

BRIEFING NOTE

Maternity services

**Background**

Between April 2015 and March 2016 there were 1,791 births at the Cumberland Infirmary Carlisle and 1,234 at the West Cumberland Hospital in Whitehaven. This meant these were two of the smallest seven consultant-led maternity units in England.

Maternity services are reliant upon a wide range of other specialisms and are closely interconnected with acute children’s services. The availability of obstetricians (maternity doctors), midwives, anaesthetists, paediatricians (children’s doctors) and other specialists is making it increasingly difficult, across the country, to provide 24-hour consultant-led maternity care in small district general hospitals with low numbers of births. Many hospitals are now struggling to recruit key staff. The number of available obstetricians is likely to fall further in the coming years and there is a national shortage of paediatricians with 1 in 4 senior trainee general paediatric posts vacant. Currently, across the country, over half of paediatric units are not meeting recommended staffing levels.

In 2014 we asked the Royal College of Obstetricians and Gynaecologists (RCOG) to look at the issues we were facing in maternity services and to provide expert advice. Their report said that the preferred option should be to continue with two consultant-led units – one at the Cumberland Infirmary Carlisle and one at the West Cumberland Hospital – however, the report also said: “the delivery of this option will succeed only if the staffing and quality issues are met.” The report noted how difficult this would be and recommended that we should explore other options at the same time and be prepared to move on to one of these other options if the RCOG preferred option proved impossible to deliver within a reasonable timeframe.

Following publication of the report, we worked for over a year to explore how we could deliver and sustain consultant led units. We have continued to meet with women who use the maternity service, local clinicians and regional and national experts. We have looked at maternity units that operate differently around the UK, and we have paid close attention to the National Maternity Review published earlier this year.

**Consideration of risk and benefit**

Whatever the configuration of maternity services giving birth involves elements of risk. One of the keys to high quality and safe maternity provision is to understand and minimise those risks. Midwives and obstetricians are highly skilled in understanding the risks for individual women and at taking action to keep things safe.

In considering the future of local maternity services the NHS in West, North and East Cumbria has had to take into account a number of factors including the risks and benefits attached to each option.

We have been honest about the challenges we face in recruiting the necessary staff to run two consultant-led maternity units in Carlisle and Whitehaven. We have been honest about the challenges we face in seeking to maintain quality standards in two of the smallest consultant-led maternity units in England. We have been honest in stating there are a range of clinical views about the best way forward.

The NHS would not suggest that one of the maternity options is ‘safe’ whiles others are ‘unsafe’. We have been clear that this consultation involves a choice between options that carry different risks.

* Maintaining a consultant-led maternity unit (option 1) makes the achievement of clinical standards more difficult and as related services – such as surgery and acute children’s services - would continue to rely on locum doctors there would be a continuing risk of closure at short notice due to lack of staff. This would be a particular risk for women living in West Cumbria who might be expecting to give birth at West Cumberland Hospital and who might discover at short notice that they couldn’t do so.
* Developing a standalone midwife-led maternity unit (option 2) would be more deliverable and would carry a lower risk of maternity unit closures at short notice due to lack of staff but some women would have to travel further to give birth or would need to be transferred during labour. Such journeys obviously carry an element of risk in an emergency.
* Consolidating maternity services in Carlisle (option 3) would help meet modernclinical care standards and would remove the need for transfers in labour (apart from women choosing home births or the Penrith Birthing Centre). It would also reduce the risk of maternity unit closures at short notice due to lack of staff. However, with this option more women would have to travel further to give birth.

Since the publication of the RCOG report detailed and comprehensive work has been undertaken to determine the feasibility of the options that were recommended with particular focus on how we could deliver Option 1. We have continued to involve national experts in our discussions, and we have looked to see if there are models or examples of units that operate differently around the UK. We have also looked at practice in other countries where workforce pressures aren’t so acute and where staff, including midwives, work differently.

However, examples from other parts of the world are not always transferable and do not necessarily fit with the way staff are trained and services are delivered in the UK. We explored many models of care to see if they could be adapted to work here and we have concluded there is no ‘off the shelf model’ that will fit West, North and East Cumbria. We have enlisted the help and advice of specialist colleagues within our clinical networks both in the north east and the north west and we have looked closely at the staffing issues and workforce forecasts for the next few years. We have also sought the help of nationally renowned maternity and children’s experts.

