

# North East Local Supervising Authority



## Annual Report to the Nursing and Midwifery Council

April 2008 to March 2009

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September 2009

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## **Introduction**

The Local Supervising Authority (LSA) is the body responsible in statute (the Nursing and Midwifery Order 2001) for the general supervision of all midwives practising within its boundaries. The LSA's have been in existence since 1902 and the first Midwives Act. Currently the LSA is deemed within the Nursing and Midwifery Order (2001) to be situated within Strategic Health Authorities in England.

Statutory supervision covers all midwives practising within the LSA boundary, whether employed in the NHS, through agencies or the private sector, in higher education, in prisons, in the armed forces, in independent practice or employed by general practitioners.

The primary purpose of the LSA function is the protection of the public. The LSA is charged with ensuring that the statutory supervision of midwives is exercised to a satisfactory standard within its geographical boundary. This is achieved by ensuring that all midwives are eligible to practise, by maintaining the standard of midwifery practice, by ensuring appropriate training and development for midwives, and by investigating allegations of misconduct.

The function is delivered locally by supervisors of midwives, who contribute to the clinical governance framework by supporting the professional development of midwives, and participating in local risk management systems.

## **North East Local Supervising Authority**

The North East Local Supervising Authority (code 80)

The area covered by the LSA stretches from the Scottish borders and Berwick upon Tweed to Northallerton in North Yorkshire. The population of approximately 2.5 million people live in urban conurbations and rural communities. In 2008/09 there were 8 Acute NHS Trusts with 16 maternity units providing maternity services. The units vary in size from large regional referral units in cities to smaller midwifery led units in remote areas. 31,275 mothers gave birth in 2008/09.

1432 midwives notified their intention to practice between April 2008 and March 2009. As of March 2009 there were 112 appointed supervisors of midwives in the LSA. There were a further 6 midwives who were in the process of completed their preparation of supervisors of midwives and were awaiting the results of their course assessment.

### **The Chief Executive Officer**

The Chief Executive Officer for the North East LSA for the reporting year 2008/09 is Ian Dalton.

### **The LSA Midwifery Officer**

The LSA Midwifery Officer for the North East LSA is Kath Mannion.

### **Location of LSA office**

The LSA office is sited at the North East Strategic Health Authority Headquarters at the following address:

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## **North East Local Supervising Authority Annual Report 2008/09**

This report is written in accordance with Rule 16 of the Nursing and Midwifery Council (NMC) Midwives rules and standards as published in August 2004.

*A written, annual local supervising authority report will reach the Midwifery Committee of the NMC, in a form agreed by the Nursing and Midwifery Council, by the 1<sup>st</sup> of June each year.*

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

*The report will include but not necessarily be limited to:*

- *Number of Supervisor of midwives appointments, resignations and removals*
- *Details of how midwives are provided with continuous access to a supervisor of midwives.*
- *Details of how the practice of midwifery is supervised.*
- *Evidence that service users have been involved in monitoring supervision of midwives and assisting the local supervising authority midwifery officer with the annual audits.*
- *Evidence of engagement with higher education institutions in relation to supervisory input into midwifery education.*
- *Details of any new policies related to the supervision of midwives.*
- *Evidence of developing trends affecting midwifery practice in the Local Supervising Authority.*
- *Details of the number of complaints regarding the discharge of the supervisory function*
- *Reports on all local supervising authority investigations undertaken during the year.*

***Midwives Rules and Standards (NMC 2004) (page 34-5)***

The report is also written according to the guidance given within the NMC Circular 01/2009 issued on 30 January 2009. The risk profile and score from the previous annual report is attached in Appendix 1.

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

The LSA report is available in both hard copy and electronic versions. It is made available to all supervisors of midwives, local Trusts, the Strategic Health Authority, Northumbria University and University of Teesside once it has been signed off by the Chief Executive and submitted to the NMC.

A leaflet informing the public of statutory supervision and the LSA informs the public that if they wish to obtain the annual report they may contact the LSA Midwifery Officer for a copy. The annual report will also be available on the Strategic Health Authority web site [www.northeast.nhs.uk/](http://www.northeast.nhs.uk/)

No requests for copies of the annual report from 2007/08 have been received within this reporting year.

## 2. Number of Supervisor of midwives appointments, resignations and removals.

At 31<sup>st</sup> March 2009 there were 112 supervisors of midwives holding active appointment in the LSA consortium area. For the practice year 2008/09 1423 midwives notified their intention to practise with the North East LSA being their main area of practise. This gives a ratio across the LSA of 1:12.7

	<b>April 2008 to March 2009</b>	<b>April 2007 to March 2008</b>	<b>April 2006 to March 2007</b>
<b>Total number of supervisors</b>	112	114	117
<b>Total number of midwives submitting ITP to LSA</b>	1432	1418	1430
<b>Ratio of SOM to midwives</b>	1:12.7	1:12.4	1:12.2
<b>Number of supervisors appointed</b>	5	10	12
<b>Numbers of supervisors who have resigned/retired/deceased</b>	7	13	9
<b>Number of supervisors suspended from role</b>	0	0	0
<b>Numbers of supervisors removed from role</b>	0	0	0

The ratio across the LSA meets the NMC standard of no more than 15 midwives to 1 supervisor with seven Trust areas below that ratio and one marginally above. The table below details the individual Trust ratio's as of 31 March 2009.

Trust	Number of Midwives supervised			Number of SOM's			Ratio		
	2008 /09	2007 /08	2006 /07	2008 /09	2007 /08	2006 /07	2008 /09	2007 /08	2006 /07
1	133	131	135	13	12	13	1:10.2	1:10.9	1:10.3
2	247	257	257	22	23	26	1:11.2	1:11.7	1:9.8
3	97	98	109	9	11	11	1:10.7	1:8.9	1:9.9
4	226	232	217	13	15	14	1:17.4	1:15.4	1:15.5
5	163	168	164	11	10	13	1:14.8	1:16.8	1:12.6
6	215	221	231	20	19	20	1:10.7	1:11.6	1:11.5
7	228	217	229	16	16	13	1:14.2	1:13.5	1:17.6
8	84	87	87	8	8	6	1:10.5	1:10.8	1:14.5

### Key to Trusts

Number	Trust
1	City Hospitals Sunderland NHS Foundation Trust
2	Co Durham & Darlington NHS Foundation Trust
3	Gateshead Health NHS Foundation Trust
4	Newcastle Hospitals NHS Foundation Trust
5	North Tees & Hartlepool NHS Foundation Trust
6	Northumbria Healthcare NHS Foundation Trust
7	South Tees Hospitals NHS Trust
8	South Tyneside NHS Foundation Trust

In the Trust where the ratio is more than 1:15 active recruitment to the supervisory team is taking place. In June 2009 this ratio was within the NMC standard with the appointment of supervisors who were currently completing the preparation course or who are supervisors of midwives who have relocated to the North East and are eligible for appointment.

The number of midwives in the table include midwives outwith individual Trust employment e.g. midwives employed by universities, private sector, self employed midwives but whose main area of practice falls within the geographic boundary of the Trust. It does not include midwives notifying their intention to practise whose main area of practise is with other LSA's.

### Recruitment strategy

Succession planning was actively considered by all and appropriate numbers of prospective supervisors were prepared to meet losses due to retirement. From exit interviews with supervisors of midwives who had chosen to resign their appointments the main reason for their resignations were due to changes



within their posts including moving to posts where their focus would not be primarily on midwifery practice.

The number of nominations for appointment and commencing the preparation for supervisors of midwives course was static for this reporting year. Several appointments were made where the supervisors had held appointment in other LSA's and had relocated to the North East.

	<b>April 2008 to March 2009</b>	<b>April 2007 to March 2008</b>	<b>April 2006 to March 2007</b>	<b>April 2005 to March 2006</b>
<b>Number of midwives accessing preparation course</b>	7*	7*	11 *	19 *

\* Not all midwives attending the course completed the programme or accepted offers of appointment.

Challenges to maintaining the current ratio and not exceeding the NMC ratio in the future include:

- Trusts remunerating the number of supervisors only to the 1:15 ratio
- Succession planning for the predicted retirement of SOM's
- Static number of midwives coming forward for nomination
- Increased number of midwives coming into practice

The nomination, selection and appointment as a supervisor of midwives is in accordance with the National Guidelines – guideline C and can be viewed on <http://www.midwife.org.uk/>

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

#### **Continuous access to a supervisor of midwives**

The midwives in the North East are offered continuous access to supervisors of midwives in a variety of ways and examples of local arrangements include:

- Trust wide on call in large Trust which spans 5 maternity units.
- On call for local area but available for calls from adjoining area (in the same Trust).
- On call list held at Trust telephone switchboards and all calls forwarded to designated supervisor of midwives for that day.
- All supervisors available 8 am to 5 pm with on call arrangements out with that time.
- Supervisors on call for 24 hour period
- Supervisors on call for full week
- All midwives on supervisors caseload are given their named supervisors contact details including out of hours provision.
- On call supervisor calling the unit at predetermined times each day to see if any issues/supervisory assistance required.

The supervisors of midwives span all grades and expertise of staff. Coupled with the ratio being well within the NMC recommendation of 1:15 this means that supervisors of midwives are readily available to midwives and women.

The feedback from midwives during the annual audits of each Trust indicates that the local arrangements work well as they are designed to meet the needs of the midwives. In particular the midwives in the Trust where the on call supervisor telephones in at predetermined times have commented that this is very proactive approach. The midwives feedback that support from the supervisors was offered without the midwives having to seek it first and they found this very helpful.

#### **How midwives contact their named supervisor of midwives**

All midwives on supervisors caseload are given their named supervisors contact details including out of hours provision. Midwives are advised that if their own supervisor of midwives is not available that they may contact any other supervisor within the area. Contact telephone numbers of supervisors of midwives are available within each individual Trust.

#### **How midwives contact a supervisor of midwives in an emergency**

Midwives in the North East LSA are offered continuous access to supervisors of midwives in various different ways depending on local arrangements. Contact telephone numbers include mobile phones and/or a designated telephone number at the local Trusts. These telephone numbers are widely publicised in the area and there have been no reported difficulties in accessing a supervisor of midwives.

### **Contingencies if a supervisor of midwives is not contactable**

Midwives are advised that if the on call supervisor of midwives or their named supervisor of midwives is not contactable for any reason and they need to contact a supervisor urgently they can call any of the supervisors. Details of communication links are as in the section above.

### **Audit of access to supervisors of midwives**

The LSA audit visits to all Trusts tests compliance with the national standards of supervision (see appendix 2). Supervisors of midwives within each Trust are expected to provide evidence of how they meet Standard 4 – *Supervisors of Midwives are approachable and accessible to midwives to support them in their practice*. In addition during the audit visits midwives and supervisors of midwives were questioned by the LSAMO and peer auditors on achievement of the seven sub criteria within Standard 4. In all Trusts the midwives and student midwives reported that they were aware of the mechanism for contacting a supervisor of midwives. They also reported that they were able to and had accessed a supervisor at any time of the day or night should they require supervisory advice.

The process of how continuous access to a supervisor of midwives is reported within each individual Trusts annual report to the Local Supervising Authority. The LSA Midwifery Officer regularly tests out the availability of supervisors by randomly calling individual Trusts and requesting to speak to the on-call supervisor of midwives. She has had no difficulty in obtaining access to the on call supervisor of midwives.

Although there has not been any identified problems with midwives being unable to access a supervisor of midwives several Trusts have included the event '*unable to contact supervisor of midwives*' within their criteria for completion of Datex forms. In the unlikely event of a supervisor of midwives not being available this would flag up to the Trust and the LSA the non availability of a supervisor of midwives and would entail an investigation by the LSA Midwifery Officer.

### **Response times from supervisors of midwives to requests for advice from midwives in challenging situations**

Within each individual Trust communication logs are kept of contact made by midwives. It is planned that for 2009/10 these will include response times. During the annual audit visits midwives did not report any delays when they sought advice from a supervisor of midwives.

### **Response times from supervisors of midwives to requests for advice from women in challenging situations**

Within each individual Trust communication logs are kept of contact made by women. It is planned for 2009/10 that these will include response times. The LSA Midwifery Officer has not received any complaints from women regarding response times.

As part of the annual audit visits to each Trust the LSA Midwifery Officer has not had any complaints regarding response times by supervisors of midwives

from either midwives or women. Both have commented favourably on the availability of supervisors of midwives and their ability to support them in all situations.

**Outcomes and action plans**

No delay in responding to midwives or women when necessary. Future audits will include detailed response times.

#### **4. Details of how the practice of midwifery is supervised.**

All midwives intending to practise in the North East LSA area notify their intention to practise in accordance with the *Midwives rules and standards* (NMC 2004). Each midwife meets at least annually with her named supervisor of midwives and discussion includes eligibility to practice and maintenance of registration. Professional development and learning opportunities based on each individual's needs are also identified at that time.

When poor practice has been identified or allegations of misconduct have been made supervisors investigate the issue and report to the LSA Midwifery Officer.

The LSA Midwifery Officer audits how midwifery practice is supervised using the National LSA Standards (Appendix 2) which is based on the *Midwives rules and standards* (NMC 2004). Evidence is presented by the supervisors of midwives at the time of the audit visit. The LSA Midwifery Officer also meets with groups of midwives and women to ask their views of statutory supervision and cross check against the evidence presented by the supervisors of midwives.

#### **Methods of communication and dissemination of information to supervisors of midwives**

The North East LSA hold regular meetings for all supervisors of midwives in the area. There were five full day Supervisor of Midwives/LSA meetings held during the reporting year at the North East Strategic Health Authority headquarters. These meetings are open to all supervisors of midwives and midwives undertaking the preparation for supervisors of midwives course.

The meetings have agreed terms of reference, a standard agenda and action plan. The meetings during the reporting year offered supervisors and the LSA Midwifery Officer opportunities to discuss local and national issues. Supervision guidelines and standards were reviewed at these meetings. There were also educational opportunities incorporated into the meetings to enable supervisors of midwives to meet their PREP requirements for supervision. These educational opportunities are now part of the standard agenda at every SOM/LSA meeting.

All appointed supervisors of midwives within the North East have access to the LSA extranet site. This site contains minutes of all LSA meetings, local and national guidelines, reports and forms associated with the LSA. In addition the LSA Midwifery Officer uses group emails to the identified contact supervisor of midwives in each Trust for the purpose of cascading information.

An annual conference is organised by the LSA Midwifery Officer to ensure that supervisors are offered educational activities. The conference for 2008 dealt with issues requested by the supervisors at previous events. The conference covered the broad picture of healthcare and society that impact on midwifery and supervision. It was held on the 13th November 2008 at the Marriott Metrocentre, Gateshead and was attended by 70 delegates.

The conference also gave local supervisors and midwives an opportunity to network with colleagues. See Appendix 3 for the details of the conference agenda. The conference was well evaluated and the themes for the conference in 2009 are based on topics that delegates have requested at the 2008 conference.

### **Mechanisms to ensure consistency when carrying out supervisory functions**

All appointed supervisors of midwives in the area have a copy of the North East LSA standards and guidelines for supervisors of midwives. The guidelines are reviewed on a regular basis and new ones formulated according to local requirements. National guidelines formulated by the National Forum of LSA Midwifery Officers have also been adopted within the LSA. This ensures parity across both the local area and nationally for guidelines and issues that are common to all.

All investigations undertaken by supervisors of midwives are reviewed by the LSA Midwifery Officer to check for compliance and consistency against the NMC Standards as described in *The standards for the supervised practice of midwives* (NMC 2007).

### **Evidence of the LSA has improved care to women or enhanced and supported the practice of midwives**

The North East LSA through the appointed supervisors of midwives has enabled improved care to women whilst supporting the practice of midwives.

Close collaboration between the LSA Midwifery Officer, the CEMAC Regional Manager and the Patient Safety Team at the Strategic Health Authority enabled a very successful multidisciplinary study day based on the *Saving Mothers Lives* (CEMAC 2007) report. The learning from this event is hoped to both ensure safe delivery of care and support midwifery practice.

The national drive for promoting normal birth has been encompassed in the North East. Supervisors and midwives are involved in promoting normality and have been working with the NHS Institute. The LSA Midwifery Officer has facilitated working between the NHS Institute and local Trusts on increasing normality and reducing Caesarean Section. Two successful workshops were run during 2008/09 with further collaboration taking place in 2009/10. Supervisors of midwives have been involved with these events and also within the two Trusts selected by the NHS Institute for a more concentrated programme of support.

Breast feeding promotion continues with maternity services working towards targets to increase the number of women breast feeding in the North East. Supervisors of midwives have been instrumental in taking this forward and several units have achieved certificates of commitment from UNICEF and are working hard to achieve 'baby friendly' status.

There are birth reflections services in most Trusts offering support for women after birth. These services include supervisors of midwives as an integral part of the team helping women with issues raised at sessions

Within South Tees Hospitals NHS Trust the supervisors of midwives have been instrumental in service changes including the day assessment unit now being in operation on a 24/7 basis. The supervisors of midwives have developed protocols including triage for all women presenting to the unit. This enables women to be cared for in the most appropriate surroundings.

The supervisors within South Tees Hospitals NHS Trust have also been active in the review and management of 3<sup>rd</sup> and 4<sup>th</sup> degree tears within delivery suite. They have also enabled the use of aromatherapy and enhanced massage skills by staff working at the Friarage Hospital.

Two supervisors of midwives from South Tyneside NHS Foundation Trust were supported to present their work surrounding supporting practice at the LSA National Conference in April 2008 at the East Midlands Conference Centre. These supervisors have supported the women in their area to access water birth both at home and in the hospital. Their experiences have been disseminated within the North East with supervisors and midwives from other Trusts accessing their knowledge and support when setting up and maintaining similar services.

The supervisors of midwives at North Tees and Hartlepool NHS Foundation Trust have supported midwives and women with the transition from consultant led to midwifery led unit at Hartlepool. This unit opened in July 2008 and offers midwifery led care. The supervisors of midwives have supported the midwives with the transition and ensured that the focus on normality included the best evidence.

### **Challenges that impede effective supervision**

The increasing birth rate and complexity of care required by some women place challenges on all Trusts providing maternity services. Supervisors of midwives are an integral part of the workforce and are in the main clinically based. Competing demands on their time challenge them in maintaining all aspects of their role e.g. ensuring all midwives have annual reviews, timely investigations to name but a few.

### **How challenges are addressed**

The supervisors of midwives recognise that effective time management is key to maintaining their function. Support is sought from both Trust management in incorporating dedicated time for supervision and the LSA Midwifery Officer in prioritising their key functions of their roles.

Different ways of working have been implemented by some supervisors. For example, clinically based supervisors who are working alongside their supervisees on a daily basis are ensuring that part of the day to day contact is identified as related to supervision.

The current ratio of supervisors to midwives of 1:12.7 across the North East is being maintained and this will ensure that supervisors of midwives are not overburdened with large caseloads which may limit time for each individual midwife.

**Progress towards an electronic method of storing supervision related data**

The North East LSA commenced using the LSA national database in June 2008. A programme orientation and training was put in place with Linda Anderson, PA to the LSAMO, providing training and support both on site in individual Trusts and by telephone and email.

All annual reviews are now recorded on this database and information on all midwives eligibility to practice is also kept up to date. Records of when investigations have been undertaken and the outcome are also recorded.

Serious incidents such as maternal deaths and unit closures can also reported via the database.

The LSA extranet site also provides electronic access to LSA reports, minutes of meetings, guidelines and standards, administration forms etc.



## **5. Evidence that service users have been involved in monitoring supervision of midwives and assisting the local supervising authority midwifery officer with the annual audits.**

### **Service user involvement in the supervision of midwives**

In 2008/09 the LSA Midwifery Officer continued to employ various strategies in seeking the views of women and statutory supervision. Local users have been interviewed as part of the LSA audit visits and have very complementary of the standards of midwifery practice. Attendance by the LSA Midwifery Officer at local maternity health improvement groups ensures that regular dialogue with user groups is maintained.

