



Local Supervising Authority Lanarkshire

Annual Report

1 APRIL 2008- 31 MARCH 2009

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Content

Section		Page
	Executive summary	3
1	Introduction	4
2	Each local supervising authority will ensure their report is made available to the public	6
3	Numbers of supervisor of midwives appointments, resignations and removals	6
4	Details of how midwives are provided with continuous access to a supervisor of midwives	8
5	Details of how the practice of midwives is supervised	9
6	Evidence that service users have been involved in monitoring supervision of midwives and assisting the local supervising authority midwifery officer with the annual audits	14
7	Evidence of engagement with higher education institutions in relation to supervisory input into midwifery education	14
8	Details of any new policies related to the supervision of midwives	17
9	Evidence of developing trends affecting midwifery practice in the local supervising authority	18
10	Details of the number of complaints regarding the discharge of the supervisory function	20
11	Reports on all local supervising authority investigations undertaken during the year	20
12	Conclusion	23
	References	
	Appendices	

Local Supervising Authority Lanarkshire

Executive Summary

The Local Supervising Authority (LSA) is responsible for ensuring that the statutory supervision of all midwives and midwifery practice as set out in the Nursing and Midwifery Order (2001) and the Nursing and Midwifery Council (NMC 2004) Midwives rules and standards is carried out to a satisfactory standard for all midwives working within its geographical boundaries.

This report follows the guidance set out by the Nursing and Midwifery Council Guidance for LSA Annual report submission to the NMC for the practice year 1st April 2008-31st March 2009.

The principle function of the LSA is to ensure the safety of the public through the effective supervision of midwifery practice and this is achieved through the promotion of best practice, preventing poor practice and intervening in unacceptable practice (NMC 2006).

There are 54 standards contained within the midwives rules and the role of the LSAMO is to ensure the standards are met. A self assessment tool is undertaken within the LSA on an annual basis and any actions required are incorporated into an action plan, which the supervisors of midwives review on a regular basis.

Each midwife is required to have a supervisor of midwives and supervisors of midwives are appointed to the LSA. As set out in the NMC (2004) midwives rules and standards the LSAMO plays a pivotal role in clinical governance by ensuring the standard of supervision of midwifery practice meets that required by the NMC.

This report will provide details on how the statutory requirements are being met in Lanarkshire LSA and where challenges or risks to the function of statutory supervision of midwifery have been identified will demonstrate how they are being mitigated against to ensure that there is a safe standard of care for the public.

Local Supervising Authority Lanarkshire

1. Introduction

This report covers the reporting year 1st April 2008-31st March 2009. This report has been produced to meet the requirements of Rule 16 of the NMC (2004) Midwives rules and standards for the Local; supervising Authority of Lanarkshire. Articles 42 and 43 of the Nursing & Midwifery Order 2001 requires that the practice of midwives to be supervised. The purpose of the statutory supervision of midwives is to protect the public and to support and promote good midwifery practice. The LSA is responsible for ensuring that statutory supervision of midwifery practice is exercised to a satisfactory standard and this is delegated to the Midwifery Officer.

The Local Supervising Authority sits within the NHS Board Lanarkshire. The Chief Executive and LSAMO details are as follows

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1.1 Standards

In the NMC (2004) Midwives rules and standards there are 54 Standards that should be met by LSAs and supervisors of midwives and a self assessment of the 54 standards will be included in the appendices. Where standards are not met or only partially met action plans have been developed in conjunction with supervisors of midwives to achieve the standard.

1.2 This is the third report since the inception of a fulltime LSAMO in the West of Scotland. There are four LSAs in the West of Scotland. Each Chief Executive in the West of Scotland requires an annual report to enable them to have assurances that there is a robust framework of statutory supervision of midwifery practice within its geographical boundaries. Therefore this report aims to demonstrate how the standards are met with in Lanarkshire and the activities undertaken by the supervisors of midwives to meet those standards.

1.3 Over the past three years the LSAMO has made steady progress alongside the supervisors of midwives in establishing a strategic direction for supervisors of

midwives. This includes the establishment of West of Scotland link supervisors of midwives forum, a process for auditing LSAs throughout the region and a system to notify serious untoward incidents to the LSA. Supervisors of midwives are undertaking investigations when there has been a serious incident to address practice issues and identify systems failures if this contributed to the incident. Guidelines and policies have been reviewed and this year the LSAMO Forum UK Guidance has been adopted in the area to ensure the standard of supervision of midwifery practice is consistent with all other areas in the UK. A website has also been established across the region.

Networks are firmly established throughout the region and there is evidence of progress in achieving the targets set out in the previous annual reports.

1.4 NMC Risk Register

When the annual report is submitted to the NMC they use a risk scoring framework (appendix 1) to assess non compliance with the 54 NMC standards for LSAs. This risk score is applied collectively by the NMC across the four LSAs in the West of Scotland. In the practice year 2006-2007 a risk score of 129 was applied to the West of Scotland. Supervisors of midwives across the area have undertaken much work in ensuring a strategic and consistent approach to statutory supervision of midwifery practice has been implemented across the area as well as ensuring a robust framework is in place in the individual LSA. In the year 2007-2008 a risk score of 12 (appendix 2) was given to the West of Scotland which demonstrates the significant work undertaken by supervisors of midwives to ensure there is a consistent and strategic approach to statutory supervision of midwifery practice.

1.5 The risk identified by the NMC following submission of the annual report is:

SOM/MW ration about 1:20 within individual services or across the LSA

This risk is not applicable to Lanarkshire LSA as there is a ratio of 1:9 in place within the LSA. Therefore based on the NMC risk score effectively this LSA has a risk score of 0.

1.6 Challenges identified for Lanarkshire in last years annual report were identified as :-

- Continue reducing identified risks by the NMC
- Continue raising the profile of supervision of midwifery practice
- Continue to engage with service users
- Ensure West of Scotland LSAs website is live
- Ensure the framework of supervision of midwifery practice is proactive and supports midwives in their roles
- Continue developing evidence to meet the standards for supervision of midwifery practice

Progress is being steadily made in meeting these challenges. No risks were identified for this LSA on application of the NMC risk register. The supervisors are striving to raise the profile of supervision within the organisation and with service users. This is ongoing work and is still a challenge following this years LSA audit. The West of Scotland web site became live in July 2009. The supervisors of midwives show continued commitment to their role in striving to achieve a proactive framework for supervision and meeting the standards for supervision of midwifery practice.

2. *Each Local Supervising Authority will ensure their report is made available to the public*

This report will be distributed to

- NMC
- Each Supervisor of Midwives
- The LSA /NHS Board
- Maternity Liaison Service Committee
- Clinical Governance Committee
- Any member of the public on request
- West of Scotland LSA website
- NHS Lanarkshire website
- Lead Midwives for Midwifery Education
- Head of Midwifery
- Director of Nursing

NHS Lanarkshire publishes information in relation to statutory supervision of midwifery practice on its website. A web site on statutory supervision of midwifery practice has also been available since July 2009 and can be found on www.midwiferysupervision-woslsa.scot.nhs.uk. The report for the LSA of Lanarkshire will be published on the West of Scotland website.

3. *Numbers of Supervisor of Midwives Appointments and Referrals*

- 3.1** There are currently 37 supervisors of midwives in Lanarkshire. There is also one other supervisor of midwives who is on a one year's leave of absence.

337 midwives submitted their intention to practice in the reporting year in the LSA. This gives a ratio of 1 Supervisor of Midwives to 9 midwives within the LSA. This is below the recommended ratio by the NMC of 1:15. The Supervisor

of midwives to midwives ratio in the West of Scotland was identified as a risk by the NMC following last year's annual report. However this is not the case for Lanarkshire as the ratio is below the NMC recommendation of 1:15.

The NMC Risk Register Key has been applied to the numbers of supervisors to midwives in table 1 below. Table 2 depicts the number of supervisors of midwives, appointments, resignations and leave of absence for the previous two years.

Table 1 2008-2009

LSA	Number of SOM's	Number of M/WS	Appointments	Resignations	Leave of Absence	Ratio of SOM:MW
L	37	337	2	1	1	1:9

Key to Risk Severity

Risk Green =Low Yellow = Moderate Red =High

Table 1 demonstrates that the ratio of supervisor to midwives in Lanarkshire is 1:9 therefore this is of low risk as applied to the NMC risk register.

Table 2

Year	Number of supervisors of midwives	Number of Midwives	Appointments	Resignations	Leave of Absence	Ratio SOM:MW
2007-2008	38	337	11	1	0	1:9
2006-2007	27		1	4	0	1:15

Table 2 demonstrates that the ratio of supervisor of midwives was also within the NMC ratio in the two preceding years and is therefore low risk as applied to the NMC risk register.

3.2 NHS Lanarkshire has a ratio of 1 supervisor to 9 midwives. Since 2006-2007 the supervisors of midwives have made steady progress in attaining a ratio of 1:9. They have maintained this ratio now for the past two years. This ratio is supported by the Director of Nursing in this NHS Board as a standard of best practice due to the proactive nature of statutory supervision in safe guarding the public.

3.3 There are no recruitment problems in Lanarkshire. The LSA is now in the position where the demand outstrips the number of available places. Interviews are therefore held on a competitive basis for this LSA.