We are keenly aware, of course, that travel distances and times are a key concern for mothers-to-be, for professionals and for the public so we have looked for evidence that addresses this concern.

We have reviewed key documents such as the Public Health Wales Observatory Review from 2015 into the impact of distance/travel time to maternity services on birth outcomes.

Our discussions and literature reviews suggest we should be cautious about interpreting what little evidence there is in relation to distance and travel. The Public Health Wales Review notes that it “did not find conclusive evidence to support a causal link between increasing distance, or the time, required to travel from mothers’ residence to maternity services and adverse birth outcomes”. Where studies found some evidence of such an association they were “limited by their inability to account for important contributory factors and confounders” and relied on a number of “unsupported assumptions”.

We also had discussions with colleagues in the National Perinatal Epidemiology Unit at Oxford. We asked them if we could compare the relative risks of the maternity options available to us in order to establish a clear quantifiable understanding of the comparative risk. They advised us that any attempt to do this would be limited by the available evidence and would be unlikely to point to an obvious solution.

The National Perinatal Epidemiology Unit has undertaken a lot of research in this area which can be accessed on the following website:

<https://www.npeu.ox.ac.uk/birthplace/publications>

Faced with this information we cannot simply conclude that if the research evidence is not there we should make no changes to services at all. There are clear risks associated with continuing to provide a small consultant team service which is reliant on locums in a number of key specialties. We need to recognise these risks and compare the relative risks (and benefits) of all the possible options.

We have tried to be entirely transparent about the challenges and the risks. We do not suggest there is clear evidence on any of the options. So, in the absence of such evidence, we have worked with regional and national experts to consider the best way forward.

We are also clear that whichever option is chosen it will require risk mitigation and it will take some time to implement. It will not be implemented overnight. Our expert advice continues to be that option 1 will be difficult to sustain in the long term and although option 3 may be more straightforward it would mean there would be less choice for women in West Cumbria. This is why maternity option 2 was identified as our preferred option. No decisions have yet been made and we are genuinely interested in everyone’s perspective on the right way forward.

**The options described in the consultation document are as follows:**

**Option 1**

* Maintaining consultant-led units on both sites, with ‘alongside’ midwife-led units and special care baby units.
* This option is not the status quo – some high-risk mothers will birth at Carlisle.
* This option will use new ways of working to maintain safe staffing – one team across two sites with an innovative staffing structure.
* There will be a full range of antenatal and postnatal services as well as gynaecological services both in Whitehaven and Carlisle.
* The option for home birth and Penrith Birthing Unit will be available.

**Option 2**

* At Cumberland Infirmary in Carlisle: a consultant-led unit and ‘alongside’ midwife-led unit for births. There will be a full range of antenatal and postnatal care and a special care baby unit serving all of west, north and east Cumbria.
* At West Cumberland Hospital in Whitehaven: a 24-hour standalone midwife-led unit for low risk births and a daytime consultant service offering antenatal and postnatal care and some gynaecological services (non-emergency cases) (8am-8pm).There will not be a consultant-led service for births. There may be the ability to offer elective caesareans in this new staffing model in the future. It is anticipated women will not be transferred back to WCH for postnatal care as NICE guidance supports discharge to home as soon as possible. Women requiring medical treatment will remain in Carlisle. There will be an antenatal day assessment unit (8am-8pm) provided five days a week (Monday-Friday) and could be staffed by midwives with telemedicine support.
* Consultant obstetric and gynaecology input would be solely during the day but would include day case services across gynaecology (including day case surgery), outpatient investigations, emergency gynaecology unit, fertility, colposcopy and uro-gynaecology. All inpatient emergency gynaecology and complex elective gynaecology as well as the consultant-led obstetric unit would be at CIC.
* The option for home birth and Penrith Birthing Unit will be available.
* There will be a Dedicated Ambulance Vehicle (DAV) for maternity and paediatric transfers.

**Option 3**

* Cumberland Infirmary in Carlisle: a full obstetric service and a special care baby unit serving all of west, north and east Cumbria. Consultant-led service and ‘alongside’ midwife-led unit for births. There will be a full range of antenatal and postnatal care.
* West Cumberland Hospital in Whitehaven: no births at West Cumberland Hospital. Consultant and midwife out-patient antenatal and postnatal care available.
* There will be an antenatal day assessment unit (8am-8pm) provided five days a week (Monday-Friday) and could be staffed by midwives with telemedicine support.
* Consultant obstetric and gynaecology input would be solely during the day but would include day case services across gynaecology (including day case surgery), outpatient investigations, emergency gynaecology unit, fertility, colposcopy and uro-gynaecology. All inpatient emergency gynaecology and complex elective gynaecology as well as the consultant-led obstetric Unit would be at CIC.
* The option for home birth and Penrith Birthing Unit will be available.