All units have contact with user groups and supervisors of midwives are well represented at these forums. Maternity Liaison Committees are successful and active in some areas and where they have been disbanded efforts are being made to reform these groups. All Trusts have user representatives on their Labour Ward Forums ensuring that the voice of the women is heard. All Labour Ward Forums have supervisor of midwives representation further heightening user representatives awareness of the role of statutory supervision and supervisors of midwives.

### **Progress against action plans to improve service user involvement**

To publicise the role and function of supervision and supervisors the LSA has published information posters and leaflets. These were widely distributed around the LSA area and incorporated into the documentation given to women using the maternity services. This information also includes asking women if they are interested in becoming service user representatives. Despite meeting with women during LSA annual audit visits and other local maternity events the uptake of service users has been limited. However for 2009/10 service users have been recruited and will be part of the LSA audit team assisting in the annual audits of practice.

### **Evidence of service users assisting with the annual audits of practice**

Service users interviewed during the annual audits of Trusts have commented on the standard of midwifery care that they have received. These comments have been incorporated into each individual Trust's reports.

### **Training provided to service users involved in the supervision process**

Individual training is to be provided by the LSA Midwifery Officer to individuals who have come forward to become service user auditors. This training is based on the experiences of the North West LSA and once a small cohort of auditors is available group training and sharing of experiences will be possible.

## **6. Evidence of engagement with higher education institutions in relation to supervisory input into midwifery education.**

The LSA Midwifery Officer is a visiting lecturer at Northumbria University and the University of Teesside. She regularly lectures to groups of student midwives on statutory supervision and related topics. This offers her the opportunity for discussion with the students on their learning environments.

The LSA Midwifery Officer and supervisors of midwives are also involved with both universities Return to Midwifery Practice Programmes.

### **How the LSA gains information about the clinical learning environment for pre registration midwives**

All student midwives are offered a named supervisor of midwives during their practice placements. This ensures that students are able to see how supervision of midwives forms an integral part of midwifery practice. This also offers the opportunity for the supervisors of midwives to feedback to the LSA Midwifery Officer on the clinical learning environment.

Student midwives interviewed during the LSA audit visits were appreciative of the support of the supervisors of midwives. They were also complementary of the practice environments and the variety of experiences that they are offered.

### **Process to feedback information to the higher education providers and commissioners**

Along with supervisor of midwives representatives from Trusts the LSA Midwifery Officer meets with Northumbria University and the University of Teesside to discuss midwifery education. Discussions include developments within pre and post registration midwifery courses to meet the needs of service. The changing nature of the clinical environment and how it fits the learning needs of the students is incorporated in the programmes of education. Revalidation activity and events are always attended by supervisors to midwives.

The LSA Midwifery Officer liaises directly with the commissioning workforce team at the Strategic Health Authority regarding both pre and post registration education.

### **Approved education providers for the supply of preparation of supervisors of midwives programmes**

Northumbria University provides the preparation for supervisors of midwives course for nominated candidates within the North East LSA. The LSA Midwifery Officer is an integral part of the education team for the course and she works in partnership with the midwifery teachers to deliver the programme. This close working relationship enables early identification of any issues that the students may have. All parts of the portfolio that each student is required to complete is reviewed by the LSA Midwifery Officer and therefore she is immediately aware of any midwife who fail to successfully complete the course.

**How the LSA determines that new supervisors of midwives are competent to undertake the role at the end of the programme**

Part of the portfolio that the student supervisors of midwives are required to complete relates to the NMC competencies required by a supervisor of midwives. Each student is required to work through the competencies and has to be signed off by a supervisor of midwives who is also a NMC sign off mentor. These competency records are reviewed by the LSA Midwifery Officer and unless all are achieved the student would not meet the criteria for successful completion of the course. A copy of the competencies and workbook is included in Appendix

The preparation for supervisors of midwives course, which was validated in 2007, is a comprehensive programme and feedback from students and mentors alike indicate that it prepares them for the role of supervisor of midwives. Preceptorship is offered to all newly appointed supervisors of midwives to assist and support them in their role.

All supervisors of midwives within the North East LSA have to complete a self audit of their compliance against the NMC standards for their practice (*Standards for the preparation and practice of supervisors of midwives NMC 2006*). The LSA Midwifery Officer personally reviews all the self audits and gives individual written feedback to all supervisors of midwives. The self audits identify to the LSA Midwifery Officer the learning needs of the supervisors of midwives and she can plan both individual and group activities to meet these needs.

## **7. Details of any new policies related to the supervision of midwives.**

The National guidelines formulated by the National Forum of LSA Midwifery Officers have been adopted by the North East LSA. During the formulation and review of these guidelines supervisors of midwives in the North East are offered opportunities during the regular meetings with the LSA Midwifery Officer to comment on the guidelines. Their comments are considered and incorporated into the final ratified version.

All supervisors of midwives have access to the guidelines on the North East LSA extranet. The guidelines are also available on: <http://www.midwife.org.uk/>

## **8. Evidence of developing trends that may impact on the practice of midwives in the Local Supervising Authority.**

### **Outline of the public health picture across the LSA**

The North East has large pockets of deprivation with some of the most deprived wards in England. There are many Sure Start programmes, all of which are incorporating midwifery services. Supervisors of midwives have been involved with the continued support of these services ensuring that midwives working in these areas are enabled to maintain their practice and registration requirements.

Maternal mental health has continued to be identified as been a priority amongst supervisors of midwives. The recommendations of the confidential enquiry into maternal deaths *Saving Mothers Lives: Reviewing maternal deaths to make motherhood safer 2003-2005* (CEMACH 2007) have been implemented in all Trusts. This has been achieved by the supervisors of midwives ensuring that all midwives are aware and updated in current recommended best practice. They have supported midwives in identifying mothers who have experienced various forms of depression and have also been involved in the development of local clinical guidelines. Examples of this include early referral to a consultant following antenatal booking providing mothers and midwives with increased support in order to provide effective individualised care for women.

Safeguarding children causes on increasing workload for midwives working in all areas. The need to produce reports, attend case conferences increases each year. Safeguarding children has also been a continued priority for mandatory training for all midwives. Again this has been supported by supervisors of midwives with many of the named midwives for child protection also being supervisors of midwives.

Teenage pregnancy rates are high in the North East of England. Supervisors have taken the lead in Trusts to ensure that these young women receive appropriate support and care. For example in one Trust the young women's service coordinator is supported by the supervisors in providing support to this group of women.

There are large numbers of asylum seekers in some parts of the North East region. These women have complex needs and supervisors and midwives have been working hard to ensure that they receive the most appropriate care and support. There are large demands on interpretation services and supervisors are very mindful of the recommendations around this as contained within the confidential enquiry into maternal deaths *Saving Mothers Lives: Reviewing maternal deaths to make motherhood safer 2003-2005* (CEMACH 2007)

Substance misuse continues to be on the increase in the North East with one area reporting the 4<sup>th</sup> highest number of people in treatment in England. They also report that in that area there is a disproportionate rise in the number of women entering treatment. Work is ongoing to support this group of

vulnerable women and drug and alcohol specialist midwives are in post in most Trusts.

Smoking cessation services have a high profile in the North East and midwifery services utilise local agencies to help women stop smoking during pregnancy. In some Trusts this includes midwives with a specific smoking cessation remit.

The 10 year vision of health services in the North East has been developed as a result of the NHS Next Stage Review led nationally by Professor Lord Ara Darzi. The LSA Midwifery Officer and supervisors of midwives contributed to the maternity and newborn groups and the strategic vision and update can be downloaded at: <http://www.adynamicworkforce.nhs.uk/publications-and-reports/our-nhs-our-future-review>  
[http://www.northeast.nhs.uk/assets/media/pdf/Our\\_vision\\_our\\_future\\_-\\_progress\\_report\\_June\\_2009.pdf](http://www.northeast.nhs.uk/assets/media/pdf/Our_vision_our_future_-_progress_report_June_2009.pdf)

Maternity services in the North East have been under review in relation to future provision of service. In the Northumberland, Tyne and Wear area extensive consultation was undertaken in 2004/05 and as a result local Trusts are working together with the reconfigured services.

In Teesside service reconfiguration has meant that consultant care for North Tees and Hartlepool NHS Foundation Trust now being concentrated at the North Tees site. The maternity unit at Hartlepool reopened as midwifery led unit in July 2008 and has demonstrated both popularity with local women and safe standards of care measured within the unit's clinical outcomes.

### **Workforce Trends**

The North East has traditionally not suffered from recruitment problems and the number of commissioned students has been maintained at both universities. Student midwives continue to be supported in learning environments that promote normality and give them exposure to a range of experiences that help them meet the requirements determined by the NMC.

Retaining midwives within the area has not been problematic as the North East of England is seen as an attractive place to live and work. The previous trend of low numbers of midwives returning to midwifery practice has continued despite the opportunity for potential returnees to access courses run at both universities providing midwifery education in the area.

However the increasing birth rate and the complexity of care now required for women accessing maternity services alongside the challenge to Trusts to operate within budget constraints has proved challenging in maintaining the high standards of care expected by the public in the North East. In this challenging climate it is encouraging to see that all Trusts have maintained or achieved higher levels within their Clinical Negligence Scheme for Trusts (CNST).

The Health Care Commission Survey of maternity units in England confirmed the North East as the best in England for providing maternity care. For information on individual Trusts please use the link below:

<http://www.healthcarecommission.org.uk/healthcareproviders/nationalfindings/surveys/healthcareproviders/surveysofpatients/maternityse/reviewofmaternityservices2007-northeast.cfm>

Birthrate Plus has been or is currently being undertaken at all Trusts. This has positively impacted on the services with the agreement in some Trusts to increase funded establishments in response to identified increase in workload and complexity of maternity services.

### Birth Trends

The most comprehensive information relating to birth trends analysis in the North East is available in the Northern Regional Maternity Survey Office (RMSO) Annual report. The most current report (2007) is available at:

[http://www.northeastpho.org.uk/publications/692/RMSO Annual Report](http://www.northeastpho.org.uk/publications/692/RMSO%20Annual%20Report)

Birth numbers and workforce statistics have been obtained from all nine Trusts and are contained within appendix 5. These figures relate to the fiscal year covered in this report. These statistics were gathered by supervisors of midwives identified within each Trust and returned to the LSA Midwifery Officer along with each Trusts annual report on statutory supervision.

In summary the table below illustrates births and staffing across all Trusts in the North East.

Trust	Births	Midwives WTE in post	Birth to Midwife Ratio
City Hospitals Sunderland NHS Foundation Trust	3553	110.55	1:32
Co Durham & Darlington NHS Foundation Trust	5671	180.39	1:31
Gateshead Health NHS Foundation Trust	2025	74.66	1:27
Newcastle Hospitals NHS Foundation Trust	6165	173.4	1:36
North Tees & Hartlepool NHS Foundation Trust	3587	127.5	1:28.13
Northumbria Healthcare NHS Foundation Trust	3433	122.58	1:28
South Tees Hospitals NHS Trust	5289	181.16	1:28
South Tyneside NHS Foundation Trust	1552	66.95	1:28.7

### Serious Untoward Incidents

There were four maternal deaths during this reporting period. All were indirect deaths and were reviewed by supervisors of midwives and the LSA Midwifery Officer. Due to the small numbers of deaths a trend analysis could not be

made but each case was reviewed and any learning incorporated into supervisory activities.

The locally agreed serious incident escalation policy is contained within appendix 6.

### **Unit closures and actions taken to ensure the safety of women and babies**

Units in the North East very rarely if ever close. This is now monitored via the LSA database and for the reporting year there were no reported closures. When activity is very high each individual Trust have escalation policies that are put in place and the on call supervisors of midwives are kept fully informed of events.

### **Collaborative working with other organisations that have a safety remit**

The LSA Midwifery Officer is a member of the Strategic Health Authority Clinical Governance Forum. She also has close links with the Patient Safety Action Team within the Strategic Health Authority. Collaborative working this year included supporting the CEMACH Saving Mothers Lives workshop which was held in January 2009. This was well attended by both supervisors of midwives and other professionals working in maternity care.

The LSA Midwifery Officer and supervisors of midwives also attended events held by the Kings Fund relating to the Safer Birth report.

The LSA Midwifery Officer is a member of the Perinatal Mortality Survey/CMACE Steering Group based at the RMSO. She ensures that active communication between the RMSO and maternity units through the network of supervisors of midwives in the North East LSA. This has contributed to comprehensive and timely reporting into CMACE enquiries.



## **9. Details of the number of complaints regarding the discharge of the supervisory function**

There have been no complaints regarding the discharge of the supervisory function.

Complaints raised against supervisors of midwives would follow the nationally agreed guidelines set by the National Forum of LSA Midwifery Officers. Complaints raised against the LSA Midwifery Officer would follow the Strategic Health Authority Complaints Procedure.

## 10. Reports on all local supervising authority investigations undertaken during the year.

The LSA Midwifery Officer is informed of any untoward incidents by the supervisors of midwives. This may be through phone calls, direct contact or alerts through the LSA national database. She is also informed via the Strategic Health Authority of any untoward incidents notified to them by Trusts using strategic executive information system (STEIS). The Strategic Health Authority define Serious Untoward Incidents (SUI) as an incident or near miss occurring on health service premises or in relation to health services provided, resulting in death, serious injury or harm to patients, staff or the public, significant loss or damage to property or the environment, or other wise likely to be significant public concern. This collaborative working ensures that any untoward incident is fully investigated and learning outcomes widely publicised.

Guidance on carrying out a supervisory investigation is available to supervisors of midwives within both local and national guidance. The LSA Midwifery Officer is available to all supervisors undertaking investigations and all reports are reviewed by her.

<b>Investigations</b>	<b>Number</b>
By supervisors of midwives	11
By LSA Midwifery Officer	3
By external supervisor of midwives or LSAMO	0

There were 11 investigations undertaken by supervisors of midwives. The key themes of these investigations were as in previous reports:

- Record keeping
- Drug administration
- Poor practice
- Misinterpretation of cardiotocograph tracings

All investigations undertaken by supervisors of midwives were notified to the LSAMO who reviewed and agreed any recommendation made in the reports.

Local action in the form of developmental support was taken as a result of the recommendations in 8 of the cases. This included supporting midwives where deficits had been uncovered during the investigations. This included support from supervisors and senior midwives including educationalists within the area.

One investigation lead to one midwife commencing supervised practice during the year 2008/09. The decision to implement supervised practice was based on a supervisory investigation which revealed poor practice that warranted increased support rather than referral to the fitness to practice directorate of the Nursing and Midwifery Council. The key themes were poor record keeping, poor decision making and lack of insight into professional accountability. The midwife had a comprehensive programme of support

during her period of supervised practice. This included support from university midwifery lecturers and supervisors of midwives. The supervised practice programme was supported by the individual midwife's employers. Unfortunately she did not achieve the objectives set out in her programme despite an extension agreed by the LSA Midwifery Officer and has been referred by the LSA to the Nursing and Midwifery Council. The midwife has also been suspended from practice by the LSA whilst awaiting an NMC decision as to the midwife's fitness to practice.

Two investigations undertaken by supervisors of midwives prompted the LSA Midwifery Officer to undertake further investigations as the allegations revealed were of a serious nature and warranted further scrutiny. The LSA investigations were carried out in accordance with the LSA guidelines for investigating cases of alleged misconduct. These included independent assessments by another supervisor of midwives as well as the investigations carried out by the LSA Midwifery Officer. All of these investigations found that the *Midwives rules and standards* (NMC 2004) and *the Code: Standards of conduct, performance and ethics for nurses and midwives* (NMC 2008) had been breached. The themes of the breaches were around providing safe and competent care, drug administration and record keeping. One midwife was suspended from practice and referred to the NMC. The midwife is now suspended from practice by virtue of Interim Orders being placed by the Nursing and Midwifery Council. The case is awaiting a hearing before the NMC Investigating Committee. The other investigation was not concluded within the reporting period of this report.

There was one midwife on an Interim Suspension from Practice Order as a result of a referral to the Nursing and Midwifery Council made by the LSA in June 2007. This case was heard by the NMC Conduct and Competence Committee in February 2009 with the hearing being adjourned to July 2009.

There was one midwife on an Interim Suspension from Practice Order as a result of a referral to the Nursing and Midwifery Council made by the LSA in December 2007. This case has been investigated by the NMC and is awaiting a hearing date before the Conduct and Competence Committee.

The LSA has not been involved with investigations by the Healthcare Commission. The LSA Midwifery Officer along with Chris Wilkinson, Head of Midwifery at Newcastle Hospitals NHS Foundation Trust have conducted a review of maternity services at Doncaster. This review was requested by Doncaster Primary Care Trust and was conducted between January and March of 2009.

### **Key trends and learning outcomes for supervised practice programmes**

As there was only one supervised practice programme initiated during the reporting year it is difficult to determine what the key trends are due to the very small number. However comparisons with supervised practice programmes for the previous two years (5 in total over three years) the trends relate to:

- Record keeping
- Drug administration
- Poor practice
- Misinterpretation of cardiotocograph tracings

Unfortunately both midwives investigated by the LSA Midwifery Officer as outline in the section above had had comprehensive supervised practice programmes within the previous two years. Both midwives had also had extensive periods of support after they had successfully completed their supervised practice programmes. The LSA investigations revealed that both had unfortunately reverted to the poor practice that had been dealt with in their supervised practice programmes.

#### **Action taken LSA to reduce repeated incidents**

The LSA Midwifery Officer and supervisors of midwives regularly review the trends emerging from investigations. Together they plan and implement updates for all midwives ensuring that identified trends are covered in both individual annual reviews and Trust mandatory training.

The annual reviews of each individual midwife's practice incorporate record keeping, medicines management, case reviews and if applicable electronic fetal monitoring. During the year the supervisors of midwives also perform regular record keeping audits and feed back the results of these audits to the midwives in their Trusts.

The supervisors of midwives also review their Trusts medicine management policy and ensure that midwives practice within these policies and the NMC Standards for medicine management (NMC 2009).

#### **Non implementation of supervised practice programmes and follow on action taken by LSA**

All recommended supervised practice programmes have been implemented.

#### **Concerns relating to the competence of newly qualified midwives**

There have been no concerns raised regarding the competence of newly qualified midwives.

#### **Communication between the LSA and the NMC**

The LSA Midwifery Officer communicates directly with both the NMC midwifery directorate and fitness to practice directorate with any matter where concerns have been raised regarding midwifery practice.

#### **Anonymised summary of NMC referrals**

There have been two referrals in the reporting year and these are summarised in earlier paragraphs within this section.

## **Appendix 1**

### **Risk score from 2007/08 report**

**NMC framework for reviewing Local Supervising Authorities –  
LSA risk scores based on 2007-08 annual reports**

	Chief Executive sign off and quality of report	Numbers of supervisors of midwives, appointments,	Details of how midwives are provided with continuous access	Details of how the practice of midwives is supervised	Evidence that service users are assisting the LSAMO with annual	Evidence of engagement with higher education institutions in	Details of any new policies related to the supervision of	Evidence of developing trends affecting midwifery practice in the	Details of the number of complaints regarding the	Reports on all local supervising authority investigations	General concerns identified in the NMC Framework for reviewing LSA's	<b>TOTAL</b>
North East	0	0	0	0	12	0	0	0	0	12	0	<b>24</b>

***Appendix 2***

**LSA Standards**



## **Statutory Supervision of Midwives LSA Standards for England**

### **Introduction**

The LSA Midwifery Officers for England have reviewed the standards for statutory supervision within the context of the NMC Midwives rules and standards. The revised standards relate specifically to the sixteen rules. The NMC published five broad principles from which, in addition to midwifery practice, these standards have been formulated. Evidence of the achievement of these standards will be used by the LSAMO to demonstrate to the NMC that standards for LSA are met in accordance with the Midwives rules & standards (NMC 2004).

