Name of Local Supervising Authority:
Western Isles Health Board

Period of report:
2005/2006

Date:
September 2006

1. Supervision of Midwives and Midwifery Practice

1.1 Designated Local Supervising Authority Midwifery Officer:
Mrs Brenda E Thorpe

1.2 Number of Supervisors of Midwives:
Two + one link Supervisor of Midwives

1.3

Names of Supervisors of Midwives	Date of appointment	Number of midwives supervised
Catherine Hughson	2000	18
Kathryn Kearney	2004	17
Karen King	**2005**	**3**
Overall ratio of supervisors to midwives	**1:16.5**	

1.4 Number of supervisors relinquishing role since last report: **0**

1.5 Number of new supervisors appointed since last report: **0**

1.6 Number of complaints regarding the discharge of the supervisory function: **0**

1.7 Number of local supervising authority investigations: **0**

1.8 Number of midwives undergoing supervised practice: **0**

1.9 How a midwife accesses a supervisor:
Through a 24 hour on-call rota:

- Directly (copies of the rota are held in all wards and departments)

All have contact numbers for their named supervisor of midwives.

1.10 How practice is supervised:

- In clinical practice by working alongside midwives.
- Through case review.
- Supervision review can include reflection on cases.
- Supervision review linked to professional development plans for midwives.

2. Continuing education and professional development of midwives

2.1 Identifying and meeting continuing education and development needs of individual midwives

Each midwife is offered an annual supervisory review when educational, personal and professional development needs are discussed. Midwives are asked to benchmark their skills against the competencies set by the Nursing and Midwifery Council (2000) and the Expert Group on Acute Maternity Services (EGAMS) Report (SEHD, 2002).

Each midwife has access to a range of "in-house" training sessions on obstetric, adult and neonatal emergencies, child protection and breastfeeding. The plan is to train generic trainers to deliver locally the Scottish Multi-Disciplinary Maternity Development Programme (SMMDP) modules as they become available. There are also opportunities for self directed learning, all midwives have access to local NHS libraries, the internet and the national e-library.

The SMMDP provides courses specific to maternity care, which will soon be made available to all maternity care professionals. This supports health care professionals in attaining and maintaining the competencies identified in the Expert Group on Acute Maternity Services Report (SEHD, 2003).

Individual midwives develop their practice to meet the needs of their client group, e.g. aquanatal, baby massage, smoking cessation, early pregnancy problems and newborn hearing screening.

All NHS Western Isles staff are required to attend mandatory training sessions on: cardio pulmonary resuscitation, fire, moving and handling, aggression and violence and infection control.

2.2 Recording and monitoring of continuing education and development needs of individual midwives

The annual supervisory review is recorded and monitored on an annual basis. The midwife is issued with a copy of the review record and a copy is retained by the supervisor of midwives.

2.3 Links with Higher Education Institutions

Higher education links are with the University of Stirling who provide undergraduate programmes for midwives, some of whom have placements in the Western Isles. Post graduate study can be accessed from the University of Stirling or other universities according to personal choice of courses offered.

3. Midwifery practice and approaches to care

The demography and geography of the Western Isles necessitates a diversity of care delivery across the region, this is also partially dictated by issues of access and the ability to recruit and retain appropriate staff groups. The vast geographical spread, sparsely populated areas and transport infrastructures pose specific challenges for care delivery. Despite these challenges the maternity services of NHS Western Isles endeavour to meet national recommendations, provide safe woman centred care and promote evidence based midwifery practice.

3.1 Models of care

Whilst care is shared between midwives, GPs and consultant obstetricians, midwife led care has evolved from 1st of June 2006, with consultant led care for high risk cases. Midwife Led Care is for Low Risk women. Risk status is fluid and women can move between categories as pregnancy and/or labour progresses. The midwife led element of care is based on a belief that pregnancy and birth are normal physiological processes. The focus is on the promotion of normality and psychosocial support with a holistic approach to care. There is also an emphasis on the prevention of morbidity and mortality, through detection of risk factors, appropriate referral and care planning.

