- centred care and caring for women throughout labour up until discharge home.'

'I feel extremely grateful to have had the privilege of practising true midwifery in a positive environment that is conducive to normal birth.'

'Practising in a stand-alone birth centre has allowed me to reclaim autonomy, promote normality and further empower women and myself!'