3.4 During this year there has been one leave of absence due to the supervisor taking on a leadership role in clinical practice and requesting time out to enable adjustment to the new role. There has been one resignation due to retirement.

3.5 There have been no removals or suspensions from the role of supervisor of midwives.

3.6 Supervisors of midwives are appointed in accordance with the LSAMO Forum UK Guidance for the selection and appointment of supervisors of midwives. Midwives either self nominate or are nominated by their peers. They are then interviewed by a panel which includes a peer, a supervisor of midwives, an educationalist and the LSAMO. This year the interviews have taken place within the University of West of Scotland. If the Midwives are successful at interview they will then undertake the preparation programme to become a supervisor of midwives. Following successful completion of the course they will then be appointed as a supervisor of midwives to the LSA. When appointed to the LSA all supervisors of midwives are mentored for a minimum of three months.

4. *Details of how midwives are provided with continuous access to a supervisor of midwives*

4.1 Each midwife in the LSA Lanarkshire has a named supervisor of midwives. All midwives are allocated a supervisor of midwives but are informed that they can choose a different supervisor of midwives if they wish. In this years audit process some midwives identified that they did not feel comfortable letting their supervisor of midwives know if they wished to change to another supervisor of midwives. Therefore to facilitate this process the supervisors have developed a new mechanism to support midwives if they wish to change their supervisor of midwives. This involves a letter advising them who their supervisor of midwives is. In future they can inform the link supervisor of midwives in writing if they wish to change their supervisor of midwives.

4.2 There is 24 hour access to a supervisor of midwives and there is an on call rota for supervisors of midwives which enables midwives to contact supervisor of midwives at all times. The LSA audit identified that the rota is known as unit coordinators rota. It was recommended that this rota is called a supervisor of midwives on call rota to minimise any likelihood for potential of confusion between management and supervision. Each Unit Coordinator is a supervisor of midwives and she provides the on call for supervision as set out on this rota. The LSA audit identified that all midwives knew their supervisor of midwives and that they knew how to contact a supervisor of midwives over a 24 hour period. The supervisors of midwives provided evidence of the on call rota in the audit. Although it was clear this was a supervisory rota it would be appropriate for the rota to be called a supervisors of midwives on call rota to ensure a distinction between management and supervision during the on call period.

It was identified in the LSA audit that midwives generally contacted a supervisor of midwives for advice and support if they had been involved in a critical incident. No issues were identified in the LSA audit to indicate that there was a problem with response times between midwives and supervisors of midwives or women and supervisors of midwives.

An audit tool to audit the response times in more detail has been developed and this will be audited in more depth by a survey as well as in the LSA audit focus groups of 2009-2010.

4.3 In this LSA each supervisor of midwives meets with his/her supervises at least once a year to review their practice and any developmental needs.

4.4 All supervisors of midwives have a lanyard denoting that they are a supervisor of midwives. This helps to ensure they are easily identifiable to midwives and members of the public.

4.5 Student midwives are also allocated a supervisor of midwives. During the LSA audit the student midwives could identify who their supervisor of midwives was and all were positive about the role of the supervisor of midwives and the support they could expect in practice when qualified as a midwife. All students reported that if they had a problem in practice they would meet with their personal lecturer in the first instance.

5. *Details of how the practice of midwives is supervised*

To ensure the effective supervision of midwifery practice a number of methods of communication are deployed to ensure a consistent approach to supervision of midwifery practice across the UK as a whole and also within the region. A variety of forums are held that ensure there is strategic direction for supervisors of midwives, that guidance is in place to support them in their roles and trends and themes from serious incidents can be shared to ensure lessons are learnt and practice issues are addressed in practice.

5.1 *Methods of communication with supervisors of midwives*

To facilitate effective communication each supervisor of midwives is able to contact the LSAMO by mobile or by email. The LSAMO will also meet with a supervisor of midwives if requested.

The following forums facilitate a communications network to ensure consistency in the supervision of midwifery practice:-

- The NMC/LSA Strategic Reference Group - one of the main functions of this group is to assist in advising the Midwifery Committee on any proposals to make, amend or revoke rules relating to the supervision, practice and education of midwives. The LSAMO is a member of the group and attends any meetings that are held.
- The Local Supervising Authority Midwifery Officer Forum UK (LSAMO Forum UK) - this forum meets every 2 months and was established to provide all the LSAMOs across the UK with support. One of the main purposes of this group is to ensure that the supervision of midwifery practice is developed and delivered in a consistent manner across the UK as a whole. There are 16 LSAMOs throughout the UK they have developed a cohesive strategy for the statutory function, with shared principles and the implementation of a common approach to achieving the NMCs standards. The published strategy describes the plan of achievements for the Forum for the next 3 years. This document can be viewed at <http://www.midwife.org.uk/>. Through the strategy the LSAMO Forum aim to ensure that midwives working in any part of the UK can expect the same standard of supervision of midwifery practice.
- A West of Scotland Link Supervisor of Midwives forum which is held every three months. Supervisors from each NHS Board and the HEI the University of the West of Scotland are represented on this forum. This contributes to ensuring a strategic approach for supervision is in place across the west of Scotland and also the promotion of cohesiveness in the approach and planning of supervision from both a clinical and educational perspective.

The forum looks at national strategies and any directives from the NMC or the Scottish government, or other relevant bodies. Supervisory issues are reviewed and discussed. This forum is used for the sharing of best practice and also working through any challenges that may arise. Lanarkshire supervisors of midwives are represented on this forum. Lyn Clyde is currently the Link

Supervisor of Midwives in Lanarkshire. The link supervisors feed information back to their local meetings. They also assist the LSAMO in undertaking the LSA audit and contribute to ensuring an effective communication network throughout the West of Scotland.

- There is a supervisor of midwives forum held in Lanarkshire every 6 weeks. The LSAMO attends this forum on an ad hoc basis. The supervisors feed back from the link forum.. They also hold a workshop in each meeting on current relevant issues to ensure practice is up to date. They also review serious incidents in the forum as a means of promoting best practice through learning from any incidents.
- The three LSAMOS based in Scotland also meet every three months to discuss issues from a Scottish perspective.
- The LSAMO also meets periodically with the Heads of Midwifery in the West of Scotland and this meeting is facilitated by the Executive Nurse Director of the LSAMO host board.
- The LSAMO also meets with supervisors of midwives in the HEI to develop systems and processes to support supervised practice and reflective activities between supervisor of midwives and midwives. As these are developed they will be disseminated to all supervisors of midwives.

5.2 *How the practice of midwifery is supervised*

The NMC (2004) Midwives rules and standards set out in Rule 12 how the practice of midwives is supervised. Rule 12 stipulates that a local supervising authority shall ensure that

- Each practising midwife within its area has a named supervisor of midwives
- At least once a year each supervisor of midwives meets each midwife for whom she is the named supervisor of midwives to review the midwife's practice and to identify her training needs
- All supervisors of midwives within its area maintain records of their supervisory activities including any meeting with a midwife
- All practising midwives within its area have 24 hour access to a supervisor of midwives

Each of these standards is now audited annually in a LSA annual audit through a self assessment tool and by questioning supervisors and midwives about their experiences in relation to these standards.

The audit demonstrated that in Lanarkshire each midwife completes an Intention to Practice form and this is signed by the midwife's named supervisor of midwives and then submitted to the LSA Office. Details are then submitted on a data base within the LSA and then submitted to the NMC. In the year 2009-2010 the West of Scotland will subscribe to the National LSA database alongside each other LSA in the UK.

Each midwife has a named supervisor of midwives and they are required to meet with their supervisor of midwives at least once a year. This enables the opportunity for the midwife to discuss their developmental needs with their supervisor of midwives and also to discuss any practice issues.

The supervisors of midwives maintain records on their case load of supervisees. An aim in the future is to promote the use of reflection on practice between supervisor and supervisee.

All midwives have 24 hour access to a supervisor of midwives.

All these standards were met by the supervisors of midwives and no significant issues were identified.

5.3 *Safety of the Public*

The NMC (2004) Midwives rules and standards stipulate that the role of the supervisor of midwives is to protect the public by empowering midwives and midwifery students to practise safely and effectively. Therefore to ensure the safety of the public supervisors of midwives may also be required to undertake supervisory investigations following critical incidents to determine if there is any evidence of poor practice and then put in place relevant programmes to develop a midwife's practice through supervised practice or a programme of developmental support.

Supervisors of midwives are involved in clinical governance arrangements within the NHS Board and supervisors of midwives support clinical governance strategies.

In Lanarkshire a supervisor of midwives sits on the local clinical risk management group and the clinical risk manager is also a supervisor of midwives. The supervisor's review critical incidents in their local forum and if there is an incident where actual or potential harm has happened the LSAMO is informed and a supervisory investigation takes place.

Any trends or themes for practice are also fed back to the local supervisors of midwives forum to ensure the sharing of lessons from the perspective of statutory supervision of midwifery practice and thereby safeguarding the public in practice. This year the supervisors identified concerns with record keeping and accountability and have implemented workshops for midwives to attend. If individual concerns are identified the supervisor of midwives makes an individual action plan with the midwife.

Midwives are also encouraged to attend debriefing sessions with their supervisor of midwives following clinical incidents. The LSA audit identified that not all midwives were conversant with this expectation and the supervisors aim to strengthen this over the next year.