*QUESTION: What is a consultant-led unit (CLU)?*

This is where there are both doctors (obstetricians) and midwives available. Obstetricians are doctors who specialise in pregnancies and births where there are complications. Obstetric units offer epidural pain relief, and have an operating theatre nearby in case a baby needs to be delivered by caesarean section. They also have special care baby units. Midwifery-led care is also offered within a CLU but has the support/availability on site of medical staff if complications arise.

*QUESTION: What is a midwife-led unit (MLU)?*

MLUs provide a welcoming, relaxed, comfortable and support environment for women and their families. We are committed to normal birth and view childbirth as a physiological process and a positive life experience, which enhances the long term physical and emotional wellbeing of women and their families.

Midwives work with women and their birth companions, involving them in all aspects of care to enable them to feel safe, confident and empowered. The midwives and support staff deliver high quality, evidence-based care, thereby supporting normal birth with competence and confidence and achieving positive outcomes for women and their families. Midwives provide antenatal, labour and postnatal care to women who fit the criteria for midwife-led care.

These are units where birth is viewed as a natural event. These are either ‘alongside’ a labour ward or delivery suite in a consultant unit, or ‘freestanding’ in a community setting. Both types of midwifery units are run by experienced midwives, who try to make the birthing environment homely and tranquil.

Such units do not offer epidurals but they offer other types of pain relief such as Entonox. The type of pain relief available will vary depending on the unit.

It is important to note that midwives are skilled and competent with managing labour and birth without medical assistance. Community midwives develop resilience to dealing with all types of scenarios and emergencies. The main point is developing strong contingency and support plans to deal with unforeseen events as they occur.

If you are having your baby in a midwifery-led unit or birth centre and the labour doesn’t progress as it should or if you or your baby need extra support, you would be transferred to the consultant unit. This would mean that a doctor and medical equipment would be on hand if needed.

*QUESTION: What type of births can happen in MLUs and homebirths?*

Women with no ongoing health problems who have been assessed as low risk can give birth at an alongside or freestanding MLU or plan a homebirth.

*QUESTION: What is a DAV ambulance?*

In Wales a Dedicated Ambulance Vehicle (DAV) is commissioned by the Health Board from the Welsh Ambulance Service Trust (WAST) to transport urgent maternal, neonatal and paediatric transfers from Withybush to Glangwili – a journey of just over 33 miles. We have used the experience in Wales to conclude that this would be a good additional service to support West Cumberland Hospital’s (WCH) services.

There are many similarities between Cumbria and Wales including geography, levels of deprivation and poor road infrastructure. Both areas have lower than average car ownership and public transport is limited.

Public concerns about the time taken to travel from the west coast in Wales are very similar to those expressed by residents in west Cumbria; in particular they are anxious that delays in reaching urgent and emergency care may result in deterioration of condition or outcome.

The DAV is staffed by a 10-strong team of paramedics and emergency technicians who provide 24/7 cover. Following a review of activity data, the RCPCH review concluded that there had been “no measurable deterioration in clinical outcomes” as a result of this service development.

As the team is underutilised in terms of transfers, the staff provide additional support to Withybush Hospital providing emergency training to staff, support for activity in the emergency department and on the wards, as well as occasional assistance in the MLU.

The vehicle is a ring-fenced resource provided to transfer women, babies and children from WCH to Cumberland Infirmary Carlisle (CIC) – and other specialist centres if the need should arise – and is in addition to the existing ambulance establishment.

*QUESTION: Why can’t the service stay as it is?*

The main issue facing small units like ours is the ability to recruit sufficient numbers of appropriately qualitied staff across a range of specialties in the short, medium and long term. Consultant-led maternity units are fully dependent on having access to other specialist support 24/7 including paediatrics, anaesthetics and emergency surgery. We currently face difficulties with the availability of paediatric doctors at different levels. Newly qualified doctors find it particularly attractive to work in large specialist units or in a specific area of children’s medicine.