### **Audit Process**

The proposed process for the audit of the new LSA standards will take a self/peer review approach verification of evidence by the LSA Midwifery Officer employing a targeted sampling technique. Self/peer review is recognised as a powerful tool that stimulates professional development and decentralises power creating awareness of personal accountability (Cheyne, Niven & McGinley (2003), Malkin (1994), Ackerman (1991)).

Evidence in support of achievement of the LSA standards should be continually updated and stored in box files available for verification by the LSA Midwifery Officer at any time. Each Maternity Service will be given a date for the audit visit by which time they should have completed their self -assessment against the criteria of each LSA standard cross referencing against each



criterion the evidence of achievement that can be found in the box. The audit team will employ a target sampling technique in respect of each of the five LSA standards.

The LSA Midwifery Officer will meet with the supervisory team at the commencement of the day to discuss the outcome of their self assessment, the current strategy for supervision and progress made on the action plan for the previous year.

A representative cross sample of midwives will be interviewed to elicit their views on supervision and triangulate the evidence presented in support of achievement of the standards.

Verbal feedback will be provided to the supervisory team on completion of the audit and this will be followed with a written report sent to the Contact Supervisor of Midwives within four weeks. A copy of this report will also be sent to the Strategic Health Authority carrying the LSA responsibility for that Maternity Service.

Following publication of the audit outcome report the supervisory team will review the strategy for supervision and develop a new action plan, thus completing the cycle. The audit outcomes of all maternity services will be collated to provide the NMC with evidence of achievement of their standards for LSA.

## **January 2005**

Amended May 2007

## **References**

Ackerman N (1991) Effective peer review *Journal of Nursing Management* **22 (8)** 48A-49D

Cheyne H Niven C Mc Ginley M (2003) The peer project: a model of peer review *British Journal of Midwifery* **11 (4)** 227-232

Malkin K.F (1994) A standard for professional development: the use of self and peer review; learning contracts and reflection in clinical practice *Journal of Nursing management* **2 (3)** 143-148

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

## Women Focused Maternity Services

**Standard 1. Supervisors of Midwives are available to offer guidance and support to women accessing a midwifery service that is evidence based in the provision of women centred care.**

Criteria	Yes	No	Supporting Evidence	Comments/Recommendations
1.1 Supervisors of Midwives participate in 'Maternity User Forums' to ensure that the views and voice of service users inform the development of maternity services.				
1.2 Information is available to women including local arrangements for statutory supervision.				
1.3 There is a working philosophy that promotes women and family centred care enabling choice and decision making in individualised clinical care.				
1.4 Supervisors support midwives to promote informed decision making about care for women and families.				
1.5 Supervisors support midwives in respecting the right of women to refuse any advice given and record in an individual care plan.				

## Supervisory Systems

**Standard 2. Supervisors of Midwives are directly accountable to the Local Supervising Authority for all matters relating to the statutory supervision of midwives and a local framework exists to support the statutory function.**

Criteria	Yes	No	Supporting Evidence	Comments/Recommendations
2.1 The supervisory team should be such as to provide a ratio no greater than 1:15 supervisors to supervisees.				
2.2 Employers provide designated time for Supervisors of Midwives to undertake their role.				
2.3 LSA processes are followed in the nomination, selection and appointment of Supervisors of Midwives.				
2.4 Supervisors of Midwives work within the framework of LSA standards, policies and guidelines.				

Criteria	Yes	No	Supporting Evidence	Comments/Recommendations
2.5 LSA guidelines and policies are accessible to midwives and the public.				
2.6 Supervisors of Midwives receive the Intention to Practise forms (ITP), check for accuracy and validity prior to forwarding them to the LSA, or before entering on the LSA database, within the agreed time frames.				
2.7 Supervisors of Midwives review midwives' eligibility to practise annually, confirming such through the NMC registration service.				
2.8 Supervisors of Midwives maintain records of supervisory activities that are stored for seven years in such a way as to maintain confidentiality.				
2.9 Regular meetings between Supervisors of Midwives are convened to share information in a timely fashion and the proceedings are recorded.				

Criteria	Yes	No	Supporting Evidence	Comments/Recommendations
2.10 Evidence exists that all Supervisors of Midwives engage in networking locally, regionally and nationally.				
2.11 There is a local strategy for supervision and an action plan is developed following audit.				
2.12 Each Supervisor of Midwives has a direct line of communication to the LSA for support and advice.				
2.13 Each Supervisor of Midwives completes at least 6 hours of approved study relating to statutory supervision each year.				
2.14 Each Supervisor of Midwives meets with the LSAMO locally and through LSA events.				
2.15 Secretarial support is provided for Supervisors of Midwives in their administrative role.				
2.16 The practice of statutory supervision by each Supervisor of Midwives is subject to audit by the LSA and removal from appointment if their performance falls below an acceptable standard.				

## Leadership

### Standard 3. Supervisors of Midwives provide professional leadership and nurture potential leaders.

Criteria	Yes	No	Supporting Evidence	Comments/Recommendations
3.1 Supervisors of Midwives are perceived as innovators and leaders of midwifery.				
3.2 Through peer or self-nomination future Supervisors of Midwives are identified and supported in their nomination.				
3.3 Appropriate mentorship mechanisms are in place to provide leadership for student supervisors undertaking the preparation course.				
3.4 Preceptorship is provided for newly appointed Supervisors of Midwives to enable their development as leaders.				
3.5 There are supervisory mechanisms to support leadership development in a variety of ways.				

Criteria	Yes	No	Supporting Evidence	Comments/Recommendations
3.6 Supervisors of Midwives contribute to the development, teaching and assessment of programmes of education leading to registration as a midwife and the continuous professional development of all midwives.				

## Equity of Access to Statutory Supervision of Midwives

**Standard 4. Supervisors of Midwives are approachable and accessible to midwives to support them in their practice.**

Criteria	Yes	No	Supporting Evidence	Comments/Recommendations
4.1 There is 24 hours access to Supervisors of Midwives for all midwives irrespective of their employment status.				
4.2 Each midwife has a named Supervisor of Midwives, of her/his choice, with the option to change to another.				
4.3 Each midwife attends a supervisory review, at least annually, in which her/his individual practice and any education and development needs are identified and a written action plan agreed.				
4.4 Midwives' views and experience of statutory supervision are elicited regularly, at least once in every 3 years and outcomes inform the local strategy for supervision.				



Criteria	Yes	No	Supporting Evidence	Comments/Recommendations
4.5 Confidential supervisory activities are undertaken in designated rooms that ensure privacy.				
4.6 Supervisors support midwives in maintaining clinical competence and the development of new skills.				
4.7 Student midwives are supported by the supervisory framework.				

## Midwifery Practice

**Standard 5. Supervisors of Midwives support midwives in providing a safe environment for the practice of evidence based midwifery.**

Criteria	Yes	No	Supporting Evidence	Comments/Recommendations
5.1 Supervisors of Midwives are involved in formulating policies, setting standards and monitoring practice and equipment.				
5.2 Supervisors of Midwives participate in developing policies and evidence based guidelines for clinical practice.				
5.3 Supervisors of Midwives ensure that midwives are made aware of new guidelines and policies and that all midwives have access to documentation in electronic or hard copy.				
5.4 Supervisors of Midwives participate in reflective activities that inform and support midwives in practice.				
5.5 Supervisors participate in audit of the administration and destruction of controlled drugs.				

Criteria	Yes	No	Supporting Evidence	Comments/Recommendations
5.6 Supervisors of Midwives make their concerns known to their employer in the maternity service when inadequate resources may compromise public safety.				
5.7 When allegations are made of suspected sub-optimal care an investigation is undertaken by a Supervisor of Midwives and the midwife is offered the support of another Supervisor of Midwives.				
5.8 Pro-active approaches are used to support midwives when deficiencies in practice have been identified.				
5.9 The recommendation for a midwife to undertake a period of supervised practice is discussed with the LSAMO who is also informed when such a programme is completed.				
5.10 Allegations of serious professional misconduct are reported to the LSAMO together with a full written report and recommendations. These records must be retained for 25 years.				

Criteria	Yes	No	Supporting Evidence	Comments/Recommendations
5.11 Supervisors of Midwives notify managers of investigations being undertaken and of action plans agreed.				
5.12 Clinical Governance strategies acknowledge statutory supervision of midwives.				
5.13 The LSAMO is informed of any serious incident relating to maternity care or midwifery practice.				
5.14 Audit of record keeping of each midwife takes place annually and outcome feedback is provided.				
5.15 Supervisors support midwives participating in clinical trials ensuring that the Midwives rules & standards and the Code of professional conduct are adhered to.				

***Appendix 3***

**Programme for North East LSA Annual Conference 2008**

**North East Local Supervising Authority  
Annual Conference  
Newcastle Marriott Hotel Metro Centre  
13th November 2008**

<del>16.30</del> 09.30 – 09.45	<p>Conference ends Registration and refreshments Networking</p>	
09.45 – 09.55 20.00	<p>Welcome and introduction Conference Dinner <i>Professor Suzanne Truttero</i> <i>Midwifery Advisor</i> <i>Department of Health</i></p>	
09.55 – 10.35	<p>Role of the NPSA in the delivery of safer care in childbirth <i>Anita Dougall</i> <i>Maternity Lead</i> <i>Child Health and Maternity Clinical Team</i> <i>National Patient Safety Agency</i></p>	
10.35 – 11.15	<p>Using IT to help delivery safer maternity care <i>Jane Doris</i> <i>Clinical Safety Officer</i> <i>Clinical Safety Team</i> <i>NHS Connecting for Health</i></p>	
11.15 – 11.30	<p>Comfort break</p>	
11.30 – 12.45	<p>Evidence and Clinical Practice <i>Dr Denis Walsh</i> <i>Reader in Normal Birth</i> <i>University of Central Lancashire</i> session)</p>	(Interactive)
12.45 – 13.30	<p>Lunch</p>	
13.30 – 14.45	<p>Safer Births <i>Anne Bury</i> <i>Service Improvement Lead</i> <i>Kings Fund</i> session)</p>	(interactive)
14.45 – 15.00	<p>Comfort break</p>	
15.00 – 16.15	<p>Evidence and Good Practise - Or The Lack Of It <i>David Glendinning</i> <i>Consultant – Regulatory Unit</i> <i>Ward Hadaway</i> session)</p>	(interactive)
16.15 – 16.30	<p>Summing up of conference</p>	

## **Appendix 4**

### **Example of competencies for student supervisor of midwives**



**PROGRAMME AREA 3**

**CONTINUING INTERPROFESSIONAL DEVELOPMENT FRAMEWORK**

ACADEMIC YEAR 2008/09

**Division of Childhood and Family Studies**

**PREPARATION OF SUPERVISOR OF MIDWIVES**

**Practice Competency Book**

**LEVEL 7**

**MODULE TUTORS: JOY CAMPBELL & FIONA McINTOSH**

**STUDENT'S NAME:** .....



## Useful Contact Details

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### Admin support

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**Mentor Contact Details** .....

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IT Open Access and Libraries Helpdesk	0191 215 6565

## **Aim of Module**

We aim to prepare practising midwives to competently fulfil the role of Supervisor of Midwives. This reflects the NMC (2004) Midwives Rules and Standards, the NMC (2006) Standards for the Preparation and Practice of Supervisor of Midwives and the statutory function of supervision within contemporary midwifery practice.

## **Learning outcomes for level 7**

The midwife on completion of the programme will be able to:

1. Critically appraise the role of the Supervisor of Midwives and debate the role of supervision in safeguarding the public.
2. Examine critically the role of the Supervisor of Midwives in appraising contemporary evidence that conceptualises childbirth as a normal event in a variety of settings.
3. Critically evaluate the role of the Supervisor of Midwives in facilitating partnerships with women, fostering a culture of respect for the right of all women to make informed choices.
4. Critically appraise theories of leadership in relation to personal development in order to promote leadership through supervision.
5. Achieve the professional competencies required to be recorded with the NMC and be eligible to be appointed by the LSA Midwifery Officer as a Supervisor of Midwives

## **Learning and Teaching Methods**

The module will be delivered via lectures, seminars, practice-based learning, tutorials and self directed study over a 26 week period. Students are allocated a mentor supervisor who will offer support and guidance in clinical practice throughout the 26 week module. The mentor supervisor will support the student facilitating a range of learning opportunities and is responsible for assessment of the competencies in practice.

E-learning and blackboard will be utilised as appropriate to support learning and teaching.

## **Assessment Details**

Formative assessment includes initial, mid point and final meetings with the student and mentor supervisor. A learning contract will be developed which facilitates this process. The mentor supervisor will assess the student's achievement of competencies against evidence provided during structured learning in practice.

Summative assessment is by an educational portfolio. The portfolio reflects the student's achievement in theory and practice supported by relevant evidence and achievement of clinical competencies. The portfolio demonstrates the achievement of the module learning outcomes.

## **Roles and Responsibilities**

### **The Role of the Student**

- Attend the initial interview and contribute to the development of the learning contract at the commencement of the module. Arrange mutual times for progress review
- Negotiate a series of regular formative opportunities to review progress completing the appropriate documentation. This will include a mid point meeting.
- Provide evidence to demonstrate achievement of competencies. If at any time there arises any issues or concerns in relation to student progress or attainment this must be documented and the module team informed.
- Highlight date for final summative assessment, present and discuss evidence of achievement of competencies.

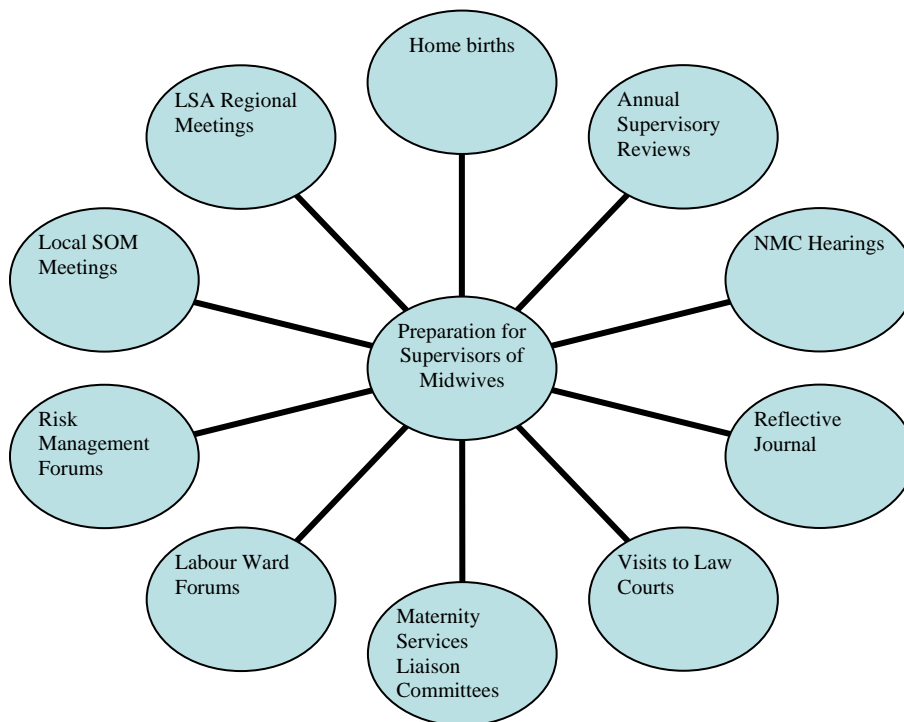
### **The Role of the Mentor**

- Undertake initial interview with student, and agree learning contract to meet competencies.
- Facilitate and advise student in identifying appropriate learning opportunities and strategies to enhance the collection of practice evidence.
- Agree mutual times for progress reviews and completing appropriate documentation.
- Undertake a midway point review to assess student's progress. If at any time there arises any issues or concerns in relation to student progress or attainment this must be documented and module team informed.
- Provide informal and formal feedback on the student's performance
- Undertake a final review of progress and determine student achievement of practice competencies by completing summative assessment documentation.

### **The Role of Module Team**

- Ensure student and mentor have necessary information and contact details of module team.
- Be available for clarification and guidance.
- Where areas of concern are identified provide support and guidance for student and mentor.

## Experiences of Particular Value



## **Potential Forms of Evidence**

- Participation in SOM activities
- Shadowing
- Reflection
- Range of relevant meetings e.g. risk management, SOM meetings
- Range of audit activities
- Critical incident analysis
- Involvement in development of guidelines
- Literature searches'
- Annotated bibliographies
- Record of discussion with members of multi disciplinary team regarding supervision
- Record of visits to courts e.g. Magistrates' Court, Coroner's Court
- Attending NMC Conduct and Competence Hearings
- Conference/study day attendance
- Review of government health and social policy documents
- Simulation/involvement in investigating cases of alleged impairment to practice
- Involvement in strategic planning relating to maternity services
- Examples of networking

**Further guidance and suggestions for forms of evidence will be available under e-learning portal**



**Competency One:  
Demonstrate Knowledge and Understanding of the Theory, Roles and Responsibilities around Statutory Supervision & Supervision of Midwives**

<b>PERFORMANCE CRITERIA</b>	<b>FORMS OF EVIDENCE</b>	<b>Achieved</b> (Mentor signature & date)	<b>Not Achieved</b> (Mentor signature & date)
1.1 Demonstrates understanding of the role of the supervisor of midwives in protecting the public.			
1.2 Appraises the statutory framework for supervision and the role of the NMC.			
1.3 Demonstrates awareness of communication links including guidance and NMC circulars with midwives and fellow supervisors of midwives.			
1.4 Devise a continuing professional development plan in relation to supervision for the next 12 months			

<b>PERFORMANCE CRITERIA</b>	<b>FORMS OF EVIDENCE</b>	<b>Achieved</b> (Mentor signature & date)	<b>Not Achieved</b> (Mentor signature & date)
<p><b>1.5</b> Enable midwives to develop and maintain competencies for their midwifery practice by demonstrating responsibilities and duties of the supervisor of midwives. To include:</p> <ul style="list-style-type: none"> <li>a) Develop strategies for achieving and appropriately documenting annual reviews.</li> <li>b) Is able to discuss NMC requirements for continuing registration and how it may be individualised to each midwife according to her role and practice area.</li> <li>c) Ensuring midwives know their responsibilities regarding NMC registration, ITP notification and the requirement to comply with the NMC Midwives rules and standards and Code of conduct</li> <li>d) Explore ways in which the SOM may act as a role model for midwives</li> <li>e) Is able to discuss and demonstrate the qualities required of a proactive SOM</li> <li>f) Explore ways in which the SOM may act as a resource for midwives to implement and support change</li> <li>g) Demonstrate how you could facilitate midwives to learn by critical analysis and evaluation of their practice</li> </ul>			



<b>PERFORMANCE CRITERIA</b>	<b>FORMS OF EVIDENCE</b>	<b>Achieved</b> (Mentor signature & date)	<b>Not Achieved</b> (Mentor signature & date)
<b>1.6</b> Discuss the legal and professional requirements set by the NMC, the LSA and NHS Trusts around record keeping.			
<b>1.7</b> Demonstrate ability to audit midwifery records in accordance with NMC Standards and LSA guidance and initiate appropriate action.			
<b>1.8</b> Identify how you would support midwives working with complex ethical, legal and professional issues.			
<b>1.9</b> Explore ways a SOM can contribute to the development and monitoring of standards and guidelines relating to supervision.			
<b>1.10</b> Participate in supervisory meetings and disseminate relevant information.			

