

NHS Grampian Local Supervising Authority

Annual Report

April 2005 - March 2006

Summary

NHS Grampian has 396 midwives working in hospital and community settings across the area and 26 Supervisors of Midwives in place.

The key influences for the delivery of Maternity Services in Grampian are the principles contained in A Framework for Maternity Services in Scotland (2001) and the subsequent Expert Group Report on Acute Maternity Services in Scotland (EGAMS 2003). These form a template for maternity care throughout Grampian whilst considering their local application in a range of geographical settings in a mixed urban and rural environment. Practice underpinned by professional best practice statements, clinical guidelines, health reports, national and local perinatal morbidity and mortality statistics, considering both clinical and staff governance as well as public expectation and involvement.

Midwives are key to the delivery of this care and their practice is supported by robust Supervision of Midwives processes.

- All midwives have a Supervisor of Midwives and audit has demonstrated that the vast majority of midwives value this activity highly and use it effectively by ensuring that their practice is supported and guided.
- In 2005-6 clinical activity has increased statistically but also in the range of expertise midwives provide. New practice is underpinned by education and training and opportunities exist for existing practice to be developed to meet the dynamic nature of maternity care.
- The learning culture is strong as evidenced by both training and education activity provided by the organisation and via the local Universities. This culture extends from students, to midwives and to the care team more widely.
- The dynamic nature of the Maternity Service and of the Health Service more widely provides challenges and opportunities for both service providers and service users. Supervision of Midwives processes and the Supervisors of Midwives have worked well to support both

midwives and women during this change process and continue to do so.

- In 2005-06 only one midwife has been subject to supervised practice and a small number of others have been supported to bring elements of practice up to an acceptable standard.
- An action plan outlines issues to be addressed in the next year.

Mr Richard Carey, Chief Executive NHS Grampian
Miss Joan Milne, LSAMO NHS Grampian

26 September 2006

Local Supervising Authority Annual Report April 2005 - March 2006

NHS Grampian

A description of the services in LSA Grampian is provided in Appendix 1

1. Each local supervising authority will ensure their report is made available to the public

NHS Grampian publishes the report on the public web site. The report will also go to NHS Grampian Clinical Governance Committee for information.

2. Supervisor of Midwives appointments, resignations and removals

At 1 April 2005 there were 26 Supervisors of Midwives and 396 midwives, 62% of whom worked part time. No independent midwives practised in Grampian during this time.

	Appointed	Resigned	Removed
2002-2003	7	2	0
2003-2004	1	0	0
2004-2005	2	5	0
2005-2006	5	2 career breaks	0

In 2005-6, 5 midwives successfully completed the programme run by Napier University, Edinburgh and were appointed to the Supervisor of Midwives (SoM) role. They received mentorship as newly appointed SoMs. During the year 2 SoMs arranged to take a career break for at least 1 year and their midwives were asked to choose another SoM for the period of their absence. Both of these SoMs met with their midwives prior to leaving so their files were handed over in an up to date format. This led to other SoMs having to increase their midwife numbers in the short term. This was done with the understanding and consent of those involved.

In February 2006 a further 6 midwives commenced a preparation programme at Napier University, Edinburgh with a view to be appointed on successful completion of the programme in July 2006.

Midwife to Supervisor of Midwives ratio varies across the Health Board, dependant on geography, the number of hours each SoM works and the hours available within the clinical role to fulfil the SoM functions.

3. How are midwives provided with continuous access to a Supervisor of Midwives?

On employment all midwives are allocated a SoM until such time as they have sufficient knowledge to choose one for themselves. A free choice may not be possible if a SoM has an existing full cohort of midwives, or if access is problematic for geographical reasons. All midwives have a named SoM but are informed that they can access any SoM for specific advice so they are not restricted to their named SoM for all supervision issues.

Midwives are given written information about the Supervision of Midwives purpose and process and this includes work telephone numbers of all SoMs. They are encouraged to use their named SoM proactively so that predictable problems are addressed before they become real ones thereby reducing the need to access a SoM in an urgent situation. A Supervisor of Midwives is on duty in Aberdeen Maternity Hospital and in Dr Gray's hospital in Elgin on the vast majority of occasions but if not, one can be accessed by bleep by any midwife.

When a SoM in an isolated area is on annual leave she arranges for another SoM to cover her area. This is notified to the Local Supervising Authority Midwifery Officer (LSAMO) so that she can give further assistance if required.

4. How is the practice of midwives supervised?

The first process is to ensure that there is a good spread of SoMs in community and hospital settings and in education. Attempts have also been made to separate Supervision of Midwives from direct line management so that midwives and SoMs do not feel conflict in the supervision relationship. Where that is not possible the Supervisors of Midwives refer to another SoM if there is possible conflict for example if an incident needs reviewed and the SoM needs to respond as a manager.