In west, north and east Cumbria we cannot offer either of these benefits and, therefore, we do not have enough paediatric doctors in permanent employment. This means we rely heavily on locums which can give problems with continuity of care and is expensive and means the special care baby unit at Whitehaven is in danger of not being staffed properly. There may also be future problems with the availability of appropriately qualified neonatal nurses.

We currently are able to recruit enough obstetricians to staff a new model of care – one team across two sites – but there are concerns that we will struggle to recruit in the near future especially if consultants are expected to do resident-on-call work at Whitehaven. The recruitment challenge at the moment is in interdependent specialities – namely paediatrics and also anaesthetics.

*QUESTION: If staffing wasn’t an issue would things stay as they are?*

The Royal College of Obstetricians and Gynaecologists (RCOG) review advised us to look at transferring some higher risk births to bigger units e.g. multiple births due to the issues arising from keeping adequate skills in place with small numbers of births and also the level of backup available when required. So things do need to change to make births in west, east and north Cumbria as safe as possible.

*QUESTION: What does this mean for antenatal services at WCH?*

Antenatal care is the care you receive from health professionals during your pregnancy. You will be offered a series of appointments with a midwife or sometimes with a doctor who specialises in pregnancy and birth (obstetrician). They will check that you and your baby are well, give you useful information to help you have a healthy pregnancy and answer questions. This is when the discussions will take place with you about the type and place of delivery available.

In all options antenatal care will be provided at both WCH and CIC or community centres, children’s centres, home visits or Penrith Birth Centre as current service delivery.

All antenatal services provided today at WCH will continue and in the future more services could be introduced such as more specialised clinics to be held at WCH.

*QUESTION: What does this mean for postnatal services at WCH?*

Postnatal care is the care you receive for six weeks after the birth of your baby. Most women are well enough to be discharged from hospital within hours of the baby being born. Once you are home the postnatal care will be provided mainly by community midwives at home or in a community setting.

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| Option 1 | Inpatient postnatal care will be provided at both WCH and CIC. Some women from west Cumbria will deliver at CIC. When a patient delivers at CIC she will be looked after postnatally at CIC until discharge home. This usually is within 24-48 hours depending on the mode of delivery. Patients will not be transferred to WCH for postnatal care. However, postnatal clinics, after thought and bereavement services during the postnatal period will all take place at WCH. No one needs to travel to CIC for postnatal services after discharge from CIC except when one needs admission for a complication.  After discharge you will receive home visits from a member of your community midwifery team until handover of care to a health visitor and GP around 10 days after giving birth. The named midwife will liaise with the heath visitor and GP whose contact details are also documented on the postnatal notes. |
| Option 2 | Inpatient postnatal care will be provided at both CIC and in patient low risk postnatal care for women who have birthed at the MLU. When a patient delivers at CIC she will be looked after postnatally at CIC until discharge home. This usually is within 24-48 hours depending on the mode of delivery. Patients will not be transferred to WCH for postnatal care. However, postnatal clinics, after thought and bereavement services during the postnatal period will all take place at WCH. No one needs to travel to CIC for postnatal services after discharge from CIC except when one needs admission for a complication.  After discharge you will receive home visits from a member of your community midwifery team until handover of care to a health visitor and GP around 10 days after giving birth. The named midwife will liaise with the heath visitor and GP whose contact details are also documented on the postnatal notes. |
| Option 3 | Full inpatient postnatal care will be provided CIC. There will no provision for inpatient postnatal care at WCH. When a patient delivers at CIC she will be looked after postnatally at CIC until discharge home. This usually is within 24-48 hours depending on the mode of delivery. Patients will not be transferred to WCH for postnatal care. However, postnatal clinics, after thought and bereavement services during the postnatal period will all take place at WCH. No one needs to travel to CIC for postnatal services after discharge from CIC except when one needs admission for a complication.  After discharge you will receive home visits from a member of your community midwifery team until handover of care to a health visitor and GP around 10 days after giving birth. The named midwife will liaise with the heath visitor and GP whose contact details are also documented on the postnatal notes. |

*QUESTION: Under option 2, what services will the consultants and midwives be providing at WCH?*

There will be a full range of outpatient antenatal and postnatal care, including:

* Antenatal clinics
* Diabetic antenatal clinics for women who already have diabetes or develop diabetes during pregnancy
* Vaginal Birth after Caesarean (VBAC) clinic to assess suitability to have a vaginal birth following a caesarean section
* Anaesthetic re-assessment clinics to ensure women are medically fit to have an anaesthetic
* Newborn hearing screening sessions offered to all parents prior to discharge to identify hearing loss in newborn babies
* Day assessment unit (8am-8pm) – all assessments including blood pressure monitoring, to assess patients with any complaints such as breaking waters, abdominal pain in pregnancy, reduced baby movements etc. They will receive a consultant opinion as to what is going on and if they need admission they will be admitted at CIC. All other problems could be managed as a day case at WCH
* Fetal telemedicine – if a patient needs opinion on a baby having a problem in the womb the consultants can speak to a specialist at Newcastle over the telemedicine facility and show the scan findings to diagnose without having to go to Newcastle
* All scanning:
  + Dating scans offered at around eight to 14 weeks gestation, most accurate way to determine baby’s due date
  + First trimester scans – these date the pregnancy, confirm viability and assess the number of foetuses present. If informed consent is given, the first trimester screening for Down syndrome (Trisomy 21) and first trimester anatomy check are performed. At this scan, fluid at the back of the baby’s neck is measured (nuchal translucency). A combined test (blood test and scan) is used to work out the risk of your baby having a congenital syndrome
  + Mid-trimester scans - around 18 to 21 weeks gestation offers further screening for abnormalities and position of the placenta. Please refer to [www.nhs.uk/conditions/pregnancy](http://www.nhs.uk/conditions/pregnancy) for further information
  + Growth scans where growth problems are suspected from fundal height measurements, referral for a growth scan and appropriate further investigations to assess fetal wellbeing will be undertaken as soon as possible. Where a problem has been identified, referral is indicated to an obstetrician for discussion and agreement of an appropriate management plan, to be seen as soon as possible.
* Early Pregnancy Assessment Clinic (EPAC) – weekday service provided by consultants and a nurse practitioner for all early pregnancy related complications (e.g. vaginal bleeding, miscarriage up to 16 weeks gestation)
* Infertility clinics
* Special gynaecology clinics (termination of pregnancy)
* General gynaecology clinics
* Uro-gynaecology clinics
* Colposcopy clinics
* Hysteroscopy clinics
* Rapid access clinics
* Post multi-disciplinary team clinics

Consultant obstetric and gynaecology input would be solely during the day but would include day case services across gynaecology (including day case surgery), outpatient investigations, emergency gynaecology unit, fertility, colposcopy and uro-gynaecology.

All inpatient emergency gynaecology and consultant-led obstetrics would be at CIC.

*QUESTION: What will be available for women in west Cumbria under option 3?*

There will be a full range of outpatient antenatal and postnatal care. Women who arrive at the hospital in labour will be transferred to Carlisle.

*QUESTION: Will there be inpatient postnatal care at WCH – can I be transferred back after birth?*

There will be no facility to accept postnatal transfers back into WCH. National guidance (NICE) says most women should be well enough to go home six hours after birth and it is good practice to support women to return home as soon as possible. If you require medical care after birth in Carlisle you will stay there until you are ready to be discharged home.

*QUESTION: Why are some ‘higher risk’ births being moved to Carlisle under option 1?*

This is because there will not be a 24 hour paediatric consultant presence at West Cumberland Hospital and women who may have babies that need extra support should be in the place with the most appropriate care.

*QUESTION: What will be the impact on staff?*

In all options there will be some effect on staff and the organisations will work very closely to support staff where change is planned.

The Trust will fully involve all staff who may be affected by change and their views and personal preferences will be taken into consideration. The Trust will work with HR and staff side representatives to ensure that staff members are treated fairly, but the priority will be to sustain good quality, safe maternity services.

*QUESTION: Can Carlisle cope with the extra numbers in any of the options?*

There will need to be careful planning to ensure the capacity and staffing issues are fully addressed regardless of option.

*QUESTION: How will you mitigate risks?*

By developing strong contingency and support plans to deal with unforeseen events as they occur. Contingency plans considered include appropriate trained A&E staff, paediatric team, community midwifery team on call, North West Ambulance Service (NWAS) staffing and a dedicated ambulance vehicle available. Robust escalation planning will be in place with the Trust and NWAS.

All midwifery staff will be required to be fully trained and competent with homebirth, working within a MLU without alongside 24/7 CLU, skills and drills for unexpected/emergency scenarios and up to date with all mandatory training such as neonatal life support, IV cannulation, perineal repair etc.