3.2 Pre-conception

Currently there is no formalised care provision for all women. However, consultant led clinics are provided for follow up following recurrent miscarriage, stillbirth/neonatal death and termination of pregnancy. These clinics give the opportunity for counselling and family planning advice. Women will also self refer to midwives on an ad-hoc basis for advice.

3.3 Ante-natal

Midwives provide all aspects of ante-natal care provision, i.e. screening, counselling following results, care planning, health education (group and one to one), liaison with other agencies to support social and/or special needs, referral to appropriate health professional when deviation from the normal detected. The aim is to try to ensure ante-natal care is provided as close to the women's home as possible with midwife clinics based in some localities. Midwives also support consultant led clinics and liaise closely with the consultant obstetrician to deliver the care planned for women considered to be high risk.

3.4 Intra-partum

Women are given a choice of place of delivery supported by information on each option to ensure informed decision making takes place. Exit criteria, based on those recommended by the EGAMS Report (SEHD, 2003), are used to identify those women who could "safely" deliver at home or in the community maternity unit located in Benbecula. Women's choice is supported regardless of risk status, supervisors of

midwives are instrumental in supporting midwives in advocating for women making choices considered to be high risk.

One to one care with a midwife is achieved for the majority of cases with a second midwife present at delivery.

Care for women defined as being "higher risk" is planned by the obstetrician, with care delivery shared with the midwife and obstetrician. Women with identified risk factors are advised to deliver in the consultant led unit. Risk is assessed and managed on an individual basis for women defined as "higher risk" who do not wish to deliver in the consultant led unit. Midwives have a responsibility to ensure women are supported in whatever decision they make, they are assisted in this advocacy role by their Supervisor of Midwives.

A small number of cases will require delivery in a tertiary unit, and close links have been established for referral. Care will be shared with the tertiary unit, local midwives and local obstetric team.

3.5 Post natal

Midwives provide immediate postnatal care to all women and babies regardless of type of delivery. In the postnatal period the midwives screen for any deviations from the normal, for mother and baby, and refer to the appropriate health professional. There is close liaison with other agencies to support social and/or special needs. The midwives play a key role in facilitating the transition to parenthood for both partners. Support is given for all aspects of parenting and health education, breastfeeding is promoted and supported in the units and at home. The majority of postnatal care is provided in the home.

The maternity services adhere to the principles of the UNICEF UK Baby Friendly Initiative for hospital and community. A well established breastfeeding support group is held in the maternity unit in Stornoway.

3.6 Neonatal

Care is planned by the consultant paediatrician, whilst care delivery is led by midwives in the consultant led unit. There are on-going programmes of training to support neonatal resuscitation, stabilisation and transfer of the neonate and examination of the newborn.

3.7 Health education/public health

Health and parenting education is incorporated into care throughout the maternity care episode. In addition midwives provide specific classes to meet the needs of their client group, these include; traditional parenting classes, breastfeeding workshops, aquanatal, and baby massage. Classes are provided at a variety of times to accommodate client preference.

Midwives incorporate many public health issues into day to day care, e.g. breastfeeding, smoking cessation, and diet. There is specific guidance and/or policy/strategy for the following issues; child protection, and mental health problems (including post natal depression). These topics are developed with the wider maternity care team and midwives have direct referral routes to each of the disciplines involved, e.g. social workers, health visitors, child protection officers, and community psychiatric team.

3.8 Risk assessment and management

The care midwives provide is underpinned by structures and processes that support risk assessment and management . These are detailed below.

3.8.1 Communication/information and referral networks

There are direct referral routes from midwives to all professions and disciplines involved in maternity care, sometimes referral is more appropriately made through the GP, obstetrician or paediatrician. The appropriate referral route would be decided on a case by case basis. Communication between professionals takes place either face to face, by telephone, electronically or written in letters or care planning in case records.