The second process is to ensure that SoMs themselves are skilled to undertake the role, that they are communicated with effectively and that they have opportunities to be involved in influencing practice issues. The practice of midwifery therefore is reviewed on a regular basis by the LSAMO and SoMs to ensure that all are aware of the influences on practice, what new evidence is being promoted, what new services are being introduced and whether SoMs themselves need support around the necessary changes. The premise is that if Supervisors of Midwives receive support then that will equip them to support their midwives.

In Grampian this is done with alternate month meetings between the LSAMO and the SoMs where such issues are discussed and necessary training for Supervisors discussed, planned and delivered. SoMs are expected to attend 4 of the 6 meetings per year thus encouraging discussion on a Grampian wide

basis and providing networking opportunities and peer support for the Supervisors of Midwives themselves.

SoMs are subject to an annual audit of their performance by the LSA and are expected to complete an anonymous audit of their own performance with the midwives they supervise. This provides evidence of how SoMs are discharging their roles and gives them personal feedback from their midwives. (Appendix 2)

All midwives have opportunity for an annual review with their Supervisor of Midwives. The SoMs invite midwives to attend for this review and enclose pre meeting preparation documentation designed to encourage midwives to reflect on their practice, to identify any necessary knowledge or skills updating and to consider whether they can recommend any changes in practice in the area where they work. This review also includes a personal discussion on record keeping. Each midwife is asked to bring a set of records to illustrate their competence in this area and action is taken according to findings. Good record keeping is commended as well as making plans for remedial action if the record keeping is not up to standard, to keep this activity as constructive as possible.

Other processes include involvement in setting up and delivery of training programmes which underpin service changes or best practice initiatives. For example, all midwives in Grampian have mandatory training for neonatal resuscitation through the Neonatal Resuscitation Programme run by the Neonatal Unit in Aberdeen Maternity Hospital and subject to biennial assessed accreditation. This is a multidisciplinary accredited programme also delivered to student midwives in year 3. This joint learning approach fosters collaborative working within the maternity team. A number of SoMs are accredited trainers on this programme. Similar activity occurs around emergency care scenarios but this is not accredited in the same way.

To assist discussion around practice issues with midwives the LSA uses the NMC standards of proficiency to be achieved for entry on to the midwifery part of the register (NMC2004). These describe the skills and ability to practise safely and effectively without the need for direct supervision and are therefore used as the springboard from which practice grows. SoMs and midwives have found the Effective Midwifery Practice section particularly useful when discussing how practice needs to be updated and maintained at a safe level.

Midwives are also being targeted for additional training in child protection, domestic abuse, smoking cessation, perinatal mental health and breast feeding. SoMs play a vital part in identifying if learning outcomes have been met and whether theory and practice are congruent.

Supervisors of Midwives are involved in clinical risk management meetings in Aberdeen and Elgin and in ad hoc reviews in the smaller units. Reports of these meetings are distributed widely to maternity staff across Grampian and form a regular part of the SoM meeting agenda. This can lead to work in

reviewing guidelines, re enforcing good practice or can lead to training being organised and targeted if this is indicated.

Supervisors of Midwives also provide support for midwives and women in home delivery situations. They provide assistance in the preparation for these and planning for any scenarios which may prove challenging to midwives. The number of home delivery requests is increasing marginally but besides some concerns about the on call commitment when multiple on call is required in the same locality, this choice has been accommodated. Further increase in numbers may require a different approach to how the service is delivered.

During the year one midwife has been subject to supervised practice and there have been no suspensions from practice. The supervised practice related to a midwife who followed the instructions of a medical practitioner without considering that what she was asked to do was outside the limits of her practice. Her actions did not change the outcome of care but it became clear that the midwife did not understand that she was bound by professional codes and rules which should have led to her asking for advice. Her insight into her actions did not reassure her SoM or the LSAMO that she would not do the same in a similar situation and a period of supervised practice was agreed and is still in process.

5. Service user involvement in monitoring supervision of midwives and assisting the local supervising authority midwifery officer with the annual audits.

Patient Focus and Public Involvement work is a priority for the Health Board and in the last year the public have been highly engaged in discussing the provision of maternity services in Grampian. From this it is hoped that a number of women who have expressed interest in working more closely with the service will be identified to help with the monitoring process.

6. Engagement with higher education institutions in relation to midwifery education programmes.

At this time 2 of the SoMs are midwifery lecturers at the Robert Gordon University, the local Higher Educational Institute providing pre and post registration education programmes. In addition another within service is a Practice Educator for maternity services in Grampian. She and the LSAMO are part of the curriculum planning group and course management team for undergraduate programmes. The effect of this is the promotion of a dynamic education programme heavily influenced by practice. This is evidenced by the ability to influence programme development to include the accredited programme for neonatal resuscitation, to involve education in participating in in house training for changes in service e.g. hearing screening, nicotine replacement therapy, domestic abuse and perinatal mental health so that the practice environment is shared and understood.