Supervisors of midwives are also instrumental in ensuring on going education for midwives and participate in mandatory training. Supervisors of midwives lead on Obstetric Emergency and documentation study days and ensure midwives attend sessions.

5.4 *Local Supervisors of Midwives Forum*

The supervisors within the unit are committed to supervision of midwifery practice and its remit in the protection of the public within the LSA. They work hard in both developing and achieving the standards of supervision. They actively develop work streams in their local meetings and where there are challenges in practice the supervisors of midwives agree actions seeking the support of the LSAMO when necessary. Strategies or action plans are also developed locally in the meetings. An example of this is the ongoing work in this area by critically evaluating CEMACH reports and recommendations and mapping this against local practice and guidance.

A Supervisor of midwives acts as the chairperson who is supported by the link supervisor of midwives. The chairperson rotates around all Supervisors and those interested gain experience in this role. An aim of this is to develop leadership skills amongst supervisors of midwives particularly those who are clinically based. This helps ensure equity amongst all supervisors and maintain the non hierarchical approach to supervision but still using it as a developmental tool.

The link supervisor of midwives or a representative attends the West of Scotland Link Supervisor of Midwives forum where ideas are shared and strategies developed for the West of Scotland and the individual LSA.

5.5 *Supervisors of Midwives as Leaders*

Supervisors of midwives attend a variety of forums. Forums where supervisors of midwives are represented in Lanarkshire include

- Clinical Risk management meetings
- Clinical Effectiveness forums
- Clinical Governance forums
- Maternity framework group
- Maternity Liaison Service Committees
- Educational Curriculum Planning Forums

The LSA audit identified that supervisors of midwives were seen as a distinct group in Lanarkshire. Midwives did not always know the full range of activities undertaken by supervisors of midwives and the supervisors were going to highlight activities undertaken by them in the forthcoming year.

5.6 *LSA Annual audit*

A consistent process has been established across the West of Scotland over the past two years to ensure that the standards for the supervision of midwifery practice are met in each of the four LSAs in the West of Scotland. A LSA audit takes place annually within the LSA of Lanarkshire.

The LSAMO Forum UK has produced an audit tool which is used by all LSAMOs to audit the standards for the supervision of midwifery practice. This national

audit tool also ensures a consistent approach in auditing the standards for the supervision of midwifery practice.

The standards depict the minimum standard of statutory supervision to be achieved. The LSA audit tool incorporates five LSA standards based on the five principles set out in the NMC (2004) *Midwives rules and standards*. The LSAMO Forum UK has developed a range of methodologies to audit the standards. This is to assist LSAMOs in deploying different approaches to enhance the audit process.

Currently a model of peer assessment is being used in the West of Scotland to monitor the standards which involves an audit team comprising of:-

- two supervisors of midwives from other units or a HEI
- a service user
- the LSAMO
- Student supervisors of midwives

The methodology to audit the standards will be reviewed following the LSA audits of 2009-2010.

The LSA audit took place in Lanarkshire on 23rd September 2008. Supervisors of midwives are asked to provide evidence prior to the LSA audit visit. Focus groups were also held with midwives, student midwives, service users and managers to triangulate the evidence. A questionnaire was also sent to all supervisors of midwives within the LSA prior to the audit with an excellent response rate. The findings from the survey, the audit and focus groups held during the LSA audit were consistent. This was also found in the LSA audit of the preceding year. The report of the LSA audit was then sent to the Chief Executive and Director of Nursing and to the Supervisors of Midwives.

On the whole the 54 standards were generally met in the LSA Lanarkshire. Where they were not met or partially met or need further development the supervisors of midwives discuss the issues in their meetings and make an action plan for the forthcoming year. There is also a West of Scotland Action Plan that is reviewed every six months in the West of Scotland Link Supervisors of Midwives Forum that has been put in place following audits across the region. Supervisors of midwives update this action plan from a Lanarkshire perspective on a regular basis (appendix 3)

As well as assessing whether the standards for the supervision of midwifery practice are met the LSA audit process also contributes to raising the profile of supervision of midwifery amongst midwives, supervisors of midwives and women. The peer review method enables supervisors of midwives to share good practice with each other, and also provides networking opportunities for them. The audit process also contributes to developing the supervision of midwifery practice further and is a positive learning experience for both supervisors of midwives and student supervisors of midwives who attend as observers on the audit team.

It can be demonstrated then that an audit process is in place to assess how the practice of midwives is supervised and that a continual process for identifying challenges and to ensure continuous improvement is in place. This helps

contribute to ensuring that supervision of midwifery practise is proactive and a gives a framework for the protection of the public.

5.7 Challenges to effective supervision

One of the major challenges effective supervision is having enough time to undertake the function of their role combined with their other roles. Supervisors in non clinical roles find this easier to manage than the clinically based supervisor of midwives. The NHS Board supports the supervisor of midwives in having protected time for supervision and each supervisor monitors time spent on supervision and if she has difficulties should discuss this with her line manager.

Other challenges identified by supervisors in this years audit were the need to continue raising the profile of supervision amongst midwives and women. They aim to do this by raising the profile of the remit of the supervisor of midwives with staff and also circulating information from local meetings.

6. Evidence that service users have been involved in monitoring supervision of midwives and assisting the local supervising authority midwifery office with the annual audits.

Service users were invited to take part in the LSA audit process for this year. Two training days were held to prepare service users to take part in the audit process this year. The programme for the training day is in the appendices (appendix 4). In total ten women attended the two sessions. There was representation from Lanarkshire on this day. In Lanarkshire a service user is a member of the supervisors of midwives forum and she represents services users on the audit team. Unfortunately although she attended the training day she was ill on the day of the LSA audit and could not attend at very short notice. Therefore although a user was not represented on the LSA audit team part of the audit team met with service users on the day of the audit to ensure their views were heard.

The audit identified that information was available on the role of the supervisor of midwives in various formats for members of the public either in individual leaflets on information for women or paragraphs in the hospital booklet on local services. Despite these measures it was evident during the audit process that women did not know about supervision of midwifery practice. Raising the profile of supervision of midwifery practice to women continues to be a target for supervisors of midwives and is an action in the West of Scotland Action Plan.

7. Evidence of Engagement with higher education institutions in relation to supervisory input in midwifery education

7.1 The LSAMO and HEI

The LSAMO attends meetings with the University of the West of Scotland on a regular basis to give advice or support and also lectures on pre registration programmes and preparation programmes for supervisors of midwives.

The UWS and LSAMO are in the process of jointly developing programmes for supervised practice which includes the development of a directory of competencies that supervisors of midwives and educationalists can use to draw on following supervisory investigations that recommend supervised practice. This work also involves the development of a process for midwives to undertake a formal reflection following a supervisory investigation when supervised or supported practice is not required. This is to ensure that learning and reflection are involved following any supervisory investigation.

The UWS also supports the LSAMO in creating training opportunities for supervisors of midwives and continues to work with the LSAMO in facilitating workshops for supervisors of midwives.

Further opportunities for the development for supervisors of midwives will be based on learning needs identified by supervisors of midwives either through LSA audit or evaluation of conferences/workshops.

The LSAMO also attends any monitoring visits in the University such as by the NMC, and curriculum planning meetings.

There are five educationalists who are currently supervisors of midwives in the UWS. Another educationalist and a practice education facilitator are due to undertake the preparation programme in September 2009.

7.2 *Supervisor of midwives engagement with HEI*

There are very good links between the HEI and supervisors of midwives. Two of the educationalists of UWS based in the Hamilton Campus are supervisors of midwives in the LSA. NHS Lanarkshire receives students from the UWS and has very good links with the University. Supervisors of midwives contribute to the development, teaching and assessment programmes of education leading to registration and continuous professional development. Supervisors of midwives are also on curriculum planning teams and undertake lectures on pre registration and post registration programmes. They also ensure that midwives remain updated.

7.3 *Supervisors of Midwives supporting student midwives*

Each student midwife is allocated a supervisor of midwives. Student midwives were part of focus groups during the LSA audits and it was evident that they were conversant with the role of the supervisor of midwives in the protection of the public.

7.4 *The Clinical Learning environment for pre-registration student midwives*

During the LSA audits focus groups are held with student midwives. They are asked about their clinical placements during this session. No issues were identified in Lanarkshire. If issues are identified they would be fed back to the Lead Midwife for Education directly by the LSAMO.

7.5 *Preparation of Supervisor of Midwives Programmes*

The Programme for the Preparation of Supervisors of Midwives is based at the University for the West of Scotland and is based on the NMC (2006) *Standards for the Preparation and Practice of Supervisors of Midwives* (2006). The programme runs in February and September of each year dependent on local need. The aim of the programme is to prepare midwives for the statutory role and to help them to understand critique and evaluate the role and the significance of self regulation of the profession for public protection. Only NMC approved educational institutions can deliver the preparation programmes and the University of the West of Scotland was validated by the NMC in 2008. Following validation programmes are monitored annually through the NMC quality assurance processes.

To recruit new supervisors adverts listing the skills required to be a supervisor of midwives are circulated to the LSA. Any midwives who are nominated or would like to become a supervisor of midwives may contact the LSAMO directly for information. The applicants then go through the selection process as set out in the LSAMO Forum UK guidance.