<b>PERFORMANCE CRITERIA</b>	<b>FORMS OF EVIDENCE</b>	<b>Achieved</b> (Mentor signature & date)	<b>Not Achieved</b> (Mentor signature & date)
<p><b>1.11</b> Understand the supervisor’s role in the investigatory process by demonstrating ability to:</p> <ul style="list-style-type: none"> <li>a) Undertake an investigation of any serious untoward incident concerning midwifery practice or of an individual midwife’s alleged impairment to practise</li> <li>b) Prepare a supervisory report of the investigation’s outcomes and recommendations and inform the LSAMO</li> <li>c) Plan, implement, monitor and evaluate a supervised practice programme in conjunction with a midwifery educationalist.</li> <li>d) support a midwife involved in the investigatory progress</li> </ul>			

**Competency Two:  
Demonstrate how the Supervisor of Midwives can Promote Childbirth as a Normal Physiological Event**

<b>PERFORMANCE CRITERIA</b>	<b>FORMS OF EVIDENCE</b>	<b>Achieved</b> (Mentor signature & date)	<b>Not Achieved</b> (Mentor signature & date)
2.1 Identify opportunities for promoting childbirth as a normal physiological life event.			
2.2 Explore statutory supervision within the governance agenda from a national and local perspective.			
2.3 Demonstrate the ability to source literature, research and professional evidence to underpin strategy and service development.			
2.4 Demonstrate the SOM's role in producing evidence based guidelines and protocols within the multidisciplinary team.			

<b>PERFORMANCE CRITERIA</b>	<b>FORMS OF EVIDENCE</b>	<b>Achieved</b> (Mentor signature & date)	<b>Not Achieved</b> (Mentor signature & date)
2.5 Discuss how a SOM monitors safe practice and audits standards in clinical practice and identify mechanisms that may rectify the situation.			
2.6 Explore strategies a SOM can utilise to promote evidence based practice.			

**Competency Three:  
Demonstrate how the Supervisor of Midwives can work in Partnership with Women**

<b>PERFORMANCE CRITERIA</b>	<b>FORMS OF EVIDENCE</b>	<b>Achieved</b> (Mentor signature & date)	<b>Not Achieved</b> (Mentor signature & date)
3.1 Discuss mechanisms and forums which create opportunities for women to engage actively with maternity services and influence their development.			
3.2 Explore the personal and professional challenges in being an advocate for the right of all women to make informed choices and to contribute to decision making related to their care.			
3.3 Explore how the SOM may promote the business of midwifery and the role of the midwife and supervisor of midwives by engaging with women.			

<b>PERFORMANCE CRITERIA</b>	<b>FORMS OF EVIDENCE</b>	<b>Achieved</b> (Mentor signature & date)	<b>Not Achieved</b> (Mentor signature & date)
3.4 Explore how the SOM can contribute to ensuring maternity services are responsive to the needs of women.			
3.5 Explore support mechanisms that are available to midwives and women when making care choices.			
3.6 Discuss the advice and support mechanisms available to women who are experiencing difficulty in achieving their care choices.			

**Competency Four:  
Demonstrate the Proactive Leadership role of the Supervisor of Midwives**

<b>PERFORMANCE CRITERIA</b>	<b>FORMS OF EVIDENCE</b>	<b>Achieved</b> (Mentor signature & date)	<b>Not Achieved</b> (Mentor signature & date)
4.1 Explore approaches to supervision that demonstrate a non-discriminatory, honesty and fair style.			
4.2 Able to discuss and apply leadership theory and strategy in practice.			
4.3 Explore strategies as to how the SOM can be visible as a leader in the practice setting.			
4.4 Explore the networks available outside the organisation that support maternity services, demonstrating an ability to engage effectively with a wide variety of individuals, groups, agencies and organisations.			

<b>PERFORMANCE CRITERIA</b>	<b>FORMS OF EVIDENCE</b>	<b>Achieved</b> (Mentor signature & date)	<b>Not Achieved</b> (Mentor signature & date)
4.5 Able to appraise the broader strategic and political factors influencing maternity service provision.			
4.6 Explore ways in which a SOM may encourage and enable SOM colleagues, midwives and members of other multidisciplinary teams.			
4.7 Demonstrates reflective skills in terms of self awareness.			
4.8 Identify strategies to support midwives to maximise their potential in practice.			



<b>PERFORMANCE CRITERIA</b>	<b>FORMS OF EVIDENCE</b>	<b>Achieved</b> (Mentor signature & date)	<b>Not Achieved</b> (Mentor signature & date)
<p><b>4.9</b> Explore multidisciplinary team working and how the SOM can foster mutual respect, regard and value for the perspectives and contributions of others.</p>			
<p><b>4.10</b> Demonstrate the ability to be able to handle conflict and achieve a consensus ensuring no party feels disadvantaged.</p>			



## **Learning Contract**

### **Initial Meeting**

A learning contract and action plan must be agreed and should include:

- Learning opportunities and evidence for achievement of competencies
- Clarify learning needs
- Plan strategies to meet learning needs and supporting evidence
- Plan of supervision to support your learning needs
- Determine dates of further meetings

**Strategy:** Please expand and additional sheets welcomed

**Student's Comments (including self-assessment):**

**Mentor Supervisor's Comments:**

**Student Signature**

**Mentor Signature**

**Date**

**Date**

## **Learning Contract**

### **Review of Progress**

Reviews should take place at regular intervals during the module. The review needs to consider the action plan, identify the student's strengths and any areas for development. Additional support and/or further strategies for achieving competence must be clearly documented. Evidence needs to be discussed and agreed as suitable for achievement of the competencies.

**Strategy:** Please expand and additional sheets welcomed

**Student's Comments (including self-assessment):**

**Mentor Supervisor's Comments:**

**Student Signature**

**Date**

**Mentor Signature**

**Date**

## **Learning Contract**

### **Review of Progress**

Reviews should take place at regular intervals during the module. The review needs to consider the action plan, identify the student's strengths and any areas for development. Additional support and/or further strategies for achieving competence must be clearly documented. Evidence needs to be discussed and agreed as suitable for achievement of the competencies.

**Strategy:** Please expand and additional sheets welcomed

**Student's Comments (including self-assessment):**

**Mentor Supervisor's Comments:**

**Student Signature**

**Mentor Signature**

**Date**

**Date**

## **Learning Contract**

### **Review of Progress**

Reviews should take place at regular intervals during the module. The review needs to consider the action plan, identify the student's strengths and any areas for development. Additional support and/or further strategies for achieving competence must be clearly documented. Evidence needs to be discussed and agreed as suitable for achievement of the competencies.

**Strategy:** Please expand and additional sheets welcomed

**Student's Comments (including self-assessment):**

**Mentor Supervisor's Comments:**

**Student Signature**

**Mentor Signature**

**Date**

**Date**

## **Learning Contract**

### **Mid Point Review of Progress**

This should take place approximately midway through the module and the mentor is required to review the student's performance towards the achievement of the competencies. If there are any concerns in relation to the student's achievement, please contact the module team as soon as possible.

**Strategy:** Please expand and additional sheets welcomed

**Student's Comments (including self-assessment):**

**Mentor Supervisor's Comments:**

**Student Signature**

**Date**

**Mentor Signature**

**Date**

## **Learning Contract**

### **Review of Progress**

Reviews should take place at regular intervals during the module. The review needs to consider the action plan, identify the student's strengths and any areas for development. Additional support and/or further strategies for achieving competence must be clearly documented. Evidence needs to be discussed and agreed as suitable for achievement of the competencies.

**Strategy:** Please expand and additional sheets welcomed

**Student's Comments (including self-assessment):**

**Mentor Supervisor's Comments:**

**Student Signature**

**Mentor Signature**

**Date**

**Date**



## **Learning Contract**

### **Review of Progress**

Reviews should take place at regular intervals during the module. The review needs to consider the action plan, identify the student's strengths and any areas for development. Additional support and/or further strategies for achieving competence must be clearly documented. Evidence needs to be discussed and agreed as suitable for achievement of the competencies.

**Strategy:** Please expand and additional sheets welcomed

**Student's Comments (including self-assessment):**

**Mentor Supervisor's Comments:**

**Student Signature**

**Mentor Signature**

**Date**

**Date**

## **Learning Contract**

### **Review of Progress**

Reviews should take place at regular intervals during the module. The review needs to consider the action plan, identify the student's strengths and any areas for development. Additional support and/or further strategies for achieving competence must be clearly documented. Evidence needs to be discussed and agreed as suitable for achievement of the competencies.

**Strategy:** Please expand and additional sheets welcomed

**Student's Comments (including self-assessment):**

**Mentor Supervisor's Comments:**

**Student Signature**

**Mentor Signature**

**Date**

**Date**

## Learning Contract

### Final Review of progress

This should take place at the end of the programme and must include a final review of action plans and evidence to support the achievement of the competencies.

Has the student demonstrated achievement of all the competencies?

Yes

No

**Mentors Signature:**

**Date:**

**If no, please identify which competencies and performance criteria have not been achieved with comments to support decision.**

**Student's Comments:**

**Mentor Supervisor's Comments:**

**Student Signature**

**Mentor Signature**

**Date**

**Date**

## **Reflective Journal**

Students are encouraged throughout the course to maintain a reflective journal. Critical incidents focused on the students learning can be included within the journal, giving the student the opportunity to reflect on the incident and the learning that has taken place. Incidents can also be used as a basis of discussion with the mentor or module team.

The student maintains personal ownership of the journal throughout the module. The journal does not form part of the assessment strategy unless the student chooses. Extracts from the journal can be included within the portfolio of evidence but confidentiality must be maintained.

### **Suggested Template of the Journal**

- Focus of reflection (e.g. Critical incident, dealing with difficult issues)
  
  
  
  
  
  
  
  
  
  
- Issues emerging from reflection
  
  
  
  
  
  
  
  
  
  
- Identified learning needs
  
  
  
  
  
  
  
  
  
  
- Action taken to support learning needs

### Log of Structured Learning in Practice

Date	Activity	Hours

## Appendix 5

### **Statistics from all eight Trusts providing maternity services**

**North East LSA  
Annual statistics for the year ending 31 March 2009**

<b>Name of Trust: City Hospitals Sunderland NHS Foundation Trust</b>	
<b>Name of Unit: Sunderland Maternity Unit</b>	
Contact Supervisor: Julie Harris	
Form completed by: Jacqui Dyson	<b>Contact details: 0191 5410126</b>
<b>Maternity Outcomes</b>	<b>Number</b>
Total number of women delivered (include all births hospital & home)	3553
Total number of babies born (including multiple births)	3601
Live births	3546
Stillbirths	29
Neonatal deaths before 6 days	11
Maternal deaths	0
Births in hospital	3491
Births in midwife-led units/birth centres	0
Planned home births	21
Actual home births – midwife in attendance	21
Births at home with no midwife present, including those delivered at home or in transit by ambulance crew	41
Does your service provide preconception care?	<b>Yes at Diabetic and Maternal medicine Clinics</b>
	<b>%</b>
Percentage of women accessing midwife as first point of contact in pregnancy	96
Percentage of women booking by 12 weeks	88
Teenage pregnancy rate (age 16 and under)	Not collected
Percentage of women accessing stop smoking facilities	10
Percentage of women still smoking at time of delivery	25.21
Percentage of women initiating breastfeeding	45.83
Percentage of women exclusively breastfeeding on transfer to HV care	23
<b>Normality</b>	
Number of unassisted spontaneous births	2264
Number of women using water for labour	5
Number of women birthing in water	3
<b>Obstetric interventions</b>	
Induction rate	15.6%
Epidural rate	22%
Instrumental rate	13%
Vaginal breach delivery rate	0.85%
Caesarean section rate total	20.8%
Elective caesarean section number	219
Emergency Caesarean section number	520
Episiotomy rate (spontaneous deliveries)	13% (inst/ spont)

<b>STAFFING ESTABLISHMENT as of 31 March 2009 (excluding neonatal unit)</b>		
(Staff that work on more than one site should be included only where their substantive post is)		
<b>Skill Mix</b>	<b>In post WTE</b>	<b>Funded WTE</b>
Band 8 a	1	
Band 8 b		
Band 8 c		
Band 8 d		
Band 7	17.3	
Band 6	92.25	
Band 5	(RGN/ODP) 6.43	
Total	110.55	
	<i>Number</i>	
Overall ratio of births to midwifery establishment (WTE)	1:32	
Ratio of births to midwives in post (WTE)		
Adjusted ratio of births to midwives excluding maternity leave, long-term sickness, secondments away from unit etc	1:36	
Total number of midwives employed (head count, i.e. allowing for part-time staff)	130	
Total number of midwives notifying intention to practise (including non-employed midwives, e.g. independent practitioners, educationalists, researchers)	138	
Vacancies according to funded establishment	0	
Vacancies according to Birthrate Plus defined establishment	5.23	
Birthrate Plus undertaken – which year	2008	
Birthrate Plus in progress	Yes	No
Birthrate Plus planned – when		
Specialist midwifery posts (please specify any not listed)	<i>Number</i>	
Consultant midwife	0	
Lecturer practitioner	0	
Practice Development Midwife	0.8	
Infant Feeding Co-ordinator	0.3	
Bereavement Midwife	0	
Drug/alcohol dependency midwife	0.8	
Child protection midwife (lead within matron role)	0	
Pregnant teenagers co-ordinator	0	
Midwife Ultrasonographer	0	
ECV practitioner	0	
<b>Maternity Care Support Workers</b>	<b>In post WTE</b>	<b>Funded WTE</b>
Band 1	0	
Band 2	20.98	
Band 3	0	
Band 4	0	
Ward Clerks	0	
Clerical/Admin	6	



**North East LSA  
Annual statistics for the year ending 31 March 2009**

<b>Name of Trust: Co Durham &amp; Darlington Foundation Trust</b>	
<b>Name of Unit: Bishop Auckland (MLU)</b>	
Contact Supervisor: Debbie Bunford	
Form completed by:	<b>Contact details: 01325 3098</b>
<b>Maternity Outcomes</b>	<b>Number</b>
Total number of women delivered (include all births hospital & home)	337
Total number of babies born (including multiple births)	337
Live births	337
Stillbirths	0
Neonatal deaths before 6 days	0
Maternal deaths	0
Births in hospital	0
Births in midwife-led units/birth centres	322
Planned home births	14
Actual home births – midwife in attendance	12
Births at home with no midwife present, including those delivered at home or in transit by ambulance crew	2
Does your service provide preconception care?	<b>Y/N</b>
	<b>%</b>
Percentage of women accessing midwife as first point of contact in pregnancy	Data not collected
Percentage of women booking by 12 weeks	78.72%
Teenage pregnancy rate (age 16 and under)	0.53%
Percentage of women accessing stop smoking facilities	-
Percentage of women still smoking at time of delivery	22.3%
Percentage of women initiating breastfeeding	56.6%
Percentage of women exclusively breastfeeding on transfer to HV care	-
<b>Normality</b>	
Number of unassisted spontaneous births	337
Number of women using water for labour	73
Number of women birthing in water	37
<b>Obstetric interventions</b>	
Induction rate	0
Epidural rate	0
Instrumental rate	0
Vaginal breach delivery rate	0
Caesarean section rate total	0
Elective caesarean section number	0
Emergency Caesarean section number	0
Episiotomy rate (spontaneous deliveries)	2.1%

<b>STAFFING ESTABLISHMENT as of 31 March 2009 (excluding neonatal unit)</b>		
<b>Skill Mix</b>	<b>In post WTE</b>	<b>Funded WTE</b>
Band 8 a	1	1
Band 8 b	0	0
Band 8 c	0	0
Band 8 d	0	0
Band 7	10.20	11.04
Band 6	18.76	20.41
Band 5	1.07	0
Total	31,03	32.45
Overall ratio of births to midwifery establishment (WTE)	1: 11trustwide1:30	
Ratio of births to midwives in post (WTE)	1:10.5 (Trustwide 1:30)	
Adjusted ratio of births to midwives excluding maternity leave, long-term sickness, secondments away from unit etc	1:11	1:10.56
Total number of midwives employed (head count, i.e. allowing for part-time staff)	34.2	
Total number of midwives notifying intention to practise (including non-employed midwives, e.g. independent practitioners, educationalists, researchers)		
1 Vacancies according to funded establishment	Birth rate has increased	
Vacancies according to Birthrate Plus defined establishment		
Birthrate Plus undertaken – which year	2006	2006
Birthrate Plus in progress	No	
Birthrate Plus planned – when	Using 1:28 marker in safer childbirth	
Specialist midwifery posts (please specify any not listed)	0	0
Consultant midwife	0	0
Lecturer practitioner	0	0
Practice Development Midwife	0	0
Infant Feeding Co-ordinator	0	0
Bereavement Midwife	0	0
Drug/alcohol dependency midwife	0	0
Child protection midwife	0	0
Pregnant teenagers co-ordinator	0	0
Midwife Ultrasonographer	0	0
ECV practitioner	0	0
<b>Maternity Care Support Workers</b>	<b>In post WTE</b>	<b>Funded WTE</b>
Band 1	0	0
Band 2	6.43	6.43
Band 3	0	0
Band 4	0	0
Ward Clerks	0	0
Clerical/Admin	0	0

Please note the midwives at BAGH also provide care for ladies delivering at UHND , DMH and other unit eg North Tees

**North East LSA**  
**Annual statistics for the year ending 31 March 2009**

<b>Name of Trust: Co Durham &amp; Darlington Foundation Trust</b>	
<b>Name of Unit: University North Durham</b>	
Contact Supervisor: Debbie Bunford	
Form completed by:	Contact details: 01325 3098
<b>Maternity Outcomes</b>	<b>Number</b>
Total number of babies born (including multiple births)	2950
Total number of women delivered (include all births hospital & home)	2982
Live births	2944
Stillbirths	13
Neonatal deaths before 6 days	1
Maternal deaths	0
Births in hospital	2939
Births in midwife-led units/birth centres	-
Planned home births	33
Actual home births – midwife in attendance	24
Births at home with no midwife present, including those delivered at home or in transit by ambulance crew	9
Does your service provide preconception care?	<b>Y/N</b>
	<b>%</b>
Percentage of women accessing midwife as first point of contact in pregnancy	Data not collected
Percentage of women booking by 12 weeks	78.72%
Teenage pregnancy rate (age 16 and under)	0.53%
Percentage of women accessing stop smoking facilities	N/A
Percentage of women still smoking at time of delivery	22.3%
Percentage of women initiating breastfeeding	56.6%
Percentage of women exclusively breastfeeding on transfer to HV care	N/A
<b>Normality</b>	
Number of unassisted spontaneous births	1891
Number of women using water for labour	39
Number of women birthing in water	4
<b>Obstetric interventions</b>	
Induction rate	21.7%
Epidural rate	16.1%
Instrumental rate	14.5%
Vaginal breach delivery rate	0.7%
Caesarean section rate total	20.8%
Elective caesarean section number	237
Emergency Caesarean section number	381
Episiotomy rate (spontaneous deliveries)	5.7%

