

# **AN INDEPENDENT RESPONSE TO “THE FUTURE OF HEALTHCARE IN GLOUCESTERSHIRE: PROPOSALS FOR DEVELOPING SUSTAINABLE NHS SERVICES”: PROPOSAL THREE – MATERNITY SERVICES**

**Dr Suzanne Tyler, Associate, Health Services Management Centre,  
University of Birmingham**

## **EXECUTIVE SUMMARY**

1. Stroud Maternity Hospital (SMH) is financially viable. Whether the incomplete data supplied by the PCT, or the financial assumptions made by the external consultant are used; it is clear that under PbR (particularly when it becomes fully operational in 2008) ‘income’ derived from activity at SMH, exceeds the cost of delivering services. This means that SMH is NOT a loss leader or a cost to the wider NHS.
2. The financial savings proposed are unrealistic. Already the PCT has revised downwards its estimates of savings achieved by closure from £400,000 to £250,000. However there are still a number of additional costs associated with reconfiguration that have not been factored in, these are highlighted in the external consultant’s report. This means that closing SMH will make a minimal contribution, less than 0.5%, to the health community’s deficit.
3. The unit is popular with staff and more importantly users. The number of deliveries at the unit has increased by 27% since 2002/03 (from 247 to 314) and continues to rise. Extrapolating activity data for the first two months of this year, deliveries could reach 350. A further 850 women receive their antenatal and postnatal care at SMH whilst delivering elsewhere. This means that SMH is NOT underused, rather is a thriving community facility.
4. The health community has not demonstrated that it has explored other means of achieving greater efficiencies at SMH in order to make a contribution to the wider deficit. It is clear that across Gloucestershire savings have to be made and that every service has to make a contribution. However, there are options other than closing, which might further improve the financial position of SMH including increasing activity, reviewing staffing levels and modernising skill mix and professional practice. These options should be explored thoroughly before an irredeemable decision to close is finally made.
5. Neither the Strategic Health Authority, nor the Local Supervisory Authority has any concerns or issues regarding safety at SMH. Serious untoward incidents are rare and by nature unpredictable. Thorough investigation and learning from events are the appropriate response to managing risk. There is no evidence that birth would be safer for women delivering in a large obstetric unit.
6. SMH is a service, which the NHS locally should rightly be proud of and provides a positive national and international profile for the NHS in the county. It scores highly in terms of NHS performance measures (access; choice; quality; recruitment and retention; public health and value for money) and reflects the Government’s priorities for health reform and modernisation.

## Introduction

This independent evaluation of the proposed reconfiguration of maternity services by the health community of Gloucestershire has been prepared by Dr Suzanne Tyler on behalf of Stroud Maternity Matters and Stroud District Council. The terms of reference for the review were to provide an independent and external perspective on the specific proposals to close in-patient maternity facilities at Stroud. However, in doing this, inevitably, comment has also been made on the accompanying proposal to close in-patient maternity facilities at Cheltenham General Hospital. The analysis of the proposals has been based on the documentation issued by the health community, national healthcare policy and guidance, publicly available information about the local services and financial data in the public domain.

Dr Tyler is an independent healthcare consultant with sixteen years experience of working in and with maternity services. She has worked with health services managers, most recently as Deputy Chief Executive of the Institute of Health Management and with midwives as Head of Policy at the Royal College of Midwives. In recent years she has acted as an advisor to the Department of Health, has drafted guidance for professional bodies and undertaken reviews of maternity services for acute trusts, PCTs and OSCs, this has included:

- Consultant to Heart of Birmingham PCT: conducted review of community midwifery; developed strategy for aligning midwifery and Children's Centres, developed service specification for community maternity services, redesigned community midwifery to tackle high infant mortality (2005-2006)
- Consultant to RCM project to explore new ways of working for midwives (2005-2006)
- Feasibility study of establishing a stand alone birth centre in Hackney for Homerton University Hospitals Trust (2006)
- Strategic review of maternity services at North Middlesex University NHS Trust (2004-2005)
- Expert opinion to a West Wiltshire Overview & Scrutiny Committee on PCT proposals to reconfigure maternity services (2004)
- Author of Teenage Pregnancy Unit's commissioning guide: Maternity Services for Teenagers (2004)
- Author DH website: "Delivering the Best" Midwives' contribution to NHS Plan (2003)
- Expert advisor to DH Task Force on Choice Responsiveness and Equity (2003)
- Member of external reference group for Children's National Service Framework - maternity element (2002-03) and assisted in preparation of public health external reference group report to NSF (2003).

The structure of this response has two aims; firstly to address the specific questions posed by the health community itself as part of its consultation document; secondly to provide the OSC with the detailed information that underpins this by reflecting on the questions suggested by Healthcare Audit in its advice to the OSC<sup>1</sup>.

## SECTION 1: CONSULTATION QUESTIONS

### Q1. PRINCIPLES UNDERPINNING CONSULTATION

The principles outlined in the consultation are in themselves acceptable, although it is interesting that six of the eight relate specifically to financial issues and concerns. This is not an accurate reflection of the Government's own principles for NHS modernisation and reform. All DH documentation and guidance issued in recent months has stressed the need to balance three principles:

- **Patient Led**  
Choice - putting patients first  
A wider selection of providers and more freedom for staff
- **Quality**  
Safe fair and high quality care
- **Value for Money**  
Money follows the patient

It would have been reassuring to have seen the local health community explicitly reflecting and working within all of these principles to convince patients and their families that the reconfiguration proposed will bring benefits, aside from addressing historical deficits created within the health economy. Additional principles, might therefore include:

- Choice for patients on where and how care is delivered
- Making the best use of staff skills and providing a rewarding working environment
- Providing a high quality service, in terms of reflecting best practice and improving outcomes
- Celebrating and promoting local centres of excellence

In fact, the proposals in this consultation, relating to maternity services, FAIL to make a positive contribution to any of the Government's principles and objectives for health reform<sup>2</sup>. See appendix 1 for a more detailed analysis.