Another SoM is participating in the Nursing, Midwifery and Professions allies to Health (NMAP) programme which provides education and support for PhD students. This activity allows the SoM to give constructive feedback to SoMs about how their practice as midwives is perceived by women. This is a powerful message to influence how one to one discussions with midwives are structured and reflection on practice is channelled.

Another SoM is involved with the University of Bradford in the establishment and delivery of an assisted birth practitioner programme. 8 midwives in Grampian are undertaking this programme designed to allow continuity of care for more women, practice underpinned by a good theory and knowledge base and assist in sustaining maternity services where they may be under threat. Supervision of Midwives processes are heavily involved in the design, delivery and clinical support of this programme. This is subject to rigorous evaluation.

7. New Policies related to the Supervision of Midwives

Nil

8. Developing trends affecting midwifery practice in the LSA.

Throughout the year the maternity service in Aberdeenshire CHP has been under review as part of the Aberdeenshire Change and Innovation Plan. The CHP is concerned that the delivery service as in patient activity in 3 of the 4 units is no longer sustainable. Delivery activity in the units has been falling over time because of a number of variables including changes in population distribution, changes in areas in deprivation in particular with the demise of the fishing industry in the North East, unsuitability of a number of women for delivery in a CMU and to some degree women choosing to deliver outwith their local area. The Review has been a prolonged exercise with many public events to debate the way ahead. The effect of this on the midwives has been working through uncertainty and through personal and professional conflicts. However the service has been maintained as a safe one for the public through the efforts and flexibility of the midwives involved. Local managers have also supported short term secondments to manage staffing levels throughout the review period.

Aberdeenshire Units

	Aboyne	Banff	Fraserburgh	Peterhead	Home
Beds	4	6	6	6	
Deliveries					
2003	34	43	68	109	3
2004	57	53	65	103	15
2005	60	57	58	114	14

Aberdeen Maternity Hospital

	2004-5		2005-6	
Delivery Numbers	4172		4204	
SVD	2325	56.4%	2291	55%
Forceps	301	7.2%	317	7.5%
Ventouse	409	9.8%	374	8.9%
Elective CS	383	9.2%	424	10.1%
Other CS	769	18.4%	840	19.9%
Total CS	1152	27.6%	1264	30%
Induction of Labour rate		24.8%		27%
Epidural rate		22.7%		21.2%
Midwife Unit deliveries	1162	27.8%	1053	25%
Home deliveries	9		12	
Still birth	16		26	
Neonatal Death	11		12	

The above statistics reflects the actual activity in AMH and includes; caesarean sections from Orkney and Shetland; preterm deliveries less than 34 weeks gestation from across Grampian; all substance misusers in Grampian, Orkney and Shetland; and excludes the normal deliveries in Aberdeenshire. As Aberdeen is the tertiary referral centre complex cases all deliver there.

Dr Gray's Elgin

	2004-5		2005-6	
Deliveries	954		965	
SVD	684	71.7%	682	70.6%
Forceps	45	4.7%	38	3.9%
Ventouse	89	9.3%	87	9%
Elective CS	49	5.1%	72	7.5%
Other CS	82	8.6%	92	9.5%
Total CS	131	13.7%	164	17%
Home deliveries	5		10	
Still births	4		1	
Neonatal death	1		0	

Dr Gray's Elgin is a Consultant Unit who care for all except babies less than 34 weeks gestation and does not have an epidural service. Very complex women are also delivered in Aberdeen.

Home Deliveries 2005

2005	Aberdeen		Aberdeenshire		Moray		Total	
	Booked	Delivered	Booked	Delivered	Booked	Delivered	Booked	Delivered
January	1	1	1	0	1	1	3	2
February	4	3	4	1	1	0	10	5
March	1	1	0	0	2	2	2	2
April	1	1	4	3	1	1	6	5
May	2	1	3	2	0	0	6	3
June	3	1	3	2	3	2	8	5
July	3	0	1	0	1	1	5	1
August	2	2	2	2	1	1	5	5
Sept	2	0	4	2	1	1	7	3
October	4	1	7	1	3	1	14	3
Nov	1	0	3	1	1	0	5	1
Dec	2	1	1	0	1	0	4	1
TOTAL	26	12	33	14	16	10	75	36

2005	Booked	Delivered	Antenatal Transfer	In Labour Transfer
January	3	2	1	0
February	10	5	5	0
March	2	2	0	0
April	6	5	1	0
May	6	3	3	0
June	8	5	2	1
July	5	1	4	0
August	5	5	0	0
September	7	3	4	0
October	14	3	11	0
November	5	1	4	0
December	4	1	3	0
TOTAL	75	36	38	1