The student supervisors have a supervisor mentor during the preparation programme that assesses their competencies. The programme is comprised of two modules; one theory and the other practice based. Students must successfully complete both components. When they have successfully completed the programme the LSAMO is informed by the LME. They are then appointed by the LSAMO as a supervisor of midwives to the LSA. The newly appointed supervisor will be provided with a period of preceptorship for a minimum of three months as per NMC (2006) standards.

During the programme the LSAMO meets regularly with the module leaders who keep her updated with the student's progress on the programme. If any issues are identified they are discussed with the LSAMO. The LSAMO is advised if students are not successful on the programme.

7.6 University of West of Scotland

The Preparation Course programme takes place in either February or September and is run as a part time module at level 6 (degree) and level 7 (masters). The LSAMO is involved in the planning of the modules, as part of the teaching team and in the evaluation.

Programme leader – Maria Pollard

Module Team -Maria Pollard, Madge Russell, LSAMO and other relevant external speakers

7.7 Challenges

Challenges were identified in the previous year by supervisors of midwives in relation to supervisory investigations and supervised practice. These included;-

- a need to have training in how to conduct a supervisory investigation
- how to write a report
- standardised programmes for supervised practice that will include identified learning outcomes for the individual practitioner

The LSAMO has worked closely with the UWS to develop workshops on conducting supervisory investigations. These were developed in conjunction

with the LSAMO from East of England who acted in an advisory capacity and conducted a workshop in this area which is subsequently being run every quarter in the West of Scotland. At the present time 10 supervisors from Lanarkshire have attended this workshop. The workshop is also part of the theoretical module on the preparation programme for student supervisors of midwives. This ensures consistency of approach amongst supervisors of midwives. Also as discussed earlier work is also being developed on supervised practice programmes and the development of a directory of competencies.

7.8 Ongoing Education for Supervisors of Midwives

The LSAMO has established an annual conference for supervisors of midwives in the West of Scotland and also runs workshops based on training needs which are identified through evaluation forms.

This year the sessions were as follows :-

Learning Opportunity	Total Number Attending
West of Scotland Annual Conference Supervision in Action – Midwifery Leadership Making it Happen	56
West of Scotland Annual Conference Supervision in Action – Midwifery Leadership Making it Happen	73
Conducting a Supervisory Investigation	27

Conference fliers can be found in appendix 5.

8. Details of any new policies related to the supervision of midwifery practice

8.1 Guidance for supervisors of midwives

To support supervisors of midwives in their role in supervising midwives practice national guidance has been produced by the LSAMO Forum UK. This National Guidance gives a framework for supervisors of midwives to undertake a consistent approach across the UK in supervising midwives practice. This consistent approach to statutory supervision of midwifery practice contributes to promoting the safety of maternity services through the protection of the public.

The supervisors of midwives in Lanarkshire alongside all supervisors of midwives in the West of Scotland formally adopted the LSAMO Forum UK guidance on February 1st 2009. This guidance can be accessed on www.midwife.org.uk or www.midwiferysupervision-woslsa.scot.nhs.uk . Each supervisor of midwives has also been issued with an individual guidance file.

8.2 Local Guidance

The LSAMO has also established a guidance group for supervisors of midwives to develop local guidance for supervisors of midwives in the West of Scotland

which are being adapted for use for from the North West of England with permission from the LSAMO there. Supervisors of midwives in Lanarkshire are represented on this group. These are under review at present. When the first guidelines have been ratified they will be able to be accessed on www.midwiferysupervision-woslsa.scot.nhs.uk.

Supervisors of midwives in Lanarkshire also contribute to developing local guidelines for midwifery practice that are used within their service. Examples of these are the Homebirth and Maternal death guideline.

8.3 *Reflection*

The LSAMO is currently undertaking work in conjunction with UWS to develop systems to support midwives in undertaking reflection with supervisors of midwives. A process is also being developed to initiate a formal reflection between a midwife and the investigation supervisor of midwives following being involved in a critical incident when supervised practice or developmental supports have not been deemed necessary.

9. *Evidence of developing trends affecting midwifery practice in the local supervising authority*

9.1 *Public Health Issues*

NHS Lanarkshire covers a wide geographical area covering rural areas and densely populated towns. There are high levels of deprivation in this area. There is a mixture of rural areas and densely populated towns. There are high levels of deprivation and high levels of addiction. There are also high levels of immigrants from Eastern Europe in the communities which bring challenges such as late booking for maternity services, poor health status and language difficulties. All these issues pose risk to women and their children.

9.2 There are pockets of deprivation in Lanarkshire with women with mental health issues, substance misuse and other vulnerable women. There are also a growing number of migrants in some of the areas. There are a range of specialist services available and specialist roles to support these vulnerable women and their families.

9.3 Lanarkshire has recruited two substance Misuse Midwives who work closely with staff and develop this service for pregnant women in an effort to maximise the health of the population. There are also plans underway to employ 0.6 of a whole time equivalent midwife in relation to nutrition in pregnant women and obesity as these are areas where it is known that there can be problems in pregnancy or birth. This will help research and take forward this agenda.

9.4 Posts for breastfeeding support workers and an Infant Feeding Advisor have also been introduced in the area and this has had a very positive impact on practice and is aimed as a means to help increase breastfeeding rates.

9.5 *Clinical Activity*

Lanarkshire has a population of approximately 557,088. There were a total of 5262 babies born within Lanarkshire last year to 5177 women. 4963 women delivered in the previous year which is an increase of 214 deliveries. The increase in births has contributed to the number of capacity issues, and supervisors report that midwives are more likely to call them for support.

- 9.6** NHS Lanarkshire is monitoring future birth trends on a monthly basis and currently the picture looks the same as last year. They are also undertaking work force planning and looking at skill mix and the age profile of midwifery staff. Plans include reviewing the structure and skill mix and they aim to have an 80/20 ratio of trained to untrained staff. This will take place over a number of years based on staff turnover and the current age profile.
- 9.7** There have been changes made in the service to ease capacity issues in the past year and these are the implementation of a triage area and also a realignment of the community areas to mirror image the Primary care areas which aims to enhance multidisciplinary working relationships. Supervisors of midwives have been involved in these processes. The introduction of triage has stopped calls being received in the wards and halved the number of admissions compared to previous year's activity.
- 9.8** The RCM recommends a midwife to birth ratio of 1:28 in maternity services. The midwife to birth ratio in Lanarkshire is 1:21.13.

9.9 *Methods of Data Collection*

Data is collated following a maternity audit and is collated by the clinical effectiveness unit. Although there is an increase in the births NHS Lanarkshire are striving to put mechanisms in place to ensure the safety and protection of women and on the learning environment for students. This includes actively managing sickness absence in the work place which has decreased from 16% to 6 % in a year. An overview of birth trends and clinical outcomes can be found in the appendices (appendix 6). Supervisors of midwives in Lanarkshire review implications for practice in their meetings and also maintain an action plan in relation to the recommendations of CEMACH in an aim to continually improve outcomes for women and their babies.

All statistics are collated within the maternity unit and collated by clinical effectiveness. Information is submitted to the LSAMO on an annual basis.

The maternity unit has participated in the national Nursing and Midwifery Workload and Workforce planning project and have undertaken Birth-rate Plus and a Professional Judgement Workforce planning tool. This work has led to the establishment of a short life working group in Scotland to develop a tool to assist in determining staffing requirements for women with complex needs and for the remote and rural areas unique to Scotland. This work will be used in conjunction with findings from Birth rate plus analysis.

9.10 *Serious Incident Escalation Policy*

There is West of Scotland guidance for supervisors of midwives on reporting and investigating serious untoward incidents. It is the role of the supervisor of

midwives to advise the LSAMO if there has been a serious untoward incident. Within the unit serious incidents are reported to the risk manager and then reviewed by the risk management team. A supervisor of midwives sits on this forum. Incidents are discussed in the local supervisors of midwives forum.

9.11 Unit Closures

There have been no unit closures within Lanarkshire in the reporting year. The unit does not close as they are the only maternity unit in the area. If problems are identified with capacity or staffing levels these would be reported by the unit coordinator to the Service Manager/Deputy Service Manager and supervisor of Midwives on call who would assess the situation and make recommendations according to the Maternity escalation guideline within the unit. An incident form would be completed to monitor trends.

9.12 Keeping Childbirth Dynamic and Natural

There has been much developmental work undertaken to keep childbirth natural and dynamic throughout Scotland. All areas have appointed Consultant Midwife posts to support this project at local levels. The project has also involved supervisors of midwives at local levels to support midwives in maximising normal childbirth. This includes supporting midwives in developing midwife led care, appropriate risk assessment of the woman and in relation to the admission CTG and giving midwives skills and confidence in risk assessing all women throughout antenatal intrapartum and postnatal care.

10. Details of the number of complaints regarding the discharge of the supervisory function

There were no complaints in this reporting year regarding the discharge of the supervisory function. With the adoption of the LSAMO Forum UK Guidance in January 2009 the process that is now being used to address a complaint against a supervisors of midwives or the LSAMO is set out in Guideline G 'Policy for the notification and management of complaints against a Supervisor of Midwives or an LSA Midwifery Officer, including appeals'. Complaints against the LSAMO are dealt with through the complaints procedure within NHS Ayrshire and Arran as this is the host Board of the LSAMO.