### Q2. MODELS OF CARE

The vision of a service that includes more support and treatment in the community and more access to specialist skills when they are needed is to be supported. It is therefore a bewildering paradox that the proposals for maternity services and the model of care outlined will achieve exactly the opposite. The model of care proposed for maternity services runs counter to the models proposed by the health community in "Investing in Excellence" (2004) and in Cotswold and Vale PCTs vision "Better Healthcare Closer to home" (2006). Furthermore there seems to be no reflection in this consultation of the model of maternity services set out in the National Services Framework<sup>3</sup> of:

- Flexible individualised services
- Women supported to have as normal a pregnancy and birth as possible
- Midwifery and obstetric care being based on providing good clinical and psychological outcomes

It is difficult to see how these proposals will help the health community achieve the NSF target of: ***"women have easy access to supportive, high quality maternity services, designed around their individual needs and those of their babies."***

Specifically the model of care proposed will inhibit access, have a negative impact on quality and is based around the financial considerations of the wider health economy not the needs of women. Instead of a model of care that is based on the needs of the majority of women in Gloucestershire, who experience pregnancy and childbirth as normal life events, the model proposed focuses on the minority of women who may require specialist care.

### **3. CHANGES PROPOSED – MATERNITY SERVICES**

The changes proposed within the consultation document for maternity services are NOT appropriate to enable the NHS in Gloucestershire to maintain sustainable services, whilst living within its means because they cannot be justified using criteria common within all national health policy. Using available evidence and experience elsewhere, these proposals are likely to have a negative impact in the following areas:

- **CHOICE**

As presently configured the Gloucester health community provides the full range of midwifery models:

- Home births
- Stand alone midwifery unit
- Along-side midwifery unit
- Two consultant led units

These alternatives all have different strengths, are appropriate and acceptable to different groups of women and are not interchangeable. Both the maternity NSF and the draft NICE guidance on intrapartum care<sup>4</sup> recognise that all of these choices are valid and to be supported. The proposed reconfiguration will remove the option of a stand-alone midwifery unit and reduce the choice of consultant unit. It is also likely that without established community bases the choice of a home birth will actually be harder to sustain in the future.

- **QUALITY**

The proposed reconfiguration will have no positive impact on the quality of maternity services and is likely to lead to increased interventions, poorer uptake of services and decreased satisfaction. The proposals will make it exceedingly difficult for the NHS in Gloucestershire to make progress in implementing the Maternity NSF or NICE guidance.

- **ACCESS**

The proposed reconfiguration will make physical access to services harder for many women and will subject them to additional travel costs and inconvenience. The reconfiguration is likely to have a detrimental effect on the NHS's ability to meet two key Government maternity targets, namely that all women should book for maternity care before 12 weeks and women should refer directly to a midwife.

- **PUBLIC HEALTH**

Removing a known and trusted community resource such as Stroud Maternity Hospital and centralising all intrapartum care on one site is likely to hit vulnerable and excluded women hardest. Excellent public health outcomes currently delivered by Stroud in terms of increased breastfeeding, reduced interventions etc are likely to be lost.

- **RECRUITMENT AND RETENTION**

The proposals presume that all staff will be happy and willing to relocate to Gloucester Royal Hospital. Experience in other units suggests this is unlikely. Larger units (those with over 5000 deliveries a year) experience greater difficulty in recruiting and retaining midwifery staff. The closure of Stroud Maternity Hospital (SMH) will have a particularly negative impact on staff morale.

- **VALUE FOR MONEY**

The savings proposed are predicated on a reduction in midwifery and support staff to undertake the existing activity. This is unlikely to be achieved without a significant impact on the quality of service available to women. Furthermore, the proposals fail to use the principles of money following the patient which underpin NHS financial reforms, because using PbR it is highly likely that SMH is not only financially viable but could be a net contributor to NHS income.

#### **4. PROPOSALS THAT ARE SUPPORTED**

It is appropriate that high cost/low volume services such as neonatal care and support for women experiencing very high-risk pregnancies should be centralised on one site. The proposal made by the health community in 2004<sup>5</sup> of providing high dependency and neonatal intensive care, either at Cheltenham General or Gloucester Royal, whilst retaining a community based service for women experiencing pregnancy as normal, is one that could be supported.

#### **5. PROPOSALS THAT ARE NOT SUPPORTED**

Gloucestershire health community has not made the case for the proposed withdrawal of inpatient maternity care from Stroud Maternity Hospital and Cheltenham General Hospital. This is because:

- Stroud maternity hospital is itself financially viable
- The financial savings presumed are unrealistic
- Closure will have a negative impact on the service in terms of quality, access, choice, public health and recruitment and retention.

In particular a number of the assumptions underpinning the proposal are not supported by evidence. These include:

- The suggested need to concentrate specialist skills (p4 of the consultation document). Whilst it is acknowledged that there are strong arguments for centralising some specialist health services both to ensure that medical staff gain sufficient experience in handling complex cases and to ensure value for money; these are not arguments that are appropriate in the case of maternity care. According to the latest national data 36% of deliveries are conducted by doctors and 64% by midwives<sup>6</sup>. Thus whilst there may be a logic in concentrating care for the highest risk women and those whose babies require neonatal intensive care on one site, this should not be the driver for a service model which will impact on the vast majority of women who will experience pregnancy and childbirth as normal.
- The presumption that 70% of births in the county can be defined as moderate to high risk (p10 of consultation). This is inaccurate and misleading and merely

reflects the fact that currently 30% of women meet the criteria for delivery in a stand-alone unit such as Stroud. However, this is not the same as suggesting that the remaining women need to be delivered in an obstetric unit. The health community would do better to base their model of provision on an assessment of the proportion of women falling into the following categories:

- Women who do not need to see a consultant (women who are eligible for total midwifery led care)
- Women for whom a consultant review is desirable (women who remain under midwifery led care unless medical care is deemed necessary)
- Women whose care should be delivered by the obstetric team (women for whom regular contact with the obstetric unit is essential).