Good Practice

Good practice in Grampian includes much collaborative working across sectors so that the care of women is as seamless as possible. The care is underpinned by Ante Natal Care in Grampian Guidelines which outlines patterns of care, referral pathways and management guidelines to prevent

unnecessary referral. Risk criteria are set out to aid discussion and decision making re care planning. These follow professional guidelines, research evidence and comply with Expert Group for Maternity Services in Scotland recommendations whereby care is delivered as near to home as possible with referral to Obstetric Units only if clinically necessary. Supervisors of Midwives are closely involved in the development of these guidelines.

There are also Labour Ward guidelines to promote consistency in the management of women who develop complications in the perinatal period. These have also been developed on a multidisciplinary basis and are updated 2 yearly.

Multi disciplinary and multi agency working is also evident in the care for women abusing substances. The activity is led by Aberdeen Maternity Hospital services but is inclusive of local services in Aberdeenshire and Moray. Joint training and learning events are held regularly and information shared widely about developments and trends in the service. Supervisors of Midwives have been involved in developing guidelines for care and promoting child protection training and support. Trainers have been established for both child protection and domestic abuse and SoMs encourage midwives to attend sessions and apply their new learning.

There has been a considerable effort made to skill midwives to manage smoking behaviour. Community midwives in particular have been targeted for training and resources allocated by CHPs to invest more time to help women change their smoking habits. This is being evaluated and will report back later in 2006. Midwives work collaboratively with the Smoking Advice Service and local pharmacists to ensure messages and practice are consistent.

There are very close links with Robert Gordon University for curriculum planning, programme management, Exam Board activity and delivery of programme events. As SoMs are embedded in education this fosters a healthy culture for valuing how Supervision of Midwives can influence change and promote women centred care.

In preparation for Baby Friendly activity there has also been a large investment in UNICEF training for midwives and in addition RGU have signed up for the status in education setting. This will be a main focus of Supervisors of Midwives activity in the next year.

In April 2006 NHS Grampian will be subject to a Maternity Services review by Quality Improvement Scotland (QIS). Supervisors of Midwives have been highly involved in gathering evidence to illustrate how the Standards have been met. This report will be on the QIS public web site in due course.

9. Complaints regarding the discharge of the supervisory function

None received.

The midwife may discontinue the role of the supervisor of midwives for various reasons such as personal or retirement. However the supervisor may be deselected where the standard of supervision falls below that expected by the LSA

Criteria

- Problems may be identified by the LSAMO, peers, supervisees or others
- The LSAMO is notified and the supervisor is informed formally of the concerns by LSAMO
- An urgent meeting is arranged with the supervisor and an investigation is carried out to confirm or refute the concerns
- Where the concerns are unfounded no further action is taken
- Where there is evidence to substantiate concerns remedial action will be proposed
- The LSAMO will meet with the supervisor to formulate a plan of action and agree a timescale for achievement of objectives
- Support and guidance strategies will be agreed and needs in terms of education, support and mentorship will be met
- The supervisor will remain in post and review of supervisory activity will be reviewed within an agreed timescale
- The LSAMO will keep accurate records throughout
- Where the standard of supervisory activity is unacceptable to the LSA the supervisor will be deselected
- The LSAMO will notify the supervisor of this in writing
- The LSAMO will inform the NMC and other supervisors when a midwife ceases to be a supervisor of midwives
- Where the supervisor wishes to appeal against this decision, a request should be made in writing within 14 days of the decision to the LSAMO
- The appeal will be heard by an external LSAMO.

If the complaint was about the LSAMO this would be referred outwith Grampian for investigation and the NMC would be involved. However these issues will be clarified when the Regional LSAMO is appointed.

10. Local Supervising Authority investigations undertaken during the year.

One investigation, as mentioned in section 4, concerned a midwife following the instructions of a medical practitioner without questioning whether what she was being asked to do was within her remit or professional codes. This has been subject to both supervision of midwives and managerial investigation. Both were of the opinion that there were significant mitigating circumstances but that the insight shown by the midwife to her own contribution to the event was not adequate and her understanding of professional accountability was deficient. For this reason a period of supervised practice was commenced.

This included agreed learning outcomes and regular review of progress. This supervised practice commenced February 2006 and is still in place at the end of March and progress is evident.

Advice was sought from NMC on this case and advice followed.

Other investigations have involved elements of practice which have come to light through record audit or risk management processes. These have been dealt with jointly with management through provision of additional support from a SoM and mentors if appropriate.

