Introduction
This paper provides an introduction to the supporting papers *Future arrangements for midwifery-led care in Berwick* presented to the Joint Locality Executive Board on 22 May 2013.

Due to safety concerns following two incidents, Northumbria Healthcare NHS Foundation Trust (NHCFT), the service provider, suspended births in Berwick in August 2012. NHCFT undertook to secure the safest model of care for low risk births at Berwick, looking at issues and seeking solutions. Paramount to this was, and remains, safety and quality of care. The NHS Northumberland Clinical Commissioning Group (CCG) Joint Locality Executive Board met to consider the report and the views of its four localities (West, Central, Blyth Valley and North) to make a collective decision about the future arrangements for provision of midwifery-led care.

The unit at Berwick is the smallest midwifery-led care unit in England. When this was first looked at a decision was made not to have a discussion about possible closure of the unit. It was felt that this would reduce choice and as a rural CCG, Northumberland has a responsibility to ensure existing services are maintained where appropriate and more services are developed in the community provided safety and quality standards are met.

The following options were offered to the CCG for consideration:

- **Option 1**
  To resume services as they were before the temporary suspension of deliveries and inpatient postnatal services on 1 August 2012. This would include all antenatal care for low and high risk women, hospital and community deliveries for low risk women and 24/7 inpatient postnatal care and community midwifery services. This option would require the recruitment of additional midwives to allow for regular rotation and the unit to remain open 24/7.

  or

- **Option 2**
  The provision of a 24/7 on call midwifery-led service which would mean low risk women could give birth in Berwick, either in a birthing room or at home. Women would return home six hours after giving birth and there would be an enhanced community midwifery service to provide more support for women at home. All of the existing hospital and community antenatal care for low and high risk women would continue. This option would also require regular rotation of midwives.

  or a variant upon either option.

The CCG members and subsequently the Joint Locality Executive Board were tasked to consider the decision in the light of the requirement under section 26 of the Health and Social
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Care Act 2012, embedded in the CCG constitution, for the CCG to:

- ‘exercise its functions effectively, efficiently and economically’

They were also reminded of national requirements in respect of reconfiguration, which comprise four tests:

- Support from GP commissioners;
- Strengthened patient and public involvement (including feedback from the consultation and the extent to which patients, the public and stakeholders had been engaged);
- Clarity about the evidence base (including national guidelines, clinical negligence scheme for trusts and evidence on free standing midwifery-led units)
- Patient choice

as initially set out in Sir David Nicholson’s letters dated 20 May 2010 and 29 July 2010 and subsequently endorsed by the Secretary of State (Gateway 14335).

Public consultation process
Before formal consultation started, the then commissioners, NHS North of Tyne engaged with key local stakeholders and commissioned independent research to find out what is important to local women in terms of service provision when they become pregnant. The formal 14-week public consultation led by NHS North of Tyne in line with Sections 242 and 244 of NHS Act started on 11 December 2012. There were concerted efforts to engage the public and involve the parish/town and county councils. Details of the consultation process and feedback can be found in section 2.3.2 of the report and in the report appendix B.

The Northumberland County Council Care and Wellbeing Overview and Scrutiny Committee was involved in line with Section 244 of the NHS Act before and during the formal public consultation and at one of its meetings concluded (and minuted) that the consultation had been robust.

Key considerations from member GP Practices and localities
Central locality – the focus of discussion was around quality and the safety of mothers and babies and included:

- Keeping midwives skills up to date
- Concern that midwives were underutilised
- Equity of access across Northumberland and why, in some cases, mothers discharged from Wansbeck go to Berwick for extended post natal stay

All nine GP Practices opted for option two.

West locality – three themes were considered, safety, equity of access to services and good and effective use of public resources.

It was felt that both models could be provided safely and would continue to provide a
service for the Berwick area. It was also noted that whilst option two could be done within resources, option one could not.

Option two was considered to free up resources to provide postnatal care.

It was also noted that going home from hospital when safe to do so would be clinically preferable to a prolonged inpatient stay after giving birth.

Eleven GP Practices chose option two, one Practice chose option one and three Practices did not respond.

Blyth Valley locality – there was extensive discussion during which concerns were expressed about equality in the system if option one with the capacity for a prolonged postnatal stay was chosen.

There was a feeling that there are far fewer births now and the risk averse medical culture means that these are done in centres of excellence. It was discussed that women often chose delivery in a midwifery-led unit as this was perceived as a safer option than a home delivery.

All ten GP Practices in Blyth Valley chose option two.

North locality – the locality has kept a close eye on the whole process and discussion.

Those GP Practices that chose option two did so after considering financial and staffing resource concerns. Those that chose option one did so in a role of a patient advocate and did not consider resources issues.

There was in-depth discussion around rotation of staff and the merits of running a 24 hour system that is not an on call system.

With regards to postnatal care, there was concern about limiting this to six hours. It was felt that the length of stay should be a clinical decision and that postnatal care should not be any different than elsewhere in healthcare.

Six GP Practices chose option two, four Practices preferred option one and two Practices abstained on the grounds that those nearer Berwick should make the decision.

**Joint Locality Executive Board consideration**

The efficiency of running a unit that remained empty for a third of the year was considered.

There were concerns about the ability to recruit the required number of midwives to sustain the numbers required for option one.
The importance that choice is retained for mothers and that it is important to ensure that this is offered following national criteria and that everyone gets the correct information.

It was noted that both the NHCFT consultants and the Royal College of Midwives support option two.

**Conclusion**

The Joint Locality Executive Board agreed to support option two, a 24 hour on call midwifery led service with the unit open during the day, 9am – 6pm Monday to Friday and 9am – 2.30pm at weekends with the following requirements:

1. Length of inpatient post natal care (that was specified as six hours in the original option two) will now be based on clinical need and mothers will not be discharged during the night.
2. Enhanced and post natal services at Berwick and availability in unit need to be clearly described.
3. Consultant-led maternity units are tasked to ensure that women from rural areas who attend thinking that their labour may have started are allowed to stay for a while to see if it progresses rather than being sent home.

In addition to this the Joint Locality Executive Board committed to reviewing this on a monthly basis as part of NHCFT contract monitoring with more in-depth reviews of quality, safety and levels of provision on a quarterly basis.