The appeals process is also set out in Guideline G. The guideline can be accessed on www.midwife.org.uk.

11. Reports on all local supervisory investigations undertaken during the year

- 11.1** The Local Supervising Authorities in the West of Scotland have guidance in place for supervisors of midwives on the Reporting and Monitoring of Serious Untoward incidents. Each supervisor of midwives has a copy of this guidance. The guidance acts as a reference guide for supervisors of midwives and includes a section to give a guide on what incidents or issues involving midwifery practice should be referred to the LSA. These include the following examples:-

- All maternal deaths
- All investigations of midwifery practice being undertaken by SOM, irrespective of outcome
- Significant changes in service configuration that may have the potential for adverse impact on women and babies,
- Sustained deficits in midwifery staffing
- Midwives reported to the NMC
- Unexpected intrauterine or neonatal deaths
- Unexpected Intra-partum death
- Unexpected significant morbidity of a mother or baby

11.2 The supervisor of midwives should advise the LSA of any issues involving midwifery practice that is of serious concern. The West of Scotland guidance specifies that this list is not exhaustive and that where there are uncertainties the LSA should be contacted for advice.

11.3 It is essential that the team of Supervisors be notified of all serious untoward incidents that involve midwifery practice. This means that there should be a link between the supervisors of midwives and the clinical risk co-ordinator, the complaints co-ordinator and any other relevant personnel within the NHS Board. In Lanarkshire a supervisor of midwives sits on the local clinical risk management forum. The clinical risk manager is also a supervisor of midwives.

11.4 A Supervisor of Midwives should undertake an investigation where circumstances suggest that there may have been poor midwifery practice. This function cannot be delegated to anyone else, although at times the clinical risk manager and Supervisor may be the same person. The LSA Midwifery Officer is always available to provide advice and support to the supervisors of midwives.

11.5 In addition to the above, guidance there is also LSAMO Forum UK National available for supervisors of midwives. This is Guideline L and is called 'Investigation into a midwife's fitness to practise'. This gives clear guidance on how to conduct a supervisory investigation, a template for documentation of the investigation and a checklist of considerations whilst undertaking a supervisory investigation. This is well attended by supervisors of midwives from Lanarkshire

The LSAMO has also held workshops for supervisors of midwives on how to conduct an investigation.

11.6 Investigations

Three supervisory investigations were conducted by supervisors of midwives during the reporting year.

Out of the three investigations one midwife undertook a period of supervised practice which she successfully completed by March 2009. This programme of supervised practice related to poor record keeping.

Another midwife had a history of impaired competence. A supervisory investigation was conducted and resulted in the midwife undergoing a period of developmental support. The other investigation is still in progress.

Key trends identified in these investigations were:-

- Failure to maintain adequate records
- Failure in duty of care
- Lack of understanding of responsibility and sphere of practice
- Failure to accept accountability
- Failure to communicate or collaborate effectively with colleagues
- Inadequate observations of mother and/or fetus
- Failure to summon appropriate practitioner for assistance

One or more of these factors were found in each investigation.

- 11.7** The LSAMO is maintaining a database on trends and themes identified in supervisory investigations across the four local supervising authorities. As supervisors of midwives undertake supervisory investigations so trends and themes are becoming evident, these are now being shared with supervisors of midwives across the region. This will enable supervisors of midwives to establish strategies to ensure learning takes place within the work place to help prevent repeated incidents.
- 11.8** In Lanarkshire the supervisors of midwives are active in their approach to ensuring lessons are learnt in the work place. They discuss practice issues arising from supervisory investigations in their local meetings. The clinical risk manager who is also a supervisor of midwives also outlines the major risks identified in the clinical risk management meeting in the supervisor of midwives forum.
- 11.9** The supervisors on Lanarkshire have identified that a failure to maintain adequate records and demonstrating accountability in practice are consistent trends. They are therefore undertaking record keeping audits and are holding documentation and accountability workshops for midwives to attend. They also contribute to ensuring obstetric emergency study days are in place for all midwives.
- 11.10** There have been no concerns identified in relation to the competence of newly qualified midwives or in their place of training during this reporting year.
- 11.11** There have been no LSA investigations in Lanarkshire this year and there have been no investigations commissioned by an external supervisor of midwives or LSAMO.
- 11.12** There were no referrals made to the NMC by the LSA in this reporting year. The NMC is contacted for advice on midwifery practice on individual cases as they arise. This could be by telephone, by email, face to face contact or by letter.

11.13 *Maternal Deaths*

The definition of maternal death defined by as defined by the Confidential Enquiry into Maternal and Child Health (CEMACH) is the death of a woman while pregnant or up to one year after abortion, miscarriage or birth. Indirect deaths are those relating from previous existing disease. Direct deaths are those resulting from Obstetric complications during pregnancy, labour and the postnatal period.

Supervisors of midwives notify the LSA MO if there has been a maternal death and also advise the LSAMO if there have been any midwifery practice issues. During this period there were two maternal deaths in Lanarkshire. One woman died at 29 weeks gestation and had a rare genetic cardiac condition. The other woman had not attended for any maternity care and had a history of substance misuse. This is still under a multi agency review. There were no midwifery practice issues identified in these cases.

12. Conclusion

This report has demonstrated the steady progress made Lanarkshire during this reporting year.

Supervisors of Midwives have been committed to achieving high standards of practice in relation to statutory supervision of midwifery practice both in Lanarkshire and have supported the LSAMO in embedding a strategic and consistent approach for supervision of midwifery practice across the West of Scotland. This contributes to ensuring a safe service for women and their families and also the provision of safe learning environments student midwives.

LSA Priorities for 2009-2010

- Continue to monitor and reduce any risk as set out in the NMC risk register
- Ensure standards of supervision are met and where they are not develop action plans
- Support leadership development of supervisor of midwives
- Continue to raise the profile of supervision amongst midwives
- Engage with service users
- Develop new guidance for supervisors of midwives as required to support them in their role
- Continue to ensure the safety of the public receiving maternity care through the monitoring of serious untoward incidents.

12.1 The LSAMO will continue to provide education and support for supervisors where required as for example in training supervisors in conducting a supervisory investigation and supervising a midwife's practice. Learning needs will continually be identified by supervisors of midwives from evaluations from training days or conferences or as identified in meetings. The ultimate aim is to ensure the protection of the public through the effective supervision of midwifery practice through meeting the needs of supervisors of midwives and women and their families at both local and national levels.

12.2 In conclusion the LSAMO will continue to support and develop the supervisors of midwives in their role and champion statutory supervision of midwifery practice in influencing services and ensuring the safety of the public.

Tim Davison
Chief Executive NHS Board Lanarkshire

Joy Payne
Local Supervising Authority
Midwifery Officer

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Signed_

By Payne.

Signed_

REFERENCES

Confidential Enquiry into Maternal and Child Health (2007) *Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer 2003-2005* London CEMACH

Local Supervising Authority (2005) *LSA standards for statutory supervision* London

Nursing and Midwifery Council (2004) *Midwives rules and standards* London NMC

Nursing and Midwifery Council (2006) *Standards for the preparation and practice of supervisors of midwives*

Nursing and Midwifery Council (January 2009) Guidance for the Local Supervising Authority (LSA) Annual report submission to the NMC for practice year 1st April 2008- 31st March 2009

Appendices

<i>Appendix 1</i>	<i>NMC Risk Score Register</i>
<i>Appendix 2</i>	<i>WOS Risk Score 2007-08</i>
<i>Appendix 3</i>	<i>WOS/Lanarkshire Action Plan</i>
<i>Appendix 4</i>	<i>Training Day Service Users</i>
<i>Appendix 5</i>	<i>Programme WoS SOM Conference</i> <i>Programme Conducting SOM Investigation</i>
<i>Appendix 6</i>	<i>Statistics</i>

NMC Framework Risk Register Key

Consequence/Severity of Impact

Likelihood	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Almost certain - 5	5	10	15	20	25
Likely - 4	4	8	12	16	20
Possible - 3	3	6	9	12	15
Unlikely - 2	2	4	6	8	10
Remote - 1	1	2	3	4	5

RISK Low Moderate High

1-8 9-15 16-25

Rating consequences and impact

Catastrophic	Critical impact on protection of the public e.g. significant contributor to higher than anticipated unexplained deaths of mothers or infants or, serious injury of mother or baby requiring life-long support. Very difficult and long term to recover.
Major	Major impact on protection of the public or function of the LSA. E.g events which risk public or professional confidence in the respective maternity services or respective LSA/SHA, non-compliance with action plans from various investigating authorities. Medium to long term effect.
Moderate	Significant impact on protection of the public, function of the LSA. E.g. events where co-partners such as Education Providers identify issues in the learning environments for student, where the LSA Framework is unattainable due to closure of education routes for Preparation of SoM Programme. Medium term effect.
Minor	Minor impact, loss, delay, inconvenience e.g. non-compliance with NMC Standard or Guidance. I.e. when appointing an LSAMO, failure to submit an ITP etc, lack of data or evidence to support Investigations or Reports issued by the LSA. Short to medium term effect.
Insignificant	Risk identified with clear mitigation from LSA including management through internal risk framework, clear plans action plans and lines of reportage, etc. Little or no effect.