<b>STAFFING ESTABLISHMENT as of 31 March 2009 (excluding neonatal unit)</b>		
(Staff that work on more than one site should be included only where their substantive post is)		
<b>Skill Mix</b>	<b>In post WTE</b>	<b>Funded WTE</b>
Band 8 a	1	1
Band 8 b	0	0
Band 8 c	0	0
Band 8 d	0	0
Band 7	20.48	21
Band 6	54.15	64.02
Band 5	7.05	
Total	82.68	86.02
	<b>Number</b>	
Overall ratio of births to midwifery establishment (WTE)	1:34.6 TRUSTWIDE 1:30.2	
Ratio of births to midwives in post (WTE)	1:36 (Trustwide 1:31.3)	
Adjusted ratio of births to midwives excluding maternity leave, long-term sickness, secondments away from unit etc	1:38	1:36.6
Total number of midwives employed (head count, i.e. allowing for part-time staff)	99.9	
Total number of midwives notifying intention to practise (including non-employed midwives, e.g. independent practitioners, educationalists, researchers)	1	1
Vacancies according to funded establishment	Birth rate has increased since birth rate undertaken. Based on 5561 deliveries indicated 17WTE midwives short	
Vacancies according to Birthrate Plus defined establishment		
Birthrate Plus undertaken – which year	2006	2006
Birthrate Plus in progress	No	
Birthrate Plus planned – when	Using 1:28 marker in safer childbirth	
Specialist midwifery posts (please specify any not listed)	0	0
Consultant midwife	0	0
Lecturer practitioner	0	0
Practice Development Midwife	0	0
Infant Feeding Co-ordinator	1	1
Bereavement Midwife	0	0
Drug/alcohol dependency midwife	0	0
Child protection midwife	0	0
Pregnant teenagers co-ordinator	0	0
Midwife Ultrasonographer	0	0
ECV practitioner	0	0
<b>Maternity Care Support Workers</b>	<b>In post WTE</b>	<b>Funded WTE</b>
Band 1	0	0
Band 2	20.66	21.39
Band 3	0	0
Band 4	0	0
Ward Clerks	1.90	1.47
Clerical/Admin		

**North East LSA**  
**Annual statistics for the year ending 31 March 2009**

<b>Name of Trust: Co Durham &amp; Darlington Foundation Trust</b>	
<b>Name of Unit: Darlington</b>	
Contact Supervisor: Debbie Bunford	
Form completed by:	Contact details: 01325 3098
<b>Maternity Outcomes</b>	<b>Number</b>
Total number of babies born (including multiple births)	2384
Total number of women delivered (include all births hospital & home)	2424
Live births	2394
Stillbirths	12
Neonatal deaths before 6 days	2
Maternal deaths	1
Births in hospital	2378
Births in midwife-led units/birth centres	-
Planned home births	25
Actual home births – midwife in attendance	16
Births at home with no midwife present, including those delivered at home or in transit by ambulance crew	8
Does your service provide preconception care?	<b>Y/N</b>
	<b>%</b>
Percentage of women accessing midwife as first point of contact in pregnancy	Data not collected
Percentage of women booking by 12 weeks	78.72%
Teenage pregnancy rate (age 16 and under)	0.53%
Percentage of women accessing stop smoking facilities	N/A
Percentage of women still smoking at time of delivery	22.3%
Percentage of women initiating breastfeeding	56.6%
Percentage of women exclusively breastfeeding on transfer to HV care	-
<b>Normality</b>	
Number of unassisted spontaneous births	1534
Number of women using water for labour	59
Number of women birthing in water	17
<b>Obstetric interventions</b>	
Induction rate	21.8%
Epidural rate	115.4%
Instrumental rate	11.3%
Vaginal breach delivery rate	0.5%
Caesarean section rate total	24.3%
Elective caesarean section number	269
Emergency Caesarean section number	321
Episiotomy rate (spontaneous deliveries)	7.1%

<b>STAFFING ESTABLISHMENT as of 31 March 2009 (excluding neonatal unit)</b>		
(Staff that work on more than one site should be included only where their substantive post is)		
<b>Skill Mix</b>	<b>In post WTE</b>	<b>Funded WTE</b>
Band 8 a	1	1
Band 8 b	0	0
Band 8 c	0	0
Band 8 d	0.4	0.4
Band 7	14.10	14.10
Band 6	49.3	51.46
Band 5	2.28	
Total	66.68	65.56
	<b>Number</b>	
Overall ratio of births to midwifery establishment (WTE)	1:37 TRUSTWIDE 1:30	
Ratio of births to midwives in post (WTE)	1:36 (Trustwide 1:30)	
Adjusted ratio of births to midwives excluding maternity leave, long-term sickness, secondments away from unit etc	1:38.6	1:39.2
Total number of midwives employed (head count, i.e. allowing for part-time staff)	88.8	
Total number of midwives notifying intention to practise (including non-employed midwives, e.g. independent practitioners, educationalists, researchers)		
Vacancies according to funded establishment	Birth rate has increased since birth rate undertaken. Based on 5561 deliveries indicated 17WTE midwives short	
Vacancies according to Birthrate Plus defined establishment		
Birthrate Plus undertaken – which year	2006	2006
Birthrate Plus in progress	No	
Birthrate Plus planned – when	Using 1:28 marker in safer childbirth	
Specialist midwifery posts (please specify any not listed)	0	0
Consultant midwife	0	0
Lecturer practitioner	0	0
Practice Development Midwife	0	0
Infant Feeding Co-ordinator	0.6	0.6
Bereavement Midwife	1	1
Drug/alcohol dependency midwife	0	0
Child protection midwife	0	0
Pregnant teenagers co-ordinator	0	0
Midwife Ultrasonographer	0	0
ECV practitioner	0	0
<b>Maternity Care Support Workers</b>	<b>In post WTE</b>	<b>Funded WTE</b>
Band 1	0	0
Band 2	10.36	12.20
Band 3	0	0
Band 4	0	0
Ward Clerks	1.9	2.45
Clerical/Admin		

## Annual statistics for the year ending 31 March 2009

<b>Name of Trust: Gateshead NHS Foundation Trust</b>	
<b>Name of Unit: Queen Elizabeth Hospital</b>	
Contact Supervisor: Gill Thompson	
Form completed by: gill Thompson	<b>Contact details: 0191 4452147</b>
<b>Maternity Outcomes</b>	<b>Number</b>
Total number of women delivered (include all births hospital & home)	2025
Total number of babies born (including multiple births)	2057
Live births	2049
Stillbirths	8
Neonatal deaths before 6 days	8
Maternal deaths	0
Births in hospital	2004
Births in midwife-led units/birth centres	na
Planned home births	
Actual home births – midwife in attendance	21
Births at home with no midwife present, including those delivered at home or in transit by ambulance crew	
Does your service provide preconception care?	<b>Y</b>
	<b>%</b>
Percentage of women accessing midwife as first point of contact in pregnancy	
Percentage of women booking by 12 weeks	
Teenage pregnancy rate (age 16 and under)	
Percentage of women accessing stop smoking facilities	
Percentage of women still smoking at time of delivery	17.9%
Percentage of women initiating breastfeeding	53.7%
Percentage of women exclusively breastfeeding on transfer to HV care	
<b>Normality</b>	
Number of unassisted spontaneous births	972
Number of women using water for labour	
Number of women birthing in water	
<b>Obstetric interventions</b>	
Induction rate	21.33%
Epidural rate	14.37%
Instrumental rate	10.7%
Vaginal breach delivery rate	0.39%
Caesarean section rate total	20.3%
Elective caesarean section number	
Emergency Caesarean section number	
Episiotomy rate (spontaneous deliveries)	

<b>STAFFING ESTABLISHMENT as of 31 March 2009 (excluding neonatal unit)</b>		
(Staff that work on more than one site should be included only where their substantive post is)		
<b>Skill Mix</b>	<b>In post WTE</b>	<b>Funded WTE</b>
Band 8 a	2.0	2.0
Band 8 b	0.5	0.5
Band 8 c	0.5	0.5
Band 8 d		
Band 7	16.18	18.5
Band 6	55.48	50.0
Band 5		
Total	74.66	71.15
	<i>Number</i>	
Overall ratio of births to midwifery establishment (WTE)	1:28	
Ratio of births to midwives in post (WTE)	1:27	
Adjusted ratio of births to midwives excluding maternity leave, long-term sickness, secondments away from unit etc	1:30	
Total number of midwives employed (head count, i.e. allowing for part-time staff)	89	
Total number of midwives notifying intention to practise (including non-employed midwives, e.g. independent practitioners, educationalists, researchers)		
Vacancies according to funded establishment	0	
Vacancies according to Birthrate Plus defined establishment		-15
Birthrate Plus undertaken – which year	2008	
Birthrate Plus in progress	Yes	No
Birthrate Plus planned – when		
Specialist midwifery posts (please specify any not listed)	<i>Number</i>	
Consultant midwife		
Lecturer practitioner		
Practice Development Midwife	0.8	1
Infant Feeding Co-ordinator	0.8	1
Bereavement Midwife		
Drug/alcohol dependency midwife	0.5	1
Child protection midwife		
Pregnant teenagers co-ordinator		
Midwife Ultrasonographer	0.3	1
ECV practitioner		
<b>Maternity Care Support Workers</b>	<b>In post WTE</b>	<b>Funded WTE</b>
Band 1		
Band 2	15.03	17.77
Band 3	20.8	3.0
Band 4		
Ward Clerks	1.8	1.66
Clerical/Admin	9.24	10.0



**North East LSA  
Annual statistics for the year ending 31 March 2009**

<b>Name of Trust: Newcastle upon Tyne Hospitals</b>	
<b>Name of Unit: RVI</b>	
Contact Supervisor: Rhona Collis	
Form completed by: Sue Miller	<b>Contact details: 0191 2825716</b>
<b>Maternity Outcomes</b>	<b>Number</b>
Total number of women delivered (include all births hospital & home)	6165
Total number of babies born (including multiple births)	6301
Live births	6249
Stillbirths	52
Neonatal deaths before 6 days	18
Maternal deaths	2
Births in hospital	6218
Births in midwife-led units/birth centres	0
Planned home births	80
Actual home births – midwife in attendance	40
Births at home with no midwife present, including those delivered at home or in transit by ambulance crew	43
Does your service provide preconception care?	<b>Y</b>
	<b>%</b>
Percentage of women accessing midwife as first point of contact in pregnancy	Not available
Percentage of women booking by 12 weeks	73.2
Teenage pregnancy rate (age 16 and under)	Not available
Percentage of women accessing stop smoking facilities	Not available
Percentage of women still smoking at time of delivery	18.6
Percentage of women initiating breastfeeding	62.2
Percentage of women exclusively breastfeeding on transfer to HV care	Not available
<b>Normality</b>	
Number of unassisted spontaneous births	1716
Number of women using water for labour	4%
Number of women birthing in water	1.5%
<b>Obstetric interventions</b>	
Induction rate	16%
Epidural rate	30%
Instrumental rate	17%
Vaginal breech delivery rate	1%
Caesarean section rate total	24%
Elective caesarean section number	10%
Emergency Caesarean section number	14%
Episiotomy rate (spontaneous deliveries) <b>this is all deliveries</b>	16%

<b>STAFFING ESTABLISHMENT as of 31 March 2009 (excluding neonatal unit)</b>		
(Staff that work on more than one site should be included only where their substantive post is)		
<b>Skill Mix</b>	<b>In post WTE</b>	<b>Funded WTE</b>
Band 8 a	2.6	2.8
Band 8 b	0	0
Band 8 c	1	1
Band 8 d	0	0
Band 7	27.21	29.7
Band 6	113.91	137.54
Band 5	30.28	0.2
Total	173.4	<b>160.24**</b>
	<i>Number</i>	
Overall ratio of births to midwifery establishment (WTE)	39:1	
Ratio of births to midwives in post (WTE)	36:1	
Adjusted ratio of births to midwives excluding maternity leave, long-term sickness, secondments away from unit etc	41:1	
Total number of midwives employed (head count, i.e. allowing for part-time staff)	212	
Total number of midwives notifying intention to practise (including non-employed midwives, e.g. independent practitioners, educationalists, researchers)	224	
Vacancies according to funded establishment	3.7	
Vacancies according to Birthrate Plus defined establishment	-	
Birthrate Plus undertaken – which year	2006	
Birthrate Plus in progress	No	
Birthrate Plus planned – when	No	
Specialist midwifery posts (please specify any not listed)	<i>Number</i>	
Consultant midwife	0	
Lecturer practitioner	0	
Practice Development Midwife	1+1 secondment	
Infant Feeding Co-ordinator	0	
Bereavement Midwife	0	
Drug/alcohol dependency midwife	1.2wte	
Child protection midwife	1	
Pregnant teenagers co-ordinator	2 job/s	
Midwife Ultrasonographer	8	
ECV practitioner	3	
Risk Management	2 p/t	
<b>Maternity Care Support Workers</b>	<b>In post WTE</b>	<b>Funded WTE</b>
Band 1	0	
Band 2/3	36.93	<b>51.5**</b>
Band 4 Nursery Nurses	6	5.6
Ward Clerks/Clerical/Admin	19.02	24.13
<b>** Money from the band 2 vacancies has been converted to appoint midwife posts</b>		

**North East LSA**  
**Annual statistics for the year ending 31 March 2009**

<b>Name of Trust: North Tees &amp; Hartlepool NHS FT</b>	
<b>Name of Unit: University Hospital of North Tees</b>	
Contact Supervisor: J Lambert / J Barry	
Form completed by: J Alderton	<b>Contact details:</b> <i>janet.alderton@nth.nhs.uk</i>
<b>Maternity Outcomes</b>	<b>Number</b>
Total number of women delivered (include all births hospital & home)	3229
Total number of babies born (including multiple births)	3284
Live births	3236
Stillbirths	19
Neonatal deaths before 6 days (NB these are not all our babies, as NNU transfer in from across the region).	7
Maternal deaths	0
Births in hospital	3187
Births in midwife-led units/birth centres	-
Planned home births	11
Actual home births – midwife in attendance	11
Births at home with no midwife present, including those delivered at home or in transit by ambulance crew	25
Does your service provide preconception care?	<b>Y</b>
	<b>%</b>
Percentage of women accessing midwife as first point of contact in pregnancy	N/R
Percentage of women booking by 12 weeks	<b>Trustwide audit</b> 87%
Teenage pregnancy rate (age 16 and under)	0.2% (n=7)
Percentage of women accessing stop smoking facilities	<b>Trustwide</b> 6.98%
Percentage of women still smoking at time of delivery	<b>Trustwide</b> 24.43%
Percentage of women initiating breastfeeding	<b>Trustwide</b> 50.29%
Percentage of women exclusively breastfeeding on transfer to HV care	NR
<b>Normality</b>	
Number of unassisted spontaneous births (no Induction, ARM, Augment, instruments or CS)	1504
Number of women using water for labour	105
Number of women birthing in water	29
<b>Obstetric interventions</b>	
Induction rate	21.7%
Epidural rate	12%
Instrumental rate	9.3%
Vaginal breech delivery rate	0.8%
Caesarean section rate total <b>North tees births only</b>	20%
Elective caesarean section number	244
Emergency Caesarean section number	402
Episiotomy rate (spontaneous deliveries)	Not available

<b>STAFFING ESTABLISHMENT as of 31 March 2009 (excluding neonatal unit)</b>		
(Staff that work on more than one site should be included only where their substantive post is)		
<b>Skill Mix</b>	<b>In post WTE</b>	<b>Funded WTE</b>
Band 8 a	1	0.96
Band 8 b	1	1
Band 8 c	0	0
Band 8 d	0	0
Band 7	16.32	17.1
Band 6	109.22	110.89
Band 5		
Total	<b>127.5</b>	<b>129.99</b>
	<i>Number</i>	
Overall ratio of births to midwifery establishment (WTE)	27.6	
Ratio of births to midwives in post (WTE)	28.13	
Adjusted ratio of births to midwives excluding maternity leave, long-term sickness, secondments away from unit etc	30.21	
Total number of midwives employed (head count, i.e. allowing for part-time staff)	159	
Total number of midwives notifying intention to practise (including non-employed midwives, e.g. independent practitioners, educationalists, researchers)	163	
Vacancies according to funded establishment	2.49	
Vacancies according to Birthrate Plus defined establishment	<b>132.10</b>	<b>39.55</b>
Birthrate Plus undertaken – which year		2008
Birthrate Plus in progress		<b>No</b>
Birthrate Plus planned – when		
Specialist midwifery posts (please specify any not listed)	<i>Number</i>	
Consultant midwife	0	0
Lecturer practitioner	0	0
Lead Midwife in Education and Training	0.5	0.5
Infant Feeding Co-ordinator	0.4	1
Bereavement Counsellors	2	2
Drug/alcohol dependency midwife	1	1
Child protection midwife	0	0
Pregnant teenagers co-ordinator	0.5	0.5
Midwife Ultrasonographer	0	0
ECV practitioner	0	0
<b>Maternity Care Support Workers</b>	<b>In post WTE</b>	<b>Funded WTE</b>
Band 1	0	0
Band 2	25.99	27.14
Band 3		
Band 4	9.63	12.57
Ward Clerks	6	5.3
Clerical/Admin	0.5	0.5

**North East LSA**  
**Annual statistics for the year ending 31 March 2009**

<b>Name of Trust: North Tees &amp; Hartlepool NHS FT</b>	
<b>Name of Unit: Birthing Centre, University Hospital of Hartlepool</b>	
Contact Supervisor: J Lambert / J Barry	
Form completed by: J Alderton	<b>Contact details:</b> <i>janet.alderton@nth.nhs.uk</i>
<b>Maternity Outcomes</b>	<b>Number</b>
Total number of women delivered (include all births hospital & home)	358
Total number of babies born (including multiple births)	358
Live births	358
Stillbirths	0
Neonatal deaths before 6 days	0
Maternal deaths	0
Births in hospital	-
Births in midwife-led units/birth centres	348
Planned home births	4
Actual home births – midwife in attendance	4
Births at home with no midwife present, including those delivered at home or in transit by ambulance crew	6
Does your service provide preconception care?	<b>Y</b>
	<b>%</b>
Percentage of women accessing midwife as first point of contact in pregnancy	N/R
Percentage of women booking by 12 weeks	<b>Trustwide audit</b> 87%
Teenage pregnancy rate (age 16 and under)	0
Percentage of women accessing stop smoking facilities	<b>Trustwide</b> 6.98%
Percentage of women still smoking at time of delivery	<b>Trustwide</b> 24.43%
Percentage of women initiating breastfeeding	<b>Trustwide</b> 50.29%
Percentage of women exclusively breastfeeding on transfer to HV care	NR
<b>Normality</b>	
Number of unassisted spontaneous births	358
Number of women using water for labour	94
Number of women birthing in water	52
<b>Obstetric interventions</b>	
Induction rate	N/A
Epidural rate	N/A
Instrumental rate	N/A
Vaginal breach delivery rate	1 only BBA
Caesarean section rate total	N/A
Elective caesarean section number	N/A
Emergency Caesarean section number	N/A
Episiotomy rate (spontaneous deliveries)	3.9%

Please note staffing for North Tees and Hartlepool NHS Foundation Trust are all included on the section relating to University Hospital of North Durham

**North East LSA  
Annual statistics for the year ending 31 March 2009**

<b>Name of Trust: Northumbria Healthcare NHS Foundation Trust Appendix 1b</b>	
<b>Name of Unit: Wansbeck</b>	
Contact Supervisor: Jan Henry	
Form completed by: V Wood	<b>Contact details: 07770824458</b>
<b>Maternity Outcomes</b>	<b>Number</b>
Total number of women delivered (include all births hospital & home)	2624
Total number of babies born (including multiple births)	2652
Live births	2641
Stillbirths	11
Neonatal deaths before 6 days	0
Maternal deaths	0
Births in hospital	2609
Births in midwife-led units/birth centres	0
Planned home births	3
Actual home births – midwife in attendance	3
Births at home with no midwife present, including those delivered at home or in transit by ambulance crew	12
Does your service provide preconception care?	<b>Y/N</b>
	<b>%</b>
Percentage of women accessing midwife as first point of contact in pregnancy	?
Percentage of women booking by 12 weeks	75%
Teenage pregnancy rate (age 16 and under)	0.9%
Percentage of women accessing stop smoking facilities	?
Percentage of women still smoking at time of delivery	24%
Percentage of women initiating breastfeeding	54%
Percentage of women exclusively breastfeeding on transfer to HV care	?
<b>Normality</b>	
Number of unassisted spontaneous births	57%
Number of women using water for labour	Not recorded
Number of women birthing in water	6
<b>Obstetric interventions</b>	
Induction rate	18.2%
Epidural rate	14.9%
Instrumental rate	14.2%
Vaginal breach delivery rate	0.8%
Caesarean section rate total	27.2%
Elective caesarean section number	10.7%
Emergency Caesarean section number	16.5%
Episiotomy rate (spontaneous deliveries)	8.5%