Using this criteria and evidence from other units, would suggest that around 25-35% of all pregnant women will require medical care during delivery and a further 20% would prefer to deliver in an acute unit. This leaves between 45-55% of women who could be expected to be clinically eligible and personally willing to deliver in a community setting<sup>7</sup>. However, even if it were accepted that 70% of women are best suited to a medically led hospital birth (which evidence does not support), then according to the health community's data, there are 1800 women across the county who do not need to deliver at a centralised Gloucester unit but would be better suited to midwifery led care. Under these proposals this option would not be available for these women.

- The assumption that these proposals will aid recruitment and retention of skilled staff (p10 of the consultation document). Whilst centralising high risk obstetric services on one site may be attractive to medical staff, all of the available evidence suggests it is exceedingly unattractive to midwives and this was explicitly recognised by the 2003 House of Commons Health Committee who recommended: ***“Given the positive effect of midwifery led services on recruitment and retention we would urge PCTs and hospital trusts to do all they can to develop midwife-led services and be aware of the possible impact of closure on staff morale, recruitment and retention”***<sup>8</sup>.

Midwives who work in community units have the opportunity to fully develop their skills and become more confident practitioners in the normal. Evidence from other midwifery led community units indicates they find it easier to recruit midwives<sup>9</sup> and have lower rates of sickness and higher team morale<sup>10</sup>.

- The assertion that the savings can be achieved without impacting on quality (p10 of the consultation document). Unlike other health services, maternity care cannot be rationed or restricted. The number of women requiring maternity services will not be reduced by these proposals in line with the reductions in the number of midwives. With fewer midwives to care for the same number of women, there must be serious doubts about the time available to spend with each woman during antenatal and postnatal care and concern at the ability of the service to provide 1:1 care in labour. This is likely to have a negative impact on intervention rates in labour and impede efforts to support normality in pregnancy and childbirth.

## SECTION 2: BRIEFING FOR THE OVERVIEW AND SCRUTINY COMMITTEE

### (i) Why are the changes being provided?

Having reviewed the consultation and supporting documentation, it is my conclusion that these changes are being proposed purely for financial reasons. The withdrawal of inpatient care at Stroud Maternity Hospital is estimated at releasing £400,000, which will contribute 1% to the health economy's overall deficit. In the longer term, the proposals have the effect of consolidating the financial position of Gloucestershire Hospitals NHS Trust at the expense of a diversity of local providers.

### (ii) What are the alternatives and why have they been rejected?

The consultation document and supporting maternity briefing paper are weak on detail and analysis and fail to explain or provide evidence to support the underpinning assumptions. Indeed the health community appears to have ignored its own earlier and more detailed review of children's services, published in 2004, which proposed that: ***"The high dependency and neonatal intensive care unit should be located EITHER at Cheltenham General Hospital or Gloucester Royal Hospital. With this there will be special care baby units at both hospitals and neonatal resuscitation available at both hospitals. Mothers will still have the choice of local antenatal and postnatal care and for most mothers there will continue to be choices of consultant-led, midwife-led, hospital or home birth. Both general hospitals will offer epidural anaesthesia and where required caesarean section operations."*** There is no explanation of why this reconfiguration is no longer appropriate.

Furthermore the health community has not demonstrated that it has considered other options for reducing its deficit by the £400,000 that it proposes will be released by closing Stroud Maternity Hospital. Equally it has not indicated that it has explored other options, which maximise efficiency but protect quality, choice and access such as increasing activity at Stroud Maternity Hospital or reviewing staffing and skill mix to promote cost effective, clinically appropriate services.

### (iii) What benefits will the proposals bring?

The proposals as set out bring no benefits for patients or staff.

### (iv) What costs will there be? What are the financial implications for the NHS and for other public services?

Robust financial data on the cost effectiveness of community midwifery led units such as Stroud is generally poor. However, those studies that have been undertaken demonstrate that these units are a cost effective option because of staffing differences, shorter duration of postnatal stay, fewer interventions and readmissions and lower 'hotel' costs. The health community has not published a thorough economic analysis of all of these factors for SMH, CGH or GRH. However, the economic evaluation of the Edgware Birth Centre reported care to be approximately 30% cheaper for women booked to have their care at EBC. These were accounted for by the significant reductions in intervention rates, length of labour and length of postnatal hospital stay<sup>11</sup>. The Crowborough Birth Centre also calculated that the midwifery staffing costs per birth were 15% lower than at the local District General Hospital<sup>12</sup>. Reducing medical involvement also increases obstetrician's time for managing high-risk women and results in better use of resources by minimising duplication by medics and midwives<sup>13</sup>.

The case for closing Stroud Maternity Hospital should be judged on two grounds, firstly whether the savings proposed are realistic and secondly whether by using Payment by Results the hospital provides value for money.

The savings initially assumed to follow the closure of SMH amounted to £400,000 comprising:

Reduction of 8 midwives and 4 HCAS	£370,000
Building costs (energy rates etc)	£25,000
Medical cover	£8,000
Administration/overheads	£25,000
	£428,000
Offset by increased costs to cover + homebirths, travel etc	£28,000
TOTAL	£400,000

However, during the course of this consultation the PCT has acknowledged that its estimates of savings were over ambitious and has now revised it's projected savings down to less than £250,000.

Even so it appears the health community is still ignoring a number of additional costs it will incur through reprovision of services. This will include:

- The financial implications of increased staffing levels at GRH to provide day care and day assessment to women who require observation or investigation during pregnancy and telephone and drop-in advice to women concerned about their or their baby's health. Currently SMH deals with almost 2000 antenatal outpatient and inpatient cases a year and provides telephone and drop-in advice on more than 4000 occasions. If this care is not funded adequately at GRH it will result in more women consulting their GP or attending A&E, both of which will have cost implications for the wider NHS.
- The financial implications of increased length of postnatal stay for women who have a traumatic delivery or who are socially at risk. Currently over 300 women per year transfer from other hospitals to Stroud for postnatal care. This is in effect a cost transfer from SMH to GRH.
- Maintaining the existing level of community antenatal and postnatal services to 1200 women a year in Stroud will entail additional expenditure for hosting consultant outreach clinics, facilities for ultrasound scanning, group sessions for childbirth and parent preparation, drop-in sessions for breastfeeding and postnatal support in addition to midwifery consulting rooms. It is also unlikely that the remaining midwifery workforce will be sufficient to provide this workload and cover the projected increase in homebirths.