A midwife's record keeping around a home delivery did not demonstrate care planning or rationales for decision making. On reviewing more of her records it became clear that her records were too brief and did not follow the required standard for sharing information and reflecting that women has been involved in decision making. This midwife spent time with her SoM reflecting on the application of the record keeping standard and had her records reviewed on a regular basis until the standard was met. Follow up has demonstrated a sustained improvement in practice.

A midwife on 2 occasions did not set up an IV infusion of syntocinon correctly. This was a near miss event as the syntocinon was not being administered as a result of her errors. This highlighted a knowledge gap which was rectified speedily and successfully. However, this also drew attention to a potential bigger issue that orientation to the Labour Ward was not covering these issues adequately and in addition that student midwives were not necessarily skilled at this on completion of their programmes. The orientation programme to Labour Ward was reviewed and remedied as a result of this.

A midwife failed to transfer a woman in labour when progress had ceased but continued to perform vaginal examinations with no further plans recorded. She did not seek advice at any stage but the woman was transferred when the next midwife took over care. On transfer from the CMU it was noted that 10 vaginal assessments had been performed. Her SoM explored her rationales for care and revealed that her exposure to women in labour had been very limited in the last couple of years as women had not gone into labour while she was working. Her experience and performance with ante and post natal care was not in question. Her confidence levels around labour care had diminished as a result. A period of updating in Aberdeen was arranged and relationships formed with the midwives in the referral unit. A SoM supported her throughout and practice improved. Her own SoM confirmed that her exposure to labour had improved and she would be able to recognise if further updating was required.

Another issue involved a woman being transferred from a CMU with inadequate assessment having been carried out. The woman had one episode of hypertension in the week prior to her going into labour but it was not reassessed by the midwife prior to her being asked to attend the Consultant Unit in early labour. The blood pressure was normal and the woman's original intention to deliver near to home was not respected. The

midwife and her SoM reflected on this practice and her decision making skills are being supported more generally.

Appendix 1

LSA DESCRIPTION

Management structures in NHS Grampian promote a single system of health care organised around 4 sectors. One of the sectors is Acute and there are 3 x Community Health Partnerships organised around local authority boundaries covering Aberdeen City, Aberdeenshire and Moray. Midwifery is provided in all of these sectors, managed differently in each. A Maternity Services Clinical Management Board acts as a Managed Clinical Network to ensure consistency of practice and provide a governance framework across the 4 sectors. Supervision of Midwifery provides the focus for consistency of practice despite different management structures

LSA Grampian has a mixture of rural and urban settings with the main centres of hospital activity being in Aberdeen and Elgin. There are also 4 small community maternity units in Aboyne, Banff, Fraserburgh and Peterhead, who provide integrated community and hospital care and except for Aboyne accept back transfers for post natal women who have delivered in Aberdeen and Elgin if there is a clinical need. At present Aboyne is piloting another model of care whereby the hospital is only staffed when women require intrapartum and immediate post natal care. A fifth community maternity unit in Huntly is currently closed for deliveries as demographic changes reduced the demand so much that the delivery service became unsustainable and recruitment of midwives was therefore problematic. The small units are all subject to a review which has run for the entire year. This review also includes Care of the Elderly and Diagnostic and Treatment Services (The Aberdeenshire CHP Change and Innovation Plan). This has not yet concluded.

Clinical care follows the model of the Maternity Services Framework for Scotland (2001) and the Expert Group for Acute Maternity Services in Scotland (2003) whereby the midwife is the lead professional for women with low risk features. General Practitioners are involved if they desire. All women receive ante natal care as near to home as possible with Consultant outreach for abnormal care. If all is normal, women can opt for delivery in a local setting or in one of the larger units.

Ultrasound services are available in both the large units and in community settings across Grampian. Level 1 and 2 scanning is provided by a multidisciplinary team of midwives and radiographers and Level 3 scanning is provided by Obstetricians in Aberdeen and Elgin. Women are offered 2 routine scans, one at 10-12 weeks and the second at 20 weeks.

Aberdeen Maternity Hospital is the tertiary referral centre for Grampian, Orkney and Shetland and the local maternity hospital for the women in and around Aberdeen. It has a full range of midwifery, Obstetric and Neonatal Services with babies only being transferred outwith the area if they require cardiac surgery. On some occasions women having premature babies need

to be transferred outwith Grampian as the Neonatal Unit is full. The majority of these return undelivered.

There is a midwife led delivery unit in Aberdeen Maternity Hospital adjacent to the Obstetric Labour Ward where normality is promoted. A water birth facility is provided.

Services also include facilities for women experiencing threatened or actual pregnancy loss and a pregnancy assessment area for those experiencing problems which need dealt with urgently but not needing admission to Labour Ward. Both of those services can be accessed directly by midwives.