<b>STAFFING ESTABLISHMENT as of 31 March 2009 (excluding neonatal unit)</b>		
(Staff that work on more than one site should be included only where their substantive post is)		
<b>Skill Mix</b>	<b>In post WTE</b>	<b>Funded WTE</b>
Band 8 a	1	1
Band 8 b	0	0
Band 8 c	0	0
Band 8 d	0	0
Band 7 + Community	24.23	24.23
Band 6 + Community	37.02	37.02
Band 5	1.92	1.92
Total	63.17	
	<i>Number</i>	
Overall ratio of births to midwifery establishment (WTE)	1:41	
Ratio of births to midwives in post (WTE)	1:41	
Adjusted ratio of births to midwives excluding maternity leave, long-term sickness, secondments away from unit etc		
Total number of midwives employed (head count, i.e. allowing for part-time staff)	82	
Total number of midwives notifying intention to practise (including non-employed midwives, e.g. independent practitioners, educationalists, researchers)	83	
Vacancies according to funded establishment	0	
Vacancies according to Birthrate Plus defined establishment	0	
Birthrate Plus undertaken – which year	2006	
Birthrate Plus in progress	Yes	No√
Birthrate Plus planned – when	No	
Specialist midwifery posts (please specify any not listed)	<i>Number</i>	
Consultant midwife	0	
Lecturer practitioner	0	
Practice Development Midwife	0	
Infant Feeding Co-ordinator	0	
Bereavement Midwife	0	
Drug/alcohol dependency midwife	1	
Child protection midwife	0	
Pregnant teenagers co-ordinator	0	
Midwife Ultrasonographer	1	
ECV practitioner	0	
<b>Maternity Care Support Workers</b>	<b>In post WTE</b>	<b>Funded WTE</b>
Band 1	0	
Band 2	2.80	
Band 3	12.42	
Band 4	0	
Ward Clerks	6.6	
Clerical/Admin	1.43	

**North East LSA**  
**Annual statistics for the year ending 31 March 2009**

<b>Name of Trust: NORTHUMBRIA</b>	
<b>Name of Unit: HILLCREST MLU</b>	
Contact Supervisor:	
Form completed by:C JENKINS	<b>Contact details:01665 626732</b>
<b>Maternity Outcomes</b>	<b>Number</b>
Total number of women delivered (include all births hospital & home)	50
Total number of babies born (including multiple births)	50
Live births	50
Stillbirths	0
Neonatal deaths before 6 days	0
Maternal deaths	0
Births in hospital	
Births in midwife-led units/birth centres	49
Planned home births	1
Actual home births – midwife in attendance	0
Births at home with no midwife present, including those delivered at home or in transit by ambulance crew	1
Does your service provide preconception care?	<b>Y/N</b>
	<b>%</b>
Percentage of women accessing midwife as first point of contact in pregnancy	5%
Percentage of women booking by 12 weeks	90%
Teenage pregnancy rate (age 16 and under)	
Percentage of women accessing stop smoking facilities	24%
Percentage of women still smoking at time of delivery	12%
Percentage of women initiating breastfeeding	70%
Percentage of women exclusively breastfeeding on transfer to HV care	60%
<b>Normality</b>	
Number of unassisted spontaneous births	50
Number of women using water for labour	0
Number of women birthing in water	0
<b>Obstetric interventions</b>	
Induction rate	0
Epidural rate	0
Instrumental rate	0
Vaginal breach delivery rate	0
Caesarean section rate total	0
Elective caesarean section number	0
Emergency Caesarean section number	0
Episiotomy rate (spontaneous deliveries)	2%



<b>STAFFING ESTABLISHMENT as of 31 March 2009 (excluding neonatal unit)</b>		
(Staff that work on more than one site should be included only where their substantive post is)		
<b>Skill Mix</b>	<b>In post WTE</b>	<b>Funded WTE</b>
Band 8 a		
Band 8 b		
Band 8 c		
Band 8 d		
Band 7	7.22	7.52
Band 6		
Band 5		
	Total	
	<i>Number</i>	
Overall ratio of births to midwifery establishment (WTE)	6.92	
Ratio of births to midwives in post (WTE)	5	
Adjusted ratio of births to midwives excluding maternity leave, long-term sickness, secondments away from unit etc		
Total number of midwives employed (head count, i.e. allowing for part-time staff)	10	
Total number of midwives notifying intention to practise (including non-employed midwives, e.g. independent practitioners, educationalists, researchers)	12	
Vacancies according to funded establishment	.30	
Vacancies according to Birthrate Plus defined establishment		
Birthrate Plus undertaken – which year		
Birthrate Plus in progress		No
Birthrate Plus planned – when		
Specialist midwifery posts (please specify any not listed)	<i>Number</i>	
Consultant midwife	0	
Lecturer practitioner	0	
Practice Development Midwife	1	
Infant Feeding Co-ordinator	1	
Bereavement Midwife	0	
Drug/alcohol dependency midwife	0	
Child protection midwife	1	
Pregnant teenagers co-ordinator	1	
Midwife Ultrasonographer	0	
ECV practitioner	0	
	0	
<b>Maternity Care Support Workers</b>	<b>In post WTE</b>	<b>Funded WTE</b>
Band 1		
Band 2	4.58	
Band 3		
Band 4		
Ward Clerks	0.28	
Clerical/Admin		

**North East LSA**  
**Annual statistics for the year ending 31 March 2009**

<b>Name of Trust: NORTHUMBRIA Appendix 1e</b>	
<b>Name of Unit: Berwick M.L.U.</b>	
Contact Supervisor: Linda Headley	
Form completed by: K Hales	<b>Contact details:01289 356622</b>
<b>Maternity Outcomes</b>	<b>Number</b>
Total number of women delivered (include all births hospital & home)	33
Total number of babies born (including multiple births)	33
Live births	33
Stillbirths	0
Neonatal deaths before 6 days	0
Maternal deaths	0
Births in hospital	0
Births in midwife-led units/birth centres	31
Planned home births	0
Actual home births – midwife in attendance	0
<b>Births at home with no midwife present including those delivered at home or in transit by ambulance crew</b>	2
Does your service provide preconception care?	<b>No</b>
	<b>%</b>
Percentage of women accessing midwife as first point of contact in pregnancy	6%
Percentage of women booking by 12 weeks	79%
Teenage pregnancy rate (age 16 and under)	0%
Percentage of women accessing stop smoking facilities	?
Percentage of women still smoking at time of delivery	?
Percentage of women initiating breastfeeding	58%
Percentage of women exclusively breastfeeding on transfer to HV care	36%
<b>Normality</b>	
Number of unassisted spontaneous births	33
Number of women using water for labour	?
Number of women birthing in water	0
<b>Obstetric interventions</b>	
Induction rate	0
Epidural rate	0
Instrumental rate	0
Vaginal breach delivery rate	0
Caesarean section rate total	0
Elective caesarean section number	0
Emergency Caesarean section number	0
Episiotomy rate (spontaneous deliveries)	3%

<b>STAFFING ESTABLISHMENT as of 31 March 2009 (excluding neonatal unit)</b>		
(Staff that work on more than one site should be included only where their substantive post is)		
<b>Skill Mix</b>	<b>In post WTE</b>	<b>Funded WTE</b>
Band 8 a		
Band 8 b		
Band 8 c		
Band 8 d		
Band 7	6.77	7.32
Band 6		
Band 5		
Total	6.77	
	<i>Number</i>	
Overall ratio of births to midwifery establishment (WTE)	4.9	
Ratio of births to midwives in post (WTE)	4.9	
Adjusted ratio of births to midwives excluding maternity leave, long-term sickness, secondments away from unit etc	4.9	
Total number of midwives employed (head count, i.e. allowing for part-time staff)	10	
Total number of midwives notifying intention to practise (including non-employed midwives, e.g. independent practitioners, educationalists, researchers)	10	
Vacancies according to funded establishment		0.5
Vacancies according to Birthrate Plus defined establishment		0.5
Birthrate Plus undertaken – which year	No	
Birthrate Plus in progress	No	
Birthrate Plus planned – when	No	
Specialist midwifery posts (please specify any not listed)	<i>Number</i>	
Consultant midwife	0	
Lecturer practitioner	0	
Practice Development Midwife	1	
Infant Feeding Co-ordinator	1	
Bereavement Midwife	0	
Drug/alcohol dependency midwife	0	
Child protection midwife	1	
Pregnant teenagers co-ordinator	1	
Midwife Ultrasonographer	0	
ECV practitioner	0	
	0	
<b>Maternity Care Support Workers</b>	<b>In post WTE</b>	<b>Funded WTE</b>
Band 1		
Band 2	4.36	
Band 3		
Band 4		
Ward Clerks		
Clerical/Admin		

**North East LSA  
Annual statistics for the year ending 31 March 2009**

<b>Name of Trust: NORTHUMBRIA</b>	
<b>Name of Unit: Hexham M.L.U. Appendix1c</b>	
Contact Supervisor: Jan Henry	
Form completed by: K Hales	<b>Contact details:01434 655350</b>
<b>Maternity Outcomes</b>	<b>Number</b>
Total number of women delivered (include all births hospital & home)	198
Total number of babies born (including multiple births)	198
Live births	198
Stillbirths	0
Neonatal deaths before 6 days	0
Maternal deaths	0
Births in hospital	
Births in midwife-led units/birth centres	176
Planned home births	13
Actual home births – midwife in attendance	12
<b>Births at home with no midwife present including those delivered at home or in transit by ambulance crew</b>	<b>7</b>
Does your service provide preconception care?	<b>No</b>
	<b>%</b>
Percentage of women accessing midwife as first point of contact in pregnancy	5%
Percentage of women booking by 12 weeks	90%
Teenage pregnancy rate (age 16 and under)	0%
Percentage of women accessing stop smoking facilities	?
Percentage of women still smoking at time of delivery	?
Percentage of women initiating breastfeeding	77%
Percentage of women exclusively breastfeeding on transfer to HV care	?
<b>Normality</b>	
Number of unassisted spontaneous births	198
Number of women using water for labour	?
Number of women birthing in water	11
<b>Obstetric interventions</b>	
Induction rate	0
Epidural rate	0
Instrumental rate	0
Vaginal breech delivery rate	1
Caesarean section rate total	0
Elective caesarean section number	0
Emergency Caesarean section number	0
Episiotomy rate (spontaneous deliveries)	3.5%

<b>STAFFING ESTABLISHMENT as of 31 March 2009 (excluding neonatal unit)</b>		
(Staff that work on more than one site should be included only where their substantive post is)		
<b>Skill Mix</b>	<b>In post WTE</b>	<b>Funded WTE</b>
Band 8 a		
Band 8 b		
Band 8 c		
Band 8 d		
Band 7 inc community	12.81	12.81
Band 6	7.61	7.61
Band 5		
Total	20.42	20.42
	<i>Number</i>	
Overall ratio of births to midwifery establishment (WTE)	10	
Ratio of births to midwives in post (WTE)	10	
Adjusted ratio of births to midwives excluding maternity leave, long-term sickness, secondments away from unit etc	10	
Total number of midwives employed (head count, i.e. allowing for part-time staff)	29	
Total number of midwives notifying intention to practise (including non-employed midwives, e.g. independent practitioners, educationalists, researchers)	31	
Vacancies according to funded establishment	0	
Vacancies according to Birthrate Plus defined establishment	0	
Birthrate Plus undertaken – which year	2006	
Birthrate Plus in progress		
Birthrate Plus planned – when		
Specialist midwifery posts (please specify any not listed)	<i>Number</i>	
Consultant midwife	0	
Lecturer practitioner	0	
Practice Development Midwife	1	
Infant Feeding Co-ordinator	1	
Bereavement Midwife	0	
Drug/alcohol dependency midwife	0	
Child protection midwife	1	
Pregnant teenagers co-ordinator	1	
Midwife Ultrasonographer	0	
ECV practitioner	0	
	0	
<b>Maternity Care Support Workers</b>	<b>In post WTE</b>	<b>Funded WTE</b>
Band 1	1.37	
Band 2		
Band 3	3.65	
Band 4		
Ward Clerks	1.38	
Clerical/Admin		

**North East LSA**  
**Annual statistics for the year ending 31 March 2009**  
**Appendix1a**

<b>Name of Trust: NORTHUMBRIA</b>	
<b>Name of Unit: North Tyneside M.L.U.</b>	
Contact Supervisor:	
Form completed by: K Hales	<b>Contact details:01434 655350</b>
<b>Maternity Outcomes</b>	<b>Number</b>
Total number of women delivered (include all births hospital & home)	528
Total number of babies born (including multiple births)	528
Live births	528
Stillbirths	0
Neonatal deaths before 6 days	0
Maternal deaths	0
Births in hospital	
Births in midwife-led units/birth centres	515
Planned home births	43
Actual home births – midwife in attendance	8
<b>Births at home with no midwife present including those delivered at home or in transit by ambulance crew</b>	5
Does your service provide preconception care?	<b>No</b>
	<b>%</b>
Percentage of women accessing midwife as first point of contact in pregnancy	5%
Percentage of women booking by 12 weeks	90%
Teenage pregnancy rate (age 16 and under)	0%
Percentage of women accessing stop smoking facilities	6%
Percentage of women still smoking at time of delivery	0%
Percentage of women initiating breastfeeding	54%
Percentage of women exclusively breastfeeding on transfer to HV care	?
<b>Normality</b>	
Number of unassisted spontaneous births	528
Number of women using water for labour	11
Number of women birthing in water	0
<b>Obstetric interventions</b>	
Induction rate	0
Epidural rate	0
Instrumental rate	0
Vaginal breach delivery rate	0
Caesarean section rate total	0
Elective caesarean section number	0
Emergency Caesarean section number	0
Episiotomy rate (spontaneous deliveries)	3.5%

<b>STAFFING ESTABLISHMENT as of 31 March 2009 (excluding neonatal unit)</b>		
(Staff that work on more than one site should be included only where their substantive post is)		
<b>Skill Mix</b>	<b>In post WTE</b>	<b>Funded WTE</b>
Band 8 a		
Band 8 b		
Band 8 c		
Band 8 d		
Band 7	6.55	7.32
Band 6	18.75	18.75
Band 5		
Total	25.30	26.05
	<i>Number</i>	
Overall ratio of births to midwifery establishment (WTE)	20	
Ratio of births to midwives in post (WTE)	21.12	
Adjusted ratio of births to midwives excluding maternity leave, long-term sickness, secondments away from unit etc	22	
Total number of midwives employed (head count, i.e. allowing for part-time staff)	36	
Total number of midwives notifying intention to practise (including non-employed midwives, e.g. independent practitioners, educationalists, researchers)	12	
Vacancies according to funded establishment	.30	
Vacancies according to Birthrate Plus defined establishment		
Birthrate Plus undertaken – which year		
Birthrate Plus in progress	Yes	
Birthrate Plus planned – when		
Specialist midwifery posts (please specify any not listed)	<i>Number</i>	
Consultant midwife	0	
Lecturer practitioner	0	
Practice Development Midwife	1	
Infant Feeding Co-ordinator	1	
Bereavement Midwife	0	
Drug/alcohol dependency midwife	0	
Child protection midwife	1	
Pregnant teenagers co-ordinator	1	
Midwife Ultrasonographer	0	
ECV practitioner	0	
	0	
<b>Maternity Care Support Workers</b>	<b>In post WTE</b>	<b>Funded WTE</b>
Band 1	2.13	2.13
Band 2		
Band 3	7.41	7.41
Band 4		
Ward Clerks	1.12	1.12
Clerical/Admin		

**North East LSA**  
**Annual statistics for the year ending 31 March 2009**

<b>Name of Trust: South Tees NHS Foundation Trust</b>	
<b>Name of Unit James Cook University Hospital</b>	
Contact Supervisor: Yvonne Regan	
Form completed by: Jan Holloran & Lynne Young	<b>Contact details: 01642 854517</b>
<b>Maternity Outcomes</b>	<b>Number</b>
Total number of women delivered (include all births hospital & home)	3994
Total number of babies born (including multiple births)	4071
Live births	4012
Stillbirths	29
Neonatal deaths before 6 days	13
Maternal deaths	1
Births in hospital	3954
Births in midwife-led units/birth centres	1187 wd 16
Planned home births	63
Actual home births – midwife in attendance	24
Births at home with no midwife present, including those delivered at home or in transit by ambulance crew	21
Does your service provide preconception care?	<b>N</b>
	<b>%</b>
Percentage of women accessing midwife as first point of contact in pregnancy	Not measured
Percentage of women booking by 12 weeks	95.4%
Teenage pregnancy rate (age 16 and under)	0.7%
Percentage of women accessing stop smoking facilities	n/a
Percentage of women still smoking at time of delivery	13%
Percentage of women initiating breastfeeding	48.8%
Percentage of women exclusively breastfeeding on transfer to HV care	Not measured
<b>Normality</b>	
Number of unassisted spontaneous births	68.9%
Number of women using water for labour	n/a
Number of women birthing in water	12
<b>Obstetric interventions</b>	
Induction rate	22.5%
Epidural rate	21.2%
Instrumental rate	22.1%
Vaginal breach delivery rate	0.55%
Caesarean section rate total	21%
Elective caesarean section number	311
Emergency Caesarean section number	531
Episiotomy rate (spontaneous deliveries)	230



<b>STAFFING ESTABLISHMENT as of 31 March 2009 (excluding neonatal unit)</b>		
(Staff that work on more than one site should be included only where their substantive post is)		
<b>Skill Mix</b>	<b>In post WTE</b>	<b>Funded WTE</b>
Band 8 a	4.0	4.0
Band 8 b		
Band 8 c	1.0	1.0
Band 8 d		
Band 7	22.93	22.7
Band 6	100.4	100.4
Band 5	6.0	6.0
Total	134.33	134.1
	<i>Number</i>	
Overall ratio of births to midwifery establishment (WTE)	1/29	1/29
Ratio of births to midwives in post (WTE)	1/29	1/29
Adjusted ratio of births to midwives excluding maternity leave, long-term sickness, secondments away from unit etc		
Total number of midwives employed (head count, i.e. allowing for part-time staff)		146
Total number of midwives notifying intention to practise (including non-employed midwives, e.g. independent practitioners, educationalists, researchers)	146	
Vacancies according to funded establishment	0	
Vacancies according to Birthrate Plus defined establishment	0	
Birthrate Plus undertaken – which year	2005	
Birthrate Plus in progress	Yes	No
Birthrate Plus planned – when	2009	
Specialist midwifery posts (please specify any not listed)	<i>Number</i>	
Consultant midwife	1.0	
Lecturer practitioner	0	
Practice Development Midwife	1.0	
Infant Feeding Co-ordinator	0	
Bereavement Midwife	0	
Drug/alcohol dependency midwife	0	
Child protection midwife	0	
Pregnant teenagers co-ordinator	0	
Midwife Ultrasonographer	3.64	
ECV practitioner	0	
<b>Maternity Care Support Workers</b>	<b>In post WTE</b>	<b>Funded WTE</b>
Band 1	0	
Band 2	9.8	9.8
Band 3	17.8	17.8
Band 4	0	0
Ward Clerks	4.0	4.02
Clerical/Admin	0	0