If these elements were thoroughly costed, it is likely that the hoped for savings would be considerably further reduced, and that year on year running costs would be increased.

In addition, the health community has not demonstrated that the existing service fails to provide value for money. The NHS reform agenda includes a new way of funding health services (Payment By Results), which for the first time introduces transparency into the NHS system by establishing a national tariff that is multiplied by activity to determine income.

Whilst PbR is not currently being used as the basis for funding Stroud Maternity Hospital, it will by 2008 become the mechanism for funding all NHS services, by which time not just inpatient but also community activity will be included within the scope of the tariff. The new funding mechanism means that regardless of where the women who currently use Stroud Maternity Hospital are cared for in the future, the cost to the PCT (and therefore the NHS) will not change. Reconfiguration as proposed will merely ensure that all maternity-generated income across the county will go to GRH, which will then have the freedom to decide how much of this income to use on maternity care and how much to use cross-subsidising its other health services.

This is an important distinction because using PbR principles and the limited financial data that is available, it appears highly likely that Stroud Maternity Hospital is not only financially viable in its own terms, but could make a small contribution to the rest of the health economy. Multiplying known activity (both inpatient and outpatient) by the tariff price, the income of Stroud Maternity Hospital can be estimated to be as much as £1.6m. Using the data provided within the consultation document relating to both staffing costs and running costs, the full cost of operating Stroud Maternity Hospital appears to be £1.0m. Even allowing for margins of error of 20% reduction in income *and* 20% increase in costs in recognition of the lack of robust financial data upon which to work, SMH would remain financially viable. Appendix 2 presents the detailed financial assumptions upon which this conclusion has been reached.

#### (v) How will the changes affect the local population?

All of the available national evidence indicates high levels of satisfaction amongst women using midwifery led units such as Stroud Maternity Hospital, because they offer women who use them a greater sense of autonomy. The long-term implications of this may be significant for the emotional and physical health of women, their babies and families. Women who choose such units are more likely to be strongly motivated to participate in childbirth decision-making<sup>14</sup>. Midwife led units also offer higher quality postnatal care, not just to the women who deliver at them, but also to women who give birth at a consultant unit but need or require a longer postnatal stay. Postnatal care is universally the element of maternity care with which women are least satisfied.

Government policy is that women should be offered a genuine choice of place of birth, a point emphasised by successive health ministers. In 2004 then Health Minister Stephen Ladyman visited and praised the Dover Midwife Led Unit, which operates in a similar fashion to Stroud Maternity Hospital, he said at that time: ***“The NHS already offers birthing facilities in various types, sizes and locations of maternity units, as well as at home. We do not favour one model over others but rather a diversity of provision so that women can choose the service that best suits her needs and wishes. And I want this range of choice to be available everywhere.”***<sup>15</sup> The importance of genuine choice is further underlined in the draft NICE guidance on intrapartum care, issued for consultation in Spring 2006, which states that: ***“Women should be offered the choice of planning birth at home, in a midwifery-led unit or a consultant unit”***<sup>16</sup>

Women within the Gloucestershire health community currently have five choices of place of delivery:

- Birth at home

- Birth in Stroud Maternity Hospital (for those fitting the criteria)
- Birth at Cheltenham General Hospital
- Birth at Gloucester Royal Hospital's along side midwifery led unit
- Birth at Gloucester Royal Hospital's consultant unit

These proposals will reduce women's choices to three places of birth, two of which will be within the campus of a large acute hospital. The consultation also suggests that one impact of the changes may be to encourage a higher home birth rate. Whilst in quality terms a higher planned home birth rate would be welcome, in fact the proposals actually make it harder for maternity services to sustain a home birth service into the future. Home births are only possible where midwives are motivated and committed to providing flexible on-call cover and where women have confidence that a known and trusted midwife will be able to attend them in labour. Without established community bases these are unlikely to be achieved and thus in time all choice of place of delivery is likely to disappear.

#### **(vi) Will the changes affect all members of the community equally?**

Inequalities in maternity care both in terms of access and outcomes remain stark. Women from the most disadvantaged groups in society are about 20 times more likely to die in childbirth than women in the highest two social classes and their babies are more than twice as likely to die before reaching their first birthday. Women living in disadvantaged or minority communities are significantly less likely to access maternity services early or to maintain contact with traditional midwifery care throughout their pregnancy. In consequence maternal and infant outcomes are poorer for women from these communities with higher rates of infant mortality, low birth weight, smoking during pregnancy and postnatal depression. Government policy highlights the need for maternity services to emphasise the needs of vulnerable and disadvantaged women. The NSF particularly mentions:

- Women who request support coping with domestic violence
- Disabled women
- Women who request support in stopping smoking
- Women who are substance misusers
- Women who have mental health problems<sup>17</sup>

Government policy emphasizes the need to ***“provide services in an acceptable way to those women who are not comfortable accessing formal health settings, including outreach services”***<sup>18</sup>.

Stroud Maternity Hospital is based firmly within its local community and therefore plays a key part in the local NHS's objective of providing local, responsive care, particularly for women who may feel uncomfortable in a large hospital environment. By knowing the local area well and by liaising with relevant agencies, staff at SMH can provide a focus for targeting and supporting vulnerable women and those with social needs<sup>19</sup>.

Stroud Maternity Hospital offers continuity of care in the antenatal and postnatal period to all women. This is particularly important for vulnerable or excluded women and is linked to improving rates of infant mortality amongst high-risk women. It also increases the chance of women experiencing domestic violence disclosing abuse and seeking

help. In these cases SMH is able to refer and work with local women's refuges. Continuity of carer is particularly important in building trust amongst families where liaison with social services may be required and midwives at Stroud ensure that women requiring additional parenting support receive a seamless service. In addition SMH has links to the "Young Mums to Be" scheme's outreach workers in Stroud and Dursley and provides specific antenatal classes for teenagers. Midwives working at SMH also have good working relationships with local health visitors. Women with special needs are encouraged to have longer postnatal stays at Stroud in order to assess and establish their parenting skills, indeed Stroud midwives have developed a specific assessment tool, which is now widely used in other units.