Rating the likelihood

Almost certain	Is expected to occur in most circumstances
Likely	Will probably occur in most circumstances
Possible	Might occur at some time
Unlikely	Could occur at some time
Remote	May occur only in exceptional circumstances

NMC Framework Risk Register

Ref	Summary of information	Source	Risk	Likelihood	Impact	Risk score
Chief Executive sign off and quality of report						
1	Chief Executive did not sign annual report and no indication that it had been viewed by him/her.	LSA Annual Report	Lack of sign off may mean non-engagement with supervisory function at SHA/board level.	2	8	16 RED
2	Some requirements of rule 16 of the midwives rules and standards not described in the LSA annual report and NMC not assured that an effective supervisory framework is in place.	LSA Annual Report	Effective supervisory framework may not be in place and therefore unable to protect the public.	4	4	16 RED
3	Inconsistent description of supervision framework described and NMC not assured that an effective and consistent supervisory framework is in place.		Effective and consistent supervisory framework may not be in place and therefore unable to protect the public.	4	4	16 RED
Numbers of Supervisors of Midwives, appointments, resignations and removals						

Ref	Summary of information	Source	Risk	Likelihood	Impact	Risk score
4	SoM/MW ratio above 1:20 within individual services or across the LSA.	LSA Annual Report	Elements of supervisory framework unachievable or unsustainable due to lack of supervisors.	3	4	12 AMBER
5	SoM / MW ratio not stated.	LSA Annual Report	Elements of supervisory framework unachievable or unsustainable due to lack of supervisors	4	4	16 RED

Details of how midwives are provided with continuous access to a Supervisor of Midwives

6	Description of how midwives are provided with continuous access to a SoM not described or variable across LSA and NMC not assured that an effective supervisory framework is in place. E.g. some areas within an LSA may use a 24/7 hour rota and some may use a contact list.	LSA Annual Report	That in an emergency midwives may not have clarity about how to contact a Supervisor of Midwives thereby delaying a decision that may have an influence on the outcome for a mother and baby.	3	4	12 AMBER
7	No evidence that 'continuous access to a SoM' process is audited so lack of assurance that process is working effectively.	LSA Annual Report	Process may not be working effectively which may have impact during emergency situations (see above).	3	4	12 AMBER

Details of how the practice of midwives is supervised

8	LSA audit process not described (or not described well) so NMC not assured that an effective supervisory framework is in place.	LSA Annual Report	Effective supervisory framework may not be in place and therefore unable to protect the public	4	3	12 AMBER
9	No description of ITP process.	LSA Annual Report	Lack of supervisory framework in place and inability to delivery function of supervision.	4	4	16 RED
10	LSA Audit Process stated as not undertaken.	LSA Annual Report	No mechanism in place to assure LSA that supervision is functioning and therefore NMC not assured that effective supervisory framework in place.	5	4	20 RED

Evidence that service users are assisting the LSAMO with the annual audits						
11	Public User Involvement in supervision audits not described.	LSA Annual Report	Lack of user input into development of supervisory framework. Risk in meeting rules and standards.	4	3	12 AMBER
12	Public User Involvement in supervision could be enhanced.	LSA Annual Report	Minimal user input into development of supervisory framework.	2	2	4 GREEN
Evidence of engagement with higher education institutions in relation to supervisory input in to student midwifery education						
13	No evidence of engagement with higher education institutions.	LSA Annual Report	Risk in meeting rules and standards.	4	4	16 RED
14	Indication that the clinical learning environment for student midwives is not an appropriate learning environment. This may include lack of qualified mentors, lack of support for undertaking mentorship programme or challenges in meeting student/mentor ratio.	LSA Annual Report QA Framework	Supervisory framework is not pro-active in improving learning environment for student midwives and/or students learning in an inappropriate clinical environment.	4	4	16 RED
Details of any new policies related to the supervision of midwives						
15	No detail of any new policies.	LSA Annual Report	Lack of pro-activity of LSA in supporting supervisors of midwives with policy development.	4	4	16 RED
Evidence of Developing Trends affecting midwifery practice in the local supervising authority						

16	Limited information or description provided on maternal death trends within LSA and interface with supervisory framework.	LSA Annual Report	Role of supervisory framework unclear. Limited analysis learning from trends and lack of opportunity to apply learning in the future to protect the public.	4	4	16 RED
17	Evidence to suggest increasing births across the LSA of over 5-10% or increase in midwife to birth ratio.	LSA Annual Report	Impact upon the protection of the public and suitability of clinical environment as a safe and supportive place for provision of care. Impact on appropriateness of clinical learning environment for pre registration midwifery students	3	5	15 AMBER
18	Maternity Service/s within LSA under review by NMC or other stakeholder or special measures in place by the Health Care Commission.	LSA Annual Report	Impact upon the protection of the public and suitability of clinical environment as a safe and supportive place for provision of care. Impact on appropriateness of clinical learning environment for pre registration midwifery	3	5	15 AMBER
Details of number of complaints regarding the discharge the Supervisory Function						

19	No description of complaints process or number of complaints.	LSA Annual Report	Possibility that complaints process is not in place or is not robust.	3	5	15 AMBER
20	Evidence of up held complaints against the LSA.	LSA Annual Report	That the LSA has been deemed to be in effective in its function to women or midwife (dependent on complaint). There may have been a compromises to protecting the public e.g. due to bullying, harassment or discrimination.	4	4	16 RED
Reports on all local supervising authority investigations undertaken during the year						
21	High or low percentage of supervisory practice programmes described and/or lack of definition on reasons for high or low numbers.	LSA Annual Report	Rules and Standards in relation to investigation leading to supervised practice not being interpreted appropriately/effectively. Risk that midwives being placed on a programme of supervised practice inappropriately.	3	4	12 AMBER
General concerns identified in the NMC framework for reviewing LSAs						

22	Inadequate supervisory framework in place to meet the Midwives Rules and Standards across the LSA.	NMC framework for reviewing LSAs	Effective supervisory framework not in place and therefore unable to protect the public.	3	5	15 AMBER
23	Where a midwife is reported to the NMC for clinical concerns without reference to the supervisory framework.	NMC framework for reviewing LSAs	Effective supervisory framework not in place and therefore unable to protect the public.	3	5	15 AMBER
24	Where the clinical environment is unsafe for midwife student learning or mentorship is ineffective and not supporting student midwives.	NMC framework for reviewing LSAs	Impact on appropriateness of clinical learning environment for pre registration midwifery	3	5	15 AMBER
25	Concerns regarding the function and performance of supervision within the LSA.	NMC framework for reviewing LSAs	Effective supervisory framework not in place and therefore unable to protect the public.	3	5	15 AMBER
26	Poor compliance with recommendations from any investigations reports from either the LSA or other bodies such as the Healthcare Commission.	NMC framework for reviewing LSAs	Effective supervisory framework not in place and therefore unable to protect the public.	3	5	15 AMBER
27	Concerns of conduct which relate to, for example, bullying, harassment or abuse of power from within the LSA or supervisory framework which may impact upon the function of supervision.	NMC framework for reviewing LSAs	Effective supervisory framework not in place and therefore unable to protect the public.	3	5	15 AMBER

APPENDIX 3

West of Scotland Action Plan 2009-

Recommendation	Action	Lead	Resource Implication	Completion Date and Evidence of completion	Six Monthly Update December 2008	Six Monthly Update June 2009	NHSL Position
1.Demonstrate the role of statutory supervision of midwives interface within the clinical governance frameworks in each LSA	<p>Ensure links with clinical governance networks within the LSA'S</p> <p>Ensure untoward incidents are reported to the LSA and that there is a mechanism in place to guide SOMS in reporting incidents that may impact on women to the LSA</p> <p>Provide Advice and support to SOMS in the investigation of practice concerns and or where sub optimal practice is alleged , irrespective of the</p>	<p>JP All SOMS</p> <p>All SOMS</p>	Staff time	<p>July 2008 SOMS on clinical risk management committees</p> <p>West of Scotland guidance for reporting serious untoward incidents published and circulated for effect 1/4/08</p>	<p>December 2008</p> <p>Process in place and investigations are being reported. Need to firm up process to trigger SOM investigation When required</p>	<p>SOMS continue to be represented on clinical risk management committees</p> <p>Untoward incidents are reported to LSA by SOMS . LSAMO is collating a spreadsheet of any incidents reported to LSA to ensure themes shared to prevent similar occurrences</p> <p>Action Review trigger list</p>	<p>SOMS represented on all clinical risk and clinical governance groups in maternity services</p> <p>Incidents reported to LSA and we now have experience of a number of joint SOM / Management investigations Action plans developed following serious incidents</p>