Dr Gray's Hospital Elgin is a small Consultant unit offering midwife, Obstetric and special neonatal care. Women having very small and premature babies are transferred to Aberdeen unless delivery is imminent and a stabilisation and transfer service operates for such babies who deliver locally or who are ill. There is not a 24 hour epidural service. Other services are similar to what is available in Aberdeen.

Aboyne provides a rural integrated hospital and community maternity unit 40 miles to the west of Aberdeen, where care is midwife led. There are 4 rooms which accommodate women delivering locally. There is no antenatal in patient service but home assessment and out patient assessment is performed by the midwives as required. There is no consultant outreach at Aboyne for historical reasons but this is provided to the south of the region in Stonehaven which serves the rural areas adjacent to Tayside.

Banff is situated 45 miles to the north of Aberdeen and 30 miles from Elgin. Women can deliver in all 3 units according to needs and choices. The service is similar to that in Aboyne but is staffed over 24 hours so transfer back for post natal women is possible. Consultant outreach is provided by Elgin.

Fraserburgh is 45 miles to the north east of Aberdeen and has a similar service to Banff. There is more deprivation in this area including a substance misuse problem. Consultant out reach is provided by Aberdeen. Fraserburgh is 20 miles from Peterhead.

Peterhead is 30 miles north east of Aberdeen. The integrated service is similar to the other areas. Consultant out reach is provided by Aberdeen.

In addition to this, Consultant out reach is also provided in Buckie, Forres, Huntly and Keith by Elgin consultants.

Ambulance transport is provided by the Scottish Ambulance Service who have their own standards to follow.

Appendix 2

SUPERVISOR OF MIDWIVES AUDIT 2005-6

Results

The audit was anonymous. There was an expectation that all SoMs would participate. 26 SoMs were eligible to respond, 20 responded.

Approximately how long do you spend on Supervision of Midwives activities each week?

Majority spend on average 2-3 hr per week on Supervision regardless of case load, but this was not distributed evenly throughout the year. More time was spent around the time when Intention to Practise forms were sent out and when meetings with LSA were occurring.

How many midwives do you supervise?

Number of midwives per SoM = 6 to 28. Small numbers reflected part time working and wide geographical range. 28 reflected a SoM in a hospital setting paired with a Supervisor undertaking a preparation programme. This SoM took over the midwives of a SoM who left unexpectedly.

How many midwives did you invite to meet you?

All reported inviting all midwives.

How many did you actually meet?

The vast majority met all of their midwives. Exceptions were those on long term sick leave, maternity leave and a small number whose appointments had to be cancelled because of high clinical activity.

How many LSA meetings have you attended in last year? (Standard is minimum of 4)

One SoM only managed 2 meetings, one managed 3 and 18 others met the standard. Average meeting attendance was 4 meetings.

Do you have records of ;

Every meeting with your midwives	all yes
When an Intention to Practise form was completed	all yes
When each midwife is due to re register	all yes

How many midwives did you counsel about the standard of their performance?

SoMs responded “some” on 12 returns, one on 4 returns and the remaining 4 stated 0 .

Were you involved in any case of alleged misconduct?

Only one midwife had been involved in alleged misconduct and LSAMO was included in the case.

Did you audit at least 1 set of records for each of your midwives?

This was successful only in part. SoMs reported difficulty in accessing records for each of their midwives so in effect had discussions about record keeping more generally.

Were you involved in any drug error cases?

Only 4 SoMs answered yes and 2 noted that these had been joint managerial approaches.

How often did you participate in risk management activities or clinical audit?

Only 1 SoM reported that she had not participated at all and the remaining 19 reported sometimes or frequently.

Did you participate in discussions about your role as a SoM with students on pre registration courses?

Some SoMs have minimal exposure to students so 4 said no.
8 reported that they did this sometimes
8 did so frequently.

How often did you participate in reviewing clinical guidelines/protocols in your area?

All had some involvement.
16 said sometimes
4 reported this as frequently.

Overall did you have difficulty in fulfilling your role as a SoM?

11 SoMs reported no difficulty
7 reported some difficulty
2 reported a lot of difficulty.

When asked what would help remedy the situation the responders stated that most difficulties related to time constraints and accessing midwives who were on different shift patterns. There remains an element of SoMs spending time

chasing midwives to attend their appointments but this has changed markedly since they have to sign the ITP form.

2 SoMs would like additional training in specific elements of the role as they feel under confident that they are performing adequately.

One in particular was very challenged by the Aberdeenshire Review and felt conflict in her role. Another felt excluded by local managers in this Review and was upset by her perceived lack of influence.

General question

SoMs were asked general question about what in their opinions would make the process more effective disregarding the time factor which the majority agree is challenging.