Centralising services at Gloucester transfers social costs (time, childcare arrangements) and economic costs (fares, parking) to women and their families. Whilst the proposal suggests that antenatal and postnatal care services will remain unchanged, this has not recognized that as a result of closing Stroud Maternity Hospital, women may have to travel to Gloucester for Consultant appointments, ultrasound scans, CTG monitoring and other clinical investigations. The travel time from Stroud to Gloucester can be anything up to 45 minutes at peak times and longer for women reliant on public transport. For women in the South of the County, travel times will be considerably longer and using public transport would make a long and difficult journey. Parking at Stroud is currently free but is charged at Gloucester. These costs will have a greater impact on those women most in need of regular and consistent contact with the maternity service. In assessing the economic basis of small units, health economists at the National Perinatal Epidemiology Unit have concluded: ***"Closure of small units on grounds of rationalization may simply represent a transfer of costs between sectors of the economy, in particular from the NHS to individual families or to social services and social security. Districts may lose unmeasured resources, as voluntary support for community hospitals may not be transferred on the closure of small units"***<sup>20</sup>.

**(vii) What is the clinical, financial and management case for proposing the changes?**

Midwifery led units such as Stroud Maternity Hospital, sometimes known as birth centres, are by definition, philosophically committed to minimising intervention in childbirth.

***"A birth centre is an institution that offers care to women with a straightforward pregnancy and where midwives take primary professional responsibility for care. During labour and birth medical services, including obstetric, neonatal and anaesthetic care are available should they be needed, but they may be on a separate site, or in a separate building, which may involve transfer by car or ambulance."***<sup>21</sup>

***"Birth Centres embrace a social model of maternity care that empower women to make their own decisions and promote an alternative wellness model of pregnancy and birth guided by principles of prevention, sensitivity, safety, appropriate medical intervention and cost effectiveness."***<sup>22</sup>

There have been no randomised controlled trials of freestanding units as compared with hospital delivery. However, from the observational studies it is clear that women using freestanding midwifery led units are significantly more likely to experience spontaneous vaginal birth, less likely to have an instrumental delivery or use intrapartum analgesia/anaesthesia and less likely to have a caesarean section. They are also more likely to initiate and continue breastfeeding and have reduced length of antenatal and postnatal stay.<sup>23 24 25</sup> Research also indicates that a positive experience of childbirth is linked to satisfaction with motherhood, a beneficial effect on women's emotional wellbeing and an enriched adjustment to parenthood<sup>26</sup>.

The draft NICE intrapartum guidelines conclude that stand-alone midwifery units (such as Stroud) ***“reduce the likelihood of pharmacological analgesia and increases the likelihood of intact perineum, a spontaneous vaginal birth and satisfaction compared with planning birth in a consultant unit”***.

Comparative data presented in Table 1 below indicates that despite it's alongside midwifery led unit, Gloucester Royal Hospital struggles to promote normality in childbirth. Its intervention rates are higher than the national average and higher than neighbouring units. Evidence suggests that in general larger units (above 5000 deliveries a year) find it more difficult to reduce unnecessary interventions than smaller units<sup>27</sup>. The data also confirm that Stroud Maternity Hospital is successful in promoting normality and minimising interventions. All women delivered at Stroud are booked before 12 weeks of pregnancy and almost all (99%) receive 1:1 care in labour – both key Government indicators of a quality service. The breastfeeding rate at Stroud is also significantly higher than the national average with 84% of women initiating breastfeeding and 74% still breastfeeding at the point of discharge compared to 61% nationally. There can be little optimism that transferring intrapartum care from Stroud and Cheltenham will improve the overall quality of maternity services, in fact it is likely that intervention rates will increase for all women.

Table 1: Comparative intrapartum outcomes 2004 (Source: Trust supplied data to Dr Foster Birth Guide)<sup>a</sup>

Intervention	Unassisted vaginal delivery	Caesarean section	Instrumental delivery	Induction	Episiotomy
Cheltenham	43.3%	26.2%	10.1%	22.4%	13.6%
Gloucester	50.7%	28%	14.8%	26.7%	14.9%
Stroud	100%	-	-	-	-
English average	46.7%	23.8%	11.4%	21.2%	12.8%

Stroud Maternity Hospital offers more than a place of delivery. It provides the following services for a much larger number of women than the 314 who actually deliver there:

- Antenatal clinics

<sup>a</sup> Statistics on intrapartum outcomes are collected by NHS Trusts and reported to the DH annually. For patients the Dr Foster website (in partnership with the DH) provides access to comparative data upon which to make choices. This data is collected annually from individual Trusts who are responsible for its accuracy.

See [www.drfooster.co.uk/localServices/birthGuide.asp](http://www.drfooster.co.uk/localServices/birthGuide.asp)

- Ultrasound scanning
- Drop-in facilities
- In patient and outpatient care for women requiring observation antenatally
- Birth preparation, parenting and health education classes
- Visiting consultant outreach clinics
- Postnatal care and transitional care

Furthermore, its activity, see Table 2, for 2005-06 illustrates a thriving community facility that is bringing a range of services closer to the community. SMH also impacts on the quality of local services in the neighbouring acute trusts by easing the pressure on Cheltenham and Gloucester's obstetric units leaving them able to devote more time and resources to high risk women.