Recommendation	Action	Lead	Resource Implication	Completion Date and Evidence of completion	Six Monthly Update December 2008	Six Monthly Update June 2009	NHSL Position
	clinical outcome	JP	Staff time		LSAMO available to provide advice and support	<p>& look at the effectiveness of the process in the WoS by Dec 2009 and link in with any outcomes from NMC road shows and LSAMO Forum UK work stream on investigations</p> <p>LSAMO available to provide advice and support as requested and during all investigations</p>	<p>Many SOMs attended SOM investigation workshop and NMC roadshows</p> <p>SOMs involved in local risk management processes and actively involved in supporting good practice and recognising poor practice within local maternity services</p>
2.Raise the profile of statutory supervision of midwives, the role of the supervisor of midwives, the role of the LSAMO and the LSA	Encourage networking across the LSA'S and the sharing of good practice through facilitating sessions for all SOMS and also through the WOS Link SOM'S Forum	JP All SOMS		Workshops to be rolled out in LSAs where required profiling the role of the SOM	LSA audits identifying verbally that SOMS seen as distinct group. Workshops to be held in and Ayrshire PRM in new year	Workshops undertaken in PRM in March 2009 to promote role of supervisor. Needs further workshops following service redesign that is currently in place	<p>Low midwife to supervisor ratios</p> <p>Plans for NMC document to be available for every women</p> <p>Opportunity for midwives to</p>

Recommendation	Action	Lead	Resource Implication	Completion Date and Evidence of completion	Six Monthly Update December 2008	Six Monthly Update June 2009	NHSL Position
	<p>Implement road shows for midwives outlining the role of the SOM, the LSAMO and the midwife</p> <p>Create opportunities for midwives to shadow SOMS to have exposure to the role and contribute to succession planning</p> <p>SOMS to sit on relevant committees to represent views via the perspective of statutory supervision of midwifery practice</p> <p>Establish a website for the public to give information on supervision of midwifery practice</p>	<p>All SOMS</p> <p>All SOMS</p>		<p>Midwives to be given opportunities to shadow SOMS when undertaking role</p> <p>SOMS to be represented on Clinical governance committees Risk management forums MLSC</p>	<p>Invitation continues for shadowing opportunities. To be implemented at local levels</p>	<p>as still difficulty in recruiting in this unit.</p> <p>Profile in Ayrshire has been raised with more midwives showing interest in coming forward to become supervisors as 5 individuals will commence September 2009 programme.</p> <p>Circulate minutes/notes of SoM meetings to all midwives in each LSA.</p> <p>SOMS represented on all committees in each LSA.</p> <p>Invitation continues for shadowing opportunities. Student SOMS to</p>	<p>attend local SOM forum as a development opportunity</p> <p>SOMS developed lead and deliver documentation study day</p> <p>Increased involvement of SOMs in investigating incidents</p> <p>NHSL to develop local information for the web site</p>

Recommendation	Action	Lead	Resource Implication	Completion Date and Evidence of completion	Six Monthly Update December 2008	Six Monthly Update June 2009	NHSL Position
		JP Link SOMS		Maternity Framework group Educational curriculum planning committees Establish a web site	SOMS continue to be represented on forums In draft format reviewed in December WOS link meeting	shadow soms in WOS meeting and encourage staff locally to shadow soms Still in draft format to be finalised in July 2009 has been reviewed by WOS SOMS	

Recommendation	Action	Lead	Resource Implication	Completion Date and Evidence of completion	Six Monthly Update December 2008	Six Monthly Update June 2009	NHSL Position
3.Demonstrate the evidence, audit trail, and trend analysis of the standards of statutory supervision and midwifery practice	Undertake an annual audit of supervision of midwifery practice to demonstrate that the standards for supervision of midwifery practice are met across the region Gather evidence within each LSA to demonstrate compliance with the standards to assess and assure quality within each LSA	JP Link SOMS SOMS		LSA Audit process established and implemented 2007-2008 For annual audit across LSAs	LSA audits in process for this year	Audits established for 2009-2010 LSA audit reports available in each LSA for 2008-2009 Each LSA local forums responsible for undertaking any individual actions as required	LSA audits and collation of maternity service data firmly established

Recommendation	Action	Lead	Resource Implication	Completion Date and Evidence of completion	Six Monthly Update December 2008	Six Monthly Update June 2009	NHSL Position
4.Increase user involvement in the work of the LSA and the LSAMO	<p>Establish a network for user involvement in supervision across the region</p> <p>Enlist the support of users in undertaking an annual audit of the LSA</p> <p>Provide training sessions for users</p>	JP All SOMS	Travelling expenses and child care expenses for users	Work with NHS Boards and birth groups to recruit users in development of strategies for supervision and also To take part in LSA audits	Users taking part in LSA audit. In liaison with Patient public participation officer in GGC to assess if user participation in audit can be developed such as audit team visiting local groups throughout year. For review following completion of this years audit process.	<p>Explore existing mechanisms for funding user expenses</p> <p>Link SOMS to recruit users in own areas for audit visits. JP will repeat training day for users</p> <p>Look at the use of postal survey to gain women's views</p> <p>LSAMO to provide training sessions dates to be arranged for August/ September 2009</p>	<p>User representative on local Superisors of Midwives Forum</p> <p>Plans for NMC document to be available for all women</p>
5.Promote active recruitment and preparation of new SOMS, to ensure standard minimum ratios are maintained, ensuring succession planning	Implement road shows in areas where there is difficulty in recruiting midwives to become a SOM.	JP Link SOM Forum All SOMS HEIs		<p>Rollout road shows workshops In LSA</p> <p>Give Midwives opportunities to shadow SOMS in meetings</p>	For recruitment in January/ February for September intake for prep course	18 midwives interviewed in May 2009 and 12 undertaking Sept 2009 course Results pending from Sept 2008	Local ratio of 1:9 with ongoing recruitment for succession planning purposed to ensure low ratio

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	<p>Create shadowing opportunities</p> <p>Encourage midwives to nominate midwives they feel will be good SOMS</p> <p>Ensure adequate support systems in place for student SOMS and newly appointed SOMS</p>			Guidance in place of buddying system to support student SOMS	<p>Student SOMS encouraged to take part in LSA audits and all supervisory activities</p> <p>All student SOMS have mentor</p> <p>Newly appointed SOMS will have a mentor</p>	<p>programme – to be appointed Sept 2009 To undertake active recruitment in GGC next Feb</p> <p>All areas to maintain own lists of mentors. Template for maintaining register circulated to all areas June 2009 by JP</p>	can be maintained
6. Provide opportunities for SOMS to expand their knowledge of the statutory processes and understanding of the role of LSAMO	<p>Ensure SOMS actively contribute to and access up to date information whilst undertaking their role</p> <p>Ensure SOMS can access information from the NMC</p>	JP Link SOMS		Links established between SOMS and LSAMO. Good links between SOMS and HEIs	Annual conference arranged for February and March 2009	Annual conference taken place on February 11th and March 11th 2009 on Leadership and the role of the supervisor	<p>Local SOM attendance at NMC roadshows</p> <p>Workshops at local meetings</p> <p>Attendance at regional and</p>

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	<p>Provide an annual conference to ensure networking and the sharing of best practice across the LSA'S Provide support to SOMS as required</p> <p>Develop leadership skills of SOMS</p>	JP Link SOMS HEIs	<p>Staff time for training Conference fees</p> <p>Staff time for training Conference fees</p>	Conference for SOMS to be held annually	<p>Information circulated as received</p> <p>Annual conference arranged this conference will be on developing leadership skills as a SOM</p>	<p>Supervisory workshops taken place –for SOMS on conducting supervisory investigations September 2008 and April 2009 more workshops planned for September 2009 and November 2009</p> <p>Information circulated as received</p> <p>Scottish Conference planned for December 2009</p> <p>National LSAMO UK conference next April 2010 in Nottingham Each area to put forward good practice seminars</p>	<p>national study days</p> <p>Attendance by local SOMs at National UK LSA conference</p>

Recommendation	Action	Lead	Resource Implication	Completion Date and Evidence of completion	Six Monthly Update December 2008	Six Monthly Update June 2009	NHSL Position
						WoS conference was on leadership	
7.Ensure registrants understand their responsibilities as registrants from the perspective of statutory supervision of midwifery practice including the requirement of the supervisory review	Implement road shows across the relevant areas profiling the role of the SOM and the registrant	JP HEIs SOMS Link SOMS		Road shows developed and rolled out. Also SOM role profiled in LSA audits	SOMS continue raising profile of supervision. For workshops in PRM in new year. LSA audits demonstrating so far that midwives becoming more aware of their responsibilities as registrants in focus groups. LSA audits are contributing to raising the profile of the SOMS	Focus groups with midwives in the LSA audits of 2008-2009 demonstrated an increased awareness in their role & responsibilities as registrants and that of the supervisor. Soms have raised the profile over the last year. Midwives are attending for	Discussed and recorded as part of annual review discussion

Recommendation	Action	Lead	Resource Implication	Completion Date and Evidence of completion	Six Monthly Update December 2008	Six Monthly Update June 2009	NHSL Position
						annual review in areas there were difficulties	
8. Ensure SOMS have adequate time to undertake the function of the role	<p>SOMS to have the equivalent of a day a month to fulfil their role</p> <p>SOMS to monitor time undertaken on supervisory function and to identify any problems in obtaining time</p>	All SOMS Line managers	As per staffing	<p>SOMS to have equivalent of 7.5 hours per month to undertake role</p> <p>Monitor time spent in undertaking role and work on difficulties</p>	SOMS monitor time some report having difficulty taking time. Managers are facilitating time	<p>SOMS monitor time - some report having difficulty taking enough time. Managers are facilitating time. SOMS should report difficulties to line managers</p> <p>Utilisation of SOMs time to be included in annual audit questionnaire in LSA Audit 2009-2010</p>	The service supports a minimum of 7.5hrs per month. Monthly returns completed by all supervisors and monitored by link SOM. Any issues are raised with Service Manager to ensure time is facilitated.
9. Each SOM to audit case records	All SOMS to audit case records and share relevant findings in practice to improve the quality of record keeping	All SOMs		All SOMs to undertake audits of records	To establish record-keeping audit across each LSA. Process in place in GGC and Lanarkshire. Lanarkshire also conduct documentation	Each area reported ongoing audits taking place. These will all be reviewed in LSA Audit 2009-2010	Undertaken as part of annual review discussion. In addition designated SOMs are allocated to undertake ongoing case