Comments included

- Changing the system for reviewing records
- More opportunity for workshop activity at meetings, scenario work
- Timing and frequency of meetings good and value the networking opportunities this brings.
- May be useful to major on some “big issues” and have sub groups to progress with LSAMO. This could increase influence of SoMs in areas where local managers do not seem to understand the role.
- SoMs need to be more willing to take lead in certain topics and be more involved and responsible for promoting supervision.
- More group work to examine recent evidence/research and discussing how we promote change in practice as needed.
- Get SoMs to audit more practice issues.
- Consider a Newsletter
- Enjoy the leadership exercises – could have more to keep us stimulated
- Make the meetings longer as valuable in every respect.

Appendix 3

ACTION PLAN

	Issue	Lead
1	Appoint 6 more SoMs to bring all SoMs within recommended ratios but also considering part time working	J Milne
2	Explore and agree on a more effective way or ways of auditing records by July 2006	AMH group SoM Elgin group SoM group
3.	Explore methods of capturing information re issues midwives are “counselled“ on by October 2006	J Milne
4.	Develop learning packages for remainder of meetings for 2006-7	J Milne J McNicol L Campbell M Vance
5.	Explore and develop more local activity around promotion of Supervision of Midwives	AMH group SoM Elgin group SoM group Aberdeenshire SoM group
6.	Explore the feasibility to increase public involvement around the monitoring of the Supervisor of Midwives processes	J Milne NHSG PFPI dept.

Appendix 4

NHS GRAMPIAN

Interim LSA Standards for the Supervision of Midwifery Practice pending publication of Scottish LSA Standards.

1. Standard 1 Communication

Standard

Supervisors have a responsibility to ensure effective communication exists between them, the midwives they supervise, the Link Supervisor of Midwives, LSA and the service providers at all levels of the organisation. For communication to be successful it has to be collaborative to maintain and improve standards of practice and care and ensure protection of the public.

Criteria

Communication between SOM and the midwife

Supervisors will:

- Ensure each midwife is provided with written information on their Supervisor of Midwives contact details and alternative cover over a 24 hour period. Also included in this will be an information sheet on the purpose of Supervision and the respective roles of the SOM and the Midwife
- Arrange regular meetings with individual midwives, at least once a year, to help them evaluate their practice and identify areas for development
- Ensure that the midwife is aware of the need to contact her SOM when her practice is under scrutiny to initiate support
- Receive and process Intention to Practise Forms to verify that the statutory requirements for practice have been met
- Ensure that midwives understand that they have statutory rules and guidance which they must adhere to
- Ensure that each midwife is aware of and has access to local policies and protocols in her area of practice.

Communication between SOM and Link Supervisor, LSA and NMC

Supervisors will:

- Attend a minimum of 4 LSA meetings annually
- Ensure that they have copies of all relevant documents issued by LSA and NMC
- Participate in the LSA audit examining the standard of Supervision, for the purpose of identifying deficiencies and planning remedial action.

Communication between SOM and service providers

Supervisors will:

- Liaise with service providers as required via the existing organisational structures
- Participate in drafting clinical guidelines and facilitate teaching sessions in pre and post registration education if required

2. Standard 2 Fitness to Practise

Standard

Supervisors of Midwives will inform the LSAMO of any untoward midwifery incidents and undertake their responsibilities in dealing with incidences of alleged misconduct with reference to the relevant documents as well as local disciplinary procedures.

Criteria

In instances of possible misconduct or impairment of fitness to practice by any midwife under their supervision, supervisors will:

- Work alongside the midwife's employer throughout
- Conduct an interview with the midwife concerning her midwifery practice
- Provide or facilitate access to support networks
- Undertake an examination of the events for consideration during the course of the interview
- Conduct an investigation of the circumstances as required by each individual case
- Establish and maintain direct meaningful communication on midwifery practice with the individual midwife
- Provide continuing support and facilitate access to education, re skilling and or updating identified as a result of the case
- Provide on going assessment with the midwife of planned interventions
- Document all interviews, actions and outcomes
- Provide professional advice on matters relating to discipline
- Report cases of alleged misconduct or impairment of fitness to practice to the LSAMO and provide a detailed report on any such cases
- Seek advice from and provide advice to the LSAMO, prior to any possible suspension of a midwife from practice.

3 Standard 3 Appointment of Supervisors

Standard

Selection and appointment of Supervisors of Midwives will fulfil the requirements outlined in Rule 11 of the Midwives Rules and standards (2004). The LSAMO will appoint supervisors using the agreed process as described in the following guidelines.

Criteria

- Supervisor vacancies will be advertised locally

- Midwives can apply through self selection, peer nomination and or recommendation.