Table 2: Activity at Stroud Maternity Hospital 2005-2006 (Source: SMH)

<b>Activity</b>	<b>Number of episodes</b>
Booking for antenatal care	1220
Deliveries	314
Home deliveries attended by midwives	44
BBA's	7
Planned Stroud Delivery but transferred antenatally to consultant care	26
Planned Stroud delivery but transferred during labour to consultant care	121
Additional postnatal care for women who delivered in consultant unit	335
Day care for women experiencing problems/concerns during antenatal period	1956
Telephone support to women in addition to scheduled antenatal care	4080

**(viii) Do local people patients and staff support the proposals**

According to a survey conducted by the Royal College of Midwives, midwives who work in midwife led units have very high levels of job satisfaction, with 80% preferring it to working in a hospital environment. They are important for midwives because they provide a focus for a social rather than a medical model of maternity care<sup>28</sup>. Midwives morale and job satisfaction is related to their perceived ability to practice in an autonomous and self organising way, utilising their full professional role assessed alongside the relative strengths of other potential factors such as pay and family-friendly working arrangements. In an empirical study Birch suggests burn out is more likely to be associated with conventional team midwifery where midwives provide care for a large group of women, but do not necessarily have the opportunity to form relationships with many of them<sup>29</sup>. This will undoubtedly be the case if maternity services are centralised into one unit. Sandal's work on stress and burn out in midwifery concludes that the three factors that mitigate against midwives being stressed are: occupational autonomy, access to social support at home and work and the opportunity to form meaningful relations with women. By occupational autonomy, Sandall identifies level of control over work, flexible hours, reduced uncertainty in organisation of work and working patterns

that suit<sup>30</sup>. Evidence from other countries, notably the Netherlands and New Zealand indicate that autonomous midwives have greater job satisfaction and although such care and particularly attending home births can be a strain, this is more than compensated by the high morale of midwives<sup>31</sup>.

It cannot be assumed that all of the midwives currently working in Stroud and Cheltenham will wish to or be able to transfer to Gloucester. This will not only lead to increased one-off costs of redundancy but will also deplete the number of skilled and highly experienced midwifery staff available to provide quality care to local women. In fact, midwives in Stroud and Cheltenham do not support these proposals and those in neighbouring units are also concerned at the negative impact the reconfiguration will have for women living on the borders.

Midwifery led units offer choice not only to women, but also to staff. As part of a strategy to offer staff a range of working patterns and opportunities, which make the full use of their skills, Stroud Maternity Hospital can be justified in terms of its impact on improving recruitment and retention.

Based on its activity data Stroud Maternity Hospital is used by around 1500 women a year. Its proposed closure has resulted in an enormous local community campaign, with 4000 people joining a march against closure of it and the neighbouring mental health unit; 2,500 "Save our Hospital" wristbands and 300 T-shirts were sold within 1 week and the dedicated website has had almost 3,000 'hits'. 15 of the 19 local GP practices have signed a statement of support indicating their view that the closure is short-sighted and will not achieve the proposed financial savings. Stroud Maternity Hospital has increased activity in recent years and appears to be a popular and successful local facility, which is highly valued by the local population.

**(ix) How do the proposed changes compare to recognised good practice and National Service Frameworks? Do they reflect current knowledge of best practice?**

Government policy stresses the importance of planning services that achieve choice, accessibility, local provision, acceptability and cost-effectiveness. The recent White Paper "Our Health, Our Care, Our Say"<sup>32</sup>, signals a shift to community-based services: ***"It will mean a maternity service in which all women are offered a choice of where they have their baby. Wherever possible, this is likely to include offering midwifery led services provided at home, in a 'home-like' setting or in hospital..."*** This commitment to retaining and expanding community hospitals has been underlined by the investment of an additional £750m to support existing community provision, announced in July 2006<sup>33</sup>.

The Maternity NSF requires hospitals to improve the quality of local services by increasing access and choice and in particular to target vulnerable and disadvantaged women by ensuring that: ***"The range of antenatal, birth and post birth care services available locally constitutes a real choice for women"***, and ***"Local options for midwife led care will include midwife led units in the community or on a hospital site and births at home for women who have been appropriately assessed."***

Since the publication of the Cumberlege Report “Changing Childbirth”<sup>34</sup> there has been a political and professional consensus that women want choice in the type of maternity care they receive and that birth outside of acute hospitals is for many women as safe as hospital birth. Maternity services were included in the 2004 national consultation exercise “Choice, Responsiveness and Equity” to improve patient and user experience in the National Health Service. The outcomes from that consultation have fed directly into subsequent policy initiatives including: midwife as first point of contact; every woman to have a birth plan and an emphasis on normality.

The case for retaining small midwifery led community units has also been upheld by the House of Commons Health Committee, which concluded after reviewing the evidence in 2003 that: ***“We believe as did our predecessor committee, that there should be a presumption against closure of smaller maternity units because without them the shift in attitude which they wanted and we want to see will be very much harder to deliver”***<sup>35</sup>.

Set against this policy backdrop and the clinical drivers for NHS reform, the proposal to centralize all intrapartum care in one site by closing successful, cost and clinically effective and popular local units appear incongruous to say the least.

## **CONCLUSIONS**

**Stroud Maternity Hospital is clinically effective, provides value for money (using PbR) and is popular with both the local community and staff.**

**These proposals run counter to national government policy for the NHS, for both community services and maternity care.**

**These proposals run counter to Gloucester health community’s own 2004 proposals for service reconfiguration and Cotswold and Vale PCT’s 2006 vision for the future of community services.**

**These proposals cannot be justified in terms of the impact they will have on key NHS performance criteria:**

- **Access**
- **Choice**
- **Quality**
- **Recruitment & retention**
- **Public health**

**These proposals are designed to achieve short-term financial savings of £400,000. The data supplied by the health community does not give confidence these can be achieved.**

**The case for closing Stroud Maternity Hospital is not demonstrated in the proposals set out by Gloucestershire Health Community. Indeed the case for retaining the unit is compelling.**

**Dr Suzanne Tyler  
Associate HSMC  
August 2006**

## NHS REFORM PRINCIPLES AND IMPACT OF GLOUCESTERSHIRE PROPOSALS

The NHS is currently midway through an ambitious 10-year plan to modernise and reform the way it delivers care. Whilst one of the central themes of the reforms is to give greater freedom to local health economies, there is a strong and clear agenda from the Government through the Department of Health about the principles and objectives of reform. These have been most recently set out in *Health Reform in England: Update and Commissioning Framework* (DH, 2006). It is therefore appropriate that any proposals made locally should be evaluated against their contribution to these objectives and principles. **The proposed reconfiguration of maternity services, and particularly the closure of inpatient facilities at Stroud and Cheltenham FAIL to make a positive contribution to any of the principles and objectives articulated by the Secretary of State in July this year.**