Clinical information is documented in the patient hand held maternity record, with the woman's consent, and the hospital obstetric record. Women may not consent to sensitive

information being documented in the hand held record, e.g. issues around domestic abuse. In those instances the information is documented separately (usually in the obstetric record) and consideration is given to the relevance of the information to the maternity care team and shared appropriately. Documentation includes care planning, identification of risk factors and progress of pregnancy. All records are stored in compliance with the Data Protection Act.

Patient information is supplied from a variety of sources and covers a comprehensive range of topics. Information is provided through discussion initially, with written materials to enhance discussions. All women are supplied with the Ready, Steady Baby book (NHS Health Scotland) which covers all aspects of health from pre-conception until five years old. Specialist information is given as appropriate, e.g. screening tests, diet, smoking cessation.

Where a woman does not speak English as her first language, staff can access interpreters from hospital practitioners or the local community who will translate on a voluntary basis. The use of friends and/or relatives is discouraged, however there is often no other option due to the remote setting.. Written materials will be accessed where possible, however supplies of written materials for the broad range of languages is limited.

3.8.2 Evidence based guidelines

Evidence based guidelines are in place for some aspects of maternity care, these can be accessed in the maternity unit, GP surgeries, and health centres. A working group has been established to develop further evidence based guidelines and review and update existing guidance.

3.8.3 Clinical Incident Reporting

Clinical incidents are kept to a minimum by effective risk assessment and management, and adherence to evidence based guidelines. NHS Western Isles operates a culture of "no blame" and when incidents do occur midwives, and other practitioners, are encouraged to report them.

3.8.4 Audit

All midwives are encouraged to participate in personal, local and national audit. Any staff wishing to undertake audit must submit a proposal to NHS Western Isles clinical

audit facilitator, who has a responsibility for monitoring quality of audit. Audit of supervisory practice is being developed and will include service users in monitoring the supervisory function.

4. Developing trends in maternity services

In view of the conclusions from the EGAMS Report ("that the current configuration of acute maternity services is no longer sustainable", 2003), over the past year NHS Western Isles maternity services have been undergoing review of sustainability. External review has been sought and a service level agreement with NHS Dumfries and Galloway has been established since August 1st 2005 to assist with the service redesign process, agreeing the strategic direction and the implementation and management of change.

In common with the rest of Scotland, in NHS Western Isles the birth rate is falling and is projected as a continuing trend (SEHD, 2001), at the same time there is increasing medical specialisation and necessary restrictions on the number of hours health professionals can work. These issues are identified as the driving forces of policy to centralise "high risk" acute obstetric and neonatal services, and develop the role of community maternity units for "low risk" cases, in Scotland. This poses particular challenges for remote and rural areas like the Western Isles. The issues are discussed under the following headings:

4.1 Recruitment and retention

The Scottish Executive Health Department published "Working for Health" the Workforce Development Action Plan for Scotland in August 2002. It recognised that workforce development was about more than just workforce planning. "It interacts with service planning and service redesign, allowing the future workforce for health to be seen dynamically, directly linked to the future shape of services, local and national employment markets, and the supply and demand that exists now and in future." In common with other Health Board areas, NHS Western Isles are working at a local and regional level to implement the detail of the national action plan.

To date NHS Western Isles has always been able to fill vacant midwifery posts, and there are midwives interested in employment. NHS Western Isles endeavour to offer midwives flexibility in terms of shift patterns, type of practice and the opportunity to cover midwifery through "crisis care".

It is recognised that the inability to recruit medical staff will have an impact on midwifery services and the appropriate training and support mechanisms must be in place to develop the workforce accordingly.

