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## **Making it Better for Mother and Baby: A strategy or a sop?**

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Sheila Shribman, National Clinical Director for Children, Young People and Maternity Services, has recently presented the current widespread reconfiguration of maternity services as an opportunity to improve choice for women (Shribman, 2007). Important parts of this strategy are midwife-led units, whether free-standing birth centres or 'alongside' midwife-led units located on the same premises as consultant-led maternity units. Whilst the rationale for such units is partially to satisfy the demands of Health Overview and Scrutiny Committees, they also fulfil important roles in terms of effectiveness and efficacy. Sheila Shribman lists these as:

- Safer care
- Improving access and outcomes
- More choice
- Promoting normality
- Local ante- and post-natal services closer to home
- Home-like birth environment

Hodnett *et al* (2005) in a systematic review of births in birth centres, found they were associated with a reduction in interventions in labour. The National Childbirth Trust (2007) identifies a range of benefits including increased breastfeeding rates and client satisfaction with services. Birth centres and midwife-led units are also associated with improved job satisfaction for midwives, and are important in the recruitment and retention of midwives (Kirkham, 2003; Walsh, 2007).

At the present time, there are approximately 112 birth centres and midwife-led units in the UK, 72 of which are free-standing birth centres, 36 are alongside midwife-led units, and four are privately owned and run. 16% of babies born in the UK are born in birth centres and midwife-led units (NCT, 2007).

However, five of the 112 units are currently temporarily closed and a further 16 are under threat of closure. This means that of the 108 NHS birth centres/midwife-led units, 21 are (or 20%) are either currently closed or threatened with closure (and this is probably an underestimate). Sheila Shribman does not mention this worrying fact in her report, despite her advocacy for such units, and the Government's pledge "to give all women a choice over where and how they have their baby... by 2009" (DoH, 2007).

We have recently been undertaking a study into one such unit, a free-standing birth centre in England that has experienced considerable problems. We believe that there

are important lessons to be learnt from struggling birth centres, and these should inform strategic planning if birth centres and midwife-led units are to be a successful part of British maternity care and not a sop to local communities faced with the loss of maternity services.

There is a recognised political dimension to birth centres and midwife-led units, most of which enjoy considerable local support and are also favoured by influential user groups such as the National Childbirth Trust (NCT) and the Association for Improvements in the Maternity Services (AIMS), as well as professional bodies such as the Royal College of Midwives. However beliefs about birth are also deeply personal. This philosophical and personal dimension can undermine the political and strategic support for birth centres, as in Sheila Shribman's report.

NHS managers, based in hospital at the hub of medical services, may often feel personally ambivalent about the very units they are responsible for. This personal ambivalence is echoed in the often-vocal professional opposition of GPs and obstetricians, who may feel threatened by non-medical care. In a highly medicalised society, midwifery-led care is likely to be seen as deviant, despite the evidence. The midwives working in birth centres and midwife-led units therefore struggle to gain and retain the support necessary to make the units successful and sustainable.

The midwives in the Birth Centre we have studied have reported many instances of deep-rooted lack of support for the unit:

*"I think the rot set in even before it opened up. I think the fact it wasn't supported by the consultants, it wasn't supported by the Trust really had a lasting effect on the midwives working in the Birth Centre."* (Manager)

*"When we went to meetings... the conversation always was "... how can we shut it down, how can we pull out, how can we do it less?" ... it was always kind of looking for a way of not doing it the way we'd have loved to do it."* (Midwife)

*"That's what they do, close it by stealth, because what they do is make it impossible for you to manage..."* (Midwife)

Whilst financial considerations are often presented as the primary reason for reducing or closing birth centre services, many supporters and midwives reason that the costs of such units are often over-estimated as 85% of costs are midwifery salaries and this cost has to be met

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wherever women give birth (NCT, 2007). Birth centres are undoubtedly an easy pickings in the current financial climate and more accurate financial analyses of such units are urgently needed.

Whilst the Birth Centre in our study was opened for all the reasons endorsed by Sheila Shribman, and has enjoyed considerable support from local women and midwives, as well as from some local NHS managers, our findings are that there was a lack of willingness to give the support and make the decisions necessary to make the Birth Centre successful. The midwives were constrained by guidelines and organisational protocols designed for hospital care, a lack of marketing and publicity, an unfavourable grading structure, and an absence of support from medical and senior managerial staff.

*"Nobody once turned round and said to any one of us "you have done a good job... we were battered all the time." (Midwife)*

No strategic or action plan was ever put into place to address the problems of the Birth Centre. Instead, every opportunity was taken to reduce staffing cover and facilities for women. Whilst the Birth Centre remains open, it is largely run through an on-call system and this has a detrimental effect on the community midwifery service, resulting in frequent closures, particularly at weekends. The midwives describe it as 'dead in the water' and not providing any true choice for women, as women in labour are often told they have to go to the consultant unit 10 miles away because of staff shortages. Disillusioned and demoralised midwives have left to work elsewhere, thereby aggravating staffing problems.

This picture is not uncommon. We have visited other

birth centres and found similar stories. Whilst Sheila Shribman and other policy makers at the Department of Health may advocate birth centres and midwife-led units, and there is ample evidence that these units offer a safe and probably cost-effective alternative to larger consultant-led maternity units, the picture on the ground is less rosy. Existing birth centres and midwife-led units need to be better supported within the current NHS structures, and the reasons why so many struggle must be better understood if newly planned units are not to suffer the same difficulties. The midwives who run such units need to be listened to and given the resources and structures to make their units successful. There is no room for managerial ambivalence about birth centres if such units are to realise their potential in tomorrow's maternity services. Without clearer commitment, things will not get better for mother and baby, despite the Department of Health's best intentions.

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#### Valuing our Worth

If this magazine has arrived on your doorstep later than usual it is because net talk was replaced to take account of ukmidwifery list responses to the *Panorama* programme screened on May 3rd.

When *Maternity Matters* came out in April there were various newspaper articles leading to internet responses on various sites from the public which showed how much of an uphill struggle it is going to be to reassure women and men that birth is safe away from consultant units, and then along came *Panorama* which showed just how much pressure midwives and maternity units are under. Women are now caught between the devil and the deep blue sea. It seems to be a choice between an 'unsafe' birth away from a consultant unit, or cattle market obstetrics in a large understaffed hospital, with staff and beds cut to the bone. As for postnatal care, beds are freed up as soon as possible after birth and, "Could you possibly manage to get to the Children's Centre, because we're so busy, they called me into hospital last night, they were short staffed and..."

I know I am painting a bleak picture, and I know it's not like this everywhere, but I think healthcare managers in

this country need to consider whether they place any value at all upon new babies and their mothers – and their midwives. All that seems to be considered is the financial cost of litigation when something goes wrong and this is a profoundly negative way of looking at maternity care. All the health managers seem to think about is how to run maternity units with the smallest number of staff compatible with the least amount of litigation. Labours are speeded up to save staff time, and time is money. There are some things that money cannot buy, a good birth, a happy family, a happy workforce. The maternity services run on the goodwill of those who work in them and when the goodwill runs out what will be left? Dead and damaged mothers and babies and litigation.

If this Government thinks that *Maternity Matters* then it must realise that midwifery matters too – and there is enough evidence to show that one-to-one midwifery care from a known midwife is the key to improving the maternity services. The Government must be prepared to put its money (no, *our* money as taxpayers) where its mouth is. Because we're worth it. Or aren't we?

*Margaret Jowitt*