NHS Reform Principle	Impact of proposed local reconfiguration	
Money follows the patient, rewarding the best and most efficient providers and giving others the incentive to improve	Patients are forced to follow money because there will be only one maternity provider. Rewards the provider which has the least good obstetric outcomes	FAILS
More choice and a much stronger voice for patients connected to strong commissioning by practices and PCTs	Restricts choice for women. Undermines PBC because GPs oppose closure	FAILS
More diverse providers with more freedom to innovate and improve services	Reduction to one provider will decrease incentive to improve	FAILS
A framework of system management, regulation and decision making which guarantees safety and quality, equity and value for money	Consultation process flawed by insufficient detail and analysis. Financial data available does not support value for money claims	FAILS
<b>NHS Objectives</b>		
Improve health and well-being and reduce inequalities and social exclusion	At best will have no positive impact at all. Reduction of local services likely to be felt most harshly by less well off.	FAILS
Improve the quality, effectiveness and efficiency of services	At best will have no positive impact at all. Likely to lead to increased intervention rates, poorer continuity of care	FAILS
Increase choice for patients and ensure a better experience of care through greater responsiveness to people's needs	Will restrict choice and lead to a worse experience of care for all women denied choice of locally based midwifery led care. Unresponsive to local demands	FAILS
Achieve best value within the resources provided	Services that appear to be financially viable are being withdrawn	FAILS

## FINANCIAL MODELLING OF VIABILITY OF STROUD MATERNITY HOSPITAL

It is understood that all activity at Stroud Maternity Hospital is currently funded by a block contract with the local PCT. The value of this will be based on historic activity levels and the negotiating position of past managers and is unlikely to reflect the true costs of providing the service. However, this will not remain the case, by 2008 all NHS services will be commissioned using Payment By Results, under which there is a national price list for all activity within the scope of PbR – this is the “national tariff”. Providers are paid according to the amount of activity they do, multiplied by the relevant tariff price. Thus Activity x Price = Income.

Using the current tariff prices it is possible to estimate that the potential income of Stroud Maternity Hospital could be as much as £1.6m if commissioners paid in full for all of the activity currently undertaken. This is made up of the value of activity currently payable within PbR (mainly inpatient care), see table 3 and an estimate of the likely value of activity currently excluded from PbR (mainly community based care and transitional care), see table 4.

Table 3: ACTIVITY PAYABLE UNDER PbR 2005-2006

Description	Activity	Tariff £	Total
Normal deliveries without complications	314	842	264,388
Routine antenatal care	1100	154/66	677,468 <sup>b</sup>
Day cases	1956	154	301,224
<b>TOTAL</b>			<b>£1,243,080</b>

Table 4: ACTIVITY EXCLUDED FROM PbR 2005-2006

Description	Activity	Value <sup>c</sup> £	Total
Home deliveries & BBAs	51	500	25,500
Intrapartum transfers	121	300	36,300
Advice calls	4080	40	163,200
Postnatal transfers in	335	500	167,500
<b>Total</b>			<b>392,500</b>
<b>ESTIMATED VALUE OF BLOCK CONTRACT</b>			<b>£300,000-£400,000</b>

<sup>b</sup> Reference cost guidance for 2006 has signalled the intention to allow non-consultant clinics to be counted as valid outpatient activity. (DH, 2006). We can therefore calculate the cost of routine antenatal care using the following formulae:

1/3 of 1100 bookings are primips and receive 1 + 9 antenatal appts (NICE guidance)

$366 \times 154 + (9 \times 66) = £273,768$

2/3 of 1100 bookings are multips and receive 1 + 6 antenatal appts (NICE)

$734 \times 154 + (6 \times 66) = £403,700$

<sup>c</sup> None of these activities yet has a tariff price. I have assumed that any tariff for these activities will be less than the existing full tariff price to reflect the different circumstances in which care is delivered

Set against the income derived from PbR has to be the actual costs of running SMH. This will be the way in which commissioners and providers can judge value for money. The full costs of running Stroud Maternity Hospital can be calculated using the financial data presented in the consultation document:

Midwifery staffing	21 x 34,713 <sup>d</sup>	728,973
HCA staffing	6 x 17,221 <sup>e</sup>	103,326
Energy rates etc		25,000
Medical Cover		8,000
Administration		25,000
CNST premium		116,000
<b>TOTAL</b>		<b>1,006,299</b>

The long term financial viability of Stroud is made more likely by the introduction in 2008 of a revised version of HRGs, see table 5 allowing far more maternity activity to be brought within tariff. Whilst the tariffs for these new HRGs are yet to be calculated, they do indicate that much of the value added services provided by Stroud (postnatal stays for women who experienced a traumatic birth at one of the acute hospitals and unscheduled antenatal contacts with midwives) will be funded. Again, unless these activities were to stop, the PCT will be funding them wherever they take place.