**North East LSA  
Annual statistics for the year ending 31 March 2009**

<b>Name of Trust: South Tees NHS Foundation Trust</b>	
<b>Name of Unit: Friarage</b>	
Contact Supervisor: Yvonne Regan	
Form completed by: jan Holloran Lynne Young	<b>Contact details: 01642 854517</b>
<b>Maternity Outcomes</b>	<b>Number</b>
Total number of women delivered (include all births hospital & home)	1295
Total number of babies born (including multiple births)	1313
Live births	1308
Stillbirths	5
Neonatal deaths before 6 days	1
Maternal deaths	0
Births in hospital	1266
Births in midwife-led units/birth centres	N/A
Planned home births	23
Actual home births – midwife in attendance	22
Births at home with no midwife present, including those delivered at home or in transit by ambulance crew	9
Does your service provide preconception care?	<b>N</b>
	<b>%</b>
Percentage of women accessing midwife as first point of contact in pregnancy	Not measured
Percentage of women booking by 12 weeks	74%
Teenage pregnancy rate (age 16 and under)	0.1%
Percentage of women accessing stop smoking facilities	4.56%
Percentage of women still smoking at time of delivery	12.3%
Percentage of women initiating breastfeeding	74.5%
Percentage of women exclusively breastfeeding on transfer to HV care	Not measured
<b>Normality</b>	
Number of unassisted spontaneous births	65.3%
Number of women using water for labour	3.4%
Number of women birthing in water	1.9%
<b>Obstetric interventions</b>	
Induction rate	22.1%
Epidural rate	10.5%
Instrumental rate	10.8%
Vaginal breach delivery rate	0.1%
Caesarean section rate total	23.5%
Elective caesarean section number	10.2%
Emergency Caesarean section number	13.3%
Episiotomy rate (spontaneous deliveries)	6%

<b>STAFFING ESTABLISHMENT as of 31 March 2009 (excluding neonatal unit)</b>		
(Staff that work on more than one site should be included only where their substantive post is)		
<b>Skill Mix</b>	<b>In post WTE</b>	<b>Funded WTE</b>
Band 8 a	1.0	1.0
Band 8 b		
Band 8 c		
Band 8 d		
Band 7	11.0	11.0
Band 6	32.83	34
Band 5	2.0	
Total	46.83	46
	<i>Number</i>	
Overall ratio of births to midwifery establishment (WTE)	1/28	1/28
Ratio of births to midwives in post (WTE)	1/28	1/28
Adjusted ratio of births to midwives excluding maternity leave, long-term sickness, secondments away from unit etc	1/29	1/29
Total number of midwives employed (head count, i.e. allowing for part-time staff)	55	
Total number of midwives notifying intention to practise (including non-employed midwives, e.g. independent practitioners, educationalists, researchers)	60 Including cross boundary	
Vacancies according to funded establishment	0	
Vacancies according to Birthrate Plus defined establishment		
Birthrate Plus undertaken – which year	2005	
Birthrate Plus in progress	Yes	No
Birthrate Plus planned – when	2009	
Specialist midwifery posts (please specify any not listed)	<i>Number</i>	
Consultant midwife	0	
Lecturer practitioner	0	
Practice Development Midwife	0	
Infant Feeding Co-ordinator	0	
Bereavement Midwife	0	
Drug/alcohol dependency midwife	0	
Child protection midwife	0	
Pregnant teenagers co-ordinator	0	
Midwife Ultrasonographer	2	
ECV practitioner	0	
<b>Maternity Care Support Workers</b>	<b>In post WTE</b>	<b>Funded WTE</b>
Band 1	0	
Band 2	3.4	3.4
Band 3	6.44	6.44
Band 4	0	0
Ward Clerks	1.1	1.1
Clerical/Admin	0	0

**North East LSA**  
**Annual statistics for the year ending 31 March 2009**

<b>Name of Trust: South Tyneside NHS Foundation Trust</b>	
<b>Name of Unit: South Shields Maternity Unit</b>	
Contact Supervisor: Susan Tweddell/Edwina Chamberlain	
Form completed by: Susan Tweddell	<b>Contact details: 01914041000 ext 2488</b>
<b>Maternity Outcomes</b>	<b>Number</b>
Total number of women delivered (include all births hospital & home)	1552
Total number of babies born (including multiple births)	1566
Live births	1555
Stillbirths	3
Neonatal deaths before 6 days	1
Maternal deaths	0
Births in hospital	1532
Births in midwife-led units/birth centres	N/A
Planned home births	50
Actual home births – midwife in attendance	25
Births at home with no midwife present, including those delivered at home or in transit by ambulance crew	10
Does your service provide preconception care?	<b>NO</b>
Percentage of women accessing midwife as first point of contact in pregnancy	100%
Percentage of women booking by 12 weeks	83%
Teenage pregnancy rate (age 16 and under)	2.33%
Percentage of women accessing stop smoking facilities	15.46%
Percentage of women still smoking at time of delivery	18.36%
Percentage of women initiating breastfeeding	47.8%
Percentage of women exclusively breastfeeding on transfer to HV care	Not collected
<b>Normality</b>	
Number of unassisted spontaneous births	1042
Number of women using water for labour	135
Number of women birthing in water	66
<b>Obstetric interventions</b>	
Induction rate	27.7%
Epidural rate	15.0%
Instrumental rate	13.9%
Vaginal breach delivery rate	0.5%
Caesarean section rate total	19.9%
Elective caesarean section number	113
Emergency Caesarean section number	144
Episiotomy rate (spontaneous deliveries)	17.2%

<b>STAFFING ESTABLISHMENT as of 31 March 2009 (excluding neonatal unit)</b>		
(Staff that work on more than one site should be included only where their substantive post is)		
<b>Skill Mix</b>	<b>In post WTE</b>	<b>Funded WTE</b>
Band 8 a	n/a	
Band 8 b	n/a	
Band 8 c	n/a	
Band 8 d	n/a	
Band 7	13.88	14.88
Band 6	39.95	39.50
Band 5	3.12	3.12
	<i>Number</i>	
Overall ratio of births to midwifery establishment (WTE)	28.7	28.7
Ratio of births to midwives in post (WTE)	28.7	
Adjusted ratio of births to midwives excluding maternity leave, long-term sickness, secondments away from unit etc		34.4
Total number of midwives employed (head count, i.e. allowing for part-time staff)	83	
Total number of midwives notifying intention to practise (including non-employed midwives, e.g. independent practitioners, educationalists, researchers)	83	
Vacancies according to funded establishment		0
Vacancies according to Birthrate Plus defined establishment	n/a	
Birthrate Plus undertaken – which year	n/a	
Birthrate Plus in progress		No
Birthrate Plus planned – when		
Specialist midwifery posts (please specify any not listed)	<i>Number</i>	1research
Consultant midwife	0	
Lecturer practitioner	0	
Practice Development Midwife	0	
Infant Feeding Co-ordinator	0	
Bereavement Midwife	team	
Drug/alcohol dependency midwife	1	
Child protection midwife	1	
Pregnant teenagers co-ordinator	1	
Midwife Ultrasonographer	2	
ECV practitioner	0	
<b>Maternity Care Support Workers</b>	<b>In post WTE</b>	<b>Funded WTE</b>
Band 1	n/a	
Band 2	10.12	13
Band 3	n/a	
Band 4	n/a	
Ward Clerks	1.91	4
Clerical/Admin		

Appendix 6  
Sudden Untoward Incident Policy

**NORTH EAST STRATEGIC HEALTH  
AUTHORITY**

*POLICY AND PROCEDURE*

*GUIDANCE FOR REPORTING AND  
MANAGEMENT OF*

*SERIOUS UNTOWARD INCIDENTS*

Version control reference	October 2008 <b>Version 2</b>
Approved by	Ian Dalton Chief Executive
Date approved	10 November 2008
Date to be reviewed	12 months from date of approval subject to national changes to policy
Author/owner	Wilma Ayris/Steve Page, Strategic Head of Patient Safety
Link/s with the NHS North East vision, if applicable	This policy and procedure applies to all areas of the SHA vision
Communication plan	<i>Chief executives briefing, intranet and email notification</i>
Accessibility checklist completed	

**The content of this policy and procedure document may be disclosed in response to a request for access under the Freedom of Information Act.**

## MISSION STATEMENT

**The Patient Safety Action Team (PSAT) is committed to proactively promoting patient safety in the North East and by so doing making an effective contribution to the NESHA vision of no avoidable deaths, injury or illness and no avoidable suffering or pain.**

**By working together with patients, carers and local healthcare and associated organisations we will improve the reporting and investigation of serious untoward incidents and near misses and ensure that learning is shared across the community to the benefit of our health community.**

### 1 INTRODUCTION

This policy sets out the procedure for reporting and management of serious untoward incidents (SUI) within the strategic health authority (SHA). It contains the **minimum** reporting requirements expected in the North East of England and is designed to help Trusts/ Primary Care Organisations (PCOs) take appropriate steps in the best interests of their patients, staff and the NHS as a whole.

All Trusts/ PCOs have developed to a greater or lesser degree their own approaches to patient safety and service improvement and it is important that the full scope of this is visible and learning is shared.

Individual PCO's and Trusts may set additional requirements through their commissioning and quality monitoring processes.

The role of the strategic health authority (SHA) in dealing with SUI's is to ensure that:

- SUIs are reported promptly in line with the guidance provided in this document
- SUIs are thoroughly investigated and the results of this investigation are communicated to the SHA in a timely manner.
- Action is taken where necessary to improve clinical quality and patient safety
- Lessons are learned in order to minimise the risk of similar incidents occurring in the future
- Learning is shared across the wider health community, locally and nationally



## **2 DEFINITION OF A SERIOUS UNTOWARD INCIDENT (SUI)**

An incident occurring on health service premises or on other non NHS premises in relation to the provision of healthcare on such premises, resulting in death, serious injury or harm to patients, staff or the public, significant loss or damage to property or the environment, or other wise likely to be significant public concern. This shall include “near misses” or low impact incidents which have the potential to contribute to serious harm.

## **3 CRITERIA FOR REPORTING TO SHA**

- 3.1 Patients, individuals or groups of individuals suffering serious harm or unexpected death whilst in receipt of health services. This includes screening and immunisation /radiation errors and equipment failures. National and regional guidelines exist in relation to specific areas i.e. breast screening and cancer which should be addressed in conjunction with this policy (see section 7 for more information).
- 3.2 Serious injury or unexpected death of an individual to whom the organisation owes a duty of care including staff, visitor, contractor or another person.
- 3.3 A serious offence including homicide committed by an individual in receipt of mental health and/or learning disability services.
- 3.4 A death of a patient due to hospital acquired infection including MRSA and Clostridium Difficile confirmed by notification on Parts 1 and/or 2 of the Death Certificate.
- 3.5 Any serious Information Technology related incident occurring which impacts or has the potential to impact on clinical care of patients and service users including all systems used or required to deliver patient and or service user care e.g. PAS,PACS GP systems, results reporting systems etc.
- 3.6 Actual or potential loss of personal information that could lead to identity fraud or have other significant impact on individuals (see section 8 for more information).
- 3.7 Allegations of serious professional misconduct.
- 3.8 Adverse incident which would invoke an emergency plan (affecting business continuity including multiple ward closure due to infection, serious damage to occupied NHS property through fire, flood or criminal damage, IT failure).

- 3.9 Patients detained under the Mental Health Act 1983 who abscond from health services and who present a serious risk to themselves and/or others.
- 3.10 The admission of a child of under the age of 16 to an adult psychiatric ward must be notified as a SUI. Where a child is over 16 and not yet 18 years of age there are specific criteria which must be met with regard to their accommodation, namely:
- The beds must be specifically set aside for this use and are single sex
  - Staff are Criminal Record Bureau checked and have support and training available to them from child mental health professionals
  - Local Safeguarding Children Board is satisfied with the measures in place
  - Adult mental health staff and CAMHS work closely together to plan the care, discharge and after care utilising the Care Programme approach
  - Education, recreational facilities and advocacy services are available to children and young people. Advocates are trained to work with children and young people and in mental health legislation
  - Local Authority and voluntary social care, vocational and housing services are part of the network supporting the young people

In the event of any of these criteria not being met the incident with regard to the child aged 16/17 should be notified to the SHA as a SUI.

#### 4. RESPONSIBILITIES OF THE STRATEGIC HEALTH AUTHORITY

- 4.1 The **Strategic Head of Patient Safety** oversees the strategic health authority's systems and processes for patient safety.
- 4.2 A serious untoward incident reported through STEIS is categorised as 'open' until the **Strategic Head of Patient Safety** is satisfied that all appropriate action has been taken and the lessons learned are recorded and understood. Only once this has happened, can an incident be 'closed' on the system.
- 4.3 Incidents involving the death of an individual(s) which is subject to an inquest cannot be closed until the coroner's verdict is known and recorded through STEIS. Once the verdict is known and if the **Strategic Head of Patient Safety** considers that no further action is necessary, the file on the case can be closed. Further discussion in relation to this may need to take place with the organisation and the SHA in view of the possible delays associated with inquests.

- 4.4 Once a SUI is 'closed' on the STEIS system the records can be viewed by the reporting Trust, but cannot be edited. In exceptional circumstances a SUI can be re-opened and re-edited but this requires the authorisation of the SHA. To do this, the Trust/PCO should contact the PSAT. A member of the PSAT will contact the STEIS Helpdesk to arrange for the case to be re-opened. Once all outstanding amendments have been made, the SHA will once again close the incident.
- 4.5 When a SUI is first notified to the SHA through STEIS the SHA will review the incident using an internal grading classification. This grading review may highlight a very high level of concern with regard to the impact or potential impact of the incident and will clarify the required reporting timescale and may result in a request to the Trust for a "same day report".
- 4.6 If there is evidence to indicate that a SUI could be part of a cluster or trend, or where the circumstances or consequences of the incident are of particular concern e.g. suicide incident or incident with regard to managing the deteriorating patient, the SHA may instigate a wider review. It is difficult to be prescriptive, as the extent of that case review will depend upon the nature of the incident. The SHA may require the Trust/PCO to undertake further inquiries or may suggest a particular course of action.
- 4.7 Monitoring of all patient safety issues including SUI information is carried out by the SHA management team. This includes updates on open cases, cases of high media attention, and reviewing national and local updates.
- 4.8 The SHA will support the development of processes which allows for sharing of information between organisations and other sectors to ensure lessons are learned. A variety of approaches will be utilised e.g. 'Safety Watch'; circulars and events, Trust newsletters etc.
- 4.9 The SHA is responsible for advancing the dissemination of information about the lessons learned from SUIs to all relevant bodies as quickly and effectively as possible. Robust and effective systems of communication are essential to ensure that this happens in a timely and orderly manner.
- 4.10 When an incident or incidents are of such a serious nature that an external (independent) inquiry is required, the SHA will commission such an inquiry and an independent panel will be established in line with relevant national guidance for example HSG (94)27 and associated amendments.

## 5 GUIDANCE FOR TRUSTS/ PCOS

- 5.1 Each Trust/PCO must nominate a single point of contact or lead officer for managing all SUIs.
- 5.2 Trusts/ PCOs should ensure that mechanisms are in place to report all incidents meeting the criteria.
- 5.3 The SUI lead officer must report a SUI through STEIS immediately on becoming aware of the incident, completing all relevant sections. At this stage it is important that any immediate learning is included in this report.
- 5.4 The SHA may request a same day report on any incident. This should take the form of an update on the STEIS system within an agreed timescale. The SHA Duty Case Manager will contact the Trust with any request for this urgent report.
- 5.5 If appropriate, the SUI lead officer must liaise with the Trusts/ PCOs communications team who will liaise directly with the SHA communications team.
- 5.6 Internal investigations will be commenced immediately on notification of the incident in line with organisations incident management policies. Where no request for a same day report has been made, the Trust will forward their routine internal investigation report to the SHA **as soon as it is completed** and within a timescale not exceeding **60 working days** from original notification
- 5.7 If the Trust/ PCO is in receipt of any significant 'new' information regarding a SUI (for example: the verdict of a court hearing or an inquest) the details on STEIS should be updated by the Trust. The Trust will need to inform the SHA SUI Case Manager as the STEIS system does not automatically alert the SHA.
- 5.8 Trusts/ PCOs should undertake investigation procedures / root cause analysis as per organisation policy and submit to the SHA within the agreed timescales. An example for the contents of a report and action plan can be found in **Appendix 1**.
- 5.9 Under the Data Protection Act 1988 organisations need to be open and transparent with regards to investigation processes, unless there are specific exceptions. Arrangements may need to be put in place to support patients and family members through the investigation process and sharing of the outcomes of investigations. The appointment of a Family Liaison Officer may be appropriate.

- 5.10 If an incident spans organisational boundaries, it is the responsibility of the Trust **where the incident took place** to formally report it through STEIS. All other organisations involved must contribute and fully cooperate with the process in line with the agreed timescales.
- 5.11 If an incident involves more than one NHS organisation a decision will be made (mutually agreed) as to which is the lead investigating organisation. Where an incident involves the independent sector or contracted services it is the role of the commissioning PCO to lead. The SHA will ask STEIS to remove the first report once the lead organisation has been agreed. The lead organisation will then submit a duplicate report to replace the original.
- 5.12 This guidance must not interfere with existing lines of accountability and does not replace the duty to inform the police and/or other organisations or agencies where appropriate. Further guidance can be obtained from the Department of Health publication *Memorandum of Understanding: Investigating Patient Safety Incidents* June 2004 and accompanying NHS guidance of December 2006. The need to involve outside agencies should not impede the retrieval of immediate learning.
- 5.13 Incidents which have impacted or have had potential to impact on children and/ or vulnerable adults must be investigated in conjunction with the identified safeguarding lead and in accordance with related guidance.
- 5.14 Where an incident is subject to the involvement of a coroner, an independent inquiry, serious case review or any safeguarding issues, this should be highlighted clearly within the STEIS report as this may affect closure date.

## 6 ADDITIONAL GUIDANCE

### 6.1 Mental Health or Learning Disability Services

- 6.1.1 Any SUI involving a former patient who has been discharged from mental health services **within the previous six-month period** must be reported by the mental health Trust through STEIS. (Note: child protection arrangements may apply).
- 6.1.2 If the SUI involves a former patient who has been discharged from the service **in excess of six months**, the mental health Trust should contact a member of the

patient safety team to seek advice about whether or not to report the incident through STEIS.

- 6.1.3 If an individual is referred to secondary care services by their general practitioner and is involved in a SUI **before** being assessed and accepted by secondary care services, it is the responsibility of the relevant primary care organisation to report the incident through STEIS and to lead the investigation process. Once the assessment of the individual is complete and the individual is **accepted** by secondary care services, this responsibility transfers to secondary care.

## 6.2 Children

- 6.2.1. PCOs are the lead health agency within their area and provide the health lead in inter-agency co-ordination and planning for Safeguarding Children. PCOs ensure health agencies from which they commission services contribute effectively to safeguarding arrangements.
- 6.2.2. In addition to the 'SUI Categories' set out above, PCOs must also inform the SHA by the SUI procedure when a Local Safeguarding Children Board (LSCB) serious case review sub-group has decided that a serious case review under Section 8 of *'Working Together to Safeguard Children'* is to be undertaken, or, if a single agency (health) management review involving the PCO or any of its provider health agencies is requested by the LSBC.
- 6.2.3 The PCO must ensure that a copy of the single agency health report and action plan is sent in a timely manner to the **Strategic Head of Patient Safety** at the SHA. The report and action plan must include the SUI reference number. The person responsible for undertaking this role e.g. PCO Clinical Governance lead or Designated Nurse should be confirmed in the PCO clinical governance policy and child protection procedures.
- 6.2.4. The SHA Safeguarding lead will comment on the final completed report and provide feedback to the PCO Lead and the Designated Nurse. Due to the possibility of public interest or potential to share lessons in some individual cases, a copy of the overview report, action plan and executive report should be sent to the SHA.
- 6.2.5. The SHA and Government Office North East (GONE) may discuss serious case reviews and share their correspondence relating to these. The PCO should

ensure that the local guidance for undertaking a serious case review includes a section confirming that the PCO will be responsible for reporting the decision to undertake a review to the strategic health authority.