4.2 Skills maintenance

A Framework for Maternity Services in Scotland (SEHD, 2001) highlighted the problems encountered by health professionals working in remote and rural areas, a key issue being competency for practice. The low throughput of women in some areas, particularly the less populated islands, mean midwives are using their skills infrequently. NHS Western Isles have responded to this by:

- implementing "in house" training and fire drills for emergency situations
- ensuring all midwives have access to guidance that uses the best available evidence

- facilitating placements to update clinical skills

4.3 Clinical trends

The recent publication "NHS Board Variations in Maternity Care and Outcomes" from NHS Scotland Information and Statistics Division (SEHD, 2005) enabled NHS Western Isles to identify trends in clinical outcomes and areas for improvement. The data presented in the report covered the time period from 1990 to 2002. The caesarean section rate for NHS Western Isles, in common with other NHS Board areas, is rising, reported figures show a rate of 20%. The rates of induction of labour are equally increasing, with the rate quoted at 32% (Scottish average rate 27%), it is however noted that this may be due to inaccuracies in coding. The rate of spontaneous vaginal deliveries whilst decreasing remains one of the highest in Scotland at 70%. This information on clinical trends will be used to inform the on-going service redesign process.

5. Midwifery services organisation and management

5.1 Configuration of units

LOCATION **Consultant led unit Stornoway**	**AVAILABLE BEDS**
Labour beds	2
Ante and post natal beds	12
Neonatal facility	2 incubator spaces for stabilisation and transfer
Community maternity unit Benbecula	2 plus separate neonatal area for resuscitation, stabilisation and transfer

5.2 Annual births

	Number	%
Total births per annum	**222**	
Home births	6	
Births in consultant led unit Stornoway	179	80.6%
Births "off island"	33	14.86%
Births in community maternity unit Benbecula	5	2.25%
Births in transit	0	0%
Multiple births	3	1.35%

5.3 Specification of births in Western Isles

Calculated from 190 actual deliveries

% rate of spontaneous vaginal birth	63.15%
% rate of ventouse delivery	3.15%
% rate of forceps delivery	2.10%
% total rate instrumental delivery	5.26%
% rate of elective caesarean section	12.63%
% rate of emergency caesarean section	13.15%

% total rate caesarean section	25.78%
% rate of induction of labour	36.84%

5.3 Proposed changes and developments

Service redesign is currently being considered and an action plan will be developed to make the changes required to sustain services locally.

NHS Western Isles will be implementing the use of the national Scottish Woman-Held Maternity Record (SWHMR) in the coming year. There will be close liaison with QIS Scotland on progress towards the electronic version of the record to ensure NHS Western Isles have the capacity to implement the record electronically as soon as it comes on line.

NHS Western Isles are working towards achievement of the NHS QIS Clinical Standards for Maternity Services, assessment has taken place in December 2005.

6. Action plan

Priorities for Supervision for next two year period	Timeframe
Identify service users to be involved in developing local guidelines and standards and monitoring of the supervisory function	August 2007
Review and update local Guidelines and Standards for Supervision.	April 2007
Audit Standards for Supervision locally.	February 2007
Develop the Supervisor of Midwives role in risk management case review.	Ongoing
Carry out awareness raising sessions about statutory supervision of midwives.	March 2007
Identify potential midwives to undertake the preparation of supervisors course and appoint a further supervisor of midwives to reduce supervisor to midwife ratios and reduce on call commitment.	January 2007

Continue to monitor service provision, and develop midwifery practice to meet changing needs and ensure sustainability.	Ongoing

References

NHS Quality Improvement Scotland (QIS), 2004. *Routine Examination of the Newborn Best Practice Statement.*

NHS QIS, 2005. *Clinical Standards, Maternity Services.*

Scottish Executive Health Department (SEHD), 2001. *A Framework for Maternity Services in Scotland.*

SEHD, 2003. *Implementing A Framework for Maternity Services in Scotland. Overview Report of the Expert Group on Acute Maternity Services.*

SEHD, 2005. *"NHS Boards Variations in Maternity Care and Outcomes".* NHS Scotland Information and Statistics Division.

SEHD, 2002. *Working for Health The Workforce Development Action Plan for NHS Scotland.*