**TABLE 5: REVISED HRGS FOR MATERNITY CARE, APPLICABLE FROM 2008**

<b>HRG v4</b>	<b>Label</b>
N13.00	Normal delivery with no complications > 18 years old
N13.0P	Normal delivery with no complications < 19 years old
N14.00	Normal delivery with complications > 18 years old
N14.0P	Normal delivery with complications < 19 years old
N16.00	Assisted delivery with no complications
N17.00	Assisted delivery with complications
N19.00	Caesarean section with no complications > 18 years old
N19.0P	Caesarean section with no complications < 19 years old
N20.00	Caesarean section with complications
N22.00	Clinical contact with observation (ante- or post-natal) > 18 years old
N22.0P	Clinical contact with observation (ante- or post-natal) < 19 years old
N23.00	Clinical contact with investigation (ante- or post-natal) > 18 years old
N23.0P	Clinical contact with investigation (ante- or post-natal) < 19 years old
N24.00	Clinical contact with full investigation (ante- or post-natal)
N25.00	Admission (overnight) with observation only > 18 years old
N25.0P	Admission (overnight) with observation only < 19 years old
N26.00	Admission (overnight) with investigation > 18 years old
N26.0P	Admission (overnight) with investigation < 19 years old
N27.00	Admission (overnight) with full investigation

<sup>d</sup> Mid point band 6 + 30% on costs

<sup>e</sup> Mid point band 2 + 30% on costs

## REFERENCES

- 
- <sup>1</sup> Health Care Audit (2006) Report on issues and concerns on 'The Future Healthcare in Gloucestershire: Proposals for Developing Sustainable NHS Services – A Public Consultation', Advice to Gloucestershire CC OSC
  - <sup>2</sup> DH (2006) Health Reform in England: Update and Commissioning Framework, TSO, London
  - <sup>3</sup> DH (2004) National Service Framework for Children, Young People and Maternity Services
  - <sup>4</sup> National Institute for Clinical Excellence (2006) Intrapartum Care: Care of Healthy Women and their Babies During Childbirth (Draft Guideline Consultation)
  - <sup>5</sup> Gloucestershire's PCTs (2004) Investing in excellence: a consultation on the specialist care of mothers, babies, children and young people
  - <sup>6</sup> The Information Centre (2006) NHS Maternity Statistics, England: 2004-06
  - <sup>7</sup> Saunders D et al (2000) Evaluation of the Edgware Birth Centre, Barnet Health Authority, London
  - <sup>8</sup> House of Commons Health Committee (2003) Provision of maternity services: 4<sup>th</sup> report of session 2002-2003 Volume 1 (HC464-1) The Stationery Office, London
  - <sup>9</sup> Saunders D et al *ibid*
  - <sup>10</sup> Personal communication with Head of Midwifery in Shrewsbury, March 2004
  - <sup>11</sup> Saunders D et al *ibid*
  - <sup>12</sup> Rosser J (2001) Birth Centres across the UK: A win/win strategy for saving normal birth, RCM Midwives Journal Vol. 4 No 3 pp88-89
  - <sup>13</sup> Reddy K, Reginald PW, Spring JE, Nunn L and Mishra N (2004) A free standing low risk maternity unit in the United Kingdom: does it have a role? Journal of Obstetrics and Gynaecology Vol. 24 No 4 pp360-366.
  - <sup>14</sup> Feldman E & Hurst M (1987) Outcomes and procedures in low risk birth: a comparison of hospital and birth centre settings, Birth, Vol. 14 No 1 pp18-24
  - <sup>15</sup> Speech by Stephen Ladyman MP, Parliamentary Under secretary of state for Community, 15<sup>th</sup> May 2004: promoting Normality
  - <sup>16</sup> NICE (2006) Intrapartum Care: Care of Healthy Women and their Babies During Childbirth (Draft Guideline Consultation)
  - <sup>17</sup> DH (2004) National Service Framework for Children, Young People and Maternity Services, TSO, London
  - <sup>18</sup> DH (2006) Our Health, Our care, our Community – investing in the future of community hospitals and services, TSO, London
  - <sup>19</sup> D'Souza L and Garcia J (2004) Improving services for disadvantaged women Child: care Health & Development Vol 30, pp599-611
  - <sup>20</sup> Campbell R, Macfarlane A (1994) Where to be born? The debate and the evidence, national Perinatal Epidemiology Unit, Oxford
  - <sup>21</sup> Birth Centre Network (2005) What is a Birth Centre? BCN
  - <sup>22</sup> Royal College of Midwives (2004) Position Statement: Birth Centres, RCM, London
  - <sup>23</sup> Hodnett ED, Downe S, Edwards N, Walsh D (2005) Home-like versus conventional institutional settings for birth (review), the Cochrane Collaboration, John Wiley & Sons
  - <sup>24</sup> Stewart M, McCandlish R, Henderson J, Brocklehurst P (2005) Review of evidence about clinical, psychological and economic outcomes for women with straightforward pregnancies who plan to give birth in a midwife-led centre and outcomes for their babies. Report of a structured review of birth centre outcomes, National Perinatal Epidemiology Unit, Oxford.
  - <sup>25</sup> Saunders D et al *ibid*
  - <sup>26</sup> Ball J (1989) Postnatal care and adjustment to motherhood, in Robinson S, Thomson A (Eds) Midwives, Research and Childbirth, Chapman and Hall, London
  - <sup>27</sup> Ryan M & Roberts C (2005) A retrospective cohort study comparing the clinical outcomes of a birth centre and labour ward in the same hospital, Australian Midwifery Journal, Vol. 18 No 2 pp17-21
  - <sup>28</sup> Kirkham M (2003) A cycle of empowerment: the enabling culture of birth centres, The Practicing Midwife, Vol 6 No 11 pp12-14

- 
- <sup>29</sup> Birch L (2001) Stress In Midwifery Practice: An Empirical Study, British Journal Of Midwifery, Vol. 9, No 12 pp730-734
- <sup>30</sup> Sandall J (1997) Midwives Burn Out And Continuity Of Care, British Journal Of Midwifery, Vol. 5, No 2 pp106-111
- <sup>31</sup> Bakker R, Groenewegen P, Jabaaij L, Meijer W, Sixma H & De Veer A (1996) Burn Out Amongst Dutch Midwives, Midwifery, Vol. 12 pp174-181
- <sup>32</sup> DH (2006) Our Health, Our Care, Our say – A new direction for maternity services, TSO, London
- <sup>33</sup> DH (2006) Our Health, Our Care, Our Community – Investing in the future of community hospitals and services, TSO, London
- <sup>34</sup> Department of Health (1993) Changing Childbirth: the report of the expert maternity group, DH, London
- <sup>35</sup> House of Commons Health Committee (2003) Choices in Maternity Services: 9<sup>th</sup> Report of Session 2002-2003, Volume 1 (HC796-1) TSO, London