Recommendation	Action	Lead	Resource Implication	Completion Date and Evidence of completion	Six Monthly Update December 2008	Six Monthly Update June 2009	NHSL Position
					workshops		note reviews on behalf of the supervisors.
New actions identified from NMC (2009) Supervision , support and safety on June 11TH 2009						June 2009	
10. Ensure a robust recruitment strategy is in place to ensure there is a ratio of 1:15 in each LSA	Develop a recruitment strategy	WoS guideline group				JAdverts circulated for interviews in February of this year and interviews took place in may 2009. this will take place annually. Workshops are held in areas where there is difficulty recruiting this has included over the past year Dumfries and Galloway. Princess Royal Maternity unit Greater Glasgow and Clyde and in Ayrshire last year by local SOMS	Current ratio 1:9 with robust succession planning strategy to maintain low ratio

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11. Audit response times from SOMs to midwives to requests for advice	Develop guideline and audit tool	WoS guideline group				This will be audited in the years LSA audit 2009-2010. In last years audit no problems highlighted by midwives in accessing a SOM	SOM available 24/7 via Wishaw switchboard. All Supervisees given contact details of own supervisor
12. Demonstrate actions taken and evidence of progress in response to risks communicated from NMC. Risk in WOS ratio Som/mw above 1:15 in AA GGC DG Some trends identified as risk i.e. poor communication	Ensure ongoing annual recruitment Cross reference recommendation 5 Ensure action plan in place & implementation	All All areas		Ongoing		Recruitment taken place throughout the WOS, 11 soms due to be appointed by August b2009 and further 12 student SOMS to commence preparation programme in September 2009	Local ratio 1:9 Individual incidents and trends /lessons learned from incidents discussed at local SOM forum
13.Feedback concerns to HEI if any concerns in learning environment for student midwives	Ensure focus groups in each LSA audit with Student Midwives	LSAMO		Ongoing		Focus groups held with student midwives in 2008-2009 LSA audits and to be repeated in 2009-2010. LSAMO would	SOM attends local Clinical Board for maternity services. This is a joint education, student, midwife and service

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						<p>feed back any concerns to HEI.</p> <p>LSAMO is going to link with NHS NES PEF to develop some work around this and also Jean Rankin will feed back minutes of any relevant meetings to LSAMO on student placements</p>	meeting where issues relating to midwifery education are discussed
14. Concerns about newly registered midwives should be reported	Any concerns with fitness to practice for all registered midwives should be investigated as per guideline L	All		Ongoing		Mechanism in place to report concerns.	Mechanism in place through risk management structure at which SOM attends
15. Each LSA/ Region should work collaboratively with organisations that have a safety remit such as SPSA	LSAMO to establish a link	LSAMO		Dec 2009		JP to establish link with SPSA and link into WOS meetings	SOMs involved in the roll out of SPSP programme in maternity services
16. Each LSA should develop action plans in response to trends	Develop action plan to meet local needs as required	All		Ongoing		Action plans to be developed by all links in	Risk registers in place and action plans developed

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impacting adversely on Safety of women and babies using maternity services Ability of midwives to provide safe quality care in the antenatal, intrapartum and postnatal period Ability of midwives to mentor student midwives to ensure competent applicants to the register						individual units	to mitigate risk. SOM represented in development
17. LSAs should move to an electronic method of storing supervision related data that uses a standard dataset agreed by LSAMO UK Forum	LSAMO to submit a bid to each NHS Board for funding	LSAMO		July 2009		Bid made to each LSA to share costs of LSA data base	NHS Lanarkshire are supportive of the purchase of LSA database
18. LSAs should explore working with organisations that have a safety remit, such as the SPSC in order to address the concerns raised in relation to poor practice	Collaboration initiated & maintained Cross reference recommendation 15	LSAMO & all SOMs		Ongoing		LSAMO to establish link with SPSC	Local maternity services actively involved in SPSC process

Joy Payne
LSAMO
West of Scotland



SERVICE USER LSA AUDIT WORKSHOP

1- 3pm

**VENUE Queen Mothers Hospital
Parent Craft Room**

LUNCH PROVIDED

Facilitator Joy Payne LSAMO West of Scotland

- | | |
|----------------|--|
| 1.00 pm | Welcome and Introductions |
| 1.15pm | Overview of Statutory Supervision |
| 1.45 pm | Reason for LSA audit visits |
| 2.15 | Proposed time table |
| 2.20 | LSA audit standards |
| 2.30 | Feedback from 2007-2008 LSA audits |
| 2.45 | Group discussion on themes for this year's audit
Ground rules and any questions |



West of Scotland Supervisors of Midwives Conference 2009

February 11th and March 11th

Supervision in Action Midwifery Leadership –Making it happen

Facilitator Liz O'Neill

Welcome and Introductions

Understanding Leadership in a Supervisory Role

Challenges and skills

Influencing and Using Power

Leading Change

Coaching for Development

Communication

Dealing with Conflict

Taking Stock

Planning and Prioritising



**West of Scotland
Supervisors of Midwives Workshop
Conducting a Supervisory Investigation**

**PROGRAMME
12th September 2008
Venue Beardmore Hotel & Conference Centre
Clydebank
Glasgow**

Facilitated by Joy Kirby LSAMO EoE

Joy Payne LSAMO WoS

09.00- 09.15 Coffee and Registration

0915 -10.30 Introduction and Conducting a Supervisory Investigation

10.30-10.45 Tea Break

10.45-12.30 Fact Finding

12.30-13.15 Lunch

13.30 -15.00 Investigation Interviews

15.00-15.15 Tea break

15.15-17.00 Coming to Conclusions & Making Recommendations

STATISTICS FOR WISHAW MATERNITY UNIT

1 April 2007 – 31 March 2008

STATISTICS FOR WISHAW

MATERNITY UNIT

1 April 2008 – 31 March 2009

CLINICAL ACTIVITY	
Total women delivered	5177
Total delivered in the hospital	5113
Total number of babies born	5262
Number of hospital births in water	30
Deliveries in community maternity units Stand alone	0
Within main unit	5113
Total number of women booked under midwife-led care (Taken as a % of deliveries)	We do not have a years worth of data.
Total number of women transferred to consultant care	We do not have a years worth of data.
Are you able to monitor reasons for transfer?	We do not have a years worth of data.
Number of intentional home births attended by a midwife	54
Women delivered at home with no midwife present, including those delivered at home or in transit by ambulance crew	BBA 29
Babies born at home, attended by a midwife, when intended/planned for hospital delivery	0
Total deliveries in the home	27
Number of homes births in water	3
Number of women initiating breastfeeding	1384 (26.7% - Missing Data = 29%)
Number of women breastfeeding on discharge to Health Visitor (% of total women birthed)	965 (18.6% Missing Data = 29%)

Number of women smokers at time of: booking	395
Delivery	395
Number of babies born to women under 18 years old (at time of delivery)	140

MATERNITY OUTCOMES DATA

Number of babies born alive	5237
Number of stillbirths	25
Number of early neonatal deaths (i.e. at 6 days and under)	4
Number of late neonatal deaths (i.e. 7 – 28 days)	3

INTERVENTIONS

Planned inductions	868
Accelerated labours (including ARM and Syntocinon, or both)	2125
Episiotomies	677
Epidurals with vaginal births	584
Epidurals/spinals with caesarean sections	
Planned caesarean sections	460

Emergency caesarean sections	910
Total caesarean sections	1370
Forceps deliveries	435
Ventouse deliveries	110
Vaginal breech deliveries	18

FACILITIES	
Type of unit (consultant/midwife/GP)	All consultant led
Total number of maternity beds (including delivery beds)	86
Number of obstetric theatres	2
Staffed by midwifery staff (other than receiving baby)	0
Staff by theatre staff	2
High dependency beds	No specific high dependency beds
Early pregnancy unit	6
Fetal medicine unit	N/A
Antenatal day assessment unit	4 DAU's
Birthing pool	2
Bereavement/quiet room	1
Partners accommodation on AN ward	As required
Family kitchens	0
Security system: Controlled door entry	Yes
Baby tagging	Yes

Pressure mattresses	No
Midwife-led beds	0
Intrapartum GP care	0
Transitional care cots	0

SOME MIDWIVES TAKE RESPONSIBILITY FOR DECISION MAKING AND UNDERTAKE:	
Neurophysiological examination of the newborn	40 Trained 30 competent
Ultrasound scans	1
Amniocentesis	0
Induction of labour by prostaglandin	All midwives
by syntocinon	All midwives
Ventouse deliveries	0
Forceps deliveries	0
Six week postnatal examination	0
Cervical smears	0
Specialised counselling	0
External cephalic version	0