6.2.6 PCOs and Trusts should inform the SHA through the serious untoward incident policy if they refer a member of staff to the Protection of Children Act 1999 list. The process for the management of information sharing when concerns are identified about health professionals through the Child Protection system will be refined and clarified by the SHA Safeguarding Lead soon to come into post.

### **6.3 Safeguarding Vulnerable Groups**

Provision for the protection of vulnerable groups is made in Part 7 of the Care Standards Act 2000. Trusts/PCOs are required to fully participate in interagency working to ensure the protection of vulnerable adults using health care services (*No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse* Department of Health, 2000, *Protection of Vulnerable Adults Scheme; A Practice Guide* Department of Health 2006). This guidance provides the bedrock for local multi-agency policies and procedures necessary to protect vulnerable adults. Trust/PCOs should also fully participate in Multi Agency Public Protection Arrangements (MAPPA) in all relevant cases. They should also be mindful of the Safeguarding Vulnerable Groups Act as its provisions are phased in, and ensure that they have appropriate arrangements in place to meet its requirements.

### **6.4 The Multi-Agency Public Protection Arrangements (MAPPA)**

NHS bodies must fulfil their 'Duty to Co-operate' with the Multi-Agency Public Protection Arrangements (MAPPA) as defined in the Criminal Justice and Court Services Act (2000). The purpose of MAPPA is to minimise the risk to the public by those who may re-offend either violently or sexually. NHS organisations are expected to:

- Attend case conferences;
- Provide advice about the assessment and management of particular cases;
- Share information about particular offenders so as to enable the responsible Authority (police and probation) to work together effectively.

Participation in POVA and MAPPA arrangements are in addition to, not instead of, the SUI arrangements. The SHA expect Trust/PCOs to inform the SHA using the SUI procedure when a serious case review has been requested and/or a staff member, including agency staff, has been referred to the POVA list.

## **6.5 Prisons Health Care**

The Prisons and Probation Ombudsman (PPO) is responsible for investigating all deaths in prisons, probation hostels and immigration detention accommodation. It will be vital that the local NHS works closely with the PPO to ensure appropriate investigation of clinical aspects of death in custody and of residents in approved premises. There is also a need to avoid any unnecessary duplication with the NHS system for investigating adverse clinical events, and maintain clear lines of accountability for services. The ombudsman is responsible for investigating clinical issues relevant to the death where the healthcare services are commissioned from the Prison Service by a contractually managed prison or by the Immigration and Nationality Directorate. The ombudsman will obtain clinical advice as necessary, and will make efforts to involve the local PCO in the investigation. Where the healthcare services are commissioned by the NHS, the PCO chief executive will have the lead responsibility for investigating clinical issues under its existing procedures.

## **6.6 Domestic Homicide Reviews**

In the event of a homicide involving a patient in receipt of health services the NHS may be asked to participate in a Domestic Homicide review.

## **6.7 Maternity Services**

Under the current legislation governing midwifery practice rule 15 of the Midwives Rules and Standards (NMC 2004) it states: 'ensure incidents that cause serious concern in its area relating to maternity care or midwifery practice are notified to the local supervising authority midwifery officer'. Therefore the existing arrangements in place to report incidents to the LSA midwifery officer remain in place ('trigger list'). Serious incidents in maternity care need to be reported through STEIS. The aforesaid categories are not exhaustive. If in doubt, the local supervising authority midwifery officer should be contacted for advice.



Serious Incidents in maternity care are reported to Confidential Enquiry for Maternal and Child Health (CEMACH) However the following should be reported to STEIS and the SHA:

6.7.1 Unexpected intrapartum still birth

6.7.2 Unexpected death of a mother and/or baby including a cot death in hospital

6.7.3 Baby abduction

## **7 ADDITIONAL GUIDANCE FOR SUIs LINKED WITH NATIONAL SCREENING PROGRAMMES**

7.1 There are a number of immunisation or screening programmes which require a broader approach to handling incidents. Important points to remember with regard to these incidents are:

- Screening or immunisation pathways cross several organisations
- Incidents affect the whole pathway and not just the local department or organisation in which the incident occurred
- Local incidents can affect the national reputation and alter public participation in the Programme nationally
- “Potential “incidents are relevant to the rest of a national programme for which it may highlight real incidents elsewhere
- Lessons need to be learned in the rest of the National Programme
- The volumes involved in screening can give individually minor incidents a major population impact
- There are established regional/national networks of experts who can help with the identification and handling of incidents
- Local Trusts are responsible for highlighting their local incidents to others in the health system who may be impacted by their local incident. These experts can help the local Trust make contact with the relevant people/networks outside the organisation in which the incident took place
- Some of the National Programmes already have defined protocols and tools for handling incidents which will be of value in the investigation and the experts can help to guide the local Trust through these e.g. Breast and cervical

7.2 The Quality Assurance Reference Centre (QARC) is accountable to the Regional Director of Public Health/SHA Medical Director for the quality of the breast and cervical screening programmes. The QARC also has advisory roles for

developing national programmes such as the bowel cancer screening programme.

- 7.3 SUIs linked to the breast and cervical screening programmes should, in addition to normal reporting, also be reported to the QARC within 5 working days. For serious incidents, the QARC should be informed immediately, and a member of the QARC team should be involved in the Incident Co-ordination Group. The QARC will inform the national Cancer Screening Programmes office as appropriate.
- 7.4 Further details on the management of incidents within the breast screening programme are available in “Guidelines for Managing Incidents in the Breast Screening Programme”  
<http://www.cancerscreening.nhs.uk/breastscreen/publications/pm-09.html>
- 7.5 Further details on the management of incidents within the cervical screening programme are available in “Guidelines for Managing Incidents in the Cervical Screening Programme”  
<http://www.cancerscreening.nhs.uk/cervical/publications/pm-07.html>
- 7.6 For SUIs linked to other national screening programmes (e.g. ante natal and child health screening, retinal screening etc) the SHA Screening Lead will provide advice to local organisations and will inform the national co-ordinating bodies as appropriate.

Further advice and Regional Contacts are included in **Appendix 3**

## **8 ADDITIONAL GUIDANCE FOR BREACH OF CONFIDENTIALITY SUIs**

- 8.1 The Department of Health have provided additional guidance for how SUIs relating to breaches of confidentiality should be dealt with.
- 8.2 Any incident involving the actual or potential loss of personal information that could lead to identity fraud or have other significant impact on individuals should be considered as serious.
- 8.3 **Appendix 4** provides a table to allow NHS organisations to assess the severity of the incident on a scale of 0-5 with incidents being dealt with in accordance with their severity level. If a Trust is unsure of the level of the incident, further guidance can be sought from the SHA Information Governance Manager.

- 8.4 Incidents rated 1-5 must be reported to the SHA through the STEIS system as soon as possible (and no later than 24 hrs after the incident during the working week). These must be categorised in STEIS using the “Confidential Information Leak” category.
- 8.5 Individual organisations are responsible for informing the Information Commissioner of any incident of severity level 3-5
- 8.6 The SHA is responsible for notifying the Department of Health of any category 3-5 incident and will do this as soon as possible after they have been made aware of such an incident (either through STEIS or other means)
- 8.7 Consideration should always be given to informing patients/service users when person identifiable information about them has been lost or inappropriately placed in the public domain.
- 8.8 When reporting to the SHA, PCOs/Trusts should provide the following information:
- Short description of incident and associated actions
  - How the information was held (paper, memory stick etc.)
  - Any safeguards to mitigate risk e.g. encryption
  - Number of individuals whose information is at risk
  - Types of information e.g. demographic, clinical
  - Whether individuals concerned have been informed, or whether a decision has/is being made whether to inform
  - Whether the Information Commissioner has been informed or whether a decision has/is being made whether to inform
  - Whether the SUI is in the public domain and extent of media interest or publication
  - Category of incident (1-5)
- 8.9 The SHA will be responsible for publishing a summary of their data loss SUIs on their public website on a quarterly basis
- 8.10 It will be the responsibility of whoever receives the details of the SUI within the SHA to pass this information on to other key individuals within the SHA namely the Patient Safety Team, Communications, the Chief Information Officer, Information Governance Programme Manager and the Caldicott Guardian.
- 8.11 Loss of encrypted media should not be reported as a SUI unless the data controller has reason to believe that the encryption did

not meet the Department of Health standards, that the protections had been broken, or were improperly applied.

- 8.12 Details of SUIs relating to data breaches should be included in organisations annual reports and reference to managing information risks should be made in annual statements of internal control.

*For further detail see Appendix 4*

## **9 INFORMATION FOR TRAINING ORGANISATIONS**

In the event an incident involves a student or trainee the relevant academic institution will be notified by the Trust/PCO as appropriate.

Where a Serious Untoward Incident concerns the commissioning or provision of medical or dental education or training, or a medical or dental trainee or trainees, there will be appropriate communication between the SHA and the Northern Deanery in the investigation of the incident and subsequent action planning.

## **10 INDEPENDENT HEALTHCARE SECTOR**

The independent healthcare sector is subject to contractual obligations for the reporting of serious untoward incidents. These should be reported on STEIS by the relevant commissioning PCO.

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## ***Appendix 1***

### **REPORT AND ACTION PLAN ON SERIOUS UNTOWARD INCIDENTS REPORTED TO THE SHA**

The report into Serious Untoward Incidents and the associated action plan should cover the following minimum information. Further work is under way with local organisations to develop and agree a common template

#### **REPORT**

- Introduction
- Constitution and investigation procedure
- Membership of the investigation team
- Terms of reference
- Background information
- Findings – to be identified against each of the terms of reference
- Conclusions
- Recommendations

#### **ACTION PLAN**

- Clearly set out which fall from the recommendations
- What needs to happen to achieve the outcome
- Identified title of who is responsible for the action
- Specific timescales ongoing except where incorporated in to the Trusts every day business for example the organisations annual programme of audit.

## **Appendix 2**

### **ALLEGATIONS MANAGEMENT**

#### **Management of Information Sharing when Concerns are identified about Health Professionals whose Children are the Subject of Child Protection Procedures.**

In the event of a member of staff having allegations against them involving children or as a parent/carer the following guidance sets out good practice on how to manage the sharing of information when child protection concerns have been highlighted.

1. Employment issues should be discussed at the Strategy meeting i.e. it should be agreed whether the concerns are such that there are concerns the health professional may be a risk professionally.
2. The Strategy Meeting should agree what information needs to be shared, with whom and who will be tasked with this.
3. Where employment concerns are identified, it is expected that the Chair of the Strategy Meeting will speak to the Local Authority Designated Officer (LADO) who will contact the Nominated Officer in the health professional's organisation who will inform the designated nurse of the action to be taken.
4. It is the role of the Named/Designated Professional attending the Strategy Meeting to ensure employment issues and sharing of information is discussed at the Strategy Meeting and will inform the designated nurse of the concerns.
5. In the event that the Named/Designated Professional is concerned about the outcome of the Strategy Meeting with regard to employment issues, they should discuss these concerns with the Chair and contact the LADO.
6. If the Named/Designated Professional remains concerned, they should contact the LADO's Line Manager (this will differ within each area) and ultimately speak to the Director of Children's Services if the issues are not resolved.
7. If concerns are raised at any point following a Strategy Meeting, advice will need to be sought from the local Designated Professionals for Safeguarding as to the best way to facilitate the appropriate discussion at a multi-disciplinary meeting.
8. For further information please refer to *Working Together to Safeguard Children*

### Appendix 3

#### ADDITIONAL ADVICE AND REGIONAL CONTACT DETAILS FOR SUIs IN SCREENING OR IMMUNISATION PROGRAMMES

Clinical Governance leads in Trusts are advised to

- Be aware of the wider needs of Screening or Immunisation Programmes
- Inform the staff involved in screening or immunisation that they should communicate with their Regional lead contacts if there is a potential incident
- Inform the regional contacts at an early stage when investigating potential incidents. They will advise on investigating and handling the incident and of the other people to inform (e.g. PCOs and others in the pathway)
- Ensure a relevant Regional representative(s) of the Programme is a key member of the incident investigation team
- Make sure that local organisations' policies on Incident Handling reflect the North East SHA's policy in respect of screening and immunisation
- Continue to formally report SUIs to the SHA in accordance with the NESHA Policy "Guidance for reporting and management of Serious Untoward Incidents"

In the event of an incident or potential incident in screening or immunisation, Trusts should make sure the following are informed in addition to their required reporting through STEIS

Primary Contact for <b>all</b> Screening or immunisation incidents in North East	Fergus Neilson, SHA Screening and immunisations Lead, Public Health North East, Government Office for the North East, 7 <sup>th</sup> Floor Citygate, Gallowgate, Newcastle upon Tyne NE1 4W  Email: <a href="mailto:Fergus.neilson@dh.gsi.gov.uk">Fergus.neilson@dh.gsi.gov.uk</a>  Tel: 0191 202 3718 mob:07880500641
Cancer Screening	Dr Keith Faulkner, Regional QA Director, Quality Assurance Reference Centre, 9 Kingfisher Way, Silverlink business Park, Newcastle upon Tyne, NE28  Email: keith <a href="mailto:faulkner@nhs.net">faulkner@nhs.net</a>  Tel: 0191219 7014 Mob: 07747795629
Ante-natal and Newborn	Kim Moonlight, Public Health North East, Government Office for the North East, 7 <sup>th</sup> Floor Citygate, Gallowgate, Newcastle upon Tyne NE1 4WH  Email: <a href="mailto:kim.moonlight@dh.gsi.gov.uk">kim.moonlight@dh.gsi.gov.uk</a>  Tel: 0191 202 3644 Mob: 07980729726

Immunisations	Julia Waller Regional immunisation Advisor, Health Protection Agency, Appleton House, Lanchester Rd., Durham DH1 5XZ  Email: <a href="mailto:Julia.waller@hpa.org.uk">Julia.waller@hpa.org.uk</a> and <a href="mailto:Julia.waller@cdd.nhs.uk">Julia.waller@cdd.nhs.uk</a>  Tel: 0191 3333372 Mob: 07990 526549
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#### **Appendix 4**

### **REPORTING SERIOUS UNTOWARD INCIDENTS (SUIs) RELATING TO ACTUAL OR POTENTIAL BREACHES OF CONFIDENTIALITY INVOLVING PERSON IDENTIFIABLE DATA (P.I.D), INCLUDING DATA LOSS.**

It is essential that all serious untoward incidents that occur in the Trust are reported appropriately and handled effectively. This document covers the reporting arrangements and describes the actions that need to be taken in terms of communication and follow up when a serious untoward incident occurs. Trusts should ensure that any existing policies for dealing with Serious Untoward Incidents are updated to reflect these arrangements.

#### **Definition of a Serious Untoward Incident in relation to Personal Identifiable Data**

There is no simple definition of a serious incident. What may at first appear to be of minor importance may, on further investigation, be found to be serious and vice versa. As a guide, any incident involving the actual or potential loss of personal information that could lead to identity fraud or have other significant impact on individuals should be considered as serious.

#### **Immediate response to Serious Untoward Incident**

The Trust should have robust policies in place to ensure that appropriate senior staff are notified immediately of all incidents involving data loss or breaches of confidentiality.

Where incidents occur out of hours, the Trust should have arrangements in place to ensure on-call Directors or other nominated individuals are informed of the incident and take action to inform the appropriate contacts.

#### **Assessing the Severity of the Incident**

The immediate response to the incident and the escalation process for reporting and investigating this will vary according to the severity of the incident.

Risk assessment methods commonly categorise incidents according to the likely consequences, with the most serious being categorised as a 5, e.g. an incident should be categorised at the highest level that applies when considering the characteristics and risks of the incident.

0	1	2	3	4	5
No significant reflection on any individual or body Media interest very unlikely	Damage to an individual's reputation. Possible media interest, e.g. celebrity	Damage to a team's reputation. Some local media interest that may not go public	Damage to a services reputation/ Low key local media coverage.	Damage to an organisation's reputation/ Local media coverage.	Damage to NHS reputation/ National media coverage.



	involved				
Minor breach of confidentiality. Only a single individual affected	Potentially serious breach. Less than 5 people affected or risk assessed as low, e.g. files were encrypted	Serious potential breach & risk assessed high e.g. unencrypted clinical records lost. Up to 20 people affected	Serious breach of confidentiality e.g. up to 100 people affected	Serious breach with either particular sensitivity e.g. sexual health details, or up to 1000 people affected	Serious breach with potential for ID theft or over 1000 people affected

### Reporting to SHA

The Trust should report the SUI, i.e. all incidents rated as 1 – 5, to the SHA through the usual SUI process. The following information should be provided in each case:

- A short description of what happened, including the actions taken and whether the incident has been resolved
- Details of how the information was held: paper, memory stick, disc, laptop etc
- Details of any safeguards such as encryption that would mitigate risk
- Details of the number of individuals whose information is at risk
- Details of the type of information: demographic, clinical, bank details etc
- Whether a) the individuals concerned have been informed, b) a decision has been taken not to inform or c) this has not yet been decided
- Whether a) the Information Commissioner has been informed, b) a decision has been taken not to inform or c) this has not yet been decided
- Whether the SUI is in the public domain and the extent of any media interest and/or publication

Reporting to the SHA should be undertaken as soon as practically possible (and no later than 24 hours of the incident during the working week).

If there is any doubt as to whether or not an incident meets the SUI reporting criteria, the Trusts' Risk Manager or the SHA should be contacted by telephone for advice. Early information, no matter how brief, is better than full information that is too late.

The Trust should keep the SHA informed of any significant developments in internal/external investigations, as appropriate. The SHA should continue to keep a watching brief on developments including following up further details/outcomes of the incident.

The Trust's communications team should contact the SHA's Communications team immediately if there is the possibility of adverse media coverage in order to agree a media handling strategy. Where necessary, the SHA Communications team will brief the Department of Health Media Centre.

### **Reporting to the Department of Health**

The SHA will be responsible for notifying the DH of any category 3-5 incident reported by forwarding details to the appropriate dedicated mailbox established within the DH. Incidents should be notified to DH comms only if only the lighter shaded risk areas in the top two rows in the table apply and to both DH Comms and the Ministerial Briefing Unit if the significant risks in the darker shaded area at the bottom right of the table apply. This latter, most serious category is the one that should be referenced as a nationally reported SUI. Those reported to DH Comms alone should be referred to as a comms alert derived from a local SUI. Once an incident has been reported to DH any subsequent details that emerge relating to the investigation and resolution of the incident should also be supplied.

The DH will review the incident and determine the need to brief Ministers and/or take other action at a national level.

### **Reporting to the Information Commissioner or other Bodies.**

The Information Commissioner should be informed of all Category 3-5 incidents. The decision to inform any other bodies will also be taken, dependent upon the circumstances of the incident, e.g. where this involves risks to the personal safety of patients, the National Patient Safety Agency (NPSA) may also need to be informed.

It is the responsibility of Trust/PCO's to inform the Information Commissioner of information breaches category 3-5. **See section 8**

The Information Commissioner may liaise with the SHA or Trusts as part of the investigation in relation to data protection breaches once they have been informed

### **Informing Patients**

Consideration should always be given to informing patients when person identifiable information about them has been lost or inappropriately placed in the public domain. Where there is any risk of identity theft it is strongly recommended that this done. The principle of '*being open*' should be used.

### **Monitoring of this policy**

The SHA is responsible for overseeing all serious untoward incidents in the region. Reports will be produced to share lessons and monitor trends