Applicants will

- Satisfy the statutory requirement of Rule 11 by having completed an approved course of preparation
- Have peer support for their application
- Submit a Curriculum Vitae
- Demonstrate evidence of continued professional development
- Demonstrate knowledge of local service
- Be interviewed by a panel including an SOM, LSAMO and the Link SOM
- Be contacted promptly and offered post interview discussion by a panel member
- Have access to a minimum of 3 months preceptorship by an experienced SOM of her own choice

LSAMO will

- The final decision to appoint rests with the LSAMO
- Notify the NMC and other SOMs of the appointment
- Review the appointment via the LSA annual audit.

4. Standard 4 De selection of Supervisors

Standard

The midwife may discontinue the role of the supervisor of midwives for various reasons such as personal or retirement. However the supervisor may be deselected where the standard of supervision falls below that expected by the LSA

Criteria

- Problems may be identified by the LSAMO, peers, supervisees or others
- The LSAMO is notified and the supervisor is informed formally of the concerns by LSAMO
- An urgent meeting is arranged with the supervisor and an investigation is carried out to confirm or refute the concerns
- Where the concerns are unfounded no further action is taken
- Where there is evidence to substantiate concerns remedial action will be proposed
- The LSAMO will meet with the supervisor to formulate a plan of action and agree a timescale for achievement of objectives
- Support and guidance strategies will be agreed and needs in terms of education, support and mentorship will be met
- The supervisor will remain in post and review of supervisory activity will be reviewed within an agreed timescale
- The LSAMO will keep accurate records throughout

- Where the standard of supervisory activity is unacceptable to the and the LSA the supervisor will be deselected
- The LSAMO will notify the supervisor of this in writing
- The LSAMO will inform the NMC and other supervisors when a midwife ceases to be a supervisor of midwives
- Where the supervisor wishes to appeal against this decision, a request should be made in writing within 14 days of the decision to the LSAMO
- The appeal will be heard by an external LSAMO.

5. Standard 5 Monitoring Professional Practice

Standard

Supervisors will monitor the professional standards of each practising midwife under their supervision through audit of records and assessment of clinical outcomes, taking action as appropriate.

Criteria

Supervisors will:

- Be aware of how to verify a midwife's eligibility to practice via NMC voice check
- Ensure each midwife is eligible to practice according to the PREP practice and education standards
- Advise each midwife to bring with them to their annual review a set of case records for review
- Contribute to activities such as risk management, clinical audit and guideline development
- Be given access annually to inspect equipment and premises as required to ensure their suitability for professional purposes.

6. Standard 6 Medicines

Standard

Supervisors will ensure that midwives comply with legislation relating to medicine and associated equipment.

Criteria

Supervisors will:

- Ensure that each midwife under the supervision has a copy of the Guidelines for the Administration of Medicines (NMC 8/2004)
- Ensure that midwives have access to information re current Grampian Medicines Policy, and are conversant with Patient Group Directions and Formulary
- Ensure that midwives have access to and are conversant with information contained in current Hazard Warnings and Health and Safety Bulletins relating to medicines and related equipment

- During monitoring of records ensure that PGD documentation has been signed
- Ensure that each midwife is aware of the need to report drug errors via route appropriate to their place of work.

7. Standard 7 Notification of Intention to Practise

Standard

Supervisors will ensure that returned completed annual notification of Intention to Practise Forms are forwarded to the LSA by 28th February each year for all midwives under their supervision. The LSAMO will ensure that all completed forms are returned to NMC by 31st March each year. Forms generated from new registrants and employees will be submitted by 2nd week of each month.

Criteria

- Midwives will receive forms directly from NMC on an annual basis and when their Registration is first entered on to the Register

On receipt of completed forms supervisors will

- Check details on individual forms for accuracy
- Verify each midwife's eligibility to practise in accordance with Midwives Rules and Prep requirements
- Forward this form to LSAMO
- Forward a letter to those midwives whose forms have not been received by Supervisor by 15th February having checked it has not been forwarded directly to LSAMO
- Notify the LSAMO of any outstanding forms by 28th February.

On receipt of this information the LSAMO will

- Forward a letter to those midwives whose forms have still not been received by 30th March
- Inform the Supervisors of those midwives who have decided to cease practice within NHS Grampian

Supporting Publications

- *Preparation for Supervisor of Midwives.* NMC (2002)
- *Guidelines for the Administration of Medicines.* London: NMC (8/2004)
- *NMC Code of professional conduct: standards for conduct, performance and ethics :* NMC (11/2004)
- *Guidelines for Records and Record Keeping.* London: NMC (2002)
- *Learning Together. A Strategy for education, training and lifelong learning for all staff in the NHS in Scotland.* Scottish Executive (1999)
- *Midwives Rules and standards.* London: NMC (8/2004)
- *The Nurses Midwives and Health Visitors Act .*House of Commons (1997)