*QUESTION: Under option 2, what happens if something goes wrong in the midwife-led unit at WCH?*

Firstly, it is important to note that midwives are skilled and competent with managing labour and birth without medical assistance and develop resilience to deal with all types of scenarios and emergencies. Midwives frequently risk assess the woman as birth progresses and will act appropriately.

If a woman needs consultant care she will be transferred to Carlisle or another CLU (if assessed as the safest option) or transferred after birth.

During any transfer to the CLU, the midwife will play a key role in providing information, support and clinical skills. The woman and birth companion(s) would be kept informed of the situation at all times and participate in decision making where possible. Good communication with all parties involved is vital and a record of any communication should be made in the maternal records.

*QUESTION: What if I go into premature labour?*

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| Option 1 | Midwives, obstetric staff and paediatric staff will all be in place to deal with any issues.  Any women who are likely to have a baby when less than 34 weeks pregnant would be transferred to Carlisle to give birth where the special care baby unit facility has access to paediatric support on site.  Women and their partners will be given specific instructions about how to contact a midwife early on and throughout the pregnancy. |
| Option 2 | Women and their partners will be given specific instructions about how to contact a midwife at booking and throughout the pregnancy. Women will have numbers to contact the Maternity unit direct. They will also have contact telephones for the community midwives team. Answerphones in the community midwifery base will tell women to contact the delivery suite if the matter is urgent or if they think they are in labour.  The midwife would advise the woman/partner on the right thing to do next. The midwife would contact the on-call paediatric, obstetric support and ambulance if required.  If a woman presents at A&E in premature labour, staff would follow their standard operating procedures which are designed for them to be able to deal with all types of emergency situations. They would call the maternity unit for advice and request an urgent paramedic ambulance.  Depending on the prematurity and the level of risk, the team would assess if it was safer to birth in the MLU at WCH or transfer to the CLU prior to birth. If transfer was required appropriate staff would accompany the woman in the ambulance. |
| Option 3 | The midwife would advise the woman/partner on the right thing to do next. The midwife would contact the on-call paediatric, obstetric support and ambulance if required.  If a woman presents at A&E in premature labour, staff would follow their standard operating procedures which are designed for them to be able to deal with all types of emergency situations. They would call the maternity unit for advice and request an urgent paramedic ambulance.  The team would assess if it was safer to birth at WCH or transfer prior to birth. Appropriate staff would accompany the woman in the ambulance. |

*QUESTION: What if a woman has a ‘high risk’ condition (i.e. twins, diabetes, obesity, high blood pressure)?*

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| Option 1 | Throughout the pregnancy they would be risk assessed and, if the risk is high, they would give birth at Carlisle or another CLU. |
| Option 2 | The birth would take place in Carlisle or another CLU. |
| Option 3 | The birth would take place in Carlisle or another CLU. |

*QUESTION: What about related emergencies such as an ectopic pregnancy?*

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| Scenario 1 | Consultants in obstetrics and gynaecology will be available 24/7 to deal with ectopic pregnancies and other conditions. |
| Scenario 2 | Consultant assessment will be available during the daytime, however women presenting later in the day or overnight will go to Carlisle. |
| Scenario 3 | Women may be scanned and assessed at WCH but will be sent to Carlisle if they require admission and treatment. |

*QUESTION: How have you used the feedback from the Maternity Matters survey in November 2015?*

The feedback collected by Healthwatch and the Maternity Services Liaison Committee (MSLC) in the survey has been used by health professionals in Cumbria to respond to concerns that were raised, the feedback has been shared with clinicians and decision makers and considered throughout the process. We know that women want clear and consistent information throughout their pregnancy, they want consistency of carer from a small team and they want the right service close to their communities. This chimes with the national findings of the National Maternity Review: Better Births. We will continue to use this valuable feedback to shape future services.

*QUESTION: How are you planning to implement the Better Births recommendations which came from the National Maternity Review?*

There are a number of recommendations made in the report and locally we are looking at how we can improve continuity of care, how we develop birth plans and how maternity hubs would work in west, north and east Cumbria. We will be working with the MSLCs to make sure we get this right for women locally.

*QUESTION: How will you staff a MLU if there is only an average of one birth a day?*

A freestanding MLU would have a minimum of two qualified midwives and a healthcare assistant on each shift. This would provide a safe working environment and ensure that a qualified midwife was available to accompany any woman requiring transfer to a consultant-led unit. In addition, a healthcare assistant would provide support for the midwifery staff.